Health Care Cost Transparency Board meeting

Washington State Health Care Authority

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

February 15, 2023
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

February 15, 2023
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Jodi Joyce	☐	Carol Wilmes
☐	Eileen Cody	☐	Molly Nollette	☐	Edwin Wong
☐	Lois C. Cook	☐	Mark Siegel		
☐	Bianca Frogner	☐	Margaret Stanley		
☐	Leah Hole-Marshall	☐	Kim Wallace		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, new member introduction, roll call	1	Sue Birch, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of December meeting summary	2	AnnaLisa Gellermann Cost Board Dir., Health Care Authority
2:10– 2:20 (10 min)	HCCTB's Analysis of Cascade Select Public Option: Planning for the Legislative Report	3	Mandy Weeks-Green Laura Kate Zaichkin
2:20– 2:50 (30 min)	Primary Care Committee Recommendation- Primary Care Definition **Discussion and Vote**	4	Dr. Emily Transue Associate Medical Dir., Health Care Authority
2:50 – 3:05 (15 min)	Public comment		Sue Birch Health Care Authority
3:05 – 3:30 (25 min)	Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark **Discussion and Vote**	5	January Angeles Bailit Health
3:30– 3:55 (25 min)	Washington's Cost Growth Driver Analysis: **Discussion**	6	January Angeles Bailit Health
4:00	Adjourn		Sue Birch, Director

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Tab 2

Washington State Health Care Authority

Health Care Cost Transparency Board meeting summary

December 14, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, Chair
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Jodi Joyce
Molly Nolette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Mark Siegel

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

Chair Birch called the meeting to order and reviewed the agenda.

Approval of November meeting summary

The Board approved the Meeting Summary from the November 2022 meeting.

Topics for Today

The main topic was an introduction to the 2022 Cost Growth Drivers Study.

Introduction to 2022 Cost Growth Drivers Study

Amy Kinner, OnPoint
Amy Kinner presented an overview of OnPoint's study of cost growth drivers. The study looked at cost trends and drivers of cost growth in the health care system by market, geography, health conditions and other demographics, and examined potential unintended consequences to inform the Board on how to curb spending growth.

Topics covered in the presentation included: changes in insurance enrollment over the last five years, changes in spending on a total and per-member basis, spending changes for different products (commercial, Medicaid, Medicare Advantage), spending variation by category of service (inpatient, outpatient, professional, primary care, and specialty care), variation by region, variation by age and gender, and how high-cost members impact spending. In quarter one of 2023, OnPoint will begin to examine chronic conditions.

The presentation began with a summary of methods used. There were five years of data, from 2017 through 2021, to align with the cost-benchmarking period. Products analyzed included commercial (limited data from self-insured plans), Medicaid (managed care only), Medicare Fee-For-Service (FFS) (only available through 2019), Medicare Advantage (MA)(covered by commercial plans), Public Employees Benefits Board (PEBB) (commercial and MA), Washington Health Benefit Exchange (HBE) (commercial), and dual-eligibles (not broken out separately due to missing FFS data beyond 2019). Categories of service are aligned with the benchmarking initiative and include hospital inpatient, hospital outpatient, a narrow definition of primary care providers, non-primary care specialty providers, other providers like physician assistants (PAs) and nurse practitioners (NPs), etc., long-term care, retail pharmacy, and all other spending (ambulances, durable medical equipment, etc.).

Board member Kim Wallace asked whether data will be broken out for PAs and NPs functioning as primary care providers. Would any service provided by these groups be referenced under the "other" category? Amy Kinner clarified that the Office of Financial Management (OFM) definition allocates a certain percentage of care based on survey data. There are some PAs and NPs included. The narrow definition requires that they be a Primary Care Provider (PCP) and that the provider bills something as primary care. The OFM workgroup developed a list of codes. There is a new definition coming out. Kim Wallace noted that for the large bucket of "other" those people typically act as a PCP providing primary care. Vishal Chaudhry clarified that OnPoint is using the same definition of primary care that OFM reported on in 2019. The Advisory Committee on Primary Care is working to refine the definition and conduct primary care spending analysis. These categories are in the context of what has been done in the broader spending analysis.

The following are limitations of the study: lack of data for self-insured individuals, no Alternative Payment Model (APM) data, no uninsured data, no Medicare Fee-for-Service (FFS) data, and no Medicaid FFS data. Long-term care data for Medicaid is not reported but is a significant contributor to spending.

Chair Sue Birch asked what percentage of the population is represented by the good/available data OnPoint has? Amy Kinner clarified that the All-Payer Claims Database (APCD) data represent about 4 out of 7 million (the total state population). Between 2017 and 2021, enrollment increased from 3.5 to 4 million (not including Medicare FFS). There would have been an even greater increase if Medicare FFS had been included - about 500,000. There isn't data for the full 12 months for every enrollee and there are changes between insurance types. In this study, six months is half a person, and a whole year is a full person – this is average membership - member months of eligibility divided by 12. The study looked at population growth compared to membership growth. Population growth was relatively stable around 1.6 percent, with a marked shift in membership in 2020, almost 6.3 percent.

The next slides showed enrollment by product: Medicare FFS (only 2017 and 2019), with all other products ranging from 2017 through 2021. There was significant growth in Medicaid, from 1.5 million to 1.7 million. Commercial remained steady. Nationwide, MA plans became more popular due to higher marketing. Medicaid lost membership in 2018 and 2019 and then increased during the COVID-19 emergency. The COVID-19 emergency also prompted some growth in the HBE population.

The next slide showed changes in total medical expenditures, claims, in billions. Medicare FFS was broken out separately and stayed stable. There was high growth in expenditures for other plans.

For spending by categories of care, inpatient was the highest category of spending in 2017 and continued to be highest in 2021 with outpatient catching up. There was more growth in outpatient than inpatient. There was no significant growth in primary care.

For the percent of medical spending by category between 2017 and 2021, inpatient spending decreased relative to other spending, as did specialist, long-term care, and primary care. Categories shifted relative to one another. Pharmacy claims increased from 4.6 to 6 percent for all APCD submitted data.
Board member Jodi Joyce asked how primary care was differentiated from outpatient. Amy Kinner clarified that outpatient means outpatient facility claims – bills from a facility and within those, providers. Specialists could also be billing in outpatient setting.
The next slide showed how spending changed on a per member per month (PMPM) basis. The PMPM calculation is total expenditures divided by member months in a group. PMPMs increased from $271 to $340 between 2017 and 2021. The aggregate growth was $69 per month, $800 per year, per person. There was an aggregate change of 25 percent over time – mostly focused in 2021. This includes commercial, Medicaid, Medicare Advantage (as a combined rate across all products) and does not include Medicare FFS. Pharmacy PMPMs showed the same aggregate percent increase of 25 percent over 5 years with an increase of $21 per month. Different products experienced different growth rates, for medical only. MA has the highest PMPMs because there are higher health needs than commercial patients. There was growth across the board, but slightly lower in MA.
The next category was pharmacy spending by product (not including MA due to Part D coverage). Spending was slightly higher under the HBE. All products increased between 21 and 29 percent.
The study also analyzed PMPM by category. Most spending was on inpatient and outpatient. Other professional and other medical, while lower than inpatient and outpatient, still saw significant growth.
The next slide showed inpatient PMPM spending by product. Inpatient spending for MA was much higher than other plans. Bianca Frogner asked whether OnPoint used inpatient for PMPM when looking across all people. Does OnPoint know the percentage that had inpatient care? Amy Kinner said that OnPoint hasn't looked at that. For the study, OnPoint took the entire eligible population and summed up the total spent. People were included in the study even if they didn't have a claim for the year because it was necessary to include everyone in the denominator. Bianca Frogner asked if inpatient usage has increased over time. Amy Kinner responded that there will be more work to analyze utilization and price and how they drive PMPMs. In general, there was low growth overall, only 5 percent growth for commercial.
The next slide showed outpatient PMPM spending by product. MA grew almost 50 percent. HBE spending growth was also high, with 47 percent growth. Commercial showed steadier growth. Medicaid growth remained low. The study also analyzed changes in professional PMPM spending by product. There was high spending for specialty, especially for MA. OnPoint looked at changes in PMPMs over time from a baseline which is also how other states look at it.
The next slide showed inpatient, outpatient, and total pharmacy PMPM spending. Outpatient PMPM growth was driven by a utilization increase of 32 percent despite no pricing increases. For pharmacy, people had the same number of prescriptions, but prices increased by 25 percent. Price was more important for pharmacy than for outpatient. Inpatient saw a decrease in utilization, but an increase in average allowed amount per service. OnPoint will look more at utilization and the average allowed amount in the future.
Leah Hole-Marshall asked whether ambulatory surgical centers (ASCs) are in the "other" category." Amy Kinner affirmed that ASCs were included in other. Leah Hole-Marshall noted that it would be interesting to track ASCs along with inpatient and outpatient to see where services shift. Bianca Frogner suggested breaking outpatient out with Emergency Departments (EDs) and diagnostic labs. EDs may be important to break out given the pandemic.
Next, Amy Kinner showed OnPoint's analysis of regional variations in spending. Sue Birch asked if OnPoint can analyze outliers for consistency. Amy Kinner responded that OnPoint could do that eventually, but didn't want to include them initially, and instead wanted to show general variation by county. Medical PMPMs ranged from $150 to $1,200. Utilization is an important aspect but not fully explored yet and will be part of the next phase of analysis. PMPM spreads expenditures over the entire enrollment base. Using utilization as the denominator would be a different level of analysis. Amy Kinner reminded that this is the first phase of analysis. A county of residence is just a proxy and isn't necessarily where a service takes place. It would be helpful to look price variation by county. This

variation could be outlier patients, or health systems in places with higher pricing, or people receiving more expensive services, or risk demographic differences. There is a wide range in geographic variation in Medicaid and MA.
The next slide showed commercial medical PMPM spending by Accountable Community of Health (ACH) of patient residence. There was a significant increase in spending growth for the Southwest ACH and great variation between ACHs. There may be outlier patients, or differences in care delivery.
The next slide showed medical PMPMs by age and gender. There was higher spending for infants (high needs for newborns) and higher spending for men in every category. There was spending growth across ages for both men and women.
The next slide showed commercial PMPM spending by age from 2017 to 2021. Spending increased at every age. This analysis did not include individuals over 65 as most are covered under Medicare.
The final slide looked at the impact of high-needs members on spending growth. There will be a different strategy if most spending growth is driven by high health needs, e.g., chronic conditions. OnPoint will perform additional analysis in the future. High-cost members were defined as those with greater than $125,000 in total medical spending. High-cost members comprised less than 1 percent of membership but 15 to 21 percent of total spending. High-cost members tend to have $20,000 or more in PMPM. Cost containment needs to account for high-cost, high-health needs.

Public Comment

Emil Chang from Health Care for All Washington shared a personal experience with drug costs in the U.S. Emil was covered under an employer-sponsored silver plan and was prescribed a better prescription for diabetes, Farxiga. Emil's insurance turned down coverage after an appeal. Emil's family in Taiwan made it possible to obtain the new drug. Good Rx is $530 per month in the U.S., in Taiwan, it is $30 per month – 17 times the price for the same drug in the U.S. versus Taiwan. There are drugs manufactured in the U.S. and shipped to Taiwan which are offered at 10 to 15 times a cheaper price. In doing the benchmark work, the Board should look internationally with respect to drug pricing.
Albert Froling, from the Washington State Hospital Association (WSHA), offered comments on the data methodology used by the Board to analyze costs. There were two comparisons the Board was directed to analyze by legislative statute. One point of comparison was provider case mix, and the other was provider input prices – these comparisons haven't been analyzed yet. Some examples of provider input prices include salaries and wages. Puget Sound is one of the most competitive markets for healthcare in the state and the nation. The cost of salaries, wages, and benefits, accounts for 50 percent of hospital spending. At earlier meetings, WSHA asked the Board to use the Centers for Medicaid and Medicare (CMS) wage index to adjust for these cost differences. The OnPoint cost growth drivers study showed growth in outpatient due to utilization and transitioning patients with complex needs from inpatient to outpatient. Hospitals use EDs and ASCs to treat the most vulnerable patients, e.g., Medicaid, and these settings are the safety net for people who can't be seen elsewhere. The Board should dig into input prices. Retail pharmacy isn't contributing to medical spending, supplies, or devices.
Consuelo Echeverria requested that the Board post meeting materials in advance of meetings. AnnaLisa Gellermann responded that materials will be posted immediately after the meeting. Consuelo Echeverria asked if HCA and consultants could dig into data the way Optimus did for the Oregon Universal Task Force on administrative burdens associated with Value-Based Purchasing (VBP) and VBP contracts. That study found administrative costs of close to $1 billion. Sue Birch noted that HCA is on a journey of discovery and will take these comments and weave them into future work.

Cost Driver Discussion

Amy Kinner, OnPoint

Amy Kinner summarized the key takeaways from the OnPoint study. The insured population has grown. There have been shifts between plans driving changes in spending. It's not clear what will happen when the public health emergency (PHE) ends but there will be impacts. Total and per capita expenditures have grown. There has also been professional spending growth in mostly specialty and other categories. There are some differences in how outpatient, inpatient, and pharmacy spending growth has occurred due to pricing and utilization and variation by geography, age, and gender. Members with high-cost needs pose unique challenges. OnPoint's phase two analysis will analyze: 1) spending growth by product, region, etc. 2) the impact of chronic conditions on spending and spending growth 3) variation in spending on primary care and behavioral health across the state 4) how out-of-pocket spending has changed 5) relationships between spending and quality/access to care 6) how utilization impacts spending and 7) how price changes impact spending.

Edwin Wong noted that the outpatient category saw the most marked increases, particularly in 2021. In future calls, it would be helpful to learn more about the growth and see how certain subcategories have increased. There should be analyses to tease out increased care that occurred due to disrupted care during the pandemic. It would be helpful to know to what extent 2021 was an outlier. Amy Kinner noted that OnPoint is close to adding 2022 data. Screenings dipped in 2020 and came back in 2021 for many Healthcare Effectiveness Data and Information Set (HEDIS) measures. Edwin Wong suggested that OnPoint analyze elective surgeries that dipped in 2020.

Margaret Stanley noted that it's important to remember that some payers have fixed rates while others don't. Commercial payers enter multi-year contracts. Medicaid pays below costs and hasn't increased its rates in decades. This causes a cost-shift and inflationary pressure on other payers. Sue Birch pointed out that many articles say there isn't a cost-shift. There is more detailed information about Diagnosis Related Groups (DRGs) being reset. There was an article released today that alluded to the lack of increase in Medicaid rates in decades. Amy Kinner noted that when the PHE ends, and people move from Medicaid to commercial, there could be spending growth.

Bianca Frogner emphasized the need to further break down spending in the outpatient setting. It would be helpful to break out labs for cost and utilization. It would also be helpful to analyze community health centers (CHCs), because CHCs change in a different way due to reliance on Medicaid and uninsured individuals. Amy Kinner clarified that it would be possible to further analyze outpatient spending to see what procedures and areas are driving change.

Kim Wallace noted that it was encouraging to see that the phase two analysis would include aspects of quality and access. What are the Board's plans to capture access, quality, and health? Amy Kinner noted that for phase two, OnPoint will provide data that relates to HEDIS measures e.g., well-child, breast cancer screening, etc., showing primary or basic care as well as all plan-cause readmissions. There are 8 or 9 measures that will be analyzed by geography, relationship to total cost, relationship to percent primary care spending, and relationship to percent spent on behavioral health care. The data has been built but not analyzed or visualized.

Leah Hole-Marshall noted that there are existing sources to examine the alleged cost-shift theory. The National Academy for State Health Policy (NASHP) has done work on break-even rates and Research and Development (RAND) studies address hospital specific costs.

Sue Birch asked how Washington compares to other states in cost containment work. Amy Kinner noted that the pattern of growth in inpatient spending showing less growth than outpatient is evident in other states. Commercial PMPM rates, Medicaid, and Medicare FFS are lower in Washington compared to other places.

Kim Wallace asked about when someone resides in a county, e.g., rural in Eastern Washington and receives intense high-cost care in Seattle, whether that cost is assigned to their county of residence, or King County. Amy Kinner clarified that the cost was assigned to the patient's county of residence. OnPoint could look at costs of specific surgeries in different areas. Kim Wallace noted that there is significant price variation across the state. A $20,000 procedure or episode of care may be twice that in another area. What is known about the variation? Is that next? Amy Kinner agreed that this would be a great next step. Vishal Chaudhry noted that provider pricing analysis hasn't been reached. The APCD will be only one source. HCA is analyzing the factors that contribute to health care expenditures. Right now, it's purely claims-based and a passive analysis.

Lois Cook asked about the large increase in the number of insured individuals in 2020. Sue Birch clarified that there was a federal requirement that all those that came onto Medicaid during the PHE stay enrolled. There will be disruption after the unwinding of the PHE. Vishal Chaudhry noted that all data provided today was sourced from the APCD. The APCD doesn't have self-funded insurance plans. Many people who lost jobs at the beginning of the pandemic would have been self-insured. HCA has retained Medicaid coverage for everyone, which has inflated the number of enrollees in the APCD. Lois Cook asked how many are covered by private insurers that aren't covered. Vishal Chaudhry responded that there are estimates, somewhere in the 2 to 3 million figures. Sue Birch noted that the Washington Health Alliance has self-insured data. There may be a true-up occurring from Milliman which the Board can look at in the future. There is a recent Health Affairs article titled, "National Health Care Spending in 2021: Decline in Federal Spending Outweighs Greater Use of Health Care." Healthcare spending in the U.S. grew 2.7 percent to reach $4.3 trillion in 2021 at a much slower rate than the increase of 10.3 percent seen in 2020. Slower spending growth was driven by a 3.5 percent decline in federal spending for healthcare after a spike in 2020, largely in response to the pandemic. The share of the economy for healthcare fell from 19.7 percent to 18.3 percent in 2021, which was still higher than the 17.6 percent share in 2019.
Edwin Wong noted the lack of FFS data in the presentation. Amy Kinner responded that there isn't a definite timeline for when this would be included in the APCD, but hopefully within the next 6 months.
Bianca Frogner noted that one of the public comments was around adjustments that account for the wage index. There is some concern that wage inputs have had a higher impact. The wage index isn't updated for 2017 to 2021. Due to lag time in data acquisition, available data couldn't capture what WSHA is concerned about e.g., high contracting costs. Data wouldn't reflect current or more recent year changes in wages or contracting costs. It is difficult to disentangle the hourly wage rate from contracting costs. It's also difficult to find contracting costs using public sources.

Adjournment
Sue Birch adjourned the meeting at 3:40 p.m.

Next meeting
February 15, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Tab 3

Washington State Health Care Authority

HCCTB's Analysis of Cascade Select Public Option: Planning for the Legislative Report

Washington State Health Care Authority

Increasing affordability of standardized plans on the individual market

The Legislature required three analyses:

- HBE must analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability.
- The HCCTB must report on the effect on consumers of enrollment in the public option.
- HBE will provide recommendations to the legislature based on both analyses.
  - HBE's final recommendations are due Dec. 1, 2023.

HCCTB's report

- The HCCTB report will analyze the effect that enrollment in public option plans has had on consumers enrolled in public option plans, including:
  - Benefits
  - Premiums paid
  - Cost-sharing amounts paid
- The HCCTB report will **not** include
  - General recommendations on the public option.
  - Recommendations on procurement or standard plan design.

Strategy and approach to the report

- **Step 1: Identifying the questions and the data**
  - Cascade Select staff (HCA and HBE) will review available potential data and methodologies for the analysis.
  - Email survey will be sent to Board members to identify areas of interest and questions for the analysis.
- **Step 2: Gathering data and initial analysis**
  - HCA and HBE will review board member surveys, gather data , and perform initial analyses
  - June HCCTB Meeting: Initial analyses presented with a request for your review and feedback.
- **Step 3: Finalizing the report**
  - July HTCCB Meeting: Final report presented

Anticipated Data & Analysis

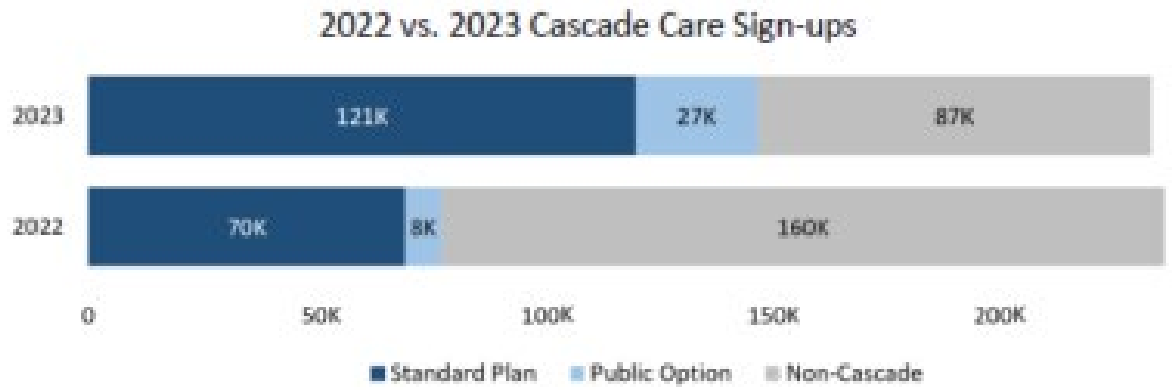
Board analysis must include review of the benefits provided to, and premiums and cost sharing amounts paid by, consumers enrolled in public option plans compared to other QHPs.

Analysis is expected to include:

- Cascade Select premiums 2021-2023
- Cascade Care plan design and cost sharing, compared to top non-Cascade plans on Exchange, 2021-2023
- Description of Cascade Select quality and value contractual requirements, and aggregate results
- Cascade Select enrollment 2021-2023
- Cascade Select availability 2021-2023

QHP Gross Premiums 2023

Plan Category	Average Rate Change	2022 Average Rate	2023 Average Rate
Non-Cascade	+10%	$426	$470
Standard	+3%	$476	$490
Public Option	-3%	$421	$408



CASCADE CARE

Mandy Weeks-Green, HCA
Coverage and Market Strategies Manager

Laura Kate Zaichkin, HBE
Senior Policy Advisor

Visit the HCA Cascade Select webpage
hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option

Washington State Health Care Authority

Tab 4

Washington State Health Care Authority

Primary Care Transformation Model update and primary care definition recommendation

Dr. Judy Zerzan-Thul, Chief Medical Officer

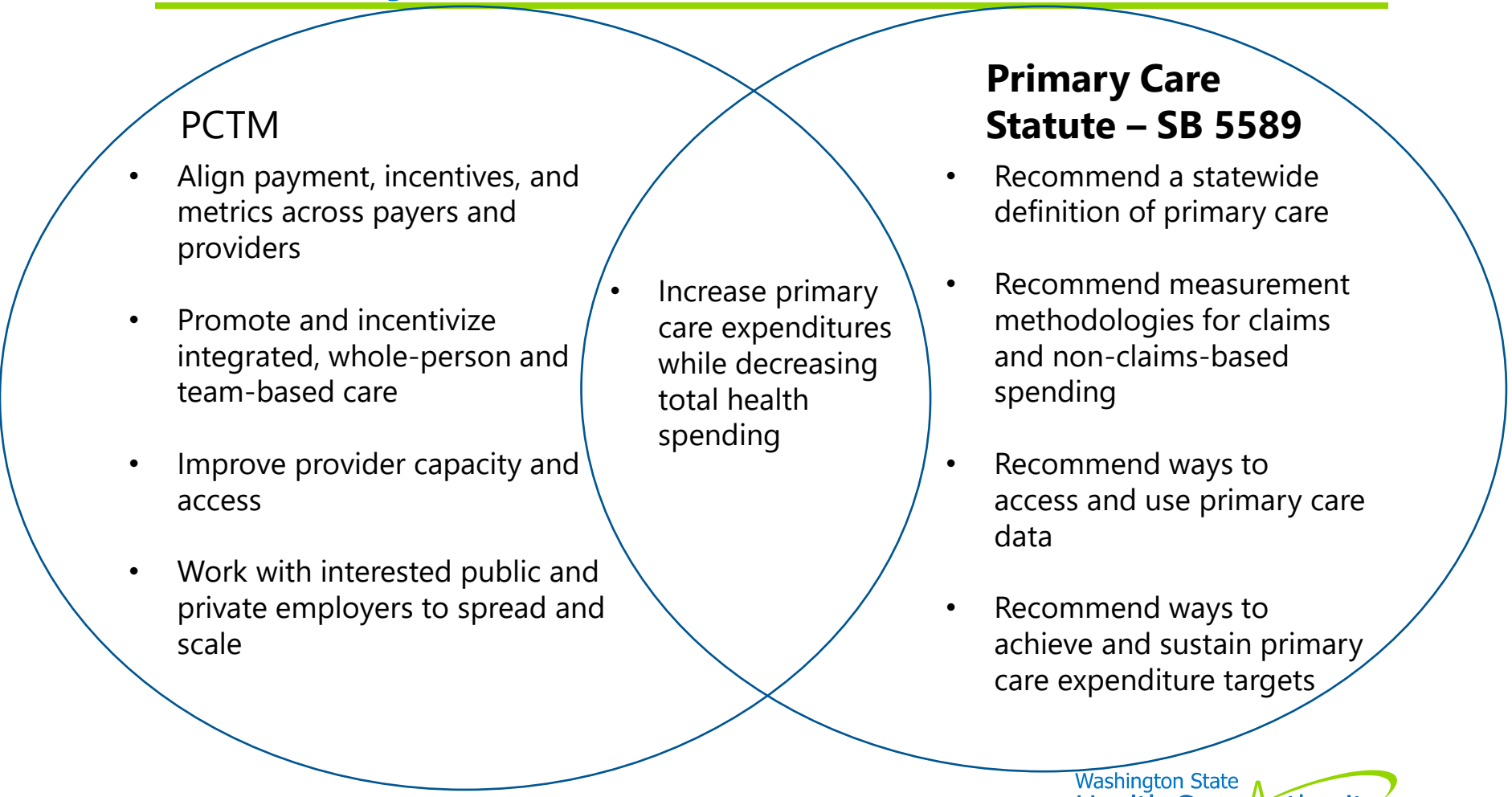
Washington State Health Care Authority

Washington State Health Care Authority

Primary Care Transformation Model (PCTM)

- Multistakeholder approach started in 2019 with goal to align quality and payment
- Conversation continues with
  - Payers
  - Purchasers
  - Providers
- PCTM was one of the solutions collectively developed to improve and support primary care
- HCA has a role, but not the only one

PCTM and Advisory Committee on Primary Care (Board assignment 5589)



5589 related primary care recommendations

- **1) Recommend a definition of primary care**
- **2) Recommend measurement methodologies to assess claims-based spending**
- 3) Recommend measurement methodology to assess non-claims-based spending
- 4) Report on barriers to access and use of primary care data and how to overcome them

Progress update

- Advisory Committee on Primary Care heard presentations on claims-based measurement methodologies at its October and November meetings
  - October 25, 2022
  - November 21, 2022
- Discussed provider codes to include in claims-based measurement at January 31 meeting
- Proposing final definition to the Health Care Cost Transparency Board at February 15 meeting

Primary care definition

- **"Team -based** care led by an **accountable** primary care clinician that serves as a person's source of **primary contact** with the larger healthcare system. Primary care includes a **comprehensive** array of **equitable**, **evidence-informed** services to create and maintain a **continuous** relationship over time. This array of services is **coordinated** by the accountable primary care clinician but may exist in multiple care settings or be delivered in a variety of modes."

Feedback received on definition

- Clarification requested for how the definition will be codified
- Clarification requested for reconciling different reporting requirements
- Clarification requested for connection between definition and measurement
- Proposal to add emphasis on SDOH

Final proposal

- The definition will serve as the Board's guide for measurement but will not be codified as a statute
  - Already have PC definition in statue
  - No change to current operations
- Claims-based measurement will be conducted in a manner similar to OFM's proposed methodology
  - Will preserve narrow and broad definitions of claims-based payments
- The definition's reference to equity helps address SDOH considerations
  - Non-claims-based measurement could also address SDOH

Public comment

Washington State Health Care Authority

Tab 5

Washington State Health Care Authority

Inflation's Impact on Health Care Spending and Implications for the Cost Growth Benchmark

Washington State Health Care Authority

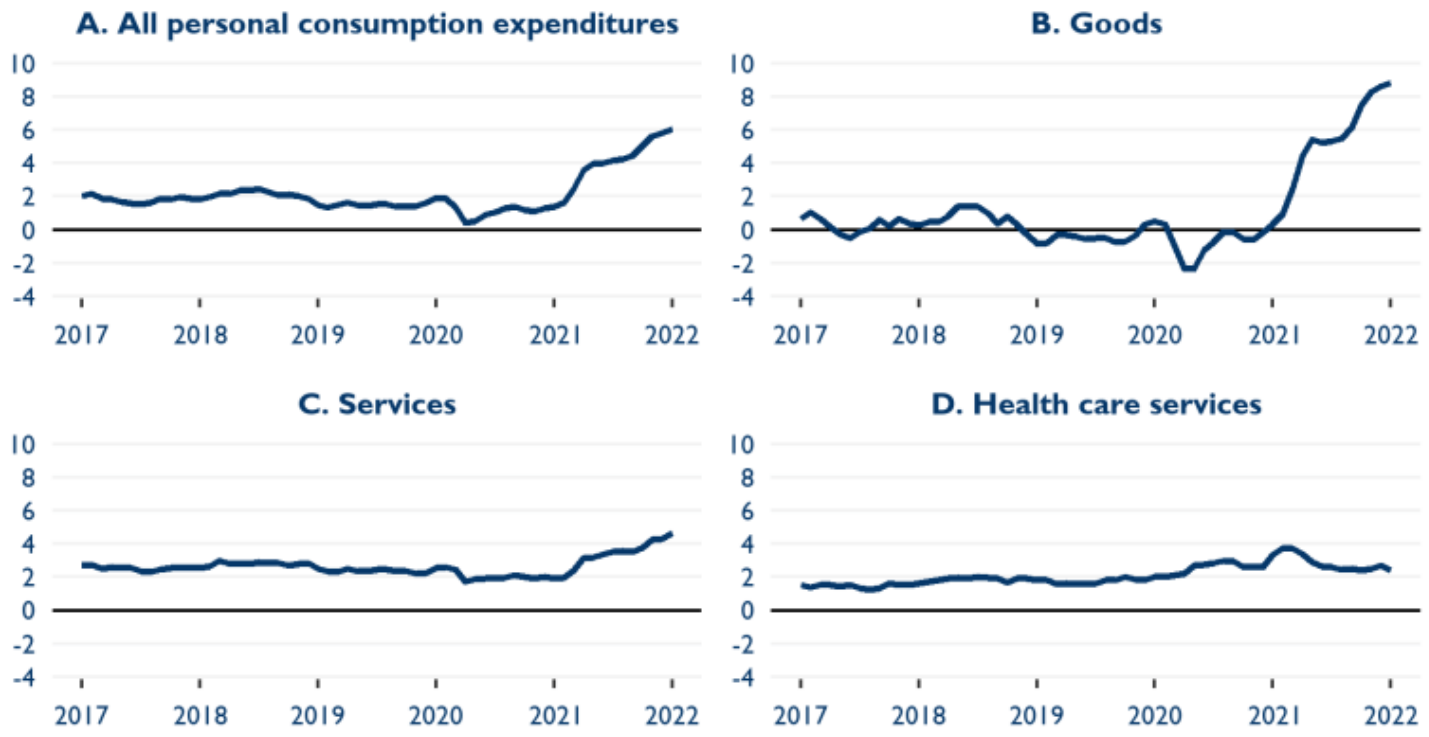
Recap of Inflation's Impact on Health Care Spending

- Research has shown that increases in health care inflation have an upward impact on health care spending.
- The impact is lagged because when prices rise in the general economy the rise does not impact health care prices right away.
  - Medicare prices for most services are updated annually based on projected growth in input costs.
    - The updates for 2021 and 2022 were finalized when expected inflation was still relatively low.
    - Medicare prices for physician services are not updated to reflect input cost changes.
  - Commercial prices are often defined within multi-year contracts.
  - Medicaid prices change infrequently and are not specifically linked to input costs.

Recent Growth in Inflation, Goods and Services, and Health Care Services (1 of 2)

Figure 1. Inflation by Product Type, Jan. 2017-Jan. 2022

Year-over-year percent change



Source: Bureau of Economic Analysis, personal consumption expenditure price indices; author's calculations.

- While prices of goods and services increased significantly in 2021, health care inflation was constant.
- This is consistent with research literature that finds macroeconomic changes affect health care spending on a lagged basis.

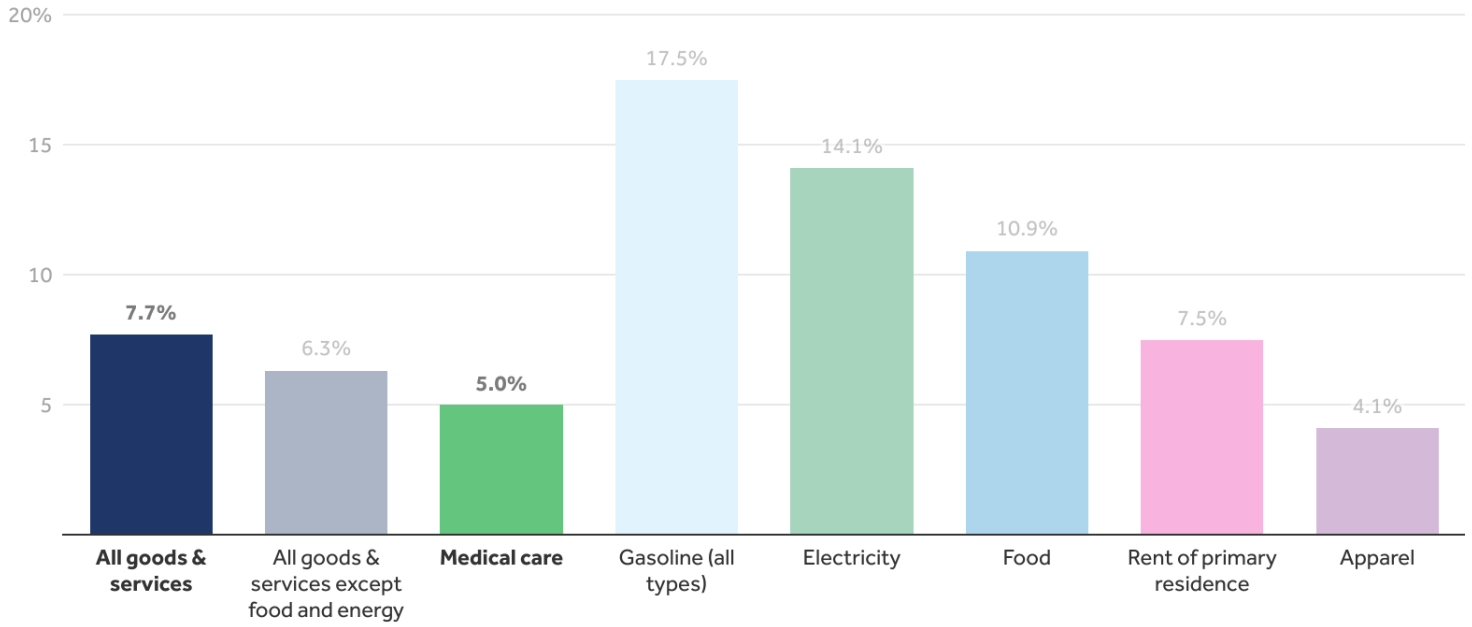
USC Schaeffer

BROOKINGS

Washington State Health Care Authority

Recent Growth in Inflation, Goods and Services, and Health Care Services (2 of 2)

Change in Consumer Price Index for All Urban Consumers (CPI-U), October 2021 - October 2022



Note: Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF Analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF Health System Tracker

- Medical prices increased slower than prices for other consumer goods and services in 2022.

Washington State Health Care Authority

Economic Indicators Used by the Peterson-Milbank States

- All six Peterson-Milbank cost growth target states have based target values on economic indicators that are affected by inflation.

State	Target Methodology
CT	80/20 blend of forecasted median income and PGSP with add-on factors
NJ	75/25 blend of median projected household income and PGSP with add on factors
NV	Changing blend of forecasted median wage and PGSP, with increasing weight on forecasted median wage over time

State	Target Methodology
OR	Historical GSP, median wage and the growth cap in the state's Medicaid and publicly purchased programs
RI	PGSP for 2019-22; For 2023-27, 25/75 blend of median projected household income and PGSP, with adjustment for inflation in 2023-25
WA	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024

Accounting for Inflation and Increased Labor Costs When Assessing Benchmark Performance

- For a limited time, states need to consider whether to allow for performance to exceed the cost growth benchmark due to inflation and/or increased labor costs.
- Making such adjustments does not necessarily mean restating the benchmark. Rather, a state could create a temporary allowance when assessing performance against the benchmark.

Considerations for Determining Whether to Create an Allowance

Arguments for Adjusting for Inflation and/or Labor Costs

- States could lose support from providers and insurers who feel the benchmark value was set using inputs that are completely different from actual experience.
- The cost growth benchmark could be viewed as unrealistic and thus unfair, leading to lost credibility as a meaningful state policy and rejection as a benchmark for contract negotiations.

Arguments Against Adjusting for Inflation and/or Labor Costs

- The benchmark value was purposely set using a methodology intended to provide long-term stability.
- It is unlikely the benchmark value or performance against the benchmark would be adjusted if providers were posting record profits; application of any adjustments should be even.
- Any adjustment could open the door to future calls for benchmark changes.

Why Credible Cost Growth Benchmark Values Matter

"Payers routinely invoke them [cost growth benchmark values] at the negotiating table."

- Rhode Island provider chief executive (2022)

Key Policy Considerations

- How should the state balance protecting consumers who face slower income growth and a potential recession with being fair to provider organizations and insurers in light of greatly increased costs?
- What precedent will be set if the state chooses to modify cost growth benchmark values?
- On what basis should any modification be made, and for what duration?

State Responses to the Rise in Inflation

State	Decision / Status of Stakeholder Body Discussions
Connecticut	Committee held initial discussions in October. Decision coming this month.
Delaware	Discussed by Economic and Financial Advisory Council in January. No decision yet.
Massachusetts	**Adjusted 2023 target up by .5 percentage points.**
Nevada	Commission recommended **no adjustment.** Topic may be **revisited in 2023.**
New Jersey	Not yet discussed.
Oregon	Advisory Committee recommended **no adjustment** and **delaying application of accountability provisions by one year**.
Rhode Island	**Adjusted 2023-25 targets by 2.7, 1.8 and .2 percentage points, respectively.**

Discussion

- Does the Board wish to make some sort of benchmark adjustment to account for inflation?
- If so, how does the Board wish to account for inflation?
  - Adjusting the benchmark methodology or value?
  - Making an allowance when assessing performance against the benchmark
- For how long and during what time period should the adjustment apply?

Tab 6

Washington State Health Care Authority

Washington's Cost Growth Driver Analyses

Washington State Health Care Authority

Key Takeaways from Onpoint's APCD Analysis of Cost Drivers (1 of 3)

- Across all markets, per member per month (PMPM) spending for medical and pharmacy services increased by 25% between 2017 and 2021.
  - There was a dip in medical PMPM spending in 2020 likely due to less utilization in the early days of COVID.
  - Between 2020 and 2021, medical spending growth was much higher than other years.
- There were some shifts in relative spending by category.
  - Outpatient hospital, "other" professional, and "other" medical spending categories increased as a percentage of total medical expenditures.
  - Inpatient, specialist, primary care, and long-term care decreased as a percentage of total medical expenditures.

Key Takeaways from Onpoint's Analysis of Cost Drivers (2 of 3)

- Key cost drivers of commercial spending were hospital outpatient services, pharmacy, and hospital inpatient services.
  - Outpatient spending PMPM grew by **34%**, driven by a 32% increase in outpatient services per 1,000 members, while average allowed amount per service grew by only 1%.
  - Pharmacy spending PMPM increased by **24%**, primarily driven by an increase in price.
  - Inpatient spending PMPM grew by **5%**, with price increasing by **14%** and number of discharges per 1,000 members decreasing by 8%.

Key Takeaways from Onpoint's Analysis of Cost Drivers (3 of 3)

- Across all markets, there is significant variation in medical PMPM spending by Washington county.
  - Regional spending may vary due to pricing as well as the age, gender, and other population risk factors.
- Across all markets, high-cost members comprise less than 1% of the membership but account for 15%-21% of total spending.

Cost Growth Driver Analyses Findings from Other States (1 of 2)

- Connecticut's annual hospital outpatient and pharmacy growth each averaged over 7% in the commercial market between 2015 and 2019.
- Oregon's commercial cost growth from 2013 to 2019 was driven by professional services.
- Rhode Island's annual hospital outpatient trend in the commercial market averaged 5%, and pharmacy trend averaged over 6% between 2017 and 2019. Retail pharmacy was the only service category that grew in 2020.

Cost Growth Driver Analyses Findings from Other States (2 of 2)

- Washington's findings are generally consistent with other state and national findings that hospital and pharmacy services are driving overall health care spending growth.
- This suggests that Washington's Phase II cost driver analyses should focus on diving deeper into hospital and pharmacy spending increases to inform strategies to mitigate them.

Potential Phase II "Drill-Down" Analyses to Consider for Hospital Spending

- Analysis of **hospital price growth** – overall and by hospital to assess whether price increases are **concentrated** among specific facilities
- Analysis of procedure and service code **movement between inpatient and outpatient settings** to determine if inpatient procedures and services shifting to outpatient settings could be driving increases in outpatient utilization and spending.

Example of Hospital Drill-Down Analysis from Massachusetts (1 of 3)

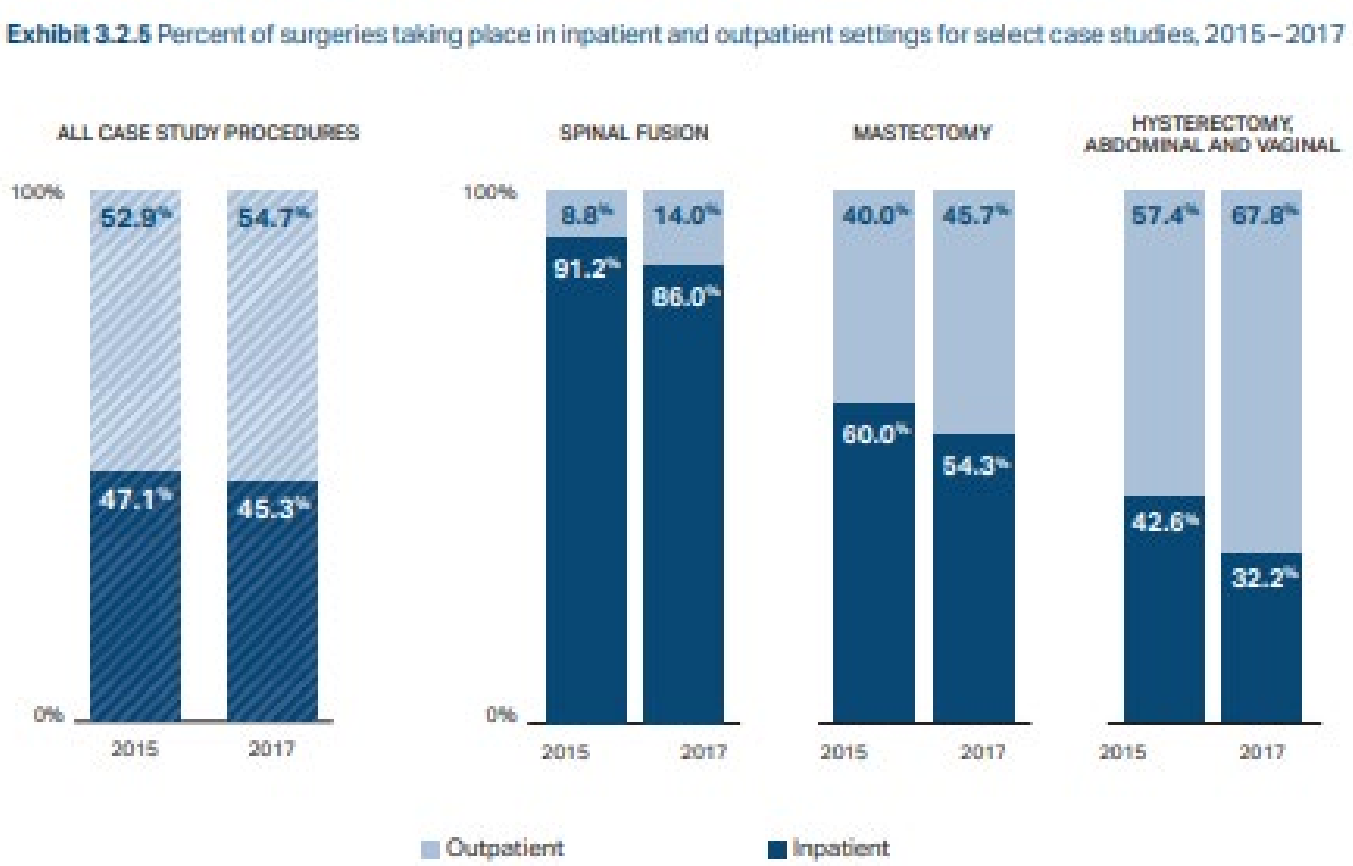
- Massachusetts looked at 11 surgical procedures that accounted for 21.3% of the overall decline in commercial inpatient admissions and 39.1% of scheduled admissions.

Exhibit 3.2.4 Number of selected commercial inpatient discharges in Massachusetts, according to major surgical procedure, 2013 and 2018

Description	2013	2018	Difference	Percent change
Hysterectomy, abdominal and vaginal	2,748	1,035	1,713	-62%
Appendectomy	2,174	1,094	1,080	-50%
Cholecystectomy and common duct exploration	2,252	1,539	713	-32%
Percutaneous transluminal coronary angioplasty	2,495	1,926	569	-23%
Other vascular catheterization, not heart	2,310	1,795	515	-22%
Other hernia repair	897	391	506	-56%
Thyroidectomy, partial or complete	636	171	465	-73%
Spinal fusion	2,885	2,628	257	-9%
Diagnostic cardiac catheterization, coronary arteriography	1,850	1,658	192	-10%
Mastectomy	666	506	160	-24%
Inguinal and femoral hernia repair	154	93	61	-40%

Example of Hospital Drill-Down Analysis from Massachusetts (2 of 3)

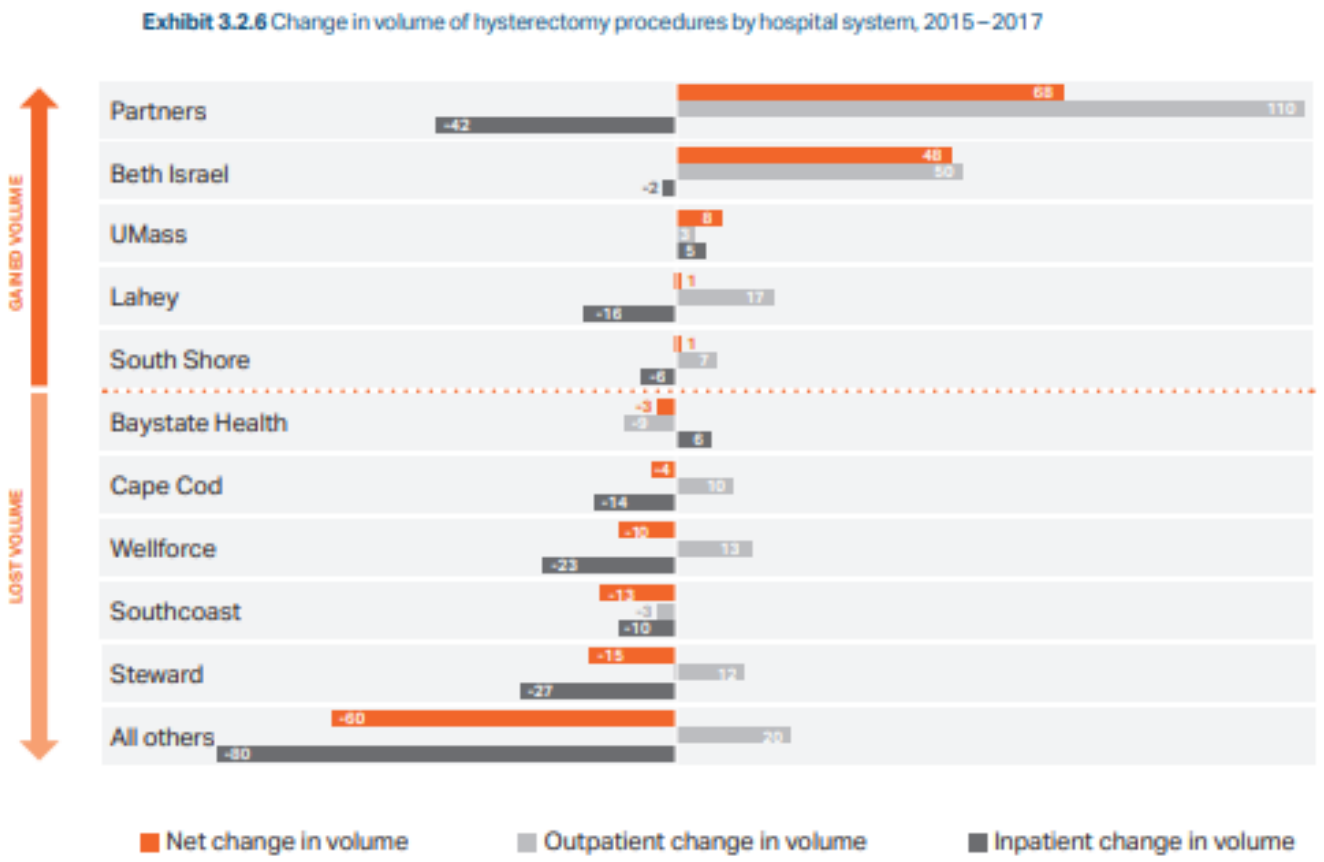
- To determine whether these declines represented shifts to the outpatient settings, the Health Policy Commission (HPC) selected three cases for further study and looked at the distribution of surgeries performed in inpatient and outpatient settings.



Washington State Health Care Authority

Example of Hospital Drill-Down Analysis from Massachusetts (3 of 3)

- The HPC further drilled down and looked at the change in the inpatient and outpatient volume by hospital system for one procedure, which showed cross-provider shifts in outpatient care.



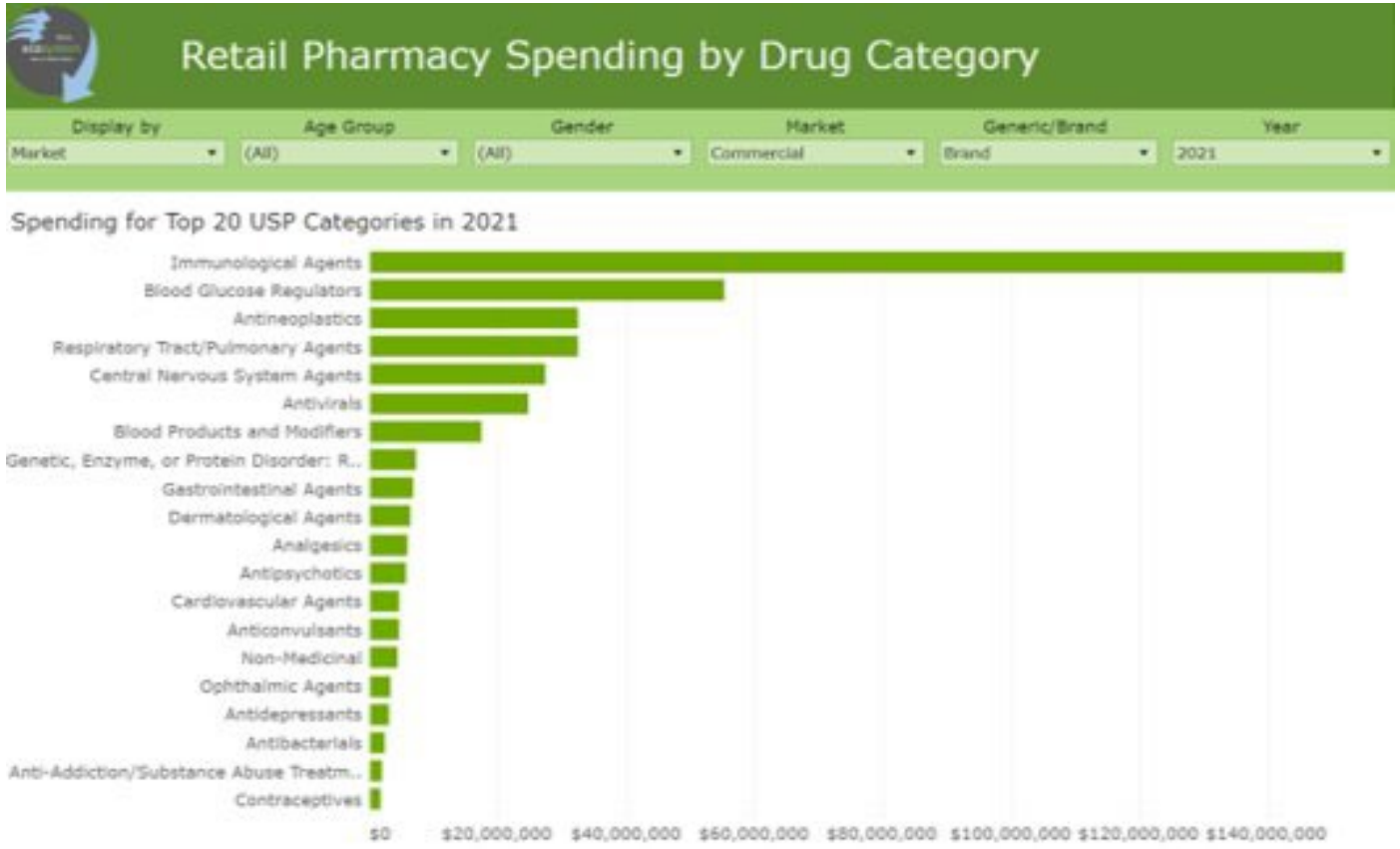
Washington State Health Care Authority

Potential Phase II "Drill-Down" Analyses to Consider for Retail Pharmacy Spending

- Analysis of retail pharmacy spending overall and broken down by generic vs. brand-name drugs:
  - Per member per month spending
  - Price per unit
  - Utilization using a standardized metric (e.g., Units per 1,000, days of therapy, 30 day equivalent)
- Analysis of retail pharmacy spending by drug class or drug category.

Example of Pharmacy Drill-Down Analysis from Rhode Island (1 of 2)

- Seven categories accounted for almost all 2021 spending.
- Spending on immunological agents was the top driver, accounting for $152m.



Washington State Health Care Authority

Example of Pharmacy Drill-Down Analysis from Rhode Island (2 of 2)

Drug	2017 PPU & units/1000		2021 PPU & units/1000		PPU Δ 2017-21	Units/K Δ 2017-21
Humira (cf) Pen	*Not on the market*		$6,801	15	20% (since 2019)	66% (since 2019)
Stelara	$10,515	2	$15,231	4	45% (11% per yr)	200%
Enbrel Sureclick	$4,472	7	$5,909	6	32% (8% per yr)	-14%
Humira Pen	$4,996	14	$6,304	3	26% (7% per yr)	-79%

What is going on here?

- Very high prices per unit for this category of drugs
- High annual price increases, especially for drugs with growing market share

For more on Humira, read "How a Drug Company $114 Billion by Gaming the U.S. Patent System", *New York Times*, January 28, 2023.

Phase II Analyses Identified by HCA and Onpoint

- Drill down further into areas of growth by product, region, etc.
- How do chronic conditions impact spending and spending growth?
- How does spending for primary care and behavioral health vary across the state?
- How has out-of-pocket spending changed?
- Are there relationships between spending and quality/access to care?
- How are utilization changes impacting spending?
- How are price changes impacting spending?

Discussion

- What types of drill-down analyses does the Board wish to prioritize for Phase 2?
  - What categories of services should HCA analyze further?
  - What types of analyses to isolate the effects of price vs. utilization does the Board wish to see?

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Washington State Health Care Authority

January 18, 2023

Dear Members of the Health Care Cost Transparency Board (Board),

On behalf of the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the Washington State Medical Group Management Association (WSMGMA), and the Association of Washington Health Plans (AWHP), we are writing to share an update on the continued impact of inflation and workforce shortages on the healthcare system, and our concerns around the inability of our members to meet the annual benchmark targets adopted by the Board.

Our associations desire to be engaged and constructive partners in your important work intended to address our joint goal of lowering the cost of providing and receiving healthcare in our state. However, as shared previously with the Board, targets were calculated and adopted before various market distortions began to severely impact healthcare delivery. As such the baseline that our members will be held to is artificially low. The aggressive benchmarks would have been a challenge under normal circumstances, but given the current environment, they will be impossible to meet in a responsible way that does not severely impact quality and access to care.

We believe that for this endeavor to be successful, the benchmarks should be *meaningful* but also *achievable* to maintain credibility and garner confidence and support from stakeholders. At current, we are being set up to fail.

While down from 7.1 percent in November, general inflation is still very high at 6.5 percent per the recently released December Inflation Report. According to McKinsey & Company, the "impact of inflation on the broader economy has driven up input costs in healthcare significantly. Moreover, the likelihood of continued labor shortages in healthcare—even as demand for services continues to rise—means that higher inflation could persist. Our latest analysis estimates that the annual US national health expenditure is likely to be $370 billion higher by 2027 due to the impact of inflation compared with prepandemic projections."

McKinsey and Company go on to explain, "the acceleration in nonlabor costs, including supplies, hit the healthcare system hard in the early stages of the COVID-19 pandemic, especially in personal protective equipment. Global bottlenecks have also created supply chain difficulties and increased costs across the economy. We expect that continued supply chain issues will push nonlabor costs above the trend we would have projected in 2019. Using consumption deflators as a proxy for how costs could rise across the system, we expect additional nonlabor costs to increase by up to $110 billion in 2027. These costs would likely become permanent."

A realistic growth target should account for inflation. If the Board continues to insist on not adjusting the benchmark to align with the reality our healthcare system is facing, our suggestion is to create an inflation add-on looking at both healthcare inflation and inflation impacting the broader economy. This would allow the Board to maintain its original growth targets but add a separate factor each year that accounts for forecasted and then actual inflation. For example, if inflation is zero the original growth target stands. If the growth target is 3.2 percent but healthcare and/or general inflation is driving up prices by 3 percent, then total allowable growth would be 6.2 percent.

We would request the Board to consider our suggestions and determine how it will account for inflation at its upcoming February meeting.

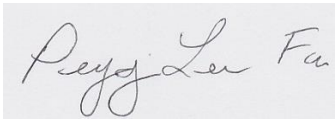
Sincerely,

Cassie Sauer
CEO
Washington State Hospital Association

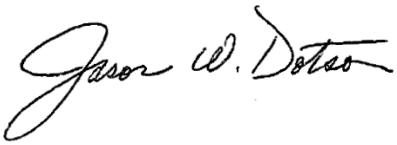
Jennifer Hanscom
CEO
Washington State Medical Association

Mike Marsh
President & CEO
Overlake Medical Center & Clinics

Mika Sinanan, MD, PhD
Past President
Washington State Medical Association



Peggi Lewis Fu
Executive Director
Association of Washington Healthcare Plans



Jason W. Dotson
President
Washington State Medical Group Management Association

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Washington State Health Care Authority

Washington State Hospital Association

Washington State Medical Association
Physician Driven, Patient Focused

December 20, 2022

Dear Members of the Health Care Cost Transparency Board (Board),

The Washington State Hospital Association (WSHA) and Washington State Medical Association (WSMA) offer these comments in response to the Board's 2022 annual report to the legislature. WSHA and WSMA support the Board as it works to address our shared goal in understanding health care spending and strategies to control the overall trend of health care cost growth in Washington State while maintaining appropriate, effective, affordable, and accessible care. In that spirit, we offer the following concerns with the information provided in the annual report and highlight critical omissions.

Health care cost growth benchmark

The annual report details the Board's milestone of establishing the health care cost growth benchmark. The cost growth benchmark has been set at an unrealistically low level, particularly in the current environment of labor and supply cost growth. It is set at a level that will be impossible for health care entities and physician practices to achieve. Setting an impossible goal prevents stakeholder buy-in around this process.

The reasons for the gap between the cost growth benchmark goal and our day-to-day reality are clear to practitioners and administrative staff who are trying to make ends meet in our highly stressed healthcare environment. Rising inflation has a huge impact on the economics of healthcare – just as experienced by the rest of our national economy. The current inflation rate is the highest in decades.

However, there is little recognition in the report about this, and particularly about the impacts of the global pandemic. The pandemic challenged our health care workforce at all levels and led to major supply chain disruptions and price increases. It also prevented routine preventive healthcare and elective surgery, which caused abrupt declines in medical group and hospital revenue.

The cost of labor has skyrocketed due to persistently high inpatient censuses across the state, amplified by the large number of traveling frontline health care professionals. These newest members of the team are costly but essential to being able to keep the doors open and providing safe and effective care to inpatients at our packed hospitals.

We have seen an increase in high-cost, high-acuity patients with delayed care during COVID who are now emerging with worsened chronic illness. We are being overwhelmed with delayed care needs, crisis levels of difficult-to-discharge patients, and ongoing nationwide labor shortages. Despite all this, we remain committed to doing all that we need to do to care for our patients and community. But it is harder, and relief is not in sight.

The baseline from which the Board worked represented an earlier, more stable time. The Board has set a cost growth benchmark of 3.2 percent for 2022 and the same or lower amounts for the next four years. As responsible members of our community, we too would like to see the trends in healthcare cost growth reduced, but the goals must be realistic. A 3.2 percent growth rate is not realistic when inflation is nearing 10 percent, salary increases for health care workers are over 10 percent, goods are scarce and more expensive, and national projections estimate health care cost growth is over 5 percent. Workforce salaries have always been the biggest single budget item for hospitals and practices, but these are increases are crushing. A 3.2 percent cap on workforce salaries is not a viable solution.

Many hospitals, health systems, and physician practices are dependent on Medicare – fixed reimbursements that do not allow them to absorb or deflect the impact of historic inflation levels. Unless Congress acts before the new year, a statutory Pay-As-You-Go (PAYGO) sequester and other Medicare payment cuts equaling 8.42 percent for physician practices will go into effect, which will have a devastating effect on our members' ability to maintain operations much less meet unrealistic spending targets.

While we have raised these concerns repeatedly, the Board continues on an unachievable path. It is setting the health care community up for failure and, it seems, justifying its position by noting that other states with healthcare cost growth benchmarks are not adjusting their targets. While we sense some openness to these realities, we were dismayed to see that the recent report to the legislature did not acknowledge the profound effects of inflation, salary wage increases, and other factors as critical context.

Despite these concerns, we believe that curbing healthcare cost growth is still a very worthwhile and important goal. We look forward to working more closely with the Board to identify areas of productive savings, from eliminating low value care to ensuring patients are treated in the most cost- effective settings. Washington can also improve prevention and mental health care and offer better public healthcare options that address social determinants of health while streamlining the low value, administrative burdens that pull clinicians away from their patients. Working with the Advisory Committee, we hope the Board will also help us avoid well-intended but flawed cost-saving options that inadvertently diminish access or curtail high-value care our communities have come to expect.

Underlying Washington State health care costs

The benchmark model is built on the experience of states such as Massachusetts where per capita health care expenditures have historically been far above the national average. That is not the case in Washington. As the Board reviews solutions, we hope it will prioritize those which fit within the context of care in Washington and start with an appreciation of the efficiencies that have already been achieved in our state.

The Board report to the legislature zeros in on hospitals and shows the price and cost of Washington hospital services are above the national average. The analysis, however, did not control for significant factors, such as Washington hospitalizes fewer people than the high-cost states, those treated in our hospitals are more severely ill, and wages for Washington health care workers are higher than average. When controlling for these factors, Washington costs are average. The consultant who provided this analysis, as detailed in the August 17 meeting minutes, advised the Board that more work needs to be done to understand hospital costs. Regardless, the legislative report included this flawed and incomplete analysis even though the Board itself had requested a revised approach.

The Board's consultant has also brought forward his experience from other states where hospital profit margins are high. Again, that is not the case in Washington where margins are low and sometimes below a sustainable level. Most Washington hospitals are having significant financial challenges due to inflation, labor shortages and wage increases. Hospitals lost $1.5 billion delivering care to patients from January to June 2022.

Adding to the complexity is the unsustainable level of Medicaid funding. Physician fee schedules are extremely low and urban hospitals have not received a Medicaid rate increase in more than 20 years. This should raise questions on how additional savings can be achieved within a hospital or at a physician practice, without addressing the larger health care context. We encourage the Board to consider how cost control efforts will impact equitable health care access for Medicaid patients, including specialty care.

Important cost drivers not discussed

In the report, hospitals receive scrutiny while major cost drivers such as pharmaceuticals are briefly mentioned. The report is silent on administrative and insurance-related cost drivers.

According to a literature review by the journal Health Affairs, administrative costs driven by regulatory and insurance requirements accounts for between 15 and 30 percent of medical spending. A review of relevant studies indicates that at least half of total administrative spending is likely ineffective, not contributing to better access or quality of patient care. If administrative spending is about 15–30 percent of national health spending, then wasteful administrative spending comprises half of that, or 7.5–15 percent of national health spending (or $285–$570 billion in 2019). Excessive regulatory and administrative requirements contribute significantly to the cost of providing care and are a major contributor to record levels of "physician burnout," increasing the number of doctors who choose to leave their practice during the current and projected health care workforce shortage.

This should be one focus of the Board to the curb cost growth that benefits our patients and our healthcare community alike. Reducing the cost of health care without addressing the system in which wasteful administrative requirements and resulting costs are perpetuated will have a devastating effect on physicians, patients, and practices. We urge the Board to account for this cost burden when making recommendations and reporting to the legislature around reducing the cost of care.

Opportunity for public comment going forward

This work is important and we are all accountable for the integrity and practical utility of our recommendations. For future reports, we request that the Advisory Committee of Health Care Providers and Carriers be given the opportunity to review the report before submission and provide feedback. This should include an Advisory Committee Comment section as discussed at the last Committee meeting on December 1, 2022, to ensure full transparency and that the report offers a balanced, comprehensive, and accurate approach to looking at cost drivers.

Thank you for your review of our comments. We would be pleased to discuss any of the issues raised here. Meaningful discussions that include different points of view strengthen the outcomes and lead to a deeper understanding of the issues. We look forward to continued engagement in this process so together we can improve the value of the health care system for Washington residents.

Sincerely,

J. Michael Marsh, President and CEO, Overlake Medical Center, Health Care Cost Transparency Board Provider Advisory Committee Member

Mika Sinanan, MD, Ph.D. General Surgeon, University of Washington Medical Center and President, Washington State Medical Association, Health Care Cost Transparency Board Provider Advisory Committee Member

Jennifer Hanscom, CEO Washington State Medical Association

Cassie Sauer, CEO, Washington State Hospital Association

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Washington State Health Care Authority

February 7, 2023

Washington State Health Care Authority
Health Care Cost Transparency Board
628 8th Ave SE
Olympia, WA 98501

Dear Members of the Health Care Cost Transparency Board,

We write to you as the patient and consumer, business, and labor union members of Fair Health Prices Washington, joining forces with one goal: to bring Washington state's health care prices under control.

For too long, we have stood by while ever-rising health care prices have caused serious harm to Washingtonians. A recent survey shows 4 out of 5 Washington respondents are worried about being able to afford health care in the future and 3 in 5 had at least one health care affordability burden in the past year. We write today to express our concern that the mission of the Health Care Cost Transparency Board (Board) is being forgotten.

In recent months, the Board has heard from health industry stakeholders encouraging you to revise the benchmark to account for inflation. But what these voices fail to say is that the high annual inflation in health care spending we are seeing now is not an anomaly. Rather, it is the pattern we have seen time and time again in our state. The Board's annual report makes this clear: from 1995 to 2014, Washington's average annual health care spending growth was 6.7%, the highest among states that have implemented a benchmark.

The Board was created to change that trend. In the first hearing for the Board's enabling legislation, former House Health Committee Chair Cody explained the need for the Board: "We are all concerned about the cost of health care and how much more can this country spend out of the gross national product? We need to get a handle on how much are we spending and how do we bring down the trend line?" At a subsequent hearing, Representative Cody stated, "the impetus for this bill is so that we actually measure how much the whole state is spending on health care and the goal being that we set a benchmark and try to stay below it, instead of having runaway health care costs."

Three years later, the Board's work is even more pressing, as Washingtonians continue to suffer from escalating health prices. Debt collectors are chasing nearly 400,000 residents for medical bills. Washington is ranked 44th worst in the country for the average cost of a hospital stay. And recent polling shows that consumers are struggling under pressure from inflation too: a record number delayed health care due to cost in 2022. Unfortunately, consumers have no choice when it comes to inflation. Washingtonians can't apply an inflation adjustment factor to their paycheck and have it automatically increase to address higher costs.

The Board is now at a critical juncture. After extensive research and careful deliberations, the Board thoughtfully established a benchmark of 3.2% benchmark for 2023. At the time, the Board recognized that the benchmark was assertive, but Board members focused on the impact of

increasing prices on consumers as the primary issue. We ask for you to remain strong in this goal now. Simply put, adding an inflation adjustment factor would defeat the purpose of setting a benchmark: to set a goal for our health system spending that responds to what our state can afford, and work together to curb spending over time toward that goal.

You will no doubt continue to hear from health industry stakeholders that an inflation adjustment is necessary due to post-pandemic ripple effects. We disagree for the following three reasons:

1. Our state's benchmark is already higher than the majority of other states that set a 2023 benchmark.
2. Currently, there are no enforcement mechanisms in place that would hold an entity accountable for exceeding the benchmark. Though such measures have been proposed in the Legislature, they are set out on a longer trajectory, well after the pandemic's impacts.
3. The Board can acknowledge the unusual post-pandemic inflation trends without adjusting the benchmark, for example by tracking other inflation trends as an additional data point to contextualize the findings. The Board can also continue to monitor general inflation in the months to come and evaluate further action later, recognizing that inflation is forecast to drop significantly in 2023.

If the Board chooses to stay the course, we will be in good company: Oregon's Cost Growth Target Advisory Committee recently voted to retain its current cost growth target at 3.4%.[1]

Every day, Washington families set a budget and do their best to live within their means. We ask you to hold fast in your commitment to Washington patients, workers, and employers and retain the current benchmark. Please contact emily@nohla.org with any questions.

Sincerely,

Economic Opportunity Institute
Health Care for All - Washington
Health Care is a Human Right - WA
National Multiple Sclerosis Society
North Seattle Progressives
Northwest Health Law Advocates
Patient Coalition of Washington
Physicians for a National Health Plan - WA
Pro-Choice Washington
Pugset Sound Advocates for Retirement Action
Purchaser Business Group on Health
SEIU Healthcare 1199NW
Washington Poor People's Campaign
Washington State Labor Council
Washington State Nurses Association

[1] Oregon's advisory committee also voted to delay performance improvement plans for 2021-2022; this is not salient in WA since we do not have any accountability measures for the benchmark.

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Washington State Health Care Authority

Mathematica
Progress Together

The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanisms: Stakeholder Perspectives

October 2022

Debra Lipson, Cara Orfield, Rachel Machta, Olivia Kenney, Kelsey Ruane, Marian Wrobel, and Sule Gerovich

This project was supported by the Peterson Center on Healthcare and Gates Ventures. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Peterson Center on Healthcare or Gates Ventures. Mathematica assumes responsibility for the accuracy and completeness of the information contained in this report.

Acknowledgements

The authors would like to acknowledge the contributions of many people to this report. We thank Sarah Berk and Keanan Lane at the Peterson Center on Healthcare for their guidance and support throughout the evaluation. We also appreciate receiving behavioral economics insights from colleagues at ideas42.

We are indebted to the Massachusetts Health Policy Commission staff for providing background on the history of the benchmark initiative and contact information for interview candidates, and for conducting a thorough review of the factsheets to ensure their accuracy. We would also like to thank the many individuals and organizational representatives of key stakeholders in Massachusetts, who generously shared their time and perspectives with us about the influence of the benchmark and the HPC's use of accountability mechanisms on their actions.

At Mathematica, we thank Kavita Choudhry for leading the effort to assemble and categorize hundreds of documents on the HPC's use of accountability mechanisms. We also thank Maura Butler for editorial assistance, Cindy Castro and Sharon Clark for production assistance, and Brigitte Tran and Yvonne Marki for graphic design.

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Exhibits

Executive Summary

Background. In 2012, Massachusetts became the first state in the country to adopt legislation establishing a statewide benchmark for health care cost growth. This benchmark sets a target for the annual rate of increase in health care spending and ties it to expected growth in the state's overall economy. Known as Chapter 224, the law applies the benchmark to public and private expenditures and most types of health spending.

The law also established the Health Policy Commission (HPC) and gave it the authority to monitor and promote payers' and providers' compliance with the benchmark through a set of accountability mechanisms. These mechanisms include annual Cost Trends Reports and annual Cost Trends Hearings, which increase transparency of health care costs and spending; Cost and Market Impact Reviews (CMIRs), which monitor the impact of proposed mergers and acquisitions of health care entities on cost growth; and Performance Improvement Plans (PIPs), which require individual health care entities whose spending growth exceeds the cost growth benchmark to develop strategies to address excessive spending. While the term accountability is often understood to mean enforcement, Chapter 224 gave the HPC limited authority to enforce payer and provider compliance with the benchmark.

Several years after the Massachusetts benchmark initiative began, it was heralded as a success. From 2012 to 2017, state spending growth was lower than both the benchmark and the national rate of growth. Although the rate of spending growth exceeded the benchmark in 2018 and 2019, the state's achievement spurred policymakers in other states to adopt similar initiatives.

Study purpose and methods. Supported by the Peterson Center on Healthcare and Gates Ventures, this study (1) examined the influence of the benchmark and the HPC's accountability mechanisms on the motivation and actions by state agencies, payers, and providers to control health care cost growth, and (2) identified lessons and considerations about the design and use of accountability tools for other states implementing similar initiatives. From November 2021 to March 2022, we interviewed nearly 50 key stakeholders involved in, or affected by, Massachusetts' cost growth benchmark initiative. We also collected extensive documentation about the HPC's use of each accountability mechanism through a systematic search of publicly available documents.

Key findings

- **Benchmark.** The benchmark for annual growth in statewide health care expenditures is tied to the potential rate of growth in the state's overall economy. This benchmark helped constrain the rate of health care cost growth in Massachusetts by creating a focal point for conversations about cost trends. During its initial years, the benchmark reportedly influenced contract negotiations between payers and providers and increased providers' willingness to participate in accountable care organizations (ACOs), which reward improved quality and lower costs. The influence of the benchmark on health care organizations' incentives to control cost growth appears to have diminished over time, due in part to perceptions that the HPC's accountability mechanisms are insufficient to address some of the major drivers of health spending growth (for example, the high prices charged by some providers to commercial payers, which have contributed to annual rates of increase higher than the benchmark in recent years). When providers did not incur adverse consequences for spending in excess of the benchmark, some may have been less inclined to keep cost growth below the target than they were in early years when they perceived a higher risk of such consequences.

- **Annual Cost Trends Hearings.** The annual Cost Trends Hearings convene leading policymakers, state officials, payers, providers, and other key stakeholders to examine cost growth trends statewide (as well as by payer, provider, and service type), along with the major drivers of cost growth and cost control strategies. The hearings are an important venue for making health care costs and spending trends transparent and shining a spotlight on how major payers and providers are trying to address key cost drivers. Over time, however, public attention to the hearings has waned, and some respondents thought panelists' responses to questions had become more evasive. Further, some respondents did not think that the hearings had a lasting influence on organizations' behavior.
- **Annual Cost Trends Reports and policy recommendations.** The annual Cost Trends Reports are valuable to many types of stakeholders, because they provide deeper insight into cost trends and growth drivers. The governor and legislators often use the policy recommendations from the Cost Trends Reports to draft bills, some of which have been adopted. For example, in line with the HPC's recommendations, the legislature passed a law in 2020 (Chapter 260) to reduce surprise bills by requiring providers and health plans to notify patients of a provider's network status before non-emergency procedures are performed and tell them how much they would pay for planned hospital stays and other health services. The HPC also recommended steps to create accountability for drug prices by pharmaceutical manufacturers, and while several legislative bills were introduced to do so, none have been adopted to date. Indeed, relatively few of the HPC's recommendations have been enacted, leading many respondents to believe the recommendations have had little influence in the political debate. Some respondents also believe that policy recommendations should be better balanced with recommended cost-containment strategies that payers, employers, and providers could implement.
- **Cost and Market Impact Reviews.** CMIRs analyze the impact of proposed health care market transactions, such as mergers and acquisitions, on costs. They are regarded as the HPC's most important tool for restraining consolidation in the health care market. Although the HPC's investigations and reports have played a role in blocking some transactions, most respondents did not think the CMIR process has slowed the overall trend toward consolidation. However, the HPC has conducted CMIRs for the vast majority of acquisitions of general acute care hospitals and mergers of hospital systems, and there have been fewer of these types of market changes over time. In addition, some providers indicated that knowing a CMIR might be required influences their decisions about how to structure a proposed consolidation and with whom to partner.
- **Performance Improvement Plans.** If the HPC Board finds excessive spending growth by an individual health care entity raises "significant concerns," it can require the entity to submit a formal PIP that describes the key drivers of spending growth and proposes strategies to address them. Many respondents reported they believe the HPC's PIP review process is rigorous, taking into account a range of factors that can cause an individual payer's or provider's spending growth to exceed the benchmark. However, until 2022, HPC did not require any entity to submit a PIP, despite conducting numerous PIP reviews, which led many respondents to believe that the process was ineffective and led payers and providers to minimize or dismiss the importance of PIP reviews. In addition, the entities and type of spending subject to potential PIP referral are defined in Chapter 224 in a manner that excludes a large share of hospital spending, which stakeholders perceive as a serious shortcoming.

Evolution of the overall influence of the health care cost growth benchmark initiative. The HPC achieved early success shortly after it began operating in 2012 by using its accountability tools and authority to effectively persuade health care entities to hold spending growth below the benchmark. Most

respondents believe the benchmark initiative as a whole has helped control cost growth; however, many say its influence has waned over time in response to how the HPC implemented some of the accountability mechanisms and as all stakeholders came to understand the limitations of the statute's accountability tools to constrain spending growth. Nearly all stakeholders say they still support the goal of cost containment, but the benchmark's influence on payers and providers has diminished over time. Also, the sentinel effect of the HPC's accountability mechanisms has become less powerful as the limits of the scope and authority of HPC's accountability mechanisms have become clear. Some respondents also had concerns about particular HPC decisions, such as not approving a formal PIP review for dozens of entities referred for PIP review over time (until recently). To address the limitations of Chapter 224, most respondents recommend stronger enforcement and "more teeth" going forward.

Considerations for other states

As of 2022, eight states have followed Massachusetts' lead and adopted programs setting health care cost growth benchmarks; several other states adopted elements of the initiative. The findings from this study highlight important lessons and raise considerations (Exhibit ES.1) for policymakers in other states about designing and using mechanisms to hold payers and providers accountable for keeping health care spending growth below the benchmark.

Exhibit ES.1. Lessons and considerations for other states

Accountability for meeting the benchmark

Which entities should be accountable for keeping spending growth below the benchmark?

Policymakers should consider which entities will be accountable for keeping spending growth below the benchmark. In Massachusetts, Chapter 224 allows the Health Policy Commission to hold some payers and certain types of providers accountable for excessive spending growth, but it does exclude some entities and types of spending that contribute to spending growth, such as pharmacy spending and hospital spending not attributable to affiliated physicians. To hold accountable all the health care entities whose business decisions drive health care spending growth, state policymakers should consider the full range of entities that drive cost increases, decide which to hold accountable, specifically define them, and devise spending metrics appropriate to each type of accountable entity.

Should state benchmark laws hold entities accountable for level of spending as well as growth?

Cost growth targets do not take into account variation across providers in the total level of spending per member or patient (the result of price times volume). By limiting accountability for cost growth alone, state policymakers can do little to address price variation and high prices charged by some providers, which is one of the primary drivers of cost growth. State policymakers should consider whether and how to hold entities accountable for level of spending as well as annual spending growth.

How should consumer out-of-pocket costs be considered in cost growth benchmarks?

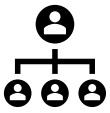
State policymakers should consider whether to establish separate standards for consumer affordability that take into account growing out-of-pocket costs to accompany the total statewide growth benchmark.

Accountability for meeting the benchmark

How much flexibility should state agencies have to decide whether spending growth above the benchmark is justified?

To make Performance Improvement Plans an effective deterrent to exceeding the benchmark, state policymakers can give the agency responsible for monitoring compliance the discretion to apply judgement as Massachusetts did. If state policymakers want to make the Performance Improvement Plan criteria less subjective, they could make the criteria that trigger a plan more prescriptive. For example, the criteria could specify that a Performance Improvement Plan is mandatory if spending growth exceeds the benchmark for a certain number of years, or they could define the cost growth factors that are within a payer's or provider's control.

Oversight authority and resources



Which agencies should have power to enforce compliance with the benchmark?

When setting up the structures, processes, and enforcement mechanisms associated with a cost growth benchmark, states need to decide which agencies have the power to hold entities accountable for meeting the benchmark and what type and how much authority these agencies should be granted. Separating powers across agencies according to their focus and expertise can maximize their effectiveness, but doing so runs the risk of yielding inconsistent decisions. Consolidating authority for all accountability and enforcement mechanisms within one agency can increase consistency in how it applies its authority but may give it too much power and make it more vulnerable to political pressure.

Which criteria warrant the use of greater enforcement powers or regulatory levers?

States should consider which criteria warrant the use of greater enforcement powers or regulatory levers if statewide health care spending growth exceeds the benchmark and what types of enforcement powers this could entail. Criteria could include the number of years that overall spending increases are above the benchmark, the degree to which spending growth exceeds the benchmark, the number of entities exceeding the cost growth benchmark, or other factors indicating that transparency and persuasion are insufficient to control cost growth.

What are the critical capabilities and resources needed to successfully implement accountability mechanisms?

Regardless of which agency or agencies are entrusted to monitor or enforce compliance, state policymakers should consider the level of funding and resources needed to hire qualified staff and fulfill its mandate effectively.

Incentives for compliance

What types and amounts of penalties are appropriate to motivate compliance? Should states balance penalties with positive incentives?

State policymakers should consider what financial penalties are sufficient to motivate agencies to meet the benchmark. It may also be useful to consider the value of adding positive incentives (carrots) to the negative incentives (sticks). Positive incentives could include awarding honorable mention on a website, in an annual report, or in other materials.

What tools can states use to encourage submission of timely, complete, accurate data?

The importance of high-quality data to the success of health care cost benchmarking initiatives also suggests the need for incentives to submit timely, complete, accurate data or penalties for failure to do so.

Conclusion

Massachusetts' experience illustrates the strengths and limitations of a cost control framework that relies on public oversight and transparency of health care spending, and on voluntary cooperation by payers and provider health care entities to keep annual cost growth below the target, but that grants the HPC few (or

weak) enforcement tools. Other states can learn many things from Massachusetts' use of accountability mechanisms, but the most important might be that constraining cost growth is not a "one and done" exercise. State policymakers must continually monitor market trends and refine or enact new measures to address emerging drivers of health care cost growth and respond to changes in the health care market. States that establish cost growth benchmark programs should also develop mechanisms to solicit feedback from key stakeholders—for example, by establishing advisory boards on the effectiveness of accountability mechanisms and potential improvements to them to ensure the state achieves its cost growth targets.

I. Introduction and Study Goals

In 2012, Massachusetts became the first state in the country to adopt legislation establishing a statewide benchmark for health care cost growth. This benchmark sets a target for the annual rate of increase in health care spending and ties that target to expected growth in the state's overall economy. Known as Chapter 224, the law applies the benchmark to public and private expenditures and to most types of health spending. The law also established the Health Policy Commission (HPC), an independent state agency with the authority to monitor and promote payers' and providers' compliance with the cost growth benchmark through a set of accountability tools.

The Massachusetts cost growth benchmark initiative is an opportunity to test and learn how well this cost control strategy—one that relies on market competition, the voluntary cooperation of payers and providers, and accountability through public oversight and transparency—works to control spending growth at the state level. The Massachusetts approach stands in contrast to approaches that regulate or limit the prices paid to providers, and controls on the supply of services or facilities (Stadhouders et al. 2019).

Several years after the Massachusetts benchmark initiative began, a number of reports noted its apparent success (Ario et al. 2019; Waugh and McCarthy 2020; Block and Lane 2021). From 2012 to 2017, state spending growth, on average, was lower than both the benchmark and the national rate of growth.[1] Although the rate of spending growth exceeded the benchmark in 2018 and 2019,[2] the state's earlier track record spurred policymakers in other states to pursue a similar strategy. In 2020, the Peterson Center on Healthcare and the Milbank Memorial Fund created a program to support states' efforts to set and implement their own targets for health care cost growth.

Policymakers in other states have a keen interest in understanding how Massachusetts has used the tools its legislature authorized to hold payers and providers accountable for keeping health care spending growth below the benchmark. Conversations with program leaders around the country indicate particular interest in understanding the scope and limits of the HPC's accountability tools; how they were implemented and evolved over time; and how payers, providers, and other key stakeholders perceive their influence on actions that affect the rate of cost growth. State policymakers also want to learn lessons from Massachusetts' pioneering approach.

The goals of this study were (1) to examine how the benchmark and the HPC's accountability mechanisms influenced the motivation and actions of state agencies, payers, and providers to control health care cost growth, and (2) to identify lessons and considerations for other states implementing similar initiatives about designing and using accountability tools.

HPC accountability mechanisms. The study examined the influence, design, and use of the HPC's four accountability mechanisms. Exhibit I.1 shows the relationship of these accountability mechanisms to the cost growth benchmark. Two of the mechanisms—**the annual Cost Trends Hearings** and **the annual**

[1] "In 2018, the Massachusetts total health care spending growth rate of 3.1 percent per capita was below the U.S. rate of 3.5 percent, continuing a consecutive nine-year trend of spending growth below the national growth rate." Massachusetts Health Policy Commission. "2019 Annual Health Care Cost Trends Report." https://www.mass.gov/doc/2019-health-care-cost-trends-report/download.

[2] In 2018 and 2019, total health care expenditures in Massachusetts grew by 3.6 and 4.3 percent, respectively. These numbers represent higher rates of growth than the 3.1 percent benchmark that applied to those two years (which was 0.5 percentage points lower than the 3.6 percent benchmark that applied from 2012 to 2017).

Cost Trends Reports—are public events and reports that assess the state's overall cost trends relative to the benchmark and examine major cost trend drivers and their relationship to quality, access, and equity. The other two mechanisms—**Cost and Market Impact Reviews (CMIRs)** and **Performance Improvement Plans (PIPs)**—involve confidential reviews of individual health entities' proposed market actions that could affect the state's ability to meet the benchmark in the future and their cost growth performance in the preceding year relative to the benchmark; only final CMIR reports or formal PIPs become public. Appendix A contains factsheets that describe the four accountability tools in more detail and how they have been used to date.

This report intentionally uses the term "accountability mechanisms," rather than enforcement tools (see sidebar). The HPC uses these mechanisms to assess cost trends and promote voluntary compliance with the benchmark. But it has limited authority to enforce compliance with the benchmark, and it cannot impose penalties on payers and providers, with one exception at the end of the PIP process.

What is an accountability mechanism?

- In this report, we use "accountability mechanism" to refer to activities intended to **increase transparency** of health care costs and spending, **monitor** the impact of changes in the health care market on costs, and **promote** payers' and providers' compliance with the cost growth benchmark.
- We do not refer to the Health Policy Commission's (HPC's) four accountability mechanisms as enforcement tools, because Chapter 224 did not give the HPC the authority to impose penalties on payers and providers with excessive cost growth (with one exception, listed next).
- The HPC can levy a maximum fine of $500,000 if an entity required to submit a performance improvement plan fails to do so.
- If appropriate, the Attorney General's Office can take action to protect consumers from anticompetitive behavior by filing an antitrust case or stipulating conditions for certain types of transactions to proceed. ◢

Study questions. This study focused on three key questions:

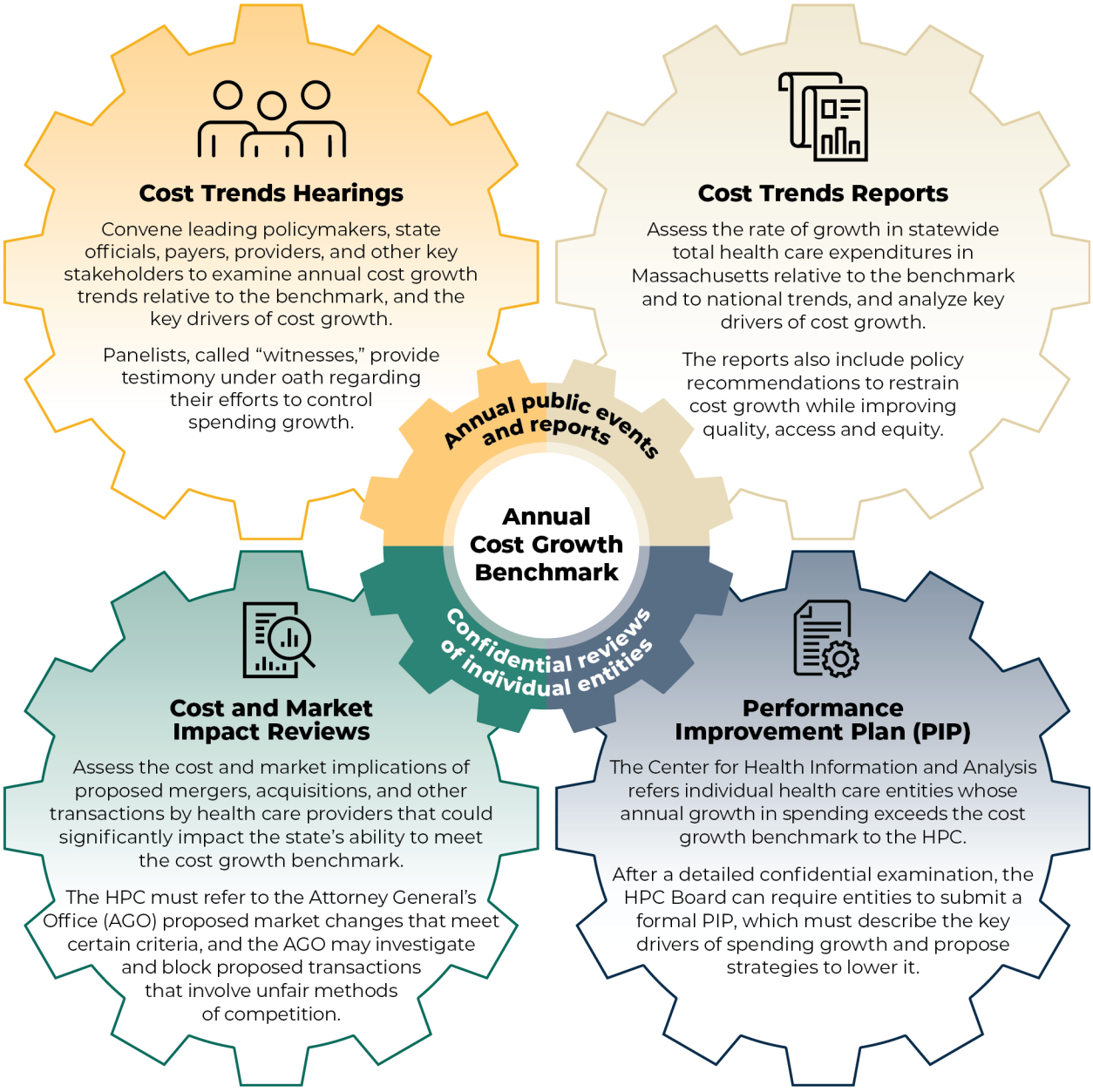
1. How did the HPC implement the accountability mechanisms authorized by Chapter 224 to induce payers and providers to meet the annual growth benchmark?
2. How did **state agencies** view the benchmark and engage with the HPC, and what policies or actions did they take in response to its recommendations?
3. How did **private payers and providers** view the benchmark and engage with the HPC's accountability mechanisms, and what business decisions or actions did they take in response?

This study was not designed to evaluate whether or to what degree the Massachusetts cost growth benchmark and the HPC's use of its accountability mechanisms *caused* statewide health spending growth to be higher or lower than the benchmark since 2012 or in any individual year. In addition, although we explored how factors other than the benchmark and the HPC's actions influenced health care entities' decisions, this study did not attempt to quantify the effect of these factors. Instead, the study used the findings to (1) understand how the accountability mechanisms, individually and overall, affect incentives to comply with the benchmark, and (2) identify issues with designing and using such mechanisms, for other states implementing cost growth benchmarks.

Data and methods. We used qualitative research methods to examine how the HPC implemented the four accountability mechanisms; the policy and market context in which implementation occurred; and myriad factors that might have influenced the responses of state agencies, payers, and providers. We compiled information about the HPC's use of each accountability mechanism, as well as payers' and providers' responses, through a systematic search of publicly available documents. We developed a

searchable database of these documents that classified the relevance of each document to the HPC's four accountability mechanisms, topics addressed, publication date, and relevance to each study question.

Exhibit I.1. Relationship of the Massachusetts Health Policy Commission (HPC) accountability mechanisms to the cost growth benchmark



We then interviewed nearly 50 key stakeholders involved in or affected by the Massachusetts cost growth benchmark and the HPC's accountability mechanisms. Interviews occurred between November 2021 and March 2022. To encourage candid responses, we assured all interviewees their identity would not be disclosed in this report. Interview topics included the strengths and limitations of the cost growth benchmark and the four accountability mechanisms, experience with and perception of the HPC's use of

these mechanisms, and the influence on organizations' decisions and behaviors. We developed a logic model based on the Consolidated Framework for Implementation Research to identify the factors that could influence organizations' views of and response to the benchmark and accountability mechanisms, and we created a set of codes to categorize them. We used NVivo qualitative software to code all interview responses and analyze themes by respondent type.

See Appendix B for more information about the study methods and analytic framework.

Study limitations

Because interviews with key stakeholders were the primary data source, the findings are subject to several limitations. First, some interview respondents did not hold their positions long enough to be familiar with the evolution of the HPC's implementation of Chapter 224 since it was enacted in 2012. Second, even those that were in key positions throughout this period are subject to recall bias. That is, they might not remember previous events or experiences accurately, they might omit important details, or they might interpret events based on hindsight. Third, in some cases, an important milestone in the PIP process occurred after we conducted most interviews, which could have changed respondents' views about this accountability mechanism (see sidebar).

First PIP announced during data collection

We conducted interviews for this study from November 2021 to March 2022. On January 25, 2022, during this period, the Health Policy Commission voted to require Mass General Brigham to implement a Performance Improvement Plan (PIP), the first in the HPC's history. Because we conducted interviews with respondents both before and after this critical milestone in the use of this accountability mechanism, we interpreted respondents' views about the PIP process based on the timing of their interviews. Had we conducted this study after the PIP was announced, we might have uncovered more about the PIP process. ◢

Another limitation concerns the sensitive nature of the issues discussed. Some interview questions concerned information that some respondents regarded as proprietary, such as contract negotiations and prices. Other questions concerned political aspects of health care and health policy—that is, how the interests of key stakeholders affect public policy decisions. Although we assured all interview respondents that their identity would not be disclosed and that we would keep all interview notes and recordings confidential, respondents might have given guarded or misleading answers to avoid revealing sensitive information.

In addition, although we made many attempts to interview all major stakeholders, some of the organizations we invited declined to participate in an interview. Consequently, the findings of this study may be biased toward the views of those who did participate.

Organization of the report

Following this introduction, Section II provides background on the history and health system and policy context leading up to 2012, and describes the major provisions of Chapter 224. Section III presents key findings from this study, and Section IV discusses lessons and considerations for other states based on Massachusetts' experience using the four accountability mechanisms. Section V concludes by discussing the strengths and limitations of state strategies to control health care cost growth that rely on market competition, public oversight, and transparency, modeled on Massachusetts' approach.

Behavioral economics as a lens for understanding stakeholder responses

The Peterson Center on Healthcare commissioned a separate analysis of stakeholder responses to the Massachusetts cost growth benchmark and accountability mechanisms, using a behavioral economics framework. Behavioral science is the study of human decision-making and behavior. Drawing from the fields of behavioral economics, psychology, and sociology, behavioral science enhances the traditional economic and legal models typically used to design policy and practice, accounting for myriad psychological and contextual factors that can promote better decisions and actions–leading to better outcomes overall. Incorporating behavioral science perspectives is important because even well-intentioned policy, system, and communications design can lead to nonoptimal outcomes if it does not account for these behavioral influences. In the case of the Massachusetts cost growth benchmark, this means that payers and providers may not always respond to HPC accountability mechanisms in ways that system architects had anticipated. Uncovering the factors that drive these entities' actual behavior could help identify ways to improve the impact of the benchmark and accountability mechanisms. ◢

II. Massachusetts' Cost Growth Benchmark – Origins and Chapter 224 Statutory Requirements

Chapter 224, enacted into law in 2012, established the cost growth benchmark and specified the mechanisms the HPC could use to hold payers and providers accountable for meeting it. This section explains the health market and policy context that preceded and led to the adoption of Chapter 224. It also describes the law's major provisions related to the cost growth benchmark and the design of the accountability mechanisms.

High rate of insurance coverage. By 2012, Massachusetts had the highest rate of health coverage in the country, in large part because of a landmark law in 2006 that expanded Medicaid eligibility, subsidized coverage for residents with household incomes of less than 300 percent of the federal poverty level, and required employers with 10 or more employees to provide coverage or pay a "fair share contribution" (Chapter 58 of 2006). By 2012, nearly 96 percent of residents had some form of coverage, compared with 85 percent nationally.[3]

Rising health care costs. In 2009, health care spending per capita in Massachusetts was among the highest in the United States: $9,417 which was about 35 percent higher than national spending per capita of $6,892 (Lassman et al. 2017). Health insurance costs were also growing rapidly. The average monthly health plan premium in Massachusetts was $421 in 2011, 9.7 percent higher than in 2009 and about twice the rate of general inflation, even though enrollees on average received less generous benefits for these higher prices (CHIA 2013). In 2011, about 80 percent of health care spending for acute hospitals and physicians was concentrated among higher priced providers (CHIA 2013).

In addition, as more people gained coverage, policymakers realized that the costs would be unsustainable without efforts to control the rate of spending growth (Mechanic et al. 2012). Chapter 58 was borne from a commitment to shared responsibility to finance the cost of expanded coverage by employers, consumers, taxpayers (to subsidize coverage for the poor), and insurance companies. The theme of shared responsibility sustained support for expanded coverage and built support for new efforts to control health care cost growth (Kingsdale 2009).

Market concentration. Growing concern about the high degree of concentration in the Massachusetts health care market also propelled the adoption of Chapter 224. By 2012, there was strong evidence that higher concentration in payer and provider markets reduced competition and led to higher prices (Dafny et al. 2012; Berenson et al. 2020).[4] In 2012, three large insurance plans (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan) made up nearly 80 percent of the commercial market. Most commercial payments went to a few large provider systems. Providers affiliated with Partners HealthCare System received 28 percent of all commercial hospital and physician group payments, three times the amount paid to the next largest system, CareGroup, at 9 percent. Partners

[3] Kaiser Family Foundation. One-year estimates based on the Census Bureau's March Current Population Survey https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/

[4] According to Berenson et al. (2020), "Hospitals and, to a somewhat lesser extent, physicians have organized into horizontally and vertically consolidated 'must-have' organizations that can exert market power to raise prices and resist payer contract provisions intended to constrain their exercise of market power. Conversely . . . insurance market concentration fails to provide a sufficient counterweight to provider market power because dominant insurers lack an incentive to negotiate low rates."

HealthCare accounted for nearly one-quarter of total commercial physician group payments, almost two and half times higher than the second largest physician group system, Atrius Health (CHIA 2013).

Adoption of state laws in 2008 and 2010. In response to these developments, the Massachusetts legislature passed two laws that laid the foundation for public oversight and greater transparency of health care costs and spending:

- **Chapter 305 of 2008** required the state to hold annual hearings on health cost trends, authorized the collection of detailed spending data from health care entities, and required an annual report to the legislature. Chapter 305 also created a special commission to make recommendations on provider payment reform, prompted by a *Boston Globe* investigation featuring a dozen articles and numerous op-eds and blogs that exposed higher payments to hospital systems with the greatest negotiating leverage.[5]
- **Chapter 288 of 2010** gave the state insurance commissioner explicit authority to disapprove excessive rate hikes for small-group insurance premiums. It also required the state to develop uniform methods for calculating and reporting prices, costs, and total spending.

A. Overview of Chapter 224

After several years of debate, Massachusetts adopted Chapter 24 of 2012 "to improve the quality of health care and reduce costs through increased transparency, efficiency, and innovation."[6] The statute contained many health reforms, the most notable of which were the establishment of a cost growth benchmark and the HPC.[7] The elements of the final bill, including the tools it gave to the HPC to hold payers and providers accountable for holding cost growth below the benchmark, represented policy solutions that were politically feasible at the time— those on which major interest groups could agree (Garlick 2017).[8] For example, the law did not address high prices charged by some providers to commercial payers, because provider groups would not accept price regulation even though price increases account for about 60 percent of the overall growth in health care spending per person (Health Care Cost Institute 2021). In addition, "a luxury tax on high-priced health care entities and restrictions on how health systems negotiate contracts with insurers, were removed from the final version of the act." (Steinbrook 2012).

To keep health care spending growth in line with growth in the state's overall economy, Chapter 224 established the first health care cost growth benchmark in the country. The benchmark constitutes a target for annual growth in statewide per capita total health care expenditures (THCE, see sidebar for

[5] The Boston Globe's series "Unhealthy system: Is medical giant Partners HealthCare good for Massachusetts?" is available online at: http://www.boston.com/news/specials/healthcare_spotlight/.

[6] Commonwealth of Massachusetts Chapter 224 of 2012. An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency, and Innovation. https://malegislature.gov/laws/sessionlaws/acts/2012/chapter224

[7] Other provisions included requirements to establish accountable care organization standards, steps to simplify administration, consumer protections, and medical liability reform. The law also incorporated strategies to reduce legislators' perception of one of the root causes of high costs–overutilization--for example by encouraging the use of alternative payment methods that give incentives to providers to reduce unnecessary care (Garlick 2017). This report did not assess the implementation of these provisions.

[8] According to one interview respondent, the state hospital association was influential in crafting the PIP provisions to specify that only hospital spending associated with patients seen by the hospitals' affiliated provider groups would be subject to PIP review, rather than all hospital spending.

definition). Chapter 224 set the benchmark at the forecasted growth in annual potential gross state product (GSP) to bring spending in line with growth in the states' overall economy. From 2012 to 2017, the law set the benchmark at projected GSP growth, which at that time was 3.6 percent. The law reduced the benchmark to 3.1 percent from 2018 to 2022, unless the HPC determined that an adjustment was necessary. For 2023 and beyond, the HPC has authority to recommend changes in the benchmark to the legislature, if approved by a two-thirds vote of the HPC Board.

Total Health Care Expenditures

Total health care expenditures (THCE) are a per-person measure of total state health care spending. The Center for Health Information and Analysis calculates this figure each calendar year from a variety of public and private data sources. The measure is reported on a per capita basis to account for changes in population. THCE includes spending by the following entities:

- Commercial payers for both the fully insured and self-insured populations, including claims for medical expenses, administrative expenses, and incentive payments
- Insured members' cost sharing, including co-payments, co-insurance, and deductibles
- State government, including Medicaid and public employee health benefits
- Federal government, including Medicare, Medicaid, and the Veterans Health Administration

THCE does not include out-of-pocket payments for goods and services not covered by insurance, such as over-the-counter medicines. It also excludes other categories of spending not covered by private commercial medical insurance, such as vision and dental care.

THCE calculations before 2020 were considered preliminary, because the statutory deadline for producing the figure did not allow enough time for claims runout. Starting with calendar year 2020, the reporting timeline was changed to September of the following year (that is, September 2021), which allowed a longer claims runout of six months, on average, to consider the data final for calendar year 2020.

Source: *CHIA Annual Report 2022, https://www.chiamass.gov/assets/2022-annual-report/2022-Annual-Report-Rev-2.pdf, and technical appendices, https://www.chiamass.gov/assets/2022-annual-report/2022-Annual-Report-Technical-Appendices.zip*

B. Role and responsibilities of the Health Policy Commission

Chapter 224 created the HPC as an independent government agency and charged it with conducting a variety of functions to achieve the chapter's overall goals. These activities included monitoring and reviewing the impact of changes in the health care market on the state's ability to keep cost growth below the benchmark and using various tools to encourage payers and providers to keep cost growth below the benchmark.[9] As one observer described the HPC's accountability tools, "The commission may encourage, cajole, and, if needed, shame them into doing their part to control costs" (Steinbrook 2012).

[9] Chapter 224 Section 15 specifies that the HPC shall "(i) set health care cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations [performance]; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace and (vii) protect patient access to necessary health care services."

One interview respondent recalled that "The goal of the law was to shame, move, push, not necessarily to have it be draconian in nature."

In addition to implementing the four accountability mechanisms, the HPC conducts a variety of other activities to improve health care delivery and improve health outcomes and equity for Massachusetts residents. For example, it sets standards for ACOs and makes grants to community organizations to enhance the delivery of effective, efficient care; promote innovative models; and address the social determinants of health. This report did not assess the implementation or effectiveness of these other activities.

Chapter 224 also consolidated several health data activities into the Center for Health Information and Analysis (CHIA), which is also an independent agency, and increased its funding to support enhanced data collection on health care use and spending.[10] The law requires CHIA to calculate total health care spending growth each year and compare the rate of growth with the benchmark, statewide and for individual payers and providers. CHIA also conducts a wide range of other data collection and analysis functions. It manages the state's all-payer claims database and hospital discharge database, conducts surveys, and maintains data sets on cost and utilization for a variety of health care providers and services (see the CHIA website for more information).

As explained in detail in the factsheets in Appendix A, Chapter 224 specified the approach that the HPC must follow in carrying out four major accountability mechanisms.

- **Cost Trends Hearings**: Each year following the release of CHIA's Annual Report on the Performance of the Massachusetts Health Care System, which compares health care spending growth to the health care cost growth benchmark, the HPC organizes an annual Cost Trends Hearings (Chapter 224, Section 8). The hearings are intended to focus public attention on health care costs and increase understanding of the factors that drive cost growth. They are also designed to hold health care entities publicly accountable for their organizations' efforts to keep spending growth below the benchmark. The HPC invites a cross-section of health care entities, specified in Chapter 224, to submit pre-filed written testimony on key issues before the hearings; some of these entities are then invited to present oral testimony. Presenters, known as witnesses, are sworn in and provide testimony under oath. Witnesses may be asked questions (cross-examined) by the HPC Board members, representatives from the Attorney General's Office and CHIA, and the HPC Executive Director. *More information about the types of organizations that have participated most frequently as witnesses, and the topics addressed, can be found in the CTH Factsheet.*
- **Cost Trends Reports:** Each year, following the Cost Trends Hearings, the HPC must prepare an annual Cost Trends Report (Chapter 224, Section 8). The reports present the results of in-depth analyses of health care spending growth patterns, how they compare to the benchmark rate of growth and national trends, and the key drivers of cost growth. Using data provided by CHIA and other sources, the HPC compares statewide spending trends to national rates, examines per person spending trends by market sector (commercial, Medicaid, Medicare fee-for-service, and Medicare Advantage), and breaks out spending growth trends by major service types. To identify major drivers of cost growth, the Cost Trend Reports examine changes in price and utilization. The HPC reports drill down

[10] CHIA is financed through an assessment on hospitals and payers. In state fiscal year (SFY) 2013, the year after Chapter 224 passed, CHIA's budget was about $22 million plus another $4 million allocated to support the all-payer claims database. In SFY 2021, CHIA's total budget was approximately $31 million (Blue Cross Blue Shield of Massachusetts Foundation, August 2013 and August 2021).

into the factors that explain changes in utilization, including how many people use services, how often they use them, in which care settings they receive services, and the intensity of services. Based on its analysis of cost trend drivers, the HPC Board makes recommendations to address them to keep cost growth below the benchmark through state policy changes and actions by government agencies, private purchasers and insurers, and health care providers. *More information about the recommendations can be found in the CTR Factsheet.*

- **Cost and Market Impact Reviews**. The statute charged the HPC with assessing the impact of proposed mergers, acquisitions, contract affiliations, and other market changes on the state's ability to meet the health care cost growth benchmark (Chapter 224, Section 13). All provider organizations must file a notice with the HPC for any proposed material change that involves a merger or affiliation with, or acquisition of or by, an insurer, another hospital or hospital system, and any other transaction that "would substantially increase revenue, or result in a provider having a near-majority of market share in a given service or region." For any transaction that is likely to have a significant impact on the state's ability to meet the health care cost growth benchmark or on the competitive market, the HPC conducts a cost and market impact review, which investigates the impacts of the proposed transaction and make recommendations to the Attorney General's Office (AGO), the Department of Public Health (DPH), or other state agencies. *More information on the CMIR process, criteria for referring proposed transactions to the AGO, and a case example, are in CMIR Factsheet.*
- **Performance Improvement Plans**. Each year, CHIA refers health care entities whose growth in health-status adjusted total medical expenditures (HSA TME) exceed the cost growth benchmark for each line of business (commercial, Medicare, and Medicaid) to the HPC. The HPC then conducts a detailed, confidential examination of the referred entities' spending performance, relative market share, trends over time, and utilization patterns. The confidential nature of the PIP review process was designed to protect the privacy of referred entities. Organizations subject to PIP review are limited to payers and managing physician groups, because these are the only entity types for which the statutorily required metric of HSA TME exists. The focus of the HPC's PIP review is to understand the factors that explain spending growth and whether they are within their control. If the HPC finds that an organization's spending growth is excessive—that is, that it has significant concerns and that a PIP could result in meaningful, cost-saving reforms—the HPC Board of Commissioners can require the entity to submit a formal PIP, which must describe the key drivers of spending growth and propose strategies to lower it. Once a formal PIP is required, the identity of the organization and its PIP become public. *More information on how HSA TME is calculated and the strengths and limitations of the PIP process can be found in the PIP Factsheet*.

The HPC's relationship to other state agencies. In addition to working closely with CHIA, the HPC collaborates with and supports regulatory action by other state agencies, particularly the **AGO** and the **DPH.** If the HPC conducts a CMIR and its findings meet certain criteria, it must refer the final report to the AGO, which can then decide to investigate whether health care entities are engaged in unfair methods of competition that significantly affect the state's ability to meet the cost growth benchmark (Chapter 224 Section 13(h)). The AGO may use the HPC's final report as evidence in any anti-trust action. The HPC is also a party of record eligible to submit formal comments to the DPH regarding applications for determinations of need (DON) that must be approved before a provider can build new facilities or make major investments above a certain dollar threshold.

HPC governance. The HPC is led by a nonpartisan independent board of 11 commissioners. Chapter 224 specified the board's composition; members are appointed by the state's top elected officials:

- Five members are appointed by the governor; two of these members are ex-officio state cabinet members who lead the Executive Office of Health and Human Services and the Executive Office of Administration and Finance.
- Three members are appointed by the attorney general.
- Three members are appointed by the state auditor.

By law, appointed members must have expertise in specified areas of health care, including management, behavioral health services, consumer advocacy, medical technology, health economics, health workforce, health insurance purchasing, primary care, and health plan administration. To avoid conflicts of interest, commissioners cannot represent health care entities subject to HPC oversight. The HPC also convenes a 35-member advisory council, whose members must "reflect a broad distribution of diverse perspectives" to provide input into HPC deliberations.[11]

[11] Ch. 224 specifies that the advisory council shall be chosen by the executive director and shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational institutions, consumer representatives, medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers, providers, provider organizations, labor organizations and public and private payers. For a list of current members and their affiliations, see https://www.mass.gov/service-details/hpc-advisory-council-membership.

III. Key Findings

This section discusses the study's key findings related to the three primary research questions. First, it summarizes respondents' views about the strengths, limitations, and influence of the benchmark on payer, provider, and state agency actions. The study examined the influence of the cost growth benchmark on stakeholders' motivation for controlling costs, separate from the accountability mechanisms, because it represents the shared goal established by Chapter 224 and gives the state and health care entities a concrete target for its accountability tools. It then summarizes respondents' views of the strengths, limitations, and influence of each of the four accountability mechanisms. It concludes by discussing how the overall cost growth benchmark initiative, including the HPC's use of its accountability mechanisms, influenced efforts by key stakeholders to control spending growth and how that influence has changed over the time.

A. Benchmark: Annual rate of growth in statewide health care expenditures

- The benchmark helped constrain the rate of health care cost growth in Massachusetts by creating a focal point for conversations about cost trends. During its initial years, the benchmark reportedly influenced contract negotiations between payers and providers. It also increased providers' willingness to participate in accountable care organizations, which reward improved quality and lower costs. The influence of the benchmark on payer and provider motivation to control cost growth has waned over time, due in part to perceptions that the HPC's accountability mechanisms are insufficient to address some of the key drivers of spending growth. ◢

Strengths

Most respondents agreed that the benchmark has helped constrain the rate of cost growth over time by creating a focal point for important conversations about trends in health care spending. For example, most payers see strong alignment between the goals of the cost growth benchmark and their own core strategic goals of keeping premiums rate increases reasonable. Many providers said they believe that both payers and providers try to maintain growth rates below the benchmark, because "We all have internal pressure [to contain costs]." In the initial years of the initiative, payers cited the need to hold cost growth below the benchmark in contract negotiations with providers, and said it increased provider willingness to participate in ACOs. Even when it was not an explicit part of contract negotiations, payers said they still viewed the benchmark as a guideline for reasonable rate increases, and most providers accepted these increases to keep their own cost growth rate below the benchmark.

Although most state agency respondents thought the benchmark aimed to hold commercial payers and providers more accountable for cost growth, the benchmark still serves as a goal for major state purchasers. For example, MassHealth (the Medicaid program), the Group Insurance Commission, and the Massachusetts Health Connector said they use the benchmark as a growth target when negotiating contracts with ACOs, and as a target for premium growth in the health plan re-procurement process.

Limitations

Not all providers agreed that the benchmark had an effect on their business decisions. Some providers said the benchmark had little direct influence on their organizations' internal decision making. For example, speaking about their decisions to invest in ACO models, one said, "If [we] discuss something

that will require a major financial investment, we aren't saying... that could bump us up against the benchmark." Some providers also criticized payers' attempts to use the benchmark as the upper limit on payment rate increases in contract negotiations, because it does not take into account differences in providers' financial circumstances. For example, safety net providers have less opportunity to control spending because their primary source of revenue comes from public payers (Medicare and Medicaid), which set prices that are commonly well below the rate paid by commercial payers and sometimes below the actual cost of care. For this reason, these types of providers may seek to increase the rates they charge to commercial insurers to offset uncompensated care costs and do not believe they should be penalized if this results in annual spending increases above the benchmark rate. Safety net providers also believe an increase in the HSA TME above the benchmark rate of growth should not trigger a PIP referral if their level of spending is low, relative to providers that derive a larger share of revenue from commercial payers.

Other stakeholders pointed to another limitation of the benchmark: by focusing on cost growth, it ignores individual providers' level of spending—that is, total spending per member or patient (the product of price times volume). For instance, payers say that large, high-priced providers have been able to negotiate significant rate increases above the benchmark rate of growth (a form of rent-seeking[12]), which has been a major driver of spending growth in recent years.[13] As the HPC's 2021 Cost Trends Report explained, "shifts in volume from lower-priced to higher-priced hospitals, combined with commercial price levels which can be three times as high as Medicare prices, were a key reason Massachusetts failed to meet the benchmark in 2018 and 2019." Because Chapter 224 did not allow the state to control prices, the HPC recommended establishing price caps for the highest-priced providers as a complement to the health care cost growth benchmark.

Some respondents also said that by focusing on spending growth, the benchmark does not adequately account for changes in quality, access, and equity. Chapter 224's title emphasizes quality ("An Act Improving the Quality of Health Care and Reducing Costs..."), and the HPC has produced several reports on quality, access, and equity issues over the years.[14] But some providers believe the HPC could strike a better balance in reporting quality of care measures along with costs and hold organizations accountable for their performance on quality metrics in addition to spending. For that reason, another provider thought the benchmark is better suited to value-based payment arrangements, in which spending growth is assessed in conjunction with quality outcomes. Finally, consumer advocates noted that the benchmark does not take into account consumer out-of-pocket spending for costs and benefits not covered by insurance, nor does it account for the disproportionate share of out-of-pocket costs borne by people with low incomes.

[12] Rent-seeking is an economic concept that means engaging in or involving the manipulation of public policy or economic conditions as a strategy for increasing profits. Even though many health care organizations are legally organized as nonprofit entities, they may seek to maximize revenue to support salary increases, build new facilities, purchase new equipment, and provide amenities that increase their competitive advantage.

[13] Research has consistently shown that prices are one of the most significant contributors to growth in health spending, particularly in the commercial sector (*Health Affairs* Research Brief, "The Role of Prices in Excess US Health Spending." June 2019. https://www.healthaffairs.org/do/10.1377/hpb20220506.381195/full/).

[14] Chapter 224, Section 20 requires CHIA, in consultation with the HPC and other state agencies, to maintain a consumer health information website comparing the quality, price and cost of health care services. The Compare Care site (https://www.masscomparecare.gov/) provides comprehensive information to health care consumers to help them make informed decisions about their health care.

B. Cost Trends Hearings

- The annual Cost Trends Hearings convene leading policymakers, state officials, payers, providers, and other key stakeholders to examine cost growth trends statewide (as well as by payer, provider, and service type), along with the major drivers of cost growth and cost control strategies. The hearings are an important venue for making health care costs and spending trends transparent and shining a spotlight on how major payers and providers are trying to address key cost drivers. Over time, however, public attention to the hearings has waned, and some respondents thought panelists' responses to questions had become more evasive. Further, some respondents did not think that the hearings had a lasting influence on organizations' behavior. ◢

Strengths

Nearly all respondents agreed that the annual Cost Trend Hearings, often referred to as the "Super Bowl of health policy" in Massachusetts, are an important venue for making health care costs and spending trends transparent and shining a spotlight on efforts by major payers and providers to keep the rate of spending growth below the benchmark The hearings are an opportunity for the state's top elected officials, including the governor, the speaker of the House, the Senate president, and the attorney general, to share their views on health care costs. The HPC, CHIA, and outside experts deliver presentations on health care cost trends and key cost drivers.

The HPC requires a broad set of providers and payers to submit pre-filed written testimony on a variety of questions each year, and invites a select group of "witnesses" to testify at the hearings. (Chapter 224 specifies which types of payers and providers must be represented.) Representatives of organizations called to testify at the hearings speak under oath, and HPC Board members, the AGO, and CHIA and HPC directors may cross-examine witnesses. These are regarded as important mechanisms to ensure transparency. Several respondents thought that the entities called to testify take the hearings seriously and invest time in preparing their remarks. One respondent thought that the HPC calls the right entities to testify at the hearings, and that those put on the "hot seat" are the entities that contribute most to the cost growth problem.

"[Cross-examinations at the Cost Trends Hearings are intended to] make it somewhat uncomfortable… [so that payers and providers] don't get a free pass to do whatever they want, or whatever they can, and to create some countervailing pressure [to cost growth actions]."

Several respondents said they believe the Cost Trend Hearings have maintained their relevance over time and remain "a can't-miss event for those that care about health care policy." In recent years, the HPC has tried to maintain interest and engagement in the hearings, for example, by shortening them and becoming more focused in its questions to payers and providers. The HPC has tried to reduce the burden on payers and providers of preparing pre-filed testimony by asking fewer questions and directing them to get to the "heart of the issue."

Limitations

Many respondents believe that public attention to, and media coverage of, the hearings has waned over time. One thought this reflected a natural drop in interest over time, once the hearings were no longer new. Others thought that the hearings lost their impact during 2020 and 2021 because the COVID-19 pandemic meant they switched from in-person events of several

days to virtual gatherings that lasted a few hours. According to respondents, the virtual setting limited engagement and opportunity for discussion and public comment. If meetings are held in person again, however, this issue might just be temporary.

Some respondents believed that, as time passed, witnesses got better at evading tough questions. Other respondents believe that the HPC board members do not ask tough enough questions or hold witnesses to account. One respondent said that the incentive for payers and providers to take the hearings seriously is to "protect themselves," and "no real changes" happen as a result. Many respondents were skeptical that the hearings represent a strong form of public accountability, because they do not have a lasting influence on organizations' behavior.

C. Cost Trends Reports and Policy Recommendations

- The annual Cost Trends Reports are valuable to many types of stakeholders, because they explain and provide deeper insights into cost trends and growth drivers. Although the governor and legislators use recommendations from the Cost Trends Reports to develop policy proposals, because so few have been enacted, many respondents believe the recommendations have little influence. Some respondents said they believe the policy recommendations would be more helpful if they proposed specific cost-containment strategies that payers, employers, and providers could readily implement. ◢

Strengths

Overall, most respondents found the HPC's annual Cost Trends Reports to be valuable, because they provide insight into cost trends and cost growth drivers. For example, a few respondents said that without the HPC's unbiased analysis, each stakeholder group would cite partial or biased reasons for growth (for example, CEO salaries). In addition, employers and smaller providers who do not have the time or resources to analyze cost drivers said they benefit from the HPC's analyses.

Respondents almost universally commended the HPC for presenting complex data and information about health system performance in the annual Cost Trends Reports in a digestible way. They cited the value of data regarding price variation by provider type, trends in outpatient hospital utilization, low-value care, and trends by service category. For example, by examining spending by service category (hospital, physician, pharmacy, etc.), the HPC found that hospital outpatient spending was the fastest-growing service category in the state in 2019. It also found that state residents used hospital outpatient care 40 percent more than residents of other states. Respondents said that these types of data make it harder for providers, particularly large health systems, to evade responsibility for spending growth. Several also noted that by regularly publishing cost data, the reports create an overall climate of accountability that encourages payers and providers to constrain spending growth.

With regard to the policy recommendations in the annual Cost Trends Reports, many state agency respondents said that they use the recommendations in the HPC's annual reports regularly to inform their policy decisions. For example, one said that the governor's health policy proposals are often based on the recommendations. Another said that the HPC's recommendations regarding the need to advance alternative payment models informed the development of the Medicaid ACO program. While some of the HPC's recommendations are intended to test the waters and spark debate among stakeholders, legislators and their staff often use the HPC's reports and recommendations to inform budget decisions and bills (see sidebar for recent examples).

Respondents cited several examples of the HPC's policy recommendations that became law. For example, following several recommendations to address the high cost of pharmaceutical drugs, the 2020 budget act gave the HPC authority to review MassHealth supplemental drug rebate negotiations.[15] Another law expanded nurse practitioners' scope of practice pursuant to an HPC recommendation to do so. With regard to out-of-network billing (also called surprise billing), the HPC made recurrent recommendations to address this issue in five consecutive Cost Trends Reports (2016–2020). In 2021, the legislature finally adopted a law to address this issue.[16] Other recent legislative activity reflects the HPC's 2021 recommendation to reduce drug spending, align pricing with value, and improve affordability. Both S.2774 and S.2397—the Senate's Pharmaceutical Access, Costs and Transparency (PACT) Act—would create accountability and transparency measures for drug manufacturers and establish oversight authority over pharmacy benefit managers. At the time of this report, those bills had not passed both the Senate and House.

Examples of 2021–2022 policy proposals and state agency actions designed to implement the recommendations in the 2021 Annual Cost Trends Report

The HPC recommended strategies **to constrain excessive provider prices**.

- In March 2022, the Baker-Polito Administration introduced S.2774, a comprehensive health care bill that includes measures to address provider prices, such as establishing limits on hospital outpatient facility fees, setting a default rate for out-of-network services, and confidential reporting of provider price changes. Similarly, H.4264, introduced in November 2021, proposed to enhance scrutiny of material changes to provider organizations' structures and/or governance.

The HPC recommended actions to **advance health equity for all** by setting new health equity targets, addressing the social determinants of health (SDOH) and improving data collection.

- The Medicaid agency, MassHealth, included proposals in its section 1115 waiver renewal application that would strengthen its Flexible Services Program to address SDOH and health-related social needs.
- The health exchange, Health Connector, included equity-focused reforms in its upcoming Seal of Approval process.
- CHIA recently launched a research series that focuses on health equity issues in Massachusetts.
- The Executive Office of Health and Human Services' Quality Measure Alignment Task Force Health Equity Technical Advisory Group recommended standardized data collection for social risk factors.

Source: HPC Board Meeting Slides July 2022, https://www.mass.gov/doc/presentation-board-meeting-july-13-2022/download. ◢

One state agency leader cited the influence of an HPC recommendation on their purchasing decisions to increase scrutiny of high-priced ambulatory providers. Most providers also thought the recommendations

[15] Under this statute, the Executive Office of Health and Human Services (EOHHS), in which the Medicaid agency (MassHealth) sits, has authority to negotiate a supplemental rebate agreement directly with pharmaceutical drug manufacturers. Beginning in Fiscal Year 2019, if the two parties are unable to reach an agreement, drug manufacturers could be referred to the HPC for review, which would trigger a broader public process. To date, the EOHHS has reached agreement on rebates with drug manufacturers, so it has not had to refer any entity to HPC.

[16] S 2984 (Chapter 260 of 2020) requires health care providers and insurance plans to notify patients of a provider's network status before a non-emergency procedure occurs so the patient can decide where to seek care and avoid receiving a surprise medical bill. The law also requires the state health department, the HPC, CHIA, and the Division of Insurance to prepare a report and make recommendations to establish fair out-of-network rates. This law also expanded nurse practitioners' scope of practice. A summary of the law's major provisions can be found at Fact Sheet: S.2984 - An Act promoting a resilient health care system that puts patients first - Senator Cindy Friedman.

are relevant and useful by identifying policies to address cost growth drivers that hospitals and physicians do not control, such as pharmaceutical costs.

Limitations

Although the governor and some legislators use recommendations from the HPC's Cost Trends Reports to develop policy *proposals*, few respondents thought the HPC's recommendations were influential, because relatively few of these recommendations have been adopted. Although the HPC board and staff members are asked by the governor, legislators, and their staff to advise on the design and operational issues associated with legislative proposals, some respondents thought the HPC should do more to promote their recommendations. One respondent said, "The reports themselves do not do much to hold people accountable to the benchmark, and unfortunately, they have largely been ignored by the legislature." Other respondents attributed the failure of the legislature to adopt HPC's recommendations to the lack of political consensus.

Several payers and providers said they do not find the HPC's policy recommendations relevant for a variety of reasons. First, there is a lag of almost two years between the measurement period and the HPC's analysis and recommendations in the Cost Trends Report. One respondent said, "You cannot use data from 2019 when making major policy recommendations for the future post-COVID." Another said, "There's so much change between 2020, 2021, and 2022 that [it's useless to] look back even to two or three years." Some payers, employers, and providers noted that the recommendations offered by the HPC were generally policy-related recommendations that were not geared toward individual organizations. Several payers thought the HPC recommendations would be more helpful if they offered specific cost containment strategies that payers, employers, and providers could readily implement. However, many of the HPC's recommendations in its early years focused on the need to develop ACOs and increase the use of Alternative Payment Models—strategies that are within the control of payers, providers, and employers.

Some respondents also thought the HPC's policy recommendations have not addressed some critical issues, such as the link between health equity and spending. The HPC's 2021 Cost Trends Report made an effort to rectify this omission by making several recommendations to advance health equity. However, some respondents believe the HPC could be a stronger voice for health equity.

D. Cost and Market Impact Reviews

- Cost and Market Impact Reviews (CMIRs) are regarded as the Health Policy Commission's most important tool for restraining consolidation in the health care market. The HPC's investigations and reports have played a role in blocking some transactions, and the HPC has conducted CMIRs for the majority of proposed acquisitions of general acute care hospitals and mergers of hospital systems, which have declined in number over time. In addition, some providers indicated that knowing a CMIR might be required influences their decisions about how to structure a proposed consolidation and with whom to partner. Still, most respondents did not think the CMIRs slowed the overall trend toward consolidation .◢

Strengths

CMIRs are regarded as the HPC's most important tool for restraining consolidation in the health care market that can affect the state's ability to meet the cost growth benchmark. CMIR investigations and

reports provide evidence to support decisions by the AGO about whether to allow or block mergers, acquisitions, and affiliations that are likely to have a significant impact on the ability of the state to keep growth below the benchmark. For example, shortly after the HPC began operations in 2013, it conducted a CMIR of Partners HealthCare System's proposed acquisitions of South Shore Hospital and Harbor Medical Associates. The report concluded that the proposed transactions would increase health care spending, likely reduce market competition, and result in increased premiums for employers and consumers. Based on the HPC's recommendations, the attorney general filed a lawsuit, which a court upheld, to block the purchases.[17] The result put the provider community on notice. Nearly all respondents believed that the CMIR process has effectively slowed or stopped some individual transactions. One respondent said, "Although [the HPC] can't say yes or no to a given proposal, [it has] a very powerful voice in the [attorney general's] decisions."

CMIRs can also shape the conditions the AGO requires for allowing transactions to proceed. For example, one respondent said that the strings attached by the AGO to the Beth Israel Leahy Health merger mirrored concerns about that transaction raised in the CMIR.[18] Other respondents commended the HPC's CMIR for findings that persuaded the attorney general to establish cost, quality, and access parameters for the merger. To the extent the HPC and AGO monitor compliance with these conditions, it represents another way to hold entities accountable.

Some providers indicated that the knowledge that certain types of transactions might be subject to a CMIR influences these providers' decisions about how to structure a merger, acquisition, or affiliation, and with whom to partner. For example, one respondent said that they decided not to merge with one of their preferred partners because they knew the HPC was closely monitoring that entity. Providers also know that if a CMIR is required, the process will be time-consuming, which can be a deterrent. Because the HPC can compel confidential information about potential transactions, organizations also think carefully about what type of information will be shared.

Providers who had been the subject of a CMIR believed that, in general, the HPC process was fair, balanced, and highly professional. Several respondents noted that the HPC's CMIRs typically received good media coverage, and helped to raise public awareness of the impact of mergers on potential cost increases. This finding is a counterpoint to the case often made by providers that mergers are beneficial, because they expand access to care.

Limitations

Although the CMIR process has affected some individual transactions, many respondents did not think it has slowed the overall trend toward market consolidation. According to one, the process "has not had an extraordinarily chilling effect. You're still seeing a lot of consolidation." Some state agency respondents also believed that the trend toward consolidation has continued over the years and that keeping up with all

[17] HPC-CMIR-2013-1: Partners HealthCare System, Inc. and South Shore Hospital https://www.mass.gov/lists/transaction-list-cost-and-market-impact-reviews#hpc-cmir-2013-1:-partners-healthcare-system,-inc.-and-south-shore-hospital- and HPC-CMIR HPC-CMIR-2013-2: Partners HealthCare System, Inc. and Harbor Medical Associates NOTE: At the request of Harbor Medical Associates https://www.mass.gov/lists/transaction-list-cost-and-market-impact-reviews#hpc-cmir-2013-2:-partners-healthcare-system,-inc.-and-harbor-medical-associates-note:-at-the-request-of-harbor-medical-associates,-certain-figures-were-redacted-from-its-written-response.-

[18] Conditions for the Beth Israel Lahey Health merger included a seven-year price cap, participation in MassHealth, and $71.6 million in investments supporting health care services for low-income and underserved communities.

of proposed mergers and acquisitions can feel like a cat-and-mouse game for the HPC and the AGO. (Since 2013, there have been 136 notices of material change.) However, the HPC noted that it has conducted CMIRs for the vast majority of proposed acquisitions of general acute care hospitals and mergers of hospital systems, and there have been fewer of these types of market changes over time. Some payer respondents thought that providers view CMIRs as just another "step they have to go through," rather than a process to ensure mergers will lower cost, and that there was "standard language that people use" regarding how mergers will produce efficiencies.

Some respondents believe the HPC's authority to review certain types of market changes is too limited. Specifically, the HPC does not have the authority to review and approve proposals to build new facilities or expand services that involve large capital expenditures, even though such market changes can have an important impact on cost increases. Instead, the DPH has the authority to review and approve such expansions under the DON process. Although the HPC can submit comments to the DPH on DON applications and on applicants' cost analyses, the HPC cannot conduct an independent review of the costs and benefits of such transactions. Several respondents thought that the HPC should have a greater say in these decisions to strengthen its oversight of market transactions that affect cost trends.[19]

E. Performance Improvement Plans

- Many respondents believed that the Health Policy Commission's review process for Performance Improvement Plans (PIPs) was rigorous, taking into account a range of factors that can cause an individual payer's or provider's spending growth to exceed the benchmark. However, until 2022, the HPC did not find "significant concerns" about any entity's spending growth after conducting numerous PIP reviews. Many respondents thought that the HPC's decision not to require any PIPs for so long led payers and providers to minimize or dismiss the importance of PIP reviews. The criteria that define which entities are subject to PIP referral and review are also perceived to have several shortcomings.◢

Strengths

Providers familiar with the PIP process said that "there is rigor to every element of that process," from how CHIA analyzes spending data to how HPC reviews the factors that contribute to excessive spending growth to determine whether to require a PIP. One respondent thought that this rigorous process caused payers and providers to be more conscientious about trying to keep their spending growth within the benchmark. Other respondents noted that the HPC's rigor extended to using multiple years of data from a variety of sources. This approach reduced the risk of making a Type 1 error—that is, a false conviction—when a payer or provider could not have controlled the factors that led to spending growth above the benchmark

[19] Since 2017, the HPC has been an official "party of record" authorized to submit comments to the DPH on DON cost analyses. For example, HPC submitted comments on Mass General Brigham's (MBG's) three DON applications in January 2022, concluding that the projects were likely to increase health care spending, drive substantial patient volume and revenue to MGB, and negatively impact market functioning. (MGB withdrew its multisite DON applications as of April 1, 2022.) In 2021, the Massachusetts House of Representatives passed bill H4253, which requires entities to notify the HPC of any proposed expansions, similar to notices of proposed mergers and acquisitions, and authorized HPC to conduct a detailed review and analysis to inform the DPH's DON decision. However, the Senate did not take up the bill, and it has not been signed into law.

Many respondents also saw the confidential nature of the PIP review process to be a strength. Meetings between the HPC and entities under PIP review are private. The confidential nature of the discussions enables the HPC to examine a range of factors that contribute to spending growth, distinguish between factors within or outside their control, and decide whether the performance of individual payers and providers referred for a PIP could "result in meaningful, cost savings" reforms.[20]

Limitations

The fact that the HPC did not find that excessive spending growth by any entity rose to the level of "significant concern" until 2022 led some respondents to question whether the PIP process is an effective accountability mechanism. Many respondents said they believe this delay led payers and providers to minimize or dismiss the importance of this accountability mechanism. One respondent noted, "If it's taken [this long] for one PIP to be required, something is not working." Another said, "There is a sense among providers and payers that [they] don't need to worry about this. 'Well, we'll have a nice, quiet conversation in the HPC boardroom, and we can all go home and feel good.'" Many payer respondents wanted to see the PIP process "actually utilized" and hoped that the HPC would take actions to make the PIP process more robust.[21]

Total Medical Expenditures (TME)

- For payers, total medical expenditures (TME) measure all amounts paid to providers for their members, including all categories of medical expenses; non-claims-related payments, including provider performance payments; and member cost-sharing.
- For providers, TME measures total medical spending for patients required by their insurance plan to select a primary care provider (PCP) or be attributed to a PCP under a contract between a payer and the provider, referred to as managing physician groups.
- Because hospitals and health systems are only held accountable for spending by their affiliated physicians' primary care patients, they are not accountable for hospital spending for patients with primary care providers affiliated with other systems, or are not attributed to any PCP.
- TME is adjusted for health status, based on the diagnoses and conditions recorded in patients' medical records, age, and other demographic characteristics. ◢

Many respondents agreed with the HPC's assessment that the health care entities subject to the PIP review process do not include some that are responsible for major cost growth. For example, the PIP referral criteria are defined in such a way that they exclude consideration of hospital spending for patients with primary care providers that are not affiliated with the hospital's health system (see sidebar, Total Medical Expenditures).[22] In addition, pharmaceutical companies are not subject to PIP review.

Further, many providers thought that the criteria for PIP referrals focus too much on annual growth in spending, and not enough on the level of spending. Limiting the criteria for PIP referrals to spending growth enables high-price providers to continue charging high prices to commercial payers, as long as their growth rate remains below the benchmark, perpetuating inequities between high- and low-priced providers. On a related note, some providers thought that the PIP referral criteria should make exceptions for safety net providers, whose payer mix is disproportionately from public programs like Medicaid and Medicare. The PIP review process takes into account price increases from public payers. However, some safety net providers thought that the criteria for making referrals should grant an exemption for entities

[20] Massachusetts Health Policy Commission. "Performance Improvement Plan Process Overview." January 2022. https://www.mass.gov/doc/performance-improvement-plan-process-overview/download.

[21] Respondents' comments were made before the HPC voted to require its first PIP in January 2022.

[22] Massachusetts Health Policy Commission. "Meeting of the Market Oversight and Transparency Committee." October 6, 2021. https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

whose share of total revenue from public payers exceeds a certain threshold. Providers are also concerned about the HPC's recommendation in the 2021 Cost Trends Report to allow CHIA to use metrics other than health-status adjusted TME, including potentially non-adjusted TME, to address medical condition "upcoding," which masks spending growth. Providers are concerned that such a change would hold them responsible for spending growth factors beyond their control. One respondent said, "We have to agree on what is appropriate adjustment versus utilizing unadjusted figures." Payers also took issue with the time lag between the period when spending growth exceeded the benchmark and the PIP review. They said it was hard to act on findings when they reflect contract negotiations that occurred several years earlier. To address this problem, CHIA indicated that it is trying to shorten the lag between data collection and PIP referrals.

Few respondents could comment on how the PIP process influenced individual organization's behavior due to the opaque nature of the process. Those that could comment said that they often discussed the factors that they could or could not control that contributed to spending growth. For example, large providers indicated they can control certain factors that affect total spending, such as the use of tertiary medical centers, and admissions to hospitals and skilled nursing facilities. In contrast, physicians in small practices and clinics said that they do not consider how the cost of providing care to their patients affects spending in relation to the benchmark. Small providers are not insensitive to costs, but they do not have the time or data systems needed to track spending. Private and public payers alike cited the COVID-19 pandemic as an external factor that made it difficult to control spending.

F. Evolution in the overall influence of the health care cost growth benchmark initiative

- Although most respondents believe the benchmark initiative as a whole has helped to control cost growth, many say its influence has waned over time in response to how the Health Policy Commission implemented some of the accountability mechanisms, and as all stakeholders came to understand its limitations.◢

The HPC achieved early success shortly after it began operating in 2012 through effective use of its accountability tools and authority. After the HPC conducted the first CMIR and issued its final reports on Partners HealthCare System's proposed acquisitions, and the attorney general filed a lawsuit to block the purchases, payers and providers took the HPC seriously. The achievement demonstrated the HPC's independence from political interference that otherwise might have limited its ability to challenge the state's biggest health system. In addition, the first several annual Cost Trends Hearings were major events that raised public awareness and transparency around health care costs. By convening key stakeholders annually to discuss cost trends and cost growth drivers and requiring payers and providers to speak on record about their cost containment practices, the HPC created an overall climate of accountability. Many stakeholders emphasized the importance of the benchmark itself as a shared goal amongst all parties to ensure health costs remain affordable.

Although all stakeholders still support the goal of cost containment in concept, the practical influence of the benchmark on payers and providers has waned over time, and the sentinel effect of the HPC's accountability mechanisms has become less powerful. The cost growth benchmark helped unite key stakeholders around a common goal to contain costs. In the early years of the initiative, payers and providers were motivated to meet the benchmark, reinforced by the media attention paid to the HPC's

reports and CMIRs.[23] One respondent noted that "most of the law is predicated on public shaming," and payers and providers did not want to be called out for noncompliance. Over time, however, the broad commitment to the goal of restraining cost growth and the influence of transparency on payer and provider behavior has diminished. As the novelty of the HPC wore off, there was less public attention and media coverage of the benchmark and the entities that surpassed it, diminishing payers' and providers' concern about negative press. During the COVID-19 pandemic, when providers faced extraordinary demands, concerns about holding down cost growth were put on the back burner. But according to some payers, a number of providers were asking for double-digit rate increases even before the pandemic, with little regard to the implications on meeting the cost growth benchmark, after many years in which none of the entities referred for PIP review were deemed to have excessive spending growth.

Limits of the scope and authority of HPC's accountability mechanisms became clear over time. Over nearly a decade, stakeholders gained a better understanding of the limits of Chapter 224, and the way in which it confines the HPC's ability to manage or influence certain drivers of cost growth. The HPC can promulgate regulations and has done so 11 times.[24] But the HPC has limited authority to directly regulate providers or health plans. The HPC can submit official comments to the DPH regarding Determination of Need applications, but it does not have the authority to block the expansion or building of new health facilities. The HPC can identify a critical cost driver—such as hospitals' acquisition of physician practices, which allow hospitals to charge higher facility fees—but the HPC does not have authority to implement the policy recommendations it made to address this problem.

The limits of PIPs as an accountability mechanism have also become clear—in particular, the way the definition of TME limits the types of entities that can be held accountable (that is, the exclusion of hospital spending for patients with primary care providers affiliated with health systems owned by other hospitals or those who are not attributed to any primary care provider). As a result, only payers and primary care providers are subject to PIP referral, while hospital spending for patients not assigned by their insurer to a primary care provider is exempt. [25] In addition, high spending levels and high prices do not trigger a PIP referral. Pharmaceutical manufacturers and pharmacy benefit managers are also exempt from accountability for spending growth.

Respondents believe the HPC has implemented the accountability mechanisms effectively, but

The First PIP

It took more than seven years for the HPC to require an entity to prepare a Performance Improvement Plan (PIP), leading many payers and providers to believe that a PIP referral did not having serious consequences. After the HPC Board voted to require Mass General Brigham (MGB) to prepare a PIP in January 2022—the first one in its history—the prospect of preparing a PIP might regain its influence on payer and provider spending. All stakeholders are watching closely to see how the MGB PIP process plays out to shed light on the strength of this accountability mechanism.

For details, see https://www.mass.gov/service-details/performance-improvement-plan-mass-general-brigham

[23] For example, see www.bostonglobe.com/business/2013/06/19/state-commission-launches-review-partners-plan-take-over-south-shore-hospital/Dr3E4qKnKda3CZni5IKYmI/story.html and https://www.bostonglobe.com/business/2013/12/17/commission-report-warn-partners-expansion-south-shore-would-raise-costs-hurt-competition/snjBrHJohHUJDRAmapLHOO/story.html.

[24] https://www.mass.gov/service-details/hpc-regulations-and-guidance

[25] HPC Market Oversight and Transparency Committee, October 6, 2021. Accountability for the Health Care Cost Growth Benchmark, Slides 44–45. https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

some had concerns about some of its decisions and the HPC Board representation. All respondents uniformly regard HPC and CHIA staff as highly skilled and knowledgeable analysts, lending a high degree of credibility to their analyses and reports. More broadly, many respondents said that the HPC's use of its accountability mechanisms has helped to advance the conversation on the drivers of health care costs and educate legislators and consumers about cost drivers. Before the benchmark and HPC's activities, the insurance rate review process was the only mechanism to examine cost growth, and focused on spending by insurers. The HPC has shed light on the role high prices charged by some providers play as a major cost driver. As one respondent said, "The data about the cost drivers is essential, or else there'll be urban legends about what the cost drivers are, like CEO salaries."

> ***"I think that what really makes [the cost growth benchmark] so powerful is the credibility that the HPC and CHIA bring to the table. We know that very thoughtful and thorough data analysis underlies their work. They are highly respected, both the staff and the commission. They command a place that they've been given by the statute, and I think that is really what has made them as successful as they have been."***

Some respondents raised questions about some of the HPC's decisions and board representation. Before January 2022, when the HPC Board first voted to require an entity to submit a PIP, several respondents criticized the HPC for being too lenient in its use of PIPs. In addition, consumer representatives say that most consumers cannot participate meaningfully in the annual Cost Trend Hearings because of the technical nature of the discussions, and that the benchmark does not account for growth in consumers' out-of-pocket costs. Consumer representatives also noted a lack of diversity among HPC board members that dampens the board's credibility with underrepresented populations. Other respondents thought the board did not include enough hospital administrators and employer representatives.

To address the limitations of Chapter 224, most respondents recommend stronger enforcement and "more teeth" going forward. The limited scope and reach of PIP, combined with cost growth trends in 2018 and 2019 that exceeded the benchmark, led most respondents to say the time had come to give the HPC or other state agencies stronger enforcement tools to curb cost growth trends. The HPC's 2021 Cost Trends Report recommended that the legislature take several steps to strengthen accountability for excessive spending (Massachusetts HPC 2021; see sidebar). Most respondents supported these recommendations, and several bills were introduced in the House and Senate that would adopt the recommendations. At the time of this report, none have been enacted yet.

2021 Cost Trends Reports recommendations

The HPC recommended that the legislature:

1. Establish price caps and limit price growth for the highest-priced providers
2. Limit facility fees that raise the cost of care at hospital outpatient sites higher than the cost of the same care in physician offices and require site-neutral payment for basic office visits and common ambulatory services
3. Enhance scrutiny of providers' major expansion plans
4. Adopt default out-of-network payment rates for surprise billing situations

IV. Lessons and Considerations for Other States

Following Massachusetts's lead, as of 2022, eight states (California, Connecticut, Delaware, Nevada, New Jersey, Rhode Island, Oregon, and Washington) adopted programs by law or executive action setting health care cost growth benchmarks. In addition, Maine recently passed legislation requiring annual reports and public hearings on cost trends to enhance transparency of health care spending.[26]

Setting a cost growth benchmark is an important step toward restraining health care spending increases, because it establishes a shared goal and gives the state and health care entities a concrete target around which cost growth can be measured and accountability mechanisms attached. But the influence of a benchmark on payers and providers depends on the ability to hold them accountable for meeting it. The findings from this study raise important lessons and considerations for policymakers in other states about the design and use of accountability mechanisms. This section discusses these lessons and considerations and organizes them into three sets: (1) accountability for meeting the benchmark, (2) oversight authority and resources, (3) and incentives for compliance (Exhibit V.1). Policymakers in other states might answer these questions in different ways, depending on the characteristics of the health care market, the capacity and resources of state agencies tasked with implementing benchmarking initiatives, and the political environment in each state.

Exhibit V.1. Considerations for the design and use of accountability mechanisms

Issues	Considerations
Accountability for meeting the benchmark	**1.** Which entities should be accountable for keeping spending growth below the benchmark? **2.** Should state benchmark laws hold entities accountable for level of spending as well as the annual rate of growth? **3.** How should consumer out-of-pocket costs be considered in cost growth benchmarks? **4.** How much flexibility should state agencies have to decide whether spending growth above the benchmark is justified?
Oversight authority and resources	**5.** Which agencies should have power to enforce compliance with the benchmark? **6.** Which criteria warrant the use of greater enforcement powers or regulatory levers? **7.** What are the critical capabilities and resources needed to successfully implement accountability mechanisms?
Incentives for compliance	**8.** What types and amounts of penalties are appropriate to motivate compliance? Should states balance penalties ('sticks') with positive incentives ('carrots')? **9.** What tools can states use to encourage submission of timely, complete, and accurate data?

A. Accountability for meeting the benchmark

Which entities should be accountable for keeping spending growth below the benchmark?

Chapter 224 gave the HPC the authority to require PIPs to hold individual payers and certain types of providers accountable for excessive spending growth. By excluding hospitals from accountability for spending increases above the benchmark for patients not seen by affiliated primary care physician groups,

[26] Maine Act 459, 2021.

the statue effectively removed hospitals from the HPC's reach. The law also excluded pharmaceutical manufacturers and pharmacy benefit managers. To be able to hold accountable all health care entities whose business decisions drive health care spending growth, state policymakers should consider which entities should be held accountable through the PIP process. This approach might require state officials to list and define all accountable entities, and to devise spending metrics appropriate to each type of accountable entity.

Should state benchmark laws hold entities accountable for the level of spending as well as growth in spending?

Massachusetts compares the annual rate of growth in TME by individual payers and providers with the cost growth benchmark. However, TME does not consider the entities' baseline level of spending, which is total spending per person (the product of price times volume). Therefore, high-priced providers with yearly changes that fall below the benchmark are not be subject to a review, but low-priced providers with high single-year increases might be subject to a PIP review. In this way, some providers felt that the benchmark maintains payment inequities and ties the HPC's hands when trying to address price variation and high prices, one of the primary drivers of cost growth. State policymakers should consider whether to give state agencies authority to review and hold accountable entities for the level of spending and/or prices charged to commercial payers that are significantly above the state average. Washington State granted authority to the Health Care Cost Transparency Board to establish the benchmark by selecting "an appropriate economic indicator" and initially apply the benchmark to the "highest cost drivers" in the health system, which could open the door to addressing high prices if they are identified as a major cost growth driver. However, examining spending through metrics in addition to growth adds a layer of complication, and states need to consider the additional resources that may be required to analyze them.

How should consumer out-of-pocket costs be considered in cost growth benchmarks?

State policymakers should also consider whether and how the benchmark addresses out-of-pocket costs paid by consumers. For example, although the expenditures counted in the Massachusetts TME include patient cost sharing for deductibles, copayments, and co-insurance, the benchmark growth rate does not consider how such costs are borne by household with varying income levels.[27] In addition, it does not take into account services that are not covered in insurance packages, such as vision and dental care, and long-term services and supports (nonmedical services that help people with disabilities remain at home). According to one respondent, "For the benchmark to be effective, it needs to connect with what consumers pay for and how their costs are rising."

In Massachusetts, the HPC's 2021 Cost Trends Report recommended the development of consumer affordability standards and targets, and bills were introduced to create a consumer health care benchmark (HB1247/SB782), defined as the average aggregate growth in out-of-pocket health care cost growth and premium cost growth, initially set at the same as the state's overall cost growth benchmark. The bills proposed to hold insurers accountable for keeping consumer cost growth below the benchmark, and would be enforced by the Department of Insurance through its annual rate reviews. The Massachusetts Health Connector also has an affordability schedule that is used to determine eligibility for financial assistance to cover the cost of insurance premiums.

[27] In 2019, 17 percent of insured Massachusetts residents said that their family had medical debt attributable to insurance costs (CHIA 2021).

Some states have already developed a **consumer affordability standards** separate from the overall cost growth benchmark. Connecticut, for example, created a Healthcare Affordability Index that measures the impact of health care premiums and out-of-pocket costs on households' ability to meet their basic needs (Connecticut Office of Health Strategy 2021). In designing such a benchmark, it is important to consider how it will be enforced, and if the consumer benchmark is exceeded, how to hold accountable insurance companies and employers that are responsible for increases in premium growth and out-of-pocket costs.

How much flexibility should state agencies have to decide whether spending growth above the benchmark is justified?

Chapter 224 listed the criteria that can be considered when deciding whether to require a PIP.[28] However, the list leaves considerable discretion to the HPC Board and staff. They can decide which factors to consider, how much weight to give each one, whether the drivers of cost growth are within or outside the entity's control, whether the entity has made a good faith effort to control spending growth, and whether taken together, the considerations raise "significant concerns and that a PIP could result in meaningful, cost-saving reforms."[29]

To make PIPs an effective deterrent to exceeding the benchmark, state policymakers should consider whether to make the criteria that trigger a PIP more prescriptive and objective. For example, the criteria could specify the number of years in which spending growth exceeds the benchmark that make a PIP mandatory, or they could define the factors that are within payer and provider control.

In 2021, Oregon passed legislation authorizing the Oregon Health Authority to issue enforcement rules that are somewhat more prescriptive than those in Massachusetts, although they still give regulators room to apply judgment. [30] The rules must define the criteria for penalizing any provider or payer that "exceeds the cost growth target without reasonable cause in three out of five calendar years." The criteria must be based on the size of the entity; good faith efforts to address costs; payer or provider cooperation with the authority; overlapping penalties imposed for failing to meet the target, such as those related to medical loss ratios; and a provider or payer's overall performance in reducing costs across all markets. The Oregon Health Authority can waive the requirement for a provider or payer to undertake a PIP according to criteria established by rule, "if necessitated by unforeseen market conditions or other equitable factors."

B. Oversight authority

Which agencies should have power to enforce compliance with the benchmark*?*

When setting up the structures, processes, and enforcement mechanisms associated with a cost growth benchmark, states need to decide which agencies will be responsible for monitoring and holding entities accountable for meeting the benchmark, and how much authority such an entity should be granted. Massachusetts legislators granted power to monitor and assess performance relative to the benchmark to

[28] These include an organization's health-status adjusted TME, size of the entity, its market share, spending trends over time, and utilization patterns, among others. See the complete list of factors required by statute and HPC regulation at https://www.mass.gov/doc/performance-improvement-plan-process-overview/download.

[29] MA HPC. Performance Improvement Plan Process Overview. January 2022. https://www.mass.gov/doc/performance-improvement-plan-process-overview/download.

[30] Oregon House Bill 2081, Sec. 2. Oregon Revised Statues, 442.386 (9)

https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled.

the HPC, an independent agency that operates with support from the data collection agency (CHIA). They also intentionally separated the HPC's authority from other agencies with established regulatory authority, such as the Division of Insurance, which regulates insurance companies, or the DPH, which regulates health providers and facilities.

There are pros and cons to this structure. The HPC Board, at least to some degree, is insulated from political influence of the executive branch and elected officials. In contrast, the Insurance Commissioner in Massachusetts is elected, as is the case in many other states. The DPH, which has the authority to review and approve facility expansions, might be more susceptible to political influence than the HPC because its commissioner is appointed by the governor. But although the HPC can share the findings and conclusions of its investigations with the AGO, DPH, and Division of Insurance—both formally and informally—these other agencies are not required to follow the HPC's recommendations, nor must these agencies abide by the benchmark when making policy and regulatory decisions.

Other states gave responsibility for monitoring and holding entities accountable for meeting the benchmark to an agency with existing regulatory authority—for example, the Delaware Health Care Commission, the Rhode Island Office of the Insurance Commissioner, and the Oregon and Washington State Health Care Authorities. This approach might strengthen these agencies' ability to use the benchmark in policy decisions, such as insurance rate reviews.

Which criteria warrant the use of greater enforcement powers or regulatory levers?

Chapter 224 created a framework for increased regulation by directing the HPC commission to make recommendations for proposed legislation if spending trends fail to moderate (Mechanic et al. 2012). However, Chapter 224 did not grant the HPC or other state agencies authority to adopt specific policies or regulations. As noted above, after CHIA and the HPC reported that total health care expenditures in 2019 exceeded the benchmark for the second year in a row, the HPC recommended that the state enact legislation to strengthen accountability mechanisms. Several bills were introduced in the House and Senate to do so, but at the time of this report, none have passed. The challenge of gaining political support for stronger enforcement tools led several respondents stakeholders in Massachusetts to advise policymakers in other states to build in flexibility for the benchmark model to evolve, in response to changing market dynamics.

Policymakers in other states thus have a choice. First, they can take the same approach as Massachusetts, requiring elected officials to decide whether to give state agencies more authority or stronger tools to enforce compliance with spending growth targets. This was the approach taken by Massachusetts to gain payer and provider support for the benchmark initially, which gave them a chance to demonstrate their commitment voluntarily before resorting to stronger measures. Alternatively, policymakers can grant state agencies authority to use stronger enforcement tools from the start, and establish the criteria for their use without enacting new laws or amending state statutes. Such criteria could include the number of years that overall spending increases are above the benchmark, the degree to which spending growth exceeds the benchmark, the number of entities exceeding the cost growth benchmark, or other factors indicating that transparency and persuasion are insufficient to control cost growth.

Whether one of the enforcement tools should include the imposition of price caps or other forms of price regulation is an important decision. As noted earlier, for the last several years, the primary cause of health care cost increases has been high prices that health care providers and drug companies charge to private health insurance companies. In most states, price regulation is regarded as a last resort, after all other

efforts to strengthen market competition have failed. If evidence shows that price increases continue to be the primary driver of cost growth, states could consider adding legislative provisions that authorize price caps for the highest priced providers, or adding high prices or high rates of price growth to the criteria for PIP referral and review. States could also grant authority to the Insurance Commissioner, as in Rhode Island, to require insurers to limit annual hospital inpatient and outpatient price growth and enforce such limits through review and approval of annual premium rate increases.

What are the critical capabilities and resources needed to effectively implement accountability mechanisms?

The success of state programs to set benchmarks for health care cost growth depends on the ability to collect and analyze detailed cost and spending data from a range of sources; validate the data to ensure they are as accurate, complete, and timely as possible; and conduct robust analyses to identify cost drivers and draw well-reasoned policy recommendations. In Massachusetts, the HPC and CHIA staff have expertise in a range of health policy issues, and in data, legal, and policy analysis. The HPC also has authority to compel entities to provide propriety information for CMIRs. CHIA has enhanced the collection and validation of spending data. Both agencies have relatively ample budgets.

Consequently, when establishing the structure and authority of the entity responsible for monitoring the benchmark, it is important that state policymakers consider the level of funding and resources required to ensure its success. As an independent agency, the HPC staff can be paid at higher levels than other state government employees. The HPC's budget also includes funds to hire outside consultants that are particularly useful in conducting CMIRs, both because of the complex financial and legal issues, and because they involve a high level of effort. According to one respondent, "If you don't commit the resources, you're doing a disservice" to the staff charged with this responsibility.

C. Incentives for compliance

What types and amounts of penalties are appropriate to motivate compliance? Should states balance penalties with positive incentives?

In Massachusetts, the maximum financial penalty for failing to meet the spending growth target is $500,000 if an entity that is required to submit a PIP does not do so, or prepares a PIP that the HPC Board deems unsatisfactory. This amount is not related to the entity's revenue or spending levels, and some respondents thought this amount was insufficient to motivate the state's largest providers to comply. One stakeholder said, "The real power in the PIP process is probably shame and humiliation more than it is the $500,000 fine if you don't do it." The HPC's 2021 Cost Trends Report recommended increasing financial penalties for noncompliance or spending above the benchmark. To strengthen the incentives to comply with the benchmark and cooperate with state officials, state policymakers could consider tying the financial penalty to an entity's total revenue. States could also consider imposing penalties for payer and provider actions, such as medical coding practices, that mask spending increases.

The HPC uses several strategies to encourage compliance with the benchmark. It identifies entities that do not adhere to the benchmark in its annual Cost Trends Reports. It raises the risk of legal action by conducing CMIRs. It can also require entities with excessive cost growth to submit a PIP that will be made available publicly, and impose fines on entities that fail to comply with mandated PIPs. However, entities that comply with the benchmark do not receive any rewards. State policymakers could consider the value of adding positive incentives (carrots) to the negative incentives (sticks). For example, states

could consider public recognition programs for entities that consistently comply with the benchmark, such as honorable mention in the Cost Trends Reports, on state websites, or other materials.

What tools can states use to encourage submission of timely, complete, accurate data?

The importance of high-quality data to the success of health care cost benchmarking initiatives also suggests that state policymakers could consider incentives to submit timely, complete, accurate data. This is not something Massachusetts currently does, but several stakeholders recommended this as a potential improvement. For example, states could allow the agency to levy penalties on entities that submit late, incomplete, or inaccurate data, just as some Medicaid agencies do when managed care organizations submit encounter data that do not meet certain thresholds.

V. Conclusion

Massachusetts was the first state in the country to adopt and implement a health care cost growth benchmark initiative. Ten years after the state legislature enacted Chapter 224, all parties involved in its implementation continue to support a cost control framework that makes cost and spending data more transparent, promotes public dialogue, prospectively assesses the impact of health market transactions on costs, and holds individual health care payers and providers accountable for cost growth performance.

Although the influence of the benchmark and the HPC's accountability mechanisms appear to have waned over time, their collective impact remains strong. Expectations for payers, providers, and state agencies to control cost growth have become embedded in the cultural values of the state's health care system. Individual health care entities know they can, and will, be held up for inspection if cost growth becomes excessive, as the HPC's decision to require the first PIP demonstrated.

At the same time, Massachusetts' experience illustrates the limitations of a cost control framework that relies on public oversight and transparency of health care spending, and on voluntary cooperation by payers and provider health care entities to keep annual cost growth below the target, but that grants the HPC few (or very weak) tools for enforcement. These limitations reflect the political compromise that led to the adoption of Chapter 224 in 2012. Rather than relying on either unfettered market competition or regulation to control costs, the benchmark and the HPC's accountability mechanisms represent a middle ground.

But after nearly 10 years using these accountability mechanisms, it is time to reassess their strength. The factors that led to statewide health care spending growth that exceeded the benchmark in 2018 and 2019 led the HPC to conclude that despite efforts to address health care pricing failures, they "have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider prices" (Massachusetts HPC 2021). This finding is not an indictment of market competition. Instead, it indicates the limits of transparency—shining a bright light on health spending—and relying on good faith efforts by all parties to control costs.

Other states can learn many things from Massachusetts' experience, but the most important might be that constraining cost growth is not a "one and done" exercise. State policymakers must continually monitor market trends and refine existing policies or enact new ones to address emerging drivers of health care cost growth and respond to changes in the health care market. California policymakers learned the same lesson after failing to update policies in response to changes in the hospital market that led to large cost increases (Melnick et al. 2018). States that establish cost growth benchmark programs could benefit from mechanisms to solicit feedback from key stakeholders—for example, by establishing advisory boards on the effectiveness of accountability mechanisms and potential improvements to them to ensure the state achieves its cost growth targets.

For market competition and transparency to serve as effective strategies to contain costs, states must continually assess whether oversight is sufficient to control cost increases. If it is not sufficient, states need to determine what measures are needed to shift competition toward quality, or use regulation to restrain the forces that increase spending.

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Appendix A

Massachusetts Health Care
Cost Growth Benchmark Factsheets

Massachusetts Health Care Cost Growth Benchmark Factsheets

1: Annual Health Care Cost Trends Reports

To contain health care cost increases, Massachusetts enacted Chapter 224 in 2012, which established a first-in-the-nation target, called a benchmark, for annual growth in total statewide health care spending. Among other things, the law created a Health Policy Commission (HPC) and granted it authority to hold payers and providers accountable for keeping annual cost growth below the benchmark. To inform other states that have adopted similar cost growth benchmark initiatives, this Factsheet series describes the HPC's four accountability tools and how they have been used to date.

Overview

The Health Policy Commission (HPC) prepares annual **Health Care Cost Trends Reports**, which assess overall health care spending growth patterns in Massachusetts and analyze key drivers of cost growth. These reports also make recommendations regarding public policies and actions by private payers and providers that can help to restrain cost growth and improve the efficiency of the health care system. Along with the annual Cost Trends Hearings, the annual Cost Trends Reports are key mechanisms to inform policymakers, health care stakeholders, and the public about health care spending and the major factors that contribute to its cost.

Development of annual Cost Trends Reports

Collect and analyze spending data

Evaluate state performance against the benchmark

Analyze data to identify cost drivers

Develop policy recommendations

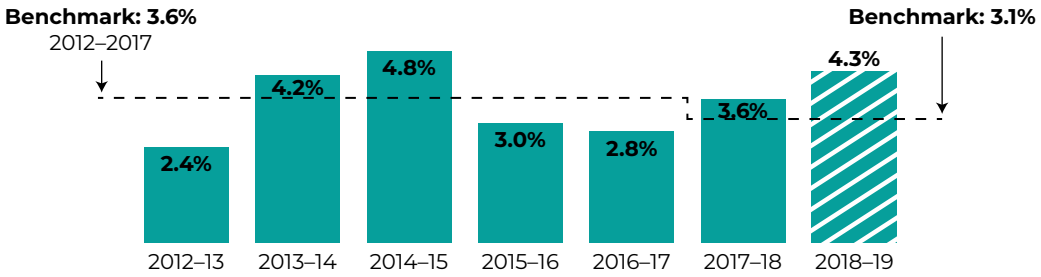
Publicly release annual Cost Trends Report

Monitoring spending trends

Every year, the Center for Health Information and Analysis (CHIA) collects data from payers and prepares a report evaluating the state's total health care spending growth per capita (including public and private payers) relative to the cost growth benchmark (see below chart for an example). The HPC then compares annual spending trends to national growth rates, examines per person spending trends by market sector (commercial, Medicaid, Medicare fee-for-service, and Medicare Advantage), and breaks out spending trends by major service categories.

Total health care expenditures include health care spending by individuals (e.g., co-payments, co-insurance, and insurance deductibles), health insurers (e.g., claims, administrative expenses, incentive payments), the state (e.g., Medicaid and public employee health benefits), and the federal government (e.g., Medicaid and Medicare).

Annual growth in total health care expenditures per capita in Massachusetts



Notes: 2018-2019 spending growth is preliminary.
Sources: Center for Health Information and Analysis Reports 2013-2020

Chapter 224 set the total health care spending growth benchmark equal to the projected growth in annual potential gross state product (PGSP) from 2013-2017, which was 3.6 percent. It reduced the benchmark to 3.1 percent of GSP from 2018-2022, unless the HPC determined that an adjustment was necessary. For 2023 and beyond, the HPC has authority to recommend changes in the benchmark, approved by a two-thirds vote of the board, to the legislature.

The Peterson Center on Healthcare commissioned Mathematica to conduct a process evaluation to understand how key stakeholders perceive the influence of the cost growth benchmark on their actions, and the HPC's use of policy levers and strategies to hold payers and providers accountable for meeting the benchmark. The final report will identify lessons from Massachusetts' experience for other states now setting cost growth benchmarks. This factsheet synthesizes information from numerous HPC documents, available at https://www.mass.gov/orgs/massachusetts-health-policy-commission.

Massachusetts Health Care Cost Growth Benchmark Factsheets: Annual Health Care Cost Trends Reports, #1. May 2022. Mathematica.

Analyzing cost drivers

The Cost Trends Reports examine changes in the two key components of health care costs: price and utilization. The HPC assesses change in average prices due to the amounts paid to providers for each service (the unit price) as well as prices charged by individual providers, which can vary substantially for any given service and across payers. The HPC reports also drill down into the factors that explain changes in utilization, including how many people use services, how often they use them, in which care settings they receive services, and the intensity of services.

Hospital outpatient spending has consistently been a major driver of spending in Massachusetts, and the 2021 Cost Trends Report found it was the largest category of spending growth in 2019.

- **Price:** Prices for hospital outpatient care grew overall, but prices varied by facility type. Smaller community hospitals tend to charge prices on par with Medicare, while other hospitals have prices nearly triple that of Medicare. Higher prices are more common at large Academic Medical Centers (AMCs).
- **Utilization:** Utilization of hospital outpatient services also increased in 2019. Because much of that growth occurred at AMCs, it drove cost growth even more due to higher prices at those centers.

Recommendations to control cost growth

Based on the analysis of cost trend drivers, the HPC Board of Commissioners makes recommendations that focus on aspects of the health care system that can be influenced by policymakers, government agencies, and market participants in the state. The HPC commissioners make recommendations that cover a broad range of issues, though the main focus is on four major categories.

	Description	Recurring issues	Example recommendations/legislation
Cost Containment	Prices, system capacity, payment and delivery reform, and market structure and consolidation	• Hospital outpatient spending (see box) • Prescription drug prices consistently drive spending growth due to high prices and lack of price transparency by pharmacy benefit managers • Low-value care and unnecessary care result in higher spending and waste in the health care system	• Encourage greater use of Alternative Payment Models, which encourage high-value care and coordination • Grant payers the authority to directly negotiate with drug manufacturers • Increase transparency and state oversight of Pharmacy Benefit Managers
Accountability	The HPC's authority and tools to hold health care providers accountable for excessive spending	• "Upcoding" practices that inflate patient health status to justify higher spending, thereby avoiding accountability through the Performance Improvement Plan (PIP) referral process (see PIP Factsheet for more information) • The HPC has authority to review individual providers whose annual spending growth exceeds the benchmark, but it does not have the authority to review providers solely based on high prices or spending	• Strengthen accountability for excessive spending by allowing CHIA to use metrics other than health-status adjusted total medical expense growth to identify entities contributing to excessive spending growth, and allow the HPC to hold hospitals, in addition to primary care groups, accountable for spending growth • Establish price caps for the highest-priced providers and a Provider Price Variation Commission to distinguish acceptable and unacceptable factors contributing to price
Affordability	Actions to make health care costs more affordable to consumers and employers	• Low-income people who cannot afford out-of-pocket costs are more likely to delay primary care, resulting in higher-cost care later on • Health insurers that cover low-value health care drive up insurance premiums	• Enhance protections for out-of-network billing to prevent surprise bills for consumers • Incentivize employers to choose more affordable, high-value plans which incentivize efficiency and coverage of high-value health care
Quality, Innovation, and Access	Recommendations to improve public health, enhance data collection and transparency, and increase access to primary and preventive care	• Consumers face barriers receiving primary care due to health professional shortages • Inadequate integration of primary and behavioral health care	• Broaden the pool of primary care providers by expanding scope of practice for nurse practitioners • Invest in primary and behavioral health care and improve access for consumers
Emerging Issues	Health care issues and trends that have gained more attention in the recent years	• Health equity and social determinants of Health • Behavioral health access and integration with primary care	• The Commonwealth should set measurable goals to advance health equity • Payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations

Massachusetts Health Care Cost Growth Benchmark Factsheets

2: Annual Health Care Cost Trends Hearings

To contain health care cost increases, Massachusetts enacted Chapter 224 in 2012, which established a first-in-the-nation target, called a benchmark, for annual growth in total statewide health care spending. Among other things, the law created a Health Policy Commission (HPC) and granted it authority to hold payers and providers accountable for keeping annual cost growth below the benchmark. To inform other states that have adopted similar cost growth benchmark initiatives, this Factsheet series describes the HPC's four accountability tools and how they have been used to date.

Overview

The HPC organizes annual **Health Care Cost Trends Hearings** to focus public attention on health care cost growth and increase understanding of the factors that drive cost growth, and what major health market actors are doing to restrain growth in spending. The hearings, sometimes referred to as the "Super Bowl of Health Policy in Massachusetts," convene leading policymakers, health care providers, private and public payers, and analysts to discuss these issues in a public forum. Panelists are sworn in and provide testimony under oath, answering questions from the HPC commissioners, representatives from the Attorney General's Office and the Center for Health Information and Analysis (CHIA), and the HPC's Executive Director. The hearings set a stage for holding health care entities publicly accountable for their organizations' efforts to control spending and enhance quality and equity.

Annual Cost Trends Hearings process

Annual Cost Trends Hearings are held in the fall after CHIA releases the annual Report on the Performance of the Massachusetts Health Care System, which compares health care spending growth to the health care cost growth benchmark, creating the context for the hearings. Each year, HPC requires a cross-section of health care entities, as specified in Chapter 224, to submit pre-filed written testimony on key issues before the hearings; some of these entities are also invited to present oral testimony. Payers and providers most frequently asked to serve on witness panels are the largest, based on enrollment or revenue (Chapter 224, Section 8). HPC livestreams the hearings and posts video-recordings of them for public viewing. The testimony informs the HPC's annual Health Care Cost Trends Report, which provides in-depth analysis of health care spending growth patterns and key drivers of cost growth, along with recommendations for policymakers, payers, and providers.

HPC identifies and requests written (pre-filed) testimony from select payers, providers, and other entities

HPC collects and reviews pre-filed testimony

HPC selects and notifies entities to provide oral testimony at hearings

Entities provide oral testimony at hearings as part of topic-specific Witness Panels

Participation of elected officials and state agencies

In addition to Witness Panels, the hearings also feature Expert, Discussion, and Reactor Panels, composed of stakeholders from state agencies, academia, consumer advocacy organizations, and pharmaceutical companies, among others. Elected officials and state agencies play a large role in the hearings, both as attendees and presenters. Due to COVID-19, the 2020 and 2021 hearings were held virtually, with fewer panels and reduced participation from elected officials and state agencies.

- Staff from the **HPC, CHIA,** and the **Attorney General's Office (AGO)** present findings and trends at the hearings.
- The **Governor** and **Attorney General** deliver remarks at the hearings.
- The **HPC Board members, HPC Executive Director, CHIA Executive Director,** and **AGO** representative sit on the panel and pose questions to panelists.
- **State legislators**, including the Senate President, Speaker of the House, and chairs of the Joint Committee on Health Care Financing and Joint Committee on Public Health, have presented remarks in all in-person hearings.
- **The Group Insurance Commission (GIC)** and **MA Health Connector** (the state's Marketplace) staff are the only state agencies that have testified in Witness Panels, and **Executive Office of Health and Human Services (EOHHS)** staff have participated in one discussion panel.

The Peterson Center on Healthcare commissioned Mathematica to conduct a process evaluation to understand how key stakeholders perceive the influence of the cost growth benchmark on their actions, and the HPC's use of policy levers and strategies to hold payers and providers accountable for meeting the benchmark. The final report will identify lessons from Massachusetts' experience for other states now setting cost growth benchmarks. This factsheet synthesizes information from numerous HPC documents, available at https://www.mass.gov/orgs/massachusetts-health-policy-commission.

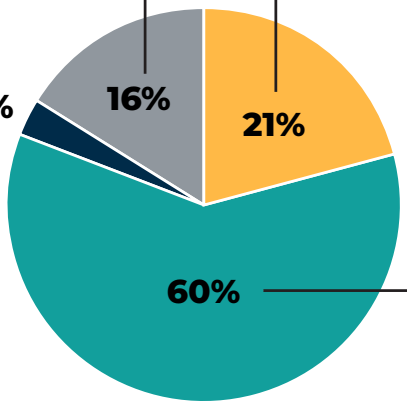
Massachusetts Health Care Cost Growth Benchmark Factsheets: Annual Health Care Cost Trends Hearings, #2. May 2022. Mathematica.

Panel composition (2013-2021)

This graph represents participation in all panel types mentioned on page one. Payers and providers participate in Witness Panels, whereas state agencies, employer groups, advocacy organizations, and others participate in Discussion and Reactor Panels.

Other
Other entities called upon to participate as panelists include researchers, consumer advocacy organizations, employers, and pharmaceutical companies.

State Agency Appointee/Staff
The GIC, MA Health Connector and EOHHS staff have participated in panels at the hearings, while staff from other state agencies participate through presentations and remarks.



Payer
Executives from the three largest payers have testified at multiple hearings, including Blue Cross Blue Shield (9 hearings), Harvard Pilgrim Health Care (7 hearings), and Tufts (6 hearings).

Provider
Hospital-based health systems are most frequently called to testify. Executives from Partners/Mass General Brigham and Lahey Health have each testified in seven cost trends hearings.

Evolution of themes in topics

Panelists at the hearings speak to topics identified by the HPC. Some themes in panel topics have remained consistent since 2013, such as the impact of changes in the provider market on overall spending; care quality, access, and affordability for consumers; and pharmaceutical spending. Topics such as primary care and advancing equity in health care have become more frequent in recent years.

Panel topic key words, 2013-2016

Panel topic key words, 2017-2021

Massachusetts Health Care Cost Growth Benchmark Factsheets

3: Cost and Market Impact Reviews

To contain health care cost increases, Massachusetts enacted Chapter 224 in 2012, which established a first-in-the-nation target, called a benchmark, for annual growth in total statewide health care spending. Among other things, the law created a Health Policy Commission (HPC) and granted it authority to hold payers and providers accountable for keeping annual cost growth below the benchmark. To inform other states that have adopted similar cost growth benchmark initiatives, this Factsheet series describes HPC's four accountability tools and how they have been used to date.

Overview

Cost and Market Impact Reviews (CMIRs) are prospective assessments of the cost and market implications of proposed mergers, acquisitions, contracting affiliations, and other market changes by health care providers. CMIRs are one of the tools that the HPC uses to hold health care providers accountable for controlling the growth of health care costs. The CMIR process ensures transparency of provider actions involving mergers, acquisitions, and other material changes that are likely to result in a significant impact on the state's ability to meet the health care cost growth benchmark, or on the competitive market (Chapter 224, Section 13). Although the HPC has authority to review and analyze the impact of proposed market changes, the HPC's process is separate from and in addition to the authority of the Attorney General's Office (AGO) to investigate and enforce laws, for example, relating to antitrust, consumer protection, and unfair methods of competition.

CMIR process

Step 1

Provider organizations file a "notice of material change."

At least 60 days before making any material change, providers must file a public notice with the HPC. Material changes include, but are not limited to:

1. A merger or affiliation with, or acquisition of or by, an insurer;
2. A merger with or acquisition of or by a hospital or hospital system;
3. An acquisition, merger, or affiliation that would substantially increase revenue, or result in a provider having a near-majority of market share in a given service or region;
4. A clinical affiliation between two or more providers;
5. A formation of a partnership, joint venture, accountable care organization, parent corporation, management services organization, or other organization created for administering contracts with carriers or third-party administrators or current or future provider contracting.

Step 2

The HPC determines if the transaction is likely to have a significant impact on the health care market.

The HPC then has 30 days to determine whether the change is likely to have a significant impact on the state's ability to meet the health care cost growth benchmark, or on the competitive market. If so, the HPC may conduct a Cost and Market Impact Review.

The HPC has conducted CMIRs for the vast majority of acquisitions of general acute care hospitals and mergers of hospital systems. These types of notices have become less frequent over time.

Year	# of notices	# of CMIRs
2021	14	0
2020	11	0
2019	11	0
2018	8	0
2017	16	2
2016	20	1
2015	20	2
2014	17	0
2013	19	4
Total number of CMIRs since 2013		**9**

Step 3

If warranted, the HPC conducts detailed analyses and releases a report summarizing its findings (the CMIR).

The HPC examines relevant factors related to the provider's market position, including:

- Size and market share;
- Prices compared to other providers for the same services in the same market;
- The provider's health-status adjusted total medical expense;
- The quality of the services it provides;
- Provider cost and cost trends;
- The role of the provider in serving public payer populations and individuals with substance use disorder and mental health conditions; and
- Any other factors the HPC determines to be in the public interest

The HPC then releases a preliminary report (allowing 30 days for provider comments) and a final report detailing the impacts of the proposed transaction on costs and market functioning, quality, and access to care.

Step 4

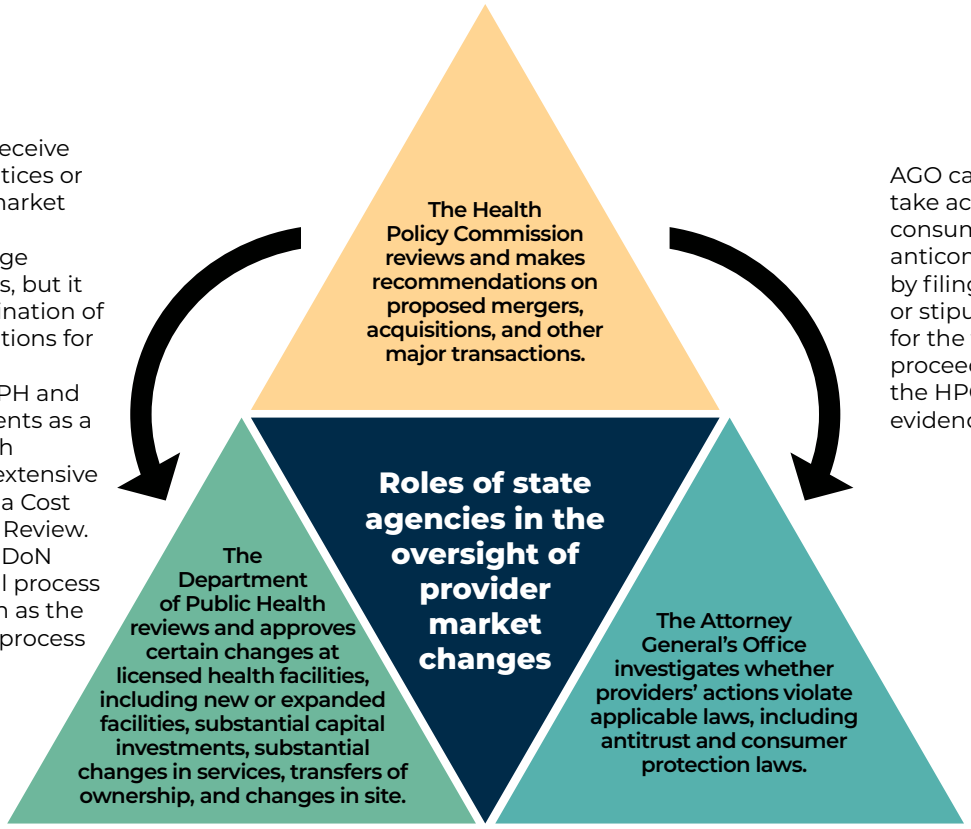
Following the CMIR, the HPC may refer its report to AGO or other state agencies.

The HPC may refer providers and make recommendations to AGO, the Department of Public Health (DPH), or other state agencies in connection with a CMIR, and must refer to AGO its report on any provider organization that meets the following criteria:

1. Has a dominant market share;
2. Charges prices for services that are materially higher than the median prices charged by all other providers for the same services in the same market; and
3. Has a health-status adjusted total medical expense that is materially higher than the median total medical expense for all other providers for the same service in the same market.

AGO may investigate the matter or pursue other action under any applicable law, including antitrust and consumer protection laws.

The HPC does not receive material change notices or conduct cost and market impact reviews in connection with large capital expenditures, but it receives all Determination of Need (DoN) applications for facility expansions submitted to the DPH and can provide comments as a party of record. Such comments can be extensive and comparable to a Cost and Market Impact Review. The Massachusetts DoN review and approval process is commonly known as the Certificate of Need process in other states.



AGO can, if appropriate, take actions to protect consumers from anticompetitive behavior by filing an antitrust case or stipulating conditions for the transaction to proceed. AGO can rely on the HPC CMIR reports as evidence in such actions.

Case example:

the Beth Israel Lahey Health Cost and Market Impact Review

In July 2017, Lahey Health System & Beth Israel Deaconess Medical Center submitted a notice of material change to merge and become a new corporate entity, Beth Israel Lahey Health (BILH).

After a 30-day initial review, the HPC determined the transaction was likely to have a significant impact on costs and market functioning in Massachusetts.

In July 2018, the HPC issued a preliminary report presenting the analysis and key findings from its review. In its final report, it concluded:

> "BILH's enhanced bargaining leverage would enable it to substantially increase commercial prices that could increase total health care spending by an estimated $128.4 million to $170.8 million annually for inpatient, outpatient, and adult primary care services."

The HPC referred the final report on the transaction to AGO to assess whether:

> "there are enforceable steps that the parties may take to mitigate concerns about the potential for significant price increases and maximize the likelihood that BILH will enhance access to high quality care, particularly for underserved populations."

The HPC also made recommendations to DPH:

> "The HPC additionally recommends that the Commissioner of the DPH reconsider the approval with conditions of the Determination of Need (DoN) Application NEWCO-17082413-TO and assess the need for additional or revised conditions to ensure that the applicable DoN are met."

In October 2018, DPH amended its April 2018 decision approving the DoN application on the formation of BILH to include additional conditions responsive to issues raised in the HPC's final report.

In November 2018, the AGO announced a resolution with BILH, which allowed the merger to proceed subject to a set of enforceable conditions, including seven-year price caps and $71.6 million in financial commitments to support health care services for low-income and underserved communities in Massachusetts.

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Massachusetts Health Care Cost Growth Benchmark Factsheets: Cost and Market Impact Reviews, #3. May 2022. Mathematica.

Massachusetts Health Care Cost Growth Benchmark Factsheets

4: Performance Improvement Plans

To contain health care cost increases, Massachusetts enacted Chapter 224 in 2012, which established a first-in-the-nation target, called a benchmark, for annual growth in total statewide health care spending. Among other things, the law created a Health Policy Commission (HPC) and granted it authority to hold payers and providers accountable for keeping annual cost growth below the benchmark. To inform other states that have adopted similar cost growth benchmark initiatives, this Factsheet series describes the HPC's four accountability tools and how they have been used to date.

Overview

Through the **Performance Improvement Plan (PIP)** process, the HPC is empowered to hold accountable individual payer and provider entities with an annual rate of spending growth that is considered excessive. Each year, CHIA refers health care entities whose health-status adjusted total medical expenditures (HSA TME) exceed the benchmark to the HPC, which then conducts a detailed, confidential examination of the entities' spending performance (of the referred contract of business and across contracts over time), market share, utilization, and other information. Currently, organizations subject to PIPs are limited to payers and managing physician groups because these are the only entity types for which the statutorily required metric of health-status adjusted total medical expenditures exists.

Since 2016, CHIA has referred dozens of entities to HPC that have exceeded the annual cost growth benchmark for one or more contracts or books of business (steps 1-2, next page). The HPC reviews the entities' performance (step 3), decides whether to examine the entity's spending patterns in detail (step 4) and collects additional information to understand the factors that explain spending growth (step 5). If the HPC finds that an organization's spending growth is excessive—that is, that it has significant concerns and that a PIP could result in meaningful, cost-saving reforms—the HPC Board of Commissioners can require the entity to submit a formal PIP (steps 6-8). The entity's PIP must describe the key drivers of spending growth and propose strategies to lower it.

Calculating HSA TME

Referrals to the HPC are based on growth in HSA TME. CHIA calculates HSA TME for two sets of entities: (1) private commercial health plans and privately administered Medicare and Medicaid plans and (2) managing physician groups, which are multi-specialty practices that include primary care providers (PCPs) and are responsible for managing and coordinating the care of their patients.

- For payers, TME is a measure of all amounts paid for their members, including all categories of medical expenses, non-claims-related payments (including provider performance payments) as well as member cost-sharing.
- For managing physician groups, TME is the measure of total medical spending for patients required by their insurance plan to select a PCP.
- In both cases, HSA TME is a measure of all medical spending for a group of patients, adjusted based on age and other demographic characteristics as well as health status, based on the diagnoses and conditions recorded in patients' medical records. TME is not adjusted for differences in covered benefits within payers and between providers. TME is segmented by insurance category (commercial, Medicare, Medicaid) and by service category (hospital inpatient, hospital outpatient, professional, pharmaceutical, etc.).

The Peterson Center on Healthcare commissioned Mathematica to conduct a process evaluation to understand how key stakeholders perceive the influence of the cost growth benchmark on their actions, and the HPC's use of policy levers and strategies to hold payers and providers accountable for meeting the benchmark. The final report will identify lessons from Massachusetts' experience for other states now setting cost growth benchmarks. This factsheet synthesizes information from numerous HPC documents, available at https://www.mass.gov/orgs/massachusetts-health-policy-commission.

Massachusetts Health Care Cost Growth Benchmark Factsheets: Performance Improvement Plans, #4. May 2022. Mathematica.

PIP referral and review process

1 CHIA collects expenditure data
CHIA collects data from health care entities on total medical expenses.

2 CHIA refers entities to the HPC
CHIA reviews all data to identify health care entities with excessive growth in health-status adjusted TME for the most recent year of data and refers these entities to the HPC.

Year of data reviewed	# of health care entities referred to the HPC by CHIA
2021	HPC stopped releasing data publicly
2020	
2019	41
2018	26
2017	20
2016	33

3 The HPC notifies referred entities and reviews available data
The HPC provides written notice to all health care entities identified by CHIA as having exceeded the benchmark. For each, the HPC conducts a confidential review and analysis of data regarding payers' and providers' performance across multiple factors.

> Criteria that the HPC considers at this stage include an organization's HSA TME, size, market share, long-term spending, financial impact, spending trends over time, and utilization patterns, among others.

4 The HPC Board of Commissioners decides whether to examine the entity's spending in detail
The commissioners deliberate and vote whether to follow up with entities based on findings in step 3.

5 The HPC gathers additional information
The HPC meets selected entities to gather additional data and assess potential explanations for cost growth.

> Additional information may include an organization's explanation for growth, data on the impact of care delivery, strategies to control spending, and referral patterns, among others.

6 The HPC Board of Commissioners decides whether to require a formal PIP
The commissioners deliberate and vote whether to require a PIP. See box at right for additional factors the HPC considers; the list is not exhaustive.

> An organization can meet with the HPC to explain its cost growth and to ensure that data being used in the determination are correct and current. The HPC may continue monitoring before or instead of requiring a PIP.

In January 2022, the HPC commissioners voted to require the first PIP. Reasons cited for requiring Mass General Brigham to complete this PIP include (1) higher baseline spending for the entity's primary care population on a health-status adjusted and unadjusted basis, (2) above-the-benchmark spending growth rates on primary care patients across multiple years and payers, (3) higher hospital and physician prices than nearly all other Massachusetts providers, and (4) spending growth for primary care patients that was driven more by price than utilization.

7 The HPC informs the organization if a PIP is required
After an affirmative vote, the HPC provides notice to the organization that it is required to file a PIP.

8 Organization files PIP, requests waiver, or requests extension
Within 45 days of receipt of written notice from the HPC, the organization either files a PIP with the HPC or files an application to waive or extend the requirement to file a PIP. In the PIP, the organization identifies the causes of its cost growth and proposes specific strategies, adjustments, actions, and measures it will implement to improve cost performance over a period of up to 18 months.

Strengths and limitations of the PIP process

Strengths

- The PIP process provides deeper insight into payer and provider spending performance.
- The PIP process distinguishes between factors that are within a payer's or provider's control (e.g., prices) and those that are unexpected or outside their control (e.g., enrollment changes, new high drug costs).
- Organizations have generally been willing to cooperate with the HPC to reduce spending growth, even without a formal PIP.
- The PIP process encourages entities to keep spending growth below the benchmark by raising the risk of having to submit a formal PIP if an organization does not take steps to improve spending performance.

Limitations

- Only payers and managing primary care groups can be referred and subject to a PIP; providers are also accountable only for their own primary care patients' spending (not, for example, spending for patients at their hospitals who have primary care providers affiliated with other systems). The HPC recently recommended that the legislature allow other types of organizations to be subject to spending review and PIP.
- Criteria for a PIP referral focuses on annual increases in HSA TME rather than price or spending levels; payers or providers with consistently high spending or prices may not be referred.
- Increasing coding intensity, or upcoding, can inflate patient risk scores and mask spending growth in health-status adjusted measures like HSA TME.
- Incentives to meet the cost growth target are relatively weak. The maximum fee for non-compliance with the PIP process is $500,000, an amount that is unrelated to the entity's spending levels.

Source: Massachusetts Health Policy Commission, October 6, 2021. Slide 45. https://www.mass.gov/doc/presentation-1062021-moat-meeting/download

Appendix B

Data, Methods and Analytic Framework

This study employed qualitative research methods to systematically examine how policies and programs are implemented, the context in which they occur, and the factors that determine whether intended outcomes are achieved. Below, we describe the data, methods, and the conceptual framework used for the analysis.

Data sources

Information and data for this study came from two major sources. First, we compiled a comprehensive set of information about the use of each accountability mechanism, and payer and provider responses through a systematic search of publicly available documents on the websites of the Health Policy Commission (HPC), Center for Health Information and Analysis (CHIA), and other Massachusetts state agencies. We developed a searchable database of the documents that classified the relevance of each document to the HPC's four accountability mechanisms, topics addressed, publication date, and relevance to the study questions. We used the database content to (1) trace the history and evolution of HPC policies and accountability mechanisms; (2) document state agency, payer and provider use of the cost growth benchmark, and involvement in HPC activities; and (3) provide background about, and tailor interview guides for, key informants participating in interviews.

Second, we developed structured protocols to conduct interviews with key stakeholders, and selected interviewees representing five groups involved in or affected by the Massachusetts health cost growth benchmark and its accountability mechanisms: (1) policymakers, including HPC Commissioners and staff, and legislators; (2) leaders of state agencies, including CHIA, the Attorney General's Office, MassHealth, the Department of Public Health, the Group Insurance Commission, and others; (3) payers, including major insurance companies and business associations; (4) providers and provider associations; and (5) consumer representatives and other key stakeholders. With assistance from HPC staff, we identified individuals in each of these respondent groups, giving preference to those in decision making positions and those who were familiar with HPC activities for much of the last decade. We adapted the protocols to each respondent type and to specific organizations, based on their role in the Massachusetts health care system and their involvement in various HPC activities.

We invited representatives from these groups to participate in interviews, ultimately holding 33 interviews with 47 people from November 2021 to March 2022 (Table B.1). For each interview, we took detailed notes and with permission from respondents, recorded the interviews, and had them transcribed. All interview respondents were assured that their identity would not be disclosed in this report.

Table B.1. Study interviews by respondent type

Respondent type	Number of interviews	Number of participants
State officials (HPC, other state agencies)	13	20
Payers	8	11
Providers	9	12
Consumer representatives and other stakeholders	3	4
Total	**33**	**47**

Interviews typically lasted 60 minutes and included discussion of the following topics:

1. **The cost growth benchmark.** We asked respondents to identify the strengths and limitations of the benchmark, describe its influence generally and on their own behavior, and discuss whether and how that influence has changed over time.
2. **The four accountability mechanisms used to implement the benchmark.** We asked respondents about their involvement with the HPC's accountability mechanisms, and their views of the strengths and limitations these mechanisms for holding entities accountable for cost growth. We also asked whether and how each of the mechanisms affected their organization's decisions and behaviors, and barriers to using or applying the HPC reports and recommendations.
3. **Lessons for other states.** We asked respondents, based on their experience, what advice they would give other states interested in using similar accountability mechanisms for cost growth benchmark initiatives.

Analytic methods and framework

To guide our analysis, we employed the Consolidated Framework for Implementation Research (CFIR), a commonly used set of domains and constructs for conducting qualitative research on the implementation of complex interventions. Using the CFIR, we developed a logic model (Exhibit B.1) that maps the components of the Massachusetts health care cost growth benchmark initiative to four applicable CFIR domains.[31] The logic model illustrates how the cost growth benchmark and HPC accountability mechanisms interact with a variety of factors to influence the actions and behaviors of state agencies, payers, and providers. The major domains include the following:

1. **Intervention elements,** which include the cost growth benchmark and the HPC accountability mechanisms, are shown in light blue boxes.
2. **Process,** which involves how HPC, including its board and staff, engages stakeholders, promotes compliance in meeting the benchmark, and overcomes resistance. These elements, which we call *mediating factors,* are shown in the dark blue box. They include (1) **timing** for when HPC began holding payers and providers accountable for cost growth; (2) **framing**, or how well HPC uses its accountability mechanisms to spur cost control efforts; (3) **credibility**, which is the degree to which stakeholders regard HPC's analysis as objective and rigorous; and (4) **the use of incentives** (positive or negative) for payers and providers to act on HPC recommendations.
3. **Outer setting,** which covers the external forces that influence organizational buy-in and voluntary compliance in keeping cost growth below the benchmark, is shown in the upper gray box. For example, for private payers and providers, external forces include health care market pressures, such as consolidation, consumer preferences and perception of quality, labor market dynamics, and reputation.
4. **Inner setting,** which covers the organization's capacity and readiness to implement the intervention, and the extent to which it is rewarded or penalized for doing so, is shown in the lower gray box. For payers and providers, internal factors include an organization's revenue and profit targets, and its leaders' commitment to cost control versus other goals. For state agencies, internal factors include the

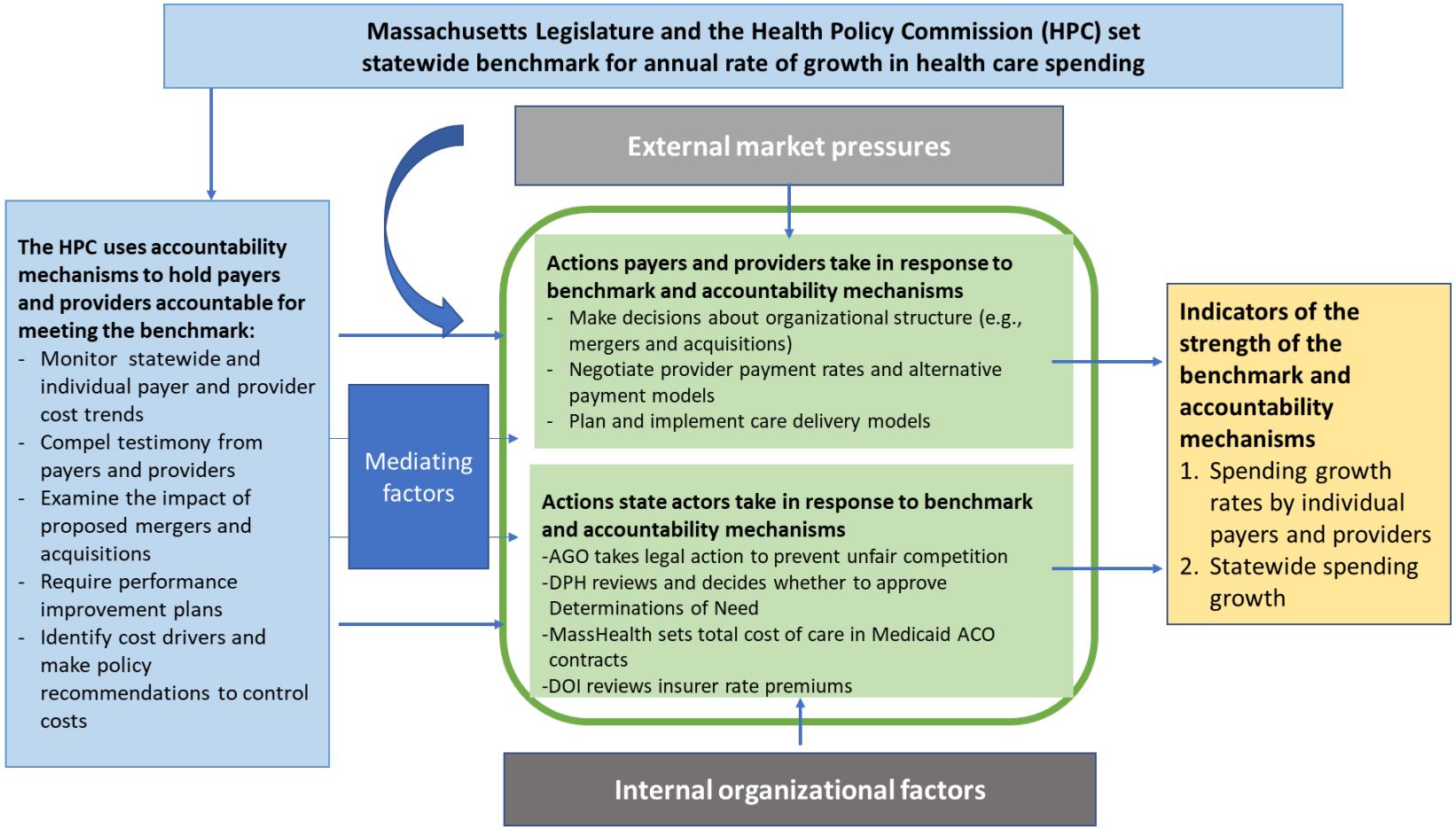
[31] The fifth domain—characteristics of the individuals involved in implementing an intervention—is not applicable to this study because the Massachusetts cost growth benchmark initiative is implemented at the organizational level.

scope or limits of their regulatory authority, their role in purchasing health care, and the degree to which they act as stewards of public funds.

The study focused on **intermediate outcomes**, which concern the responses of state agencies, payers, and providers to the benchmark and HPC's accountability mechanisms (shown in green boxes). The ultimate outcomes of the initiative are statewide spending growth and that of individual payers and providers, shown in the yellow box. But as discussed in the report, that was not the focus of this study.

To analyze the interview responses, we developed a coding scheme based on CFIR domains above. We developed a set of codes in three major categories: (1) intervention elements, including the benchmark, accountability mechanisms, and HPC's research and policy activities; (2) setting and process, including historical context, external market dynamics, internal organizational factors, and stakeholder engagement; and, (3) valence codes, including strengths, limitations, evolution, and mediating factors, with the last group primarily consisting of incentives and disincentives drawn from behavioral economics science. We used NVivo software to enter and store the coded interviews and NVivo tools to analyze thematic content.

Exhibit B.1. Logic model for evaluation of Massachusetts health care cost growth benchmark



ACO = Accountable Care Organization; AGO = Attorney General's Office; DPH = Department of Public Health; HPC = Health Policy Commission; MassHealth = Massachusetts Medicaid agency; DOI = Department of Insurance.

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