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Beyond Obamacare: Lessons from Massachusetts

A Brief History of Health Care Reform in Massachusetts

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BEYOND OBAMACARE: LESSONS FROM MASSACHUSETTS

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September 2017

Prepared by

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Foreword

This article is intended to be read by state and federal policymakers; healthcare advocates and researchers; providers and insurers; organized labor groups; small and large business organizations; healthcare policy students and academics; consumers; and all those who know how hard it is to make healthcare policy changes in the United States but who still believe (hope) our best days are ahead. The goal of the paper is to provide perspective, information and analysis to those who strive to improve access to affordable, quality healthcare.

The article comes at a time of great potential upheaval and uncertainty in terms of national healthcare policy. The evolution of health care reform in Massachusetts is important because the reforms enacted in 2006 provided the model for the Affordable Care Act (ACA), known as “Obamacare.”

In 2006, Massachusetts was the first state in the country to try to expand access to healthcare to all its citizens within the structure of the existing marketplace. The goal was to get as close as possible to universal access to healthcare. The current resurrection of a national debate around universal access to healthcare is a step backwards in time for Massachusetts healthcare policy makers who considered this basic issue – universal access - settled.

Subsequent to its 2006 reforms, Massachusetts turned its attention to cost containment. In 2012, Massachusetts became the first state in the country to try to limit the growth of both private and public healthcare spending. That effort, known as “Chapter 224 or Ch. 224” is still unfolding. Many states are currently working on affordability and expanded access for their citizens and are looking for new paths forward, in particular, to control healthcare costs. This work is intended to serve as one alternative to help those who are looking for ideas that might be adapted or modified to their circumstances.

The article draws largely on the author’s years of experience in healthcare policymaking positions, most recently, as former Massachusetts Undersecretary of Consumer Affairs and Business Regulation from 2009 to 2015. In addition, the work also benefits from her years of experience in private healthcare advocacy, and other federal and state government roles that exposed the author to the dynamics of healthcare policymaking. Over these periods, the author either participated in or chaired hundreds of meetings around healthcare reform issues involving all major stakeholder groups and initiated or worked on numerous public policy developments. Her analysis comes from a perspective that radical change in healthcare pricing and delivery systems is not good medicine on either the state or federal level. But she also appreciates that fundamental change in the distribution of healthcare spending dollars especially among private sector players is a pre-requisite to sustaining and improving access and affordability.

The Chapter 224 experiment in Massachusetts is still evolving. At this stage, the outcome remains uncertain but hopeful.

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Introduction and Background

In 2006, Massachusetts passed Ch. 58, An Act Providing Access to Affordable, Quality, Accountable Health Care (Ch. 58 or “Romneycare”). The 2006 health reform legislation provided broad access to health insurance for many previously uninsured residents. Ch. 58 primarily addressed issues of access to health insurance in Massachusetts, and was the model for the ACA. Many of the most potent and controversial features of the ACA came from the 2006 Massachusetts law: a mandate that individuals buy insurance or pay a penalty for failure to so do; a penalty for employers above a certain size that did not offer coverage to their employees; an expansion of Medicaid to cover more low income individuals; subsidies for those below a certain level of income; a required health benefits package that carriers had to offer; an online exchange where consumers could shop for insurance; and many other features. At the time Ch. 58 was passed, a deliberate decision was made by state policymakers to leave the issue of cost control to another day.

Massachusetts has among the highest healthcare costs in the nation and for many years the growth of those costs outpaced the growth of household income and the overall Massachusetts economy. Average family premiums for employer-sponsored health insurance in the state rose from \$11,400 in 2005 to nearly \$17,000 by 2011.¹ In 2015, such premiums were \$18,454, while they were \$17,322 for the nation as a whole. Four states and the District of Columbia had higher average family premiums.² According to the Massachusetts Health Policy Commission’s 2016 Cost trends Report, average statewide family premium and cost sharing was about \$20,000.³

While healthcare costs continued to escalate in Massachusetts and elsewhere, the state and national economies plunged into a deep recession. Against this backdrop of recession and continued growth both in healthcare costs and enrollment in health insurance, the state turned its attention to cost control.

In Massachusetts, the law that “officially” addresses healthcare costs is Chapter 224 of the Acts of 2012, An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation” (Ch. 224). Ch. 224 became effective on November 5, 2012, and established a so-called “benchmark” to control the growth of healthcare costs in Massachusetts. The benchmark will be described in more detail later in this article, but generally, Ch. 224 is a set of interlocking provisions designed to tie the rate of healthcare cost growth to the rate of growth in the state’s economy. Ch. 224 established an independent agency, the Health Policy Commission (HPC), to implement and enforce the benchmark for healthcare cost growth established in the statute.

Massachusetts is the first state in the nation to establish a legislative growth target to control healthcare costs. At present, the law is unique to Massachusetts, although a few states, such as Rhode Island and Connecticut, are taking a look at similar approaches to controlling healthcare costs.⁴

This article examines a number of issues raised by Ch. 224. (1) The culture developed by Massachusetts’ policymakers and healthcare stakeholders to pass Ch. 224; (2) A description of the implementation tools in Ch. 224; (3) The effectiveness of those tools and of the Health Policy Commission in controlling the growth of Massachusetts’ healthcare costs; and (4) Whether or not this approach is good public policy. An exciting feature of this Massachusetts experiment is that it is still evolving and adapting to changing market conditions; with time, new tools may be added to its cost control provisions. Its ultimate success or failure may not be readily apparent for years to come.

The Development of Healthcare Policy in Massachusetts

Ch. 58 was the product of intense bipartisan negotiations that involved officials across the political spectrum from conservative Massachusetts Governor Mitt Romney (who was preparing to run for the US presidency) to the liberal icon, Massachusetts Senator Ted Kennedy, and everyone in between. At the same time that these negotiations were taking place, there was the threat of a ballot initiative that contained a “pay or play” mandate for employers. The ballot initiative never took place and ultimately Ch. 58 emerged from the negotiating process. Importantly, this law involved key organized stakeholder groups such as providers, insurance carriers, unions, physicians, employers, religious organizations, consumer advocates and many others, working with state agencies, legislators and high level public officials. This coalition of diverse and competing interests was already a hallmark of healthcare market reform efforts in the Bay State. Whether there is agreement or disagreement, all stakeholder groups and government healthcare officials expect a seat at the negotiating table.

Ch. 58 itself was the culmination of almost two decades of reforms to the Bay State’s healthcare marketplace that began as early as 1988 with then Governor Michael

Dukakis's signature "Health Care for All" legislation, Ch. 23 of the Acts of 1988.⁵ The same coalition of stakeholders that was involved in Ch.58 had previously worked to pass or oppose the Dukakis legislation. The Dukakis law, passed amid great fanfare in April 1988, was the first in the nation designed to provide basic health insurance for all residents of a state. "We have good reason to rejoice today," the former Governor said from the Massachusetts State House steps, "as we once again become the nation's laboratory ...for affordable, quality healthcare" for all.⁶ The law was aimed at insuring 600,000 Bay State residents who lacked health insurance, 10% of the state's population, and included a "pay or play" mandate for employers and subsidies for low-income citizens. Ch. 23 was never implemented after Governor Dukakis left office following an unsuccessful bid for the presidency. The state legislature never funded its price tag, which it pegged as between \$900 million and \$1.4 billion, and eventually, it was repealed.⁷

The coalition of stakeholders that was formed around the Dukakis initiative did not dissolve but continued to advance insurance market reforms. In 1991, Republican Governor William Weld, signed a law known as Chapter 495⁸ deregulating the state's hospital rate-setting system. This law also contained provisions aimed at reforming the state's health insurance market. It required insurance companies to treat all businesses equally actuarially, and made it illegal to have disproportionate variations in premium increases and benefits. Most importantly, the law required that insurance policies were renewable annually for small businesses with reasonable (and proportionate) premium increases, unless these businesses proved unworthy of renewal. The law also defined and regulated 'waiting periods' for group plans for no longer than six months; previously, waiting periods were not regulated and could last for much longer. In addition, the 1991 law required that 'emergency services' were covered during the waiting period.

Chapter 495 was an effort by Governor Weld to repeal the most controversial parts of Governor Dukakis's 1988 law, particularly the "pay or play" provisions, which penalized businesses with over 5 employees if they did not provide health insurance to employees. However, it also relied on market forces to try and control healthcare prices through carriers and providers negotiating individual hospital contracts. It created fairness standards for the way insurers could treat small businesses and helped to finance hospitals with a majority of Medicaid patients by creating the uncompensated care pool. This mechanism placed an assessment on profitable hospitals in order to help finance those hospitals that treated the most disadvantaged patients.

In the 1990s, a number of states including Massachusetts, began experimenting with ways to expand access to healthcare insurance for state residents. The two most popular reforms, "guaranteed issue" and "community rating," were added to Massachusetts' health insurance laws in 1996.⁹ These reforms in Massachusetts grew in part out of a "Non-Group Commission" formed by Attorney General Scott Harshbarger's office in the mid-1990's. This group included the CEOs of major

carriers, unions, hospital trade groups, consumer advocacy organizations and others. Its recommendations were part of the reforms of 1996.¹⁰

Under guaranteed issue, insurers cannot deny coverage to an individual because of that person's health status. The community-rating requirement barred insurers from charging higher premiums to a person because of that individual's health status.¹¹ In addition, Chapter 297 established minimal health plan requirements and created a mini- COBRA for small businesses.¹²

Unfortunately, these well-intentioned laws had adverse, unintended consequences. Because insurers were no longer able to adjust their prices based on pre-existing conditions, there was evidence that people waited until they got sick before buying coverage.¹¹ There was no incentive to buy insurance if an individual was healthy because the individual could always buy it later if she became ill. As a result, the pool of insureds becomes smaller and smaller and sicker and sicker, and the cost of insurance becomes more and more expensive for those who are buying it. This phenomenon is called "adverse selection" and it leads to an economic "death spiral."¹¹ The number of people without insurance actually increases. This is what occurred in the 1990's into the early 2000's in Massachusetts and around the country.

Meanwhile What Was Happening at the National Level before 2006?

During the period that Massachusetts and some other states were passing the reforms described above, the nation witnessed the failed efforts of the Clinton administration for broad scale reform of the healthcare market. This effort led by then First Lady Hillary Clinton was known officially as the Health Security Act. The bill itself was a complex proposal running more than 1,000 pages and had an enforced mandate for employers to provide health insurance coverage to their employees. Criticism from conservatives, libertarians, the health insurance industry and even fellow Democrats doomed the Clinton plan and it was never enacted into law. By 1994, there was no chance it would be revived.^{13,14}

While the effort at national reform was defeated, subsequently in 1996, the Health Insurance Portability and Accountability Act (HIPPA),¹⁵ known as the "Kennedy-Kassenbaum" bill was enacted by Congress and signed into law by President Clinton. HIPPA improved portability of health insurance coverage for workers when they changed or lost their jobs by restricting the time period that an insurer could deny care based on a 'pre-existing condition' given previous creditable coverage. HIPPA is best known for establishing national standards for privacy around electronic healthcare transactions.

Indeed, at the time, a major lesson derived from the failed attempts by the Clinton and Dukakis Administrations to tackle broad scale health reform was that incremental change held more promise of success than major reform. However, a

strong take-away from the incremental insurance reform efforts of the 1990s was that there were unintended consequences to well-intentioned laws aimed at lowering costs for one group or trying to guarantee that sick people would not end up uninsured. Thus, over time the shortcomings of certain incremental reforms provided empirical evidence for more broad scale reform. It appears that the small steps may have been a necessary prelude to gathering consensus for more fundamental change.

With no Federal Plan in Sight, Massachusetts Enacts Broad Scale Health Insurance Reform

Meanwhile back in Massachusetts, notwithstanding some success at reforms, and some lowering of the uninsured rate, in 2004, the uninsured rate in Massachusetts was still fairly high at 7.4%.¹⁶ In addition, Massachusetts still had (and has) among the highest per capita health care costs in the United States. In 2004, health care costs per capita in the Commonwealth reached \$6683 and were projected to grow faster than that of the United States or other industrialized countries.¹⁶

So, in 2006, Romneycare was passed and the state went about the business of implementing Ch. 58 and the series of insurance market reforms described above. The result was that over the next few years there was a drop in the uninsured rate from 7.4% in 2004 to 2.6 % in 2008.¹⁶ (However, since then, the rate of uninsured has crept up and in 2015 was between 3 - 4%.¹⁷). Ch. 58 also saw the establishment of the Connector Authority and the creation of the first in the country market exchange for the sale of health insurance to individuals and small businesses. While the Connector has not developed into a robust market for the small business sector, it serves approximately 182,000 (non-Medicaid) low-income people who receive some kind of premium subsidy, and about 30,000 individuals who are not subsidized.¹⁸ And, while the Connector did suffer serious setbacks after the passage of the ACA, it seems to be back on track now.¹⁹

Laying the Groundwork for Beyond Obamacare

In government regulation, as elsewhere, the devil is in the details and one detail in Ch. 58 proved to be an extremely important precursor to current events. Ch. 58 established the Health Care Quality and Cost Council (HCQCC), which ultimately led to the establishment of the current Health Policy Commission (HPC). The HCQCC was charged with collecting all types of data on the costs, quality and payment delivery systems of healthcare in Massachusetts. The HCQCC was made up of high-level state healthcare, insurance and watchdog officials together with health benefits specialists from the private sector. This agency collected and analyzed data, issued reports and generally exposed the growth of healthcare costs to public scrutiny through public hearings. Its final report issued on October 21, 2009, "Roadmap to Cost Containment," strongly recommended the need to move the healthcare payment system away from fee for service and toward payment reform

strategies where quality rather than volume would be rewarded. This recommendation was aimed squarely at the issue of cost containment that had been left to another day by Ch. 58. In addition, in 2008, the Legislature established a Special Commission on Health Care Payment Reform (Section 44 of Ch. 305 of the Acts of 2008). Its final report, issued in July 2009, also strongly called for healthcare payment reform.²⁰

By 2009, for over two decades, various and diverse stakeholders around the Commonwealth had worked together. They held hearings, testified, and lobbied; everyone from government officials to carriers, employers, providers, businesses, consumer groups, labor organizations, and more became involved - the Commonwealth was a virtual hotbed of health care policy activists.

Much of this activity focused on the problems of ever escalating healthcare costs and the promotion of alternative payment methodologies to replace fee for service payments as a primary cost containment strategy. The HCQCC and the Special Commission on Payment Reform focused laser-like attention on fee for service payment models, which were regarded as largely responsible for ever escalating healthcare costs.

It is a widely held belief among many healthcare stakeholders that fee for service medicine –which generally means charging a fee for every healthcare service or procedure rendered - provides the wrong economic incentives to healthcare providers and replacing fee for service with alternative payment methodologies, such as, global or bundled payments, or pay for performance contracts, or other risk-bearing arrangements is the key to slowing down the growth in healthcare costs. Generally, alternative payment methodologies seek to reward providers for good quality outcomes with the provider assuming some downside risk if the level of treatment exceeds some or all of the overall payment. Specifically, the Special Commission on Payment Reform recommended, among others, the following major actions:

1. The development of Accountable Care Organizations (ACOs)
2. Cost and quality reporting
3. Risk-sharing between ACOs and payers
4. Creation of an independent entity to oversee implementation and transition strategy

With the fourth recommendation, the groundwork was laid for the idea of a separate agency to oversee health care costs and to implement payment reform strategies. But there were still some unforeseen events that would take place before all the stars were in alignment for the passage of Ch. 224 and the establishment of the Health Policy Commission.

The Insurance Wars of 2010

The year was 2010, four years after Ch. 58, and health care costs in Massachusetts continued to escalate especially for small employers and individuals at a double-digit annual pace. The Massachusetts economy was suffering from almost 10% unemployment, thousands of residential foreclosures were taking place, and, while, generally, neither wages or profits were increasing by much, if at all, health care prices continued to rise and providers and carriers overall enjoyed sound economic health.

The employer community, in particular, was growing more and more vocal about double-digit increases in insurance premiums. Various employer trade groups visited the administration of then Governor Deval Patrick. Some groups brought their complaints to the state's Executive Office of Housing and Economic Development and its Office of Consumer Affairs and Business Regulation. This latter office oversaw the state Division of Insurance which regulates all insurance companies, including health insurers.

The Patrick administration held meetings with various insurance carriers concerning health insurance premiums. Carrier after carrier told the same story: each was locked into multi-year contracts with providers that called for automatic cost escalation clauses regardless of whether or not costs were actually increasing. One company told the state's Office of Consumer Affairs and Business Regulation that it was locked into a 3 year, 10% per year increase with one of the state's most powerful provider systems. When the Office of Consumer Affairs and Business Regulation encouraged carriers to try and re-open those contracts with providers, it was told that they could not be re-opened.^{21,22}

Even though both carriers and providers acknowledged that costs were a problem, there were a variety of reasons proffered as to why voluntary restraint by carriers or providers was not going to materialize. Carriers were stuck in multi-year contracts, and could not cut premiums without endangering their own financial health. Generally, providers could not reduce prices because of various cross-subsidies in their systems and the effect on industry employment. While industry officials commiserated about the high cost of healthcare, they claimed there was nothing that they could do about it. Indeed, Governor Deval Patrick often expressed exasperation that carriers would point fingers at providers and providers would point fingers at carriers and the structure of the system.²³ He expressed this in meetings as well as in public speeches. No one seemed willing to help come up with a solution.

These fruitless attempts to garner support for industry solutions for cost control led the Patrick Administration to search for ways to unilaterally take action. Massachusetts has a peculiar calendar for renewing health insurance contracts and the filing of health insurance rates in the so-called "merged market." The merged market in Massachusetts is made up of individuals (non-Medicaid) and small

business employees, amounting to about 700,000 covered lives. These are the individuals and employees of employers who have to buy insurance from an insurance company as opposed to larger companies that self-fund their own health insurance and hire third party administrators, usually insurance companies, to administer their plans.

In the merged market, carriers and customers enter into yearly contracts but new rates and contracts are available at the start of each calendar quarter for the following 12 months. (For individuals in the merged markets, annual enrollment is now just once a year in January, while small groups in this market continue annual renewals on a quarterly basis.) A contract can begin on January 1 for the next 12 months; April 1 until March 31 of the following year; July 1 for the next 12 months; and October 1 to September 30 of the following year. The April 1 to March 31-contract year is the largest renewal period. Before a carrier can collect its new annual premiums, it must first file those rates with the state Division of Insurance. Under the law, the Insurance Commissioner has thirty days to disapprove the new proposed rates. If he takes no action, the rates can go into effect.²⁴

Generally, merged market health insurance premiums are higher than large group prices for a variety of reasons. Small business groups claim they lack market clout in negotiating rates with individual carriers, but there are some higher costs in the small group market distribution system, such as brokers' commissions. Additionally, there is some evidence showing that health risks in the merged market are higher than large group risks.²⁵ Regardless of the reasons, small businesses in the merged market voiced strong concern for a number of years leading up to 2010 that they were unfairly paying higher premium prices, especially at a time when the economic recession was causing serious financial harm to that sector.

In January 2010, approximately 10 different carriers filed 285 proposed rates for contract renewals on April 1 in the merged market. Of the 285 rates that were filed, 235 were for increases of 10 percent or more over the previous 12 months' rates.²⁶ Although the filings are technically confidential until reviewed and placed on file per the Commissioner's authority, news had leaked out that another round of double-digit increases was in the offing. This created additional pressure on the Patrick Administration to take action to alleviate increases in healthcare costs.

There are different legal opinions as to whether the insurance laws, Ch. 176J, give the Commissioner the power to disapprove rates. The language of the statute states that "the Commissioner shall disapprove" the rates if he finds they are "excessive, inadequate or unreasonable in relation to the benefits conferred.... "And, there is language stating that the Commissioner can disapprove if the rates are not "actuarially sound." Some insurance law experts believe that the language itself is more consistent with traditional "file and use" insurance statutes. This means that after waiting a requisite period of time, insurance company rates automatically go into effect. Others hold the view that the language is very clear and the Commissioner has the legal authority to disapprove a proposed rate on one of the

enumerated grounds. This view holds that although the Commissioner is not empowered to establish health insurance premiums, he has the power to disapprove a proposed rate change, although that had never been done in the history of the-20 year-old statute.

Ultimately, the Administration decided that under the statute, if the Commissioner found rates to be unreasonable, he did have the power to disapprove. On April 1, 2010, the Commissioner disapproved 235 proposed rates, including every rate that involved a hike of 10% or more. The disapproved rates ran the gamut from 10% to increases by one carrier of 34%.²⁷

The result of his disapproval was fairly explosive within the carrier and provider communities. As a practical matter, when the Commissioner disapproves a rate, the carrier cannot charge the new rate but must continue charging the existing rates that have been in effect for the preceding 12 months. Still, the new contracts between a carrier and provider containing increases in prices for the coming 12 months remained legally binding. Because the Commissioner disapproved the proposed rate hikes a carrier could not pass on to consumers and small employers the rate increases it had to pay the providers. Those few carriers with rate hikes below 10% could go forward and market their plans for the coming 12 months to the disadvantage of competitors.

Those rates scheduled to go into effect on April 1 were now thrown into uncertain territory. Carriers could not market policies that were to begin on April 1 because they did not know the price they would be able to charge for such policies. Under the law, when the Commissioner disapproved a rate, carriers have 10 days to appeal the Commissioner's decision to the independent hearing officers within the Division of Insurance.²⁸ Every carrier appealed its denial and a hearing schedule for each carrier was set up that would take place over many weeks. The Attorney General's office became involved as an intervener in each hearing. Every hearing is like a mini trial. The carrier, the Attorney General representing consumers, and counsel representing the Commissioner defending his decision are all involved.

The hearings are open to the public and the media. In addition, prior to the start of these administrative hearings, the carriers as a group brought the Patrick Administration to the state Superior Court to fight the Commissioner's directive that carriers could not charge their new proposed rates but instead had to charge the old rates pending appeal. The carriers lost that legal battle and the superior court upheld the Commissioner's position, the new rates could not be charged during the appeals process. The result was that precious time was passing, it was now well beyond April 1, and the aggrieved carriers were stuck with charging the prior year's rates. The proceedings were played out in public view with lots of media coverage that was unfavorable to the insurance industry.

Then the unpredictable occurred. The DOI's independent hearing officers found that while the Commissioner had the power to disapprove rates, he did not prove

“unreasonableness.” As a result, the Commissioner’s actions disapproving rates were not upheld. The hearing officers found that the rates were “actuarially sound” and therefore, the Commissioner’s disapproval was overturned in the first decision that came down.

Notwithstanding this legal win, the clock was still ticking for the remaining carriers who claimed that they were losing money every day the administrative hearing process dragged on. And despite the win, all carriers, including the carrier that won, were willing to negotiate with the Patrick Administration for a set of rates that could be agreed upon. Also, the public spotlight that had been turned on these large rate requests, created an atmosphere in which carriers may have believed it to be in their best interests to settle with the Administration, not charge their members retroactively, and move on.

Ultimately, over a period of two to three months, all but one of the carriers reached a settlement with the state and agreed on rate increases that were generally under 10%. And, no settlement contained any retroactive rate provisions. Even the one carrier, with which the state did not settle, did not charge its members retroactively.

It is also noteworthy that carriers were able to persuade some providers to re-open their contracts and renegotiate for lower prices in their contracts. Indeed, it came to light that the contracts themselves had provisions that permitted re-opening negotiations if there was a significant change in the regulatory environment.

This very public battle over insurance rates set a precedent for future dealings between the Patrick Administration and insurance carriers. There was a tacit understanding going forward that the era of double-digit rate increases was over and there was also a realization that the Division of Insurance would continue to take a long and serious look into proposed rates that seemed to be based on projections for cost or utilization components that were not firmly supported by past experience. Even though there was diminished appetite on the part of the Administration for another round of rate disapprovals and public warfare, state regulators still had the authority to request additional data and information from carriers for any proposed rate hike. Such requests were often time-consuming for carriers to fulfill, and rates could not be marketed until the Commissioner signaled he would not disapprove. This time consuming process could result in competitors getting to market with approved rates while the carrier from which additional data was requested was still being reviewed. This “quieter” rate review process resulted in a steady decline in the level of rate increases for the merged market and by 2012, rate increases were generally in the 5 to 6 percent range. For 2013, 2014 and 2015, annual average rate increases ranged from 1.8% to about 4.8%.^{29,30} (This trend somewhat mirrored national trends in that healthcare spending was lower nationally during the same period.) (Subsequently, in 2015, after the Patrick Administration left office, the Division of Insurance reported rate increases for premiums in the merged market of between 5.4 and 8.3% from the end of 2015

through the first quarter of 2017. This is after 12 quarters of growth below 4 percent.³¹).

Following this period of intense activity around insurance premiums in the merged market, the Massachusetts legislature passed Ch. 288 of the Acts of 2010 known as the Small Business Relief Act. This law was passed to give some immediate and long-term relief to the small business community in the health insurance market. Ch. 288 established standards for medical loss ratios (MLRs), administrative expenses and surplus earnings for insurance companies. The standards for MLRs set the amount of each dollar that an insurer had to spend on health claims. For example, a MLR of 90% meant that insurers had to spend 90 cents of every dollar on paying health claims. If they spent less, at the end of the year, their customers were entitled to rebates. The MLRs established in Ch. 288 are tougher than those established in the ACA (80% for the individual and small group markets, and 85% for the large group market comprised of firms with more than 50 employees) and are currently at 88%.³² In 2014, 2015, and 2016, rebates of tens of millions of dollars were returned to small business customers for MLRs that were not met by insurers.

BEYOND OBAMACARE: CH 224

The insurance imbroglios and Ch. 288 took place within a year or so after the HCQCC and Special Commission recommendations calling for both payment reform and the establishment of an independent authority to control the growth of Massachusetts healthcare costs. There were serious and intense deliberations taking place within the Patrick Administration and the Legislature with all the various stakeholder groups over a new bill that would embody the recommendations of the HCQCC.

In 2011 and 2012, the country was focused on the implementation of the ACA. Its opponents were waging battles and several court suits were filed to repeal parts or all of the ACA. While Massachusetts set about to implement the ACA, the Patrick Administration and the Massachusetts House and the Senate were also considering payment reform bills. In Massachusetts, while access to healthcare continued to gain ground, these new efforts were aimed at legislatively enshrining cost control measures.

There were similarities among the bills. For example, they all encouraged the formation of Accountable Care Organizations (ACOs) in the private sector and the Group Insurance Commission, and required their establishment for MassHealth (Medicaid) members. Generally, ACOs are networks of doctors, hospitals, and other health care providers that share responsibility for coordinating care and meeting health care quality and cost metrics for a defined patient population. The bills also promoted alternative payment methodologies (APMs) in the private sector and required them in the public sector. APMs can be defined broadly as payments to providers based on improved outcomes, with providers sharing in some downside

financial risk, rather than payment based solely on volume. However, there were also some early differences among the bills. The most notable differences involved issues of oversight, implementation and enforcement and some way to measure savings in healthcare costs. A contentious issue in the debate was what to do about hospitals that use market clout to extract higher prices in their contract negotiations with carriers. There was a proposed surcharge on hospitals that could not justify their higher prices that did not ultimately make it into the final version of Ch.224.

There was also a failed plan to require separate contracting for subsidiary hospitals of systems with market power. This issue, separate contracting, was also contentious among certain hospitals and carriers. Payers claimed they were forced to pay so-called “downtown rates” to the community hospitals that were part of large systems, because large systems negotiated as single entities for all their hospitals. Payers argued that they should be able to negotiate separate contract rates with such community hospitals and thereby pay rates more in line with lower cost community hospitals. In fact, there is mixed evidence from antitrust cases that separate or “component” contracting actually leads to lower rates in the long run.³³

While the Patrick Administration did not initially favor the creation of a separate agency to oversee cost control implementation, it did support the need for a coordinating body made up of government and stakeholder organizations. Some in the legislature, however, favored the creation of a separate and independent agency to carry out implementation and enforcement. Certain legislative leaders wanted to ensure that cost control efforts would survive the Patrick Administration and its pro-cost-control orientation. Many in the legislature believed that only an independent agency, not dependent on budgetary appropriations, and not subject to the control of the executive branch would be an effective vehicle for long term progress.³⁴

In addition, there was the issue of how to measure progress in restraining healthcare costs. In this regard the legislature and consumer advocates felt strongly that numerical goals should be part of the effort to control costs. There had been much evidence collected that the growth of Massachusetts’ healthcare costs significantly outpaced the growth of the state’s economy. Going forward, there was one estimate that showed that unrestrained, healthcare costs would grow from about \$72 billion in 2012 to over \$140 billion by 2022. If such costs were constrained to the rate of growth in the state’s economy, the increase was projected to grow from \$72 billion in 2012 to almost \$99 billion by 2022. Overtime, between 2012 and 2022, this estimate pegged the savings at almost \$200 billion.³⁵ It’s unclear who first came up with the idea to tie the growth of healthcare costs to growth in the state’s economy but the relationship between the two had been discussed for many years and was broadly known. It appears that the benchmark feature itself was first presented in a House bill.³⁶

According to Professor David Cutler of Harvard, who is currently a member of the HPC, there were two good reasons for ultimately including a target growth

benchmark in the formation of Ch. 224. First, there is “virtue” in having a number to establish clarity in terms of achieving a specific goal. Second, having a benchmark figure was a way of stabilizing healthcare costs for the public sector.³⁷ In addition, there was a need at the time to assure the public that this reform would save money for the Commonwealth in terms of reducing the growth of healthcare costs. Therefore, the benchmark was a way of measuring the savings of the proposed legislation.

There were internal discussions about the inclusion of the benchmark in the Patrick Administration. Some believed that a benchmark would become a guaranteed rate of return for an industry that was not a public utility where rate of return was needed to preserve the means of production. This would be the first time that a state government was stipulating the growth rate of any private sector. Also, by tying such growth to the economy, the benchmark was assuring upward growth regardless of whether or not it was warranted. At the end of the day, however, the Administration and the Legislature agreed to the benchmark concept as a practical solution to controlling healthcare costs. Keeping costs in line with economic growth would be a significant improvement over the then current situation. The only other alternative would have been a return to rate regulation, which was not a serious option in the Patrick Administration or the Legislature.

Interestingly, the benchmark concept though not embraced with great fervor by carriers and providers was not fought as vociferously as might have been expected. Although these stakeholders opposed the concept, once the concept became a virtual certainty, the issue was over what it should be rather than efforts to remove it from the legislation. One reason powerful providers may have been willing to go along with the benchmark is because the concept “baked in” existing wide variations in healthcare pricing. The benchmark did not call for a roll back in prices; rather it was concerned with future increases. In Massachusetts, there exist wide variations in healthcare prices, which many attribute to the exercise of market power by some of the largest healthcare systems. The establishment of growth targets or ceilings going forward did not disturb the pricing disparities that exist between more powerful and less powerful providers. Payers would still be paying providers with so-called market clout much more money relative to their competitors.

And so it came to pass that 6 years after the passage of Romneycare and 2 years after the passage of the ACA, Governor Patrick signed Ch. 224 into law. On August 4, 2012, there was a triumphant signing ceremony in the Great Hall of the Massachusetts State House jammed pack with stakeholders and media.



Governor Patrick signs the health care reform bill in Nurses Hall at the State House. (Photo Credit: Eric Haynes / Governor's Office) [View full size photo.](#)

Key Features of Ch. 224

There are many important, progressive provisions in the 350 pages of Ch. 224. Although this article focuses on just a few of those provisions, it is helpful to place such features – the benchmark and its enforcement by the HPC -- in the context of some other major components of the legislation. In order to appreciate the overall framework of Ch. 224 one needs to understand the belief system within which it was developed.

The overriding principle behind Ch. 224 was the belief that wide scale adoption of payment reform is key to reducing the growth of healthcare costs.³⁶ To some in the state legislature, payment reform was a panacea to the intractable problem of high healthcare costs³⁶ There was good evidence produced through the HCQCC hearings and Special Commission that not only was there significant growth in fee for service healthcare costs, but also there was significant waste, estimated at 25% to 50% of healthcare spending.²⁰ In addition, in 2010, under the requirements of Ch. 305³⁸ the Attorney General started issuing annual reports on cost trends. Her reports documented that there was no correlation between high prices and quality in the healthcare marketplace. The relationship could not be explained by variables, such as, underlying costs, teaching status or patient acuity.³⁹ These findings gave more support for the notion that prices rather than utilization drove increases in spending and fee for service payment systems were producing high health care

prices without concomitant quality. This bolstered the view that payment reform was an imperative.

The development of Ch. 224 was also taking place against the backdrop of the implementation of the ACA. Although, as a practical matter, the ACA did little in its initial years in the payment reform arena, there was a great deal of conversation around the concept and the prospective formation of Accountable Care Organizations or ACOs. As a matter of structure, an ACO, made up of a group of providers, physicians and hospitals, who are coordinating care for a group of patients, under a financial arrangement that includes partial risk-sharing, is the poster child for payment reform. So the conversations around Ch. 224 were taking place within a national conversation about the promise of ACOs to control costs and theoretically to provide better quality care.

The issue for the framers of Ch. 224 was how to promote payment reform through a legislative vehicle. Decisions were made relatively early on that a mandatory or compulsory approach that required the adoption of alternative payment methodologies was not the most desirable route to travel. This was probably because forcing payment reform on providers and carriers would likely meet with stiff resistance from the industry as well as risking consumer and perhaps labor backlash. Up until this time, healthcare reform legislation in Massachusetts had been developed with input from a broad array of savvy stakeholders. And even though providers, carriers, businesses, advocates or others were oftentimes not satisfied with a legislative outcome, they never gave up their seat at the negotiating table and their interests were not steamrolled or ignored.

Discussions within the Patrick Administration looked carefully at whether payment reform should be a mandatory feature of Ch. 224. The final decision from the executive branch was to follow a non-prescriptive approach. One of the reasons was the great uncertainty such measures would inject into the healthcare marketplace. No one could predict how global or bundled payments would affect access to healthcare by consumers. A number of officials remembered the failed experience with capitated payments in the late 1980's and early 1990's and were not sure how this new era would differ from that period. The earlier period was characterized nationally by consumer backlash and litigation over what was regarded as denials of care by insurance executives, although Massachusetts was spared the worst of such practices and its subsequent discord.

So if a mandatory directive toward payment reform was not in the offing, what was the best alternative? The framers of Ch. 224 saw the statute's mission to control costs as a long-term undertaking. Success would take place over a period of years. There was no one silver bullet to speed adoption of payment reform and slow down the growth of healthcare costs. One high-level legislative aide talked about Ch. 224 as trying to create a perfect "good storm," that would "push" rather than "shove" the industry toward slowing cost growth.³⁶

One major industry stakeholder succinctly describes Ch. 224 as follows:

Chapter 224 has the ambitious goal of bringing health care spending growth in line with growth in the state's overall economy. It aims to do so through a number of mechanisms, including the creating of commissions and funds, the adoption of alternative payment methodologies, increased transparency for consumers, a focus on wellness and prevention, an expansion of the primary care workforce, health information technology improvements, and health resource planning, among other initiatives.⁴⁰

There are many components in Ch. 224 that are intended to intersect with one another to "push" the industry along over time to achieve a transformation in the way health care is delivered and paid for toward outcomes of lower costs and better quality. The primary provisions are described below.

(1) New oversight agencies set statewide spending goals and monitor provider organizations.

The Health Policy Commission

Ch. 224 created the **Health Policy Commission (HPC)** as an independent agency residing in but not under the control of the state's Executive Office of Administration and Finance (A&F). The HPC is governed by a diverse 11-member board appointed by various state officials as specified in the law.

HPC Board members are not compensated and may not have any financial stake in or affiliation with a health care entity.⁴¹ This is intended to create a board free of real or potential conflicts of interests. It also means that no one currently working for an insurance company or hospital or any other type of provider sits on the board. The current board chair is the esteemed Professor Stuart Altman, the Sol C. Chaikin Professor of national Health Policy at Brandeis University, who has served as health policy advisor to five Presidents, authored countless articles and served on numerous state and federal health policy task forces and commissions.

In December 2012, the Board named David Seltz as its first Executive Director. Mr. Seltz was instrumental in drafting Ch. 224 when he served as policy advisor to the then Massachusetts Senate President Therese Murray.

The HPC was funded through 2016 by a one-time assessment on hospitals and insurers that raised \$11.25 million for the HPC over four years. Beginning July of 2016, the HPC is funded through further assessments on the health care industry.⁴² Its most important responsibilities include establishing the annual cost growth benchmark, monitoring progress towards and enforcing the benchmark.

The Center for Health Information and Analysis

Ch. 224 also created a sister agency to the HPC, the **Center for Health Information and Analysis (CHIA)**. CHIA is an independent state agency led by an Executive Director who is appointed by the Attorney General, the Auditor, and the Governor for a term of five years. In 2012, Aron Boros was appointed the first Executive Director of CHIA, which is funded by an assessment on hospitals, ambulatory surgical centers (ASCs) and certain purchasers of ASC services such as commercial health plans. In 2016, Ray Campbell, the acting Executive Director of the Massachusetts Group Insurance Commission, was appointed by Massachusetts Governor Charlie Baker to head up CHIA.

CHIA's responsibilities include measuring the annual change in the state's total health care expenditures (THCE), which is the basis for measuring the state's performance against the HPC's annual cost growth benchmark. Very importantly, CHIA is also responsible for identifying payers or providers whose performance falls outside the benchmark parameters and providing that information confidentially to the HPC for further action.⁴³

Under Ch. 224, CHIA calculates THCEs as the annual total of all health care expenditures from public and private sources, including all medical expenditures, public and private, paid to providers, all patient cost-sharing amounts, such as deductibles and co-payments, and the net cost of private health insurance.⁴⁴ If CHIA identifies a health care entity whose spending is excessive and which threatens the ability of the Commonwealth to meet the benchmark, the HPC can require the entity to submit a Performance Improvement Plan.

(2) The Health Policy Commission calculates and enforces a spending benchmark

The benchmark is established by a formula tied to the growth in the state's long-term potential gross state product (PGSP), an estimate that is prepared by the state's Executive Office of Administration and Finance. Under Ch. 224, the benchmark for calendar years (CY) 2013-2017 was equal to the PGSP which is 3.6%. For CY 2018 to 2022, the benchmark is equal to PGSP minus 0.5%, and is currently 3.1%. For CY 2023 and beyond, the benchmark is set to PGSP but under the legislation, can be modified by the HPC to any figure.⁴⁵ [By way of comparison, overall United States healthcare spending is projected by the Centers for Medicare and Medicaid Services (CMS) to grow at a rate of 5.8% per year from 2015 to 2025.³¹]

As stated above, under Ch. 224, the HPC can require an entity to submit a Performance Improvement Plan (PIP). PIPs must identify the factors that led to

cost growth and include specific cost savings measures for the entity to undertake within 18 months.

The HPC is empowered to approve a PIP that has a reasonable expectation of successful implementation. However, if the HPC determines that a PIP is not acceptable, the entity may be requested to resubmit another PIP for approval.

If the HPC determines that a health care entity has willfully neglected to file a required plan, or failed to file a PIP in good faith, or failed to implement a PIP in good faith, or knowingly failed to provide or falsify information required by the HPC, the HPC may assess a civil penalty on the health care entity of not more than \$500,000. The HPC website is supposed to include the names of entities required to file a PIP. Recently, the HPC has issued regulations governing the PIP process. All the information provided to the HPC under a PIP process is confidential and cannot be disclosed without consent except in summary form or when the HPC believes such disclosure is in the public interest. The HPC regulations state that such information is not a public record.⁴⁶ To date, no entity has been publicly named to file a PIP.

(3) The Health Policy Commission registers and monitors provider organizations

Ch. 224 also requires the central registration of provider organizations, especially Risk Bearing Provider Organizations (RBPOs) which are organizations that engage in risk bearing contracts with carriers. Unless exempt due to small size, provider organizations are required to give detailed information about their organizational structure, finances and operations to the HPC and to register with the HPC for two year terms. This information and data will be used by the HPC when determining the need for an entity to file a performance plan.

In addition, RBPOs must provide the HPC with an annual risk certificate from the state Division of Insurance (DOI). In order to obtain a risk certificate from the DOI, RBPOs must demonstrate that they are not assuming financial risk that could threaten their financial solvency when entering into downside risk contracts with insurance companies.⁴⁷ The “muscle” in this provision is that insurance carriers are prohibited from entering into downside risk contracts with RBPOs unless the RBPO has obtained a risk certificate or a risk certificate waiver.⁴⁸ The purpose, of course, is to insure that providers do not take on significant performance risk that they may not be able to fulfill.⁴⁹

Under Ch. 224, provider organizations of all types are required to inform the HPC, CHIA and the AG before making material changes (Material Change Notices or MCN) to their governance structure or operations. Such changes include mergers, acquisitions, and corporate affiliations.⁴⁷ Providers must give 60 days notice to these regulatory authorities before making any such changes.

If the proposed changes are likely to significantly impact the competitive market or the state's ability to meet the cost growth benchmark, the HPC can conduct a Cost and Market Impact Review (CMIR). In addition, should actual health care cost growth exceed the benchmark in a given year, the HPC can also conduct a CMIR on any organization identified by CHIA as having excessive spending.

If the HPC embarks on a CMIR of any proposed transaction, it must issue a preliminary report and identify any provider entity that has a dominant market share for the services it provides; charges prices for services that are materially higher than the median prices charged by other providers; and has a health-status-adjusted Total Medical Expenditures (TME) that is materially higher than the median for other providers.⁴⁷ As of mid-2017, the HPC had received approximately 82 Notices of Material Change and it has conducted CMIRs on five of those notices.⁵⁰ The applications of the entities filing such notices, the type of transaction and the HPC's CMIR reports are all public information.

In addition, the HPC must refer to the Attorney General any entity that meets the last three criteria. Similarly, under Ch. 224, the Attorney General can investigate suspected unfair competitive conduct or anti-competitive behavior and issue a report about such conduct such to the HPC. Of course, none of this affects the Attorney General's powers under existing state or federal antitrust or consumer protection laws to bring actions directly on behalf of the Commonwealth without any involvement or referral being made by or to the HPC.

(4) Statewide health care entities must transition into Alternative Payment Contracts

Ch. 224 requires the Health Connector, the Group Insurance Commission (GIC), and the state Office of Medicaid to implement APMs to the maximum extent possible. Specific enrollment goals were set for the Office of Medicaid. By 2015, 80% of Medicaid members were to be enrolled in APMs.⁵¹ Consistent with Ch. 224, the GIC which manages health and other benefits for more than 430,000 public employees, retirees, and their families, has been moving forward with a project to require its plans to meet specific numerical targets for the percentage of members covered by risk-based contracts. By FY 2016, roughly 50% of its members were covered by such contracts.⁵²

(5) Requires carriers and providers to make price information transparent for Consumers

Another important feature of Ch. 224 concerns price transparency. Ch. 224 requires carriers and providers to make prices available to consumers. The issue here is that even with the growth of High Deductible Health Plans and significant increases in out-of-pocket spending, consumers are still in the dark

when it comes to the price of healthcare. As a general proposition there is also virtue in making healthcare prices transparent based on the belief that markets function better when prices are known and not secret or hard to obtain.

Ch. 224 requires that carriers make online cost estimator tools available to their members so that members can shop for common procedures and see the amount of money such procedures will cost the consumer and how much of their deductibles will remain. Providers, including hospitals, physicians, and dentists are also required, upon request, to provide information about their charges or if a patient is insured on the amount of money the patient's insurer is paying for the procedure

(6) The Health Policy Commission holds annual public hearings to monitor cost drivers and growth

There are numerous public reporting requirements prescribed by Ch. 224. Perhaps the most important are the Annual Cost Trends Hearings and Report. Under Ch. 224, the HPC is required to hold public hearings based on CHIA's annual report on the Massachusetts health care market. The hearings which are held in October examine health care provider and private and public health care payer costs, prices, and trends with particular attention to factors that contribute to cost growth. Pursuant to the law, each year a comprehensive set of witnesses testify and present information under oath. HPC must then publish an annual report by December 31 that is based on the hearings and testimony and which describes spending trends, underlying factors and recommendations for strategies to increase health system efficiency.³⁰

How is it Going So Far?

While Ch. 224 is still in its early years of implementation, there is *some* evidence that it is producing results that are going in the direction intended by its framers. The statute imposes specific annual ceilings on healthcare cost growth and relies primarily on market players to adopt payment reform strategies to stay within the specific cost growth goal. The law does not require that each provider or payer reach a specific goal in terms of cost control, rather, it sets a general goal for the industry and then seeks to measure the performance of individual players who may be impeding the attainment of the industry goal.

In doing so, there are a number of ways that Ch. 224 relies on a bully pulpit or "name and shame" paradigm to accomplish results. In the reports of CHIA and the HPC there is some amount of entity specific data available to the public and to industry watchdogs and there is the potential under the law for more such

transparency, such as the public posting of entities who are under a PIP or the entities that have filed Material Change Notices.

As of October 2015, CHIA had supplied the HPC with a confidential list of entities that experienced excessive cost growth, including 20 providers and five insurers for 2012 and 2013. While the list is confidential by law, according to Seltz, the name of any entity selected for a PIP would be made public.⁵³ As no PIPs were required in 2016, 2017 will be the first year that industry outliers could be required to develop PIPs and that list should be made public under the HPC recently adopted regulations.

Second, in 2015, the proposed mergers of Partners Healthcare Systems (Partners) and South Shore Hospital System and Partners and Hallmark Health System (on Massachusetts north shore) presented an unexpected opportunity for the HPC to perform a highly visible and influential CMIR. As of mid-2017, the HPC had received over 80 Material Change Notices, see *supra*, pages 23, but the Partners proposals were by far the most important from a market conduct standpoint. The high quality work produced by the HPC on the likely effects on healthcare costs of the proposed mergers provided the court with an objective analysis that was relied upon in its decision not to approve a proposed settlement in that case.⁵⁴ Moreover, it gave the public a transparent and easy to understand view of the likely impacts of the proposal: higher prices and higher costs. Perhaps most importantly, its analysis in the Partners case established the HPC as an objective and competent watchdog in the pursuit of its statutory mandate to monitor and control the growth of healthcare costs in Massachusetts.

Third, the decision to not mandate APMs in the private sector, but rather to encourage goals for APM adoption, may have been the right call, although the adoption of APMs by both government and the commercial sectors has not been at a rapid pace. Although there are no penalties for failure to meet APM goals, if an entity ends up with cost growth that is an outlier compared with the benchmark, the “encouragement” of APM goals could become more prescriptive in a subsequent PIP. David Seltz, HPC Executive Director recently said, somewhat tongue in cheek, that entities called to prepare PIPs should not regard such as being called to the principal’s office as much as being called in to see the guidance counselor.⁵⁵ But, earlier in an article in the Boston Business Journal, HPC member Professor David Cutler said the opposite: “...it’s important that we be clear about what it is that will get you sent to the principal’s office.”⁵³ Either way, it seems the HPC can use the PIP provision as a way to move the market toward APM adoption at a faster pace.

The state Medicaid Office and the GIC are moving forward toward meeting their APMs goals and objectives.⁵⁶ APM coverage among MassHealth managed care organizations (MCOs) and primary care clinician plans (PCC) is now about 32 and 23 percent, respectively.⁵⁷ In addition, MassHealth has some ambitious ACO pilot projects involving shared savings/risk arrangements with quality incentives to promote the adoption of APMs in this public program.⁵⁷ It should be noted,

however, that Massachusetts anticipates that investments in these new programs will continue to be supported by a waiver worth \$52.4 billion that had been negotiated with the Obama administration.

Among commercial HMOs, the rate of APM coverage increased 8 percentage points between 2012 and 2014 and the three major commercial payers met the HPC's 2016 target of at least 60% of each payer's HMO lives covered by APMs. However, in 2016, the HPC noted that the expansion of APM coverage had stalled in the commercial sector and it recommended two specific goals: (1) all commercial payers should increase the use of global APMs to pay for at least 80 percent of their health maintenance organization (HMO) – covered lives in 2017; and (2) payers and providers should begin introducing APMs for preferred provider organizations (PPO) products with a goal of reaching 33 percent of their PPO lives in 2017.^{57,58}

Overall, the rate of Massachusetts residents covered by APMs declined in 2015 to 36% from 38%. Even APM coverage across commercial plans fell to 58% from 60%. According to the HPC, this drop in APM coverage within HMOs is due largely to a drop in HMO members among the largest health plans in the state.⁵⁷ Notwithstanding the HPC's goal of 80% HMO coverage by 2017, that objective does not seem attainable.

With respect to PPO APM members on the commercial side, the results are disappointing. In 2015, the commercial PPO market's APM coverage overall rate was 1 percent, although some payers report APM coverage in PPO plans ranging from 11% percent to 26%.⁵⁷ It is only recently that health plans have begun to try and expand APMs to PPO products. A major challenge in the application of APMs to PPO markets is trying to link patients to a given primary care provider (PCP) since PPO members are not required to select a PCP.⁵⁷

The evidence to date on the use of APMs to reduce costs is still inconclusive. Some believe that when providers are presented with lower payments in the form of APMs, providers may forgo costly investments in a new building or research but do not zero in on reducing the unit costs of healthcare. Instead providers look at potential costly inputs and make decisions on which inputs to forgo. Nonetheless, these observers also believe that APMs can have a modest effect on cost control. For example, most hospitals are now investing heavily in patient discharge planning to avoid costly re-admissions (although this likely reflects Medicare penalties rather than Ch. 224). They are also looking at better ways to manage high cost chronically ill patients as well as focusing on better management of the severely mentally impaired.³⁷ On balance, it appears that not mandating APMs for the private sector was the right decision as the market is experimenting albeit slowly with APM adoption. Since the prospect of unintended consequences is always a problem in healthcare market changes, strategies that avoid abrupt changes can be a safer route to travel.

Fourth, the notion of establishing an independent agency with its own funding source and whose leadership is not dependent on who occupies the Governor's office appears to have been a sound decision. In January 2016, the governorship of Massachusetts changed from Democrat Deval Patrick to the moderate Republican Charlie Baker. The new administration has not pursued major legislative or administrative policy changes to the HPC or CHIA, although the new administration appears not to be continuing the previous administration's handling of insurance rate increases. [The Administration did propose governance changes to CHIA and while, ultimately, CHIA remained independent, it now has an Oversight Council.] As noted previously, *supra* at 15-16, the state reported premium increases in the merged market of between 5.4% and 8.3 % from the end of 2015 through the first quarter of 2017 and there are strong indications that payers are preparing for a return to double-digit increases in the merged market which they are blaming in part on drug prices.⁵⁹

That said, recently, in an effort to more directly attack high healthcare costs, Governor Baker issued a series of proposals including one that would limit the percent increase that insurers could agree to pay to providers based on the size of the provider. The largest providers would be unable to obtain any increase under his "conversation starter" proposal.⁶⁰

Fifth, the overall idea of a benchmark itself is thought by some to provide leverage to carriers in provider-carrier contract negotiations.⁶¹ Indeed, the presence of the 3.6% benchmark was articulated by some carrier representatives to the Patrick Administration as a helpful ceiling during contract negotiations with providers following the insurance wars of 2010.⁶¹ Other carriers, however, see the implementation of the benchmark as falling unfairly on carriers at least in the immediate term because carriers are subject to rate review while providers are not subject to such scrutiny.⁶² Of course, this begs the question that the ceiling becomes the goal very quickly and efforts to control costs may be driven by the desire among carriers to fall, first and foremost, in the safe-harbor zone. A more negative view of the benchmark's effectiveness was expressed by a high level insurance industry representative who opined that all the cost controls in Ch. 224 nibble around the edges because no one wants to take on the high priced providers.⁶²

Meeting the Benchmark

Since 2012, CHIA has collected health care data to gauge compliance with the state's benchmark of 3.6%. The HPC has reported that the final numbers for growth of THCEs in 2013 was 2.4%,⁶³ in 2014, 4.2%, and in 2015, 4.1%.⁶⁴ In its January 20, 2016 release, the HPC identified two primary reasons for growth over the benchmark of 3.6%: first, the effect of the ACA which led to both permanent and temporary increases in MassHealth (Medicaid) enrollment, and, second, high drug spending, which resulted from the introduction of new high-cost drugs, large increases for existing drugs, and a relatively small number of drugs going off-patent.

It should be noted, however, that in each of these years, healthcare spending grew in the United States as well as in Massachusetts. Analysts attributed national growth to the expansion of ACA coverage, increased prescription drug spending and economic growth.

Interestingly, in its 2016 report, the HPC also highlighted the continued low growth in commercial insurance spending. The HPC reported that in 2015, the largest insurers, Blue Cross Blue Shield, Harvard Pilgrim Health Care and Tufts Health Plan all kept spending below the benchmark, but that healthcare providers had more mixed results. All major insurers have been below the benchmark from 2012 through 2015.^{29,30,65} It is also the case that during 2013 and 2014, the Patrick Administration continued to vigorously scrutinize proposed rate increases from insurance companies. The final average premium increase for 2013 was less than 3% and for 2014, it was under 4%.^{29,30} It could be that the leverage of 3.6% in carrier negotiations also played a part in this growth rate below the benchmark.

Another factor influencing the slow growth on the commercial side for is the explosion of high deductible health plans (HDHPs). In 2014, in Massachusetts, 1 out of 5 families had deductibles of \$3,000 or more and the number is growing. The use of high deductible plans is particularly common in the merged market of individual and small business employers, with 45% of the individual and 38% of small-group membership in such plans.⁶⁶

A major rationale behind HDHPs is the belief that making consumers sensitive to the price of health care services will incentivize consumers to seek less-expensive care and reduce unnecessary utilization. The growth of HDHPs is a national phenomenon and presents some troubling issues. It can result in less financial protection when people need to use care and some research shows that consumers with HDHPs are making decisions not to spend their deductibles and defer or forgo needed care.⁶⁷

While we do not know for sure if the care that is deferred is necessary or unnecessary, studies suggest that this phenomenon is in part responsible for the slowdown nationally in commercial healthcare cost growth.^{68,69} It could be that on the commercial side of the market, Massachusetts is not exceeding the benchmark minus drug prices and MassHealth hikes, but the reason may or may not be attributable to Ch. 224. It is too early to know with any certainty.

The 2014 data presents an interesting problem. Medicaid total medical expenditures have blown through the benchmark, and we know the reasons why this has occurred: a badly managed MassHealth system that permitted many people not otherwise eligible for MassHealth to enroll and receive taxpayer funded benefits, and an escalation of drug prices, especially for new break through cures such as Sovaldi and Harvoni for Hepatitis C. The state has since re-determined eligibility for MassHealth recipients and assuming that the MassHealth problems will not be repeated, that would leave the state to grapple with the high cost of drugs, clearly a

national problem. The HPC could play a leadership role in terms of exploring state or national policy options regarding drug prices. With respect to the spending of public dollars for prescription drugs, there are 1.8 million people in MassHealth and 430,000 members in the Group Insurance Commission. We don't know if the state is maximizing its purchasing clout in this market. Similarly, we don't know the range of options that may be available to commercial carriers or providers to maximize their purchasing power with drug companies, although they certainly have an incentive to minimize costs. We do know that some payers have been able to negotiate better deals with drug companies than some of their competitors.⁷⁰

In its recent 2016 report, the HPC made a series of recommendations that focused on cost issues under the control of local providers and payers. The HPC focused on hospital price variation that does not reflect differences in quality or other common measures of value and concludes that policy action is required to address price variation. The HPC does not state what specific policy actions it recommends but reports that it will undertake additional research and analysis to discuss further policy options.⁷¹

Tracking Trends in Provider Markets

As described above, Ch. 224 directs the HPC to track and report on material changes to the operations or government structures of provider organizations. The HPC is directed to engage in a more comprehensive review of transactions anticipated to have a significant impact on healthcare costs or market functioning. Specific regulations governing this process were issued in December 2014, and all providers are on notice about the process and what it entails.⁴⁶ After receiving a Material Change Notice (MCN), the HPC has thirty days to conduct a preliminary, quantitative analysis of the proposed change and to issue a preliminary report with findings. There is a period of feedback from the parties and other market participants and a final report is issued within 185 days from the date the notice is filed. The HPC cannot stop a transaction or require certain conditions. However, the HPC can refer its report on the transaction to the AG or to any other public agency for further action as warranted. While the information gathered in its reviews is exempted from the public records law, the HPC is given the latitude under Ch. 224 to engage in a balancing test and disclose information in its CMIR report. This possibility of disclosure is another aspect of the transparency powers of the HPC.

As noted above, from 2013 to May 2017, the HPC received and reviewed 82 MCNs.⁵⁰ Nearly half of the proposed transactions involved mergers of hospitals, physician groups or other providers or payers.⁵⁰ The HPC also reviews clinical affiliations that do not result in ownership changes, such as, contracting arrangements among providers that may facilitate coordination of care and involve risk-sharing arrangements, such as ACOs.

Perhaps the most important of those transactions to date are those involving three community hospitals and a large physician practice by Partners. The HPC CMIRs found that: 1. The proposed transactions were anticipated to increase total medical spending by more than \$38.5 million to \$49 million per year as a result of unit price increases and shifts in care to higher-priced Partners facilities; 2. The resulting system would increase the ability and incentives to leverage higher prices and other favorable terms in contract negotiations with payers. This effect was not included in the projected costs increases; and 3. The parties in the proposed transaction did not provide adequate evidence to support claimed improvements or efficiencies in care delivery systems post-merger. The HPC's CMIR was filed with the Superior Court, which did not approve the proposed transactions; ultimately, the transactions were abandoned.

Regardless of the form, the HPC is charged with examining any potential material changes in market structure. A major undertaking is HPC's monitoring of the growing numbers of acquisitions of physician groups by hospitals and the transition from independent or affiliated practices to employment models. For many years, there has been growing evidence that hospital acquisition of physician practices leads to higher prices for both types of providers.⁷² Market growth and power is dependent on referral patterns from physicians to hospitals and keeping patients within the hospital-doctor network. The Partners transactions included the proposed acquisition of the physician group, Harbor Medical Associates (HMA). While the HPC analysis included this component, the court did not block Partners from acquiring HMA.

As a practical matter, much of the HPC's analysis of market impact is similar to what federal or state antitrust authorities may undertake in reviewing mergers or clinical or financial collaborations among providers. The HPC threshold for review is somewhat different than that required by federal authorities. Its review considers impacts on cost, quality and access, although the HPC does not have the power to disapprove these affiliations. A federal antitrust review has to be guided, under law, by whether the transaction may pose a risk of a substantial lessening of competition in a relevant market or whether in the absence of clinical or financial integration, restraints of trade may take place.⁷³

The HPC, under Ch. 224, casts a broader net to expose transactions that while not legally anti-competitive may nonetheless be able to exercise a negative impact on the state's ability to stay within the cost benchmark. This is potentially a very significant power and is consistent with the overall Ch. 224 framework of transparency in transactions and using the HPC's bully pulpit to "name and shame" outlier entities.

Where is All That Price Transparency?

The issue of price transparency was the subject of scrutiny at the HPC's 2015 Cost Trend Hearings. Although all major payers have established their online tools, the use of these sites by members thus far has been limited. The HPC reported in its 2015 Report that it is not clear whether low usage has been due to poor usability or low consumer awareness of the sites, but the rates are consistent for national rates. It should be noted, however, that Aetna, an insurer that began building its online tool in the mid-2000's, reported in an open HPC hearing that it had over one million hits nation-wide in 2014.⁷⁴ Aetna currently has over 700 procedures on its site while most Massachusetts based carriers have far fewer.

The HPC also reported on efforts by public interest groups to gauge compliance with the law by carriers and providers. In 2015 both Health Care for All (HCFA) and the Pioneer Institute (PI) (an organization the author is currently affiliated with) conducted surveys to gauge consumer friendliness and effectiveness of carrier tools and provider protocols for price transparency.

In general, HCFA reported that price information was difficult to find, cost data was not presented in conjunction with easily understood quality information, and high-value choice options were not highlighted for consumers to see. Overall, HCFA graded the carriers with a "C" grade.⁷⁵ The Pioneer Institute looked at 22 out of 66 Massachusetts hospitals in 2015 and again in 2017 and tried to obtain the price of an MRI of the left knee without contrast. PI investigators found that lots of "persistence and diligence" was required to obtain price information and many hospitals appeared not to have systems in place to answer questions about price. In addition, while Ch. 224 requires providers to give out price information within two days of request, PI found the average time took between 2 and 4 business days. A subsequent survey among almost 100 Massachusetts physician specialists and dentists by PI yielded similar results, except that dental offices were much more forthcoming with price information to prospective patients.⁷⁶

In all its annual reports, HPC advocates for the continued use of demand side incentives such as price and quality information to foster the choice of more efficient providers by consumers. At present, it appears that the Commonwealth has a long way to go. There is very little advertising or information directed at consumers that informs them of their right to price information. While there was a small campaign around carrier transparency tools led by the Commonwealth in the fall of 2014, there has been no statewide campaign or indeed much individual advertising by carriers themselves. Providers are woefully behind in terms of developing consumer friendly protocols for patients to obtain price information. The survey of hospitals also looked at their websites, the first place a consumer may go to find information. PI found that only a few hospitals had any information on their websites about a consumer's right to price information.⁷⁶⁻⁷⁸ It is also worth noting that the ACA requires hospitals to post charges or else inform consumers as to how they can be obtained. The federal government has issued guidelines to

hospitals about transparency in pricing so that consumers may have the ability to compare prices across providers.⁷⁹

Notably absent in Ch. 224 are any enforcement mechanisms around the transparency provisions in the law. While the Baker Administration is an advocate for transparency, there have been few efforts to date to move this issue forward and to create a culture of price transparency in healthcare. Similarly, the Attorney General's Office has not used its legal powers under the state's Consumer Protection Law to enforce existing transparency laws. The HPC itself merely recommends that the Commonwealth, payers and providers should enhance strategies that would increase price and quality transparency. This lack of state leadership may not be accidental. There are credible reports that in order for the legislature to obtain consensus on these transparency provisions, there was an understanding that there would be no explicit enforcement provisions, transparency would take time, and it would be regarded as an aspirational achievement.

Is The Benchmark Enforceable or Aspirational?

While the HPC's enforcement tools regarding the benchmark are not very strong, it is possible that the constant flow of public actions and hearings from the HPC may have some salutatory effect on pricing behavior of providers. While there is no cause and effect evidence that the HPC has had a direct impact on provider behavior, with the exception of the failed Partner's merger in 2015, there may be enough HPC activity and scrutiny to suspect some impact on pricing decisions.

A close reading of the HPC's 2016 Annual Health Care Cost Trends Report shows the breadth and analytical detail that both the HPC and its sister agency, CHIA, have become famous for doing. This means that the performance of various sectors - payers, hospitals, physician groups, the commercial market, pharmaceuticals, MassHealth and Medicare - are measured and held up to public scrutiny. Is each sector adding to higher healthcare costs or is it engaging in efficiency enhancing care delivery systems that lead to lower costs? For the past couple of years, price increases in the pharmaceutical industry have been called out for attention. That said, some HPC commission members themselves have been aggressive in questioning providers about cost trends apart from pharmaceuticals.

The annual HPC hearings have become quite a ritual with healthcare executives girding themselves for sometimes tough public grilling by HPC commission members. Most recently, this past winter, commission member Professor David Cutler relentlessly asked a group of providers if their organizations had seen any efficiencies from years of consolations. Cutler asked the question over and over but the respondents were unable to answer.⁸⁰ Further, Cutler pointed out that even if pharmaceutical prices were taken out of the cost equation, provider costs are still rising. He asked providers why there have not been more cost reductions resulting from integrated systems.⁸⁰

A question is whether public scrutiny from Commission members is effective in sending the following message: consolidations and growth that do not produce savings for the system that can ultimately be passed onto consumers are not heading us in the right direction.

The public shaming of providers or payers that are spending above the benchmark has yet to materialize, assuming it would yield results anyway. Ostensibly, under the HPC's new regulations, if a firm is asked to prepare a PIP, that entity's name will be made public. But the HPC has just recently put its rules for doing so into place and they will not be employed retroactively.

It is worth noting, however, that in its 2015 Cost Trends Report, the HPC reported on the cost of vaginal and C-section deliveries at all hospitals in the state providing such services. The data named specific hospitals and the average spending amounts in each category as well as the C-section rate for each hospital.⁸¹ Although the data were based on the years 2011-2012, they provided a rare public glimpse into the wide disparities in prices charged by Massachusetts hospitals for the same procedure. So-called "unwarranted price variations" have long been a topic of discussion in Massachusetts, and the HPC has repeatedly stated that unwarranted price variations in provider prices are unlikely to decrease absent direct policy action.⁷¹ Although there is no precise definition of "unwarranted price variation," it can generally be defined by differences in price that cannot be explained by inpatient acuity, high-cost outlier cases, or quality.⁸²

The HPC does not have any statutory authority over prices charged by providers. Its sister agency, CHIA, similarly, has no such authority. CHIA, however, is the repository of the state's all payer claims database (APCD) and although a recent United States Supreme Court decision, *Gobeille v. Liberty Mutual Insurance* (March 1, 2016) has cast doubt on self-funded plans' obligation to provide the state with this price information, data from fully-insured plans must still be provided.^{83,84} CHIA has the authority to share these data by provider name, but de-identified as to patient, with the public. To date, however, such sharing has been limited to research organizations which are charged a hefty fee for such de-identified data. For a while discounts were available to researchers seeking APCD data from CHIA but that no longer appears to be the practice. This is an unfortunate policy as greater, not less, transparency in healthcare prices is very needed.

So, if enforcement tools, including the \$500,000 fine, for a firm that does not fulfill its PIP, are not enough, and if the HPC has no authority over provider prices, is the whole benchmark concept and regulatory structure merely an aspirational exercise? Aspirational goals are merely that – a desired outcome without strong enforcement incentives. One outcome of aspirational goals is that when they are not achieved and in Massachusetts when price variation does not diminish, new legislative proposals arise to fill the void.

There are legislative proposals that tried to go further than the benchmark and take direct aim at high prices. As discussed, *supra*, at page 35, in 2017, Massachusetts Governor Charlie Baker proposed that insurance companies be limited to the percent increase they can pay providers based on provider revenue size. Insurers would have been prohibited from giving any increase to the largest third of providers. Although this proposal was seen as a “conversation starter,” the proposal appears to no longer be under consideration. But the fact that it was floated at all, could be a portend of things to come.

That said, the fact remains that the benchmark, now at 3.1% for calendar year 2018, is a fixed part of the regulatory landscape regardless of the efficacy of its enforcement tools. It is a backdrop to C-suite decision-making and a cudgel that hangs over the industry’s head. Although difficult to measure in terms of effectiveness, the benchmark and the HPC have become part of the inter-stakeholder cultural landscape in Massachusetts healthcare.

Does the HPC Need more Authority to be Effective?

One of the HPC’s most resource consuming functions involves Cost and Market Impact Reviews (CMIR) discussed *supra* at pages 22-23. In general, these studies look at entities that hold a dominant share in their respective market and charge prices that are materially higher than the median prices of other providers or have health-status-adjusted Total Medical Expenditures (TME) that are materially higher as well. So, what can the HPC do with a CMIR that uncovers such situations? It can issue a public report on such providers and, it can refer its report and the providers to the Attorney General’s Office (AGO). The AGO, under Chapter 224, can investigate unfair methods of competition or anti-competitive conduct and the AGO can issue a report back to the HPC.

In the midst of this circular report writing, one should not lose sight of the fact that the AGO, under existing consumer and antitrust laws, can already bring legal actions for unfair methods of competition under the state Consumer Protection Law, Chapter 93A, or for violations of the state antitrust laws, Chapter 93. Under certain conditions, the state AGO can also bring actions under federal antitrust law as well. The AGO does not need Chapter 224 for permission to enforce existing consumer or antitrust laws and Ch. 224 does not give the AGO any new authority to enforce incipient anti-competitive conduct than it already has under existing law.

So, what is wrong with this statutory framework aimed at limiting the growth or exercise of market power? First, the HPC has no legal authority at all to do anything about such conduct. And, the AGO already has legal authority to take action if the conduct amounts to a violation of existing consumer or antitrust laws. In short, Chapter 224 does nothing to limit the growth of market power (which under traditional antitrust merger analysis is the ability of the combined entity to raise price more than 5% for a non-transitory period of time).

The legislature could give the HPC or other regulatory agencies more authority over certain transactions to further limit the growth of market power by particular entities. For example, the legislature could direct the AGO to promulgate regulations proscribing as unfair methods of competition even small increases in market share if an entity already has a certain share of market or markets. Or, the HPC could be given authority to deny transactions that may not rise to the level of an antitrust violation but nonetheless would have an adverse impact on cost containment. In a time when “determination of need” or “DON” regulatory regimes are under scrutiny for impeding new competition into healthcare markets, any such new powers given to the HPC would have to be carefully tailored.

There are many courses that the legislature could take to make the HPC more effective at keeping the focus on cost containment and more targeted at the benchmark limits. In fairness, however, there are some costs that may be beyond the state’s jurisdiction, such as pharmaceutical prices, which the HPC can do little about. That said, the overwhelming majority of healthcare costs are within the control of providers and payers and thus, would be within the jurisdiction of the HPC or other state entities to control.

Conclusions: Are There Lessons from Massachusetts?

For the past 11 years, Massachusetts has engaged in an effort to achieve near universal access to healthcare, and most recently, to try and contain the cost of that healthcare. In the course of its pursuit toward health care for all its residents, Massachusetts has taken full advantage of federal dollars that are available for its Medicaid population and low-income residents who qualify for subsidies under Obamacare. Recent national events threaten some of the progress that Massachusetts has made. If federal Medicaid dollars are dramatically cut, Massachusetts will have hard choices to make in terms of maintaining coverage for its low income and non-working poor. The state currently spends 40% of its budget on Medicaid including federal dollars. While an analysis of that problem is beyond the scope of this paper, it is useful to understand that some of what happens in healthcare may be beyond the state legislature’s authority or the oversight of the HPC. However, while some events are beyond the state’s control, they will nonetheless affect non-Medicaid provider and payer markets as well, and that will implicate agencies such as the HPC and its cost control efforts.

(1) Payment Reform

The underlying thrust of Ch. 224 was payment reform and the belief that the practice of fee-for-service (FFS) medicine was a major factor in raising the level of health care spending. The prospect of various alternative payment methodologies (APM), such as global payments, bundled payments, or any form of payment that

placed some risk on providers' performance was thought to be a better alternative. Indeed, Medicare has already embarked on an ambitious program to change the way it reimburses providers to move providers toward more APM options. Ch. 224 set APM goals for public health care programs such as Medicaid and the state's Group Insurance Commission. It set "aspirational" goals for the commercial market as well. The healthcare marketplace is a dynamic place and there are payers and providers who are experimenting with various payment forms apart from FFS. The continued emergence of large healthcare systems that can command top price, in turn, incent other systems to adopt payment reform mechanisms as a way to stay competitive.

Whether it is by law or by necessity, there has been a shift toward payment reform over these past several years. As discussed earlier, it has not been as dramatic a shift as some proponents anticipated. The bottom line, however, is that payment reform in its various incarnations seems to be a permanent and evolving feature in Massachusetts and federal healthcare markets. Most recently, MassHealth has embarked on an ambitious program to overhaul the way Medicaid providers are reimbursed. As reported in the *Boston Business Journal* on June 8, 2017, MassHealth is restructuring Medicaid into 18 selected healthcare organizations where providers will be given a set amount of money per patient. The 18 networks will cover 900,000 of the state's 1.9 million MassHealth enrollees. The concept is based on an accountable care organization model where each of the 18 groups will manage patients over a period of time for a fixed amount of reimbursement, including federal funds for information technology investments.

Has payment reform produced the cost savings that Ch. 224 framers anticipated? Generally, across the country, payment reform has a mixed record in terms of cost savings and quality outcomes.⁸⁵ Indeed, in some cases, implementing payment reform and enhancing the coordination of care cause increasing costs as new technologies must be adopted to ultimately facilitate such systems. In some cases, law requires new electronic medical records technologies as was the case in Massachusetts.

Although payment reform is required in the public sector under Ch. 224, it is aspirational in the commercial market. The decision not to require payment reform in the commercial market appears to have been a correct decision if only because the alternative, mandatory payment reform in private markets, was fraught with unintended consequences.

Currently, FFS medicine and APMs exist simultaneously in the Massachusetts commercial healthcare marketplace, with FFS still dominating the market. And, we cannot conclude that, where adopted, APMs have generally yielded lower healthcare cost growth or greater quality outcomes. Consolidation in healthcare markets may ultimately prove to be a primary driver of the adoption of payment reform as competitors seek to lower costs to remain viable. In addition, it seems critical that the state act by example in terms of embracing APMs in its various programs that spend public dollars for healthcare.

(2) The Establishment of an Independent Health Care Agency

It was not always certain that Ch. 224 would result in the establishment of a new healthcare agency – the Health Policy Commission, with broad powers over the industry. There were those who believed that establishing new healthcare bureaucracies was unnecessary and that new powers should instead be given to existing agencies, such as the Department of Public Health, the Division of Insurance, and various other regulatory agencies, most of which are in the Executive Branch of state government. However, there was a view in the Legislature that in order to create change that would not be dependent on the policies of Commonwealth's Governors, it was necessary to create an independent agency that was not subject to the control of the chief executive. Thus, the HPC was created and funded through assessments on the healthcare industry. (See, *supra*, p. 20, for a description of the Commission itself.)

It appears that an independent agency was likely the correct decision, especially once the concept of a benchmark became embedded in the law. The benchmark needs an enforcement agency and mechanisms. It would be difficult though not impossible to entrust benchmark enforcement to agencies within the control of the governor. That said, although the legislature chose the independent agency route, it did not grant the toughest enforcement powers to this agency. Thus, we see enforcement powers that are slow moving, involving lots of reports and analyses, ample time for compliance and some would argue a rather weak ultimate penalty of \$500,000.

It would not be a fair assessment, however, to judge the efficacy of the HPC solely on its fining abilities. The market impact analysis which the HPC performed and provided to the court in the previously mentioned proposed mergers among Partners Healthcare and hospitals on both the north and south shores of Massachusetts was extremely important in the court's final decision in those cases. In addition, the HPC was viewed publicly as an independent voice in these proceedings with a professional and sound economic analysis. These proposed mergers created an unexpected opportunity for the HPC to establish itself as an honest watchdog on behalf of cost containment.

(3) The Establishment of a Cost Control Target

Ch. 224 established a growth level for Total Health Care Expenditures (THCE) that was tied to the overall long-term economic performance of the Commonwealth. It includes all healthcare expenditures including public (Medicaid, Medicare, the Group Insurance Commission) and private spending. While the benchmark may have been proposed as a way to demonstrate savings for public consumption, tying growth in healthcare costs to economic growth is not irrational. However, the

underlying principle is that Massachusetts does not expect an actual decline in healthcare costs, just a slowing in the growth of such costs.

As stated earlier, the benchmark “baked in” the high prices that already existed. This feature may account for the lack of vociferous opposition to the benchmark by the state’s most powerful healthcare industry entities. It may have been the price that had to be paid for enactment. It is also interesting to note that no other non-public utility industry in the state is subject to this form of regulation. Probably the most important feature of any benchmark is that it sets expectations and establishes the norm around which the industry will be measured.

A September 7, 2016 headline in the Boston Globe read as follows: “Mass. Makes progress in containing health care spending.” The first sentence claimed that “the growth of healthcare spending moderated last year.... a sign that its groundbreaking experiment to rein in medical costs is making tentative progress.” This story which was written before the final THCE figure for 2015 was adjusted upward to 4.1% from a preliminary 3.9%, painted an optimistic view that healthcare expenditures were moderating.⁸⁶

In the article, Stuart Altman, Chair of the HPC, says that Massachusetts is the only state to try and do something about total healthcare spending. In fact, states have limited options when it comes to cost control of healthcare expenditures. Massachusetts used to regulate hospital prices but repealed that law in the mid-nineties. Maryland is a state that continues to regulate hospital unit prices and per capita hospital spending. A state can either regulate prices directly as Maryland does or try for broader systemic reforms that may ultimately lead to lower costs. In Ch. 224, Massachusetts chose the latter route. It is a more circuitous route than direct regulation and much depends on cooperation and the bully pulpit. These are tough public policy calls to make as no one can predict if the outcome will be positive. One issue for any state considering this direction should be the degree of authority needed to regulate conduct that enables the growth or exercise of market power. Such conduct may not implicate antitrust concerns but nonetheless may result in non-transitory pricing behavior. Remedies such as heavy fines and cease and desist orders, as well as having as much as possible a matter of public record would seem appropriate given the Massachusetts experience from Ch. 224

(4) Healthcare Price Transparency

When Ch. 224 was first passed, some of its most promising features were the provisions requiring transparency in healthcare prices. Nationally, Massachusetts was applauded for having enacted among the best transparency laws in the nations. Transparency would be good for consumers and for the market as a whole. At long last, the usual secrecy and obfuscation surrounding healthcare prices would be

stripped away. Unfortunately, the state has not lived up to the promise of those provisions.

At the time, there was a widely held view that high healthcare costs warranted scrutiny and transparency. The idea was a simple one, given high deductible health plans and/or the development of financial incentives, consumers would choose high quality – lower cost providers for non-emergent care. Some thought there was a natural alliance between consumers and their insurance companies where both would benefit from transparent pricing. Competitor providers would seek to lower costs so as to remain competitive. The market would work better. So, what could go wrong?

First, there was a lack of understanding that teaching consumers that healthcare price transparency matters is a cultural revolution that requires ongoing education, high visibility and material rewards. Employers are an important part of the learning curve as well, and they require time and attention and financial incentives from payers and providers. It is not enough to build mediocre cost estimator tools and expect their adoption and use simply because they are available. Building consumer friendly tools, employing helpful staff to teach and facilitate value choices – these are just first steps. Employees and employers must be approached as partners in an ongoing endeavor that can benefit everyone.

One example is a recent project adopted by the indemnity plan of the state's Group Insurance Commission managed by Unicare. This project pays employees – all with very low deductible plans - anywhere from \$15 to \$500 for choosing value providers from among 40 common procedures. There is ongoing education and targeted marketing to reinforce the transparency message. Other employers in the state are experimenting with their own programs to incent employees to save on overall healthcare costs.

Second, there were no explicit compliance or enforcement mechanisms in the laws that were passed. This allows providers especially to flaunt the law with impunity. They are not required to post prices or make them available online. Only recently, has the Massachusetts Health and Hospital Association even provided lip service to the idea that transparency for consumers is worthwhile.⁸⁷

Third, there has been an absence of leadership at the state level in terms of promoting these laws and encouraging consumers to learn about healthcare prices.

Fourth, there has been significant resistance among providers and their trade associations and from payers as well in terms of investing in systems and programs to promote transparency.

These are a set of negative lessons that can be taken from Ch. 224's transparency provisions. None of these problems, however, is insurmountable. The ingredients of a successful transparency initiative are simply the reverse of what we are doing

wrong in Massachusetts. First, state leadership should understand that institutionalizing transparency means changing attitudes and this will take time. We have seen education and targeted marketing change attitudes on any number of public policy issues from drunk driving to tobacco use to littering. The state is in a unique position to bring stakeholders together and to challenge them to develop consumer friendly, effective price transparency tools and programs. Second, enforcement mechanisms are needed to challenge payers and providers to work with the business community to develop innovative programs to promote consumers' choosing high value providers over high-priced providers.

All the rhetoric about "patient-centered" care is fairly meaningless if as a matter of public policy we choose to keep consumers in the dark about healthcare prices.

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