POLICY PIONEER HEALTH BRIEF

What's the Purpose of the Healthcare Cost Growth Benchmark?

by Scott Haller and Barbara Anthony

Beginnings of the Benchmark

Chapter 224 of the Acts of 2012 was enacted to combat the state's rising healthcare costs following the expansion of health insurance to nearly all Bay State residents in 2006. Massachusetts' growth in per capita healthcare spending has, until 2012, consistently outpaced national spending leaving us with relatively high costs — partly due to the high prices at our prestigious hospitals.

Designed to encourage the adoption of alternative payment methodologies (APM) and formation of accountable care organizations (ACO), Ch. 224 has a wide reach that also requires transparency of pricing, establishment of the Health Policy Commission (HPC) and a reconfiguring of the Center for Health Information and Analysis (CHIA), and implementation of various other measures. Despite its broad impact, the true thrust of Ch. 224 was the adoption of payment reforms through APMs.

Traditional fee-for-service payment arrangements can provide the wrong economic incentive to providers; for example, by increasing the volume of tests and procedures, an organization can maximize revenue. To counter such a misaligned incentive, one version of an APM, instead, pays providers a lump sum — a so-called bundled payment — based on the treated condition. Under APMs, therefore, the provider assumes some financial risk and is incentivized to hold down costs while still maintaining quality. However, under such an arrangement some have expressed concern that the incentive could be to underprovide care. Only time and further research will show the effectiveness of APMs in decreasing costs.

While the state has forced APMs on MassHealth and the Group Insurance Commission, to varying degrees of success, there is no requirement for the commercial market to make the switch. The HPC is supposed to encourage the commercial market over time to adopt APMs, but a big question is the degree to which there has been a concerted focus on this central tenet of Ch. 224.

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One of the most frequently discussed and scrutinized elements of Ch. 224 is the setting of a healthcare cost growth benchmark, created to tie the increase of medical expenditures to the growth of the state economy. Pioneer, has raised questions about this link in the past.

Through 2016, the benchmark for total medical expenditures (TME) growth per capita was pegged to potential gross state product growth (PGSP, the economic forecast for Massachusetts), which has been held at 3.6 percent since 2013. In its first year, growth in TME was only 2.4 percent, well below the benchmark. However, 2014 and 2015 saw growth at 4.2 and 4.1 percent respectively.

This year marks the first time that the benchmark is supposed to drop 0.5 percentage points below PGSP growth, and though the HPC had the power to delay this decrease, last week they acquiesced to the statutory schedule.

The state has admittedly struggled to consistently achieve the benchmark's prescription, but that isn't necessarily a knock on Ch. 224. Amidst all the hubbub over the benchmark, there is a distinct lack of public discussion about the performance of the legislation's main policy thrust: Is the industry successfully stressing behavioral objectives — such as instituting payment reforms, boosting transparency, and policing abuses of market power — and more importantly, are these reforms helping?

Does the Benchmark Affect Behavior?

As far as policies go, some observers believe that the benchmark is relatively toothless. Providers and payers found to be noncompliant with the benchmark are first warned that the HPC may investigate them, and, at worst, may be publicly shamed on the HPC website.

While the HPC can ask for a performance improvement plan (PIP) from noncompliant institutions, their only further recourse is a paltry $500,000 fine. The HPC, however, has not issued any fines or required any PIPs from flunking organizations, although it has recently issued new regulations about fining procedures, thereby giving notice that this ship may soon be sailing.

Even if the HPC aggressively pursued every institution failing to comply with the benchmark, it's unclear that this is the best way to encourage positive behavior and highly unlikely that a little public shaming is enough to whip this multi-billion dollar industry into shape.

Finally, one of the worst "offenders" has been the state government themselves. Continued growth in MassHealth (Massachusetts' Medicaid program) has added significant inflationary pressure to the growth of spending in the state. MassHealth spending grew 17.9 and 4.6 percent in 2014 and 2015 respectively, both well above the benchmark, though the hope is that payment reforms will improve performance. Shaming of the private sector falls flat as long as the state can't set a good precedent.

Does the Benchmark Elucidate Healthcare Trends?

Massachusetts is the first state in the country to attempt this form of regulatory regime, leaving it largely up to insurers and providers to chart their own course towards cost containment in lieu of more interventionist approaches — like rate setting. While cost growth has indeed slowed under the benchmark, it is not a perfect litmus test for the success of Ch. 224 and subsequent efforts to rein in healthcare spending.

The benchmark is based on TME, which covers all facets of healthcare industry spending including prescription drugs, hospitals, health insurance, public health programs, and more. It is difficult, if not impossible, to dramatically reduce spending in any one category, while it is fairly common for a specific segment of the market to see significant upticks. This means that even if the industry as a whole reduces spending growth moderately, one sector with significant cost increases could have aån outsized effect on the aggregate benchmark.

There are other, less scrutinized, problems baked into the benchmark that promote questionable features of the healthcare market. For example, it is broadly accepted that Massachusetts' healthcare industry is rife with unwarranted price variation, as evidenced by the existence of the Special Commission on Provider Price Variation and their lengthy report (as well as numerous Pioneer studies). Yet Ch. 224 allows for uniformly proportional growth across the entire industry, meaning overpriced providers will continue to be relatively overpriced.

There is also a deeper question about whether we should be expecting to see automatic year-over-year growth in healthcare costs. The benchmark can be seen as an admission of our acceptance of this costly trend, even with a lowering of the growth rate.

Realizing Chapter 224's Goals

Pioneer applauds the HPC's decision to allow the benchmark decrease for 2017, keeping the Commonwealth's expectations high. It is inconsistent public policy to lower inconvenient, but purposefully set, targets over a failure to meet them.

That said, Ch. 224's primary focus was encouraging, and in some cases requiring, the adoption of APMs in an attempt to hold down costs. Because this was a wonky proposal without guaranteed results, the benchmark was born as a shiny object that public officials could use to tout savings to the general public and anchor the industry towards. So, the benchmark is the public face of legislation with a much a wider scope, not the actual policy prescription.

If Ch. 224 is to succeed, then we must focus on allowing the spirit of the law to change the culture around healthcare. This means carefully studying the adoption and performance of APM's and ACO's, while continuing to pursue other approaches, such as incentive-based transparency tools and reward programs. Consumers and employers must be engaged in healthcare decision-making to reduce costs, and this will require significant education and actual pricing transparency.

Fee-for-service systems have long been criticized for allowing, and arguably incentivizing, unnecessary tests and procedures that drive up TME. If Ch. 224's payment reforms incentivize improved provider performance relative to traditional arrangements, then we need to identify more ways to encourage the commercial market to embrace these approaches. If they don't succeed in doing so, we should continue exploring alternative approaches.

Instead of solely focusing on a benchmark, which is hardly prescriptive and doesn't speak with specificity to the performance of the expansive legislation it was created to monitor, we have to remember the other moving parts of Ch. 224. That means following through on payment reforms in the commercial market, enforcing and implementing transparency provisions, and limiting market power when it contributes to unwarranted price variation. If we let the lessons of our experience with Ch. 224 pass us by in the race to meet the benchmark, we may be passing another "major" reform in ten years to still try to tackle costs.

Endnote

1. Massachusetts. Health Policy Commission. February 8, 2017. **http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf**.

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