PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

Honorable James Welch October 23, 2017

Recommendations of Pioneer Institute to the Special Senate Committee on Health Care Cost Containment and Reform

Dear Chairman Welch and Committee Members:

It has been several years since Massachusetts has attempted to tackle cost containment issues in a comprehensive way. We recognize the difficulties inherent in such an undertaking and commend the efforts of the Senate Working Group, especially its willingness to listen to stakeholders, its multi-state research efforts and determination to articulate concrete steps to address rising healthcare costs.

We applaud a number of the suggested steps. For example, we support provisions of the proposed legislation that aim to reduce emergency room use and re-admissions, expand scope of practice, and embrace telemedicine. We also support the notion that Massachusetts can benefit from what other states have already accomplished in this area.

While the bill does take some very positive steps, in some instances we believe it diminishes the potential for greater cost savings by adding unnecessary guardrails or regulatory burdens. The projected savings relative to projected 2020 spending are quite modest; if we have understood the cumulative impact of the bill, the savings will be *less than 0.2 percent*.[1] Significant savings will require a bolder approach to engage patients in the health care market. It is our hope that as this bill moves through the legislative process, measures can be added that will achieve more significant cost savings.

In addition, we have deep concerns about the Medicaid buy-in program as it is presented in the proposed legislation. This radical change from the existing program structure is very much a skeleton of a proposal and will require much more elaboration and analysis. Radical change can be good and is sometimes necessary. That said, it is unclear what the impact of this proposal will be on MassHealth and providers across the Commonwealth.

Moreover, as presented, it is not at all clear what will happen to the merged market as it currently functions. The proposal could, in fact, lead to harmful unintended consequences, such as the collapse of the merged private insurance market. Such a major change warrants further intense examination.

At a high-level, Pioneer believes the legislature should consider changes with these three fundamental goals in mind:

1) **Engage the Patient:** There must be open access to individualized transparency that empowers patients to contain costs by choosing a high-value provider instead of a high-cost provider with the same or lower quality. One way to accomplish this goal would be for the Legislature to direct

[1] Pioneer projection assuming a 3.1% growth each year, and using the $59 billion spending amount for 2016.

CHIA to follow the lead of Medicare under President Obama by releasing provider-level data from the all-payers claims database (APCD). We have attached draft language on this topic for your consideration.

As you know, prices for a medical service or procedure vary by hundreds of percent. Innovative companies like MyMedicalShopper, Vitals SmartShopper and Healthcare Bluebook are able to take data and present it to patients in a consumer-friendly manner that can save those that are sick and those with chronic conditions thousands of dollars a year. Currently, the Group Insurance Commission is administering a pilot wherein over 90,000 of its indemnity plan members are engaged in such a value-purchasing program. This is one of the reasons why releasing more data to the public is so important.

As an example of the savings potential, MyMedicalShopper looked at the 100 most common procedures in New Hampshire and found that *costs could be cut by more than half* if patients were able to find the best value care in their area. Finding areas of care where value-shopping can produce 50 percent cost reductions should be incorporated into any legislative cost containment effort; this bill presents an opportunity for the legislature to follow a bolder approach than aiming for a 0.2 percent reduction. So after transparency, how do we accomplish that?

2) **Remove Barriers in Order to Expand Patients' High-Value Options and Innovation:** Health care costs, and therefore insurance premiums, are extremely expensive in the Commonwealth because of underlying costs, the bulk of which are facility-related. It is difficult to translate "innovation" into statute, but Massachusetts lawmakers can facilitate innovation by removing barriers for high-value innovative providers and aligning the incentives for patients to seek out these high-value providers. The current bill addresses some important scope of practice and telemedicine reforms, but many barriers for practitioners and patients remain.

   To move the needle on cost substantially, we recommend two additional steps. Legislators should undertake a comprehensive review of scope regulations and liberalize as many as possible.

   Second, for far too long the Commonwealth has had protectionist regulations in place that protect incumbent providers while making it more difficult for innovative and less expensive providers to gain a toehold. These protectionist DON (determination of need) measures benefit incumbents at the expense of families and employers. The bill does not appear to address costly DON regulations. We recommend an overhaul of DON regulation that favors new, more efficient market entrants. For example, all the urgent care centers in Boston are owned by major hospitals and there is not one limited service clinic in the city. These are just two examples that could result in lower health care costs.

3) **Focus on MassHealth Eligibility:** The working group has acknowledged that the Commonwealth must address the growth of MassHealth enrollment. That is especially true given the uncertainty around federal law and potential funding changes. The current bill does not propose robust MassHealth reforms. (If the Medicaid buy-in is intended as a cost savings reform, it is not clear from the legislation.)

   We believe the Commonwealth needs to put a laser focus on MassHealth eligibility. States like Illinois and Pennsylvania have had success by checking eligibility data more frequently. Codifying effective practices on income checks, adding a reasonable asset test, and increasing the frequency of data checks related to eligibility can help contain costs at MassHealth and preserve program resources for its intended beneficiaries. Some states have seen initiatives focusing on eligibility yield spending reductions of 2-to-4 percent.

> Finally, we support the attempts to gather more refined data for policy making, especially those that relate to MassHealth. While we hope information gathered by the Health Insurance Responsibility Disclosure (HIRD) form will be useful, policymakers should be cautious about placing undue administrative burdens on small businesses.

Here is some additional feedback on the bill:

Scope of Practice/Telemedicine: We applaud the steps the bill takes to expand scope of practice and the use of telemedicine.

As we have testified previously, on balance creation of the dental therapist position is a good step toward increasing access to oral health. However, we would still like to see some rational differential in reimbursement established between dentists and therapists, otherwise cost reductions may be elusive.

For all the scope of practice provisions, we recommend that if a medical provider has been trained to provide a service, she/he should be allowed to do so in daily practice, without undue requirements to obtain permission, and she/he should be able to practice without supervision for the things she/he has been trained to provide. If they are required to be supervised, their services should not be reimbursed at the higher supervising provider level. At a minimum, the bill should add clarity about payment.

If the goal is to reduce costs in health care, we need to increase the supply of high-value providers and any barriers that are erected, such as scope of practice limits, inflated training requirements, supervision restrictions, and high fees all hinder efforts to achieve that goal.

The expansion of telemedicine is an important move in the right direction. It is a win-win, helping to increase access for patients and allowing providers to deliver more high-value care in a shorter time period. In addition, a statewide embrace of telemedicine could open up new business opportunities for the Commonwealth to serve global medical needs as we are home to some of the best medical providers in the world.

However, we do have concerns that as presently constructed there does not appear to be a meaningful pay differential between in-person visits and telemedicine. The opportunities to enhance access and generate cost savings efficiencies should not be undercut by imposing payment parity.

Insurance Changes: We believe increasing tiering differentials from 14 percent to 19 percent is a step in the right direction, but recommend that even higher differentials be permitted. Let insurers and individuals decide what plan design elements are best for them, and remove any barriers that would prevent the creation of lower premium plans.

Medicaid Buy-In Could Collapse Private Insurance Market

The proposed MassHealth buy-in, Section 123, may be well-intentioned, but as presented, it certainly appears to be a move in the wrong direction for the Commonwealth. As drafted, it has the potential to spike costs at MassHealth, add administrative costs, and have huge unintended consequences for medical providers. At worst, it may lead to the collapse of the private insurance merged market in Massachusetts.

The Commonwealth has struggled to afford the MassHealth program to date. It now covers one out of every four residents and comprises roughly 40 percent of the budget. The Medicaid buy-in appears to be a form of single-payer health care, or pubic option, for a certain part of the Commonwealth's population. As drafted, it only requires an employer to pay 50 percent of the cost. This could lead to widespread

dumping of employer-based insurance—which pays providers a higher rate, harming them in the process—and could strain access for patients while lowering quality as a result.

A change of this magnitude should not be undertaken without in-depth analysis and full understanding of its consequences on patient care, access and affordability in both the public and commercial healthcare sectors. We recommend that this proposal be pulled out and studied separately. There is no price tag associated with the proposal and therefore we can neither weigh its impacts nor determine the effect on the traditional Medicaid program for the blind, disabled and elderly.

Furthermore, this provision is an acknowledgment that a real effort is not being made to reduce costs in the individual and small business market by examining the reasons for high premiums such as price variations, mandated benefits, merged market regulations, and other insurance and provider regulatory barriers that prohibit more cost-effective care options.

Similarly lacking detail is Section 110 which deals with the Connector's small business subsidy program. It is unclear who will pay for the 50 percent subsidy. It should also be noted that any focus on leveraging federal funding in this bill is cost shifting, not real cost containment, and cannot be relied upon.

Protecting Patients From High Costs: In Section 109, subsection 30, and subsections (iii) and (iv), where payment standards are set for nonemergency care to be provided by providers that are not in the patient's specific health benefit plan, there are restrictions that undermine potential cost containment. These subsections should be amended to remove "and a participating provider in the insured's health benefit plan is unavailable". This is an unnecessary condition that adds complexity to cost containment efforts.

Subsection (iv) should be further amended to add a provision that an individual may seek out a non-participating provider if the provider are below the average in-network rate. A similar provision recently became law in Maine (Public Law 232). These suggested changes will make subsection (c) in this part of the bill unnecessary, increase patient access to high-value providers, and are in the spirit of the bill to provide protection and predictability to patients. Currently, providers are hesitant to refer to high-value out-of-network providers even if they are a fraction of the cost for the same quality. As a result, the Commonwealth wastes a significant amount of money.

On the same topic, Section 22 moves in the right direction to address out-of-network provider rates, but it is incomplete. The provisions protect patients from high unexpected charges, but does nothing to protect patients from high in-network out-of-pocket costs. This can be fixed by allowing them access to high-value out-of-network providers if they find a price that is lower than the average in-network rate. The Maine law referenced above includes this protection. See appendix for suggested changes.

Finally, Section 101 moves in the right direction by offering patients additional options, but not all options are created equal. The bill should require that insurers offer plans that fulfill (iv) and (v) in every market because it finally rewards patients for finding high-value providers. A new section (vi) should be added that also requires plans to grant positive incentives in the form of cash, gift cards, or premium reduction, as examples. The Maine law has a similar provision.

The Group Insurance Commission (GIC) has adopted an incentive program for over 90,000 of its indemnity plan members that gives cash back to patients that pick high-value providers. The state of New Hampshire has saved over $14 million with this program and paid enrollees over $1 million in incentives. Extending such a program to the merged market would help enrollees seek out high-value providers, which will help reduce insurance premiums for everybody.

Readmission benchmark
Setting readmission benchmarks is an admirable goal, and the bill acknowledges that engaging hospitals and providers is essential. However, any meaningful goal is unlikely to be met without a robust discussion about overly generous plan designs in MassHealth and on the Connector, two populations with the highest rate of emergency room utilization and a very high rate of nonemergency utilization. We would recommend that the bill be changed to require MassHealth to examine the 1115 wavier to increase cost sharing for repeated nonemergency emergency room visits, and direct the Connector to look closely at the rate of emergency room utilization and test cost sharing to reduce nonemergency utilization. Numerous other states are making similar changes in their Medicaid programs.

Behavioral Health Urgent Care Centers
Behavioral health urgent care centers are an interesting idea, but it is concerning that the bill layers on restrictions, extra regulatory burdens on current behavioral health providers and facilities, and a new licensing fee. If opening the door to more high-value care is the goal, barriers should be removed, not added. A registration might accomplish the same goal without having the full licensing process. The current language in Section 39, stipulating that a "facility, department or ward shall not provide behavioral health urgent care services unless it has obtained a license under this section," is concerning if this in any way burdens current providers.

Prescription Drugs
Section 65 moves in the right direction by allowing pharmacists to disclose high-value pricing for drugs. This is a long overdue reform that will directly benefit patients. While it is good to allow for the posting of information that lets a patient know she/he can ask about pricing, it would be far more effective if the pharmacist could be empowered to proactively inform a patient on their own. This same standard would be beneficial for all medical care.

More Transparency Needed
Section 29 could be a good step toward transparency at CHIA but is unworkable in its current form. Having to obtain consent from every provider and payer is a huge administrative burden, and the restrictions on the release of data significantly undermine the potential for cost savings. The following in subsections (e) and (f) should be removed:

> "The center shall keep confidential all nonpublic data obtained pursuant to this subsection and shall not disclose such data to any person without the consent of the provider or payer that produced the data; provided, however, that the center may disclose such data in an aggregated format. The center shall promulgate regulations necessary to implement this subsection.
>
> (f) Except as specifically provided otherwise by the center or pursuant to this chapter, insurer data collected by the center pursuant to this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66."

In addition, CHIA should be granted administrative relief to reduce costs by allowing them to collect data for the majority of claims instead of for *all* payers. Setting a new threshold of 85 or 90 percent of claims would reduce administrative costs and allow data to be processed and publicly released more quickly.

In the numerous surveys Pioneer has conducted on transparency, we have discovered that even when a patient asks, it is in many cases almost impossible to obtain a price from a provider. The state's transparency laws under Ch. 224 should be enforced by the licensing agencies and the Attorney General's Office. Although these entities already have the power to enforce Ch. 224 transparency, adding such provisions to this legislation would make it explicit.

Adding Costs to Health Care
This bill adds numerous new councils, committees, task forces, and trust funds. In many cases, these will add costs to the health care system, not reduce them. Additional fees that are levied to fund these activities, such as the Mobile Integrated Health Care Trust Fund, the Hospital Alignment and Review Trust Fund, and the drug fee to fund administrative costs (as examples) will be passed onto patients, which is antagonistic to the stated goal of this legislation. For this reason any new group formed for this reason should be subject to significant scrutiny.

Increasing Payment Rates
It is unclear how describing an objective, such as setting up "a process for increasing reimbursement rates to the lowest paid providers while establishing a glide path for slowed overall growth to hospital rates of reimbursement", will achieve the goal of cost control. In fact, at face value it would seem to do the opposite. We understand that persistent unwarranted price variations are a serious economic challenge to our community hospitals and we think the Commonwealth should take meaningful steps to make it easier for these hospitals to grow their market share by using their natural advantages.

If patients were rewarded for seeking out high-value care, these "lowest paid" institutions would add privately insured patients who generate more revenue. Additionally, if out-of-network providers could be accessed (if they are below the in-network average), the Commonwealth will have organically solved the payment rate problem without increasing costs or utilizing a government-mandated process to arbitrarily redistribute money with the many unintended consequences that come with such programs.

More Benefit Mandates
Section 134 examines a possible mandate for mobile integrated health care providers. While these providers may be a great idea, the Commonwealth already has numerous mandates that increase premiums on individuals and small businesses, the opposite of the stated goal of this legislation. Incentivizing such actions instead of adding another mandate is a far better outcome.

Alternative Payment Models
We wanted to raise some questions about setting benchmarks for alternative payment models without having evaluations built in to make sure they are accomplishing the goal of cost containment.

In closing, this bill starts an important health care cost conversation in Massachusetts and we commend the Senate for taking the lead in this effort. However, if we want to move the needle on health care costs we need to take a serious and vigorous look at the regulations that keep cost artificially high, and harm patients in the process. Low-to-middle-income families in the Commonwealth are being crushed by health care costs.

For far too long, we have accepted the false narrative that health care costs always have to go up, and that it is impossible to shop for procedures. Transparency vendors such as MyMedicalShopper, Healthcare Bluebook, and Vitals (just to name a few) are proving otherwise.

We all know that small businesses are the source of most new jobs. If we don't tackle the cost issue head-on, it is not an overstatement to say that the economic future of Massachusetts could jeopardized.

Thank you for the opportunity to present these views and please know that the staff at Pioneer stands ready to assist your efforts to move these vital cost containment issue forward.

Sincerely,

James Stergios
Executive Director, Pioneer Institute

Cc: Senate Majority Leader Harriette Chandler, Senator Jim Welch, Senator Karen Spilka, Senator Jason Lewis, Senator John Keenan, Senator Patrick O'Connor

Appendix.
Changes for CHIA data:
1) To lighten the administrative load on CHIA to collect all claims from **all** payers. Significant money and time is wasted collecting claims from dozens and dozens of carriers that have just a few lives in the state. The three largest carriers in state have the vast majority of the private market, so putting a 90% threshold should capture all of their claims plus most other carriers of material size in the state.

2) To follow the Obama administration's precedent (this links a sample of this data) at Medicare of releasing de-identified claims data in raw form to the public. It will signal an important change in the cost control conversation in the state.

1) Data Collection
Section 10, Chapter 12C, Title II, Part 1, General Laws

(b) The center shall require the submission of data and other information from ~~each~~ private health care payers, that comprise at least 90 percent of privately covered lives in the Commonwealth, and offering small or large group health plans including, but not limited to:...

2) Empowering Patients and Entrepreneurs with Real Transparency on Cost

Either strike this subsection in its entirety, replace it with a new (e), or add a new subsection.

~~(e) Except as specifically provided otherwise by the center or under this chapter, insurer data collected by the center under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.~~

OR

Chapter 12C of the General Laws is hereby amended by striking subsection (e) in Section 10 and inserting in its place the following section:

(e) The center shall follow Medicare's precedent by releasing at least annually all hospital data including payment and utilization information for services that may be provided in connection with at least the 100 most common inpatient stays. The center may release claims data on at least the 10 most expensive kinds of inpatient stays on average by payer. The center shall release claims data on the 100 most common outpatient procedures. The center may release claims data on at least the 10 most expensive kinds of outpatient procedures. The center shall release physician, practitioner, and other supplier utilization and payment data that consists of information on services and procedures provided to patients by physicians and other healthcare professionals. The data shall show at least allowed amounts and submitted charges, for those services and procedures by provider. It should allow for comparisons by physician, specialty, location, types of medical services and procedures delivered, payment, and submitted charges. Claims for providers that have provided less than five of a certain procedure or service to patients may be excluded by the center. The center shall release claims data on the 100 most commonly prescribed drugs, and the 10 most expensive drugs on average by payer. The center may release any other related claims data it already collects as part of the categories listed above.

The center is not required to build a consumer tool to sort the data, but at minimum must make it available to the public on their website on an annual basis in a raw but useable form. The center may also incorporate any of the released data listed above into their consumer health information website in Section 20.

Medicare provider level data release.
CPT code
Last Name
First name
Credentials
Provider gender
Entity code
Provider MI
Full Address including country
Provider type
Medicare particaption indicator
Place of service
Hcpcs code
Hcpcs description
Hcpcs drug indication
line_srvc_cnt
bene_unique_cnt
bene_day_srvc_cnt
average_Medicare_allowed_amt
stdev_Medicare_allowed_amt
average_submitted_chrg_amt
stdev_submitted_chrg_amt
average_Medicare_payment_amt
stdev_Medicare_payment_amt

Additional Patient Choice and Protection:
If an enrollee elects to receive a covered health care service from an out-of-network provider at a price that is the same or less than the average that an enrollee's insurance carrier pays for that service to health care providers in its provider network within a reasonable timeframe, not to exceed one (1) year, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price and, upon request by the enrollee, shall apply the payments made by the enrollee for that health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by a network provider. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section.

A carrier may base the average paid to a network providers on what that carrier pays to providers in the network applicable to the enrollee's specific health plan, or across all of their plans offered in the state. A carrier shall, at minimum, inform enrollees of their ability, and the process to request the average allowed amount paid for a procedure or service, both on their website but also in benefit plan material.