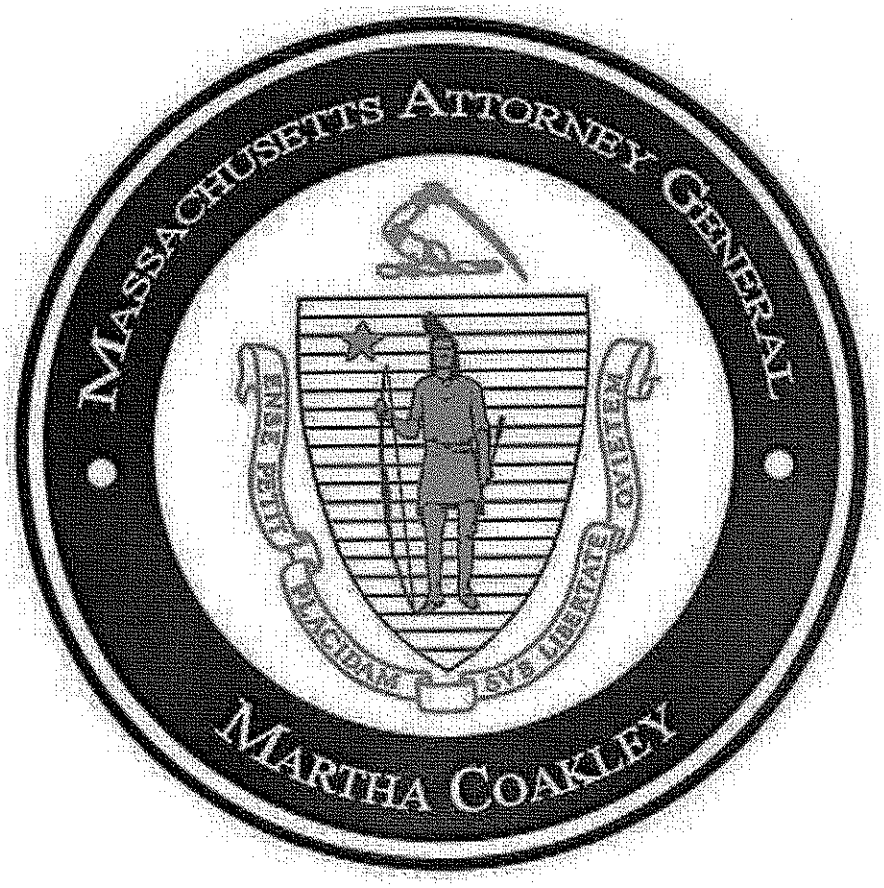

Investigation of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 118G, § 6½(b)

Preliminary Report

January 29, 2010

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
ONE ASHBURTON PLACE o BOSTON, MA 02108

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PRELIMINARY REPORT
January 29, 2010

I. OVERVIEW

The Office of the Attorney General (AGO) releases this preliminary report based on its ongoing investigation of health care cost trends and cost drivers pursuant to the authority granted to the Attorney General by Section 24 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care.* In accordance with the statutory mandate, the focus of our investigation and this preliminary report is squarely on factors that contribute to cost growth within the Commonwealth's health care system. This preliminary report identifies factors driving up health insurance premiums in Massachusetts to help policymakers in this state develop measures to control costs without sacrificing quality or access. It reflects current realities of the Massachusetts health care market to inform policymakers focused on cost containment. This report does not address health care reform efforts in other states or at the national level. This preliminary report provides a broad analysis of the Massachusetts health care marketplace and does not make any conclusions about specific health care providers or insurers.

Although our investigation is ongoing, our preliminary analysis indicates that current contracting practices by health insurance companies and health care providers have resulted in significant differences in compensation rates among hospitals and physicians that do not appear to be based on the complexity or quality of the care provided. These market dynamics and distortions should be considered by the Legislature and administration policymakers pursuing health care cost containment strategies.

Health care costs are increasing much faster than the growth in the economy, gross domestic production (GDP), and wages. Such increases, if unchecked, threaten the financial stability of individuals and businesses, and the future viability of our gains in health care access. Massachusetts is a national leader in health care. In the Commonwealth, we benefit from highly ranked health plans and hospitals, and we also have strong market reforms protecting access to health care that are a national model. As a result of Chapter 58, Massachusetts has expanded coverage to 97% of the population through the shared responsibility of individuals and employers. These landmark gains in access, however, are jeopardized by unsustainable increases in health care costs in Massachusetts.

To advance the discussion of cost containment and to help foster value-based system redesign, the Attorney General used the civil investigative demand authority the Legislature granted in Chapter 305 to scrutinize the Massachusetts health care market. The AGO analyzed information and documents produced by five health insurance companies representing more than 70% of the Massachusetts market, and fifteen health care providers from various regions of the state and representing diverse hospitals and physician groups including community, teaching,

and disproportionate share medical centers.[1] We focused our investigation on contracting practices and contract prices (i.e., the prices negotiated between health insurance companies and hospitals and physicians for hospital inpatient and outpatient care, and professional services) for commercial health insurance for the period 2004 through 2008. While our investigation continues and our analysis is not final, our preliminary review has revealed serious system-wide failings in the commercial health care marketplace which, if unaddressed, imperil access to affordable, quality health care. In brief, our investigation has shown:

A. Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.

B. Price variations are not correlated to (1) quality of care, (2) the sickness or complexity of the population being served, (3) the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.

C. Price variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.

D. Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for globally paid providers than for providers paid on a fee-for-service basis.

E. Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.

F. The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

The Attorney General expects to complete this analysis and present detailed findings through the G.L. c. 118G, § 6½ health care cost containment hearings before the Division of Health Care Finance and Policy (DHCFP), scheduled to begin on March 16, 2010. The Attorney General plans to focus attention on the preliminary findings outlined in this report during the DHCFP hearings.[2]

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[1] The Division of Health Care Finance and Policy (DHCFP) defines "teaching hospitals" according to the Medicare Payment Advisory Commission's (MedPAC) definition of a major teaching hospital: At least 25 fulltime equivalent medical school residents per one hundred inpatient beds. DHCFP defines "disproportionate share hospitals" (DSHs) as those hospitals with a large percentage (63% or more) of patient charges attributed to Medicare, Medicaid, other government payers, and free care.

[2] This cost containment investigation is the latest of several AGO initiatives to control health care costs and to protect consumers and small businesses. The Attorney General's efforts have included: (1) Medicaid fraud enforcement actions that yielded record recoveries for Massachusetts, (2) civil actions against drug companies and

Pursuant to the requirements of the statute, this preliminary report does not disclose any confidential information produced in response to our civil investigative demands. Instead, we present de-identified information at this time for illustrative purposes.

II. OFFICE OF THE ATTORNEY GENERAL INVESTIGATION

A. Statutory Authority

The Legislature, through Section 24 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*, directed DHCFP to hold annual public hearings "concerning health care provider and private and public health care payer costs and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates." The statute authorizes the Attorney General to intervene in these hearings and, with specific authority to compel the production of information from payers and providers, to conduct an investigation into the factors that contribute to health care cost growth and the relationship between provider costs and payer premium rates.[3]

B. Goals of AGO Investigation

To fulfill her responsibility under the statute, the Attorney General directed her Health Care Division to conduct an extensive investigation into how health care is paid for in the Commonwealth, focusing in particular on commercial health plan payments to health care providers. Through our investigation, we sought to understand how commercial health insurance companies (sometimes referred to as "insurers," "health plans," or "payers") and health care providers (e.g., hospitals, physician groups) contract, how insurers measure and evaluate the quality of providers, and how insurers and providers negotiate payment rates. In particular, we sought to determine whether the contracting process ultimately supports or impedes the delivery of quality health care at an affordable price.

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insurance companies that returned millions to the Commonwealth and its agencies, (3) antitrust review that monitored potentially anticompetitive market conduct, (4) community benefits guidelines that promoted non-profit hospital and health plan activity to serve their communities and provide free or low-cost services, and (5) non-profit/public charities oversight that expanded review of executive compensation at major health care providers and insurers.

[3] G.L. c. 118G, §6½(b) provides:

> The attorney general may review and analyze any information submitted to the division under section 6 and 6A. The attorney general may require that any provider or payer produce documents and testimony under oath related to health care costs and cost trends or documents that the attorney general deems necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents except in a public hearing under this section, a rate hearing before the division of insurance, or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

C. Information Gathered and Reviewed

The AGO issued civil investigative demands (CIDs) pursuant to § 6½(b) to five major Massachusetts health plans as well as to fifteen providers representing a geographical cross-section of academic medical centers, community and disproportionate share hospitals, physician organizations, and an ancillary service provider. The information we gathered pursuant to the CIDs includes contract documents, financial and operational strategy documents, as well as detailed cost and quality data discussed in this report.

In addition, we conducted more than three dozen interviews and meetings with providers, payers, health care experts, consumer advocates, and other key stakeholders. To assist with the investigation, the AGO engaged consultants with extensive experience in the Massachusetts health care market, including an actuary and experts in the areas of health care quality measurement and evaluation, and payer-provider contracting.

In preparing our analysis, we focused on documents and information reflecting how Massachusetts health plans and providers think about cost and quality and, in particular, how they compare payment rates and evaluate quality performance. Our goal was not to independently assess whether a provider is "good quality" or "poor quality" (and we make no such judgments in this report), but to determine how the market participants themselves approach these questions, so that we could assess the current functioning of the health care marketplace and, specifically, whether payers and providers are engaged in "value-based" contract negotiations that pay providers based on the quality and complexity of the services being delivered.

1. Health Care Pricing and Cost Data

We obtained and analyzed detailed information from health plans and providers regarding: (a) price – the rate at which health plans reimburse providers for each health care service, (b) total medical expenses – the per member per month medical spending attributed to each member's primary care physician or physician group, and (c) unit cost – the cost to a health care provider to deliver particular health care services.

a. Price

Price is the contractually negotiated amount (or reimbursement rate) that an insurer agrees to pay a particular hospital or health care provider for health care services. This is the "price tag" that a given insurer has agreed it will pay each time one of its members incurs a covered expense.

We obtained detailed information from the major health plans on comparative pricing for the Massachusetts hospitals and affiliated physician organizations in each plan's network. While the comparison of individual service or procedure pricing may be useful for consumer comparison as provided by the Health Care Quality and Cost Council's website

http://www.mass.gov/myhealthcareoptions, analysis of the entire payment rate structure more accurately reflects the way health plans and providers negotiate and set prices.

Typically, major health plans and hospitals negotiate prices for inpatient health care services using a base case rate. The base case rate represents a severity-neutral price that is then adjusted by a set of standard "weights" that reflect the complexity of each case and may be further modified if the case becomes atypical or an "outlier." Additional prices are negotiated for a limited set of other inpatient services such as very high-cost or experimental procedures. For hospital outpatient services, health plans have set standard fee schedules for the universe of outpatient services (e.g., standard fees are set for radiology, laboratory work, observation, behavioral health, etc.). The plans and hospitals negotiate a specific multiplier to each of these standard fees; for example, a provider with a 1.2 multiplier for radiology services would be paid 120% of the standard fee schedule rate for covered radiology services. Similarly, physicians and plans typically negotiate a multiplier to be applied to each plan's standard fee schedule for professional services.[4]

In response to our CIDs, health plans provided detailed information regarding the variation in prices and payment rates in their networks. Two major health plans provided information on the variation in payments made to each hospital and physician group in their network, as compared to the network-wide average, with no additional calculation required on our part. These plans calculated a "payment relativity factor" for hospitals taking into account volume, product mix, service mix, and other factors particular to a hospital's payment history. Both plans case mix adjusted their hospital inpatient payments for the acuity of the patients served at that hospital, in order to compare hospital rates on an "apples-to-apples" basis that strives to account for differences in the sickness of the population served and the complexity of the services provided. The information provided allowed us to measure the variations in hospital and physician payment rates in each health plan's network.

Another major health plan provided us with detailed hospital inpatient and outpatient price information, rather than payment rate information. Unlike payment rate information, this price information was not adjusted for volume, product mix, service mix, or other factors particular to a provider's payment history. With this price information, we were able to calculate the relative price paid to each hospital for the same comprehensive market basket of services by weighting each hospital's inpatient and outpatient price information to the health plan's network-wide average mix of all inpatient and outpatient services. Since this approach controls for differentiating factors such as volume, product mix, service mix (complexity), and case mix (acuity), we were able to compare the pure "price" that insurers negotiate with different hospitals for all hospital inpatient and outpatient services.

b. Total Medical Expenses

In addition to price and payment rate information, health plans track the total medical expenses (TME) incurred for each health plan member back to that member's primary care provider and/or physician group. TME is expressed as a per member per month dollar figure

[4] Our analysis accounts for variations in units of payment, such as payments based on per diems or a percent of charges, where possible based on data received.

based on allowed claims. TME accounts for *all* of the medical expenses associated with a member regardless of where those expenses are incurred (i.e., it includes physician visits as well as all hospital, laboratory, imaging, and other services, wherever those services occur). As such, TME reflects both the volume of services used by each member (utilization), as well as the price paid for each service (unit price).

Two health plans provided us with data comparing the TME of different provider systems in their respective networks based on claims data for more than one million Massachusetts members.[5] As is industry practice, the health plans adjusted their TME data with standardized health status scores to account for the demographics and sickness of the populations cared for by each provider system. This enables an apples-to-apples comparison of relative spending per patient, and ensures that systems caring for a sicker population will not inaccurately appear as higher spending solely for that reason.

c. Unit Cost

In addition to price, payment rate, and total medical expense information, we obtained detailed information from a number of hospitals regarding their internal costs for inpatient services as tracked through their own cost-accounting systems. Hospitals typically track their inpatient costs by 500 or so diagnostic related groups (DRGs), and break out the costs associated with each admission or discharge by the direct costs (such as the labor, equipment, and materials used directly in the patient's medical care), and indirect costs (such as any teaching or research that the hospital engages in as part of its mission, or the salaries of its management staff that are not attributable to any one admission or discharge). We are continuing to analyze this detailed internal cost information. We also obtained some providers' internal analyses that compare certain hospital costs on a case mix adjusted discharge basis.

2. Quality Data

We reviewed numerous quality metrics that assess the performance of hospitals and physician groups. First, we obtained data collected by health plans using their own aggregate measures of quality for both physicians and hospitals. While we found that each health plan takes a unique approach to evaluating provider quality, the major plans generally select quality measures from national government and non-profit organizations that are well-vetted and widely accepted, including: Centers for Medicare and Medicaid Services (CMS); Agency for Healthcare Research & Quality (AHRQ); National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS); Massachusetts Health Quality Partners (MHQP); and the Leapfrog Group. Second, we examined publicly reported quality metrics and results for Massachusetts hospitals and physicians, including CMS measures of patient experience and hospital performance.

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[5] While TME can only be calculated for HMO and point of service (POS) members, whose expenses can be attributed to a particular primary care physician, the large numbers of patients insured under HMO and POS products in Massachusetts means that TME is a useful metric for comparing the varying levels of expenses incurred by different provider systems per patient.

Through our investigation, we have learned that different health plans and providers view different quality measures more or less favorably for a variety of reasons. We do not reach any conclusions regarding the accuracy, statistical significance, or appropriateness of the quality measures we reviewed. Rather, our focus is to identify the quality measures that health plans use and to then determine whether those measures influence contract negotiations such that prices paid to health care providers correlate positively with quality as measured by those health plans (i.e., are health plans paying more to providers who provide higher quality care as measured by the health plans themselves).

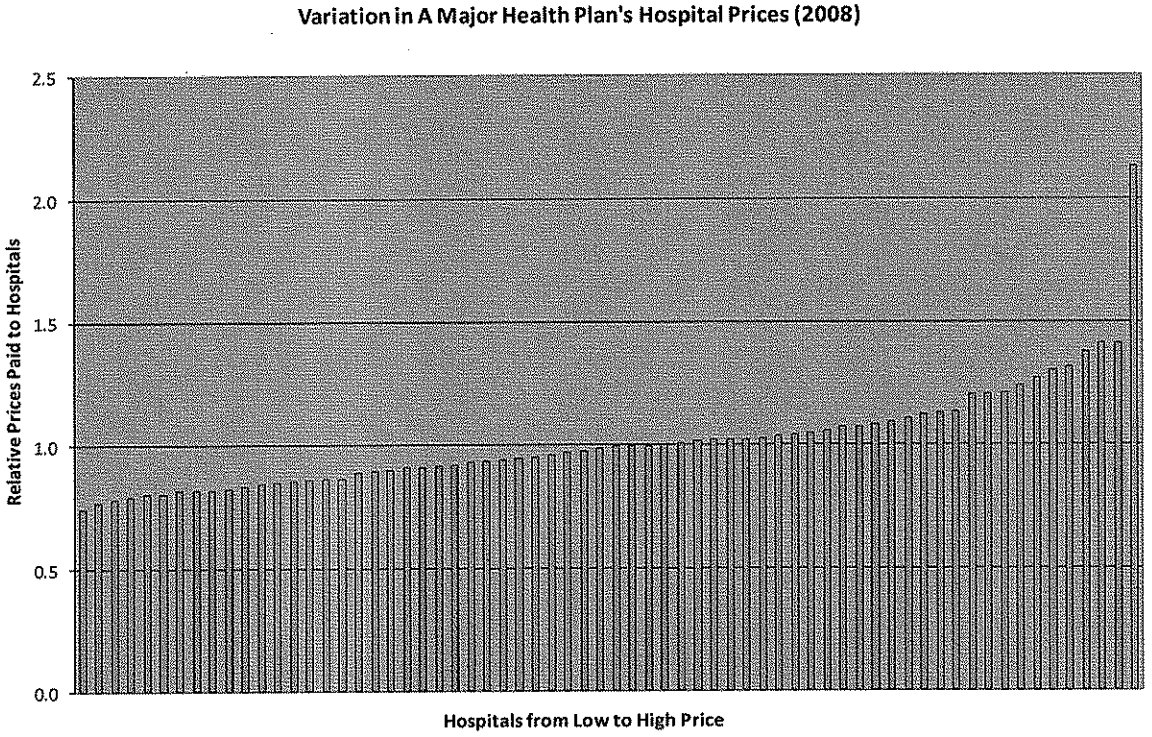
III. PRELIMINARY FINDINGS

A. Prices paid by health insurance companies to hospitals and physician groups vary significantly within the same geographic area and amongst providers offering similar levels of service.

Commercial insurers in Massachusetts pay health care providers at significantly different levels. As shown below, the disparity between the highest and lowest paid provider can exceed 200% (i.e., the highest paid provider can be paid at more than twice the rate of the lowest paid provider). We found wide disparities in both price and payment rates.

1. Variation in Hospital Prices

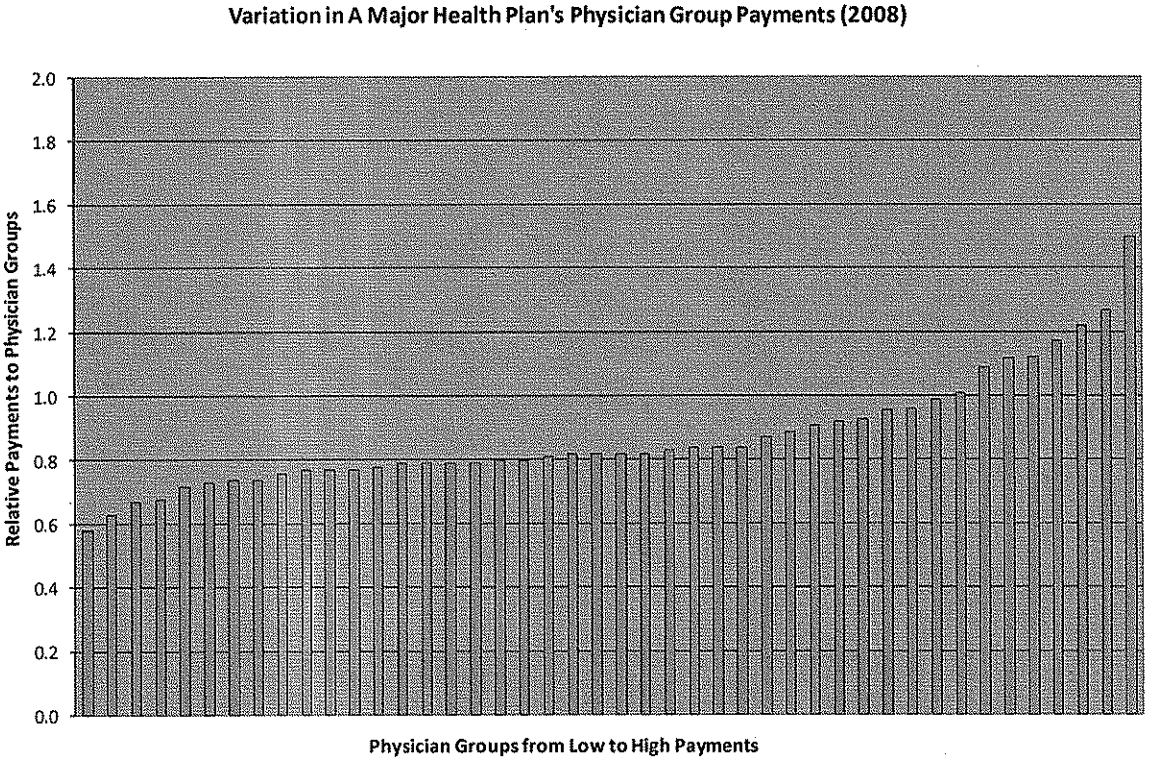
The following graph shows the variation in "pure price" paid by one major insurer to Massachusetts hospitals for the same market basket of services.



The prices paid to hospitals in this insurer's network vary by about 190% from the lowest to the *second* highest paid hospital.[6]

2. Variation in Physician Group Prices

This next graph shows the significant variation in rates paid by one major insurer to physician groups in Massachusetts with the highest paid group receiving a rate that is more than two times the rate of the lowest paid group.



The comparative price information and comparative payment information show the same results: Insurers are paying hospitals and physician groups in their networks widely varying prices.

[6] Prices vary by about 280% from the lowest to the very highest paid hospital, which is a community hospital with negotiated prices that appear to be significantly higher than all other hospitals.

B. Price variations are <u>not</u> correlated to (1) quality of care, (2) the sickness or complexity of the population being served, (3) the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.

1. Wide disparities in price are not explained by differences in quality of care

Wide variations in price are unexplained by differences in quality of care delivered as measured by the insurers themselves. We compared price and quality data using dozens of graphs and statistical calculations to determine whether there is a correlation between price paid and quality measured. These graphs include comparisons of physician and hospital prices and payment rates to insurers' own overall quality and mortality scores for those providers, as well as to publicly available CMS process and patient experience scores for those providers.

Our preliminary results indicate that there is no correlation between price and quality, and certainly not the positive correlation between price and quality we would hope to see in a rational, value-based health care market. During our investigation, we interviewed numerous providers and insurers who confirm that there is no correlation between price paid to providers and the quality of the providers' services.

Insurers track price, payment rates, and TME. They also measure the quality performance of providers in their networks. Yet they do not pay providers based on their quality performance, and are aware that providers they measure as high quality are often paid at a lower level than providers they measure as poor quality.[7]

2. Wide disparities in prices and total medical expenses are not explained by the sickness or complexity of the population being served

a. Hospitals

We have found that the prices paid to hospitals do not correlate to the acuity or complexity of the cases handled by the hospital as measured by the hospital case mix index (CMI), which is calculated for each hospital in Massachusetts by the Division of Health Care Finance and Policy and publicly available on the Executive Office of Health and Human Services' website.[8] A CMI of 1.0 is average and hospitals with a higher CMI (above 1.0) serve a

[7] Our analysis suggests that the pay-for-performance (P4P) programs implemented by all major insurers have proven inadequate to align payment with quality outcomes. First, the amount at risk in typical P4P programs is limited. Evidence shows that the amount of payment at risk in typical P4P programs is never more than 10% of a provider's total reimbursement, with one major insurer's programs ranging from 1-5% to total revenue. The vast majority of reimbursement is therefore unrelated to quality performance. Second, since P4P measures, targets, and payouts are negotiated between insurers and providers, market leverage (see Section C below) factors into the design of these programs.

[8] See http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Researcher&L2=Physical+Health+and+Treatment&L3=Health+Care+Delivery+System&L4=DHCFP+Data+Resources&L5=Hospital+Summary+Utilization+Data&sid=Eeohhs2&b=terminalcontent&f=dhcfp_researcher_hsudf_hsudf_08&csid=Eeohhs2

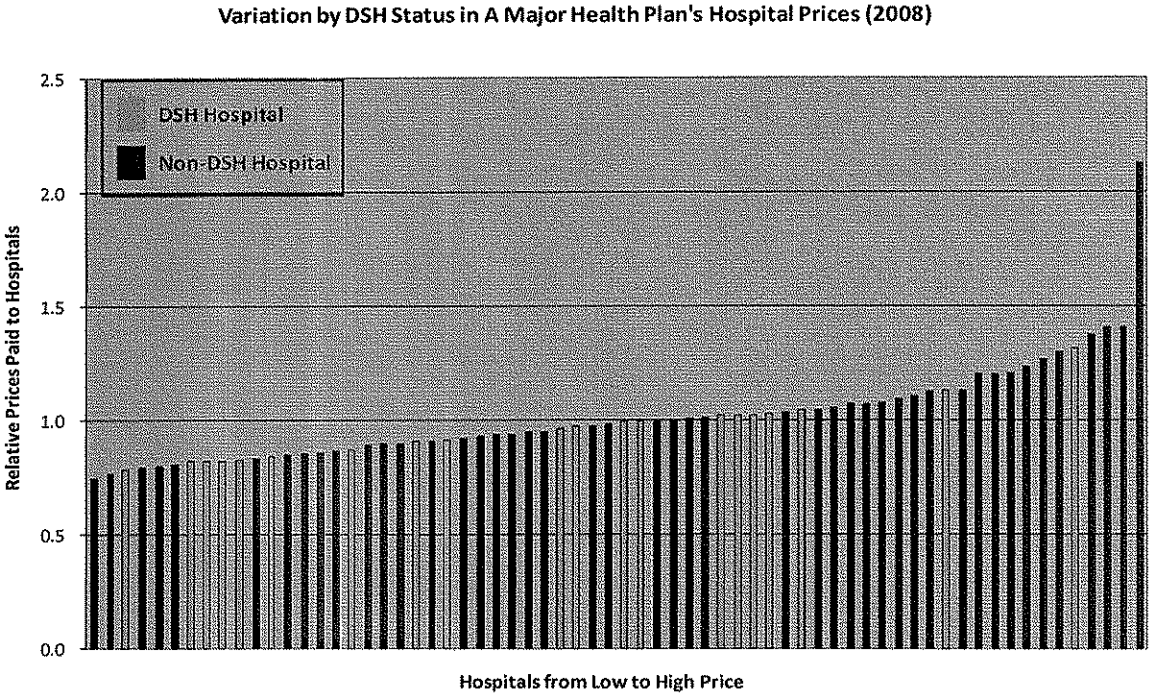
more complex or sicker population on average. The CMI for hospitals do not correlate to the price difference paid to those hospitals. As one example, on a list of 65 Massachusetts hospitals sorted from highest to lowest paid by a major health plan, some of the highest paid hospitals have some of the lowest CMIs, whereas a major tertiary medical center with one of the highest CMIs was paid less than dozens of other hospitals with lower CMIs.

b. Provider Groups

We also found that the total medical expenses (TME) associated with each provider group do not correlate to the acuity or complexity of the populations served as measured by the health status score provided to us by health plans. Plans use health status scores to adjust TME data to reflect differences in the acuity of the populations served by particular provider groups. We examined whether high-spending providers – those who have a higher TME per patient than their peers, whether due to higher prices, higher utilization, or a combination thereof – tend to care for sicker (i.e., higher acuity) populations. We found no correlation between the per member amount paid to providers and the acuity of the populations that the providers serve. Providers caring for populations that are relatively healthy (i.e., health status score of less than 1.0) are sometimes high spenders and sometimes low spenders. It appears the higher expenses of some provider groups cannot reliably be explained by the fact that these groups care for sicker populations.

3. Wide disparities in prices are not explained by the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid

Insurers generally pay lower prices to disproportionate share hospitals (DSHs), which have a large percentage (e.g., 63% or more) of patient charges attributed to Medicare, Medicaid, other government payers, and free care. The graph below shows a major health plan's relative payment rates to 67 Massachusetts hospitals with hospitals identified by DHCFP as DSH (shown in blue) generally on the lower end of the payment rate spectrum. Information from three health plans shows that on average the plans pay non-DSH hospitals rates that are 10 to 25% higher than those paid to DSH hospitals.



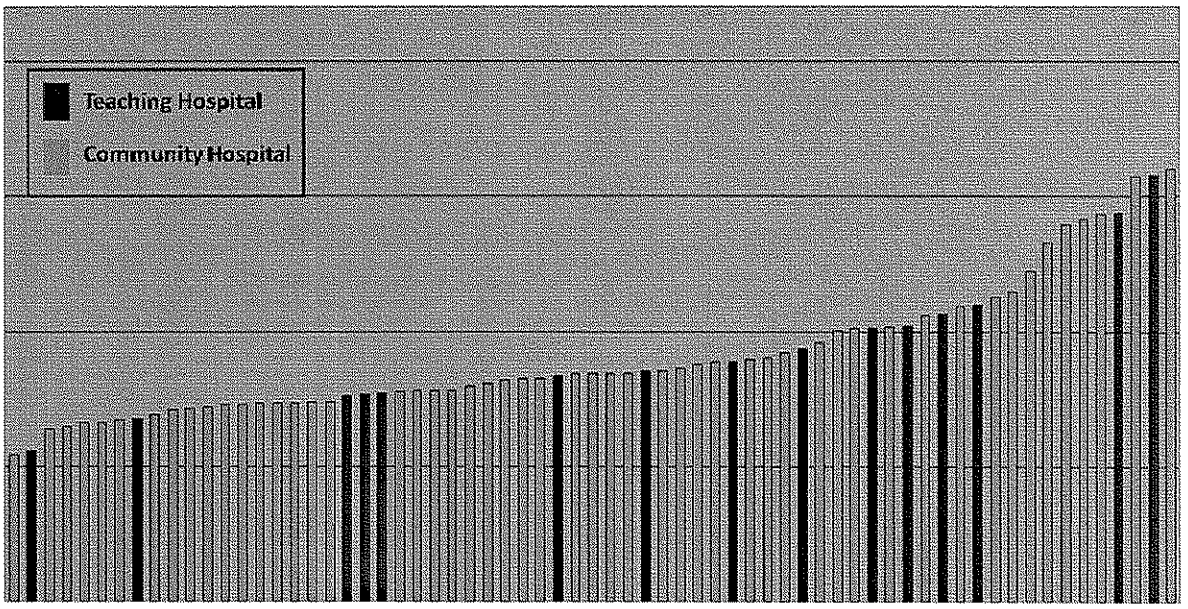
4. Wide disparities in prices are not explained by whether a provider is an academic teaching or research facility

Insurers do not consistently pay higher prices to hospitals that provide academic teaching and research services. As shown in the graph below, which illustrates a major health plan's relative payment rates to 67 Massachusetts hospitals, those hospitals identified by DHCFP as teaching hospitals (shown in red) are paid at widely varying levels.

While some teaching hospitals command above-average rates, others are paid significantly less than dozens of community hospitals that are not academic teaching or research

facilities. In fact, of the 10 best paid hospitals by this health plan, only two are teaching centers.

Variation by Teaching Status in A Major Health Plan's Hospital Payments (2008)



5. Wide disparities in prices are not explained by differences in hospital costs of delivering similar services at similar facilities

Disparities in hospital prices are not adequately explained by differences in hospital unit costs. Unit costs are the costs incurred by the hospital for the delivery of services, including direct and indirect expenses such as labor costs, supplies, overhead, costs associated with medical education and capital expenditures. It appears that higher price and payment rates are reflected in higher cost structures, but are not *caused* by them. Information we have reviewed indicates wide variations in hospital cost information that appear to track the amount those providers are paid rather than the acuity, complexity, or quality of the health care services provided. Although our review is ongoing, it appears that hospitals manage costs, including capital expenditures, to budgets based on their anticipated revenue from payment rates. Over time, hospitals receiving greater revenue from higher payment rates expend more on direct and indirect costs and capital investment while hospitals receiving less revenue struggle to manage their cost structure to make ends meet.

The variation in hospital internal costs among academic medical centers and community hospitals alike is not adequately explained by the services provided by the hospitals or by the acuity or complexity of populations being served. In fact, one provider's own analyses using publicly available DHCFP 403 Cost Report data show widely varying internal costs, viewed on a cost per discharge basis, among hospitals that the provider viewed as competitors. For example, an analysis comparing severity adjusted inpatient costs for select academic medical centers reveals that the highest cost hospital, at $8,000 per case mix adjusted discharge (CMAD), is

100% higher in cost than the lowest cost hospital at $4,000 per CMAD. Similarly, in a community hospital peer group, the highest cost hospital was 58% higher than the lowest cost hospital at $6,050 and $3,800 per case mix adjusted discharge, respectively. Since in each case the data is case mix adjusted, the difference cannot be explained by the hospital caring for sicker patients or offering more complex services. This raises the important question of why it costs more for certain hospitals to provide similar types of services to similar populations at similar levels of quality that are provided by other hospitals at a lower cost.

One telling measure of a provider's fiscal health and ability to deliver state of the art clinical services is its ability to maintain or expand its capital asset base. A provider's capacity to capitalize has a direct impact on the ability to improve its facilities, invest in new equipment, recruit physicians, and attract patient volume, all of which in turn increase revenue.

A review of selected hospital capital ratios over the past five years suggests that, while ratios can vary year to year, more highly paid providers are able to fund depreciation consistently at or above industry standard (optimally 130% or more). These hospitals are able to build new buildings, purchase new equipment and technology, and add to their cost structure. In contrast, hospitals with lower payment rates are unable to put comparable resources toward building maintenance or equipment acquisition, and in turn are disadvantaged in their endeavors to gain leverage, attract more patients, and preserve market share and revenue. This results in a loss of volume to better capitalized, more expensive hospitals.

C. Price variations are correlated to market leverage – the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers.

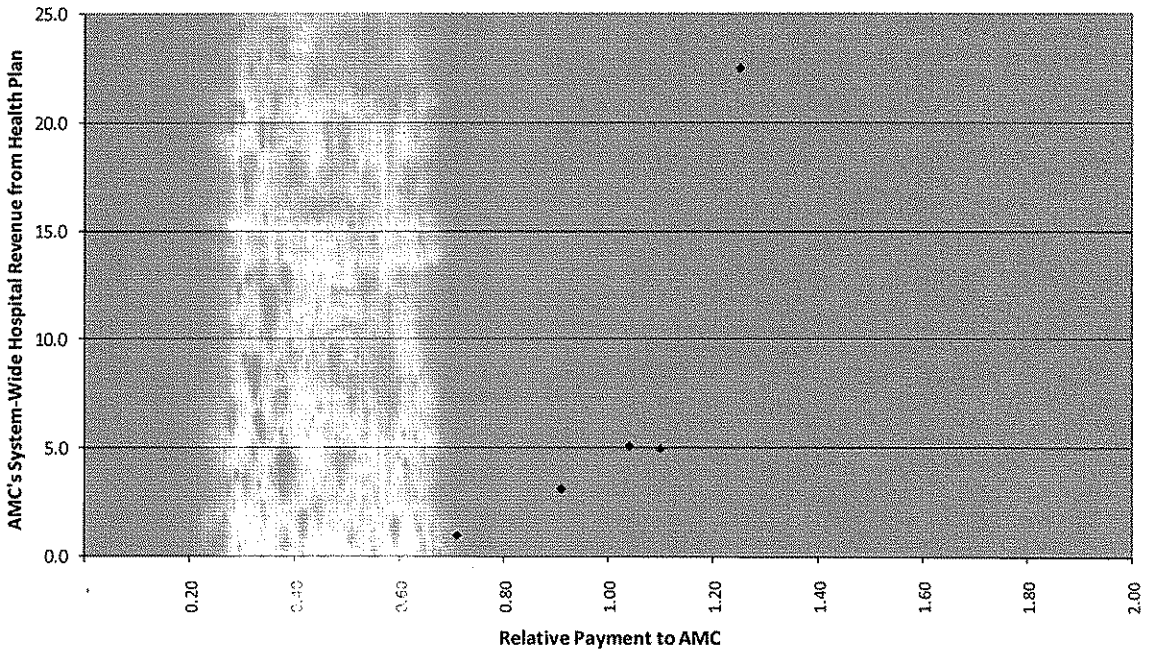
Our investigation shows that there is a strong correlation between the price insurers pay to providers and providers' market leverage. We define "leverage" as a measure of the ability to influence the other side during negotiations. Both providers and insurers can bring leverage into contract negotiations. While our preliminary investigation of market leverage has focused on providers, we anticipate refining our analysis by incorporating consideration of insurer leverage. For providers, the source of leverage varies from provider to provider. Typically, leverage results from variables such as: size, geographic location, "brand name," and/or niche or specialty service lines offered. Providers use leverage strategically to obtain higher payment rates and more favorable contract provisions. While we are continuing to explore all of these factors as well as others, our preliminary investigation has focused primarily on the size of health care providers.

Large health care provider organizations have a great deal of leverage in negotiations because insurers must maintain stable, broad provider networks. Insurers have explained to us that the failure to contract with a large provider organization would cause serious network disruption, not only because a large percentage of their members would be forced to seek care elsewhere, but because employers and others are less interested in purchasing products that do not contain the largest providers.

Two ways to illustrate the size of a health care provider include measuring the total revenue paid by an insurer to hospitals within one provider system, and counting the total number of HMO/POS member lives covered by an insurer within one provider system. Both figures create a proxy for the size of the provider system within a given insurer's network, and therefore the amount of disruption that the insurer would face if the provider were not in its network.

The following graph shows that hospitals with greater leverage, as measured by system-wide hospital revenue, are generally paid at a higher rate compared to similar hospitals with less leverage.

A Major Health Plan's Relative Payments to Select Academic Medical Centers v. Academic Medical Center's System-Wide Hospital Revenue From Major Health Plan (2008)



The x-axis shows the variation in payment rates to select academic medical centers. The y-axis shows the total revenue received by all hospitals in a given system. While some hospitals contract with insurers by themselves, others contract jointly with hospitals and/or physicians in a "multi-provider network." Showing the total revenue for *all* hospitals within a contracting system is a better proxy of a member hospital's leverage since that hospital contracts as a multi-provider system rather than as a single hospital. Note that the y-axis shows total revenue for the hospitals in a system, and does not include revenue for the physician groups in the same system.

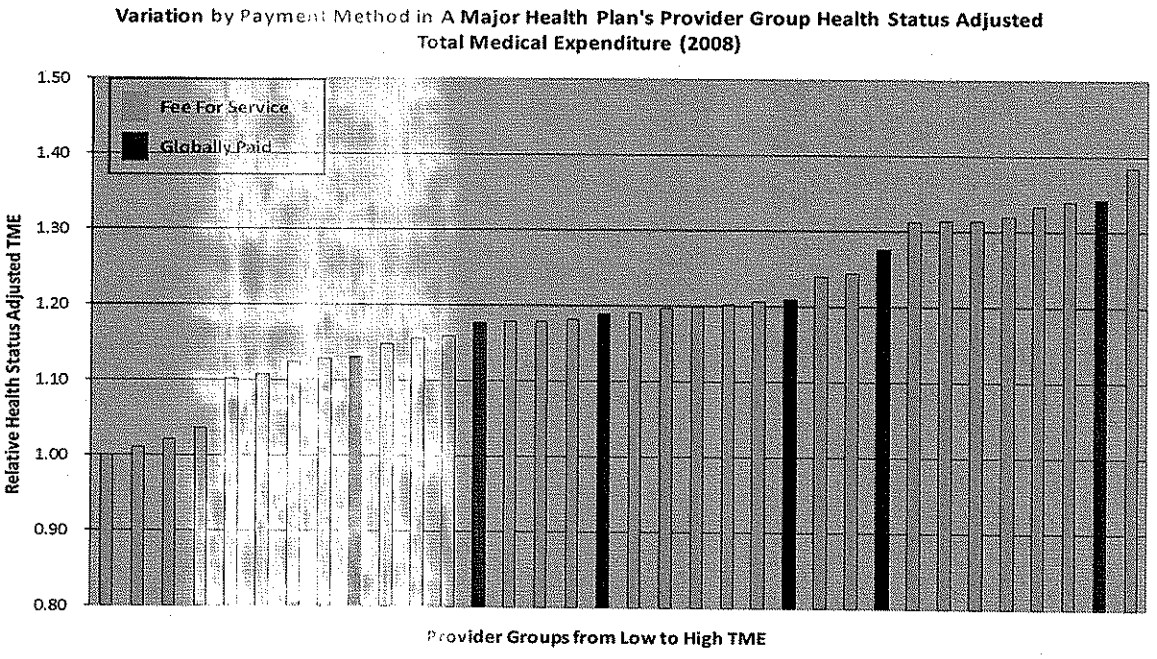
While the above graph focuses on size as a source of leverage, our investigation confirms that size is not the only factor that predicts leverage. Specifically, certain hospitals are able to negotiate higher rates because of their geographic location, subjective consumer "brand" perceptions, and/or specialty service lines. For example, insurers must include geographically isolated hospitals in their networks in order to provide hospital services to their members in that geographic location. Because there is no alternative hospital, a geographically isolated hospital

is not forced to compete for network inclusion and can garner a higher price.

While our investigation continues, it is clear that prices paid for health care services reflect market leverage. Although this report does not purport to explain all reasons for provider price disparities, our investigation shows that those disparities are not adequately explained by quality of care, patient severity, or the status of a hospital as a teaching or disproportionate share hospital.

D. Variation in total medical expenses on a per member per month basis is not correlated to the methodology used to pay for health care, with total medical expenses sometimes higher for globally paid providers than for providers paid on a fee-for-service basis.

Our investigation did not uncover any relationship between payment methodology and the total medical expenses associated with a given provider group. This graph illustrates the per member per month TME of major provider groups with those groups paid on a global budget shown in red.



Contrary to what one might expect in a risk-based contract, some globally paid provider groups are among the highest cost providers in the state.[9] The lack of correlation between payment methodology (i.e., fee for service or global risk contracts) and TME has serious implications for payment reform initiatives. Payment reform, such as the global payment methodology recommended by the Special Commission on the Health Care Payment System, may result in system benefits such as better integration of care. But, a shift to global payments

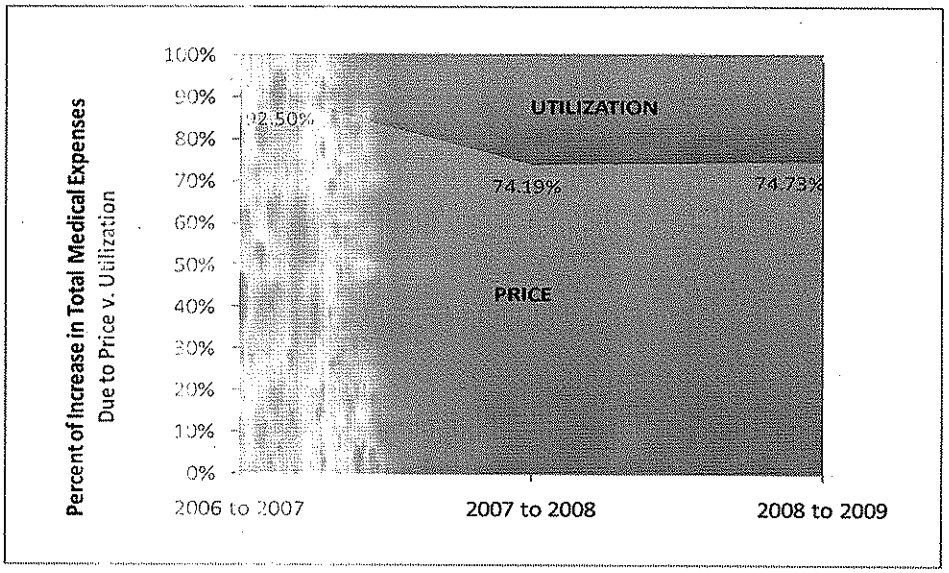
[9] Note that all globally paid providers are reimbursed for some portion of their services on a FFS basis, most notably the care they render to patients insured through PPO products.

may not control costs, and may result in unintended consequences if it fails to address the dynamics and distortions of the current marketplace.

E. Price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.

Data from two large health plans show that price increases are responsible for roughly three quarters of the total health care cost increases in the commercial health care marketplace over the past three to four years. As shown in the graph below, for one major payer for the 2006 to 2009 period, price increases – not increases in utilization – accounted for on average 80% of the growth in total medical expenses, with price increases accounting for more than 90% of cost growth from 2006 to 2007.[10]

A Major Health Plan's Cost Drivers From 2006-2009: Price as a Driver of Total Medical Expenses



NOTES
(1) **Cost drivers are expressed as a percent of unadjusted Allowed Medical Claims trend.**
(2) **The 2006-2008 data reflects 6 month re-forecasted analysis; the 2009 data is based on an initial projection.**

The Massachusetts Association of Health Plans concurs that approximately 75% of total health care cost increases are attributable to price rather than utilization.[11] This conclusion is also consistent with the trends found in the report commissioned by the Division of Insurance, *Trends in Health Claims for Fully Insured, Health Maintenance Organizations in Massachusetts, 2002-2006* (by Oliver Wyman, September, 2008).

[10] Health plans track the growth of allowed medical claims (calculated on an unadjusted basis or adjusted for change in member cost-sharing). From this, they can determine the percent increase that is attributable to price increases as compared to other factors, which include utilization, site substitution (changes in where care is received, e.g., from a community hospital to an academic medical center), changes in product mix or benefit design, and demographics.
[11] Testimony at Division of Insurance Special Session on Small Business, Docket No. G2009-07, November 4, 2009.

The fact that price is such a significant cost driver in Massachusetts has direct implications for statewide cost containment efforts and policy development. While addressing the utilization component of the cost growth problem is essential, any successful reform initiative must take into account the significant role of unit price in driving costs. Bending the cost curve will require tackling the growth in price and the market dynamics that perpetuate price inflation and lead to irrational price disparities.

F. The commercial health care marketplace has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.[12]

In our review of tens of thousands of contract documents from insurers and providers, we have identified a number of contracting practices in effect during the 2004-2008 period that reflect and perpetuate the market dynamics and pricing disparities described in this report. While these provisions vary by contract and may or may not still be in effect, they do exemplify a contracting dynamic that obscures transparency, perpetuates market leverage, and prioritizes competitive position (parity) over consumer value.

1. Payment Parity Agreements

Payment parity agreements are agreements in which a provider organization agrees not to charge an insurance company more than the price that it charges that insurance company's competitors. Our review has shown that parity agreements are pervasive in the industry, and have been used, at some time and in some form, whether in contractual provisions enforceable with a third-party audit or less formal understandings, by several major health plans in Massachusetts.

While insurance companies seek payment parity to remain competitive and gain market share, such agreements may lock in payment levels and prevent innovation and competition based on pricing. Parity clauses may decrease competition among providers by reducing their incentive to offer lower prices to insurers. Likewise, parity clauses may reduce insurers' incentive to bargain with providers, since rival insurance companies with parity provisions would obtain any price savings. Parity clauses may also deter entry to the marketplace since any discount would have to be passed on to insurers already in the market.

Parity agreements can be used by insurers to guarantee that they will not be competitively disadvantaged by giving rate increases to providers. For example, if Insurer A agrees to give a provider a rate increase – presumably resulting in a corresponding increase in Insurer A's premium rates – Insurer A wants to make sure that the provider will require its competitors to pay the same rate increase, so that all premiums will rise together and Insurer A will not be at a

[12] Through our investigation of how health plans and providers contract and negotiate payment rates, we have also indentified numerous administrative inefficiencies that contribute to overall health care costs. There is a startling amount of variation that can only contribute to administrative expenses for both health plans and providers. The tremendous variation in methods (or units) of payment creates unwarranted administrative complexity. While most major health plans pay on a case DRG basis, one major health plan pays per diem rates. Some providers are paid on a percent of charges basis, while others are paid on a fee schedule with inflators and still others are paid on a percent of premium basis. Likewise, there is no standardization in quality measures. Each plan uses and requires reporting on different quality metrics, especially for the specific measures and targets selected for P4P programs.

competitive disadvantage. Therefore, these agreements may have the net effect of allowing insurers to increase payment to providers without concern that they will be at a competitive disadvantage to other insurers.

2. Product Participation Provisions

Product participation clauses are used to dictate the terms under which a provider may (or must) participate in an insurer's new product offerings. We have found a significant number of these provisions, such as "anti-steering," "guaranteed inclusion," and "product participation parity" clauses, which inhibit the innovation in product design that could lead to better value for consumers.[13]

For example, providers with market leverage are able to obtain contractual provisions that prohibit or inhibit insurers from creating limited network products and/or tiered products that might steer patients away from them. Even clauses that guarantee participation in a limited network so long as the provider meets certain criteria may inhibit the creation of limited network products. Product participation parity provisions may discourage insurers from seeking to create innovative new products if they believe that their competitors will automatically be able to market the very same product. They may likewise discourage providers from participating in new products if the provider would be willing to participate with one insurer, but not with all insurers.

3. Supplemental Payments

We have found a widespread practice of major insurers making supplemental payments to providers, which are payments in addition to contracted or scheduled rate payments. These payments, which do not include pay-for-performance quality or utilization bonuses, include lump sum cash payments, signing bonuses, infrastructure payments, as well as bad debt or government payer shortfall payments.

As is the case with payment rates, it appears that market leverage dictates the amount and type of supplemental payments paid to providers. Although the total amount of supplemental payments has declined overall since 2004, certain providers – notably those with the strongest market leverage – continue to receive substantial amounts of money through supplemental payments.

Use of supplemental payments contributes to the lack of transparency in payment rates. Because supplemental payments are not "loaded" into unit prices and can obscure price outliers, it makes it difficult for regulators, market entities, or others to make valid comparisons of provider rates, and further complicates the ability of providers to contract for value-based,

[13] "Anti-steering" provisions prohibit insurers, in whole or in part, from creating products that might steer patients away from certain providers. "Guaranteed inclusion" provisions guarantee the participation of certain providers in certain products – for example, an insurer's limited network product – so long as the provider meets certain criteria. "Product participation parity" provisions require a provider to participate in an insurer's product if that provider agrees to participate in a similar product offered by a competing insurer.

market appropriate prices. The indefinite and flexible nature of supplemental payments also raises questions regarding how such payments affect insurers' margins from year to year.

4. Growth Caps

Growth caps are contractual provisions that limit provider growth. These clauses, which we found in contracts of a limited number of provider organizations with high physician payment rates, set a limit or "cap" on the number of newly added physicians who can be paid at the higher rate. The caps, which can be expressed as numbers of physicians or a percentage of the total or net number of physicians, target either overall physician growth or growth in specific areas, such as growth of specialty services or acquisition of practices over a certain size.

While growth caps can be seen as a reasonable attempt by insurers to save costs by limiting the growth of their most highly-paid provider groups, given the market dynamics and price disparities we have documented, we are concerned that growth caps may have the deleterious effect of freezing disparities in the market place. In practice, the growth caps can prevent smaller physician organizations from meaningfully competing with the largest provider organizations.

IV. CONCLUSION AND RECOMMENDATIONS

Our preliminary findings show that the current system of health care payment is not value-based – that is, wide disparities in payment levels are not explained by differences in quality or complexity of the health care services provided. These findings have powerful implications for ongoing policy discussions about ways to contain health care costs, reform payment methodologies, and control health insurance premiums without sacrificing quality or access in Massachusetts. The Office of the Attorney General looks forward to completing its investigation and to presenting a fuller exposition of its findings through the DHCFP cost containment hearings.

Although our investigation continues, it is clear that prices paid for health care services reflect market leverage. As a greater portion of the commercial health care dollar shifts, for reasons other than quality or complexity, to those systems with higher payment rates and leverage, costs to the overall system will increase and hospitals with lower payment rates and leverage will continue to be disadvantaged. If left unchecked, there is a risk that these systemic disparities will, over time, create a provider marketplace dominated by very expensive "haves" as the lower and more moderately priced "have nots" are forced to close or consolidate with higher paid systems.

The present health care marketplace does not allow employers and consumers to make value-based purchasing decisions. Our findings show the system lacks transparency in both price and quality information, which is critical for employers and consumers to be prudent purchasers.

These market dynamics and distortions must be addressed in any successful cost containment strategy. Payment reform, such as the global payment methodology recommended by the Special Commission on the Health Care Payment System, may result in system benefits

such as better integration of care. But, a shift to global payments may not control costs, and may result in unintended consequences if it fails to address the dynamics and distortions of the current marketplace.

The Office of the Attorney General is committed to working with the Legislature, the Patrick administration, health plans and providers, the business community, and consumer groups to develop cost containment strategies that promote value-based purchasing and ensure consumer access to high quality, affordable health care. We stand ready to assist the Legislature, the Administration, and other policymakers as the Commonwealth develops cost containment solutions. Based on our work to date, we make the following recommendations to advance the goal of providing universal access to affordable, quality health care services in Massachusetts:

1. Prompt consideration of legislative and administrative action to discourage or prohibit insurer/provider contract provisions that perpetuate market disparities and inhibit product innovation;

2. Increasing transparency and standardization in both health care payment and health care quality to promote market effectiveness and value-based purchasing by employers and consumers, including:

   - Tracking and publishing TME (total medical expenses) for all providers;
   - Promoting uniform quality measurement and reporting; and
   - Promoting standardization of units of payment and other administrative processes;

3. Consideration of steps to improve market function, including:

   - Adopting payment reform measures that account for and do not exacerbate existing market dynamics and distortions;
   - Developing legislative or regulatory proposals to mitigate health care market dysfunction and rate disparities. These proposals would be designed to promote convergence of provider rates where there are no differences in quality or other value-based factors;

4. Engaging all participants in the development of a value-based health care market by promoting creation of insurance products and decision-making tools that allow and encourage employers and consumers to make prudent health care decisions.

Working together, policymakers, health plans, providers, employers, and consumers will be able to deliver the health care quality and value that the people of Massachusetts deserve.

STATES IDENTIFIED THAT BAN OR RESTRICT THE USE OF MOST FAVORED NATION CLAUSES IN HEALTH CARE INSURANCE CONTRACTS

STATE	STATUS OF MFN CLAUSES	SOURCE
Indiana	Banned MFN clauses in 2007.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Colorado	Banned MFN clauses in 2007.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Maryland	Banned MFN clauses in 2006.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Alaska	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
California	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Idaho	Banned MFN clauses (extended to foreign-based insurers in 2007). According to another article, Idaho banned MFN clauses altogether in 1998.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007. James F. Doherty, Jr., *et al.*, *Most Favored Nation Clauses in Payor/Provider Agreements*, at 14.
Kentucky	Bars insurer with a local market share of more than 20% from putting a MFN clause in contracts with physicians.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Minnesota	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
New Hampshire	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.

STATE	STATUS OF MFN CLAUSES	SOURCE
Rhode Island	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Washington	Bans clauses or place restrictions on which plans may use MFN clauses.	Bob Cook, *States Strike at "Most Favored" Pay Clause*, AMERICAN MEDICAL NEWS, Nov. 12, 2007.
Vermont	Enacted statute banning MFN clauses effective July 1, 2009.	18 V.S.A. § 9418e.