Cost Drivers and Cost Containment
American Health Lawyers Association Annual Meeting
Antitrust, Physician Organizations, and Regulation, Accreditation, and Payment Joint Practice Groups Luncheon
June 28, 2011

ASSISTANT ATTORNEY GENERAL TOM O’BRIEN
OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY
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# Massachusetts: Health Care Reform

<table>
<thead>
<tr>
<th>Year</th>
<th>Massachusetts Health Care Reform</th>
<th>Federal</th>
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<tbody>
<tr>
<td>1990’s</td>
<td>Insurance Market Reforms</td>
<td>✔️ ✔️ ✔️</td>
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<tr>
<td></td>
<td>• Guaranteed Issue</td>
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<td></td>
<td>• Modified Community Rating</td>
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<tr>
<td></td>
<td>• Pre-existing Condition Limitations</td>
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<tr>
<td>2006</td>
<td>Chapter 58 – Health Care Reform</td>
<td>✔️ ✔️ ✔️</td>
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<tr>
<td></td>
<td>• Individual Mandate</td>
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<td></td>
<td>• Employer responsibility</td>
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<tr>
<td></td>
<td>• Medicaid Expansion</td>
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<tr>
<td></td>
<td>• Insurance exchange (Connector)</td>
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<tr>
<td>2008</td>
<td>Chapter 305 – Cost Containment I</td>
<td>?</td>
</tr>
<tr>
<td>2010</td>
<td>Chapter 288 – Cost Containment II</td>
<td>?</td>
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</table>
PROGRESS IN EXPANDING ACCESS

The number of Massachusetts residents with individually-purchased health insurance and those insured by MassHealth have slightly increased since December 2008. Of the newly insured, the majority are MassHealth and Commonwealth Care members. The majority of residents (79%), however, continue to receive coverage through the private group market.
AGO YEAR 1 COST CONTAINMENT REVIEW

Principal findings:

1. Prices paid to hospitals and physicians vary significantly, but are tied to market leverage rather than value-based factors.

2. Price increases, not increases in utilization, caused most of the increases in healthcare costs in the past few years.

3. Market leverage trumps payment method: providers paid with a global budget are not less expensive.

4. More expensive providers are gaining market share at the expense of less expensive providers.
HIGHER PRICES ARE NOT TIED TO INCREASED COMPLEXITY OF SERVICES

HIGHER PRICES ARE NOT TIED TO TEACHING STATUS
HIGHER PRICES CORRELATE WITH GREATER MARKET LEVERAGE

The diagram illustrates the correlation between higher prices and greater market leverage. The y-axis represents the academic medical center's system-wide hospital revenue from health plans (in millions), while the x-axis shows the health plan's relative payment to the academic medical center. The size of the bubbles indicates the ratio of the health plan's payment to the center's revenue. MGH and BWH have the highest ratios (1.35 and 1.31, respectively), indicating greater market leverage.
TESTIMONY IN DHCFP HEARINGS SHOW SIGNIFICANT DIFFERENCES IN HOSPITAL REPORTED MARGINS

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Commercial Payer Margin</th>
<th>Government Payer Margin</th>
<th>Other Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Medical Center 1</td>
<td>3.7%</td>
<td>-3%</td>
<td>-20.1%</td>
</tr>
<tr>
<td>Academic Medical Center 2</td>
<td>15%</td>
<td>-6.9%</td>
<td>-7.6%</td>
</tr>
<tr>
<td>Academic Medical Center 3</td>
<td>21.4%</td>
<td>-33%</td>
<td>-10.7</td>
</tr>
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</table>

“[U]nusually high hospital margins on private-payor patients can lead to more construction, higher hospital cost, and lower Medicare margins. The data suggest that when non-Medicare margins are high, hospitals face less pressure to constrain costs, costs rise, and Medicare margins tend to be low.”

PRICE INCREASES CAUSED MOST OF THE INCREASES IN HEALTHCARE COSTS DURING THE PAST FEW YEARS
MARKET LEVERAGE TRUMPS PAYMENT METHOD:
RISK-SHARING PROVIDERS ARE NOT LESS EXPENSIVE THAN PROVIDERS PAID ON FEE FOR SERVICE BASIS
MORE EXPENSIVE PROVIDERS ARE GAINING MARKET SHARE AT THE EXPENSE OF LESS EXPENSIVE PROVIDERS

Note: Statewide discharges increased by 1.3% from 2005 to 2008.
POST-YEAR 1 ACTION: CH. 288 OF ACTS OF 2010

- Requires transparency and standardization in healthcare cost and quality metrics. Uniform public reporting of:
  - Total Medical Expenses
  - Relative Prices
  - Standard Quality Measure Set
- Promotes prudent purchasing through insurance product design
  - Requires tiered and/or select network products that are tied to uniform, public metrics
- Reforms contracting practices that perpetuate market disparities and inhibit product innovation
  - Prohibits parity provisions and restricts all-or-nothing contracting
AGO YEAR 2 EXAMINATION

1. Review existing market dynamics (Similar to Year 1)
   • Examine variation in payments made by insurers to physicians and hospitals.
   • Examine relation between payment method and total medical expenses.

2. Analyze different healthcare delivery systems in MA
   • Examine existing healthcare delivery systems in MA:
     • different models (PHO, IPA, etc.),
     • different sizes and scopes of service,
     • different risk/payment methods.
   • Examine metrics of provider performance, such as quality, total medical expenses, utilization, practice pattern variation.
RESOURCES & CONTACT INFORMATION

• Report of MA Attorney General’s Examination of Health Care Cost Trends and Cost Drivers:
  http://www.mass.gov/Cago/docs/healthcare/final_report_w_cover_appendices_glossary.pdf

• MA legislation (Chapter 288 of Acts of 2010) to control costs and increase transparency in healthcare market:

• MA Division of Health Care Finance and Policy cost trend hearing materials:
  http://www.mass.gov/dhcfp/costtrends
Thank you
COST DRIVERS AND COST CONTAINMENT:
THE MASSACHUSETTS AG REPORT

THE FUTURE OF
PROVIDER CONTRACTING

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Dean Richlin
Foley Hoag LLP
“Insurers are in the best position to align price with quality, complexity, or other rational values.”
Rate Review - 2010

- In April 2010, the Massachusetts Commissioner of Insurance disapproved 235 of 274 submitted rate increases.

- The disapprovals were based in part on the fact that carriers had failed to “demonstrate that the health Plan is paying providers differing rates of reimbursement solely based on (a) quality of care, (b) mix of patients, (c) geographical location at which care is provided, or (d) intensity of services provided, as identified in 211 CMR 43.08(10)”
Final Agency Decision - 2010

“Because of factors such as member and employer preferences and expectations concerning a comprehensive network of providers, [the carriers have] no realistic option in the merged market but to reimburse providers of similar services at different rates based on reasons beyond quality of care, mix of patients, geographical location, and intensity of services provided.”
Legislative Action - 2010

- Carriers are required to promote providers “based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.”

- Agreements between carriers and providers that limit “the ability of the carrier to introduce or modify a select network plan or tiered network plan” are prohibited.
The Market’s Response

- Disclosures by carriers to consumers and employers of providers’ relative quality and cost performance.

- Emphasis on tiered networks.

- Greater use of pay-for-performance standards of reimbursement.

But still too early to tell whether these steps will lessen the effect of leverage on rates of reimbursement or moderate recent cost trends.
Proposed Legislative Action - 2011

- Increases in rates of reimbursement greater than an amount established annually by the Commissioner of Insurance are prohibited.

**AHLA ANNUAL MEETING**  
Antitrust, Physician Organizations, *and* Regulation, Accreditation, and Payment Joint Practice Groups Luncheon  
June 28, 2011

**David Marx, Jr.**  
McDermott, Will & Emery LLP
Presentation Overview

- Identification of antitrust issues associated with provider mergers or collaborations
- Recent Government enforcement actions
- Government reliance on market shares and “constructed” prices as a proxy for “market power”
- The provider-payor relationship and its implications for the Government’s “pricing effects” analysis
- The expected Government response to provider mergers and the formation of Accountable Care Organizations (ACOs)
Antitrust Issues Associated with Provider Consolidation

- “Traditional” issues raised whenever providers—hospitals, physicians, or ancillary service providers—merge or collaborate
- Horizontal Merger Guidelines approach
- Whether a merger “creates, enhances, or entrenches market power” or facilitates its exercise
- “Unilateral effects” or “coordinated effects”
Recent Government Actions

- *In the Matter of ProMedica Health System, Inc.*, FTC Docket No. 9346 (filed January 2011)

- Providence Health & Services/Heart Clinics Northwest and Spokane Cardiology (FTC investigation closed March 2011)


2010 Merger Guidelines highlight evidence of “price effects”

Many, if not most, healthcare markets are moderately, if not highly, concentrated

Government enforcers argue that high market shares, coupled with high prices (“constructed” or perceived) suggests unlawful market power

Government’s “analytic framework” is theoretically flawed and legally unfounded
The Reality of the Provider-Payor Relationship

- The difficulty inherent in “comparing” the “prices” that providers charge payors
- Payor-provider negotiations and contracts are complex, involving a variety of price and price-related terms for a wide range of non-interchangeable products
- Many factors—not just provider “prices”—influence payor or employer cost of medical coverage
- Government enforcers ignore payor “leverage”
Recent cases are (unfortunately) a reliable predictor of future enforcement actions

Draft ACO Guidelines suggest continued reliance on market share calculation and presumption of competitive effects in narrowly defined product markets
Cost Drivers and Cost Containment:
The Massachusetts Attorney General Office’s Report, Examination of
Health Care Cost Trends and Cost Drivers, and its Legal Implications for
Providers

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David Argue
Economists Inc
Antitrust Economic Issues

- Methodology
- Price variation
- Contracting practices
Price Variation: Across Hospitals v. Across Payors

- AG’s study focuses on price variation across hospitals
  - Concludes market power is an important source of variation

- What about significant price variation across payors
  - Implications are not consistent with market power thesis
  - If provider market power causes high prices, should be evident across all payors
Variation in HPHC's Hospital Payments (2008)
Variation in THP's Hospital Payments (2008)

Hospitals from Low to High Payments
# Selected Comparisons

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>Blue Cross</th>
<th></th>
<th>Harvard Pilgrim</th>
<th></th>
<th>Tufts HP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>pct +/- average</td>
<td>Rank</td>
<td>pct +/- average</td>
<td>Rank</td>
<td>pct +/- average</td>
</tr>
<tr>
<td>Brigham &amp; Women’s</td>
<td>3</td>
<td>+40%</td>
<td>18</td>
<td>0%</td>
<td>8</td>
<td>+30%</td>
</tr>
<tr>
<td>Baystate Medical Ctr</td>
<td>8</td>
<td>+20%</td>
<td>36</td>
<td>-20%</td>
<td>37</td>
<td>-20%</td>
</tr>
<tr>
<td>Dana Farber Cancer Ctr</td>
<td>21</td>
<td>0%</td>
<td>2</td>
<td>+60%</td>
<td>23</td>
<td>-10%</td>
</tr>
<tr>
<td>North Adams Reg Hosp</td>
<td>36</td>
<td>0%</td>
<td>61</td>
<td>-30%</td>
<td>2</td>
<td>+80%</td>
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Contracting Practices

- Payment Parity Agreements (MFNs)
  - Hospital will ensure equal prices to “health plan competitors after adjusting for differences in the size of such competitor’s membership…”

- Anti-Steering Provisions
  - “[Insurer] may offer products of benefit design changes that have the effect of redirecting Members from one hospital…to others in the network….Hospital agrees that it will participate…provided that the new product or benefit design change is applied uniformly to other tertiary medical centers within the network.”