

# Appendix E



Massachusetts College of Emergency Physicians

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February 11, 2017

Representative Jeffrey Sanchez  
House Chair, Price Variation Commission  
State House, Room 236  
Boston, MA 02133

Senator James Welch  
Senate Chair, Price Variation Commission  
State House, Room 309  
Boston, MA 02133

Dear Representative Sanchez and Senator Welch,

As you know, the issue of Out of Network (OON) billing is of paramount importance to the Massachusetts College of Emergency Physicians (MACEP). Emergency physicians are EMTALA providers, and Emergency Medicine is the only specialty that can never turn away or refuse to see any patient, regardless of insurance status or ability to pay for services. This distinction separates Emergency Medicine from all other specialties in terms of negotiating with health insurers.

MACEP supports the Price Variation Commission's recommendations around patient protections. We agree that patients should be taken out of the middle and held harmless when there is a "surprise lack of coverage" resulting in balance billing. There should be more transparency around the insurers' network of providers so patients can make informed choices when they have the ability to predict medical needs.

We have concerns about the Commission's recommendation to tie the reimbursement of OON providers to "contracted rates" or to some percentage of Medicare. Emergency physicians support implementing the Connecticut model, which requires the use of an independent and transparent charge database, such as the Fair Health Database ([www.fairhealth.org](http://www.fairhealth.org)) to determine usual, customary and reasonable rates, and which would eliminate high charge outliers by setting the rate at the 80<sup>th</sup> percentile.

The problem with using a percentage of Medicare rates as a determinant of reimbursement is that they were never intended to become the foundation for "fair" reimbursement. Medicare rates have no relationship to fair market value or the cost of care and are based on federal budgetary considerations

rather than on what physicians have been customarily paid. To implement Medicare reimbursement, or even a system based on a modicum reimbursement factor above Medicare rates, would bankrupt many emergency practices and departments across Massachusetts. A Rand study released in late 2016 concluded that the safety net in New Jersey – including critical access hospitals – would be in serious jeopardy if reimbursement were capped at 250% of Medicare. Such a system in Massachusetts would have equally damaging consequences, far beyond emergency departments. It would hurt community and critical access hospitals, which would be forced to either subsidize their emergency departments or close them.

A problem with using contracted rates is that the process is not transparent and will inevitably create ongoing disputes among insurance companies, hospitals and sadly, patients; while wasting valuable healthcare resources. Insurance companies must be transparent about how they calculate payments and provide fair coverage for patients. Payments for emergency visits must be based on a reasonable portion/percentage of charges, rather than arbitrary rates or contracted rates that may not even cover the costs of care.

Another issue with trying to use contracted rates as a determinant of fair reimbursement is the absence of a “ones-size-fits-all” rate. Contracted rates from insurance companies differ significantly according to size of the hospital, market share, patient population, geographic location, physician specialty, etc. An appropriate contracted rate for one emergency group/department may not be sufficient for others and could be exorbitant in another area of the state. Requiring all physicians – not just emergency physicians - to accept insurers’ contracted rates would remove negotiating power from physicians and place it all in the hands of insurers. Allowing insurers to unilaterally determine what they deem to be appropriate reimbursement will eventually drive down all contracted rates and threaten the viability of all hospitals: critical access, community, academic, tertiary-care and trauma centers alike.

The attached American College of Emergency Physicians 2016 Fair Coverage Fact Sheet details the creation of the FAIR Health Database. By way of background, the State of New York successfully sued United Health Care for fraudulently calculating rates and significantly underpaying doctors for out-of-network medical services. The database United Healthcare used, Ingenix, forced patients to overpay up to 30 percent for out-of-network doctors. United paid a \$350 million settlement to the State of New York and the American Medical Association, and agreed to the creation of FAIR Health, which, among other objectives, established an independent database of healthcare charge information with the support of academic experts.

Attached is a comparison of three different databases: Ingenix, Fair Health, and Health Care Cost Institute (HCCI). It is clear from this comparison that Fair Health is the most robust, transparent, independent database available for determinations of fair and reasonable reimbursement rates. It can be easily searched by physician specialty and zip code, and is the best mechanism available to ensure transparency and prevent miscalculation of payments.

The question of how often OON billing occurs here in Mass has not yet been determined. However, several studies from other states (attached) are noteworthy and provide excellent information from which we can extrapolate. For example, the Washington State Insurance Commissioner received insurance industry data (18 million claims) and issued a report regarding OON billing. The data had some limitations due to some high outlier charges but is overall supportive of MACEP’s position. Importantly, as mentioned above, the dataset involved 18 million claims and *was provided by the health insurance*

*plans themselves*, supporting its validity and the underlying conclusions that the magnitude of ED OON billing is small. Their conclusions include the following:

- OON Emergency physician billing is infrequent at 3%: Only 3% of Emergency physician and ED services were out of network. We are well aware of a recent NEJM article, whose authors were funded by grants from the insurance industry, and which presented an inaccurate picture of the scope of OON billing. The Washington State report demonstrates that the frequency of OON ED billing is actually very small. In fact, approximately half of the Washington State ED visits were excluded from the data that were analyzed, including Medicare and Medicaid. Once those visits are factored in only about 1.5% of ED services were provided by an out of network provider.
- High ED charges are rare: Only 3% of the OON bills were larger than \$1,500.
- ED services are not responsible for the majority of OON bills: The vast majority of OON claims were clinic/outpatient-based. Addressing ED claims alone will not fix the OON billing "problem."

I have also attached a study showing that out-of-network emergency billing in the state of Florida is rare. According to the data, which represented 10 percent of all emergency department visits in Florida, the average patient payment was just \$49 – hardly the thousands of dollars that the insurance companies would like you to believe.

I would welcome the opportunity to meet with you to further discuss the importance of fair and reasonable out of network billing recommendations for emergency physicians. I will contact your office in hopes of scheduling a meeting at your earliest convenience.

Thank you



Jeffrey Hopkins, MD, FACEP  
President

# **Modern Healthcare**

## **What New Jersey's proposed out-of-network cap would do to hospital margins**

By [Shelby Livingston](#) | November 22, 2016

New Jersey legislation to cap the amount hospitals can charge for involuntary out-of-network services would lead to operating losses at hospitals across the state and could cause some to take on severe cost-saving measures, including staff layoffs or mergers with competitors, according to a study commissioned by a for-profit hospital system.

In an emergency, patients often don't get to choose where an ambulance takes them. Some inevitably end up at an out-of-network hospital and rack up a massive medical bill.

Under New Jersey law, patients who involuntarily receive emergency care from a hospital outside of their health plan's network are responsible for paying only the portion of costs they would have been charged for similar in-network care. The rest of the bill is footed by that patient's health plan.

Insurers argue that because the state doesn't regulate how much hospitals can charge for out-of-network care, insurers are forced to pay whatever the hospital demands, even if excessive.

[Legislation](#) being debated in the New Jersey Assembly, known as the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, or A1952, seeks to cap what hospitals can charge for involuntary out-of-network care between a range of 90% to 200% of the price that Medicare pays for the same service.

According to a study conducted by RAND Corp., hospitals rely heavily on the payments from involuntary out-of-network services, which are about double the rate of in-network services. While such involuntary charges account for less than 20% of hospitals' total commercial revenue, they make up almost 40% of hospital profits for treating commercially insured patients.

The study, which was commissioned by for-profit New Jersey health system CarePoint Health, estimates that implementing the legislation would reduce New Jersey hospital payments from commercial health plans by 6% to 10%. That would lead to an operating loss at 48% to 70% of hospitals, depending on how high the cap is set, researchers found.

If the cap on out-of-network charges is limited to 90% of Medicare rates—the lowest



end of the range—less than a third of hospitals in the state would remain profitable, the study estimated.

“Hospitals live off the margins from these out-of-network payments,” said Soeren Mattke, senior scientist at RAND and lead author of the study. “If you take them away as the law proposed, you put a good chunk of them in an operating loss.”

The legislation would also weaken the hospital's power to negotiate with insurers over rates for in-network services, researchers said. Without the looming threat of high out-of-network charges, health insurers are likely to seek lower in-network rates.

If the cap is implemented, “It's possible that some (hospitals) may have to close,” Mattke said, though he added it's difficult to predict how providers will react. Most will have to find ways to cut costs, such as layoffs or closing the community clinic, he said.

Surprise out-of-network medical bills have gained attention from lawmakers nationwide, and there's [a growing trend among states](#) to limit what hospitals and doctors can charge for out-of-network bills incurred voluntarily. Several states, including California, Connecticut, Florida and New York, have passed legislation to protect patients from surprise bills and require health plans and hospitals to set up an arbitration process to work out any payment issues.

“Different states have solved that problem in different ways, and some have put more of an onus on providers and more on health plans or split the difference,” said Mark Hall, a senior fellow at the Brookings Institution. New Jersey's proposal of arbitration and payment caps, he said, is “a thoughtful approach.”

The bill has been highly contentious. It was [the second-most lobbied piece](#) of legislation in the state in the first half of 2016, following only behind the state budget bill, according to the New Jersey Election Law Enforcement Commission.

The New Jersey Hospital Association argues the legislation unfairly favors health insurers.

“We cannot yield on a bill that props up insurance companies to the detriment of the hospitals and physicians that care for the people of New Jersey,” Betsy Ryan, president and CEO of the New Jersey Hospital Association, said in an Oct. 27 statement about the legislation.

A spokesman for CarePoint Health, which paid for the RAND study, declined to comment on the bill but said “it was important to commission an unbiased study” to study “out-of-network legislation and its impact on the well-being of community healthcare in New Jersey.”



# Florida Data Suggest Balance Billing is Rare in Emergency Medicine

Dec 16, 2016

## BALANCE BILLING AND HOW IT WILL IMPACT FLORIDA

**HB 221: Health Insurance Coverage for Emergency Services**

GENERAL BILL by Trujillo; (CO-INTRODUCERS) Stark

**SB 1442: Out-of-Network Health Insurance Coverage (similar to HB 221)**

GENERAL BILL by Garcia

The proposed legislation impacts physician reimbursement in emergency departments, limiting the amount a physician can collect to the amount arbitrarily reimbursed by insurance companies. Though coined as a ban on "balance billing," the legislation has a chilling effect in a state with a debunk provider dispute program and no third party claims data base for payment transparency.

### Setting the Facts Straight

Emergency physicians are the **ONLY** specialists who see every patient, regardless of insurance status or ability to pay -- 24 hours a day, 7 days a week and 365 days per year.

The emergency physician sees an **average of \$138,000 per physician in uncompensated care yearly** and is the Safety Net for all Florida citizens, including vulnerable uninsured, Medicare, Medicaid, and Pediatric patients.

#### EMERGENCY PHYSICIAN OUT-OF-NETWORK (OON) CHARGES



**BALANCE BILLING RESULTS FROM THE UNWILLINGNESS OF INSURERS TO CONTRACT FOR ADEQUATE PAYMENT FOR PROVIDERS, WHICH OCCURS FOR ONLY ABOUT 12% OF INSURED FLORIDIANS.**

Insurers are cutting their costs by paying providers less and raising deductibles on patients, increasing the burden on consumers but raising insurers' profits.

### Customary Reimbursement of Emergency Provider Services

Physicians set charges based on the cost of recruiting and retaining qualified providers, providing for uncompensated and undercompensated care, standby costs for surge capacity, medical malpractice insurance costs, among other factors. Physicians may allow for some discounts to preferred contracted insurers. National and state databases, such as RVR Health, show aggregate and median charges per zip code for billions of provider charges.

Insurers vary widely in how they reimburse OON charges. The range of reimbursement varies from zero to a low percentage of Medicare allowances to full charges.

In a PPO, the consumer does not have indemnity coverage (as they would in a HMO or Medicare), but an arrangement that allows insurer to pay their own determination of the "Maximum Allowable Charge" or a percentage thereof.

- Consumers are buying a **flexed product** and **narrow network** makes this worse.
- Insurers are selling "in-network" hospitals, while often **NOT** negotiating with physicians who staff those hospitals.
- Allowing insurers to unilaterally determine "allowable" reimbursement lacks transparency, encourages manipulation and is not based on the costs of providing care by the physicians.
- This will lead to **downward market forces** that will hinder EM physicians from negotiating fair in-network rates, which they do now **80%** of the time.

FLORIDA COLLEGE OF EMERGENCY PHYSICIANS

EMERGENCY MEDICINE DAYS 2016

## Florida Balanced Billing Fact Sheet

WASHINGTON, Dec. 16, 2016 /**PRNewswire-USNewswire**/ -- With the support of the American College of Emergency Physicians (ACEP), the Florida College of Emergency Physicians (FCEP) today urged state and national policymakers to investigate the

reimbursement practices of insurance companies, especially when patients go out of network for emergency medical care.

"We are urging Senator Bill Nelson to investigate fully what is happening in his own state before calling for an inquiry into 'surprise bills' by emergency physicians," said Jay Falk, MD, FACEP, president of FCEP. "Our report shows that less than 4 percent of privately insured patients in Florida actually received balance bills. We are calling for an examination of what insurers are offering their patients under high-deductible plans. Many insurers pay a percentage of what they call 'usual and customary allowables' which is typically well below actual charges, or usual and customary charges listed by the Fair Health™, a national independent database of insurance claims. They must be held accountable under the newly passed legislation in Florida addressing 'surprise bills.' The fair payment provisions of the law must be enforced."

FCEP conducted an analysis of billing data provided by Martin Gottlieb & Associates, a medical billing company. Of all Floridians, about 26 percent had private insurance (the rest were either uninsured or had Medicare or Medicaid). Of privately insured emergency patients, 88 percent were treated by in-network emergency physicians. Among the 12 percent of patients who were treated by emergency physicians who were out of their insurer's network, the average emergency physician out-of-network charge was \$679. The average insurer's payment was \$307 and the average patient payment was just \$49.

"More national data are needed, but it's reasonable to say the Florida data, which represent 10 percent of all Florida emergency department visits, could be extrapolated to other states as well as nationally," said ACEP's president Rebecca Parker, MD, FACEP. "Recent focus by the media on a select group of theoretical balance bills from emergency physicians severely distorts what is really happening and distracts policymakers from what is in the best interests of patients and the health care system. The few balance bills that exist in Florida result from unwillingness by insurers to contract for fair and reasonable payment to medical providers, such as emergency physicians."

The Fair Health claims database ([www.fairhealth.org](http://www.fairhealth.org)) was developed after United Healthcare was successfully sued by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services (using Ingenix database). The formula they used forced patients to overpay up to 30 percent for out-of-network doctors. Four out of five big insurers have been sued for illegally manipulating what is deemed "usual and customary" medical charges.

"The Florida Legislature agreed a "surprise bill" should not occur when care is provided in a scenario where a patient does not have a choice of providers, and clearly defined what should be paid for out-of-network care, both for HMO and PPO patients," said Dr. Falk.

"With payment now stipulated at the provider's usual and customary charge, insurers will be paying their fair share and shifting costs less to patients. Prior to the law change, insurers were underpaying for care, which was unfair to both patients and physicians. Florida's new law, if enforced, will prevent this practice."

"ACEP is committed to getting patients out of the middle and proposing solutions to escalating health care costs," said Dr. Parker. "But bullying tactics by the insurance industry and their surrogates are creating a lot of confusion for our patients who want what emergency physicians are advocating for: fair coverage for emergency care."

ACEP is the national medical specialty society representing emergency medicine. ACEP is committed to advancing emergency care through continuing education, research and public education. Headquartered in Dallas, Texas, ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia. A Government Services Chapter represents emergency physicians employed by military branches and other government agencies.

SOURCE American College of Emergency Physicians (ACEP)

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<http://newsroom.acep.org>

Patients increasingly are facing higher premiums for health insurance but getting less coverage. They are paying more out-of-pocket costs and have higher deductibles and co-insurance. Health insurance companies are offering plans with low premiums, and people are not aware of how little coverage they actually have. Nearly all emergency physicians across the country responding to a recent poll (96 percent) said that patients don't understand what their policies cover. What's more, 8 in 10 emergency physicians said they are seeing patients with health insurance who had delayed medical care because of high out-of-pocket expenses, deductibles and co-insurance. (This is more than a 10-percent increase over 6 months ago when emergency physicians were asked the same question.) To learn more about how insurance companies are squeezing emergency patients, go to [www.FairCoverage.org](http://www.FairCoverage.org).

- **Health insurance companies are misleading patients by offering “affordable” premiums for policies that cover very little.**

- No insurance plan is affordable if it abandons you in an emergency.
  - *Nine in 10 emergency physicians polled say health insurance companies mislead patients by offering “affordable” premiums for policies that cover very little.<sup>i</sup>*
- Insurance companies shift the costs of medical care onto patients and medical providers, while enriching themselves.
  - *Nearly 80 percent of emergency physicians polled with knowledge of reimbursement issues said that insurance companies have reduced the amount they reimburse for emergency care.*

- **Patients can't choose where and when they will need emergency care and should not be punished financially for having emergencies.**

- Insurance companies exploit federal law to reduce payments for emergency care. They know that hospital emergency departments have a federal mandate to care for all patients, regardless of ability to pay (EMTALA).
- In a medical emergency, many insurance companies do better jobs of protecting themselves than protecting you.

- **Each day, emergency physicians see patients who have paid significant co-pays, up to \$400 or more, for emergency care.**

- For many, it's too much of a financial burden and we'll deter them from seeking emergency care.
  - *87 percent of emergency physicians believe insurance companies should pay the in-network rate if an emergency patient has no access to an in-network facility or physician.*
  - *Nearly two-thirds (61 percent) say most health insurance companies provide less than adequate coverage for emergency care visits to their customers.*

- **Just because you have health insurance coverage does not mean you have access to medical care.**

- Insurance companies are creating narrow networks to save money, making it more likely that patients will see out-of-network doctors and be responsible for additional costs.
- Insurance companies are forcing physicians out of network by reducing reimbursements to the point they do not cover costs. The vast majority of emergency physicians and their groups prefer to be “in network.”
  - *More than 60 percent of emergency physicians polled had difficulty in the past year finding in-network specialists to care for patients with a quarter of them saying it happens daily.*

- **Health insurance companies have created this situation. Balance billing would not exist if insurance companies paid what is considered reasonable in the insurance industry and what's known to everyone as “fair” payment.**

- When insurance companies do not pay fairly, physicians must choose between billing patients for the difference or going unpaid for their services (similar to how a dentist bills). The solution is to return responsibility for those bills back to insurance companies where they belong.
- When insurance reimbursements do not cover the costs of providing services, physicians drop out of networks.
- **Insurance companies must be transparent about how they calculate payments and provide FAIR coverage for emergency patients.**
  - Payments for emergency visits must be based on a reasonable portion/percentage of charges, rather than arbitrary rates that don't even cover costs of care.
  - Health plans have a long history of not paying for emergency care. United Healthcare was successfully sued by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services (using Ingenix database — NOTE: the former CEO of Ingenix is the current, acting head of CMS — Andy Slavitt). The formula they used forced patients to overpay up to 30 percent for out-of-network doctors. The company paid the largest settlement to the state of New York and the American Medical Association. Part of the settlement created the Fair Health database.
    - *79 percent of emergency physicians say the Fair Health database is the best mechanism available to ensure transparency and to make sure insurance companies don't miscalculate payments. (www.fairhealth.org)*
- **State and federal policymakers need to ensure that health plans provide fair payment for emergency services or emergency patients will suffer.**
  - States that seek to ban balance billing without ensuring fair coverage of emergency care will create huge benefits for health insurance companies while endangering patients and the medical safety net.
- **Patients and physicians must work together to combat these harmful practices by health insurance companies.** (Contact your state legislators.)
- **A federal regulation by CMS does not require health insurance companies to use a fair and transparent database, such as Fair Health to calculate in out-of-network payments, opening the door to reimbursements that do not even cover the costs of care.**
  - This regulation represents a failure to implement the “patient protections” promised in the Patient Protection and Affordable Care Act. It is a clear victory for health insurers at the expense of patients and physicians.
  - The health insurance industry no longer has any incentive to negotiate fairly.
  - This regulation benefits insurance companies at the expense of patients.
  - ACEP advocated for an objective standard in which benefits would be transparently determined, enforceable, reasonable, and market driven.
  - ACEP submitted claims evidence, showing how insurers were shifting hundreds of millions of dollars in out-of-pocket expenses onto patients. The evidence shows how insurance companies would use their own proprietary data to reduce payments to physicians and to shift financial liability to beneficiaries.
    - *91 percent of emergency physicians polled say this new CMS rule will make finding specialists and follow up care for patients more difficult.*

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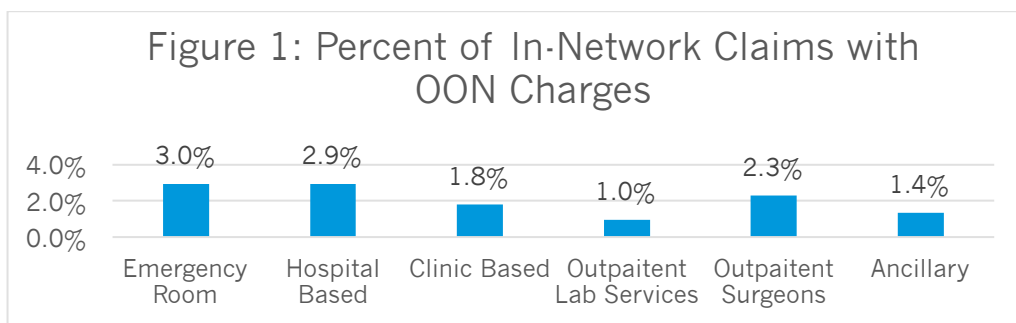
<sup>i</sup> An emergency physician survey was conducted online in the United States by Marketing General Incorporated on behalf of the American College of Emergency Physicians between April 4-11, 2016, among 1,924 emergency physicians, providing a response rate of 7 percent and a margin of error of 2.2 percent.

# Report on HB 1117 (Surprise Billing)

In 2016 the Washington Office of the Insurance Commissioner put out a call for data relating to the issue of surprise billing to all the major health insurers in the state of Washington. This data request focused on fully insured individuals who were under 65 years old and were insured in the state of Washington.

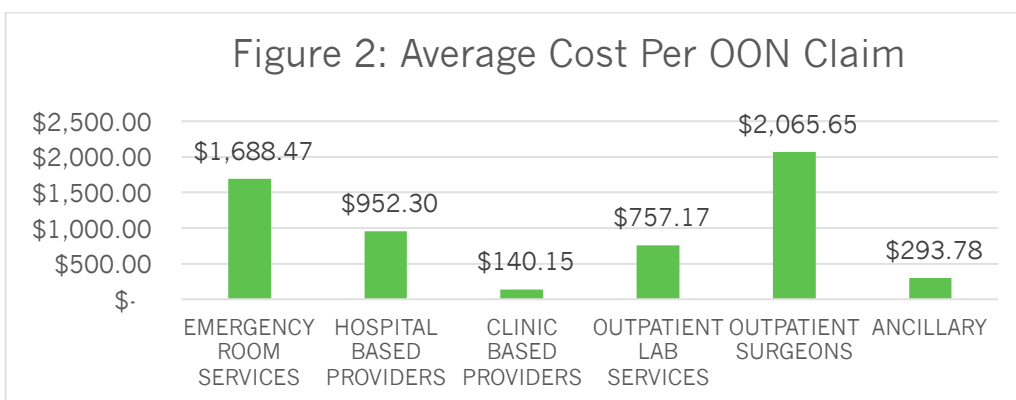
For the 2015 calendar year, 13 insurers reported receiving 18,472,855 health insurance claims. Of these, 4.8% (881,694) were described as “Out-of-Network” (OON) claims which were to be paid by the insured rather than the insurer. This includes 293,834 OON billings that resulted from in-network facility visits. These claims occur when an insured individual visits an in-network facility, such as an emergency room, hospital, clinic, outpatient lab, outpatient surgeon, or ancillary service provider facility, but receives un-covered services.

Of all the claims submitted to health insurers in 2015, the vast majority were from clinic based providers (11,780,471 claims). Clinic based providers also billed the greatest number of OON claims from in-network facilities (212,831). However, clinic based providers were less likely than average to bill OON on a per claim basis. As shown in Figure 1, emergency room services were 63.3% more likely than clinic based providers to submit an OON claim (3.0% of their claims) than clinic based providers (1.8% of claims).



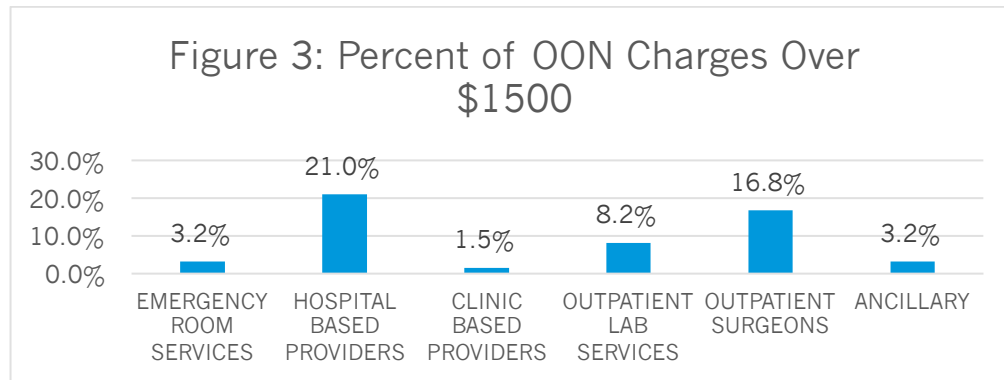
While the relative frequency of

OON billing was relatively small across most provider categories, the per-occurrence cost of OON charges was relatively high. Figure 2 shows that for both outpatient surgeons and emergency room services, the average billing rate for OON charges was \$2,066 and \$1,688 compared to an overall average OON charge rate of \$264.





However, OON charges are not evenly distributed within each provider category. While emergency room services average a relatively large cost of \$1,688.47 per charge, much of this cost is explained by a small number of large charges with only 3.2% of emergency room OON charges exceeding \$1500. Conversely, outpatient surgeon services are relatively expensive per claim (\$2,065.65 on average) with 16.8% of individuals receiving an OON bill above \$1,500. As illustrated in Figure 3, insured customers were more than twice as likely to receive an OON bill over \$1,500 from a visit to a hospital based provider or outpatient surgeon than any of the remaining four provider categories.



While the OIC is unaware of any studies that causally link the cost of surprise billing to any particular source, some authors have suggested that the large cost per claim exhibited by emergency room services and outpatient surgeons is related to how hospitals contract with insurers. While hospitals may hold billing agreements with several insurers not all providers agree to the same pricing level that insurers reimburse, resulting in denied payments or short-pays where the insured are responsible to pay balances. In cases such as emergency room visits, the insured may not have the ability to shop for in-network doctors or services when options are presented as a package deal. This results in charges from anesthesiologists, who are often not affiliated with the primary care doctor and may hold different billing agreements, being cited as one of the most costly OON billings.

Conversely, ancillary charges frequently are not covered by insurers, thus incentivizing individuals to “shop around” for pricing or forego expensive procedures. The most costly of these OON charges are frequently cited to be dental procedures by carriers. These are often covered by a separate policy and not considered to be part of full coverage and may be covered by a company not included in this data. Further, these charges tend to be relatively small with 81% of OON ancillary bills being between \$0 and \$300.

Given the rate at which OON charges above \$1500 occur in each provider category, the OIC estimates that some 11,930 cases of surprise billing for OON services at an in-network facility will be reported annually. OIC staff believes that under HB 1117, most insurers and providers will resolve disputes with values under \$1500 through arbitration. The remaining disputes are more likely to require direct intervention by OIC through a notice or fine.

**Ingenix Inc., FAIR HEALTH, Inc. AND HEALTH CARE COST INSTITUTE (HCCI)**

**Comparison/Contrast**

**Organizations and Data**

	<b>Optum360, f/k/a OptumInsight Inc. and f/k/a Ingenix Inc.</b>	<b>FAIR Health, Inc.</b>	<b>HCCI</b>
<b>Organization</b>	<p>Optum360</p> <p>Optum360 was formed in Oct 2013 by the merger of Dignity Health and OptumInsight.</p> <p>Optum is the Health Services platform of UnitedHealth Group</p> <p>UnitedHealth Group also owns UnitedHealthcare – started myHealthcare Cost Estimator</p> <p>UnitedHealth Group trades on NYSE under UNH.</p> <p>In 2010, the <u>AMA v. United Healthcare</u> lawsuit settlement of \$350 million was approved by a NY federal judge regarding the Ingenix Inc. database. The AMA with several prominent state medical societies alleged that UNH's subsidiary Ingenix had engaged in RICO conspiracies and Unfair and Deceptive Trade Practices to undervalue the "usual and customary" (U&amp;C) charges for providers and that the U&amp;C data underpaid out of network providers.</p> <p>The AMA in turn filed lawsuits against several health plans that utilized the Ingenix Inc. database including Aetna, CIGNA and WellPoint and successfully settled these cases in federal court.</p>	<p>FAIR Health, Inc. NY 2009.</p> <p>Unaffiliated with any insurer or other stakeholder Conflict-free, uncompensated board of directors.</p> <p>Fair Health Inc. was created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database (see previous notes under Optum360)</p> <p>Independent Not-for-Profit, tax-exempt under § 501(c)(3): created as part of legal settlement to establish transparent and accurate source of healthcare cost information for consumers, researchers, policymakers and healthcare industry.</p> <p>Incorporated in statutes, regs and programs: NY, NH, IN, AK, KY, ND, AZ, WI., CT, MN, NJ, PA, MD, MS, and U.S. federal departments and agencies: HHS, GAO, AHRQ, and was recommended by CMS' CCIIO contractor,</p>	<p>Health Care Cost Institute, Inc., DC 2011. Tax-exempt nonprofit research corporation formed initially by four insurance companies, (three continue to participate, to provide virtual data access to researchers for selected projects.)</p> <p>IRS Form 990 from 2014 shows the following:</p> <p>Schedule B, Schedule of Contributors to HCCI:</p> <ol style="list-style-type: none"> <li>1. UnitedHealth Group: \$3.59 Million</li> <li>2. Aetna Inc.: \$2.72 Million;</li> <li>3. Humana Inc.: \$1.65 Million;</li> <li>4. Kaiser Permanente: \$350,000</li> </ol> <p>Schedule O: Compensation to the Five Highest Paid Contractors:</p> <ol style="list-style-type: none"> <li>1. Optum Global Solutions: \$1.050 Million, consulting;</li> <li>2. Modern Climate: \$607,000, website design;</li> <li>3. Upton Hill, LLC: \$538,000, data analysis;</li> </ol> <p>Significance of the capital contributions: HCCI is likely barred from</p>

	<p>Ingenix Inc. was then merged into and the name was changed to OptumInsight in June 2011 after the AMA settlement.</p> <p>Fair Health Inc. was created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database.</p> <p><a href="http://www.lexisnexis.com/legalnewsroom/insurance/b/medicalinsurance/archive/2010/09/21/final-approval-granted-in-350-million-settlement-with-united-in-reimbursement-dispute.aspx?Redirected=true">www.lexisnexis.com/legalnewsroom/insurance/b/medicalinsurance/archive/2010/09/21/final-approval-granted-in-350-million-settlement-with-united-in-reimbursement-dispute.aspx?Redirected=true</a></p>	<p>IMPAQ, as a transparent database.</p> <p>Honors/recognitions include White House, AHRQ, URAC, eHealthcare, AppPicker.</p>	<p>being the charges database for the Connecticut minimum benefit standard (the MBS); by statute, the MBS cannot be "affiliated" with a health plan.</p> <p>Also, because of its significant business dealings with United Healthcare, HCCI may be barred under the Ingenix settlement agreement from serving as a "charges data base" or MBS for states such as CT, FL or NY.</p>
<b>Organization Website</b>	<a href="http://www.optum.com">www.optum.com</a>	<a href="http://www.fairhealth.org">www.fairhealth.org</a>	<a href="http://www.healthcostinstitute.org">www.healthcostinstitute.org</a>
<b>Data Contributors</b>	Real-life claims from FAIR Health database of over one billion current charge records	Over 60 contributors nationwide - insurers and TPAs.	Three insurers (two of them also contribute to the FAIR Health repository) – Currently Aetna, UHC and Humana
<b>Period of Data Represented</b>	Annual-current	<p>2002 -Present</p> <p>Widely available in standard products and customized datasets; research subject to security capacity but no substantive or topical restriction/qualification</p>	Available in five-year increments: 2008-2012 or 2009-2013 upon application and approval of project by HCCI
<b>Type of Claims</b>		All types of private insurance – fully-insured, self-insured, group, individual, etc. [Also Medicare – 4+Billion]	<p>Individual-, group-insured and Medicare Advantage.</p> <p>HCCI is believed to have both contracted and non-contracted claim data combined.</p>

<b>Number of Claims in Database</b>		19+ Billion	N/A
<b>Number of Individuals Covered</b>		151 million	Research: 50 million (vs. 40 million for consumer website; see below)
<b>Regions</b>		All US - 493 Geozips Florida – 23 Geozips	N/A
<b>Consumer Tools</b>		English and Spanish  Medical and Dental	English  Medical
<b>Consumer Website</b>		<a href="http://www.fairhealthconsumer.org">www.fairhealthconsumer.org</a> <a href="http://www.consumidor.fairhealth.org">www.consumidor.fairhealth.org</a>	<a href="http://www.guroo.com">www.guroo.com</a>  N/A
<b>Consumer Mobile APP</b>		FH® Cost Lookup (English) FH ®CC Salud (Spanish)	40 million covered lives
<b>Data Supporting Site</b>		151 million covered lives, updated 2X/year	78 bundled medical treatments/services
<b>Consumer Cost Information</b>	Benchmark to 50 <sup>th</sup> , 75 <sup>th</sup> and 90 <sup>th</sup> percentile then use geographic conversion factor, 2017 release has seven reference points	Search by common name and/or standard billing codes and zip code All 10,000 medical procedures, 3700 HCPCS services/medical equipment and all dental services by standard code and common name with “prompt” to add common related services (e.g., colonoscopy + ane + pathology)  Benchmarks: 50 <sup>th</sup> (median), 60 <sup>th</sup> , 70 <sup>th</sup> , 80 <sup>th</sup> and 90 <sup>th</sup> percentile charge values based on actual market (OON) charges  Allowed amount benchmarks in development to be added to site in 2016  Out-of-pocket costs &	Per Guroo, costs estimates are based on in-network costs reported as “Averages” based on a combination of means and medians (not an arithmetic mean) <a href="http://www.guroo.com/#!/terms-and-conditions/averages">http://www.guroo.com/#!/terms-and-conditions/averages</a>

		insurance reimbursement estimates for both percentage of UCR and percentage of Medicare plans	
<b>Operations</b>		<p>All In-House</p> <p>Holds all actual claims data</p> <p>Conducts auditing and validation on all collected data</p> <p>Creates standard and custom data sets for distribution to entire healthcare sector pursuant to Data Licensing Agreements</p>	NORC holds data; virtual access
Staff		Est. 65	Est. 8
			HCCI Information based on HCCI and GUROO websites

Credits: Florida College of Emergency Physicians (FCEP) Dr. Andrea Brault, member of the ACEP Reimbursement Committee and ACEP/EDPMA Joint Task Force (JTF) on Reimbursement Issues and Ed Gaines, Chair of the JTF.



**Massachusetts College of Emergency Physicians**

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December 14, 2016

Representative Jeffrey Sanchez  
Chair, Health Care Financing Committee  
State House, Room 130  
Boston, MA 02133

Senator James Welch  
Chair, Health Care Financing Committee  
State House, Room 309  
Boston, MA 02133

Dear Chairman Sanchez and Chairman Welch,

It is our understanding that the Price Variation Commission is investigating the issue of out-of-network (OON) services. As you know, the Health Policy Commission held a Listening Session on May 18, 2016 on this issue. The Massachusetts College of Emergency Medicine Physicians ("MACEP") presented oral comments at that hearing and followed up in writing on May 31<sup>st</sup>. We are attaching those comments for your reference.

Emergency physicians have a unique voice in the discussion of OON services in that, as EMTALA providers, we are mandated to provide care to anyone who believes they are having a medical emergency, regardless of insurance status. Emergency care is an "essential benefit" which is "covered" whether it is provided by in-network or out-of-network physicians. If a patient receives a larger than expected bill for emergency care, they often mistakenly assume the bill is a reflection of the doctor's charges over and above fair reimbursement from the insurance company. Yet, in most instances, it is simply a reflection of the patient's out of pocket costs related to their deductible, co-insurance or copayment responsibilities, which can be quite high. And the emergency physician is neither aware of these insurance gaps nor in control of limiting them. However, we strongly support, and share your interest, in protecting patients from inadequate coverage for emergency services.

As we expressed during the HPC listening session, and in our follow up comments, we would welcome the opportunity to participate in a meaningful discussion with the Price Variation Commission, or one of

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its subcommittees on this important issue. Please let us know if there are certain times and dates over the next several weeks when we could meet with you directly. We will reach out to you, and the HPC, to follow up on this request.

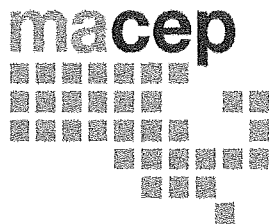
Sincerely,



Jeffrey Hopkins, MD  
MACEP President

Cc: David Seltz  
HPC Executive Director





Massachusetts College of Emergency Physicians

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**Massachusetts Health Policy Commission  
Cost Trends and Market Performance and  
Quality Improvement Patient Protection Sub-Committees**

**Testimony Regarding Out-Of-Network Concerns – Emergency Department  
Physician Perspective**

**Greg Brodek, Partner, Duane Morris LLP  
on behalf the Massachusetts College of Emergency Physicians**

Chairman, Vice Chair, and Board Members:

On behalf of the Massachusetts College of Emergency Physicians (“MACEP”), I thank you for allowing us to offer written testimony to the Massachusetts Health Policy Commission (“HPC”) and its Sub-committees concerning out-of network (“OON”) issues concerning emergency medicine services. MACEP represents a membership of 1,000 emergency medicine physicians in Massachusetts and has first-hand knowledge of issues associated with the provision of OON services by its members albeit, as noted below, these concerns appear to be limited in the Commonwealth. The issue associated with the rendering of OON services is very complicated, and we applaud the HPC for accepting testimony and scheduling hearings to investigate the scope of the problem, hear the perspectives of consumers and other stakeholders, and begin to explore possible solutions.

In its 2015 Policy Brief, the HPC enumerated its “OON Billing Concerns” as lack of patient notice, and the financial and administrative burdens its places on consumers.<sup>1</sup> As an initial matter, we believe the focus simply on “OON billing” is far too limiting and inaccurately identifies the cause(s) giving rise to, and the scope

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<sup>1</sup> The Health Policy Brief is available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-out-of-network.pdf>

of, the varied underlying concerns. We believe the complex issues associated with OON services provided in an emergency medicine context include: the extent services are covered under the patient's plan; patient education of what is, and is not, included, and at what rates or reimbursement are services covered; the legal obligation of emergency medicine providers to render care in an emergency department; the cost associated with rendering that emergency care; and the fair payment that must be made to compensate the emergency medicine providers for that care. As a result, we do not believe a myopic focus on the billing of the underlying services appropriately captures the fact that OON concerns involve the relationship of three inextricably, interrelated parties, the provider, the payer, and the patient. Therefore, we will globally refer to the issues and concerns stemming from a patient receiving OON services from an emergency medicine provider, as "OON Concerns."

Turning back to HPC's Policy Brief, HPC noted that its concerns regarding OON billing were particularly heightened for emergency medicine services due to the fact that patients, as a result of the emergent nature of their injuries, rarely have an opportunity/choice to select an in-network provider. As an initial matter, MACEP is unaware of any data that supports the position that OON Concerns for emergency medicine services is a wholesale, or systemic, problem for patients in Massachusetts, or that OON Concerns are increasing costs to consumers. Indeed, HCP conceded in its Policy Brief that there was no comprehensive data on the frequency or extent of OON Concerns in Massachusetts. Policy Brief p.3. In fact, it is our understanding that OON Concerns originated with Massachusetts health care plans and not consumers. While MACEP recognizes that patients should not be caught in the middle of reimbursement disputes between payers and physicians, particularly when the patient had little choice in who provided their care, the OON Concerns largely result from payers failing to pay the fair market value for reasonable and necessary emergency medical services.

### **Framework of existing laws/challenges**

The move to investigate OON Concerns brings into focus the complex reimbursement regimen at the heart of the U.S. and Massachusetts health care systems. Historically, payers have established limited networks of providers to leverage more favorable payment rates for health care services. Today, there are an ever increasing myriad of insurance product designs that complicate the reimbursement landscape, such as high deductible plans, and tiered and narrow

networks that involve higher out-of-pocket costs for consumers if they see providers that are considered a less preferred tier or out-of-network. This can result in increased deductibles and/or copays for consumers. Unfortunately, consumers buying these high deductible plans because they are attracted to their lower premiums, often lack the financial means to meet their “patient responsibility” particularly with regard to unexpected emergency services.

Within this complex regime, emergency medicine physicians are unique because they are required to treat any patient presenting at a hospital with an emergency medical condition, regardless of ability the patient to pay, under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). Due to the volume of uninsured and underinsured patients that emergency medicine physicians encounter, and their role as a 24/7 safety net provider, emergency medicine physicians must receive fair payment from insurance companies for the services they render. Additionally, emergency physicians cannot close their doors, and as a result have unique and significant structural cost challenges compared with other specialties. Emergency physicians provide uncompensated safety net services to payer members and the general public during low volume hours, such as in the middle of the night, when they stand ready to provide high quality care for strokes, heart attacks and other injuries and illnesses.

Further exacerbating these concerns is the situation described by Commissioner Cutler during the listening session on May 18, 2016, where the patient is treated at a hospital that is in-network, but where the emergency department physicians are out-of-network. In recognition of this unique scenario, federal and state laws have been enacted with the stated goal of protecting consumers from “surprise bills.” As noted during the listening session, we believe this characterization of an alleged patient “surprise bill” is a payer derived concept that misses the mark. If there is truly any “surprise,” it lies in the patient’s realization that he/she paid for insurance that only covers the rendering of services in certain hospitals, and if rendered outside of these facilities he/she may personally be responsible for paying a disproportionately large amount of the total bill (i.e. “surprise lack of coverage”).

The federal and state protections that have been passed, generally require insurance plans to pay OON providers, including emergency medicine providers, a reasonable rate for their services in an effort to minimize the cost of OON services to patients. Although a laudable goal, these laws have largely been “gamed” by the payers, resulting in greater patient uncertainty, and invariably, greater patient responsibility.

For example, the Patient Protection and Affordable Care Act (“PPACA”) mandated that payers pay emergency service providers the greater of three rates: the Medicare rate, the “usual and customary” rate for the area, or the payer’s median in-network rate for the service. There is no question that the intent of this law was to prevent payers from imposing greater financial burdens upon consumers, by paying an artificially low amount to OON providers. This, however, has not been the reality of how this law has played out. It is MACEP’s understanding that emergency providers are charging reasonable charges and payers are by and large reimbursing providers for those charges.

We believe that it is the payers’ use of liberal discretion in calculating the “usual, customary, and reasonable” fees that is the principal root cause of the OON Concerns, and the most important problem to be addressed. The “usual and customary” rate for emergency services has some inherent limitations, including the lack of provider involvement and transparency in setting rates. Massachusetts law has been interpreted to require an HMO to pay OON emergency services at “reasonable charges.”<sup>2</sup> As discussed below, we believe this law may provide a viable option for the consideration in addressing any true OON Concerns. Moreover, under Massachusetts law a payer must pay the OON emergency services provider “at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred [i.e. in-network] Providers.”<sup>3</sup> “Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers.” However, “Usual and Customary Charge” is defined as “the fees identified by a carrier as the usual fees charged by similar Health Care Providers in the same geographic area.”<sup>4</sup> Accordingly, both under Federal and Massachusetts law, payers are permitted to use their alleged independent “databases” to determine the usual and customary rate for the service, or “reasonable charges,” with no input from providers, and no oversight from any regulatory body. Not surprisingly, this unfettered discretion will inevitably result in OON emergency services providers

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<sup>2</sup> 176 Mass Code Reg. 5.

<sup>3</sup> 211 Mass Code Reg. § 51.05. “The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.”

<sup>4</sup> 211 Mass Code Reg. § 51.02.

often being paid well below fair market value for their services requiring emergency service providers to seek compensation from the patients.<sup>5</sup>

### **Lessons Learned and Potential Solutions**

If the HPC decides to support legislation to determine the fair value to be paid for OON services, its decision should ensure that all the stakeholders' interests and concerns are addressed.<sup>6</sup> We believe that five guiding principles should frame these deliberations: (1) payments for OON services should constitute the reasonable value for the services rendered, (2) the payment rates should be established using an unbiased methodology that sets the reasonable value for the services, (3) the overall methodology should be administratively efficient so as not to waste healthcare delivery dollars or create the need for cumbersome regulatory oversight, (4) provider-patient interactions should focus on patient care, and (5) providers need to have input into, and access to the methodology used, to ensure payments for OON services are fair and transparent. There is no perfect solution to this issue, but we believe we can learn from actions taken in other states, as well as from the existing law in the Commonwealth.

Many states, such as New York and Connecticut, have adopted various regulatory schemes that attempt to minimize the OON Concerns. Inevitably, these laws attempt to identify certain rates that are "reasonable," limit the provider's ability to seek compensation in excess of these rates, and provide a dispute mechanism that can be used by the payer, provider, and in certain rare instances, the patient. As noted at the listening session, we believe many aspects of New York's model to be overly complicated, administratively burdensome, and confusing. Significantly, a frequent misconception is that New York's model prohibits balance billing. As written, there is confusion over whether the law prohibits all balance billing of emergency medical services, or only those that are subject to "Independent Dispute Review." Moreover, the take-it-or-leave-it, baseball style discretion given to payors in determining what "reasonable" payment is, has spawned a number of disputed cases. Finally, the reliance on yet another payer populated black box pricing index,

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<sup>5</sup> Further complicating this process is that certain fraud and abuse laws prohibit the routine waiver of consumer's cost-sharing amounts unless there is a documented financial need to do so.

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>.

<sup>6</sup> HPC should note that any legislation proposed by HPC to address the perceived balance billing concerns would only apply to state regulated insurance plans, and would not include ERISA based plans, which account for \_\_\_ number of plans/covered lives in the state. This could result in a disparity among consumers regarding payment obligations for OON balance billing.

Fair Health, is equally problematic. Although carrying several of the same infirmities as New York, Connecticut's legislation seems more promising to strike a balance with all of the relevant stakeholders.

With the five guiding principles in mind, we offer the following concepts for your consideration:

- Expansion of the Commonwealth's current HMO law to all products. We believe that most providers are requesting reasonable charges, and for those outliers that are not, we believe those disputes should remain disputes between the payer and provider. MACEP has not been provided any data that substantiates the OON Concerns are widespread and is in need of extensive regulatory correction.
- If further definition of "reasonable" payment is necessary, we propose that it be tied to a reasonable current, fixed amount that is adjusted yearly based upon medical inflationary index. We are not in favor of the use of a pricing database, such as Fair Health that is populated only by payors, lacks transparency as to the claims being populated by the payors, and lacks any meaningful ability to have provider input into, or even monitor, the data.
- If it is desired that there be the ability to address the "reasonableness" of the payment being made, we propose an independent, binding dispute resolution process (IDRP) which:
  - a. Allows either a provider or payer to access the IDRP. Patients should be removed from the process;
  - b. Provides for resolution on a per CPT code basis, and not on a per visit or per encounter basis;
  - c. Uses CPT definitions for all coding disputes;
  - d. Concludes its findings within a reasonable period of time given the number and nature of the claims in dispute, but not to exceed 12 months of receiving the dispute (if adjudication takes additional time, there should be a mechanism for the provider to file for interim payment subject to a true-up based on the IDRP findings);
  - e. Allows aggregation, on both a group and claims basis, for claims with common issues of fact and/or law to be bundled together and adjudicated into one IDRP;

- f. Includes on the IDRP panel licensed medical providers in the same or similar specialty as the provider subject to the review, and individuals with healthcare claims experience including training and experience in CPT coding;
- g. Assigns a single person to each matter that is below a designated claim threshold, and a panel of three people for matters over that threshold;
- Payers must accept patient's assignment of benefits to the OON provider. The failure to recognize assignment of benefits, needlessly and inappropriately, thrusts patients into the payer/provider dispute.
- As mentioned at the listening session, we believe providers should be removed from their status of debt collector, and require that the payers pay OON providers the patient's cost-sharing obligation, and in turn bear the risk of collecting that amount from the patient. To address a concern raised in the HPC Policy Briefing, this requirement could be supported by a provision requiring payers to hold patients harmless from paying these sums to the providers. Payers, the only party that is engaged in the business of insurance, should be required to bear this financial burden, not the provider.

In sum, MACEP appreciates the opportunity to continue its dialogue with the HPC to create a fair, efficient, transparent system that ensures payment of reasonable and fair compensation that alleviates any documented OON Concerns.





Massachusetts College of Emergency Physicians

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**Testimony Submitted to:  
Price Variation Commission  
January 17, 2017**

Chairman Sanchez, Chairman Welch, and Committee Members, thank you for the opportunity to speak with you today at the Price Variation Commission hearing to discuss concerns related to out-of-network emergency services. This is an incredibly important issue that has a direct impact on our patients, providers, and the overall healthcare system in Massachusetts.

Much has been made of the ever increasing out-of-pocket expenses that our patients have been stuck with at the hands of the insurance industry, and rightfully so. With the rise of high deductible plans, large co-pays and co-insurance, patients are increasingly responsible for paying much more than their monthly premiums when it comes to healthcare. Patients are understandably confused and frustrated when they receive bills from multiple providers, as they assume that the health insurance they purchased will cover them, especially when it comes to emergencies. Nobody can predict or choose when or where they will need emergency care and patients should not be punished financially for seeking emergency care. The insurance industry would like for you to believe that the cost shifting and higher out-of-pocket expenses are due to providers who are charging above and beyond what is fair and appropriate for services rendered. This misperception is often tied to “out-of-network” providers who have been blamed for causing excessive out-of-pocket expenses, when much of the cost is simply a reflection of cost-shifting by insurers and increasing patient responsibility. It is the insurance industry itself who has created this situation, with inadequate, narrow networks and so-called “affordable” policies that actually cover very little, leaving patients to foot the bill and providers to collect payments. This is exactly the type of position that neither patients, nor providers, should be forced into – it’s a losing formula for everyone except the insurers. It is our firm belief that patients need to be taken out of the middle. Physicians should focus on practicing medicine and insurers should be responsible for collecting payments.

As we discuss healthcare costs and insurance coverage, it’s important to consider the unique position of emergency medicine and the care that is provided to over 3 million patients per year in Massachusetts emergency departments. I am a practicing emergency physician in the Hallmark Health System, and Chair of the Massachusetts College of Emergency Physicians (MACEP) reimbursement committee, and a Past President of MACEP, which represents over 1000 emergency physicians, we are first and foremost about our patients and their ability to access the highest quality emergency care, 24/7/365. Emergency

departments are the only setting in all of healthcare where patients can be treated without an appointment by highly trained physicians for any condition, at any time of the day, without consideration for the ability to pay. This is an important distinction from all other specialties and places of service and is unique to emergency medicine, where all of the care we provide is subject to EMTALA. As many of you know, EMTALA is an unfunded federal mandate, passed in 1986, that requires all patients presenting to an emergency facility to be seen and stabilized, regardless of payment or insurance status. As emergency providers, we are proud to wear the EMTALA badge and care for anyone with anything at any time. However, this federal law also places a huge financial burden on emergency departments, who see a disproportionate share of uninsured and underinsured patients. Each emergency physician provides an average of \$130,000 of unreimbursed care annually, more than any other specialty. With an increasing volume of more complex, higher acuity patients arriving at our doorsteps each day, it is more important than ever to ensure fair payment by insurers in order to support and preserve the emergency medicine safety net.

With this background information, I'd like to address the out-of-network emergency services issue. Just as patients cannot choose when they have an emergency, emergency providers cannot choose which patients they will or will not see. Insurers offer in-network rates, at below-market value, in exchange for driving patients toward a particular system or provider. There is no incentive for payers to offer fair and reasonable rates to those of us who provide emergency care, as we are bound by our EMTALA obligation. Insurers can game the system by setting high deductibles and offering unfairly low in-network reimbursement rates for emergency care. If emergency providers are forced to accept unreasonable rates that do not cover the cost of delivering 24/7/365 care, then the safety net will fall apart. Our emergency departments will not be able to appropriately staff and serve our patients and many will be forced to close altogether. The only recourse that emergency providers currently have to protect fair payment is our ability to go out-of-network. Without that option, we would be setting ourselves up for a public health emergency and abandoning our patients at the time of greatest need.

So what solutions can we suggest to preserve the safety net for patients and prevent surprises in "lack-of-coverage" as it relates to emergency services? The answer is transparency, taking the patient out of the middle and ensuring fair and reasonable payment. Health plans have a long history of undervaluing emergency care and sticking patients with balance bills, as evidenced by the multi-million dollar settlement that United Healthcare was forced to pay in New York State as a result of systemic underpayment for services using the Ingenix database. We recommend the use of an independent, unbiased, transparent UCR database based on charges to determine fair reimbursement rates.

Protecting patients: Furthermore, we recommend that patients be taken out of the middle, and that copays, coinsurance and deductibles should not apply to the professional component of emergency department care. Cost sharing would still apply to the facility component. This removes any confusion about bills coming from multiple different sources and streamlines and simplifies the overall process. This would remove the misperception that patients are receiving multi-thousand dollar balance bills from emergency physicians in Massachusetts. Finally, emergency physicians would be willing to consider a cap on professional charges related to any single ED visit, which would completely remove the possibility of

patients receiving excessive, multi-thousand dollar bills from their emergency provider. This proposed solution would protect patients, reduce waste (by removing payment disputes, arbitration, and administrative costs), and preserve fair payment to maintain the emergency safety net.

Thank you for consideration of our comments and for the opportunity to speak with you today. We look forward to continued collaboration as we work to protect the interests of our patients and preserve the ability to provide the highest quality emergency care in Massachusetts.

Sincerely,

Elijah Berg, MD, FACEP  
Massachusetts College of Emergency Physicians

## **Special Commission on Provider Price Variation - January 17, 2017 Hearing**

Good afternoon, I'm Dan Keenan and I serve as the Senior Vice President of Government and Community Relations for Mercy Medical Center. Chairman Welch, Chairman Sanchez and all the members of the commission, thank you for the opportunity to testify. I appreciate the work and time you have dedicated to examining provider price variation in the commercial market and for your efforts to put forth initiatives that will have a positive impact.

Mercy Medical Center is a 182-bed community hospital located in Springfield that provides nearly 80,000 ED visits annually. Mercy includes Weldon Rehabilitation Hospital, our 30-bed rehabilitation center located on the Mercy campus, and Providence Behavioral Health Hospital, our 125-bed behavioral health campus of Mercy, located in Holyoke. Providence is one of the largest providers of acute behavioral health care in the Commonwealth, providing inpatient and outpatient psychiatric care for children and adults, inpatient substance abuse treatment, as well as outpatient Methadone and Suboxone treatment.

Mercy serves one of the more financially challenged regions in the Commonwealth and has a payer mix that reflects our community at approximately 75% public payer, including 30% Medicaid and only 25% commercial.

Consequently, Mercy has one of the lowest relative prices paid from commercial payers at less than 80% of the statewide average.

I know that the Commission is examining a range of factors that affect provider payment rates that are both warranted and unwarranted. And, that you are investigating factors that could impact unwarranted price variation, including transparency, competition, and state monitoring.

I am here today to encourage action by the Commission in all these areas, but with a special focus on a regulatory approach that will have positive impact on providers with the lowest relative commercial rates.

Current relative price disparities for the same quality and service levels threaten the availability of affordable local healthcare. As I mentioned earlier, Mercy is one of the largest providers of inpatient behavioral health services in the Commonwealth. We lost nearly \$10M on behavioral health services in our most recently closed fiscal year and are budgeted to lose \$8M this year.

Commercial rate disparity is a contributing factor to these losses. Commercial rate disparity also impacts our ability to make needed investments in people, to build infrastructure, to recruit physicians and ultimately, in our ability to continue to provide negative margin services.

Attorney General Martha Coakley released her report, Examination of Health Care Cost Drivers in March of 2010. That report, among other findings, concluded that:

- Prices paid by health insurers to hospitals within the same geographic region vary significantly for similar services.
- These price variations were not correlated to quality of care or the cost to provide the care.
- These price variations were correlated to market share within geographic regions.
- The 2010 Report also concluded that higher priced hospitals were gaining market share at the expense of lower priced hospitals.

With the continued work of the Administration, Legislature, Attorney General, Health Policy Commission and CHIA, much has changed since 2010. Much has changed in terms of the sophistication of analysis of price disparity in the commercial market.

We have the data, now is the time to act.

I commend the commission and policy makers in Massachusetts for the continued efforts to have an impact on unwarranted price variation in the commercial market and I am hopeful that this commission will play a role in rectifying this challenging commercial payment scheme.

There is no warranted reason for Mercy's commercial rates to be so low. Transparency and market forces continue to have an impact on negotiations with the payers. Mercy will continue to do its part as high quality provider and attempt to negotiate fair rates.

We need help from the Commission to assure that we are paid at a comparable level to other like community hospitals. A commercial rate floor of .90 on the relative price index is an option worth significant consideration.

I encourage your action. Hospitals like Mercy, who are at the bottom of the relative price index distribution, need your help. We need this Commission to take action and establish a relative price floor of .90.

Thank you for the opportunity to testify.



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

January 20, 2017

The Honorable James T. Welch  
Senate Chair, Joint Committee on Health Care Financing  
State House, Room 309  
Boston, MA 02133

The Honorable Jeffrey Sánchez  
House Chair, Joint Committee on Health Care Financing  
State House, Room 236  
Boston, MA 02133

Re: Provider Price Variation Commission

Dear Chairmen Welch and Sánchez and members of the Special Commission on Provider Price Variation:

Thank you for the opportunity to provide comment to the Provider Price Variation Commission. Despite lacking an appointment to this commission, we have attended the meetings and followed your work with interest, particularly as the focus of many conversations at the commission meetings have shifted toward physician matters, including tiered insurance plan design and out of network billing.

While it is critical to engage in conversations about alternative insurance plan designs such as tiered network and the issue of out-of-network billing, we hope that they will ultimately take place in a venue that allows for full participation of relevant stakeholders, and we urge that specific recommendations related to these issues be developed when such an inclusive venue presents itself. We further note that there is plenty of work to still be done per the original charge of the commission, which is in part to identify “the acceptable and unacceptable factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services.” There appear to be many other charges to the commission that have evaded substantial discussion, as well.

I would like to highlight two general considerations that the physician community would like to convey to the Commission.

First, the issue of tiering has been raised many times in the course of this Commission- in fact; many conversations have referenced “tiering on steroids” as a possible solution to addressing price variation. The Medical Society wishes to highlight some perspectives regarding tiering which have largely evaded conversation of the Commission thus far.

- 1) Doubling down on tiering is not a panacea, as the jury is still out on the effectiveness of these plans to promote lower cost care. In their 2015 Report on Health Care Cost Trends and Cost Drivers, the Attorney General’s office said, “We found that membership in tiered products has grown, but the presence of these products has not resulted in an overall shift in patient volume away from hospitals that insurers have identified as lower value.” We urge continued study of these and other alternative payment designs to ensure focus on strategies with the strongest evidence base.

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- 2) The same Attorney General's report indicated substantial inconsistencies among tiering products, some of which lead to high price hospitals being included in the best available tier (without quality-based explanations) Tiering needs substantial fixing before it should be affirmed or even amplified in the market.
- 3) Lastly, tiering methodologies are shrouded in opacity. The above finding of the AG's report allude to a tension between the findings of their study of tiering and the Ch. 288 mandate to tier providers based on standardized and transparent cost and quality measures. Combining these concerns with longstanding issues such as variability and inconsistency of deductibles and co-payments, and still imperfect attribution methodologies, and tiering suddenly may not be the solution that should be put on steroids. For example, a study published in 2016 found that "the current methods for profiling physicians on quality may produce misleading results."<sup>i</sup> Therefore, we hope these perspectives are considered by the commission as a whole.

We have also been particularly interested in the many conversation of this Price Variation Commission around the issue of out-of-network billing.

First, the Medical Society remains committed to finding a solution to out-of-network billing that takes the patient out of the middle of all surprise bills- held harmless, with a prohibition on their receiving a balance bill. Patients seeking care at in-network facilities should not be subject to surprise bills.

That is why we are pleased to let you know that the Medical Society is finalizing legislation to address this issue- to prohibit patients from receiving "surprise bills" and providing a sustainable reimbursement strategy moving forward. The Medical Society's leadership and Committee on Legislation are currently reviewing this legislation that we hope will offer a thoughtful solution to the issue that has been the subject of so much conversation at your commission. The legislation is modeled after successful legislative solutions put forward by other states- strategies highlighted by the Health Policy Commission in its 2015 Cost Trends Report. We look forward to discussing and engaging on this issue through your roles as legislative chairs of the Joint Committee.

And second, while we don't have the data to know the exact nature of the issue, it will be critically important moving forward to ensure that patients have access to adequate networks. While we're all concerned about cost of health care, cost savings are only as good as are the ability of the underlying strategies to assure access to the care. We urge you to keep this issue in the forefront of all conversations moving forward.

Again, as the discussions of out-of-network billing have come solely from the limited membership of the Commission, I'm joined by Dr. Alex Hannenberg from the Massachusetts Association of Anesthesiologists. Dr. Hannenberg has long been closely involved in billing matters for his practice, and is here to highlight some considerations and reactions to many of the conversations of the Commission on this topic.

Sincerely,

Brendan Abel, Esq.  
Legislative & Regulatory Affairs Counsel

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<sup>i</sup> Adams JL & Paddock SM. 2016. Misclassification risk of tier-based physician quality performance systems. *Health Services Research*.





# Massachusetts Society of Anesthesiologists

PO Box 549154 Waltham, MA 02454-9154

## Comments of the Massachusetts Society of Anesthesiologists

### Presented to the Special Commission on Provider Price Variation Public Hearing

#### Officers

#### Public Hearing

January 17, 2017

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Good morning, my name is Alexander Hannenberg, M.D., and I am an anesthesiologist very recently retired from clinical practice at Newton-Wellesley Hospital. During my 26 year tenure at Newton-Wellesley, I was principally responsible for contracting and billing operations in our practice. Currently, I am leading payment reform work for the American Society of Anesthesiologists (ASA). I am a past president of the ASA, and Chairman of the Economics Committee of the Massachusetts Society of Anesthesiologists (MSA), and I am here today on behalf of the MSA, which represents over 1,000 physician anesthesiologists practicing in the Commonwealth.

MSA appreciates the opportunity to provide comments regarding out of network (OON) billing, and in particular "surprise billing" in which a patient may receive a bill for medical services provided at an in network hospital by an out of network clinician.

We understand this issue has become a subject of discussion within the Commission on Provider Price Variation, particularly in reference to discussions of tiered and limited networks. This is a complex issue that will become all the more complex as limited networks, which by definition limit provider participation, become more common. As this issue is explored, it is helpful to note that the Health Policy Commission (HPC) in its report on OON Surprise Billing acknowledges that comprehensive data on the frequency and extent to which OON billing occurs in Massachusetts is difficult to obtain or quantify.

In conjunction with the Massachusetts Medical Society, I have been asked to discuss out of network billing for services by hospital based physicians and highlight some considerations regarding the issue.

### Out of Network Hospital Based Physicians

At my hospital, Newton-Wellesley, the anesthesia group participates in all major local and regional insurance plans that have contracts with the hospital. I believe that is the case at most hospitals in the Commonwealth. However, there may be hospitals in which anesthesia groups are out of network for some payers. In the case of a low-volume national commercial plan my experience is that these plans demonstrate little interest in pursuing a participation agreement with the practice.

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## **Out of Network Surprise Billing**

In Massachusetts, hospital based physicians typically provide 24/7 services pursuant to a contract with the hospital. We have a powerful incentive to maintain a solid relationship with the hospital, and at my hospital, we work hard to keep patients, surgeons and the hospital happy. Our hospital contract is at stake. In my 26 years at the hospital, it has not had a single patient complaint relating to anesthesia OON billing, and this has been validated to me by our hospital administration. Frankly, we would benefit in some ways from agreements with some of the national insurance carriers I have mentioned previously, but our efforts to execute an agreement were stymied by indifference on the part of the insurers, or an unwillingness to stipulate to basic terms of an anesthesia agreement. In the absence of a participating agreement, the patient is out of network, and my practice walks the patient through the appeal process with their insurer and we write off a lot of the balance---thus the absence of complaints. I believe, our handling of OON billing is how most anesthesia practices in the state deal with the issue.

## **Limited Networks**

At last week's Commission meeting, I understand BCBS made a presentation about tiered and limited network plans. As you know, those plans limit members to a limited network of hospitals and clinicians. By design they achieve discounts or lower fees from the limited network providers by assuring patient volume.

BCBS implied that cost savings expected from a limited network are greatly at risk due to limited network members receiving services, including emergency services, at out of network providers, who are paid their charges. That is not the case.

If you are a participating provider with BCBS, as are most anesthesia practices in the state, you agree to treat BCBS patients per your BCBS contract and at your contracted fee. We may not be a participating provider in a BCBS limited network (typically excluded from that network), but if a BCBS limited network member receives services at my hospital, as an emergency or otherwise, the group would receive our contracted BCBS fee; **NOT** our usual and customary charge. Moreover, as a participating BCBS provider, we cannot bill the patient except for the co-pay and deductible. Alternatively, the plan may refuse to cover the service we have provided despite our participation agreement – in this case the insurer is manufacturing an OON situation. We have negotiated in good faith a contract with BCBS to treat their patients at an agreed upon fee schedule. It would be totally unfair if BCBS can throw aside its contract with us and impose a limited network fee schedule on OON providers, who are unable to participate in the limited network, in the event a limited network patient seeks care at an OON hospital.

## **Solutions**

While there does not appear to be comprehensive data regarding the extent of OON surprise billing in Massachusetts, MSA would welcome the opportunity to engage in discussions to find a reasonable solution that would remove the patient from the middle of a billing issue. Possible solution should include:

- Transparency...Up to date information for patients and referring physicians to ascertain whether hospital based providers are in network or not. This will allow patients to make a choice as to where to receive non-emergency care. Consider that by the time I encounter a patient, they have nearly always been through a facility registration process which represents the earliest and best opportunity to inform the patient. This is an activity that, in my opinion, should not occur at the bedside.
- Surprise OON billing for services that are an emergency...the patient should be held harmless except for co-pays and deductibles, and a process for determining a reasonable rate for the OON provider be established that is based on an independently recognized data base, similar to the NY law. Considering the unfortunate history of the Ingenix database, we are very concerned about the accuracy of the benchmarks that are created.
- In establishing a reasonable rate, a balance must be struck such that there are no incentives for participating providers to go OON, nor should it be so low that insurers will not contract with providers and pay an OON rate.

## **Caution on Using Medicare Fees as a Benchmark**

MSA would caution against using Medicare fees as a benchmark in any solution. We would note that for medical services other than anesthesia, Medicare payments are 80% of the average commercial payment rates. For anesthesia services, which is on a different type of payment system, the Medicare payments are 33% of the average commercial insurance payment rates. These comparisons have been established by federal agencies. The use of Medicare as a benchmark would

be devastating to anesthesia and, if implemented, would affect our ability in Massachusetts to recruit and retain anesthesiologists.

MSA supports the Medical Society's solution to OON surprise billing that will be filed for the current legislative session. We would welcome the opportunity to engage in discussions with the Commission and other stakeholders, and work with the Legislature to find a reasonable solution that takes the patient out of the middle of surprise out of network billing.



Testimony to Special Commission on Provider Price Variation

January 17, 2017

Paul Hattis MD, JD, MPH  
Tufts University Medical School

Chairpersons Welch and Sanchez:

With no consumer representatives on this Commission—I appreciate today’s hearing so that there is some opportunity for consumers to raise our voices of concern. I am Paul Hattis, faculty member at Tufts University Medical School and a member of the GBIO’s Health Care team—a social justice organization that has been working to achieve a quality, affordable health care system in our state.

Special Commissioners—I remind you that your name is the Special Commission on Provider Price Variation. And so I, like so many consumers across the state worried about health care affordability, are truly depending on you to make robust recommendations to the legislature on the issue of: reducing unwarranted commercial price variation. But I would be remiss—if I did not also say to you that I think you also have responsibilities in some way that as you craft some recommendations tied to the price variation issue, you should do so with some due consideration for taking a bigger picture look at the entire functioning of the market system for health care—particularly in the area of hospital services in our state.

From the outset, let me say that there are some very serious issues of concern with respect to those hospitals that are most underpaid in our commercial pricing scheme. When you combine that underpayment challenge with the reality that their payer mix is highly tilted towards care of government funded patients, no surprise that you can create survival challenges for some of these institutions. While today, I focus more on the issues of the overpaid, I do want to suggest that it may be wise to think about policy solutions that go beyond just raising prices for those at the bottom—to consider more a Maryland style guarantee of a total revenue flow for an ‘essential’ subset of our challenged community hospitals in order to assure their viability in the world to come.

As I now turn to the challenge of confronting the burdens placed on all of us as a result of there being a select group of hospitals that are overpaid under our state’s commercial insurance scheme, let me note that with great support, I have been able to catch a few of your meetings where you have discussed the issue of ‘Out of Network’ care pricing in all of its forms and settings. Seems to me that it is low hanging fruit for your Special Commission to make

credible recommendations that can mitigate the incredible waste of resources that flow to some physicians, hospitals, labs, ambulance companies etc. as a result of there not being subject to a payment level under an insurance contract for services they deliver to patients. (If I heard the Blue Cross VP's testimony correctly last week—15% of commercial insurance spending is for such out of network care—at the margin, some good savings can be accrued here.) At present, Massachusetts is behind a good number of other states that have already passed legislation to reign in this set of intolerable billing practices.

But as important as it is to address this issue, to stop there would really be letting Massachusetts consumers down in terms of your charge and state policy needs.

We should all admit the reality that our very expensive health care system in Massachusetts has a number of root causes, many of them not only Massachusetts in origin as there are many systemic challenges in health care delivery and financing across the US. And commercial price variation exists as well across many markets in this country. But as stated in the testimony today of John Freedman—variation in provider pricing in our market places here in Massachusetts is some of the widest in the country. And when you deal with the reality that 80% of care happens in our most expensive settings-- the TME spending and affordability challenges for people really add up when you allow such price gouging to take place.

Boston Children's Hospital and its physicians are the most extreme offenders in receiving high commercial prices in the state relative to their competitors. But with a relatively higher Medicaid patient payer mix, they pose some specific specialty referral hospital challenges that have not really been fully explored by the Special Commission; so I leave discussion of some targeted policy solutions about them to another day. But come your report in March, I don't think you can ignore them in your thinking and recommendations as BCH's specific pricing and affordability challenges cause consumers and businesses a lot of pain. And it's only going to get worse—so says the HPC about their proposed bed expansion likely to result in increased MA commercial market share and related spending.

Today, however, I wish to focus primarily on what has become the poster child for leading us down a path of high premiums and out of pocket payments in Massachusetts: Partners Healthcare.

Certainly, their existence and behavior has created a good deal of the market dysfunction that exists in health care markets in our state.

Let me say that I don't think that Partners and their providers are evil organizations or bad people. On the contrary—I think they are from a mission perspective—very well intended in so many ways. I don't come to criticize their aims, or for that matter, the substantive activities that make-up the teaching, research, patient care, and community benefit activities that they carry out every day. I praise the fact that they are national leaders in a number of these areas and should be proud of that reality. Though in each of these mission areas—the strengths that they often bring to the table can be uneven and do not exist across all of their facilities or

manifest in all of the people that come to work under the Partners banner. Even at the MGH and BWH—you can sometimes get bad care. And overall, based on the indicators that are currently used in quality measurement, their overall patient care quality compared to others does not stand out.

But to get to the heart of my concern: my biggest beef with them is that they are overpaid for the patient care that they do for commercially insured Massachusetts patients. And as I understand at least some of the historic data, that overpayment concern should also be applied to Medicare Advantage and Medicaid MCO patients they price negotiate for as well.

Their overpayment stems from Partners creation: when MGH and BWH and their doctors came together for the primary purpose of avoiding price competition with each other. Period. This allows them to negotiate prices as a total enterprise and to do so with extreme negotiating leverage.

So what should you do?

Without delving into all of the specifics of the policy ideas noted in the Freedman testimony today as well as approaches taken in Maryland—let me focus you on what could come from a definitive recommendation leading to legislative action. It relates to an idea expressed by Dr. Torchiana in a December 2015 Boston Globe interview where he acknowledged that the thought of breaking up Partners was something that “has crossed my mind.” His idea is important and one that I picked up on last June in a Commonwealth Magazine blog.

The Special Commission could make a set of recommendations, looking to legislation aimed at placing some sort of administered pricing and payment schemes such as capping payment levels, writing rules for a defined formula for a rate ‘build-up’, or perhaps suggesting a creative, ‘common carrier’ pricing scheme outlined by Longman and Hewitt in a 2014 Washington Monthly article. The key thing is that the net effect of such an approach is that commercial payments made to Mass General and Brigham and Women’s and their doctors would not only be definitively constrained, but if done correctly, could also lead these institutions and their leaders to conclude that it would be in their own best self-interest to divorce each other.

Why could such a change in the pricing or payment scheme lead to that decision?

First, ever since Partners’ creation, Mass General and Brigham and Women’s and their doctors have remained fiercely competitive with each other; manifesting minimal interest in working together as part of an integrated care system. Both hospitals and their doctors likely feel the “waste” of having to support Partners overhead without getting much in return.

Second, with the creation of the HPC and the firm line it took in its reports that convinced Judge Sanders that Partners’ planned hospital expansions in this state would only heighten our spending and market dysfunction challenges, the net effect is that today, Partners is left facing

the reality—that at least for Eastern Massachusetts, and quite possibly the whole state—further hospital acquisitions seem legally doomed so long as the system remains intact at its current level of market share.

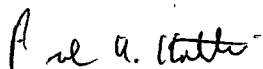
So with these two realities already at play, imagine for a moment that the Legislature enacts a law which contains a scheme that effectively reduces the allowed commercial price differential paid to Partners providers as compared with others. And then imagine further that under such a price-constrained system, Mass General and Brigham and Women's and their doctors and affiliates would get the *same prices if they were separated into two competing systems as they would receive if they remain together under the Partners umbrella*. (You could even sweeten the divorce incentive initially, and for a limited time agree to pay each hospital system separately more than if they remain as Partners.)

Put it all together and you soon come to the conclusion that MGH, its doctors and community hospital and physician affiliates and a corresponding group at BWH with their affiliates would be better off navigating the health care delivery world in their own separate integrated delivery systems. These two competitive systems would also have the possibility of growth though some new acquisitions or affiliations--if net societal value can be demonstrated for any future proposed transactions to the HPC.

If you believe in a market competition system, what a better way to try to obtain that in our state from such a break-up of Partners Healthcare. It can all start from the right sort of recommendations coming out of this Special Commission.

Thanks for the opportunity to testify today.

Respectfully Submitted,

A handwritten signature in dark ink, appearing to read "Paul A. Hattis". The signature is written in a cursive, slightly stylized font.

Paul A. Hattis MD, JD, MPH



# PIONEER INSTITUTE

185 Devonshire St, Suite 1101, Boston, MA 02110

Honorable Jeffrey Sanchez  
Honorable Steve Welch  
President Kate Walsh  
Special Commission on Provider Price Variation  
Commonwealth of Massachusetts

January 31<sup>st</sup>, 2017

## Recommendations of Pioneer Institute to the Transparency Subcommittee of the Special Commission on Provider Price Variation

Dear Representative Sanchez, Senator Welch and President Walsh:

### Introduction

Thank you for the opportunity to submit the views and some recommendations of Pioneer Institute to your Commission, and in particular to the Subcommittee on Transparency in Health Care. The Commission meetings have been interesting to attend, and staff have been very professional to work with for both the Commission and the Pioneer Working Group on Healthcare Price Transparency.

While there are many dimensions to transparency in healthcare, our current system is largely defined by one fundamental fact: **Patients and consumers have little idea of the cost of the procedures they and/or their employers are asked to pay for.** While this is especially important for consumers with high deductible health plans, it is also relevant to those with low deductibles who could be incented to make high-value low-cost provider decisions. This lack of information impedes synergistic opportunities among employees, employers and payers who can use their purchasing decisions to actually drive down the cost of medical care and reduce unwarranted price variation.

Price transparency is also extremely important to the healthcare system as a whole. There seems to be no acceptable rationale not to shine sunlight on the price of healthcare procedures and services among providers in Massachusetts. There is no question that our healthcare market is a hybrid of market forces and government regulation. Under these circumstances, suppressing price information from consumers'/employers' view leads to the inevitable result that healthcare dollars are misallocated because the price of healthcare services is not available to help guide the decision-making process of consumers and employers.

Although we have state laws requiring cost estimator tools from insurers and the disclosure of price information by providers, surveys by Pioneer,<sup>1</sup> **submitted with this**



**letter**, show that obtaining prices from providers upon request is still a daunting task for prospective patients. There is little or no information on provider websites to inform consumers that they have a right to know the price of even common procedures, and telephoning most types of providers ends up as a futile exercise for consumers. Consumers do not even know they have the right to this information. For consumers with high deductible plans who are paying the first dollar of their health care costs, this is not the hallmark of a progressive, consumer-friendly system.

As for the cost-estimator tools of Massachusetts payers, they vary in quality. Some contain a limited number of procedures, others contain hundreds. Some are easy to navigate, some more difficult. The uptake by members has been slow, but is growing. However, it appears that there is not a lot of promotion, marketing or change in plan design, for sustained periods, to incent and teach employers and employees about using these tools or offering greater incentives to do so.

The result is predictable. There is little awareness among consumers that they can shop for planned procedures, from MRIs to joint replacement (some studies show that almost 40% of procedures fall into a shoppable category). For the fearless who try to obtain such information, the experience is often not successful. Skeptics of consumer price transparency claim a lack of interest among consumers and employers for healthcare price transparency information based on low transparency tool usage rates. If consumers don't want a particular product, perhaps the product needs changing to make it attractive and more consumer friendly.

Price transparency in healthcare requires nothing short of a cultural change in the way consumers/patients and employers, aided by payers, providers and the state, consider healthcare options. There is no one-shot silver bullet, a bold multi-pronged strategy among and aimed at all stakeholders is needed.

We know that consumer behavior can be positively impacted through programs of education and incentives implemented over a sustained period. Consider smoking cessation campaigns and consciousness around healthy food. Price transparency in healthcare requires a similarly sustained effort. **From this Commission's work, we see promising models of mandatory, sustained employee education and targeted outreach by Polar Beverages and the new GIC Vitals SmartShopper program.**

Pioneer rejects the notion that consumers/patients are not medically literate enough to take advantage of price transparency for non-emergent care. In no other market is the burden placed on consumers to prove that they can handle price information. **A March 2015 national survey funded by the Robert Wood Johnson, performed by the respected Public Agenda think tank in New York, showed categorically that consumers with high deductible plans (over \$3,000) said they tried to find price information before obtaining care.<sup>2</sup>** See, "How Much Will It Cost", Public Agenda, March 9, 2015, attached to this letter.

But consumer/patients need help and reinforcement in order to change behavior and redirect healthcare dollars more wisely.

This is where this Commission can play a key role by providing a blueprint for action to stimulate initiatives and innovations to propel price transparency forward and benefit Massachusetts consumers/patients. Most importantly, this Commission is in a position to lay to rest the myth that consumers don't want this information, while simultaneously affirming that providing useful price information to patients is connected to fixing unwarranted difference in health care prices. See, *"Panel Pegs Challenge: Easily Understandable Health Care Pricing Info,"* State House News, Katie Lannan, Jan 10, 2017.<sup>3</sup>

**Pioneer recommends that the Price Variation Commission calls for the following actions:**

1. **State Wide Education Campaign:** The initiation of a two-year state-wide campaign pulling together state, payer, provider and employer resources to lead and educate Massachusetts consumers/patients and employers on the benefits of (a) knowing the cost of healthcare services and procedures, and (b) how utilizing various strategies such as cash/non-cash incentives (tiering, reference pricing, etc.) can erode unwarranted price variation and save healthcare dollars. This campaign can be coordinated by the executive branch of state government. A low cost but sustained social media/transit advertising campaign augmented by radio and TV media exposure over a sustained period of time can raise awareness and receptivity. This should be accompanied by an educational campaign aimed at, and utilizing, employers and workers through the chambers of commerce, business and trade groups and major employers, and should include every region of the state.
2. **CHIA Data Release:** Set the stage, and lead off the campaign, by releasing, on a regular basis going forward, cost data from the Center for Health Information and Analysis (CHIA) on up to 40 of the most popular procedures, de-identified by patient, but identified by provider and region. Medicare transparency has set in place a precedent to follow. This does not have to wait until a new website is developed, it simply involves posting the relevant price/provider information. It would begin to raise awareness among consumers and employers that there are real differences in prices and that directing dollars towards certain high-value low-cost providers could save millions of dollars.
3. **Use Existing State Authority:** There is a great deal more that can be done under existing state law to encourage and motivate payers and providers to more fully embrace and promote existing price transparency statutes. Payers and providers have had since 2102 to prepare robust, consumer-friendly, transparency initiatives for patients and consumers. But even today, over 4 years later, most consumers are not even aware that healthcare price transparency is their right. As stated above, Pioneer's surveys of providers, with a new



installment about to be issued this month, shows rather dismal performance even if a consumer is savvy enough to seek out price from a hospital or doctor for a procedure or service. Further, there is little marketing to employers by health plans about ways in which they can save on health costs by the addition of internal health navigators or basic education to employees on what they can do. Programs that are available to employers increase the costs of premiums, impeding their spread.

The executive branch, working through its Department of Public Health, the Division of Insurance, the Boards of Medicine, Dentistry and any other licensed entity covered by the transparency provisions of Chapter 224, can use its regulatory authority to spur much faster advancements in the area of price transparency. **We are attaching two articles on the power of the state to use its existing authority in this area.** One is an opinion piece from Pioneer in *Mass Lawyers Weekly*,<sup>4</sup> and the other is a Pioneer blog<sup>5</sup> that outlines how each agency can use its existing regulatory authority to spur a greater embrace of price transparency by both payers and providers.

We at Pioneer have also found a disconnect between what some providers have described to the Health Policy Commission in answers to questions posed by the Attorney General about their consumer facing transparency efforts and the experience Pioneer researchers have encountered. It would seem there is enough non-compliance to warrant the attention of appropriate state offices.

4. **Reward Patients in the Small Business and Individual Market for Being Smart Shoppers:** Given the regulatory regime in the merged market, patients are rarely rewarded for making smart healthcare decisions. As a first step, the state should ask insurers to grant these patients a share of the savings when they seek out a high-value provider within their plan design that is below the mean cost for that procedure or service in their area. These rewards can help offset the high deductible costs that many enrollees face, and keeps those with chronic conditions engaged in saving money even after they have blown through their deductible. An article in Forbes Magazine on the success of one such program is attached.<sup>6</sup>
5. **Give Small Businesses Access to Health Claim Information:** Through contracting arrangements, smaller companies, unlike their larger counterparts, are often prohibited from accessing health claims from their insurer. The state should level the playing field by allowing companies of all sizes access to their own claims information, with appropriate privacy around patient medical information, so they can serve employees more effectively, and understand and control healthcare costs.
6. **Use GIC To Encourage Greater Transparency:** Support and encourage, perhaps through Executive Order, the state Group Insurance Commission in its efforts to use its market clout to drive down healthcare costs. The Commission

could recommend that the GIC require that its third party administrators (TPAs) demonstrate proof of robust compliance with state transparency laws and that the TPAs in turn require the same from the providers with whom they contract on behalf of the GIC.

In addition, this Commission should look at other states' employee insurance markets, such as CalPERS in California, to recommend other ways the GIC can use its clout as a way to drive costs down and as examples to other employers and payers.

For example, CalPERS, and indeed other large employers, use reference pricing for certain shoppable procedures. CalPERS, long a leader in value-based purchasing, has recently initiated reference pricing and claims that reference pricing has resulted in price reductions, not merely slowdowns in the rate of growth. While there have to be sensible limits to reference pricing, the argument that providers will merely cross-subsidize to make up differences has to be evaluated in the context that other large employers and indeed large payers with clout are in the same position to use reference pricing or clinical centers of excellence to extricate themselves from unwarranted price variations. See, attached, "Appropriate Use of Reference Pricing Can Increase Value," Health Affairs Blog, July 7, 2015.<sup>7</sup> At some point, prices have to decline.

7. **Transparency Awards:** A Commonwealth Healthcare Transparency Award(s) could be initiated as a challenge to businesses to develop innovative transparency/financial incentive programs to reduce health care costs. These initiatives could include reference pricing models, financial/material incentive award programs, educational modules, working with payers or directly with providers to provide easy access for employees to find value-based healthcare and earn rewards. A more careful look at the Mass Challenge Awards programs may be helpful for deciding how to structure such an initiative.

The key here is that the Commission should encourage innovative programs such as reference pricing, providing employees financial rewards for choosing high-value low-cost providers, making transparency easy to navigate, and sharing savings with employees who choose low-price high-value providers. And, very importantly, all such programs have to be accompanied by long term educational efforts to employers and employees about access to price transparency in health care services.

Thank you for the opportunity to present these recommendations.

Sincerely,



James Stergios

Executive Director, Pioneer Institute



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<sup>1</sup> [“Massachusetts Hospitals Weak on Price Transparency”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. June 24, 2015.

[“Bay State Specialists and Dentists Get Mixed Reviews on Price Transparency”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. August 11, 2015.

[“Healthcare Prices for Common Procedures Are Hard for Consumers to Obtain”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. February 21, 2016.

[“Transparency in Retail Drug Prices: Easy to Obtain but Accuracy May Be Doubtful”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. October 13, 2016.

<sup>2</sup> [“How Much Will it Cost?”](#) Public Agenda. March 9, 2015.

<sup>3</sup> [“Panel Pegs Challenge: Easily Understandable Health Care Pricing Info”](#) State House News Service. Lannan, Katie. January 10, 2017.

<sup>4</sup> [“Transparency in Health Care Prices Calls for State Action”](#) Massachusetts Lawyers Weekly. Anthony, Barbara; Idelson, Sarah. December 10, 2015.

<sup>5</sup> [“How To Tell If the Price Is Right: Fostering Transparency in Healthcare Prices for Massachusetts Consumers”](#) Pioneer Institute. Anthony, Barbara; Idelson, Sarah. October 5, 2015.

<sup>6</sup> [“Right To Shop: The Next Big Thing In Health Care”](#) Forbes Magazine. Archambault, Josh. August 5, 2016.

<sup>7</sup> [“Appropriate Use Of Reference Pricing Can Increase Value”](#) Health Affairs. Boynton, Ann; Robinson, James C. July 7, 2015.



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January 17, 2017

The Honorable James T. Welch  
Senate Chair, Joint Committee on Health Care Financing  
State House, Room 309  
Boston, MA 02133

The Honorable Jeffrey Sánchez  
House Chair, Joint Committee on Health Care Financing  
State House, Room 236  
Boston, MA 02133

*Re: Provider Price Variation Commission*

Dear Chairmen Welch and Sánchez and members of the Special Commission on Provider Price Variation:

I am writing on behalf of Atrius Health to provide an independent physician group perspective as the Special Commission continues its deliberations on Provider Price Variation. We believe it is important for members of the Special Commission to hear directly from physician practices, particularly those like Atrius Health who have an advanced care model, as we have a unique perspective on the health care market in Massachusetts.

Atrius Health, an innovative nonprofit healthcare leader, delivers an effective system of connected care for more than 675,000 adult and pediatric patients in eastern and central Massachusetts. Atrius Health's 29 medical practices, with more than 35 specialties and 750 physicians, work together with the home health and hospice services of its VNA Care subsidiary and in close collaboration with hospital partners, community specialists and skilled nursing facilities. Atrius Health provides high-quality, patient-centered, coordinated care to every patient it serves. By establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives.

Atrius Health has been a leader in the state in the adoption of alternative payment contracts, advanced patient-centered medical homes, and population health management. Everything we do is focused on improving patients' lives and health outcomes, and ensuring value by reducing overall Total Medical Expenses (TME). We are unique in our decades-long experience with global payments, which currently represent about 80% of our total revenues. We take financial risk across the continuum of care, including specialty providers, hospitals, rehabilitation, home health, hospice, and pharmacy, so we are highly aligned with the Commonwealth in seeking innovative ways to reduce costs by keeping patients healthy and providing the right site of care – particularly at home instead of in a facility. Our goal wherever possible is to reduce duplication of services, enhance coordination of care and to ensure that our patients receive care in the community wherever possible.



Atrius Health believes the Commission's focus on unwarranted price variation should be on hospital prices, rather than physician prices (particularly primary care) for two reasons. First, hospital prices drive the largest portion of controllable expenses within the total cost of care. For example, about 68% of TME lies outside of Atrius Health's direct control (e.g. hospital inpatient, hospital facility outpatient care, and emergency department care and prescription drug costs). Hospital costs are generally increasing despite our many efforts to reduce costs by referring patients to high quality lower cost hospitals and through creating innovative (typically not reimbursed or subsidized) programs to care for patients in their homes, and by offering extended urgent care and phone hours. Second, within healthcare systems the hospitals often subsidize their referring physician groups. With this as a "hidden" source of revenue for the physician groups, it would be very complicated to find any solution that would be equitable for independent groups like Atrius Health which are not subsidized in any way.

Below are additional comments and recommendations for your consideration:

- Right Site of Care - We are supportive efforts to **promote the right site of care**. Clinical needs should be matched to the right resources which would also support community hospitals. HPC could measure and publish the percentage of care for each healthcare system provided in their academic medical center for procedures that could be treated in community settings and continue to trend referral patterns of care.
- Risk adjustment methodology - We believe that a **better risk adjustment methodology** (e.g. inclusive of socio-economic factors) is needed which should be applied consistently across all payers to ensure that TME is truly comparable. Even when they use the same tool (e.g. DXcG), payers are applying it differently today.
- Site Neutral Payments - We support efforts by the state to **equalize payments for the same services provided by hospital outpatient departments and physician offices** and believe such payments will level out the market for the same type of services which is currently not the case in Massachusetts. Medicare is leading the way in this area.
- PPO Attribution - TME is only compared today on plans where there is a patient requirement to select a primary care physician. Comparison needs to be done on a larger percentage of the patients to be meaningful. PPO attribution methodology was developed and agreed to by many of the larger health plans and provider organizations in Massachusetts several years ago. If CHIA asks the health plans to use this methodology and provide CHIA with the attributed medical group for each patient, then **CHIA can compare TME for PPO products** as well as HMO products. Furthermore, the state should enforce the requirement in Chapter 224 that the health plans attribute PPO patients to primary care providers (or physician groups) and **share the claims data** with that primary care provider or physician group. This would enable the physicians to do the same kind of risk assessment we do on our HMO patients so that we can proactively provide services to keep patients out of the hospital, thereby improving health and reducing TME. We feel strongly this should include sharing behavioral health data so that we can include behavioral risk in assessing overall risk for these patients.
- Reference Pricing - We suggest that the state's **Group Insurance Commission (GIC) be a leader in reference pricing** for standard procedures as a way to re-align the market and address provider price variation. The California Public Employees Retirement System (CalPERS), which purchases coverage for 1.3 million employees and their families, and has long been recognized as a leader in value based purchasing, implemented reference pricing as a consumer-oriented incentive designed to increase in health care through higher quality and lower cost care. It has been reported that a change by CalPERS to reference pricing resulted in changes in consumer choices that in turn resulted in reductions in prices and payments as certain high-priced providers reportedly reduced their prices in order to address the potential loss of patient volume. We believe that adoption of reference pricing by GIC (and other employers) has the potential to reduce health care costs and reduce provider price variation and warrants further examination by this Commission or the Health Policy Commission (HPC).



- End of Life Care – As was reported by the HPC in its report dated November 2, 2016, “Serious Illness and End of Life Care in the Commonwealth” there need to be significant improvements made in the quality of care at the end of life. As the report (which studied Medicare patients) points out, **spending in the last six months of life is concentrated in inpatient acute-care hospitals** which in most cases is nearly three times more expensive than in other settings. We believe that significant opportunity exists in the state to reduce health care costs for patients at the end of life and that additional analysis and policy recommendations should be considered. For example, MassHealth might find that reimbursing for hospice care could be less expensive than paying for hospital or skilled nursing home care at end of life.
- Tiering – We support the **creation of tiered products** with tiering methodology for hospitals and providers that is consistent across the plans and transparent to both providers and patients. Such products should be structured to provide more meaningful differential between higher and lower co-pays and to include key quality measures such as readmission rates.
- Telemedicine - The administration, legislators and the HPC should help foster reforms on both the state and federal level that lead to reimbursement for innovative technologies such as **telemedicine that can drive down TME**. Expanding such reimbursement would encourage more efficient operations by allowing patients to be cared for in the home, rather than by ambulance to the emergency departments, when transportation, mobility issues or other factors might limit a patient’s ability to come for an office visit. Payment should be assessed on time required, not simply at parity to in-person services, to enable telemedicine to bring down total TME. Some consideration should also be given to the site where telemedicine is received; it should not be possible to increase revenue simply by moving the telemedicine provider to a different site with a higher reimbursement rate.
- Limited Network Plans – Patients have not historically understood what they have purchased when buying a limited network product. This is frustrating to patients and creates difficulty for referring providers who may be linked with hospitals and specialists not in the network. However, we can support the development of additional offerings of **limited network products** as part of a multi-pronged approach if the limited network is created around the ACOs rather than by the payer.
- Contracts – Hospitals within a system should have separate **rates as appropriate** to account for various factors such as teaching, acuity levels of patients, and geography, but not separate contracts or separate negotiations which just add administrative work without adding value.

Thank you again for the opportunity to provide input to members of the Commission with our thoughts on provider price variation. We would welcome the opportunity to discuss any of the above-mentioned items with you at your convenience. Please feel free to contact me at (617) 559-8042 or Kathy Keough, Director of Government Relations at (617) 559-8561.

Sincerely,



Steven Strongwater, MD  
President & CEO, Atrius Health



**Cambridge Health Alliance**

**Draft Testimony: Provider Price Variation Commission – January 17, 2017**

Chairmen Sanchez and Walsh and Commission Members:

Thank you for the opportunity to testify today. My name is Jill Batty, Senior Vice President and Chief Financial Officer, of Cambridge Health Alliance (CHA).

We join together with other hospital colleagues you will hear from today in urging the Commission to recommend systemic actions now to address unwarranted price variation faced by underpaid hospitals.

Despite the high quality and high value services we provide, our hospitals are among the lowest paid hospitals by private insurance with a relative price of less than 0.8 compared to an average commercial rate of 1.

On behalf of our patients and communities, urgent action is needed to generate a systemic fix and meaningful progress toward a private insurance rate floor of no less than 0.9 of the average commercial rate.

The longer we wait for action, the challenges are compounded.

The Health Policy Commission's 2015 report found that unwarranted price variation "perpetuates inequities in the distribution of healthcare resources that threaten the viability of lower-priced, high quality providers."

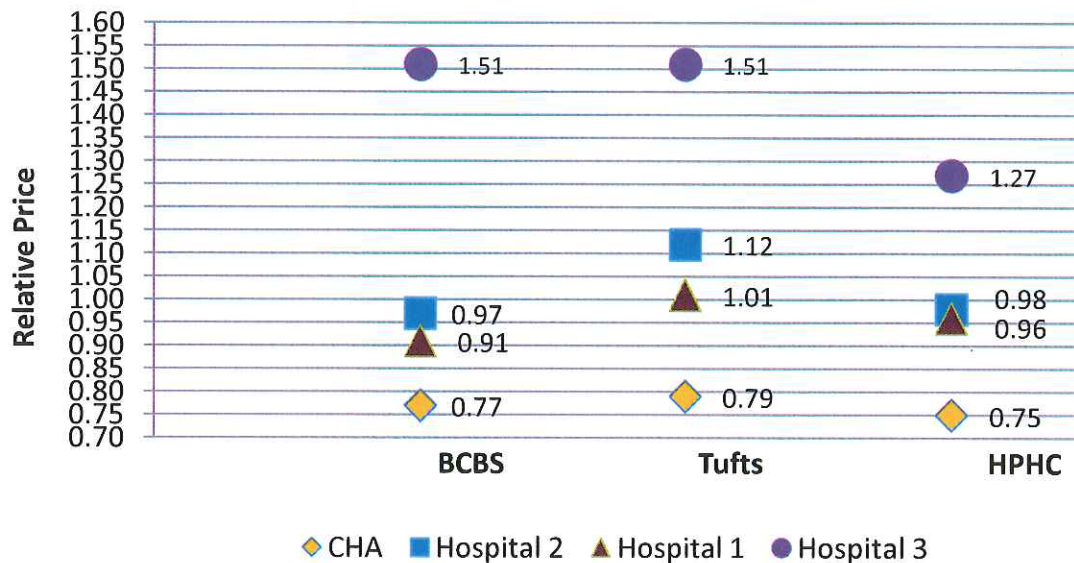
The past 7 years of transparency reporting in Massachusetts has validated that unwarranted price variation by private insurance:

- occurs extensively across the same sets and quality of services,
- contributes to higher healthcare spending due to higher prices and volume shifts to higher-priced providers,
- has not and will not diminish over time -- absent policy action.

The market will not fix this problem on its own. Over the past five years, CHA has actively pursued negotiating and contracting strategies to address this inequality. Yet, its position has stubbornly and consistently remained among one of the lowest paid in the Commonwealth.

According to the most recent publicly available data from the Center for Health Information and Analytics in the 2014 Relative Prices data book, within the 2 mile radius of our service area, the commercial insurance rate for the state's largest payer varies by about 100%, from a low of 0.77 for CHA, two hospitals between 0.91 and 0.97, and another hospital at 1.51. The chart contained in our submitted written testimony demonstrates this discrepancy exists across the state's three major commercial insurers. Contracts negotiated since 2014 have resulted in minimal increases as insurance companies cite the overall statewide growth target as a limitation in their ability to implement meaningful strategies to equitably compensate providers who are locked into low rates.

### 2014 Hospital Relative Prices by Major Private Insurer in Cambridge Health Alliance Service Area



Source: Center for Health Information & Analysis 2014 Relative Prices by Payer

These data clearly show why we respectfully urge this Commission to fulfill its charge by adopting a payment floor of not less than 0.9 of the average hospital commercial rate.

Chapter 115 calls for the Commission to undertake a “rigorous, evidence-based analysis... [of] the acceptable and unacceptable factors contributing to price variation” and make corresponding recommendations.

We urge the Commission to include in its report clear findings and recommendations which acknowledge and address the important role providers paid on the low-end of the private insurance spectrum play in maintaining access to high quality and low-cost patient and community-centered care.

- It is simply not warranted and not acceptable for providers to be paid vastly less for the same services despite the same quality of care.
- It is not acceptable to perpetuate a market system which deprives communities and patient populations of adequate payment rates to their local health care provider solely based on unwarranted factors such as:
  - freezing in place low payment rates,
  - lack of a significant commercial payer mix or market clout, and
  - greater services to poor, low-income, and government payer dependent populations.

These examples are just a few documented factors in multiple state reports contributing to private insurance underpayments.

The annual financial impact of the difference between our current payment rates and payment at the market average is in the range of \$20 million according to our internal analysis. As a way of example, I'd like to review three specific implications of the inequity to the communities and patients CHA



serves. CHA is a community-based safety net system which offers care to approximately 150,000 unique patients annually.

- Under-investment in local care delivery: CHA, as a result of the mix of services it provides, payment rates, and the patient population it serves, annually faces the challenge to reliably budget for a positive bottom line. Consequently, our capital investments in facilities and programs to deliver services in existing locations close to patients and within the local community have been severely limited.
- Threats to provider/staff recruitment and retention: Our providers and staff are mission-driven and demonstrate their commitment to the patients and communities we serve. Yet, like other underpaid providers, we experience continuing threats to physician and staff recruitment and retention from more highly resourced organizations.
- Concentration of service mix: Commercial price disparities - which can be 2 – 3 times greater rates for the same services - enable higher paid providers to invest and attract patients to higher margin services, leaving vulnerable the essential access we provide. As with all providers, CHA relies on payments from higher margin services to continue to provide access to essential lower margin services such as behavioral health, substance use treatment, and primary care services. The fact that our payment rates are far below market rates limits the scope of our investment and, consequently, access to wellness-oriented care which is correlated to lower health costs in the long run. Addressing the commercial rate disparity for lower paid providers is also crucial to our ability to maintain our regional mental health and substance use disorder services which reach beyond our service area to the entire Commonwealth.

These three consequences of continued payment inequities are significant. Over time, they have the effect of exacerbating the inability of the Commonwealth and its partners in the healthcare industry to offer the residents access to high quality, lower-cost care, close to home. They further concentrate market power and, ultimately the delivery of services, in high cost providers which, in turn, prevents businesses and consumers from having access to reasonably priced insurance products.

CHA can speak from experience that payment reforms like global payments, tiered or limited networks, or the transition to Accountable Care Organizations do not serve to address the underlying underpayment problem. We are successful participants in all of these, but they all start from a flawed, inequitable base.

Now more than ever with federal health policy uncertainty in Washington and ongoing pressure to government programs, like Medicare and Medicaid, it is critical that a level of private insurance rate equity be achieved for underpaid hospitals.

As high value health care systems (quality and price), if our private insurance rates are lifted toward the hospital average, we are collectively poised to be a greater part of the solution and serve more patients cost-effectively in community settings. As you develop your report and recommendations, we ask that a minimum payment floor of 0.9 be established to address a portion of that underpayment.

For the reasons above, policy action to lift up the private insurance rates to a minimum payment floor for underpaid providers – is an essential part of the equation to support the availability and viability of an affordable health care system across the state.

In closing, thank you again for this opportunity to testify. We are available to answer questions and serve as a resource in the Commission's work ahead.

***Testimony of Dianne Anderson, President & CEO, Lawrence General Hospital  
January 17, 2017 Price Variation Commission Listening Session***

I'm Dianne Anderson, the President of Lawrence General Hospital. Thank you Chairman Sanchez, Chairman Welch and the entire commission for the work and time you have dedicated to examining unwarranted provider price variation and solutions. This is a critical issue that impacts the sustainability of community hospitals and the affordability and access of health care. LGH is a Regional Medical Center serving the city of Lawrence and the entire Merrimack Valley. With 70,000 ED visits/year, we are one of the busiest trauma centers in the State. We are a disproportionate share hospital, with 35% Medicaid. We provide vital, high quality care to a large socioeconomically challenged area, including advanced surgery, pediatrics and neonatal care. Many of these patients would be able to access to comprehensive clinical care without us. In addition, we are the largest employer in Lawrence.

I am here today because Lawrence General is perpetually among the bottom TEN lowest paid hospitals in the Commonwealth. Our commercial rates are significantly lower than other community hospitals a few miles down the road- for the same procedures, the same diagnoses and the same- or greater acuity levels.

Eight years ago, in my very first month as the CEO of Lawrence General, I was invited to testify on rate variation among hospitals. Back then it was the Attorney General's office that organized and called for hearings, following the seminal AG report on unwarranted price – or rate- variation . I shared my vision of working to keep more care local, to position Lawrence General to provide greater access to clinical specialties, to invest in infrastructure needed. In fact, we are about to open a new surgical suite to replace the 50 yr old ORs. I focused on the high value we offered, the great quality of care and how we were part of the solution for keeping health care cost growth down. We have kept our bargain and succeeded in expanding clinical services and work hard to keep care within our high value

system of care. Our strategy is working- surgeries are up 9%, transfers to Boston down by 50% and great improvement in preventing out of network care at more expensive facilities. However, the constant Government payer cuts and our unwarranted low commercial rates are threatening our ability to preserve key clinical programs.

Naively, in retrospect, I hoped that thoughtful policy makers would find a way to turn this new transparency on hospital rates into a resolution, a commitment, and take action to improve the rates for those that we learned were paid so poorly.

More recently, when the Health Policy Commission came out with their Community Hospital Report in 2015 I thought WOW ....FINALLY, the State is showcasing how important it is that we have a vital community hospital segment because it's community hospitals that offer the most value. It is community hospitals that are the keys to containing costs. If more patients go to community hospitals for community-appropriate care it creates cost savings for the entire health system.

Chairman Sanchez and Welch, members of this Commission – Hospitals like Lawrence General Hospital are part of the SOLUTION for cost savings to the Commonwealth and every person who seeks health care in Massachusetts. Every time someone chooses my hospital they save the system. We are part of the solution for unsustainable health care costs- but only if we are sustainable!!

There is no warranted reason for our commercial rates to be so low. Market forces have not changed this dynamic- and neither do negotiations with the payers. LGH must be reimbursed at a comparable level to other like community hospitals. That is the difference between being in the red and being able to make a margin to reinvest in clinical programs and staff to benefit the region- and provide easy access to high quality high value care.

However, nothing has changed in the past 8 years since my original testimony on the AG report. . Actually, one thing has changed, there are TWO COMMUNITY HOSPITALS THAT WERE PAID AT THE BOTTOM, that have CLOSED.

My colleagues and I who lead hospitals that are paid in the bottom 10 need a permanent systemic fix, and we need it urgently. We need this Commission to take action and establish a floor of .90.

The future of some community hospitals and our capacity to reduce overall health care costs in the Commonwealth, by keeping care in high value community hospitals, hangs in the balance.

I urge you to find a way to adopt a permanent fix that ends the practice of unwarranted price variation before it is too late.



**Embargoed Until 12:01 a.m.  
Tuesday, January 17, 2017**

**CONTACT: Eric Linzer  
617-338-2244**

## **New Health Care Pricing Analysis: MA Among Nation's Highest** *Review Questions Affordability Assumptions in Commonwealth*

**Boston, MA** – Massachusetts health care costs are among the most expensive in the United States and provider price variation is more extreme in the Commonwealth than nearly all other markets in the nation, a new analysis of state and national reports reveals. The review, conducted by Freedman HealthCare, shows how market-based efforts have failed to improve affordability and that short-term regulatory efforts may be necessary to improve the functioning of the health care market.

"While the AIM board has not endorsed regulatory intervention as recommended in this report, rising health care costs are the number one issue facing AIM members. The Freedman analysis is important to help us all better understand how Massachusetts health care costs impact employers and consumers, and his analysis that the market has failed to correct this variation requires us to provide health plans with the necessary tools to rein in costs and to continue to monitor the market to see if more robust product designs can drive employers and consumers to lower cost, more efficient providers," said Rick Lord, President and Chief Executive Officer of Associated Industries of Massachusetts.

With health care spending exceeding the state's cost benchmark the last two years, the analysis outlines the challenges high health care costs create for residents and employers. Among them:

- Employee health care costs as a percentage of income continues to grow;
- Massachusetts businesses competing nationally are disadvantaged by higher premiums; and
- Rising health care costs force crowding out of household and government spending.

"Despite the suggestion that Massachusetts' health care costs are affordable, continued increases in the cost of health care are a serious threat to small businesses, so it's important to provide a complete picture on health care spending in the Commonwealth," said Retailers Association of Massachusetts President, Jon Hurst.

The analysis also found that provider price variation in Massachusetts is much wider than nearly all other markets across the U.S. For example, the state's highest-priced hospitals were 2.5 to 3.4 times more expensive than the lowest-priced hospitals, a significantly higher spread than the range among hospitals in neighboring states. Further, the analysis noted that price variation has contributed to increases in health care spending and that disparities will continue to grow as providers consolidate and volume shifts to higher cost providers.

"Rising health care costs are the number one issue facing small businesses and the people who work for them. While it is important to address provider price variation, it is essential that any solution results in lower health care costs for Massachusetts employers," said Bill Vernon, Massachusetts State Director for the National Federation of Independent Business.

Despite efforts to address provider price variation through "market-based" reforms, such as tiered and narrow network plans and the use of alternative payment methods, the analysis concludes that these measures have had no discernible effect on price variation or market dysfunction.

– more –



Moreover, as suggested in reports from the Health Policy Commission and the Office of the Attorney General, further market based intervention are unlikely to help and short-term regulatory action is warranted. The analysis outlines a series of potential options to address price variation, including:

- Expanding authority under the Performance Improvement Plans;
- Driving price convergence through "guardrails" on contracted prices;
- Capping payments at a percentage of Medicare;
- Addressing overcharges in surprise bills; and
- Considering longer-term regulation such as Maryland-type rate setting

"Multiple state reports have shown that the price of services that doctors and hospitals charge is the main reason for increasing health care costs and the gap between the highest-priced and lower-priced providers is widening," said Lora Pellegrini, President and Chief Executive Officer of the Massachusetts Association of Health Plans. "As premiums reflect the cost of care, addressing unwarranted differences in provider prices must result in making health care more affordable for employers and consumers."

The analysis, conducted for the Massachusetts Association of Health Plans (MAHP), the National Federation of Independent Business (NFIB), and the Retailers Association of Massachusetts (RAM), examined the more than two dozen Massachusetts state reports on health care costs, as well as national data for all states on health care spending and prices, including information from the U.S. Department of Commerce, Centers for Medicare and Medicaid Services, and the Commonwealth Fund.

"Despite years of effort, four health care reform laws, and more than two dozen state reports, limited progress has been made in addressing high health care costs with no improvement in price variation. Given the impact of rising health care costs on employers and consumers, short-term regulatory action could address health care spending and price variation in a way that market-based solutions have not," said John Freedman, MD, MBA, President of Freedman HealthCare.

#### **About AIM**

*Established in 1915, Associated Industries of Massachusetts is the largest nonprofit, nonpartisan association of Massachusetts employers. With nearly 4500 member companies employing more than 600,000 people in Massachusetts, AIM's mission is to promote the well-being and prosperity of the Commonwealth by reducing business costs, shaping state and federal business regulation, and ensuring a skilled and highly educated work force. For further information, visit [www.aimnet.org](http://www.aimnet.org).*

#### **About RAM**

*The Retailers Association of Massachusetts is a statewide trade association of 4,000 retailers and restaurants of all types and sizes. The retail sector in Massachusetts employs 600,000 residents, or 17% of all jobs, and has total sales of over \$100 billion annually.*

#### **About NFIB**

*The National Federation of Independent Business is the leading small business association representing small and independent businesses nationwide. Its mission is to promote and protect the right of its members to own, operate and grow their businesses. A non-profit, nonpartisan organization founded in 1943, NFIB represents the consensus views of its members in Washington and all 50 state capitals.*

#### **About MAHP**

*The Massachusetts Association of Health Plans represents 17 health plans covering more than 2.6 million Massachusetts residents. It is dedicated to improving health for all in Massachusetts by promoting affordable, safe and coordinated health care.*

#### **About Freedman HealthCare**

*Established in 2005, Freedman HealthCare is a leader in performance measurement, health care reform, and the data needed to guide change. Through Freedman HealthCare's work with state health organizations, healthcare providers, payers and policymakers, the firm assists diverse stakeholder groups in adopting policies and programmatic changes that drive quality improvement and cost containment.*

###



Good morning and thank you for the opportunity to share with you some interesting information about provider price variation in Massachusetts. My name is John Freedman, and I am a physician and consultant. In the past, I have held clinical appointments at Boston Medical Center, Beth Israel Deaconess Medical Center and the Massachusetts General Hospital. Later, I was responsible for quality and medical management at Tufts Health Plan. More recently, I have advised many states on health care markets and reform, including numerous Massachusetts state agencies.

Today, I would like to address three major points with you. First, I will demonstrate the huge magnitude of provider price variation in Massachusetts as it compares to other markets around the United States. After all, this is the Commission on Provider Price Variation in Massachusetts, and it seems fitting that you consider these comparative data as part of your deliberations. Frankly, regardless of whether our market has more variation than others, the evidence presented to you has already made it clear that it's a problem here. Yet the data I will share will further demonstrate that Massachusetts not only has a high degree of variation but that it has a higher degree of variation than nearly every other market in the country. Second, I will reiterate what others have shown: that health care costs in Massachusetts indeed are expensive and are expensive despite the fact that Massachusetts is wealthier on average than other states. Further, I will show that due to those high costs, health care spending has been crowding out spending on other priorities, in both our public expenditures and our private household expenditures. Massachusetts, because it is devoting more resources to healthcare is devoting fewer resources elsewhere. My third point is that thus far, the market-based solutions that we have pursued have failed to address health care costs sufficiently and have failed to address provider price variation at all.

**Provider Price Variation.** Let me begin with provider price variation in Massachusetts. Multiple state reports have documented the degree of variation in Massachusetts, which has persisted at about 2.5-3.4 fold, and I would like to discuss six reports that have looked at variation in other states, so that we can compare. First is the work of the Health Policy Commission which compared Massachusetts to Maryland, finding that Massachusetts has greater variation for the large majority of services. Studies in Rhode Island, Vermont and New York all found less variation in hospital prices. In Rhode Island, no more than 2-fold, Vermont 1.8-fold, and New York—across three different markets within that state—ranges from 1.5-2.7-fold. These 4 studies all find lower variation in other states than in Massachusetts.

Looking further, for comparisons across all states, I will turn to two good studies. One is from the BCBSA and the other from researchers at Yale. Each uses multiple years' of data across the entire country, for different procedures. And although each uses different payers' data (Blue Cross payers in one and a number of large national payers in the other), and uses somewhat different definitions for health care markets (one using census areas and the other hospital referral regions), the results could not be more similar or more striking. On average, our market is at the 83<sup>rd</sup> percentile of all markets in its degree of price variation. In fact, looking at how our market stacks up against the 120 markets in the Yale study, our average variation puts us in the top 10 of those 120. Although my

good friends at the hospital association have called this finding “entirely erroneous,” I invite you—and them—to consider these data, with the understanding that wide provider price variation causes higher health care costs, causes volume shifts away from lower-cost hospitals to higher-cost ones, and exacerbates the Reverse Robin Hood effect that we have here—where residents of poorer neighborhoods perversely pay for the higher cost care of residents of wealthy neighborhoods.

As for health care costs, it is gratifying that Massachusetts has fallen from #1 in the country to #3 or #5, depending upon which figures you use. Yet, health care is hardly affordable here. Just last week, the Health Policy Commission showed the impact of high costs on a wide swath of Massachusetts residents, essentially all but the most wealthy. Lauren Taylor and others have shown the crowding out of public expenditures on everything from mental health, education and public safety due to the increase in health spending.

The Commonwealth Fund has shown that health premiums as a percentage of income have risen steadily from 15 to 19% over the past decade. According to Commerce Department data, this pressure has squeezed out other household expenditures. From 2006 to 2014, as a fraction of household spending, health care costs have grown 11.3%, the largest of any category. At the same time, spending on household furnishings has fallen 19.8%, clothing 12.3%, housing and utilities 6.4%, recreational goods by 5.7%, and non-durable good by 1.8%.

Massachusetts has been a leader in innovative and market-based approaches to health care. After 4 reform laws, 2 dozen state reports and lots of innovation, provider price variation is no better, and health costs continue to consume an increasing share of our public and private spending. Health care is a market like no other—it really is not much of a market at all in some ways. Therefore, let us consider our innovation in context. Thus far, we have failed to substantially change the dynamics in our market. If we wish to continue with market based solutions, some radical redesign is needed. In fact, supplementing market-based solutions with targeted, temporary, regulatory action may be needed.

What could those actions be? As possibilities, please consider expanding the authority of the Performance Improvement Plan (PIP) program, so that the HPC can enforce corrective action. Or adding pricing “guardrails” that payers would follow to drive toward rate convergence. Commercial payments could be capped at some rate, which might be most needed as part of a solution to the surprise billing problems we face. It is my hope that a vigorous framework of market and regulation can get us to where we need to go. Other options such as Maryland-type rate setting could also be effective and perhaps using short term regulatory action could make that unnecessary.

Thank you for your time and consideration, and for the work of the Commission.

# Provider Price Variation and Health Costs in MA—an Analysis of State and National Data

Presentation to Provider Price Variation Commission  
January 17, 2017



Freedman HealthCare on behalf of the Associated Industries of Massachusetts, the Massachusetts Association of Health Plans, the National Federation of Independent Business, and the Retailers Association of Massachusetts



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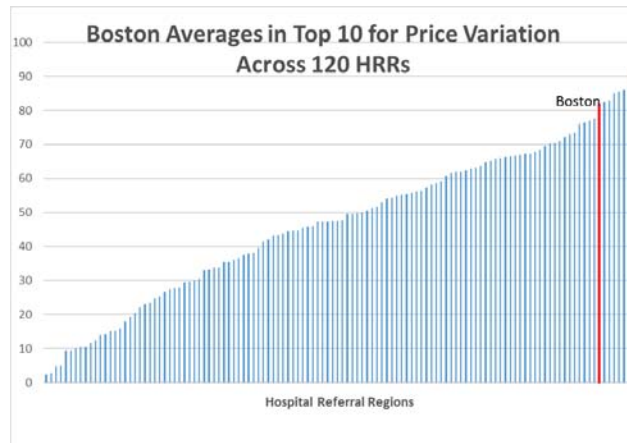
## Contents



- ▣ Background on provider price variation in Massachusetts
- ▣ Regional and national perspectives on health care spending, utilization, and price variation
- ▣ Harmful effects of provider price variation in Massachusetts
- ▣ Existing and potential market-based interventions in Massachusetts
- ▣ Challenges of health care as a market
- ▣ Options for short-term regulatory action

# Executive Summary

- ▶ Provider price variation in MA is more extreme than nearly all other U.S. markets
- ▶ Disparities grow as providers consolidate and volume shifts to higher cost providers
  - This results in higher health care costs and significantly impacts individuals and employers
- ▶ Policy action and short-term intervention would help to address this issue
  - Market-based interventions have not solved this problem to date



Reference: FHC analysis of 2008-2011 data from HCCI, available through the Health Care Pricing Project<sup>15</sup>

Understanding provider price variation in Massachusetts

## OVERVIEW

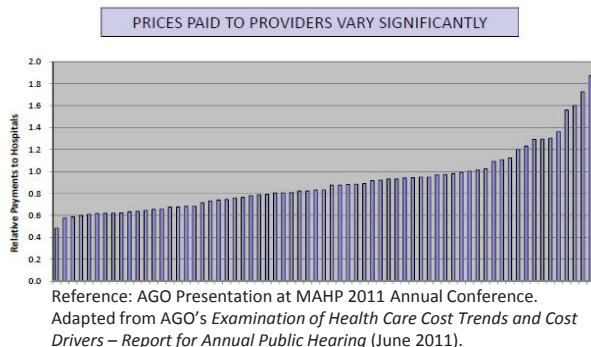
# Understanding Provider Price Variation in MA

- ▶ The MA Attorney General's Office (AGO) first identified provider price variation in the health care market in 2010<sup>1</sup>

- Higher-priced hospitals received payments up to 3 to 4 times higher than those received by lower-priced hospitals in 2008<sup>1</sup>

- ▶ Provider price variation

- Not due to differences in quality<sup>2,3</sup> or patient severity<sup>1</sup>
  - Seen in both fee-for-service and global payment arrangements<sup>2,3</sup>
  - Seen among both hospitals and physician groups<sup>2,4</sup>
  - Driven by market share (both providers' and payers')<sup>4,5</sup>
  - Hospitals persist as higher- or lower-priced year after year<sup>2,3</sup>

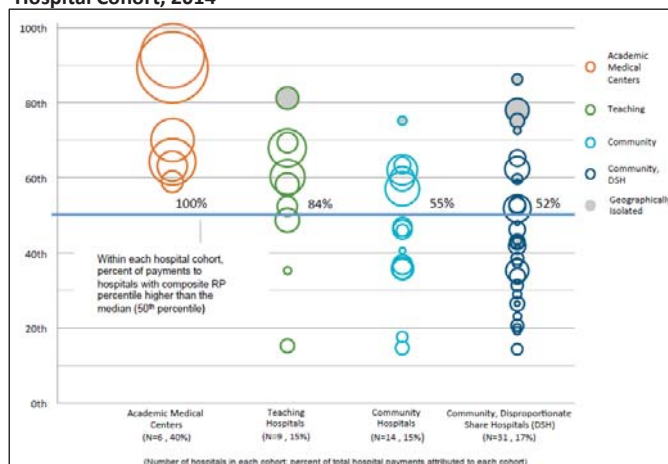


# Understanding Provider Price Variation in MA

Among acute hospitals in 2014<sup>5</sup>:

- ▶ Price variation appears among all hospital cohorts
- ▶ Academic medical centers (AMCs) were consistently priced above the network average
- ▶ AMCs had the largest share of total hospital payments

Acute Hospital Composite Blended Relative Price Percentile, by Hospital Cohort, 2014

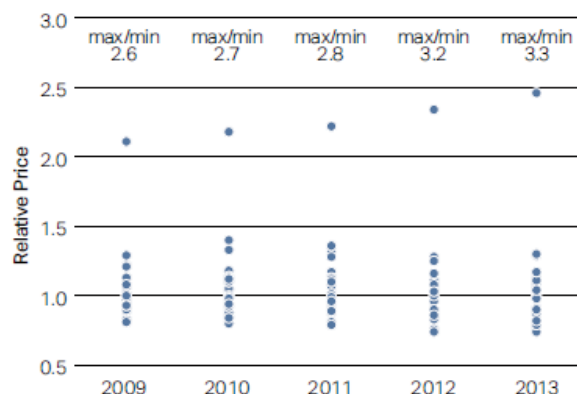


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# Understanding Provider Price Variation in MA

- ▶ Since 2010, price variation has not improved, and evidence suggests that the price gap is growing wider<sup>2,3,6</sup>
  - From 2010-2014, highest-priced hospitals have consistently been 2.5 to 3.4 times more expensive than lowest-priced hospitals<sup>2</sup>
  - Price variation worsened among physician groups from 2009-2013<sup>2</sup>
- ▶ HPC and AGO have called for regulatory action to address price disparities<sup>2,3,6</sup>

Distribution of Physician Group Relative Prices, 2009-2013

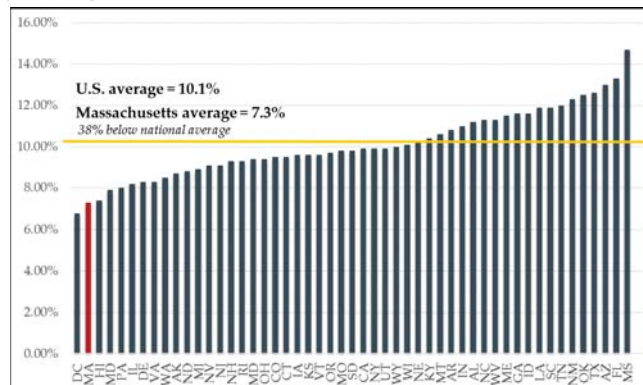


Reference: Health Policy Commission. 2015 Cost Trends Report: Provider Price Variation. Exhibit 9. Available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>. Data Source: CHIA Relative Price Databooks (2012-2015).

# Understanding Provider Price Variation in MA

- ▶ Some argue that Massachusetts' high health care costs are affordable
  - Employee health care costs as a percentage of median household income are the second lowest in the nation<sup>7</sup>
  - Hospital prices, adjusted for wages, are low (bottom 20%)<sup>8</sup>
  - MA ranks highly in terms of overall quality and health system performance<sup>9</sup>
  - High-priced providers, such as AMCs, are driving the local economy through medical research and innovations
  - High commercial payments offset low public reimbursement rates

Average employee health care costs (premium and deductible) as a percentage of median household income, 2015

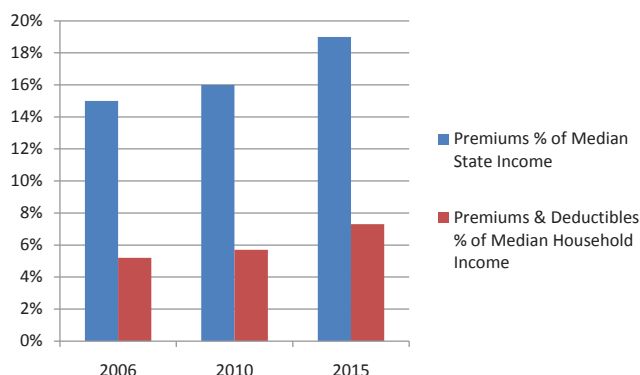


Reference: Meeting materials for Special Commission on Provider Price Variation Market Forces Subcommittee (December 6, 2016). Adapted from: S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel. *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch*. The Commonwealth Fund (October 2016). Available at: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/oct/1910\\_collins\\_slowdown\\_employer\\_ins\\_cost\\_growth\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/oct/1910_collins_slowdown_employer_ins_cost_growth_ib.pdf).

# Understanding Provider Price Variation in MA

- ▶ Yet Massachusetts' high health care costs are harmful to residents and businesses
  - Employee health care costs as a percentage of income keep growing<sup>7</sup>
  - MA employee premiums are 3<sup>rd</sup> most expensive (for both family and individual plans) in U.S.<sup>10</sup>
  - MA businesses competing nationally are disadvantaged by MA's higher premiums
  - MA failed to meet cost benchmark for 2014 & 2015
- ▶ Price level arguments ignore the problems of large, persistent provider price variation

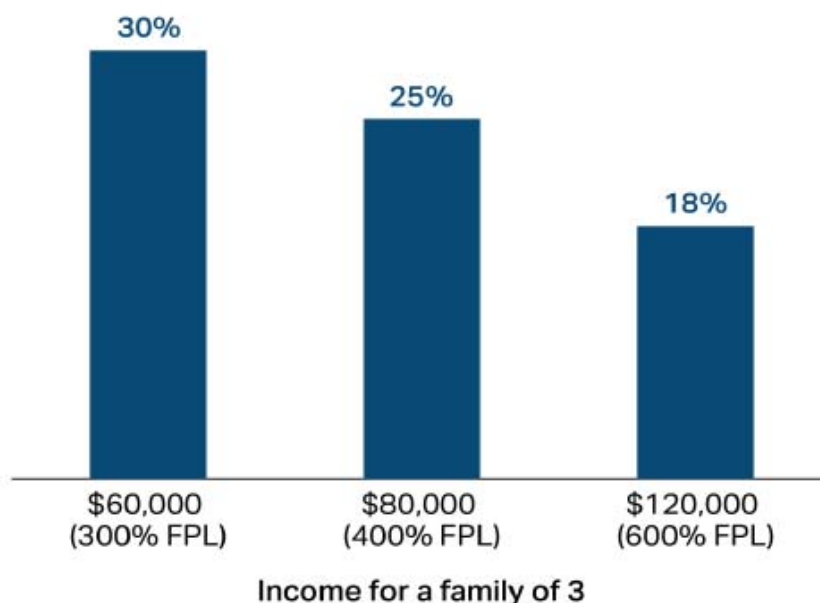
MA employee health costs as a percentage of income keep growing



Reference: Adapted from: S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel. *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch*. The Commonwealth Fund (October 2016). Available at: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/oct/1910\\_collins\\_slowdown\\_employer\\_ins\\_cost\\_growth\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/oct/1910_collins_slowdown_employer_ins_cost_growth_ib.pdf).

## Health care costs have a higher impact on individuals of low to middle incomes

Total healthcare spending relative to income for a family with employer-based coverage, 2015



"What these slides show is that for a significant amount of our population, it is a real problem and we can't mask it over by the fact that some of us earn significantly above the national average and can afford it."

Stuart Altman, Chairman  
Health Policy Commission  
*Commonwealth Magazine*  
January 11, 2017

Reference: Health Policy Commission. "Select Findings: 2016 Cost Trends Report." Presentation for January 11, 2017 HPC Board Meeting. Data sources: Agency for Healthcare Research and Quality, 2015 Medical Expenditure Panel Survey (MEPS); 2015 Executive Office of Labor and Workforce Development, Massachusetts Workforce and Labor Area Review. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170111-commission-document-ctr-presentation.pdf>.

Comparing Massachusetts to other health care markets

## PROVIDER PRICE VARIATION: WORSE IN MASSACHUSETTS THAN ELSEWHERE

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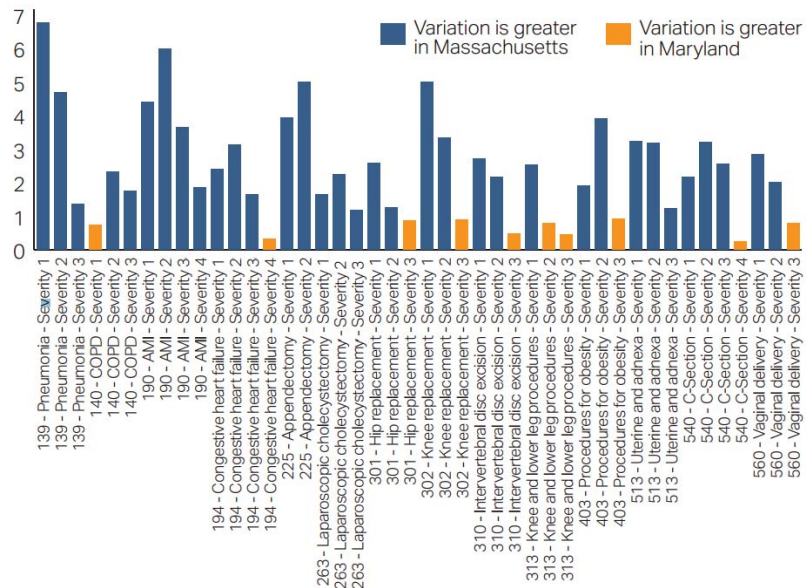
### High Provider Price Variation in MA

- ▶ The highest-priced hospitals in MA have been **2.5-3.4x** more expensive than the lowest-priced hospitals from 2010-2014<sup>2</sup>
- ▶ This price variation is wider than that in neighboring states
  - New York: Commercial prices were 1.5-2.7x higher in some hospitals than in others within the same region (CY 2014 data)<sup>11</sup>
  - Rhode Island: Commercial payments to hospitals are up to 2x more in some hospitals than in others (CY 2010 data)<sup>12</sup>
  - Vermont: Commercial price for most expensive hospital was 1.8x higher than for least expensive hospital (CY 2012 data)<sup>13</sup>



# High Provider Price Variation in MA

- For 77% of services, Massachusetts had greater variation in price than Maryland

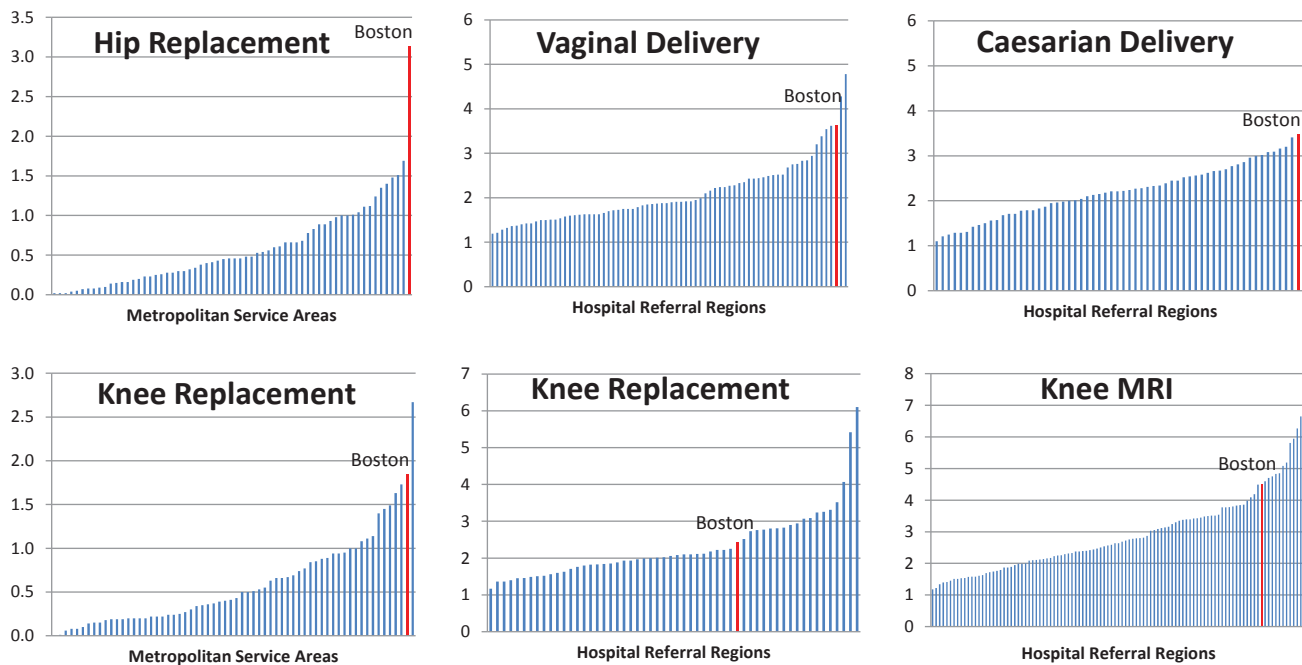


Reference: Health Policy Commission. 2015 Cost Trends Report: Provider Price Variation. Exhibit 12: Ratio of Massachusetts Variation to Maryland Variation. Data sources: DHCFP 2011 Report; Maryland Health Services Cost Review Commission.

# High Provider Price Variation in MA

- MA has more price variation than other US markets
  - BCBS study on hip and knee replacements<sup>14</sup>
    - Among 64 Metropolitan Service Areas (MSAs), examined 2010-2013 payments by BCBSA plans for hip and knee replacement procedures.
  - Yale study on various common procedures<sup>15</sup>
    - Compared between 56 and 105 Hospital Referral Regions (HRRs), examining 2008-2011 payments by Health Care Cost Institute payers for caesarean and vaginal deliveries, lower limb MRI, colonoscopy, and knee replacement.

# Extreme Variation – Boston Averages the 83<sup>rd</sup> Percentile Nationwide



Hip & knee replacement by MSA. Adapted from Blue Cross Blue Shield (January 2015) study using 2010-2013 data from Blue Health Intelligence.<sup>14</sup>

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Vaginal & caesarian deliveries, knee replacement, knee MRI & colonoscopy (not shown) by HRR. Adapted from Health Care Pricing Project using 2008-2011 data from HCCI.<sup>15</sup>

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## High Provider Price Variation in MA

- ▣ In addition to high health care costs, provider price variation in MA is more extreme than nearly all other markets across the US
- ▣ Disparities grow as providers consolidate and volume shifts to higher cost providers

Comparing Massachusetts to other health care markets

# HEALTH CARE SPENDING: REGIONAL AND NATIONAL PERSPECTIVES

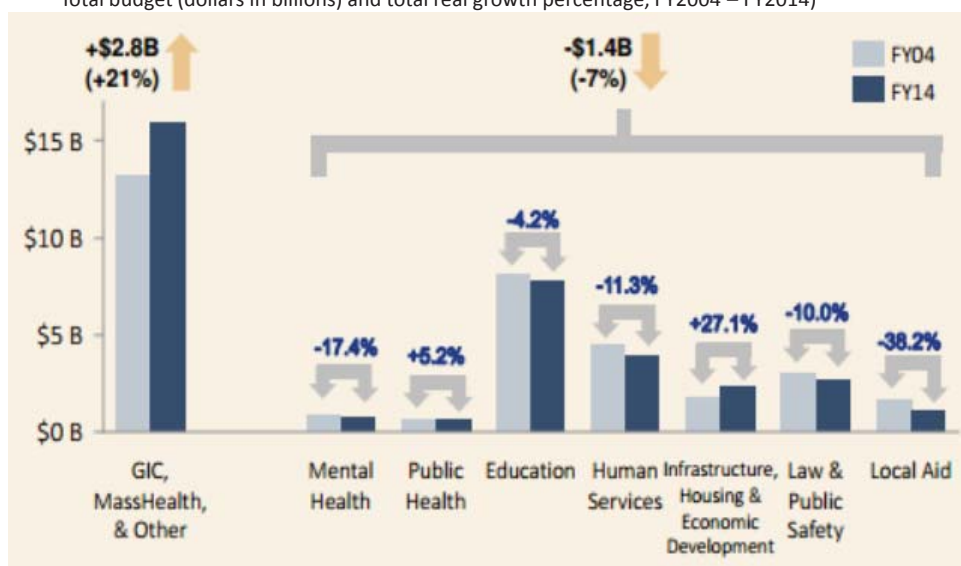
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## Health Care Spending in MA is High

### Health care costs crowd out other priorities

State Budgets for Health Care Coverage and Other Priorities, FY2004-FY2014<sup>16</sup>  
Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014)



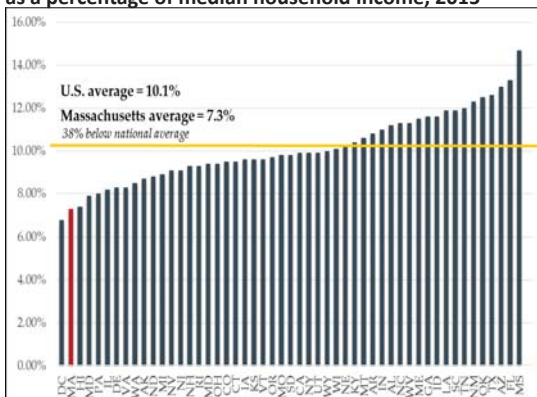
Reference: L.A. Taylor. "Social Determinants of Health: Opportunities and Challenges." Presentation to MA Annual Cost Trends Hearing, October 18, 2016. Data source: Massachusetts Budget and Policy Center. Note: Figures adjusted for GDP growth.

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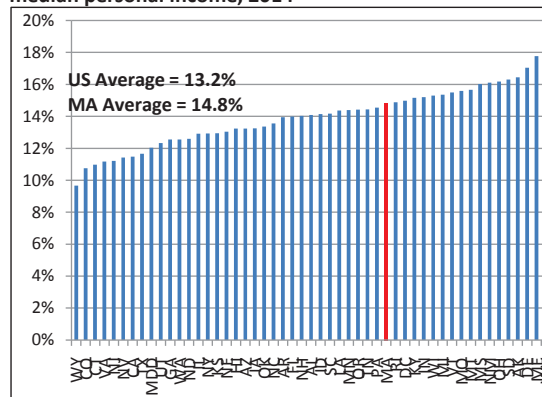
# Health Care Spending

Average employee health care costs (premium and deductible) as a percentage of median household income, 2015



Data source: Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey – Insurance Component, 2015. Health care costs include premiums and deductibles. Reference: Meeting materials for Special Commission on Provider Price Variation Market Forces Subcommittee (December 6, 2016). Adapted from The Commonwealth Fund (October 2016).<sup>7</sup>

Personal Health Care Expenditures as a percentage of median personal income, 2014



Data source: FHC analysis of Per capita personal consumption expenditures by state for selected categories, 2014. Bureau of Economic Analysis, US Department of Commerce.<sup>17</sup> Personal health care expenditures include spending on outpatient services and hospital and nursing home services. Outpatient services consist of physician services, dental services, and paramedical services. Adjusted for 2014 median personal income using data from the Bureau of Economic Analysis, US Department of Commerce.<sup>18</sup>

- Adjusted spending in MA is relatively lower than gross spending, though it appears above US average
- Rising health care costs force crowding out of household and government spending

# Health Care Spending

- MA is a wealthy state, and its income-adjusted spending is comparatively lower across many spending categories – not just health. Yet personal spending on health is among the highest in MA

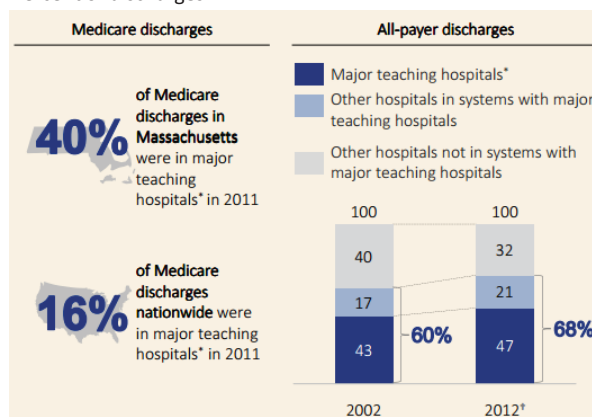
Public Expenses*	MA Rank	Private Expenses*	MA Rank
Public health	50	Motor vehicles	46
Transportation	50	Durable household equipment	44
Government administration	46	Gasoline & energy	44
Education	44	Groceries	40
Public safety	40	Restaurants	28
Social service & income maintenance	33	Housing & utilities	23
Environment & housing	27	<b>Health care</b>	<b>18</b>
Utilities	21	Recreation services	18
Interest on debt	11	Transportation services	15
Total Expenditures	36	Total Personal Consumption	29

\*MA ranked out of 50 states plus District of Columbia. Adjusted for per capita income. Data sources: FHC analysis of 2014 public expenditures data from the US Census Bureau,<sup>19</sup> adjusted for population and median income using data from the Bureau of Economic Analysis.<sup>18</sup> FHC analysis of 2014 per capita personal consumption expenditures data from the Bureau of Economic Analysis,<sup>17</sup> adjusted for median income using data from the Bureau of Economic Analysis.<sup>18</sup>

# Health Care Utilization

- ▶ MA AMCs have higher prices, higher payments, and higher volume than other hospitals.<sup>5,20,21,22</sup>
- ▶ MA residents use AMCs more than the national average
  - MA major teaching hospitals (including AMCs) represented 40% of Medicare discharges, compared to national average of 16%<sup>23</sup>
  - In just 2 years, MA's 5 largest health systems (3 of which have AMCs) increased commercial inpatient share from 51% to 56%<sup>24</sup>
- ▶ MA has 4x more major teaching hospitals than average
  - In 2011, major teaching hospitals (including AMCs) represented 23% of acute hospitals in MA, compared to 5% of acute hospitals nationwide<sup>23</sup>

Discharges in Massachusetts hospital systems, 2002-2012  
Percent of discharges



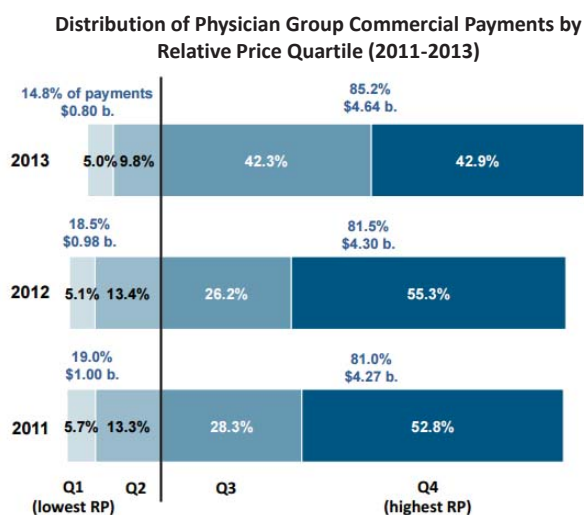
Reference: Health Policy Commission, 2013 Cost Trends Report. Figure 1.7. Available at: <http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf>. Data source: CHIA; Medicare Payment Advisory Commission; HPC analysis. Major teaching hospitals are defined as those with at least 25 residents per 100 beds.

## HARMFUL EFFECTS OF PROVIDER PRICE VARIATION IN MASSACHUSETTS

## Harmful Effects of Provider Price Variation in MA

### ▣ Volume shifts to higher-priced providers

- Higher-priced hospitals have high and growing shares of inpatient stays, outpatient visits, and revenue<sup>2</sup>
- In 2014, 80.3% of commercial payments for acute hospitals went to higher-priced hospitals<sup>5</sup>
- Higher-priced AMC's consistently hold the major share of total hospital payments (2010-2014)<sup>4,5,21</sup>
- From 2011-2013, more than 80% of total physician group payments went to physician groups above the average relative price<sup>5</sup>
- Since 2009, three acute hospitals have closed or converted to other health care uses due to financial strain<sup>25,26,27,28</sup>



Reference: CHIA. Annual Report Series. Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market (February 2016). Available at: <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>.

## Harmful Effects of Provider Price Variation in MA

- ▣ Price variation has contributed to increased health care spending<sup>2</sup>
- ▣ The recent proposed expansion of a major AMC (one of the highest-priced hospitals in the state) is likely to result in increased health care spending, due to predicted shifts in utilization away from lower-priced facilities and reduced market competition, according to the HPC<sup>29</sup>
- ▣ Low-income neighborhoods pay for people's health care in high-income neighborhoods<sup>30</sup>
- ▣ Premiums are not adjusted to reflect whether a consumer chooses between high- or low-priced providers – which may reduce consumers' incentives to make value-based health care decisions<sup>30</sup>
- ▣ Price variation has persisted despite years of reform efforts
- ▣ If current conditions remain as they are, provider price variation will most likely continue in the future<sup>2,3,6</sup>

# Payment Disparities Expected to Persist

Effect of Increased Pharmacy Trend and Illustrative Provider Contractual Increases on "Allowed"  
Commercial Unit Price Trend for All Other Providers and Services under State Cost Growth  
Benchmark

Unit Price Increase Negotiated for Providers Comprising One Third of Non- Pharmacy TME		Unit Price Increase Remaining Under Benchmark for All Other Non-Pharmacy Providers and Services	
1.0%		0.7%	
2.0%		0.2%	
3.0%		-0.3%	

	Estimated % Commercial TME in 2014	Estimated Commercial Expenses in 2014	Total Assumptions for 2015		Benchmarked Commercial Expenses in 2015
			Utilization	Unit Price	
Prescription Drug Expenses	16.7%	\$3.2 billion	12.5%		\$3.6 billion
All Other Expenses	83.3%	\$15.8 billion	1.0%	0.8%	\$16.1 billion
Total Medical Expenses	100.0%	\$18.9 billion	3.6% Benchmark		\$19.6 billion

Source: MA AGO, Examination of Health Care Cost Trends and Cost Drivers, September 2015.

"In its current form the benchmark is being used as a tool to further entrench the current healthcare pricing disparities."

Tufts Medical Center  
pre-filed testimony for  
HPC's 2016 Cost Trends  
Hearing<sup>31</sup>

# Payment Disparities Expected to Persist

- ▶ The cost growth benchmark may inadvertently widen the provider price gap
  - In order to maintain moderate price increases for higher-priced providers and still meet the benchmark, commercial payers must reduce their reimbursement rates to already low-priced providers.
- ▶ Updated for 2016's projected national pharmacy growth of 6.7%,<sup>32</sup> the effect is smaller than in 2015, but still the same: the gap between the higher- and lower-paid providers will worsen
- ▶ If higher-paid providers representing one-third of the market get price increases of as little as 2%, then lower-priced providers must fall further behind



# Overall, Hospitals are Faring Better Financially than Health Plans

- On the whole, MA hospitals were profitable in 2015, with 80% reporting positive total margins<sup>33</sup>

- Statewide median total margin across 65 hospitals in 2015 was 3.7%
- Five out of six AMCs had positive margins
- DSH hospitals had the highest median margins of any hospital cohort in 2015

**Financial Performance of Acute Hospitals: Median Total Margin Trend by Cohort, FY2013 – FY2015**

	FY13	FY14	FY15
<b>Statewide Median</b>	<b>4.1%</b>	<b>4.2%</b>	<b>3.7%</b>
AMC	4.6%	4.7%	2.4%
Teaching	7.6%	8.2%	4.2%
Community	3.6%	2.9%	3.0%
Community-DSH	3.7%	5.3%	5.4%

Reference: Adapted from Center for Health Information and Analysis. *Massachusetts Acute Hospital Financial Performance, Fiscal Year 2015* (August 2016). Available at: <http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/HFY15-Acute-Financial-Report.pdf>.

- Conversely, many MA health plans are struggling financially

- Median total margin across 10 health plans in 2015 was -0.05%, down from 0.67% in 2013

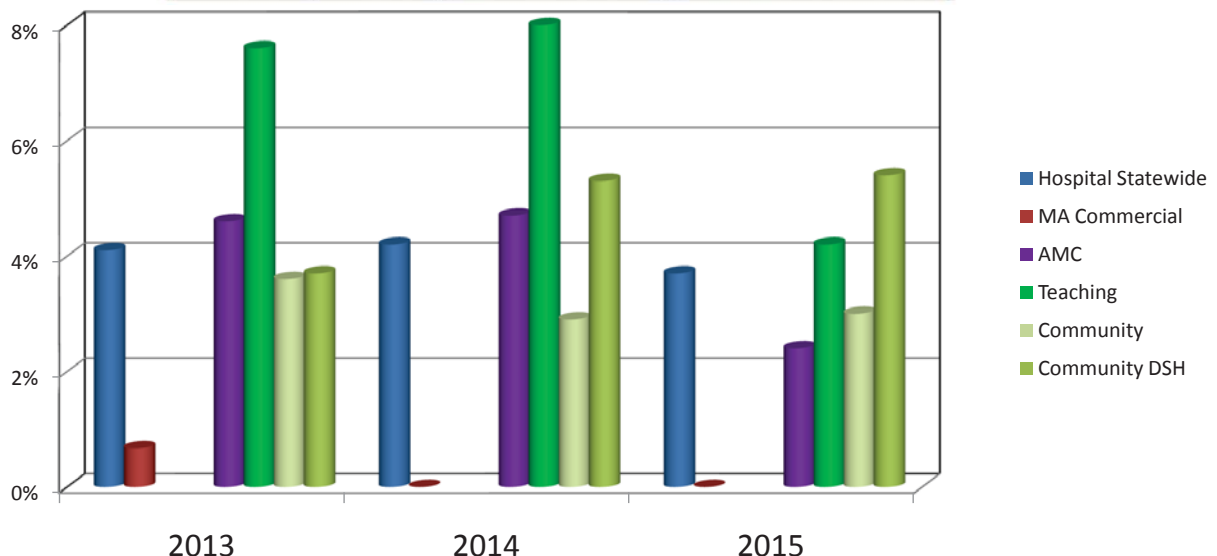
**Financial Performance of MA Commercial Health Plans: Median Total Margin Trend, FY2013 – FY2015**

	FY13	FY14	FY15
<b>Median Total Margin for MA Health Plans</b>	<b>0.67%</b>	<b>-0.11%</b>	<b>-0.05%</b>

Reference: FHC analysis of statements filed with the MA Division of Insurance for MA commercial plans.

# Overall, Hospitals are Faring Better Financially than Health Plans

**Median/Average Total Margins: 2013-2015**



Hospital Reference: Adapted from Center for Health Information and Analysis. *Massachusetts Acute Hospital Financial Performance, Fiscal Year 2015* (August 2016). Available at: <http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/HFY15-Acute-Financial-Report.pdf>.

Health Plan Reference: FHC analysis of statements filed with the MA Division of Insurance for MA commercial plans.



# Summary of Analysis

- ▣ Health care costs continue to exceed state benchmark, and to consume larger shares of public and personal spending
- ▣ Massachusetts has extremely high price variation compared to other states and markets
- ▣ Health care utilization and spending is concentrated among high-priced providers such as AMCs and dominant, high-paid community hospitals
- ▣ Price variation has not improved for hospitals and has worsened for physicians
- ▣ Projected pharmacy spending and moderate price increases for high-priced providers virtually ensures price variation will persist or worsen under the cost growth benchmark

Existing and potential approaches for addressing provider price variation in Massachusetts

## **INTERVENTION OPTIONS TO ADDRESS COSTS AND PRICE VARIATION**

# Interventions Implemented in MA Since the 2000s

## ▶ Demand-side interventions implemented over past decade

- High-deductible health plans
- Tiered networks
- Narrow networks

## ▶ Supply-side interventions

- Accountable Care Organizations (ACOs)
- Alternative payment methodologies (APMs)

APM growth has stalled



Reference: Adapted from Center for Health Information and Analysis. *Performance of the Massachusetts Health Care System: Annual Report* (September 2016). Figure 5. Available at: <http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report.pdf>.

# Ineffectiveness of Market-Based Interventions in MA

- ▶ Four MA health care reform laws between 2006-2012
- ▶ MA recognized as national leader in both supply- and demand-side efforts
- ▶ Supply- and demand-side reforms have not managed to meet the cost benchmark, reduce provider price variation, or support lower-priced providers
- ▶ Residents across income spectrum continue to struggle with health costs<sup>34</sup>

# Why Have Our Market-Based Efforts Failed?

- ▶ Attempted interventions assume that we are in a neo-classical economic market<sup>35</sup>
- ▶ Health care is a market like no other
  - Few services are truly “shoppable”
  - Majority of cost paid for persons who have exceeded their out of pocket maxima
  - Buyers usually have incomplete information to make informed purchasing decisions
  - Decisions about health care are often emotional and often urgent
- ▶ Supplementing market-based solutions with targeted regulatory action may be a needed catalyst for curbing health care costs and disparities

## Potential Regulatory Solutions

- ▶ Short-term regulatory action could be successful in addressing health care spending in a way that market-based solutions have not
- ▶ Potential solutions include:
  - Expanded Performance Improvement Plan (PIP) authority
  - Pricing “guardrails” to bring rate convergence
  - Capping commercial payments at percentage of Medicare
  - Preventing inflationary behaviors, such as surprise billing by capping rates for out-of-network providers at network facilities
- ▶ These options are moderate alternatives to further regulation such as Maryland-type rate setting

# Conclusion

- ▶ Despite years of effort, 4 reform laws, and more than 20 state reports, we have made limited progress in addressing high health care costs, no improvement of price variation, and have largely failed to remedy the market dynamics observed in Massachusetts
- ▶ We have missed the cost benchmark in 2014 and 2015, and anticipate missing the 2016 benchmark as well
- ▶ Market-driven solutions have limited ability to address prices, price variation and the volume shift to higher priced providers
- ▶ Short-term regulatory solutions would help catalyze improvements

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January 20, 2017

The Honorable Jeffrey Sánchez  
House Chair, Joint Committee on Health Care Financing  
State House, Room 236  
Boston, MA 02133

The Honorable James T. Welch  
Senate Chair, Joint Committee on Health Care Financing  
State House, Room 309  
Boston, MA 02133

### **Re: Special Commission to Review Variation in Prices among Providers**

Dear Representative Sánchez and Senator Welch:

On behalf of Health Care For All (HCFA), thank you for the opportunity to submit testimony on the on the issue of provider price variation in Massachusetts. HCFA works in support of policies that advance a patient-centered health care system that is affordable, accessible, and high quality, and we are particularly concerned about the most vulnerable residents of Massachusetts.

Health care costs are one of the most significant issues facing Massachusetts residents, and the wide variation in hospital prices is a major driver of health cost growth in the Commonwealth. The Center for Health Information and Analysis (CHIA) has been documenting this problem for years. Their latest chart book, which came out in February 2016, demonstrates a wide variation in prices, with a majority of payments going to the most expensive quartile of acute hospitals.<sup>1</sup> Reports of the Office of the Attorney General have also documented provider price variation in MA over time,<sup>2</sup> and the Health Policy Commission (HPC) conducted a rigorous analysis of the issue in a report issued in 2015.<sup>3</sup>

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<sup>1</sup> Relative Price: Provider Price Variation in the MA Commercial Market, Center for Health Information and Analysis (February 2016), available at: <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>

<sup>2</sup> Examination of Health Care Cost Trends Cost Drivers, Office of the Attorney General (September 2015), available at: <http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf>

<sup>3</sup> 2015 Cost Trends Report: Provider Price Variation, Health Policy Commission, available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>

These reports confirm a number of troubling trends. First, as previously stated, rising provider prices are one of the main drivers of the growth in health care spending in Massachusetts. Second, among hospitals, prices vary dramatically between higher-priced and lower-cost institutions. According to the CHIA data, on average, looking at all their payers on an apples-to-apples basis, our most expensive hospitals have prices two to four times higher than the least-expensive hospitals. Furthermore, the wide variation in hospital prices has not been improving over the past few years. Third, this variation in price is harmful to our health care system. The higher-priced hospitals do not produce better quality care or better health outcomes. Higher prices are not associated with higher value, but with more market leverage. This is despite the fact most consumers are more likely to equate high cost with high quality. As a result, more and more patients are going to the higher-priced hospitals, leading to increasing costs for health care overall. The conclusions of multiple reports over a number of years from the Attorney General, CHIA, the HPC and others, are clear: state action is needed to address the issue of unwarranted price variation.

We represent patients and consumers who are paying the price for high-cost health care. As costs continue to rise, it is increasingly difficult for many consumers to not only afford the health care services they need, but to navigate and understand why price varies so widely among hospitals and providers. These high costs are reflected in increased premiums, and in higher deductibles and other cost sharing. Division of Insurance rate filings show that for individuals and small business, rates are going up by double digit percentages for some insurers.<sup>4</sup>

Increasing co-pays and deductibles have become an obstacle to good health care in MA. According to the most recent CHIA Annual Report on the Performance of the Massachusetts Health Care System, Massachusetts continues to see increased enrollment in high deductible health plans – which are now 19% of the commercial market – and increased consumer cost-sharing, which rose by 4.4% from 2014-15, while benefit levels remained constant. The 2015 Massachusetts Health Reform Survey (MHRS) found that nearly one in five fully-year insured adults reported problems paying family medical bills in the past year, and more than one in five reported having medical bills they are paying off over time (i.e., medical debt). More than 43% of insured adults reported that health care costs had caused problems for them and their families over the last year and 19.3% reported that they went without needed care because of health care costs.

People who have low incomes and those who are in poor health or have chronic conditions needing regular care or medication experience even greater difficulties with the high cost of health care. Studies show that for vulnerable populations, increased cost-sharing is associated with adverse health outcomes.<sup>5</sup> Recent HPC findings confirm that MA residents with low to middle incomes face a higher

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<sup>4</sup> “Health insurance rates rising faster for small businesses.” *The Boston Globe* (August 17, 2016), available at: <https://www.bostonglobe.com/business/2016/08/17/mass-small-business-health-insurance-rates-rising-average-percent/sHRgbzo98ztwhkA81y8IdM/story.html>; “Premiums soar 21 percent for popular health plan.” *The Boston Globe* (September 9, 2016), available at: <https://www.bostonglobe.com/metro/2016/09/08/premiums-soar-for-popular-health-plan/xAcJy1ye9lcLGGJznLLZKP/story.html>

<sup>5</sup> Swartz, K. Cost-Sharing: Effects on Spending and Outcomes, Robert Wood Johnson Foundation (December 2010), available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2010/rwjf402103/subassets/rwjf402103\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1)



burden of health care costs relative to income.<sup>6</sup> The 2016 AGO Examination of Health Care Cost Trends and Cost Drivers found that in the Massachusetts commercial insurance market, health care spending relative to health burden continues to be higher for patients from higher income communities than for patients from lower income communities.<sup>7</sup> In other words, while members in lower income communities are less healthy than members in higher income communities, we are spending less health care dollars on those members with the highest health needs.

HCFA strongly agrees that provider price variation among hospitals should be examined and addressed, and we would strongly encourage the Committee to do so in a way that moves our health care system toward rewarding high quality care first and foremost. This testimony will focus on a number of issues that have come before the Special Commission that directly impact consumers, including “demand side incentives” such as price and quality transparency, tiered network and high deductible health plans; value-based insurance design; and the issue of surprise out-of-network billing.

### **Price and quality transparency**

Transparency around health care cost and quality is critically important to the state’s efforts to reduce the growth in health care costs, yet effectively implementing this “demand side incentive” also presents a number of challenges and limitations.

First and foremost, consumers often equate cost with quality, and in the absence of other usable signals of quality, consumers will rely on cost as a proxy. For example, in focus groups commissioned by the HPC as part of the *Community Hospitals at a Crossroads* report,<sup>8</sup> patients indicated that they generally did not perceive that community hospitals provide high-quality care, and that Boston academic medical centers (AMCs) and teaching hospitals provide better quality of care. Few patients were familiar with validated clinical quality scores, and quality performance information was not a significant factor in directing where patients choose to go to for care. In fact, patients valued the experience of peers over quality measures when choosing where to access care.

In addition, the focus groups showed that consumers feel they have little choice in where to get hospital care. Many patients indicated that provider referrals dictated what hospitals they used. Furthermore, only a small percentage of health care is shoppable, since patients generally only choose the location for non-emergency care that can be scheduled in advance.

While solutions for increased transparency are difficult, we offer the following six core principles to make cost and quality data most relevant for consumers:

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<sup>6</sup> Health Policy Commission Board Meeting Presentation, Slide 25 (January 11, 2017), available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170111-commission-document-presentation.pdf>

<sup>7</sup> Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General (October 2016), available at: <http://www.mass.gov/ago/docs/healthcare/cc-market-101316.pdf>

<sup>8</sup> Community Hospitals at a Crossroads, Health Policy Commission (March 2016), available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>

1. *Data must be meaningful for patients:* Consumers need to have easy-to-interpret quality information alongside cost information, and highlighting high-value options. Quality data must go beyond the basic process measures, and include a mix of patient experience, access, and outcomes measures.
2. *Data must be accessible:* Consumers need to be aware that the information exists and should be able to access data when they need it. This means having displays of information available in a number of ways and formats, expanding or contracting to fit the differing needs of consumers.
3. *Data must be understandable:* Information presented should be easy to read, use, and navigate. This is especially important for populations that have difficulty in using basic health information, including those with low health literacy skills, limited numeracy skills, and Limited English Proficiency. Simplifying information for consumers through appropriate language and reading level empowers all consumers to make cost-effective healthcare choices.
4. *Data must inspire action:* Consumers must be able to translate cost and quality transparency data into health care decisions. This means explicitly showing consumers their options, and supplying decision aids to teach how to navigate through data, and how to use cost and quality information to reach an informed decision about treatment.
5. *Data must be presented with consumers in mind:* Clear and organized data presentation, along with a practical design, will guide consumers through the decision-making process from start to finish. This means making transparency data engaging and easy-to-use, providing consumers information in a “one-stop shop,” and incorporating their feedback on the material to help improve any online tools, setting an expectation of continuous improvement.
6. *Consumers must be made aware of cost and quality, and their importance, through targeted promotion efforts:* Once transparency data is made publicly available, carriers, providers and state agencies should consistently promote the data and tools. Transparency efforts must also strengthen the capacity of providers, staff and insurance company personnel to discuss prices

For the last few years, state agencies have begun to comply with and support transparency initiatives, but the efforts are diffuse, duplicative, lack a unified vision, are of varying quality and do not meet core principles of consumer education. For example, Massachusetts insurers’ cost estimation tools are in need of improvement: in 2015 HCFA’s ”Report Card” gave major insurers a C+ on basic consumer education principles.<sup>9</sup> HCFA’s more recent review of the cost estimation tools show that the tools still vary widely in their use of comparative quality information, the number and type of searchable services, and consumer accessibility.

Massachusetts should also look to other states who are further along in transparency efforts, such as New Hampshire, Maine and California. New Hampshire has a website run by the state insurance department allowing people to compare the cost and quality of specific medical procedures, dental procedures and prescription drugs. The website lets consumers see how much they would have to pay based on the price their insurer negotiated with each provider, and also shows the price uninsured people must pay. The latest version of [NHHealthCost.Org](http://NHHealthCost.Org) features 31 additional medical procedures, including physical therapy, behavioral health and chiropractic care. Cost estimates for 16 dental

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<sup>9</sup> Health Care For All Consumer Cost Transparency Report Card (July 2015), available at: [https://www.hcfama.org/sites/default/files/consumer\\_cost\\_estimation\\_report\\_card.pdf](https://www.hcfama.org/sites/default/files/consumer_cost_estimation_report_card.pdf)

procedures are now available, as well as new information on the retail price of 65 brand-name and generic drugs. Maine allows consumers to compare cost and quality information via a publicly accessible website (<http://www.comparemaine.org/>). California released an expanded version of its quality report cards on 154 large physician groups. The report cards, which already assessed clinical quality and patient experiences, now also summarize the total cost of medical services run up by the average patient of each group.

### **Tiered network plans**

Health insurers using a tiered-network model classify doctors and hospitals based on a combination of cost and quality measures. Patients, in turn, are required to pay higher copays and/or deductibles for utilizing providers in a high-cost tier. In theory, tiered network plans create incentives for health care providers to deliver high quality, cost efficient care, and for consumers to select these high-value providers. However, tiered networks have proven to be opaque and confusing for both patients and providers, making it difficult for patients to make informed choices about where to seek care based on cost and quality data. We have concerns with recent recommendations for “strengthening” tiered networks to increase the difference in consumer cost sharing differentials between tiers until the below concerns have been addressed.

*Tiered network plans, in their present form, are not transparent or consumer-friendly.* Carriers do not use uniform or standardized cost or quality criteria to classify providers into tiers, resulting in inconsistent determinations of a provider’s tier level from one health plan to another. Based on what we hear from consumers, people are often totally unaware of how these tiered plans work, and are frustrated when they discover they owe higher copays for their regular provider. Tiering cannot promote behavioral change if consumers do not fully understand how their tiered plans work or lack other basic information, such as which providers are tiered separately and at what level, as well as understanding the tiering levels when there are multiple providers for a single episode of treatment.

*Tiered networks may disrupt continuity of care in existing treatment plans and patient-physician relationships.* When carriers move providers from a lower-cost tier to a higher-cost tier, patients may face a disruption in care if they cannot afford the additional out of pocket expenses to continue seeing their usual providers. Patients may also face such disruptions in care if their employer switches to a tiered network plan, forcing them to choose between seeing a longtime provider placed in a higher-cost tier or forming a new relationship with a lower-tier provider. These choices are especially difficult for patients who have long-standing relationships with particular caregivers, such as mental health providers, or those receiving care for serious or chronic conditions.

For example, one consumer who contacted Health Care For All faced a potential disruption in care when her employer switched to a tiered network plan. Under the plan, she had the option of paying a \$25 copay per visit to stay with her current PCP, or traveling 45 minutes to see a new PCP for a copay of \$15 per visit. Since she has a chronic illness, she felt that continuity of care was essential. Between her health condition, the cost (both in time and money) of transportation, and her trust in her longtime PCP of over 10 years, she chose to stay with her current provider. However decision this came at a

significant expense. She paid over \$1,000 more in copays over the course of a year. If her copays increase again, she will be forced to stop seeing her longtime physician.

*Tiered network plans do not take into other limitations on provider choice.* As mentioned previously, factors other than cost can be fundamental to a consumer's choice of provider. For example, geography and available transportation limit the ability of many consumers to access lower-cost care in tiered plans. Patients who live in communities not conveniently located to low-tiered providers are left with higher copays or an unmanageably long commute to seek care. For individuals in certain regions of the state, such as Cape Cod and the Berkshires, choosing a provider in a low-cost tier may not be an option at all when the only providers in their area are classified as high-tier. As a result, some may forgo needed care altogether. In addition, consumers in need of urgent care are in no position to "shop around" or research which provider is in the tier most appropriate for their health care needs.

*Finally, tiered network plans may discourage coordinated care if providers within the same facility or organization are placed in different level tiers.* Incentives for consumers to choose providers based on quality and efficiency under tiered network plans may conflict with provider incentives under contracts that require them to manage patient care under a global budget. Consumers who would prefer to obtain care in one location or from one organization may be unable to do so where its providers are differentially tiered. Therefore, we recommend that all providers affiliated with an Accountable Care Organization or in a Patient Centered Medical Home should be assigned to the same tier.

Given that continuity of care, quality of care, and accessibility of care may all be threatened under the current framework of tiered network plans, we urge the Special Commission to address these concerns along alongside any recommendation to "strengthen" tiered network products.

### **High deductible plans**

According to CHIA, 52% of individual health insurance purchasers and 43% of those receiving coverage through small employers (50 or fewer employees) were enrolled in a high deductible health plan (HDHP) by 2014.<sup>10</sup> Multiple studies show that high deductibles don't make patients into better shoppers for their care. Instead, higher deductibles mean that patients forgo needed care. Preventive care is reduced and the sickest people are those who are most likely to reduce their use of care while still under the deductible, even though this is the group that needs the most care.

Increased cost-sharing has the potential to slow the growth of health spending *only if*: (1) there is a reduction in use of low-value or medically unnecessary care; (2) any utilization reduction is not offset by the use of more expensive services; *and* (3) reductions in service use do not result in adverse outcomes that may be more expensive to treat. However, patients are often not able to discern between appropriate and inappropriate care in response to increased cost-sharing. Studies of patients with high deductibles show that patients reduce use of both high-value and low-value care. Furthermore, for

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<sup>10</sup> Annual Report, Massachusetts High Deductible Health Plan Membership, Center for Health Information and Analysis (November 12, 2015), available at: <http://www.chiamass.gov/assets/docs/r/pubs/15/High-Deductible-Health-Plans-Brief.pdf>

vulnerable populations, increased cost-sharing is more likely to reduce use of high-value care, resulting in adverse health outcomes.<sup>11</sup> We therefore urge the Special Commission against recommending HDHPs as an effective demand side incentive until we have more information on how these plans are impacting consumer cost-sharing and utilization for Massachusetts consumers.

### **Value-based insurance design**

One strategy proven effective at addressing rising out-of-pocket costs for consumers is called “value-based insurance design” (VBID), which aligns patients’ out-of-pocket costs with the value of health services. As out-of-pocket costs rise, patients may be less likely to access care or follow prescribed treatments and medications, especially patients with low incomes or chronic conditions who need multiple medications and services. When patients delay or forgo obtaining necessary health care, this can in turn lead to more intensive and expensive care. As cited above, a review of the literature documents that increased cost-sharing increases the underuse of needed treatments and medications, particularly for individuals with chronic conditions.

Cost-effective treatments, however, help avoid the need for expensive acute care. Research shows that certain medications and services for chronic conditions such as hypertension, high cholesterol, diabetes, asthma, depression, and HIV/AIDS are considered “high value,” because they provide large health benefits with comparatively low costs. The health system should therefore encourage patients to use these treatments, instead of imposing high co-pays and deductibles that discourage their use.

Removing barriers to essential, high-value health services through VBID results in significant increases in patient compliance with recommended treatments, while also being cost-neutral, and even potentially cost-saving in the long term. The Health Connector has introduced some VBID elements in their 2017 requirements for Qualified Health Plans, directing insurers to eliminate all out-of-pocket costs for medication-assisted addiction treatment, including drugs such as methadone or Suboxone, along with counseling. HCFA has proposed comprehensive legislation using the VBID framework to eliminate co-pays, deductibles, and co-insurance for high value cost-effective prescription medications and treatments in order to increase adherence and help patients avoid further complications and hospitalizations. We encourage the Special Commission to highlight VBID as a strategy to encourage choice of high value care.

### **Out-of-network surprise billing**

Out-of-network billing occurs when patients receive out-of-network care that they did not or could not intentionally choose to receive, and are subsequently faced with unaffordable medical bills. This predominantly occurs in two key scenarios: 1) the patient receives emergency care at an out-of-network facility but because of the circumstances, the patient was not able to choose care at an in-network facility; or 2) the patient seeks care at an in-network facility, but during the course of treatment the patient is unexpectedly treated by an out-of-network provider. HCFA has heard from patients, for

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<sup>11</sup> Swartz, K. Cost-Sharing: Effects on Spending and Outcomes, Robert Wood Johnson Foundation (December 2010), available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2010/rwjf402103/subassets/rwjf402103\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1)

example, who go to a hospital that is in their network, choose a surgeon that is in their network, and then find out after the fact that the anesthesiologist was out of their network.

These scenarios can result in balance billing, where the patient is billed for the difference between the out-of-network provider's charge for services and the insurer's in-network payment rate to the provider. They can also result in surprise bills, where a patient receives an unexpected bill from an out-of-network provider after seeking and receiving care at an in-network facility. In the latter case, the consumer may not know that she received care from an out-of-network provider until she receives a surprise bill for the services. As cited at a recent HPC Board meeting, a 2016 study showed that of emergency department visits at in-network hospitals in Massachusetts, 22% involved out-of-network physicians.<sup>12</sup> In these cases, out-of-network emergency physicians charged an average of 798% of Medicare rates, and these costs are borne by both patients and insurers.

We recommend that the Special Commission consider recommending real protections to consumers in these cases of surprise billing, and propose the following in order to enhance out-of-network billing protections in Massachusetts. These protections can draw on New York<sup>13</sup> and Connecticut<sup>14</sup> laws, which implement consumer-friendly safeguards that would be effective in Massachusetts.

First, providers should be required to furnish accurate, up-to-date information to consumers with respect to whether they are in or out-of-network. For example, in New York hospitals are required to post on their website the insurance plans in which they are a participating provider, the contact information of physicians groups the hospital has contracted with to provide services (including anesthesiology, pathology, or radiology) and instructions how to contact the groups to determine which plans those physicians participate in, and information about physicians employed by the hospital and the plans in which they participate. In Connecticut, providers must determine whether a patient is insured prior to any scheduled admission, procedure, or service for nonemergency care. If the patient is uninsured or the provider is out-of-network, the provider must provide written notification to the patient about the charges for the upcoming treatment, the fact that the patient may be charged and is responsible for unforeseen service that may arise out of the proposed care, and that any out-of-network rates under the patient's health plan may apply.

Second, insurers should be required to keep provider directories and online tools updated and accurate, subject to auditing and ramifications for non-compliance. Accurate and comprehensive provider directories are necessary because health plan enrollees need accurate information about which providers and facilities they can use in-network. In New York, insurers must provide examples of out-of-pocket costs for frequently billed out-of-network services, written information (including on the insurer's

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<sup>12</sup> Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise*, New England Journal of Medicine 375, 1915-18 (2016).

<sup>13</sup> 23 NYCRR 400; *see also* New York Department of Financial Services, Protection from Surprise Bills and Emergency Services, available at <http://www.dfs.ny.gov/consumer/hprotection.htm>

<sup>14</sup> An Act Concerning Hospitals, Insurers and Health Care Consumers, Pub. Act No. 15-146 (Reg. Sess.), available at <https://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf> (to be codified at Conn. Gen. Stat. §§ 19a-904a, 38a-477e, 38a-477aa, 38a-591b, 20-7f, and 38a-193, respectively).



website) that reasonably permits a patient to estimate anticipated out-of-pocket costs for out-of-network services, and upon request, insurers must disclose the approximate dollar amount that the insurer will pay for a specific out-of-network service (though the approximation is not binding). In Connecticut, insurers must also maintain a website and toll-free phone number that enables consumers to request and obtain information on network status, including information on out-of-network costs for inpatient admissions, health care procedures and services.

Third, providers should be prohibited from balance billing consumers, and insurers should be required to hold members harmless, in emergency situations and in other situations where a consumer unknowingly sought care from an out-of-network provider. In these situations, consumers would still be responsible for their usual in-network cost-sharing. In New York, balance billing by out-of-network providers for emergency care is prohibited. Surprise billing for non-emergency out-of-network services is also prohibited if the patient assigns the provider's claim to the insurer. New York utilizes a "Member Assignment of Benefits Form," which clearly informs the consumer what constitutes a surprise bill and explains the consumer's ability under the law to assign these rights to their insurer so that the provider cannot seek payment from the consumer beyond any cost-sharing which would have been owed had the provider been in-network.

Fourth, the protections should include a well-defined process for determining payment of surprise out-of-network bills or setting a standardized level at which out-of-network providers are paid. Under New York law, insurers must pay providers at a reasonable payment amount. The methodology for determining reasonable payment amounts must be disclosed, including how the calculation compares to the usual and customary rates, which are defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area. Under Connecticut law, insurers must reimburse out-of-network providers the greater of the following: (1) the amount the plan would pay for emergency services if rendered by an in-network provider; (2) the usual, customary, and reasonable rate; or (3) the amount Medicare would reimburse for such services.

Finally, another option to consider is including an arbitration process between providers and insurers, which would shield patients from becoming involved in payment negotiations and provide additional financial protection. Under New York law, if a provider is not satisfied with the amount paid, the provider may pursue an Independent Dispute Resolution (IDR) process, which includes a binding arbitration utilizing a reviewing physician in active practice in the same or similar specialty as the doctor providing the service and a reviewer with training and experience in billing, reimbursement and usual and customary charges. Reviewers can choose either the provider's original billed charge or the plan's original payment – as opposed to any amount in the middle. In making a decision, the IDR must consider the patient's characteristics, the doctor's training and experience, and the usual and customary rate.

These provisions, as a whole, directly address the problems that consumers face and represent a balanced compromise between the competing concerns of providers, insurers and consumers.

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We urge the Special Commission to take into account these issues and the direct impact on cost for consumers as it formulates recommendations to address the problem of unwarranted provider price variation in the Commonwealth. Please don't hesitate to contact us with any questions at [avangeli@hcfama.org](mailto:avangeli@hcfama.org) or 617-275-2922.

Sincerely,

A handwritten signature in black ink, appearing to read "Alyssa Vangeli".

Alyssa R. Vangeli, Esq., MPH  
Associate Director, Policy and Government Relations  
Health Care For All

cc: Members, Special Commission to Review Variation in Prices among Providers

Submission of the Massachusetts Society of Pathologists  
To the Massachusetts Special Commission on Provider Price Variation  
January 19, 2017

The Massachusetts Society of Pathologists (MSP) welcomes the opportunity to comment on the issue of out-of-network balance billing. The nature and extent of the problem of out-of-network balance billing has not been established in Massachusetts. It should be noted that the national Blue Cross/ Blue Shield Executive Director recently stated (October 13, 2016) at a Brookings forum on this issue that “there is a dearth of evidence” and “the problem at least as I see from the evidence cited to date has yet be explicated very rigorously or comprehensively.” This is one area where we concur with Blue Cross/Blue Shield in that more information and analysis is needed to determine both the scope of the problem and appropriate solutions. Consequently, we respectfully suggest that the Commission’s recommendations not address the issue, and, instead, we ask that the matter be referred to the legislature’s Joint Committee on Health Care Financing, which will have at least one bill on this topic in the 2017-2018 session.

Intuitively, we know there is a fundamental correlation between out of network balance billing and health plan network adequacy. When regulators approve health plans that do not have hospital based physicians under contract, patients of these facilities are likely to have out of network charges. It is logical that enrollees with health insurance plans providing robust network adequacy, including hospital based physicians, have fewer bills for out of network services. Thus, the problem of out of network billing will only be exacerbated by the failure of regulators and health plans to ensure physician networks at in-network hospitals and facilities. Another factor exacerbating patient reliance on out-of-network (OON) physicians at in-network facilities is the deliberate narrowing of insurance networks by health plan payers.

“Second, under existing market forces, provider networks are becoming narrower, creating more situations where patients encounter a mix of network and non-network providers. This is particularly the case in the non-group (individual) market, where narrow networks are especially pronounced as a result of competition on premiums for cost-conscious consumers (Cousart 2016; Bauman 2015; Polsky 2015), though network narrowing is also seen to some extent in the group market (Kaiser Family Foundation 2015).”<sup>1</sup>

Current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: “Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties, (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.”

Accordingly, health insurance plans should be scrutinized by state insurance regulators, prior to approval, to ensure that such plans are capable of providing their enrollees with

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<sup>1</sup> [“Solving Surprise Medical Bills,”](#) Center for Health Policy at Brookings, A Brookings Institution-USC Schaffer Center Partnership, Mark Hall, Paul Ginsberg, Steven Lieberman, Loren Adler, Caitlin, Caitlin Brandt, Margaret Darling, October 2016

reasonable and timely access to in-network physician specialties at in-network hospitals and facilities.

When health plan enrollees purchase health insurance products that list in-network hospitals and facilities, but such plans have failed to contract with certain essential hospital based physician specialties at these locations, the health plan has deceived the enrollee into purchasing an insurance product that is fundamentally deficient. Such deceptive trade practices should be subject to state sanction.

Of related concern regarding the conduct of health insurance plans, some payers construe any physician waiver of co-payments, co-insurance, or deductibles whether occurring up front at the time of medical services or after receipt of payment by the plan, on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. It has been noted in the legal community that "...the practice of out-of-network providers waiving copayments and deductibles has continued and is occurring with such frequency in the market that one national insurer in particular has resolved to commence a major legal campaign to curtail the billing practice."<sup>2</sup> Furthermore:

A provider may receive significant legal protection similarly by including a statement on its insurance claim that it will waive the copayment or deductible, or that it reserves the right not pursue the patient for these amounts. This disclosure, however, could result in the insurer's denial of the claim, and if the insurer does not agree to the statement, a provider risks displaying the requisite intent for being accused of insurance fraud.<sup>3</sup>

Nevertheless, according to a recent national survey, approximately 22% of individuals who used OON providers negotiated an OON bill with the insurer or provider, and 58% were successful in reducing their costs for at least one of the bills.<sup>4</sup>

Health insurance plan efforts to legally assail physician authority to waive charges, on a case-by-case basis, based upon a patient's economic condition, creates a hostile legal atmosphere that is designed to deter such benevolent financial actions by physicians for their patients. Accordingly, physicians should have an explicit legal safe harbor in state law to conduct such waivers on out-of-network charges on a case by case basis so as to financially benefit economically distressed patients.

The issue of out-of-network balance billing is multi-dimensional. Simplistic solutions that favor health insurance plans with governmental price setting for out-of-network physician services would, and should, raise questions about the fundamental purpose and need for health insurance plans if they have no financial incentive, nor legal obligations, to contract for physician services.

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<sup>2</sup> "Out of Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies," The Health Lawyer, Charles C Dunham, Esq. O'Connell & Assoc. Albany, NY., Volume 25, Number 5, June 2013.

<sup>3</sup> Ibid.

<sup>4</sup> "Patient's Success in Negotiating Out-of-Network Bills," The American Journal of Managed Care, Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

The non-partisan National Association of Insurance Commissioners (NAIC) in its annotations on this issue (MDL 74-22) noted that states should consider a payment formula such as: “a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.” Importantly, the NAIC notes the imperative need for states to recognize the need for payment equilibrium in the market:

“In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility based providers and health carriers to agree on a contract.”

It is the position of the Massachusetts Society of Pathologists, and the College of American Pathologists, that patients are best served by insurance products that provide in-network services through the continuum of care that an enrollee is likely to need and receive in the hospital setting. Health policy measures that do not compel health plans to contract for the provision of such services for their enrollees alter the public policy rationale for participating provider (PPO) insurance products and should raise fundamental questions about the role of insurance in the value chain of health care delivery.

Thank you for your consideration.

# **Provider Price Variation Commission Public Listening Session**

**Filaine Deronnette; 1199SEIU Vice President of BMC/Community Hospitals**

**January 17, 2017**

Good afternoon.

My name is Filaine Deronnette and I am the 1199SEIU Vice President of Community Hospitals and Health Systems.

Thank-you Chairman Sanchez and Chairman Welch - and the other members of this Commission - for this opportunity. I'm pleased to offer these brief remarks on behalf of the 56,000 Massachusetts members of 1199.

As many of you know, this Commission was formed early last summer under a comprehensive settlement and agreement that 1199 would withdraw our "Fair Care" ballot initiative. A ballot initiative that would have established several new laws and regulations designed to reduced provider price variation.

We're very happy, therefore, to have seen the Commission taking its job so seriously for the past several months.

And to see so many policy experts and advocates joining us here at today's Listening Session and in search of a comprehensive solution to this persistent problem.

Since at least 2010, multiple state agencies have documented significant and "unwarranted" variation in provider prices. Variation that's not tied to measurable differences in quality, complexity of care, or other common measures of value.

Meanwhile, provider price variation seems unlikely to decrease absent significant policy reform. And comparatively low reimbursement has meant that many of our community and safety net hospitals are struggling to remain financially viable.

A successful approach to reducing provider price variation in the commercial market must include solutions that are consistent with our policy priorities.

To be specific, it is essential that the work of this Commission, its final report, and any recommended reforms ensure the following:



- That, at least in the short term, the state is ensuring that we have adequate public payer rates and the other supplemental support needed to ensure the financial viability of community hospitals;
- Second, that we avoid placing too much of the burden of reform on either healthcare consumers or the low-wage healthcare workforce;
- Third, that addressing provider price variation is part of a comprehensive approach to controlling statewide health care costs;
- And, finally, that the proper incentives are in place to guarantee affordable, accessible and high-quality health care for all.

We urge the Commission to issue a strong final report and recommendations that offer comprehensive solutions to this persistent problem. It is very important to reach consensus on “warranted” and “unwarranted factors for price variation, including the appropriateness of efforts to mitigate existing socio-economic health disparities.

In addition, at a very minimum, our community and safety net hospitals need immediate financial relief. The newly created Community Hospital Revitalization Trust Fund is well-designed to support supplemental payments to hospitals receiving lower relative commercial payments. But the funding of just \$45 million over 5 years is insufficient. In the short term and as we allow market-based reforms and additional state oversight to work, this Commission should also ensure that there’s adequate support to guarantee the financial viability of the lowest-paid tier of community and safety-net hospitals.

To wrap-up, we look forward to continuing our work within the Commission. In the end, we remain open to supply-side, demand-side and direct regulatory solutions that are consistent with the priorities laid out above. And we understand that all may be needed to fully address the issue.

Thank you again for the opportunity to offer these remarks. Now I hope you’ll appreciate hearing from the community hospital worker members of our panel.

[Introduce first member: Name, Employer, Job Title]

## **Provider Price Variation Commission Public Listening Session**

**James Farren; St. Elizabeth's Hospital; January 17, 2017**

Good afternoon members of the commission. My name is Jim Farren and I am a Patient Access Representative in the Steward Healthcare System, which is made up of many community and DSH hospitals. I am an original 10 signer of the ballot initiative that helped bring us here today.

I want to thank the Commission for undertaking the task in front of us. As a leader of 1199 and a healthcare worker at a community hospital it is vital that industry leaders from across the state come together around real solutions to support accessible, quality care across Massachusetts that protects our most vulnerable community hospitals.

I feel very proud of the fact that I have a good, union job in the community where I am from. We are a diverse mix of ages and most of the patients that we see depend on Medicaid or Medicare. This is reflective of who our community is made up of in this part of the city.

Working at St. Elizabeth's, I know I'm making a difference for the residents that depend on us most. Because I am the first stop for a lot of our patients, I hear countless stories of people who feel like St. Elizabeth's is their hospital—they truly feel ownership of it and regardless of where they may go, they end up back at St. Elizabeth's for care.

Clearly, the importance of our hospital for our patients and residents cannot be understated and we are here today to come together around solutions that at their core protect and preserve hospitals like these.

When I became an original signer of this initiative petition, I was excited to have the opportunity to make more of a difference for community hospitals. I still feel optimistic that this commission will take this charge to heart. Please remember the voices of healthcare workers as you work towards a real policy solution. If we cannot come to agreement on more complex policy solutions, at a minimum we must maintain the consensus we have heard over the past two years--community hospitals must be given the support they need to remain affordable, community providers.

We need to stand up for access to quality care, and to ensure the economic engines of our gateway cities operate under a more level playing field. I believe in affecting change and I believe we must do more for our community providers. I'm here today because I want to ensure my hospital is still here 10 years from now. Thank you.

## **Provider Price Variation Commission Public Listening Session**

**Sheilah Belin ; Boston Medical Center; January 17, 2017**

Good morning. My name is Sheilah Belin, I am a Medical Assistant at Boston Medical Center and a proud member of 1199SEIU. Thank you for the opportunity to testify at this important hearing.

I am here today to stand up for safety net hospitals like mine that are on the front lines of caring for vulnerable and diverse communities. From dealing with mental illnesses, tackling substance abuse addictions, to providing primary and preventive care and saving lives in our world-class trauma center, we treat not only the ailments that afflict our patients, but also help break down barriers that prevent them from being healthy.

The patients we see every day come from all across the city, often taking several modes of transportation just to get their medications. They are children, seniors, people with disabilities and low-income families. And these folks are not just our patients - they're our friends, families and neighbors too.

I am proud to be part of the BMC healthcare team that provides "exceptional care without exception" to every patient who walks through our doors. Regardless of you are, where you're from, or your ability to pay.

Eventually, however, someone has to bear the burden of those costs. And it often falls on safety net hospitals to make up the difference. But with this inequity in payment, how can we compete with other providers that admit only patients with the financial means to afford private insurance? How can my hospital continue to keep its doors open to the people who need us?

We must level the playing field in our hospital payment system and ensure our community and safety net hospitals have the resources we need to provide the quality care our patients deserve. Our private insurance rate shouldn't suffer just because the majority of our patients are MassHealth beneficiaries. We need better Medicaid reimbursement rates as well as fairer private insurance rates that take into consideration socioeconomic factors like the demographics and income of our patients.

I join my 1199SEIU brothers and sisters here today in thanking the Commission for the critical work you are all doing.

Your task is not an easy one, and I am sure you have many different opinions about how best to address the unfair way Massachusetts hospitals currently are reimbursed for care. But I hope we all can agree on one thing - if we want to reduce healthcare costs and ensure quality care for all, community and safety net hospitals must continue to thrive and survive.

February 10, 2017

Dear Commission Member:

The physician community has watched with interest as the *Special Commission to Review Variation in Prices among Providers* has met and deliberated on important issues related to provider price variation. The legislature tasked your commission with the difficult goal of “conducting a rigorous, evidence-based analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services.” We have watched as recommendations about this primary charge and other tangential issues have been developed among the various subcommittees. The twenty physician organizations undersigned here write to comment on and share concerns regarding one particular recommendation discussed at the January 31<sup>st</sup> meeting.

Out-of-network billing has increasingly been a topic of conversation in multiple health policy forums in Massachusetts over the past year. The Medical Society and many medical specialty societies undersigned here have also been engaged on this issue as it relates to out-of-network physicians at in-network facilities. We have pledged for some time our commitment to finding a solution to this issue. The Medical Society has proposed legislation that will do just that: remove patients from the middle of the situation by holding them harmless from any unavoidable out of network bill. **To that end, the physician community supports three high-level principles related to out-of-network billing: 1) greater education of patients by plans and providers, 2) provision of strong patient protections by holding patients harmless for unavoidable out-of-network bills, and 3) a process by which all affected parties, including physicians, can participate in the establishment of a payment formula for out-of-network providers.**

**We write to share our strong opposition to the use of this Commission to provide detailed recommendations on a default rate of reimbursement for Out-of-Network providers.** Details regarding a formula for reimbursement are far afield from the charge of the Commission, and discussions of them should take place in a venue that is inclusive of the primary party affected by this issue.

As discussed at the public hearing of your Commission, the undersigned physician organizations believe that many important perspectives of the issue of Out-of-Network billing have evaded consideration as a result of the limited membership of the Commission. This is not a repudiation of the Commission—again many important discussions about price variation will lead to improved health care delivery in the Commonwealth—but rather, an urging that the Commission to return to its focus on those larger issues. Continuing to move forward with detailed recommendations about a default out-of-network reimbursement rate without inviting the parties most affected by the reimbursement formula to join in the discussion could have unintended, harmful consequences for patient care and the delivery of medical care.

We offer a sampling of the concerns of the physician community regarding the details of the Out-of-Network default reimbursement rate recommendations.

### **References to Medicare as a Benchmark for Default Commercial Payment Are Problematic**

The physician community opposes references to Medicare fee schedules in these conversations about default out-of-network physician reimbursement. Medicare is not currently and was never intended to be a broadly applicable index for commercial physician payment. Medicare rates are not established to represent a valuation of professional services provided; instead, they function as a distribution of an already limited budget of this social service program. Further, Medicare rates differ widely across specialties as evidenced by a study published recently in *JAMA Internal Medicine* that found significant

variation in the relative price of services across specialty billing Medicare. A driving factor of this variation is that the denominator—the rate of Medicare payment—varies significantly across specialties. For example, a GAO report highlighted, “Medicare payments were lower than private payments [for anesthesia] by an average of 67%.” While other specialties may not have such wide variation, this example underscores why tying any payment formula to Medicare is not appropriate and will have incredibly negative impacts for certain specialties which could ultimately impede patient’s access to good quality medical care.

### **References to “Significantly Below Charges” is also Problematic**

The undersigned physician organizations oppose the inclusion of this level of vague detail in any recommendations put forward by the Commission. The Medical Society has put forward a legislative proposal to solve the out of network billing issue that puts forth a nuanced reimbursement formula that includes one option that defines the usual and customary rate based on a percentile of charges in the geographic area, as determined by a neutral third-party non-profit organization, such as Fair Health. This formula was recently adopted by the legislatures of the states of New York and Connecticut, states that are both good models for Massachusetts as they are similar geographically, population, etc.

### **The details of Reimbursement for providers “in broad network” are Problematic**

While we are not privy to the working documents of the Commission that detail some of these recommendations, we have strong concerns about the language requiring those contracted to a broad network to accept the contracted rate. While our initial interpretation was that a “Physician Group A” who is contracted with “Insurer B” for many plans, but not of patient’s “Narrow Network Plan C” offered by Insurer B would receive the physician’s contracted rate per their broader contract with Insurer B, this language could also be interpreted as to reimburse the physician at the rate of Narrow Network Plan C.

This latter interpretation would be unacceptable and have significant detrimental unintended consequences by imposing a potentially inadequate rate of reimbursement on a physician organization that is not a party to the contract. The valuation of physician services includes many warranted factors for price variation, as highlighted by the Commission at its last meeting. These factors include patient acuity, high cost outliers, and quality. The Commission indicated that several more factors could likely be added to that list upon further discussion, including area wages, teaching, stand-by capacity, and lower or no margin services. **A narrow network rate contracted between an insurer and one physician organization may be acceptable for one physician organization but not sustainable for another physician organization based on factors for price variation recognized by your Commission as entirely warranted.** The imposition of one privately contracted reimbursement rate on another physician practice could have serious effects on the sustainability of physician practices, jeopardizing access to care for patients. It could also allow insurers to take advantage of inadequate networks by relying upon this law to prevent patients from receiving bills while forcing inadequate rates on physicians not a party to the narrow network contract.

### **The Medical Community is Concerned with the Consequences of Unsustainable Reimbursement**

The physician community again urges discussion of the reimbursement formula in a more inclusive venue as the failure to establish a sustainable reimbursement formula could have substantial implications on broader contracting dynamics, and could extend well beyond physician groups and affect low-margin hospitals.

An unsustainable default reimbursement formula recommended by this Commission could have broad implications beyond just the narrow sliver of reimbursement presently attributed to unavoidable out-of-



network care. If a default rate is set that is substantially below market value, insurers would have little incentive to negotiate in good faith with physician practices, knowing that any resulting out-of-network scenario would be reimbursed at a low rate. This would significantly jeopardize the sustainability of many physician practices, threatening access to care for patients across the Commonwealth. This also has the potential for disincentivizing physicians from practicing in Massachusetts, making recruiting and retaining physicians increasingly difficult.

We point out that many in the physician community are concerned about the impact that insufficient reimbursement formulas could have on hospitals and patients. Hospitals rely upon these physician groups for the very heart of their mission- emergency physicians, anesthesiologists, radiologists, and pathologists, among others, are the lifeblood of the hospital. If these physician groups cannot remain solvent due to lower reimbursements and unfair negotiating dynamics, hospitals will be forced to find ways to retain these services, often through subsidization of the physician practice. If these levels of subsidization increase, many hospitals with low operating margins—often those that provide critical access in geographically isolated locations often to low-income patients in need—the very sustainability of the hospitals and access to care for thousands of patients could be in jeopardy.

### **Network Adequacy Needs to be Properly Considered**

The physician community supports strategies to promote the sustainable delivery of health care in Massachusetts, and will welcome policies that protect our patients from rising premiums and out-of-pocket expenses.

But, costs reductions are only as good as the good care that they continue to facilitate. Unfortunately, an unintended consequence of narrowing networks to reduce cost is that networks may become so narrow that they can jeopardize consumers' access to care, potentially driving up the costs they were designed to reduce while negatively impacting quality of care and health outcomes. Specifically, narrow networks may lack an adequate mix of provider specialties or not provide enough physicians to care for patients, essentially giving consumers no choice but to obtain out-of-network care. For example, researchers at Harvard found that approximately 15 percent of health plans offered on the 2015 Federal Marketplace lacked in-network physicians for one or more specialties. Without adequate transparency and education by insurers, narrow networks can be confusing and frustrating for consumers. In fact, the Commonwealth Fund found that as many as one in four Marketplace enrollees were unaware that the plans they were choosing from had different networks, and McKinsey and Company found 40 percent of newly enrolled consumers were unaware of the network configuration of the Marketplace plan they chose. Therefore, we urge further examination and monitoring of network adequacy as conversations continue about increasing these narrow network plans.

**The medical community reiterates its commitment to working with members of the Provider Price Variation Commission, patient advocacy groups, and others to see the adoption of public policy to address out of network billing.** We write to support that work by highlighting many of the perspectives that have not been included in meetings of the Commission, largely due to the lack of physician representation. We urge that broad principles regarding out of network billing as outlined at the outset of this letter be adopted, but that all references to a specific default reimbursement formula should be left for a venue inclusive of physicians, patients, and all other affected parties. As laid forth in this letter, the implications of recommending factors that will lead to an unsustainable reimbursement rate are too great for the patient and physician communities.

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Massachusetts Society of Eye Physicians & Surgeons

Michael Medlock, MD, President  
Massachusetts Society of Neurosurgeons

Robert Patz, MD, President  
Massachusetts Orthopedic Association

Jeffrey Brown, MD, President  
Massachusetts Society of Otolaryngology

William D. Kasimer, MD, President  
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**Special Commission on Provider Price Variation**  
**Public Hearing on January 17, 2017**  
**Summary of Oral Testimony with No Written Submission**

**Jon Hurst**

**President of the Retailers Association of Massachusetts**

- Represents 4,000 employers in the retail and restaurant sphere
- The goal of RomneyCare was to increase coverage and lower the cost of insurance.
  - While more people are insured, premiums have increased especially for small businesses.
  - Surveyed members every year since the passage of RomneyCare and found that the average increase for small businesses, of 15 employees and under, per year is about 12%, which he noted is well above the 3.6% target and above the 4.2% mark.
  - Premium increases are a contributing factor to the closing of small businesses.
  - Need for action, not the creation of new committees or research.
  - The average inflation from the passage of Romney Care through the recession was about 0 to 2%, yet there has been significant increases in premiums for small businesses and their employees.
  - The law is unfair and it has created an unequal market place depending on the size/type of the business you work because providing and paying for insurance and healthcare largely varies based on where you work.
  - In the years since RomneyCare, 26 mandates and/or assessments have been passed which have been paid for by the consumer through higher health insurance premiums and are often avoided by large self-insurers who make up 60% of the marketplace.
    - This has created a marketplace that really discriminates based on where you work because if you work for a small business you cannot escape those mandates.
    - Those mandates help the provider groups who lobbied for them because it increases their utilization and their reimbursements which results in increased medical inflation in the state, and makes insurance less and less affordable for small businesses.
    - A DOI survey of third party administrators found that 9-10 state mandates are not covered by 90% of self-insured businesses. This is an unfair playing field created by the government.
  - Proposed a rate cap to deal with high cost providers and believes that high cost providers are expensive because their expenses are too high.
    - Providers failed to address their high expenses because they have an endless amount of money coming in through insurance premiums and taxes, and therefore they have no incentive to lower their expenses. Instead they “pass the bill” to small businesses.
  - Lower cost facilities don’t need to be brought up and paid at higher rates. Instead, more consumers should be pushed towards low cost providers.
    - This can be accomplished by utilizing tiered and limited networks but to have them capped off at a 14% differential does not make any sense because it does not create an incentive to buy them and it does not give high cost providers a reason to bring down their costs.
    - Need real incentives for consumers to buy a tiered network product meaning that premiums should reflect in-network vs. out of network providers.
  - State agencies, maybe the DOI, should look into the expenses of these providers that are driving premiums up because someone needs to be looking out for the consumers on that expense growth.
  - It was a mistake to merge the individual and small business insurance marketplace because employees of small businesses now have a hidden “tax” in their premiums that works to subsidize the healthcare of an individual.
    - MA is the only state that does this, ACA did not do this
    - This does not affect self-insurers.

- Proposed separation of risk pools and re-implementation of some rating factors to ensure that insurance premiums are fair because while insurance is about subsidization, subsidies should be fair. Right now they are not.
- Urged government to give small businesses a break when it comes to state mandates since the majority of self-insured businesses do not cover them. Give small businesses the ability to opt-in or opt-out of state mandates.
- The 3.6% benchmark needs to be revisited because it is too high. It is far higher than the economy and even still we are exceeding it. Not everyone was at 4.2% last year if you look at the different risk pools, and it needs to be transparent to consumers.
- Asked why very large, nonprofit healthcare providers are exempt from sales tax, it would bring in more tax revenue and help these providers look at their expenses more thoughtfully.

### **Spiros Hatiras**

#### **CEO of Holyoke Medical Center**

- The purpose of the Commission is to figure out if “somebody can get something for nothing.”
- The question is: As a state, can we say it is okay for somebody to get something for nothing? Is it okay to cheat, or should we have equal pay for equal work?
- It is not the responsibility of this commission to come up with a solution.
- Holyoke is a 3-year running experiment and worked to fix its own issues when they were losing patients to other hospitals in 2013. They created and executed a plan to let their community know about all of the great work they were doing.
  - In those three years between 2013 and 2016, Holyoke received the top safety hospital award 2 out of 3 three years which is given to about 50-60 hospitals in the country, they have the best admissions rates, best care, best numbers in stroke care, they were voted by our patients one of the top 3 cleanest hospitals in our state, and have had no central line infections in two years.
  - At the end of 2016, they closed with \$140 million in revenue but their expenses increased by \$20.1 million, so there was no net gain. That is a result of being paid less than the cost of care.
- Acknowledged that with Ch. 224 the legislature set a ceiling, but did not think about creating a safety floor. This has allowed insurance companies to pay lower and lower commercial rates.
- There needs to be a safety floor, especially for those 11 hospitals on the bottom (referenced a chart with CHIA relative price data) that are receiving rates so low it is not sustainable for those hospitals to remain open.
  - Bring all hospitals up to at least 0.9 on relative price.
- Price caps and tiered networks won’t work because even if more business was brought to Holyoke, it would increase their expenses and therefore their bottom line would not improve, which is what happened between 2013 and 2016.
- Reminded legislators that they will be held accountable by the people of the Commonwealth, specifically the employees of those 11 worst paid hospitals even though it was the insurance companies, not Partners, that created this issue.