



**HEALTH CARE DIVISION PRESENTATION AT MAHP ANNUAL CONFERENCE:
FINDINGS FROM ATTORNEY GENERAL'S EXAMINATIONS OF HEALTH CARE COST
TRENDS AND COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)**

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

November 18, 2011

EXAMINATION APPROACH

- We issued dozens of subpoenas for data, documents, and testimony to major health plans and many different types of providers.
- We conducted dozens of interviews and meetings with providers, insurers, health care experts, consumer advocates, employers, and other key stakeholders.
- We engaged experts with extensive experience in the Massachusetts health care market.
- We greatly appreciate the courtesy and cooperation of payers and providers who provided information for these examinations.

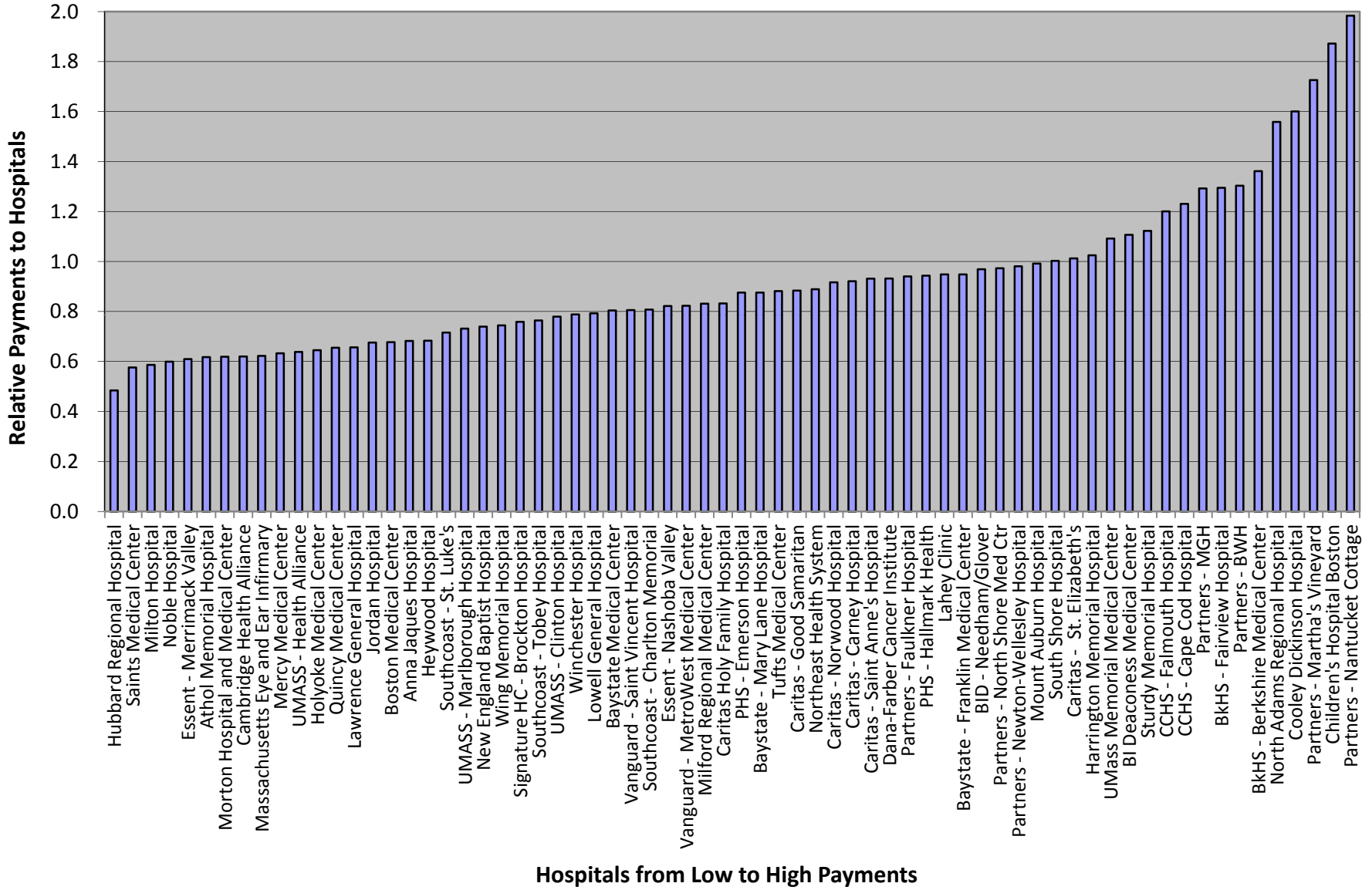
MEASURING HEALTH CARE COSTS

- TOTAL MEDICAL EXPENSES (TME): The total cost of all the care that a patient receives, including the payments by the health plan for the care of the patient, and any copayment or deductible for which the patient is responsible. TME reflects *both* price of services and volume of services.
- PRICE: The contractually negotiated amount that an insurance company pays a health care provider for providing health care services; we reviewed relative price information, which shows the prices paid by health plans to providers for all services in aggregate as compared to other providers in the health plan network.

2010 and 2011 EXAMINATION HIGHLIGHTS

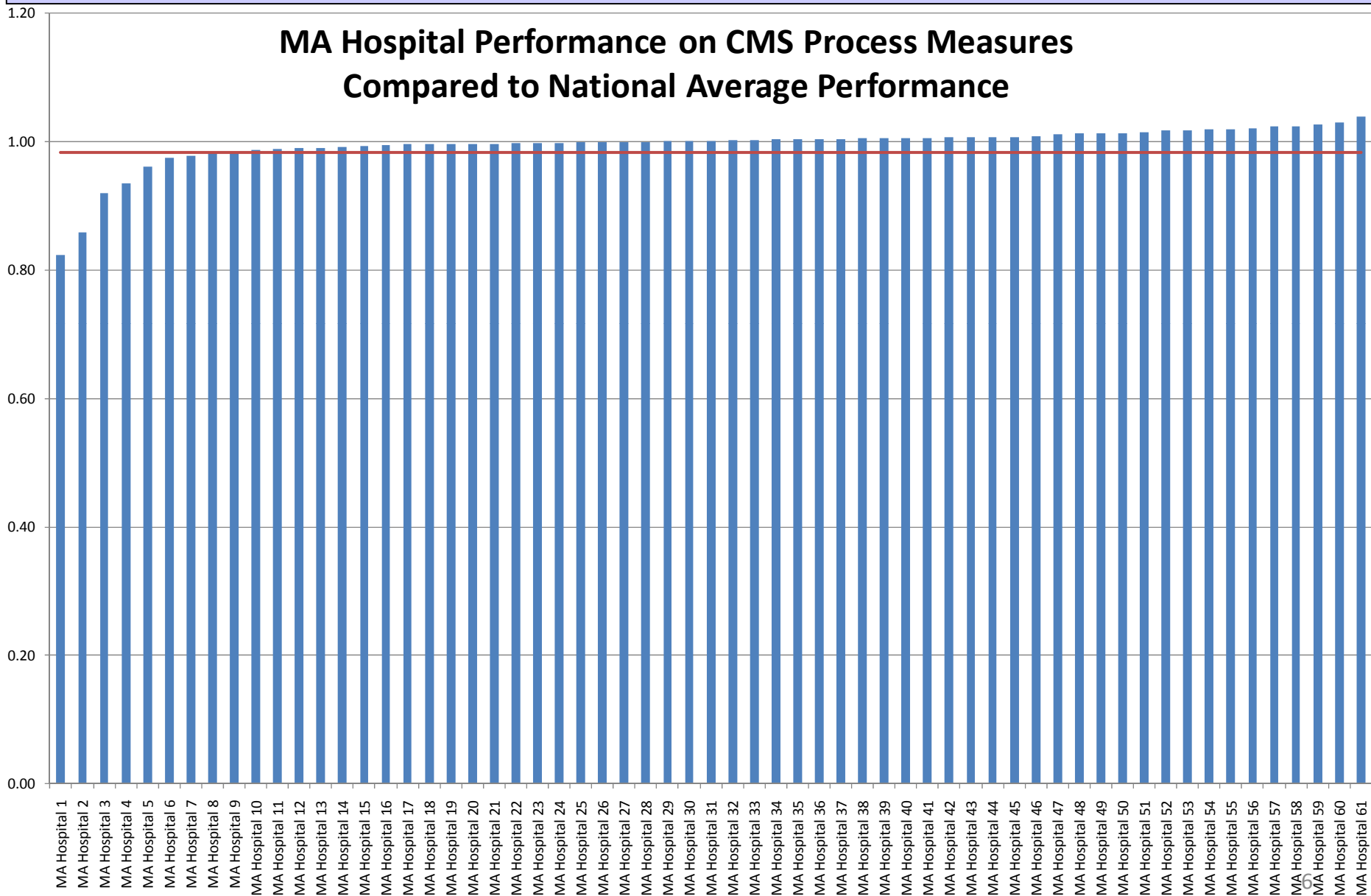
1. Prices paid by health insurers to hospitals and physician groups vary significantly.
2. Variations in prices are not adequately explained by value-based differences in the services provided.
3. Variations in prices are correlated to provider and insurer market leverage.
4. Global budgets vary significantly and globally paid providers do not have consistently lower TME.
5. Variations in prices impact the increase in overall health care costs.

PRICES PAID TO PROVIDERS VARY SIGNIFICANTLY

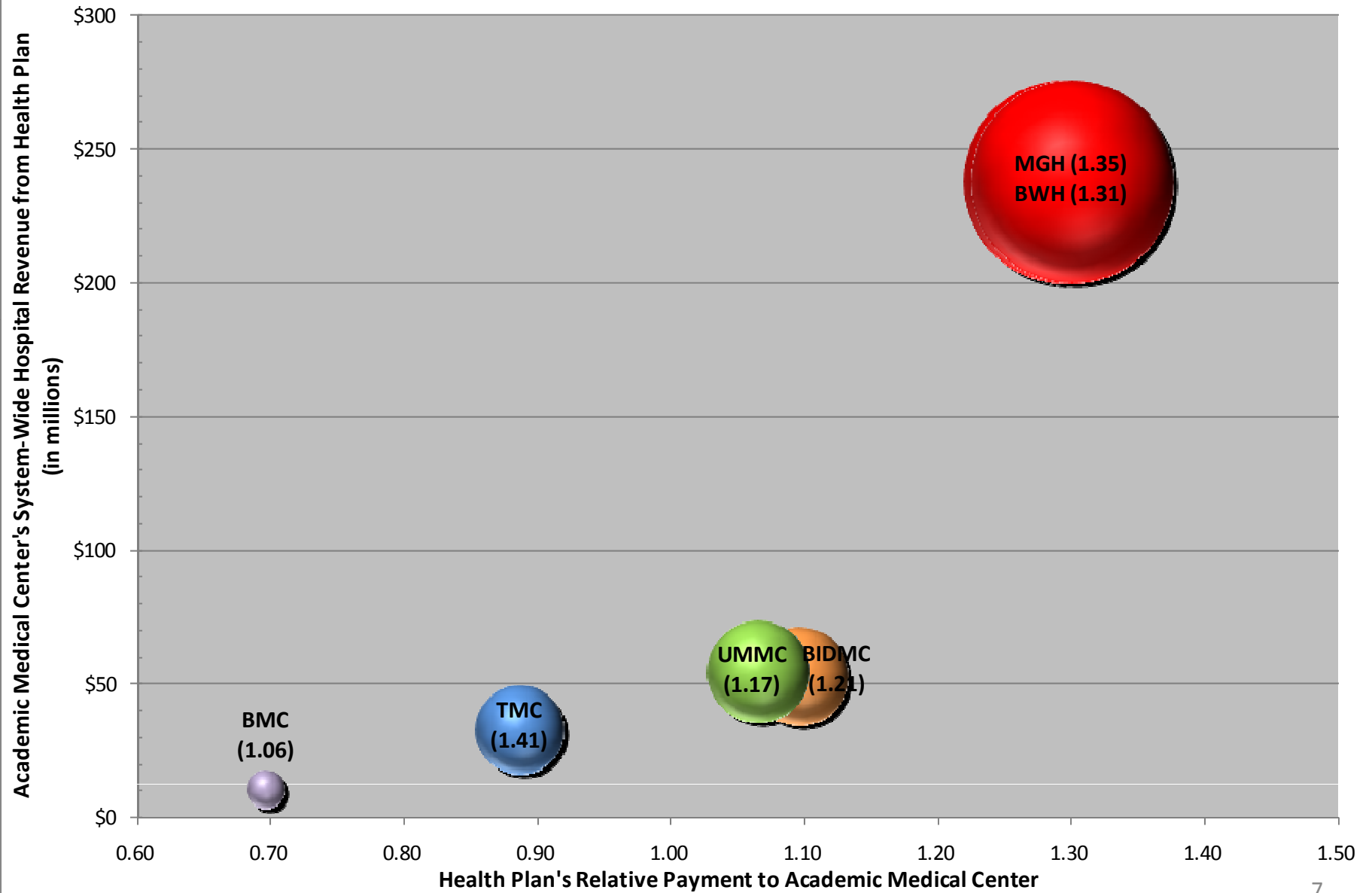


DIFFERENCES IN PRICES ARE NOT ADEQUATELY EXPLAINED BY VALUE-BASED FACTORS

MA Hospital Performance on CMS Process Measures Compared to National Average Performance



HIGHER PRICES ARE EXPLAINED BY MARKET LEVERAGE

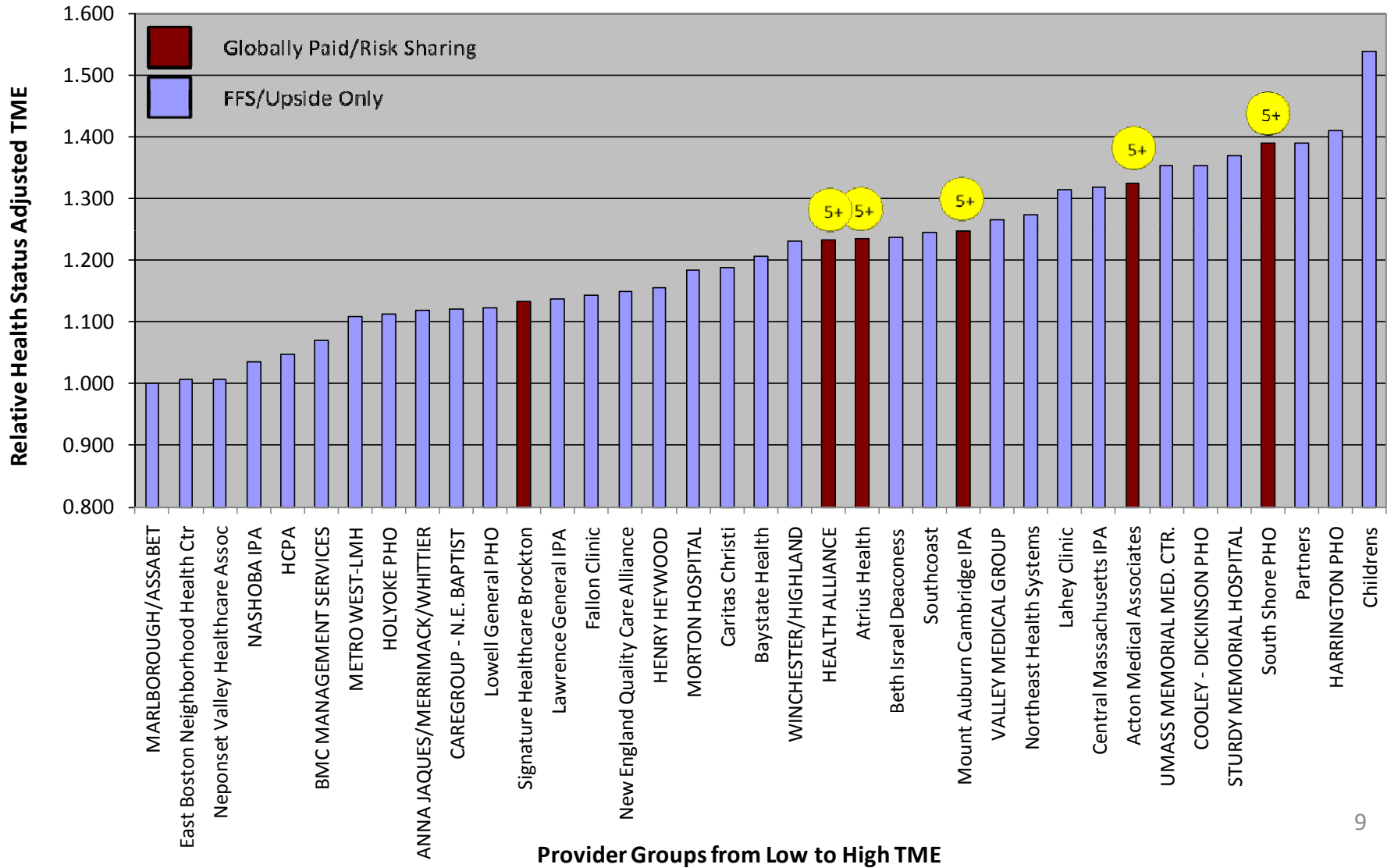


VARIATIONS IN PRICES PAID TO PROVIDERS EXIST IN GLOBAL RISK BUDGETS AS WELL AS IN FEE-FOR-SERVICE ARRANGEMENTS

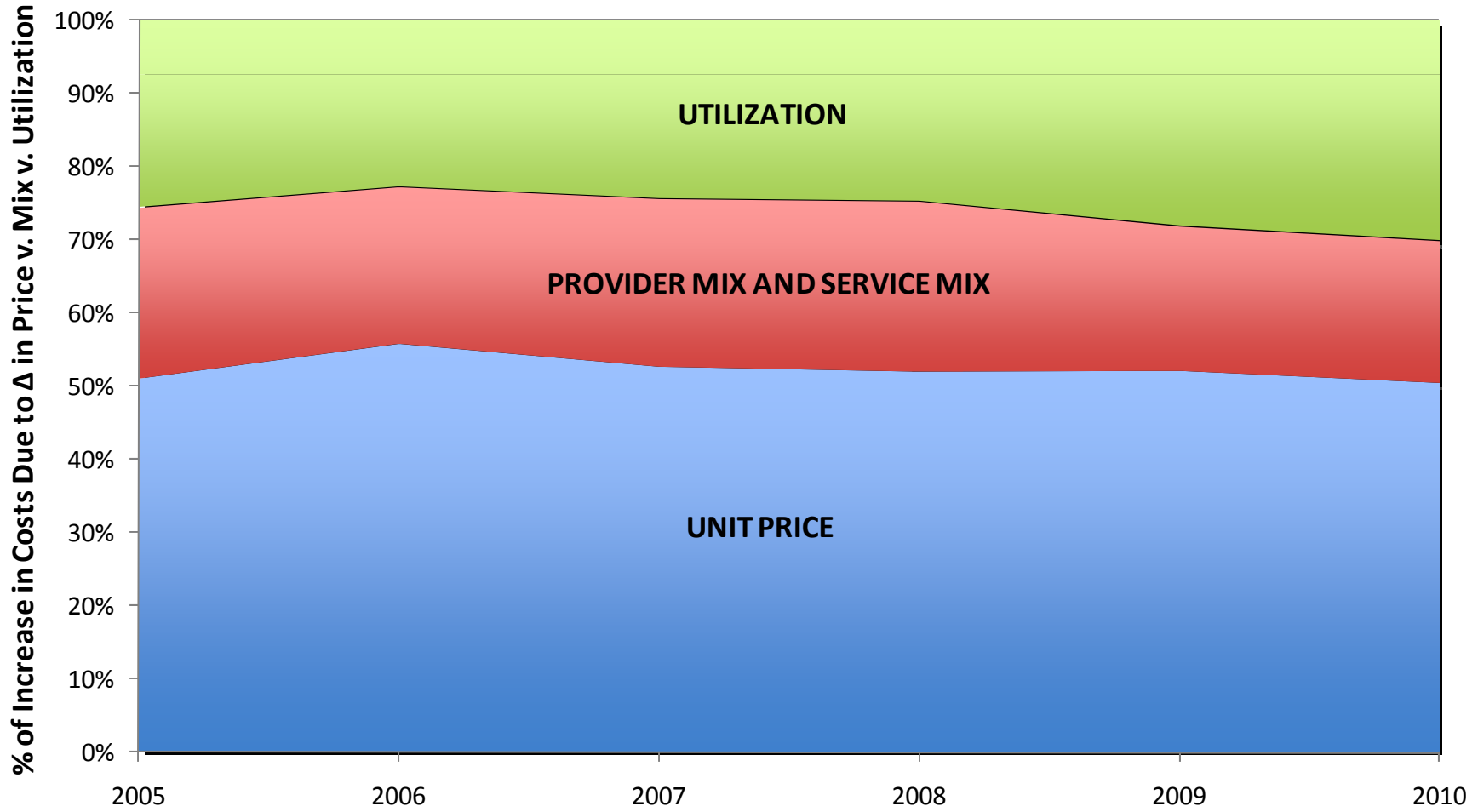
- We found wide variations in the health status adjusted global payments made by health plans to at-risk providers.
- For example, in one health plan's network in 2009, one globally paid provider had a health status adjusted budget of approximately \$428 per member, per month, while another had a health status adjusted budget of only \$276 per member per month.

GLOBALLY PAID PROVIDERS DO NOT HAVE CONSISTENTLY LOWER TOTAL MEDICAL EXPENSES

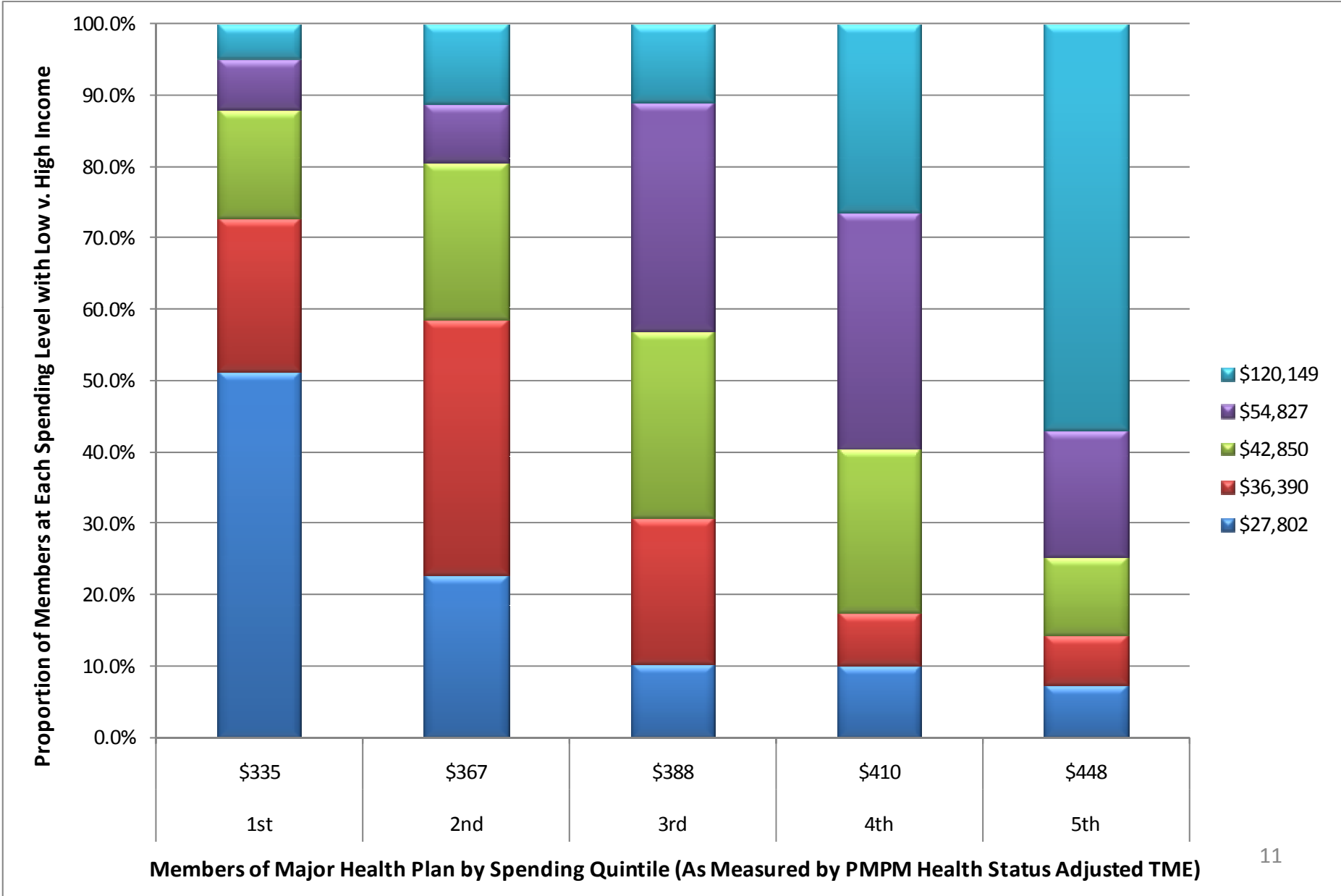
Variation by Payment Method in one Major Health Plan's Health Status Adjusted Total Medical Expenses (2009)



PRICE INCREASES CAUSED THE MAJORITY OF THE INCREASES IN HEALTH CARE COSTS IN THE LAST SIX YEARS



TOTAL MEDICAL SPENDING IS HIGHER FOR THE CARE OF COMMERCIAL PATIENTS FROM HIGHER-INCOME COMMUNITIES



TIERED AND LIMITED NETWORK PRODUCTS HAVE INCREASED CONSUMER ENGAGEMENT IN VALUE-BASED PURCHASING

- Health insurance products that do not differentiate among providers based on value do not give consumers an incentive to seek out more efficient providers, because consumers are not rewarded with the cost savings associated with that choice.
- As a result: (1) consumers are de-sensitized from value-based purchasing decisions and (2) providers are not rewarded for competing on value.
- There have been recent developments in tiered and limited network products; these types of innovative products should be encouraged.

- 1) How can we best improve market function?
- 2) How can we improve care coordination?

MOVING FORWARD ON COST CONTAINMENT

1. Promote tiered and limited network products to increase value-based purchasing decisions.
2. Reduce health care price distortions through temporary statutory restrictions until tiered and limited network products and commercial market transparency can improve market function.
3. Encourage consumers to select a primary care provider who can assist consumers in coordinating care based on each consumer's needs and best interests.
4. Promote coordination of patient care through primary care providers by recognizing the need to improve funding of care coordination, including the infrastructure necessary to coordinate care, and by giving providers timely access to relevant patient data regardless of their size or payment methodology.

MOVING FORWARD ON COST CONTAINMENT

5. Consider steps to improve the use of the all payer claims database (“APCD”) by: (i) developing reports for providers and the public to guide development of patient care coordination improvements and system accountability, and (ii) increasing the standardization of claim level submissions by reducing differences in how payers report payment level information.
6. Develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations.



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