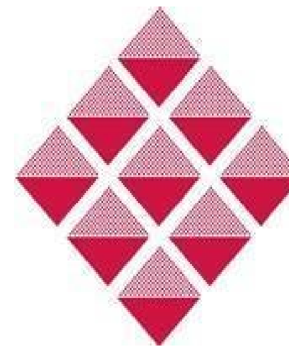
MASSACHUSETTS
HEALTH POLICY COMMISSION

Introduction to the Health Policy Commission and the Path to Affordability in Massachusetts

January 11, 2023



The Massachusetts Health Policy Forum

Outline

BACKGROUND ON THE HPC

Spending and Pricing Trends

Care Delivery Transformation

Implications for Affordability, Access, and Equity

HPC Policy Recommendations

When health spending grows faster than the rest of the economy, families and employers are acutely impacted.

300%
250%
200%
150%
100%
50%
0%

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

243% Employee premium contribution

192% Total family premium

179% Employer premium contribution

92% Personal income increase

53% General price inflation

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

HPC

CHAPTER 224 OF THE ACTS OF 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

The Health Care Cost Growth Benchmark

HPC

- Sets a **prospective target** for controlling the growth of total health care expenditures across all payers (public and private) and is tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a cap on spending or provider-specific prices**, but is a measurable goal for restraining excessive health care spending growth and **advancing health care affordability.**
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans** and submit to public monitoring.
- A PIP of an individual provider or health plan is only required following a **retrospective, comprehensive, and multi-factor review** of the entity's performance by the HPC, **including evaluating cost drivers outside of the entity's control** and the entity's market position, among other factors.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:

- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Administrative cost of private health insurance

Chapter 224 established two independent state agencies to work together and monitor the state's health care performance and make data-driven policy recommendations.

Massachusetts Health Policy Commission (HPC)		Center for Health Information and Analysis (CHIA)
Policy hub	**PURPOSE**	Data hub
Independent state agency governed by an 11-member board with diverse experience in health care	**OVERSIGHT**	Independent state agency overseen by a Council chaired by the Secretary of Health and Human Services
Sets statewide health care cost growth benchmark Enforces performance against the benchmark Registers provider organizations Conducts cost and market impact reviews Holds annual cost trend hearings and produces annual cost trends reports Supports innovative care delivery investments Certifies accountable care organizations and patient-centered medical homes Conducts research and analysis to support the HPC's policy agenda	**DUTIES**	Collects and reports a wide variety of provider and health plan data Examines trends in the commercial health care market, including changes in premiums and benefit levels, market concentration, and spending and retention Manages the All-Payer Claims Database Maintains consumer-facing cost transparency website, CompareCare

The HPC's Mission and Goal

The HPC's mission is to advance a more transparent, accountable, and ***equitable*** *health care system through its independent policy leadership and innovative investment programs. The HPC's overall goal is better health and better care – at a lower cost –* ***for all residents*** *across the Commonwealth.*

The work of the HPC is overseen by an 11-member Board of Commissioners who are appointed by the Governor, Attorney General, and State Auditor.

GOVERNOR
Maura Healey

- Chair with expertise in health care delivery
- Primary care physician
- Expertise in health plan administration and finance
- Secretary of Administration and Finance
- Secretary of Health and Human Services

ATTORNEY GENERAL
Andrea Campbell

- Expertise as a health economist
- Expertise in behavioral health
- Expertise in health care consumer advocacy

STATE AUDITOR
Diana DiZoglio

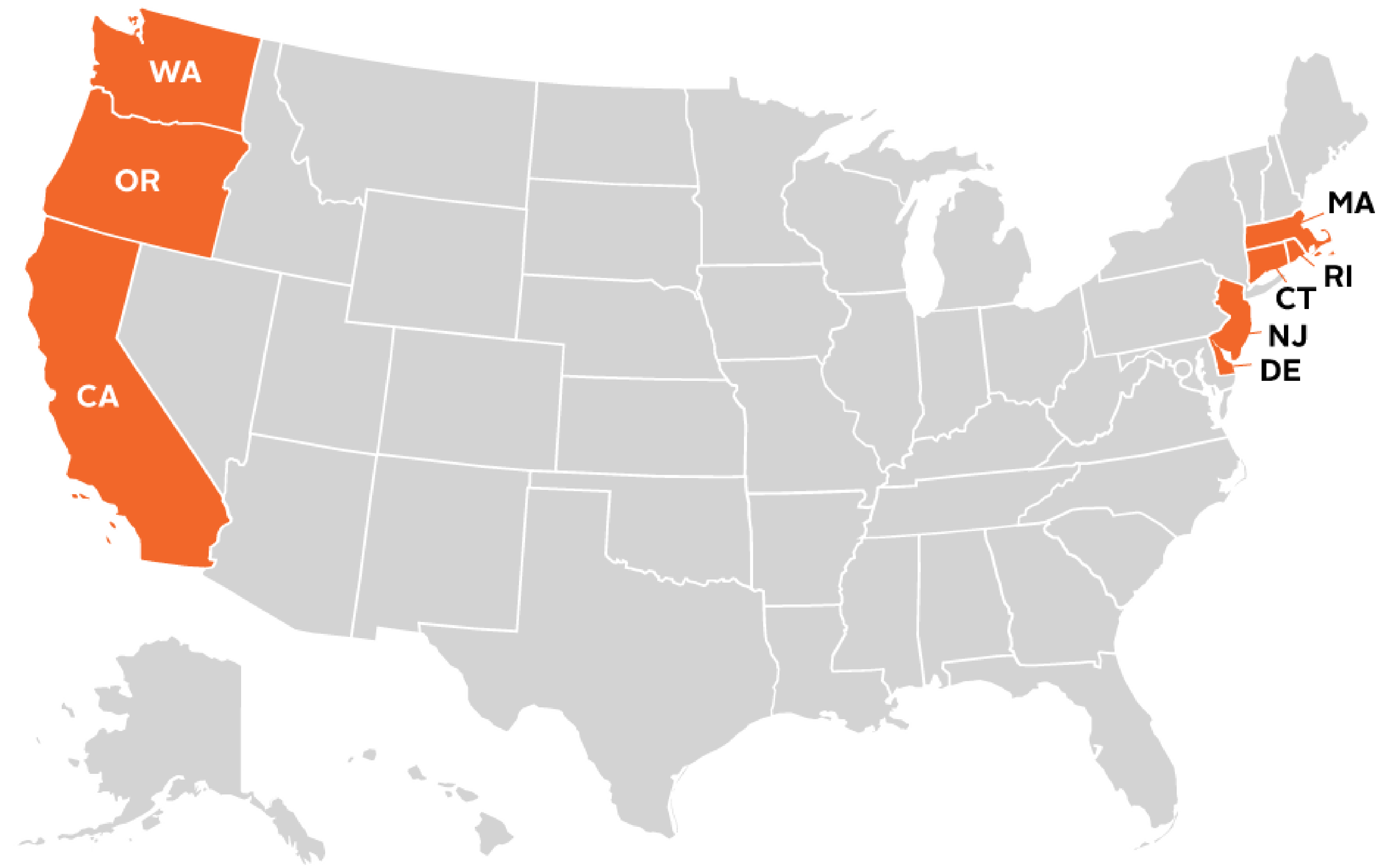
- Expertise in innovative medicine
- Expertise in representing the health care workforce
- Expertise as a purchaser of health insurance

HEALTH POLICY COMMISSION BOARD
Deborah Devaux, Chair

EXECUTIVE DIRECTOR
David Seltz

ADVISORY COUNCIL

Eight states have now established statewide health care cost growth targets, cumulatively representing one in five residents in the U.S.



How states use cost-growth benchmark programs to contain health care costs. The National Academy for State Health Policy. (2022, February 1). Retrieved from https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

WATCHDOG

Monitor and intervene when necessary to assure market performance

PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

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After exceeding the benchmark in 2018 and 2019, total spending declined in 2020 due to reduced use of care resulting from the COVID-19 pandemic.

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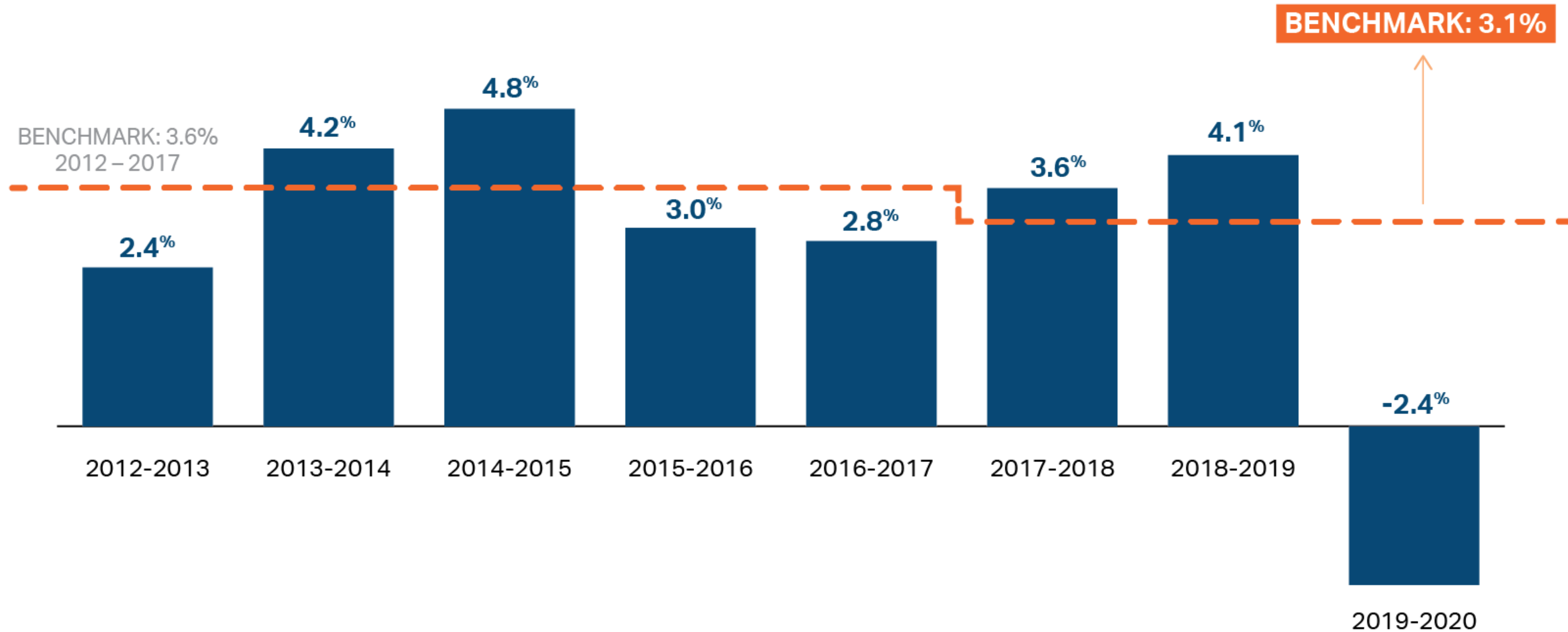
Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012 to 2020



Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2022.

Massachusetts' commercial spending was below the national average for seven of the past eight years.

Annual growth in per capita commercial health care spending, Massachusetts and the U.S., 2006-2020

12%
10%
8%
6%
4%
2%
0%
-2%
-4%

2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

MA U.S

Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2020

One large Massachusetts health plan reported that commercial prices accelerated further in 2021, coupled with a rebound in utilization.

Payer-reported percent change in commercial unit costs (prices) and utilization for a large Massachusetts insurer from previous year to the year shown

Year	Unit cost	Utilization
2017	1.7%	0.0%
2018	2.1%	1.0%
2019	2.3%	0.1%
2020	2.7%	-4.8%
2021	2.8%	9.9%

Source: Pre-Filed Testimony submitted to the HPC in advance of the 2021 and 2022 Annual Cost Trends Hearings.

Prescription Drug Trends

HPC

GROWING SPENDING ON PRESCRIPTION DRUGS

Retail prescription drug spending net of rebates grew from **14.5% to 18.6%** of per-capita commercial health care spending in Massachusetts between 2013 and 2020.[1] Growth in retail prescription drug spending has remained above the benchmark in most years.

SPENDING DRIVEN BY A SMALL NUMBER OF HIGH-COST PRODUCTS

Between 2016 and 2021, the number of specialty prescriptions filled in the U.S. increased 0.5% but gross spending on these medications in retail and non-retail settings increased **42.5%** and accounted for **50%** of total drug spending in 2021.[2]

LAUNCH PRICES CONTINUE TO RISE

The median prescription drug launch price grew from **$2,000 to $180,000** between 2008 and 2021.[3]

PRICE INCREASES ALSO DRIVE SPENDING GROWTH

CBO found that net prices for branded drugs increased by an average of **6.3% per year** from 2010 to 2017 in the Medicare Part D program, after removing the effects of general inflation.[4]

Sources: 1. HPC analysis of Center for Health Information and Analysis Total Medical Expenditure (TME) Data, which include commercial full claims only.
2. The Assistant Secretary for Planning and Evaluation. Sep 2022. “Trends in Prescription Drug Spending, 2016-2021.”
3. Rome, Benjamin N., Alexander C. Egilman, and Aaron S. Kesselheim. "Trends in Prescription Drug Launch Prices, 2008-2021." JAMA 327.21 (2022): 2145-2147.
4. Congressional Budget Office. Jan 19, 2022. “Prescription Drugs: Spending, Use, and Prices.”

Average out of pocket spending for a 30-day supply of prescription drugs for common chronic conditions grew approximately 50% from 2017 to 2020.

Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2017-2020

	2017	2018	2019	2020	Growth
Antiarthritic drugs	$84	$103	$117	$123	47.2%
MS drugs	$66	$78	$95	$103	56.6%
Non insulin diabetes	$39	$48	$61	$64	62.1%
Insulin	$37	$44	$53	$55	47.7%

Notes: Drugs were identified based on lists or clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, American Diabetes Association, and National MS society. Clinician-administered drugs, which are typically covered under a plan's medical benefits, are excluded.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) All-Payer Claims database, 2017-2020, V 10.0

Market Consolidation Trends

HPC

SHIFT TOWARD HIGHER-COST SITES OF CARE

The proportion of Massachusetts hospital outpatient visits occurring at high-priced hospitals **increased from 2016 to 2020** (27.6% to 30.2%).[1]

SHIFT IN MATERNITY CARE AWAY FROM COMMUNITY HOSPITALS

The percentage of **births taking place in community hospitals declined** from 2010 to 2020 (54% to 50%) while the percentage taking place in AMCs increased (34% to 37%).[2]

MORE PHYSICIANS EMPLOYED BY HOSPITALS

The percentage of physicians employed by hospitals in the Northeast region of the U.S. **grew from 22% to 49%** from 2012 to 2021.[3]

HOSPITAL SERVICE CLOSURES

Hospitals were more likely to close services if they had low commercial prices, high public payer mix, and were located in less urban areas. Most closures involved either pediatric or maternity services.[4]

Sources: 1) HPC analysis of CHIA Acute Hospital Profiles dataset. High priced hospitals defined as those with statewide relative price>1.2. 2) HPC analysis of CHIA hospital inpatient discharge data. 3) Data compiled from reports by Avalere for the Physicians Advocacy Institute based on data from IQVIA. 4) HPC analysis of inpatient service closures from 2016 to 2019.

Total commercial spending per hospital discharge increased 48% from 2013 to 2020.

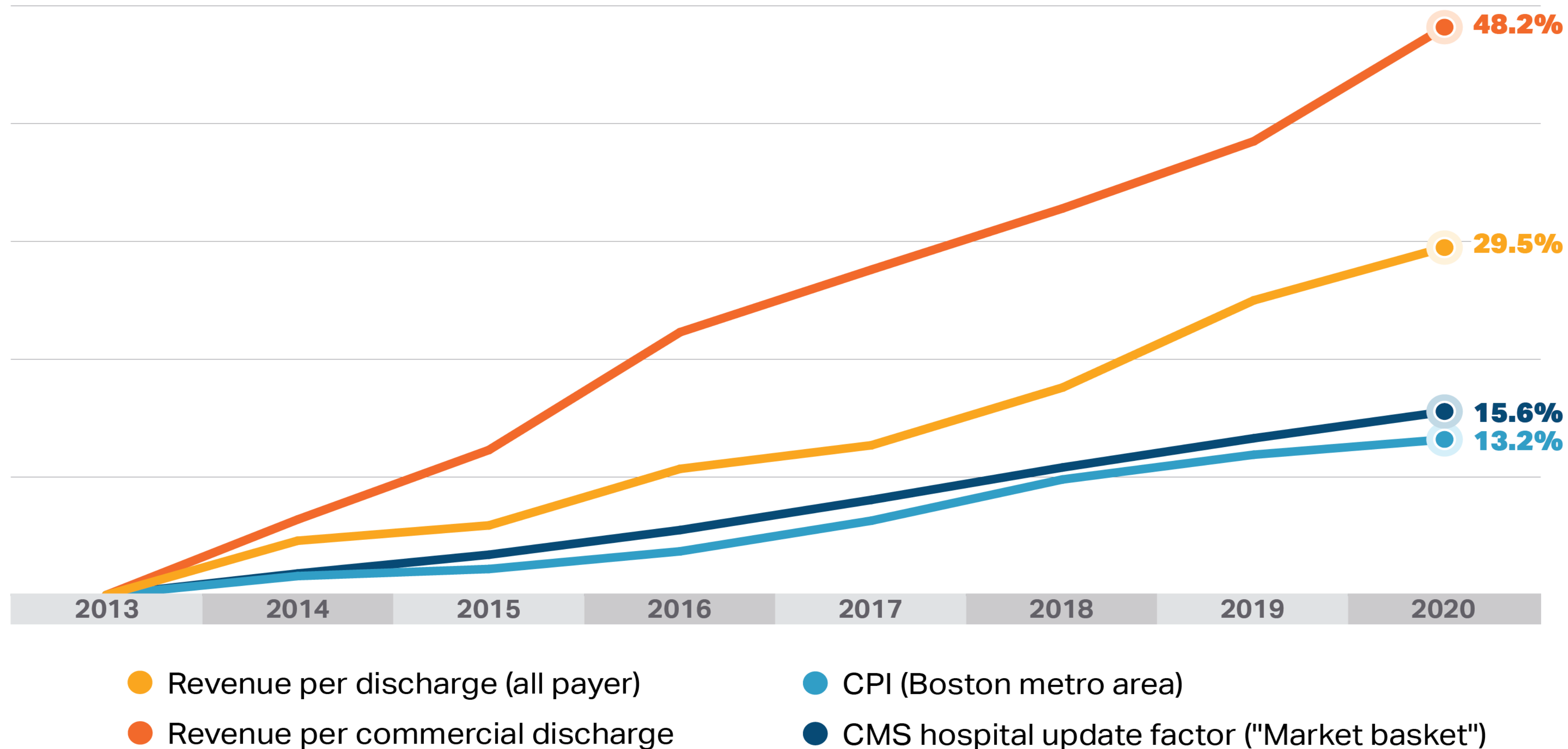
Total inpatient spending per commercial discharge and average length of stay for commercial hospital stays, 2013-2020

Notes: Certain discharges were excluded from the analysis including transfers, rehabilitation stays, those from Shriner's Hospital, and those with LOS more than 180 days.
Sources: Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Data, 2013-2020 (volume and LOS). Spending data are derived from full and partial-claims commercial spending by category for 2016-9, full claims only from 2013-6 (based on data availability) and from CHIA's Annual reports from 2013-2022.

The growth in hospital revenue per discharge exceeded measures of inflation from 2013 to 2020.

HPC

Growth in aggregate acute hospital revenue per discharge (commercial and all-payer) and in two measures of price inflation, 2013-2020



Notes: Estimate of revenue per commercial discharge described in HPC Annual Cost Trends Report, 2022 (Technical Appendix) and on previous slide.
Sources: Revenue per discharge: Total Medical Expenditures, Hospital Discharge Data and Acute hospital profiles from Center for Health Information and Analysis. CMS hospital update factor: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData. CPI-U Boston/Cambridge/Newton from the BLS.

Commercial payments to hospitals for joint replacement surgeries vary 2:1 across hospitals and are often twice what Medicare would pay.

Commercial and Medicare facility payments for inpatient major joint replace surgery without complications (DRG 470), 2019

$40,000
$30,000
$20,000
$10,000
$0

MGH
BWH
St. Elizabeth's
UMass Memorial
Berkshire
Southcoast s Group
BIDMC
Lahey MC
Tufts
Saint Anne's
Newton-Wellesley
Emerson
Cooley Dickinson
Falmouth
North Shore
BWH Faulkner
Boston MC
Cape Cod
Baystate
South Shore
Good Samaritan
Holy Family
Saint Vincent
Norwood
Winchester
Hallmark Health
Signature Healthcare Brockton
Sturdy Memorial
BIDPlymouth
Northeast
Mount Auburn
BIDMilton
New England Baptist
BIDNeedham
Milford Regional
Anna Jaques
MetroWest
Lowell General
Marlborough

Medicare average payment
Commercial average payment
Medicare base payment (no DSH, teaching, etc.)

Notes: Includes hospitals with >10 commercial discharges for DRG 470 in 2019 APCD. Only facility payment is shown.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2019, V 10.0

Hospital systems with higher outpatient prices in 2018 also tended to have higher price growth from 2018-2020.

Total price of a 50-item HOPD market basket in 2020 and price growth from 2018-2020 by hospital system

Index Growth by System, 2018-2020

10%
8%
6%
4%
2%
0%

UMass
Berkshire
Cape Cod
Overall
BILH
Wellforce
MGB
Tenet
Baystate
Steward
Heywood

$18,000 $20,000 $22,000 $24,000 $26,000 $28,000 $30,000

Index Level by System, 2020

Notes: Data are based on the cost at each hospital of an identical market basket of the 50 highest-spending hospital outpatient services in Massachusetts in 2018. See HPC Annual Cost Trends report and technical appendix for details. Hospital systems are defined based on data from the Center for Health Information and Analysis: Hospital Profiles. Bubble size corresponds to percent of statewide index service volume attributed to each system. “Overall” index growth and index level is based on a weighted average. The ‘Overall’ data point bubble size is stylistic only.
Source: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2018-2020, V 10.0

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Why the HPC Invests in Innovative Health Care Programs

HPC

RESPOND TO PRESSING HEALTH CARE CHALLENGES

Since its inception, the HPC has leveraged investment programs to address emerging issues in health care such as the opioid epidemic, maternal health inequities, and upstream social determinants of health.

TEST PROMISING INTERVENTIONS THAT SUPPORT ACCESS TO HEALTH CARE

The HPC designs programs from an existing evidence base and incorporates novel solutions to determine whether and how programs improve care and quality at a lower cost.

FACILITATE COMMUNITY PARTNERSHIP WITH HEALTH CARE PROVIDERS AND HEALTH SYSTEMS

The HPC intentionally incorporates community engagement in its programs to ensure they best meet the needs of the people they're designed to serve.

Investing in Health Care Transformation and Innovation

HPC

Health Care Innovation Investment (HCII)

Launched 2016

Created innovative models to deliver better health and better care at a lower cost through three pathways: Targeted Cost Containment, Telemedicine, and Neonatal Abstinence Syndrome

Moving Massachusetts Upstream (MassUP)

Launched 2019

Funds upstream initiatives that improve health, lower costs, and reduce health inequities across communities through effective collaboration among government, health care systems, and community organizations

Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE)

Launched 2021

Aims to address inequities in maternal health outcomes and improve the care and patient experience of Black birthing people by increasing access to and use of doula services.

COMPLETE | **ACTIVELY OPERATING**

Community Hospitalization and Revitalization, and Transformation (CHART)

Launched 2015

Invested in community hospitals to enhance the delivery of efficient, high-quality care.

SHIFT-Care Challenge

Launched 2018

Supported sustainable, transformative care models seeking to reduce avoidable acute care utilization across two pathways: Health-related Social Needs, Behavioral Health

Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN)

Launched 2021

Supports efforts to improve quality of care of substance-exposed newborns and their caregivers and contribute to the collective knowledge about clinical and operational best practices for supporting SEN and caregivers through the postpartum period.

Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Program Overview

HPC

The purpose of the $500,000 BESIDE Investment Program is to address inequities in maternal health outcomes and improve the care and patient experience of Black birthing people by increasing access to and use of doula services.

Specifically, the BESIDE Investment Program aims to:

- Increase the number of Black birthing people who are informed about the benefits of doula care and offered the opportunity to work with doulas, particularly doulas who are from the communities (e.g., geographic, cultural) of or share lived experience of inequities with Black birthing people.
- Improve the prenatal, labor and delivery, and postpartum care of Black birthing people through the support of doulas.
- Support the development of a culture of understanding and mutual respect between doulas and clinical and administrative staff within Massachusetts birthing hospitals and birth centers.
- Embed principles of racial equity and cultural humility in the design and implementation of programs offering doula services.

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IMPLICATIONS FOR AFFORDABILITY, ACCESS, AND EQUITY

HPC Policy Recommendations

Family health insurance premiums in Massachusetts have increased 202% since 2000 while the price of a new compact car increased 9%.

Average Massachusetts family health insurance premium (employer and employee contribution combined) and national cost of a new compact car, 2000-2021

Notes. Data are in nominal dollars of the year shown.
Sources: Family Health Insurance premiums are for Massachusetts from the Agency for Health Care Quality – Medical Expenditure Panel Survey, Insurance Component. Car cost information is based on car-specific inflation from the BLS and the compact car price index from Kelly Blue Book. https://www.prnewswire.com/news-releases/average-new-car-prices-up-nearly-4-percent-year-over-year-for-may-2019-according-to-kelley-blue-book-300860710.html

Premiums in the Massachusetts merged market grew in 2020, despite lower overall spending, and are continuing to grow faster in recent years.

Approved final average rate increases among plans in the Massachusetts merged market for the rate year shown

Year	Rate increase
2019	4.7%
2020	5.2%
2021	7.9%
2022	6.9%
2023	7.6%

Source: Massachusetts Division of Insurance as reported in: https://www.healthinsurance.org/health-insurance-marketplaces/massachusetts/ and https://www.wbur.org/news/2022/09/15/massachusetts-health-connector-insurance-premiums-increase.

High-deductible plans have become far more common while tiered and limited networks have remained a small share of all health plans.

Share of all Massachusetts commercial plans with each of the noted benefit design features, 2013-2020

50%
40%
30%
20%
10%
0%

38.6%
20.9%
15.5%
19.5%
20.5%
14.7%
6.1%
3.3%
2.7%

2013 2014 2015 2016 2017 2018 2019 2020

Limited Network Plans
Tiered Network Plans
HDHP Plans

68% of small group plans in 2020 were high-deductible plans.

Notes: High deductible plans are defined federally as a plan having a single/family deductible of $1,250/$2,500 in 2013-2014; $1,300/$2,600 in 2015-7; $1,350/$2,700 in 2018-9 and $1,400/$2,800 for 2020. GIC plans all include tiered networks and do not allow high deductible plans. Excluding the GIC the 2020 percentages would be 41.5%, 14.7% and 5.8% for HDHP, Tiered, and Limited, respectively.

Source: Center for Health Information and Analysis Annual Reports, 2013-2022. Data include the Group Insurance Commission.

In a 2021 survey, more than half of Massachusetts adults experienced a health care affordability burden in the past year.

HPC

Percent of Massachusetts adults who reported the following outcomes based on survey of 1,158 Massachusetts adults, May 2021

46% of Massachusetts adults delayed or skipped care due to cost, including:

Skipped needed dental care (27%)

Delayed going to the doctor or having a procedure done (25%)

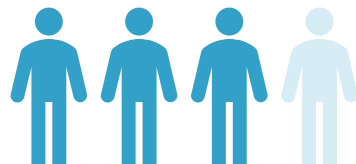
Cut pills in half, skipped doses of medicine, or did not fill a prescription (22%)

Almost **10%** of adults reported that due to the cost of medical bills, they:

Were unable to pay for basic necessities like food, heat, or housing

Used up all or most of their savings

Were contacted by a collection agency



3 in 4 Massachusetts residents are worried about affording health care in the future.

Source: Altarum Healthcare Value Hub, Data Brief 97, September 2021," Massachusetts Residents Struggle to Afford High Healthcare Costs; Worry About Affording Care, Leading to Support for Government Actions to Address High Healthcare Costs". Data based on survey of 1,158 Massachusetts adults conducted in May 2021.

People with lower incomes, people of color, and people with activity limitations were more likely to report forgoing medical care due to cost.

Share of population going without medical care due to cost by indicated characteristic and income, 2021

	ESI: Income below 400% FPL	ESI: Income above 400% FPL
White	22.3%	10.9%
Black, Hispanic, or other/multiple races	25.4%	13.7%
Activity limitation	33.4%	24.7%

Note: Respondents were considered to have an unmet health need if they went without needed care because of cost, including forgoing prescription drugs, medical equipment, mental health or counseling, substance use care, or care from a doctor, specialist, NP, PA and/or midwife.
Sources: HPC's analysis of the Center for Health Information and Analysis (CHIA) Massachusetts Health Insurance Survey, 2021

The cost of health care (including premiums and out of pocket costs), combined with the average cost of other household necessities, exceeds the income of middle-class families in the Boston metro area.

Average income and typical spending for a middle-class family of 4 with income between 3 and 5 times the FPL, 2020

$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0

$9,693
$9,518
Out of pocket health care spending
Health insurance premiums
Taxes
Other necessities
Transportation
Child care
Food
Housing
Monthly income
Monthly spending

WORCESTER METRO AREA

$9,693
$11,260
Out of pocket health care spending
Health insurance premiums
Taxes
Other necessities
Transportation
Child care
Food
Housing
Monthly income
Monthly spending

BOSTON METRO AREA

Notes: Spending for non-health care categories are estimated based on typical local area expenditures by the Economic Policy Institute. Health care spending for over-the counter medicines or for providers not covered by health insurance is not included. Employer contributions to health insurance premiums are included in both health care spending and income.
Sources: Economic Policy Institute (https://www.epi.org/resources/budget/), Medical Expenditure Panel Survey – Insurance Component, Current Population Survey, Annual Social and Economic Supplement

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HPC POLICY RECOMMENDATIONS

Priorities for Action: The HPC recommends immediate action to improve state oversight and accountability.

- **Target Above Benchmark Spending Growth.** The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

- **Constrain Excessive Provider and Pharmaceutical Prices.** The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

- **Limit Increases in Health Insurance Premiums and Cost-Sharing.** The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

The 2022 Policy Recommendations reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity.

2022 Policy Recommendations (Abridged)

HPC

1. **Strengthen Accountability for the Health Care Cost Growth Benchmark.** As recommended in past years, the Commonwealth should strengthen the mechanisms for holding providers, payers, and other health care actors responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark.
   - **A. Improve Metrics and Referral Standards for Monitoring Health Care Entity Spending**
   - **B. Strengthen Enforcement Tools in PIPs Process**

2. **Constrain Excessive Provider Prices.** Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices for Massachusetts providers (without commensurate differences in quality) continues to divert resources away from smaller and/or unaffiliated community providers, many of which serve vulnerable patient populations, and toward generally larger and more well-resourced systems.
   - **A. Establish Price Caps for the Highest-Priced Providers in Massachusetts**
   - **B. Limit Facility Fees**
   - **C. Enhance Scrutiny and Monitoring of Provider Expansions**
   - **D. Adopt Default Out-of-Network Payment Rate**

2022 Policy Recommendations (Abridged)

HPC

3 **Enhance Oversight of Pharmaceutical Spending.** As drug spending continues to grow in Massachusetts, patients are acutely feeling rising out-of-pocket costs and other barriers to access in their insurance plan design.

A. **Enhance Transparency and Data Collection**
B. **PBM Oversight**
C. **Expand Drug Pricing Reviews**
D. **Limit Out-of-Pocket Costs on High-Value Drugs**

4 **Make Health Plans Accountable for Affordability.** As both health insurance premiums and the use of higher deductibles increase, further squeezing families in Massachusetts, the Commonwealth should require greater accountability of health plans for delivering value to consumers and ensuring that any savings that accrue to health plans (e.g., from provider price caps as described above or reduced use of high-cost care) are passed along to consumers.

A. **Set New Affordability Targets and Affordability Standards**
B. **Improve Health Plan Rate Approval Process**
C. **Reduce Administrative Complexity**
D. **Improve Benefit Design and Cost-Sharing**
E. **Alternative Payment Methods (APMs)**

2022 Policy Recommendations (Abridged)

HPC

5 **Advance Health Equity for All.** Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery and the impact of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

- A. Set and Report on Health Equity Targets
- B. Address Social Determinants of Health
- C. Use Payer-Provider Contracts to Advance Health Equity
- D. Improve Data Collection

6 **Implement Targeted Strategies and Policies.** To further advance cost containment, affordability, and health equity, the Commonwealth should adopt the following additional strategies and policies.

- A. Improve Primary and Behavioral Health Care
  - i. Focus Investment in Primary Care and Behavioral Health Care
  - ii. Improve Access to Behavioral Health Services
- B. Examine Increases in Medical Coding Intensity and Improve Patient Risk Adjustment
- C. Support Efforts to Reduce Low-Value Care

HPC 2023 Summer Fellowship Program

HPC

- Ten-week program from June 5 – August 18
- Paid opportunity for up to twelve graduate students
- Applicants must be enrolled full-time in a Master's, PhD, law, or medical program
- Apply on the HPC website by **Monday, January 23!**

2022 Summer Fellow Projects Included:

- A cross-state analysis of the investment of American Rescue Plan Act (ARPA) funds in public health workforces
- An assessment of trends in inpatient admissions from the emergency department during the COVID-19 pandemic
- Research into Massachusetts pediatric market changes, including closures and consolidation
- Drafting of guidance related to the federal No Surprises Act and implications for the Commonwealth
- The design and launch of racial equity-focused collaborative learning opportunities for HPC investment program awardees

Questions?

HPC

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