

The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanisms: Stakeholder Perspectives

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Executive Summary

Background. In 2012, Massachusetts became the first state in the country to adopt legislation establishing a statewide benchmark for health care cost growth. This benchmark sets a target for the annual rate of increase in health care spending and ties it to expected growth in the state's overall economy. Known as Chapter 224, the law applies the benchmark to public and private expenditures and most types of health spending.

The law also established the Health Policy Commission (HPC) and gave it the authority to monitor and promote payers' and providers' compliance with the benchmark through a set of accountability mechanisms. These mechanisms include annual Cost Trends Reports and annual Cost Trends Hearings, which increase transparency of health care costs and spending; Cost and Market Impact Reviews (CMIRs), which monitor the impact of proposed mergers and acquisitions of health care entities on cost growth; and Performance Improvement Plans (PIPs), which require individual health care entities whose spending growth exceeds the cost growth benchmark to develop strategies to address excessive spending. While the term accountability is often understood to mean enforcement, Chapter 224 gave the HPC limited authority to enforce payer and provider compliance with the benchmark.

Several years after the Massachusetts benchmark initiative began, it was heralded as a success. From 2012 to 2017, state spending growth was lower than both the benchmark and the national rate of growth. Although the rate of spending growth exceeded the benchmark in 2018 and 2019, the state's achievement spurred policymakers in other states to adopt similar initiatives.

Study purpose and methods. Supported by the Peterson Center on Healthcare and Gates Ventures, this study (1) examined the influence of the benchmark and the HPC's accountability mechanisms on the motivation and actions by state agencies, payers, and providers to control health care cost growth, and (2) identified lessons and considerations about the design and use of accountability tools for other states implementing similar initiatives. From November 2021 to March 2022, we interviewed nearly 50 key stakeholders involved in, or affected by, Massachusetts' cost growth benchmark initiative. We also collected extensive documentation about the HPC's use of each accountability mechanism through a systematic search of publicly available documents.

Key findings

- **Benchmark.** The benchmark for annual growth in statewide health care expenditures is tied to the potential rate of growth in the state's overall economy. This benchmark helped constrain the rate of health care cost growth in Massachusetts by creating a focal point for conversations about cost trends. During its initial years, the benchmark reportedly influenced contract negotiations between payers and providers and increased providers' willingness to participate in accountable care organizations (ACOs), which reward improved quality and lower costs. The influence of the benchmark on health care organizations' incentives to control cost growth appears to have diminished over time, due in part to perceptions that the HPC's accountability mechanisms are insufficient to address some of the major drivers of health spending growth (for example, the high prices charged by some providers to commercial payers, which have contributed to annual rates of increase higher than the benchmark in recent years). When providers did not incur adverse consequences for spending in excess of the benchmark, some may have been less inclined to keep cost growth below the target than they were in early years when they perceived a higher risk of such consequences.

- **Annual Cost Trends Hearings.** The annual Cost Trends Hearings convene leading policymakers, state officials, payers, providers, and other key stakeholders to examine cost growth trends statewide (as well as by payer, provider, and service type), along with the major drivers of cost growth and cost control strategies. The hearings are an important venue for making health care costs and spending trends transparent and shining a spotlight on how major payers and providers are trying to address key cost drivers. Over time, however, public attention to the hearings has waned, and some respondents thought panelists' responses to questions had become more evasive. Further, some respondents did not think that the hearings had a lasting influence on organizations' behavior.
- **Annual Cost Trends Reports and policy recommendations.** The annual Cost Trends Reports are valuable to many types of stakeholders, because they provide deeper insight into cost trends and growth drivers. The governor and legislators often use the policy recommendations from the Cost Trends Reports to draft bills, some of which have been adopted. For example, in line with the HPC's recommendations, the legislature passed a law in 2020 (Chapter 260) to reduce surprise bills by requiring providers and health plans to notify patients of a provider's network status before non-emergency procedures are performed and tell them how much they would pay for planned hospital stays and other health services. The HPC also recommended steps to create accountability for drug prices by pharmaceutical manufacturers, and while several legislative bills were introduced to do so, none have been adopted to date. Indeed, relatively few of the HPC's recommendations have been enacted, leading many respondents to believe the recommendations have had little influence in the political debate. Some respondents also believe that policy recommendations should be better balanced with recommended cost-containment strategies that payers, employers, and providers could implement.
- **Cost and Market Impact Reviews.** CMIRs analyze the impact of proposed health care market transactions, such as mergers and acquisitions, on costs. They are regarded as the HPC's most important tool for restraining consolidation in the health care market. Although the HPC's investigations and reports have played a role in blocking some transactions, most respondents did not think the CMIR process has slowed the overall trend toward consolidation. However, the HPC has conducted CMIRs for the vast majority of acquisitions of general acute care hospitals and mergers of hospital systems, and there have been fewer of these types of market changes over time. In addition, some providers indicated that knowing a CMIR might be required influences their decisions about how to structure a proposed consolidation and with whom to partner.
- **Performance Improvement Plans.** If the HPC Board finds excessive spending growth by an individual health care entity raises "significant concerns," it can require the entity to submit a formal PIP that describes the key drivers of spending growth and proposes strategies to address them. Many respondents reported they believe the HPC's PIP review process is rigorous, taking into account a range of factors that can cause an individual payer's or provider's spending growth to exceed the benchmark. However, until 2022, HPC did not require any entity to submit a PIP, despite conducting numerous PIP reviews, which led many respondents to believe that the process was ineffective and led payers and providers to minimize or dismiss the importance of PIP reviews. In addition, the entities and type of spending subject to potential PIP referral are defined in Chapter 224 in a manner that excludes a large share of hospital spending, which stakeholders perceive as a serious shortcoming.

Evolution of the overall influence of the health care cost growth benchmark initiative. The HPC achieved early success shortly after it began operating in 2012 by using its accountability tools and authority to effectively persuade health care entities to hold spending growth below the benchmark. Most

respondents believe the benchmark initiative as a whole has helped control cost growth; however, many say its influence has waned over time in response to how the HPC implemented some of the accountability mechanisms and as all stakeholders came to understand the limitations of the statute's accountability tools to constrain spending growth. Nearly all stakeholders say they still support the goal of cost containment, but the benchmark's influence on payers and providers has diminished over time. Also, the sentinel effect of the HPC's accountability mechanisms has become less powerful as the limits of the scope and authority of HPC's accountability mechanisms have become clear. Some respondents also had concerns about particular HPC decisions, such as not approving a formal PIP review for dozens of entities referred for PIP review over time (until recently). To address the limitations of Chapter 224, most respondents recommend stronger enforcement and "more teeth" going forward.

Considerations for other states

As of 2022, eight states have followed Massachusetts' lead and adopted programs setting health care cost growth benchmarks; several other states adopted elements of the initiative. The findings from this study highlight important lessons and raise considerations (Exhibit ES.1) for policymakers in other states about designing and using mechanisms to hold payers and providers accountable for keeping health care spending growth below the benchmark.

Exhibit ES.1. Lessons and considerations for other states

Accountability for meeting the benchmark



Which entities should be accountable for keeping spending growth below the benchmark?

Policymakers should consider which entities will be accountable for keeping spending growth below the benchmark. In Massachusetts, Chapter 224 allows the Health Policy Commission to hold some payers and certain types of providers accountable for excessive spending growth, but it does exclude some entities and types of spending that contribute to spending growth, such as pharmacy spending and hospital spending not attributable to affiliated physicians. To hold accountable all the health care entities whose business decisions drive health care spending growth, state policymakers should consider the full range of entities that drive cost increases, decide which to hold accountable, specifically define them, and devise spending metrics appropriate to each type of accountable entity.



Should state benchmark laws hold entities accountable for level of spending as well as growth?

Cost growth targets do not take into account variation across providers in the total level of spending per member or patient (the result of price times volume). By limiting accountability for cost growth alone, state policymakers can do little to address price variation and high prices charged by some providers, which is one of the primary drivers of cost growth. State policymakers should consider whether and how to hold entities accountable for level of spending as well as annual spending growth.

How should consumer out-of-pocket costs be considered in cost growth benchmarks?

State policymakers should consider whether to establish separate standards for consumer affordability that take into account growing out-of-pocket costs to accompany the total statewide growth benchmark.

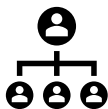
Accountability for meeting the benchmark



How much flexibility should state agencies have to decide whether spending growth above the benchmark is justified?

To make Performance Improvement Plans an effective deterrent to exceeding the benchmark, state policymakers can give the agency responsible for monitoring compliance the discretion to apply judgement as Massachusetts did. If state policymakers want to make the Performance Improvement Plan criteria less subjective, they could make the criteria that trigger a plan more prescriptive. For example, the criteria could specify that a Performance Improvement Plan is mandatory if spending growth exceeds the benchmark for a certain number of years, or they could define the cost growth factors that are within a payer's or provider's control.

Oversight authority and resources



Which agencies should have power to enforce compliance with the benchmark?

When setting up the structures, processes, and enforcement mechanisms associated with a cost growth benchmark, states need to decide which agencies have the power to hold entities accountable for meeting the benchmark and what type and how much authority these agencies should be granted. Separating powers across agencies according to their focus and expertise can maximize their effectiveness, but doing so runs the risk of yielding inconsistent decisions. Consolidating authority for all accountability and enforcement mechanisms within one agency can increase consistency in how it applies its authority but may give it too much power and make it more vulnerable to political pressure.



Which criteria warrant the use of greater enforcement powers or regulatory levers?

States should consider which criteria warrant the use of greater enforcement powers or regulatory levers if statewide health care spending growth exceeds the benchmark and what types of enforcement powers this could entail. Criteria could include the number of years that overall spending increases are above the benchmark, the degree to which spending growth exceeds the benchmark, the number of entities exceeding the cost growth benchmark, or other factors indicating that transparency and persuasion are insufficient to control cost growth.



What are the critical capabilities and resources needed to successfully implement accountability mechanisms?

Regardless of which agency or agencies are entrusted to monitor or enforce compliance, state policymakers should consider the level of funding and resources needed to hire qualified staff and fulfill its mandate effectively.

Incentives for compliance



What types and amounts of penalties are appropriate to motivate compliance? Should states balance penalties with positive incentives?

State policymakers should consider what financial penalties are sufficient to motivate agencies to meet the benchmark. It may also be useful to consider the value of adding positive incentives (carrots) to the negative incentives (sticks). Positive incentives could include awarding honorable mention on a website, in an annual report, or in other materials.



What tools can states use to encourage submission of timely, complete, accurate data?

The importance of high-quality data to the success of health care cost benchmarking initiatives also suggests the need for incentives to submit timely, complete, accurate data or penalties for failure to do so.

Conclusion

Massachusetts' experience illustrates the strengths and limitations of a cost control framework that relies on public oversight and transparency of health care spending, and on voluntary cooperation by payers and provider health care entities to keep annual cost growth below the target, but that grants the HPC few (or

weak) enforcement tools. Other states can learn many things from Massachusetts' use of accountability mechanisms, but the most important might be that constraining cost growth is not a "one and done" exercise. State policymakers must continually monitor market trends and refine or enact new measures to address emerging drivers of health care cost growth and respond to changes in the health care market. States that establish cost growth benchmark programs should also develop mechanisms to solicit feedback from key stakeholders—for example, by establishing advisory boards on the effectiveness of accountability mechanisms and potential improvements to them to ensure the state achieves its cost growth targets.

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