



Medical Spending Control: The Massachusetts Setting

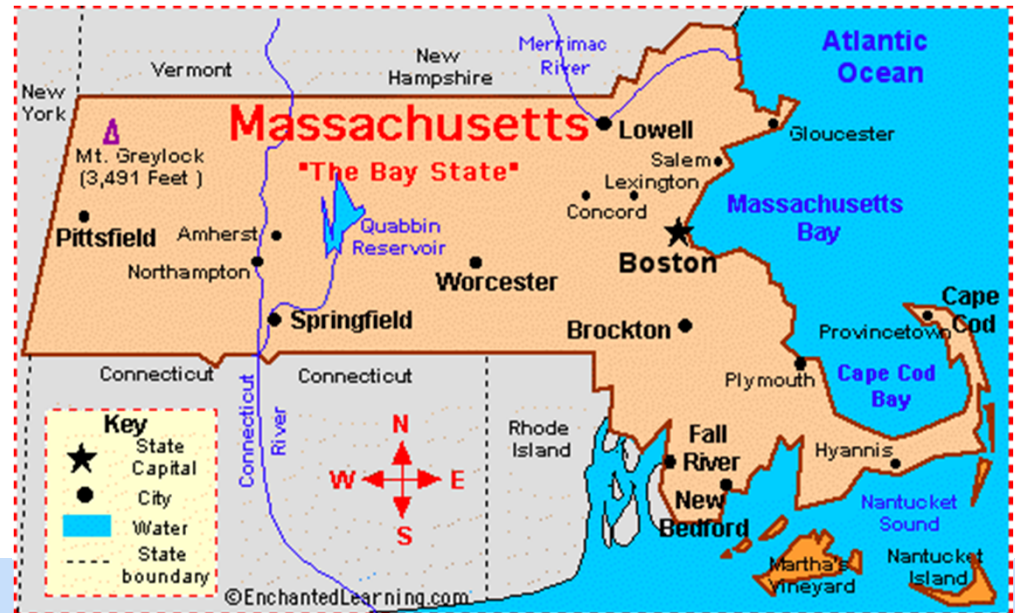
David M. Cutler
Department of Economics
Harvard University
July 16, 2012



The Setting

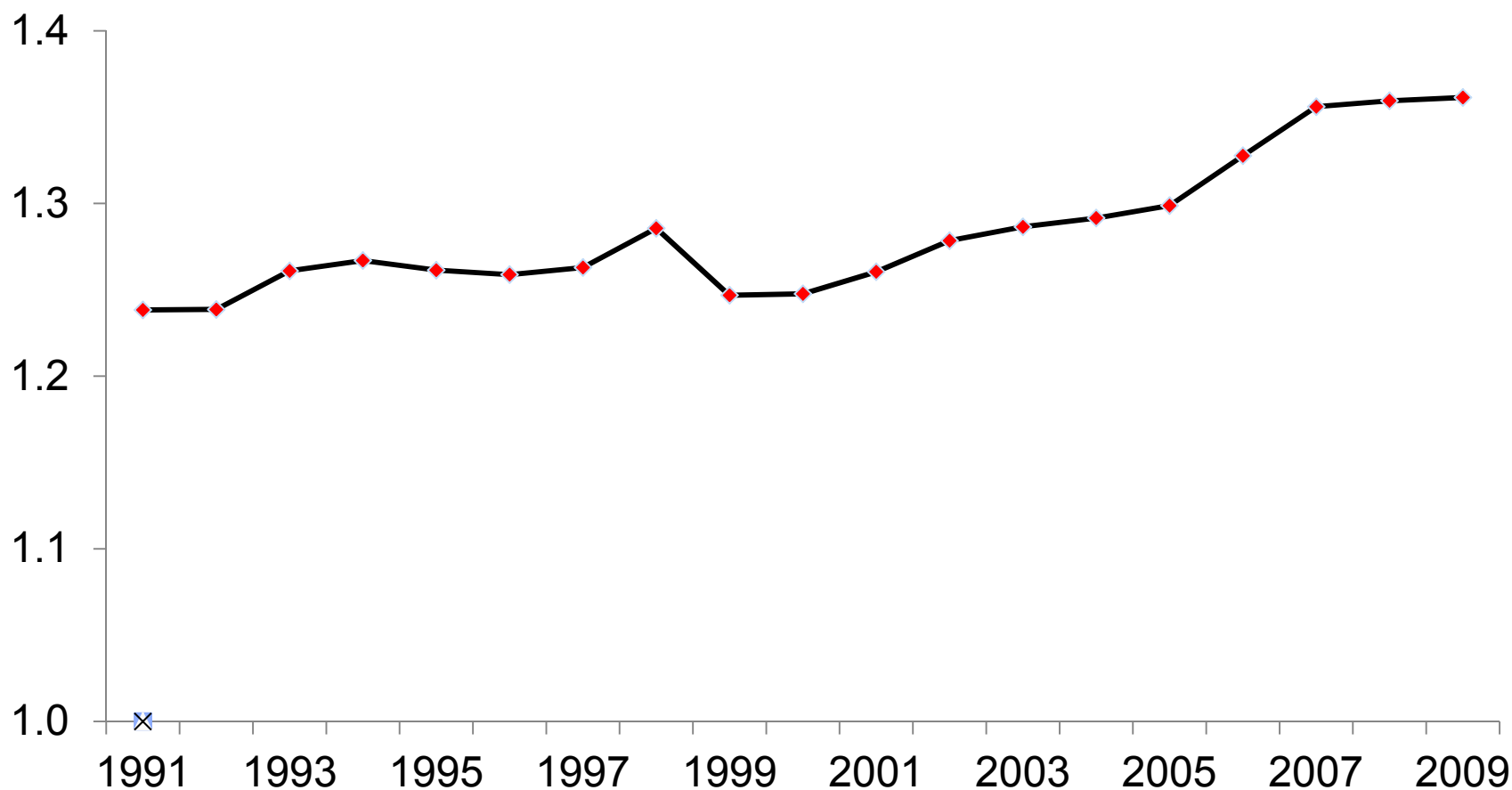
1. Successful coverage expansion, 2006

- 98%+ coverage
- Costs about what was expected
- Overwhelming public support
- Enormous pride



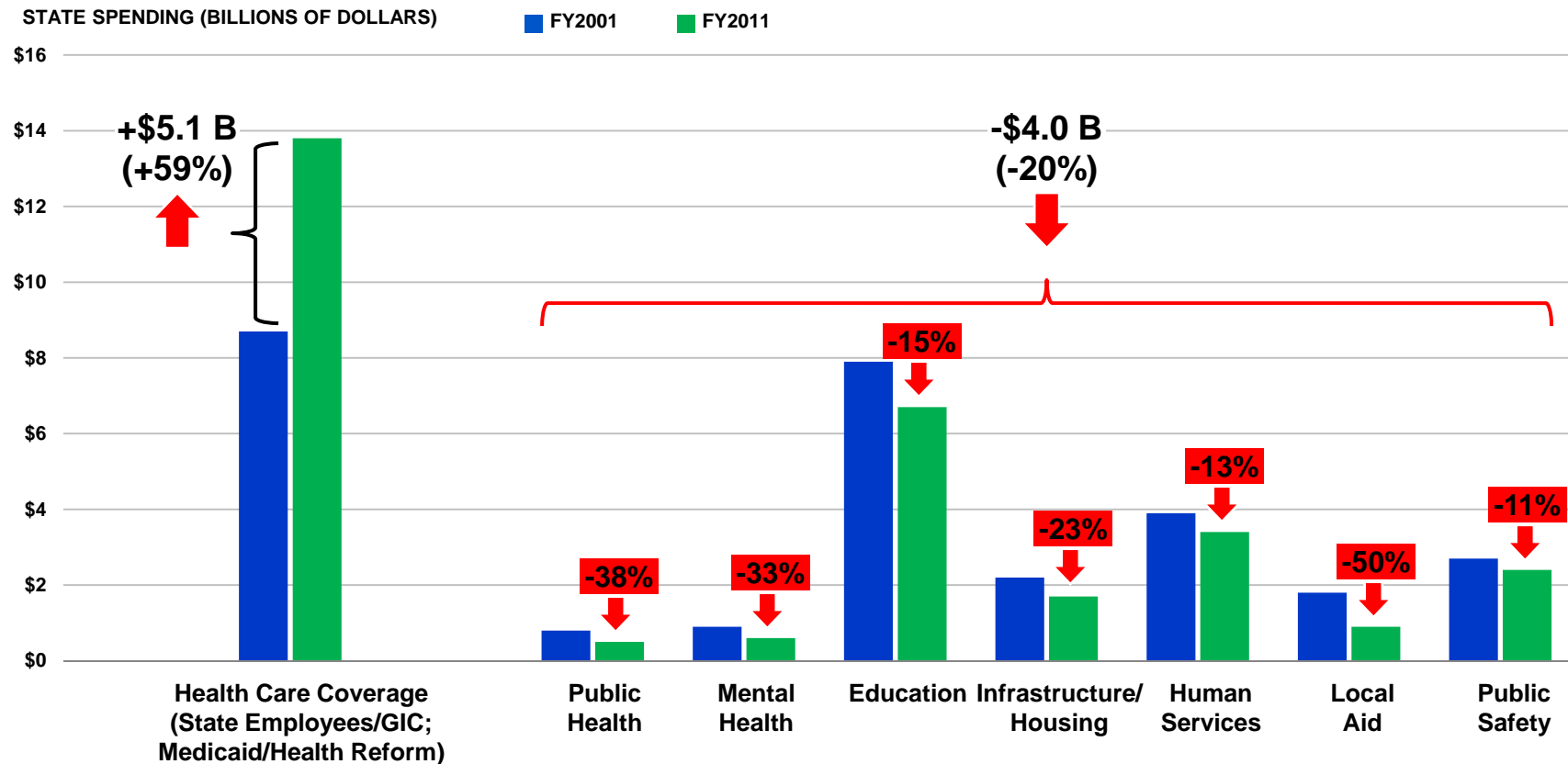
2. High and rising costs are a lingering issue

Ratio of per capita medical spending:
MA / US



Spending has crowded out every part of the state budget.

MASSACHUSETTS STATE BUDGET, FY2001 VS. FY2011



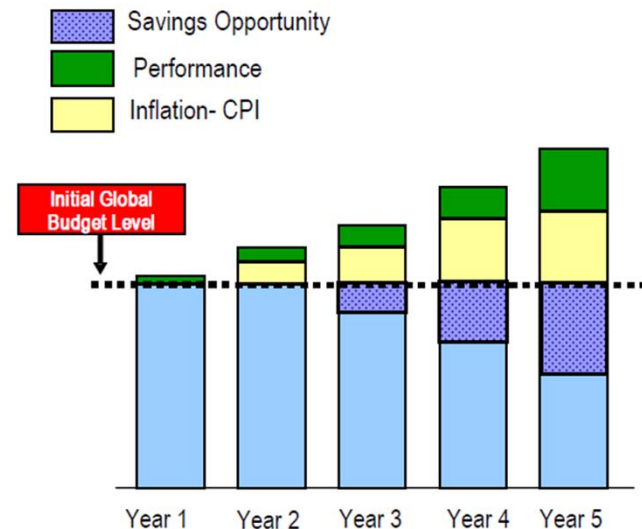
SOURCE: Massachusetts Budget and Policy Center [Budget Browser](#).

3. A history of global payment efforts

- 2009, Special Commission

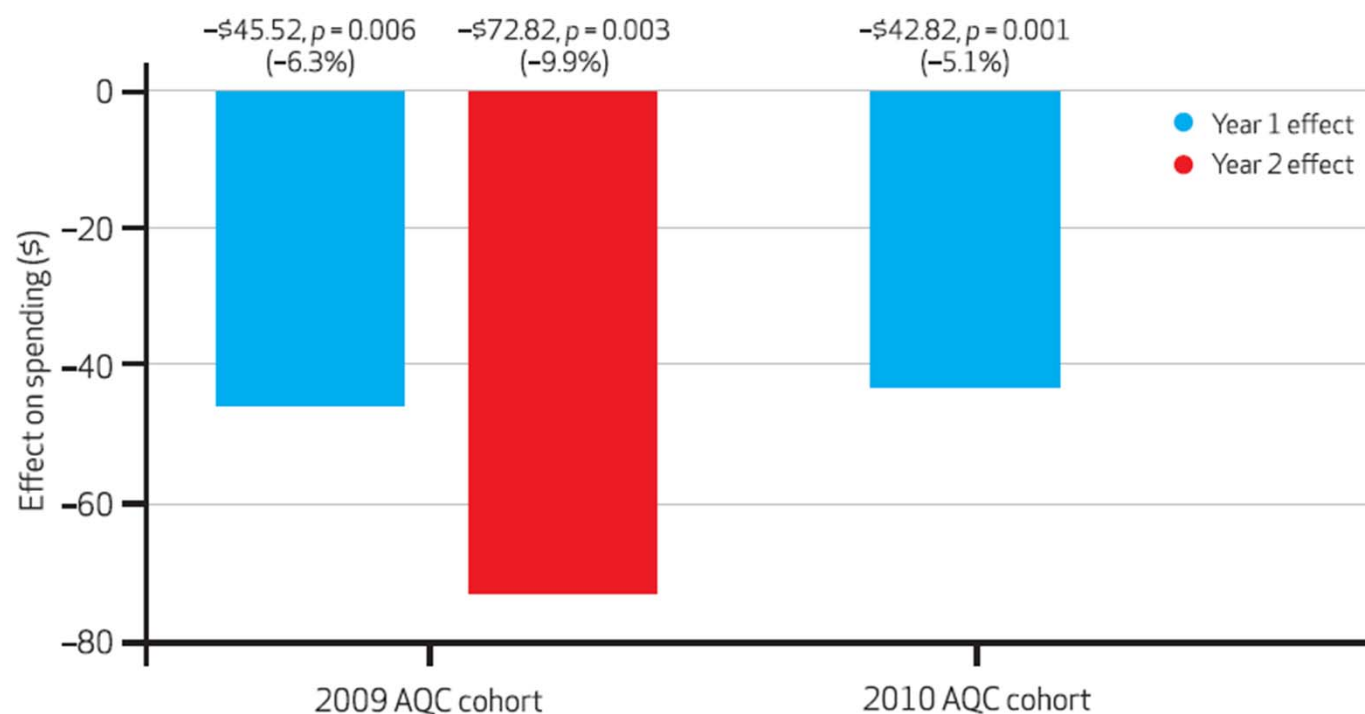
“The Special Commission recommends that global payments with adjustments to reward provision of accessible and high quality care become the predominant form of payment to providers in Massachusetts within a period of five years.”

- Blue Cross Blue Shield Alternative Quality Contract (2009)



The AQC is having an effect

Estimated Year 1 And Year 2 Effects Of The Alternative Quality Contract (AQC) On Spending In The 2009 And 2010 Cohorts' No-Prior-Risk Groups, Blue Cross Blue Shield Of Massachusetts



SOURCE Authors' analysis of 2006–10 claims data from Blue Cross Blue Shield of Massachusetts.

NOTES The figure shows difference-in-differences estimates of the separate year 1 and year 2 effects of the AQC on health care spending per member per quarter. For descriptions of the 2009 and 2010 cohorts, see the text.

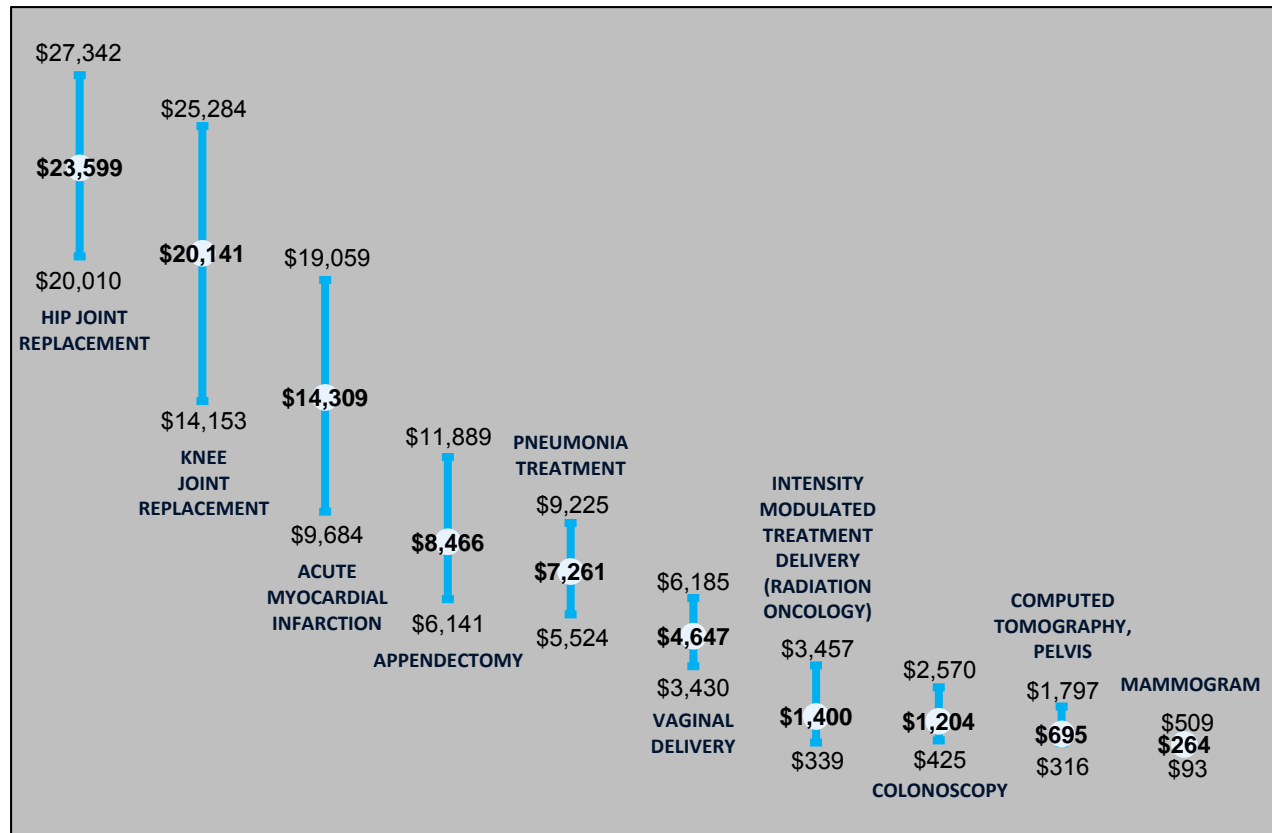
4. Best guess: 1/3 of medical spending is unnecessary

Estimates of excessive spending in medical care		
Category	Amount	% of total
Poor care delivery		
Unnecessary services	\$192 billion	7%
Failures of care delivery	\$128 billion	5%
Failures of care coordination	\$35 billion	1%
Excessive prices	\$248 billion	9%
Administrative costs	\$131 billion	5%
Fraud and abuse	\$177 billion	7%
Total	\$910 billion	34%

Source: Berwick and Hackbarth, *JAMA*, 2012.

The Prices Paid to Providers for Delivering the Same Services Vary Enormously

HOSPITAL-SPECIFIC SEVERITY-ADJUSTED PRICE VARIATION FOR SELECTED PROCEDURES IN MASSACHUSETTS



Prices can vary enormously, even for common services unlikely to be affected by patient sickness or complexity. Prices at the highest-paid providers can be more than 10 times as much as prices at the lowest-paid providers.

NOTE: Includes only hospitals with at least 30 discharges.

SOURCE: Massachusetts Division of Health Care Finance and Policy, ["Massachusetts Health Care Cost Trends: Price Variation in Health Care Services,"](#) May 2011.

Examples of cost savings

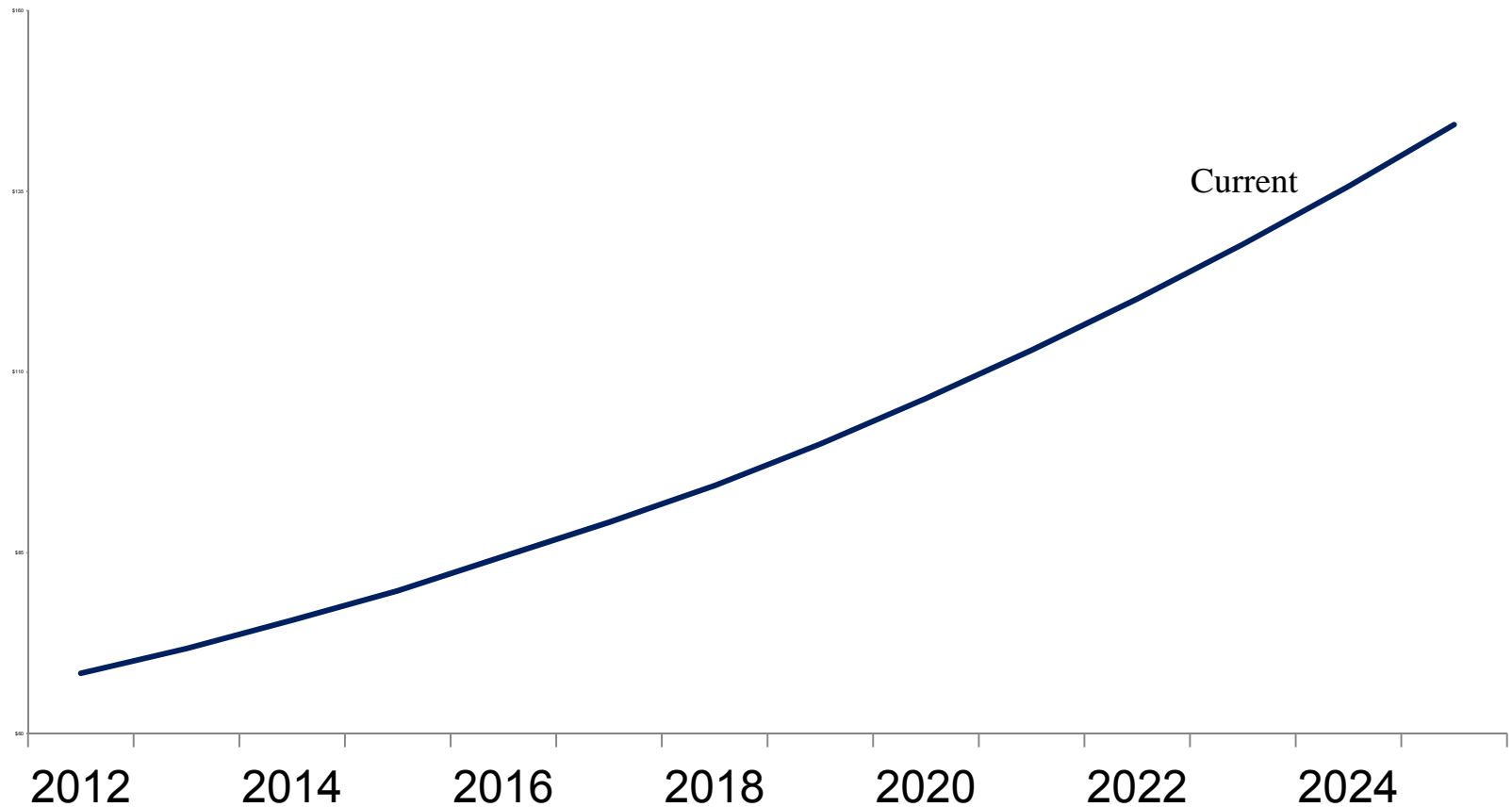
Provider	Type of care	Specific problem	Intervention	Annual cost savings	Projected national savings
Kaiser	Primary care	Wasted visits	EHR	\$500 m	\$7 bn
Mayo clinic	Primary care	Specialist consultations	Team approach	---	---
Geisinger	Acute	CABG	ProvenCare	5% of hospital	\$400 m
Inter-mountain	Acute	Pre-term births	Collaborative	\$50 m	\$4 b
Virginia Mason	Acute	Back surgery	Collaborative	\$1.7 m	\$45 b

WHAT DOES ONE DO?

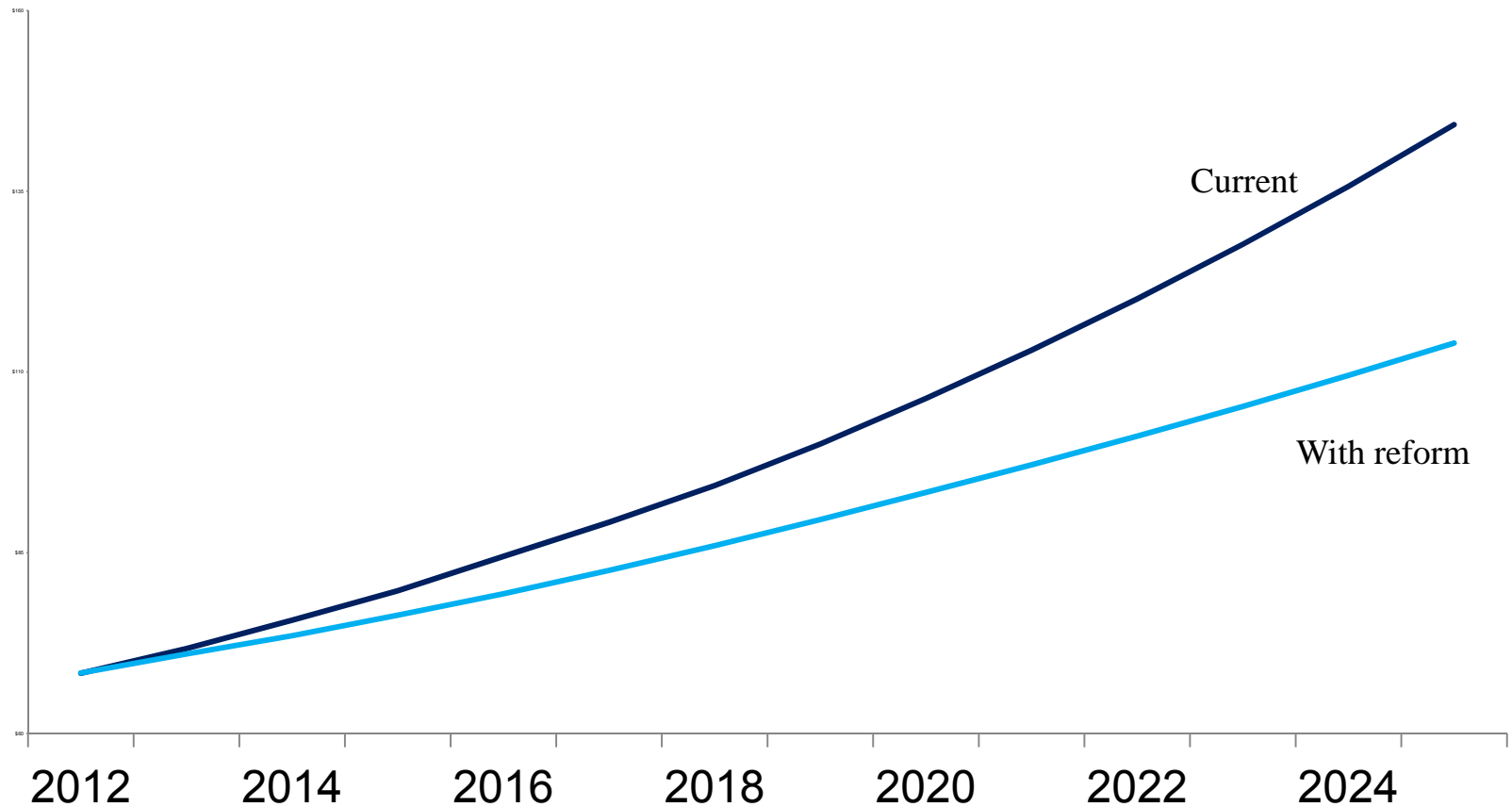
The goal: slow down cost increases

Benchmark	Approximate magnitude
Premiums	8.0%
Forecast medical spending per capita	5.5% - 6.0%
Forecast GSP per capita	4.0%
Inflation rate	2.0%

Medical spending with and without reform



Medical spending with and without reform



Consensus in MA

Statement	Perceived accuracy
About one-third of medical spending is not necessary	A-
We can squeeze out this waste in {5, 10, 15} years	C
A very important step in reducing waste is:	
Payment reform	A
'Smarter' cost sharing for individuals	B+
Administrative simplification	B
Rate regulation	C
Malpractice reform	C

Consensus in MA

Statement	Perceived accuracy
About one-third of medical spending is not necessary	A-
We can squeeze out this waste in {5, 10, 15} years	C
A very important step in reducing waste is:	
Payment reform	A
'Smarter' cost sharing for individuals	B+
Administrative simplification	B
Rate regulation	C
Malpractice reform	C

1. Invigorated demand side

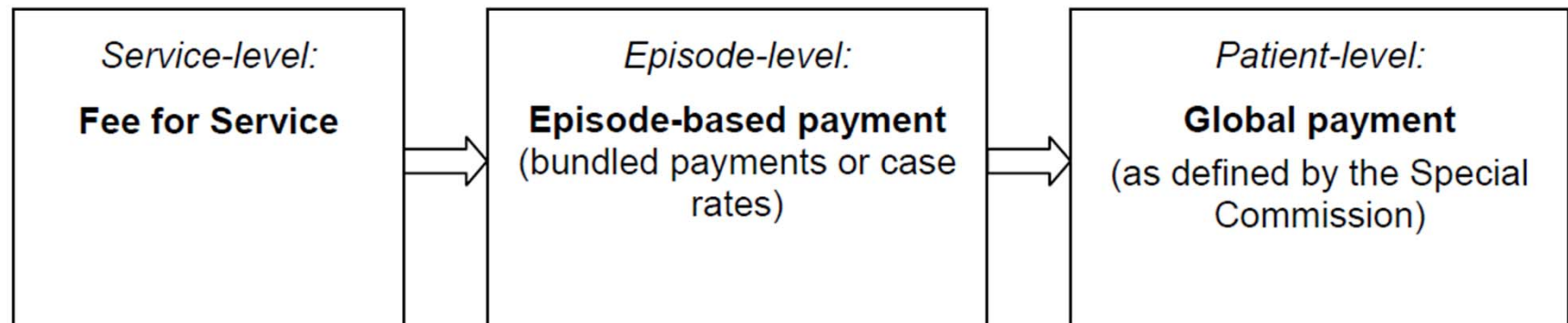
- Dissemination of price, quality information
 - ✓ Require this in legislation
- Tiering / sensitive cost sharing for more expensive care
 - ✓ Already required in legislation and doing well.



2. Supply side – payment reform

- Move to bundled payments for all payers, with a residual FFS vs. the reverse now
 - Either episode-based payments or global payment
- ✓ Require this in legislation; need Medicare waiver or Innovation Center demonstration

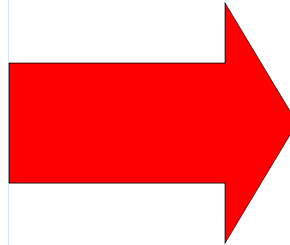
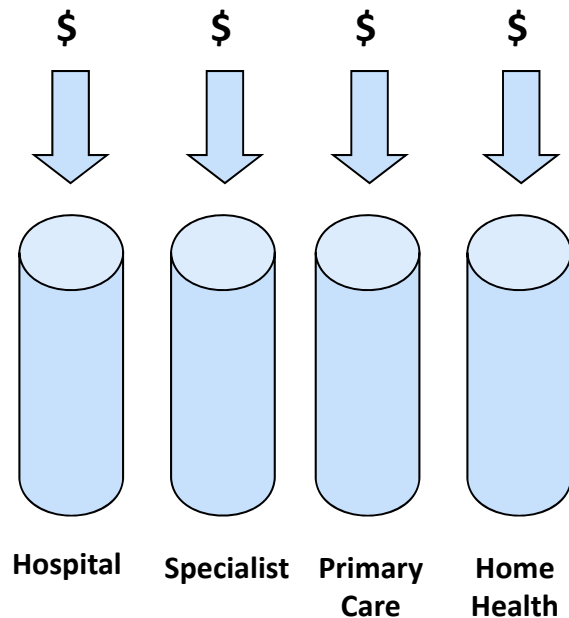
ALTERNATIVE PAYMENT MODELS (INCREASING LEVEL OF SERVICE BUNDLING):



Current Fee-for-Service Payment System

The Problem

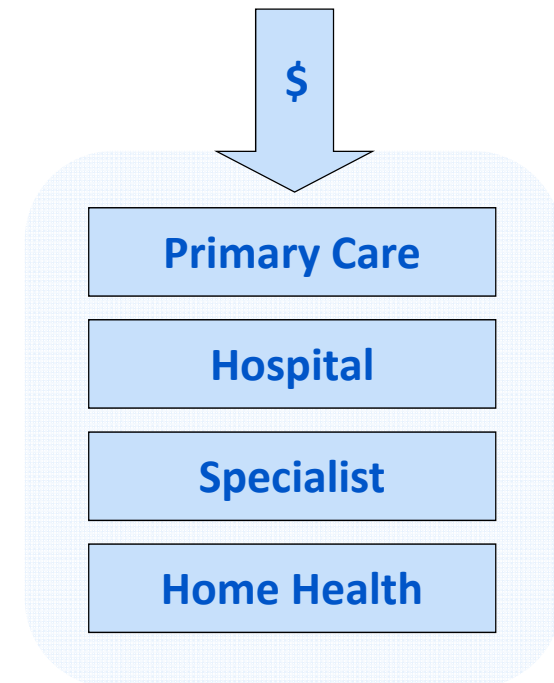
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



Patient-Centered Global Payment System

The Solution

Global payments made to a group of providers for all care. Providers are not rewarded for delivering *more* care, but for delivering the *right* care to meet patient's needs.



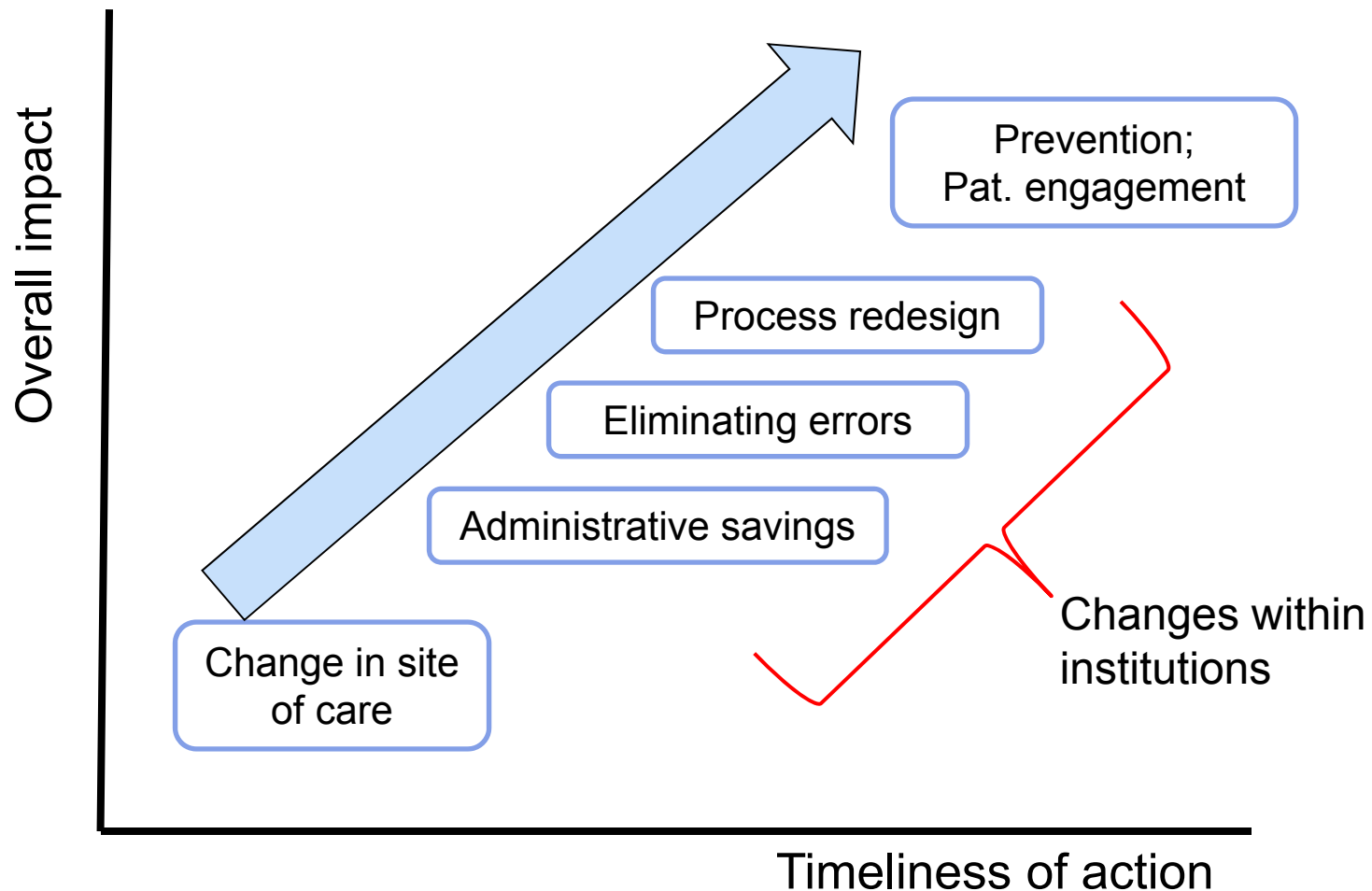
Other components

3. Medical malpractice: less litigation

4. Administrative simplification

- Build on our efforts through NEHEN

How long does it take to save one-third?



The goal: slow down cost increases

Benchmark	Approximate magnitude
Premiums	8.0%
Forecast medical spending per capita	5.5% - 6.0%
Forecast GSP per capita	4.0%
Inflation rate	2.0%

GOAL:

By 3 years

Potential GSP (+/- .5%)

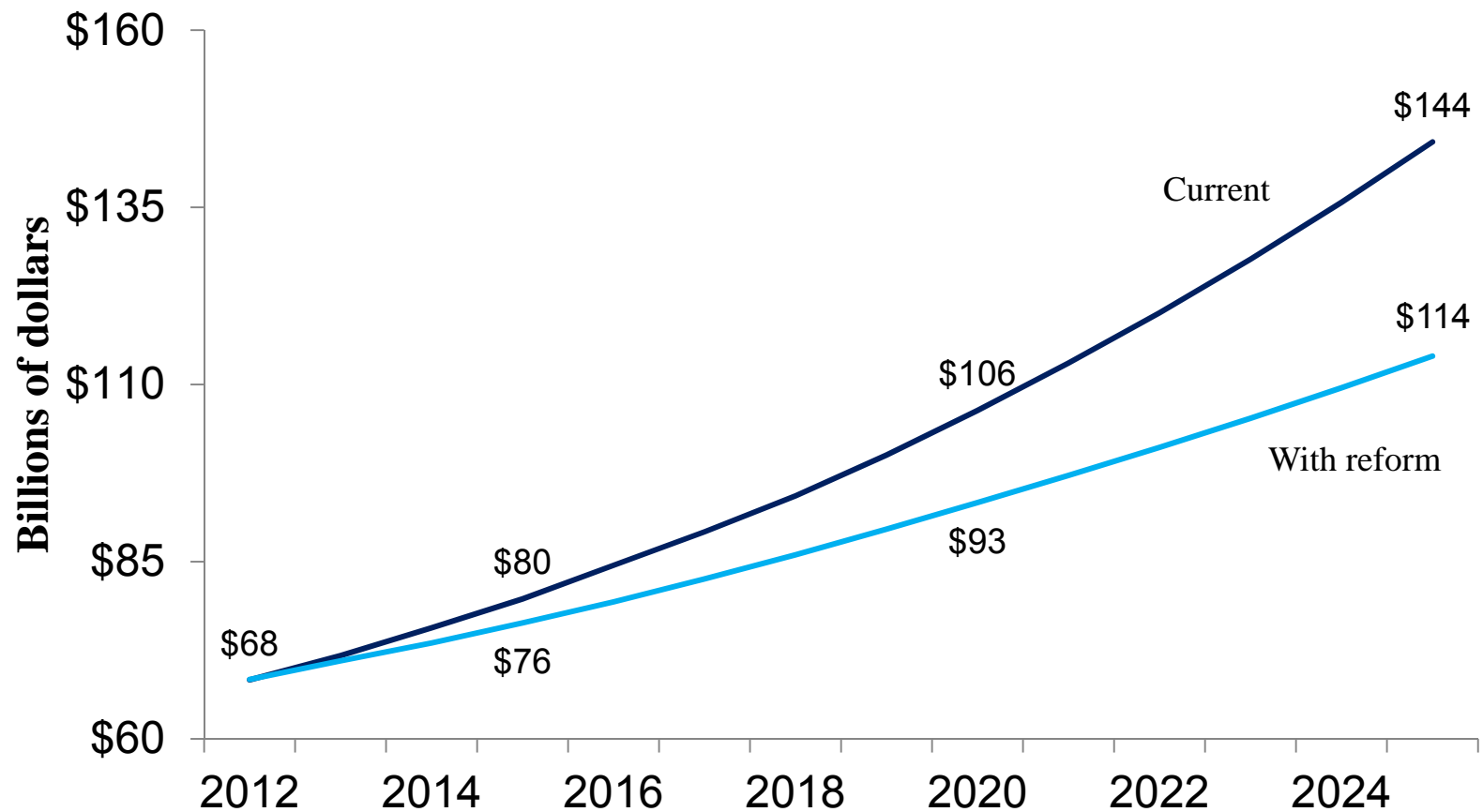
After 13 years

Potential GSP (maybe + 1%)

The target

- Legislation is likely to have a target growth rate.
 - Board to monitor growth and determine explanations
- What if the target is not met?
 - Action plan required
 - Possible changes to payment methodologies
 - No sentiment for rate regulation

Medical Spending With and Without Reform (\$ billion)



The savings will be over \$160 billion in the first 15 years.