CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

BOSTON • MASS.

NUMBER 1 OF 12 • SEPTEMBER 2010

In March 2010, a team of researchers from the Center for Studying Health System Change (HSC), as part of the Community Tracking Study, visited the Boston metropolitan area to study how health care is organized, financed and delivered in that community. Researchers interviewed more than 50 health care leaders, including representatives of major hospital systems, physician groups, insurers, employers, benefits consultants, community health centers, state and local health agencies, and others. Researchers also conducted several follow-up interviews by phone from April through July 2010. The study area encompasses Essex, Middlesex, Norfolk, Plymouth and Suffolk counties.

STATE REFORM DOMINATES BOSTON HEALTH CARE MARKET DYNAMICS

Massachusetts' 2006 landmark health reform law has reverberated throughout the Boston health care market as providers, insurers, employers and consumers adjust and adapt to a post-reform world of nearly universal health insurance coverage. Political support for health reform has remained strong and broad-based, but reform opponents are more vocal—especially small employers whose premiums have increased substantially since the merger of the small group and individual health insurance markets. Statewide, uninsurance rates dropped to 2.7 percent in 2009, down from 8.2 percent in 2006 before passage of the law that included an individual mandate for most adults to gain health coverage and new requirements for employers. The recession, which started later and was not quite as severe in Boston compared to many other metropolitan areas, has had little impact on the insurance coverage expansions gained through reform.

Key developments include:

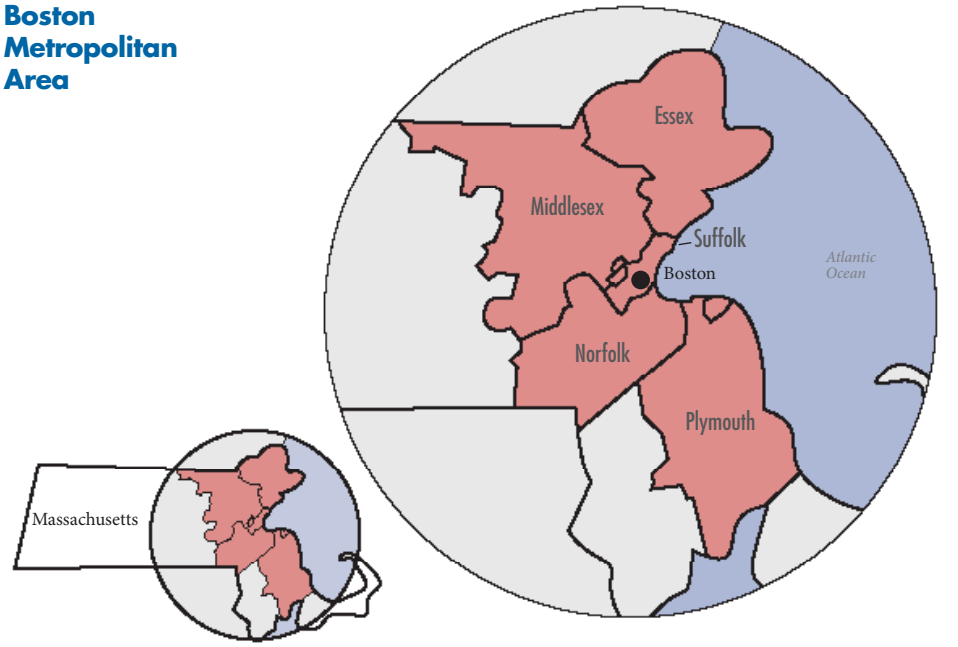
- With state policy makers deferring hard decisions in the reform law about slowing the growth of health care spending, costs have continued to increase rapidly, fueled in part by the ability of Boston's renowned academic medical centers (AMCs) to command higher prices and attract more patients from community hospitals.
- State regulators and health plans have been embroiled in disputes over proposed rate increases for the small group market, even though the major plans faced operating losses as medical costs continued to increase.
- The fabric of Boston's traditionally strong health care safety net is changing with most community health centers (CHCs) benefiting from coverage expansions and safety net hospitals struggling financially as the state shifts uncompensated care funding toward insurance subsidies to expand coverage.

Bellwether for National Reform?

Massachusetts was a focal point as the national health reform debate unfolded, prompting many to view the state as a bellwether for implementation of national health reform. However, Massachusetts and the greater Boston area (see map on page 2) were better positioned to achieve universal coverage than other parts of the country, given their low uninsurance rates prior to health reform. In addition, Boston—an affluent community with better health and greater health care provider capacity than other metropolitan areas—has not experienced significant provider shortages and access issues as a result of coverage expansions.

At the same time, Boston's very affluence and the prominent standing of its renowned academic medical centers have made cost containment a

Boston Metropolitan Area



particular challenge. Historically, the Boston community has taken pride in its health care institutions, especially the flagship hospitals of Partners HealthCare—Massachusetts General Hospital and Brigham and Women's Hospital—and Children's Hospital Boston. But with a high concentration of AMCs and specialists, the market also is characterized by a high proportion of medical care—even relatively routine care—provided in expensive advanced settings. This pattern has been accentuated in recent years as the AMCs extended their reach into the suburbs with the construction of satellite outpatient facilities and growing affiliations with community-based physicians. These developments have resulted not only in a greater volume of ambulatory care provided at higher rates by providers affiliated with or owned by the AMCs, but also increased referrals to the flagship hospitals for inpatient care.

The large and growing share of medical care provided by the AMCs—for outpatient as well as inpatient care—has been a major factor in costs rapidly escalating from a historically high base. Stakeholders all agreed that cost trends are unsustainable, but many observers were not convinced that there is sufficient political will to curb rates for high-cost hospital systems, given the potential impact on employment. Not only is the hospital sector among the largest employers in the market, but it was also the only one to have grown during the recession.

Costs Higher in Merged Insurance Market

A key provision of Massachusetts' health reform law was the merger of the small group and individual, or nongroup, insurance markets, which was designed to make premiums more affordable for individual purchasers. Originally, the state estimated that the merged market would reduce nongroup premiums by 15 percent and raise small group premiums by only 1 percent to 1.5 percent on average. Health plan executives indicated the merger has caused small group premiums to increase more—the result, they say, of a weak individual mandate, relaxation of pre-existing condition limitations and waiting periods, and allowing some of the youngest and healthiest to avoid the merged risk pool by purchasing less expensive coverage in the separate young adult market or remaining on their parents' plans up to age 26.

Many observers considered the individual mandate to be weak because, for adults with incomes of at least 300 percent of poverty, or $32,490 for a single person in 2010, the penalty for being uninsured ($1,068 in 2009) amounts to only half the cost of the available lowest-cost plan. In addition, the penalty is assessed on a pro-rated basis ($89 per month) for the months a resident lacks coverage. According to health plan executives and several market observers, this mild penalty invites individuals—known as "jumpers"—to purchase insurance only for periods when they expect to need care—especially expensive care. Reportedly, some people already covered by employer-sponsored insurance have been buying short-term policies in the merged market to gain access to fertility treatments—a mandated benefit for fully insured policies, but one that self-insured employers that are exempt from state mandates tend not to provide.

A state-commissioned report, released in June 2010 and comparing data between 2006 and 2008, estimated that the merger—principally because of adverse selection, or attracting sicker than average enrollees—increased premiums in the small group market by 2.6 percent statewide, rather than the projected 1 percent to 1.5 percent. The effects varied widely across health plans—ranging from -4.3 percent to 5.9 percent—but plan-specific estimates were not publicly available.

Health plans have pushed for changes, including eliminating continuous open enrollment; assessing the full annual penalty for any significant period of continuous uninsurance, such as

60 days; imposing waiting periods for certain services; and barring consumers from buying in the merged market if they have access to employer-sponsored coverage. While state policy makers have conceded that the individual mandate needs to be tightened, their proposed solutions have been less stringent than those favored by the plans.

The state Legislature passed Senate Bill 2585—widely referred to as the "small business health care cost containment bill"—and Gov. Deval Patrick signed the bill into law in August. The law limits open enrollment in the merged market to twice a year in 2011 and once a year thereafter—a change that should improve the merged market risk pool by reducing the ability of individuals to jump in and out of coverage. However, the new law did not change the amount of the penalty for being uninsured or the method for monthly pro-rating the penalty. As one market observer noted, "It's a tough balancing act for the state…clearly, too weak a mandate, as we've had, means that some people inevitably will opt out [of coverage] and the pool suffers from [adverse] selection, but once you impose serious penalties, you'd really see public support for reform fall off."

State Forces Rollback of Small Group Premiums

The Boston market continues to be dominated by three local, nonprofit health plans: Blue Cross and Blue Shield of Massachusetts (with approximately 50% commercial market share), Harvard Pilgrim Health Care (20%) and Tufts Health Plan (15%). These three major plans consistently earn high ratings in national health plan rankings and have medical loss ratios in the range of 88 percent to 90 percent. The rest of the commercial market is shared by national for-profit plans and smaller local, nonprofit plans, including Fallon Community Health Plan and Neighborhood Health Plan.

Health plans—citing substantial losses in the small group market in 2009—planned double-digit premium increases in 2010. However, in February, the governor filed emergency regulations authorizing the state Division of Insurance (DOI) to disapprove any small group rate increases exceeding medical inflation by a certain margin. In determining whether to disapprove rates, DOI used a threshold of 7.7 percent, or 150 percent of medical inflation for the northeast region of the country. DOI has long had the authority to review rates but had never exercised it until 2010.

The governor's action to cap premiums was widely viewed as politically motivated in a gubernatorial election year. One market observer captured the views of several respondents when he commented, "It allows [the governor] to paint himself as a champion of small businesses…Never mind that his own agencies are producing all this [evidence] showing…it's the big-name hospitals and those rural [hospitals with geographic monopolies] that are driving [cost] trends. It plays better politically to vilify [insurers]."

As widely expected, the DOI in April rejected nearly all small group rate increases proposed by the major local health plans—a move that forced the plans to reinstate rates from April 2009. The plans, which incurred operating losses in 2009—except for Harvard Pilgrim—because of the recession and higher-than-expected medical utilization, had expected 2010 to be a recovery year. Instead, the local plans all recorded sizable operating losses for the first quarter of 2010 and had to draw on reserves to cover expected losses resulting from the rate rollbacks. This stood in stark contrast to the strong financial performance reported by health plans nationally in the first quarter of 2010, according to Goldman Sachs.

Boston Demographics

Boston Metropolitan Area	*Metropolitan Areas 400,000+ Population*
Population, 2009[1]	
4,165,815	
Population Growth, 5-Year, 2004-09[2]	
2.9%	*5.5%*
Age[3]	
Under 18	
22.0%	*24.8%*
18-64	
65.2%	*63.3%*
65+	
12.8%	*11.9%*
Education[3]	
High School or Higher	
89.6%	*85.4%*
Bachelor's Degree or Higher	
*42.6%**	*31.0%*
Race/Ethnicity[4]	
White	
76.4%	*59.9%*
Black	
7.1%	*13.3%*
Latino	
8.7%	*18.6%*
Asian	
6.4%	*5.7%*
Other Race or Multiple Races	
1.4%	*4.2%*
Other[3]	
Limited/No English	
9.7%	*10.8%*

* Indicates a 12-site high.

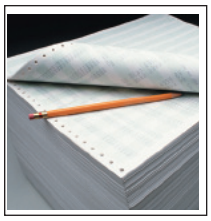
Sources:

[1] *U.S. Census Bureau, Annual Population Estimate, 2009*

[2] *U.S. Census Bureau, Annual Population Estimate, 2004 and 2009*

[3] *U.S. Census Bureau, American Community Survey, 2008*

[4] *U.S. Census Bureau, American Community Survey, 2008, weighted by U.S. Census Bureau, Annual Population Estimate, 2008*



Economic Indicators

Boston Metropolitan Area	*Metropolitan Areas 400,000+ Population*
Individual Income less than 200% of Federal Poverty Level[1]	
20.9%	*26.3%*
Household Income more than $50,000[1]	
64.0%	*56.1%*
Recipients of Income Assistance and/or Food Stamps[1]	
7.4%	*7.7%*
Persons Without Health Insurance[1]	
4.1%#	*14.9%*
Unemployment Rate, 2008[2]	
4.6%	*5.7%*
Unemployment Rate, 2009[3]	
7.4%	*9.2%*
Unemployment Rate, March 2010[4]	
8.4%	*10.4%*

# Indicates a 12-site low.

Sources:

[1] *U.S. Census Bureau, American Community Survey, 2008.* 200% of Federal Poverty Level is $21,660 for an individual in 2010.

[2] *Bureau of Labor Statistics, average annual unemployment rate, 2008*

[3] *Bureau of Labor Statistics, average annual unemployment rate, 2009*

[4] *Bureau of Labor Statistics, monthly unemployment rate, March 2010, not seasonally adjusted*

[5] *U.S. Census Bureau, American Community Survey, 2008*

After DOI rejected the rate increases, the plans joined together in suing the state and also filed separate administrative appeals. In an unexpected development, a DOI review panel reversed Harvard Pilgrim's rate disapprovals, finding that the increases initially sought by the plan were reasonable in light of the rates the plan pays providers. Despite prevailing on appeal, Harvard Pilgrim subsequently reached a surprise settlement with the state, as did Blue Cross and Tufts, whose appeals had yet to be decided. Each plan agreed to rate increases averaging slightly above 8 percent—in most cases, well below their initial proposed increases—and also promised not to seek retroactive rate increases for 2010 policies that had been renewed at 2009 rates. The plans contend that the agreed-upon rate increases are insufficient to cover their costs in the merged market but said they chose to settle to put the contentious standoff behind them and encourage the state to turn its attention to addressing underlying cost drivers.

The new small business cost containment law broadens state authority over health plans. In the future, plans will be required to file all small group rate proposals with DOI 90 days before they are to take effect. Among other provisions, the new law stipulates that plans failing to maintain aggregate medical loss ratios of 88 percent in the merged market will either have their rates disapproved by DOI or be required to refund excess premiums to policyholders. While the law tightens restrictions on plans, it does bring more certainty to the rate-filing process, by setting timelines for how quickly DOI must conduct hearings and rule on disapproved rates. This may alleviate some of the turmoil and uncertainty clouding the merged market since early 2010, when the state first took action to cap rates.

Hospitals as Key Cost Drivers

While the state has focused on capping premium rates, health plans and market observers pointed to high and rapidly rising hospital prices as the primary factor underlying high premium increases. This point has been reinforced in the past year by a series of high-profile reports and hearings, all pointing to hospital prices as key cost drivers. Most notably, state Attorney General Martha Coakley released a February 2010 report showing large disparities in hospital payment rates and emphasizing that those disparities were not related to quality gaps. The report attributed 75 percent of medical spending trends to provider price increases and 25 percent to increased utilization.

Others in the market, including health plans, have broken down spending trends in greater detail, decomposing provider price increases (75% of spending trends) into two components: increases in unit price (50%) and changes in provider mix (25%). Changes in provider mix involve shifts in care from lower-cost to higher-cost settings—that is, from freestanding outpatient facilities to hospital outpatient departments and from community hospitals to academic medical centers, which are reimbursed at the highest rates.

According to health plan respondents, AMCs not only receive the highest payment levels, but also are able to negotiate the largest percentage increases, thus increasing spending trends and widening the disparities between have and have-not providers in the market. Many market observers spoke of different tiers of hospital leverage in the Boston market, with universal agreement that Children's Hospital and the hospitals in the Partners system are "rate setters" occupying the top tier. The prestige and brand name associated

with Massachusetts General Hospital, Brigham and Women's Hospital and Children's Hospital allow these hospitals to exercise market leverage far beyond what their market shares might suggest, according to market observers. The strong market position of these three hospitals is reflected not only in consistently robust operating margins but also, according to the state, very large reserves—$951 million for Children's Hospital and $710 million for Massachusetts General Hospital.

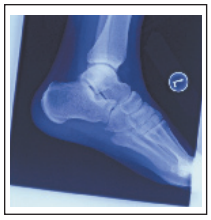
Beth Israel Deaconess Medical Center reportedly has some leverage in rate negotiations with heath plans, while the remaining hospitals in the Boston market were viewed as having little or no negotiating power. These include Tufts Medical Center (a smaller, financially weaker AMC), Caritas Christi Health Care (which owns six community hospitals in the greater Boston area), and two safety net hospitals—Boston Medical Center and Cambridge Health Alliance.

Nearly all hospitals in the greater Boston area currently have nonprofit status, but a notable development in March 2010 was the proposed sale of Caritas Christi, owned by the Catholic Archdiocese of Boston, to private equity firm Cerberus Capital Management for $830 million. For many years, Caritas struggled financially. A new management team turned around the system's financial performance, but the system has been seeking a buyer because of a weak balance sheet. Under the Cerberus deal, the Caritas management team will stay in place, all employees will be retained and Cerberus has pledged to maintain Caritas' charitable mission. However, the sale of Caritas remains a topic of intense debate, with public advocates questioning whether a for-profit company, especially one with no background in hospital operations, will maintain Caritas' mission of serving low-income people over the long run. The attorney general held hearings on the proposed purchase, and the state has yet to approve the deal.

AMCs Reach into Suburbs, Expand Market Share

Compared to other metropolitan markets, Boston has always stood out in the importance and status of its AMCs and the extent to which many patients seek care at these downtown facilities, even for services that are not highly specialized. Over the past several years, all AMCs have extended their reach into the suburbs by constructing satellite outpatient facilities as well as purchasing and affiliating with existing community providers. Within the last three years, for example, Partners has opened large outpatient centers in Danvers (on the North Shore) and Foxborough (on the South Shore) and a cancer center operated jointly with the Dana-Farber Cancer Institute in South Weymouth (on the South Shore). AMC expansion poses a serious threat to community hospitals in the vicinity, which are at a competitive disadvantage in physician recruitment, reimbursement rates and referrals.

Health plans noted that suburban expansion by AMCs has put pressure on costs in two ways: by raising the rates paid for services delivered in community settings and by increasing the number of referrals to downtown AMCs, which command the highest rates. As noted earlier, plans attributed about one-quarter of their cost trends to a shift in provider mix toward higher-cost settings. A state report confirmed that an increasing share of outpatient expenditures has been concentrated in Boston-area AMCs since 2006. Compared to many other metropolitan markets, Boston has relatively few freestanding ambulatory surgery centers and imaging centers to begin with. A recent development noted by several respondents is that physician-



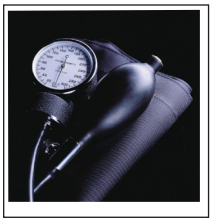
Health Status[1]

Boston Metropolitan Area	*Metropolitan Areas 400,000+ Population*
Chronic Conditions	
Asthma	
15.2%	*13.4%*
Diabetes	
6.2%#	*8.2%*
Angina or Coronary Heart Disease	
3.5%	*4.1%*
Other	
Overweight or Obese	
53.2%#	*60.2%*
Adult Smoker	
13.6%	*18.3%*
Self-Reported Health Status Fair or Poor	
10.9%#	*14.1%*

# Indicates a 12-site low.

Source:

[1] *Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2008 (values do not include Essex County)*



Health System Characteristics

Boston Metropolitan Area	*Metropolitan Areas 400,000+ Population*
Hospitals[1]	
Staffed Hospital Beds per 1,000 Population	
2.5	*2.5*
Average Length of Hospital Stay (Days)	
5.0	*5.3*
Health Professional Supply	
Physicians per 100,000 Population[2]	
*366**	*233*
Primary Care Physicians per 100,000 Population[2]	
*114**	*83*
Specialist Physicians per 100,000 Population[2]	
*252**	*150*
Dentists per 100,000 Population[2]	
84	*62*
Average monthly per-capita reimbursement for beneficiaries enrolled in fee-for-service Medicare[3]	
$701	*$713*

* Indicates a 12-site high.

Sources

[1] *American Hospital Association, 2008*

[2] *Area Resource File, 2008 (includes nonfederal, patient care physicians)*

[3] *HSC analysis of 2008 county per capita Medicare fee-for-service expenditures, Part A and Part B aged and disabled, weighted by enrollment and demographic and risk factors. See* www.cms.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp.

owners of these facilities have been approaching hospitals with offers to sell the facilities, reportedly because recent updates to the Medicare physician fee schedule and more aggressive health plan utilization management have made these facilities less profitable, particularly for cardiac imaging. If freestanding facilities are purchased by hospitals, the short-term impact will likely be a substantial increase in rates paid for services delivered at these facilities.

Efforts to Curb Provider Rates Stalled

Policy makers have proposed curbing provider rates—in particular, hospital rates. Some state legislators had proposed pegging rates to a percentage of Medicare—110 percent, in one proposal—as a temporary measure. The governor had proposed giving the state the authority to tie provider rate increases to medical inflation—as the state already has the power to do for insurer rates. Many stakeholders had opposed the governor's "one-size-fits-all" approach, noting its potential for exacerbating disparities between hospital haves and have-nots, since some hospitals in the latter group may need significant rate increases to remain financially viable. Some of these stakeholders supported an approach of restricting rate increases only for hospitals with rates above the median.

Respondents expressed skepticism that strong measures aimed at curbing hospital costs would be enacted. As one market observer commented, "The largest employers are all health care related…Anything anyone suggests to curb provider costs is labeled a 'job killer' bill immediately." Another observer noted, "When the Coakley report came out in February, many of us thought it would be a game changer…but did anything happen with the hospitals? No, only the insurers got hammered. Then, when the hospital surplus report came out [in May], some of us said, 'Maybe this is the game changer at last'...but the political will to rein in the big hospitals just doesn't seem to be there."

Indeed, as many observers had predicted, the new small business cost containment law contains no provisions curbing provider rate increases. Instead, it calls for financially strong hospitals to make voluntary, one-time contributions aimed at easing premium increases for small groups. Partners volunteered to contribute $40 million, an offer that one market observer said "is regarded in the community as a pitifully small amount compared to what people believe [Partners] can afford…It has generated a tremendous amount of cynicism in the community." Proponents of the voluntary fund countered that it is intended only to provide short-term relief to small businesses until more substantial contracting and payment changes can be implemented for the medium and long term. With the new law increasing requirements for health plans to control expenses and premium increases, some observers expect to see financially strong providers facing intensifying pressure to make significant concessions in rate negotiations with plans.

Hospital respondents all viewed cost containment as the major challenge facing their organizations and acknowledged that current cost trends are unsustainable. Hospitals pointed to union contracts as a barrier to controlling their costs, noting that the sector is highly unionized and unions have strong negotiating leverage. Hospitals also argued that inadequate Medicaid payment rates continue to make cost shifting to private payers a necessity.

Some observers argued that if provider rate caps are introduced in the future, they are likely to have an unintended impact: causing providers to reduce or eliminate unprofitable

services, such as mental health. Other respondents suggested that rate caps would simply lead providers to induce utilization to make up for lost revenues, and that meaningful trend moderation can only come through broader-based and longer-term payment reform.

Global Payment as Long-Term Reform Strategy

Global payment for providers gained traction as a long-term strategy for moderating health cost trends in mid-2009, when the Massachusetts Special Commission on the Health Care Payment System recommended that the state adopt global payments as the predominant form of provider payment within a five-year timeframe. Instead of fee-for-service reimbursements, providers would receive prospective payments for all or most of the covered care they provide to patients, along with additional financial rewards for "the provision of accessible and high quality care," according to the state. In contrast to episode-based payments, which bundle services for clinically defined episodes of care for specific conditions or procedures, global payments bundle a broad range of services at the patient level over a defined period.

Most observers expected that the state would implement global payment by prescribing the payment method for private insurance and Medicaid and seek to apply the same method to Medicare through a waiver. In addition, many expected that the state would not just specify a uniform payment method, but also determine actual payment rates through all-payer rate setting. However, some respondents expressed skepticism that sweeping payment changes would be possible, given that stakeholders who stood to lose under global payment would be formidable opponents. As one market observer noted, "Those doing extremely well under fee for service want to keep change at bay as long as possible, and you shouldn't underestimate their political influence."

One notable payment reform development already taking place in the Boston market is the Alternative Quality Contract (AQC) rolled out by Blue Cross at the beginning of 2009. The AQC is a five-year contract, with each provider's initial global payment level set based on historic payment levels to that provider. The payment amount is adjusted annually for inflation, and in an effort to avoid one of the pitfalls of capitation—avoidance of sick patients—the payment is also risk adjusted annually for health risk changes in the population attributed to the provider. The global payment level is not reset for actual costs annually, so providers can retain or share margins from any efficiencies they achieve and maintain. In an attempt to ensure that provider efficiencies don't involve stinting on needed patient care—another pitfall of traditional capitation—AQC includes performance incentives based on process, outcomes and patient experience measures for both inpatient and ambulatory care.

The first providers Blue Cross targeted and signed up for the AQC included Atrius Health, the largest independent medical group in the market, and Mount Auburn Cambridge Independent Practice Association, the physician organization affiliated with Mount Auburn Hospital and Cambridge Health Alliance. Both organizations are integrated providers with a history of accepting capitated payment for health maintenance organization (HMO) patients. Other providers that have since signed up for the AQC span a wide range of size and structure; the larger providers include Caritas Christi, Tufts Medical Center, and South Shore Hospital and its physician hospital organization, or

Some respondents expressed skepticism that sweeping payment changes would be possible, given that stakeholders who stood to lose under global payment would be formidable opponents.

For physicians, a key advantage of aligning with hospitals is the ability to obtain substantially higher rates from health plans compared to what small practices would be able to negotiate on their own.

PHO. Currently, AQC contracts cover approximately 32 percent of Blue Cross' HMO enrollees, or about 16 percent of all its enrollees.

Blue Cross was exploring whether to expand the AQC model to preferred provider organization (PPO) contracts. However, executives said they were fully aware that, even with a successful expansion of the model to PPO contracts, the impact of global payment on realignment of provider incentives will be limited, unless government and other commercial payers embrace the global payment model as well.

Physicians Align with Hospitals, Join Larger Practices

While direct employment of physicians by hospitals remains relatively rare in the Boston market, physician alignment with hospitals through physician organizations (POs) is high and growing, according to many respondents. Physicians belonging to medical school faculty typically are employed by their universities and belong to POs that contract with AMCs on an exclusive basis. Community physicians also affiliate with hospitals through POs, and respondents noted that Partners, Beth Israel Deaconess and Tufts have all added community physicians to their POs in the past few years.

For physicians, a key advantage of aligning with hospitals is the ability to obtain substantially higher rates from health plans compared to what small practices would be able to negotiate on their own. Respondents noted that this was particularly true for physicians affiliated with Partners and Children's.

For community physicians, another advantage of affiliating with hospitals is the technical support, and in some cases, the financial subsidies that systems can provide for electronic medical record (EMR) implementation and use—a particular challenge for smaller practices. The degree of financial support for ambulatory EMRs varies widely, with Caritas Christi offering subsidies as an inducement for physicians to align with its system, while Partners requires affiliated physicians to adopt its EMR but provides no subsidy. Hospital systems in the Boston market have focused on using information technology as a strategy to bind affiliated physicians more tightly to their organizations.

Atrius Health, which consists of Harvard Vanguard Medical Associates and four smaller suburban multispecialty practices, continues to be the Boston area's premier independent medical group—one that is able to command high rates from health plans. Recently, Atrius shifted a substantial share of referrals that previously had gone to Brigham and Women's Hospital over to Beth Israel—apparently the result of a combination of factors, including tense relations between Atrius and Brigham specialists (primarily over loss of Atrius patients after inpatient stays), better information technology integration between Atrius and Beth Israel, and cost concerns resulting from rate differentials between Brigham and Beth Israel (Atrius bears risk for the cost of hospital care for many of its HMO patients).

With increasing incentives to align with hospital systems or join large groups, physicians remaining in small practices face an increasingly difficult situation. With no leverage over health plans, these physicians reportedly are deeply dissatisfied with low reimbursement rates and talk about dropping out of health plan networks, especially Blue Cross. However, opting out of networks does not appear to be a viable strategy in a market where HMOs still account for more than half of health plan enrollment and where so many top physicians participate in networks through the large organizations they are affiliated with. Small practices risk losing a large share of their patient panels if they drop out of health plan networks.

Tiered Networks Develop in Response to Cost Pressures

There is little differentiation across the major local plans—Blue Cross, Harvard Pilgrim and Tufts—in provider networks, product design or prices, according to most respondents. The commercial market is split about equally between PPOs and HMOs, but HMOs in this market have broad networks almost identical to PPOs—including all hospitals and the vast majority of physicians in the state. Most employers and consumers have continued to demand broad provider networks, but the willingness to trade provider choice for cost savings may be slowly growing in the Boston market.

The state's largest purchaser, the Group Insurance Commission (GIC), which purchases health benefits on behalf of all state and some municipal employees, has been a pioneer in demanding tiered-provider networks from health plans. While the exact network design varies by plan and product, all GIC products have a three-tier copayment structure at the individual specialist physician level (for designated specialties only), and most GIC products feature a two-tier or three-tier hospital copayment structure. Most GIC products do not separate primary care physicians into tiers. Participating plans all use the same pooled dataset to develop their provider tiers, but because each plan applies its own methodology, provider designations vary by plan and product—which has undermined credibility with physicians. GIC tiered networks have resulted in physician pushback, culminating in a lawsuit filed in 2008 by the Massachusetts Medical Society against the GIC and two plans (Tufts and UniCare). The suit argued that faulty data and methods were being used in rating physicians; the case has yet to be resolved.

Harvard Pilgrim and Tufts have made their GIC tiered products available to other employers but with little success. Among the key reasons are reportedly the lack of a steep premium discount or strongly differentiated copayment tiers, and the fact that the GIC benefit year begins in July while many private employers' benefit years start in January. As a result, the plan would have to re-tier providers halfway through the benefit year for private employers—a prospect that most employers find unappealing and that may run afoul of state consumer disclosure rules.

In 2010, the GIC began requiring its two largest plans—Harvard Pilgrim and Tufts—to offer narrow-network products. These products—with premiums about 20 percent lower than tiered full-network products—all exclude Partners teaching hospitals and the Lahey Clinic in Burlington; the Tufts offering also excludes Beth Israel. Within the narrow-network structure, these new products retain the same tiered-network structure as other GIC products. Because narrow-network products have just been rolled out for July enrollment, it is not yet clear how much take up there will be from GIC enrollees.

Blue Cross, which does not participate with the GIC, offers tiered-network products substantially different from those offered to the GIC. Its products, called Blue Options, do not tier specialists at all; instead, they tier primary care physician groups and hospitals. A revamped design rolled out in January 2010 introduced very large cost-sharing differentials across the three Blue Options hospital tiers. In one popular PPO version, Tier 1 has a $150 inpatient copayment with no deductible; Tier 2 has a $150 copayment/$500 deductible; and Tier 3 has a $1,000 copayment/$2,000 deductible. It is reportedly the high cost sharing for Tier 3 hospitals, including Brigham, Mass General and Children's, that employers find most attractive about Blue Options. These products appear to have gained signifi-

Most employers and consumers have continued to demand broad provider networks, but the willingness to trade provider choice for cost savings may be slowly growing in the Boston market.

Consumer-driven health plans—high-deductible insurance products typically paired with spending accounts—have grown in the Boston market over the past few years, largely because of the recession and ongoing but intensifying cost pressures on employers.

cant traction with small and mid-sized employers that want alternatives to high-deductible health plans.

The new small business cost containment law requires health plans in the merged market to offer, beginning in 2011, at least one narrow-network or tiered-network product, at a premium at least 12 percent below that of a full-network product with equivalent benefits. Once these new products are developed for the merged market, plans are likely to make them available to larger groups as well, but the extent to which these products will gain traction remains uncertain in a market accustomed to broad provider access.

Consumer-Driven Health Plans Grow

Consumer-driven health plans (CDHPs)—high-deductible insurance products typically paired with spending accounts—have grown in the Boston market over the past few years, largely because of the recession and ongoing but intensifying cost pressures on employers. Blue Cross estimated that CDHPs now account for about 15 percent of its total commercial enrollment and approximately half of its small group enrollment.

It has become increasingly common for large employers to offer a CDHP as an option alongside a traditional HMO and/or PPO, according to benefit consultants. Some large employers have moved to a fixed-dollar premium contribution as a way to incentivize take up of CDHPs, but very few large employers have gone to full replacement. Many employers still stop short of implementing CDHPs with deductibles high enough ($1,200/individual, $2,400/family) to be eligible for health savings accounts (HSAs). Instead, some large employers "are easing into the high-deductible market" by offering products with individual deductibles around $1,000 and pairing those products with health reimbursement arrangements (HRAs) where the employer might contribute half of the deductible amount. While HSAs have grown in the past few years, HRAs are still favored by many employers for the greater degree of control retained by employers.

Some small employers have moved aggressively to full replacement with CDHPs—in some cases moving to products with deductibles far larger than the HSA statutory minimums. Depending on their financial circumstances and the labor markets in which they compete, some small employers (such as professional services companies competing for high-wage workers) make substantial contributions to HRAs or HSAs, while other small employers do not contribute to these accounts and have been paring the share of premiums that they pay. Some small employers struggling to survive the recession dropped insurance coverage altogether.

Effects of Reform Vary Greatly by Employer Size

Large employers have felt almost no direct impact from state health care reform, except for the "hassle factor" of complying with reporting requirements, according to most respondents. The smaller the employer, the more burdensome it has been to comply with reporting and other requirements—which apply to all employers with 11 or more full-time equivalent workers—because smaller employers typically lack the personnel and expertise to guide them through the requirements. Respondents observed that changing state requirements, including a shift from annual to quarterly filing for some employers, have made compliance more challenging for employers and "multiplied the nuisance value."

Employers small enough—with 50 or fewer employees—to be in the merged small group and nongroup markets have felt the impact of rising premiums

most acutely, in large part because they are now subsidizing individuals in that market. Their vocal complaints about double-digit premium increases played a key role in the governor's election-year move to cap premiums, according to many respondents.

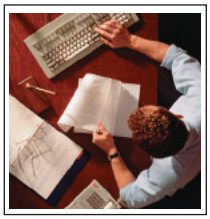
The high cost of premiums in the merged market has created a resurgence of interest in association health plans, which were banned by the state in 1996. Several small business coalitions, including the Retailers Association of Massachusetts, pushed for the return of these plans—now being called group purchasing cooperatives. Consumer advocates pushed back, arguing that the only way for these plans to achieve lower costs is to cherry-pick younger, healthier people from the merged market, which would destabilize and raise costs for the remaining merged market. The new small business law allows for the creation of group purchasing cooperatives but contains safeguards against adverse impact on the merged market. These safeguards include broad DOI oversight, limits on the aggregate size of cooperatives, and prohibitions against denial of coverage based on health status, age, race or sex.

When the Health Connector, the state's insurance exchange, was established as part of health reform, some observers predicted that the role of brokers would be much diminished, if not eliminated, since small groups would be able to purchase coverage directly through the Connector. However, small employers have continued to purchase coverage almost entirely through brokers, and the Commonwealth Choice Contributory Plan, aimed at employers with 50 or fewer employees, has enrolled few people. Respondents observed that the model was premised on the notion that small employers would value offering a choice of products from different health plans, when what employers value most are convenience and administrative ease, which they receive from brokers. Clearly, price is also a top priority for small employers, but purchasing within the Connector confers no price advantage. The Connector is replacing the Contributory Plan with a revamped small business program, Business Express, but the three largest plans in the market have not yet agreed to participate.

Plans Renew Emphasis on Utilization Management

Controlling utilization continues to be a challenge for health plans, which estimated that increased utilization accounts for up to a quarter of their cost trends. The response from plans over the past few years has been to impose tighter utilization management, with Blue Cross reportedly being the most aggressive in implementing these programs. Plans reported a wide variety of services now receiving more scrutiny and sometimes requiring prior authorization, including hysterectomies, spine surgeries, neuropsychological tests, chiropractic services, sleep clinics and bariatric surgery.

The major plans have had imaging management programs in place for several years, aimed at controlling use of high-cost services, such as magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET) and nuclear cardiac imaging tests. These programs have been fairly effective at curbing imaging volume, which has remained flat or increased at a modest 1 percent to 2 percent a year, according to one plan executive. However, overall imaging costs continue to soar because of increases in provider prices, shifts in provider mix and changes in technology. One plan estimated that the unit prices it pays hospitals for imaging have grown at an annual pace of 8 percent to 10 percent—in contrast to prices paid to freestanding imaging centers, which have increased at only 3 percent a year,



When the Health Connector, the state's insurance exchange, was established as part of health reform, some observers predicted that the role of brokers would be much diminished, if not eliminated.

While the uninsurance rate has fallen to approximately 2.7 percent, with more than 400,000 people gaining coverage statewide, most mainstream providers in the greater Boston area reported that increased demand has been modest to moderate and has not overwhelmed their capacity.

from a much lower base. Over the past few years, the market has seen a pronounced shift in the setting for imaging services—away from freestanding facilities, toward hospitals—and this development has exacerbated cost trends for plans. Adoption of new imaging technology, such as the shift from traditional to digital mammography, also has been costly for plans, which reimburse providers 35 percent to 45 percent more for digital mammograms.

The major plans all reported imposing tighter controls on prescription drug utilization over the past few years, with Blue Cross reportedly the most aggressive in implementing step therapies and taking drugs, such as antihistamines, off formulary. For high-cost specialty drugs, Blue Cross has been aggressively moving some drugs—particularly oncology drugs—from a medical benefit to pharmacy benefit, in part to avoid high markups charged by providers for such drugs and to allow its specialty pharmacy benefits manager to oversee utilization and dosage. Blue Cross also has taken steps to move patients from infused and injectable drugs that have to be delivered in clinical settings to self-injectable drugs that can be administered at home. Other plans have not yet adopted similar measures for specialty drugs, but one market observer suggested that "after Blue Cross has taken the heat from the providers, we might see the others following suit…There's no question—the number of these high-tech drugs…and the costs have ballooned over the last several years."

Provider Capacity Largely Adequate to Meet Coverage Expansions

When state health reform was enacted in 2006, there was concern about whether hospital capacity overall, and emergency department (ED) capacity in particular, would be sufficient to meet the demand for services of newly insured people. While the uninsurance rate has fallen to approximately 2.7 percent, with more than 400,000 people gaining coverage statewide, most mainstream providers in the greater Boston area reported that increased demand has been modest to moderate and has not overwhelmed their capacity. Although the state banned ED diversions, EDs appear to be coping with increased demand fairly well. Hospital respondents noted that patients who in the past would have been uninsured are now showing up as insured patients. But, they also observed that reimbursement under MassHealth, the state Medicaid program, and Commonwealth Care, the new subsidized insurance program, which pays rates similar to MassHealth, has been roughly the same as earlier subsidies from the state's uncompensated care pool, which was restructured and reduced with the implementation of state health reform.

Approximately two out of three newly insured people are covered by MassHealth or Commonwealth Care, and most of them have continued to use the same safety net providers they had used when uninsured, though perhaps at a higher utilization rate. As a safety net provider explained, "The system is already designed for them so that there are a lot of social needs met by safety net providers, whether it's linguistic, access, transportation…The safety net provides that, and they go to the places that are most easily accessible." As a result, Boston's robust safety net continues to play a central role in delivering care for low-income people. These providers have a smaller proportion of uninsured patients now, but more patients overall, particularly for outpatient services. Despite ongoing concerns about a shortage of primary care physicians, access to both primary and specialty care continues to be relatively strong. Dental and pharmacy capacity has increased with federal grants, but mental health capacity has become increasingly sparse.

A stable set of providers makes up the Boston community's strong safety net. The main safety net hospitals continue to be Boston Medical Center (BMC) and Cambridge Health Alliance (CHA). BMC has twice the inpatient capacity of CHA and is a Level I trauma center and tertiary care provider, while CHA, the only public hospital remaining in Massachusetts, focuses half of its inpatient services on mental health. BMC operates the busiest emergency department in the greater Boston area, followed by CHA. BMC primarily contracts with community health centers (CHCs) for outpatient primary care, while CHA operates its own primary care clinics for low-income people.

Low-income people in the Boston area continue to be well served by 31 CHCs—26 of them within the city of Boston. Most of these clinics are federally qualified health centers (FQHCs), which receive federal funding and enhanced payment rates for MassHealth and Commonwealth Care patients. Several clinics are FQHC look-alikes, eligible for enhanced rates but not federal grant funding. Historically, the CHC movement began in Boston, and CHCs have received strong federal funding. In the last few years, CHCs have been able to expand their physical and operational capacity with the help of federal stimulus dollars and state funding aimed at reducing non-urgent ED use.

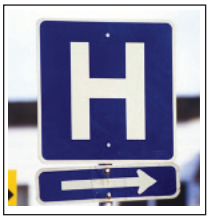
Coverage Expansions Survive, but Financial Strains Emerge

The high level of coverage achieved under state health reform has been largely sustained through the recent recession. Despite state budget pressures and threatened cuts by the Legislature, MassHealth eligibility and benefits have been largely protected both because the state placed a high priority on universal coverage and because the federal government required states to maintain Medicaid eligibility levels to receive stimulus funding. State budget problems, combined with a lack of federal matching funds, did lead Commonwealth Care to transition legal immigrants from full eligibility to a more limited insurance product.

While MassHealth coverage has been protected, budget strains have led the state to pull back on provider rate increases promised under health reform. The reform law included rate increases to physicians and hospitals totaling $270 million over three years, from fiscal years 2007 through 2009. It was this provision that enabled state reform to gain support from many stakeholders, including health plans and mainstream providers. However, because of the recession and budget concerns, in 2009, MassHealth reduced some of the previous provider rate increases and adopted a new "efficiency standard," changing its hospital reimbursement methodology to pay all acute care hospitals 75 percent—down from 90 percent—of the 2005 state average cost per discharge. Additional cuts in hospital reimbursement took place in 2010. Along with the direct impact of MassHealth rates on providers, there is concern that inadequate Medicaid reimbursement increases cost shifting to private insurers, resulting in higher premiums.

The financial impact of reform and the recession has varied across safety net providers, with most CHCs faring better than the two safety net hospitals. In 2009, both BMC and CHA had operating losses (-2.5% and -8%, respectively), representing significant deterioration in financial performance from prior years. Both hospitals' financial problems have resulted from declines in long-standing supplemental disproportionate share hospital (DSH) payments under reform. Also, the change in MassHealth payment methodology resulted in reimbursement rates for BMC and CHA being reduced by approximately one-quarter. BMC, along with several community hospitals, is suing the state for

Despite state budget pressures and threatened cuts by the Legislature, MassHealth eligibility and benefits have been largely protected.



On the whole, the Boston safety net has been somewhat insulated from the recession. Despite rising unemployment, state data show no overall reduction in insurance coverage in either the general or working-age populations from 2008 to 2009.

declining Medicaid support. In contrast, CHA did not participate in the litigation, instead working to reduce its costs by consolidating facilities and streamlining care delivery and working with the state to gain more funding. According to recent media reports, CHA is actively seeking to affiliate with or be acquired by a larger Boston-based hospital system, and to that end, has engaged in discussions with both Partners and Caritas.

Another financial challenge for safety net hospitals comes from state changes in reimbursement to hospitals from the uncompensated care pool, now called the Health Safety Net Trust Fund (HSN), for treating the remaining uninsured. More than one-third of the funding has been shifted to help pay for insuring more people, particularly through Commonwealth Care. Previously, most of the uncompensated care funds had gone to hospitals, and it was hospitals that essentially bore the entire funding cut—their payments have declined approximately 40 percent. In 2006, BMC and CHA were reimbursed at approximately 125 percent of costs, while the HSN now pays BMC 103 percent of costs and CHA 79 percent (with BMC reportedly receiving a higher rate because of its tertiary services).

In contrast to the safety net hospitals, most CHCs have benefited under reform, with slightly higher and faster reimbursement through MassHealth and Commonwealth Care than the uncompensated care pool. For the remaining uninsured, fee-for-service, claims-based reimbursement from the HSN has replaced lump-sum payments. In fact, overall HSN payments to CHCs grew 13 percent from 2008 to 2009, which the state attributed to higher reimbursement rates for medical and dental visits, as well as more prescription drug claims resulting from increased CHC pharmacy capacity.

While CHCs as a whole have fared relatively well under reform, the five CHCs operating under BMC's hospital license have been under increasing financial strain. These CHCs used to receive enhanced payments from the uncompensated care pool, but under the HSN, payments are the same across CHCs. Also, given the smaller cushion that BMC itself receives from the HSN, these five clinics are in jeopardy of losing the uncompensated care funding that BMC passed through to them in the past.

Safety net providers now bear more responsibility for getting their patients insured and keeping them insured. The state has decentralized the process for enrolling and renewing coverage in public insurance and other programs, with safety net providers reporting they are not adequately compensated for this additional administrative expense. Also, CHCs and hospitals are unable to obtain HSN reimbursement for treating uninsured patients that are eligible for public coverage but not enrolled.

Medicaid managed care plans also have felt increasing financial strains from state budget pressures. Approximately half of the MassHealth population is in managed care, with enrollment split primarily among three plans—BMC's HealthNet, CHA's Network Health and Neighborhood Health Plan—with a fourth plan, Fallon, also having a small presence in the market. In 2009, three of the four plans reported losses, which they largely attributed to a lack of MassHealth payment increases over the past three years. The plans, in turn, reportedly have required some providers to accept lower reimbursement for MassHealth managed care enrollees.

On the whole, the Boston safety net has been somewhat insulated from the recession. Despite rising unemployment, state data show no overall reduction in insurance coverage in either the general or working-age populations

Authors of the Boston Community Report:

Ha T. Tu
Center for Studying Health System Change (HSC)
Marisa K. Dowling
HSC
Laurie E. Felland
HSC
Paul B. Ginsburg
HSC
Ralph C. Mayrell
HSC

About the Community Tracking Study (CTS)

The 2010 CTS and resulting Community Reports were funded jointly by the Robert Wood Johnson Foundation and the National Institute for Health Care Reform. Since 1996, HSC researchers have visited the 12 communities approximately every two to three years to conduct in-depth interviews with leaders of the local health system.

Community Reports are published by HSC:

President: Paul B. Ginsburg
600 Maryland Avenue SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258

www.hschange.org

from 2008 to 2009. In addition to some unemployed workers becoming eligible for public programs, the state's Medical Security Program (MSP) helped to maintain coverage for unemployed workers with incomes up to 400 percent of poverty. Largely financed by an employer tax, the MSP subsidizes COBRA continuation coverage or, for those without COBRA access, pays the entire premium for enrollment in a Blue Cross product in the merged market. However, increasing enrollment and rising costs present financial challenges to maintaining the program.

Issues to Track

- To what extent will new restrictions on open enrollment in the merged small group market succeed in improving the risk pool and moderating premium increases?
- What measures, if any, will the state take to curb hospital price increases? Will the state proceed to implement all-payer global payment as recommended by the Payment Reform Commission? If so, will it evolve to an all-payer rate setting program?
- Will the trend of increasing market share for academic medical centers continue? What will be the impact on utilization and costs?
- To what extent will limited-network products gain traction in the market?
- What impact will state budget pressures have on MassHealth and Commonwealth Care covered services and provider reimbursement rates? What impact, in turn, will that have on access for low-income populations, the financial health of safety net providers and cost shifting to private payers?
- In what ways will state health reform be reshaped by national health reform requirements?

Community Tracking Study

Boston is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

HSC, funded in part by the Robert Wood Johnson Foundation, is affiliated with Mathematica Policy Research.