



Healthcare Inequality in Massachusetts

Breaking the Vicious Cycle

March 2014

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Executive Summary

In the past decade, Massachusetts has led the nation in healthcare policy reform by expanding access to healthcare services and working to contain healthcare costs. However, long-standing disparities in our healthcare financing system persist, and middle-class and lower-income communities suffer the consequences of this inequitable system.

We believe that a vicious and unsustainable cycle exists in the current healthcare system. It drives significant annual increases in healthcare premiums, makes healthcare less affordable for middle- and lower-income families, and compromises the viability of community hospitals in lower-income areas.

This paper details how policies, regulations, and market dynamics created and exacerbated these disparities over time. It also offers policy solutions to ensure that all Massachusetts residents have access to affordable and equitable healthcare.

The following are policy recommendations to address these critical issues:

- 1. Reduce Disparities in Hospital Reimbursement**—The Commonwealth's cost growth benchmark should be adjusted to account for providers' relative price differentials, requiring high-cost providers to hold cost growth below the benchmark and simultaneously reduce the wide variation in hospital reimbursement.
- 2. Consider Provider's Payer Mix when Setting Medicaid and Commercial Insurance Reimbursement Rates**—Healthcare providers that care for a high percentage of Medicaid patients should be compensated for Medicaid underpayment through higher Medicaid and/or commercial insurer reimbursement rates.
- 3. Implement a Medicaid Accountable Care Organization (ACO)**—As the second-largest payer in the state, the Commonwealth should use its \$13 billion purchasing power in the Medicaid program to immediately implement a Medicaid ACO program similar to the successful Medicare Pioneer ACO program, which rewards high-quality care and cost efficiency.
- 4. Encourage Insurance Companies to Design Products and Plans that Reward Members Utilizing Lower-Cost Providers**—Insurance companies should introduce products that reward employers and employees who choose to receive their care within cost-effective provider networks with lower premiums.

There are serious consequences if these problems are not urgently addressed. If left unchecked, healthcare disparities along socioeconomic lines may worsen, community hospitals in low-income areas may close, and access to healthcare services for low-income patients may be badly diminished.

A vicious and unsustainable cycle exists
in the current healthcare system.

The Vicious Cycle

Repeated studies have shown that the wide variation in rates paid to healthcare providers is not related to the quality of services delivered, but the result of the provider's "market power."¹ In 2010, the Massachusetts Office of the Attorney General concluded that "there is no correlation between price and quality, and certainly not the positive correlation between price and quality we would expect to see in a rational, value-based health care market."²

Regardless, commercial payment rates to providers have continued to grow over time. In 2010, hospitals in the top price quartile enjoyed a payment rate of 144 percent of the median, while those in the bottom quartile received payments that were only 84 percent of the median. By 2012, this gap had widened. Hospitals with the highest reimbursement rates received 150 percent of the median payment rate, while those at the bottom remained at 84 percent.³

Despite the widely acknowledged nature of these payment disparities and calls for reform,⁴ the implications of such practices have not been sufficiently explored (see **Figure 1**). Enduring inequities have allowed high-cost Boston teaching hospitals to realize significant profits that are often invested in new facilities and marketing efforts aimed at convincing patients from outside of Boston to seek routine care at their higher-cost facilities. Moreover, some of these profits may be used to expand a provider's network through new physician and other provider affiliations outside of Boston. Such affiliations draw even more commercially insured patients out of their communities and into high-cost Boston teaching hospitals, where similar procedures and routine medical care are performed at significantly higher rates despite no discernible difference in quality.⁵

Commercially insured patients are highly desired by healthcare providers because reimbursement rates for services rendered to commercially insured patients are much higher than those paid by Medicare or Medicaid. If more commercially insured patients go to higher-cost teaching hospitals for routine care, then community hospitals are left with a greater proportion of Medicare and Medicaid patients, and therefore less revenue. As a result, community hospitals struggle to overcome low or negative operating margins.⁶

Further, this "patient migration" to high-cost providers for routine medical services drives up total medical expenses (TME).⁷ As a consequence, middle-class and lower-income communities are effectively subsidizing the healthcare of individuals who live in wealthier communities, an issue this report will explore in more detail.

¹"Examination of Health Care Cost Trends and Cost Drivers," Office of Attorney General, March 16, 2010; "Massachusetts Health Care Cost Trends: Trends in Health Expenditures," Division of Health Care Finance and Policy, June 2011; "Health Care Provider Price Variation in the Massachusetts Commercial Market," Center for Health Information and Analysis, February 2013; "Annual Report on the Massachusetts Health Care Market," Center for Health Information and Analysis, August 2013.

²"Examination of Health Care Cost Trends and Cost Drivers," Office of Attorney General, March 16, 2010.

³"Annual Report on the Massachusetts Health Care Market," Center for Health Information and Analysis, August 2013; "Health Care Provider Price Variation in the Massachusetts Commercial Market Baseline Report," Center for Health Information and Analysis, November 2012.

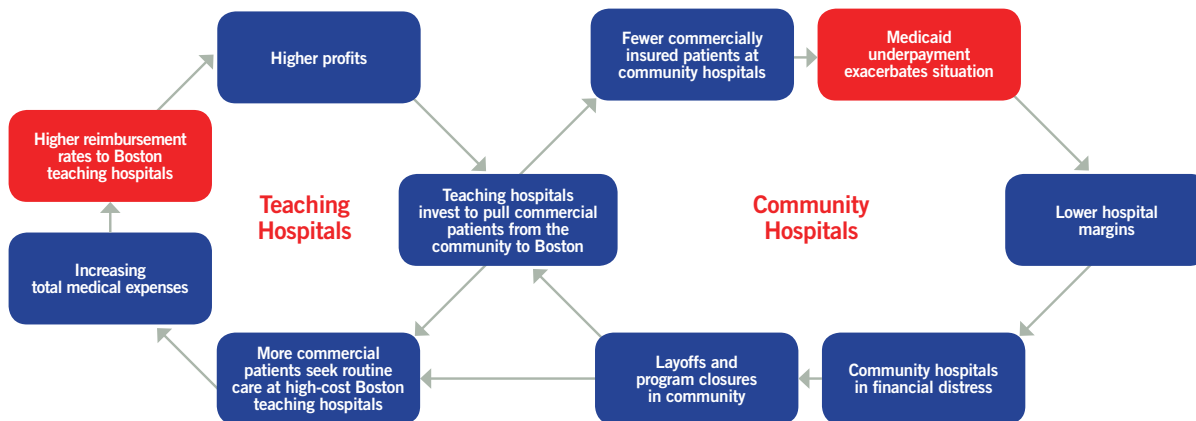
⁴Section 67 of Chapter 288 of the Acts of 2010 created a special commission on provider price reform for the purpose of examining "policies aimed at enhancing competition, fairness and cost-effectiveness in the health care market through the reduction of reimbursement disparities."

⁵"Annual Report on the Massachusetts Health Care Market," Center for Health Information and Analysis, August 2013.

⁶"Massachusetts Acute Hospital Financial Performance" reports, Center for Health Information and Analysis, FY2005–FY2012.

⁷TME measures the total spending on medical care for a covered patient population, including all categories of medical expenses and all non-claims-related payments to a provider.

Figure 1. The Vicious Cycle Harms Communities



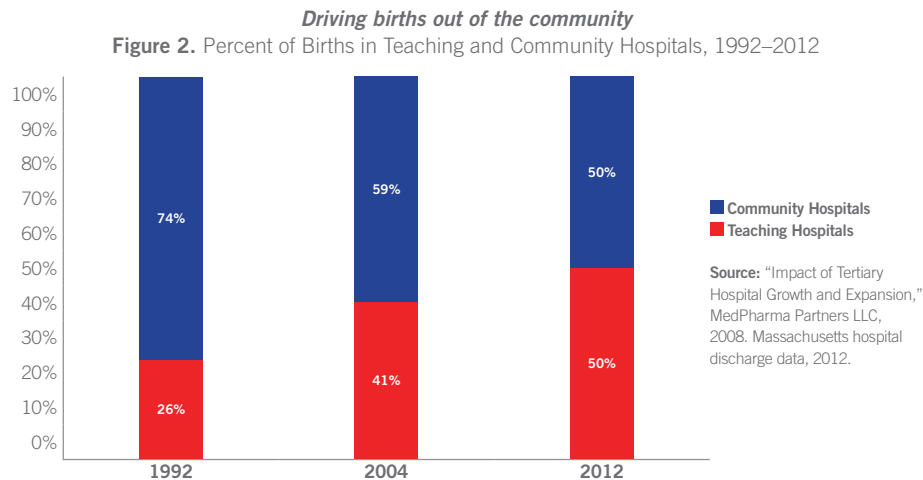
The negative financial impact on community hospitals is worsened by Medicaid’s underpayment and cuts to payment rates by other government-funded healthcare programs. All of these factors depress the capacity of community hospitals to invest, and leave them less able to compete with higher-priced hospitals, especially when those higher-priced providers establish “satellites” in the communities from which they draw commercially insured patient referrals.⁸

As a result, many community hospitals experience financial distress, are unable to fully modernize facilities, and often resort to cuts in services and layoffs. These circumstances may ultimately lead to closures as well as negative consequences for local employment and economic development in middle- and lower-income cities and towns where community hospitals are located.

⁸Brigham Radiology Network, available at: http://www.brighamandwomens.org/Departments_and_Services/radiology/images/BWHRadiologyNetwork_SitesMap.pdf; BIDMC Satellite Locations, available at: <http://www.bidmc.org/About-BIDMC/Affiliates-and-Partnerships/BIDMC-Satellite-Locations.aspx>.

A Closer Look at Patient Migration Trends

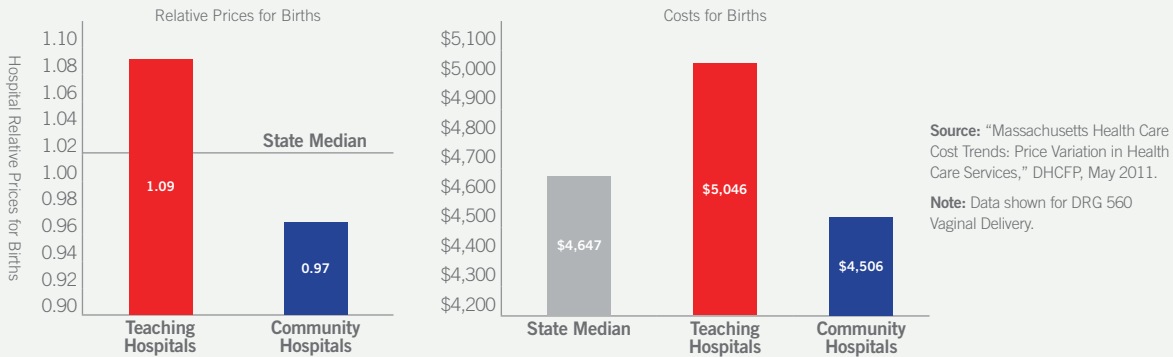
Nationally, teaching hospitals are seen as the institutions to visit for non-routine, highly specialized, complex care. Yet in Massachusetts it has become the norm for patients to leave their communities to receive routine, non-complex medical care at teaching hospitals, at a much higher cost to the overall healthcare system. This was not always the case. As recently as 1992, three-quarters of Massachusetts' babies were born at community hospitals, and only one-quarter at teaching hospitals. By 2004, fewer than three out of five babies were born in community hospitals. At present, the Commonwealth has approximately twice as many community hospitals as teaching hospitals; however, more babies are born at teaching hospitals rather than at high-quality, cost-efficient community hospitals (see **Figure 2**).



Community hospitals receive significantly lower rates for routine medical services such as births (see **Figure 3**), resulting in a payment difference of approximately \$500 per birth and adding at least \$11 million of excess cost into the healthcare system in 2012 alone.

Community hospitals receive significantly lower rates for routine services such as births

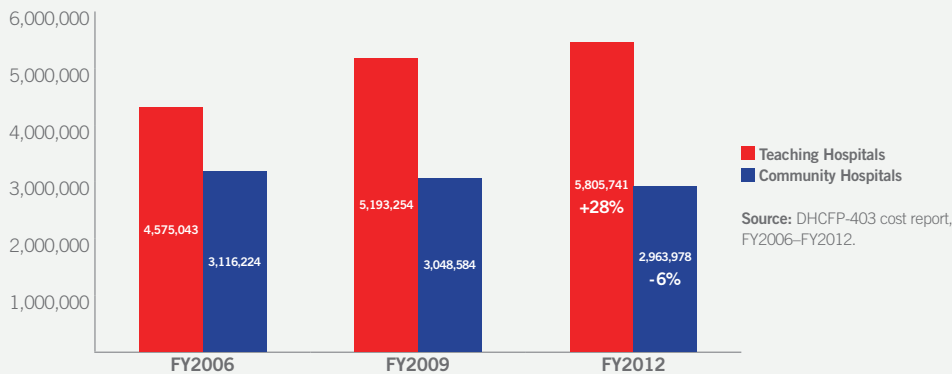
Figure 3. Teaching and Community Hospital Relative Prices for Births, 2009



The shift of births out of the community into teaching hospitals is not an isolated example. The phenomenon is prevalent across a wide range of routine services. Overall, clinic visits to teaching hospitals jumped 28 percent from 2006 to 2012 (see Figure 4).

One way that Boston teaching hospitals are drawing patients into the city for higher-cost routine care is through "satellite" offices located outside of Boston. A 2008 *Boston Globe* Spotlight Series documented the expansion of downtown Boston teaching hospitals into communities such as Danvers, Foxboro, and Weymouth.⁹ The trend shows no sign of stopping. For example, two hospitals in Brockton already offer high-quality advanced imaging and radiology services. Nonetheless, Brigham and Women's Hospital recently opened a similar center in nearby West Bridgewater, receiving commercial insurance payments for MRI and CT scans that are significantly higher than those available at the two lower-cost community hospitals.¹⁰ Unsurprisingly, referrals from the imaging center in West Bridgewater are often made to Brigham and Women's Hospital in Boston. This requires patients to make a 30-mile trip out of the community for expensive care, and drives up premiums for local residents and employers.

Figure 4. Teaching and Community Hospital Clinic Visits, FY2006–FY2012



⁹"Fueled by Profits, a Healthcare Giant Takes Aim at Suburbs," *Boston Globe*, December 21, 2008.

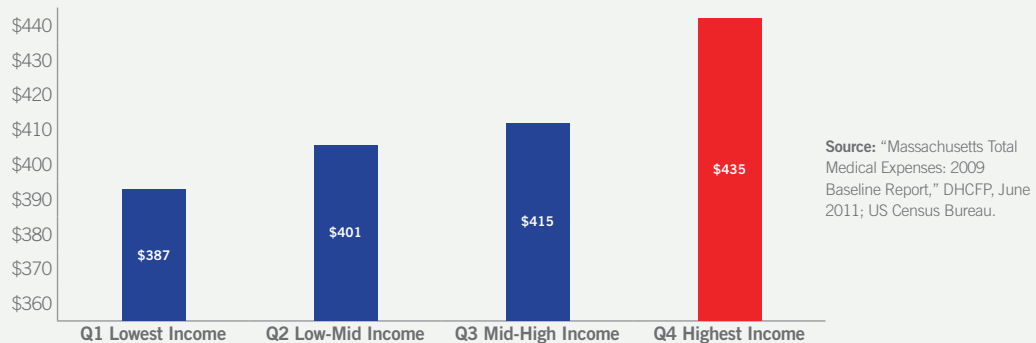
¹⁰"Health Care Provider Price Variation in the Massachusetts Commercial Market: Results from 2012," Center for Health Information and Analysis, October 2013.

Negative Consequences for Middle- and Low-Income Families

Price variation and shifting of care to higher-cost providers have real consequences for families in middle- and lower-income communities. Migration into Boston for higher-cost care is more common for residents of higher-income communities, who generally have more flexibility to travel to hospitals in Boston, access to paid sick time for doctors' appointments, and other factors. Subsequently, residents of higher-income communities have higher TME per person, while residents of lower-income communities—who pay similar insurance premiums through their employers and the Group Insurance Commission (GIC)—generate lower TME (see Figure 5).

Residents of high-income communities have higher medical expenses

Figure 5. Total Medical Expenses (TME) by Town Income Quartile, 2009

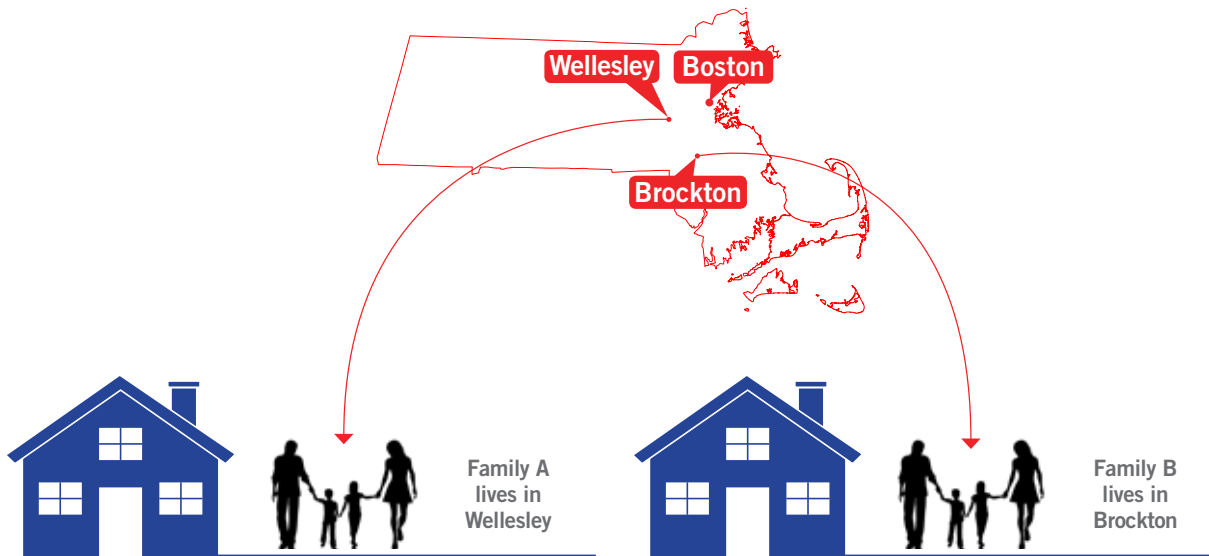


This cycle exacerbates the disparities between higher- and lower-income communities because high TME is spread across the entire population in the form of higher premiums. **The net result is that middle-class and low-income communities are effectively subsidizing the healthcare of individuals who live in wealthier communities.**

Consider the example of these two commercially insured families who pay the same premiums, co-pays, and deductibles, but make different choices when it comes to seeking routine care. Family A has an estimated TME of \$503, while Family B has an estimated TME of \$417 (see Figure 6).¹¹

¹¹TME based on CY2009 figures reported for the towns of Brockton and Wellesley in the Division of Health Care Finance and Policy "Total Medical Expense Baseline Report," and adjusted to account for inflation since CY2009.

Figure 6. A Tale of Two Households



Family A went to a high-cost Boston teaching hospital for the routine delivery of their two children. Their PCPs are in their local community, but when they see a specialist, they go to a high-cost Boston teaching hospital.

Family B had their two children at a lower-cost community hospital. Their PCPs are part of a low-cost integrated system, and most of their specialists are in their local area.

Same Commercial Insurance Provider
Monthly Premium: \$1,670

Estimated TME: **\$503** (per member, per month) **VS.** Estimated TME: **\$417** (per member, per month)

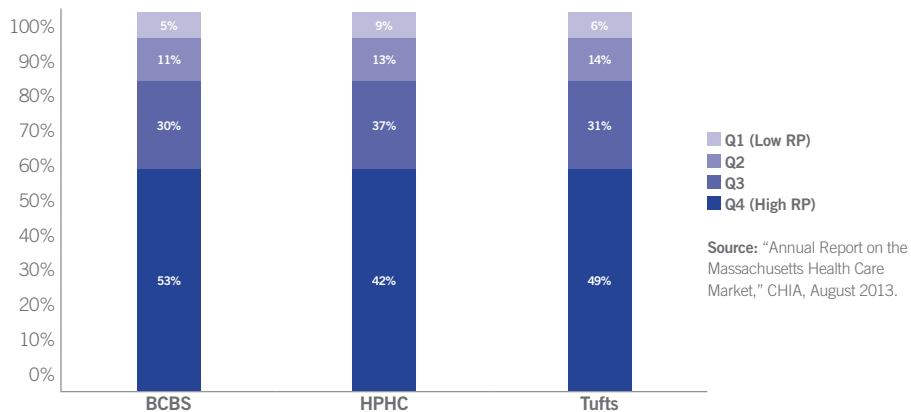
In an effort to contain healthcare costs, many insurers have introduced health insurance plan products that require members to pay higher out-of-pocket expenses for seeking services at higher-cost providers. However, in health insurance plans with significant out-of-pocket costs, lower-income members are more likely to forgo or delay care due to cost concerns.¹² This further exacerbates the subsidization problem, as lower-income individuals generate less medical spending to avoid out-of-pocket costs. As plans with high out-of-pocket costs increase across Massachusetts, lower-income individuals will increasingly subsidize the more costly care of wealthier individuals.

¹²“Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans,” Kullgren et al., *Arch Intern Med*, 2010; “Examination of Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing,” Office of Attorney General, April 24, 2013; “State Trends in Premiums and Deductibles, 2003–2011,” The Commonwealth Fund, December 12, 2012; “2013 Cost Trends Report,” Health Policy Commission; BCBS Pre-Filed Testimony, <http://www.mass.gov/anf/docs/hpc/bcbsma-response-to-exhibit-c2-q2.pdf>.

Financial Impact on Community Hospitals

Another dynamic exacerbating the current inequity in Massachusetts' healthcare market and driving rising premiums is that the most expensive hospitals—those with prices in the top quartile of all hospitals in Massachusetts—receive more than half of all commercial health plan payments from the three largest private insurers in the Commonwealth. Recent data show that more than 80 percent of commercial payments are made to hospitals that are more expensive than average, providing those high-cost hospitals with even more resources to compete against community providers and contributing to the acceleration of premiums (see **Figures 7 and 8**). This leads to dire consequences for community hospitals and the lower-income patients they serve.

Commercial payments concentrated in high-cost providers
Figure 7. Hospital Payments by Relative Price Quartile, 2012



The 50 percent of hospitals in the Commonwealth with below-average commercial payment rates receive a mere 20 percent of total commercial health plan payments. This imbalance perpetuates a system where community hospitals—especially those in lower-income communities—are placed at a significant competitive disadvantage with teaching hospitals. As a result, community providers struggle to balance their financial books and keep their doors open.

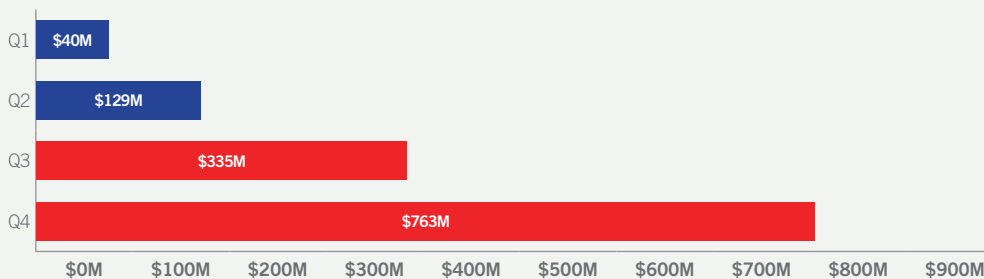
Figure 8. Hospitals by Relative Price Quartile, 2012

Blue Cross Blue Shield		Harvard Pilgrim Health Care		Tufts Health Plan	
Q1					
Anna Jaques Hospital Athol Memorial Hospital Beth Israel Deaconess Hospital—Milton Cambridge Health Alliance HealthAlliance Hospital Heywood Hospital Holyoke Medical Center Lawrence General Hospital	Mercy Medical Center Noble Hospital Saints Medical Center Steward Holy Family Hospital, Inc. Steward Merrimack Valley Hospital Steward Morton Hospital Steward Nashoba Valley Medical Center Steward Quincy Medical Center	Anna Jaques Hospital Beth Israel Deaconess Hospital—Needham Beth Israel Deaconess Hospital—Milton Cambridge Health Alliance Emerson Hospital HealthAlliance Hospital Heywood Hospital	Lawrence General Hospital Massachusetts Eye and Ear Infirmary New England Baptist Hospital Saints Medical Center Signature Healthcare Brockton Hospital Steward Carney Hospital, Inc. Steward Merrimack Valley Hospital Steward Nashoba Valley Medical Center Steward Quincy Medical Center	Anna Jaques Hospital Athol Memorial Hospital Baystate Mary Lane Hospital Beth Israel Deaconess Hospital—Milton Boston Medical Center Cambridge Health Alliance Heywood Hospital Holyoke Medical Center	Lawrence General Hospital Mercy Medical Center Noble Hospital Saints Medical Center Steward Merrimack Valley Hospital Steward Nashoba Valley Medical Center Steward Quincy Medical Center Wing Memorial Hospital
Q2					
Beth Israel Deaconess Hospital—Needham Boston Medical Center Clinton Hospital Emerson Hospital Jordan Hospital Lowell General Hospital Marlborough Hospital	MetroWest Medical Center Milford Regional Medical Center Saint Vincent Hospital Signature Healthcare Brockton Hospital Steward Carney Hospital, Inc. Steward Good Samaritan Medical Center Steward Norwood Hospital, Inc. Steward Saint Anne's Hospital, Inc. Wing Memorial Hospital	Harrington Memorial Hospital Jordan Hospital Lowell General Hospital Marlborough Hospital MetroWest Medical Center Milford Regional Medical Center Mount Auburn Hospital Noble Hospital	Northeast Hospital Saint Vincent Hospital Southcoast Hospitals Group Steward Good Samaritan Medical Center Steward Holy Family Hospital, Inc. Steward Morton Hospital Steward Norwood Hospital, Inc.	Beth Israel Deaconess Hospital—Needham Clinton Hospital HealthAlliance Hospital Jordan Hospital Marlborough Hospital Massachusetts Eye and Ear Infirmary MetroWest Medical Center	New England Baptist Hospital Northeast Hospital Saint Vincent Hospital Signature Healthcare Brockton Hospital Steward Good Samaritan Medical Center Steward Holy Family Hospital, Inc. Steward Morton Hospital Steward Norwood Hospital, Inc.
Q3					
Baystate Franklin Medical Center Baystate Mary Lane Hospital Cooley Dickinson Hospital Dana-Farber Cancer Institute Hallmark Health Harrington Memorial Hospital Lahey Clinic Massachusetts Eye and Ear Infirmary Mount Auburn Hospital	New England Baptist Hospital Newton-Wellesley Hospital North Adams Regional Hospital Northeast Hospital Southcoast Hospitals Group Steward St. Elizabeth's Medical Center UMass Memorial Medical Center Winchester Hospital	Baystate Mary Lane Hospital Baystate Medical Center Beth Israel Deaconess Medical Center Boston Medical Center Brigham and Women's Faulkner Hospital Hallmark Health Holyoke Medical Center Lahey Clinic	Newton-Wellesley Hospital North Shore Medical Center Steward St. Elizabeth's Medical Center Sturdy Memorial Hospital Tufts Medical Center UMass Memorial Medical Center Winchester Hospital Wing Memorial Hospital	Baystate Franklin Medical Center Baystate Medical Center Brigham and Women's Faulkner Hospital Emerson Hospital Hallmark Health Harrington Memorial Hospital Lahey Clinic Milford Regional Medical Center	Mount Auburn Hospital Newton-Wellesley Hospital South Shore Hospital Steward Carney Hospital, Inc. Steward Saint Anne's Hospital, Inc. Steward St. Elizabeth's Medical Center Tufts Medical Center Winchester Hospital
Q4					
Baystate Medical Center Berkshire Medical Center Beth Israel Deaconess Medical Center Boston Children's Hospital Brigham and Women's Faulkner Hospital Brigham and Women's Hospital Cape Cod Hospital Fairview Hospital	Falmouth Hospital Martha's Vineyard Hospital Massachusetts General Hospital Nantucket Cottage Hospital North Shore Medical Center South Shore Hospital Sturdy Memorial Hospital Tufts Medical Center	Baystate Franklin Medical Center Berkshire Medical Center Boston Children's Hospital Brigham and Women's Hospital Cape Cod Hospital Cooley Dickinson Hospital Dana-Farber Cancer Institute Fairview Hospital	Falmouth Hospital Martha's Vineyard Hospital Massachusetts General Hospital Mercy Medical Center Nantucket Cottage Hospital South Shore Hospital Steward Saint Anne's Hospital, Inc.	Berkshire Medical Center Beth Israel Deaconess Medical Center Boston Children's Hospital Brigham and Women's Hospital Cape Cod Hospital Cooley Dickinson Hospital Dana-Farber Cancer Institute Fairview Hospital	Falmouth Hospital Massachusetts General Hospital Nantucket Cottage Hospital North Adams Regional Hospital North Shore Medical Center Southcoast Hospitals Group Sturdy Memorial Hospital UMass Memorial Medical Center

■ Q1 (Low RP) ■ Q2 ■ Q3 ■ Q4 (High RP) Source: "Annual Report on the Massachusetts Health Care Market," CHIA, August 2013.

Unsurprisingly, this concentration of commercial payments also leads to a concentration of profits among a handful of higher-paid hospitals. In fact, ten non-profit hospitals together realized net operating revenue of over \$850 million in 2012, accounting for almost two-thirds of all hospital profits in Massachusetts. That year, those same providers with above-average commercial payment rates accounted for approximately 87 percent of all hospital profits in Massachusetts (see Figure 9).

High-cost providers accounted for 87% of statewide profit in 2012
Figure 9. Hospital Profits by Relative Price Quartile, FY2012



Source: "Annual Report on the Massachusetts Health Care Market," CHIA, August 2013; "Massachusetts Acute Hospital Financial Performance: Fiscal Year 2012," CHIA, May 2013.

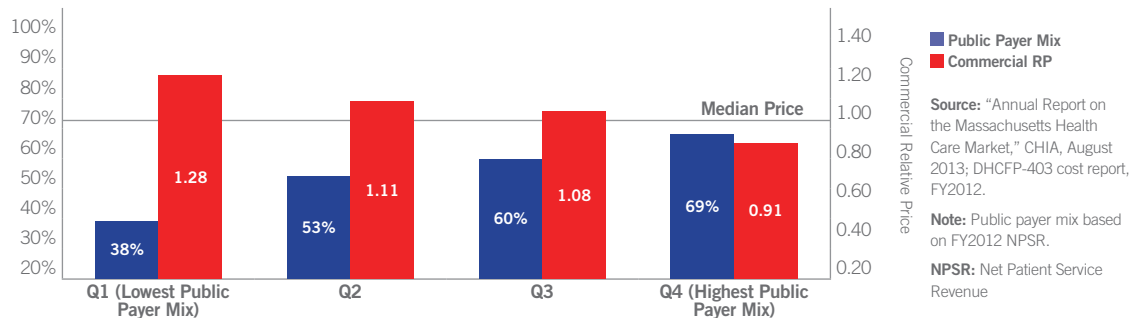
Consequences of Chronic Medicaid Underpayment

Community hospitals that care for the *highest* percentage of publicly funded patients receive the *lowest* average rates from commercial health plans. Meanwhile, hospitals with the *lowest* percentage of public patients receive the *highest* average commercial rates (see Figure 10). The same payment inequity exists in state taxpayer-funded health insurance programs managed by health plans.

For example, Medicaid Managed Care Organizations (MCOs), which contract with the state to provide health insurance to low-income residents, are perpetuating the hospital reimbursement inequities observed in the commercial market (see Figure 11). Publicly available data shows that Medicaid MCOs reimburse Boston teaching hospitals at reimbursement rates that are more than 40% above their community hospital peers.

Hospitals with highest commercial prices serve fewest public patients

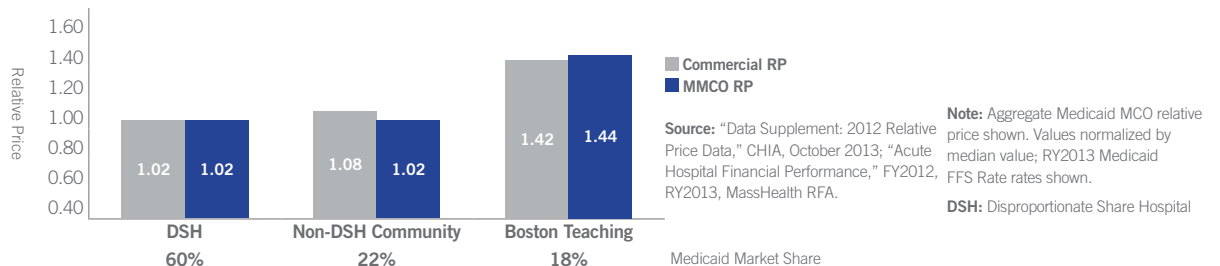
Figure 10. Relative Price by Public Payer Mix Quartile, 2012



This is a primary component of the vicious cycle. Government payers (Medicare and Medicaid), which represent the majority of the remaining market, are chronically underpaying providers at rates significantly lower than those of commercial health insurance plans.

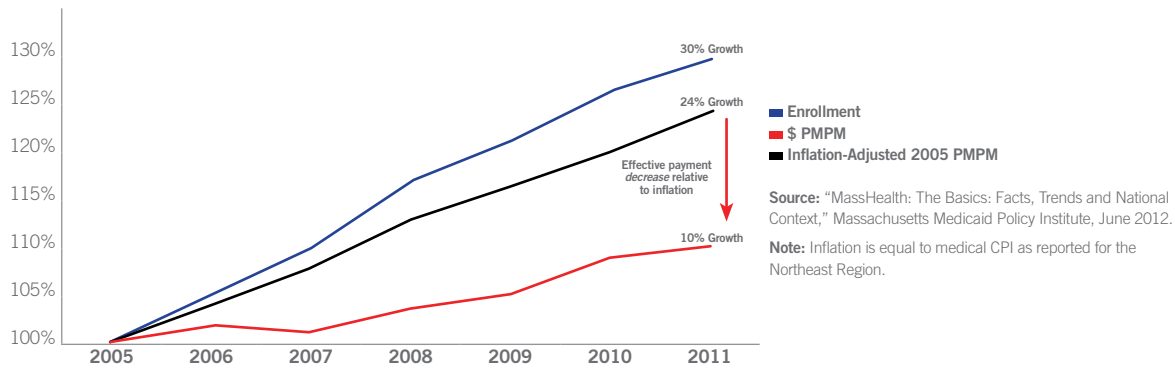
Medicaid managed care health plans' reimbursement rates also disadvantage community hospitals

Figure 11. Commercial and Medicaid MCO RP by Cohort



For community-based providers, chronic Medicaid underpayment exacerbates the net disparity in payment. In addition to Medicaid’s payment rate for services being consistently well below actual cost,¹³ Medicaid rates have actually declined over time relative to inflation (see Figure 12).

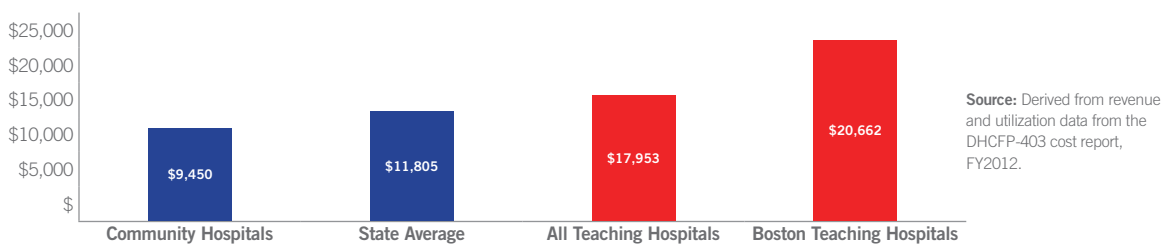
Medicaid reimbursement—already low—has not kept up with inflation
Figure 12. Medicaid Payments and Discharges, 2005–2011



The impact falls hardest on lower-income communities and their hospitals, who care for the majority of Medicaid patients. Thus, community-based hospitals are doubly disadvantaged by a combination of large numbers of low-income Medicaid patients and lower commercial payment rates for their remaining commercially insured patients. The net result of these payer mix and payment rate differentials can be summarized using a measure called the weighted average payment amount (WAPA),¹⁴ which accounts for payer mix and relative reimbursement rates by payer. Boston teaching hospitals have a WAPA that is more than double that of their community counterparts (see Figure 13).

Simply put, this means that a Boston teaching hospital is generating revenue at more than twice the rate of a community hospital, leaving community hospitals struggling to compete.

>2x difference between Boston teaching hospitals and community providers
Figure 13. Weighted Average Payment Amount (WAPA), FY2012



¹³"Underpayment by Medicare and Medicaid," American Hospital Association, February 2014.

¹⁴WAPA is a function of inpatient and outpatient revenue received per unit (discharges and visits, respectively) from commercial, Medicare, and Medicaid payers as well as the payer mix of these categories.

Solutions

Chapter 58 of the Acts of 2006, “An Act Providing Access to Affordable, Quality, Accountable Health Care,” has achieved its goal of near-universal coverage. However, high and rising healthcare costs continue to threaten the sustainability of these hard-won gains and threaten other state budget priorities, including education, transportation, and public safety.

If implemented effectively, Chapter 224 of the Acts of 2012, “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation,” has the potential to address many of the inequities in the system that are highlighted above. By addressing the disparities in the current Massachusetts healthcare system, the Commonwealth will be better positioned to succeed in its cost-containment goals and to achieve long-term sustainability. MassHealth (the Commonwealth’s Medicaid program), the GIC, commercial health plans, employers, and others have important roles to play in eliminating socioeconomic disparities in healthcare access.

Without careful consideration of the existing inequities and public-private market dynamics, implementation of the new cost-containment law could further penalize middle-class and lower-income communities and erode many of the gains made in providing near-universal access to healthcare for Massachusetts residents. Specifically, failure to address the current imbalance may result in sustained double-digit increases in annual health insurance premiums for individuals and employers. Similarly, without intervention, the aggressive move to the suburbs by high-cost Boston teaching hospitals may result in service reductions and job losses at community hospitals that provide care to Massachusetts’ most vulnerable residents. Therefore, we recommend the following four policy solutions to better address healthcare financing issues comprehensively across public and private payers:

1. Reduce Disparities in Hospital Reimbursement

Chapter 224 called on the Health Policy Commission to establish a healthcare cost growth benchmark based on total healthcare expenditures (THCE), which will be used to establish an annual growth rate for the Commonwealth’s spending on healthcare. Entities that exceed the growth benchmark—and any others whose THCE increase is considered excessive—will be required to implement healthcare performance improvement plans to bring their cost growth back into line. However, establishing a uniform growth benchmark for all entities assumes that the relative payment status quo represents an appropriate baseline. Since some providers are overpaid and others—especially those in lower-income communities—are underpaid, a uniform benchmark will lock in and even widen the current inequities. The cost growth benchmark should be adjusted to account for hospitals’ relative payment differentials, requiring high-cost hospitals to hold cost growth below the benchmark and simultaneously reduce the wide variation in reimbursements among hospitals.

2. Consider Provider’s Payer Mix when Setting Medicaid and Commercial Insurance Reimbursement Rates

Providers that take care of a high percentage of Medicaid patients should be compensated for Medicaid underpayments through higher Medicaid and/or commercial insurer rates. Accordingly, the WAPA is a useful formula that should be utilized in developing payment rates for providers.

3. Implement a Medicaid Accountable Care Organization (ACO)

As the second-largest payer, the Commonwealth should use its \$13 billion purchasing power to immediately implement a Medicaid ACO program similar to the Medicare Pioneer ACO program. Massachusetts’ five Pioneer ACO program participants recently demonstrated that when providers are placed clinically and financially at risk for coordinating patient care needs, good quality and lower costs are achieved. Further shifts from fee-for-service to risk-based payments could help break the vicious cycle by compensating providers for a patient’s overall care needs rather than for a series of à la carte services. Such a shift would end the need for continuing reductions in fee-for-service rates. It would also give providers and MassHealth the ability to better manage their budgets and align provider payments with appropriate clinical and financial outcomes that better serve patient care needs.

4. Encourage Insurance Companies to Design Products and Plans that Reward Members Utilizing Lower-Cost Providers

Insurers should introduce products that reward employers and employees who choose to receive their care within cost-effective provider networks. Specifically, “percent of premium products” would enable employees to receive tangible value through lower annual premium growth by sharing directly in the savings from choosing providers that are high quality and lower cost. This “shared savings” approach is preferable to insurance designs that share costs by increasing out-of-pocket payments for access to all providers—including higher-cost providers. Such across-the-board cost-sharing is particularly harmful to those for whom high out-of-pocket costs are a major deterrent to seeking needed care.

In Massachusetts we are justifiably proud of the high-quality care provided by our academic and community providers, our leadership in research and education, and our groundbreaking work in healthcare reform. We now have the opportunity to match those achievements by crafting a more equitable, integrated, and cost-effective healthcare delivery system for the Commonwealth.



About H.E.A.L.

Founded in 2013, the Healthcare Equality and Affordability League (H.E.A.L.) is committed to a high-quality, cost-efficient, and equitable healthcare system in Massachusetts.

In order for community and safety-net hospitals to continue providing high-quality affordable healthcare as well as meeting the mandates of healthcare reform, the payment disparities in the healthcare system must be addressed. Improvements in the provider payment system are needed to preserve access to affordable community-based care and to maintain essential healthcare jobs.

Steward Health Care System LLC and 1199SEIU United Healthcare Workers East are members of H.E.A.L.

About Researcher

David E. Williams is a healthcare business and policy expert with 25 years of professional experience. He is president of the Health Business Group, a consulting firm that helps healthcare companies, investors, and non-profits to research markets and develop robust business strategies. A sought-after healthcare expert for media such as NPR, *Businessweek*, Al Jazeera America, and *U.S. News & World Report*, David is also the producer of the Health Business Blog, where he presents his analysis of healthcare business and policy. He holds a BA in economics from Wesleyan University, where he was elected to Phi Beta Kappa, and an MBA from Harvard Business School. Earlier in his career he worked at the Boston Consulting Group and the LEK Partnership.



Healthcare
Equality and
Affordability
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