HEALTH INSURANCE REFORM AND COST DRIVERS IN MASSACHUSETTS HEALTH PLAN

The Massachusetts Attorney General, Martha Coakley, issued a preliminary report on January 29, 2010 on the conclusions of her Investigation of Health Care Cost Trends and Drivers, required by a Massachusetts statute. (Yes she is the infamous Democrat who lost Kennedy's Senate seat to Scott Brown and stymied the Obama Administration's health care reform drive.) The results are interesting, if not totally surprising. The biggest cost driver seems to be hospital and provider leverage on insurance companies and a steady increase in price rather than utilization over the past four or five years.

The Attorney General issued Civil Investigative Demands ("CIDs") to various hospitals. physician groups and insurance companies to obtain pricing and utilization data. She found that some hospitals were being paid up to 200% more than others and that some physician groups were paid up to 190% of others for providing similar services. The price variations were not related to the quality of the services, the relative sickness of the population, the percentage of Medicare or Medicaid population, whether the provider was a teaching facility or research facility or relative hospital costs. It was also not related to the methodology of payment, that is, global billing or fee for service.

The only significant correlation for price was market leverage, based mostly on size and location. They also were related to brand name and specialty service line factors. Insurance companies indicated that their failure to contract with a large provider organization would handicap their provider network.

"Data from two large health plans show that price increases are responsible for roughly three quarters of the total health care cost increases in the commercial health care marketplace over the last three years."

The report, while not minimizing the necessity to control utilization, underscored the fact that controlling health care costs must address the problem of unrestricted price increases based upon market leverage.

"Bending the cost curve will require tackling the grown in price and market dynamics that perpetuate price inflation and lead to irrational price disparities."

The Report faulted the leveraged based disparities among health providers in pricing as the principal driver in health care cost increases in Massachusetts over the past five years. In particular it noted that providers with leverage due to size, geographic location and branding had a substantial leg up in negotiations with insurance companies. Interestingly, the study identifies a number of specific health insurance contract provisions that have had a substantial negative impact on cost containment.

One of the principal contract provisions that tended to chill competition was the "payment parity provision" that tend to lock in payment levels and prevent innovation and competition based on pricing. If an insurance company gives a rate increase to providers it uses payment parity provisions to insure that the provider will insist on similar rate provisions from the insurance company's competitors, so that all premiums will rise together and the initial insurer will not be at competitive disadvantage in giving a rate increase.

Product Participation Provisions are contract clauses that high market leverage providers insert in health insurance provider agreements that prohibit insurers from created limited network products and tiered products that might steer patients away from them. Examples of these provisions are called "anti-steering", "guaranteed inclusion" and "product participation parity" clauses. "Anti-steering clauses stop insurers from creating new products that might steer patients away from certain providers. "Guaranteed inclusion" clauses guarantee the participation of certain providers in certain products. On the insurance company side "product participation parity" provisions mandate a provider's participation in an insurer's product if that provider agrees to participate in similar product offered by a competing insurance company.

The Attorney General found that there was widespread practice of insurance companies making supplemental payments to providers, for such things as signing bonuses, infrastructure payments, as well as bad debt or government shortfall payments. These are murky payments which tend to reduce the transparency of real insurance cost structures.

Growth caps are contract provisions that limit the growth of provider organizations. These contractual provisions can limit growth in the number of physicians who will be paid under a newly increased rate or limit growth of particular specialties in a geographic area or in acquisitions of practices over a certain size. Although these provisions might be seen as advancing competition at one level, in practice they can prevent smaller physician groups from meaningfully competing with larger physician organizations.

True health care reform that attempts to effectively control costs will have to address these kind of structural impediments to containing price advances and diminishing competition the health care system.