Controlling Health Care Costs in Massachusetts With a Global Spending Target

Robert Steinbrook, MD

Massachusetts is a small state; its 6.6 million residents represent only about 2% of the US population. With 4 medical schools, world-renowned academic medical centers, and health insurance coverage among nonelderly adults of about 95% in 2010, the general quality of health care is considered high. However, health care in Massachusetts is also staggeringly expensive, even for the United States. In 2009, health care spending per capita in Massachusetts was $9278, considerably more than the national average of $6815 and more than per-capita spending in any other state. Only the District of Columbia had higher per-capita spending on health care. Within Massachusetts, there is concern that the market clout of Boston’s brand-name teaching hospitals and leading physicians allows them to command high prices.3,4

In July 2012, after years of consideration, Massachusetts enacted wide-ranging health care reform legislation that aims to control costs and improve quality. A signature feature of the act, signed into law by Deval Patrick, the state’s Democratic governor, on August 6, 2012, is the creation of an annual global spending target for total health care expenditures, which is tied to the growth rate of the state’s economy. Massachusetts is the first state to set statewide benchmarks to control health care costs, albeit with limited enforcement mechanisms and targets that may slow the rate of increase of health spending, but not decrease it. Stricter provisions, such as a luxury tax on high-priced health care entities and restrictions on how health systems negotiate contracts with insurers, were removed from the final version of the act. Health care entities as defined in the act include clinics, hospitals, ambulatory surgical centers, physician organizations, accountable care organizations, and payers. Health care providers are defined as persons or organizations that provide medical or health services or that furnish, bill, or are paid for delivering such services.

The new legislation builds on the far-reaching health insurance reforms that Massachusetts enacted in 2006, including the mandate on state residents to carry a minimum level of insurance or to pay a tax penalty. The reforms became the model for key aspects of the US Patient Protection and Affordable Care Act of 2010. The many features of the 2012 state act include provisions to improve transparency and accountability for health care providers with regard to cost, financial performance, quality, and competition within markets and to improve the clarity for consumers of information about the out-of-pocket costs of care. The provisions also include reforms to medical malpractice laws that would allow a physician, hospital, or others who provide health care to admit to a mistake or error, without the acknowledgment being used in court as an admission of liability. Attention, however, is likely to focus on the global spending target and its potential value as a cost-containment tool. From 2004 to 2009, health care spending in Massachusetts increased by 5.8% per year, regularly exceeding economic growth.7

The act creates a Health Policy Commission to implement the new law and a Center for Health Information and Analysis to collect and analyze data on health care costs and quality. The commission is charged with establishing by April 15 of every year “a health care cost growth benchmark for the average growth in total health care expenditures . . . for the next calendar year.” Total health care expenditures are defined as “all health care expenditures in the commonwealth from public and private sources,” including “all categories of medical expenses and all non-claims related payments to providers . . . all patient cost-sharing amounts, such as, deductibles and copayments,” and “the net cost of private health insurance.” The “growth rate of potential gross state product” is defined as the “long-run average growth rate of the commonwealth's economy, excluding fluctuations due to the business cycle.”

For 2013, the health care cost growth benchmark is set at 3.6%. For 2014 to 2017, the benchmark is set at the growth rate of potential gross state product, and for 2018 to 2022, it is set at the growth rate of gross state product minus 0.5%, with some provisions for adjustment. The state will not dictate how the annual benchmark is met. The act encourages greater use of global payment arrangements and risk-based

Author Affiliations: Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut. Corresponding Author: Robert Steinbrook, MD, Department of Internal Medicine, Yale School of Medicine, 333 Cedar St, I-456 SHM, PO Box 208008, New Haven, CT 06520 (rsteinbrook@attglobal.net).
contracts, for example, by requiring the Medicaid program, the state’s employee health care program, and other state-funded health care programs to transition to new payment methods. Physicians and institutions, however, could also achieve needed savings through the parsimonious practice of fee-for-service medicine or other means. Physician contracting units are exempt if they have “a patient panel of 15,000 or fewer,” or “represent providers who collectively receive less than $25 million in annual net patient service revenue.” Each health care entity is responsible for not exceeding the annual percentage increase in costs permitted for the state as a whole.

The Health Policy Commission is to “establish procedures to assist health care entities to improve efficiency and reduce cost growth.” The commission may encourage, cajole, and, if needed, shame them into doing their part to control costs. Starting in 2016, the commission may require some to file and implement a “performance improvement plan” because they have exceeded the cost growth benchmark and have not adequately explained potential mitigating factors. Such an entity will be identified on the commission’s website until its plan is successfully completed. The commission’s options to enforce compliance are limited, however. Under extreme circumstances, the commission may impose civil penalties of up to $500,000 but only “as a last resort.” By comparison, approximately $61.2 billion was spent on health care for state residents in 2009. The commission can also conduct a “cost and market impact review” of a health care entity and refer to the state attorney general any that meet certain criteria, including having “a dominant market share for the services it provides” and charging “prices for services that are materially higher than the median prices charged by all other providers for the same services in the same market.” The attorney general would determine if a health care provider “engaged in unfair methods of competition or anti-competitive behavior” and potentially take action to protect consumers.

There will be no way to know if this plan for Massachusetts is working until it has been in effect for at least several years. Until then, skepticism about the amount of projected savings is appropriate. Notably, the plan does not offer incentives for organizations to save more money than is required to meet the annual cost growth benchmark. The legislation might have rewarded organizations that performed better than their target, thus saving the system more money. Of course, health care is also a large part of the state’s economy. A major slowing in health spending could reduce employment in health care and related industries, while boosting overall economic activity and making medical care more affordable.

It is uncertain if Massachusetts’ approach to controlling health care costs could become a model for the rest of the country. The commonwealth’s high costs and concentration of physicians and academic medical centers create an environment that differs from that in most other states. Nonetheless, Massachusetts has opened a discussion about global costs and will test an approach that other states could follow, even if they were to adopt plans with different details or set other spending targets. Massachusetts may also lay the groundwork for further reforms that would control health care spending within its borders more completely. With a global spending target, health care in Massachusetts is still likely to be very expensive as compared with the United States and all other member countries of the Organisation for Economic Co-operation and Development. Health care may just not be quite as expensive as it could be without a spending target.

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REFERENCES