Health Care Transformation

Business & Workforce Impacts of New Health Care Law

(Chapter 224 of the Acts of 2012)

1:00 pm - 3:00 pm

Featuring:

City of Brockton Mayor Linda M. Balzotti
Brockton Area WIB Chair John Lloyd
Panel Moderator: Association Chair Stan Usovicz, Verizon
David Seltz, Senior Health Care Advisor to Governor Patrick
Celia A. Wcislo, Vice President, 1199SEIU, United Healthcare Workers East
Joanne Goldstein, Secretary, Executive Office of Labor & Workforce Development
Dr. Charles Wall, President, Massasoit Community College
Responses from Regional Health Care Partnerships

Business & Community Impact of Chapter 224 of the Acts of 2012

An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation – Signed into Law August 6, 2012

Presentation to Massachusetts Workforce Board Association

Inspiration and Motivation to craft Chapter 224

* Massachusetts Spends More on Health Care than any other State
  * Per Capita Personal Health Care Expenditures in 2009 were $9,278 in Massachusetts
  * State Average in USA was $6,815 (Source: Kaiser State Health Facts)
* All payers in Massachusetts Have Experienced Spending Growth – Private, Medicare and Medicaid due to higher per capita spending, and increasing enrollment (Source: CMS Health Expenditures by State of Residence, 2011)

The Future for Health Care Spending was Grim in terms of Cost Growth

* According to the Massachusetts Division of Health Care Policy, total health care spending will double from 2009 to 2020 from $61 billion in 2009 to $123 billion in 2020
* Medicare and Medicaid account for 40% of Massachusetts health care spending, the rest is Private, out of pocket, and a modest amount is veterans and worker's compensation

Where do the health care dollars go?

* In every major category of health care services, Massachusetts per capita spending is higher than the national average – physician and hospital services, prescription drugs, nursing homes.
* Recent increases in private spending has been driven by outpatient care and physician services.
* Higher spending on nursing homes and hospitals accounts for 73% of the $2,463 difference between MA spending and US average per capita spending
  (Source: CMS Health Expenditures by State of Residence, 2011)

Where do the dollars go?

* Not toward Administrative Spending – in Massachusetts it is lower than average – 11% vs. 16% nationally
* Not toward medical malpractice. Nationally it's 2.4% of total health spending (0.5% for lawsuits + 1.9% for defensive medicine). 1.47 billion it's estimated in MA

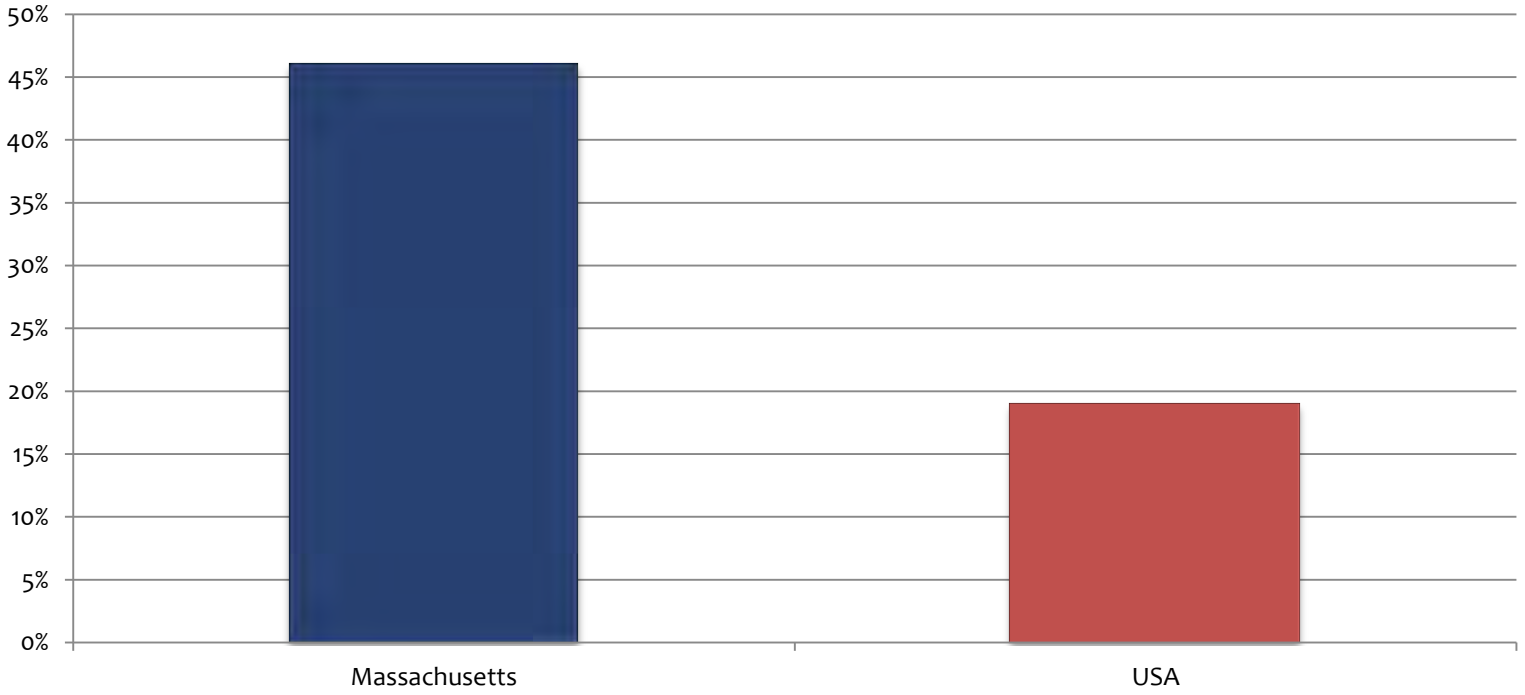
Source: MA Division of Finance & Policy "Massachusetts Health Care Cost Trends, Part II: Private Health Insurance Premiums Trends 2006-2008, Feb 2010"

Where do the dollars go?

* Provider Mix – Population in MA began to make disproportionate use of higher-priced providers (e.g. specialist physician vs. primary care, academic medical center vs. community hospital).
  * Massachusetts residents get more of their care at academic medical centers than people elsewhere in the US do. And some are paid ten times more for the same services as community providers.
  * The State also has more specialists per capita than anywhere else in the country

Massachusetts Residents Rely More on Academic Medical Centers than Residents of Other States

Percent of Licensed Hospital Beds Located in Academic Medical Centers



Where else do the dollars go?

* Provider Mix
* Utilization – Massachusetts' demographics contribute. Admissions per 1000 is 124 in MA, 116 in US – a 6.9% difference (Source: MA DHFCP Feb 2010 report)
* Service Mix – Health care spending rises if a population starts to access more expensive services (MRI's, CT scans instead of lower-priced x-rays)
* Price – Health care spending rises if the price of each service increase

Additional Inspiration

* With wages stagnant, health care costs consume a greater proportion of household budgets, and the Commonwealth's budget, squeezing out other spending and investments
* Employers are shifting more of the cost of premiums onto Employees – In 2001 employers paid 82% of individual premiums, and 75% of family premiums. In 2010 they paid 75% of individual and 70% of family premiums. (Source: DHCFP Employer Survey)

Goals and Objectives for Chapter 224

* Increase transparency on prices, utilization, beyond current state for consumers and government authorities
* Devise new tools and innovations
* Put health care spending on a budget to discourage health care costs to grow more than gross state product
* Political – State and National

What are the specific benefits for employers and their employees

* Moving away from fee-for-service, toward new service models – e.g. Accountable Care Organizations, paying alternative payment methods
* Controlling the growth in costs through setting health care growth targets/budget and a process to encourage innovation
* Administrative Simplification – Standardizing prior authorization forms, EOB's, electronic all payer/all provider automated approval system and data exchange
* Wellness Focus, Support and Encouragement – Tax Credits for business

Encouraging Innovations Should Keep Employees in Better Health

* Alternative payments for costly state-covered plan enrollees
* Patient Centered Medical Homes
* New Commissions and Authorities to encourage better health care planning, IT adoption, workforce development, and address price variation.
* A Center for Health Information and Analysis (CHIA) to analyze trends and develop reporting processes (e.g. Uniform Reporting of Revenues)

Requiring health plans to offer Alternatives and Work harder to make health care Affordable

* Insurer Consumer Transparency – toll free phone and website to enable consumers to obtain real time estimated or max allowed charge for service, and estimate of what the insured will be responsible to pay
* Smart Tiering Plans -1 per carrier with 14% discount
* Medical Loss Ratio – permanently 88% MLR in 2015