Published in final edited form as:
N Engl J Med. 2012 April 26; 366(17): 1560–1561. doi:10.1056/NEJMp1201261.

Controlling Health Care Spending — The Massachusetts Experiment

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As debate rages on about implementation of the Affordable Care Act (ACA), national attention is once again focused on Massachusetts, which instituted a similar comprehensive health care reform package in 2006. After expanding health insurance coverage to almost 98% of the state population, Massachusetts is now struggling to control increasing health care costs that threaten the continued viability of its reforms. This second phase of health care reform presents entirely new challenges. Whereas expanding coverage has popular appeal, cost control does not. Whereas expanding coverage injects additional dollars into the health care system, cost control does the opposite. Whereas expanding coverage can be relatively simple, cost control is difficult. Yet despite these obstacles, Massachusetts forges ahead, with a combination of public and private efforts at payment reform on an unprecedented scale.

Massachusetts spent more than $61 billion on health care in 2009, a figure that places it among the highest-spending states in the country.[1] In the past 5 years, growth in health care spending has consistently exceeded economic growth, resulting in challenges both for lawmakers dealing with a constrained state budget and individuals required to purchase coverage privately. In fiscal year 2012, health care will consume 54% of the state's budget, up from 49% in fiscal year 2009, with the bulk going toward Mass Health (Medicaid) and individual subsidies for purchasing health insurance. For individuals, monthly premiums for a minimal ("bronze") plan purchased through the Commonwealth Choice connector (the state insurance exchange) increased from about $175 in 2007 to $275 in 2012 (a 57% increase), despite slowed growth in overall health care spending since the start of the recession in 2008.

To address these concerns, Governor Deval Patrick convened the Massachusetts Special Commission on the Health Care Payment System, which voted unanimously in July 2009 to recommend that the state transition from a fee-for-service to a global payment system within 5 years. The commission also encouraged providers to band together into accountable care organizations (ACOs) — organizations of providers held jointly accountable for spending and quality of care for a defined population of patients. Meanwhile, the Health Care Quality and Cost Council, created by the 2006 coverage-expansion law, issued its *Roadmap to Cost Containment* in 2009; in it the council argued strongly for global payment and systemwide redesign to lower spending.[2] Recognizing that price and volume together account for spending, the Office of the Attorney General and the Division of Health Care Finance and

Policy embarked on a landmark effort to document the substantial price variations in the state — illustrating, in several influential reports, the role of providers' market power in determining the prices charged to commercial insurers.[3]

These activities culminated in a comprehensive payment and delivery reform bill released by Governor Patrick in February 2011. The bill proposes migrating into global payment arrangements most state employees and Medicaid enrollees, groups that together include about 25% of Massachusetts residents.[4] It also encourages but does not require providers to form ACOs — with the state providing oversight of market power and price transparency — and includes provisions for malpractice reform favored by physicians. The bill also grants the commissioner of insurance the authority to strike down increases in insurance premiums that result from excessive increases in underlying provider-payment rates. The appropriateness of increases in provider-payment rates will depend on how they compare with growth in the Massachusetts gross state product (the state-level equivalent of the national gross domestic product) and the growth of total medical expenses in the providers' particular region. Combined with global payment, this authority to indirectly regulate providers' prices would be among the strongest policy tools available for cost control. Since the bill's release, state legislators have been drafting their own proposals, and both public and closed-door debates have intensified. The legislative outcome remains unclear.

While the state aggressively pursues its agenda, innovations in the private sector have arguably taken the lead. Most notably, Blue Cross Blue Shield of Massachusetts, the largest commercial insurer in Massachusetts, launched the Alternative Quality Contract (AQC) — based on global payment with shared savings and shared risk, as well as pay-for-performance incentives — with seven provider organizations in 2009. Since then, the AQC has been extended to cover more than a dozen provider organizations and more than 600,000 enrollees. Encouraged by provider organizations and the AQC, Harvard Pilgrim Health Care and Tufts Health Plan, the state's other major insurers, have also negotiated global payment contracts with their provider networks, which will probably push the number of enrollees in commercial insurance plans that have global payment arrangements to more than 1 million.

Finally, and perhaps most important, the Center for Medicare and Medicaid Innovation launched its Pioneer ACO program in January 2012 with 32 advanced provider organizations around the country. Among them are 5 large organizations in eastern Massachusetts (Atrius Health, Beth Israel Deaconess Physician Organization, Mount Auburn Cambridge Independent Practice Association, Partners Healthcare, and Steward Health Care System), which will together care for approximately 150,000 Medicare beneficiaries (roughly 75% of Medicare beneficiaries in the Boston area) under their Pioneer contracts. Additional provider organizations in the state will probably join the Medicare Shared Savings ACO Program later this year.

These synergistic efforts by public and private payers have resulted in a watershed moment in Massachusetts health care. By our estimates, if the Group Insurance Commission, which purchases insurance for state employees, and Medicaid follow Medicare and commercial payers into global payment, substantially more than half of residents of eastern Massachusetts would be cared for by providers working under risk-based contracts. Primary

care physicians will have the opportunity and responsibility to steer resource utilization for their organizations, and providers in all specialties will have strong incentives to better coordinate care, improve quality, and intensify their focus on patient-centered care. Referral patterns and the movements of patients from one provider system to another will probably change considerably. Similarly, with strong incentives to reduce spending, provider organizations will probably take an active role in identifying and discouraging the use of low-value services. Opportunities will be ripe for designing incentives within organizations directed at individual physicians as well as teams of providers.[5]

Yet immense challenges loom. Because enrollees in preferred-provider organizations and most employees of self-insured firms remain largely outside of global payment arrangements, the fee-for-service system retains a substantial role. With global payment expected to constrain spending for a growing proportion of patients, undesirable spillover effects, such as cost shifting onto the fee-for-service population, may occur. At a macro level, Massachusetts relies heavily on specialty-driven tertiary care delivery systems not only for its health care but also for jobs and the education of thousands of physicians-in-training each year. Indeed, health care is an engine of the Massachusetts economy. A crucial question is whether lawmakers will gain the stakeholder support needed to embrace cost control and tackle the roots and drivers of Massachusetts health care spending, given that unintended consequences for the labor market and the broader economy may lie downstream.

No matter the outcome, this wholesale Massachusetts experiment should offer invaluable lessons for other state and federal cost-control efforts, particularly as the ACA is implemented. One lesson is already resoundingly clear: the growth of health care spending threatens the sustainability of every other public service, from education, to public health, to infrastructure, to defense. Indeed, health care spending is the most important determinant of our growing national debt. In a society of limited resources, the imperative for cost control now comes from outside health care. Payment reform may well be a reasonable beginning, but fundamental reform of the delivery system is needed if we are to truly succeed.

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