MEETING MINUTES:

MARKET OVERSIGHT AND TRANSPARENCY COMMITTEE

Meeting of February 9, 2022

MASSACHUSETTS HEALTH POLICY COMMISSION

Market Oversight and Transparency Committee
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, February 9, 2022, 9:30 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Market Oversight and Transparency (MOAT) Committee held a virtual meeting on Wednesday, February 9, 2022, at 9:30 AM.

Members attending remotely included Dr. David Cutler (Chair); Ms. Patricia Houpt; Mr. Ron Mastrogiovanni; and Ms. Cassandra Roeder, designee for Secretary of Administration and Finance Michael Heffernan.

Dr. Stuart Altman (HPC Chair), Dr. Donald Berwick, Mr. Martin Cohen were also in attendance virtually.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.
A video of the meeting can be seen here.

ITEM 1: APPROVAL OF MINUTES FROM THE October 6, 2021, MEETING
Dr. Cutler called for a motion to approve the minutes from the October 6, 2021, meeting. Mr. Mastrogiovanni motioned to approve the minutes. Ms. Houpt seconded the motion. The vote was taken by roll call. The minutes were approved with four votes in the affirmative.

Dr. Cutler turned the presentation over to Mr. David Seltz, Executive Director, who provided a brief introduction to the meeting.

ITEM 2: Office of Patient Protection (OPP) Annual Report
Mr. Seltz turned the presentation over to Nancy Ryan, Director, Office of Patient Protection, who gave an overview of the OPP's Annual Report. For more information, see slides 6-15. The portion of the meeting on the *OPP Annual Report* can be viewed here.

Ms. Houpt asked if there was a particular carrier that stands out in who is above the fold in terms of denial of claims or is it spread uniformly across the book of business? Ms. Ryan said that the report does give a breakdown of the different plans and how many internal reviews and external reviews they have had in relation to the member months, averaging out for the larger plans. Ms. Ryan noted that having more appeals requested or more external reviews requested is not necessarily a bad thing and could be showing they are doing a good job reaching out to their patients.

Dr. Berwick noted that the numbers were pretty low and asked if the staff have a sense of an underlying latent need that, if the communications were great and everyone was aware, there ought to be some higher number of calls to you or do you think we're kind of hitting the need? That would bear on anything that the commission should be thinking about in terms of support to you, for more outreach and awareness regarding appeals. Ms. Ryan said it's really hard to know what the right number should be, but that staff works with the health insurance companies to make sure they are providing good and

accurate notice and listing everything as they should in their notice to consumers. OPP staff always tries to perform as much outreach as possible.

Dr. Cutler noted that the health plans were looser with many of the rules during COVID and asked if staff was observing that the plans are now tightening up again on the rules? Is that how staff interpret some of the recent trends that are going back up because of the rules loosened during COVID are now being tightened again? Ms. Ryan said staff can't say we have noticed anything specific as that and noted that it's difficult to see trends at OPP because they serve such a small segment of the market.

Mr. Cohen asked if the behavioral health appeals were treatment options, parity issues, medication, or specialized treatment? Ms. Ryan said that out of the 17 behavioral health external reviews in 2020, 9 of the eligible requests were for residential mental healthcare and noted that these are all denied because of lack of medical necessity according to the health plan. Four were eligible requests related to substance use disorders. All of which were for residential or inpatient treatment.

ITEM 3: Growth in Out-of-Pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts

Mr. Seltz provided an introduction to the presentation on growth in out-of-pocket spending for pregnancy, delivery, and postpartum care in Massachusetts. Mr. Seltz then turned the presentation over to Dr. Sasha Albert, Senior Researcher, Research and Cost Trends, who gave an overview of the upcoming DataPoints. For more information, see slides 17-23. The portion of the meeting on the DataPoints issue can be viewed here.

Ms. Houpt said that one thing that is hard to measure is that as employers increasingly offer higher deductible programs, they are subsidizing a portion of that cost through a health reimbursement account or allowing employees to enroll in an Health Savings Account (HSA). She noted that the data that HPC has available to it is only going to look at the insurance claim and not seeing the impact of that other subsidy that may be there. She said if you're a non-group person, you're just looking for the cheapest coverage out there. It's an affordability issue just for the premium. She said that larger employers showing that lower deductible because employees have a choice of plans, they can enroll in each year and often, pregnancy is planned, not always, but people can choose a richer program that year where they know they're going to have a child. One of the things from insurance plan design that employers can be looking at is providing an incentive or a higher level of coverage for more efficient, cost efficient, higher quality hospitals in terms of delivery where their overall cost with the employer is limited but the employee would be getting a higher benefit level within the system. Dr. Albert noted that the HPC cannot measure contributions to HSAs, but that Kaiser Family Foundation put out work finding that the smallest employers are also the least likely to offer HSAs. Dr. Albert added that HSAs disproportionally benefit higher earning workers because they have more pretax income to put away for future healthcare costs.

Mr. Mastrogiovanni asked whether staff are seeing a change in the number of firms that are taking advantage of ICHRA (Individual Coverage Health Reimbursement Arrangement). Mr. Mastrogiovanni explained that an ICHRA is a program designed to allow an employer to allocate money for employees for healthcare and the employee goes and shops for coverage in their state. Mr. Mastrogiovanni explained that the program limits what the employer pays for healthcare and the responsibility falls on the employee. Dr. Albert said that staff has not looked into ICHRA but plan to.

Dr. Cutler made a comment about cost sharing and health insurance design, citing his time on the Harvard Benefits Committee and the effort to buy a maternity policy that would incentivize utilizing non-tertiary hospitals for low-risk pregnancies and tertiary hospitals for high-risk pregnancies. Dr. Cutler said the health insurance plans couldn't design this type of plan. Dr. Albert agreed and stated that designing plans like the one described is tough because some patients will know in advance that they are high risk and others will not.

Item 4: Children with Medical Complexity in The Commonwealth

Dr. Sasha Albert, Senior Researcher, Research and Cost Trends, gave an overview of findings from the Children with Medical Complexity in the Commonwealth Report. For more information, see slides 24-32. The portion of the meeting on the *Children with Medical Complexity Report* can be viewed here.

Dr. Cutler noted that the U.S. Congress passed the infrastructure bill, which included funds for broadband and other kinds of IT infrastructure and wondered if the HPC's recommendation could go further and recommend a way to utilize infrastructure funds to set up a way to link data systems. Dr. Albert said they would follow-up and see what can be learned.

Item 5: Performance Improvement Plan Update

Dr. Cutler turned the presentation over to Mr. David Seltz, who provided a brief introduction to the performance improvement plan (PIP) update. Mr. Seltz then turned the presentation over to Ms. Kara Vidal, Director, Health System Planning & Performance, who summarized the next steps in the PIP process for Mass General Brigham (MGB). For more information, see slides 33-40. The portion of the meeting on performance improvement plans can be viewed here.

Mr. Cohen asked for a walk-through of the criteria for granting a waiver request. Ms. Vidal walked through the specific factors that the HPC would consider before approving a waiver request, noting that such factors are similar to those reviewed in determining whether a PIP was warranted. Those factors include costs, price, utilization of trends of the entity over time, any demonstrated improvements to reduce health status adjusted TME, ongoing strategies or investments that the PIP entity is implementing to improve long term efficiency and cost growth, whether the factors of increased cost can be unanticipated or outside of its control, overall financial condition of the PIP entity, any significant difference between the growth rate of potential gross state product and the growth rate of the actual gross state product, and any other factor that the HPC considers relevant.

Dr. Cutler noted a scenario the HPC should avoid during the performance improvement plan process where MGB and the HPC are stuck in an "infinite loop" of disagreement on proposed cost saving measures, describing MGB's claim that developing new ambulatory settings would reduce spending while HPC found that, when all cost drivers are taken into account, new MGB ambulatory settings would likely increase, rather than reduce, spending. Dr. Cutler asked Dr. Altman, Mr. Cohen, Mr. Seltz, and Ms. Vidal to weigh in and asked how the HPC can avoid the infinite loop scenario. Dr. Altman agreed and noted that MGB's past statements have not acknowledged the complete picture of its spending. Dr. Altman described that the HPC's option, if MGB submits an insufficient plan, is to say that this is "not an acceptable plan to address your spending problem." Mr. Seltz noted that the HPC's regulatory factors explicitly require the HPC to examine the plan, including the plan's impact on the benchmark and on total healthcare spending, and that the regulation and statute contemplates a bit of back-and-forth between the HPC and a PIP entity prior to submitting a PIP. Mr. Seltz added that the HPC stands ready to engage in a collaborative process with MGB, and that back-and-forth may be the path to articulate the process and factors so that MGB can file a plan that will have a higher likelihood of approval. Dr. Cutler

noted that it seems like that process would be beneficial to all parties. Dr. Altman reiterated the desire to avoid the “infinite loop”, but noted that, to date, MGB has been forthcoming in having discussions but is not acknowledging the complete picture of its spending performance and is working to find ways to increase revenues. Mr. Seltz ended the discussion by reiterating that the HPC wants to have a successful performance improvement plan that makes a meaningful difference in improving the affordability of care, and that he both hopes and expects that HPC and MGB can find common ground to work together on that goal.

Mr. Seltz previewed the Health Care Cost Growth Benchmark Hearing.

ITEM 6: Adjournment
Dr. Cutler adjourned the meeting at 11:00 AM.