MASSACHUSETTS
HEALTH POLICY COMMISSION

2021 Pre-Filed Testimony

PAYERS

As part of the
Annual Health Care
Cost Trends Hearing

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2021 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, November 5, 2021**, please electronically submit testimony to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's pre-filed testimony responses from 2013 to 2019, if applicable. If a question is not applicable to your organization, please indicate that in your response.

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

You are receiving questions from both the HPC and the Attorney General's Office (AGO). If you have any difficulty with the templates or have any other questions regarding the pre-filed testimony process or the questions, please contact either HPC or AGO staff at the information below.

HPC Contact Information

For any inquiries regarding HPC questions, please contact:
General Counsel Lois Johnson at HPC-Testimony@mass.gov or lois.johnson@mass.gov.

AGO Contact Information

For any inquiries regarding AGO questions, please contact:
Assistant Attorney General Sandra Wolitzky at sandra.wolitzky@mass.gov or (617) 963-2021.

HPC QUESTIONS

1. UNDERSTANDING THE IMPACT OF COVID-19:

Please briefly describe how you believe COVID-19 has impacted each of the following:

a. Your organization and its employees:

Our associates are key to our success in meeting the needs of our members, the clinician community that cares for them, and our employer customers. We are proud that our company continues to operate at a high level as more than 90% of our employees continue to work remotely under challenging circumstances. We have continued to develop and promote well-being offerings for our associates, understanding that stress is elevated during these times. We have worked hard to ensure that our employee programs, communications, and benefits are broadly accessible, affordable and align with changing needs resulting from the pandemic. Specifically, we have:

- Assisted our associates challenged with caring for children and elders during the pandemic, providing over $5 million in direct assistance for needed emergency back-up care. We have also allowed unlimited emergency back-up care to be converted to on-line virtual tutoring for the children of our associates.

- Continued to host biweekly webinars with our in-house mental health experts where associates can ask questions live as well as chat with others in similar circumstances. Recognizing possible financial challenges, we introduced financial coaching assistance to help our associates navigate financial questions including specific concerns related to COVID-19. We offer competitive paid personal, wellness and family leave benefits, policies that we continue to strongly support in a broadened manner across the Commonwealth.

As we contemplate the broader return to office settings, we have developed training for all of our leaders to ensure we are working inclusively in a hybrid environment. We have added safety protocols including health verifications, mask requirements and a vaccine requirement for on-site building access. This is in addition to contact tracing protocols that we implemented last year. We have also invested significantly in various building improvements including upgrades to our HVAC systems, on-site cafes and workspace configuration and spacing to ensure that our employees have safe and healthy work environments.

b. Your members, including but not limited to the direct health effects of COVID-19 as well as indirect health effects, such as the effects of deferred or cancelled care, exacerbation of

behavioral health and substance use conditions, and effects from economic disruption and social distancing (e.g., evictions, food security):

BCBSMA approached COVID-19 not only in terms of the impact to our members, but to the community as a whole. Our state's clinicians have spent the last 20 months on the frontline caring for our neighbors with brilliance and compassion, often risking their own health and safety. We are proud to support these efforts and since the start of the pandemic, BCBSMA has provided $13.9 M in additional, community-wide support of COVID-19 efforts.

Community Impact

Given the broad impact of the COVID-19 vaccine, we partnered with numerous organizations to promote vaccine confidence. This included a transportation support program in partnership with Lyft and the Massachusetts League of Community Health Centers to provide free rides for community health center patients to access vaccination appointments, in addition to a dedicated BCBSMA call center. We also partnered with CIC Health and Field First to increase vaccination rates in Massachusetts cities and towns with below-average vaccination rates. We ensured that these communities had equal access to the vaccine by underwriting vaccine clinics, promoting, and providing incentives to drive participation.

BCBSMA understood that the pandemic affected more than just the direct health care system. According to the latest projections from Feeding America, food insecurity in eastern Massachusetts is expected to remain 30% above pre-pandemic levels through 2021. For children in eastern Massachusetts, this rate is anticipated to be 47% higher compared to 2019. As part of our ongoing assessment of the impact of COVID-19 on food insecurity, BCBSMA facilitated a six-week series for nonprofits in the food justice and anti-hunger space to allow for shared learning. BCBSMA continued our partnership with East Boston Neighborhood Health Center and the work of their Community Resource and Wellness Center to overcome social determinants of health and reduce food insecurity. BCBSMA provided seed funding for an additional care navigator assistant position, as well as funding to jumpstart a new, linguistically and culturally-relevant care navigator program.

We also continued our partnership with our vendors to reengage cafeteria employees and managers to create pre-made meals to share with not-for-profits that serve community members in need of food. In 2021, BCBSMA succeeded in donating close to 131,000 meals to support our colleagues and community members facing food insecurity resulting from the pandemic. As a further example of this commitment, we also provided $70,000 in funding to the Weymouth Food Pantry to launch a new regional hub for food

distribution between the Greater Boston Food Bank and pantries across the South Shore. This new warehouse will provide increased storage, refrigeration, and workspaces, as well as a second loading bay, ensuring more Massachusetts residents have access to healthy foods.

BCBSMA also provided a $150,000 grant to Health Care for All to support the growth and sustainability of a multilingual consumer assistance Help Line, the only statewide multilingual phone service – answering an average of 20,000 calls annually in English, Spanish and Portuguese. During the pandemic, the Help Line supported calls from consumers who would have normally gone to hospitals and community health centers. Blue Cross' funding made it possible to provide vital assistance to non-English speakers statewide, particularly for those communities that have been disproportionately impacted by the COVID-19 crisis.

Member Impact

For our members, we have ensured they can access the care they need, when they need it. We waived member costs for all COVID-related care, and all federally authorized COVID vaccines are covered at no cost to our members. In 2020, we extended grace periods for customers having difficulty paying premiums and issued rebates for our Dental Blue customers.

From March 2020 through September of this year, BCSBMA has spent $760 million on Blue Cross members with a confirmed or suspected COVID-19 diagnosis. Over 1.1 million members have had a confirmed or suspected COVID-19 diagnosis, and over 2.2 million COVID-19 diagnostic tests have been administered for our members. It is worth noting that we are starting to see an uptick in COVID-19 diagnosis testing. Starting in August 2021, we are closer to our highest levels of testing in December 2020.

From the beginning of the pandemic, BCBSMA reached out to members at high risk for COVID-19. Our case management team ensured that COVID-19 education on personal safety, isolation requirements and testing was provided for members. Once vaccines were authorized and available, we then ensured that the COVID-19 information available to members included vaccine education. Case managers helped members identify and understand accessible vaccine sites, transportation options, and guidelines for eligibility.

We are troubled to see an increase in our members' behavioral health needs since the start of the pandemic. Utilization levels in 2021 have exceeded comparable utilization levels in 2019 by 30%. Anxiety disorders, depression, and substance use disorders now account for over 60% of all mental health diagnoses. We are pleased to have been able to

offer behavioral health telehealth to meet our members' needs. Almost 70% of behavioral health utilization and spending is occurring via telehealth, most of which is through local clinicians.

We continue to work with our members and clinicians on closing any gaps in cancer screenings and other care that may have resulted by deferring care. Preventative colonoscopies, mammograms, and preventative office visits have bounced back rather quickly, returning to pre-pandemic levels starting in 3Q 2020.

A subset of elective services (comprising approximately 35% of our total medical expenses) are now close to or above their 2019 levels. Medical office visits quickly returned to 2019 levels starting in 3Q 2020. We are also seeing elevated costs for outpatient surgery compared to 2019. We are still exploring the causes for this elevation, but both utilization and cost/severity appear to be playing a role. While non-urgent ER use declined during the height of the pandemic, we saw a return of non-urgent ER to 2019 levels in early 2021.

c. The health care system as a whole, including but not limited to how you think the health care system will change going forward, and any policies or innovations undertaken during the pandemic that your organization believes should continue (e.g., telehealth, licensure and scope of practice changes):

COVID-19 led to a revolution when it comes to telehealth use, both for medical and mental health treatment. Between March 2020 and October 2021, BCBSMA processed almost 11.7 million telehealth claims. Telehealth will continue to be a vital option for our members moving forward, although we are seeing a decline in claims. While 58% of our processed telehealth claims during this full period were behavioral health-related, as we have seen more in-person medical visits taking place in the recent months, the rate of behavioral health telehealth visits is closer to 70% of the total telehealth claims.

We have seen a 30% increase in behavioral health visits overall during the pandemic. Given the increasing need, BCBSMA added more than 500 new mental health clinicians to our network since March 1, 2020, bringing the total number of psychologists, psychiatrists, social workers, family therapists and other mental health clinicians to nearly 15,000. BCBSMA remains concerned about the workforce limitations within the behavioral health field as the needs can outpace capacity and some clinicians may choose to not accept private insurance from patients.

2. EFFORTS TO COLLECT DATA TO ADVANCE HEALTH EQUITY:

a. Comprehensive data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity is foundational to advancing health equity in the Commonwealth. Please describe your current efforts to collect these data on your members. Please also describe specific barriers your organization faces in collecting such data and what policy changes or support has your organization identified as necessary to overcome such barriers.

We have begun new efforts to collect race, ethnicity, and preferred language data from many sources — prioritizing self-reported data directly from our members — and advanced measurement methods that are foundational to accurately measuring inequities. Consistent with our longstanding commitment to valid and reliable measurement, we view these data and analytic steps as necessary for high-stakes uses of equity measures, such as in provider payment, and to holding ourselves accountable for achieving measurable improvements over time.

Starting in December of 2020, BCBSMA began to ask all members to share information about their race, ethnicity, and preferred language when they log into the Blue Cross member portal, MyBlue. The overall response rate has remained stable at about 30% and our estimated response rates among Asian/Pacific Islander, Black, and Hispanic members have exceeded the response rates among White/non-Hispanic members. In addition to leveraging our member website, our efforts will include a mailed survey to our members to collect additional race, ethnicity and preferred language data. Moreover, beginning next year, we expect that our employer partners will also be able to submit race, ethnicity and preferred language from employment records.

Collecting data on disability status and sexual orientation/gender identity is a high organizational priority. Lack of widely-accepted data standards for these important member attributes is a barrier to data collection, storage, analysis, and usage in core health plan operations. With this limitation, BCBSMA is committed to creating an atmosphere that demonstrates sensitivity to gender identity by updating gender references in our communications, and developing educational content for associates, members, providers, accounts, and the public. We have also initiated work to accept a non-binary gender identifier during enrollment, including the necessary information technology roadmap to deliver the system enhancements in the future. Currently, information expressed by members about pronoun preferences to our member service representatives is stored manually in our customer relationship management system for reference during future contacts.

A key barrier to having complete and accurate data on race, ethnicity, language, disability status, and sexual orientation/gender identity is the current lack of routine exchange of these data between and among providers and health plans. When data exchange is lacking, each provider and health plan must ask patients and members the same questions, in a potentially duplicative fashion, at substantial cost. Without data exchange, providers and health plans might also disagree over the magnitudes of inequities in health care quality because they disagree on the underlying data on race, ethnicity, language, disability status, and sexual orientation/gender identity; these disagreements over inequity measurement could waste resources that would be better spent collectively working towards improving the equity of care. Aligning toward a common vision and principles for data exchange, with the possibility of mandated exchange for the purposes of measuring and improving health equity, would be welcomed by BCBSMA and would avoid fragmented and conflicting databases on race and ethnicity.

3. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

a. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2017 to 2020 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2017 to 2020, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., unit cost, utilization provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

Please see attached HPC Payer Exhibit 1 for BCBSMA.

b. Reflecting on current medical expenditure trends your organization is observing in 2021 to date, which trend or contributing factor is most concerning or challenging?

In 2021 we continue to observe the impact of the pandemic on health care costs although to a lesser degree compared to 2020. Some of the primary drivers of recent trends that are challenging include:

1. Hospital and Physician Reimbursement -- More than half of total trends are driven by trends in provider reimbursements. BCBSMA anticipates additional pressure on unit cost trends in the commercial market as patient mix continues to shift to historically lower reimbursement payers, such as Medicaid and Medicare, as well as with the continued expansion of higher price hospital systems.

2. Pharmaceutical Costs – The impact of blockbuster high-cost biologics and other innovative emerging therapies has a material impact on current trend. As the pipeline for new biologics strengthens significantly over the next 2-5 years, the pressure on trend will continue to grow.
3. COVID-19 – Costs related to the pandemic, including treatment, testing and vaccines costs, remain persistent and are difficult to predict.
4. Increase Demand – Across the Commonwealth, we are seeing a surge in need for certain services such as behavioral health and substance use services. BCBSMA members are no exception to this challenging environment, and we continue to monitor this trend.

AGO QUESTION

Chapter 224 of the Acts of 2012 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures, and services through a readily available "price transparency tool." In the table below, please provide available data regarding the number of individuals that sought this information.

Health Care Service Price Inquiries Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2019	**Q1**	17,718	102*
	Q2	14,486	103
	Q3	17,837**	101
	Q4	26,496	104
CY2020	**Q1**	28,886	95
	Q2	14,504	45
	Q3	27,800	91
	Q4	28,003	89
CY2021	**Q1**	33,157	155
	Q2	29,811	170
	TOTAL:	271,538	849

*Correction from previous pre-filed testimony submission
**MyBlue app cost estimation capability added as of Q3 2019

---- End of BCBSMA Responses ----

I affirm that the facts contained in the preceding responses are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that the facts stated with respect to such matters are true.

Sincerely,

Andrew Dreyfus
President and Chief Executive Officer

HPC Payer Exhibit 1

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2017	1.7%	0.0%	0.2%	0.2%	2.2%
CY 2018	2.1%	1.0%	0.4%	0.4%	3.9%
CY 2019	2.3%	0.1%	0.3%	0.3%	3.0%
CY 2020	2.7%	-4.7%	-0.3%	-0.3%	-2.6%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

5. Estimated changes in benefit buydown and demographics have stayed fairly constant over the past few years although benefit buydowns in 2019 and 2020 emerged lower than prior years.

6. Changes in health status were estimated using DxCG risk scores.

7. Overall health status deteriorated every year from 2017-2019. However, overall risk score in 2020 was lower than 2019 due to the deferral of care resulting from the COVID-19 pandemic. Change in health status can potentially impact all components of trend except unit cost

8. Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA and include both non-pharmacy and pharmacy claim expenses

9. There is volatility in the components of trend due to macro and micro factors impacting health care trends including but not limited to economy, pandemics, advances in medical technology a and treatment including new drugs, increased consumer engagement resulting from new product designs and transparency tools

10. Note that CY 2020 trends are significantly impacted by the deferral of care resulting from the COVID-19 pandemic and do not represent a run rate trend.

NOTE: The Health Policy Commission (HPC) trend methodology set forth in this question reflects benefit buy downs. In order to respond reliably for each year requested, in its response BCBSMA has used the unit cost trends consistent with CHIA TME submissions for all years. Provider mix and severity are based on a historical analysis of components of trend and utilization is estimated as the total trend net of unit cost, provider mix and severity. This is a change in methodology vs prior years. In prior year submissions to the HPC, a consistent allocation methodology based on historical analysis was used to allocate the total trend across the four components. It should be noted that, in light of the fact that preliminary data was used to estimate 2020, these numbers will likely change. Also note that the trends above are not directly comparable to the THCE annual cost benchmark set by the HPC. The THCE includes administrative expenses and operating margins for Commercial and public plans in addition to the total medical expense. Additionally, the THCE and CHIA reported TME are adjusted for changes in health status whereas the total medical expenses above are not.