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:

Response: The COVID-19 pandemic dramatically altered the landscape of the Health New England workplace, as it did for many other organizations. Although HNE was able to continue operations throughout the pandemic due to our status as an essential employer, our onsite workers were reduced to a small number of about 12-15 essential workers per day. Our remaining 370+ associates transitioned to working fully remotely beginning mid-March of 2020. Our associates had a mostly strong positive response to our flexibility towards remote work – many reported being able to take advantage of opportunities for additional wellness activities, such as healthy eating, exercise and physical activity, mindfulness exercises, and increased time outdoors and/or with loved ones and pets.

Despite the challenges of living through a time of historic disruption, Health New England's overall Press Ganey (PG) engagement scores increased from the 65th to 66th percentile, compared to the National Healthcare average. High Performing themes include:

- Perceptions of fair pay
- Diversity and value of employees from different backgrounds
- Employees feel they are treated with respect, and
- Ethical business practices

We attribute the overall increase in engagement scores to a number of activities including, increased employee communication through regular company-wide Town Halls, increased business updates and establishing a way for associates to ask questions of the leadership team through a dedicated email inbox, new associate support groups, and transparent Return to Office (RTO) planning and communication. We also offered a number of wellness programs to our Associates, from family fitness challenges, and mindfulness and resilience classes to cooking demonstrations. Another key contribution to the increased scores was due to the organization's Diversity, Equity, Inclusion and Belonging (DEIB) efforts including educational opportunities and events honoring Black History and Pride months. One of the areas of greatest improvement (0.17 increase from 2019) was in valuing employees of different backgrounds.

The employee engagement survey also helped us identify areas for improved engagement in the following low performing focus areas:

- Connection to Work,
- Positive Process Change and
- Job Fit/Career Development

The pandemic has impacted our associates' mental health and caused increase stress and burnout. From formal and informal sources of feedback, we understand that longer hours spent working from home with no interruption by time spent commuting or socializing in the office, remote meeting fatigue, social isolation from and/or loss of friends and family members, personal and family illness, and people's initial hesitancy to take time off for vacation or sick time, were all contributing factors. We saw an increase in utilization of our Employee Assistance Program for 2020 and 2021 when compared to the same time periods in years prior to the pandemic, in particular for services in the areas of bereavement/grief and depression related issues.

Also, as many other organizations have experienced in this unprecedented labor market, HNE has seen an increase in resignations when compared to previous years. Exit interviews indicate some of these resignations have been attributable to the pandemic as some associates have taken it as an opportunity to rethink personal priorities, including accelerating plans for retirement. We have struggled to backfill these positions at the same rate. Staffing concerns may also contribute to the burnout, stress, and long work hours across HNE, as associates who leave the organization also leave behind team members who must pick up their job duties. However, Health New England's engagement scores in these areas were much higher when compared to national averages, which we attribute to our role as an essential employer throughout the pandemic and our flexible approach to remote work options. We continue to listen to our associates and review our policies, practices and systems to meet the tremendous needs of our associates in this moment, personally and professionally, and to continue to support our associates to move into an uncertain future with optimism and resilience.

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):

Response: Our members have been affected, as all members of the US population have, by the isolation, illness, and social disruption of COVID-19. Hospitals across the country are seeing rises in more severe cancer diagnoses and chronic care diagnoses as the result of deferred or cancelled care. Patients who are presenting for care are more ill and have worse outcomes and worse ongoing chronic illness. These will ultimately affect the cost trend adversely because of the cost of treating chronic illness in more advanced stages.

We are also seeing a significant increase in mental health diagnoses, substance use disorders, and "diseases of despair" as a result of COVID-19. To the north of us, Vermont predicted a 20% increase in mental health utilization. In Massachusetts, we have also experienced a similar increase in mental health utilization constrained, of course, by the availability of mental health providers. There has been a dramatic increase in the reporting of behavioral health and substance use needs and in use of behavioral health and substance use treatment. Access to higher levels of behavioral health care, especially for inpatient care for children and youth, has been stretched to the limit and wait times for beds have become untenable. The availability of telehealth for outpatient behavioral health and substance use treatment has also led to longer wait times to access care, as

providers are having far fewer cancelled and missed appointments with telehealth and not able to maintain as a high a caseload. Unfortunately, members are struggling to access in-person outpatient behavioral health and substance use care as many providers are slow to return to their offices or have closed their offices altogether.

In addition, the pandemic exacerbated pre-existing racial, ethnic and socioeconomic health care disparities for members across all lines of business. COVID-19 infections and the economic effects of the pandemic disproportionately impacted individuals and communities of color. Worsening Social Determinants of Health (SDoH), such as eviction, job loss, and food insecurity, compound both chronic and acute disease and will result in a higher utilization of the medical system and of the mental health system. Making matters worse, social safety net programs around SDoH, including food insecurity and housing protection, have begun to recede and people are reporting more of the financial concerns that they were reporting prior to COVID. We predict that all of these factors will put substantial increased pressure on cost trend and rates.

Health New England has worked diligently to find ways to support members and our community, for example, by expanding our Community Benefits Program. In 2020, we established two new Mini Grant programs:

- First, our COVID-19 Response Mini Grant Program, which is available to organizations working to address the impact of the COVID-19 pandemic on underserved and vulnerable populations in our region and funds must support access to healthy foods, childcare, chronic conditions, COVID-19 vaccine education and outreach, digital divide, education, housing needs, lack of resources to meet basic needs, mental health and substance use, pediatric/adolescent isolation and anxiety due to COVI, preventative health (i.e., physical activity and nutrition). Since launching the program, we have awarded $391,700 to 123 organizations, with an average grant size of $2,950 apiece.

- Second, HNE established a DEIB Mini Grant Program to community organizations addressing racial health equities and focusing on at least one Social Determinant of Health. Since the program began in 2020, we have directed over $135,535 in funds to 33 organizations, with an average grant size of $4,100.

However, to truly address the disparities and SDoH, a systemic, statewide approach must be taken to equalize access to healthcare and resources that support preventative health and wellbeing.

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):

Response: Telehealth utilization, access, and quality. Telehealth utilization has expanded dramatically as a result of the pandemic. With the passage of Chapter 260 of the Acts of 2020, an "Act promoting a resilient health care system that puts patients first," the Commonwealth established new statutory provisions that also required carriers to provide coverage of services provided via telehealth, including when the same in-person service would be covered and when telehealth services are appropriate – telehealth reimbursement parity. Telehealth increased significantly at the beginning of the pandemic, but has not served as an offset to office visits. Telehealth visits continue at a high rate, with office visits returning to pre-pandemic levels. We therefore continue to see increased utilization and resulting costs as a result of the new mandate.

We believe telehealth offers an excellent opportunity for outpatient behavioral health and substance use treatment for members who have scheduling, transportation, mobility, or geographic difficulties. For that reason, we support the ongoing option for members to utilize services that may be appropriately delivered via telehealth.

However, we recognize substantial limitations to broad scale usage of telehealth as a modality for treatment. For example, telehealth isn't a good option – or even accessible – for all members, including those who have barriers to accessing compliant platforms or smart technologies that enable them to receive high quality care via telehealth. We also note that the quality metrics for telehealth have been outpaced by the dramatic expansion in usage. Although there is substantial data to suggest a high value to mental health services delivered through telehealth, the same quality and value metrics, as well as safety data, is not as robust for the widely expanded use of telehealth in the medical arena. In addition, as more people continue working remotely and want to receive in-network telehealth treatment while in other states, licensure requirements that require providers to be licensed in the state where the patient is located can be a barrier to accessing care for some.

Also, due to providers experiencing a significant reduction in "no show" rates for outpatient behavioral health treatment, our members have experienced significant access issues to seeing providers within our network. Many of our providers are either not accepting new members, or are simply continuing to only offer telehealth services when in-person therapy is being requested by our members. The current workforce issues that providers are experiencing as a result of the pandemic have also continued to create barriers to access across the entire Behavioral Health system for our members, not just those seeking outpatient services.

In summary, the ongoing use of telehealth needs to be refined to align with quality, cost, and safety data to ensure a high value experience for patients. It also needs to function effectively and efficiently within a preexisting delivery system, not work against it.

Increased focus on health equity and Social Determinants of Health. In light of the health inequities exacerbated by the COVID-19 pandemic, Health New England supports the robust and system-wide efforts to analyze and offer support around Social Determinants of Health (SDoH) and health education, especially in ways that helps counter

misinformation, systemic discrimination, and bias. We would support the entire health system's continuation of efforts to address SDoH and mitigate health inequities on an ongoing basis, not only relative to COVID-19, and intend to do so ourselves.

In particular, there has been an increased focus on data collection to support healthcare interventions for SDoH. Health New England strongly supports this commitment to data collection across all lines of business. We also promote the development of a statewide, uniform approach to data collection utilized by payors and providers. As we have seen within our own health system and Accountable Care Organization (ACO), well-meaning attempts at data collection can backfire and create more issues that arise when people self-identify differently across the healthcare system. Ensuring that there is a constant flow of consistent race, ethnicity and language (REL), disability, and sexual orientation and gender identity (SOGI) data across health plans, sites of service and community partners will ensure that there can be an equal comparison of data in the development of meaningful health interventions.

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.

Response: Health New England realizes the broad importance that SDOH/REL/SOGI data have on the ability to effectively combat issues of health inequity and to provide more effective utilization and access of care. This data is key in assisting Health New England anticipate the needs of our members in a more comprehensive manner.

Race, Ethnicity and Language (REL) data are our most captured data of the three aforementioned categories though we are still a ways away from a sufficient amount of data. This data is member reported and is often left blank. Language is the most completed data type followed by race and ethnicity. Ethnicity is sparsely populated leaving us with only rough aggregations by race.

Social Determinants of Health (SDOH) data tend to encompass REL/SOGI. The Health New England Quality Improvement team led a SDOH medical record review in the summer of 2021 to scope out the rate of capture and utilization of SDOH data in provider EMRs. The goal was to understand what data were available, how is that data being used and how that data can be shared in an automated format. HNE will continue to work with providers where HNE has direct EMR access to attempt ongoing acquisition of this data. HNE will host a Community Provider discussion as a part of our Quality Management Committee to discuss SDOH/DEIB and Health Equity so that we may further understand current and future investments our provider network is making and how HNE may assist or compliment those investments. Additionally, HNE is investigating possible vendor

acquisition of data. A full investigation into the complete anticipated effect on health plan operations relative to SDOH data acquisition is being conducted.

As a part of Health New England's DEIB Committee and with our Provider Parent Baystate, we have begun the discussions around the collection, utilization and management of Sexual Orientation Gender Identification (SOGI) data. This is in its nascent stage and careful attention must be paid to how the usage of this data is developed in order to ensure appropriate clinical care is rendered.

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.

Response: Please refer to HNE-HPC Payer Exhibit 1, accompanying this document. HNE has observed mostly consistent utilization and unit cost trends year over year, with the exception of 2020 utilization which dropped significantly from previous levels, a direct result of the impact Covid had on patients' behaviors related to elective procedures and other non-emergent services.

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

Response: Significant increases in utilization are the most concerning trend factor in 2021. This appears to be a combination of pent up demand and new utilization patterns across all markets.

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**	649	1
	Q2	576	4
	Q3	548	12
	Q4	704	20
CY2020	**Q1**	611	18
	Q2	342	30
	Q3	537	36
	Q4	567	45
CY2021	**Q1**	700	62
	Q2	638	57
	TOTAL:	5,872	285

HPC Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2017	5.3%	0.8%			6.1%
CY 2018	2.2%	2.5%			4.7%
CY 2019	3.1%	3.0%			6.1%
CY 2020	2.4%	-7.3%			-4.9%

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.