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:

The primary impact on our employees due to COVID-19 has been a shift in our work environment. The majority of our employees pivoted to working remotely in late March 2020 and have continued to do so since. A small portion of our employee population were deemed "essential" and have continued to work in the office since March 2020. Our Human Resources and other internal teams have offered multiple measures for employees that have provided support during the COVID-19 pandemic including:

- A stipend to purchase home office equipment for some staff
- Tip to support their home life including seminars related to homeschooling, resiliency, online resources and more
- Waived co-pays for back-up care through Bright Horizons for some staff
- Wellness days to rest and recharge away from work
- Our Employee Assistance Program
- Remote work tips
- Employee Relief Fund

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):

Point32Health has more than 2.2 million members across our geographic footprint, and more than 1 million members in Massachusetts. We offer coverage in every segment of the health care market, including commercial insurance, Medicare Advantage, Medicaid and dual-eligible products. The pandemic has affected everyone universally but has had disproportionate impacts on socially- and economically-disadvantaged communities and those that have historically experienced disparities in the delivery of health care. We discuss some of these below.

Direct health impacts of COVID-19 on members have included some very long hospital stays due to acute COVID-19 infections and some outpatient visits for those with milder cases. We are still early in the process of understanding the impact of long-term COVID-19 on members, especially since some infections have relatively mild symptoms and may not be associated with significant claim history in the acute phase. COVID-19 testing is still used frequently by members and will continue as the number of local cases remain relatively high. Testing will also persist as colds and flu appear, and providers need to differentiate the cause of the symptoms. We are less able to fully understand the impact of COVID-19 vaccines since the claims from some of the large state vaccine centers have still not been submitted to health plans' claims system. This means our vaccine rates continue to track significantly below the state numbers, making it hard to address gaps in vaccinations. There has clearly been an uptick in some preventive services, such as mammography and colonoscopy, starting in the late spring. This is good news, but we are also hearing from members that they are having delays in getting appointments for these

services due to the pent-up demand. Providers are prioritizing so that higher risk patients get earlier appointments. Orthopedic procedures are also returning with some shift of services to the outpatient space. Care of chronic diseases is more complex. Prescription data indicates that members have been getting their long-term medicines. However, monitoring such as lab testing and other follow-ups had some decrease with more data needed to know if catch-up care has occurred. There is ongoing concern that delayed care will result in conditions presenting at later stages, resulting in higher severity of disease. Pediatricians did great work with getting children in for their vaccines, but it is likely that adult vaccines are lagging. The variable schedules for some of these immunizations makes it more difficult to delineate gaps. Members also had to miss work for COVID-19 and for other issues such as childcare. This may also lead to further deferral of medical care since members fear that taking off more days could jeopardize their job. We also know that some members were furloughed but still had access to employer-based insurance. Some in this group likely resumed working, but some may have moved to government-sponsored programs if they were then terminated. These economic disruptions make it harder for members to follow their treatment plans, including staying on medicines, eating healthy foods and having time for exercise.

During the pandemic we saw a marked increase in the demand for outpatient behavioral health services, particularly services delivered through telehealth, where capacity reached its limit. Treatment requests, especially for anxiety were up. More children required care due to disruption in school. Both adults and children didn't get required lab work to rule out potential side effects from psychotropic medications, due to the fear of catching COVID-19 at laboratories. A lot of intensive outpatient programs (IOP) and partial hospitalization programs (PHP) programs became virtual, and families suggested that these virtual programs were not as effective as face-to-face programs, even though they may have been easier to access. Residential beds for substance use disorder (SUD) and mental health (MH) were harder to find, and the required COVID-19 testing for admittance became a barrier to accessing an already limited supply of beds. We have seen an influx in peer support referrals for members in recovery due to Alcoholics Anonymous/Narcotics Anonymous, etc. meetings being cancelled or moved to virtual platforms that were otherwise inaccessible. There was an increase in reports of isolation and loneliness from social distancing for members with both behavioral health and complex medical needs, especially for those who relied on day programs (like adult foster care), social programs and clubhouses, and recovery meetings.

The crisis of people boarding in emergency departments worsened, as we saw adults and children waiting longer due to the shortage of beds. COVID-19 exacerbated the wait times for both members who were COVID-19+ and needed an inpatient unit that could accommodate them and members who were waiting for COVID-19 testing to rule out COVID-19 before regular admission to an inpatient unit.

We experienced a major increase in reports of food insecurity, especially for members with children. With food pantries and soup kitchens struggling to keep up with the demand, there were more requests and authorizations for home delivered meals. With housing agencies closed and figuring out how to assist vulnerable folks virtually, we had an increase in referrals for members in need of assistance applying for rental and economic relief to pay back rent and avoid eviction. We also saw a large number of members who needed personal protective equipment (PPE), hygiene and sanitizations supplies because they were unable to afford them or access them. With so much demand on existing agencies, the communities in which our members live became a wonderful resource for the clinical team. We referred members to

community refrigerators that were popping up and connected individuals to people who were making and donating masks in order to meet the demand for PPE.

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):

Telehealth: The adoption of telehealth accelerated by about a decade nearly overnight. As noted above, we saw a dramatic increase in behavioral health services delivered via telehealth during the pandemic, and we expect that prevalence to continue even after the pandemic is over, creating a "new normal" for service delivery. Many members found telehealth to be safer, quicker, easier, and more convenient. Providers reported fewer missed appointments, and telehealth enabled engagement with people who may otherwise not have sought care. Technology was especially useful for specialists, like addiction doctors prescribing medication to treat opioid dependency after video chat visits, or podiatrists using cameras to treat patients with diabetes.

In a broader sense, the push toward more virtual/remote care is only likely to accelerate in the coming years. Technology has enabled patients to self-monitor their conditions and report data electronically (glucose meters, pulse oximeters, physical activity trackers, mobile health applications, etc.). Payers, providers and many technology startup companies are thinking about how best to leverage these tools to improve quality of care and patient outcomes. Ultimately, artificial intelligence and machine learning will play more important roles in many areas of health care. These include improving drug development/discovery; examining medical images and medical charts and performing pattern detection; enabling greater personalization of medical interventions; and even forecasting future pandemics.

Health Equity and Racial Justice: The pandemic has created a more urgent need to understand and address racial disparities and inequities in the delivery of health care. Black people and other historically marginalized populations have long experienced unfavorable outcomes across a broad range of health care services, and those communities experienced a disproportionately high number of COVID-19 infections. How we collect data on health equity (discussed below) is important, but it also important that we take measurable steps to improve areas with documented disparities like maternal health. We are committed as an organization to addressing health disparities. One part of that effort is a study we are undertaking in partnership with the Massachusetts Association of Health Plans and the Harvard Pilgrim Health Care Institute to evaluate socioeconomic, racial, and ethnic inequities in telehealth usage in Massachusetts before, during and since the COVID-19 pandemic.

Other trends we are likely to see continue include: Moving away from traditional care settings. The pandemic saw the rise of COVID-19 services like testing and vaccination at community settings like drive-through lots, grocery stores, pharmacies and schools, as well as new programs like hospital at home that delivered acute care outside of a hospital setting and in a more culturally-appropriate manner.

Combined with the technology impacts noted above, it's likely that there will continue to be new ways to deliver health care services closer to the where the member lives and works. Rethinking how people age. COVID-19 spread rampantly through many nursing homes, and deaths in nursing homes represented a disproportionate share of all COVID-19 deaths. It seems likely that we will re-examine our long-term care system, particularly as Baby Boomers age, and there will be decreased appeal of housing a vulnerable population in close quarters. A renewed interest in alternative payment methods. As the pandemic suppressed utilization, models that relied on fee-for-service payment suffered and there have

been discussion of how to support service delivery, particularly for primary care services, through payment methods like capitation.

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.

Core to Point32Health's strategic vision as a combined organization, our health equity program was established with a focus on race- and income-based disparities to reduce racial and economic health disparities. Recent efforts focus on three key areas: (1) prioritize expanding the collection of self-reported race/ethnicity data and expand utilization of race/ethnicity data to analyze and address health inequities (2) expand the collection of cultural data including disability data and sexual orientation/gender identity data with our provider partners and (3) increased utilization of REL/Social Determinants of Health (SDOH) data to identify disparities, reduce medical cost, and improve member service and quality. With the use of demographic data and SDOH data, Point32Health believes there is enormous value in the development of health equity programs to inform culturally-oriented health interventions and address social services needs to achieve equitable outcomes for the diverse communities we serve. Given current data constraints, we continue to prioritize increasing our self-reported data repository, which we believe is the foundation for decreasing health disparities. When no self-reported information is available, we use the RAND corporation algorithm to derive Race and Hispanic Indicator for records without self-reported or otherwise gathered responses. Additionally, we purchase annually services from Ethnic Technologies to impute detailed Ethnicity, Hispanic Indicator and Spoken Language for records without self-reported or otherwise gathered responses. As such, we anticipate challenges aligning race/ethnicity data standards with the Commonwealth to enable state-wide comparisons. We are implementing a plan to collect race/ethnicity data on all our members in collaboration with multiple provider organizations to obtain detailed member lists with REL data. Some of the groups which have provided information include Atrius Health, Children's Hospital, Lahey Clinic, South Shore Hospital, UMASS Medical Center. We collect ICD-10-CM-Z codes as a source for REL data. To underscore the importance of ICD-10-CM-Z codes, we have started to include quality metrics related to Z code submission in our provider contracts. This approach creates an additional incentive for providers to include these codes on their claim submissions (when appropriate) and offers us additional insight into our members' needs. As we continue to meet with provider groups to assess their efforts, we intend to develop trends, benchmarks, and peer comparisons of these activities to inform future contracts and provider partnerships. Additionally, we have utilized the Massachusetts Highway electronic medical records exchange with Beth Israel Hospital Systems and to obtain REL data in the provider provided EMR exchanges. While these efforts are well underway, we anticipate a long runway to implement these policies system wide. We recommend policies to standardize race/ethnicity data standards within the Commonwealth to enable state-wide comparisons and a concerted effort to boost health equity as a public health priority to analyze/address health inequities so that everyone has the opportunity to attain their full health potential.

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.

   On average, the aging of the population adds about 1% to 2% to trend annually, while the health status of the population increased by 3% to 6% per year, depending on the line of business (including demographics changes). Note that for 2020, risk coding has been suppressed due to the pandemic. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Point32Health has observed a similar rate of benefit buy down in each year over this time period.

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?

   Point32Health is most concerned about pharmacy trends and the unknown ongoing impact of COVID.

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 (Harvard Pilgrim Health Care) Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2019	**Q1**	2,539	613

Health Care Service Price Inquiries (Harvard Pilgrim Health Care) Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
	Q2	2,255	547
	Q3	2,248	350*
	Q4	2,179	444
CY2020	**Q1**	2,118	362
	Q2	1,250	167
	Q3	2,064	265
	Q4	2,285	268
CY2021	**Q1**	2,996	360
	Q2	2,661	334
	TOTAL:	22,595	3,710

*Telephone data from July 2019 missing

Health Care Service Price Inquiries (Tufts Health Plan commercial*) Calendar Years (CY) 2019-2021			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2019	**Q1**	2,764	109
	Q2	2,889	95
	Q3	2,567	114
	Q4	2,657	94
CY2020	**Q1**	2,959	103
	Q2	1,369	39
	Q3	3,180	43
	Q4	3,779	75
CY2021	**Q1**	3,266	100
	Q2	2,561	65
	TOTAL:	**27,991**	**837**

*Does not include Tufts Health Public Plans, which is primarily subsidized commercial membership

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

HPHC Commercial fully insured and self-insured product lines

Year	Unit Cost	Utilization	Mix	Total
CY 2017	3.1%	2.4%	0.0%	5.6%
CY 2018	1.8%	1.3%	0.9%	4.0%
CY 2019	2.9%	1.9%	1.8%	6.8%
CY 2020	1.9%	-6.5%	-0.8%	-5.5%

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. The impact from non-claims items are in unit cost.

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

THP Commercial fully insured and self-insured product lines [6]

Year	Unit Cost	Utilization	Mix	Total
CY 2017	3.1%	0.8%	-1.2%	2.7%
CY 2018	2.9%	1.9%	-0.9%	3.9%
CY 2019	1.2%	3.1%	0.1%	4.5%
CY 2020	2.6%	-6.5%	0.5%	-3.6%

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. The impact from non-claims items are in unit cost.

6. THP previously submitted fully-insured trend information only. All years submitted above include both fully insured and self-insured business, so any years previously submitted (CY 2017 and 2018) have been restated to include both fully and self-insured business.

HPC Payer Exhibit 1

All cells should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines, Tufts Helath Public Plans Direct only

Year	Unit Cost	Utilization	Mix	Total
CY 2017	2.9%	-7.1%	12.8%	7.8%
CY 2018	3.4%	2.6%	1.0%	7.2%
CY 2019	3.1%	-0.3%	3.6%	6.5%
CY 2020	7.2%	-6.0%	-0.7%	0.1%

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. The impact from non-claims items are in unit cost.

6. THPP previously submitted fully-insured trend information for all products combined, while the current submission includes only fully-insured Direct product.