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:

Coronavirus (COVID-19) has profoundly impacted the health of people around the world, as well as our global economies. The safety and health of the people we serve, our team members, their families, our stakeholders, broader communities and the reliability of our health care system consume our resources and our focus. During the pandemic, UnitedHealthcare employed and paid full wages to our entire workforce. Team members who contract COVID-19, or are subject to quarantine, are paid fully and not required to take paid time off. Compensation for our front-line clinical workforce serving in high incidence communities was increased. We launched UnitedCARES, a support program for team members who have, or had, a family member diagnosed with COVID-19. As part of the UnitedCARES program, any team member with COVID-19 is assigned a Health Care Advisor who will help them get the prompt care they need. The program includes a nurse line for questions and care guidance, dedicated benefits information line, help from behavioral and mental health experts, support for needs like transportation, meals and childcare as well as financial support services. UnitedHealthcare is committed to providing support, resources, and current information that will keep our employees, their families and those we serve healthy now and beyond the pandemic.

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):

The emotional, financial and physical toll the pandemic has had on our members is unprecedented. We have ensured that our members are able to access the care, resources and support they need during this time. We have provided two billion dollars ($2,000,000,000) in direct customer and consumer support through premium credits, cost-sharing waivers and other efforts. We have waived all cost sharing for COVID-19 diagnoses through the national public health emergency, expanded assistance for our socially isolated members, and coordinated access to medications, supplies, food, care and support programs. We partnered with the AARP Foundation to create a public education campaign about social isolation, its impact on mental and physical health, and resources to address it. We have facilitated coverage transitions to ensure members maintained their health insurance. We have witnessed a shift in how members are willing to receive their care using new technologies and in response, we deployed 700 advanced practice clinicians to serve members and patients on telehealth lines during the height of the pandemic. We remain committed to the introduction of new technologies and innovation to support easier access to needed care by our members.

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):

UnitedHealthcare provided mental health professionals with a free Sanvello Clinician Dashboard to support COVID-19 response. Sanvello for Clinicians is a web-based way to engage with patients on a compliant platform using technology to view member data and track progress over time with tools to assign cognitive behavioral therapy-based homework and clinical assessments. We provided more than one hundred million dollars ($100,000,000) in support to date to those affected by COVID-19, including relief efforts in highly impacted areas, as well as efforts to support health workforce safety. To help ease the burden and aid in recovery from the effects of the pandemic, UnitedHealthcare donated over twelve million dollars ($12,000,000) through Empowering Health grants to community-based organizations in highly impacted areas. More than half of those grants will help organizations increase their capacity to fight COVID-19 and support affected communities. UnitedHealthcare believes that virtual care has played and will play a vital role in creating a more seamless, accessible, coordinated and personalized health care experience for our members. We will continue to evaluate and implement innovative ways to support our members who have told us that they value the convenience and ease of virtual care and the demonstrative ways it has and will keep them healthy.

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.

UnitedHealthcare routinely evaluates care utilization and outcomes data by member demographics such as age, gender, address, preferred language, and race, when available. As part of our Health Disparities Action Plan process, we integrate member age, gender, address, race/ethnicity and language data with clinical data to identify health disparities, as well as monitor improvement in identified health disparities. Health Plan Manager, an integrated analytic platform, a primary tool used by our analytics team to perform analyses, augments medical information with social attributes, geographic and economic data. Health Plan Manager contains community health data, including a set of metrics related to social determinants and derived ethnicity data to allow targeting of high needs/low engagement populations. Ethnicity data is also incorporated into our proprietary tool, the Health Activation Index (HAI), which evaluates health care decisions based on various

measures and decision categories and further segments member populations by ethnicity to identify opportunities for greater engagement and improved plan results. When health care disparities are identified, we develop tailored action steps to address these disparities. For example, UnitedHealthcare has developed health disparities action plans for all UnitedHealthcare Community & State health plans that focus on health measures and populations that need improvement. One identified gap area among our Medicaid enrollees was related to postpartum care. We responded by designing and piloting culturally/ regionally tailored interventions, home visits and care coordination, using community health workers to evaluate and assist members with their unique needs. These pilots have successfully reduced disparities in timely postpartum care. We were honored for our efforts with the CMS 2020 Health Equity Award for reducing disparities in maternal health. As an organization we are committed to giving the best care to individuals of diverse backgrounds, and we understand the importance in recognizing and understanding how health disparities can affect one's values, learning and behavior. Therefore, we launched education, including an industry-leading, no-cost, accredited series to promote health equity and eliminate health-related disparities. The three-part series about cultural health disparities and the skills needed to work toward health equity is available to all employees and providers on the OptumHealth Education website. We also have developed initiatives to specifically address disparities in avoidable adverse maternal health outcomes associated with childbirth, including the "Addressing Maternal Mortality" training in partnership with Morehouse School of Medicine, March of Dimes and the Centers for Disease Control & Prevention. The program provides information related to maternal care, offers best approaches to improve health equity related to maternal care and the impact of implicit bias. This training is also available to both internal and external participants on the OptumHealth Education site.

3. INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS:

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.

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	3.63%	8.49%	N/A	N/A	12.44%
CY 2018	3.80%	0.98%	N/A	N/A	4.82%
CY 2019	3.33%	4.00%	N/A	N/A	7.46%
CY 2020	3.77%	-5.62%	N/A	N/A	-2.06%

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
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.

UnitedHealthcare Bridge

Actual Observed Total Paid Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

Year	Total	Leveraging	Demo	Plan Changes	Business Mix	Net
CY 2017	12.4%	1.8%	1.7%	0.0%	3.9%	20.9%
CY 2018	4.8%	0.8%	0.4%	-1.7%	-11.0%	-7.2%
CY 2019	7.5%	1.4%	0.9%	-1.0%	-0.6%	8.1%
CY 2020	-2.1%	0.4%	0.9%	1.5%	0.4%	1.1%

1. Business Mix includes Customer/Geographic/Industry/Market segment/New Sales/Termination mix changes

UnitedHealthcare Plan Liability Risk Score (PLRS)

	Final 2018	Final 2019	Final 2020
PLRS Change	-6.4%	-5.1%	-12.5%

Please see the above table HPC Payer Exhibit 1 which reflects Massachusetts trends in calendar years 2017 to 2020. This table represents the unit cost, utilization and overall trend for each year. The second table, UnitedHealthcare Bridge, illustrates the impact of leveraging, demographics, plan changes and business mix. The final table (PLRS) demonstrates the change in risk scores of our UnitedHealthcare population. It does not account for any changes to the PLRS score methodology.

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?

Given the block for UnitedHealthcare in Massachusetts and its corresponding low market share, it is challenging to extract meaningful trend observations using only UnitedHealthcare's data. We have seen unit cost trends increase by four percent (4%) nearly each year, with the largest increases in inpatient and outpatient care. Utilization trends have been less predictable.

Click or tap here to enter text.

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**	15,209	
	Q2	8,141	
	Q3	11,600	
	Q4	11,401	
CY2020	**Q1**	13,023	
	Q2	5,088	
	Q3	6,891	
	Q4	9,481	
CY2021	**Q1**	17,661	
	Q2	8,227	
	TOTAL:	80,834	

UnitedHealthcare offers members mobile and online resources to give them health care cost estimates based on their health plan and location. These tools combine provider search and cost transparency, allowing members to view and better understand their health care estimated costs to make more informed decisions. The numbers in the above table reflect the total volume of full cost estimates made for our Massachusetts Commercial members using these tools. There have been no inquiries using the Massachusetts specific process.

CERTIFICATION

The foregoing statements, opinions and data were compiled from responses provided to me by employees of UnitedHealthcare and are true and correct to the best of my knowledge and belief.

I affirm that I am legally authorized and empowered to represent UnitedHealthcare Insurance Company for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Dated this 5th day of November, 2021

UNITEDHEALTHCARE INSURANCE COMPANY

Signed:

Timothy C. Archer
Chief Executive Officer
New England Health Plan

HPC Payer Exhibit 1

All cells should be completed by carrier*

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UnitedHealthcare Bridge Report

Actual Observed Total Paid Medical Expenditure Trend by Year
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