MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 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 WRITTEN 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 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 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 2021, if applicable. If a question is not applicable to your organization, please indicate that in your response.

Your submission 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.

INTRODUCTION

This year marks a milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

Blue Cross Blue Shield of Massachusetts (BCBSMA) takes seriously our role in controlling health care costs for our members, employer customers and the community. We have numerous initiatives designed to reduce health care expenditures while ensuring our members receive high-quality care. As the state has documented, hospital and physician reimbursement is a main driver of trend. For BCBSMA, hospital and physician reimbursement accounts for more than half of our total trends. We are seeing strong pressure to increase unit costs in our negotiations with providers across our Commercial and Senior business. BCBSMA anticipates additional pressure on unit cost trends in the Commercial market as patient mix shifts to lower reimbursement payers, such as public payers, as well as the continued expansion of higher-priced hospital systems. Given the proportion of premium dollars that go to pay hospitals and physicians, this continued growth will directly impede our collective drive to ensure affordable health care.

BCBSMA is also focused on the impacts of the type of care needed and where care is delivered. The number of services used by our members has increased every year for the last decade, except for the COVID related dip. We are experiencing an overall increase in the cost per services since the beginning of the pandemic, particularly for outpatient care. Additionally, more of our members are utilizing higher cost settings rather than community-based care. If this issue can be addressed, there is potential to reduce health care cost growth.

Lastly, pharmaceutical costs remain a concern for BCBSMA as they represent the fastest growing segment of commercial health care spending. Pharmaceutical costs account for nearly 25% of the premium dollar. The impact of high-cost biologics and innovative therapies affects our trend. In fact, we anticipate the pipeline for new biologics to strengthen significantly over the next 2-5 years, thus placing increased pressures on cost control. BCBSMA works hard to provide balance so that our members have access to new and improved treatments while keeping premiums affordable.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

For provider prices, we are in the midst of negotiating with physicians and hospitals in our network and some are seeking rate increases 4-6 times above the benchmark. While we understand the challenges that labor costs and inflation present to all health care stakeholders, these large price increases are incompatible with our customers' need for

affordability. We balance our clinical partners' needs with the needs of our members and employer customers who cannot afford to pay for this level of increase. As we work hard to negotiate more modest contracts, we are also innovating on the next generation of value-based care, focusing on new, more efficient and affordable models of care for our members, and introducing innovative benefit designs. For example, we recently launched our Virtual First Primary Care solution to provide greater access to high-quality, convenient, and affordable care.

For our second concern related to site of care, we are utilizing digital care management tools so that we can assist members in finding sites of care that are high-quality, lower cost, and potentially more convenient. We have also launched new programs to address the high costs associated with the management of chronic illnesses like diabetes. These programs can improve our members' health care and advance our collective affordability goals. For example, we have partnerships with two innovative kidney treatment programs that better align patient care for at-home dialysis and transplant candidate options. On a related front, we are also looking at ways to reduce administrative burden through modernizing our medical management and prior authorization programs. For example, we are piloting utilizing artificial intelligence for real-time prior authorizations for some services to reduce wait times for care.

We also regularly evaluate our strategic partnerships to ensure that our innovative programs best meet the needs of our customers and members. In January 2023, we will be transitioning to CVS Caremark as our new pharmacy partner. This change will result in a cost savings for our members. We are also pleased to be participating in value-based agreements for new, high-cost treatments including gene therapies.

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

We continue to expand our methods and sources for the collection of race, ethnicity, and preferred language data of our members, prioritizing self-reported data directly from our members. Advanced measurement methods 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 more consequential - 5 - uses of equity measures, such as provider payment. We are holding ourselves and our provider partners accountable for achieving measurable improvements over time.

Our member portal, MyBlue, is an important tool in the collection of race, ethnicity, and preferred language data from members directly. Since 2020, the month-to-month response rate has ranged roughly 25-30%, and estimated response rates among Asian/Pacific Islander, Black, and Hispanic members continue to exceed the response rates among White/non-Hispanic members. In addition to leveraging our member website, newer efforts

have included a mailed survey to our members to collect this data. We also hope to work with our accounts to use electronic enrollment files to collect this important information over time.

In addition to advancing collection and use of race and ethnicity data to measure inequities in health and health care, we are working to be the first health plan in Massachusetts to incorporate measures of equity performance into provider risk contracts starting in 2023. Linking payment to measurable improvements in the equity of care is intended to create a substantial and sustained rationale for provider organizations to invest in effective equity-improving capabilities.

To accompany this new pay-for-equity component of BCBSMA's Alternative Quality Contract, in 2021 we began collaborating with the Institute for Healthcare Improvement (IHI) to create an Equity Action Community that provides technical support and consultation to AQC provider organizations to address inequities in health care. As part of this work, BCBSMA made a $25 million grant to IHI for distribution to support clinical equity improvement projects and to build providers' capacity to collect, store, and manage race and ethnicity data. In addition to supporting providers' internal equity measurement capabilities, BCBSMA began sharing confidential reports of performance on health equity measures with each AQC group in 2021. These reports gave groups first ever quantitative performance data on equity measures coupled with blinded comparisons to all other AQC groups on the same equity measures.

In addition, 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 are in the process of implementing a change that will allow us to accept a third gender identifier of non-binary during enrollment, with the prospect of future system enhancements.

However, we do note that the lack of routine exchange of these data between and among providers and health plans remains a key barrier to having complete and accurate race, ethnicity, language, disability status, and sexual orientation/gender identity data.

Currently, each provider and health plan must ask patients and members the same questions, in a likely duplicative fashion, at substantial cost. Without complete, compulsory, and standardized data exchange, providers and health plans might 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 and quality 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.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

In the past few years, Massachusetts has missed the goal of containing health care costs. BCBSMA strongly supports renewed efforts to further spur multi-stakeholder cost containment, as first codified within Chapter 224 of the Acts of 2012. BCBSMA would recommend greater public oversight and transparency of health spending increases. The Commission's use of PIPs is a particularly powerful lever and we believe the HPC should consider using the PIP process when an insurer or health care organization threatens the spending benchmark, with appropriate consideration for COVID's impact over a multiyear view. The legislature should also consider increased transparency of hospital and health system financial information to allow the state to better assess the financial stability of all health care market participants.

As the HPC has noted, consolidated health systems often charge prices that are among the highest in the state, in many instances without demonstrably better quality. The legislature should consider greater authority to evaluate hospital market changes to promote affordability, access, quality, and equity. Any promised efficiencies should lead directly to more moderate prices and state regulators should be able to monitor that progress.

As we have seen in recent years, health care becomes more expensive when patients do not get the care they need or are given inappropriate care. Health plans that offer value-based payment models pay clinicians more for providing quality care and hold them accountable when they miss the mark. Massachusetts should recommit to value-based care and increased adoption. Health plans and the hospital systems need to collaborate on a new generation of contracts to address primary care, health equity gaps, and mental health access issues, that have only worsened due to the pandemic.

There have been legislative opportunities to constrain prescription costs in a way that continues to protect affordability while ensuring that this vibrant sector of the economy continues to flourish. We would support these efforts coming to fruition in the next legislative session.

Lastly, as mentioned in our response to Question C, BCBSMA would support efforts to align around a common vision and principles for data exchange, with the possibility of mandated exchange for the purposes of measuring and improving health equity statewide.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2018 to 2021 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2018 to 2021, 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.

It is important to note that the COVID-19 pandemic presented an aberrational impact on trend and any resulting data should be viewed in a multi-year view rather than one year.

b. Reflecting on current medical expenditure trends your organization is observing in 2022 to date, which trend or contributing factor is most concerning or challenging?

As we begin to emerge from the effects of the pandemic, we are entering a period of high economic uncertainty. Some of the primary drivers of recent trends include:

1. Provider Reimbursement – More than half of total medical expense trend is driven by increases in provider reimbursements. The effects of inflation and labor shortages have led to large price increase requests from healthcare providers across our Commercial and Senior business. In addition, we anticipate further pressure in the Commercial market as patient mix continues to shift to historically lower reimbursement business such as public payers, as well as with the continued expansion of higher price provider 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. In addition, the shift in utilization high-cost brand specialty drugs continues to be a major driver of pharmacy trends.

3. COVID-19 – Costs related to the pandemic, including treatment, testing and vaccines costs, remain persistent and difficult to predict.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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) 2020-2022			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
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
	Q3	32,840	145
	Q4	33,325	128
CY2022	Q1	38,806	92
	Q2	33,423	117
	TOTAL:	300,555	1,127

HPC Payer Exhibit 1

All cells should be completed by carrier*

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 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%	-4.8%	-0.3%	-0.3%	-2.7%
CY 2021	2.8%	9.9%	1.7%	1.7%	16.8%

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.