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.

Since 2010, over 30 state reports have examined health care costs and the key cost drivers in the Commonwealth – all have found that the prices charged by high-cost providers remain the most significant factor driving health care costs.[1] Price, rather than utilization, has been identified as a primary driver of health care spending and the Center for Health Information and Analysis (CHIA) estimates that more than half of spending growth in Massachusetts is explained by growth in unit prices.[2] Separate analyses have placed this percentage closer to 75%.[3] The pandemic has not alleviated the pressures of these increasing costs; rather, health plans continue to face requests for double digit rate increases from certain high-cost providers and hospitals, further threatening our ability to meet the cost growth benchmark.

In Massachusetts, nearly 90 cents of every premium dollar is spent on members' prescription drugs, medical care, and related health care services. As health insurance premiums and cost-sharing are a direct reflection of the underlying costs of care, health care affordability is dependent on addressing the underlying drivers of health care costs. The concerns identified below are the primary drivers of health care cost growth in the Commonwealth.

Covid-19 has significantly disrupted an already complex health care delivery system resulting in soaring temporary labor costs and substantially lower investment market performance. In addition, the impact of general economic inflation has been delayed within the healthcare marketplace, due to the inflexibility of long-term pricing contracts. However, we are concerned that as these contracts come up for renewal or are opened early as the result of the severe financial pressures on hospitals and providers, these three issues will put significant, long-term, upward pressure on unit costs. In addition, continued increases in inflationary costs and the losses sustained by health insurers, providers and hospitals make it difficult to free up capital that can be reinvested into improving health equity and access. Hospitals and providers must continue to drive efficiency and innovation in health care delivery to meet these new challenges. Small, local insurers remain at risk as the pressure grows to keep pricing competitive in a landscape of ever-growing provider reimbursement pressures, especially when focused on the government product space.

Hospital and physician prices. According to national research, health care price growth has been above prior years' trends and continues to accelerate. As of March 2021, hospital price growth has emerged as the fastest growing price component, with prices 4.8% higher than they were at the start of the pandemic.[4] Hospital price growth has accelerated over the past year, hitting their fastest growth rate since 2004 in March of 2021 (previously presented in the Health Policy Commission's Interim Report on the Impact of COVID-19) with physician services prices, dental care price growth, and nursing home care prices following closely behind. In Massachusetts, while

hospital spending declined in 2020 due to the COVID-19 pandemic, over the past decade hospital spending has accounted for the largest share of commercial spending and spending growth. In the commercial inpatient market in Massachusetts, hospital spending accounted for 54% of growth from 2018 to 2019. Hospital inpatient spending has continued to grow despite a constant or declining number of hospital stays - commercial inpatient utilization declined by 9.3% between 2014 and 2018, while spending, associated with higher prices charged, continued to grow by 5.2%. Hospital outpatient spending has also grown quickly in the commercial market, increasing by $700 million between 2015 and 2018 to account for 31% of all commercial spending growth. Between 2018 and 2019, hospital outpatient spending was the fastest growing commercial service category, increasing by 8.1%. Increases in instances of outpatient surgery have driven spending growth in this category; however, any potential cost savings have been mitigated by a shift to higher-cost outpatient centers as there is considerable variation in average payments for hospital outpatient surgeries, with the highest priced hospital systems garnering payments between 40% and 78% above the median.[5] In addition, hospitals and physician groups with greater market power garner price increases that exceed their costs to deliver care. As Massachusetts, like other states across the country, sees the continuing trend of mergers, acquisitions, expansions and consolidations, the impact of these transactions is borne out in the cost of hospital and provider services. The academic evidence on the effect of hospital mergers and provider consolidation has made clear that, in most cases, consolidation does not lead to better care and lower prices, but rather leads to enhanced bargaining power with no notable improvement in quality for patients.[6]

Prescription drug prices. Prescription drug spending remains a significant challenge, with pharmacy costs accounting for 42.3% of spending increases in 2020 and 18.2% of total health care spending according to CHIA's Annual Report on the Performance of the Massachusetts Health Care System for 2022. In January of 2022 amidst a surge in COVID-19 cases, drug manufacturers hiked prices for over 800 everyday medications by an average of 5%[7]. Since 2014, prescription drug prices have risen 33 percent, 20 times faster than the rate of inflation and outpacing price increases for any other medical commodity or service.[8] In addition to price increases for existing generic and specialty medications, launch prices for new brand-name prescription drugs increased 20% per year between 2008 and 2021. Median launch prices increased from $2,115 per year in 2008 to $180,007 per year in 2021, while the share of drugs priced at $150,000 per year or more rose from 9% in 2008-2013 to 47% in 2020-2021.[9] As prescription drug costs account for between 18-22% of the premium dollar, continued price increases directly impact premium affordability for employers and consumers.

[1] Freedman Healthcare. *Re-examining the Health Care Cost Drivers and Trends in the Commonwealth – A Review of State Reports (2008-2018).* (2019). Available at: https://secureservercdn.net/198.71.233.29/9a2.583.myftpupload.com/wp-content/uploads/2019/05/freedman-report-2018-final.pdf [2] Health Policy Commission, *2021 Health Care Cost Trends Report.* Available at: https://www.mass.gov/doc/2021-health-care-cost-trends-report/download [3] Health Care Cost Institute, *2018 Health Care Cost and Utilization Report, Massachusetts.* Available at: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report [4] Corwin Ryan, *Perspective: Are Rising Health Care Prices Another COVID-19 Side Effect?* Altarum. April 2021. Available at: https://altarum.org/news/are-rising-health-care-prices-another-covid-19-side-effect [5] Health Policy Commission. *2019 Health Care*

Cost Trends Report. Available at: https://www.mass.gov/doc/2019-health-care-cost-trends-report/download [6] See: O'Malley AS , Bond AM , Berenson RA . Rising hospital employment of physicians: better quality, higher costs? Washington (DC) : Center for Studying Health System Change ; 2011 Aug . (Issue Brief No. 136). Google Scholar & Delbanco S , Galvin R , Murray R . Provider consolidation and health spending: responding to a growing problem . Health Affairs Blog [blog on the Internet]. 2012 Nov 14 [cited 2016 Dec 1]. Available from: http://healthaffairs.org/blog/2012/11/14/provider-consolidation-and-health-spending-responding-to-a-growing-problem/ Google Scholar [7] GoodRx Health. *January 2022 Drug Price Increases (*2022). Retrieved from https://www.goodrx.com/healthcare-access/drug-cost-and-savings/january-drug-price-hikes-2022 [8]GoodRx Health. *Prices for Prescription Drugs Rise Faster Than Prices for Any Other Medical Good or Services* (2020). Retrieved from: https://www.goodrx.com/blog/prescription-drugs-rise-faster-than-medical-goods-or-services/ [9] Rome BN, Egilman AC, Kesselheim AS. Trends in Prescription Drug Launch Prices, 2008-2021. JAMA. 2022;327(21):2145–2147. doi:10.1001/jama.2022.5542 https://jamanetwork.com/journals/jama/article-abstract/2792986

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

We continue to leverage value-based contracting to shift value from unit costs to performance. Additionally, we are applying price transparency data made available through federal and state mandates, to understand our relative position in the market and therefore the rates we can sustain and remain competitive. We appreciate that the health care system is challenged by inflation and the impact of COVID and seek to work with providers to establish sustainable financial terms and support our shared commitments to health access and equity. We also recognize that changes in our network composition may be necessary when provider revenue demands cannot be met. However, as a payer-provider organization, we work actively with our parent system to improve both cost and quality, and thus to increase the value of the health care that our members receive. We are incentivizing the total member service experience. We use our data to highlight high value providers who give exceptionally high-quality care, and we continually evaluate the performance of our network. Our payer-provider partnership allows us to take a holistic approach to patient/member care. In 2023, we will be seeking NCQA certification for health equity.
Click or tap here to enter text.

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.

In early 2022 Health New England established a Health Equity Committee for the explicit purpose of examining how to capture necessary data, assess, strategize and implement programs or initiatives to close equity gaps. Knowing that we had significant gaps in our exiting member reported Race,

Ethnicity, and Language ("REL") and Sexual Orientation and Gender Identity (SOGI) data we have begun to develop a strategic plan for comprehensive data acquisition. To prevent a delay in analyzing and developing directionally appropriate programs we decided to perform REL imputation utilizing the RAND methodology. After validation we were able to predict REL for 97% of HNE membership with a confidence between 75-80%. With this information we are able to start performing analysis and directionally understanding the existing equity gaps in our population. There are two notable analyses that have taken place and that have led to program development:

1. Controlling High Blood Pressure in Members Who Identify as Black. We found that members who identify as Black were less likely to have a controlled blood pressure when compared to the population identifying as White. Additionally, the population identifying as Black was less likely to engage in preventative visits and blood pressure related lab monitoring, all highly correlated with better blood pressure control. From this analysis we are developing a direct outreach and engagement program, including a community-based health marketing campaign.
2. Initiation and Engagement of Alcohol or Drug Treatment in Members Identifying as Hispanic Females. We found that members who identify as Hispanic Females were statistically less likely to engage in treatment for alcohol or drug use compared to members identifying as White. From this analysis we are developing a direct outreach and engagement campaign along with available telehealth services to help make behavioral health services more conveniently available to members in need. We are further developing our strategy for primary collection of RELD and Sexual Orientation and Gender Identity ("SOGI") data through member enrollment, member services, provider-health plan data sharing and member surveys. We continue to develop our strategy around how this data will be stored and appropriately utilized within health plan operations in order to achieve more equitable health care. HNE is currently pursuing NCQA Health Equity Accreditation in 2023.

As a member of the Massachusetts Association of Health Plans, our board recognized the need for evidence-informed policies to address inequities in telehealth access. As such, MAHP engaged the Department of Population Medicine at Harvard Medical School and Harvard Pilgrim Health Care Institute, who alongside the Massachusetts Health Quality Partners, conducted a comprehensive research study on telehealth use in the Commonwealth since the onset of the COVID-19 pandemic.

The goals of the research study were to measure differences in telehealth use across populations, investigate the root causes of inequities from the perspectives of patients, providers, and community leaders, and create a series of evidence-informed recommendations, applicable across the health care sector, aimed at promoting telehealth equity.

MAHP member plans collaborated with the research team to create common data definitions and provide claims data across all lines of business to analyze enrollment, outpatient visits, and telehealth visits monthly from January 2019 – December 2021. The findings and recommendations from this report will provide a firm foundation for MAHP member plans to bridge the digital divide.

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

Addressing Prescription Drug Prices. Given the outsized impact of prescription drug costs on health care spending, it is critical that drug manufacturers are held accountable. We are supportive of the following proposals to provide greater transparency and accountability:

1. **Add pharmaceutical companies to HPC oversight**. The legislature should require pharmaceutical manufacturers be held accountable to the state's Cost Growth benchmark, be called as witnesses at the annual Cost Trends Hearing and be subject to the associated data collection requirements by the HPC, CHIA, and the state's Attorney General, just as health plans and providers are today.
2. **Expand HPC drug pricing review authority.** We also strongly support the HPC's recommendation from the 2021 and 2022 Cost Trends Reports that the Legislature authorize the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts. This enhanced authority complements current strategies health plans use to maximize value and enhance access for consumers through risk-based contracts and value-based benchmarks and ensuring access to high-quality pharmacy services at competitive prices.
3. **Greater transparency relative to the pharmaceutical industry's funding of patient groups and advocacy groups and the legislative priorities of those groups**. Unlike payments to providers, pharmaceutical manufacturers are not legally required to disclose donations to patient advocacy organizations. Patient advocacy groups play an important role when testifying before the Legislature and other government agencies. It's vital that policymakers understand the funding sources for these organizations. We recommend the Legislature enact transparency reporting requirements for pharmaceutical manufacturer donations to patient advocacy groups.

Addressing non-evidence-based therapies. To maximize the value of the health care provided in Massachusetts, the quality of the care provided is critical. Therapies outside of the professionally accepted standard of care are at risk of being of low value and in many cases should not be covered as medical benefits. The quality of therapeutic standards becomes critically important, especially as it relates to Behavioral Health/Substance Use Disorder treatments and treatment programs. In addition, with regard to the management of pharmaceuticals, value is also critical, and requires a careful balance of the quality of the result provided by the medication and the rapidly escalating costs of brand name therapies.

Telemedicine and teletherapy expansion: Commercial plans are leveraging the benefits of virtual care and telemedicine along with innovative programs for diabetes and other chronic conditions, but the stringent requirements for the provision of Medicaid services in the state are preventing plans from leveraging these programs for Medicaid patients. It would be helpful to make it easier to

leverage out of area providers without an active MCD profile for access to Telehealth and disease management programs.

No Surprises Act implementation: In addition, stricter policy with regard to the No Surprises act, and a cap on payments to non-contracted providers would be helpful for those providers who do not participate with payers.

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.

The allowed medical expenditure trends observation demonstrated the following:

1. Population demographics were consistent from 2018 – 2020. Beginning 2021 HNE saw significant growth in the individual market in a new region. This additional membership coupled with a return to services post COVID caused a large trend increase in 2021.
2. The impact of benefit buy down year to year is not significant.
3. Health status/risk scores of the population dropped in acuity in 2020. This is more driven by the decrease in availability in services. Lower services dropped risk scores and reported acuity in the population. However, in 2021 this number has returned to near pre-covid levels.

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 2018	2.2%	2.5%			4.7%
CY 2019	3.1%	3.0%			6.1%
CY 2020	2.3%	-7.4%			-5.1%
CY 2021	2.3%	14.6%			16.9%

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.
*HNE does not break out service or provider mix from either cost or utilization trend calculations

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?

Pharmaceuticals remains our top area of concern. Gene therapies, medical pharmacy costs, and the growing fields of biologic therapies and personalized therapeutics such as CAR-T are driving costs in the pharmacy arena well out of proportion to growth in medical expense.

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	611	17
	Q2	342	29
	Q3	537	36
	Q4	567	44
CY2021	Q1	700	62
	Q2	638	55
	Q3	588	65
	Q4	607	19
CY2022	Q1	570	20
	Q2	486	28
	TOTAL:	5,160	375

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	2.2%	2.5%			4.7%
CY 2019	3.1%	3.0%			6.1%
CY 2020	2.3%	-7.4%			-5.1%
CY 2021	2.3%	14.6%			16.9%

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.