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.

In the decade since Chapter 224 of the Acts of 2012 (Chapter 224) created the framework for cost containment, AllWays Health Partners - which will become Mass General Brigham Health Plan in January 2023 - has been and remains committed to this effort. We look forward to continuing this effort in partnership with all stakeholders.

In response to the pandemic, Mass General Brigham Health Plan has worked hard to remove barriers and ensure timely access to high-quality care for our customers during an unprecedented time. The pandemic has also brought to the forefront both longstanding challenges *and* opportunities to work collectively – in the spirit of Chapter 224 – to improve health equity and access to affordable, high-quality healthcare. We have identified top challenges in this regard within the framework of cost containment and amplified by a world-wide pandemic.

1) A crisis in access to mental health services

We are emerging from the peak of the pandemic with a greater recognition of mental health needs in the community. As the public data has revealed, access to mental health care represents a crisis that began before, but has been accelerated by the pandemic. There has been a clear increase in mental health expenditures to meet increased demand and to improve access and this has significantly outpaced other medical expenses since 2019.

2) Effective management of provider cost pressures

Many providers are facing unprecedented strain through new workforce challenges due to burnout and staffing shortages, as well as increasing labor and supply costs related to the highest inflation in decades. These economic pressures, combined with an increasing number of patients covered by underfunded government payer programs, have led to significant cost pressures for providers which have been, and will likely continue to be shifted to commercial payers. We are encountering requests for significant provider rate increases, and we expect to face additional requests due to workforce issues that have worsened during the pandemic.

3) The high cost of new and emerging specialty pharmaceuticals

The high cost of specialty pharmaceuticals is driving both our drug and medical benefit trend. We anticipate costs to increase with new therapies and the expansion of indications for existing therapies in the pipeline. In addition, we are currently on the cusp of an explosion of biologically based treatments and gene therapies in the market. These treatments and therapies, while holding promise for breakthrough medical treatments, can each exceed millions of dollars. A few recent examples include Zolgensma for spinal

muscular atrophy approved by the FDA in 2019, Zynteglo for ß-thalassemia approved in August 2022, and Skysona for cerebral adrenoleukodystrophy (CALD) approved by the FDA in September 2022. While federal approvals slowed in 2020-2021 due to the COVID-19 pandemic, the expectation is that the pace will pick up again as more treatments in the pipeline become available at a very high cost.

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

Mass General Brigham Health Plan is committed to increasing affordability, while improving access to critical healthcare services through unique mental health solutions, expanded network access, and innovative programs and product offerings.

Innovative mental health solutions

Mass General Brigham Health Plan has a long history of addressing unmet mental health needs in our communities. Building on our foundation of innovative and member-centric approaches, we have uniquely employed recovery coaches as part of our care management programs to respond to an increase in substance use disorders (SUD). A recovery coach is someone with lived experience who can meet members where they are and support their recovery journeys.

Responding to a mental health crisis exacerbated by the COVID-19 pandemic, Mass General Brigham Health Plan has also launched a new, comprehensive solution through a partnership with Lyra Health to expand the availability of high-quality mental health services and promote overall health and well-being. This comprehensive solution, available to all members by January 2023, blends in-person, remote, and self-guided services, as well as care coordination for complex mental health needs. Through Lyra Health, members have faster access to mental health care, more clinical options, and greater ease of use.

Lyra Health also ensures mental health care is more equitable and accessible by removing traditional barriers to care. The company can actively track and prioritize the diversity of their provider network. More than 42% of Lyra Health providers identify as BIPOC (compared to 14% of APA providers in the U.S), 13% are sensitive to/identify as LGBTQ, 16% self-identify as Black/African American (compared to only 4% of APA providers in the U.S.) and more than 80% of Lyra providers are female.

Supporting our provider partners

We are working hard to support our provider partners to expand access to high-quality and affordable healthcare.

Health plans have an opportunity to leverage public data now available through provider cost transparency requirements as one tool to help ensure competitive rates. We are also pursuing additional opportunities to include alternate payment methodologies in our provider contracts as part of our value-based care strategy.

In addition, Mass General Brigham Health Plan offers innovative, value-based products that provide site-of-service benefits. A key part of our value-based care model is the flexibility to deliver services in the most medically appropriate, cost-effective, and convenient setting, whether it is an academic medical center, a community-based provider, in the home or

virtually. In addition to improving health outcomes and reducing costs, this flexibility creates opportunities to better manage the health of certain populations or to address the social issues underlying and exacerbating healthcare disparities.

One example of this approach is innovative benefit design as seen in our *Allies* suite of products. *Allies* is a high-performance network that provides high-quality community-based care, access to AMCs (academic medical centers) for more complex cases, expanded access to virtual services, dedicated navigation support, and lower costs. Originally launched in July 2020 with Newton-Wellesley Hospital, *Allies* was expanded to Salem Hospital, with additional geographic expansion planned for South Shore Hospital. The product drives affordability by shifting care to more convenient and affordable options in the community as appropriate.

Mitigating the cost of specialty pharmaceuticals

To help blunt the increase in specialty pharmacy costs as well as genetic and biologically based treatments, both in the retail and medical setting, we have implemented a biosimilar strategy to move utilization to the lowest net cost products. We are continually reviewing the pipeline for both new products and anticipated generic or biosimilar launches. We utilize this information to establish coverage strategies to allow access to the most cost-effective options for our members.

We have also been focusing on a medical specialty drug site of care optimization program. This allows us to evaluate the best site of care by drug that is lowest cost, safe, and convenient for the member. As an integrated healthcare system, we are also addressing the expected high costs of new treatments through medical policy review in concert with Mass General Brigham by exploring contracting strategies and evaluating reinsurance options. In addition to these pharmacy programs, we have rolled out a program for our commercial and Massachusetts Health Connector membership that identifies opportunities for member savings by making changes to their current medication including, but not limited to - changing to alternative medications, changing dosage forms, switching to generics, as well as several other identified opportunities.

Additionally, we continue to improve utilization management criteria and processes to include automation. The goal is to avoid unnecessary care and encourage use of the most appropriate community site of care – whether that is in an outpatient hospital, surgical center, physician's office, or the home.

We welcome opportunities to partner with the state and other organizations to bring more biosimilars to the marketplace as well as other solutions to improve the value of pharmaceuticals for consumers.

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.

As a consciously inclusive organization, Mass General Brigham Health Plan has a longstanding commitment to embracing diversity and ensuring equitable access to

healthcare and coverage. As part of our annual business goals, we use specific metrics to advance workforce, health equity and community support goals, and our cross-functional Diversity, Equity and Inclusion Committee ensures that these business goals are met.

We understand the need to collect adequate and accurate data regarding race, ethnicity, language, disability status, and sexual orientation/gender identity so that we can ensure that members have access to high-quality, equitable healthcare. One of the biggest barriers in addressing healthcare disparities is the lack of accurate, validated data on race and ethnicity. Improvements in this data will allow the health plan to track health outcomes based on race and identify effective care.

In 2022, Mass General Brigham Health Plan embarked on an enterprise-wide project with the objective of increasing our race, ethnicity, and language data rate. Through this project we have implemented a new process to track race, ethnicity and language through data and improved reporting and more accurate data elements. This project is modeled on a similar strategy employed by Mass General Brigham's Health Equity team, as part of the system's "We Ask Because We Care" campaign.

Strategies that we plan to employ include targeted member communication through the member portal and application and a texting/letter campaign to increase the capture rate of this data. Although the primary objective is improvement in our race, ethnicity, and language rates, through this project, we will develop a framework for collection of additional information including sexual orientation and gender identity to further ensure members have equitable healthcare. We currently measure how we are performing in HEDIS (Healthcare Effectiveness Data and Information Set) prevention and treatment metrics stratified by race to ensure we are addressing healthcare disparities and making appropriate interventions. Improved collection of race and ethnicity data will ensure that these interventions are targeting the right populations and result in a reduction in healthcare disparities.

In addition, Mass General Brigham Health Plan is committed to advancing health equity in a variety of ways:

- As part of the Mass General Brigham healthcare system, we support and participate in the United Against Racism (UAR) initiative, a long-term, multimillion-dollar endeavor to directly address the impacts of racism on patients, employees, and community. Through UAR, Mass General Brigham has supported equitable solutions that deliver better patient outcomes in a variety of ways. These initiatives include a comprehensive workforce training program and a $50 million investment in a new, comprehensive community and mental health strategy for the communities we serve.

- Mass General Brigham Health Plan has a longstanding legacy of supporting health equity by addressing social determinants of health. Our care managers carry out initial assessments for members engaged with this program to understand the impact on care and overall member health. We then follow through with referrals to specific resources that address these unmet needs. One example is our food insecurity partnership program that provides medical meals to eligible members through the Boston-based organization Community Servings. Another example of our comprehensive approach is the Your Care Circle (YCC) program, which enrolls our most complex cases and utilizes a multidisciplinary team of registered nurse care managers, community health workers, and social care managers. Available to our most at-risk members, the YCC team understands the impact social determinants can have on healthcare disparities. The YCC team works

with many of our members including the Merrimack Valley Medicaid ACO with our partner Lawrence General Hospital.

- As a member of the Massachusetts Association of Health Plans (MAHP), we 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 the 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' action.

- Mass General Brigham Health Plan also supports health equity as part of our participation in the 1115 waiver for our MassHealth line of business. The upcoming MassHealth ACO (Accountable Care Organization) model includes a renewed focus on health equity to address health-related social needs and target specific disparities such as maternal health and coverage for members with disabilities. In addition, we are pursuing the NCQA (National Committee for Quality Assurance) Health Equity Accreditation. This will serve as a framework to expand upon health plan performance in health equity. Mass General Brigham Health Plan has completed a gap analysis and readiness review among the 21 Health Equity standards in the following areas: member data, hiring/recruiting practices, member language needs and preferences, provider network data and responsiveness and culturally and linguistically appropriate services program. In the upcoming months, we will address gaps in these areas to meet accreditation standards. Mass General Brigham Health Plan intends to be NCQA Health Equity Accredited by January 1, 2025.

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

(1) Addressing Prescription Drug Prices

Given the longstanding impact of prescription drug costs on health care spending, it is critical that drug manufacturers are held accountable and collaborate on solutions. We are supportive of the following proposal to provide greater transparency and accountability in healthcare cost:

- As considered in the past, pharmaceutical manufacturers should be included in the HPC's process and 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 (Center for Health Information and Analysis), and the Attorney General, just as health plans and providers are today. We support this effort as it is supported by years of cost trend data and would help provide a fuller sense of overall health expenditures.

(2) Self-Insured Products for Merged Market Groups (less than 50 employees)

We are seeing an increase in national carriers offering level funded products to small groups which has the potential to destabilize the merged market pool. These are self-funded products that allow these carriers to gain market share by targeting and attracting small groups with better MLR (Medical Loss Ratio) performance and removing them from the merged market pool. The removal of these better performing groups from the merged market negatively impacts the individuals and small businesses that remain in the merged market to provide insurance to their employees by increasing merged market premiums. This may be appropriate for state agencies' review of this risk and potential unanticipated impact on the affordability of the current merged market.

(3) Shift to value-based care

With the continued rise of healthcare costs, we support the shift that the state and CMS are leading from fee-for-service to value-based care, aligning providers and health plans to together lower healthcare costs and improve outcomes and experiences for members. As a health plan aligned with a delivery system, we are given the unique opportunity to not only change incentives but to also help influence the delivery system reform needed to translate value to consumers. Assuring excellent member experience is the plan's priority and specific focus as we develop and implement important programs in Medicare Advantage and Medicaid. As an example, we have built out a navigator function that bridges the health plan and the provider to help orient a member to their benefits but also help schedule a timely appointment in the delivery system, reducing the friction for the member in managing their health.

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.

Our expenditure trends summary table is below and attached as **HPC Payer Exhibit 1 – Mass General Brigham Health Plan**.

Trends	Unit Cost	Utilization	Mix of Services	Total TME	Change In Risk	Risk Adjusted TME Trend
CY2018	8.3%	0.7%	-0.5%	8.6%	7.7%	0.8%
CY 2019	6.4%	3.1%	0.7%	10.5%	0.6%	9.8%
CY2020	1.0%	-6.4%	2.6%	-3.1%	-6.0%	3.1%
CY2021	1.6%	15.7%	-5.8%	10.7%	10.0%	0.6%

Consistent with our strategy for growth and evolution to expand our lines of business to better meet the healthcare coverage needs of our members – Mass General Brigham Health Plan has expanded our network and innovative, competitively-priced product offerings. Over the last five years, Mass General Brigham Health Plan's total medical cost trends were driven by the transition from a predominantly Medicaid plan to a broad network commercial plan.

Building out a robust commercial network between 2017-2019 required a transition to commercial market reimbursement rates. Unit cost increases during the same period reflect this shift from Medicaid to commercial payment rates to align with the change in our membership mix.

Mass General Brigham Health Plan has experienced significant enrollment shifts over the past five years, driving substantial changes in underlying risk. This trend was compounded by the state's discontinuation of premium smoothing in 2017 and created higher acuity in our ConnectorCare population. We remained an attractive option for merged market members with significant health needs because we provide access to several major health care delivery systems. The higher acuity members were incurring higher costs, with material year-over-year increases in the prevalence of Hierarchical Condition Categories (HCC), or conditions considered for risk adjustment.

Mass General Brigham Health Plan has taken several steps to reduce the total cost of care and improve health outcomes. In 2020, we developed a select network to improve our ability to offer competitive, affordable plan options for the ConnectorCare market segment, driving the lower unit cost trend observed from 2019 to 2021. We also launched our *Allies and Allies Choice* integrated offerings that seek to improve patient access while lowering costs through direction to community hospitals where appropriate.

In addition to medical network investments, Mass General Brigham Health Plan significantly expanded our behavioral health network and increased reimbursement beginning in 2019 to improve access. The expanded use of telehealth for mental health visits continues even as medical services return to more in-person settings.

Trends from 2019 to 2021 reflect the ongoing impacts of the COVID-19 pandemic. In 2020, utilization was sharply curtailed due to the suspension of elective procedures in the spring of 2020. This is reflected in lower overall trends, and higher impact of mix of services. The reduction in preventive and routine visits may have also led to artificially low risk scores, as the true illness burden was not captured. In 2021, we have seen the bounce back of utilization to pre-COVID levels combined with the continuing costs related to COVID, including treatment, vaccinations, and lab testing. In addition, we are seeing higher risk scores due to increased overall morbidity of the population, likely a result of delayed care in 2020.

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 look forward, there are four primary areas of concern or challenging trends that we expect to confront. First, there is continued pressure on provider financials, including wages and inflationary costs that are placing upward cost pressures on provider rates. In this respect, it will be challenging to collaborate with providers to remain within the current HPC cost growth target, which does not fully account for the impact of inflation and real-time economic trends. A second concern is continued increases in specialty pharmacy costs, delivered both in the retail pharmacy setting and in medical settings. While we continue to look for strategies to reduce costs, including the use of preferred biologic equivalents and site of service direction, the expansion of this sector is likely to continue. Third, the introduction of multimillion-dollar, life-saving genetic and biologically based treatments will continue to put pressure on health plan trends. These medical breakthroughs come with extremely high price tags. As a health plan that offers access to some of the premier medical research institutes in the country, the medical needs of our membership may drive higher costs than average. While variation can be mitigated through private reinsurance mechanisms, these mechanisms must be absorbed in the overall trend. Finally, the COVID-19 pandemic will continue to impact our trends both through direct costs of prevention and treatment, the ongoing impact of Long COVID, and the continued repercussions of delayed care during the pandemic. The federal government recently signaled the beginning of the commercialization of COVID treatments and vaccines – or the expected shifting of COVID costs to commercial carriers. In addition, the impact of treatment for Long COVID or Post-COVID Conditions remains unclear but is likely to be significant. The CDC (Centers for Disease Control) recently published data indicating that 11% of all adults in Massachusetts have experienced symptoms of Long COVID and the prevalence is higher in the under-65 population, while the costs of treatment are still unknown. In addition, apart from the direct

COVID-19 related costs, the pandemic exposed inequities in our health care system and exacerbated unmet needs in mental healthcare that will require continued investments and commitment to address access and availability.

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	871	208
	Q2	445	68
	Q3	705	140
	Q4	655	312
CY2021	Q1	854	376
	Q2	594	210
	Q3	640	83
	Q4	1232	112
CY2022	Q1	1818	99
	Q2	3277	112
	TOTAL:	11091	1314

HPC Payer Exhibit 1 Allways Health Partners

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	Change In Risk	Adjusted TME T
CY 2018	8.3%	8.3%	n/a	-0.5%	**8.6%**	7.7%	**0.8%**
CY 2019	6.4%	6.4%	n/a	0.7%	**10.5%**	0.6%	**9.8%**
CY 2020	1.0%	1.0%	n/a	2.6%	**-3.1%**	-6.0%	**3.1%**
CY 2021	1.6%	1.6%	n/a	-5.8%	**10.7%**	10.0%	**0.6%**

Notes:

Demographic changes are included in the change in risk score. All trends are on an allowed basis.

Service Mix changes in mix of services and providers, as well as the impact of non-claims payments such as provider incentives.

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.