MASSACHUSETTS
HEALTH POLICY COMMISSION

2024 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 2024 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, November 4, 2024**, please electronically submit testimony as a Word document 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 2023, 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 Office of the Attorney General (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.

THE 2024 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2024 Health Care Cost Trends Hearing will take place in a period of significant upheaval and reflection for the Commonwealth's health care system. The bankruptcy and dissolution of Steward Health Care, previously the third largest hospital system in Massachusetts, led to substantial disruptions to the state's health care market and has taken a significant toll on communities, patients, provider organizations, and health care workers across the region. This market instability is occurring while many providers across the health care continuum are still struggling to adapt to a post-pandemic "new normal" state, wrestling with capacity constraints, financial volatility, administrative burdens, and workforce recruitment and retention challenges.

At the same time, an increasing number of Massachusetts residents are struggling with health care affordability and medical debt. Massachusetts has the second highest family health insurance premiums in the country. The average annual cost of health care for a family exceeds $29,000 (including out of pocket spending). Recently, more than half of residents surveyed cited the cost of health care as the most important health care issue, far surpassing those that identified access or quality. Due to high costs, 40 percent of survey respondents said they are putting off seeing a doctor or going to a hospital. These affordability challenges are disproportionally borne by populations of color, and those in Massachusetts with less resources, contributing to widening disparities in access to care and health outcomes. The annual cost of inequities experienced by populations of color in Massachusetts is estimated to exceed $5.9 billion and is growing every year. These challenges require bold action to move the health care system from the status quo to a new trajectory.

This year, in the wake of the considerable harm caused by the bankruptcy of Steward Health Care and other recent market disruptions, the HPC is focusing the 2024 Cost Trends Hearing on moving forward, from crisis to stability, and building a health care system that is more affordable, accessible, and equitable for all residents of Massachusetts.

Since 2012, pre-filed written testimony has afforded the HPC an opportunity to engage more deeply with Massachusetts health care market participants. In addition to pre-filed written testimony, the annual public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the Health Care Cost Growth Benchmark and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. Reflecting on the health care market disruptions in Massachusetts in recent years, including the bankruptcy of Steward Health Care and related closures, what have been the most significant impacts of these disruptions on your members, your network(s), and your organization?

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We have been fortunate at Health New England to have had minimal disruption to our networks. The Steward Health Care closures have not affected our service area. We have had some provider consolidation, specifically as Southern New England Healthcare (SoNE) transitioned away from Trinity Health of New England and became their own free-standing clinically integrated network. SoNE is relatively small in our area and has lost a number of providers over the last five years. Fortunately, these providers have often transitioned to other organizations in our network, and therefore access has not been particularly impacted.
We do have persisting issues with access, especially to primary care providers, but also to specialists. This is part of the ongoing loss of providers in primary care which has been occurring over the past 20 years. The Covid-19 pandemic hastened the exit of primary care providers from the market, however, without some equalization in income to primary care providers, relative to specialists in the market, we will continue to see severe access issues across the country. We also see challenges with nursing staffing which is affecting access in clinics. Sometimes there are enough providers, but lack of nursing keeps there from being enough available spots.

Baystate Health System is now under new guidance, with a change in CEO. Financial challenges for the health system suggest that they will have significant changes over the next 12 months. We will be monitoring closely to assure that these changes do not affect access to care for our members.

2. Please identify and briefly describe any policy, payment, or health care market reforms your organization would recommend to better protect the Massachusetts health care system from predatory actors, strengthen market oversight and transparency, and ensure greater stability moving forward.

Engage in Robust Statewide Planning. It is essential that the Commonwealth have a baseline inventory of the availability and distribution of health care resources, including acute care, non-acute care, specialty care, skilled nursing, assisted living, long term care, ambulatory surgical centers, office based surgical centers, urgent care, home health, adult and pediatric behavioral health and mental health, substance use disorder services, emergency, ambulatory, primary care, pediatric care, pharmacy, family planning, OBGYN, allied health, community health centers, and technologies or equipment. This inventory should be accompanied by an analysis of the health resource needs of the Commonwealth over a set period of time – between 3 and

5 years. The Health Policy Commission, Attorney General's Office, and the Department of Public Health should be required to consult the state plan prior to approving any merger, acquisition, expansion, consolidation or closure of essential services to assess the transactions impact on health care resources in the state. In the absence of a state plan, an ongoing wave of mergers, acquisitions, and consolidations in the state has resulted in increased health care costs for consumers without any meaningful improvements to quality. Indeed, 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. At the same time, continued closures of pediatric and maternity care services in the state have raised concerns about the availability of timely and adequate access to these services in Massachusetts.
Strengthen Department of Public Health Oversight and Authority. The Department of Public Health's (DPH) oversight of hospitals and providers is paramount to ensuring stability in the Massachusetts health care system. The following recommendations for strengthening DPH's authority are aimed at further linking the regulatory review processes conducted by DPH, the HPC, and AGO to provide a more holistic analysis of the impact of health care transactions on the Commonwealth. DPH's Determination of Need (DoN) process should be strengthened to include a more robust review of criteria related to the impact of the proposed transaction on the health care system in Massachusetts, including a more rigorous evaluation of the potential impact of the transaction on health care costs, the long-term financial sustainability and impact of the proposed transaction, how the proposed transaction will address health disparities and improve access to care for underserved populations, and how the proposal aligns with the state's cost containment goals. For all approved transactions, DPH should implement stronger monitoring mechanisms to ensure that the proposal has been delivered on its promised benefits. This includes tracking whether the transaction achieved improvements in access, quality, or cost control. DPH's DoN process should also have a definitive link to the Health Policy Commission's Material Change Notice and Cost and Market Impact Review Process, as well as the Performance Improvement Plan (PIP) process. Applicants should be barred from applying for a DoN until a material change notice, if required, has been submitted to the HPC. If the HPC has advanced the transaction to a cost and market impact review, approval of the DoN must be stayed until the DPH can consider the findings of the CMIR. Transactions subject to DoN approval should not be permitted to advance if the applicant is presently under a PIP. The hospital essential services closure process should be expanded to include other provider types, including registered provider organizations. DPH's authority under the hospital essential services closure process should also be strengthened to include earlier notification of a potential reduction in services or closure, the authority to issue fines or civil penalties if entities do not comply with the essential services process, allow DPH to require hospitals to post bonds or otherwise finance the safe winding down of services and operations. As part of the essential services closure process, the HPC should be able to request information and weigh in on closures, be able to request fact-specific supplemental information, including confidential information. Finally, DPH should be required to consult the state plan in determining whether a

service is essential. Strengthen the Health Policy Commission and Attorney General's Office's Market Oversight Authority. Provide the Health Policy Commission (HPC) and the Attorney General's Office (AGO) greater authority over proposed transactions, including the authority to prohibit proposed material changes that have not meet certain criteria, to impose additional requirements and restrictions on providers that fail to meet the state's cost growth benchmark, and to conduct a lookback of all of the approved market transactions to analyze their impact on the market. The HPC and the AGO should be granted the authority to prohibit any proposed material change by a provider that the HPC finds:• Has resulted or is likely to result in an unfair method of competition,• Has resulted or is likely to result in an unfair or deceptive act or practice,• Has resulted or is likely to result in increased health care costs that threaten the health care cost growth benchmark, • Will substantially lessen competition, or otherwise violate antitrust laws, • Will not result in or produce increased efficiencies, higher quality of care, and lower costs for payers and patients, or • There is no persuasive evidence that the proposal lower costs, efficiencies, and improvements to quality can only be achieved through this transaction. We also support more authority for the HPC within the existing PIP process, including allowing the HPC to set savings targets and require reporting on how savings flow through to purchasers of insurance, with greater penalties for non-compliance or above-benchmark spending as have been enacted in other states. In addition, we support expansion of the HPC's authority to review above benchmark spending, including baseline levels of spending in addition to price growth and baseline prices relative to the market. Enhance the Center for Health Information & Analysis Oversight Authority. The Center for Health Information & Analysis (CHIA) oversight authority should be expanded to include data collection and analysis for registered provider organizations, including the collection of data on gross and net patient service revenues; sources of revenue; total payroll as a per cent of operating expenses, as well as the salary and benefits of the top 10 highest compensated employees, identified by position description and specialty; and other relevant measures of financial health or distress. CHIA should annually report on RPO financial trends. We also recommend increasing the penalties associated with failure to report and requiring CHIA to notify the HPC and DPH if a provider or provider organization has failed to timely report or if CHIA has assessed a penalty for failure to report, which should be required to be considered by the HPC in any Cost and Market Impact Review for the entity and by DPH in determining licensure and suitability for approval of a DoN application. Improve Patient Safety Data Collection and Dissemination. The Betsy Lehman Center for Patient Safety's Roadmap to Health Care Safety for Massachusetts recommends 5 goals for driving measurable improvements in patient safety – all of which should be adopted to improve health care safety in the Commonwealth. Goal #5 which seeks a more complete view into the health care safety landscape through enhanced reporting and systems harmonization, offers opportunity for regulators to have insight into important signal data that could indicate challenges at a particular health care entity. Improving state health care safety data systems by streamlining reporting processes, addressing data duplication and gaps, and promoting appropriate data analytics and sharing across agencies will have a measurable impact on the state's ability to intervene before a crisis occurs. We recommend annual reporting on the state

of health care safety in Massachusetts, as informed by improved data collection and integrated systems. Mandate provider adoption of interoperable electronic health records. One of the primary challenges arising out of both sudden and planned closures of health care facilities is the loss of easy access to patient medical records. Without a truly interoperable system, hospitals, health systems, and ancillary health care providers are not able to easily share patient information across health care systems, resulting in duplicative testing and the provision of unnecessary or inappropriate care. True electronic medical record interoperability will improve patient care and coordination across providers, enhance patient safety by minimizing risks associated with incomplete or inaccurate information, reduce duplicative testing and lower health care costs. Interoperable EHRs could also allow health care organizations, DPH, and local public health commissions to aggregate data for population health management, helping the Commonwealth to better identify trends, manage chronic conditions, and plan interventions at a community or state level.

As mentioned in prior responses, HNE has continued to focus financial investment in primary care and behavioral health care. While financing is necessary it is not sufficient to address access issues driven by limitations in provider availability. Workforce investments by the Commonwealth in training and education are needed to stabilize accessibility over the long term, particularly if access to educational materials and research on equity and health disparities is prioritized. We continue to emphasize telehealth solutions for our underserved populations, especially those in rural and urban areas who may not have access to in-person care. We have partnered with Teladoc to open behavioral health telehealth services up to adolescents between ages 13 and 17 across all of our lines of business. As we continue to struggle with Primary Care access for our members we have begun evaluating telemedicine options to address the shortage of available Primary Care Physicians. As we consider policy and reform changes through products, policy and oversight, HNE believes that there are a few areas we can address to ensure greater stability moving forward. First, it is of primary importance to address prescription drug costs. Prescription drug costs account for between 18-22% of the premium dollar, continued price increases directly impact premium affordability for employers and consumers. Given the outsized impact of prescription drug costs on health care spending and prices, it is critical that drug manufacturers are held accountable. We are supportive of the following proposals to provide greater transparency and accountability. It is critical to remember that prescription drugs are dispensed in multiple places, including in the retail setting, in hospitals, and in outpatient clinics and practices. A comprehensive approach to addressing prescription drug prices must take all of these locations into account, as a significant amount of spend is in drugs dispensed or used in the clinical setting. As identified in HNE's response in 2023 we can address these concerns through: 1. Limit margin/mark-up on medical pharmacy- As stated above, medical pharmaceuticals are those drugs which are administered in hospital and office-based settings. These include chemotherapeutics, as well as CAR-T therapies, and biologics. The mark-up on these medications can be staggering. We have documented mark-ups of as much as 500% over the Average Wholesale Price from some of our specialty hospitals. Limiting the allowed mark-up on these already extremely expensive medications is

an efficient way to lower overall medical spend.

2. Add pharmaceutical manufacturers to HPC's 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.

3. Expand HPC drug pricing review authority. We also strongly support the HPC's recommendation from the 2022 and 2023 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.

4. Establish penalties for price gouging — To address unwarranted price increases by pharmaceutical manufacturers, the Legislature should require pharmaceutical manufacturers to report and justify increases in drug prices and to face financial penalties for unjustified increases. Establishing a penalty on manufacturers for excessive price increases addresses affordability concerns due to higher prescription drug spending and prices. Secondly, we need to address hospital and provider costs. Policymakers have proposed a number of actions to address rising hospital and provider prices and ease price variation. We are supportive of the following proposals, which complement the work health plans are doing to reduce costs.

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3. Reflecting on consistent HPC findings showing increasing health care affordability challenges, growing difficulties accessing needed care, and widening health disparities based on race, ethnicity, and income among Massachusetts residents, what are your organization's top two to three strategies for addressing these trends? What are the most significant challenges to implementing these strategies?

Health New England is proud to be Health Equity accredited across all lines of business. As we prepared for accreditation and as we have continued on the path of robust competency development the below three domains capture our ongoing challenges.

Data and Analytics: In order to effectively and appropriately close equity gaps in health care, we must have the ability to better understand our members. Where they are? Who are they? How do they identify? What are the barriers they may experience? What are their cultural sensitivities? What is their ability to understand their health, the healthcare system or their benefits? These questions along with a host of other socioeconomic or demographic characteristics may have an effect on one's ability to achieve equitable access and outcomes. One of our primary strategies is to be able to understand these characteristics of our members through enhanced data collection. In 2024, Health New England has implemented bi-directional data

feeds with some provider groups, sharing race, ethnicity and language data when available. We have implemented the RAND imputed methodology. The issue is having a sufficient volume of data that allows an analysis to be meaningful. The more and more that data is segmented the less likely it is to be statistically significant if the underlying volume of data is low. As we try to establish data sharing relationships with provider organizations, we are faced with high costs. We ourselves are faced with costs or investments to acquire, standardize and store data but we see it as part of our strategy to share that data with regional entities to help expand the total availability of that data. We are not always met with the same approach. We believe that as the State continues to look for ways to assist providers and health plans to close the equity gaps, it would be helpful to address the data issue. Is there the ability to develop a standardized collection and submission process to regional HIEs. The fact that providers are required to collect, health plans are required to collect will cause patients to be inundated with different collection points.

Provider Engagement:
Health New England actively engages with providers in health equity discussions, reviews of segmented measures and in the development of health equity initiatives. As we work with providers to review the data and to develop solutions, they are a key partner to helping close the gap. The issue is the current bandwidth of our provider organizations to dedicate themselves to the work required to comprehensively approach health equity. In Western Massachusetts we have a significant provider shortage. With this shortage and with the difficult financial situation of most hospitals and PHOs, there has been a much larger focus on fee-for-services and closing financial gaps rather than value-based care, quality or health equity.

Access: The primary challenge in creating strategies to address disparities in health based on race, ethnicity, and income among Massachusetts residents is the collection and aggregation of this data. We have a widely disparate population in western Mass, and it would be naïve to think that our socioeconomic challenges for our members are limited to those residents of cities. In fact, we are finding that socioeconomic challenges often top race or ethnicity as drivers of health disparities. For Medicaid, we have implemented a new app called Wellth which rewards our members with Htn, COPD, diabetes, or asthma for taking their medication or checking their blood pressure or sugar. The app has been very popular in our Medicaid population, and we hope to have enough money to be able to expand its uptake. Wellth has been very good at targeting otherwise disengaged members from the plan, especially those with very low incomes for whom the financial rewards can be used to pay for clothing or food.

Additionally, we are currently exploring the implementation of Primary Care telemedicine solution. We believe that this would help members otherwise challenged to find an open provider or to travel to a provider.

4. Please identify and briefly describe any policy, payment, or health care system reforms your organization would recommend to achieve a health care system that is more affordable, accessible, and equitable in Massachusetts.

As discussed above, we continue to have access issues in western Mass, however, the dramatically increasing costs of health care are unsustainable. Any approach that can stabilize prices, whether forming a region-wide buying coalition for specialty pharmacy and biologic drugs, standardizing pricing across hospitals, or stabilizing out of network costs would help keep the costs of healthcare under control. The Commonwealth will be unable to achieve a health care system that is accessible and equitable for all residents without addressing the affordability crisis facing employers and consumers. Continued price increases by hospitals, providers, and pharmaceutical manufacturers are resulting in heightened premium rates, driving greater uptake of high-deductible health plans, and influencing consumers' ability to access care. The following recommendations have been longstanding priorities of the HPC, and we urge adoption of these actionable steps to rein in costs, which will in turn increase accessibility and equity. Address Hospital and Provider Prices. Policymakers have proposed a number of actions to address rising hospital and provider prices and ease price variation. We are supportive of the following proposals, which complement the work health plans are doing to reduce costs. 1. Implement Vital Consumer Protection Provisions of Chapter 260 of the Acts of 2020 – The Legislature has already taken action to protect consumers from unforeseen health care costs. Chapter 260 of the Acts of 2020 require providers, upon request, to share the amount that the patient will be charged for admission, a procedure, or a service, including costs for services done by an out-of-network provider; require providers to notify patients if the patient is being referred to an out-of-network provider; and prohibit providers from billing insured patients in excess of the typical, applicable coinsurance, co-payment, or deductible that would have been charged if services were provided by an in-network provider. In accordance with the law, the Department of Public Health issued comprehensive guidance in March of 2022 for providers to comply with the statutory requirements which were broadly endorsed by policymakers, the business community, and consumer advocates. However, since that time the effective date of the law has been extended, most recently in Section 33 of the House FY25 Closeout Supplemental Budget to 2027. These simple notice requirements and the prohibition on balance billing are common sense solutions that will have a meaningful impact on consumers. 2. Adopt a default out-of-network payment rate – As recommended in the 2023 Health Care Cost Trends Report, the Legislature should enact the default out-of-network payment rate for surprise billing situations recommended by the Executive Office of Health and Human Services in its Report to the Legislature. The default reimbursement rate for out-of-network emergency and non-emergency

services should be set at a health plan's median contracted rate for that service in the geographic region in the relevant market, compliant with the federal No Surprises Act. Adoption of the default OON rate must also include an explicit prohibition on balance billing by providers. The establishment of reasonable OON reimbursement rates will increase patient access to health care services by reducing an insured's out-of-pocket costs for services from a provider that is unknowingly not contracted with their health plan and produce cost savings across the state health insurance system by encouraging OON providers to charge more reasonable rates and to participate in health plan networks. 3. Prohibit facility fees – As outlined in the 2023 Cost Trends Report, the greatest increase in medical spending was in hospital outpatient department spending, growing an average of 5.5% per year per enrollee, with facility fees (which account for 80% of HOPD spending) growing by 6.7%. Facility fees generate billions of dollars in annual revenue for hospitals, but at a cost to consumers. The Legislature should prohibit providers from charging a facility fee, except for 1) services provided on a hospital's campus, 2) services provided at a facility that includes a licensed hospital emergency department, or 3) emergency services provided at a licensed satellite emergency facility. The Legislature should also require that a hospital-based facility that charges or bills a facility fee for services must inform patients with written notification. 4. Adopt site neutral payments – A complement to the prohibition on facility fees, adoption of site neutral payments for routine health care services that can be safely provided in either hospital outpatient departments or non-hospital settings. 5. Address Prescription Drug Prices. As prescription drug costs account for between 18-22% of the premium dollar, continued price increases directly impact premium affordability for employers and consumers. Given the outsized impact of prescription drug costs on health care spending and prices, 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 manufacturers to HPC's 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 2022 and 2023 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. Establish penalties for price gouging — To address unwarranted price increases by pharmaceutical manufacturers, the Legislature should require pharmaceutical manufacturers to report and justify increases in drug prices and to face financial penalties for unjustified increases. Establishing a penalty on manufacturers for excessive price increases addresses affordability concerns due to higher prescription drug spending and prices.

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TRENDS IN MEDICAL EXPENDITURES

1. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2020 to 2023 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2020 to 2023, 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 fluctuations in annual trends are largely driven by COVID related utilization impacts. In 2021 utilization increased significantly as certain services rebounded post COVID. 2022 utilization dipped again both driven by a lack of capacity from providers and COVID impacts in January and February of that year.

2. Reflecting on current medical expenditure trends your organization is observing in 2024 to date, which trend or contributing factor is most concerning or challenging?

In 2023, we stated that pharmaceuticals were our top area of concern. This continues to be very challenging, as we are seeing trends of 25% in medical pharmacy costs, as well as ballooning requests for GLP-1s for weight loss. We continue to see exhorbitant costs in the biologic and oncology medications. Gene therapies have not rolled out as fast as one might expect, although single treatments remain in the multi-million dollar range, often between $5M and $10M for a course of therapy. Treatments of this magnitude and the concurrent uncertainty about long term efficacy suggest that a regional New England risk pool or buying group might be helpful. We are also seeing skyrocketing costs for behavioral health, aided by the flat rate being paid to the CBHCs, regardless of the service actually provided. And finally, like last year, we are continuing to see increasing demands from hospital systems and provider groups for out-sized increases in their overall fee schedules, reflecting inflation, higher staffing costs, and the overall decline in provider margins.

QUESTIONS FROM THE OFFICE OF THE ATTORNEY GENERAL

1. 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) 2022-2024			
Year		Aggregate Number of Written Inquiries	Aggregate Number of Inquiries via Telephone or In-Person
CY2022	**Q1**	570	20
	Q2	486	28
	Q3	490	33
	Q4	635	40
CY2023	**Q1**	535	22
	Q2	615	27
	Q3	541	20
	Q4	602	24
CY2024	**Q1**	678	34
	Q2	557	25
	TOTAL:	5,709	**273**

2. When developing benefit plan options for employer groups, do you consider point-of-service cost-sharing affordability separately from premium affordability? If so, how do you do this and what metrics and data sources do you use?

When developing product and benefit plans for our employer groups we use a balanced to both member cost sharing (Point of Service) and the member's premium affordability. While these are two separate components they are closely related and influence the overall appeal of the plan to the employer groups and members. Point of service costs such as copays, coinsurance and deductibles are evaluated to ensure we are providing the best and most appropriate care of our members based on the location of service. Creating the appropriate balance between these two factors is important for Health New England to provide competitive, yet affordable benefit options to meet the needs of our employer groups and their associates. In order to balance these factors we use several metrics and data sources including but not limited to: Medical Loss Ratio (MLR) – assessing the percentage of premium dollar spent on medical care versus overall administrative costs, Actuarial Value (AV) –measurement of the expected percentage of healthcare costs a health

benefit plan will cover. This assists in guiding the process of product development, Utilization and Risk Adjustment Data – usage patterns and population health metrics and Member Satisfaction and Experience Scores – HNE uses metrics such as CAHPS to assess member satisfaction, Competitive Intelligence – reviewing market trends for competitor plan offerings and cost structures, benefits

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3. Are there any accommodations you offer to providers in consideration of point-of service cost sharing bad debt under your global risk arrangements? For instance, is the full allowable amount (i.e., both the insurer and the member portions) charged against the global budget even if the provider was never able to collect the member portion? Please provide details.

Health New England does not offer accommodations as described above at this time.

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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 2020	2.4%	-7.4%			-5.0%
CY 2021	2.5%	14.7%			17.2%
CY 2022	4.7%	-5.2%			-0.5%
CY 2023	5.8%	1.8%			7.6%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.