Mass General Brigham
Health Plan

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SENT VIA EMAIL TO: HPC-Testimony@mass.gov

November 4, 2024

David Seltz, Executive Director
Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street
Boston, MA 02116

Dear Mr. Seltz:

On behalf of Mass General Brigham Health Plan, I want to thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's request received on October 2, 2024, as provided for in Massachusetts General Law, chapter 6D §8.

Included with this cover letter is a copy of our Pre-Filed Testimony response in the attached submission template. As a legally authorized and empowered representative of Mass General Brigham Health Plan, I have signed under the penalties of perjury, that the testimony, including **HPC Payer Exhibit 1_Mass General Brigham Health Plan**, is to the best of my knowledge, complete and accurate.

Sincerely,

Alice Moore
Senior Vice President
Legal, Regulatory Affairs & Compliance

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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?**

Over the last several years, the evolution of the industry and the worldwide COVID-19 pandemic have significantly impacted the healthcare landscape. Mass General Brigham Health Plan continues to provide solutions to create exceptional experiences and support the comprehensive health needs of our members.

Currently, Mass General Brigham Health Plan is monitoring the unprecedented situation with Steward Health Care, including news of its recent closures and sales. As we continue to track new developments, we have prepared contingency plans to ensure that our members have access to the care they need. This has included proactive outreach to members who were impacted by the hospital closures to help facilitate transition of care and offer support. As the situation develops, our goal remains to ensure continuity of care and minimal disruption for our members. We commend the Commonwealth for working diligently to support continued access to healthcare services. Moving forward, we will continue to collaborate with the Commonwealth and the healthcare systems that are purchasing Steward facilities to ensure a seamless transition of care for our members.

In addition, like many other health plans and providers across the country, we continue to experience impacts from the COVID-19 pandemic, which include:

- **Deferment of care:** The deferment of care during the pandemic has put a strain on the healthcare system. Today, providers and other healthcare professionals are operating in a challenging environment due to higher-acuity health needs post-pandemic, as well as labor shortages and significant capacity challenges.
- **Access to mental health services:** The pandemic has also continued to amplify the impacts of the ongoing mental health crisis. We are seeing the need for mental health support continue to grow significantly. In response, we consulted clinical experts across the Mass General Brigham system to identify a comprehensive solution – with Lyra Health – that makes it easier and faster for our members to access high-quality mental health services and match members with providers based on their clinical needs and preferences.
- **Medicaid Redetermination:** The COVID-19 pandemic also led to a pause in the Medicaid redetermination process nationwide, which created shifts in membership enrollment across Medicaid, commercial, and exchange plans. Through the Commonwealth's leadership, MassHealth and the Massachusetts Health Connector took a highly coordinated approach to ensure members who were no longer eligible for MassHealth were redirected to other coverage options through the Health Connector or employer-sponsored plans. At Mass General Brigham Health Plan, we worked across the Mass General Brigham system on outreach to ensure that members understood the redetermination process and their options for health

insurance coverage. While the impact of these changes on the commercial market may still take shape over time, members with greater health needs could affect cost trends in the state moving forward.

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.**

To support our goal of creating exceptional member experiences by expanding access to high-quality, affordable, and equitable healthcare, we are providing recommendations to help strengthen the state's healthcare marketplace through our collaboration with the Commonwealth. These include:

- **Statewide planning:** The recent disruptions to the healthcare marketplace, such as the Steward Health Care situation, have brought to light opportunities to ensure continuity of care for healthcare consumers across the state. To help mitigate disruption, we recommend that the Commonwealth consider creating a robust inventory of essential healthcare services and resources that members need and tools to help monitor access to these resources, as well as opportunities for the Commonwealth to conduct audits on third party owners of healthcare facilities and require additional monitoring if quality standards are not met. As a result, we believe this inventory will help to better equip the Commonwealth and healthcare marketplace quickly, and effectively address and mitigate any potential issues concerning access to care.
- **Oversight of small group market trends:** We have noticed significant shifts in the commercial small-group market that would benefit from additional oversight and support from the Commonwealth. There has been an increase of self-funded offerings for small groups, more specifically through level-funded plans such as Individual Coverage Health Reimbursement Arrangements (ICHRAs). Market data and trends have shown that these types of plans can benefit from regulations to drive affordability, support the claims process, and mitigate issues to the risk pool. To address these concerns, we ask the Commonwealth to consider regulating offerings in which renewability does not apply. Other states have done this by addressing the associated stop loss coverage components where they have regulatory authority. The

Commonwealth could also consider adopting the National Association of Insurance Commissioner (NAIC) Stop Loss Model Act that includes minimum attachment points or prohibits insurers from selling stop-loss insurance to certain small employers. Finally, the Commonwealth may consider requiring that level-funded options or options with low stop loss attachment points meet all the same requirements that apply to fully insured plans, or an application of the premium tax to stop loss premiums.

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?**

Providing access to high-quality, equitable care is a top priority for Mass General Brigham Health Plan. To support this effort, we have engaged in the following initiatives:

- **United Against Racism:** As an integrated healthcare system, advancing health equity is a top priority. Mass General Brigham launched United Against Racism (UAR) to acknowledge systemic racism as a public health issue that impacts patients, employees, and the communities we serve. Objectives under patient care, for example, include improving collection of race, ethnicity, and language data, eliminating racialized medicine practices, expanding access to interpreter services and written translations, providing screenings and responses to social risk factors, integrating community health workers at 22 primary care practices across the system, and increasing equitable access to virtual healthcare services.
- **Health Equity Accreditation:** Mass General Brigham Health Plan is in process of obtaining Health Equity Accreditation from the National Committee for Quality Assurance (NCQA). As part of this process, we are improving the collection of demographic data to provide more personalized support to our members. Our efforts have significantly increased the completion rate of the data, in some cases more than doubling the race and ethnicity data that we have on file. Additionally, we are working with our provider network to survey their ability to provide culturally competent care to our Medicaid Accountable Care Organization (ACO) members. We have developed education and training materials to provide targeted and personalized support and training based on the survey results.
- **Programs that address health disparities:** Mass General Brigham Health Plan has a legacy of providing high-quality and affordable care for our communities, and we continue to introduce new and innovative solutions to support a broader range of populations. This includes our application to provide Dual-Eligible Special Needs Plans (D-SNP) to create exceptional healthcare experiences that achieve the best possible health outcomes for populations most in need. Dual-eligible individuals, meaning

those eligible for both Medicare and Medicaid programs, have complex care needs and often require some combination of behavioral health and long-term services and supportive health services based on age or disability. We have deep experience serving high-risk populations, including Medicaid members through the Mass General Brigham Accountable Care Organization (ACO). With Mass General Brigham and our provider partners, we are uniquely positioned to support coordinated and high-quality care in the community.

Another example is our leadership in women's health. Mass General Brigham Health Plan offers a robust portfolio that addresses underrepresented and often stigmatized areas of women's health. Our solutions support the full spectrum of women's health issues – from pregnancy to post-partum and loss, to pelvic health, and menopause. The portfolio goes beyond traditional coverage by taking a data-driven approach that research shows is also critical to address health disparities.

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.**

- **Continued support for government-based programs:** We applaud the efforts of the Commonwealth to ensure equitable and affordable access to care, especially for individuals who receive health insurance from MassHealth and those who purchase health insurance from the Massachusetts Health Connector. We believe it is important that the Commonwealth continue to advance these efforts to maintain affordability in our evolving healthcare marketplace. At the state level, we recommend that the Commonwealth consider permanently implementing the two-year pilot expansion of ConnectorCare eligibility to 500% of the Federal Poverty Level. At the federal level, we recommend additional advocacy and support to maintain the premium tax credits enacted by the American Rescue Plan Act and extended by the Inflation Reduction Act, which are set to expire after 2025.
- **Addressing prescription drug costs:** Across the country, the increasing costs of prescription drugs continue to impact healthcare spending. With the continued introduction of new-to-market drugs and life-saving medications, such as cell and gene therapies, it is important that the Commonwealth help to ensure fair and equitable access to these treatments. We would also encourage the Commonwealth to ensure that the risk does not fall disproportionately on the merged market. As a result, we recommend that the Commonwealth consider additional funding mechanisms, such as a state-level reinsurance program, that could help spread costs across insurers and markets. In addition, we are supportive of the Health Policy Commission's work to require pharmaceutical manufacturers to provide greater transparency, accountability, and equity for prescription drug costs.

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.

Year	Unit Cost	Utilization	Provider/ Service Mix	Total	Change in risk	Health Status Adjusted TME Trend
CY 2020	1.0%	-6.5%	1.8%	-3.9%	-5.8%	1.8%
CY 2021	1.6%	15.6%	-7.7%	8.4%	10.3%	-1.9%
CY 2022	2.1%	-3.0%	4.0%	3.0%	-0.4%	3.4%
CY 2023	2.3%	0.5%	5.2%	8.2%	3.6%	4.6%

Mass General Brigham Health Plan's expenditure trends summary table above and attached as **HPC Payer Exhibit 1 – Mass General Brigham Health Plan** represents commercial members for which we have full claims. Additionally, the trends table includes the impact of pharmacy rebates and other non-claims items.

The impact of the evolving demographics of the population are reflected in the mix and utilization, as well as the change in risk that we have noted above. The COVID-19 pandemic also had significant impacts on mix, utilization, and reported risk, especially as it relates to 2020 and 2021. In addition, utilization decreased in 2020 during the early pandemic-related shut-downs,

followed by an increase in 2021 that reflects a return to care and broader access to COVID-19 tests.

All trends are reported on an allowed basis, including both member and health plan share. Therefore, employer benefit buy downs are isolated to the potential impact of cost share on utilization and are reflected in the utilization and provider and service mix data.

The impact of demographic and acuity trends are represented in the change in risk, which we have populated in the table above through the DxCG risk model. DxCG risk models are a commonly used set of software tools that utilize healthcare data to calculate risk scores for patients. These tools can also be used to predict concurrent or future costs as specified for commercial, Medicare, or Medicaid populations. It should be noted that the risk scores were understated due to deferred care in 2020, resulting in a change in risk in 2021 that is not reflective of true population changes. We observed significant increases in acuity in 2023, which appear to be continuing in 2024.

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?**

Overall, we are seeing high trends driven by an increasing acuity of our membership. This is consistent with national data showing an increase in mortality for adults under 65. On a service line basis, pharmacy services, including those processed through the medical benefit, continue to be the single largest contributor toward trend in 2024, year to date. Finally, trends have also been impacted by a continued increase in the use of critical mental health services.

Given the health plan's unique population and risk profile, medical and specialty pharmacy continue to be a significant driver of this trend. Increased costs associated with new chemotherapies contribute significantly to the growth in medical pharmacy, while anti-psoriatic agents continue to be a key drug class driving trend specialty pharmacy. Brand name drug expenditures were driven primarily by increased use of Glucagon-like peptide-1s (GLP-1s) for weight loss and diabetes.

While GLP-1s have proven to be clinically effective, the healthcare industry is working on ways to manage the associated costs. In addition, we are committed to expanding access to innovative approaches and treatments for cancer care, while collaborating across the industry to manage costs.

Mass General Brigham Health Plan has successfully implemented a variety of changes to effectively mitigate these trends, in which we:

- Re-contracted our pharmacy benefit manager in 2024.
- Facilitated the use of biosimilars in cases where it makes sense to do so,
- Implemented product design changes encouraging use of high-quality care at the right time and the right place at a lower cost, such as the expanded use of virtual care services and home hospital programs.

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.

Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2022	Q1	1818	99
	Q2	3277	112
	Q3	2677	125
	Q4	2417	112
CY2023	Q1	6415	165
	Q2	6258	74
	Q3	6571	61
	Q4	7403	54
CY2024	Q1	7302	104
	Q2	4315	107
	TOTAL:	48453	**1013**

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?**

Mass General Brigham Health Plan designs benefits to create exceptional healthcare experiences by expanding access to convenient, affordable, and flexible care options.

Nationwide, consumers have continued to identify gaps within their healthcare experiences. According to the J.D. Power 2024 U.S. Commercial Member Health Plan Study, access to care, cost of care, and chronic condition management all play a critical role in shaping the consumer healthcare experience. In response to feedback and to support members in the ways they

access critical healthcare services, Mass General Brigham Health Plan has designed enhanced, competitive benefits to meet the needs of the whole member at all stages of life and health.

Similarly, as we think about the balance between point-of-service cost sharing and premium affordability in our plan designs, we incorporate market feedback when we develop our standard plan portfolios.

For example, we recently announced that our new Complete Access EPO℠ (Exclusive Provider Organization) plan, now available to large groups, will be available to individuals and small businesses on January 1, 2025 to expand affordable coverage solutions. This high-value, competitively priced product supports an increasingly remote workforce and enables employers to access an affordable national network compared to traditional PPO plans.

Many employers can also impact their employees' premium affordability through their level of employer contributions, as well as their contributions to Health Savings Accounts, Health Reimbursement Accounts, Medical Savings Accounts, and Flexible Spending Accounts.

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.**

Provider risk arrangements vary by provider and service. Our agreements with global budgets are primarily based on percent of premium, which reflects "plan liability" or net of member cost share – an important part of plan design to allow for more efficient and effective care, including incentives to access high-quality care in a lower cost setting when appropriate.

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	Change in risk	Health Status Adjusted TME Trend
CY 2020	1.00%	-6.50%	n/a	1.80%	-3.90%	-5.80%	1.80%
CY 2021	1.60%	15.60%	n/a	-7.70%	8.40%	10.30%	-1.90%
CY 2022	2.10%	-3.00%	n/a	4.00%	3.00%	-0.40%	3.40%
CY 2023	2.30%	0.50%	n/a	5.20%	8.20%	3.60%	4.60%

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.