Attached please find Point32Health's written pre-filed testimony for the 2024 Cost Trends Hearing. I am legally authorized and empowered to represent Point32Health and this testimony is signed under the pains and penalties of perjury.

Subscribed and sworn to, this fourth of November, 2024.

Eileen Auen

Executive Chair

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?

In our 2023 testimony, we described significant delivery system disruptions we saw coming out of the Covid-19 pandemic and how those disruptions put upward pressure on medical trend. We have continued to experience similar cost pressures this year, which are described in more detail below. Behavioral health trends were elevated coming out of the pandemic and have not significantly moderated in the years since. If the increased demand for these services represents a "new normal," then there are important implications for both health care spending and the delivery system, as new capacity will need to be created to meet members' needs. In our written testimony last year and during the Division of Insurance's public information session earlier this year, we highlighted several factors (exacerbated by pandemic conditions) that providers have cited in demanding significant unit cost increases. These include labor shortages, high medical inflation and increasing debt burdens. These trends have persisted, as have provider requests for significant rate demands. Such requests are frequently at multiples of the cost growth benchmark annually over the course of multi-year contracts. With respect to Steward Health Care, we are mindful that community members in Dorchester, Ayer, Norwood, Foxboro and the surrounding areas have lost important local healthcare resources. We support additional actions the state should take to prevent a similar situation from happening in the future, which are discussed in more detail in the questions below. There have been operational challenges associated with the transition of the remaining Steward assets to new owners, including mapping facilities and providers to new NPI and TIN numbers, and ensuring continuity of care for members receiving services at the former Steward locations. These challenges should be acknowledged. All of that notwithstanding, we have been able to work with the new owners in a collaborative fashion. We applaud the cooperation between state leaders, regulators, the provider community and health plans that has ensured that the exit of Steward from the Massachusetts healthcare landscape was not worse and did not result in a catastrophic disruption in services for 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.

We supported parts of legislation debated this session that enhanced existing market oversight mechanisms of the Health Policy Commission (HPC), the Center for Health Information and Analysis (CHIA), the Department of Public Health (DPH) and the Attorney General's Office (AGO). While large parts this legislation were drafted in response to the Steward Health Care

situation and aimed at better monitoring the role of private equity in healthcare, many of the policies have broader and important implications. Specifically, the Commonwealth should conduct comprehensive statewide planning by creating a detailed inventory of healthcare resources and analyzing the state's projected needs over the next 3-5 years. The HPC, AGO and DPH should only approve market transactions that advance the Commonwealth's goals and meet those projected healthcare needs. The Determination of Need (DoN) process should be strengthened and tied more closely to the HPC's Material Change Notice Process, specifically through an evaluation of all proposed transactions on healthcare spending and meeting the state's projected healthcare needs. The HPC and the AGO should have greater authority over proposed transactions, including the authority to prohibit proposed material changes that have not meet certain criteria and to impose additional requirements and restrictions on providers that fail to meet the state's cost growth benchmark. 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 the transaction. We also support more authority for the HPC within the existing Performance Improvement Plan 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. We support expansion of the HPC's authority to review above benchmark spending, including baseline levels of spending in addition to year-over-year trend and baseline prices relative to the market, and extending those provisions to provider types other than physicians, specifically hospitals. Transactions approved through the DON and MCN processes should be monitored and evaluated on an ongoing basis to determine if they have achieved the stated goals, improved efficiency or delivered savings. 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 make recommendations. DPH should be required to consult the state plan in determining whether a service is essential. In addition to these ideas for greater market oversight, we would note that some of the policy suggestions below would also address what might be described as predatory behavior; whether that is pharmaceutical manufacturers increasing drug prices during market exclusivity periods, out of network providers sending

members exorbitant medical bills, or the application of facility fees at locations nowhere near a hospital campus.

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?

Healthcare costs continue to consume an ever-increasing percentage of income, particularly for middle- and low-income families. Employer groups (particularly smaller employer groups) continue to turn to high-deductible health plans in an effort to mitigate premium increases caused by higher costs. In these plan designs, members are asked to pay more out of pocket costs, which can exacerbate the affordability and access to care issues described above. For these reasons, we believe an urgent and renewed focus on affordability and the underlying drivers of affordability challenges is paramount. Reducing healthcare cost growth will make healthcare more affordable and accessible for all. With respect to Point32Health, we have outlined strategies below that we are using to address medical trend and pharmacy trend. As highlighted above, the most significant affordability challenge we face are demands from our provider network that far outpace the cost growth benchmark. With respect to pharmacy, high and rising unit costs are also persistently challenging for affordability. Efforts to mitigate these trends through medical management are often met by pharmaceutical manufacturers with restrictions or eliminations of rebates otherwise used to lower net costs for premium payers. Strategies to address total cost of care: 1. A focused effort to reduce inpatient (IP) utilization and trend through a payment policy to pay very short IP stays at an observation level instead of an inpatient case rate. 2. Increased and more intense review of IP stays that are approaching outlier status to reduce length of stay and minimize outlier spend of claims and manage unit cost; 3. Adding new medical policies in the areas of cosmetic and reconstructive procedures, intensity-modulated radiation therapy and proton beam administered through prior authorization; 4. Potential change to core value formulary with a to address high-cost drugs is being investigated for 7/1/2025 5. Developing a unit cost strategy around labs with potential volume consolidation in the reference labs space and some renegotiation for specialty labs to bring to standard rates. Strategies to address pharmacy trend. In addition to our ongoing efforts to manage pharmacy, including utilization management, formulary review, new drug evaluation and specialty pharmacy programs, we are implementing the following programs, effective 1/1/25. 1. Copay Card program– Removes copay card funds from the member's out-of-pocket accumulation and maximizes available copay card funds for plan sponsor. 2) Orphan Drug Program – offers individualized longitudinal care to members helping address impact to cost, safety and efficacy concerns through therapy optimization and deprescribing. 3) Medical Drug Step Therapy - Encourages the clinically proven use of first-line therapies covered under the medical benefit to ensure the utilization of the most therapeutically appropriate and cost-effective agents first before other treatments may be covered.

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.

The Health Policy Commission (HPC) has, for more than a decade now, made many policy recommendations to address costs drivers and make healthcare more affordable. As we have said in prior testimony, we continue to support many of these recommendations. HPC research presented during last year's Cost Trends Hearings showed that commercial insurers are often paying more than 200% of the Medicare price for common outpatient procedures. We think it is time to consider an upper cap on provider reimbursement at that level, which would immediately save at least $2 billion annually in healthcare spending according to data presented by the HPC. We support additional policies that rationalize healthcare prices for common services and would again recommend that the state explore a site-neutral payment policy for outpatient hospital services. Facility fees associated with hospital outpatient settings are driving a large part of significant price variation for these services. The Department of Public Health should be tasked with developing a licensure procedure for hospital outpatient clinics that identifies settings that are geographically located on or very close to a hospital campus, and those that cannot be designated as hospital outpatient clinics due to geographic distance. The state should then take action to prohibit facility fees in the latter case and to monitor that the costs are not otherwise passed on to payers. As healthcare spending on pharmaceuticals continues be a major driver of cost growth (even after rebates), the state should take action to mitigate the impacts of these costs to support the Commonwealth's shared goal of affordability. We support a variety of policy interventions to address pharmaceutical trend, which at a minimum should include reporting from both pharmaceutical manufacturers and pharmaceutical benefits managers (PBMs) to CHIA and the HPC, as well as participation in the Annual Cost Trends Hearing process, including an examination of each entities' impact on meeting the state's cost growth benchmark. The HPC should be given authority to examine some subset of drugs (the top 10, the top 25, etc.) that are most impacting spending in Massachusetts and to determine whether the prices of those drugs is commensurate to the value they provide. If not, the HPC should be able to intercede and apply a process like a Performance Improvement Plan (PIP) to bring the price of the drug more in line with value. Too often are manufacturers using, extending and abusing market exclusivity periods to push prices higher. We support policies that hold manufacturers accountable for price increases above a certain threshold (such as the cost growth benchmark or some other measure of reasonableness) and apply penalties for excessive increases, similar to Medicare legislation that has been enacted in Congress or to policies proposed under the Baker Administration. The state should consider legislation that leverages the Medicare drug negotiations to bring the same price relief to the commercial market. We support policies that allow the HPC to examine health care spending in different ways, including examining the year-over-year trends of providers other than physician groups (hospitals, specifically) and empowering the HPC to look at aggregate price levels (in addition to

year-over-year trend) in determining whether to apply a PIP or not. The PIP process should be amended to allow HPC to set savings targets that bring actual cost savings to the system, rather than bringing entities within the growth target. The state should enact an out-of-network default payment rate for situations in which consumers may be exposed to a surprise medical bill (out of network specialists at in-network facilities, out of network emergency providers, etc.). The Executive Office of Health and Human Services in its report to the Legislature on the matter recommended a default reimbursement rate for out set at a health plan's median contracted rate for that service in the geographic region. Adoption of the default OON rate must also include an explicit prohibition on balance billing by providers. Reasonable OON reimbursement rates can protect patients from receiving large medical bills through no fault of their own and produce cost savings by encouraging providers to charge more reasonable rates and to participate in health plan networks.

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.

a. On average, the aging of the population adds about 1% to 2% to trend annually, while the health status of the population increased by 2% to 5% per year, depending on the line of business (including demographics changes). Note that for 2020, the risk coding has been suppressed due to the pandemic. The impact of these changes (which are not normally exclusive) is seen in the utilization and service mix trend. Other factors such as greater employee cost sharing may have been suppressing utilization trends during that time. Shifting care patterns such as movement away from the inpatient setting to outpatient and ASC, as well as movement out of the ED are impacting unit cost and mix trends. Point32Health has observed a similar rate of benefit buy down in each year over

this time-period. Unit cost for HPHC and THP is suppressed due to the increases in pharmacy rebates in the measure. The lower trends in 2020 and subsequent increase in 2021 is the result of service suppression during the pandemic. For THP specifically, there were two unique dynamics influencing the trends – one was the introduction of a new pharmacy benefits manager with enhanced rebates, and the other was the beginning of the process of migrating all THP Commercial members to HPHC. This later issue changes the member mix and impacts all the trends reported for 2023. For THPP specifically, the unit cost trend observed for 2023 is largely the result of converting to a new pharmacy benefits manager with favorable rebates and the 2023 utilization trends are largely the results of lower acuity associated with redetermined Medicaid members joining the Plan. The impact of redetermination is not expected to continue.

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?

b. Of most concern are pharmacy cost trends including GLP-1s and unit cost pressure from providers, and general utilization increases in inpatient and professional services.

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 **Website** Inquiries	Aggregate Number of Inquiries via **Telephone or in-person**
CY2022	**Q1**	5,443	226
	Q2	4,740	223
	Q3	5,097	160
	Q4	5,221	184
CY2023	**Q1**	4,789	80
	Q2	5,793	70
	Q3	7,457	82
	Q4	7,041	90
CY2024	**Q1**	7,271	85
	Q2	5,478	53
	TOTAL:	**58,330**	**1253**

*Numbers are aggregated across all Point32Health products, including Tufts Health Plan, Harvard Pilgrim Healthcare and Tufts Health Public Plans

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 plan options, we consider overall affordability trying to balance out of pocket costs with premium costs. Employer groups can choose plan designs with higher member cost sharing, which in turn reduce or mitigate premium increases they might otherwise see. Plans with lower cost sharing would take higher premiums. We do consider cost share differentiation at the point of service whereby the member will pay a lower cost share when receiving a service at a non-hospital setting for certain services. This design incentivizes members to select lower-cost sites of care based on cost sharing differentials. These options are considered based on actuarial analysis of claims experience and review that member steerage takes into account lower cost settings.

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.

We do not make accommodations for bad debt in our provider agreements as our premiums are not priced to include bad debt collection. Similar to the response above, efforts to make accommodations for bad debt collection through contracting and/or efforts to reduce out of pocket member cost sharing through regulatory activity will only make premiums increase for employer groups. Out of pocket costs are balanced with and accounted for in premium development.

HPC Payer Exhibit 1

All cells should be completed by carrier

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines, Tufts Health Public Plans Direct only

Year	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2020	4.2%	-3.2%		-0.6%	0.3%
CY 2021	3.6%	14.6%		2.0%	21.1%
CY 2022	2.2%	-4.5%		4.8%	2.3%
CY 2023	0.5%	-5.8%		8.5%	2.7%

Note: Provider and Service mix trends are all included in the Service mix column

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.