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

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## 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?

Located in Woburn, Massachusetts, Wellpoint, formerly known as UniCare, is a wholly owned subsidiary of Elevance Health and administers health care coverage for Massachusetts state employees, retirees and municipal employees insured by the Group Insurance Commission (GIC). In Massachusetts, Wellpoint functions solely for the purposes of supporting the GIC, its only client. Wellpoint serves over 200,000 members who work in Massachusetts.

The Steward Health Care bankruptcy negatively impacted some consumers' access to care in eastern Massachusetts, but ***it is not the most significant factor*** negatively impacting consumers in the Commonwealth. The most significant factors negatively impacting consumers access to care are the rising prices for outpatient hospital services, professional services, and prescription drugs, as well as the underinvestment in primary care and lower cost services that promote health.

The Massachusetts Center for Health Information and Analysis (CHIA) Hospital System Performance Dashboard indicates that Steward Health Care served many Massachusetts residents but did not make up the majority of hospital health system utilization. The CHIA Hospital System Performance Dashboard indicates that Steward Health Care represented the following in 2022 hospital health system utilization:

- 8.2% of hospital inpatient discharges
- 10.4% of hospital emergency room visits
- 6.7% of inpatient net patient service revenue (NPSR)
- 4.2% of outpatient NPSR[1]

Certainly, the Steward Health Care bankruptcy was disruptive to consumers, especially in the communities where its hospitals were located. However, as stated above, the ***most significant disruption*** to consumers are the increasing prices for outpatient hospital care, professional services, and prescription drugs and the underinvestment in primary care and lower cost services that promote health.

[1] CHIA Hospital and Hospital Health System Performance Dashboard. Available at: https://www.chiamass.gov/hospital-and-hospital-system-performance-dashboard/

Wellpoint's cost benchmarking filings show that the GIC's Total Medical Expenditure (TME) trend for hospital outpatient was 9.8% and professional services was 6.3%. These trends are not sustainable for state employees and for state retirees who live on fixed incomes.

CHIA's "Performance of the Massachusetts Health Care System" annual report indicates that:

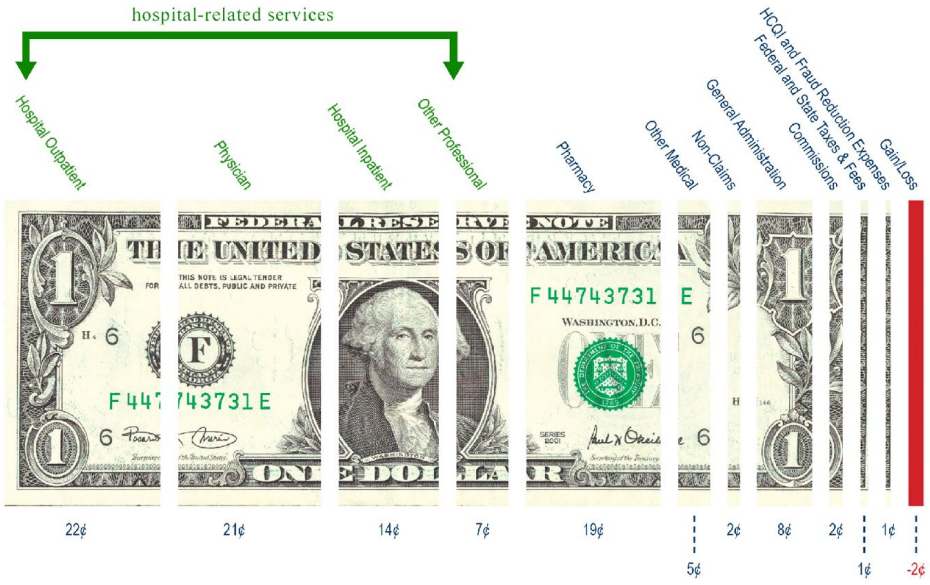
- As in prior years, hospital services accounted for the largest share of overall Total Health Care Expenditures (THCE) spending in 2022, with inpatient and outpatient expenses together totaling $25.3 billion. From 2021 to 2022, hospital outpatient spending increased by 5%, totaling $13.1 billion.
- Consistent with prior years, prescription drug spending was the largest component of medical expenditure growth, accounting for 21.6% of the increased spending. Pharmacy spending has continued to increase consistently, with gross pharmacy spending experiencing the fastest growth among all service categories, increasing 8.8% from 2021 to 2022, totaling $13.6 billion.[2]

As shown in Figure 1 below, the vast majority of spending of Massachusetts's residents' premium dollar (83 cents of every dollar) goes towards hospital, physician and pharmacy services.

- 36 cents of every premium dollar goes towards hospital inpatient and outpatient services;
- 28 cents of every premium dollar goes towards physician and other professional services; and
- 19 cents of every premium dollar goes towards pharmacy costs.

[2] Center for Health Information and Analysis (CHIA), "Performance of the Massachusetts Health Care System." March 2024. Available at: https://www.chiamass.gov/assets/2024-annual-report/2024-Annual-Report.pdf.

Figure 1: 2022 Premium Dollar Distribution - Massachusetts[3]




Wellpoint shares the same concerns around the key findings in the Massachusetts Health Policy Commission's 2024 Health Care Cost Trends Report.

- **"Excessive spending from high prices.** Commercial health care prices have continued to grow substantially in recent years, with variation by setting of care. Between 2018 and 2022, inpatient prices increased by 17.1%, hospital outpatient department (HOPD) prices increased by 15.4%, and physician office prices increased by 12.6%."
- **"Price trends.** Escalating price trends are evident from 2018 to 2022, with commercial prices increasing for various services including: office services, hospital outpatient care, and inpatient services. Payments for ED hospital care grew by 29% in this time period, while inpatient payments per stay for non-maternity stays increased 34%."
- **"Hospital utilization**. Massachusetts continues to have higher rates of hospital utilization than the U.S. overall, including inpatient stays (10.5% higher), outpatient visits (41.8% higher), and ED visits (12.4% higher), and higher rates of potentially preventable hospital utilization including the second highest rate among states of preventable hospital admissions among Medicare beneficiaries in 2022 and the third highest readmission rate."

[3] Massachusetts Association of Health Plans, "2022 Premium Dollar Distribution – Massachusetts." Available at: https://mahp.com/wp-content/uploads/2024/04/Premium-Dollar-Infographic-2022-Premium-Dollar.pdf

- **"Hospital consolidation.** Hospital consolidation continued to increase in Massachusetts with the top 5 health systems in Massachusetts accounting for 62% of hospital visits in 2022, an all-time high."[4]

Wellpoint continues to undertake efforts to control rising health care costs to mitigate the effects of provider price increases and market consolidation. Below, we go into more detail regarding Wellpoint's efforts to control rising healthcare costs and detail specific and actionable proposals that Massachusetts policy makers can consider to mitigate rising costs of healthcare.

Wellpoint firmly believes that reimbursing providers to enable consumers' whole health is key to driving healthcare value, affordability, and better health outcomes. Piece by piece, the healthcare system must be financially incentivized and aligned to advance a more holistic view of health and leverage financial incentives that reward health as opposed to sick care.

Wellpoint agrees with the goal of supporting the primary care office as the nexus for health, in support of well-coordinated, evidence-based care, and ultimately, holding care providers and ourselves accountable for ensuring consumers receive the right quality care, at the right time, in the right place, with the right experience. However, broader delivery system reforms are needed to achieve this goal and reform how primary care is delivered and utilized today:

- Shortages of primary care providers (PCPs) are a limiting factor as we collectively support primary care offices as the nexus for health; and,
- Primary care offices need to be available to consumers when care is needed. When the primary care office is unavailable over the weekend or for two weeks, consumers cannot wait to be seen to address their illness or symptom. Consumers will utilize other avenues for care including specialists, retail clinics, emergency rooms, and urgent care centers.

We recommend that policymakers enact reforms and incentives that will (1) increase the number of PCPs, and (2) expand Massachusetts' scope of practice laws for mid- level practitioners. As we move together in pursuit of this common goal, we must be mindful of the existing constraints regarding the supply of PCPs, how primary care is practiced today, and the sites of service consumers use for their primary care today.

We are also concerned that some mental health professionals refuse to join an insurer's network and only serve patients who will pay out-of-pocket. Wellpoint makes every effort to contract with high quality mental health professionals. However, some mental health professionals refuse to contract with Wellpoint and there are several reasons for this:

[4] Massachusetts Health Policy Commission (HPC), "2024 Health Care Cost Trends Report." October 2024. Available at: https://masshpc.gov/news/press-release/hpc-focuses-new-slate-recommendations-market-oversight-and-stability-post

- Some mental health professionals are in small or solo practices with limited office support and, as a result, are less willing to take on the administrative requirements of joining networks or increasing patient loads.
- Some mental health professionals refuse to contract in-network at a reasonable rate and prefer self-pay patients.
- Some mental health professionals, especially those highly sought after, see no reason to contract with insurers given an abundance of patients who will pay out-of-pocket.
- Some patients decide to go out-of-network because of idiosyncratic personal preferences.
- Some out-of-network low quality or fraudulent mental health professionals pursue aggressive (and often illegal) marketing and patient recruitment tactics.

Wellpoint has asked policymakers to look at provider bilateral accountability including quality and continued focus on self-pay. We also recommend reporting requirements for providers related to adherence to evidence-based practices and to ensure provider accountability.

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.

As the composition of the provider market in Massachusetts continues to evolve with increasing mergers, acquisitions, affiliations, and consolidations, the largest providers and hospital systems continue to have the highest health care prices with no direct correlation to increased value or equity in care. In concentrated health system markets, prices do not flow from competitive negotiations. Instead, they are the result of the outsized leverage and inability to negotiate.

The trend of large hospitals and health systems acquiring physician practices often results in gaming reimbursement to maximize revenue. In 2021, nationally, nearly 70%[5] of physician practices were owned by hospitals, health systems, private-equity firms, and other corporate entities—a 12% increase in just two years. When big hospitals and health

[5] Avalere, "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020," Prepared for Physicians Advocacy Institute, June 2021, http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20 Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d.

systems acquire these practices, the prices they charge grow by an average of 14%.[6] This is often a result of how hospitals bill for their services; specifically, they bill hospital outpatient rates for the same services that were previously billed at the rate for a physician office—rates that are two to three times higher.[7]

These growing monopolies have the predictable effect of refusing to participate in networks in order to demand higher prices from health insurance providers, which results in higher premiums for everyone. This problem is especially present in Massachusetts, where over 90% of hospital medical expense is led by non-profit hospitals.

As of September of this year, the HPC has reviewed nearly 200 market changes through the Notice of Material Change (MCN) process which governs providers and provider organizations seeking to merge, affiliate, acquire, or establish a partnership or joint venture with carriers, other providers, hospitals, or health systems.

As noted in the 2023 HPC's Special Policy Report on Consolidation and Closures in the Massachusetts Pediatric Health Care, the Massachusetts pediatric market has been particularly affected by consolidation, with increases in provider prices and spending variation.

- As the total volume of inpatient pediatric care for patients has decreased by 37% from 2010 to 2019, over 200 licensed pediatric beds were closed in 2017, most of which were smaller providers outside of urban areas and had a higher share of pediatric patients covered by MassHealth, while academic medical centers (AMC) with specialized pediatric programs have expanded.
- In turn, pediatric inpatient services are now concentrated primarily within the three largest provider organizations, accounting for 73% of total pediatric discharges statewide. The largest providers of hospital-based pediatric care in the Commonwealth have the highest inpatient commercial prices, even after adjusting for differences in patient acuity.
- Some of these facilities have an average commercial price per case mix adjusted pediatric discharge in 2018 that was 47% higher than the statewide average. Prices for common evaluation and management services varied widely with some brand name facilities commercial prices being more than 3 times those of other instate facilities, with no relation to increased value of care.[8]

[6] Capps, Dranove and Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," Journal of Health Economics, vol. 59, May 2018, https://pubmed.ncbi.nlm.nih.gov/29727744/.
[7] Higgins et al., "National Estimates of Price Variation by Site of Care," American Journal of Managed Care, 22(3), 2016, http://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_03_2016_Higgins%20(final).pdf.
[8] Massachusetts Health Policy Commission, "Consolidation and Closures in the Massachusetts Pediatric Health Care Market: Special Policy Report on Implications for Cost, Quality, Access and Equity." September 2023. Available at: https://masshpc.gov/sites/default/files/Pediatric-Policy-Report.pdf.

Health plans' provider networks are an effective tool to meet the needs of their members and provide affordable access to high-performing providers. Health plans build networks that are of value to consumers and employers. If, in a region, there are two hospitals that are viewed as good alternatives – i.e. consumers want to be able to access them – the health plan can negotiate with both and substitute one for the other, limiting the bargaining leverage of each hospital. If the hospitals merge, the health plan loses the negotiating leverage because the health plan will lose value to consumers and employers without the merged organization in their network. The merger, therefore, creates substantial bargaining leverage for the providers and has the ability to charge the health plan much higher rates to participate in the network.

The existing state cost benchmarking program and reporting are not identifying the big hospitals and health systems that are driving the increased cost of care in the Commonwealth. This is a complex problem that will require changes in the approach to how health care entities are evaluated against the cost benchmark. After 10 plus years with this program, Wellpoint recommends that we take a step back and revisit what is being measured today, whether the actors driving cost increases are at the center of the discussion, and make improvements going forward.

As policymakers consider ways to temper cost growth, it is important to have a comprehensive understanding of the oversight and reporting requirements in place for each sector today, paired with a full picture of the financial performance of each sector. These sectors include hospitals and health systems, pharmaceutical companies, and health plans. This understanding is vital for developing strategies to tackle the underlying drivers of health care costs. Further, the Steward Health Care crisis underscores the imperative to understand the urgent need for robust financial reporting and provider accountability to ensure a stable health care system.

Health plans are subject to a series of stringent state and federal requirements regarding their financial performance, including a cap on contributions to surplus, federal and state medical loss ratio (MLR) requirements, and robust rate review through the Division of Insurance (DOI). In other words, state and federal requirements regulate how much of the premium dollar should go to medical care, how much is allowable for administrative spending, and how much surplus (or profit) a health plan can make in a given year.

- **Oversight on profits:** State and federal laws governing health plans' MLR require fully insured health plans to spend a certain percentage of premiums on medical care and limit the portion of premium dollars that can be spent on administration, marketing, and profit. The Affordable Care Act requires health plans in the individual and small group markets to spend at least 80% of premiums on claims and quality improvement; the MLR threshold for large group plans is 85% of premiums.

  Massachusetts imposes even more stringent rules, requiring health plans in the individual and small group markets to spend 88 cents of every premium dollar on health care services. If a health plan does not meet these thresholds, it is required

to issue premium rebates to members. Massachusetts state law also requires that if a health plan's contribution to surplus exceeds 1.9% of premiums or if the aggregate MLR for plans is less than 88%, premium rates filed by the health plan may be disapproved as excessive by the DOI.

- **Oversight on financial solvency:** State regulations outline the measures in place to ensure the financial stability, compliance, and accountability of health plans in Massachusetts. The DOI can take regulatory actions against a health plan under certain conditions. If the Commissioner finds that the health plan is in an unsound financial condition, engaging in fraudulent practices, inadequately reserving for unearned premiums, or failing to comply with legal requirements, among other issues, the Commissioner may pursue various actions including administrative supervision, rehabilitation, liquidation of the health plan, or revocation or suspension of its license.

  In addition, health plans are subject to extensive reporting requirements to the DOI that cover various aspects of financial disclosure and examination. Plans are required to promptly report any significant losses or claims that may impact on their financial stability. They must submit quarterly financial filings and file unaudited annual reports verified by top executives by March 1 of each year. Additionally, plans undergo annual audits by independent certified public accountants and must submit audited financial reports to the Commissioner by June 1.

  Separate and distinct from both MLR and surplus requirements, state and federal regulators utilize an additional tool known as the risk-based capital (RBC) formula to assist them in the financial analysis of health plans. While surplus represents the difference between assets and liabilities, the RBC formula is used to establish a minimum amount of capital appropriate for a health plan to support its overall business operations in consideration of its size and risk profile.

In contrast to the strict oversight requirements imposed on health plans, hospitals, health systems, and pharmaceutical companies operate within a regulatory framework that lacks comparable controls over solvency, profit margins, and surplus.[9]

Lastly, Wellpoint recommends Determination of Need (DoN) reforms to ensure that hospitals demonstrate a need prior to increasing capacity. Unnecessary expansion results in hospitals needing to cover larger fixed costs and that supply can create its own demand in an environment where charges are paid by third parties. However, DoN reforms must also

[9] Massachusetts Association of Health Plans, "Ensuring Stability in Health Care Access and Costs: The Need for Robust Reporting and Oversight Across the Entire Health Care System." April 2024. Available at: https://mahp.com/wp-content/uploads/2024/04/onpoint-april-2024-final.pdf

ensure that new, lower cost and innovative providers can enter the market to competitively lower prices, enhance access to primary and urgent care and lower costs.

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?

As previously stated, Wellpoint firmly believes that focusing on consumers' whole health is key to driving healthcare value, affordability, and outcomes. Piece by piece, the healthcare system is starting to prioritize a more holistic view of health. Wellpoint is committed to accelerating value-based care – particularly through shared-risk arrangements. The data shows that shared-risk arrangements lead to better and more equitable health outcomes, increased patient and care provider satisfaction, better access, and more affordable care.

Wellpoint's top strategies for reducing health care cost growth include:

- Contracting for value via reimbursement models and aligned clinical and financial incentives that mitigate the annual rate of growth in unit costs year over year and enable providers to focus on preventive care, behavioral health, and social needs.

  Wellpoint's Enhanced Personal Health Care (EPHC) program is our flagship value-based reimbursement tool. EPHC incents providers to improve quality outcomes as well as lower the annual rate of growth in costs in Massachusetts. By rewarding providers to proactively engage members with prevention and wellness services, personalized plans, and coordinated services across the spectrum of care, Wellpoint has been able to maintain overall cost trends and premiums below our competitors in the market.

  With EPHC, a performance-based Per-Member-Per-Month (PMPM) clinical coordination payments compensates PCPs for important clinical interventions that occur outside of a face-to-face visit. These services include care planning, enhancing access (such as responding to emails or offering web-based visits) or following up with patients via phone or email to make sure that they fill new prescriptions. This type of proactive clinical coordination improves health and reduces costs. The second part of the payment model is shared savings payments that reward providers when they meet quality measures in a manner that lowers

costs for their attributed patients. In this way, the provider is incentivized to deliver the highest quality care in the most proactive, and affordable manner.

- **Advancing robust access to primary care and behavioral health** is paramount to Wellpoint's affordability strategy. It is well documented that better health and prevention improve care outcomes and lower costs. Over the past three years, Wellpoint has proactively met with over three dozen primary care, urgent care, community health centers, and digital primary care providers. Our main objectives are to strengthen member access to primary care and direct-to-member solutions, while prioritizing prevention, wellness, and access to primary care as levers that will lower the annual rate of growth in costs.

  Wellpoint also launched Primary Care Centers of Excellence with several independent primary care provider organizations in Massachusetts. One of them is a community health center. Health centers offer robust and quality access to primary care at a lower cost. Data shows that commercially insured members seldom use community health centers. We are confident that value-based arrangements with health centers will both boost access to lower cost primary care, enhance choice and support health centers to grow their infrastructure.

  Wellpoint's Case Management team will reach out to members with interventions and communications, as well as digital engagement and virtual support options. Members who opt in (adopt) will work with Wellpoint's care team who will provide coaching and connectivity to Sydney, LiveHealth Online, TytoCare, AIM Specialty Health, Inc. (AIM), as well as member engagement collaborations with Enhanced Personal Health Care (EPHC) providers, incented to proactively care for members.

- **Collaborating for success** with tools and resources that make it easier for members and providers to access the data necessary to help patients make the right care decisions at the right time. This includes:
  - ***Sharing Data:*** Effective and efficient access to data is critical for payers, care providers, and most importantly, patients. It is why we are simplifying the authorization process for care providers and our consumers through increased Electronic Health Record (EHR) access and implementation of the prior authorization API in Massachusetts and across the country. Facilities that partner with Wellpoint to allow their teams to access data benefit from a more timely and efficient inpatient authorization process. This reduces administrative burden for care providers to help ensure our consumers receive timely, holistic care.

- *Aligning Care Management:* Instead of relying upon the traditional case-manager-to-consumer relationship model, we focus on a case-manager-to-care-provider partnership model. By aligning our case managers with individual care providers, we see more seamless, improved experiences for providers and patients. As our case managers collaborate with care providers directly on our consumers' care, clinical teams are experiencing a broader and deeper reach when it comes to care coordination. This more direct team-based approach has helped reduce emergency room use, supported expedited admissions to home health, met needs related to social drivers of health, and helped with recovery from addiction.

- Utilization management: Laws and regulations should not impede issuers' ability to conduct reasonable utilization management. Health plans use prior authorization in limited circumstances to protect patients and prevent misuse, overuse, and unnecessary or potentially harmful care; and to ensure that care is consistent with evidence-based practices. These care coordination and utilization management practices lower patient's out of pocket costs on an individual basis while collectively protecting the entire healthcare system from harmful, unnecessary or low value care. Without these important tools, health plans will be left with few, if any, strategies to effectively drive quality and safety, ensure proper utilization, and rein in unnecessary spending. With ever increasing restrictions on health plans, payers have fewer tools in which to enhance quality, access and affordability.

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.

- Address anti-competitive contracting practices: Wellpoint recommends prohibiting the following anti-competitive provisions in contracts between carriers and providers: all-or-nothing clauses, anti-tiering clauses, and anti-steering clauses in provider contracts. These reforms will enhance competition among providers and create an opportunity for health plans to engage in access and network innovation.

  Large health systems are able to leverage their significant market shares by requiring contracts with all affiliated facilities and preventing steering patients to lower-cost, higher-quality care. These anti-competitive contract terms, in the form of "anti-steering," "anti-tiering," "all-or-nothing" and similar contract provisions, protect providers' highly inflated costs – costs that patients and consumers pay through higher premiums and out-of-pocket costs.

Hospital systems can and do use this leverage in their negotiations with health plans in several ways, including:

- Demanding exorbitant rate increases;
- Requiring favorable positions in a carrier's network, such as placement in a higher tier to the exclusion of competitors, regardless of cost or quality;
- Insisting on the same preferential treatment for all owned hospitals; and
- Threatening to terminate all providers in the system when a contract for only one hospital is the subject of negotiations.

- **Require appropriate billing for professional healthcare services:** Wellpoint encourages the passage of legislation that would require hospitals to bill in a manner that accurately reflects not only the service rendered but also the location where the services were rendered to clearly prohibit the practice of systems submitting for services rendered at one of location but billing for those services under one of their higher cost locations. This would enable insurers to apply the correct professional reimbursement rate and the member pays the appropriate cost share.

- **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.

- **Enact the following prescription drug reforms.** While Wellpoint does not manage the prescription drug plan benefit for the GIC, rising drug costs are a significant healthcare cost driver and the following reforms would benefit Massachusetts residents by lowering the cost of care:

    - ***Protect the use of specialty pharmacies to access lower drug costs.*** Provider-acquired drugs often come with high mark-ups, creating distorted incentives to select high-cost drugs. Research shows that for drugs administered in hospitals, costs per single treatment can average $7,000 or more than those purchased through a specialty pharmacy, while drugs administered in physician offices can average $1,400 higher. Hospitals, on average, charge double the prices for the same drugs than specialty pharmacies; Lawmakers

should support the use of specialty pharmacies and reject policies that take away lower-cost choices from patients.[10]

- ***Address drug manufacturers' abuse of charitable structures and copay coupons:*** Charities created by or affiliated with drug manufacturers should help someone other than the drug manufacturers. Drug manufacturers can provide legitimate and meaningful assistance to patients by donating to truly independent charities that assist patients in need. However, copay coupons are designed to mask the high prices set by manufacturers, encouraging patients to use more expensive brands instead of equally effective, less expensive generics and brand alternatives, and limit an important market constraint on drug prices. Self-serving structures masquerading as charities are neither legitimate nor beneficial. For example, a Health Policy Commission study estimated excess spending attributable to coupons for the 14 drugs studied totaled $44.8 million per year in Massachusetts[11]; Further, to protect patients from drugmakers' marketing schemes, the Massachusetts lawmakers should preserve the ability of plans to utilize copay accumulator and maximizer programs.
- ***Increase drug cost transparency*** by requiring price disclosure from drug manufacturers at time of launch and at time of list price increases and requiring disclosure of patient assistance programs.

  Massachusetts policymakers should also mandate pharmacy reporting to the National Average Drug Acquisition Cost (NADAC). Pharmacies currently manipulate the market to skew the NADAC upwards by not reporting drugs with lower acquisition costs. One study found that mandating NADAC reporting from all pharmacies could exceed $10 billion in savings to state Medicaid programs over ten years. These savings come from the lower per unit costs paid when all retail pharmacies participate in the survey; and,
- ***Roll back any willing (or any willing specialty) pharmacy laws.*** As discussed above, payers use several tools to ensure quality care and contain costs. Any willing pharmacy requirements in Massachusetts limit Wellpoint's ability to do both.

[10] AHIP, "New Study: Hospitals Charge Double for Drugs - Specialty Pharmacies More Affordable." February 16, 2022. Available at: https://www.ahip.org/news/press-releases/new-study-hospitals-charge-double-for-drugs-specialty-pharmacies-more-affordable

[11] Massachusetts Health Policy Commission, "Prescription Drug Coupon Study." July 2020. Available at: https://www.mass.gov/doc/prescription-drug-coupon-study/download

## 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.

   We do not believe the actual observed allowed claims trend has been impacted by changing demographics. Wellpoint's GIC population has been steady over the years 2019 to 2023. The benefit buy-down effect is also minimal, as the benefit structure of our plans has been fairly constant. The change in health status risk has been more of an annual rollercoaster from 2019 to 2022, as the COVID pandemic substantially affected utilization patterns, which in turn informs the risk level per the claims experience. Recent risk score changes have stabilized. Risk score changes: 2020 -5.2%; 2021 +9.3%; 2022 +0.1%; 2023 -1.0%.

| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| (a) Change in Demographics | Included in ( c ) | | | |
| (b) Benefit Buy-down Effect: | 1.6% | 0.1% | -0.3% | 0.5% |
| (c) Change in Health Status / Risk Score | -5.2% | 9.3% | 0.1% | -1.0% |

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?

   Hospital and provider prices remain one of the most concerning challenges facing collective efforts to advance cost containment in Massachusetts.

## 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<br>Calendar Years (CY) 2022-2024 | | | |
|---|---|---|---|
| Year | | Aggregate Number of Written Inquiries | Aggregate Number of Inquiries via Telephone or In-Person |
| **CY2022** | **Q1** | 3,157 | |
| | **Q2** | 4,128 | |
| | **Q3** | 3,033 | |
| | **Q4** | 2,631 | |
| **CY2023** | **Q1** | 3,705 | |
| | **Q2** | 5,472 | |
| | **Q3** | Pending Completion | |
| | **Q4** | Pending Completion | |
| **CY2024** | **Q1** | Pending Completion | |
| | **Q2** | Pending Completion | |
| | **TOTAL:** | Pending Completion | |

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?

Not applicable. The Group Insurance Commission (GIC) determines the benefit plan design and options.

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.

Not applicable. Wellpoint does not have these types of arrangements.

# 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 | 3.9% | -10.0% | -0.4% | -0.3% | -7.3% |
| CY 2021 | -1.1% | 18.0% | -1.8% | -1.5% | 13.0% |
| CY 2022 | 0.6% | -5.2% | 0.5% | 10.1% | 5.6% |
| CY 2023 | 2.4% | -1.8% | 0.1% | 7.3% | 8.0% |

**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.