Minutes of the
Merged Market Advisory Council (Council or MMAC) Meeting of December 2, 2020 Approved by Council at the Meeting Held on February 26, 2021.
Motion of Council Member Rina Vertes and Seconded by Council Member Michael Caljouw
The Motion Passed by a Unanimous Vote of the Council Members Present.
Held via video conference

Members participating by video conference or by phone:
Gary D. Anderson, Chairman, Commissioner Division of Insurance
Louis Gutierrez, Exec Director, Massachusetts Health Connector
Lauren Peters, designee of Marylou Sudders, Secretary of Health and Human Services
Michael Caljouw, Blue Cross & Blue Shield, Health Insurance Carrier representative
Lora Pellegrini, Massachusetts Association of Health Plans, Health Insurance Carrier representative
Mark Gaunya, Health Insurance Broker representative
Rosemarie Lopes, Insurance Broker representative
Rina Vertes, Health Insurance Industry Actuary
Amy Rosenthal, Small Group/Individual Health Insurance Purchaser representative
Patricia Begrowicz, Small Group/Individual Employer representative
Jon Hurst, Health Insurance Business Community representative
Joshua Archambault, Health Insurance Business Community representative
Wendy Hudson, Small Group/Individual Employer representative

Attending to the Council:
Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau, Division of Insurance
Michael D. Powers, Counsel to the Commissioner Division of Insurance
Jackie Horigan, Director Consumer Services Section Division of Insurance

Call to Order
Chairman Gary D. Anderson called the meeting to order at 2:01 PM.
Ms. Horigan called a roll of the Council Members and reported a quorum was present.

Minutes
Chairman Anderson noted that the draft meeting minutes from the November 17, 2020 meeting were still being finalized as the Division wanted to ensure everyone's comments were captured, and would be distributed to the Council for review upon competition. No vote on minutes occurred.

Commissioner Anderson noted that he intends to hold another meeting in January to enable the Division to consider the observations, suggestions, and recommendations offered by the Council and to prepare a final report to be discussed at that time.

Discussion by Council Members of Healthcare Cost Drivers

Mr. Beagan noted that the Council had discussed products offered in the market, the composition of the market, different product designs, different levels of subsidizations in the market and the issue of reinsurance and federal waivers, but he understood from the last meeting that MMAC members felt it was important to have a discussion about the factors driving health care costs and premiums. He showed a few slides to help the Council understand healthcare cost trends.

Mr. Beagan explained that the statutory Medical Loss Ratio for the merged market is 88%. He presented information from an HPC report that illustrated a breakdown of how different costs went up in the market from 2015 -2017. He noted that there are different reasons that costs are going up, including the introduction of new technology and new services, as well as increased utilization of services in high cost facilities. Mr. Beagan thought it would be useful to point these cost pressures out at outset of the meeting so that Council members would have an opportunity to come up with ideas about changing cost pressures.

Ms. Vertes thanked Mr. Beagan for enabling the Council to have this discussion. She agreed that focusing on the fact that 90% of premium is tied to medical cost is vital. She also noted that holding all stakeholders accountable is necessary, including consumers who choose to obtain care from high cost providers when they do not need to. Ms. Vertes suggested that careful thought should be given to reference based pricing models where consumers who choose to go to high-cost providers pay the difference between the provider's cost and the reference price. It is necessary to have products that allow consumers to understand the costs of care. Deductibles have not been effective, because when the deductible is met, the consumer does not have any incentive to understand the cost of choosing high-cost providers.

Mr. Gaunya brought up medical trend having three components: unit cost, utilization, and provider mix. Mr. Gaunya noted that 50% of the increasing costs can be tied to increases in the actual price of care people are receiving (trend), 35% can be tied to increases in overall utilization and 15% can be tied to patients going to higher cost facilities. Mr. Gaunya stressed that members have a right to know the price they are charged for the service that they get. Mr. Gaunya that there should be more time and energy used to increase awareness of the transparency law so that consumers know that they have a right to price and quality information. Last, he further recommended that there needs to be increased investment in primary care, telehealth and behavioral health services.

Mr. Caljouw noted that efforts to increase provider price transparency that are unrelated to product design and costs have failed and are likely to continue to fail. Mr. Caljouw noted that consumers need to know and also care about the price of health care services they choose (non-emergency services). He pointed out that there was a mandate in Chapter 224 that providers must provide price information to consumers but very few obtain or use this information. He thought the group should look at product design changes and creating product differentials based upon provider price, an idea that the Provider Price Commission studied and endorsed a few years ago. Finally he noted the Council should examine existing regulatory levers, including at the HPC, and how they should change so that agencies would be able to collect, analyze and report on hospital-based total medical expense (TME) information. Such information is released on health plans and medical groups,

but not on hospitals or hospital systems. He said that BCBSMA is concerned that hospitals have already started to seek to increase reimbursement (sometimes by double digits) for the near future and that will have direct impacts on consumer premiums. He noted that 90% of premiums is comprised of medical expenses and therefore any approach should focus on the 90%.

Mr. Hurst agreed with the previous comments. While transparency is important, it is not the only answer. The design of health plans should encourage individuals to use the transparency information. If someone with a high deductible health plan needs surgery and can choose to go to a high-cost or low-cost hospital, they are not impacted by the relative cost of the two hospitals if the cost is above the plan deductible. Once the deductible is satisfied, the cost does not matter to the consumer. Mr. Hurst thought that maybe reimbursements should be tied to a certain percentage of Medicare for certain parts of a risk pool.

Mr. Archambault agreed transparency is not a silver bullet but thought more should be done so that patients would learn more about pricing, including automatic disclosures from providers about estimated costs. He suggested that carriers do more to educate their patients, including encouraging they to shop around and save money. He agreed with the concept of referenced based pricing and noted that it occurs more often in the public sector than in the private sector. He hoped the report highlights the barriers to lower cost options (scope of practice reform, determination of need). Certificate of need does not lower prices. Telehealth should be allowed across state lines as it increases access and hopes the Legislature does not mandate payment parity with telehealth.

Undersecretary Peters didn't disagree with any of the stated comments but thought that this group was created to discuss issues unique to merged market, and urged that the final report highlight recommendations to address the dynamics in the merged market. One such dynamic as an example is around ConnectorCare that the premiums are lower and it's not because they're getting that cross subsidization from the small group but rather they are in narrower, limited tiered networks with providers that have lower costs. Ms. Peters thought the group should consider product designs that help consumers make wiser choices.

Ms. Pellegrini said it is hard to disentangle the cost of care from premium. Transparency is a piece of the puzzle and we need to encourage people to shop for providers but systems are also built to keep people within that system of care. She noted it will be hard to address a lot of what the Council is discussing during COVID and the stressors placed on our frontline providers. If we could reign in surprise billing that would help consumers save money. There are policy initiatives the Council can focus on in the report.

Ms. Vertes suggested the group think about the most popular ConnectorCare plans where the cost and premium are substantially cheaper than costs and premiums for other statewide network plans. She thought that the Council should recommend further education to promote that these are not inferior products and provide access to good health care. She also supports greater investment in primary care and less reliance on specialty care.

Ms. Rosenthal noted that the driving costs of healthcare have not been the topic of conversation for the majority of meetings. She supports looking at the Division's rate review process to get at

the affordability of insured health products. While she supports transparency, she cautioned that consumers don't necessarily understand how to shop around and she thought that Mr. Gaunya was correct about the need to have better tools to explain the relative costs of care.

Ms. Hudson brought up the pending Harvard/Tufts merger and asked about its potential impact to the market/consumers. Ms. Rosenthal indicated that she hoped that the merger would not cause any disruption and would be beneficial to consumers. Mr. Gaunya noted that he heard that the merger would produce a $100 million in administrative savings. Mr. Beagan asked Commissioner Anderson if he wanted to comment on the transaction and Commissioner Anderson noted that it would not be prudent to comment on the proposed transaction as it was still pending but noted that the hearing on the transaction is scheduled for December 3.

Commissioner Anderson said good points have been made and explained that building a base to understand what is going on in the market was essential and Ms. Gorman's presentations helped to look at this from an actuarial analysis.

Mr. Beagan noted that certain products offered through ConnectorCare do cost considerably less than other available products and that there could be more attention made to educate individuals and small groups that these are not inferior products is key. He recalled a "peace of mind" product offered by Fallon which offered a Worcester-centric network but offered access to Boston teaching hospitals when medically necessary. Individuals and small employers might be amenable to these products if they knew they could go to certain hospitals when needed.

Mr. Gaunya reinforced the notion of healthcare literacy and that people need to understand how their healthcare works and to debunk myths that what costs more is better care. Transparency might not be a magic elixir, but it is still important.

Ms. Lopes echoed Mr. Gaunya's thoughts about health literacy. She thought there needed to be much more work done by government and producers to convince people that providers who cost less do not provide inferior care. She and Mr. Gaunya said that government and producers need to help employers maximize their benefits, but it is difficult to convince them about this item.

Undersecretary Peters said we need to pair education with some sort of product redesign so that those wishing to see a high-cost provider will pay more to do so. Mr. Caljouw said there need to be incentives for consumers to shop wisely and referenced a GIC campaign that suspended premiums for 3 months if a consumer purchased a lower-cost tiered network product. Ms. Pellegrini cautioned about this idea because too many people signed up for these plans and reversed course because they did not understand what they were buying.

Mr. Hurst said in the early years of RAM's cooperative, the most popular plan was the Fallon Steward Network plan and it was so popular because the cooperative was involved in designing the product and it wasn't forced on employers. It is better to have a system where individuals and small employers can choose a plan that works for them. Ms. Rosenthal said that designing products with "skin in the game" only works for people who can afford the "skin" and cautioned the group to think about economic disparities. She noted that the MMAC should also remember to consider health equity as it thinks about recommendations, so they are win-win solutions.

Mr. Gutierrez said a tiered product is the best of both worlds. The overall theme of tying product design, "skin in the game" and consumer education –we have the mechanisms for all of this. Ms. Vertes said tiered network products with a 10% price differential are not enough for consumers to feel they are getting any value for giving something up and there need to be more aggressive designs. Ms. Pellegrini pointed out that there needs to be changes to existing law so that carriers have more latitude in designing products because existing law allows providers to "opt out" or products if they do not like product designs; this has made it extremely difficult to design more affordable options. Undersecretary Peters noted that there was language proposed by the Governor is his pending bill that was intended to address this.

Conclusion

Commissioner Anderson thanked the Council Members for their participation and engagement. He again noted that the Governor's Order gave the Council certain directives, and while the Council is tasked with performing an independent analysis of the merged market, part of that includes looking at drivers of health care costs which is not isolated to the merged market. The Commissioner noted that the Council has been given the opportunity to analyze at the merged market and that the Council should take advantage of that and suggest meaningful options for the Governor to consider. Commissioner Anderson talked about developing pilot products where appropriate and even a legislative initiative to create a pilot program changing how a subset of small groups are rated (i.e., removing a small subset of the merged market and rating the subset ou8tside merged market rules to see if the group receives more favorable rates outside these rules.)

Mr. Beagan noted that the next meeting of the Council will be virtually held on the same Teams platform at some point in January and that a doodle poll would be sent around to confirm member's availability. Chairman Anderson called for a motion to adjourn. Mr. Hurst made the motion, and it was seconded by Mr. Gaunya. The motion passed by a unanimous vote of the Council Members, with Chairman Anderson abstaining.

Whereupon, the Council's business was concluded at 3:31 P.M.

These minutes are exempt from the requirements of M.G.L. c. 30A, § 22(a) based on the definition of a "public body" as defined under c. 30A, § 18.

List of Documents provided at the Council meeting:

1. **Proposed workflow of meeting.**
2. **November 2020 membership numbers**