MASSACHUSETTS
HEALTH POLICY COMMISSION

2023 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 2023 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 27, 2023**, 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 2022, 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.

INTRODUCTION

This year marks a critical inflection point in the Commonwealth's nation-leading journey of health care reform. As documented in the Health Policy Commission's 10th annual Cost Trends Report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care also contributing to the trend.
- Massachusetts employers of all sizes, but particularly small businesses, are responding to ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent, wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

The HPC report also contains nine policy recommendations that reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

This year's Cost Trends Hearing will focus these policy recommendations and on the efforts of all stakeholders to enhance our high-quality health care system in Massachusetts to ensure that it is also affordable, accessible, and equitable.

ASSESSING EFFORTS TO REDUCE HEALTH CARE COST GROWTH, PROMOTE AFFORDABLE, HIGH-QUALITY CARE, AND ADVANCE EQUITY

a. Reflecting on the findings of the HPC's 2023 Cost Trends Report showing concerning trends of high and increasing health care costs and widening health disparities based on race, ethnicity, and income, please identify and briefly describe your organization's top 2-3 strategies for reducing health care cost growth, promoting affordability, and advancing health equity for residents of the Commonwealth.

Since 2010, over 30 state reports have examined health care costs and the key cost drivers in the Commonwealth – all have found that the prices charged by providers remain the most significant factor driving health care costs.[1] High provider prices, rather than utilization, remain the primary driver of health care spending and growth. Persistent increases in prices and provider price variation, often driven by market leverage rather than value, equity, or access to care, have continued to challenge health plans' leverage to negotiate lower prices with contracted providers. Health insurance premiums are a direct reflection of the cost of health care - when pharmaceutical companies, hospitals, and providers raise their prices, employers and consumers bear those costs in their premiums and cost-sharing.

Labor costs remain high as hospitals struggle to hire and to retain staff. Staff are demanding significantly higher pay due to the stress of the work, staffing shortages, and the impact of general economic inflation. As we projected last year, as provider and hospital contracts are coming up for renewal, hospitals and providers are showing less interest in value based contracting, and are instead opting for an increased emphasis on fee-for-service structures and dramatic increases in requested pricing. This is putting significant, long-term, upward pressure on unit costs.

Health plans serve as stewards of the premium dollar on behalf of employers and consumers purchasing insurance coverage. Indeed, the central function of a health insurer is to provide the highest quality health care for the most people with the premium dollars available. As prices continue to rise at an unsustainable rate, the following demand-side levers implemented by health plans remain some of the few promoters of high value health care which constrain a landscape which would otherwise have unfettered health care spending and cost growth without regard for quality:

1. **Utilization Management.** Utilization management practices, including care management and coordination, prior authorization, and fraud waste and abuse efforts, are tools utilized by health plans to protect patients, reduce medical expenses, and prevent fraudulent care. When employers purchase health insurance coverage, they expect health plans to utilize these tools to ensure that their members can access safe, evidence-based, and cost-effective care at the right time and in the right setting.

[1] https://secureservercdn.net/198.71.233.29/9a2.583.myftpupload.com/wp-content/uploads/2019/05/freedman-report-2018-final.pdf

Health plans and government programs use prior authorization in limited circumstances to lower patients out of pocket costs, prevent misuse, overuse, and unnecessary or potentially harmful care, and to ensure that care is consistent with evidence-based practices. Utilization management practices, like prior authorization, are needed in our healthcare system for three reasons:

a. To protect against unnecessary care – doctors themselves estimate that nearly a quarter of care is unnecessary. Over the past 30 years, doctors and researchers have flagged more than 600 procedures, treatments, and services that are unnecessary and unlikely to help patients, including tests like MRIs done early for uncomplicated low back pain, prostate cancer screenings for men over 80 and routine vitamin D tests. [2]
b. To protect against harmful care – inappropriate care can be more than merely wasteful, it can be harmful, such as exposure to unnecessary radiation, missed diagnoses and false positives, and ineffective procedures and treatments. In 2019, physicians across the United States were surveyed on their experiences with "cascades" of health care, or medical services that spur a "cascade" of low-value care. Of the physicians surveyed, 99.5% reported that they have seen cascades as physicians, or had even had them as patients or as patients' family members, directly leading to psychological, financial, and physical harm. [3]
c. To increase health care affordability – needless medical tests waste billions of dollars every year; $200-$800 billion is wasted annually on excessive testing and treatment. In 2018, the HPC found that Massachusetts residents received at least $80 million worth of medical tests and procedures that were not necessary and added little value to their care between 2013 and 2015. This problem impacts more than overall health care spending; it impacts individual consumers' out of pocket costs. Out of the $80 million spent on low-value care, consumers spent $12.2 million out of pocket. [4] This is especially true in the area of prescription medications, as the price of new drugs entering the market continues to skyrocket, and as the burden of chronic disease in the Commonwealth continues to increase. The ability to use step therapies or "generic-first" approaches significantly improves health care affordability.

2. **Engaging Members in their care:** MAHP member plans utilize medical management programs and additional tools to engage their members in their health care.

   MAHP member plans utilize medical management programs, such as health education programs, to actively engage members in their health care. For example, health education programs such as Chronic Condition Management programs are offered by health plans to provide their members with educational resources, online resources, social services, pharmacy services, and other services. Health plans utilize medical management programs to engage members in their care on a population basis which

[2] https://www.npr.org/sections/health-shots/2022/06/13/1104141886/cascade-of-care
[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752991
[4] https://www.mass.gov/doc/presentation-december-13-2018-board-meeting/download
http://medecon.pbworks.com/w/file/fetch/58367928/Best%20Care%20at%20Lower%20Cost.pdf

in turn can reduce health care costs, improve access to and quality of care, and improve patient self-management.

MAHP member plans engage members in their care through the use of tiered networks and cost sharing. Under these tiered network plans, health plans are able to "tier" providers by quality and cost efficiency measures. In doing so, health plans are encouraging its members to choose lower cost or higher quality providers, which result in improved patient outcomes and lower health care costs.

3. Health Equity Initiatives:

Health New England has become accredited for NCQA Health Equity Accreditation in 2023. We are actively working to collect data on race, ethnicity, and language across our membership, as well as sexual orientation and gender identity data. Having this data in a central repository will allow us to further generate actionable data and therefore strategy for health equity.

We continue to emphasize telehealth solutions for our underserved populations, especially those in rural and urban areas who may not have access to in-person care. We have partnered with Teledoc to open behavioral health telehealth services up to adolescents between ages 13 and 17 across all of our lines of business.

To address inequities in telehealth access through evidence-informed policies, the Massachusetts Association of Health Plans engaged the Department of Population Medicine at Harvard Medical School and Harvard Pilgrim Health Care Institute, who alongside the Massachusetts Health Quality Partners, conducted a comprehensive research study to evaluate socioeconomic, racial and ethnic inequities in telehealth usage before and since the onset of the COVID-19 pandemic. Recommendations from the report provided MAHP members plans a firm foundation to bridge the digital divide, through evidence-based recommendations, applicable across the health care sector.

In Massachusetts, the prevalence of severe maternal morbidity has nearly doubled in Massachusetts from 2011 to 2020, and black women consistently experience the highest severe maternal morbidity rates among all race and ethnicity groups, widening an already large racial inequity gap.[5] MAHP member plans have committed to address inequities in maternal health care and improve maternal health outcomes and experience women, including people of color who experience greater complications and worse birthing outcomes. MAHP member plans have committed to increasing access to comprehensive, high-quality, evidence based maternal health care, increasing awareness of maternal health issues, increasing cultural diversity in the maternal health workforce, and advancing analysis of maternal health data.

[5] https://www.mass.gov/doc/an-assessment-of-severe-maternal-morbidity-in-massachusetts-2011-2020/download

b. Please identify and briefly describe the top state health policy changes your organization would recommend to support efforts to advance health care cost containment, affordability, and health equity.

Addressing Hospital and Provider Prices. Policymakers have proposed a number of actions to address rising hospital and provider prices and ease price variation. We are supportive of the following proposals, which complement the work health plans are doing to reduce costs.

1. **Limit margin/mark-up on medical pharmacy-** Medical pharmaceuticals are those drugs which are administered in hospital and office-based settings. These include chemotherapeutics, as well as CAR-T therapies, and biologics. The mark-up on these medications can be staggering. We have documented mark-ups of as much as 500% over the Average Wholesale Price from some of our specialty hospitals. Limiting the allowed mark-up on these already extremely expensive medications is an efficient way to lower overall medical spend.
2. **Expand accountability for Performance Improvement Plans –** Today, the PIP process applies only to health plans and primary care provider groups. The Legislature should expand accountability to include hospitals and health systems in light of continued increases in hospital inpatient and outpatient spending. Expanding the PIP process will strengthen and improve the mechanisms to hold all health care entities responsible for meeting the health care cost growth benchmark and ensure that price increases are not masked by medical upcoding.
3. **Adopt a default out-of-network payment rate** – As recommended in the 2023 Health Care Cost Trends Report, the Legislature should enact the default out-of-network payment rate for surprise billing situations recommended by the Executive Office of Health and Human Services in its Report to the Legislature. The default reimbursement rate for out-of-network emergency and non-emergency services should be set at a health plan's median contracted rate for that service in the geographic region in the relevant market, compliant with the federal *No Surprises Act.* Adoption of the default OON rate must also include an explicit prohibition on balance billing by providers. The establishment of reasonable OON reimbursement rates will increase patient access to health care services by reducing an insured's out-of-pocket costs for services from a provider that is unknowingly not contracted with their health plan and produce cost savings across the state health insurance system by encouraging OON providers to charge more reasonable rates and to participate in health plan networks.
4. **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.

Addressing Prescription Drug Prices. As prescription drug costs account for between 18-22% of the premium dollar, continued price increases directly impact premium affordability for employers and consumers. Given the outsized impact of prescription drug costs on health care

spending and prices, it is critical that drug manufacturers are held accountable. We are supportive of the following proposals to provide greater transparency and accountability. It is critical to remember that prescription drugs are dispensed in multiple places, including in the retail setting, in hospitals, and in outpatient clinics and practices. A comprehensive approach to addressing prescription drug prices must take all of these locations into account, as a significant amount of the spend is in drugs dispensed or used in the clinical setting. :

1. **Limit margin/mark-up on medical pharmacy-** As stated above, medical pharmaceuticals are those drugs which are administered in hospital and office-based settings. These include chemotherapeutics, as well as CAR-T therapies, and biologics. The mark-up on these medications can be staggering. We have documented mark-ups of as much as 500% over the Average Wholesale Price from some of our specialty hospitals. Limiting the allowed mark-up on these already extremely expensive medications is an efficient way to lower overall medical spend.
2. **Add pharmaceutical manufacturers to HPC's oversight.** The legislature should require pharmaceutical manufacturers be held accountable to the state's Cost Growth benchmark, be called as witnesses at the annual Cost Trends Hearing, and be subject to the associated data collection requirements by the HPC, CHIA, and the state's Attorney General, just as health plans and providers are today.
3. **Expand HPC drug pricing review authority.** We also strongly support the HPC's recommendation from the 2022 and 2023 Cost Trends Reports that the Legislature authorize the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts. This enhanced authority complements current strategies health plans use to maximize value and enhance access for consumers through risk-based contracts and value-based benchmarks and ensuring access to high-quality pharmacy services at competitive prices.
4. **Establish penalties for price gouging** — To address unwarranted price increases by pharmaceutical manufacturers, the Legislature should require pharmaceutical manufacturers to report and justify increases in drug prices and to face financial penalties for unjustified increases. Establishing a penalty on manufacturers for excessive price increases addresses affordability concerns due to higher prescription drug spending and prices.

c. Many Massachusetts health care providers continue to face serious workforce and financial challenges, resulting in the closure and reorganization of care across the Commonwealth. How are these challenges impacting your organization today? What steps is your organization taking to address these challenges?

The majority of Health New England's business is in Western Massachusetts. Our market has observed physicians leaving the market and the reorganization of facility resources. Our provider partners and contracting colleagues have noted decreased capacity in physician services as providers leave the market and retire. The impact is currently most visible in pediatrics, endocrinology, neurology, pulmonology, behavioral health, and primary care. Facility reorganization has been particularly challenging as contracted providers consolidate services with providers who are not in our network. This is disruptive

to a course of treatment and requires considerable administrative effort on behalf of both the provider and the plan to preserve the patient's experience. We have worked to address capacity challenges by increasing provider compensation for primary care and behavioral health, adding providers to our network, expanding our telehealth options, and investing in innovation. While important and likely to reduce medical expense over time value-based contracts have proven less effective than hoped in increasing panel sizes by incentivizing team-based care since workforce challenges impact all roles on the team. Health New England searches for innovations that work to address this limitation. For example, we are implementing a Medic in Home program with one provider which will offer specialized support for individuals at greatest risk for avoidable service use. Providers are making their own investments in stability. Some of these will drive efficiencies but some will not. As a result, we are negotiating rate demands that are in many cases far more than historical unit cost trend.

d. Please identify and briefly describe the policy changes your organization recommends to promote the stability and equitable accessibility of health care resources in Massachusetts?

HNE has continued to focus financial investment in primary care and behavioral health care. While financing is necessary it is not sufficient to address access issues driven by limitations in provider availability. We support the state's commitment to advancing primary care and recommend that the policy and research initiatives focus on geographic variation. The Health of US Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care reported that although there are wide variations in primary care access, the access gap between medically underserved areas (MUAs) and non-medically underserved areas is particularly significant. MUAs have an average of 55.8 primary care physicians per 100,000 people; non-MUAs have an average of 79.7 and this gap in getting worse increasing by 5% nationwide from 2012 to 2020. Workforce investments by the Commonwealth in training and education are needed to stabilize accessibility over the long term, particularly if access to educational materials and research on equity and health disparities is prioritized. There are shorter term opportunities to leverage policy that encourages the delivery and insurance system to focus on health equity. For example, HNE has achieved Health Equity Accreditation which is not currently required of health plans participating in MassHealth but could become a standard. Investments in population health, such as clinics based in schools, senior centers, and refugee centers would encourage timely care and reduce demand for hospital and urgent care. Lastly, changes in policy to increase the scope of services that can be provided by nurses, particularly in the home, could enable a broader array of care to be supported during a visit with a single provider.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2019 to 2022 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2019 to 2022, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., unit cost, utilization, provider mix, service mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.

The fluctuations in annual trends are largely driven by COVID related utilization impacts. In 2021 utilization increased significantly as certain services rebounded post COVID. 2022 utilization dipped again both driven by a lack of capacity from providers and COVID impacts in January and February of that year.

b. Reflecting on current medical expenditure trends your organization is observing in 2023 to date, which trend or contributing factor is most concerning or challenging?

Pharmaceuticals remains our top area of concern. Gene therapies, medical pharmacy costs, and the growing fields of biologic therapies and personalized therapeutics such as CAR-T are driving costs in the medical and retail pharmacy arenas well out of proportion to growth in medical expense.

In addition, we are seeing increasing demands from hospital systems and provider groups for out-sized increases in their overall fee schedules, reflecting inflation, higher staffing costs, and the overall decline in provider margins.

QUESTION FROM THE OFFICE OF THE ATTORNEY GENERAL

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) 2021-2023			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In- Person
CY2021	Q1	700	62
	Q2	638	55
	Q3	588	65
	Q4	607	19
CY2022	Q1	570	20
	Q2	486	28
	Q3	490	33
	Q4	635	40
CY2023	Q1	535	22
	Q2	615	27
	TOTAL:	5,864	371

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 2019	3.1%	3.0%			6.1%
CY 2020	2.4%	-7.4%			-5.0%
CY 2021	2.5%	14.8%			17.3%
CY 2022	4.6%	-5.2%			-0.6%

Notes:

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