Attached please find Point32Health's written pre-filed testimony for the 2023 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 twenty-seventh of October, 2023.

Cain Hayes
CEO

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.

Unit costs and provider price variation continue to be the most significant drivers of medical trend in the Commonwealth, Therefore, our primary strategies to control costs continue to be negotiating the lowest unit cost (targeting unit cost increases below the cost growth benchmark) and contracting for value through alternative payment arrangements. As described in more detail below (addressing labor workforce issues), delivery systems are currently wrestling with economic headwinds and have been clear that they fully expect rate payers to close their funding gaps. Additionally, providers have indicated that they find government reimbursements insufficient and that commercial rate payers must make up for the shortfall in government receipts. While the focus on unit cost remains a paramount strategy, imbalances in negotiation leverage are prevalent. Potential contract terminations can result in continuity of care and access issues for patients in the short term and limited choice in the long term. Finally, the demands of providers with negotiating leverage leaves fewer resources for providers who tend to treat the most vulnerable patients (those enrolled in MassHealth) so that payers can stay at or near the cost growth benchmark. We discuss this dynamic in more detail in part d. below.

Prior authorization remains an important strategy to controlling medical trend, and we are deeply concerned by efforts to eliminate or severely restrict plans' ability to use authorization processes. Prior authorization is used so that members can access safe, evidence-based, and cost-effective care at the right time and in the right setting. Commercial health plans and government programs use prior authorization in limited circumstances to lower patient's out of pocket costs, prevent misuse, overuse, and unnecessary or potentially harmful care, and to ensure that care is consistent with evidence-based practices documented in clinical literature. In March, Point32Health experienced a cybersecurity incident that impacted many systems we use to conduct plan operations. To ensure that members continued to receive services in uninterrupted fashion, we removed prior authorization on some Harvard Pilgrim Health Care plans for a duration of about 12 weeks. During this time, we saw our claims experience increase by approximately $1 million per week above what our baseline expectations otherwise would have

been. We are worried that policy interventions in this space could overreach in removing authorizations and materially impact trend.

Below are additional strategies we have for managing behavioral health trends and pharmacy trend. Strategies to manage medical cost trends for behavioral health (BH): 1.) We use an integrated, whole person model for medical and behavioral health clinical operations, simultaneously focused on physical, emotional, and social health, to make long term sustainable improvements in members' quality of life. Starting in November, Harvard Pilgrim Health Care will insource BH, moving our entire organization to an insourced BH model. Our self-developed, locally managed provider network allows us to quickly leverage relationships with community partners, shifting to quality based, cost effective reimbursement models. We expect a reduction in total cost of care from this model based on a) the coordinated treatment of medical, physical, and social needs; b) an ability to utilize integrated advanced analytics; and c) implementation of cost efficient, quality-based reimbursement structures. 2.) In the past year, substance use disorder (SUD) trends have shown a 3% overall increase, with a higher increase in intensive outpatient programs (IOP), partial hospitalization programs (PHP) and residential costs. To reduce risk of re-admissions to higher levels of care, we are working with a provider partner that offers a wholistic, community-embedded approach to outpatient SUD care with demonstrated success in rural areas in increasing length of time sustained in outpatient services. We are also entering value-based arrangements with SUD providers to shift from reimbursement based on volume to reimbursement based on data-supported metric and targets that drive improved health outcomes and reduced costs. Furthermore, our SUD care management programming focuses on helping members with SUD to engage in outpatient supports that are proven to help them remain in the community. Our Addiction Recovery Care Management works directly with members during and after transition to outpatient care to ensure they connect with the right providers and community resources. 3.) Emergency department (ED) visit costs have trended up 27% in the past year, reflective of the broader national mental health crisis in the United States. To mitigate this trend, we implemented rapid access contractual arrangements with broad based network of providers to provide expedited appointments for members of rising risk with a provider that can offer ongoing care. Additionally, we brought all Community Behavioral Health Centers into our commercial network offering urgent visits and 24/7 community-based crisis intervention and stabilization services as an alternative to EDs. To further support BH needs, regardless of location and outside business hours, we created a network of multimodal access to care through expansion of virtual providers that offer a full range of outpatient clinic services including prescribers for children, adolescents, and adults and 24/7 on demand digital programs. Finally, we are

addressing ED boarding through the creation of an internal ED Strategy Support Team that advocates on behalf of all members, supporting communication between hospitals and emergency departments, to help facilitate rapid hospital placement with our network of hospitals offering acute behavioral health services. Strategies to manage pharmacy cost trends: 1.) As part of the combination and integration of our heritage organizations, we negotiated aggressive unit cost discounts for retail, mail, and specialty drugs which was validated by independent consultants who evaluated our competitive position relative to industry benchmarks. 2.) We analyze, forecast, and communicate financial and utilization impacts of specialty drugs or biologicals to providers. Efficacy and cost analyses drive coverage and utilization management (UM) decisions. When a biosimilar has a lower net cost compared to the brand product, it is given preferred status on our formularies. We also continuously monitor the growing GLP-1 market, adjusting policy and coverage decisions based upon FDA and clinical guidelines. For example, GLP-1 drugs criteria for members with diabetes is different than those for obesity. This helps to reduce off-label use. While we expect utilization to continue, more competition should have a mitigating impact on cost over time. 3.) Utilization Management programs, including Prior Authorization, Step Therapy, New-to-Market, Non-covered Medications with Recommended Alternatives (NC) and Specialty Infusion (SI), ensure members have access to the medications they need while keeping costs down and adhering to prescriber recommendations. 4.) We support risk based, global budget contract models (inclusive of pharmacy risk) that pay providers for their ability to manage overall cost and quality of care. Our product designs support members seeking the appropriate therapy in the most cost-effective setting. The Pre-Check My Script tool allows providers to review formulary status at the time of prescribing to encourage selection of high value options and the Rx Savings Center (OptumRx tool accessed from our website through single sign on) alerts members to out-of-pocket savings opportunities that may exist. 5.) To support our goal of achieving the lowest net cost drug therapy while ensuring access to safe and effective care, we employ preferred medication strategies where possible for medical benefit medications. Our preferred medical pharmaceuticals have favorable cost profiles with consideration to manufacturer rebates as well as overall costs of treating chronic and complex diseases.

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.

As healthcare spending on pharmaceuticals continues to exceed the cost growth benchmark, averaging 7.2% growth annually over the last three years, it's clear that 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, top 25, etc.) that are most impacting spending in Massachusetts and to determine whether the prices of those drugs is commensurate to the value. 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. Finally, we support policies that hold manufacturers accountable for price increases above a certain threshold (such as the cost growth benchmark) and apply penalties for excessive increases, similar to Medicare legislation that has been enacted in Congress.

We support policies that rationalize healthcare prices for common services and would specifically recommend that the state explore a site-neutral payment policy for outpatient hospital services. As this year's HPC Cost Trends Report demonstrates, there is tremendous variation in the commercial prices for basic outpatient procedures, and commercial payers are often paying more than double, and sometimes five times as much as what Medicare would pay for the same services. Facility fees associated with hospital outpatient settings are driving a large part of these price differentials. 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. Lastly, 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.

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?

Labor costs experienced by hospitals (both in the form of high hourly wages for traveling nurses, and the follow-on increases in employed staff wages, given what employed staff saw travelers getting paid) are exerting significant pressure on unit costs. Based on our experience, hospitals expect to pass these increased costs through to the rate payers. Additionally, some hospitals are confronting a debt burden, which exerts further upward pressure on rates as contracts renew. These factors cause upward pressure on provider demands, and contract negotiations continue to be challenging in this environment. Plans are also experiencing workforce challenges related to salary demands, talent scarcity, and the demand for insurance professionals to manage through post-pandemic economic challenges in a consolidating New England market.

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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?

We support legislation filed by Speaker Ron Mariano to enhance the Determination of Need (DON)process and give the HPC a more direct role in examining provider expansions. The HPC has documented how expansions of downtown Academic Medical Centers into community settings can have a material impact on healthcare spending in the Commonwealth, both by raising price levels in those settings and impacting referral patterns to more expensive settings. These impacts are compounded by adverse impacts on community hospitals, which generally serve a high proportion of Medicaid patients and receive lower reimbursement levels from commercial payers for the small proportion of commercial members they do see. The legislation would allow HPC to evaluate these cost impacts more directly and highlight the underlying equity issues as the state considers DON applications.

We also support policies to rationalize pricing at the top of the hospital market and address longstanding provider price variation. As data from CHIA continues to show, a handful of very expensive hospitals (with statewide relative prices that average 1.36, or 36% higher than the network) also receive the most patient volume (more than 50% of commercial payments for the top six systems). More than any other single factor, this dynamic of care being delivered at the most expensive settings continues to drive medical trend in Massachusetts. In its annual report, the HPC has again recommended price caps for the most expensive provider systems. If such a policy were enacted, it would not only address a primary source of high healthcare spending, but also free up resources to invest in community hospitals, while still reducing commercial premiums due to the high concentration of commercial payments described above. It has become clear that price variation is a driver of inequity as healthcare resources continue to be driven to the largest, most expensive provider organizations.

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.

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 4% per year, depending on the line of business (including demographic changes). Note that for 2020, risk coding has been suppressed due to the Covid-19 pandemic. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Shifting care patterns such as movement away from the inpatient setting to outpatient and ambulatory surgical centers, as well as movement out of the emergency department are impacting unit cost trends. Point32Health has observed a similar rate of benefit buy down in each year over this time period.

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?

Of most concern are pharmacy cost trends, the impact of high medical inflation (and high inflation, generally), general unit cost pressure from providers and the uncertain duration of the care pattern changes related to the Covid-19 pandemic.

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	4254	96
	Q2	4006	83
	Q3	3740	63
	Q4	3690	89
CY2022	Q1	4690	74
	Q2	3944	71
	Q3	5097	89
	Q4	5221	94
CY2023	Q1	7789	110
	Q2	5188	85
	TOTAL:	**47,619**	**854**

** Please note, totals are aggregated across all Point32Health entities

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	3.0%	2.3%		1.7%	7.1%
CY 2020	0.9%	-7.6%		0.5%	-6.4%
CY 2021	-1.0%	21.6%		-4.5%	15.0%
CY 2022	1.4%	-2.6%		2.3%	1.0%

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.