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	6.1%	4.7%	-1.4%	2.2%	12.0%
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	1.2%	-5.6%	0.3%	9.8%	5.2%

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.

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.

Located in Woburn, Massachusetts, 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). UniCare functions solely for the purposes of supporting the GIC, its only client. UniCare serves over 200,000 members who work or live in Massachusetts.

Employers, individuals, and families purchasing health insurance coverage entrust health plans to manage care and ensure that members receive the right care, in the right setting, at the right time. UniCare'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.

  UniCare'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, UniCare has been able to maintain overall cost trends and premiums below our competitors in the market.

  With EPHC, a fixed 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 are 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 UniCare's affordability strategy. It is well documented that better health and prevention improve care outcomes and lower costs. Over the past two years, UniCare 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. UniCare 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.

  UniCare'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 UniCare'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 Medical Record (EMR) access in Massachusetts and across the country. Facilities that partner with Unicare to allow their teams to access EMRs 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.

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.

- **Address anti-competitive contracting practices:** UniCare 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 "antisteering," "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**: UniCare 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.

- **Enact the following prescription drug reforms:**

  - Pharmaceutical related costs have been increasing steadily over time and have a significant impact on the overall affordability of health care in the United States. (Prescription drug costs currently account for 18% to 22% of the overall premium dollar for fully insured health plans.)
  - ***Prevent harmful mark-ups and increased costs for patients by protecting 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;
  - ***Address drug manufacturers' abuse of charitable structures:*** 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, including by reducing their high prices that make drugs unaffordable and by donating to truly independent charities that assist patients in need. Self-serving structures masquerading as charities are neither legitimate nor beneficial. A recent study in Massachusetts estimated excess spending attributable to coupons for the 14 drugs studied totaled $44.8 million per year;
  - ***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 Unicare's ability to do both.

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 impact of closures and consolidation on prices. As the structure and composition of the provider market in Massachusetts continues to evolve with increasing rates of mergers, acquisitions, affiliations, and consolidations, the largest providers and hospital systems continue to have the highest health care prices with no direct relation to increased value or equity in care. As of September of this year, the HPC has reviewed a total of 159 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, with Boston Children's Hospital having 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, with Boston Children's Hospital commercial prices being more than 3 times those of Baystate Hospital, with no relation to increased value of care.

Over the past decade, hospital spending has accounted for the largest share of commercial spending and spending growth, with hospital inpatient spending

continuing to grow despite a constant or declining number of hospital stays, while hospital outpatient spending increased by close to $675 million between 2019 and 2021 alone.[1,2] Hospitals and physician groups with greater market power garner price increases that exceed their costs to deliver care. As Massachusetts, like other states across the country, sees the continuing trend of mergers, acquisitions, expansions and consolidations, the impact of these transactions is borne out in the cost of hospital and provider services. A 2023 report from the Journal of the American Medical Association confirms the effect of hospital mergers and provider consolidation has made clear that, in most cases, consolidation does not lead to better care and lower prices, but rather leads to enhanced bargaining power for providers with no notable improvement in quality for patients.[3]

UniCare along with other health plans have undertaken efforts to control rising health care costs as a result of price increases due to market consolidation. 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.

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?

- **Determination of Need (DON) reform:** UniCare recommends 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 ensure that new, lower cost and innovative providers can enter the market to competitively lower prices and costs.

[1] Health Policy Commission. *2019 Health Care Cost Trends Report.* Available at: https://www.mass.gov/doc/2019-health-care-cost-trends-report/download
[2] Center for Health Information and Analysis. *Annual Report March 2023.*
[3] Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. *JAMA.* 2023;329(4):325–335. doi:10.1001/jama.2022.24032

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.

We do not believe the actual observed allowed claims trend has been impacted by changing demographics. UniCare's GIC population has been steady over the years 2019 to 2022. 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. Risk score changes: 2020 -5.2% ; 2021 +9.3%; 2022 +0.6%. It appears that the risk scores have levelled out in the 2022 experience.

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?

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

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**	N/A	
	Q2	4,888	
	Q3	3,099	
	Q4	2,390	
CY2022	**Q1**	3,157	
	Q2	4,128	
	Q3	3,033	
	Q4	2,631	
CY2023	**Q1**	3,705	
	Q2	5,472	
	TOTAL:	32,503	