MASSACHUSETTS
HEALTH POLICY COMMISSION

2022 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 2022 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Monday, October 24, 2021**, please electronically submit testimony 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 2021, 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 Attorney General's Office (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 milestone anniversary in the Commonwealth's ambitious journey of health care reform. Ten years ago, through the advocacy of a broad coalition of stakeholders, Massachusetts adopted an innovative approach to slowing the rate of health care cost growth by establishing an annual cost growth benchmark and providing oversight authority to the newly established HPC.

In the first several years of benchmark oversight, the Commonwealth made notable progress in driving down health care spending growth. In recent years, however, spending growth has exceeded the benchmark (with the exception of 2020) and appears likely to continue that upward trajectory.

This trend is driven largely by persistent challenges and market failures that have not been adequately addressed in the past ten years. These challenges, which have been consistently identified by the HPC and others, include:

- Excessive provider price growth and unwarranted variation,
- Increased market consolidation and expansion of high-cost sites of care,
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value,
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers,
- Stalled uptake of value-based payment models and innovative plan offerings, and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

The ongoing impact of the COVID-19 pandemic has only exacerbated many of these dynamics, contributing to greater health disparities, while adding to inflationary headwinds in the form of increasing labor and supply costs.

These challenges are not unique to Massachusetts, and many other states are evolving their cost containment strategies accordingly to respond to them. In order for Massachusetts to continue to be the national leader on health care cost containment, it must similarly adapt. Unless the state's health care cost containment approach is strengthened and expanded by policymakers, the result will be a health care system that is increasingly unaffordable for Massachusetts residents and businesses with growing health inequities.

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

a. Reflecting on the past ten years of the Massachusetts health care cost containment effort, and the additional context of ongoing COVID-19 impacts, please identify and briefly describe the top (2-3) concerns of your organization in reducing health care cost growth, promoting affordability, and advancing health equity in future years.

Headquartered in Andover, Massachusetts, UniCare has exclusively served members insured through the GIC for 34 years. UniCare offers three commercial plans, as well as a Medicare Supplement plan and is the only indemnity plan serving GIC members. UniCare is a unique organization in that it does not have reserves, but functions as a true health benefits organization focused on advancing access to health and medical services, as the Commonwealth sets the policy and financial risk for the members.

UniCare has a long history of offering financial and clinical value to the Commonwealth and the members it serves. Its premiums (except for- the BASIC plan) are typically the lowest premiums available to GIC members and its medical cost trend has been historically lower than its competitors.

In terms of concerns regarding health care costs and affordability, UniCare can point to the following:

1. Provider Prices: It is widely known and well documented that provider prices make up approximately two thirds of the drivers behind health care costs. Over the past 18 months, provider prices and their unit costs have risen dramatically. Many of the providers -in particular hospitals systems- have requested fee for service rate increases of between 10% to over 20% per year. These levels of rate increases are unprecedented and are being made at a time where inflation is at historic levels and consumers cannot afford to pay higher costs for the same or deteriorating services in health care. Further, these rate increases are requested despite the enormous subsidies that state and federal government has advanced to hospitals and providers.

2. The slow pace in shifting away from today's sick care model: Nationally, health care spending has ballooned to roughly 20% of our nation's GDP. In Massachusetts, we are seeing the same trend toward increased cost. One of the major obstacles UniCare has observed is reluctance from providers to shift away from their reliance on fee for service as their main source of reimbursements.

3. Regulatory constructs that impede competition and innovation: One of the most important lessons learned during the pandemic was the need for regulatory flexibility to allow for nimble, innovative solutions that enabled health and medical services to support people wherever they lived or work. Today's health care regulatory landscape must evolve quickly to enable new solutions that enable start ups and competitors to drive value in the market. For example,

primary care start ups cannot financially compete with large systems who have the capital and regulatory advantage in a market that desperately needs more primary care services. Similarly, regulations to allow for in-home services must change in order to allow new entrants like mobile integrated health, to serve people at home at a lower cost than existing incumbents.

b. Please identify and briefly describe the top strategies your organization is pursuing to address those concerns.

Affordability is UniCare's number one strategic imperative. As such, UniCare continues to take proactive steps to advance affordability and to mitigate the rate of growth in medical costs over time.

While UniCare's initial value-based payment model predominantly incentivized providers in upside only gain share arrangements, over the past two years, UniCare has implemented a total cost of care model that progressively incents providers to move up the risk spectrum and prepares them to accept significant downside risk under pompom arrangements and ultimately, global capitation, if appropriate.

Our total cost of care reimbursement model is structured in a mutually beneficial manner to ensure that each provider contract keeps the annual rate of growth in total medical cost at no more than 3.6% year over year, including any value-based payments on top of shared savings pmpm's.

UniCare's long term goal is to advance a Whole Health model whereby financial incentives for providers are designed to improve member health, shift services away from avoidable hospital-based care, address social drivers of health and mitigate the annual rate of growth in total medical spending.

UniCare's Whole Health approach leverages three reimbursement models to drive this goal: Enhanced Personal Health Care (EPHC) model, Essentials model and a modified fee-for service model, whereby UniCare shifts higher payments toward primary, urgent and digital-based care and services and lower payments toward avoidable hospital-based services. Ultimately, all three payment models promote primary care, urgent care, digital tools and home-based settings to advance "right setting of care" through member engagement and financial incentives designed to support a robust primary care infrastructure. This approach encourages facilities to transform their operating platforms to advance health, not sick care and develop services that are delivered beyond the hospital walls.

c. Please describe your progress in the past year on efforts to collect data to advance health equity (i.e., data capturing race, ethnicity, language, disability status, and sexual orientation/gender identity, see 2021 Cost Trends Testimony), including specific metrics and results. Please also describe other specific activities your organization has undertaken to advance health equity.

UniCare's long term objective is to create a "Whole Health" platform that supports our members health journey from birth to post retirement. UniCare understands that in order to

achieve that purpose, obtaining comprehensive data that enables a deep understanding of both the drivers of health and underlying reasons for health equity / inequity, is of strategic importance.

To that end, UniCare has taken a market leading role to collect racial, ethnic and income data. To date, UniCare has racial and income data for over 80% of our membership. This data is not imputed data, rather UniCare has collected member self-reported data from various sources to achieve this goal.

UniCare has begun leveraging the data to better understand members' social drivers of health, community needs, equity barriers, as well as food access issues depending on member demographic and / or geographic place of residence.

In addition, UniCare is in the early stages of partnering with both medical and nonmedical community-based providers via contractual arrangements to align our services, missions and financial incentives toward better outcomes and equitable solutions that advance better health for everyone in the communities we serve.

For example, we have included contractual language that includes antidiscrimination language, as well as reportable clinical measures to assess social drivers of health and define actionable steps to address health disparities.

d. Please identify and briefly describe the top state health policy changes your organization would recommend to support your efforts to address those concerns.

UniCare recommends the following policy suggestions as tools to advance affordability and enhanced access to lower cost care in Massachusetts:

A. Index the state's cost containment benchmark to the median;

B. Eliminate regulatory barriers that impede non-hospital based primary care providers and non-hospital based urgent care facilities from growing and offering lower cost services and alternative sites of care in Massachusetts;

C. Eliminate regulatory barriers that impede non-hospital-based providers from advancing medical and health services that offer at-home interventions at a lower cost, i.e., mobile integrated health, etc.

In order to make health care better and affordable, we must realign financial incentives that strengthen the patient-doctor relationship and reward all providers for keeping patients healthy instead of by the number of treatments ordered or procedures performed.

We must also realign how the price people pay toward their health insurance ties to their choice of provider and ensure all providers and payers are incentivized to lower their unit costs and premiums.

UNDERSTANDING TRENDS IN MEDICAL EXPENDITURES

a. Please complete a summary table showing actual observed allowed medical expenditure trends in Massachusetts for calendar years 2018 to 2021 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2018 to 2021, 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.

See exhibit 1

b. Reflecting on current medical expenditure trends your organization is observing in 2022 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) 2020-2022			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2020	Q1	545	
	Q2	154	
	Q3	231	
	Q4	144	
CY2021	Q1	151	
	Q2	56	
	Q3	200	
	Q4	Not available	
CY2022	Q1	Not available	
	Q2	Not available	
	TOTAL:	1,481	