



September 11th, 2015

David Seltz, Executive Director
The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Executive Director Seltz:

On behalf of Neighborhood Health Plan (NHP), thank you for the opportunity to provide written testimony in accordance with the Health Policy Commission's (HPC's) request dated August 6th, 2015, under Exhibit B, Exhibit 1, and Exhibit 2 as provided for in Massachusetts General Law, chapter 6D §8.

NHP serves approximately 6 percent of the fully insured commercial market, including Connector Care, in the Commonwealth. In addition, commercial represents 31 percent of our total book of business with the remainder being Medicaid.

NHP is a Massachusetts-based not-for-profit corporation with operational headquarters located at 253 Summer Street in Boston. NHP is fully licensed as a health maintenance organization by the Massachusetts Division of Insurance. NHP's mission is to promote the health and wellness of our members and to help ensure equitable, affordable, health care for the diverse communities we serve.

Our testimony is provided in the attached submission templates. I, as a legally authorized and empowered representative of Neighborhood Health Plan, Inc., sign under the pains and penalties of perjury, that the testimony herein located at Exhibit B, Exhibit 1, and Exhibit 2 to the best of my knowledge is complete and accurate.

Sincerely,

A handwritten signature in blue ink, reading "David Segal", is written over a horizontal line. The signature is fluid and cursive in style.

David Segal
President and CEO

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: <http://www.suffolk.edu/law/explore/6629.php>. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** 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 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: Neighborhood Health Plan Responses for HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
 - a. Please describe your organization’s efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

NHP Response:

NHP continues to move forward with APM contracting. As of 7/1/15, NHP has APM contracts with 24 entities. Approximately 41.5% of NHP’s total membership (including both commercial and MassHealth) is assigned to a PCP who participates in an APM arrangement. These arrangements include shared savings programs and capitated risk contracts. NHP does not currently have any bundled payment arrangements. Please refer to the table below for the analyses on total medical expense (TME).

Provider Group	Commercial		Medicaid	
	Risk Adjusted TME	% of Network Average	Risk Adjusted TME	% of Network Average
Community Health Centers (APM) 14	\$ 284.74	75%	\$ 410.41	88%
Community Health Centers Non-APM (32)	\$ 433.42	114%	\$ 413.14	89%
Other Long term APM	\$ 351.58	93%	\$ 435.63	94%
Other NonAPM/Recent APM	\$ 380.73	100%	\$ 526.12	113%
Blended Average	\$ 379.15		\$ 464.22	

- b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

NHP Response:

NHP is in active discussions with four integrated delivery systems (hospitals, specialists, PCPs, and certain ancillary providers) for global risk arrangements with various

implementation dates that are targeted between 1/1/16 and 10/1/16. NHP expects over 50% of its membership to be in APMs by 10/1/16.

NHP is also exploring the development of a unique primary care behavioral health integration model under an APM framework with key network providers.

In an effort to expand upon our APM initiatives,, including the introduction of new models, such as bundled payments, NHP has recently reorganized to better address new payment methodologies by forming a Reimbursement Strategy Department. The primary function of this department is to research and implement new payment methodologies, such as bundled payments. NHP is in process of recruiting for the director of this department. In addition, NHP has participated in a bundled payment workshop, sponsored by the Association of Community Affiliated Plans (ACAP), to gain experience with this type of methodology. In order to support additional APMs, NHP has budgeted new FTE's in the following areas: Clinical, Contracting, Medical Economics, and Provider Relations.

- c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

NHP Response:

Members enrolled in NHP's PPO products (currently less than 500 individuals) are required to select a PCP, and in doing so may select a PCP that is under an APM contract with NHP. Given this small membership, NHP has not directed any analysis/action to date that is specific to the PPO membership. As membership in this product grows, NHP will examine whether specific analysis/action is needed.

NHP does not currently operate in the self-insured business market and therefore cannot address specific barriers for moving self-insured business into APM arrangements.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members'

choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

NHP Response:

NHP is continually evaluating its product designs in an effort to provide the highest value and lowest premium plans available in our market. Our entire current product portfolio is built on a high-value, defined network that is limited in size (compared to most Massachusetts health plans) that results in member premium savings. We have introduced additional high-deductible health plan options, which when paired with our member self-serve 'My NHP Cost Estimator,' gives members both the incentive and the tools to make informed choices.

NHP has product standards that are applied across all plan designs to drive members to the most appropriate level of care needed. For example, cost sharing for limited services clinics and urgent care is set at the same level of cost sharing as a visit to the PCP's office so that members are provided additional options for obtaining necessary services, especially when outside of normal PCP office hours. NHP has also developed specific marketing material that is included in all new member kits to guide the progression of obtaining lower cost services available to our members, such as urgent care. NHP also provides plan options that can tier physician cost sharing and allow members to access high-quality providers at a lower cost who can provide enhanced services such as:

- * Coordination with specialists to ensure patients get the very best in personalized care*
- * Easy access to urgent care through convenient expanded hours*
- * Helpful reminders about necessary tests, checkups, and follow-ups*

NHP's agreements with Integrated Risk Bearing Organization (IRBO) providers guide members away from high-cost hospitals by shifting referral patterns. This is done by identifying lower cost labs, imaging centers, DME, and ambulatory centers. Additionally, in an effort to direct care to urgent care locations and discourage more expensive emergency room utilization, IRBO providers agree to expand the hours of their urgent care facilities beyond the typical work day.

Related decision support programs include a 24/7 toll-free Nurse Advice Line that encourages all members to call if they are unsure of whether an emergency room visit is needed. NHP also contracts with urgent care providers in a variety of settings. Members using this option for off-hour diagnosis and treatments that do not warrant expensive emergency room visits are rewarded with much lower out-

of-pocket costs. NHP also has a process by which we outreach, via mail, to members who may have lower cost facility options for services that could be performed outside of an emergency room visit.

In an effort to continue to meet the evolving needs of our customers in a rapidly changing marketplace, NHP has developed a new tiered pharmacy offering that will be available in 2016. It is designed to drive the utilization of lowest cost generic drugs by reducing member cost sharing for these prescriptions and help to slow escalating general health care costs. As part of our efforts to address rising prescription drug costs, NHP has also contracted with the Pharmacy Benefits Manager CVS/caremark. Our partnership will increase medication adherence, drive down pharmacy cost, and improve member engagement.

Additionally, NHP is currently in the early stages of evaluating and researching initiatives that will encourage and reward members to use high-value services, settings, and providers. One example, a Telehealth benefit, will offer members the ease and efficiency of accessing care in the privacy of their own home. We are also exploring a high-value network product to further encourage the use of high quality providers at overall lower costs. To ensure understanding of any high-value plan offered, NHP will introduce these plans with a comprehensive communication campaign targeting providers, brokers, employers, and consumers.

Post-marketplace introduction, these plans will be monitored for growth, plan understanding and satisfaction of enrolled members.

Of critical importance to NHP is to ensure that any new product we design and introduce aligns with our overall value proposition of simplicity, quality and value, as well continuing to satisfy access and clinical standards. NHP will be conducting several research studies to help inform our product strategy to introduce new solutions that uniquely address unmet needs.

3. Chapter 224 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.” Please describe your organization’s progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization’s prior experience, including how long your tool has been in use and any changes you have made to the tool over time.
 - a. Using **HPC Payer Exhibit 1** attached, please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

NHP Response:

See attached Excel Sheet titled "HPC Payer Exhibit 1."

- b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Outpatient	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Diagnostic	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Office Visits (medical)	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
Office Visits (behavioral)	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>

- c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.

Yes No

- d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes No

- e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes No

- f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

NHP Response:

An analysis of member searches indicates that NHP members are primarily using the online "cost estimator" tool to search for well-known high-cost and other common services such as MRI, colonoscopy, and mammogram. While the online tool includes costs for a wide range of medical procedures, high-cost procedures are the most frequently searched. The tool effectively breaks out various sub-options when appropriate. For example, the tool lists ten different options for MRI (depending on the body part).

Members with deductible plans use the tool to determine their direct cost for a particular service. Since the implementation of NHP's online cost estimator in June 2014, the top two most frequently searched terms continue to be MRI and colonoscopy.

Members sometimes search for services conducted by their PCP. While routine physicals are covered, other non-routine services such as thyroid or vitamin D lab work are not covered at 100%. Consequently, NHP sees a number of requests for detailed lab work to be broken out by specific test.

Some procedures are not available in our online tool and requests for cost estimates come in manually through NHP Customer Service. Common requests that are not covered in the online tool include those related to durable medical equipment (DME), including continuous positive airway pressure (CPAP) as a frequent type of DME request. Other commonly requested procedures that are excluded include knee replacement surgery and genetic testing.

An analysis of the manual requests revealed that members may not understand how services are billed. For example, a member may provide us with a request for the cost of each of the numerous blood tests that are included in a CBC, not realizing that the provider "bundles" the tests and there is one charge for the CBC, not for each individual test.

Given the number of members on plans that have deductibles and coinsurance, total volume of cost estimate requests (both online and manual) continue to be much lower than anticipated. NHP continues to design and implement ways to increase members' awareness of these tools.

NHP is looking at ways to increase member awareness of and satisfaction with cost estimation. Options under consideration include: enhancing NHP's ability to provide estimates on DME items and detailed lab tests; making mention of the availability of cost estimates part of the customer service interaction; enhancing member materials with information on the cost estimation process; and increasing the online tool's prominence on our web portal.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

NHP Response:

Consolidation in the marketplace has allowed NHP to pursue alternative payment models (APM) with providers who, prior to consolidation, would not have been eligible given their low NHP

membership. NHP continues to work successfully with providers to lower costs. Its APM arrangements have resulted in lower total medical expense and are aligned with entity referral patterns. In addition, NHP will work with providers in 2016 to enhance its pay for performance programs to include even more HEDIS measures. NHP continues to offer a comprehensive provider network while monitoring access to care.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.

- a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

NHP Response:

Generally speaking, NHP believes that there should not be significant variations in prices for the same services, except under certain situations. The circumstances where variations might be acceptable include: clearly documented differences in the quality of care provided and patient outcomes; and operating cost disparities between providers based in metropolitan vs. non-metropolitan areas, and academic vs. non-academic medical facilities.

- b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

NHP Response:

NHP has had a great deal of success in reducing high cost providers to yield a very responsible overall unit cost rate increase compared with unit cost increases over time. We have adopted a negotiation strategy to reduce variances in provider reimbursement rates vs. standard pricing targets for both the MassHealth and Commercial lines of business. Additionally, to further the goal of expanding our non-traditional fee-for-service payment models, NHP continues to negotiate alternative payment arrangements including capitated risk and gain sharing arrangements.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of-network providers. Please describe any

policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.

NHP Response:

NHP has a robust network and expects members to be treated by in-network providers as most covered services are available within our network. NHP requires in-network providers to refer within NHP's network. NHP's Member Handbooks and Provider Manual indicate that all out-of-network non-emergent services require prior authorization to be covered. NHP's out of network authorization process is designed to remove any additional cost impact to the member who, with authorization, receives a services form from an out-of-network provider. For all covered in-network facility treatment, treating providers are required to submit charges for that episode of care directly to the plan. Additionally, NHP mandates that providers must use our online referral tool which only includes in-network options. Any request for an out-of-network provider is reviewed by NHP's clinical team on a case-by-case basis for medical necessity. It is NHP's policy to hold the member harmless for any additional costs related to services performed by an out-of-network provider working within an in-network facility.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

NHP Response:

NHP has not seen an increase in visits to outpatient-based practices which can bill "facility fees." To incorporate a full claims run out, NHP compared the utilization between 2013 and 2014 and has found there to be a decrease in the visits/1000 for outpatient-based practices, by 2.62% for commercial business, and a decrease of 8.04% for MassHealth business. NHP therefore does not have sufficient information to analyze outpatient-based practices' effects on health care costs, quality, and access.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
 - a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.

NHP Response:

Integrated Partner Model:

NHP and Beacon Health Options (Beacon), our Behavioral Health partner, continuously work to identify our members with co-morbid behavioral health and chronic medical conditions. Once identified, members are referred to Beacon's Intensive Care Management (ICM) Program so that the care is fully integrated for these high risk/ high cost members of our health plan.

As part of and consistent with our Integrated Partner Model (IPM), all Beacon and NHP licensed clinical staff are onsite at NHP alongside medical management staff, prompting care coordination and integrated medical and behavioral health case management. Sitting side-by-side—as well as the clinical rounding and care coordination meetings that occur on a daily basis—our clinicians collaborate on specific cases, ensuring that members receive person-centered, holistic care. Through the care management process, NHP members' needs are addressed as care is coordinated across all domains—behavioral, medical, and social.

An analysis of utilization and cost data for the members enrolled in this Intensive Care Management Program demonstrates that after participating in the program for 7-12 months, the combined (Medical and Behavioral Health) PMPM decreased. That decrease is largely attributable to members being diverted from the more restrictive and costly services to the least restrictive and less costly community-based services along with better medication compliance.

Behavioral Health Medical Integration Pilot Program:

Consistent with the IPM model, NHP and Beacon jointly run a Behavioral Health Medical Integration Pilot Program in which NHP and Beacon jointly fund care coordinators at two community health centers in the Northeast and Southeast parts of the state serving over 50 NHP members. (Please note each pilot site has 25-40 members in the program at any given time. This is the maximum that the single staff person supported jointly by NHP and Beacon at each health center is expected to manage at a given time since these are very complex members with medical, behavioral, and social co-morbidities).

This pilot, too, seeks to bridge the coordination gap that often exists between behavioral and physical health. In CY2014, the program achieved significant utilization and cost outcomes:

- *24% decrease in PMPM medical costs*
- *42% increase in PMPM behavioral health costs*
- *26% Increase in PMPM pharmacy costs*
- *Decrease in total healthcare costs by 26% (-6% PMPM)*

- 90% of members reported an improvement in their quality of life (after 12 months of enrollment) as measured by World Health Organization, WHO, Quality of Life questionnaire—specifically in the Physical, Psychological and Environmental Domains
- 60% of members indicated improvement in Patient Health Questionnaire (PHQ) scores

iCMP Program:

NHP and Beacon also work with the Partners HealthCare system on coordinating case management efforts. Partners' Integrated Care Management Program (iCMP) is designed to coordinate care for high-risk patients with chronic, complex conditions and/or multiple medical conditions, with staff located throughout its primary care provider offices. NHP and Beacon have developed this program with Partners to coordinate treatment and have jointly delivered multiple trainings in 2014 to Partners iCMP staff at multiple locations so they understand the medical and behavioral resources available to NHP members.

- b.
- c. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization (“a carve-out”) or manage behavioral health care within your organization.

NHP Response:

For the next 12 months, the Integrated Partner Model, the Behavioral Health Medical Integration Pilot, and the iCMP Programs will continue along with our emerging Beacon/NHP Intensive Community Care & Support program (ICCS)—a care coordination model that outlines a provider-based, innovative, and integrative approach to the delivery of care coordination services. In recognizing that there are unmet needs and ineffective service delivery and payment mechanisms for highly acute populations, Beacon and NHP are actively working to develop and implement this program with an anticipated go-live date of January 1, 2016.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

NHP Response:

As requested, trends do not adjust for changes in benefit design, risk level or demographics of the population. In general, benefit levels increased in 2014 due to ACA mandates, which drove some of the trend. NHP demographics have been getting younger; however, the risk score is increasing. Concerning population, NHP has experienced significant growth over the past few years.

More specifically, NHP Experienced close to a 3.5% increase in risk level from 2013 to 2014. The pure demographic factor was a decrease of about 1%. The changing risk level or demographic levels typically drive the utilization and service mix trends, however standard risk adjustment tools due not allocate between the two. In addition risk adjustment tools include a demographic factor so the two above numbers may not be additive. In addition there was a major change in benefit design due to ACA with on average about a 1.5% increase in benefit level. Most of this increase is from lower member cost share levels and does not impact allowed trend levels. However, we assume that about 25% to 30% of the increase (0.3% to 0.5%) should drive up the utilization trend. In contrast, during the period of 2012 to 2013, NHP observed an increasing demographic factor of close to 2% (consistent with increasing risk scores) but observed a significant drop in benefit levels (about 1.5%).

Demographic impact would be reflected in utilization and service mix; benefit buy down would be reflected in utilization; and health status would be reflected in utilization and service mix.

HPC Pre-Filed Testimony - Payer Questions
HPC Payer Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person	Aggregate Average Time to Resolve Inquiries*
CY2014	Q1	NA	97	4 Days**
	Q2	NA	28	8 Days**
	Q3	211	78	3 Days
	Q4	327	78	2 Days
CY2015	Q1	244	64	3 Days
	Q2	231	60	2 Days
TOTAL:		1013	405	

** Please indicate the unit of time reported. The Unit of Time = Days*

** During the first two quarters, NHP was, on average unable to resolve member inquiries in a timely manner until all parties (providers and carriers) became familiar with the new transparency requirements and processes for requesting price information. By Q3 of CY2014, the system and supporting processes had become better established and therefore the turnaround time for providing pricing information to NHP members decreased to on average 2-3 days. NHP continues to work towards the goal of a 2 day turnaround time.

*****In addition, payers MUST identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")*****
All 3 tabs must be completed.

Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:

CY2014 Q1	1	NA
	2	NA
	3	NA
	4	NA
	5	NA
	6	NA
	7	NA
	8	NA
	9	NA
	10	NA
CY2014 Q2	1	NA
	2	NA
	3	NA
	4	NA
	5	NA
	6	NA
	7	NA
	8	NA
	9	NA
	10	NA
CY2014 Q3	1	MRI
	2	Colonoscopy
	3	Lab Test
	4	X-ray
	5	Pregnancy
	6	OB/GYN
	7	Primary Care
	8	Orthopedic surgeon
	9	Physical Therapy
	10	
CY2014 Q4	1	MRI
	2	Colonoscopy
	3	Pregnancy
	4	Lab Test
	5	Primary Care
	6	OB/GYN
	7	X-ray
	8	Orthopedic surgeon
	9	Physical Therapy
	10	Hysteroscopic biopsy

Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:

CY2015 Q1	1	Colonoscopy
	2	MRI
	3	Pregnancy
	4	OB/GYN Care
	5	Primary Care fo Adults
	6	Lab Test
	7	X-Ray
	8	Mammogram
	9	Visual Field Test
	10	Eye Doctor
CY2015 Q2	1	Lab Test
	2	Colonoscopy
	3	Visual Field Test
	4	OB/GYN Care
	5	Eye Doctor
	6	Primary Care fo Adults
	7	Pregnancy
	8	MRI
	9	Dermatologist
	10	X-Ray

HPC Payer Exhibit 2

****All cells shaded in BLUE should be completed by carrier****

Actual Observed **Total Allowed Medical Expenditure** Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	2.5%	-2.9%	0.0%	-3.5%	-3.9%
CY 2013	3.8%	1.1%	0.0%	1.3%	6.2%
CY 2014	4.2%	0.3%	0.0%	2.4%	6.9%

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.