



MASSACHUSETTS

Massachusetts Division of Insurance

Informational Hearing

Second Quarter 2016 Small Group Health Insurance Rate Filings

January 11, 2016

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Introduction

Good morning First Deputy Commissioner Anderson, Deputy Commissioner of the Health Care Access Bureau Beagan, Ms. Davidson and Mr. Lewandowski, other staff of the Division of Insurance, fellow panelists, and guests. Thank you for the opportunity to present remarks on behalf of Blue Cross Blue Shield of Massachusetts. My name is Michael Caljouw and I am the Vice President for State Government and Regulatory Affairs for Blue Cross. Alongside me today is Sara Wilcox, FSA, MAAA, who is the Commercial Pricing Manager for Blue Cross. Let me make clear that our remarks today are generally made on behalf of the company with respect to two separate filings before you – your hearing notice noted them as the “Blue Cross Blue Shield of Massachusetts, Inc.” filed rates and the “Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.” filed rates for the Second Quarter of 2016.

Blue Cross Blue Shield of Massachusetts is proud to be a Massachusetts health plan. Since 1937, we have been a Massachusetts company with deep roots in the community. We have 3,600 employees throughout Massachusetts. In 2015, we wrote health insurance for over 2.8 million members, representing over 29,400 businesses across the state and 75% of Massachusetts’ cities and towns. As part of our work, we manage approximately \$ 13 billion in annual health care spending, process 47 million claims and handle more than 2.9 million phone calls annually. We contribute \$1.6 billion in annual economic impact to the Commonwealth.

Before I begin my specific remarks, let me commend the Division of Insurance for your individual and collective leadership in implementing Chapter 224 and the continuing focus you

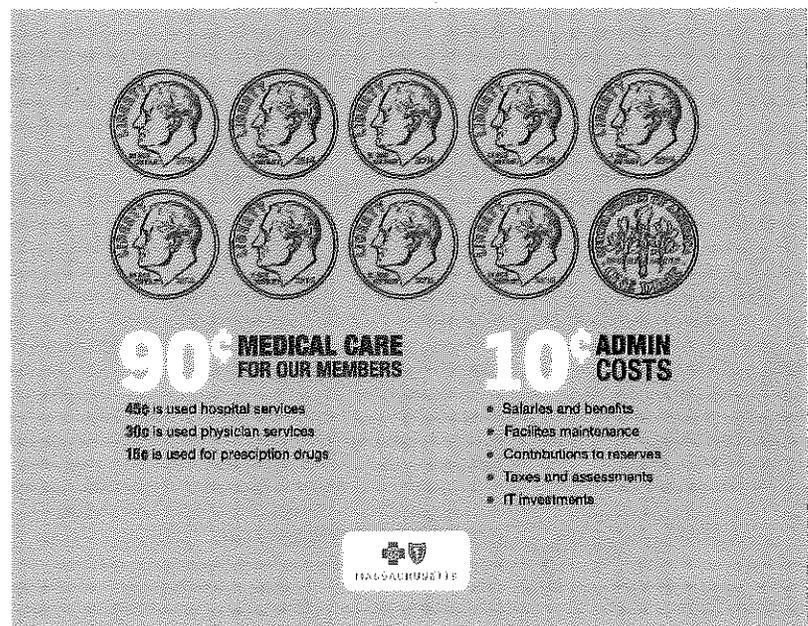
have brought to the critical issue of how we can make high-quality health affordable for everyone in our state while ensuring that the all-important tenets of solvency are met. To Commissioner Judson and his whole team at the Division of Insurance: your ongoing work as a stable, primary regulator of insurance markets, not just in health care but in other insurance fields, ensures that consumers are protected and can receive insurance benefits from solvent and strong companies. I also appreciate your ongoing analytical work that helps facilitate productive conversations about the true drivers of health care costs, as well as potential solutions, as you and your partner agencies at the Health Policy Commission and the Connector continue your collective efforts.

We greatly appreciate the opportunity to participate in today's hearing.

At Blue Cross Blue Shield of Massachusetts, our vision is to make quality health care affordable for the people and employers who choose us as their trusted health plan. We're leading the market in developing new and innovative products and services that simplify our members' interactions with the health care system and support them in choosing the best care at the best price. Importantly, we're partnering with physicians and hospitals to advance new ways of paying for health care with incentives that reward quality over quantity. These steps, along with others, are helping to ensure that our members get the most value for what they spend.

Over the past several years, we've made significant progress in making care more affordable. We've worked aggressively to lower our administrative spending. For example, between 2015 and 2016 alone, we will reduce our spending by more than \$40 million and our total administrative spending in 2016 will be the lowest in nearly four years.

Working with others in a spirit of shared responsibility, we've also made real gains in moderating the cost of medical care. In fact, the growth in our total medical spending has been below the state benchmark established under Chapter 224.



Despite this progress, we recognize that we have much work to do. And, we're committed to working with others to achieve the community's collective goal of high quality, affordable health care.

What is driving increases in health care premiums?

At Blue Cross, over 90 percent of each premium dollar we receive is directed to medical spending on our patients. These medical costs are beginning to increase¹ after historic lows, in part due to:

- A significant increase in pharmacy costs.
- The cost of the Affordable Care Act (ACA) and other assessments.
- The prevalence of chronic illness and the increased cost of new procedures and technologies.
- The cost of providing care, especially in Massachusetts, which has higher labor costs than other part of the country.

What are we doing to address growing medical spending?

To ensure that we're able to continue to deliver affordable products and services to our members, we've developed a comprehensive approach to effectively managing medical spending. Among the steps we are taking:

- We work closely with physicians and hospitals, with the goal of achieving contract terms consistent with the physician and hospital contracts negotiated over the past three years. This is especially important since the price of health care services remains the single largest driver of health care costs and insurance premiums.
- We developed an innovative way to pay for care that focuses on promoting quality and rewards positive health outcomes. We introduced our Alternative Quality Contract (or AQC) in 2008 and it now includes 85 percent of the physicians and hospitals in the Blue Cross HMO network. It is a crucial component of the hard work needed to make quality health care affordable for our members and employer customers; we are proud to state that it is now our predominant contract model with network physicians and hospitals. The alternative payment model fosters shared responsibility for both improving care and moderating the unsustainable rate of increase in health care costs. The AQC is currently one of the largest private payment reform initiatives in the United States and

¹ Health Affairs, National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends, August 2015 vol. 34 no. 8

has become a model for state and national policymakers. An October 2014 study in the New England Journal of Medicine showed that the AQC has improved the quality of patient care and lowered costs in the four years since it was first implemented.

- And now, in 2016, physicians and hospitals in Massachusetts will begin participating in our new payment model that rewards value of care over quantity for our PPO members (who represent about half of our commercial membership). There are now five provider groups participating in this contract and we are working hard every day to expand that group over time.
- We partner with our pharmacy benefits manager, Express Scripts, Inc., to negotiate the best value possible for our members. This is critical, now more than ever. The Health Policy Commission in their recently concluded Cost Trends Hearing specifically called out the vexing issue of pharmaceutical costs. They found that in Massachusetts, “pharmacy spending grew 13% per capita from 2013 to 2014. Trends in MA mirror US growth of 12% per capita growth from 2013 to 2014.” As part of our own work, we negotiated a discount for Gilead Sciences Inc.’s Harvoni and Sovaldi medications to treat Hepatitis C. The discount means that our employer customers will save millions of dollars while making sure that our members continue to access these life-changing drugs. This issue, as noted later, will continue to be a critical issue for all of us in 2016 and beyond.

How are we keeping our administrative costs low?

At Blue Cross, approximately 10 percent of each premium dollar is used to cover administrative costs, such as health and wellness programs, information technology (IT) as well as federal, state and local taxes and assessments. We have found new and better ways to run our business more efficiently so we can keep administrative spending as low as possible.

- Over the past decade, our administrative spending has grown modestly, at an average of one percent per year. This is roughly half the rate of the Consumer Price Index growth over a similar period. In 2016, we expect our administrative spending to be the lowest it has been in nearly four years.
- Massachusetts has some of the strongest administrative expense requirements in the country. As you well know, state and federal law limits what we’re allowed to spend on administrative costs. Health plans are required to pay refunds to customers if our costs exceed that threshold. Blue Cross is the only major health plan in Massachusetts which has not been required to issue a rebate since the law was instituted.
- We pay a significant amount of taxes and fees in order to comply with regulations, such as the Affordable Care Act. This amount continues to increase. For example, in 2013, we paid more than \$177 million in federal, state and municipal taxes and assessments in

2014; in 2014, we paid \$287 million. And in 2015, that number shot up to approximately \$300 million in taxes and assessments.

- Many employees now work remotely and Blue Cross is able to save on the amount of space we lease. This has also resulted in an increase in worker productivity. Additional rental property and data center negotiations produced comparable savings of well over \$2 million per year.

How do we make health care simpler and more responsive to member needs?

We operate in a complex health care system out of step with what consumers demand in many other aspects of their lives, especially when their money or well-being is at stake. That has to change. Whether they're choosing where to get their care, trying to understand a deductible, or managing a health savings account, our members want us to simplify their experience, anticipate their needs, and engage with them on their terms. Guided by our promise to always put our members first, we're developing new programs and tools – some using the latest personal technology and others based on old-fashioned person-to-person outreach – to ensure that we deliver what contemporary health care consumers require.

Some of our innovative products and tools include:

Innovative Offerings

- Our tiered network offerings, *Options* and *Hospital Choice Cost Sharing*, encourage the use of providers that deliver higher quality and lower cost care by creating differences in cost sharing.
- *Healthy Actions* and *Pathways to Savings* engage employees and encourage smarter health care decisions. We currently have more than 1,000 employer customers enrolled covering over 26,000 employees. Over \$3 million in rewards have been earned by more than 11,000 participants to date. Businesses have been awarded approximately \$2 million to date for their participation.
- We offer a full line of ancillary products, including dental and eye insurance products. We are able to sell our products as a bundle, offering our customers one-stop shopping.
- We are beginning to educate our members about new *Value Based Benefit* plans in which members can receive cost sharing reductions when following recommended care for diabetes, asthma and heart disease. Member success with this care is increased by their own knowledge and understanding of out-of-pocket costs, their condition, and management of their illness. This benefit design incents appropriate care by lowering

applicable cost sharing amounts for specific medications and services while also providing members with advice and support in managing their condition.

- Our Smart Shopper Cost Sharing Program creates incentives for members to shop for and use appropriate care by lowering cost sharing amounts.

Easy to Use Tools

- Our BlueCare Line enables all of our members to speak with a registered nurse 24/7 about urgent medical conditions or health questions, and if necessary receive advice in terms of self-care or when to seek urgent or emergency care.
- Our newly introduced Telehealth program – starting this month - provides benefits such as more efficient care and increased access, avoidance of unnecessary trips to the emergency room, convenient in-home medication management and adherence guidance, improved post-surgical outcomes and better integration of behavioral health into primary care practices to manage “whole person care.”
- We offer leading-edge health and wellness solutions such as *A Healthy Me*, our interactive wellness website designed to help members reach their personal wellness goals. These products and tools continue to be a popular option for employers throughout the state, enhancing wellness at the worksite, chronic illness prevention, and careful management of medical costs.
- We have enhanced wellness in the workplace and chronic illness prevention initiatives, especially for the five percent of our members who account for approximately 50 percent of our total medical spending.
- Our Find-A-Doc tool provides real time, personalized estimates to our members, and is now available on both smart phones and tablets.

While health care can be a challenging environment, we work hard every day to improve the patient care experience and lower health care costs. I would remiss if I didn't also touch briefly on one important aspect of our payment innovations of particular interest to state policymakers at the Division of Insurance and elsewhere, and that is the integration of behavioral health and primary care included within the AQC's global budget. One of the most exciting aspects of the AQC is the way it offers physician groups both the incentives and the freedom to innovate, especially when caring for the serious chronic illnesses so often accompanied by emotional issues and depression. Unless the whole person is cared for, these patients can fall into a downward spiral of physical and mental problems that are both debilitating and costly. With behavioral health care as part of the global budget, we applaud this kind of ongoing integration.

And there's one related side note: We are currently launching a behavioral health incentives program for about a dozen hospitals that care for Blue Cross members. It is not a global budget or population management program, but it is significant since it is the first time we have used performance-based measures and incentives to increase accountability for the inpatient care of our members with behavioral health needs.

Specific 2Q Rate Information

With that, I'd like to turn to specific information about our 2016 second quarter rate filings. To provide a sense of scope and detail, we have attempted to answer topics following the specific format suggested by the Division of Insurance.

Scope

Blue Cross Blue Shield of Massachusetts operates in all Massachusetts counties. The rate filings submitted in late December of 2015 are applicable to small businesses renewing in the second quarter of 2016. It should be noted that the second quarter shows an especially high volume of renewals for the smallest account sizes including, for example, the many member groups of the Retailers Association of Massachusetts. In total for BCBSMA, approximately 8,500 employer groups with over 65,000 employees and their dependents are set to renew during the second quarter of 2016.

Products

Turning to product options, BCBSMA offers a variety of plan designs to meet our small account needs, including a range of cost-sharing levels, innovative value-based benefits, enhanced benefits like telemedicine and end-of-life planning, and products that encourage the use of high-quality and efficient providers. For 2016, we are offering 10 Platinum-level plans, 35 Gold-level plans, 25 Silver-level plans, 5 Bronze-level plans, and a Catastrophic plan to the merged market. 8 of these plans are also sold on the Massachusetts Health Connector.

Applicable Rates / Period

We confirm that the rate filing submitted to be effective for 2nd quarter 2016 only applies to those small employers with coverage effective dates between April 1, 2016 and June 30, 2016. We also confirm that the rate filing does not apply to individual coverage because individual rates were established in the 1st quarter 2016 rate filing and will remain the same for all months in calendar year 2016.

Our 2nd quarter 2016 filed rate increase is 4.1 % on average for Blue Cross Blue Shield of Massachusetts, Inc. and 4.3 % on average for Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. These rates are both below our 1st quarter 2016 rate increases approved at 5.0 % on average.

Medical Loss Ratio

Turning to Medical Loss Ratios, it would be helpful to remember that the Massachusetts' Medical Loss Ratio (MLR) (the most restrictive limits in the country) is a measure of the proportion of each premium dollar that is spent directly on claims expenses. Calculations are made for federal programs under the Affordable Care Act and administrative expenses to cover health care quality improvement and fraud, waste and abuse activities. These adjustments are consistent across carriers when performing an MLR calculation. Per Massachusetts Division of Insurance regulation and state law, the prescribed minimum MLR and presumptive disapproval level is 88% for the merged market in 2016. Although 2015 is not final, we expect to meet state MLR requirements for 2015. As a guidepost for you, the 2014 Actual filed MLR was 96.8% for the Parent Company and 92.6% for the Subsidiary.

Projected Costs / Specialty Drugs

Turning to specific questions on provider reimbursement, as noted earlier, Blue Cross continually seeks to improve the quality of care our members receive through performance-based incentive contracts with our network providers. We periodically renegotiate these agreements in a manner to maintain this focus on high-quality affordable care while providing robust network options. It is timely to illustrate the details of our key contracting option called the Alternative Quality Contract. The Alternative Quality Contract model generally works in two important ways that help moderate costs:

Global Payment. In an effort to focus providers on coordinating systems of care and to break away from fee-for-service medicine tied to volume and complexity, Blue Cross will pay providers a "global payment" to cover all of the services and costs associated with their Blue Cross patients. Providers have flexibility in how they use that payment to address the health care needs of their patients. The payment is based on regional medical expense averages and is appropriately adjusted for the age, sex, and health status of the provider's patients, and will also be adjusted annually for inflation.

Performance Incentives. Moreover, performance incentives are directly tied to the quality of care our members receive. They are based on nationally recognized measures for clinical care and patient care experiences. For example, if providers deliver higher quality care on measures

in areas such as cardiovascular disease, diabetes, hospital infections, and pediatric care, they will receive greater incentives from Blue Cross.

As it relates to the various types of medical service categories noted by the Division, we also regularly track the cost and utilization at various levels. In the most recent period, we have observed ongoing volatility among the types of service and do not react to any one data point. Rather, we measure the utilization and severity of healthcare services over time and make projections based on historical data points with adjustments for changes in benefits, demographics and extraordinary events such as weather-related impacts.

One particular category worth noting specifically is Specialty Pharmacy. Specialty Pharmacy continues to show especially high cost trends that we expect will continue for the foreseeable future. In addition to the Hepatitis C drugs that have garnered much media attention, prescription drugs for cancer and the new injectable cholesterol-lowering medications known as PCSK9's are expected to continue driving up cost. We are taking steps to help make these specialty medications more affordable and to control healthcare costs. As seen earlier with the specific example of the Harvoni and Sovaldi discounts that we negotiated, we work closely with our pharmacy benefits manager to secure the best value possible for our accounts and members from the Specialty Pharmacies in our network. In some cases, we also have utilization management programs in place for certain drugs. However, these tools cannot work when there are simply no alternatives to the particular specialty drugs being offered. In 2016, this work will need to be – and will continue to be - an important feature so that our employer customers can save millions of dollars while making sure that our members continue to have access to these life-changing drugs. This issue is specifically noted in this forum since it will continue to impact premiums across the Massachusetts and national landscape for some time.

Administrative Expenses

As set forth in our 2nd quarter 2016 rate filings, administrative expense per member per month (PMPM) inherent in our filed premium rates show a 5.82% annualized decrease from 2014 Actual Administrative Expenses for HMO Blue. Furthermore, as set forth in our 2nd quarter 2016 rate filings, administrative expense per member per month (PMPM) inherent in our filed premium rates show a 8.55% annualized decrease from 2014 Actual Administrative Expenses for the parent company filing. We are justifiably proud of the hard work it took to achieve these decreases. They are both significantly below the NE Medical CPI benchmark which serves as the Massachusetts law's guardrails and therefore clearly satisfy the statutory requirements for our filed rates on this point.

Taxes and Assessments

As noted previously, Blue Cross Blue Shield's payment of taxes and assessments continues to increase. In 2015 alone, the amount paid by Blue Cross was approximately \$300 million, with much of it owing to Affordable Care Act compliance.

One critical part of the federal law includes the mandatory Risk Adjustment pool, a permanent protection. In fact, the Affordable Care Act is hinged upon the successful execution of effective risk adjustment. More than a quarter of a million Massachusetts consumers at Blue Cross and other health plans have already seen – and will likely continue to see – the direct benefits of risk adjustment in the form of premium relief.

How does mandatory risk adjustment work? Congress established the program over five years ago to ensure that high-risk patients continue to get cost-effective insurance and protect them from adverse selection by insurance companies. This a key protection for members that is commonly used in other markets, including, notably, Medicare. Basically, premium relief goes to those members, at BCBSMA or any other health plans that qualify, whenever they are determined by the government to be high-risk. The Massachusetts Connector, assisted by experts at CHIA and the Division of Insurance, established "rules of the road" for risk adjustment well in advance of the first premium relief. This work involved painstaking and detailed claims analysis that was checked and double-checked by state agencies and then verified by outside experts retained by the state. As seen in the final risk scores set by the state and confirmed independently, our members again made up a large share of higher-risk members. As a result, our members received direct premium relief, as far back as 2013 filings. It should be noted that other health plans with higher-risk membership likewise fell into the same category when claims were fully analyzed.

We would note that future pool estimates can change materially during the course of the year due to, among other items:

- new entrants and terminating members;
- changing health status, demographics and benefits of each carrier's members;
- uncertainty around subsidized enrollment;
- reporting errors resulting in inaccurate issuer and state estimates; and
- incomplete reporting.

Final risk scores and transfer payments for a given Calendar Year period are released 6 months *after* the end of the year. In addition, Massachusetts will be moving to the Federal risk adjustment methodology in 2017. This will also be expected to create some volatility in the results.

Reserves

Reserves are a bedrock principle of insurance regulation ensuring a critical safety net for insurance consumers – in health care and in every insurance product. Reserves provide security against the unknown and ensure stability so we can always pay our members' claims – in good times and bad. For context, as of year-end, Blue Cross' present reserves levels allow the payment of:

- 45-50 days or less than two months of typical claims and administrative expenses for each of our members
- \$650-\$700 for each of our members
- Three-to-four routine office visits for each of our members (or one emergency room visit).

Contribution-to-reserves or as the Division regulations call it, "contribution-to-surplus" is measured as a percent of premium and is set at a level required to maintain a certain level of Risk-Based Capital, or RBC. The contribution-to-surplus for all products in this filing is 1.0%, which is well below the state merged market statutory threshold of 1.9%.

Rating Factors

We also confirm – in response to the Division's question - that the 2nd quarter 2016 rate filings do not include any changes to the rating factors that are in use for the 1st quarter 2016 rates. This is consistent with both Massachusetts and federal law.

Conclusion

In conclusion, for the past two years, total medical spending at Blue Cross Blue Shield of Massachusetts has been below the state-set cost benchmark, and we believe our collective work (including the expanded payment reforms outlined today) will help us to maintain and improve upon that trend.

At the same time, we are well aware of some "red flags." As is the case with all private and public payers, we are especially concerned about the rising costs of new, breakthrough therapies, technologies and drugs that hold so much promise for people with serious medical

conditions. We are all going to want these drugs for ourselves and our families and our workers, and we will want health insurance to cover them. But as our recent experience with life-saving hepatitis C drugs has shown, they come with very high price tags. As a community, we must be willing to tackle some very tough questions: What is the right price for new drugs and therapies? What is their appropriate use and who decides? How can we achieve a better balance between medical advancements and affordability?

There is no doubt that health care costs continue to be a disproportionate burden in our state – eating into individual and family budgets, making our businesses less competitive, and crowding out other government spending priorities. While we at Blue Cross are proud of the progress we have all made in recent years, please know that we will continue to work hard to ensure that that progress continues.

Thank you for the opportunity to shed additional light on the important topic of health care costs.



January 11, 2016

Daniel R. Judson, Commissioner
Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Commissioner Judson:

Boston Medical Center Health Plan, Inc., d/b/a Boston Medical Center HealthNet Plan (BMCHP), provides the following testimony in response to the Division of Insurance (Division)'s Notice of Informational Hearing, dated December 30, 2015, regarding the Second Quarter 2016 small group health insurance rate filings. BMCHP is pleased, to provide the Division with the data and assumptions used to develop BMCHP's proposed rates, including an explanation of the most significant factors affecting BMCHP's rate development. BMCHP appreciates the opportunity to provide information on BMCHP and its Second Quarter 2016 rate filing.

BMCHP commends the Division and the Administration for its efforts to increase transparency related to health care costs, and we share the concerns regarding the impact rising health care costs. BMCHP is committed to providing high quality, low premium merged market product offerings in partnership with the State.

Through its testimony, BMCHP will provide an overview of its business and presence in the Massachusetts merged market. BMCHP's testimony will also provide a high level overview of how BMCHP's merged market premium rates are developed and some detail on key drivers that place upward pressure on BMCHP's merged market premiums. Finally, BMCHP's testimony will provide details on the programs and initiatives that BMCHP employs throughout its entire business to provide its customers efficient, high quality care.

By way of summary, BMCHP, in its Second Quarter 2016 merged market rate filing, is proposing an average composite year-over-year rate increase of 0.6%. This represents a 0% increase over BMCHP's First Quarter 2016 merged market premiums that have been previously placed on file. BMCHP has 7 accounts totaling 26 members that are renewing in the second quarter of 2016 and that will be impacted by this rate change.

BMCHP Profile

BMCHP is a managed care organization that primarily focuses on providing health insurance in partnership with the Commonwealth to individuals eligible for MassHealth and other subsidized coverage, including ConnectorCare. BMCHP was established by Boston Medical Center (BMC) in 1997 as a 501(c)(3) not for profit organization. It was organized to support the mission of BMC, and to participate in the Massachusetts Medicaid program. BMCHP's mission is to provide and enhance access to effective,

efficient medical care among low income, underserved, disabled, elderly and other vulnerable populations.

Commonwealth Care Program:

With the passage of Massachusetts health care reform in 2006, the State established the Commonwealth Care Program to make subsidized health insurance available to eligible adults with incomes up to 300% of the federal poverty level (FPL). As you know, the program provided coverage for individuals who were not eligible for Medicaid and who generally did not have access to employer-sponsored insurance. BMCHP was one of the original managed care organizations to participate in the Commonwealth Care program, and from 2007 through 2014 BMCHP covered between 36,000 to 85,000 Commonwealth Care members annually.

Commonwealth Choice Program:

Also as part of Massachusetts health care reform, the Health Connector subsequently established the Commonwealth Choice Program in 2007 where eligible individuals and small groups could shop for unsubsidized/commercial health insurance coverage. BMCHP entered the Commonwealth Choice market in 2012 to support these individuals and small businesses. BMCHP's Commonwealth Choice membership was very modest with approximately 200 members in 2012, 400 members in 2013, and 100 members in 2014.

Qualified Health Plan (QHP)/ConnectorCare Program:

In response to the enactment of the Affordable Care Act (known as the ACA), Massachusetts established Qualified Health Plans (QHPs) in 2014 that were required to meet certain benefit (Essential Health Benefits) and cost-sharing standards (Actuarial Value). With these new QHPs under the ACA, the State discontinued both the Commonwealth Care and Commonwealth Choice programs formed under the State's health care reform efforts.

Massachusetts also established a new subsidized program known as the ConnectorCare Program. The program was created to serve essentially the same population segment as its predecessor program (Commonwealth Care): individuals with incomes of up to 300% of the FPL. Like Commonwealth Care, ConnectorCare includes three plan types with progressively higher cost-sharing depending on an individual's ability to afford certain premium levels. In addition, the ACA also made available federal subsidies known as premium tax credits and cost-sharing reductions for individuals with incomes of up to 400% of the FPL.

As the Health Exchange for the Commonwealth, the Health Connector serves as the marketplace that allows eligible individuals to shop and purchase ACA-compliant QHPs that are divided into four metallic tiers - Platinum, Gold, Silver, and Bronze - each representing a range of premium and cost sharing options.

In response to these changes under federal health care reform, BMCHP began offering QHPs through the Health Connector in 2014 in an effort to continue to serve the prior Commonwealth Care population as it transitioned to the new ConnectorCare program.

BMCHP Overall Membership

As primarily a Medicaid managed care organization, BMCHP serves approximately 295,000 members across Massachusetts and New Hampshire, 90% of which are Medicaid members and 10% of which (or 31,000) are Massachusetts Merged Market Members.

Current population – subsidized vs. unsubsidized, individual vs. small group:

Of BMCHP's 31,000 merged market members, 99.8% are non-group individuals and 90% (or 27,000) of them receive subsidies from federal and state government sources. Only 57 or 0.2% of BMCHP's members are small group members.

Product offerings / Networks / Service Areas:

In 2016, BMCHP offers one Platinum, two Gold, one Silver, and one Bronze plan. BMCHP does not offer a catastrophic plan. BMCHP's Silver product offering is largely statewide with the exception of service areas within Berkshire county, Martha's Vineyard, and Nantucket. It is through this Silver product offering that BMCHP serves its ConnectorCare population. BMCHP's other metallic tier products primarily serve the Greater Boston area service area.

Number of accounts / members impacted by 2Q rate filing:

Under the ACA, premium rates for non-group business are set once annually through each year's first quarter rate filings. Currently, small group rates are allowed to change on a quarterly basis.

Only seven (7) accounts totaling twenty-six (26) members are impacted by BMCHP's Second Quarter 2016 rate filing. The rates contained in BMCHP's rate filing submitted to be effective for second quarter 2016 only apply to those small employers with coverage effective dates between April 1, 2016 and June 30, 2016. This rate filing does not apply to individual coverage because individual rates were established in the First Quarter 2016 rate filing and will remain the same for all months in calendar year 2016.

As previously outlined, the average composite rate change year over year for BMCHP's second quarter 2016 premium rates is 0.6%. The premium rates that BMCHP is proposing for Second Quarter 2016 are the same as BMCHP's rates placed on file for First Quarter 2016.

BMCHP's Pricing Approach

At the highest level, BMCHP develops merged market premium rates by developing a credible set of historical claims data that is representative of its anticipated membership. BMCHP relied heavily on its prior Commonwealth Care program claims experience because it anticipated that the vast majority of members would be in the ConnectorCare

program which serves a very similar population. BMCHP then projects the historical claims data forward to the 12 month period for when the premium rates will be effective. BMCHP relies on its MassHealth Medicaid program trends in concert with national commercial market trend information for projection purposes.

Once historical claims data is projected to the premium rate period, BMCHP layers on any claims or premium related adjustments that are unique to the projection period. These adjustments include but are not limited to projected estimates for new benefits, sub-capitations, reinsurance recoveries, risk adjustment transfer amounts, medical management savings initiatives and pharmacy rebates. Finally, BMCHP includes allowances for administration, taxes, fees, and contribution to surplus.

Percentage of Projected Medical Costs for FFS vs. Capitations

Ninety five (95) percent of BMCHP's projected medical cost as included in its Second Quarter 2016 rate filing is associated with fee for service medical payments, whereas the remaining five (5) percent is associated with sub-capitation payments for behavioral health. The main categories of cost drivers are as follows:

- inpatient hospital admissions which comprise approximately 17% of total medical expense;
- outpatient radiology/lab/pathology costs which comprise approximately 15% of total medical expense;
- all other outpatient hospital costs which comprise approximately 18% of total medical expense;
- physician and other professional provider related costs which comprise 21% of total medical expense;
- pharmacy costs which comprise approximately 22% of total medical expense;
- behavioral health sub-capitation which comprises 5% of total medical expense; and
- the remaining 3% is attributable to durable medical equipment and other services.

Key Cost Pressures and Drivers

Despite BMCHP's nominal proposed annual rate increase of 0.6%, there are two specific areas of note that place significant pressure on BMCHP's merged market premium levels:

Specialty Pharmacy. New, innovative specialty drugs continue to be released into the marketplace. While these drugs provide important cures and treatments, many come with a high price tag per treatment and in addition, some apply to relatively large population bases. Specialty pharmacy costs for BMCHP's Medicaid population increased by 28% in 2015. Specialty pharmacy costs now comprise more than 25% of total pharmacy cost, and it is one of the main drivers of medical cost trend. This trend is expected to continue into the future as more potential breakthrough drugs come into the marketplace.

Risk Adjustment. The ACA established a risk adjustment program to provide marketplace stability and promote competition. It strives to do this by transferring premium dollars from merged market issuers with relatively low health acuity populations to merged market issuers with relatively high health acuity populations.

The existing federally certified risk adjustment program creates significant volatility that impacts premium development. The volatility is driven by the potential magnitude of transfer amounts as well as challenges in accurately estimating the risk adjustment transfer percentages, particularly for issuers like BMCHP, whose merged market population is changing significantly.

The use of the statewide average premium in determining risk adjustment transfer amounts contributes to the volatility as it can cause disproportionately large transfer amounts relative to an issuer's premiums. Challenges in estimating significant components of premium such as risk adjustment transfers place a great deal of pressure on premium levels.

Commitment to Affordability

Notwithstanding these pressures on health care premiums, BMCHP is committed to keeping health care affordable for its employers, consumers, and stakeholders. BMCHP has employed a number of initiatives to promote the affordability of health care coverage. The following is an overview of the clinical programs BMCHP has in place to promote the affordability of quality health care coverage.

Care Management:

BMCHP's care management program provides members the information and tools they need to build and maintain a healthy lifestyle, and manage any medical conditions they may have. Our care management program is free for members (adults and children). BMCHP's experienced staff includes registered nurses, licensed social workers, and trained health care coordinators. BMCHP staff works with members to help them get the right information and services so they can manage their condition and be healthy. BMCHP's care management program includes the members, their health care providers, and BMCHP staff, working together to help members be healthy. BMCHP care managers are in touch with members to check on their progress, provide education about their condition, and help coordinate care with all necessary health care providers.

BMCHP also helps members learn what benefits and community resources are available because we want to help them with more than just health care. Our experienced staff can link members with services such as transportation to health care appointments, food stamps, housing and emergency shelter, assistance with utilities, and support groups. These community resource services are available to all members, not just those enrolled in care management.

Medical care management, including disease management, consists of the following program levels to make sure members receive the appropriate level of care management. The levels are:

- HealthCare Education
- Population Management
- Transition to Home
- Complex Care Management

In addition to our medical care management program, through our behavioral health partner, Beacon Health Strategies (Beacon), BMCHP offers members Behavioral Health Care Management and Intensive Clinical Management (ICM) services. For members with both medical and behavioral health care needs, BMCHP ensures full coordination of care.

Behavioral Health Care Management:

BMCHP supports members with certain behavioral health conditions in partnership with Beacon. Our care managers are licensed behavioral health clinicians that are trained to help members with their behavioral health care needs. With Beacon, we can help members to find a behavioral health counselor near the member or explain available treatment options. Some of the conditions followed in this program are:

- Depression
- Emotional distress significantly impacting relationships, school, work, job performance
- Difficulty with sleep or eating patterns
- Mental health needs such as bipolar disorder, mood disorder, psychotic disorders, schizophrenia
- Substance use or misuse such as alcohol, pain medications, illegal drugs

Intensive Clinical Management:

The ICM program provides additional support. This is a care management program for members who are experiencing complex behavioral health or psychosocial conditions, sometimes in addition to medical concerns.

Pharmacy Management:

Finally, BMCHP employs number of pharmacy expense management initiatives, including Prior Authorization, Quantity Limitation, Step Therapy, Mandatory Generic requirements, and New to Market Medication Management.

Medical Loss Ratio (MLR)

The programs and initiatives described above help manage medical claims expense levels. Medical claims expense is the most significant component of premium. Medical Loss Ratio represents the percentage of its premium an insurer spends on medical claims

expense for its members. It is traditionally expressed as a percentage. For example, a 90% MLR means that 90% of the premium an insurer writes is spent on medical claims expense for its members. Medical claims expense primarily includes payments to health care providers, but also includes expenditures on activities that promote the improvement of healthcare quality as well as ACA risk mitigation transfers (e.g. risk adjustment transfers, reinsurance recoveries, and risk corridor transfers). Premium includes the value of healthcare policies sold less taxes, fees, and fraud, waste, and abuse prevention expenditures.

An insurer in the state of Massachusetts is required to spend at least 88% of its premium dollars on medical claims expense for its merged market members. BMCHP has included an MLR of 91.6% within its Second Quarter 2016 rate filing. This means that BMCHP expects to spend 91.6% of collected premium on medical claims expense for its members.

Administrative Expenses

Another component of premium is administrative expense which represents the cost that the health plan incurs to administer the program. In its Second Quarter 2016 rate filing, BMCHP included a 1.5% year-over-year increase in non-tax, non-government fee related administrative expenses. This increase represents general inflation on the cost required to administer the complexity of ACA programs.

In terms of government taxes and fees, BMCHP has incorporated the following ACA-related fees into its premium rate development: the Patient Center Outcomes Research Institute (PCORI) fee; the transitional reinsurance fee; the risk adjustment user fee; the exchange user fee; and other state assessments such as the Health Safety Net Surcharge.

Because BMCHP is a non-profit organization with greater than 80% of its revenues derived from government programs, it is currently not liable for the ACA insurer fee. Therefore, this fee is not included in its merged market premium rates. The year over year change in government taxes and fees is -0.3% driven by the lower transitional reinsurance estimate in 2016. Overall, BMCHP's administrative expense in 2015 was in the top 25th percentile of Medicaid managed care organizations in the nation.

Contribution to Surplus

The final component to premium is contribution to surplus. Insurance companies are required to maintain certain capital requirements, also referred to as surplus, in order to operate. Adequate levels of surplus must be maintained in order to ensure all valid claims are paid in a fair and timely manner. Whereas for-profit insurers are able to sell shares in order to accumulate surplus, non-profit insurers accumulate appropriate surplus through periodic contributions. Contribution to surplus refers to the portion of an insurer's premium that is reserved to ensure appropriate surplus levels.

BMCHP targets a contribution to surplus of 1.9% for its entire merged market business. The contribution to surplus percentage included in BMCHP's Second Quarter 2016 rate filing is unchanged from its 2Q15 rate filing.

Rating Factor Change Confirmation

BMCHP's Second quarter 2016 rate filing does not include any changes to the rating factors that are in use for the 1Q16 rate filing.

Conclusion

In conclusion, BMCHP reiterates its commitment to provide high quality, low premium merged market product offerings in partnership with the State. While BMCHP has a significant presence in the non-group market, specifically the ConnectorCare population, its small group portfolio is very small and its Second Quarter renewals comprise of seven accounts totaling 26 members. Despite the current volatility in the market, BMCHP has proposed a nominal 0.6% year-over-year increase for its Second Quarter 2016 premium rates and no change from its First Quarter 2016 rates.

BMCHP thanks the Division again for the opportunity to provide it with information on the data and assumptions used to develop BMCHP's proposed rates, including an explanation of the most significant factors affecting BMCHP's rate development of its Second Quarter 2016 rate filing.

Sincerely,



Michael Guerriere
Chief Actuary

January 14, 2016

BY EMAIL TO Healthcare2016@state.ma.us

Honorable Kevin Beagan
Deputy Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02117

Re: Health Plans Informational Hearing

Dear Deputy Commissioner Beagan:

Thank you and your colleagues, First Deputy Commissioner Anderson and Heath Actuary Lewandowski, for affording ConnectiCare of Massachusetts, Inc. ("CMI") the opportunity at the Division's Informational Hearing on January 11, 2016 to provide oral comments in support of our small group health insurance rate filing for the 2nd Quarter of 2016.

CMI has proposed a composite rate increase of approximately 18.6 percent for the 2nd Quarter of 2016. The expected Medical Loss Ratio in the filing is 90.8%, well above Massachusetts' 89% minimum. The filing does not include any changes to the rating factors that are in use for CMI's 1st Quarter 2016 rate filing. CMI has a total of approximately 1300 members in Massachusetts. Of those, approximately 340 members in 91 groups will be impacted by the proposed rate increase. The filing applies to two Platinum plans, seven Gold plans, and five Silver plans.

As you requested at the Informational Hearing, the purpose of this letter is to summarize in writing the comments I made on behalf of CMI on January 11. CMI wishes to emphasize the following points in support of its current rate filing.

1. At a very high level, CMI's costs fall into two categories: medical costs for the care and prescription drugs our members receive and administrative costs for doing business, including expenses related to complying with the requirements of the Affordable Care Act.
2. The key drivers behind the proposed rate increase are:

- a) **Baseline Experience:** When building rates for a future year, we begin with the underlying known costs in an earlier period called the “experience period.” Our current 2016 rate submission is based on the historical experience of our merged market business in Massachusetts. Given the relatively small size of our Massachusetts business, experience from one year to the next is subject to fluctuations. According to actuarial standards, a book of business of this size is not considered credible for rate setting. In order to enhance the credibility of the experience, we use three years of historical claim experience in setting our rates.
 - b) **Medical Trend:** “Medical Trend” is projected future change in costs for services. Each year the cost of medical services changes. Our members’ use of medical services also changes. To the extent that individuals are using different health care services from the ones they used in the past, and to the extent that the costs of that care are different from the costs in the past, the amount of premium we charge changes, too.
 - c) **Specialty Drugs:** The introduction and use of so-called “specialty drugs” is a key driver of medical trend. For example, the class of specialty drugs that cure Hepatitis C – Sovaldi, Harvoni and Vekira Pak – became available to the public in early 2014, and the use of these drugs has skyrocketed. Specialty drugs are typically very expensive: Sovaldi and Harvoni each carry a price tag of up to \$100,000 per course of treatment. As we look ahead, we know that drug costs will be affected by the recent introduction of a class of specialty drugs known as “PCSK9,” which treat high cholesterol. We expect that the PCSK9 specialty drugs will cost between \$7,000 and \$12,000 annually for each person taking them, and that person must take these drugs for life.
 - d) **Massachusetts Risk Adjustment Program:** As related to the 2014 benefit year, CMI paid \$1.2 million into this program, and expects to pay for both 2015 and 2016.
 - e) **Insurer Fee and Other Costs:** CMI anticipates increases in administrative expenses and fees associated with compliance with the federal regulatory requirements of the Affordable Care Act including, in particular, the Health Insurer Fee, and with the complex technical rate filing requirements of regulation 211 CMR 66.09 (which has a disproportionate cost impact on smaller health plans, such as CMI).
3. Approximately 97% of the costs in CMI’s rate filing is associated with Fee for Service costs, constituting approximately \$401.67 per member per month.
 4. CMI’s administrative costs are decreasing as a portion of its rates. Administrative costs represent approximately 9.5% of the filed rates, compared to 11.2% in our 2nd quarter 2015 rate filing.
 5. Taxes and other government programs (and in particular the Insurers Fee and the Risk Adjustment program) add \$27.19 per member per month, or 5.7% to the filed rates. This represents an increase of \$22.23 from the 2nd quarter 2015 filing. Specifically, the

Affordable Care Act imposed an industry-wide fee on health insurers as a way to fund the costs associated with the Act. In 2016, this fee will collect \$11.3 Billion from the insurance industry. This fee was not included in the 2nd Quarter 2015 filing, and represents \$10.63 per member per month in the latest filing. It is anticipated that CMI will be required to pay into the Risk Adjustment program. This adds \$12.88 per member per month to the rates.

6. In this filing CMI projects a contribution to surplus of approximately 1.9% of the proposed rate. This is consistent with the assumption in the 2nd Quarter 2015 rate filing.

In closing, we hear the impact rate increases have on our members. We take our responsibility to control costs very seriously. We pledge to continue to do everything reasonably possible to control the rising cost of health care and health insurance for our members, while making it easy for them to get the care they need. One measure of our success comes from the National Committee for Quality Assurance which ranked ConnectiCare in the top 15% of health plans in the country.

As a leader in our home state and in Massachusetts, our goal has been, and continues to be, to partner with all constituents to bring about the changes needed to deliver high quality, affordable health care to all.

Thank you for your consideration of CMI's rate filing.

Sincerely,

A handwritten signature in blue ink, appearing to read "Neil S. Kelsey". The signature is fluid and cursive, with a long horizontal stroke at the end.

Neil S. Kelsey FSA, MAAA
Vice President & Chief Actuary
ConnectiCare, Inc.

January 11, 2016

Division of Insurance Public Informational Hearing

Fallon Health

We are committed to *making our communities healthy*

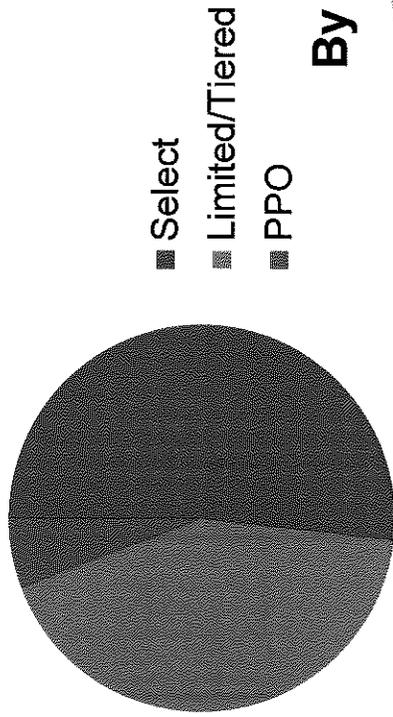


About Fallon Health

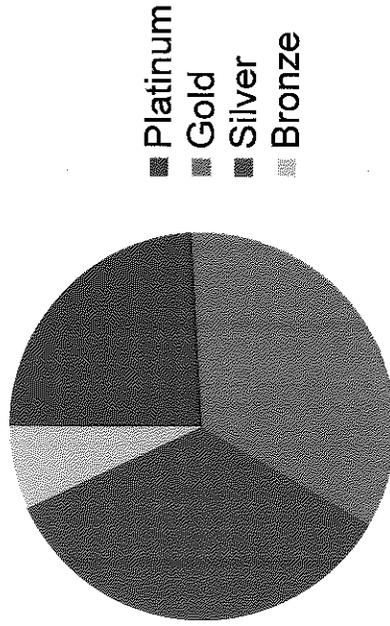
- Founded in 1977, Fallon Health provides health care services designed to meet the unique and changing needs of all we serve.
- Fallon is the only health plan in Massachusetts that is both an insurer and provider of care.
- Our insurance and self-insurance product portfolio includes a variety of group and non-group health plan options (limited and broad network HMOs, PPO, ASO, ConnectorCare, Medicaid, Medicare Supplement and Medicare Advantage plans) featuring flexible and innovative benefit designs.
- In addition, Fallon offers a Program of All-inclusive Care, called Summit ElderCare®, and a Medicare Advantage Special Needs Plan/Senior Care Options program, called NaviCare.
- Our uniquely developed provider networks offer high-quality, cost-effective, coordinated care and give our members access to physicians and hospitals throughout Massachusetts and southern New Hampshire.
- We offer a broad spectrum of health and wellness services and programs to ensure our members, at every stage of life, remain as healthy and productive as possible.

As of November 2015, Fallon Health had 31,000 Merged Market Members

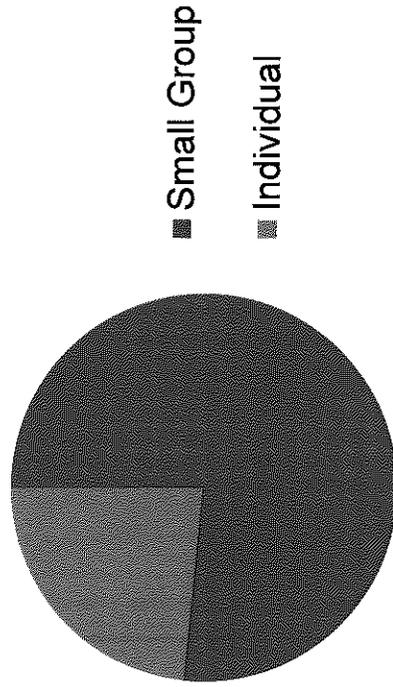
By Product



By Metallic Level

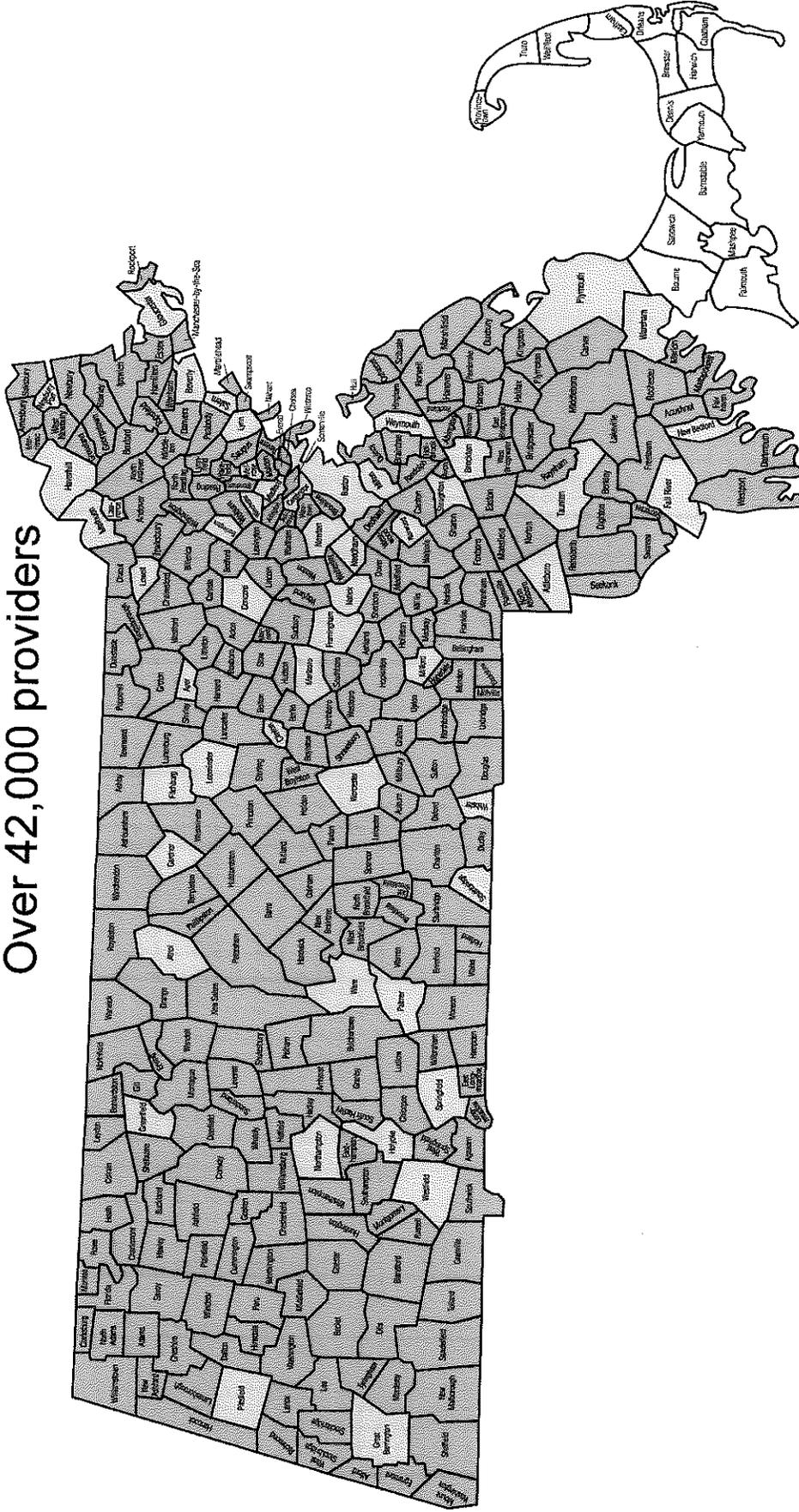


SG versus Individual



Select Care

Over 42,000 providers

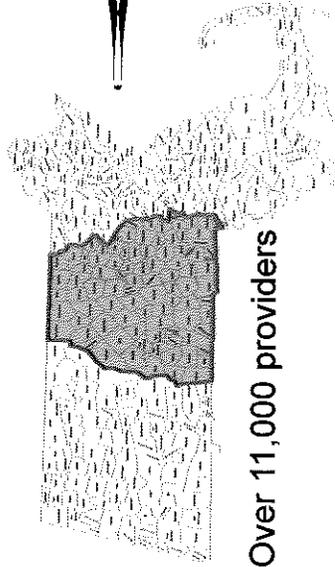


Limited HMO network

Direct Care

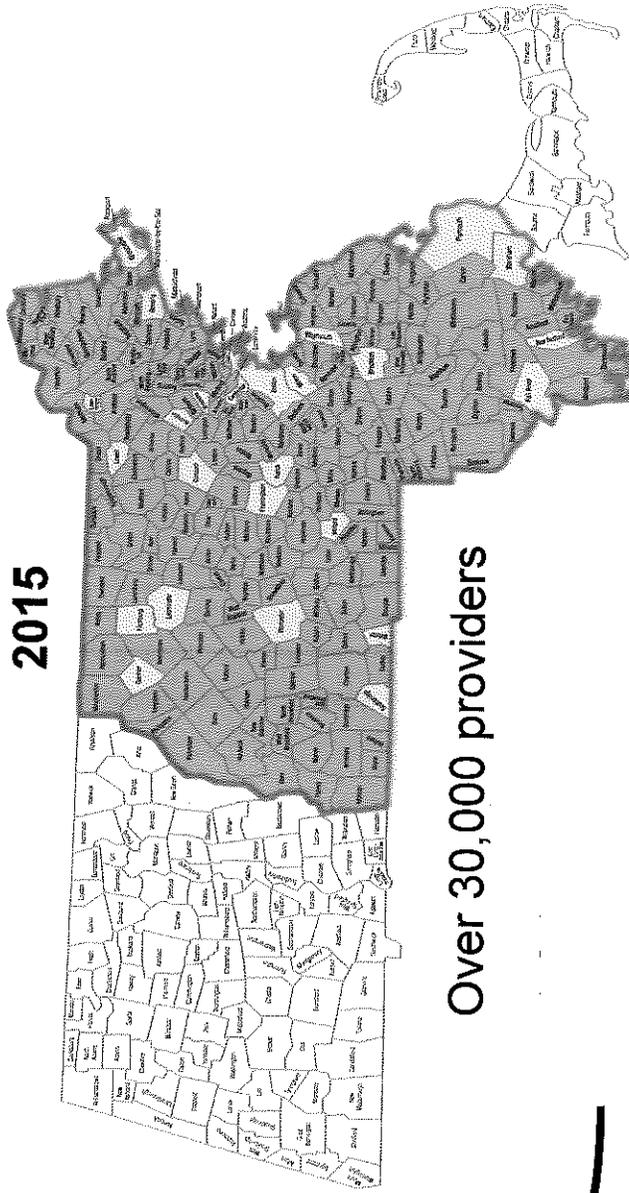
the evolution of a limited network

2002



Over 11,000 providers

2015



Over 30,000 providers

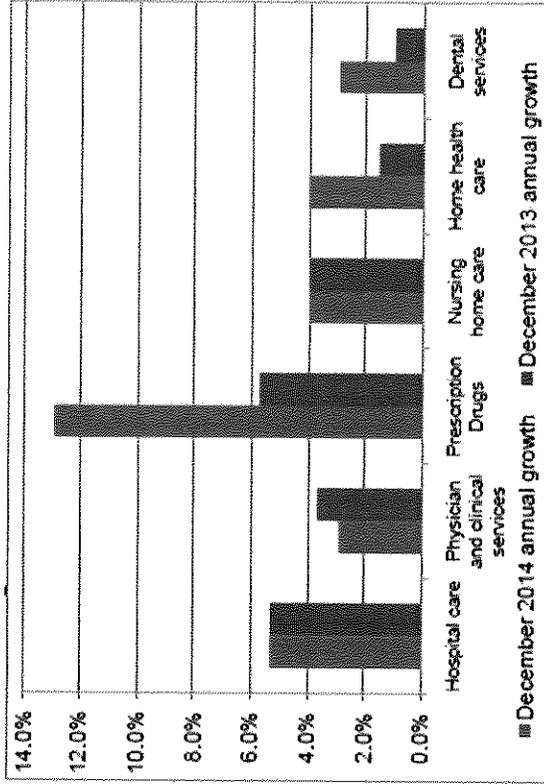
This plan provides access to a network that is smaller than the Select Care network. In this plan, members have access to network benefits only from the providers in Direct Care. Please consult the Direct Care provider directory—a paper copy can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fallonhealth.org to determine which providers are included in Direct Care.

Keys to a successful limited network

- ✓ The right providers
 - Perform most of their care in the community setting
 - Closely coordinated between PCPs, specialists and community hospitals
- ✓ Pricing
- ✓ Choice
- ✓ The right incentives
- ✓ Member and provider education

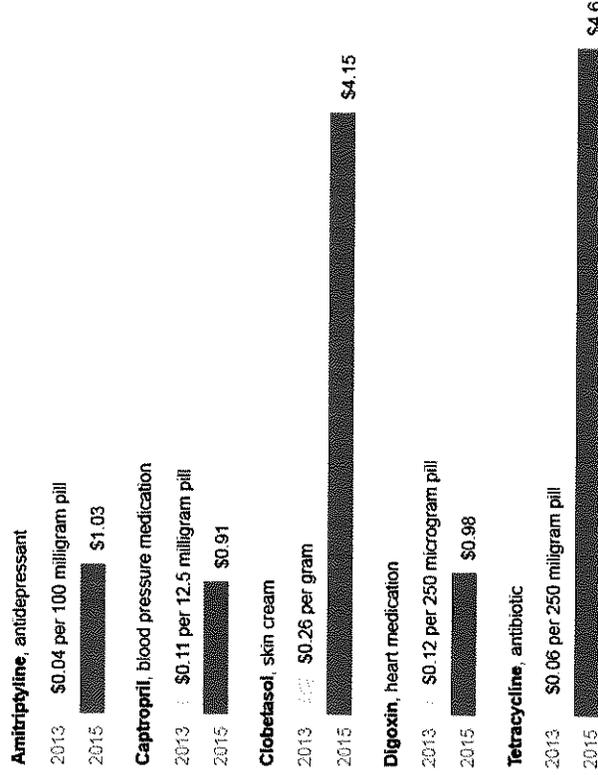
1. Nationwide pharmacy costs are increasing in double digits year over year, outpacing other components of medical care. Nearly all of the change is a result of an increase in the average cost per prescription.

Health spending year over year



Rising drug prices

How select drugs have changed in price over the last two years:



Source: EvaluatePharma – Priyanka Dayal McCluskey, Globe Staff, November 06, 2015

2. Affordable Care Act

- Fallon's Q2 Merged Market Rates would be 6% lower if we did not need to account for ACA's risk adjustment provision.
- ACA has added assessments and fees to the system and also added administrative burdens.
- The lack of having a fully funded risk corridor program has created additional risks and uncertainty for health plans.

3. Provider consolidation and higher priced care settings

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12, § 11N

Report for Annual Public Hearing Under G.L. c. 6D,



SEPTEMBER 18, 2015

Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12, § 11N

efforts, including expansion of tiered network products and global payment arrangements. At the same time, unexamined price variation among providers persists. More expansive payments, while having positive effects, have tended to entrench historic payment differentials, and have thus sustained disparities in the resources available for patient care. These trends, coupled with new growth in pharmacy costs and utilization of health care services, project spending increases below the 3.6% benchmark the Commonwealth set for 2015. This suggests that additional efforts to address underlying market dysfunction may be warranted.

We suggest that longer term solutions require continued investment in innovations that strengthen the capacity of the health care system to deliver high quality care and expand consumer choice, particularly by leveraging the critical role of employers in shaping the cost and quality of health care options available to their employees. We also suggest ways to improve existing initiatives to help ameliorate other than entrench historic disparities. We recognize that more direct regulatory interventions merit consideration as well, and may help set some guardrails for meaningful improvement of continuing market dysfunction. Our principal findings and our principal findings and set forth recommendations for enhanced interventions, market based as well as regulatory, to address continuing market dysfunction.

Our principal findings:

- A. There has been progress in both consumer directed and provider oriented initiatives, but important challenges remain:
 1. Consumers are interested in obtaining information on the price of health care services but experience challenges in doing so.
 2. Enrollment in tiered insurance products has increased, but the presence of these products has not resulted in an overall shift in patient volume away from higher priced providers. Current approaches appear hampered by inconsistent incentives for consumers to obtain care at higher value providers.
 3. Massachusetts has continued to expand its use of global payment arrangements and is a national leader in adoption of these types of alternative payment approaches. However, like fee-for-service payments, global payments continue to vary in ways that are not patient centered. This results in widely differing details available to care for similar patient populations.
- B. Market dysfunction persists, with continued cost and access consequences for consumers:
 1. Price variation unexplained by quality persists, contributing to providers having different levels of resources to carry out their mission.
 2. Across the state and within specific regions, higher priced providers continue to draw greater patient volume.
 3. Projected growth in health care spending underscores the urgency of addressing market dysfunction. Such projected increases in pharmacy costs and utilization

Statewide Summary

More expensive providers continue to draw greater patient volume, adding to health care costs. Global payments, while having positive effects, have tended to entrench historic payment differentials, and have thus sustained disparities in the resources available for patient care. These trends, coupled with new growth in pharmacy costs and utilization of health care services, point to a likely failure to hold health care spending increases below the 3.6% benchmark the Commonwealth set for 2015.

Fallon Health filed for 39 specific products across our multiple networks for the Q2 Merged Market filing:

<u>Metallic Level</u>	<u># of Products</u>
Platinum	8
Gold	14
Silver	13
Bronze/Catastrophic	4

Basic Facts on our Filing

- Fallon's Q2 2016 Merged Market filing applies to small employers with coverage effective/renewal dates between April 1, 2016 and June 30, 2016.
- Any individuals applying for coverage would fall under rates submitted in our Q1 2016 Merged Market filing.
- There has been no change to rating factors between our Q1 2016 Merged Market filing and our Q2 2016 Merged Market filing.
- Fallon Health made considerable changes to rating factors in our Q1 2016 Merged Market filing, including:
 - Elimination of size and industry factors
 - Changes to our regional pricing factors
 - Changes to the underlying sloping of our product/network factors
 - Built new products

Fallon filed Q2 Merged Market rates for two companies:

Fallon Community Health Plan (*HMO designs*):

Our year over year rate change from Filing exhibit 66.09(3)(a) that we filed for Q2 2016 calculated at 12.08%

Fallon Life & Health Assurance Company (*PPO designs*):

Our year over year rate change from Filing exhibit 66.09(3)(a) that we filed for Q2 2016 calculated at 14.89%

Fallon's process for setting rates

- Quarterly trend process
- Data/Assumption gathering
- Core Rate Review process
- Review with Leadership
- Filing Process

Our process utilizes claims information incurred through August, 2015 and paid through October, 2015. The rate review process and filing utilize the latest 12 months of incurred data to trend off of (September, 2014 through August, 2015 paid through October, 2015).

As we review and set trends on a quarterly basis, we generally utilize three methods:

- Build-up approach
 - Anticipated changes to utilization
 - Quantify known and unknown unit cost changes over time; we spend considerable time reviewing the assumptions from our Network Development team
 - Estimate the impacts from mix and intensity
- Allowed cost trend methodology
 - Group similar cost sharing plans together and review how they have trended over time
- Target Medical loss ratio (MLR) trend methodology
 - What trend was needed from our historical rate review to hit our targeted MLR

Final trends utilized for the filing equate to:

- Medical trend of ~7.25%
- Pharmaceutical (Rx) trend of ~16.6%
- Total trend expectation of ~8.9%

Components of the Medical trend

- ~25% utilization
- ~25% mix/intensity
- ~50% unit cost

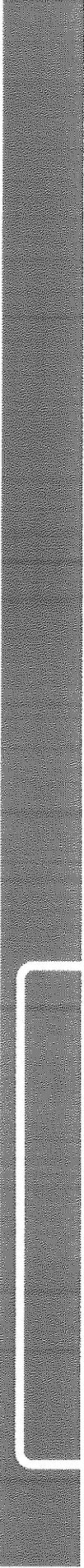
Components of the Rx trend

- ~25% utilization
- ~75% mix/intensity/unit cost
- Specialty Rx = mid 20's impact

- Fallon's filed MLR level is 89.7% using the State's formula {Filing exhibit 66.09(3)(j)} which is consistent with the MLR rebating formula.
- This formula uses:
 - A numerator of Incurred Claims +/- Risk Adjustment – Federal Transitional Reinsurance Recoveries + Health Care Quality Improvement Expenses + Deductible Fraud and Abuse Detection/Recovery Expenses
 - And a denominator of Earned Premium – Taxes and Fees
 - Numerator / denominator cannot be less than 88%
- Out of the remaining 10.3% the large majority goes towards our administrative costs with a contribution to surplus of only 0.13% {Filing exhibit 66.09 (3)(i)}
- Fallon's Legal/Regulatory Affairs department is reviewing the potential moratorium on the ACA assessment. We anticipate this will lower our proposed rates by about 4/10^{ths} of one percent.

Increase explanation

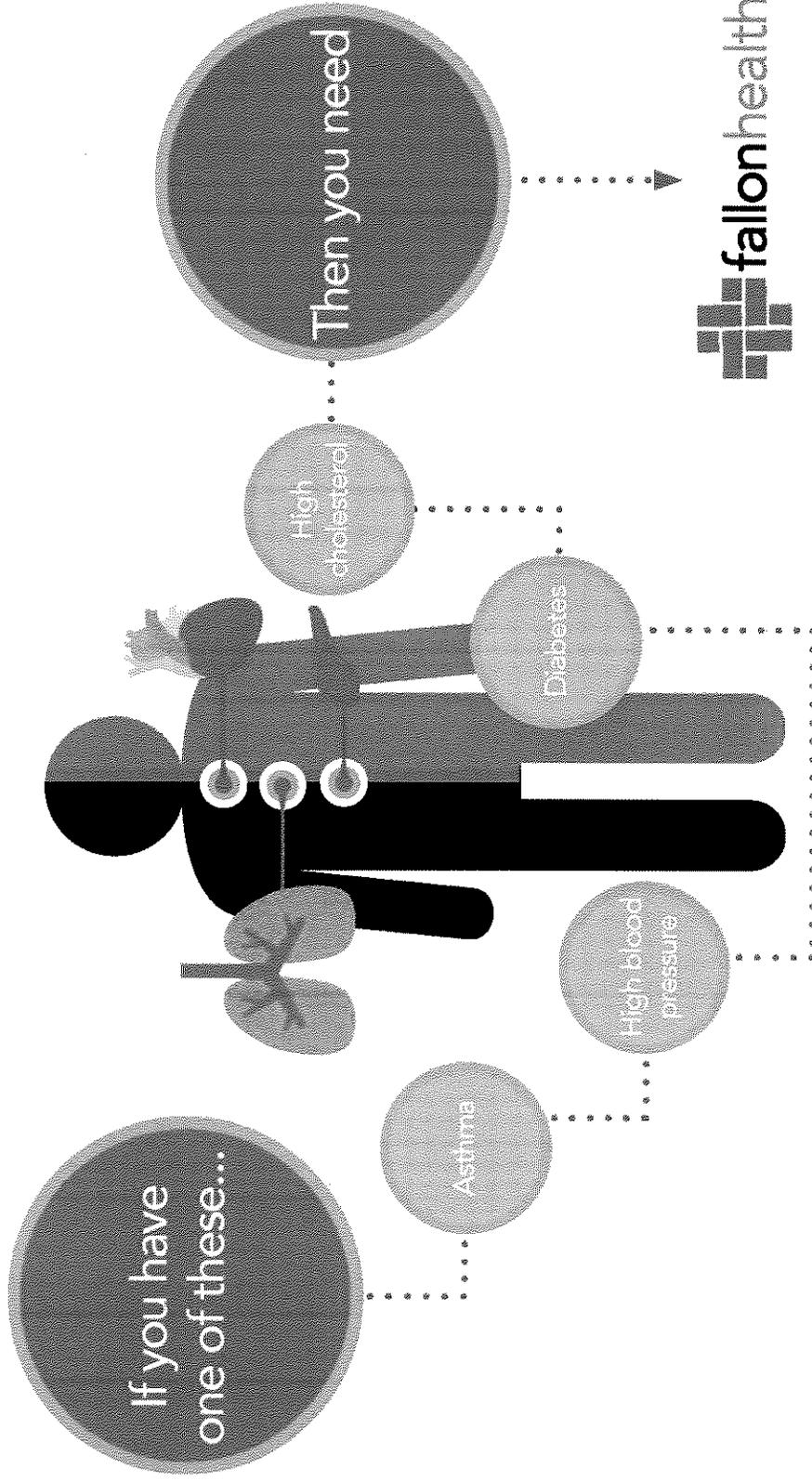
- Our trend outlook equates for >70% of our filed increase
- The remainder is due to the current premium levels being too low, making our latest emerging MLRs higher than anticipated and producing a loss for this line of business



Appendix

New plan offerings

Introducing Hybrid Plans



Plans to Keep Members Healthy



- Asthma**
- \$5 copay for PCP visits
 - \$1 copay for Tier 1 on control medications such as:
 - Budesonide
 - Cromolyn sodium
 - Flovent
 - Ipratropium bromide/albuterol sulfate
 - Qvar
 - Ipratropium bromide
 - Theophylline
 - Pulmicort Flexhaler
 - Zafirlukast
 - More!

Plans to Keep Members Healthy



Coronary Artery Disease

- \$5 copay for PCP visits
- \$1 copay for Tier 1 on medications to treat high blood pressure and cholesterol such as:
 - Atenolol
 - Atorvastatin
 - Benazepril
 - Captopril
 - Cartia XT
 - Carvedilol
 - Cholestyramine
 - Furosemide
 - Hydrochlorothiazide
 - Lisinopril
 - Metoprolol
 - Nifedipine
 - Pravastatin
 - Simvastatin
 - More!

Plans to Keep Members Healthy



Diabetes

- \$0 Copay for Diabetes Management Office Visits (up to 4 per benefit year)
- \$5 Copay for PCP visits
- \$1 Copay on Tier 1 diabetes medications, test strips, lancets, and syringes.

- | | | |
|----------------|-----------------|-----------------------|
| ○ Acarbose | ○ Glipizide | ○ Glyburide/Metformin |
| ○ Glyburide | ○ Humalog | ○ Humalog MIX 50/50 |
| ○ Humulin F | ○ Humulin 70/30 | ○ Humalog MIX 75/25 |
| ○ Humulin N | ○ Lantus | ○ Metformin |
| ○ Metformin ER | ○ Nateglinide | ○ More! |

New plan offerings

Benefits	Copay 1000 Hybrid	Deductible 1000 Hybrid	Deductible 2000 Hybrid
Office Visit – PCP/Specialist	\$5/\$10	\$5/\$15	\$5/\$15
Rx – pharmacy	\$1/\$5/\$30/50% \$400 max per 30-day supply (per med)	\$1/\$5/\$30/50% \$400 max per 30-day supply (per med)	\$1/\$5/\$30/50% \$400 max per 30-day supply (per med)
Emergency Room	\$250	\$250	\$250
Inpatient Hospital	\$1,000	\$800 after deductible	\$1,000 after deductible
Same Day Surgery	\$500	\$800 after deductible	\$500 after deductible
Preventative Services	Covered in full	Covered in full	Covered in full
Diagnostic Services	Covered in full	Covered in full	Covered in full
Imaging	\$250	\$300 after deductible	\$300 after deductible
Deductible	N/A	\$1,000/\$2,000	\$2,000/\$4,000
OOPM	\$4,500/\$9,000	\$6,850/\$13,700	\$6,850/\$13,700

Ways that Fallon Health controls costs:

- **Cost of Care Committee:** A cross functional team whose goal is to find ways to reduce inefficient care and provide cost savings to our members and employers.
- **Pharmacy management:** Fallon employs a wide range of strategies to control both the cost per prescription and the use of expensive medications. The goal of our pharmacy program is to provide the member with a wide variety of medications that are safe, effective, and affordable.
- **Smart Shopper:** Online cost transparency tool that incentivizes the use of lower cost providers
- **Provider Risk:** Fallon engages providers to progress along the risk continuum in order to provide patients/members with high quality, efficient, and cost effective care.

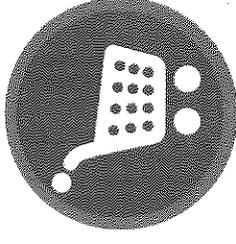
Cost of Care committee

- Hospital Readmission Program
- High Flyer ER Diversion Program
- Site of Service Education

Pharmacy management

- **Formulary Development and Maintenance:** Fallon's Pharmacy and Therapeutics Committee reviews new and existing medications and selects drugs to be included in the formulary based on safety, how well they work and cost-effectiveness. The committee helps to make sure the Plan has a range of drugs in each therapeutic class. Fallon's formulary is organized into tiers, each with a different copayment or coinsurance level. Preferred medications are those that offer the highest efficacy with the lowest cost.
- **Prior Authorization:** The criteria for which drugs require prior authorization is based on drug effectiveness and cost. A number of medications are used for more than one purpose, and it's important to be sure the best drug is used for each individual's situation. Prior authorization helps us make that determination.
- **Contracting:** Fallon Health partners with CVS/Caremark to maximize volume discounts and rebates when purchasing drugs.
- **Quantity Limits:** Fallon limits the amount of some drugs that can be dispensed at once and limits the amount of times it can be taken. This helps prevent waste, overuse, and misuse of some drugs.

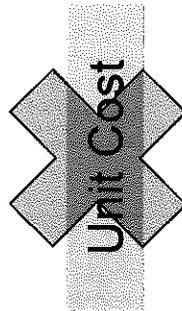
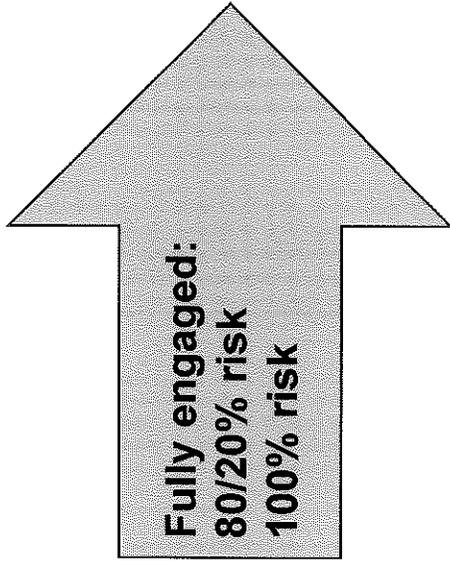
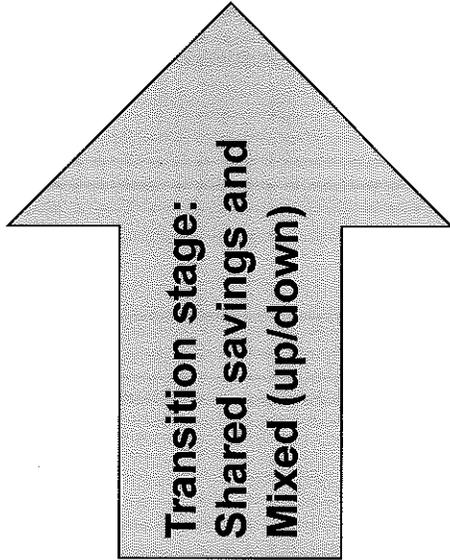
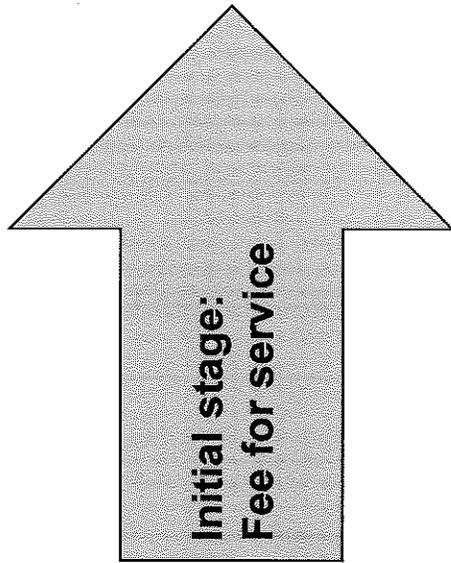
Fallon SmartShopper



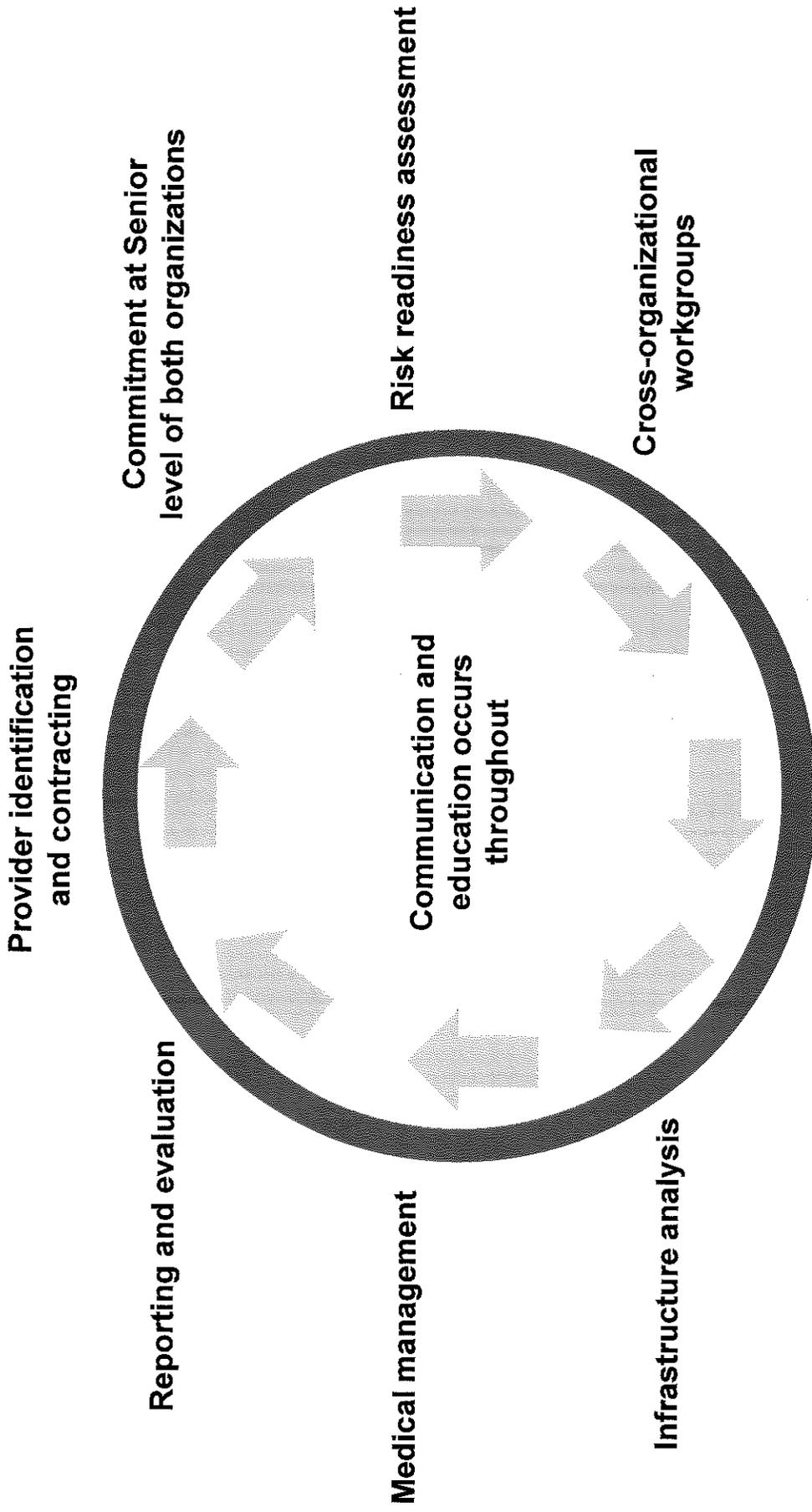
Fallon's cost transparency and incentive rewards program:

- **Established in partnership with Vitals** as a result of the Affordable Care Act and Chapter 224 state legislation requiring real-time cost-transparency to members.
- **Online tool** based on member's geographic area and provider cost.
- **Offers incentive rewards** to eligible members who use the tool and utilize services at cost-effective facilities.
- **62 procedures** for shopping based on high volume utilization, including certain outpatient and inpatient medical procedures and diagnostic tests.

Provider risk readiness continuum



By looking at **total medical expense**, Fallon takes into consideration the care of the whole patient, not just the individual expense of each service provided.



Good afternoon. My name is Bill Graham. I am the Senior Vice President of Public Affairs and Government Programs for Harvard Pilgrim Health Care. I am joined today by Brian Mackintosh, Harvard Pilgrim's Director of Actuarial Pricing for the Massachusetts Market. Harvard Pilgrim appreciates the opportunity to testify today regarding its second quarter merged market rate filing.

Harvard Pilgrim understands the burden that increasing health care costs and health insurance premiums place on individuals and small businesses. We take very seriously our obligation to work to control medical and administrative spending and to keep premium rates as low as possible and, later in my testimony, I will describe some of the steps that Harvard Pilgrim has taken and continues to take to control costs.

Despite these efforts, we are currently experiencing higher medical cost trends, especially as it relates to pharmaceutical drugs, than we have seen in a number of years. We are also facing cost pressures from the Affordable Care Act, in particular, the law's risk adjustment program. As a result, we anticipate losing tens of millions of dollars on our merged market business in 2015. While Harvard Pilgrim has more than adequate reserves to weather a bad year, it is not sustainable of any business to continue to lose money. Our premium revenue

must be sufficient to cover the cost of the care that we provide to our members.

Our second quarter rate filing reflects this reality.

Harvard Pilgrim Health Care has filed for a combined average rate increase of 13.9% for its HMO and insurance company legal entities. The average rate increase for the HMO legal entity, representing the majority of our membership, is 12.9%. The average rate increase for the insurance company legal entity, representing a much smaller portion of the membership is 35.1%. Even with this increase, rates for the plans offered on our insurance company license will continue to be significantly lower than our other plans and, we anticipate, will continue to be among the lowest cost plans in the market. Harvard Pilgrim's filed rates assume a medical loss ratio of 88.7%.

As I mentioned earlier, Harvard Pilgrim faces two key cost pressures in the merged market – the increasing costs of prescription drugs and costs associated with ACA's risk adjustment program.

After many years of more moderate growth, prescription drug costs are growing at an astronomical rate. Our second quarter rate filing reflects the fact that spending on prescription drugs for our merged market members has increased by close to 30% over the past year. Much of this increased spending is related to

introduction of new specialty medications, including those for the treatment of Hepatitis C, that are extraordinarily expensive. It also reflects significant price increases that we have experienced for lower-cost, but higher-volume prescriptions.

Harvard Pilgrim is working aggressively to moderate the impact of these trends. Harvard Pilgrim was the first local carrier to negotiate a discount with Gilead Sciences for its Hepatitis C drug. We were the first carrier in the nation to negotiate a pay for performance contract with Amgen for its new cholesterol drug, Repatha. In addition to providing us with a discount, that agreement contains financial guarantees related the effectiveness and appropriate prescribing of the drug. We have also renegotiated our contract with our pharmacy benefits manager. We will continue to seek opportunities to slow the rate of growth in prescription drug costs.

The ACA's risk adjustment program is intended to level the playing field between carriers by ensuring that no one carrier is disproportionately impacted from having enrolled less healthy members than its competitors. When functioning properly, risk adjustment should support greater competition in the market. Unfortunately, that has not been the result to date in Massachusetts. Risk

adjustment has resulted in greater uncertainty and volatility in the market and is placing some carriers, including Harvard Pilgrim, at a competitive disadvantage.

The risk adjustment program is exceedingly complex. At its inception, it was very difficult for carriers to determine the impact that program would have on their financials. The initial risk adjustment simulations that Harvard Pilgrim received from the Connector indicated that we would need to make a much larger transfer payment into the risk adjustment pool than we anticipated based on our observations of the market and what we believed our relative risk to be. Given the conflict between the initial data and what we believed our actual relative risk was, we needed to decide how much that we should be adding to pricing to account for the payments that we might ultimately need to make. This was a very difficult choice, but we decided that the best course of action for our customers would be to assume that we would not need to make as large of a risk adjustment payment as the initial simulations suggested.

We then continued to work with the Connector, CHIA, Milliman and other carriers in the market to continue to improve the data used for the simulations and the final transfer payment calculations. Based on this work, Harvard Pilgrim's transfer payment for 2014 was lower than initially anticipated. However, we also now

expect that Harvard Pilgrim will need to make a much larger transfer payment for 2015 than we has anticipated in our 2015 pricing, contributing significantly our anticipated loss for 2015. While another of the ACA's 3R's, the risk corridor program, was intended to protect carriers from losses attributable to market volatility in the ACA's initial years of implementation, recent decisions in Washington have limited risk corridor payments for 2014 to 12% of what was due to carriers and there is considerable uncertainty as to whether anything will be paid for 2015 and 2016.

While Harvard Pilgrim is not seeking to recover its losses from 2015, we must incorporate what we now know about our anticipated risk adjustment payments for 2016 into our rates for 2016. Our second quarter rate filing reflects that we anticipate paying 5.5% our merged market premium into the risk adjustment pool for our HMO legal entity for 10.5% for our insurance company legal entity. We continue to be very concerned that the transfer payments are significantly greater than the relative risk between carriers, resulting in Harvard Pilgrim having to make large payments to our competitors that are not warranted.

Despite the continued pressures that we face, Harvard Pilgrim continues to work to control both medical and administrative costs. I previously described some of

our efforts to prescription drug costs. We have also continue to negotiate contracts with providers that incorporate alternative payment arrangements and that slow the rate in growth of both unit costs and total medical expenditures. Almost half of Harvard Pilgrim members are now receiving their care from providers participating in alternative payment arrangements. For the past two years, Harvard Pilgrim's rate of growth in risk-adjusted total medical expenditures has been below the state's cost growth benchmark.

Harvard Pilgrim has continued to take action to control its administrative costs.

Our second quarter rate filing reflects the fact that our administrative costs, exclusive of taxes, are essentially flat, despite general inflation in the market.

Among other things, we have renegotiated key vendor contracts on more favorable terms. We have also recently completed a significant multi-year investment our technology systems that will allow us to operate more efficiently.

We have taken these actions while continuing to maintaining the high level of quality and service that Harvard Pilgrim has long been known for and that has resulted in our commercial plans receiving a 5-star rating from NCQA.

In summary, while our second quarter rate filing reflects higher increases than any of us would like to see, they do reflect our cost to provide coverage and the

significant efforts Harvard Pilgrim has undertaken to keep those costs as low as possible. I am now going to turn things over to Brian who will walk through our filing and the assumptions behind it in greater detail.

Testimony to the Division of Insurance Q2 2016 rate filing hearing

January 11, 2016

Brian Mackintosh

Thank you Bill, and thank you to the Division for the chance to speak today about the key factors in Harvard Pilgrim's 2nd quarter rate filings.

Before I dive into the numbers I want to reiterate what Bill mentioned a minute ago: that the main drivers of our rate increase are (1) increases in the underlying costs of claims, which I will detail shortly; and (2) costs associated with the Affordable Care Act, or ACA. These include known taxes and fees which I will get into later, as well as significant unknowns arising from the ACA's risk stabilization programs, known collectively as the 3Rs: Reinsurance, Risk Corridors, and Risk Adjustment. While the first two programs – Reinsurance and Risk Corridors – are temporary programs that expire at the end of 2016, the third program, Risk Adjustment, is permanent. Later I will describe how Harvard Pilgrim has evaluated our exposure to the Risk Adjustment program and how we have reflected it in our 2nd quarter rates.

Now let me give some general information about our rate filing. And please note that any figures I mention today refer to our 2nd quarter 2016 rate filing, unless specifically noted otherwise.

Harvard Pilgrim's service area includes the entire state of Massachusetts. We offer merged market products on our HMO and PPO networks that are available in all regions of the state. Furthermore we offer limited network HMO products, known as Harvard Pilgrim's Focus Network, which provide comprehensive coverage from our extensive, high-performance

network of efficient and effective providers across Massachusetts. These plans, which feature the same benefits and member cost share as in their full network counterpart plans, are available at premiums up to 15% less expensive than our full network options. Focus Network products are available for individuals and groups in any region of Massachusetts with the exception of the Cape and Islands. For rating purposes Harvard Pilgrim subdivides the Massachusetts service area into 7 regions as defined by Massachusetts regulation.

Let me pause here to remind you that Harvard Pilgrim offers products to the Massachusetts merged market through two separate legal entities: Harvard Pilgrim Health Care, Inc., where the vast majority of our products and membership lie and for which we file a 12.9% rate increase for the 2nd quarter; and HPHC Insurance Company, Inc., for which we file a 35.1% rate increase for the 2nd quarter. Where appropriate today I will identify figures for each legal entity separately: first the larger entity (Harvard Pilgrim Health Care, Inc.), then the smaller entity (HPHC Insurance Company, Inc.), and if applicable a combined total of the two.

As of October 31, 2015, there were 129,546 individual and small group members enrolled in Harvard Pilgrim Health Care, Inc. plans. Of those, 44,376, or 34%, were enrolled in plans due to renew coverage in the 2nd quarter of 2016.

For the same time period there were 20,380 individual and small group members enrolled in HPHC Insurance Company, Inc. plans. Of those, 3,881, or 19%, were enrolled in plans due to renew coverage in the 2nd quarter of 2016.

Harvard Pilgrim offers a variety of products, ranging from first-dollar coverage plans, to deductible plans, to consumer driven options such as HRA and HSA plans. In accordance with ACA regulations each of these products fits into one of four metal levels. In the 2nd quarter of 2016, Harvard Pilgrim Health Care, Inc. will offer 9 Platinum, 12 Gold, 10 Silver, and 2 Bronze products. HPHC Insurance Company, Inc. will offer 0 Platinum, 0 Gold, 2 Silver, and 1 Bronze product. Neither entity will offer a Catastrophic coverage product. Harvard Pilgrim discontinued its Catastrophic coverage product in 2016 due to extremely low enrollment.

I confirm that the rate filings submitted to be effective for 2nd quarter 2016 only apply to those small employers and sole proprietors with coverage effective dates between April 1, 2016 and June 30, 2016. This is true of both Harvard Pilgrim entities.

I also confirm that the rate filings do not apply to individual coverage because individual rates were established in the 1st quarter 2016 rate filing and will remain the same for all months in calendar year 2016. Again, this is true of both Harvard Pilgrim entities.

As mentioned earlier, the average composite rate change year-over-year within the 2nd quarter rate filing for Harvard Pilgrim Health Care, Inc. is 12.9%. This is a member weighted average across all 33 plans offered within that entity. 16 plans will see an average rate increase lower than 12.9%, while 17 plans will see an average rate increase greater than 12.9%. A key assumption when calculating the average composite rate change is what products individuals and small groups will purchase in 2016. Consistent with past rate filings, we have assumed that members will renew into the same or most similar products in 2016 as what they were enrolled in for 2015. However in practice we regularly see individuals and small groups change their

benefit coverage options, either to take advantage of new product offerings or to better suit their healthcare needs to other options within Harvard Pilgrim's product portfolio. Drivers of this entity's rate increase are rising costs of medical care and ACA related programs.

The average composite rate change for HPHC Insurance Company, Inc. is 35.1%. We offer 3 products through this entity, 2 of which are new for 2016. The main driver of this entity's rate increase is the anticipated exposure to the ACA Risk Adjustment program. But before I go into detail about the Risk Adjustment program, let me provide some history and context for the large rate increase we are filing for this entity.

The statistic "annual rate increase" only makes sense when comparing products that were offered in both 2015 and 2016. Because only 1 of the 3 HPHC Insurance Company, Inc products fits this criteria, the entity's entire rate increase is derived from that 1 product. Before most rating aspects of the ACA were implemented on January 1, 2014, members enrolled in this product incurred, on average, relatively low medical costs. Heading into an ACA regulated market in 2014 and beyond, Harvard Pilgrim priced this product consistent with the relatively low medical cost utilization of prior years, which is in line with claim levels expected in our actuarial models. In consideration of the structure of the 3 federal premium stabilization programs in place at that time, Harvard Pilgrim set rates for this plan such that we could continue to offer competitive premiums to our members while at the same time avoiding significant financial exposure to the new 3Rs. In fact, HPHC Insurance Company Inc. filed and was approved for rate decreases for 3 consecutive quarters in 2015, including a 32% year-over-year rate decrease for the 1st quarter of 2015. While in retrospect, one might question the

wisdom of reducing rates so significantly only to reverse course several quarters later, our rate filings reflected what we knew at the time about our expected costs and, in fact, we would have risked not meeting the state's medical loss ratio requirements had we not reduced the rates.

However during the course of 2015 changes to all three Rs, including the way they are administered by the federal government and the market's impact on Harvard Pilgrim members, led to significant effects on both Harvard Pilgrim entities. First, the parameters around the federal Reinsurance program were adjusted; secondly, as Bill mentioned, the Risk Corridor program was altered in such a way as to allow the federal government to continue to collect 100% of required payments FROM insurance carriers, while only returning to carriers 12.6% of funds DUE to them; and finally and most materially, evolving data and simulations from the Risk Adjustment program indicate significantly higher exposure for Harvard Pilgrim than was anticipated during pricing of our 2014 and early 2015 rates.

Bill alluded to the enormous complexity of the Risk Adjustment program earlier. Risk Adjustment became effective, and indeed mandatory, on all ACA compliant plans in the market as of January 1, 2014. While carriers have had to make estimates of their Risk Adjustment exposure when determining future premium rates, the first—and to the day, the only—finalized liabilities from the program, for CY2014, were not made available until June 30, 2015. By that time carriers had filed rates for 8 separate quarters subject to Risk Adjustment without knowing the exact final liability. In effect, carriers had to develop rates for 2 years' worth of premiums before knowing the full impact of this key program.

Risk Adjustment is a closed program across all states, in the sense that insurance carriers with members that are healthier than the statewide market average risk will make payments to insurers with members that are less healthy than the statewide market average. We are fortunate in Massachusetts to have had committed state partners that have attempted to help carriers understand the volatility and potential exposure to this program. The MA Health Connector, which administers our state's Risk Adjustment program, as well as CHIA, the state's Center for Health Information and Analysis, and the actuarial consulting firm Milliman have been instrumental and indeed unique in the country in their efforts to provide regular simulations to carriers for the purpose of understanding their relative risk. As a pricing actuary I sincerely appreciate these organizations' help as this permanent ACA program is a key part in building prospective premium rates.

Unfortunately, even as we sit here today there remains tremendous uncertainty about carriers' liability under the Risk Adjustment program. Harvard Pilgrim received 8 different simulations for our 2014 Risk Adjustment exposure prior to the final calculation. Those simulations implied a liability anywhere from receiving over \$10M to an obligation to pay out over \$50M, an extremely large range to put into pricing. Indeed, we continue to have the same concerns about 2015 Risk Adjustment exposure, whose simulations continue to fluctuate and which our state partners agree that it is still too early today—January 11, 2016—to know where the final 2015 results will land. Note that these are historical exercises in estimating the relative risk of membership and claims incurred in the past. In our 2nd quarter rate filings we must quantify the prospective risk over the time period from April 1, 2016 all the way through June 30, 2017. When evaluating this risk we must again rely on the most credible data available, which is the

most recent market-wide simulation from the MA Health Connector released in mid-December 2015. This simulation of the Risk Adjustment program within the state of Massachusetts showed each Harvard Pilgrim entity liable for approximately \$19M in payments into the program, for a total liability of over \$38M for one 12 month time period. Despite the fact that Harvard Pilgrim Health Care, Inc. insures over 7 times more members than the smaller HPHC Insurance Company, Inc., both entities are on pace to pay a large and nearly equal sum into the Risk Adjustment program. Our 2nd quarter 2016 rate increase differential between these two entities reflects this leveraging impact of health risk that the Connector simulations continue to show with regard to the HPHC Insurance Company, Inc. membership.

The federal Risk Adjustment program presents several difficulties for carriers trying to establish stable and competitive premiums. These are not unique problems for Harvard Pilgrim, nor for the Massachusetts market. Across the country health plans continue to deal with the uncertainty this program has brought to their finances. Based on a survey of final 2014 transfer payments, insurers with fully 10% market share in their states still saw Risk Adjustment liabilities that fluctuated between receiving funds equal to 30% of their premiums collected, to paying out funds equal to 30% of their premiums collected, and with a host of insurers falling somewhere in between. In an industry where carriers typically aim to collect 1-2% of premiums to build their claim reserves to provide for years of high cost claim volatility, an unknown swing of the magnitude seen in the Risk Adjustment program can put severe financial strain on insurers.

Let me add one last note about the 35.1% rate increase for HPHC Insurance Company, Inc. It is important to note the difference between relative values, such as a percentage change from last year's rates, and absolute values, such as the actual premium charged to individuals and small groups. In 2015 the product offered through this entity was not only one of the lowest cost products in Harvard Pilgrim's portfolio, but it was also less expensive than 95% of products available to the Massachusetts merged market from any insurance carrier. With the 2nd quarter 2016 rate increase we have filed, Harvard Pilgrim estimates that this product will be very near the median price point in the merged market – in other words, still less expensive than half of the plans in the market.

Next I will address the expected claims costs associated with our rate filing. Please note that in order to use the most credible experience available, and thus get a more accurate representation of claim costs, Harvard Pilgrim pools the historical claims from both legal entities in order to develop its base rate. The comments I will now make about claims costs apply to the combined experience and anticipated future costs of Harvard Pilgrim's merged market members.

First, let me address the Medical Loss Ratio which I mentioned in passing earlier. In its simplest form, the Medical Loss Ratio, or MLR for short, is the ratio of total claim costs that Harvard Pilgrim pays providers on behalf of services rendered for our members, divided by the total premium payments that individual subscribers and small group businesses pay Harvard Pilgrim for their insurance coverage. This is typically represented as a percentage. For example, an MLR of 100% would mean that for a given period the total claim costs were exactly equal to the

premium payments collected. That may seem like an ideal MLR, but in practice there are operational costs associated with offering insurance coverage, such as government taxes and fees, establishing quality provider networks, member services, and much more that I will detail later. For a not-for-profit organization like Harvard Pilgrim to offer insurance we historically need to collect about 10 cents of every premium dollar to fund these costs. How does this relate to MLR? In the merged market insurers are required by state law to meet a minimum MLR threshold of 88%. This MLR is measured slightly differently from the simplified version I mentioned just now; insurers are required to make minor adjustments for items related to administrative efforts that reduce claim costs, as prescribed by the National Association of Insurance Commissioners, or the NAIC. Specifically, the NAIC definition of MLR allows quality improvements and fraud detection expenses to be included with claim costs in the numerator, and taxes to be excluded from premium in the denominator. There are also adjustments made in consideration of the federal 3Rs programs. On this NAIC basis of reporting MLR, Harvard Pilgrim's 2nd quarter 2016 rate filing includes a targeted MLR of 88.7%. This meets the state's minimum MLR threshold requirement.

Next I'd like to address how different types of care are impacting the overall levels of projected costs. Historically it was common in the insurance industry to reimburse medical services through a fee-for-service payment model, where for every service that a provider performed for a member, the member's insurer would pay a fee to the provider. On the other end of the historical contractual spectrum was the capitated payment model, in which insurers pay a provider a fixed fee up front and the provider in turn ensures coverage for all applicable members regardless of the frequency or severity of their subsequent claim costs. Today,

Harvard Pilgrim's portfolio of risk contracting models includes long-established global payment models, a shared-savings model (structured similarly to CMS's shared savings model for Medicare Accountable Care Organizations) and pay-for-performance programs, where participating provider groups are eligible to share in demonstrated savings when actual cost trends are below a pre-determined benchmark.

Other than payments under fully capitated arrangements, we treat payments under alternative payment arrangements as fee-for-service payments for purposes of determining projected claims costs in our rate filing. Let me detail the smaller items first so we can then continue with the expected trends in this larger piece of medical costs.

Harvard Pilgrim estimates approximately 3.9% of total projected claim costs are associated with service categories that are reimbursed on a capitated basis. About 80% of this amount goes towards Mental Health and Substance Abuse services through our contracted behavioral health benefit manager, United Behavioral Health, or UBH. The remainder goes toward pediatric dental coverage, which under the ACA became mandatory for insurers to offer coverage beginning in 2014. Costs associated with both of these capitated arrangements are slightly different than what was included in our 2nd quarter 2015 rate filing: the behavioral health capitation rate has increased slightly per our contractual agreement with UBH and is reflective of continued increase of behavioral health services; our pediatric dental rate has decreased slightly over the same time period due to lower usage of this benefit relative to initial estimates.

Next, we estimate that an additional 3.9% of total projected medical costs are associated with other types of payments. About 80% of this amount goes towards Other Provider Payments, which are contractual obligations to providers beyond the standard fee for service or capitation payment models. Risk sharing amounts are also included in this item. The balance of these types of payments are for contributions to the state's Health Safety Net Fund and pediatric immunization program assessments. In total, these items are contributing about 0.5% to our total 2nd quarter rate increase.

The remaining proportion, or about 92%, of our total projected claim costs are attributed to medical and pharmacy services performed under a risk arrangement contract or fee-for-service model. This category includes costs associated with inpatient stays, outpatient visits, doctor's office visits, emergency room visits, and pharmacy costs among others.

Approximately 7.1% of our year-over-year rate increase is due to observed and expected cost increases for these services. In particular, pharmacy coverage is driving more than half of this amount. This is a very high contributor to total claims trend, especially for a service category that historically makes up less than 20% of all claims costs. Like other carriers Harvard Pilgrim has seen a large increase in spending on high cost specialty drugs in recent years. The biggest example is a series of breakthrough drugs that treat Hepatitis C. While undeniably transformative for members seeking treatment for Hep C, these drugs come at a steep price, often over \$100,000 per affected member. In 2014 Harvard Pilgrim paid over \$2.6M for merged market members who took Sovaldi, which was the first of several new drugs to market that treat Hep C. In 2015 Harvard Pilgrim paid over \$6.2M for merged market members who

used the next big Hep C drug, Harvoni. This unprecedented growth saw more than 200% cost increase in only 1 year. In addition to the data in our historical claims period, we know there were several new high cost drugs released in late 2015 as well as a pipeline of drugs coming to market in 2016 & 2017 from major pharmaceutical companies that Harvard Pilgrim's pharmacy benefit manager and other consultants advise will continue to put upward pressure on overall drug costs. Exacerbating this emerging high trend in drug costs is the slowdown of new generic drugs in the market and fewer brand drug patent expirations than was seen in the late 2000s and early 2010s. In those years having a pipeline of low cost generic drugs that offer clinically effective substitutes for higher cost brand drugs had the effect of dampening overall drug spending. The combination of new high cost specialty drugs and the relative slowdown of new generics to market has had the impact of raising pharmacy costs to new highs.

On the medical services side, as with every year we see fluctuations in claim trends on a cost per unit basis, which reflects provider reimbursement levels; on a utilization basis, which reflects the change in the volume or number of services each year; and on a mix basis, which reflects the change in type of services performed each year. None of the separate medical service categories we monitor are having an impact on total cost trend near the magnitude seen on the pharmacy side. We have noticed a slight increase in Inpatient hospital utilization, which in prior rate filings we estimated were slightly declining. Unit cost trends seem stable compared to the prior rate filing. However we note that, consistent with much prior analysis on Massachusetts healthcare payment reform, there continues to be a large gap between the highest and lowest reimbursed provider organizations, with a particularly skewed distribution at the relatively few providers who command the highest payment rates. If Harvard Pilgrim

instead reimbursed all providers at the median contractual payment levels, our 2nd quarter rate increase would be significantly lower than what we are presenting today. Harvard Pilgrim continues to work with providers to ensure that our members have access to care that offers value as well as quality.

Now I will turn to the administrative expense projections included in the Harvard Pilgrim rate filings. Key areas covered by administrative costs include: marketing and sales, including broker commissions and other distribution costs; claims operations, including the processing and payment of claims; member services including customer support call center activity, generating member ID cards, helping members understand their benefits and navigate the health care system; network operations including provider contracting; medical administration including care and disease management programs; capital costs; and other general administrative tasks associated with providing health insurance. While the costs of any one program will vary from year to year, in aggregate Harvard Pilgrim's expected administrative expenses in the 2nd quarter 2016 rate filing, excluding government taxes and fees, are slightly lower than the adjusted expenses incurred in calendar year 2014, by -0.1% on a per member per month basis. This is well below the Massachusetts threshold of the increase in the New England medical CPI index change, which indicates a 6.58% increase in costs in the most recent period available.

Our rate filings also include costs related to government taxes and programs including:

- The federal transitional reinsurance program assessment, which is applied to all merged market members.

- The ACA insurer tax, also applied to all members.
- 2.5% Connector user fee, which applies to members who enroll through the state's ACA exchange.
- A federal assessment to fund the Patient-Centered Outcomes Research Institute, or PCORI, which was established by the ACA.
- And finally, a Massachusetts state tax on PPO plans.

Some of these items are assessed as fixed percentages of premium and therefore do not change from year to year. Others will vary. In total, Harvard Pilgrim's rate filings for the 2nd quarter of 2016 include no material change in aggregate expenses due to government taxes and programs compared to the prior year's rate filing. Please note that the list above only includes expenses for assessments and operation of government programs. It excludes the annual transfer payment liabilities of the Risk Adjustment program, which I detailed earlier and which have very material and substantial influence on our rate filings.

In addition to these explicit cost components, Harvard Pilgrim also builds into its 2nd quarter 2016 rate filings a 1% contribution to surplus. This is essentially the health insurance version of a rainy day fund – it represents contribution to build and maintain our claims reserve at adequate levels to ensure that we are able to cover the costs of care in the future if there are shocks to the market, such as pandemics or other unforeseen events that cause claim costs to rise above that which was anticipated at the time premiums were developed. Contributing to surplus is a necessary and appropriate measure, particularly in the current ACA environment which continues to generate uncertain obligations with respect to the Risk Adjustment

program. Indeed, insurers need to contribute to their reserves in order to maintain adequate reserve levels that are required by federal and state regulations. Our 1% contribution to surplus in the 2nd quarter 2016 rate filings represent a 1% increase over the zero contribution to surplus in the 2nd quarter 2015 rate filings.

AND FINALLY, I'd like to comment on the rating factors Harvard Pilgrim uses in the merged market. When calculating the premium for every product Harvard Pilgrim offers, we begin with the base rate for the product that an individual or small group has chosen. We then determine their customized premium rate by using rating factors based on their own characteristics such as age, industry, area, group size, and participation rate. I confirm that none of these rating factors have changed from the Q1 2016 filing.

Thank you again for this opportunity to speak today. I hope I've clarified the main drivers behind both of Harvard Pilgrim's 2nd quarter 2016 rate filings. At this time I'd be happy to address any questions that I am able to—understanding the amount of detail that goes into a rate filing—or to take them as follow up items if I don't have the ability to speak to it today.

Thank you.

Testimony for Massachusetts Division of Insurance Informational Hearing
Monday, January 11, 2016

Good morning. My name is Jim Kessler. I am the Vice President & General Counsel for Health New England, Inc. in Springfield. I am here today with Elin Gaynor, Health New England's Associate General Counsel and through the miracle of technology, we have Michelle Klein, our Underwriting Manager available through the telephone. Thank you for the opportunity to present our testimony today.

Health New England's service area includes Hampden, Hampshire, Franklin, Berkshire Counties in Western Massachusetts, where most of our members reside, and Worcester county in Central Massachusetts. Western Massachusetts is the most rural and by many measures poorest section of Massachusetts. Based on U.S. Census data, the four counties of Western Massachusetts are among the five counties with the lowest per capita income in Massachusetts and the highest percentage of poverty. The largest county in Western Massachusetts, Hampden County, which comprises over half of the population in Western Massachusetts, and the largest source of our membership, is the poorest county in Massachusetts based on per capita income.¹

Our area of the state also faces many public health challenges. In county health rankings published by the Robert Wood Johnson Foundation based upon data obtained through the Center for Disease Control's Behavioral Risk Factor Surveillance System, Hampden County ranked lowest among the 14 counties in Massachusetts, with rates of adult obesity and adult smoking at 5% and 4% higher, respectively, than the statewide average. The same data also shows that rates of self-reported illness (a measure of average number of poor physical health days per month) in all four Western Massachusetts counties are greater than the statewide average.²

Data compiled by the Massachusetts Center for Health Information and Analysis ("CHIA") also indicate a higher disease burden in Western Massachusetts compared with the statewide averages. For example, CHIA maintains data regarding rates of stroke and hip fracture. CHIA's data shows that there are 111.16

¹ Data available at <http://quickfacts.census.gov/gfd/states/25000.html>

²

<http://www.countyhealthrankings.org/app/massachusetts/2015/compare/snapshot?counties=003%28011%28013%28015>

discharges for hip fractures per 100,000 people in Western Massachusetts compared with 93.19 per 100,000 in Worcester and 89.6 per 100,000 people in the remainder of Massachusetts. Similarly, CHIA's data shows that there are 224.49 discharges for strokes per 100,000 in Western Massachusetts, 168.28 per 100,000 in Worcester County and 184.38 per 100,000 in the remainder of Massachusetts.³ In addition, large portions of Western and Central Massachusetts have been recognized as medically underserved areas.

In other words, we face many challenges in realizing our mission of improving the life and health of the communities we serve. But as my mother has frequently told me, "No one ever said it would be easy."

Along with the economic and public health factors just described, any discussion of the cost or availability of health care coverage needs to include consideration of the legal and regulatory context in which we are operating. Even though that context is well known and well understood by the Division of Insurance, it is still, unfortunately, not completely taken into account by the public or the press. I would like to briefly mention some of that context, even at the risk of repeating other testimony that you have heard or will hear, because it is so important.

Massachusetts has led the nation in expanding the availability of health care coverage, and we can be proud that well over 90% of the people of the Commonwealth have some form of health insurance. The Center for Health Information and Analysis, CHIA, most recently reported that "In 2015, the uninsurance rate in Massachusetts was 3.6 percent, compared to a 9.2 percent uninsurance rate for the rest of the nation."⁴

One key explanation of these high rates of insurance coverage, is that Massachusetts has, in reforms that extend back over a number of years, gone beyond the Affordable Care Act to closely regulate health care coverage. One such reform, the comprehensive health care reform law passed in Massachusetts in 2006, merged the health insurance market for individuals with the health insurance market for members of small groups of 50 or fewer eligible employees. The combined individual and small group markets are described as the "Merged Market." As a result of creating the Merged Market, premiums for individual coverage decreased substantially, making health care more accessible and affordable for individuals. As of December, 2015, almost 30% of HNE's commercial enrollment was in the Merged Market.

³ Source: Massachusetts Center for Health Information and Analysis

⁴ <http://www.chiamass.gov/>

The Merged Market is highly regulated. Premium rates must be filed with the state Division of Insurance, which can disapprove the rates. Under both Massachusetts and federal law, small group premiums must be based on an underlying or base rate that applies to the entire merged market. The premium rates charged can vary from person to person or group to group based only on a few rating factors, such as age, and the same rating rules must be applied consistently to individuals and small groups within the merged market. The health status or medical costs of any individual or group do not affect the premium charged to that person or group. As one consequence of the rating rules, individuals and small groups in Massachusetts are in the same coverage risk pool even though the costs to health plans to arrange care for individuals are generally higher than the costs of doing so for members of small groups. To illustrate, in a recent calendar year⁵, for every \$1.00 of premium revenue received from individual commercial enrollees, HNE spent, on average, \$1.11. In the same year, for all of our commercial members as a whole, for every dollar of premium we received, we spent, on average, only \$0.88.

Another important aspect of how the merged market is regulated is that health plans and carriers are subject to very stringent rules about how the premium dollar is allocated. As you know, the portion of the health care premium that is used to pay for medical care is somewhat misleadingly called the “Medical Loss Ratio,” or MLR. Calling it a “Loss” ratio is misleading, because paying for medical care is not really a loss: it is a cost. It is either an *appropriate* cost, and therefore a valuable investment in the health of the person receiving the care, or an *inappropriate* cost, because the care given in a particular case is unnecessary, excessive or even harmful. In either case, however, it is a cost. Massachusetts requires that a *minimum* of 88 cents of every premium dollar in the Merged Market be spent for such medical costs, which is I believe the highest such requirement in the nation, and significantly higher than the equivalent requirement in the Affordable Care Act. In any year in which the MLR ratio falls below 88%, the amount not expended must be refunded to consumers. The remaining 12 cents of each premium dollar must cover all other costs, including administrative costs, marketing costs, broker commissions and margin. The *maximum* margin or surplus allowed in rates in the Massachusetts Merged Market is 1.9%. These funds are a small part of the total, but are essential for allowing a health plan or carrier to continue serving the merged market.

⁵ 2014

Our small margin is vital. It is needed to pay for essential capital investments like new and replacement computer systems, and for supporting the adequate financial reserves needed to maintain licensure and protect consumers. If a plan's membership grows, the reserves must grow at a corresponding rate. In addition, the amount of these reserves is directly tied to the cost of care. As the cost of care grows, the reserves must grow at a corresponding rate. Since health care coverage has actuarial and financial risks, even this small margin is not guaranteed, and tools like reinsurance provide only partial protection against the risk of financial losses.

When these regulatory requirements are understood, their clear consequence is that any increase in the underlying medical costs, whether in the quantity of the services provided, their price, or both, must be reflected in a corresponding increase in premiums. There is insufficient leeway in the premium to allow the health plan or carrier to absorb these increases as losses. Health plans and carriers with a commitment to the Merged Market must do everything in their power to make sure that the premiums reflect expected costs as accurately as possible: if the premium is set too high, competition from the other outstanding health plans in Massachusetts will mean a loss of enrollment; if medical costs are overestimated and the MLR falls below 88%, the money must be refunded; if the premium is set too low, it will be a difficult and lengthy process to recoup the losses.

In addition to these important, primarily state-specific provisions regulating the Merged Market, there is also a regulatory provision at the federal level with an important impact on premium rates. One paragraph nestled within the thousand or so pages of the Affordable Care Act mandated the imposition of "risk adjustment," a program intended to stabilize health premium rates during and after the implementation of the Act. In fact, in Massachusetts and probably elsewhere, it has had the opposite effect.

Massachusetts is the only one of the 50 states that elected to develop its own approach to risk adjustment, but the aspects of the risk adjustment methodology described in this testimony are the same in Massachusetts as at the federal level, and in any case, Massachusetts will be adopting the federal approach beginning in 2017. The risk adjustment methodology is based on the assumption that carriers and health plans in the individual and small group market may have enrollees who are more healthy or less healthy than the overall average of all people in the market. At the end of the year, claims data from all participating plans and carriers is reviewed, and the data is used to give each plan and carrier a risk score that is intended to reflect the relative health of all of its enrollees as compared with the average risk score. Plans and carriers with lower risk scores, which, theoretically at least, have healthier enrollees, are then asked to make a payment into a central

pool, and plans and carriers with higher than average scores each receive a distribution from the pool.

Health New England and other plans have raised many questions about the fairness, accuracy and value of the risk adjustment methodologies being used at both the state and federal level. One very important concern, very relevant to this hearing, is that the risk adjustment process takes place on a very challenging schedule. For example, for our first quarter 2016 rates, we were required to make preliminary submissions to the Division of Insurance as early as the spring of last year, and of course our rates for the second quarter of 2016 have already been submitted. We will not learn the results of last year's, that is 2015's, risk adjustment process for several months, and won't learn the results of 2016's risk adjustment until the middle of the coming year. Despite the tremendous uncertainty that therefore remains about what our risk adjustment obligation will be, our premium must reflect a component that reflects our best estimate or projection of what the risk adjustment obligation *might* be.

For the largest plans in the Commonwealth, whose enrollment represents a large portion of the total enrollment in the merged market, this prediction is easier. The risk score is likely to be close to the state average risk score, if for no other reason than the fact that a large enrollment will have a big effect on creating the average. Larger numbers are in any event more accurately predictable from an actuarial perspective, and are drawn from across the Commonwealth and from nearly all providers. For a smaller plan, or a plan newer to the market, or a regional plan like Health New England, it is more difficult to predict not only our own future risk score, but also, how that risk score will compare with the scores of all other participants in the merged market. This uncertainty is compounded, of course by the facts that the risk adjustment methodology is still new, and that the merged market itself has been in flux as a result of the Affordable Care Act.

Another effect of risk adjustment has to do with how the payments ended up being distributed in their first year. In 2014, the first year of risk adjustment, approximately \$60 million dollars was transferred in the risk adjustment process. Most of the money paid in came from plans with comparatively smaller enrollments, including a number of plans that are comparatively lower in cost, such as Health New England and the state's Co-Op plan, Minuteman Health, as well as the plans which participate in the Massachusetts Medicaid program. Nearly all of the proceeds of the pool went to two of the largest plans in the Commonwealth. Because of the workings of the risk pool transfers, smaller and lower cost plans must put aside a significant part of the premium to provide for what may be a large risk adjustment obligation, but because of differences in scale and circumstances,

the payments will represent only a small percentage of the premiums of the plans which are the recipients of the payment.

With this very extensive but important background in place, I would like to turn to my colleague, Elin Gaynor, who will discuss our rating process and the factors contributing to our projected premiums for the second quarter of 2016.

We currently have 25,000 members enrolled in the combined small group and individual markets. Of those 25,000 members we will be issuing renewal rates for groups renewing in April, May and June based on the second quarter 2016 small group rate filing. Individual (or non group enrollees) are only issued renewals based on a January effective date, so no individual policy holder will be provided rates based on the 2nd quarter rate filing. We have 992 groups with 5,739 members that will be renewing in the second quarter of 2016. Each group's renewal will be calculated using the rating methodology prescribed by state law and within the requirements of the Affordable Care Act. For the second quarter of 2016, the change in our weighted average base rate will be 8.3%. There are a large number of factors that combine to create that change in the premium. Factors that must be considered as a part of our rate filing include:

- changes due to rating factors;
- reinsurance assessments;
- risk adjustment charges or payments;
- reinsurance recoveries;
- the insurer tax imposed by the Affordable Care Act;
- the payment to the federal Patient Centered Outcomes Research Institute;
- the Massachusetts Connector user fee;
- administrative charges;
- contributions to surplus and reserves;
- predicted trends or changes in the amount or mix of medical care used by our members;
- predicted trends or changes in the price of medical services, devices and drugs;
- adjustments for prior year projections to reflect actual results; and

- effects of benefit or cost sharing changes.

Some of the factors just recited have little or no effect on premium rates. There are two factors, however, that should be discussed because they have such a significant impact on our premium rates: the two factors I am referring to are risk adjustment and medical trend.

The first of these, risk adjustment, which was discussed earlier in our testimony, has a very serious effect on our premium rates. HNE is required, as a part of our rate submission, to make a provision for the expected percentage impact to the prior year rates and to rates as of the rate filing effective date due to risk adjustment. As we explained earlier, risk adjustment is still a new program, and we have only one year of actual results of the risk adjustment program, from 2014, along with some projections or simulations of the results for 2015 to go by. The final outcome for both 2015 and 2016 will compare HNE's risk scores to the risk scores of all other participants in the merged market, so our projections depend not only on our own risk score data and computations, but also on the risk score results for all other plans. Our provision for risk score payments in the second quarter of 2015 was 2.0%. Our provision for risk score payments for the second quarter of 2016, based on the additional information we have obtained since last year, is 7.2%. This has the effect of contributing a 6.1% increase to our second quarter 2016 rate calculations. We understand that this is a significant amount. However, since underestimating our likely risk score results could lead to significant losses, it is imperative that we include within our premium an allowance for risk score results that is appropriate and adequate.

A second important factor determining our premium for the second quarter of 2016 is medical trend. Medical trend has two components: utilization of medical care and the cost (or price) of medical care.

Medical utilization, the first of these factors, has two aspects, utilization rates and utilization mix. To correctly anticipate medical utilization trend, it is first necessary to understand whether the number of medical services, procedures, pharmaceutical compounds and medical equipment and supplies used by our members in the second quarter of 2016 will reflect an increase over the same period in 2015, and to estimate of the size of that increase or decrease. Once the rates of utilization are projected, it is necessary to understand any projected changes in the *mix* of services, procedures, prescriptions, devices and supplies. Consider, for example, inpatient surgical procedures. To reflect changes in enrollment, we review our data on a "per member per month" basis. If we determine, as mentioned a moment ago, that the utilization rates, or in other words, the number of inpatient surgeries per member, per month will increase, our costs

will of course increase as well. In addition, however, even if we were to project that the number of surgeries per member will stay the same, if a larger percentage of the surgical procedures are very serious and complex (and therefore more expensive) and a smaller percentage are less serious or more routine (and therefore less expensive), our costs will go up because of the change in the *mix* of the surgeries we cover.

In addition to these projections of utilization, we also must project changes in the cost or price of the care we will cover. Obviously, if the price of medical procedures, drugs and devices go up, the cost of care will go up. As a result, to determine our premium rates, we must review all of our data on how the price of care will have changed since last year during the same period.

When the two components of medical trend, utilization and cost are combined, they show the expected change in the cost of covered care that must be reflected in the premiums. It would be wonderful to be able to tell you that these trends were stable or even decreasing, but unfortunately, our projections project a considerable increase. Based on our projections, we have incorporated a 7% increase into our second quarter base premium rates to reflect the combined effects of medical utilization and medical cost or price.

There is not a single or simple explanation for these increases. A number of factors have combined to create this upward cost pressure. Many, but not all of these developments have to do with prescription drugs. For example:

- The unit cost of prescription drugs has increased for some commonly used medications for people with chronic diseases like diabetes and asthma.
- New medications with hefty price tags are surging onto the market. In 2015, the FDA approved 45 new drugs (that is, those with new-to-the-market ingredients), the highest number since 1996, including the drug Orkambi, for cystic fibrosis, with a reported cost of \$259,000 per year and Ibrance for breast cancer, at \$118,200 per year⁶
- It has been widely reported that new treatments for hepatitis C have been introduced which have costs for a course of treatment that can exceed \$100,000, but in addition to the new drugs just mentioned other, less well known high cost treatments have also been introduced for treatment of diseases such as multiple sclerosis and cancer.
- The number of very high priced injectable drugs has been increasing, significantly raising the cost of a class of medications that was once a relatively minor portion of medical care costs

⁶ Report by Matthew Perrone, Associated Press, January 5, 2015.

- According to the Wall Street Journal, from 2010-2014, the prices for the 30 top selling US drugs went up by 76%, about four times faster than the increase in prescription volumes. The cost of Enbrel went up 88%, the cost of Humira went up 91% and the cost of Lantus went up 168% during that period.⁷

One important aspect of changes in drug prices has to do with generic drugs. For many years, Health New England and other plans have had some success in restraining increases in drug costs by encouraging the use of generic drugs where the generics were an effective clinical substitute for much more expensive brand name medications. Over the years, competition among generic drug manufacturers helped to control or even reduce the cost of generic drugs. More recently, as we have approached the limits of the effective substitution of generics for brand equivalents, there has been a disturbing change in the cost of generics. Over all, the previous decline in the cost of generics has slowed or even reversed. In addition, some manufacturers of generic drugs have taken advantage of being the sole source of certain medications by raising the price of the drugs dramatically, as much as hundreds of times the previous price. An illustration of the magnitude of these changes can be seen in changes in the retail price of some generic drugs. It was widely reported that one drug, Daraprim, increased in price from \$13.50 to \$750 per pill⁸, but that is not the only example. Some other increases in price, as reported by AARP, include the following:

- Over one six month period, the retail price of the antibiotic Doxycycline hyclate went from \$20 for 500 capsules to \$1,849
- Glycopyrrolate (20 milliliters), which controls heart rate during surgery, went from \$65 for 10 vials to \$1,277.
- The cholesterol control drug Pravastatin sodium went from \$27 to \$196 for a one-year supply.⁹

In all, these factors have produced double digit increases in prescription drug costs, which in turn has put strong upward pressure on overall medical trend and on premiums.

⁷ <http://www.wsj.com/articles/for-prescription-drug-makers-price-increases-drive-revenue-1444096750>

⁸ http://www.nytimes.com/2015/09/21/business/a-huge-overnight-increase-in-a-drugs-price-raises-protests.html?_r=0

⁹ <http://www.aarp.org/health/drugs-supplements/info-2015/prices-spike-for-generic-drugs.html>

Although these many sources of increase in prescription drug costs are of concern, they are not the only source of medical cost increases. Some other examples include the following:

- Medical Providers with geographic monopolies are demanding higher contracted unit cost increases
- We have seen greater use of emergency room services due to access of care challenges, particularly an issue for Western Massachusetts
- New to market and greater use of genetic testing procedures
- Increases in use of diagnostic testing (i.e. labs and imaging) by physicians
- Areas such as sleep studies, durable medical equipment and physical and occupational therapy are seeing increases in the number of individuals using these services.
- The use of Skilled Nursing Facilities (SNFs) or sub-acute days per 1000 is up close to 5% from the prior year

As we mentioned earlier, the change in our rated average base rate will be 8.3%. It is important to note that the base rate does not necessarily determine the actual change in premium for a particular family or small group. The premium charge is based on demographic factors at both the individual and group level. In developing the rates for groups, the age of each member is calculated at the time of the group's renewal to determine the appropriate age factor used in the calculation. The mix of rating classes (for example the number of single vs. family rates) also affect premium calculations. These calculations are significant because changes in the demographic factors for a group will change the premium for the group. In a small group, a fairly small turnover of employees can have a significant effect on the premium charged, and can make the year to year change in premium larger or smaller than it would be otherwise.

We hope that this testimony has been a helpful explanation of some of the many factors that influence HNE's premium rates at this time. Thank you for your attention.



January 12, 2016

Kevin Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118-6200

RE: Division of Insurance Informational Hearing regarding Q2:2016 Small Group Health
Insurance Rate Filings

Dear Deputy Commissioner Beagan:

Minuteman Health, Inc. ("MHI") testified before the Division of Insurance on January 11, 2016, regarding its Q2:2016 small group health insurance rate filings. The Division asked that MHI provide the Division with a written summary of that testimony. MHI therefore respectfully submits this summary. We note that it is only a summary, and encourage the Division to review the hearing record for details of MHI's testimony. If the Division has any additional questions or concerns, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Susan Brown".

Susan Brown
General Counsel, Minuteman Health, Inc.

Summary of Testimony of Gregory Pence, Interim CFO and Chief Actuary of Minuteman Health, Inc.

Introduction

- MHI was founded in 2012
- In 2014, MHI entered the Massachusetts market as a not for profit private HMO issuer
- In 2015, MHI entered the New Hampshire market
- MHI's mission is to provide low cost products to price-sensitive consumers by partnering with a select network of high quality, low cost providers
- In 2016, MHI is operating as a domestic HMO in Massachusetts and as a foreign HMO in NH.
- Minuteman has grown to over 23,000 members across two states
- The Massachusetts Health Connector experienced significant challenges in 2014 which resulted in the failure of the launch of the Connector exchange platform
- As a result of the Connector's failure, Minuteman issued less business than expected in 2014, ultimately having only 1400 members
- Therefore, Minuteman has extremely limited experience or data, both because it is a new entrant, and because the Connector's collapse compromised Minuteman's roll out in 2014
- Because of that lack of experience and data, for 2014, 2015, and 2016, MHI has engaged in a manual rate setting process
- The Company starts with Milliman's large group commercial database of experience across the United States
- We then make actuarial adjustments to that data using our own expected experience as well as publicly available data on Massachusetts experience in order to set premium rates

Division Questions

1. Identify the service area that your plan operates in.
 - a. 014, 015, 016 (Central)
 - b. 017, 020 (Western/southern suburban Boston)
 - c. 018, 019 (Northern suburban Boston)
 - d. 021, 022, 024 (Metropolitan Boston)
 - e. 023, 027 (Southeastern)
 - f. MHI does not offer plans in Western Mass

2. Identify the number of individual/small group members enrolled in your plans as of October 31, 2015.

MHI Paid Membership	
Enrollment by Channel	
Member Nbr Distinct Count	Column Labels
	2015
Row Labels	201510
MA	5,775
Individual	4,972
Small Group	663
Large Group	140
Grand Total	5,775

3. Identify the number of products that your company proposes to offer within each of the following metallic tiers in the second quarter of 2016:

- i. Platinum
- ii. Gold
- iii. Silver
- iv. Bronze
- v. Catastrophic

COUNT OF PLANS		
	Q4 2015	Q1 2016
Platinum	2	1
Gold	10	9
Silver	13	11
Bronze	10	10
Catastrophic	1	1

4. Confirm that the rate filing submitted to be effective for 2nd quarter 2016 only applies to those small employers with coverage effective dates between April 1, 2016 and June 30, 2016.

Confirmed

5. Confirm that the rate filing does not apply to individual coverage because individual rates were established in the 1st quarter 2016 rate filing and will remain the same for all months in calendar year 2016.

Confirmed

6. Identify the average composite rate change year-over-year within the rate filing. .

*2Q 2015 Average Base Rate = \$207.03, 2Q 2016 Average Base Rate = \$200.27
Rate Change = (3.27%)*

7. Explain what is meant by a Medical Loss Ratio and what is the Medical Loss Ratio that you have included within your 2nd quarter 2016 rate filing.

MLR is the ratio of estimated paid medical expenses over net premiums collected.

Paid medical expenses are based on projected individual and small group member claims for medical, prescription drug and clinical quality improvement costs.

Net premiums are derived from member premiums received, and associated ACA subsidies. This is offset by ACA and connector related taxes and fees.

Our projected MLR is 90.2% for Q2 rate experience.

8. Explain the approximate proportion of your company's projected medical costs, as included in the rate filing that is associated with fee-for-service medical payments. Explain the reasons that your company's rate filing may include different medical fee-for-service medical cost projections on a per member per month basis than was filed in the 2nd quarter 2015 rate filing.

We have assumed that approximately 98% of our projected medical costs are for FFS claims. The remaining 2% portion of the assumed medical cost is due to clinical quality improvement and reinsurance adjustments.

For 2015 Q2 small group rates, FFS PMPM costs are based entirely upon the projected FFS claims from our actuarial consultant, Milliman, which is called the manual experience basis. This is an actuarially adjusted database of commercial large group experience from across the US. It is further adjusted actuarially to reflect estimated ACA individual and small group experience. We assumed that our experience results would reflect a member population that has a risk score of the average of the individual and small group insurance ACA market.

For 2016, the reason our 2016 Q2 rate filing FFS projection differs from Q2 2015, is that our expected FFS experience for Q2 2016 is a blend of two basis:

- o The first is the manual basis using Milliman market wide average plan FFS claims for commercial large groups costs, adjusted for MHI specific demographic and utilization actuarial adjustments*
- o And the second is additional data reflecting ACA expected.*

9. Explain how the fee-for-service costs of any of the following types of care may be impacting the overall levels of projected costs:

- a. Inpatient hospital-based care
- b. Outpatient hospital-based care

- c. Freestanding facility based care
- d. Specialist doctor office visits
- e. Primary care doctor office visits
- f. Behavioral health utilization (both inpatient and outpatient)
- g. Emergency room visits
- h. Medical supplies

Because of the small size and limited credibility of MHI experience, projected changes are made in aggregate, not by each benefit category, in the manner describe in item 8. Therefore the only factor that would change the PMPM levels of projected costs are related to two factors, changes in the projected market average provider discounted FFS costs in the underlying Milliman manual projected experience, and in the assumed proportion of these services that are on assumed to be in network compared to out of network.

10. Explain the approximate proportion of your company's projected medical costs, as included in the rate filing that is associated with capitated payments for medical services. Explain the reasons that your company's rate filing may include different capitation cost projections on a per member per month basis than was filed in the 2nd quarter 2015 rate filing.

None

11. Explain how the capitation costs of any of the following types of care may be impacting the overall levels of projected costs:
- a. Inpatient hospital-based care
 - b. Outpatient hospital-based care
 - c. Freestanding facility based care
 - d. Specialist doctor office visits
 - e. Primary care doctor office visits
 - f. Emergency room visits
 - g. Medical supplies
 - h. Prescription drugs

None

12. Explain the approximate proportion of your company's projected medical costs, as included in the rate filing that is associated with other medical payments other than fee-for-service or capitation payments. Explain the reasons that your company's rate filing may include other payment projections on a per member per month basis than was filed in the 2nd quarter 2015 rate filing.

We have assumed our medical costs will not include other medical payments and that they will reflect the expected average experience for market risk. In other words we assume that our experience will reflect the market average cost and utilization adjusted for MHI specific network contracts and member enrollment.

13. Explain how the other payment costs of any of the following types of care may be impacting the overall levels of projected costs:

- a. Inpatient hospital-based care
- b. Outpatient hospital-based care
- c. Freestanding facility based care
- d. Specialist doctor office visits
- e. Primary care doctor office visits
- f. Emergency room visits
- g. Medical supplies
- h. Prescription drugs
- i. Prescription drugs

Because of the mix of Milliman manual and other relevant information, we have used overall trends to project costs and are not able to detail the impact of each of these categories based on MHI experience alone.

Our overall projected trends are in the low single digits. The only category that is trending higher than the other categories in our projections is prescription drugs which has been seen by actuaries as having higher unit cost and utilization trends overall.

We believe that none of our experience to date raises concerns with respect to the manual rate driven process. But we are keeping an eye on potential under-utilization of PCP and over-utilization of ER that appears to be a market phenomenon.

14. Explain what is included in your filing's administrative expense projections and the reasons that your company's rate filing may include different administrative expense projections on a per member per month basis than was filed in the 2nd quarter 2015 rate filing.

We have revised our administrative expense projections due to a mix of individual and small group experience that we forecast which impacts the assumed administrative costs. In addition there are other factors that impact our projection.

- *Allocated expenses by state*
- *Assumed PMPM expenses allocated across enrollment*
- *Accounting basis moving from % of premium to an amortized approach*

15. Explain how any changes to government taxes or other government programs may have impacted your company's expected administrative costs for the period between April 1, 2016 and June 30, 2017.

Primary factors for these categories for changes in administrative expenses are due to the risk adjustment and connector user fees which have increased

16. Explain what is meant by your company's contribution-to-surplus projections and the reasons that your company's rate filing may include a different contribution-to-surplus on a per member per month basis than was filed in the 2nd quarter 2015 rate filing.

Our projected contribution to surplus is the same in both of our 2015 and 2016 filings.

17. Confirm that the rate filing does not include any changes to the rating factors that are in use for the 1st quarter 2016 rate filing.

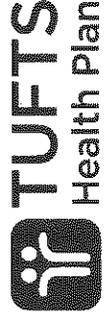
Confirmed

Conclusion

- We would like to spend a few moments on the issue of risk adjustment
- As you've heard from many other carriers already today, the issues of risk adjustment continues to be a major concern and a force of instability in the Massachusetts market
- As already discussed, Minuteman is a new entrant with limited available data.
- In addition, as you have already heard, carriers must project potential risk payment transfer amounts and incorporate those predictions into rate filings almost one and a half years before the actual payment amount is known
- Complicating this is the fact that the Connector risk transfer payment simulations are widely variable
- For all these reasons, Minuteman projects risk adjustment transfer amounts for the purposes of rate filings by setting premium rates assuming a market-average member risk profile
- If the risk adjustment methodology is working correctly, this approach should ensure that Minuteman is appropriately pricing its products regardless of the risk profile of members that it actually enrolls
- We are concerned that many aspects of the current risk adjustment program create technical issues that impact the effectiveness of the program. For example,
 - o The current program utilizes a market-wide average premium to calculate risk payment transfer amounts; this penalizes low cost plans by forcing them to pay out risk adjustment transfer amounts simply because their products are lower cost
 - o The program also appears to over-score some HCCs while underscoring others
 - o The program does not adequately compensate for lack of data or for new member growth, so small plans, new plans, or high growth plans are unfairly disadvantaged
- Although Minuteman's small group second quarter rates do not include a year over year increase based on risk adjustment, we caution that as Minuteman obtains more data and more experience with the risk adjustment program, future rates may be impacted
- Thank you again for the opportunity to speak with you today.

DOI Informational Hearing 2Q 2016 Merged Market Rates Tufts Health Plan

January 11, 2016



Key Messages

- Tufts Health Plan (THP) is committed to keeping health care affordable for employers and consumers
- Our overall weighted increases for 2Q 2016 are 4.8% for TAHMO and 4.6% for TICO
- The overall driver of our requested rate change is the increase in the utilization and unit cost of medical services and prescription drugs
- To keep our rate increases as low as possible, we have implemented many utilization and cost management programs, including programs to control costs when members receive care out of area, new pharmacy contracts and updated plan designs to encourage more efficient use of medical services

Background

- THP's service area includes all counties in Massachusetts
- The number of individual & small group members enrolled in our plans as of October 31, 2015 is as follows:

	Membership									
	TAHMO			TICO			Total			Grand Total
	Individual	Small Group		Individual	Small Group		Individual	Small Group		
Platinum	710	13,740		0	272		710	14,012		14,722
Gold	2,337	34,378		320	1,958		2,657	36,336		38,993
Silver	2,147	7,736		0	128		2,147	7,864		10,011
Bronze	311	22		0	0		311	22		333
Catastrophic	20	0		0	0		20	0		20
Total	5,525	55,876		320	2,358		5,845	58,234		64,079

Background

- The number of products proposed for 2Q 2016 in each of the metallic tiers is as follows:

	TAHMO	TICO	Total
Platinum	11	0	11
Gold	22	8	30
Silver	17	7	24
Bronze	2	1	3
Catastrophic	0	0	0
Total	52	16	68

- The rate filings submitted for 2Q 2016 applies only to Small Groups with coverage effective dates between April 1, 2016 and June 30, 2016

Background (Cont.)

- The number of groups and members expected to renew in 2Q 2016 are as follows:

	Groups	Members
TAHMO	6,848	32,045
TICO	76	498
Total	6,924	32,543

- The rate filing does not apply to Individual coverage as those rates were filed for 1Q 2016 and will remain the same for all months in calendar year 2016

2Q 2016 Rate Development

- The starting point for rate development is the claims experience of our Merged Market population
- The claims experience is then trended forward to the rating period based on projected utilization and unit cost increases
 - THP analyzes trends in over 40 medical service categories (e.g., inpatient med/surg, outpatient surgery, physician office visits, etc.) and over 7 pharmacy category break outs (e.g., retail, mail, brand, generic, etc.)
- ACA fees, such as risk adjustment, reinsurance, health insurance provider fees, PCORI and Connector fees are then added to the rate

2Q 2016 Rate Development (Continued)

- Administrative expense, including taxes, assessments, broker commission, general administrative expense and a modest margin is added to the rate to get a final premium amount

THP 2Q 2016 Rate Increase

- The overall rate increase for 2Q 2016 for TAHMO & TICO is 4.8%, broken down as follows:

Category	2Q 2016 Rate Increase
Trend	5.3%
Claims Experience and Trend Restatement	-0.3%
Rx Rebate and State Mandates	-0.7%
Fixed Medical	1.3%
Capitation	0.0%
Risk Adjustment Payment Transfer	0.0%
Reinsurance recoveries	0.9%
ACA Fees	-0.3%
Other taxes	0.1%
Administrative expenses	1.1%
Profit/Loss	-0.5%
Prior Period Rate Inadequacy	0.9%
Benefit plan changes	-3.0%
Weighted Average Rate (TAHMO & TICO)	4.8%

THP 2Q 2016 Projected Medical Expense Fee-For-Service (FFS) Payments

- FFS payments represent ~93% of the projected medical costs
- THP is projecting modest utilization (~1.0%) and unit cost trends (~2.5%) for medical services
- The greatest impact on premium is the projected unit cost for drugs (15.8%)
- FFS trends and their impact on premium is as follows:

Service Category	% of FFS cost (a)	Utilization Trend (b)	Unit Cost Trend (c)	Total Trend (b) * (c)	Premium Impact (a) * (b) * (c) *
Inpatient Hospital Care	15.2%	0.9%	3.0%	4.0%	0.5%
Outpatient Hospital Care	25.7%	0.7%	3.0%	3.7%	0.8%
Rad./lab/path. cost	6.1%	1.2%	2.4%	3.7%	0.2%
All other outpatient cost	19.6%	0.6%	3.2%	3.8%	0.6%
Health Care Provider Cost	37.4%	1.1%	2.1%	3.2%	1.0%
Medical and osteopathic phy.	24.2%	0.5%	2.6%	3.1%	0.6%
Mental health providers	2.1%	3.9%	0.4%	4.3%	0.1%
All other practitioners	11.1%	1.9%	1.2%	3.1%	0.3%
Supplies	0.7%	3.4%	0.2%	3.6%	0.0%
Outpatient Prescription Drugs	20.9%	0.9%	15.8%	16.9%	2.9%
Total (Medical and Rx)	100.0%	0.9%	5.3%	6.3%	5.3%

Prescription Drug Trends

- Prescription drug trends have escalated over the last two years, driven by the increase in the cost of drugs, most notably the cost of specialty drugs
- For example, in the last couple of years new drugs became available for the treatment of Hepatitis C that cost ~\$100,000 per patient
 - THP spent \$4.1M on Hepatitis C drugs in 2015 for Merged Market members
- During this past year, new drugs for cystic fibrosis (~\$300,000/patient/year) and cholesterol (~\$20,000/patient/year) became available
- Even generic drug prices have increased, as a recent white paper reported that 8% of generic drug groups increased by 100% or more and 3% increased by at least 200%
- While THP has many programs to manage prescription drug utilization, pricing changes are at the discretion of the manufacturers, who can adjust prices any time during the year

THP 2Q 2016 Projected Medical Expense Fixed Medical Payments

- Fixed Medical payments are non-ffs, non-capitated payments that represent between 5%-6% of total medical expense
- These payments include such things as provider settlements, uncompensated care pool payments, immunization surcharges, etc.
- The year over year PMPM change in Fixed Medical payments is as follows:

		2Q 2016		2Q 2015	
		PMPM	% of Medical Costs	PMPM	% of Medical Costs
Fixed Medical	\$	32.14	6.7%	26.27	5.7%
				\$	5.87
					Premium Impact
					1.3%

Medical Loss Ratio

- Traditionally medical loss ratio is the portion of premium that represents medical costs
 - MLR Formula = Medical Costs / Premium
- Under ACA rules, administrative expenses that improve quality, fraud prevention expenses, risk adjustment, reinsurance recoveries and risk corridor payments are added to medical costs in the numerator. The denominator excludes certain taxes, fees and assessments.
- The ACA MLR formula is as follows:

$$\frac{\text{Medical Costs + Quality + Fraud + Risk Adj. + Reinsurance + Risk Corridor Payments}}{\text{Premium - Taxes - ACA Fees - Assessments}}$$

- For 2Q 2016, THP filed a medical loss ratio of 90.9%, which is higher than the state requirement of 88%



Risk Adjustment

- Massachusetts Health Connector estimates of THP's risk adjustment receipts and payments have been highly volatile
 - Estimates have ranged from a receipt in excess of 10% to a payment of over 5%
- Given that we continue to see considerable volatility in the simulation results, we didn't change our projected risk adjustment assumption of 0% for 2Q 2016, which is consistent with the assumption in our 2Q 2015 rates

Reinsurance Recoveries

- Reinsurance Recoveries reflect reimbursement for members that incur high claims costs
- This program started in 2014 and phases out after 2016
- For each consecutive year, the claims eligible for reimbursement decrease therefore reducing the value of the program
- The year over year PMPM change in Reinsurance recoveries is as follows:

	2Q 2016		2Q 2015	
	PMPM	% of Medical Costs	PMPM	% of Medical Costs
Reinsurance Recoveries	\$ (3.19)	-0.7%	\$ (8.10)	-1.8%
			\$ 4.91	0.9%
			Premium Impact	

ACA Taxes & Fees and Other Taxes

- ACA Taxes & Fees and Other Taxes represent approximately 2% of premium
- Component pieces of these costs and the year over year change are as follows:

	2Q 2016		2Q 2015		Premium Impact
	PMPM	% of Premium	PMPM	% of Premium	
Health Insurance Providers Fee	\$ 5.24	1.0%	\$ 5.12	1.0%	\$ 0.12 0.1%
PCORI	\$ 0.18	0.0%	\$ 0.18	0.0%	\$ 0.00 0.0%
Reinsurance Contributions	\$ 1.64	0.3%	\$ 3.20	0.6%	\$ (1.55) -0.3%
User Fees	\$ 0.59	0.1%	\$ 0.88	0.2%	\$ (0.29) -0.1%
Total ACA Taxes	\$ 7.65	1.4%	\$ 9.37	1.8%	\$ (1.72) -0.3%
Other Taxes	\$ 2.49	0.4%	\$ 2.15	0.4%	\$ 0.34 0.1%

Administrative Expenses & Margin

- Administrative Expense includes general administrative cost and broker commissions
- Margin in 2Q 2016 rates is 0%, which is a reduction of 0.5% from the margin in 2Q 2015 rates
- The year over year change in these components is as follows:

	2Q 2016		2Q 2015		PMPM Increase	Premium Impact
	PMPM	% of Premium	PMPM	% of Premium		
Administrative Expenses	\$ 54.36	10.0%	\$ 50.14	9.7%	\$ 4.22	1.1%
Margin	\$ -	0.0%	\$ 2.59	0.5%	\$ (2.59)	-0.5%

2Q 2016 Rating Factor Changes

- For 2Q 2016, the rating factors are consistent with what was filed for 1Q 2016

Conclusion

- Tufts Health Plans is committed to keeping health care affordable for employers and consumers
- Our overall weighted increase for 2Q 2016 is 4.8% for TAHMO & 4.6% for TICO
- To keep our rate increases as low as possible, we have implemented many utilization and cost management programs, including programs to control costs when members receive care out of area, new pharmacy contracts and updated plan designs to encourage more efficient use of medical services

DOI Informational Hearing 2Q 2016 Merged Market Rates Tufts Health Public Plans

January 11, 2016



Key Messages

- Tufts Health Public Plans (THPP) is committed to keeping health care affordable for employers and consumers
- Our overall weighted increase for 2Q 2016 is 0.7%
- The overall driver of our requested rate change is the increase in medical expense and risk adjustment charges, offset by benefit changes and a prior period experience & trend restatement
- To maintain high quality of care while keeping our rate increases as low as possible, we have many clinical and cost management programs, including integrated care management, chronic disease management, transitions of care, etc.

Background

- THPP’s service area includes all 7 rating regions, with the exception of Franklin, Nantucket and Dukes Counties
- The number of individual & small group members enrolled in our plans as of October 31, 2015 is as follows:

	Membership	
	Individual	Small Group
Platinum	493	85
Gold	967	240
Silver	68,168	1,976
Bronze	872	52
Catastrophic	139	0
Total	70,639	2,353



Background (Continued)

- The number of products proposed for 2Q 2016 in each of the metallic tiers is as follows:

	# Plans
Platinum	1
Gold	2
Silver	2
Bronze	1
Catastrophic	0
Total	6

- The rate filings submitted for 2Q 2016 applies only to Small Groups with coverage effective dates between April 1, 2016 and June 30, 2016
- The number of groups and members expected to renew in 2Q 2016 is as follows:

	# Groups	# Mems
2Q 2016 Renewals	441	1,087

Background (Continued)

- The rate filing does not apply to Individual coverage as those rates were filed for 1Q 2016 and will remain the same for all months in calendar year 2016

2Q 2016 Rate Development

- THPP has limited individual and small group data to use in the development of Merged Market rates. Therefore we have used historical Commonwealth Care (CwC) and Medical Security Plan (MSP) claims cost as our base for rate development
- The CwC & MSP claims cost is trended forward to the rating period based on projected utilization and unit cost increases
- The rating period claims cost is then adjusted to reflect the benefit plans offered in the Merged Market

2Q 2016 Rate Development (Continued)

- ACA fees, such as risk adjustment, reinsurance, PCORI and Connector fees are then added to the rate
- Administrative expense, including taxes, assessments, general administrative expense and a modest margin is added to the rate to get a final premium amount

THPP 2Q 2016 Rate Increase

- The overall rate increase for 2Q 2016 is 0.7%, broken down as follows:

Category	Q2 2016 Rate Increase ¹
Utilization Trend	0.4%
Unit Cost Trend	5.6%
<i>Inpatient</i>	0.4%
<i>Outpatient</i>	0.8%
<i>Professional</i>	0.7%
<i>Medical Supplies</i>	0.1%
<i>Prescription Drugs</i>	3.6%
Risk Adjustment	7.5%
Benefit Changes	-8.8%
Reinsurance Accessment	-0.5%
Reinsurance Recovery	0.9%
Exchange User Fee	-0.1%
Admin / Contribution-to-Surplus	-0.5%
Trend Difference	-3.7%
Weighted Average Rate	0.7%

Note:

- Represents impact to premium.

THPP 2Q 2016 Projected Medical Expense

- THPP's projected medical cost is 100% fee-for-service
- THPP is projecting modest utilization (0.5%) and unit cost trends (~3.0%) for medical services
- The greatest impact on premium is the projected unit cost for prescription drugs (13.6%)
- Fee-for-service trends and their impact on premium are as follows:

Service Category	% of Medical Cost (a)	Utilization Trend (b)	Unit Cost Trend (c)	Premium Impact (a)*(b)*(c)* .857
Inpatient	15.7%	0.5%	2.8%	0.4%
Outpatient	27.2%	0.5%	3.5%	0.9%
Professional	24.1%	0.5%	3.5%	0.8%
Medical Supplies	1.9%	0.5%	2.8%	0.1%
Prescription Drugs	31.1%	0.5%	13.6%	3.8%
Total	100.0%	0.5%	6.5%	6.0%

Prescription Drug Trends

- Prescription drug trends have escalated over the last two years, driven by the increase in the cost of drugs, most notably the cost of specialty drugs
- For example, in the last couple of years new drugs became available for the treatment of Hepatitis C that cost ~\$100,000 per patient
- During this past year, new drugs for cystic fibrosis (~\$300,000/patient/year) and cholesterol (~\$20,000/patient/year) became available
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- While THPP has many programs to manage prescription drug utilization, pricing changes are at the discretion of the manufacturers, who can adjust prices any time during the year

Medical Loss Ratio

- Traditionally medical loss ratio is the portion of premium that represents medical costs
 - MLR Formula = Medical Costs / Premium
- Under ACA rules, administrative expenses that improve quality, fraud prevention expenses, risk adjustment, reinsurance recoveries and risk corridor payments are added to medical costs in the numerator. The denominator excludes certain taxes, fees and assessments.
- The ACA formula is as follows:

$$\frac{\text{Medical Costs} + \text{Quality} + \text{Fraud} + \text{Risk Adj.} + \text{Reinsurance} + \text{Risk Corridor Payments}}{\text{Premium} - \text{Taxes} - \text{ACA Fees} - \text{Assessments}}$$

- For 2Q 2016, THPP filed a medical loss ratio of 89.9%, which is higher than the state requirement of 88%



Risk Adjustment

- Massachusetts Health Connector estimates of THPP's risk adjustment receipts and payments have been highly volatile
 - Estimates have ranged from a receipt in excess of 15% to a payment of over 30%
- THPP paid in over 30% of premium for calendar year 2014
- In our 2Q 2015 rate development we assumed a risk adjustment receipt of 7.5% of premium
- Given the latest simulation indicated THPP would have a significant risk adjustment payment, and the volatility of the prior estimates, THPP assumed no receipt or payment in our 2Q 2016 rates

ACA Taxes and Fees

- Although ACA taxes and fees represent roughly 3% of premium costs, the impact on the rate increase from 2Q 2015 to 2Q 2016 is not significant
- Component pieces of the taxes and fees and the year over year change are as follows:

ACA Items	2Q15	2Q16	Change	Premium Impact
Reinsurance Fee	\$ 3.43	\$ 1.63	\$ (1.80)	-0.5%
Reinsurance Recovery	\$ (6.29)	\$ (3.06)	\$ 3.23	0.9%
Health Insurer Tax	\$ 2.43	\$ 2.32	\$ (0.12)	0.0%
PCORI Fee	\$ 0.19	\$ 0.28	\$ 0.09	0.0%
Exchange User Fee	\$ 10.17	\$ 9.70	\$ (0.46)	-0.1%
Total	\$ 9.93	\$ 10.87	\$ 0.94	0.3%

Administrative Expense & Margin

- Merged market membership has significantly increased during 2015 resulting in an administrative expense PMPM that is lower for 2Q 2016 as compared to 2Q 2015
- Margin is 1.5% of premium for both 2Q 2016 and 2Q 2015, but due to the lower expected revenue in 2Q 2016 the margin PMPM is slightly lower for 2Q 2016
- The year over year PMPM change in administrative expense and margin is as follows:

	2Q15 PMPM	2Q16 PMPM	PMPM Change	Impact to Premium
Administrative Expense	\$ 33.04	\$ 31.42	\$ (1.62)	-0.5%
Margin	\$ 5.22	\$ 4.96	\$ (0.26)	-0.1%
Total	\$ 38.25	\$ 36.38	\$ (1.87)	-0.5%

2Q 2016 Rating Factor Changes

- For 2Q 2016, the rating factors are consistent with what was filed for 1Q 2016

Conclusion

- Tufts Health Public Plans is committed to keeping health care affordable for employers and consumers
- Our overall weighted increase for 2Q 2016 is 0.7%
- To maintain high quality of care while keeping our rate increases as low as possible, we have many clinical and cost management programs, including integrated care management, chronic disease management, transitions of care, etc.