Harvard Pilgrim
HealthCare

September 8, 2014

David Seltz
Executive Director
Health Policy Commission
2 Boylston Street
Boston, MA 02116

Re: Annual Health Care Provider and Insurer Cost Trends Hearings

Dear Mr. Seltz:

Enclosed please find Harvard Pilgrim's written testimony in response to the Commission's letter to Eric Schultz, President and CEO of Harvard Pilgrim Health Care, Inc., dated August 1, 2014. We have enclosed completed Exhibits B and C, the two templates from Exhibit C and Appendices A – C which contain our responses to questions from the Health Policy Commission where the responses did not fit into the questionnaire template's format. We have also enclosed the required certification.

Harvard Pilgrim looks forward to the upcoming hearings on October 6 and 7, including the panel discussion in which Eric Schultz will participate. In the meantime, if you have any questions about our response, please feel free to contact me at 617-509-4744 or Teresa Gallinaro, Legislative Consultant, at 617-509-7208.

Thank you for your consideration.

Sincerely,

William J. Graham
Senior Vice President, Public Affairs and Government Programs

Attachments

CERTIFICATION OF WRITTEN TESTIMONY FOR MASSACHUSETTS ANNUAL PUBLIC HEALTH CARE COST TRENDS HEARINGS PURSUANT TO M.G.L. CHAPTER 6D, §8

I, William J. Graham, am the Senior Vice President for Public Affairs and Government Programs of Harvard Pilgrim Health Care, Inc. (Harvard Pilgrim). As such, I am legally authorized and empowered to represent Harvard Pilgrim for the purpose of submitting the written testimony and supporting documentation provided herein.

To the best of my knowledge, the factual and quantitative information presented in this submission is true and accurate. The information contained in the appendices of this submission was collected and compiled by employees of Harvard Pilgrim who are responsible for this type of information. To the best of my knowledge, such information was collected and compiled in a reasonable and diligent manner and accurately represents the underlying data.

Signed under the pains and penalty of perjury, on this 5th day of September, 2014.

By: _____

William J. Graham
Senior Vice President for Public Affairs and Government Programs
Harvard Pilgrim Health Care, Inc.

Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

Monday, October 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but if necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

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

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

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.
   SUMMARY: Harvard Pilgrim continues to undertake significant actions to help ensure the Commonwealth will meet the 3.6% benchmark. We believe that our actions listed below have borne fruit and proudly note that CHIA recently determined that the change in Harvard Pilgrim's risk-adjusted TME from 2012 to 2013 was 0.92%, significantly below the cost benchmark of 3.6%.
   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

      1. Provider Contracting: Upon renewal, Harvard Pilgrim has negotiated more favorable contract terms that also emphasize improving quality of care. We have worked with larger providers with the necessary infrastructure to develop alternative payment arrangements that emphasize quality over quantity of care provided (see our response to Q.2). As a result, we have negotiated contracts with the large majority of our provider groups that include price increases below the benchmark. This is significant since several state-issued reports have shown that increases in prices charged by health care providers are the primary driver of rising health care costs.

      2. Payment Reform: As noted above and in our response to Q.2, Harvard Pilgrim believes that alternative payment arrangements, when done right, are key to the state's effort to control the rise in costs. The percentage of our primary care providers under some type of alternative payment agreement increased from a little over 1/5 of our HMO/POS members in 2011 to approximately 75% in 2013. In Eastern Massachusetts, it increased to more than 80%.

      3. Network and Plan Designs that Engage Consumers: Harvard Pilgrim has, over the past few years, expanded its product offerings to include limited and tiered network products that emphasize greater consumer engagement and provide incentives for consumers to go to providers that have lower costs but maintain a high quality of care standard. Please see Q.7 for more details about these offerings.

      4. Consumer Transparency and Engagement Tools: In late 2013, Harvard Pilgrim launched NowIKnow, a state-of-the-art consumer transparency tool that allows our members to search and compare providers.

   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

Harvard Pilgrim continues to focus on the four areas noted in (a). In terms of provider contracting, the heightened public interest and focus on the trajectory of health care cost growth, especially among employers, has also assisted our efforts to keep provider rate increases reasonable. Regarding payment reform, we expect alternative arrangements to grow due to the growing interest in the market and the incentives and expectations built into C. 224 and the Affordable Care Act. In addition, Harvard Pilgrim has also been working with many of its self-insured groups to move in this direction. This is critical since the self-insured market comprises approximately half of Massachusetts' commercial health care market and is growing. We expect that by the end of 2014, most of our self-insured accounts will be linked with groups operating under some type of global budget. Harvard Pilgrim will continue to develop innovative products including those that also address cultural differences, such as our Eastern Harmony program, in order to engage diverse communities that may follow effective health care methods other than traditional Western medicine. Finally, we will continue to expand the services and information provided in the NowIKnow tool in order to engage consumers to be informed shoppers of health care services, driving volume to value, and ultimately reducing health care costs.

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2. C. 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high quality, efficient care delivery. SUMMARY: Harvard Pilgrim has increased the percentage of providers in some type of shared responsibility payment arrangement to approximately three-quarters of its fully-insured HMO/POS members since 2011. We are currently expanding these arrangements to PPO products and to other funding arrangements (i.e., self-insured employers). However, work must be done internally to different systems and in different areas to support these arrangements. Moreover, different providers are at different stages in terms of their ability to successfully handle alternative payment arrangements.
    a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

    Since 2011, Harvard Pilgrim has increased from 22% to over 75% (more than 80% in Eastern Massachusetts) its network of providers contracted through some type of shared responsibility payment arrangement for fully-insured HMO/POS members. Furthermore, Harvard Pilgrim has developed a PPO primary care physician attribution model and is in the process of enhancing reporting, business processes and systems capabilities to support such models for all product types and funding arrangements. Beginning in 2014, Harvard Pilgrim has entered into arrangements with several key providers to extend such payment models to self-insured PPO groups. Current focus has centered on supporting the Group

Insurance Commission's (GIC) efforts related to Patient-Centered Care. We have plans to reach agreement with additional, targeted providers within the next year to meet our requirements with the GIC.

As Harvard Pilgrim's shared responsibility models and footprint have grown over the past few years, we have sought to measure the effectiveness of these models compared to FFS-based arrangements. Results indicate that the overall total medical expense for providers under an alternative model is approximately 1% lower than for providers who are not. Emergency Room visits are 31% lower. Each indicator positively impacts the premiums we set with our employers. Furthermore, quality scores are consistently higher for providers under risk than those who are reimbursed at fee-for-service.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

Please see our response to 2(a). We believe there is general acceptance among the provider community in moving away from traditional fee-for-service payment mechanisms. There may be, however, certain limiting factors. The first would be providers' agreement on future cost and utilization trends and the impact that would have on the risk they would assume over time. Another limiting factor may be simply the size of the risk pool of plan members associated with those provider groups who have not yet contracted under risk-type arrangements. Random variability effects that may exist in performance among smaller risk pools may limit movement away from fee-for-service (FFS) arrangements. Additionally, providers' readiness to consider PPO populations in the same manner as HMO populations could be another limiting factor. Plans and providers are in relatively early stages of understanding how coordination of care principles applied to HMO, primary care physician-centered care populations may be best applied to PPO patient populations. Some providers are considering their ability to successfully manage PPO populations who have access to providers who may be outside of the accountable care organization.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.
   SUMMARY: The percentage of Harvard Pilgrim physicians in its provider networks has continued to increase since 2011 as noted in Q. 2(a). The percentages noted below differ from those in Q. 2(a) primarily because the %'s in Q.2(a) refer only to HMO/POS products and to primary care physicians. For both questions, however, it is clear that the trend is to increase the percentage of providers in an alternative payment arrangement, particularly in PPO and self-funded products.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	13339	59
CY2013	14775	65

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.
   SUMMARY: Harvard Pilgrim is committed to applying robust and clinically appropriate risk adjustment to our risk based contracts in order to fairly and accurately compensate provider groups for the care they provide for their populations. The principal factors that we consider are 1) the relevance of the model -- using models "tuned" for the product type, demographics and market of the affected members; 2) accuracy -- using models that have been well vetted in the marketplace and employing the most appropriate input data; 3) application of appropriate benchmarks (comparisons) for that provider group, covered population and contract. Harvard Pilgrim adjusts risk-based budgets at annual and semi-annual frequencies to capture changes in population health risk. When necessary, to accommodate changes resulting from provider movements, modification to the above mentioned adjustments are introduced.
   a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations? Harvard Pilgrim's preferred approach is to use a common DxCG risk adjustment methodology (different models may be employed, depending on the type of the risk arrangement). However, there are certain legacy contracts that still utilize an age/gender adjustment to account for health status. We have found the DxCG models to be accurate, reliable and well accepted by the provider community.
   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both

across providers and across payers? What are the values and/or drawbacks of differentiation?

Harvard Pilgrim agrees that setting standards for risk adjustment can be productive, efficient, help ensure that sound business practices are followed and allow for across-the-market comparison of populations covered under different contracts. It eliminates speculation and uncertainty about "actual" population risk. At the same time, a particular health plan's business relationship with a particular provider group or population of members may require flexibility to respond most optimally to their business needs and preferences. We believe that any public standards be adopted as guidelines rather than mandates so as to allow both flexibility and innovation in the marketplace. The capacity to innovate is often the engine that leads to new learning and competitive differentiation that, in turn, enables the entire market to improve.

c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

Harvard Pilgrim does not currently employ socio-economic adjustments to risk budgets. We understand and support the intention of encouraging providers to service potentially underserved populations in socio-economically disadvantaged areas. We are open to learning more about applying such adjustments, and would be interested in seeing data that substantiates the use of this risk adjustment to further this goal. We also appreciate the argument that traditionally underserved populations may initially require more services when first covered by insurance. This phenomenon may be relatively short-lived and therefore would not be an appropriate ongoing adjustment factor. It is worth noting that Harvard Pilgrim does not currently require members to disclose detailed socio-economic information and this could raise member privacy concerns.

d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

Harvard Pilgrim has measured differences among adjustment types, specifically whether we employ normalized or raw DxCG risk scores. Our approach has been to use normalized DxCG adjustment, as our analysis demonstrates that this more accurately represents relative risk across our markets, providers and members. Harvard Pilgrim has also found that the degree to which a group has assumed financial risk for clinical and cost outcomes directly influences their behavior, particularly how engaged they are in changing their practice habits, studying outcomes data and working with the health plan. Harvard Pilgrim has not perceived or measured any differences in provider performance based on the specific measure or methodology used in their adjustment.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.

SUMMARY: The goal of Harvard Pilgrim quality performance programs is to reward providers for delivering high quality, safe, and efficient care that creates demonstrable value for members and employers. Measures selected are:
1. clinically relevant to Harvard Pilgrim members
2. representative of a diverse array of provider clinical activities
3. drawn from nationally accepted measure sets, whenever possible
4. based on empirical evidence and demonstrated to provide stable and reliable information 5. in areas with sufficient provider variability or insufficient performance overall
6. preferably based on outcomes, rather than on processes or structures
7. structured to reward either achievement or improvement when feasible
8. based on national or other appropriate benchmarks, and reasonable and attainable.

a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?
   Harvard Pilgrim has a standard quality program, with standard measures. Payments for these measures are negotiated as part of the provider contract.
b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?
   Providers prefer standardization of quality measures so that quality efforts can be focused for their organizations. It is critical that measures selected for standardization have readily available data in the public domain and have national/regional benchmarks. Differentiation can benefit providers, payers or purchasers by allowing them latitude in designing specific quality improvement efforts, which can lead to innovation and overall market advancement.

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.
   SUMMARY: Members who purchase one of Harvard Pilgrim's PPO products are not required to select a PCP. As a result, Harvard Pilgrim has developed a claims-based methodology to attribute PPO members to the single provider who appears to be their principal PCP. For most PPO members, identification of their PCP is fairly unambiguous from claims. Additional rules have been developed to address members who have used services other than well visits. Harvard Pilgrim seeks to maximize attribution while maintaining clinically appropriate results. The resulting methodology enables Harvard Pilgrim to attribute PPO members to contracted providers in a manner where they can confidently take responsibility for their financial and clinical outcomes.

   a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:

i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)
Note: Please see Appendix A for Methodology and responses to the remaining sections of Question 6.

ii. units used in counting services (e.g., number of claims, share of allowed expenditures)

iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)

iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and

v. whether patients are attributed retrospectively or prospectively.

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.
SUMMARY: Harvard Pilgrim continues to re-shape and design products that encourage members to seek high-value care and providers. In terms of product offerings, Harvard Pilgrim has developed products that engage members in the choices around course of treatment, sequencing of services and sites of service.
ANSWER: Please see Appendix B for description of our efforts and products.

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8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's

progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.
SUMMARY: At this time, NowIKnow, our cost estimator tool, is available to all MA members. Because the tool is still relatively new, we have not yet conducted any analyses or can provide any qualitative observations regarding its value to members.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	226		
	Q2	776		
	Q3	434		
	TOTAL:	1436		

** Please indicate the unit of time reported.*

ANSWER: Please note that we have not tracked the number of inquiries via telephone or in person and do not know how members use this information. The top ten searches by members are for the following: MRI; primary care for adults; laboratory tests; colonoscopies; pregnancies; dermatologists; mammograms; X-rays; orthopedic surgeons; Ob/Gyns.

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9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.
SUMMARY: Harvard Pilgrim promotes providing the right care in the right setting. We believe that higher quality will eventually lead to lower costs by providing more appropriate care which leads to better outcomes.
ANSWER: It is important that Harvard Pilgrim continues to support and assist members in their decisions in finding appropriate care based in a community setting through a combination of plan design incentives (please refer to Q. 7 response) targeting providers and members. It is critical that both groups have access to robust decision-making support tools to help them make more cost-effective choices with improved outcomes. We believe it is imperative that re-direction also include quality measures. The hope is

higher quality will eventually lead to lower costs by providing more appropriate care leading to better outcomes. We do not have analyses on "outmigration" or savings that accrue from redirection of care.

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10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    SUMMARY: Harvard Pilgrim has a longstanding commitment to encourage integrated care to address the needs of members who have chronic medical conditions including behavioral health difficulties. We demonstrate this commitment by developing and maintaining a nearly seamless care model with our behavioral health care vendor and our medical providers. Care managementfor individuals with both medical and behavioral health conditions must be patient and family-centered.
    a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.
       Please see Appendix C
    b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.
       Please see Appendix C

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11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.
    SUMMARY: Harvard Pilgrim launched three 18 month PCMH pilots in MA in Q3 2012. The pilot model included elements from NCQA's PCMH standards including access, care planning, care coordination, self-care and measuring and improving performance. Throughout the 18 month term, the pilots were evaluated across the domains of Clinical Effectiveness (HEDIS), Efficiency (TME), Patient Centeredness and Patient Experience. Pilots were funded by a quarterly pmpm care coordination fee and a pay for performance incentive at the end of the pilot term.
    ANSWER: For the combined pilot sites, the risk-adjusted TME trend for the period July 2012 -Dec 2013 (pilot term) was - 2.5%. For the same period, the Harvard Pilgrim network trend was + 0.6%. The most dramatic pilot pmpm trend decreases relative to the Harvard Pilgrim network were seen in Hospital Inpatient (-17.5%) and ER visits (-9.8%). In addition to the favorable TME performance, the pilots demonstrated gains in patient centeredness, clinical effectiveness (HEDIS) and patient experience (CG-CAHPS) surveys.

The pilots advanced Harvard Pilgrim's provider partnership agenda and have served as the foundation for inclusion of PCMH elements in our provider contracting and incentive programs. Several 2015 provider group contracts include pay for performance elements from the PCMH pilots. In addition, our network-wide 2015 Physician Pay for Performance program (QualityAdvance) now includes PCMH requirements. Specifically, the infrastructure support component includes a required initiative related to one of the 6 PMCH standards. The Health IT component requires participation and performance on CMS Meaningful Use Stage 1 measures. The program also includes, for the first time, a Patient Experience Survey component.

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12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.
SUMMARY:

ANSWER: We do not have any comments regarding the findings of the 2013 Cost Trends Report and the July 2014 Supplement to that Report.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Completed in Attachment AGO Payer Exhibit 1

   Please refer to Section 2 Attachment 1 (OAG Exhibit C2) for the summary table showing actual observed allowed medical expenditure trends in Massachusetts for the specified time periods.

   The impact of demographics on trend is 0.0% for 2011, 0.2% for 2012, and 0.5% for 2013. Benefit buy down affects the allowed trends via deterrence effect. The benefit buy down influencing the submitted actual trends are -0.7% for 2011, -0.5% for 2012, and -0.2% for 2013. These factors do not represent a portion of actual claims trend as requested. The buy down factors, do however, indicate that groups have changed their benefit plans from smaller member share to greater member share for each year. The effect of the change in health status is primarily incorporated in the demographic factors and is not developed separately at this time.

   The demographic, benefit, and health status trends would mostly impact utilization trend, but they would also have some effect on mix.

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold

returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
d. Membership in a tiered network product by market segment
(Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
e. Membership in a limited network product by market segment
(Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
f. Membership in a high cost sharing plan by market segment
(Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

Our response to this question is not that different from our response to a similar question in 2012. We have had one major large account move from fully-insured to self-insured status and we continue to see a trend, even among much smaller size groups than in the past, to move to self-insurance. Price continues to be the key factor in determining whether an account chooses one carrier over another and in Massachusetts' very competitive market, this leads to a certain amount of movement between carriers. PPO accounts continue to increase in number as employers seek to offer employees more choice in benefit packages, especially employers with multi-state sites, and employees look for flexibility in choosing providers as well as peace of mind if they or family members develop a very complex or serious condition and they wish to use a provider not in a closed network. At the same time, price sensitivity on the part of employers and the increasing share of premium costs, coinsurance and copayments that employees must pay have contributed to the popularity of tiered and, to a lesser extent, limited networks.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

Consistent with conversations Harvard Pilgrim had with the AGO on its recent CID that asked a similar question, we are not providing a response to this question at this time.

We can note that we had only one large self-insured group over this period of time for which we did not provide behavioral health network or management services.

APPENDIX A

Question 6

Summary:
Members who purchase one of HPHC's PPO products are not required to select a PCP. As a result, Harvard Pilgrim has developed a claims-based methodology to attribute PPO members to the single provider who appears to be their principal PCP. For most PPO members, identification of their PCP is fairly unambiguous from claims. Additional rules have been developed to address members who have used services other than well visits. HPHC seeks to maximize attribution while maintaining clinically appropriate results. The resulting methodology enables Harvard Pilgrim to attribute PPO members to contracted providers in a manner where they can confidently take responsibility for their financial and clinical outcomes.

a. Step 1 assigns PPO members to the PCP provider who has provided their well care services. Step 2 expands on step 1 by looking for any services provided by a PCP. This step picks up those PPO members who never had any well visits with a PCP, but did see a PCP for other services. Step 3 looks for cervical cancer screenings where the member had no other services from a PCP. Step 4 expands the view further by looking for PPO members who only received services from providers who are dually credentialed with HPHC as both specialists and PCPs (usually medical specialties who are also boarded as Internists). Our final Step 5 allows physical exams by certain medical specialists who have an on-going relationship with the patient.

   i. Steps 1 and 2: Internal Medicine, Family Practice, General Practice, Geriatric Medicine, Pediatrics, Adolescent Medicine, Preventive Medicine, OB/GYN, Nurse Practitioner, Physician's Assistant, Midwife. Step 3: OB/GYN, GYN. Step 4: Providers who are dually credentialed with HPHC as both specialists and PCPs (usually medical specialties who are also boarded as Internists). Step 5: Cardiovascular Disease, Endocrinology, Diabetes And Metabolism, Neurology, Gastroenterology, Rheumatology, Hematology, Gynecology, Pulmonary Disease, Sports Medicine, Nephrology, Pediatric Endocrinology, Infectious Disease, Pain Management, Naturopathic Medicine, Neurology With Special Qualifications In Child Neurology, Pediatric Gastroenterology, Pediatric Pulmonology, Pediatric Nephrology, Developmental Behavioral Pediatrics, Pediatric Cardiology, Pediatric Neurodevelopmental Disabilities, Pediatric Infectious Disease, and Neurodevelopmental Disabilities.
   ii. Attribution is performed based on the greatest number of services provided in each step (not dollars), where ties are broken by giving precedence to the most recent event.
   iii. Step 1: well care only; Step 2: all other services performed by a PCP; Step 3: cervical cancer screenings; Step 4: all other services performed by a dually credentialed provider (PCP and specialty); Step 5: physical exam E&M codes.
   iv. In all of the steps of HPHC's attribution methodology, 24 months of claims data are used, with 2 months of run-out to ensure completeness of the claims record.
   v. Analysis of retrospective claims data are used in some applications to assign financial responsibility for members prospectively (for the coming time period), and it is also used in other applications to retrospectively understand who was taking care of which members. The use of this information is related to the particular program or application, negotiated with individual provider groups for specific contractual purposes.

b. As the above description illustrates, Harvard Pilgrim has enhanced our attribution methodology over time so as to maximize the number of PPO members attributed, while maintaining the clinical appropriateness of the assignments. For example, we have identified a list of specialties that medical leaders within Harvard Pilgrim have deemed appropriate for sustaining a comprehensive, physical, on-going care relationship with a PPO member. Harvard Pilgrim routinely meets with our contracted provider organizations to review our methodology, engage them in mutual testing and validation, and explore ways to enhance and expand its scope.

c. Harvard Pilgrim is currently in collaborative talks with other payers (BCBS, Tufts) and providers (Beth Israel, Partners, Atrius) to define a common methodological approach to PPO attribution that is acceptable and meaningful to all parties. The value of standardization lies in the fact that it instills credibility and confidence in the methodology. It offers an opportunity to heighten the comfort level of provider groups assuming clinical and financial responsibility for those PPO members assigned using the common methodology. It also simplifies and streamlines health plans' operational processes. The drawbacks in such standardization involves near term IT costs if change is required as well as provider re-education. Also, during a transitional period, multiple methodologies will persist, due to contractual obligations between different payers and providers. In addition, some providers may run attribution themselves and over-ride payers' results. The key values of differentiation include retaining current contractual commitments and IT processes. However, differentiation perpetuates inconsistency in the rules used and outcomes when different payers assign PPO populations to provider groups.

d. Harvard Pilgrim constantly explores new ways to improve and expand our PPO attribution methodology. For its Group Insurance Commission (GIC) membership, Harvard Pilgrim has enabled a functionality whereby GIC PPO members are informed of their attributed PCP and allowed the opportunity to confirm or change their PCP assignment.

APPENDIX B

Question 7.

Describe efforts and results in developing insurance products that encourage members to use high-value care and providers….

Harvard Pilgrim continues to re-shape and design products that encourage members to seek high-value care and providers. In terms of product offerings, Harvard Pilgrim has developed products that engage members in the choices around course of treatment, sequencing of services and sites of service. These products include:

Copay differentials for primary care and specialist - Members have a financial incentive to work with their PCPs at what is generally a less-costly site of service to diagnose and treat an illness, injury or condition. The higher copay to access a specialist is designed to be large enough to encourage members to work with their PCPs, but low enough not to become a barrier to care for services that require the knowledge and technology that a specialist can bring to diagnosis and treatment.

Best Buy HMO and Best Buy PPO products - We designed HMO and PPO products with many preventive services covered in full and most diagnostic services and treatments subject to deductible (while keeping office visits and prescription drugs subject to copay). These products are designed to eliminate financial barriers to care and encourage prompt cost-effective diagnosis and treatment. The Best Buy product suite is available with or without a Health Reimbursement Arrangement (HRA).

HPHC Insurance Company Best Buy HSA PPO with a Health Savings Account (HSA) - The Best Buy HSA PPO is a qualified High Deductible Health Plan (qHDHP), thus allowing the member who meets certain other criteria to establish and contribute to a Health Savings Account (HSA). These products differ from the Best Buy HMO and Best Buy PPO products in that the deductible is generally higher and more inclusive (including all non-preventive office visits and prescription drugs, per federal guidelines). We offer a variety of deductible options to help employers balance up-front premiums with employee out-of-pocket responsibility.

The philosophy is similar to the standard Best Buy product: A member with deductible exposure will be a more engaged consumer and will work more closely with the provider to map a course of diagnosis and treatment that makes sense medically and financially.

Focus Network products - We have introduced a narrow network option called Focus Network to provide employers with cost-effective insurance options. These products offer networks of hospitals and affiliated providers who offer the best combination of quality and cost-effectiveness. Members are referred outside the network only when network providers do not offer a certain service. These products are offered side-by-side with a traditional product so that employees can choose whether they want to pay a higher premium for access to our full network or enjoy premium savings by agreeing to receive care in a focused network.

ChoiceNet - Network products - These products include our full network, but we tier all network hospitals and physicians based on cost and quality. We then place the providers into one of three tiers and assign lower cost sharing to providers that score highest on cost/quality measures. Under a tiered network product, members make a choice every time they have a medical need. As with the Focus Network products, members make diagnosis and treatment decisions based in part on economic

considerations. The difference is that while members make the Focus Network choice at open enrollment, they choose their site of care under the ChoiceNet products at the time of service, with full access to the entire network at any point in time.

Hospital Prefer- Network products – Like ChoiceNet, these products also include our full network, but we tier network hospitals only, based on cost and quality. Physicians and non-hospital providers are not tiered under Hospital Prefer, offering members a simplified product design. The hospital tiering methodology and tier assignments for Hospital Prefer are the same as for ChoiceNet, placing hospitals in one of three tiers and assigning lower cost sharing to those that score highest on cost/quality measures. Hospital Prefer members make a choice every time they have a medical need for hospital services, based in part on economic considerations.

In conclusion, HPHC believes that one of the best opportunities to reduce medical expense trend is through a combination of plan design incentives targeting providers and members. It is critical that both members and providers have access to robust decision-making support tools, such as our NowIKnow tool, to help them make more cost-effective choices with improved outcomes. We also believe it is imperative that reimbursement to providers include some measures of quality, like HEDIS measures around conditions such as diabetes, asthma and congestive heart failure. The hope is higher quality will eventually lead to lower costs by providing more appropriate care which leads to better outcomes.

APPENDIX C

Question 10

HPHC has a longstanding commitment to encourage integrated care to address the needs of members who have chronic medical conditions including behavioral health difficulties. We demonstrate this commitment by developing and maintaining a nearly seamless care model with our behavioral health care vendor and our medical providers. Care management for individuals with both medical and behavioral health conditions must be patient and family- centered.

10 a. On initial contact with members, a comprehensive assessment elicits a medical history inclusive of psychosocial issues, past/current treatment, and co-morbidities for individuals at high risk for depression. Harvard Pilgrim's nurse care managers and certified health and wellness coaches screen for depression and related problems. Ongoing clinical training addresses the importance of understanding and looking for potential links between medical conditions and behavioral health and cultural issues, as well as reviewing current research on how these issues may impact care. Weekly case conferences provide nurses and coaches with the opportunity to present challenging cases with a department behavioral health nurse and social worker providing input. Once needs are identified, Harvard Pilgrim's staff works with the member to establish a plan, including treatment for behavioral health issues. If the member is unable to attend therapy due to mobility issues, work begins with our behavioral health vendor to locate resources for in- home treatment. The behavioral health nurse is the internal resource to Harvard Pilgrim staff and the liaison to Harvard Pilgrim's behavioral health vendor for medically complex members. Department staff utilizes her background when issues require immediate attention. The vendor also provides a highly skilled behavioral health care manager with whom Harvard Pilgrim care management staff partner to manage emergency situations and very complex cases. An article appears in the monthly provider news letter on recognizing and working with behavioral health difficulties.

10 b. The Harvard Pilgrim care managers discuss cases as needed with Harvard Pilgrim's behavioral health nurse and/or directly with the behavioral health vendor contact. Weekly meetings with the vendor review these cases and those of hospitalized behavioral health patients at risk with medical co-morbidities. At- home members are referred to our behavioral health vendor, United Behavioral Health (UBH), and encouraged to utilize this service as part of their comprehensive plan of care. Harvard Pilgrim coordinates with behavioral health care advocates including nurses, social workers, and psychologists to establish a care plan, delineate follow-up, and encourage maintenance of recommendations. Harvard Pilgrim nurses also proactively work with our behavioral health vendor to place resources in the home prior to a complex member's discharge from skilled nursing and rehab facilities. The Harvard Pilgrim medical director, a psychiatrist, meets bi-monthly with the medical director of UBH to review identified diagnoses to look for patterns and develop interventions. The Harvard Pilgrim medical director reviews difficult cases with the UBH medical director daily.

Harvard Pilgrim-UBH have worked with medical groups regarding their needs for medical/therapeutic coverage including medically assisted treatment for opiate-dependent individuals. Harvard Pilgrim worked with UBH to identify members receiving medical assisted treatment (primarily Suboxone) and identified members who only received medication and no psychotherapy. Outgoing calls were then made to providers of the

Suboxone to facilitate referrals to specialized therapists. Treatment of chronic behavioral health conditions such as depression, ADHD, and substance abuse, as measured by HEDIS, are brought to medical groups for review and to identify gaps in care which need to be closed in order to ensure appropriate and timely care for these patients with chronic medical and behavioral health needs. Both Harvard Pilgrim and UBH staff attend these meetings and also take the opportunity to describe services available.

Exhibit # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2011	4.50%	-1.00%	NA	-1.00%	2.40%
CY 2012	4.40%	-0.60%	NA	0.40%	4.10%
CY 2013	3.80%	-0.60%	NA	-0.10%	3.20%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the change in provider. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

AGO Payer Exhibit # 2, Question #2
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	15,630	17,928	19,045	19,087
Commercial Small Group	128,180	142,236	139,851	130,706
Commercial Large Group	462,186	453,693	458,058	473,199
Medicare	40,841	34,809	24,801	35,992
Medicaid MCO	0	0	0	0
MassHealth	0	0	0	0
Commonwealth Care	0	0	0	0
Other Government	0	0	0	0
Total	646,837	648,666	641,755	658,984

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	8,554	9,850	8,434	4,892
Commercial Small Group	70,482	76,780	57,158	29,690
Commercial Large Group	228,079	222,287	190,317	109,834
Medicare	232	2	0	0
Medicaid MCO				
MassHealth				
Commonwealth Care				
Other Government				
Total	307,347	308,919	255,909	144,416

c. In-State Membership by Commercial Market Segment and Product Line

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured	12525	14396	15779	16,349
		Self-Insured	0	0	0	0
	PPO/Indemnity	Fully-Insured	3105	3532	3266	2738
		Self-Insured	0	0	0	0
Commercial Small Group	HMO/POS	Fully-Insured	107252	119,483	119,877	113,873
		Self-Insured	0	0	0	0
	PPO/Indemnity	Fully-Insured	20,928	22753	19974	16833
		Self-Insured	0	0	0	0
Commercial Large Group	HMO/POS	Fully-Insured	129,448	135,643	177,986	189,075
		Self-Insured	223,693	216,980	191,214	185,493
	PPO/Indemnity	Fully-Insured	32676	25847	19940	19752
		Self-Insured	76369	75223	68918	78879

d. In-State Membership in Tiered Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	6,164	7,100	6,482	3,376
Commercial Small Group	8,201	5,034	3,404	2,133
Commercial Large Group	268,113	251,040	176,809	171,095
Total	282,478	263,174	186,695	176,604

e. In-State Membership in Limited Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	109	102	39	0
Commercial Small Group	2,694	2,025	568	0
Commercial Large Group	7,607	6,446	279	0

Total	10410	8573	886	0

f. In-State Membership in High Cost Sharing Plan by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	9,257	10,256	11,055	11,520
Commercial Small Group	89,287	96,847	92,940	75,926
Commercial Large Group	71,975	60,120	46,407	35,955
Total	170,519	167,223	150,402	123,401

Numbers in tables reflect MA residents in MA-sitused contracts