Health New England, Inc.

HEALTH POLICY COMMISSION Response to Questionnaire

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HNE'S Response to Health Policy Commission (HPC)

Summary

Health New England has continued its efforts to develop new approaches to integration and coordination of health care through appropriate use of care management, cooperation and consultation with providers, promotion of population health strategies and risk sharing. HNE has continued to pursue improvements in quality and efficiency from its investments in technology for care management and data analysis, and continues to encourage development of patient-centered medical homes, wellness and health education.

We believe that our efforts have continued to have some success in dealing with the very significant challenges of restraining health care costs. The 2015 CHIA Annual Report on the Performance of the Massachusetts Health Care System[1] found that among the health plans listed, HNE had the second lowest fully insured adjusted premiums, and that HNE's Total Medical Expense was lower than Blue Cross/Blue Shield, Harvard Pilgrim, Tufts, Fallon, Neighborhood, United and CIGNA-West[2].

One very important issue affecting the cost of health care coverage is the effect of the risk adjustment transfer payments based on provision of the Affordable Care Act. Attached to this testimony as Payor's Exhibit 3 is a letter to the Commonwealth Health Insurance Connector Authority describing how the current methodology inappropriately imposes costs on consumers while producing little or no apparent benefit.

Exhibit B: HPC Questions for Written Testimony

1. **Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.**

   SUMMARY: Transforming the payment model is difficult to achieve and can have many meanings. HNE continues to work closely with its providers to move closer to a population-health approach to health care, and continues its efforts to develop shared responsibility for the overall performance of the health care delivery and payment system. Based on CHIA data,[3] as of 2015, HNE had the highest Alternative Payment Method (APM) adoption rate of any commercial carrier in Massachusetts.

   a. **Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.**

[1] Sept. 2015 http://www.chiamass.gov/assets/2015-annual-report/2015-Annual-Report.pdf
[2] Id. Premiums from Databook Tab 2i. Premiums adjusted by age, gender area, group size and benefits. TME is from the Annual Report, p. 19.
[3] Annual Report on the Performance of the Massachusetts Health Care System, September 2015, Page 22 http://www.chiamass.gov/assets/2015-annual-report/2015-Annual-Report.pdf

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HNE Response: As we have reported in the past, HNE uses a number of strategies to effectively control cost increases. Our primary approach has been to move to alternative payment models (APMs) (mostly global budgets) with primary care groups and other integrated provider groups. While we believe that this has slowed overall cost trends, there are several challenges to ensure that this model remains successful and sustainable:

- The underlying mechanism for submitting claims and calculating reimbursements for hospitals, specialists and ancillary providers (even under a global capitation agreement) remains fee-for-service (that is, payments are reported on a fee-for-service basis even when the final settlement uses an alternative methodology). Providers continue to pursue fee schedule increases, many of which are in excess of the Gross State Product cost benchmark. In 2015, we continue to experience unit cost pressures from hospitals and other providers. Much of the rationale for cost increases is being blamed on flat/reduced Medicare and Medicaid reimbursements, coupled with rising operating costs. Additionally, hospitals and specialists do not always participate in APM arrangements, since some of those arrangements are exclusive with primary care providers. Utilization/cost savings associated with these arrangements typically reduce hospital and specialist care, but with no sharing of APM bonuses.

- Drug cost increases complicate the implementation and effective use of APMs After years of modest increases (mostly driven by patent expirations), beginning in 2014, PMPM prescription drug costs have been trending at double digit levels (in excess of 15%). While utilization (scripts per member) have been flat, cost per script has been rising across all categories (traditional band, traditional generic and specialty), with the biggest increase in the cost of specialty drugs. This is being driven by a combination of unit cost and drug mix changes. While the introduction of new drugs (especially specialty) has contributed to the overall trend increase, cost increases associated with brand and generic medications have also increased. HNE's generic dispensing rate continues to increase (currently above 85%), however this is having a minimal impact on counteracting the overall drug trend. A larger portion of total pharmacy expenditures is now being concentrated in a smaller number of scripts. Out of pocket limits have also reduced the member share of drug costs to a historical low (under 15%). Drug cost increases have made negotiating and managing APM's more difficult.

- Because, in many cases, hospitals and specialists do not participate in savings from global budgets, changing their behavior has proven difficult, especially in areas where there are few choices among competing hospitals and specialists. Changes in the health care environment have also affected hospitals' willingness/ability to focus on payment reform given the multitude of competing priorities. The fragmented nature of the healthcare delivery system make it difficult to offer alternative payment arrangements without

increasing overall costs. In light of these pressures, we have focused on our provider contracting activities in efforts to reduce the variability in unit costs across our network. We have attempted to introduce more commonality in both payment methodologies and in fee schedules and have had some success doing so. We continue to have difficulty in cases where hospitals, specialists and ancillary providers enjoy geographic exclusivity. It has been especially difficult (if not impossible) to reach agreement on reasonable contracts with most Eastern Massachusetts academic medical centers. The expansion of Eastern Massachusetts based providers into the western part of Massachusetts continues to raise concerns over how such expansion will increase unit costs.

- While many of our larger physician groups and PHO's (or portions of them) participate in some type of alternative payment arrangement, the nature of the healthcare delivery system in Western Massachusetts is such that many providers operate in small groups or as sole practitioners. While we have introduced APM's to these providers and have worked with PHOs to provide shared resources and infrastructure, the results thus far have not been consistent.

Overall, the expansion of risk and surplus sharing arrangements, if successful, will help us to temper the increases in provider fee schedules and make such increases less relevant to total medical costs. HNE believes that as the percent of providers under these types of arrangements increase and as the percentage of their patient panels subject to APM arrangements increases, providers will focus on better managing the care of their membership, which should decrease medical expenditures. However, in order for these payment mechanisms to work in the long term, providers will need to show a track record of positive results and plans will need to demonstrate that these arrangements have lower costs and increases in overall quality and patient experience.

In addition to our contracting efforts, we have invested in data analysis staff and supporting software capabilities to help us with a variety of tasks, such as improving our understanding of provider payments across our network and better understanding of how to benchmark payments for similar provider types. We have also been thoughtful about the composition of our network in order to negotiate lower rates with our network hospitals and to encourage appropriate, utilization of services susceptible to overuse. We have also limited the provision of certain services in provider offices, such as CT and other diagnostic testing.

In response to increased emphasis on new risk models, and emphasis on quality and pay for performance, HNE and our providers are placing renewed emphasis on management of chronic conditions. Generally this is a collaborative effort between HNE and the practices, since HNE is in the position to identify members with chronic conditions through claims data analysis and through its recently implemented utilization and care management system. The practices with electronic medical records (EMRs) or other appropriate systems are able to maintain their own registries of patients with chronic conditions. HNE has a number of disease management programs, but has generally not dictated to practices how to prioritize their own chronic disease management efforts. We

believe that the practices are in the best position to address the needs of their patients. HNE also maintains a staff of nurses who assist with care management and coordination, especially for patients with complex cases or conditions. HNE has also supported development of care management capabilities within medical practices in our network.

In addition, HNE has developed bundled payment programs for certain conditions such as, joint replacement and bariatric surgery. HNE is currently negotiating an obstetrics bundle with Baystate Medical Center and two groups of obstetricians. The hallmark of the management of these episodic conditions revolves around consistent physician ordering, timely provision of appropriate medical services and effective post discharge planning.

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

HNE RESPONSE: As noted above, in CHIA data for 2015, HNE had the highest rate of APM adoption of any commercial carrier. Some of the difficulties in continuing to strengthen and implement alternative methodologies are described in the previous response. HNE will continue its efforts, along generally the same lines, through 2016, and continues to look for ways to improve and refine its approaches to provider compensation.

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

HNE Response: PPO membership currently represents approximately 4% of our commercial membership. Most of these members reside outside of HNE's core service area. At this point we do not have any plans to incorporate these members into APM arrangements.

2. **Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and**

providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

SUMMARY: Over the course of the last several years, the health care market has seen a dramatic change in the role a member plays in the financing of healthcare. Members are being asked to shoulder more of the costs in the form of increased co-pays, deductibles, and co-insurance. The government responded by passing legislation that allows for medical expenses to be paid with pre-tax dollars using vehicles such as Health Savings Account (HSA), Health Reimbursement Arrangements (HRA) and Flexible Spending Accounts (FSA). However, regardless of whether a member has a tax advantageous account or not, the simple fact remains the same – everyone is being asked to become an engaged consumer in their health care decisions. HNE's vendor (HealthEquity) helps consumers understand and manage the financial side of healthcare by aggregating consumer information, analyzing personal data, and advising consumers on how to best manage their health.

HNE has increased development of new health care delivery models involving collaboration, coordination and shared risk, which requires new attention to population management and access to primary care. Because of the unique challenges of operating almost entirely in Western Massachusetts, such as the relatively smaller size of both our plan and our provider network, HNE does not offer a tiered or limited network (aside from one plan created for the GIC). By the nature of its size and geography, however, HNE already has many of the positive aspects of a selective network plan. For the same reasons, there are fewer providers in HNE's network, less diversity of providers, and in some geographic areas, less competition among providers that would be true in Eastern Massachusetts. These factors make it difficult to create a limited-network product that achieves significant premium savings while providing full geographic coverage.

This year HNE has focused on reducing out of network use of high cost providers in the eastern part of the state. A pilot program was started in March for several high cost specialty areas to contact members directly, educate them directly about potential out of pocket costs of using an out of network provider, and redirect them to an in network provider. A second part of this program includes referring provider education with specific information about in network providers available.

In an effort to reduce avoidable emergency room visits, HNE has recently introduced a new innovative option, Teladoc, to our members. Teladoc provides 24/7/365 access to doctors via phone, web or mobile apps. Member cost sharing for this service is the same as regular Primary Care Physician visits.

The health care delivery environment in Western Massachusetts is significantly different than in some other parts of the Commonwealth. A single hospital or physician specialty group may serve a fairly large geographic area. As a result, consumer engagement may require tactics other than tiered or selective provider networks. As noted elsewhere in these responses, HNE's focus has been on efforts to increase development of new health care delivery models involving

collaboration, coordination and shared risk, which in return requires new attention to population management and access to primary care.

Population Management: HNE has actively promoted the development of Patient Centered Medical Homes (PCMH). Approximately 50,000 HNE members currently receive care in PCMHs in over 20 practices. A number of PCMH practices are involved in population management as part of the mission and vision of a new ACO, Pioneer Valley Accountable Care. These initiatives include embedded care management in the practices, as well as plans for development of "hot spot' programs to treat certain kinds of complex medical conditions.

3. **Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.**

Summary: HNE established the OpCon web portal in our HNE Direct website effective 10/1/2013 to serve as a communication platform in which a member can request an estimate of out of pocket expense prior to seeing the provider.

HNE Response: Since its inception HNE has received an approximate combined total of 47 cost of care requests. No two requests were alike regarding the coding, none were replicated. All requests to date were to gain prior knowledge of deductible/coinsurance/copay information for members enrolled in the High Deductible Health Plans.

a. Using <u>HPC Payer Exhibit 1</u> attached, please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

HNE Response: This information is included as Attachment HNE HPC Payer Exhibit 1.

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

Inpatient	Yes	☒	No	☐
Outpatient	Yes	☒	No	☐
Diagnostic	Yes	☒	No	☐
Office Visits (medical)	Yes	☒	No	☐
Office Visits (behavioral)	Yes	☐	No	☒

HNE Response: Our vendored solution allows consumers to estimate the cost of an office visit, and will display Behavioral Health provider estimates, but consumers are not

able to specifically search for mental or behavioral health office visits. For 2016, we are evaluating adding some mental health services to our estimation tool.

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

Yes ☒ No ☐

HNE Response: Non-provider specific cost data is based on an average of paid claims. Provider-specific cost data is based on that specific provider's paid claims.

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

Yes ☒ No ☐

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

Yes ☐ No ☒

HNE Response: HNE does not collect provider quality metrics. HNE does not share patient experience data.

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

HNE Response: HNE has gathered detailed utilization data since January 2015, however, we have not yet begun to analyze that information.

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

HNE Response: Health New England is taking a "watchful waiting" view toward changes in provider relationships in Western Massachusetts, an area very different from eastern portions of the Commonwealth, and with unique challenges and opportunities. We are hopeful, for example, that the relatively new affiliation between Cooley Dickinson Hospital and Partners will not result in cost increases in Hampshire County. We believe that some affiliations reflect attempts to bring innovative approaches to health care delivery in our communities. For example, HNE has entered into a practice lease arrangement with Valley Medical Group (VMG), a large primary care group in Hampshire and Franklin counties, and is working closely with VMG (which retains clinical autonomy) to improve integration and coordination of care and improve overall efficiency, service and quality.

Further, HNE is partnering with providers by raising awareness through data and reports to develop a clearer understanding of performance benchmarks, cost outliers and over utilization. We are trying to assist providers in recognizing when services are available in Western Massachusetts and when members need to access services outside of the HNE HMO network.

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

    HNE Response: Health New England believes that differences in the nature and community role of different providers (such as academic medical centers as compared with community hospitals) are appropriate bases for differences in reimbursement levels, but that large price disparities between one community or teaching hospital and another are often based on market power and not quality or value. These differences are, however, difficult to overcome. As noted in an earlier response, it has been especially difficult (if not impossible) to reach agreement on reasonable contracts with most Eastern Massachusetts academic medical centers. The expansion of Eastern Massachusetts based providers into the Western part of the State continues to raise concerns over how such expansion will increase unit costs.

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

    HNE Response: HNE has been working with providers to increase the portion of our provider agreements reflecting alternative payment arrangements and new approaches (including our practice lease arrangement with Valley Medical Group, described in the previous response), as means to increase consumer value.

    HNE has developed a rate comparison sheet which is meant to add transparency to the renewal process. On a blinded basis, HNE shows contracted hospitals the variation and use this an opportunity to explain the reasons behind moving to standard fee schedules or consistent reimbursement methodologies.

6. **Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of- network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.**

   HNE Response: All pre-service referrals from an in-plan provider to a non-plan provider require a Prior Authorization. This process is outlined in the member's Evidence of Coverage and the Provider Manual.

   The HNE Complaints & Appeals Department has guidelines in place for when a member is referred to an out-of-network provider by an in-plan provider or if the member is at an in-plan facility and receives services from an out-of-network provider. If a member appeals for one of these scenarios, the Complaints & Appeals Department will review the member's individual circumstances and may approve the denied services as a one-time exception due to provider error. If approved the member is advised that any future services received from the out-of-network provider will not be covered unless pre-authorized by HNE. Please note that more than one exception can be made if the services the member received were beyond that member's control. When the Complaints & Appeals Department receives appeals for these situations an email is sent to the HNE Provider Relations Department for them to contact and educate the provider in question about their error in an effort to ensure the error does not happen again.

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

   HNE Response: We typically pay non-facility rates in outpatient based practices. Facility fees generally only affect Health New England's Medicaid Line of Business. Of the total Medicaid membership 39% of the members are within these outpatient-based practices. As our membership has increased within these practices Health New England has seen a corresponding increase in "facility based payments" related to these members. This increases our costs for these Medicaid members. We are not aware of any effects on quality or access.

8. **The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.**

a. **Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.**

HNE Response: Our entire care management approach is based on integration of medical and behavioral health management, and the case management team includes a clinical social worker. Needs of members with co-morbid behavioral health and chronic medical conditions are addressed through a number of different programs, including a depression disease management program, care coordination and complex case management. A case management programs with analytics aimed at identifying members with depression and other behavioral health needs became fully implemented in 2014. The number of individuals enrolled in the depression program increased from 7 in 2014 to 69 to date in 2015.

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

HNE Response: As noted above, our care management approach integrates behavioral health and medical management. We use a carve-out vendor only for Medicaid (in order to provide programs specific to Medicaid enrollees); we require our carve-out vendor to integrate their efforts with our own, including a request that the vendor co-locate a care manager at HNE. Outcomes of identified goals are measured as well changes in clinical outcomes and utilization.

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

HNE Response: This information is included in Attachment HNE PHC Payer Exhibit 2.

Payor Exhibit 3: Risk Adjustment

See next page.

July 30, 2015

VIA ELECTRONIC MAIL AND REGULAR MAIL

Louis Gutierrez
Executive Director
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, MA 02108

RE: Massachusetts Risk Adjustment Methodology

Dear Executive Director Gutierrez:

Health New England, Inc. ("HNE") writes to reiterate HNE's concerns with the Commonwealth Health Insurance Connector Authority's (the "Connector") risk adjustment methodology, which it believes is producing incorrect results and harming consumers.

HNE understands that the Connector's regulations purport to exclude its risk adjustment methodology from the Final Risk Adjustment Payments and Charges Report reconsideration process. *See* 956 CMR 13.06(2).[1] It is HNE's position that this purported limitation, combined with the significant flaws in the Connector's risk adjustment methodology, is invalid as a violation of the Due Process and Takings Clauses of the U.S. Constitution (*see* U.S. Const., amend. 5; U.S. Const., amend. 14, § 1), the due process and other provisions of the Massachusetts Constitution (*see* Mass. Const., part I, art. VII, art. X, art. XI), and the federal regulations requiring Massachusetts to provide an administrative appeals process for risk adjustment (*see* 45 CFR 153.350). While HNE is prepared to challenge this procedural limitation in the appropriate forum, HNE urges the Connector not only to reevaluate its methodology, as it says it is doing in its Massachusetts Notice of Benefit and Payment Parameters 2016, but also to correct the methodology so that it furthers the purposes of risk adjustment to improve access to affordable care, balance risk among health plans, promote competition and good medical practice, and increase stability in the marketplace.

[1] In its Request for Reconsideration filed today with the Connector, HNE seeks reconsideration of the 2014 risk adjustment charge imposed on it by identifying an "incorrect application . . . of the risk adjustment methodology, including issues related to unresolved data discrepancies." 956 CMR 13.06(1).

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HNE's concerns with the Connector's methodology have been raised previously to the Connector, including in written and oral testimony submitted by HNE to the Connector regarding the Connector's proposed risk adjustment regulations; in a March 11, 2015 meeting among you, Edward DeAngelo and representatives of HNE; and in a June 24, 2015 letter to you by the Presidents and CEOs of HNE, Fallon Health and Minuteman Health. They are also set forth in more detail in an analysis conducted by the Wakely Consulting Group submitted with HNE's Request for Reconsideration at Exhibit A ("Wakely Actuarial Analysis"). HNE highlights some of these issues here.

1. ***The Massachusetts risk adjustment methodology should be corrected to address regional biases.***

In its Request for Reconsideration, HNE identified an unresolved data discrepancy between the Hierarchical Conditions Code ("HCC") data included in HNE's Plan Liability Risk Score ("PLRS") and the HCC data included in the statewide PLRS average. HNE makes clear that intensity of medical practice in the eastern portion of the state creates an "observational bias," which artificially inflates the average PLRS for those areas and the Commonwealth as a whole. The Connector's risk adjustment methodology does not correct for these data problems and when the methodology is applied to the biased and discrepant data, it produces incorrect risk comparisons that are invalid as a basis for transferring funds.

When the data is examined on a regional basis, it is clear that the existing methodology produces an unintended result. In a regional analysis prepared by the Connector and provided to HNE,[2] Western Massachusetts (Region A), which represents 97.3% of HNE's enrollment, had an average PLRS of 0.908.[3] HNE's PLRS – 0.961 – was significantly higher than the Region A average. In the region where virtually all of HNE's enrollees are located, HNE has significantly more than its share of higher-risk enrollees. The logic of risk adjustment – which should take regional observational intensity bias into account – would require that this extra burden be balanced by a payment *to* HNE from the risk pool. The Connector's current methodology –

[2] The figures cited are from the most recent data provided to HNE prior to today.

[3] As explained in the Request for Reconsideration and the affidavit of Dr. Peter Lindenauer submitted therewith ("Lindenauer Aff."), the Region A PLRS is deflated or suppressed by observational intensity bias when compared with the state average PLRS. This is a consequence of the regionally-biased data and not of any true regional difference in population health or risk status. (Lindenauer Aff. ¶¶ 21-22.) In addition, the research cited by Dr. Lindenauer makes clear that although the observational intensity bias is based on intensity of medical treatment, that intensity does not produce improvements in population health. (*Id.* ¶¶ 14-19.)

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which does not correct for observational intensity bias – requires a multi-million dollar payment *from* HNE. In addition to correcting the data discrepancy created by this bias, as HNE asks the Connector to do and is permitted in response to a request for reconsideration, the Connector can resolve this issue permanently by adjusting its methodology, such as comparing of risk scores among regions rather than against the statewide average.

2. The risk adjustment model, when applied, harms consumers.

The incorrect and biased results produced by the Connector's current risk adjustment model means that Western Massachusetts consumers are penalized by paying higher premiums, with no counterbalancing public benefit. A comparison between HNE and HMO Blue, the two plans with the largest share of the Western Massachusetts market, demonstrates the dysfunction of the current risk adjustment methodology. HNE and HMO Blue have by far the largest share of the Western Massachusetts merged market (HNE alone has nearly 40% of the market according to data from the Connector). In accordance with Division of Insurance ("DOI") requirements, HNE and HMO Blue have adjusted their 2015 premiums to anticipate the impact of risk adjustment. HNE increased its premiums by 7.5%, and, per DOI filings, HMO Blue decreased by 2.5%. Because HMO Blue is so much larger than HNE, while HNE's risk adjustment provision imposes a substantial burden on HNE's members, the benefit to HMO Blue's members from HNE's payment is negligible.[4]

Attached is a printout from the Connector's website comparing rates for a 55-year old in Franklin County for HNE and HMO Blue plans for coverage beginning in September 2015. When comparing the two lowest-priced, non-catastrophic tiers of coverage, HNE's plans are approximately $7 (for the Bronze plan) and $37 (for the Silver plan) per month less expensive than the HMO Blue coverage. Even with an unfair risk adjustment burden on HNE's premium, the Western Massachusetts consumer in this example will pay approximately $450 *more* per year for the HMO Blue Silver plan than for the comparable HNE Silver plan. If HNE were relieved of its risk adjustment burden by an accurate balancing of risks, the consumer would save approximately $900 per year by enrolling in the HNE Silver plan instead of the comparable HMO Blue Silver plan. The presence or absence of HNE's risk adjustment payment, however,

[4] HNE's 2014 risk adjustment payment represents approximately 4.0% of the monies transferred. Since the HMO Blue risk adjustment provision is to be funded by its share of contributions from all carriers paying in, HNE's payment represents about one-tenth of one percent (4% of 2.5%, or 0.1%) of the HMO Blue premium, or about $6.60 per *year*.

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would have no appreciable effect on HMO Blue's premium.

3. ***The risk adjustment model is biased against health plans with a greater percentage of members with zero HCCs.***

The problem of regional observational intensity bias is exacerbated in the Massachusetts risk adjustment model by the very low risk score assigned to members with zero HCCs, who are likely to be overrepresented in areas with lower observational intensity like Western Massachusetts.[5] Under the Massachusetts risk adjustment model, health plans lose significant amounts of money (224% loss ratio) on members who are not assigned any HCCs. Any health plan with a larger proportion of zero HCC members than the market as a whole, which at least in part is likely to be the result of successful implementation of wellness programs, is penalized under the Massachusetts risk adjustment model.

4. ***The use of statewide average premiums in the risk adjustment formula penalizes low-cost health plans like HNE.***

In the current risk adjustment methodology, transfer amounts are calculated using a statewide average premium in order to arrive at the total risk transfer amount. In addition to the general problem of statewide comparisons, discussed above and in the Request for Reconsideration, use of the statewide average premium is problematic for two additional reasons. First, the use of *premiums* includes a transfer of administrative fees among health plans, not just the claims portion of the premium, which is unwarranted to the extent that administrative expenses do not vary with the level of claims. Second, since risk adjustment involves comparisons against a *statewide average* premium, a payment to the risk adjustment pool puts a larger burden on lower-cost health plans, like HNE, than on higher-cost plans, since it represents a relatively larger part of that carrier's premium.[6] The current methodology penalizes health plans that pay into the pool for creating and maintaining lower cost options, and generally disfavors lower cost and more efficient regions.

5. ***The risk adjustment methodology is biased against smaller health plans, like HNE.***

The smaller the population analyzed for risk adjustment, the greater the uncertainty about

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[5] The risk score for a member with one HCC is nearly 10 times higher than the risk score for a member with zero HCCs. (*See* Wakely Actuarial Analysis at 32.)

[6] The use of the statewide average premium is defended by an argument that it increases the payment to a lower premium plan. Since all of the payments in Massachusetts in 2014 go to higher premium plans, this argument is not applicable here and the use of the statewide average premium does not balance the harm to lower premium plans that are typically smaller and more efficient.

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the ability of the score to predict actual claims costs and the resulting risk adjustment payment transfers may not be appropriate. Smaller health plans, with smaller staffs, fewer actuarial resources and more limited data systems than those of larger health plans, are less able to prepare for and accommodate risk adjustment. If a smaller plan is new to the market, region specific or has a large percentage of enrollment in discounted, limited network products (plans that typically have lower than average premiums), the impact of the problems described above are compounded. The Connector's current risk adjustment methodology includes no safeguards to protect these health plans, such as capping payments or applying it on a regional basis, and to ensure that the plans can continue to exist and to provide affordable health care options in Massachusetts.

The initial results from the application of the Connector's risk adjustment methodology to the Massachusetts market highlight how it is not meeting its purposes of greater premium stability and certainty. Substantial risk adjustment payments for 2014 went from small plans, like HNE, with relatively fewer resources and generally lower premiums to large plans with more resources and higher premiums. As the Connector is well aware, these smaller plans are generally the lower-cost options for consumers in the merged market in Massachusetts. Analyzed from a slightly different perspective, of the $61 million in transfers, over $50 million came from plans that also offer coverage to Medicaid enrollees through Medicaid Managed Care Organization ("MCO") plans, plans which perform a valuable service to the Commonwealth, but which have been financially stressed in recent years. Yet over 80% of the risk adjustment transfers will be paid to HMO Blue, one of the health plans in the Commonwealth with the highest amount of capital and most expensive premiums.[7]

When the current methodology's effect is compared with the purposes of the Affordable Care Act's risk adjustment requirement, it not only fails to meet those goals, it accomplishes the opposite result in nearly every case:

- **Making care more affordable:** Risk adjustment makes care significantly more expensive for HNE members (just under 40% of the merged market in Western Massachusetts) while having no perceptible effect of lowering prices for enrollees of HMO Blue, which has a large Western Massachusetts presence.

[7] Neither HMO Blue nor its companion Blue Cross Blue Shield of Massachusetts (which is also slated to receive millions in risk adjustment payments) offers a Medicaid MCO plan.

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- **Balancing Risk:** HNE, whose membership has a significantly higher average risk score than the average in Western Massachusetts (which means that HNE carries more than its share of higher risk individuals) pays into the risk pool instead of receiving a payment.
- **Promoting good behavior:** Dr. Lindenauer's affidavit and the research it cites show that care in regions with higher observational intensity is less efficient. Higher observational intensity, however, does not improve population health. The Connector's current methodology rewards this inefficiency with higher risk scores. Other desirable behaviors (such as promoting use of efficient providers in limited networks and effective wellness programs) are also punished.
- **Promoting competition:** The unreasonable burden placed on HNE in the current risk adjustment methodology provides HNE's main Western Massachusetts competitor, HMO Blue, with a significant advantage. This unfair imbalance may have the long-term effect of driving HNE out of the merged market. Consumers will lose an affordable choice, and competition will be seriously damaged.
- **Promoting stability:** The current risk adjustment methodology requires HNE, a health plan with one of the lowest reserves per member in Massachusetts, to pay a large sum that will be received primarily by the largest and one of the most capitalized health plans in Massachusetts. HNE was forced to adjust its premiums to anticipate risk adjustment at a rate that is nearly four times its maximum allowable margin in the merged market. To the extent that HNE is rendered, over time, unable to continue to do business in the merged market, it will no longer be able to provide a stable, low-cost option for consumers.

The current risk adjustment methodology causes real harm to consumers, is counterproductive to the goals of risk adjustment and the Affordable Care Act, and provides no apparent benefit to the Commonwealth. Following the reasoning and direction of the U.S. Supreme Court, the Affordable Care Act must be interpreted not in a narrow literal sense but in a manner that is consistent with "improv[ing] health insurance markets"[8] and to furthering the policies of the Act. In order to so do, Massachusetts's risk adjustment methodology must be corrected.

[8] *King v. Burwell*, No. 14–114, slip op. at 21 (U.S. June 25, 2015).

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Thank you for your consideration.

Very truly yours,

James Kessler, Esq.
Vice President and General Counsel of Health New England, Inc.

Attachment

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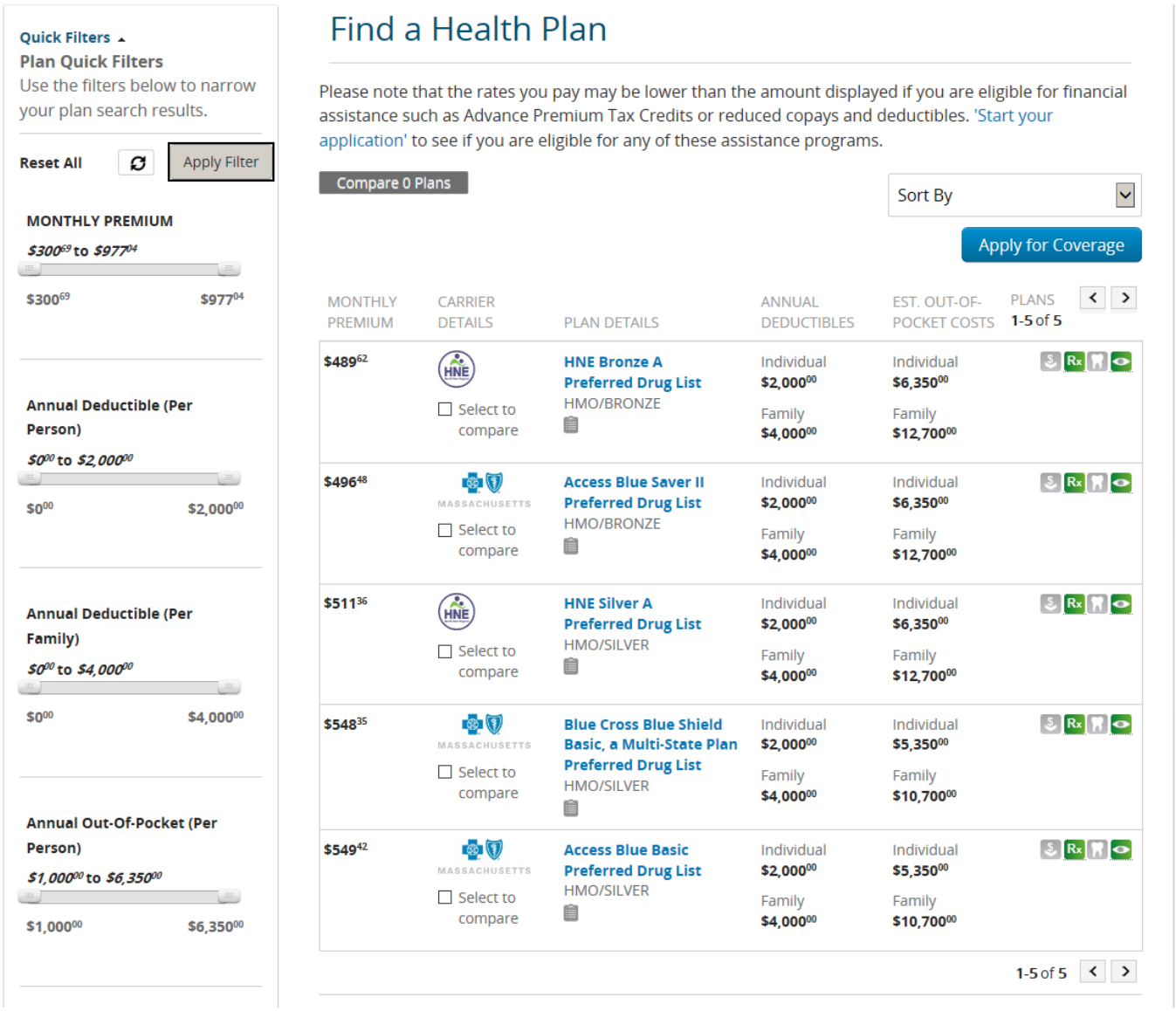

Quick Filters ▲

Plan Quick Filters

Use the filters below to narrow your plan search results.

Reset All | Apply Filter

MONTHLY PREMIUM

$300.69 to $977.04

$300.69 — $977.04

Annual Deductible (Per Person)

$0.00 to $2,000.00

$0.00 — $2,000.00

Annual Deductible (Per Family)

$0.00 to $4,000.00

$0.00 — $4,000.00

Annual Out-Of-Pocket (Per Person)

$1,000.00 to $6,350.00

$1,000.00 — $6,350.00

Find a Health Plan

Please note that the rates you pay may be lower than the amount displayed if you are eligible for financial assistance such as Advance Premium Tax Credits or reduced copays and deductibles. 'Start your application' to see if you are eligible for any of these assistance programs.

Compare 0 Plans

Sort By

Apply for Coverage

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	EST. OUT-OF-POCKET COSTS	PLANS 1-5 of 5
$489.62	☐ Select to compare	**HNE Bronze A Preferred Drug List** HMO/BRONZE	Individual **$2,000.00** Family **$4,000.00**	Individual **$6,350.00** Family **$12,700.00**	
$496.48	MASSACHUSETTS ☐ Select to compare	**Access Blue Saver II Preferred Drug List** HMO/BRONZE	Individual **$2,000.00** Family **$4,000.00**	Individual **$6,350.00** Family **$12,700.00**	
$511.36	☐ Select to compare	**HNE Silver A Preferred Drug List** HMO/SILVER	Individual **$2,000.00** Family **$4,000.00**	Individual **$6,350.00** Family **$12,700.00**	
$548.35	MASSACHUSETTS ☐ Select to compare	**Blue Cross Blue Shield Basic, a Multi-State Plan Preferred Drug List** HMO/SILVER	Individual **$2,000.00** Family **$4,000.00**	Individual **$5,350.00** Family **$10,700.00**	
$549.42	MASSACHUSETTS ☐ Select to compare	**Access Blue Basic Preferred Drug List** HMO/SILVER	Individual **$2,000.00** Family **$4,000.00**	Individual **$5,350.00** Family **$10,700.00**	

1-5 of 5

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

Health Care Service Price Inquiries CY2014-2015				
Year		**Aggregate Number of Inquiries via Website**	**Aggregate Number of Inquiries via Telephone or In Person**	**Aggregate Average Time to Resolve Inquiries***
CY2014	**Q1**	6	1	6 minutes 30 seconds**
	Q2	6	1	6 minutes 30 seconds**
	Q3	6	2	6 minutes 30 seconds**
	Q4	293	1	6 minutes 30 seconds**
CY2015	**Q1**	261	1	6 minutes 30 seconds**
	Q2	202	1	6 minutes 30 seconds**
	TOTAL:	774	7	

** Please indicate the unit of time reported.*

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

Top 10 Services by Amt Paid
Commercial Members Only
Run Date: 8/24/2015
Source: MedInsight SQL Query Path: SFTP\Users\SQL Scripts\Pereira\HPC RFI_08242015

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

CY2014 Q1	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Inpatient Medical General
	5	Radiology - Diagnostic
	6	Pathology and Laboratory
	7	Surgery - Digestive System
	8	ER Visits and Observation Care
	9	Surgery - Musculoskeletal
	10	Anesthesia
CY2014 Q2	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Radiology - Diagnostic
	5	Inpatient Medical General
	6	Pathology and Laboratory
	7	Surgery - Digestive System
	8	ER Visits and Observation Care
	9	Surgery - Musculoskeletal
	10	OP Psych-Alcohol/Drug Abuse
CY2014 Q3	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Inpatient Medical General
	5	Radiology - Diagnostic
	6	Pathology and Laboratory
	7	ER Visits and Observation Care
	8	Surgery - Digestive System
	9	Physical Exams
	10	OP Psych-Alcohol/Drug Abuse
CY2014 Q4	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Inpatient Medical General
	5	Radiology - Diagnostic
	6	Pathology and Laboratory
	7	Surgery - Digestive System
	8	ER Visits and Observation Care
	9	Surgery - Musculoskeletal
	10	OP Psych-Alcohol/Drug Abuse

Top 10 Services by Amt Paid
Commercial Members Only
Run Date: 8/24/2015

Source: MedInsight SQL
Query Path: SFTP\Users\SQL Scripts\Pereira\HPC RFI_08242015

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

CY2015 Q1	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Inpatient Medical General
	5	Radiology - Diagnostic
	6	Pathology and Laboratory
	7	Surgery - Digestive System
	8	ER Visits and Observation Care
	9	Surgery - Musculoskeletal
	10	OP Psych-Alcohol/Drug Abuse
CY2015 Q2	**1**	Inpatient Surgical
	2	Office/Home Visits
	3	Non Prescription Drugs (Injectable Drugs)
	4	Radiology - Diagnostic
	5	Inpatient Medical General
	6	Pathology and Laboratory
	7	Surgery - Digestive System
	8	ER Visits and Observation Care
	9	Surgery - Musculoskeletal
	10	OP Psych-Alcohol/Drug Abuse

Exhibit # 2 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 2012	2.3%	-1.3%			1.0%
CY 2013	1.4%	0.4%			1.7%
CY 2014	3.5%	-1.5%			1.9%

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.

***HNE does not break out service or provider mix from either cost or utilization trend calculations.**