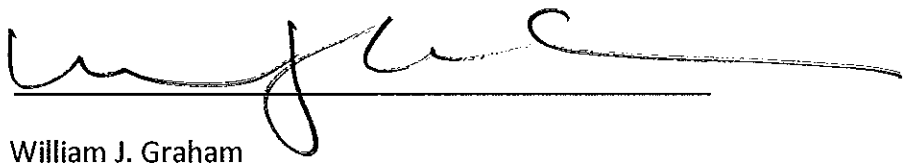
Harvard Pilgrim
Health Care

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 pain and penalty of perjury, on this 11th day of September, 2015.

By: 

William J. Graham

Senior Vice President for Public Affairs and Government Programs

Harvard Pilgrim Health Care, Inc.

Harvard Pilgrim Health Care, Inc.
93 Worcester Street, Suite 100
Wellesley , Massachusetts 02481

Harvard Pilgrim
Health Care

September 11, 2015

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

Re: Harvard Pilgrim Health Care's Written Testimony for 2015 Hearing on Health Care Cost Trends

Dear Mr. Seltz:

Enclosed please find Harvard Pilgrim's written testimony in response to the Health Policy Commission's letter to Eric Schultz, President and CEO of Harvard Pilgrim Health Care, Inc., dated August 6th, 2015. Our testimony consists of the completed Exhibit B: *HPC Questions for Written Testimony* including Appendices A and B, HPC Payer Exhibits 1 and 2 and the required certification statement.

Harvard Pilgrim looks forward to the upcoming hearing on October 5 and 6, including the panel discussion in which Eric Schultz will participate. If you have any questions concerning our responses, 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

Harvard Pilgrim Health Care, Inc.
93 Worcester Street, Suite 100
Wellesley , Massachusetts 02481

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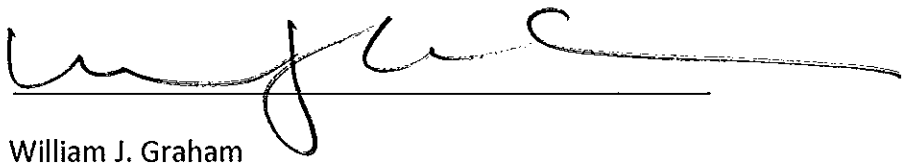
By: 

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Exhibit A: Notice of Public Hearing

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

Scheduled hearing dates and location:

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

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

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

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

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

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

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

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

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Exhibit B: HPC Questions for Written Testimony

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

Answer: Harvard Pilgrim Health Care (HPHC) believes that well-constructed alternative payment arrangements are crucial to efforts to control health care costs, and continues to advance alternative payment methods (APM) that emphasize quality over quantity of care provided. We define alternative payment methods as shared savings and budgeted capitation arrangements that include fee-for-service payments, which are settled or reconciled with a bundled or global payment. As reflected in the recently released CHIA report, in the last twelve months we have increased network participation for fully-insured HMO/POS products; secured alternative payment models for self-insured HMO/POS products and PPO products, and completed provider report development aimed at supporting APMs.

Currently, more than 83% of our Massachusetts provider network participates in some form of an Alternative Payment Model for *fully insured* HMO/POS products; this is an increase of 5% over the previous year. In the last year, a particular area of focus has been the *self-insured* HMO and POS products, and HPHC now has 47% of our provider network in Massachusetts contracted under an alternative payment arrangement for self-insured HMO and POS.

In addition, HPHC successfully negotiated with providers to participate as Integrated Risk-Bearing Organizations (IRBO) as part of the Group Insurance Commission's (GIC) Centered Care initiative. We contracted with 6 large provider entities, and these IRBOs will provide care for more than 50% of HPHC's GIC members.

When considering overall APM adoption, participation has nearly doubled since 2013, rising from approximately 25% to almost 50% of HPHC's members now receiving care from providers participating in alternative payment arrangements.

In addition to APM contracting efforts, in the summer of 2014 HPHC participated in a Massachusetts cross-functional work group of providers and health plans whose goal was to develop consensus guidelines on PPO attribution. The group produced a report in September 2014 that outlined a common approach to patient attribution, and we are continuing to participate to advance this work.

In further support of alternative payment arrangements, HPHC invested in and completed efforts to enhance provider reporting, improve business processes, and upgrade systems capabilities to support alternative payment models to self-insured groups.

As HPHC's shared responsibility models (both shared savings and different types of capped models) and footprint have grown over the past few years, we have sought to measure the effectiveness of these models as compared to Fee-for-Service (FFS) arrangements. Results indicate the following:

Fully & Self Insured Performance (APM – Two-sided Risk and Shared Savings only vs. FFS)

- Year end 2014 PMPM Risk Adjusted trends for APM and Fee-for-Service groups were similar in that they both experienced relatively small trend increases (+0.7% versus +0.4%).
    - Both groups experienced significant increases in Pharmacy expenses (12.5% vs. 7.45%). The increase in specialty drug costs (Hepatitis-C and others) appears to be the primary driver for these increases.
    - Excluding the pharmacy expenses results in Total Risk Adjusted PMPM trends of -2.42% for APMs and -1.1% for FFS
    - Overall performance was driven by material decreases in Hospital Outpatient Services for the APMs
- Risk Adjusted Utilization trends were favorable for both groups, however, not as favorable for the APM groups (-0.93%) as for the fee-for-service (-3.0%) providers
    - Utilization trends were primarily driven by decreases in Inpatient volume for the FFS groups (-6.9%) and decreases in the Hospital Outpatient services for the APM groups (-5.8%)
- Risk Adjusted Average Cost Per Unit trends were markedly lower for APM groups (-2.9%) versus the increase that was observed for the fee-for-service groups (+2.0%)
    - For example, Radiation Therapy Unit Cost drove the decreased trends for the APM groups (-17.2%) versus a +2.9% increase for the fee-for-service groups

The 2014 APM overall performance was similar to the FFS groups. However, given that the two populations significantly changed over the measurement period with membership in APM groups increasing 27% while FFS membership declined by 12%, caution should be used in assessing the effectiveness of the two groups. We expect that the 2015 performance results will be more credible. Not surprisingly, given our expansion of APMs, the risk profile of the APM groups is increasing at a higher rate than the FFS groups (+4.5% vs 1.9%) resulting in higher expenses.

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**.

Answer: HPHC's efforts to renew contracts with a January 1, 2016 effective date are well underway. These efforts include securing additional APM-based contracts for self-insured HMO and POS products. As mentioned in our previous response, our efforts to expand APMs include the adoption of PPO attribution models that encourage greater coordination of care, a key component in improving quality and controlling cost. HPHC has successfully executed agreements with several key providers for PPO members and will continue to assess the feasibility of such models as it relates to their expansion based on minimal membership risk thresholds. As we continue to move providers from sharing savings arrangements to up and downside risk arrangements, HPHC will continue to evaluate outcomes and the application of the PPO attribution model.

We're committed to continual improvement and ensuring that we are advancing payment models that are effective. Our approach in pursuit of APM-based contracts is broad. In contracting with providers, HPHC aims to create incentives aligned with quality, cost, and effective delivery of care for all product types and funding arrangements. However, as stated in Part.c. below, limitations also exist when risk pool size is too small. The smaller the risk pool the greater the possibility of random variability, which can contribute to provider reluctance to move away from a FFS arrangement. As the number of providers not in an APM arrangement becomes smaller and reflects either single providers or providers in a very small office practice, we are approaching a saturation point in terms of viable alternative payment arrangements in the fully-insured market in Massachusetts.

Furthermore, significant downside risk is not appropriate for all providers nor absolutely necessary as an incentive to change provider behavior. For example, Pay-for-Performance arrangements also provide incentives for providers to change their behaviors in ways that may improve outcomes and the efficient delivery of care.

HPHC has developed, and continues to develop, bundled payment models in MA and in our other New England states. Over the past 12 months, we have worked on a bundled payment model in MA for tonsillectomy. This has been a successful payer/provider collaboration with a quality approach to tonsillectomy. There have been cost savings related to the successful shift of clinically appropriate patients to the satellite setting for this procedure.

While not specific to MA, over the past 12 months bundled payment models in ME and NH for screening colonoscopy and cardiac surgery (CABG) have shown substantial TME reductions. Our bundle models are prospectively paid and include quality guarantees. Both bundle models have booked withholds of 5-10% of the bundle price that are contingent on attaining all quality targets. Going forward, the CABG bundle will have a guarantee that any related services within 30 days post-discharge are included in the bundle price.

Based on the success of these initial bundles, we expect to expand the number of MA bundled procedures and MA partners between now and Oct. 1, 2016.

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.**

Answer: One of our recent areas of focus with regard to PPO APM was the development of a claims-based methodology to attribute PPO members to a single provider who will act as their PCP. For most PPO members, claims have been used to accurately identify a PCP. Our methodology enables HPHC to attribute PPO members to contracted providers in a manner where they can confidently assume some financial responsibility for their HPHC members' clinical outcomes.

As referenced in a prior response, as part of our PPO attribution efforts, in the summer of 2014 HPHC participated in a cross-functional work group of providers and health plans to develop consistent guidelines for PPO attribution across the marketplace. All recognized the potential benefits of developing a common approach to patient attribution and the group produced a report in

September to engage other constituents. HPHC continues to serve on this workgroup, using the information and develop a base of experience to further refine PPO attribution guidelines.

Understanding that it is essential to have the appropriate reporting and infrastructure to support providers in APM arrangements, HPHC has invested considerable resources over the last year to developing reporting and business operations required to accurately capture, track and disseminate cost, quality, and utilization data to providers.

Current renewals with several key providers this year have focused on PPO models as parties seek to align payment models across all lines of business. In our experience, providers are generally accepting of moving away from FFS-based payment models to APM-models. However, we have encountered some limiting factors. Chief among them is lack of provider confidence in predicting medical costs, particularly among PPO populations. Providers may feel uncertain about their ability to predict medical costs — for example, costs from blockbuster pharmaceutical drugs — and utilization trends, and the ways in which these factors impact the risk assumed over time. As a result, some providers are reluctant to enter into PPO APMs. This is why the attribution methodology referenced above is so important. The hope and expectation is that as providers gain more confidence in attribution, we will have more success in bringing them into risk arrangements for a growing portion of PPO members.

Limitations also exist when risk pools are not of a sufficient size. Smaller risk pools may experience random variability, which can contribute to reluctance to move away from a FFS arrangement.

A challenge specific to PPO products is that many providers are still grappling with how to successfully manage PPO populations in which members can access providers outside their ACO for care. The advancement of a provider attribution model has been helpful, but additional work is needed around applying HMO/PCP-centered coordination of care principles to PPO populations.

Continuing to evaluate the results of our APMs will help HPHC gain further understanding and allow us to apply best practices to future contracting efforts, helping us ensure that APM models deliver the intended results.

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?**

Answer: Appendix A provides a comprehensive overview of HPHC's products and plan designs that encourage members to use high-value services and providers.

HPHC has a keen focus on provider and consumer engagement. Practical innovation drives much of the value we bring to our customers. We offer employers and members choice and savings through different approaches like network-based products and high-deductible plans with HSAs and HRAs. They bring premium savings, but just as importantly, they engage members as health care consumers. We continue to build on those efforts by providing opportunities to influence member behavior with positive reinforcement programs and tools.

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.**

Answer To help members make informed decisions about their health care services, HPHC launched Now iKnow℠, an online cost and quality tool, in partnership with Castlight Health. Now iKnow℠ will enable our members to access actual claim-based cost estimates for hundreds of services and conditions. The tool provides access to individual cost information for professional and facility costs such as a visit to a dermatologist or an outpatient surgical procedure to repair the knee. In addition, the tool bundles cost information for treatment episodes, such as the cost of a healthy pregnancy from pre-natal care through delivery and post-natal care follow-up. While the tool is being continually improved, and the scope of searchable services has expanded over time, it is easy to navigate and is available online to HPHC members through HPHConnect.

HPHC did not have a transparency tool in place prior to November 2012.

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

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

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

*Now iKnow℠ currently contains very limited information regarding anxiety disorders, depression and pediatric behavioral health providers, the latter primarily associated with autism and developmental disorders.

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

Yes X☐ No ☐

35T

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

Yes X☐ No ☐

35T

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

Yes X☐ No ☐

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

Answer: Now iKnow[SM] is a relatively new tool which we intend to improve and expand over time and as such we do not yet have a robust database to fully understand member usage patterns and outcomes. However, based on our CAHPS survey measuring member experiences with obtaining cost information indicates positive experiences approaching or exceeding national benchmarks. We will continue to work with Castlight to collect more of the cost and quality information that members are researching in order to make better informed decisions about their care.

Our CAHPS survey includes statistics on the % of members by product that were able to obtain cost information either always or usually when they searched for it. However, the CAHPS survey does not differentiate the channel that the member used to ask for and/or obtain the information. The composite data measuring our performance in 2014 and 2015 against the national benchmark is shown below:

CAHPS Data: 2015	HPHC Composite Rate*	National Benchmark
HPHC, Inc. (HMO)	67.0%	64.9%
HPHC, Inc. (PPO)	70.2%	60.4%
CAHPS Data: 2014		
HPHC, Inc. (HMO)	63.3%	64.8%
HPHC, Inc. (PPO)	72.0%	59.6%

*The Summary rate represents the percentage of respondents answering "Always" or "Usually." Due to anticipated small denominators, this composite is calculated on a rolling average methodology over a period of two years.

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.**

Answer: The current health care environment has made it difficult for many smaller hospitals and provider groups to remain independent. As a result, the healthcare landscape in Massachusetts is changing rapidly and, if current trends, that vast majority of care will be provided by a few very large integrated delivery systems (IDS). Theoretically, an IDS should lead to care being delivered at the appropriate site and level, in a more coordinated manner, and at the appropriate price level for each site of care. However, this has not always been the case to date. Instead, the consolidated systems may demand higher prices for community hospital care than would have been the case if the community hospitals weren't affiliated with an academic medical center or with a large system of hospitals. Compounding this issue is the fact that in Massachusetts academic medical centers are much more likely to provide routine care than is the case in other parts of the country because of their reputation. As a result, these provider systems and academic medical systems maintained relatively higher rates at least in past negotiations. Furthermore, while consolidation may be one way to facilitate care being organized and delivered in a more coordinated way, these outcomes can also be produced through partnerships or initiatives between separate entities that do not require acquisitions.

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?**

Answer: While price disparities continue to persist, we have observed progress in the marketplace, with price variation narrowing since the Attorney General's initial report in 2010. Contributing factors to this progress include cost transparency, the attention and review of regulators such as the Health Policy Commission (HPC), and plan design (such as products that offer lower cost-sharing to members who choose more cost effective providers). However, market power and other factors continue to influence price disparity. Factors that limit the ability of health plans to negotiate arrangements at appropriate reimbursement levels include the following:

1. Market position: Market position continues to be a key factor in price variability. Massachusetts includes several renowned, large integrated delivery systems whose market position aids them in maintaining higher levels of reimbursement than other providers. As a result, these entities can offer physicians higher rates of reimbursement, which allow them to successfully recruit primary and specialty physicians from smaller competing entities. This can lead competing providers to also demand higher rates of reimbursement so that they can recruit and retain their affiliated physicians.

2. Geographic isolation: Historically, if a provider is a sole practitioner in the area, he or she has a much greater ability to negotiate contract terms and rates. Both provider and plan recognize that if the health plan is unable to sign sole providers such as these, the plan is at risk of not meeting minimum network requirements for that area, resulting in the health plan being unable to meet members' needs for medical services and/or not being considered as an option by certain accounts.

3. Certain provider specialties: There are certain provider specialties (specifically pathologists, emergency room physicians, anesthesiologists and radiologists) and service providers (such as ambulance providers), for which health plan and members have limited ability to actively choose. As a result, some specialty groups that provide the majority of services in a given facility or location will use that leverage in the negotiation process, if they agree to negotiate at all.

4. Provider consolidation/reputation: As described in our response to Question 4, the current health care environment has made it difficult for many smaller hospitals and provider groups to remain independent. Many of these smaller providers have been acquired by larger systems, resulting in higher prices.

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**.

Answer: At its core, our approach in contracting is to develop alternative payment models in which our provider partners are incented to improve performance in terms of both cost and quality. In negotiating specific alternative payment contracts, HPHC considers prior and current utilization trends, price consistency, and quality. We take into account provider cost and performance in relation to other providers in the marketplace, and we utilize relative cost data to support these contract negotiations. As part of our efforts to continue to reduce price variation, we actively seek to negotiate contracts with higher paid providers that will result in cost increases that are below the cost growth benchmark though this continues to be a challenge. In addition, in certain instances, we have negotiated increases greater than the benchmark with lower paid providers to make their reimbursement more equitable and strengthen them as high value, lower cost options for our members.

HPHC is continuing to invest in improving the data and reporting capabilities for providers to offer them the tools they need to better manage care and cost.

In addition, we have designed and revised products to encourage members to seek care from high-value providers. For example, our Focus network products feature a narrow network of hospitals and affiliated providers that offer a combination of quality and cost-effectiveness for employers and members. HPHC's ChoiceNet and Hospital Prefer products are tiered, with providers that score highest on cost and quality measures being assigned to the lower cost-sharing tier. This provides a financial incentive to members to receive care from a cost-effective, high-quality provider.

In our view, it's crucial that members have access to robust decision-making support tools, such as our NowiKnow online quality and cost estimator tool. NowiKnow provides members, via secure login, with information to help them better understand and plan for potential out-of-pocket costs related to treatment options.

We also believe it is imperative that reimbursement to providers include some measures of quality, such as HEDIS measures for diabetes, asthma, congestive heart failure, and other conditions. The expectation is that providing appropriate care that's consistent with clinical guidelines, particularly preventive care, will lead to better outcomes and lower costs.

In conclusion, HPHC takes a broad, holistic approach to cost management and believes that reduction of medical expenses can best be achieved by weaving together a variety of approaches, tools, and incentives.

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.**

Answer: HPHC offers tools and resources to verify member's eligibility and educate providers on in-network status and product requirements. Our website (www.harvardpilgrim.org) includes referral policies, product descriptions, and the provider directory, which is available to both members and providers as a valuable tool to identify provider's in-network status by product. Members who have an HMO plan must use in-network providers through referral by their PCP, except in limited circumstances, such as care needed in a medical emergency or when, in rare instances, the service cannot be provided within HPHC's network. Members with a PPO or POS product have the option of obtaining care from an out-of-network provider at a higher level of member cost sharing. The member's plan handbook describes the circumstances when a member can obtain out-of-network care depending on whether they have an HMO, POS or PPO product.

HPHC's participating provider agreements require providers to coordinate care within HPHC's network for members with in-network benefits only, except in the case of emergency care or when authorized by HPHC in advance. In addition, HPHC's "Referral" and "Specialists" policies, which are published in our online Provider Manual and incorporated into the provider agreement, also describe the referring providers' obligation to refer within the member's care unit/network. If a member obtains care from an out-of-network provider, our policies require the provider to inform the member of his/her financial liability and ask the member to sign a financial liability statement. HPHC's "Selected Provider Networks" policy also states that, unless HPHC approves a referral to a non-participating provider, facilities and clinicians must direct HMO members (and are encouraged to direct POS and PPO members) to providers participating in the designated selected networks.

One longstanding issue for all health plans and state regulators is the situation where certain specialists who deliver care in participating facilities choose not to contract with commercial health plans. Pathologists, Anesthesiologists, Radiologists and Emergency Room physicians (PAREs) in particular do not have an incentive to contract with commercial plans because of the essential nature of the services they provide and the inherent lack of local competitive options. Health plans have limited options to address this situation. One option would be to pay these providers the usual and customary fee for their services; however, since this is usually lower than the rate they charge, the provider could bill the

member for the difference between their charge and the usual and customary fee paid by the plan. In other words, the member would be "balance billed." Harvard Pilgrim's policy is to pay billed charges to PARE providers to prevent member balance billing. This policy protects the member but removes any incentive for the provider to become a contracted network provider. Potentially, the movement towards global payment arrangements or bundled episodes of care could decrease the occurrence of this situation.

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.**

   Answer: HPHC has not observed a shift toward the increased use of outpatient based practices or associated costs. This is likely due to the fact that we maintain policies that preclude facilities from separate reimbursement for facility charges. HPHC will continue to monitor for shifts and trend changes.

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.**

Answer: 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. Please see Appendix B for a detailed description of our efforts, including 2015 projects.

   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.**

Answer: HPHC and our partner Optum Behavioral Health will continue to utilize our successful integrated care management and quality approaches described in Appendix B. In the next year, we will work with our provider quality grant recipients who have received a second year of funding and new grantees. We will focus on measuring the results of these care coordination and integration initiatives. We will also focus on improvement in HEDIS measures for depression, ADHD, follow-up after behavioral health hospitalization and particularly substance abuse.

We are currently evaluating for 2016 the addition of specific behavioral health Patient Reported Outcome Measures to our Pay for Performance programs. These are self-reported outcome measures based on information collected from the member through standard instruments regarding their functional status. A baseline is established then improvement in quality of life with treatment is tracked over time.

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).**

Answer: Please see the completed HPC Payer Exhibit 2 that is included as a separate attachment to this questionnaire.

a). The impact of demographics on actual observed allowed trend is 0.0% for 2012, 0.6% for 2013, and 1.4% for 2014.

b). The impact of benefit buy down on the submitted actual trends are -0.5% for 2012, -0.2% for 2013, and -0.6% for 2014. The buy down factors indicate that groups have changed their benefit plans from smaller member cost-share to greater member cost-share for each year.

c). We do not measure health status as a separate factor at this time. The effect of the change in health status is primarily incorporated in the demographic factors.

The demographic, benefit, and health status trends would mostly impact utilization trend, but they would also have some effect on mix. We would like to note that the primary reason our unit cost increase is above the benchmark is due to pharmacy manufacturer price increases which are materially above the benchmark. Provider unit cost increases are below the benchmark.

APPENDIX A: Response to Question 2

Network Innovations: Narrow and tier network designs create strong opportunities for cost savings – on premiums and at the point of service. Over the past several years, Harvard Pilgrim has created several products with the intent of encouraging members to use high quality/low cost providers.

Harvard Pilgrim offers several tiered networks and limited network products:

ChoiceNet has three levels of tiering for both physicians and hospitals. **ChoiceNet**, features thousands of Harvard Pilgrim-participating doctors and clinicians and more than 130 hospitals. It highlights the reality of medical care cost differences through three cost-sharing tiers for doctors and hospitals. It also calls attention to the shared responsibility of insurers, providers, employers and members to work together in containing costs. Harvard Pilgrim tiered physicians and hospitals for cost and quality performance, placing each affiliated physician group and hospital in Tier 1, Tier 2 or Tier 3. Tier 1 features the most cost-effective doctors and hospitals. When members see doctors in a lower tier, they pay less.

Hospital Prefer is a 3-tiered network product highlighting only hospital tiers. This plan encompasses the cost and quality metric to all participating hospitals. Members have the choice to see any physician or hospital they like. Hospital Prefer keeps it simple by tiering only hospitals and their affiliated facilities. Tiering has three levels of cost sharing: Tier 1 with the lowest deductibles and copayments and Tier 3 with the highest.

Harvard Pilgrim also offers a state-wide limited provider network product option called **Focus Network-- MA** to provide employers with cost-effective insurance options. These products offer networks of hospitals and affiliated providers (including PCPs, Specialists, Labs, etc.) 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.

Product Innovation: Harvard Pilgrim has also focused on fostering consumerism with state-of-the-art tools for cost and quality. We believe that Consumer-Driven Health (CDH) plans incent members to be more prudent in shopping for health care. With financial responsibility (via the deductible) for services, members can save money by determining whether to seek care and then where to seek that care. We provide many online tools for members to practice this form of medical consumerism:

- To help members make informed decisions about their health care services, Harvard Pilgrim launched Now iKnow[SM], an online cost and quality tool, in partnership with Castlight Health. Now iKnow[SM] will enable our members to access actual claim-based cost estimates for hundreds of services and conditions. The tool provides access to individual cost information for professional and facility costs such as a visit to a dermatologist or an outpatient surgical procedure to repair the knee. In addition, the tool bundles cost information for treatment episodes, such as the cost of a healthy pregnancy from pre-natal

care through delivery and post-natal care follow-up. While the tool is still being improved, it is easy to navigate and is available online to Harvard Pilgrim members through *HPHConnect*.

- Our SaveOn Program engages members and rewards them financially for making smart health care decisions. With a simple phone call, a SaveOn nurse can help members find lower-cost providers for elective, outpatient medical procedures and diagnostic tests. Members who elect to have their health care service from the more cost-efficient provider can earn a customized financial reward sponsored by the employer. The SaveOn program provides high-touch service. When members switch to lower cost, more efficient providers, the SaveOn nurse will assist members in rescheduling appointments, arrange for the transfer of medical records, and coordinate required referrals and/or authorizations, if needed. The program enhances the member's health care benefit, reduces their out-of pocket expenses, and reduces claims costs for the employer, which can help in managing year over year claims expense.·

- New in 2015, Harvard Pilgrim introduced our Value formulary to offer better prices to our customers while still giving our members cost-effective choices. With Value 4-Tier and Value 5-Tier options, it will also help us strike a better balance between benefits and costs, as well as manage our prescription drug trend. We are the only local insurer to offer mid-sized and large employers the choice of a Premium (open) formulary or Value (closed) formulary option.

- Mail-Order prescription drug prices are also posted on our Web site. This tool allows members to see the contracted rate for prescription drugs by dosage for all prescriptions available through our mail-order program with Walgreens. It also gives members a rough idea of the cost of their drug at retail. (While retail prices vary somewhat by chain, members can bring a prescription and their ID card into any pharmacy in the country and ask the pharmacist to run a claim – which doesn't trigger a fill – to determine the cost of that prescription at that pharmacy if purchased then).

Telemedicine: Telemedicine is an important component of medical care, integrating care across the medical system. Harvard Pilgrim strongly supports telemedicine programs that offer providers the ability to be in contact with patients remotely to assist in their diagnosis and treatments and be part of the solution by enabling a more cost effective way to engage members in self-management of chronic conditions. Currently our wellness and disease management platform supports feeds from various devices that can be used for telemonitoring.
Harvard Pilgrim has launched a number of pilot telemedicine projects with small populations, which promise greater efficiency and engagement with members. These include bedside consults in community hospitals with tertiary doctors before transfer; electronic monitoring of diabetic values and remote assessment and follow-up; and video visits with tertiary physicians in rural underserved areas. The success of these efforts will inform future initiatives.
Regarding cost, our current approach is to explore reimbursement models for providers who will invest in telemedicine tools and use them for improving patient outcomes via "e- visit" encounters. This is the focus of one of our current pilots.

Wellness: Harvard Pilgrim has a long legacy of offering comprehensive wellness programming. We believe that the most critical component to designing and implementing a successful wellness program is to take into account the individual needs of the customer. We take a highly strategic approach with our customers to understand their culture, goals, and objectives, to assist in the design of their wellness offering. Our wellness platform offers the capability to incent members for completing such activities as biometric screenings, taking a health questionnaire, participating in employer-sponsored events and challenges, and much more. This program allows for a great deal of flexibility for customers in configuring a unique rewards strategy.

We are also pleased to launch *EatRight Rewards*, a first-in-New England nutrition program with Harvard Pilgrim being the only health insurer in the nation to offer this unique wellness offering to employers. *EatRight Rewards* is a "pioneering program that provides financial rewards to employees who buy healthy foods at the grocery store." The sophisticated, yet easy to understand, program is based on a nutritional scoring that assigns healthiness values to more than 100,000 foods, taking more than 30 different nutrient factors into account. Each food item that a member places in their shopping cart is scored. The healthier the food item, the higher the score. And members can earn coupons and employer-sponsored incentives based upon healthier shopping purchases by simply registering their grocery store loyalty cards with the program. The goal of the program is to educate our members to learn which foods are more health sustaining and to encourage prolonged behavior change toward healthier eating. The program is completely mobile, which makes accessing the nutritional information easy and convenient. In addition to the scoring, the program and mobile site offer recipes on how to prepare the healthy food items, articles and other tips for healthier living.

Health Care Equity: In our approach to health care equity**,** we build on and expand our existing capability to provide equally excellent care and service to Harvard Pilgrim members of all and differing backgrounds. In the marketplace, we launched Eastern Harmony, a new program integrating the health and wellness practices of Eastern and Western medicine, including acupuncture, ayurvedic practices, herbal medicine and mindfulness, with Harvard Pilgrim's core benefit plans. This program is available to employers who want to offer greater access to alternative health care approaches.

APPENDIX B: Response to Question 8a

Harvard Pilgrim is committed to integrating behavioral health and medical care, both through our care management programs and our efforts to support our contracted providers.

Integration of behavioral health within medical case management programs occurs during the initial assessment of a member, weekly case conferences that include a behavioral health nurse and social worker, and ongoing clinical training of our nurse case managers and certified health and wellness coaches. As described in our 2014 testimony, our nurse case managers are trained to assess psychosocial issues, past/current treatment, and co-morbidities for individuals at high risk for behavioral health issues. Once needs are identified, Harvard Pilgrim's staff works with the member to establish a plan, including treatment for behavioral health issues.

Harvard Pilgrim and Optum Behavioral Health maintain a very close relationship to manage medically complex members. The Harvard Pilgrim medical director, a psychiatrist, reviews difficult cases with the Optum medical director daily and they meet bi-monthly to review identified diagnoses, look for patterns and develop interventions. In addition, our contract with Optum embeds a number of quality and performance metrics that they are required to meet.

Optum provides a highly skilled behavioral health care manager with whom Harvard Pilgrim care management staff partner to manage emergency situations and very complex cases. The Harvard Pilgrim care managers discuss cases as needed with Harvard Pilgrim's behavioral health nurse who is also the liaison with Optum and/or directly with the Optum contact. Weekly meetings with Optum review these cases and those of hospitalized behavioral health patients at risk with medical co-morbidities. At-home members are referred to Optum and encouraged to utilize this service as part of their comprehensive plan of care.

Harvard Pilgrim-Optum have worked with medical groups regarding their needs for medical/therapeutic coverage including medically assisted treatment for opiate-dependent individuals. In 2015, Harvard Pilgrim has worked with Optum to identify members receiving medical assisted treatment (primarily Vivitrol) and identified members who only received medication and no psychotherapy. Outgoing calls were then made to providers of Vivitrol 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 Optum staff attend these meetings and also take the opportunity to describe services available.

Measures for treatment of depression and ADHD are built into "Pay for Performance" contracts for Primary Care Physicians. An article appears in the monthly provider news letter on recognizing and working with behavioral health difficulties. In addition, Harvard Pilgrim Health Care has sponsored quality grants and this past year nine of the grants involved behavioral health integration, with six of the grantees involving Massachusetts providers. The grants ranged from $56,000 to $100,000. A collaborative met during the year to share challenges and solutions. All of the grantees plan to continue to integrate their programs into

regular operations. Below are Year One results from a few of the sponsored Integration of Behavioral Health grants:

1. A large integrated delivery group worked with their pediatric practices on the development of a high risk patient strategic model to identify patients with complex needs who could benefit from behavioral health services. The grantee also created the role of Care Facilitator and incorporated this position into 3 of the pediatric practices along with workflows for the high risk patient identification and roster review sessions. Patient satisfaction survey results pre- and post- care coordination demonstrated improved satisfaction with care. By the end of the grant year there were over 100 complex pediatric members engaged in this integrated program with improved care coordination and reduction of unneeded services as well as overall improvement in patient /family satisfaction with care

2. A small pediatric practice engaged a LICSW into the practice and developed work flows for identifying patients with complex needs. The LICSW has provided individual behavioral health sessions with 232 unique patients in the pediatric office setting. Subsequent data demonstrated improved patient/ family experiences in care and savings on unnecessary medical care, such as a decrease in ED utilization.

3. An adult practice in western MA integrated a Behavioral Health Specialist into their PCMH practice with the goal of performing depression and substance abuse screening for patients with chronic conditions such as diabetes. 56 patients were screened into the program, with 97% patient participation rate. Results from the depression screening and treatment showed 83% improvement in PHQ-9 score. In Feb 2015, a second site was added and the intake criteria were expanded to include PTSD, anxiety and eating disorders. 96 patients were screened with a 100% participation rate; 27% have received follow-up services to date.

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**	1,463	N/A*	N/A*
	Q2	6,395	N/A	N/A
	Q3	5,374	N/A	N/A
	Q4	16,136	N/A	N/A
CY2015	**Q1**	10,201	219	N/A
	Q2	9,338	239	N/A
	TOTAL:	48907	458	

** Please indicate the unit of time reported.*

Note: N/A indicates "Not Available."

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

All 3 tabs must be completed.

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

CY2014 Q1	**1**	MRI
	2	Colonoscopy
	3	Lab test
	4	Pregnancy
	5	Primary care for adults
	6	Ob/Gyn
	7	Mammogram
	8	Dermatologist
	9	Eye doctor
	10	Chiropractic care
CY2014 Q2	**1**	MRI
	2	Primary care for adults
	3	Lab test
	4	Colonoscopy
	5	Dermatologist
	6	Pregnancy
	7	X-ray
	8	Mammogram
	9	Ob/Gyn
	10	Orthopedic surgeon
CY2014 Q3	**1**	Primary care for adults
	2	MRI
	3	Lab test
	4	Pregnancy
	5	Colonoscopy
	6	Orthopedic surgeon
	7	Dermatologist
	8	X-ray
	9	Ob/Gyn
	10	Mammogram
CY2014 Q4	**1**	Primary care for adults
	2	MRI
	3	Colonoscopy
	4	Lab test
	5	Dermatologist
	6	Pregnancy
	7	Ob/Gyn
	8	X-ray
	9	Mammogram
	10	Obstetrics and gynecologic care

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

CY2015 Q1	**1**	MRI
	2	Primary care for adults
	3	Lab test
	4	Colonoscopy
	5	Pregnancy
	6	X-ray
	7	Physical therapy
	8	Mammogram
	9	Ob/Gyn
	10	Dermatologist
CY2015 Q2	**1**	MRI
	2	Primary care for adults
	3	Lab test
	4	Colonoscopy
	5	Dermatologist visit
	6	X-ray
	7	Ob/Gyn
	8	Pregnancy
	9	Mammogram
	10	Physical therapy

HPC Payer Exhibit 2

All cells shaded in BLUE should be completed by carrier*

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	4.4%	-0.6%	NA	0.4%	4.1%
CY 2013	3.8%	-0.5%	NA	-0.1%	3.3%
CY 2014	4.1%	-0.3%	NA	0.3%	4.1%

Notes:

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

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

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

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