Harvard Pilgrim HealthCare

September 9, 2016

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

Re: Harvard Pilgrim Health Care's Written Testimony for 2016 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 July 19, 2016. Our testimony consists of the completed Exhibit B: HPC Questions for Written Testimony including HPC Payer Exhibit 1 and the required certification statement, and Exhibit C: AGO Questions for Written Testimony.

Harvard Pilgrim looks forward to the upcoming hearing on October 17 and 18. If you have any questions concerning our responses, please feel free to contact me at 617-509-4744 or Steven Larrabee, Senior Government Affairs Specialist, at 617-509-9138.

Thank you for your consideration.

Sincerely,

William Graham
Senior Vice President, Public Affairs and Government Programs
Attachments

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

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 9th day of September, 2016.

By: _____

William 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

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

While there are a number of factors and areas that challenge the ability of the Commonwealth to contain health care cost growth below the benchmark, the rapid growth in prescription drug prices and persistent price gap between the highest and lowest paid providers continue to be of primary concern to Harvard Pilgrim Health Care (HPHC).

1. Prescription Drug Prices

As was noted in CHIA's 2015 Annual Report, health care spending by commercial payers was driven, in part, by a 13% increase in pharmacy spending. This trend was also identified as one of two primary reasons that health care costs grew in excess of the benchmark in 2014. Unfortunately, we continue to attribute pharmacy spending as a key driver in CY2015 and beyond. In 2015, prescription drug trend totaled 10.8% at HPHC, while total allowed medical trend was 3.8%. For 2016, pharmaceutical claims continue to exceed our budgeted expectations. There are several factors attributable to this increase:

- **Specialty medications have added substantial new cost to the health care system.**

  In the last few years, transformative new drugs have revolutionized the treatment of a number of conditions from Hepatitis C to cancer. Unfortunately, the price of these medications have garnered as much attention as the benefit they provide to patients. Certainly, Sovaldi, with its initial $1,000-per-pill price, represents the most highly publicized example, despite its nearly 90% cure rate for Hepatitis C, type 1 – the most common form of Hepatitis C in America. Similarly, health plans continue to monitor the pipeline for new oncology medications. According to the Pharmaceutical Research and Manufacturers of America (PhRMA), 771 new drugs and vaccines are in development by US companies, including: 98 being developed for lung cancer; 87 for leukemia; 78 for lymphoma; 73 for breast cancer; 56 for skin cancer; and 48 for ovarian cancer. Yet, despite the promise presented by these new drugs, according to a recent study by the Mayo Clinic, the average annual cost of oncology drugs increased from roughly $10,000 before the year 2000 to over $100,000 by 2012.[1] As another study noted, all new US Food and Drug Administration (FDA) cancer drugs approved in 2014 were priced above $120,000 per year of use.[2]

- **Generic drugs, once relied upon by health plans to deliver pharmacy costs savings, have increased dramatically in price over the last couple of years.**

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[1] Kantarijan H, Rajukmar SV. *Why are cancer drugs so expensive in the United States, and what are the solutions?* Mayo Clinic Proceedings. 2015; 90(4): 500-504.

[2] Howard DH, Bach PB, Berndt ER, Conti RM. *Pricing in the market for anticancer drugs*. Journal of Economic Perspectives. 2015; 29 (I); 139-162.

While most have focused their attention on the high cost of specialty drugs, unexpected and significant price increases have also been occurring with generic drugs. Much of this is driven by the consolidation among generic manufacturers which has produced a much less competitive market. For example, a 30 gram tube of generic topical ointment used to treat eczema and psoriasis cost roughly $8.00 in 2013. Today, the same 30 gram tube costs $180, a 2200% increase in just 3 years. Similarly, a common generic drug to treat congestive heart failure increased by nearly 820%, from $0.12 a tablet in 2013 to $0.98 a tablet. There is no shortage of examples. While these prices may seem modest, especially when compared to new specialty medications, it is important to remember that generics account for a significant portion of prescription drug utilization. At HPHC, for example, generics make up 86% of all prescription drug fills, and therefore the cost of these increases can add up quickly.

- **The pricing power of pharmaceutical manufacturers remains strong.**

  According to the Bureau of Labor Statistics' Producer Price Index, prices received by US-made, pharmaceutical manufacturers rose 9.8% from May 2015 to May 2016, which outpaced all but one other industry – securities brokerage and investment services – in the United States. And, while pharmaceutical companies often note that list price increases do not reflect rebates and discounts provided to patients and insurers, financial disclosures show that net prices, and company revenue, continue to rise. According to the Wall Street Journal, "when Biogen Inc. reported that U.S. sales of its multiple sclerosis pill (Tecifera) rose 15% to $744.3 million in the first quarter, the Cambridge, Mass.-based company explained it 'was primarily due to price increase.'"[3] Similarly, the Boston Globe has noted a Credit Suisse analysis, which reported that pricing was a "key driver" of overall industry profit growth last year, adding an estimated 8% to overall net income.[4] Recently, Mylan's decision to increase the price of its widely used EpiPen by over 400 percent in the last 7 years has drawn intense scrutiny. At Harvard Pilgrim, the average cost of an EpiPen prescription in the first half of 2016 was $665, which is roughly double the cost of the same prescription during the same time period in 2013. In fact, while the total number of Harvard Pilgrim members using EpiPens has increased by less than 6% since 2013, the amount Harvard Pilgrim paid for EpiPen prescriptions increased by more than 170%.

2. Provider Prices

The price of services that doctors and hospitals charge continues to be a primary contributor to health care costs and significant gaps exist between the highest and lowest paid providers with no correlation to quality. As health insurance premiums reflect the underlying cost of care, containing the cost of medical services is of primary importance, and closing the gap between lower and higher paid providers is essential to ensure a more competitive and functioning marketplace. Numerous studies have highlighted this central point. Last year marked the fifth edition of the *Examination of Health Care Cost Trends and Cost Drivers* produced by the Office of the Attorney General (AGO), and for the fifth year the report found persistent market dysfunction with regard to provider prices. In 2015, the report highlighted 3 key findings: (1) Price variation continues to be unexplained by quality, contributing to providers having different levels of resources to carry out their mission; (2) Across the state and within specific regions, higher priced providers continue to draw greater patient volume; and (3) Growth in health care spending underscores the urgency of addressing market dysfunction. Similarly, the report produced by Freedman HealthCare on behalf of the Massachusetts Association of Health Plans (MAHP) highlights, among several things, a significant gap between the highest and lowest paid providers and that health care is most often delivered in higher priced settings. Finally, the Center for Health Information and Analysis' (CHIA) February 2016 provider price variation chart book (*Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market*) found that commercial payments continued to be concentrated among the highest-priced acute hospitals in 2014 and that for physician groups the share of payments to higher-than-average priced providers grew from 81.5% in 2012 to 85.2% in 2013. The growing disparity leaves fewer resources

[3] Walker J. *Drug Makers' Pricing Power Remains Strong*. The Wall Street Journal. July 14, 2016.
[4] Silverman E. *State laws seeking to shed light on drug pricing might not work*. The Boston Globe – STAT. August 16, 2016.

for lower-paid providers to invest in new services, while the pressure to raise rates to support these providers makes it more difficult for health plans to meet the Commonwealth's health care cost benchmark. At Harvard Pilgrim, we are concerned that this trend is continuing in to 2016. In a preliminary analysis of medical expenses for the first half of 2016, we have identified several Boston-area providers whose billings have increased significantly year-over-year; however, this increase does not appear to be attributable to patient volume.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

1. Prescriptions Drug Costs

With regard to prescription drug costs, while there are a number of policies that could be adopted at the federal level, such as prohibiting drug companies from delaying access to generic drugs (pay-for-delay) or reforming the patent system to shorten product exclusivity; admittedly, there are fewer solutions available to the states. One such solution, however, may be to expand the state's strong commitment to transparency to include pharmacy costs. Requiring pharmaceutical and biotech companies to participate in the HPC's cost trends hearings, for example, would provide for a more complete picture of the health care system.

Massachusetts should also consider transparency legislation, such as legislation proposed here in Massachusetts or enacted in Vermont. Here in Massachusetts, legislation was proposed this session that would provide the Health Policy Commission with the authority to determine a list of prescription drugs where there is substantial public interest in understanding how its pricing is determined and requires the manufacturers of such drugs to report specific information to the HPC and CHIA. Under a recently enacted law in Vermont, state officials must identify: (1) 15 drugs for which "significant health care dollars" are spent, and where list prices rose by 50 percent or more over the previous five-year period; or (2) 15 medicines with list prices that rose 15 percent or more over a 12-month period. Each year, the state attorney general will contact drug makers to obtain justification for price hikes and the companies would have to submit detailed breakdowns explaining the price increases. Ultimately, this information would be collected in a report and posted on a public website, and failure to comply will carry a $10,000 penalty. Similar legislation here in Massachusetts should include close collaboration between the HPC, CHIA and the Attorney General.

Finally, as prescription drug costs continue to rise and insurers are left to grapple with the expense, it is important that policymakers preserve the breadth of tools available to insurers to manage costs and utilization. Recent efforts in the Legislature to limit the use of step therapy, mandate coverage for specific drugs, or set maximum cost sharing for specific prescriptions handcuff the ability of health plans to manage these costs.

2. Provider Prices

With regard to provider prices and the variation between providers, while Harvard Pilgrim does not support rate setting, it may be necessary for the state to consider measures to address unwarranted variation. One such option could be to strengthen the existing Performance Improvement Plan (PIP) process. PIPs are an important tool available to the HPC that require healthcare providers to take corrective action if their TME increases threaten the ability of the Commonwealth to keep health care cost growth below the benchmark. Unfortunately, this mechanism only applies to health care entities that have high TME and the statute does not allow the HPC to apply this mechanism to hospital systems with outlier relative prices. There is now a vast body of evidence that indicates that high-priced hospital systems contribute significantly to healthcare cost growth. The PIP mechanism could be expanded by empowering the state to review an entity's relative price and by requiring any provider with a relative price above a certain threshold to submit a clear strategy

for lowering its prices below the identified threshold. Such a proposal could go a long way in rebalancing current health care spending between the highest and lowest priced providers, while also providing relief for consumers and employers by lowering health care costs.

2. Strategies to Address Pharmaceutical Spending Trends.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising pharmaceutical prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Do you contract with a pharmacy benefit manager (PBM)? Yes

i. If yes, please identify the name of your PBM.

MedImpact Healthcare Systems

ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*

- ☐ Negotiating prices and discounts with drug manufacturers
- ☐ Negotiating rebates with drug manufacturers
- ☐ Developing and maintaining the drug formulary
- × Pharmacy contracting
- × Pharmacy claims processing
- ☐ Providing clinical/care management programs to members

b. In the table below, please quantify your projected per-member-per-year (PMPY) rate of growth in pharmaceutical spending for different lines of business and drug types from 2015 to 2016.

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	**7.2%**	**5.8%**	**7.6%**	**15.1%**
Medicaid	**N/A**	**N/A**	**N/A**	**N/A**
Medicare	**8.7%**	**7.6%**	**1.9%**	**23.5%**

Please also note the following comments and explanations that should accompany the above information:

- Projected annual trends are provided on a net paid basis and for Massachusetts fully insured business only. Self-insured business has not been included.
- Projected annual trends are based upon 6 months of actual 2016 experience and 6 months' projection for the remainder of 2016.
- Trends do not include non-claim based expenditures and are based upon a forecast of actual observed claims trend.
- Specialty drugs (including the impact of Hepatitis C related medication) are also included as a component of the Brand sub-category.
- Medicaid product is not offered by the company.

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.

i. Risk-Based or Performance-Based Contracting

Currently Implementing

ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
Does Not Plan to Implement in the Next 12 Months

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Currently Implementing

iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends
Currently Implementing

v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs
Currently Implementing

vi. Implementing programs or strategies to improve medication adherence/compliance
Plans to Implement in the Next 12 Months

vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Currently Implementing

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Currently Implementing

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers
Currently Implementing

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Plans to Implement in the Next 12 Months

xii. Other: Provides clinical leadership to ICER in the development of value-based analytical frameworks for emerging pharmaceuticals and technology.
Currently Implementing

xiii. Other: Insert Text Here

3. Strategies to Increase the Adoption of Alternative Payment Methodologies.

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. In the 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

a. What are the top strategies your organization is pursuing to increase use of APMs, including efforts to expand APMs to other provider types including hospitals, specialists (including behavioral health providers), and new product types (e.g., PPO)? (Please limit your answer to no more than three strategies)

Over the last two years, Harvard Pilgrim continued to expand the number of risk contacts, and we've seen participation in our APM models more than double for HMO/POS products since 2012. We've taken a multi-prong approach in developing strategies to engage providers in effective risk arrangements. For example, HPHC built PPO attribution capabilities; implemented self-insured risk models; and invested in enhanced provider reporting.

Harvard Pilgrim's current strategy includes:

1. Leveraging experience with APMs to refine these models — HPHC will study our recent APM model experience to identify ways to improve the effectiveness of these models in promoting higher quality, more

efficient care. One area of focus is developing quality programs that better engage specialists in population health management. Additionally, HPHC is studying changes observed in population health status, to not only analyze the effectiveness of APMs but also to understand the drivers of reported changes in population health status, including testing the possible effects of more complete and accurate coding.

2. Pursuing innovative payment models — HPHC is exploring innovative payment models that support high value, high quality health care, including bundled payment models. Since 2014, HPHC has developed, and continues to develop, bundled payment models among physician specialties and hospitals in MA and in our other New England states. In addition, HPHC's hospital contracts include pay-for-performance quality programs in which a proportion of any increases must be earned. Efforts to date have been a successful payer/provider collaboration focused on quality and efficiency, with documented cost savings and quality improvement. Our bundle models are prospectively paid and include quality targets. In 2017 in Massachusetts, we expect to further develop our orthopedic bundle with a key provider, and also expect to expand the number of bundled procedures and partners.
3. Advancing PPO risk — HPHC will be adopting the Massachusetts consensus PPO attribution model, working to integrate PPO data across all our technical platforms to support PPO APMs with viable membership at the practice level, and pursuing additional PPO APM contracts across our provider network.

b. What are the top barriers to increased use of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

There have been several barriers and challenges as it relates to expanding the use of APMs including:

Size of population: One of the primary limitations is when the risk pool size for a particular provider 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. Based on our experience in the market, the threshold on a plan and provider's willingness to offer and assume downside risk is approximately 5,000 members. For APM models that have limited or no downside risk the threshold is 2,000 to 3,000 members. 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. 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 incentivize providers to adopt practices that may improve outcomes and increase efficiency in delivering care.

PPO attribution: In our experience, provider groups are more cautious about embracing PPO risk than they have been with HMO/POS risk, due to the product's inherent design, which allows patients freedom to seek health care from providers and specialists of their choice. This greater movement among and between provider practices makes referral management and cost- and quality-focused managed care efforts more challenging. Another challenge unique to HPHC is that our PPO risk populations at the practice level may not always be of sufficient size to support a viable risk unit.

Variability: Volatility and variability in the marketplace is another central barrier. Examples of this include health system consolidations, mergers and acquisitions; changes in provider affiliations; large employer groups moving from products or plans; and technology changes aimed at gaining a better understanding of the health status of a population. Providers seek to insulate themselves from these variables by avoiding APMs or seeking financial arrangements in APMs that negatively impact cost savings goals.

c. Please describe your organization's specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.

In working with smaller providers who may not have a large enough patient population or the necessary infrastructure to support an APM, Harvard Pilgrim utilizes other programs and practices to engage them in population health management, including promoting a shared savings model and quality programs that reward excellence and encourage improvements in clinical outcomes.

4. **Strategies to Align of Technical Aspects of APMs.**
   In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.
   a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

HPHC has made progress in aligning the technical aspects of APMs with Medicare and other plans in the Commonwealth. For example, HPHC's Hospital Pay for Performance (P4P) quality program is based on CMS measures that are currently reported by all hospitals. Also, our Quality Advance program for provider groups allocates a majority of its funding to nationally based HEDIS measures. As previously mentioned in Question 3.a., HPHC participates in a cross-functional, Massachusetts-based work group of providers and health plans that is charged with developing consensus guidelines on PPO attribution. Additionally, HPHC utilizes industry accepted Verisk for its health status adjustor (DxCG).

   b. What are the top barriers to alignment on these technical aspects and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

   Given that there is not a regulatory requirement that supports consistency between APMs with Medicare and other plans in the Commonwealth, providers have the opportunity to negotiate modifications to any aspects of these programs that are unappealing to them.

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.**
   Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.
   a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

HPHC, though our behavioral health partnership with Optum, has removed prior authorizations for several medicated assisted treatment (MAT) programs, including, but not limited to methadone and suboxone. In addition, we have initiated some creative contracting around bundled-rate programs in MA for agencies that provide not only MAT-like services, but also include counseling and drug testing on a monthly per diem (e.g. Column Health, CRC-Habit Management, and Clean Slate). For these services, we require only procedural notification so that we can activate the bundled service. Lastly, we have created a Substance Use Disorder (SUD) communication plan that has been shared with members (via newsletter), employer accounts, HR departments, EAPs, etc. regarding the value of these services.

   b. What are the top barriers to increasing access to pharmacologic treatment for your members and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

The biggest barrier to these services as it relates to substance abuse is Chapter 258, which requires immediate access to a detox/rehab facility in lieu of MAT-like programs. Often, when members go to emergency rooms, they tend to be immediately admitted into these higher levels of care programs, when in most cases they would benefit from a MAT-like service. This law, while well-intended, has negatively impacted the ability of insurers to re-direct members (when medically appropriate) to this level of care. Finally, member education continues to be an issue; however, we are hopeful that the steps described previously will improve this issue.

6. **Strategies to Support Telehealth.**
   In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.
   a. Does your organization offer or pay for telehealth services? Yes
      i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

HPHC allows all contracted providers with appropriate technology to provide telemedicine services; however, providers must comply with standard policies and coding guidelines. HPHC also covers tele-mental health for providers that have attested to providing these services, as well as contracted providers.

HPHC is also expanding access to telemedicine services though a new partnership with Doctor On Demand, a leading telemedicine provider with a national provider group of board-certified physicians. Since July of this year, HPHC has offered all commercial and self-insured members access to Doctor On Demand's video platform for urgent care services that would be an appropriate, less costly alternative to emergency department visits. Member cost sharing is equal to the primary care cost sharing on a member's plan, and payable with a credit or debit card via the Doctor On Demand application. All Doctor On Demand physicians are licensed in the state the member is calling from at the time of the visit.

      ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?

HPHC reimburses providers according the specific terms of a contract, which can include FFS payments or equivalent FFS rates for risk and global budget contracts. For behavioral health services, payments are FFS and are equivalent to an office visit with a coding modifier.

HPHC believes that the cost, utilization and efficacy of telemedicine services will need to be monitored and studied over time. HPHC will be reviewing provider reimbursement and utilization for telemedicine services in accordance with the value opportunities expected from telemedicine.

      iii. If no, why not?
      N/A

7. **Strategies to Encourage High-Value Consumer Choices.**
   In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.
   a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? Yes
      i. If yes, please describe the types of cash-back incentives offered.

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 and reduces out-of pocket expenses claims costs.

This program is currently available to large employers throughout our service area; however, we have recently begun to offer the program to small group employers in New Hampshire. As we begin to evaluate member experience with the program in the small group market, we will be making an assessment regarding its effectiveness, whether to expand the program, and evaluate any changes that may be necessary.

ii. If no, why not?
37T

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? Yes
   i. If yes, please describe the types of incentives offered.

Harvard Pilgrim has emphasized the adoption of innovative network designs that 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 tiers 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 receive care from doctors in a lower tier, they pay less.

Harvard Pilgrim also offers a state-wide limited provider network product option called **Focus Network-- MA** to provide employers with cost-effective insurance options. This product offers 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. This product is 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.

ii. If no, why not?
37T

8. Strategies to Increase Health Care Transparency.

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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	10,201	219
	Q2	9,338	239
	Q3	8,926	248
	Q4	10,665	280
CY2016	**Q1**	13,722	356
	Q2	10,504	467
	TOTAL:	63,356	1,809

9. Information to Understand Medical Expenditure Trends.

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, 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).

Please find HPHC Payer Exhibit 1 attached, which demonstrates the total allowed medical expenditure for CY13 to CY15.

(a) The impact of demographics on actual observed allowed trend is 0.5% for 2013, 1.2% for 2014, and 2.1% for 2015.

(b) The impact of benefit buy down on actual observed trends are -0.3% for 2013, -0.5% for 2014, and -1.4% for 2015. The buy down factors indicate that groups have changed their benefit plans from smaller member cost-share to greater member cost-share in 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 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.

In addition to the above, please also note the following comments and explanations that should accompany the above information:

- Historic annual trends are provided on an observed allowed basis, prior to any adjustments for benefit design, and for Massachusetts fully insured business only. Self-insured business is not available.
- Trends include non-claim based expenditures and are based upon actual observed claims and non-claim based trend.
- Provider mix is not separately tracked at this time.

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.
    37T

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that subject the provider to limited or minimal "downside" risk.)

    a. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

HMO/POS	70.7%
PPO/Indemnity Business	29.3%

    b. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	84%
PPO/Indemnity Business	2%

    Note: The 84% for HMO/POS reflects HPHC's fully insured membership in risk contracts; 48% of HPHC's self-insured HMO membership is covered under risk contracts. The PPO/Indemnity figure above reflects both fully and self-insured membership.

    Currently, more than 80% 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 more than 30% since 2012. Over the past two years, a particular area of focus has been the development self-insured HMO and POS APMs, and now nearly half of Harvard Pilgrim's provider network in Massachusetts is contracted under an alternative payment arrangement for self-insured HMO and POS products.

    HPHC has fully developed capabilities to support PPO alternative payment models and in 2014, implemented PPO alternative payment models with 6 major provider entities under the Massachusetts Group Insurance Commission's (GIC) Integrated Risk Bearing Organization (IRBO) program. Together, these alternative payment models covered more than 50,000 GIC PPO members. In July 2015, HPHC's PPO GIC plan converted to a new POS plan, and this membership then migrated to HMO/POS APMs.

    Our response to question 3B references some of the barriers to increasing adoption of alternative payment models.

    c. What percentage of your HMO/POS business that is under a risk contract has carved out the pharmaceutical benefit? What percentage of your PPO/indemnity business that is under a risk contract has carved out the pharmaceutical benefit?

HMO/POS	0%
PPO/Indemnity Business	0%

Currently, HPHC's contracts do not expressly carve out pharmacy services from provider's risk under our APMs. For certain contracts, there may be a high cost carve out provision.

d. For your risk contracts that include the pharmaceutical benefit, how is the provider's pharmacy budget set? How is the budget trended each year?

Our APM contract budgets are developed based on Total Medical Expense (TME), which includes medical and pharmacy experience from the prior two years (a baseline "target"), weighting the most current year at 67% and the prior year at 33%. Trend is calculated by incorporating cost of care in light of practice patterns and projections that consider changes in cost, health status, and benefits.

e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?

HPHC uses historical medical expenses to develop budgets that are net of pharmaceutical discounts rebates. Likewise, trends applied to budgets include discount and rebate experience.

HPC Payer Exhibit 1

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 2013	3.8%	-0.5%	N/A	-0.1%	3.3%
CY 2014	4.1%	-0.3%	N/A	0.3%	4.1%
CY 2015	3.9%	-0.9%	N/A	0.7%	3.8%

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.