

The Commonwealth of Massachusetts
Executive Offices of Health and Human Services
Center for Health Information and Analysis

AGO Written Testimony
Submitted September 16, 2013





1. Please submit a summary table (see attached) showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g. utilization trends, payer mix trend).

Below is the summary table showing Fallon Community Health Plan's (FCHP) actual observed allowed medical trends. For the time frames requested FCHP did not have specific studies to break out the mix between provider and service, so provider and service have been combined in the Service Mix column. FCHP believes that this "allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though the data includes allowed trends of both the payer and member share of the expense, because as the member's share of the cost rises it has an impact on reducing the underlying utilization. This understates the utilization and therefore the total trend in the table below. The trends in the table below indicate that the slow economy had a significant effect of lowering utilization in 2010, which then rose in 2011 and 2012 as the economy improved.

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 2010	5.40%	-2.70%	N/A*	-1.10%	1.50%
CY 2011	3.90%	0.20%	N/A*	-0.90%	3.20%
CY 2012	3.80%	1.30%	N/A*	0.80%	5.90%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					3.90%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					3.60%

2. Please submit a summary table showing your total membership as of December 31 of each year 2009 to 2012, broken out by:

****Please see attached Excel spreadsheet in folder titled "AG Question 2 – Membership Totals" for answers to the following membership questions.**

- a. Market segment (Hereafter "market segment" shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)
- b. Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that do not subject the provider to any "downside" risk; hereafter "risk contracts")
- c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)

- d. **Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for inpatient and outpatient services (e.g. lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)**
 - e. **Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)**
 - f. **Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations).**
3. **To the extent your membership in any of the categories in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying this growth.**

There have been minor changes to FCHP's overall membership from 2009 to 2012 (question 2a). FCHP does not attribute the minor changes to any particular factor, rather these small changes are due to the expected "ebbs and flows" that exist in the insurance marketplace.

While the overall membership has seen little change, there has been a significant increase in membership in FCHP's tiered network plans from 2009 to 2012 (question 2d). We attribute this increase to the development and sale of our "Advantage Plans", which are tiered network plan designs FCHP has offered to certain of our self-insured clients since 2010. To date, FCHP has built Advantage Plans for 6 large employer groups.

4. **Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g. HMO, PPO, self-insured, fully-insured).**

FCHP currently has risk arrangements in place for various Commercial, Medicare, and Medicaid HMO provider groups.

Items such as interim cash flow (capitation payments or fee for service equivalents), unit cost assumptions, utilization trend assumptions, intensity of services assumptions, as well as risk sharing parameters, risk caps, and reinsurance attachment points are all negotiated between the provider group and the health plan.

At-risk providers will attempt to meet or beat the annual budget. The provider group will be supported in this effort by FCHP reporting on a monthly, quarterly, and annual basis as well as by any internal infrastructure that the provider group has established on its own or in collaboration with FCHP. If the provider group also services members who are not part

of the provider group's risk pool, they would typically be reimbursed at fee for service rates for services provided to non-risk members. If the provider group wants infrastructure payments, PCP management fees, and/or pay for performance incentives for certain quality measures, these amounts will also be negotiated between the parties and included as part of the total at-risk PMPM annual budget. Upside only risk is typically a shared savings model. Models with both up and down side risk can be either low risk, moderate risk, or high risk.

FCHP's models for risk contracting in general use a global medical expense budget approach, inclusive of almost all medical expenses, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. FCHP starts with the population-based claims experience of the DS. A minimum membership threshold is required. Actuarial techniques are applied to the claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience. Specific localized adjustments are made to the claims expense, such as adjustments for known local hospital payment changes. Expenses are translated into a cost per member per month (\$PMPM) expense so that the budget varies based on total membership enrollment. In addition, each budget is given a baseline age/gender factor, a product adjustment factor and a benefit adjustment factor. These factors are used to adjust budgets during the contract year to account for changes to the baseline assumptions. By example, increased purchase of high deductible products could trigger a downward adjustment in the benefit adjustment factor and thus a reduction in the global medical expense budget. Non-claims based payments such as for quality goals, infrastructure fees and medical director fees are incorporated into the budget. Within the global medical budget, various sub capitation arrangements may be arranged on a service specific basis. Stop loss reinsurance premiums are included in medical expense budgets. Risk contracting is limited to insured HMO populations.

- 5. Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured plans. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.**

FCHP's models for risk contracting use a global medical expense budget approach, inclusive of all almost all medical expenses tied to the delivery system through the member's PCP, including pharmacy. Mental health and substance abuse expenses are generally not included in delivery system (DS) risk arrangements. In building risk budgets, FCHP starts with the population-based claims experience of the DS. A minimum

membership threshold is required. Actuarial techniques are applied to claims expenses to finalize an expense budget for a specific risk budget period: incurred but not reported (IBNR) completion factors; medical trend; member liability adjustments, and adjustments to normalize for the effect of high cost cases on the baseline experience.

Standard adjustments to risk budgets include age/gender, product mix, and benefit change. These adjustments are made during the course of the contract year as a result of a change between baseline assumptions and actual contract year experience. By example, a 1% change in the age/gender factor would trigger an adjustment to the global budget. Health status adjustment, as measured by predictive modeling techniques, is generally not included. FCHP does not believe these models are stable enough to use in general application. By using a delivery system's own experience, the health status of its members as well as their socioeconomic conditions are built into its expense base. (This does not preclude use of predictive modeling from analyzing the performance of a delivery system.) Also, as reported above, baseline budgets are adjusted both upward and downward to account for under- or overrepresentation of catastrophic cases.

To protect for insurance risk, and depending on the size of the population at risk, delivery systems typically purchase individual member stop loss insurance that covers 90% of all member expenses (inpatient, outpatient and pharmacy) beyond the stop loss level. Aggregate risk management is typically accomplished through the use of risk corridor gain and loss sharing on the global medical budget. The goal of risk arrangements should be to have delivery systems focus on standard "every day" management of care rather than to be concerned over risk of catastrophic cases.

FCHP has several risk model variants that are made available to health care providers who are interested in risk and have the necessary infrastructure to manage member populations at risk. The common denominator for any risk model is that at-risk providers attempt to perform at or below a targeted per member per month (PMPM) medical cost budget for their assigned member population.

FCHP risk models are only applicable to fully insured members. FCHP does not assume any risk associated with self-insured groups. Providers do not assume any risk associated with self-insured groups. Each self-insured employer, health and welfare fund, or state approved collaborative retains any and all risk associated with their members. Typically, the self-insured entity will purchase reinsurance on their own behalf to mitigate the risk associated with their member population's health expenses.

With fully insured commercial members FCHP may use any of the following models with a provider group interested in risk:

- A full capitation arrangement where the provider group has close to 100% upside and downside performance risk for a designated set of medical services with a specific

PMPM annual budget. FCHP remains at risk for services excluded from the target budget.

- A limited risk capitation arrangement where the provider group still wants upside and downside performance risk but wants to limit its risk on both the upside and downside to designated PMPM thresholds.
- A transitional risk model that uses fee for service (FFS) payment combined with a withhold percentage. In this model the provider group typically has never had a risk arrangement with any payer. The provider group wants to have a trial run at managing to a PMPM budget but with very little downside. So, the provider group negotiates FFS rates but agrees to a small withhold such as 5%.
- A final transitional model to help a provider group become accustomed to the idea of risk is a shared savings program. In this model there is FFS payment but the group is again trying to meet or beat the PMPM annual budget that has been set as the appropriate risk adjusted goal for the target member population. If the provider group can beat the budget by coming in at a lower PMPM, FCHP will share the savings, typically up to an agreed upon PMPM limit, with the provider group.

6. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

FCHP's assessment as to whether a provider group can assume risk is determined on a case by case basis after extensive discussions between the provider group and FCHP. During these meetings the following variables are typically examined:

- Membership. Does the provider group have enough members in the particular product(s) to have an actuarially sound risk pool? If not, is the membership pool at least large enough that the provider group should not experience the significant random variations often seen with very small patient populations?
- Provider Group Infrastructure. Does the provider group have or is it willing to develop the infrastructure needed to manage member population health and the associated financial risk? Does the provider have an electronic medical record system, a referral coordination program, a formal CQI plan, and a Medical Director or Assistant Medical Director to focus efforts on a risk venture? What management reports and support are needed from FCHP and is the provider group willing to work with clinical staff resources at FCHP? Does the group have embedded case management staff or are they willing to embed FCHP case management staff at their site?
- Managing Clinical Care. What subpopulations does the provider group know best? What does the provider group see as its mission and which type of members (Commercial,

Medicaid, and Medicare) tend to seek out the provider group for services? Is the group comfortable treating a population with a high number of chronic conditions? What tools does the provider group use or is willing to use to reduce inappropriate hospital readmissions or unnecessary skilled nursing admissions? Is the provider group's model for integrated care consistent with FCHP's expectations for integrated care? What has been the provider group's experience with risk arrangements with other health plans?

- **Structure, Governance, and Leadership.** How is the provider group organized? Are they employed, independent, or a mixture of both? How are decisions made and funded? If, as is typical, the risk contract is made at a contracting entity level, how are individual providers within the physician organization bound by the risk contract? Do the physicians have to opt in individually to a risk deal or can they all be bound by one signatory? If there is downside risk how will that downside risk be funded and accrued for by the provider group? How will the physician leadership communicate the risk deal initially to rank- and -file providers within the group and how will the physician leadership work to make sure that performance feedback is given on a regular basis to their individual providers?
- **Proposed Budget.** Does the provider group understand the budget by service type? Do they see the potential areas where changes in utilization, choice of provider setting for services and reduction of unnecessary hospital admissions/readmissions could result in better quality care at a lower total cost? Do they have a targeted focus with priorities for managing types of care that has historically been an outlier from state and national norms with respect to episode frequency and total cost?

To proceed with a risk venture between FCHP and a provider group, the majority of answers to the above topics would have to indicate that the provider group is able to manage care from a population perspective, has the appropriate infrastructure to manage care and assure high quality cost effective outcomes, is adequately organized and financed to accept risk on a health plan population, and is willing to be an active business partner with FCHP to appropriately care for and manage the target member population.

7. Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.

FCHP believes that limited networks are a more effective way to manage costs than tiered products. We introduced the first limited network product in Massachusetts, FCHP Direct Care, over 10 years ago. In 2012, we added a second limited network, FCHP Steward Community Care, built around Steward Health Care.

FCHP has successfully utilized a multi-network option strategy to employer groups of all sizes. This allows employers to offer the same benefits to all employees, and then lets each employee choose a network at point of enrollment. FCHP offers all benefit designs available with our broad network through both Direct Care and FCHP Steward Community Care.

In 2009, FCHP used a 13% differential between its Direct Care and Select Care products within the merged market. This decrement was reduced to 10% in 2010, but expanded to 12% starting in 2011. It has remained at that differential throughout 2013.

Since there are no benefit differences between products offered through FCHP's non-limited Select Care network and FCHP Direct Care, the 12% pricing differential is a combination of unit cost and better than average state-wide utilization, which reduces the total medical expenditure. We do attempt to negotiate savings close to the pricing differential in these contracts compared to similar contracts with the same providers in our broad network, but it is the criteria for selecting the providers in Direct Care which drives most of the overall reduction in price. There are also differences in member health status; however, these do not drive the standard pricing difference between the two networks.

FCHP utilized its experience with limited networks to develop the pricing for FCHP Steward Community Care. FCHP Steward Community Care has been priced 20% below Select Care since its introduction. Unit cost differences from our broad HMO contracts and anticipated efficiency improvements due to the contracting arrangements and collaborative efforts with FCHP's Care Management team were reflected, as well as a small incremental amount for member health status was also included in the 20% differential. Experience with this network is still developing, but early indicators show that the difference in costs are in line or better than expected.

In the fully insured market, FCHP did not begin offering a tiered network product until March 1, 2012. Depending on the specific plan design, this product is priced about 7-9% below a broad-based Select Care HMO network product with a plan design similar to the Tier 1 benefits.

Our pricing assumes the total cost for Tier 1 providers is 10-20% less than Tier 2 and that the Tier 3 providers are about 30-50% more expensive. Although we believe there will be shift in utilization towards more efficient providers, we have assumed less than 5% steerage towards tier 1 providers on a total cost basis due to limited differences in the benefits between the three tiers which may not effectively deter the trend for sickest patients to seek care in the more expensive facilities throughout the state. Membership for this product is not credible at this point to draw meaningful conclusions regarding the assumptions used.

- 8. Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter "wellness programs"). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.**

FCHP believes it is a "healthier" health plan. FCHP focuses on preventive care, as reflected by the many programs and initiatives we offer our members. These include tobacco cessation programs, multi-faceted wellness programs, a fitness reimbursement program, and preventive screenings. In addition, FCHP is the first health plan in Massachusetts to introduce a wellness program to all members that rewards them for being—and becoming—healthy. The "Healthy Health Plan" is a robust solution for members looking to engage in a comprehensive wellness solution.

The Healthy Health Plan provides members financial incentives for (1) taking an online health assessment and, based on the results, (2) completing a customized action plan that may involve workshops and health coaching. This program also provides FCHP with the ability to aggregate important member health information that will help craft appropriate health and wellness programs customized towards our entire membership base.

In addition to The Healthy Health Plan program, FCHP provides a wide variety of wellness programming that helps to ensure members receive the information, skills and care they need to maintain optimal health. This includes:

Wellness Works

- FCHP works directly with employers and their Wellness Committees to build population specific wellness programs to promote a healthy lifestyle for employees. These programs can include personal health assessments, preventive screenings, individual and group wellness challenges, and educational workshops.



Quit to Win!

- FCHP's tobacco cessation program has one of the best quit rates of all health plans in the nation. Participants can receive discounted nicotine replacement therapy while attending weekly group sessions. Members may opt to choose individual telephonic counseling and receive patches in the mail.

Oh Baby!

- Expectant parents receive information, resources and literature, plus complimentary items such as prenatal vitamins, a toddler car seat, breast pump, and home safety kits.

It Fits!

- FCHP offers one of the richest fitness reimbursement programs in the state. "It Fits" reimburses eligible families up to \$400 and individuals \$200 for participating in a variety of healthy activities: membership at local fitness centers, home fitness equipment, aerobics, Pilates and yoga classes when taught by a certified instructor, Weight Watchers® programs, and local town and school sports programs for all ages when they include an aerobic and instructional component.

For members who want to meet with health and wellness professionals, FCHP has opened a walk-in information center. The FCHP Information Center is a place where members can come to learn about many of the healthy offerings that are available, receive handouts and attend seminars, and sign up for a large number of wellness initiatives.



CERTIFICATION OF WRITTEN TESTIMONY FOR THE 2013 COST TREND HEARINGS FOR THE
HEALTH POLICY COMMISSION AS REQUIRED BY M.G.L. c. 6D, SECTION 8.

I, Richard Burke, am the President of Senior Care Services and Government Programs for Fallon Community Health Plan, Inc. (FCHP). I am legally authorized and empowered to represent FCHP for the purposes of this testimony. The responses contained in this submission were prepared by employees of FCHP who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY: 

Print Name: Richard Burke

Title: President of Senior Care Services and Government Programs

Date: September 16, 2013