Harvard Pilgrim's Response to Request for Written Testimony

Health Policy Commission Questionnaire

September, 2013

Harvard Pilgrim
Health Care

September 19, 2013

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

Re: Annual Health Care Provider and Insurer Cost Trends Hearings

Dear Mr. Seltz:

Enclosed please find Harvard Pilgrim's written testimony in response to the Commission's letter dated August 16, 2013. We have enclosed completed Exhibits B through D and supporting attachments in response to the questions from the Health Policy Commission, the Office of the Attorney General and the Center for Health Information and Analysis. In accordance with the instructions we received from your Office, we are submitting our materials in Word and Excel formats.

Harvard Pilgrim looks forward to the upcoming hearings on October 1 and 2, including the panel discussion in which Eric Schultz, President and CEO of Harvard Pilgrim Health Care will participate. In the meantime, if you have any questions about our response, please feel free to contact me at 617-509-4744 or Teresa Gallinaro, Legislative Consultant, at 617-509-7208.

Thank you for your consideration.

Sincerely,

William J. Graham
Senior Vice President, Policy and Government Affairs

Attachments

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

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 Policy and Government Affairs of Harvard Pilgrim Health Care, Inc. (Harvard Pilgrim). As such, I am legally authorized and empowered to represent Harvard Pilgrim for the purpose of submitting the written testimony and supporting documentation provided herein.

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

Signed under the pains and penalty of perjury, on this 19th day of September, 2013.

By: _____

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

Response to
Request for Information

Harvard Pilgrim's Response to Health Policy Commission Questionnaire

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SECTION 1

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:
On or before the close of business on September 16, 2013, electronically submit in both PDF and Microsoft Word format written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please submit any data tables included in your response in Microsoft Excel or Access format.
Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an `other-, `miscellaneous-, or similar category in any response, please explain what such a category includes.

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

Questions:

1. C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state-s economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.

a. What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?

Harvard Pilgrim has undertaken a number of actions to help to ensure that the Commonwealth will meet the benchmark. These included negotiating lower rates of increase with providers, increasing the use of alternative payment methodologies, launching new products and consumer transparency tools. The descriptions below are brief but some items are expanded in later responses:

1. Provider Contracting: As provider contracts come up for renewal, Harvard Pilgrim has negotiated more favorable contract terms that also emphasize improving quality of care. For those larger providers with the necessary infrastructure, we have worked with them to develop alternative payment arrangements that emphasize quality over quantity of care provided (see Payment Reform section below). As a result, Harvard Pilgrim has been able to successfully negotiate contracts with the large majority of our provider groups that include price increases below the benchmark. This is especially important since several state-issued reports over the past few years have shown that increases in prices charged by health care providers are the primary driver of rising health care costs. The heightened public interest and focus on the trajectory of health care cost growth, especially among employers, has also assisted our efforts to keep provider rate increases reasonable.

2. Payment Reform: As noted above, Harvard Pilgrim has been working with providers to develop alternative payment arrangements that move away from the fee for service system that creates incentives for providers to increase the volume of care to a system that rewards

value over volume. Harvard Pilgrim believes that alternative payment arrangements, when done right, are key to the state's effort to control the rise in costs. In 2011, a little over 1/5 of our HMO/POS members were cared for by primary care providers under a risk agreement. In 2013, that number is approximately 60% and in Eastern Massachusetts it rises to 75%. We expect these numbers to grow in the years to come due to the growing interest in the market and the incentives and expectations built into C.224 and the Affordable Care Act. In addition, Harvard Pilgrim has also been working with many of its self-insured groups to move in this direction. This is critical since the self-insured market comprises approximately half of Massachusetts' commercial health care market and is growing. We expect that by the end of 2014, most of our self-insured accounts will be linked with groups operating under some type of global budget.

3. **Developing network and plan designs that engage consumers:** Harvard Pilgrim has, over the past few years, expanded its product offerings to include limited network and tiered network products that emphasize greater consumer engagement and provide incentives for consumers to go to providers that have lower costs but maintain a high quality of care standard. Hospital Prefer, our most recent suite of plans developed since the passage of C. 224, allows consumers to choose the hospital of their choice for treatment but their out-of-pocket costs will vary depending on which hospital they choose. All of our network hospitals are included, but consumers are placed in one of three tiers depending on their relative cost and quality. Consumers will pay less for hospitals in Tier 1 and more at Tiers 2 and 3 hospitals. In addition to Hospital Prefer, Harvard Pilgrim has other innovative plan designs such as Choice Net and Focus, described in previous years' filings, which engage consumers to be attentive buyers when they shop for health care. These plans provide options for employers and health care consumers with premiums that are up to 15% lower than traditional HMO plans.

4. Consumer Transparency and Engagement Tools: Sec. 208 of C.224 of the Acts of 2012 requires health plans to establish a website at which a health care consumer can obtain information about their expected costs related to a health care service they are seeking. In the fall of 2013 Harvard Pilgrim Health Care will launch NowiKnow^{sm}, a state-of-the-art consumer transparency tool which will allow our members to search and compare providers for a wide array of health care services. Information will be customized to each member, including benefits, deductible balances and out of pocket costs. NowiKnow^{sm} is central to our strategy of engaging consumers to be informed shoppers of health care services, driving volume to value, and ultimately reducing health care costs. This tool was in development at Harvard Pilgrim well before the passage of Ch. 224, putting us in a position to be first-to-market.

In addition to NowiKnow^{sm}, Harvard Pilgrim also unveiled an innovative service to members called SaveOn^{sm} in the fall 0f 2012. An add-on program for employers, SaveOn^{sm} allows them to offer their employees cash rewards for making smarter, value-based choices when seeking certain diagnostic health care services. Upon referral from their PCP for such a service, a member can call an 800-number where a nurse will provide options for less expensive options for that same service. If a member agrees to go to a lower cost facility, the nurse will assist in rescheduling and the member will receive a check in the mail ranging from $25-$100. The member wins with a cash incentive and lower out-of-pocket costs if

they are in a deductible plan, and overall health care costs are lowered by use of the higher value provider.

b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?

As noted above, Harvard Pilgrim believes that alternative payment arrangements, when done right, are key to the state's effort to control the rise in costs. Alternative payment arrangements, to be successful, must be more than a mechanism to keep provider price increases in check. These arrangements must also provide incentives to avoid unnecessary treatments or procedures that add costs by emphasizing care coordination, patient understanding of and engagement in treatment, and outcomes consistent with high quality care. On the plan design side, the increasing use of carefully structured tiered or limited network plans such as Hospital Prefer, Choice Net and Focus will help make consumers more conscientious purchasers of health care that has value, i.e. health care that is appropriately priced and that meets accepted quality of care standards.

What current factors limit your ability to address these opportunities?

While we expect the vast majority of the Commonwealth's health care providers to be in alternative payment arrangements within the next year or two, there are certain factors that limit our ability to negotiate alternative payment arrangements at appropriate reimbursement levels:

1. Geographic isolation: Historically, there have been providers in geographic areas who have been the sole provider in the area and have a much greater ability to negotiate the terms and rates of contracts. If Harvard Pilgrim were unable to reach agreement with such providers, the Plan could run the risk of not meeting minimum network requirements for that area, not meeting members' needs for medical services or not being considered or selected as a plan option by certain accounts.

2. Certain provider specialties: There are certain provider specialties, specifically pathologists, emergency room physicians, anesthesiologists and radiologists, as well as service providers such as ambulance providers, for which the plan and its members have limited ability to actively choose the physician or company that provides these services. 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.

3. Provider consolidation/reputation: 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 continue the 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 have been able to demand higher rates at least in past negotiations.

4. Utilization: Many experts believe that one of the reasons health care cost growth has moderated in recent years is the slow economy, which leads consumers to defer seeking health care services, especially elective procedures. If this is the case, one can expect that with the improving economy consumers may begin seeking these services, which would put upward pressure on health care costs, and therefore premiums. One observation in this regard that we have found encouraging is that our members have largely not been putting off preventive or other needed procedures.

5. ACA Transition: While bringing significant benefits to the Commonwealth and consumers, there are several changes to the Massachusetts merged market that will put some upward pressure on premiums. As described in detail in a report recently completed by Wakely Consulting and commissioned by the Massachusetts Association of Health Plans and Blue Cross Blue Shield of Massachusetts, merged market premiums will increase, on average, by 3.7% due to requirements of the ACA. This increase is on top of trend and will affect carriers differently depending on a number of factors. In addition, changes to small group rating factors will cause some groups to see increases and others decreases.

c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?

In this time of rapid change in the health care system, it is important that health plans, such as Harvard Pilgrim, have regulatory flexibility to offer new and innovative products and services and to enter into new partnerships with providers that will allow us to improve the quality of care that our members receive while at the same time helping the state meet its overall cost control goals.

d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

Harvard Pilgrim, like the other major non-profit health care carriers in the state, exists in a very competitive environment. In order to attract new accounts and members, as well as retain existing accounts, we try very hard to keep our rates at a reasonable level that will permit a small amount of net income for reinvestment in necessary systems improvements. As we see slowing in health care spending, it is passed along to consumers and businesses in the form of lower premium rate increases. It should also be noted that Massachusetts has the most stringent MLR requirements in the country (for its merged market). If our medical spending falls below the MLR, the amount must be returned to employers (or individuals in the case of non-group members) in the form of a rebate.

2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General-s Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?

Harvard Pilgrim described in question 1 the initiatives it is taking around payment reform, provider contracting, network and plan designs that engage consumers, and consumer transparency and engagement to keep health care cost growth and the underlying medical trend that fuels this growth in check. In addition to these initiatives, Harvard Pilgrim is also engaging with providers in delivery system redesign that is described in more detail below.

Delivery System Redesign: Moving toward a delivery system that can operate in these new financial arrangements requires massive change, and the spectrum of provider readiness is very wide. We believe that health plans can play a critically important role in helping providers along the continuum of change, especially for those with the farthest to go. Harvard Pilgrim has a long and rich history of working in collaboration with providers. We understand that transforming practice and payment to produce value and good outcomes for patients is hard and complex work, and that one size does not fit all. Our vision is to work in collaboration with our provider partners along this journey. In this spirit, we've developed four delivery and payment pilots that meet providers where they are, design customized payment methodologies around their unique competencies and structures, and reward them for producing positive outcomes for their patients.

1. **Patient Centered Medical Home:** Building on the patient centered medical home, we are developing customized models with providers that help them understand downstream costs (hospital, specialist, etc) and build shared savings incentives for success in containing them. We are also working with them to think about how to integrate behavioral health into the PCMH model.

2. **Specialist Medical Home:** We are working with Commonwealth Hematology/Oncology, affiliated with Beth Israel Deaconess Medical Center, to develop a "Specialist Medical Home" which organizes care using medical home principles for patients with a cancer diagnosis, patients whose care calls for a central role for a specialist. In these cases, specialists may be best positioned to coordinate care and interact with a PCP and other specialists as needed, but many aren't trained to play this role.

3. **Bundled Care / Case Rates**: The goal of this model is to align payment with quality and outcomes for high-cost surgical procedures, reduce practice variation and drive volume to highest value providers. For example, Harvard Pilgrim is developing a bundled payment model that builds a case rate for total hip and knee replacements. What makes this model different from traditional bundled payments is that we define the scope of services very broadly, so that it's not just an extended DRG. We look at the entire episode of care, all related services 30 days before a procedure to 90 days after, including all needed services – rehab, ER, readmits for complications/infections. All these services are included in the case rate.

4. **Complex or Progressive Diseases/Conditions:** This model develops a bundled payment for complex chronic conditions, such as diabetes and congestive heart failure, which often have multiple co-morbidities. Similar to Specialist Medical Home, this model seeks to organize and coordinate the many levels of care around the core diagnosis, with a payment model more like a bundled payment. For this model, we are working with **InterMed** in Portland, ME around diabetics, developing a very broad scope of services that include not only checking blood sugars but also including related services such as cardiac care, renal care, and care for eye problems, etc. On this model we are working closely with Michael Porter at the Harvard Business School.

In these four models, we maintain a high level of engagement with providers across all the changes in payment methodology and clinical practice. We work with them to develop customized models, based on their competences and resources, which align payment and clinical delivery to deliver value. Our care managers meet with providers regularly (weekly) to review cases, and review analytics to track progress, identify new opportunities for improvement. These models serve as our own internal innovation center. As we develop more refined models and a broader base of experience from our work with providers, we can export these practices and models to our broader network.

3. C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?

Since 2011, Harvard Pilgrim has increased from 22% to over 65% (78% in Eastern Massachusetts) its network of providers contracted through shared responsibility payment arrangements (risk, shared savings, or care model) for Fully Insured HMO/POS members.

Harvard Pilgrim has developed a PPO primary care physician attribution model and is in the process of enhancing reporting, business processes and systems capabilities to support such models for all product types and funding arrangements. Beginning in 2014, Harvard Pilgrim will be extending such payment models to HMO and PPO self-insured members. We believe there is general acceptance among the provider community in moving away from traditional fee-for-service payment mechanisms. There may be, however, certain limiting factors. The first would be providers' agreement on future cost and utilization trends and the impact that would have on the risk they would assume over time. Another limiting factor may be simply the size of the risk pool of plan members associated with those provider groups who have not yet contracted under risk-type arrangements. Random variability effects that may exist in performance among smaller risk pools may limit movement away from fee-for-service arrangements. Additionally, providers' readiness to consider PPO populations in the same manner as HMO populations could be another limiting factor. Plans and providers are in relatively early stages of understanding how coordination of care principles applied to HMO, primary care physician- centered care populations may be best applied to PPO patient populations. Some providers are considering their ability to successfully manage PPO populations who have access to providers who may be outside of the accountable care organization.

The following physician groups and hospitals participate in some form of shared responsibility arrangement: Atrius Health, Acton Medical Associates, Beth Israel Deaconess, Dartmouth

Hitchcock, Lowell PHO, Mount Auburn Community IPA, Partners Community Healthcare, Physicians of Cape Cod, South Shore PHO and Steward Healthcare and Sturdy Memorial. We are currently in discussions with several additional provider organizations with the goal of re-contracting under shared responsibility models.

Harvard Pilgrim current shared responsibility models include: Please note ALL models include a quality component.

Shared Savings Model:

- Provides opportunity for additional financial rewards for a provider group while promoting efficiency and cost effectiveness without downside risk for the provider.
- Excludes MH/SA and high cost cases over $100,000
- Upside Risk sharing percentage is 50/50.
- Maximum payout required.
- 2% Corridor prior to sharing savings (to address random variation).
- Quality gate is required (Harvard Pilgrim standard QAP/HEDIS measures).
- Infrastructure payments.
- No withhold required.
- No reinsurance required.
- Allows the provider to decide areas to work on and allows focus on *Quality, Efficiency and Cost.*

Shared Risk Model:

- Provides opportunity for additional financial rewards for a provider group while promoting efficiency and cost effectiveness includes both upside and downside risk for the provider.
- Providers compensated on a PMPM basis for a set group of services
- Providers share both up and down side of risk- however LOW risk (i.e. limited on both up and down side risk)
- PMPM calculated monthly and allocated into a budgeted payment pool
- Both capitated and referral services are billed as claims and paid fee for services rates
- Percent is withheld from claims payments to cover deficits (withhold)
- Reinsurance is required
- Settlement occurs on a set schedule

Harvard Pilgrim's Shared Risk Models include the following: Full Capitation/Full Risk; Budgeted Capitation/Full Risk; Budgeted Capitation/Partial Risk, and Budgeted Capitation/limited Risk. Question 4 in the Attorney General's Exhibit C provides more detail on these shared risk models.

4. C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk payments, care management, etc.), and limitations or barriers you face in meeting this expectation.

Attribution is an issue for our PPO family of products, since HMO and POS members must choose a PCP during enrollment. Since 2011, Harvard Pilgrim has been developing and refining its attribution methodology and expanding the number of PPO members attributed to a PCP.

Harvard Pilgrim HMO/POS members choose a primary care physician (PCP) through our standard member enrollment process. In contrast, PPO members historically have not been required to select a PCP although most PPO members, in fact, tend to have a particular physician that they see for primary care visits.

In 2011, Harvard Pilgrim developed a claims-based algorithm to attribute members to physicians. This algorithm is a multi-step process of attributing members based on the PCP (Internal Medicine, Family Practice, General Practice, Pediatrics, Nurse Practitioner, Geriatric Medicine, Adolescent Medicine) and specialty (OB/GYN) well visits taking place over a 24 month period. Approximately 18% of our PPO members had no claims experience. The algorithm resulted in Harvard Pilgrim attributing approximately 87% of our PPO members with claims experience.

Harvard Pilgrim utilized this attribution logic when we implemented our Patient-Centered Medical Home Care Delivery Pilots in mid 2012. The algorithm was put into production in our Enterprise Data Warehouse in early 2013 for corporate-wide reference. The data is now refreshed on a monthly basis.

We are in the process of reviewing our algorithm with key providers in an effort to expand our standard alternative payment arrangements to include PPO membership beginning in 2014. Nevertheless, as described in our response to question 3 regarding care coordination among PPO populations, both plans and providers will need to analyze and understand the reliability of PPO attribution models and may need several years of data in order to test the persistency of the patient PCP relationships before fully adopting single care delivery and risk-type models across patient populations irrespective of the type of health plan design (HMO or PPO) which their patients choose.

5. Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?

Harvard Pilgrim believes that one of the best opportunities to reduce medical expense trend is through a combination of plan design incentives targeting providers and members. It is critical that both members and providers have access to robust decision-making support tools to help them make more cost-effective choices with improved outcomes. We also believe it is imperative that reimbursement to providers include some measures of quality, like HEDIS measures around conditions such as diabetes, asthma and congestive heart failure. Attainment of benchmark measures leads to increased reimbursement; that is, higher quality equals higher reimbursement.

The hope is higher quality will eventually lead to lower costs by providing more appropriate care which leads to better outcomes and reduced morbidity and mortality.

In terms of product offerings, Harvard Pilgrim has developed products that engage members in the choices around course of treatment, sequencing of services and sites of service. These products include:

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

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

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

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

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

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

the Focus Network choice at open enrollment, they choose their site of care under the ChoiceNet products at the time of service, with full access to the entire network at any point in time.

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

6. Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.

Harvard Pilgrim works diligently to control provider rate increases through contracting efforts. We employ comprehensive financial, statistical and market analyses in our contracting process with the goals of managing medical costs while maintaining a competitive, stable and comprehensive provider network (with the exception of the narrow Focus Network described above). From 2009 through 2012, we have continued to see a moderation in our unit cost increases but more time will be needed to assess the impact on trend of provider consolidations and affiliations over the past three years. However, we have seen cases where such provider consolidations have the effect of increasing medical cost when the higher contract rates of the acquiring provider become applicable to the acquired provider entity. Over time the value of clinical integrations on medical cost trends will need to be assessed.

7. Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.

Technology is now permitting Harvard Pilgrim to provide consumers with the tools and support they need to take advantage of our newer products and make cost-effective choices that will lead to better quality outcomes. Bolstering this effort is the fact that employers are increasingly looking to products that involve greater cost-sharing for their employees in order to keep overall premiums affordable. As a result, consumers are more cost-conscious but also must be assured that they are still receiving quality care at the providers of their choice.

The information below is also found in our response to Question 1a:

Sec. 208 of C.224 of the Acts of 2012 requires health plans to establish a website at which a health care consumer can obtain information about their expected costs related to a health care service they are seeking. In the fall of 2013 Harvard Pilgrim Health Care will launch NowiKnow, a state-of-the-art consumer transparency tool which will allow our members to search and compare providers for a wide array of health care services. Information will be customized to each member, including benefits, deductible balances and out of pocket costs. NowiKnow is

central to our strategy of engaging consumers to be informed shoppers of health care services, driving volume to value, and ultimately reducing health care costs. This tool was in development at Harvard Pilgrim well before the passage of Ch. 224, putting us in a position to be first-to-market.

In addition to NowiKnow[sm], Harvard Pilgrim also unveiled an innovative service to members call SaveOn[sm] in the fall of 2012. An add-on program for employers, SaveOn[sm] allows them to offer their employees cash rewards for making smarter, value-based choices when seeking certain diagnostic health care services. Upon referral from their PCP for such a service, a member can call an 800-number where a nurse will provide options for less expensive options for that same service. If they agree to go to this lower cost facility, the nurse will assist in rescheduling, and the member will receive a check in the mail for between $25-100. The member wins with a cash incentive and lower out-of-pocket costs if they are in a deductible plan, and overall health care costs are lowered by use of the higher value provider.

8. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization-s experiences.

Harvard Pilgrim would like to thank both the Attorney General and the Center for Health Information and Analysis for their detailed reports that focus not only on carrier and provider behavior and their impact on health care spending, but also on purchaser and consumer behavior. This information will help to inform policymakers' decisions in both the public and private spheres. We have focused our comments on the Attorney General's executive summary.

Purchasers/Consumers

The Attorney General's findings regarding trends in Purchaser/Consumer behavior and spending mirror the trends we have seen and that we describe in our response to Question 3 in Exhibit C.

Purchasers have become increasingly cost-conscious and are demanding plan designs that will result in meaningful reduction in premium. Tiered and limited network plan designs help meet this goal, as well as high deductible health plans coupled with an HSA or HRA. Consumers also have reasons for choosing these health plan designs. Employers have been shifting a larger share of the costs to employees through higher deductibles, copayments or coinsurance. With wages remaining relatively flat, more employees have been willing to opt for some restrictions on their provider choice in return for a lower premium. Even where employees do not have a choice of health plans, affordability is often a high priority particularly if the employees are lower consumers of health care services. Tiered networks allow employees to choose their provider at the point of service and consciously decide whether one provider offers more value than another. The imminent introduction of on-line tools such as *NowiKnow* will support members in their decision-making process. HSAs, while not appropriate for all individuals, can offer significant tax advantages, are portable and allow members to build equity in their accounts that may be used for future health care needs, even the purchase of retiree health insurance. Finally, by providing consumers with the appropriate on-line and other tools to be able to determine not only price but also the quality of care provided by different providers, health plans can educate and inform consumers to consider "value" - the junction of low costs and quality care, and not only reputation of an institution.

The Attorney General's report also found an increase in PPO enrollment. The movement to PPO products, as opposed to more tightly managed HMO products may, at first glance, appear to contradict the desire of employers and consumers for lower premium products. It is important to note that employers may select PPO plays for a variety of reasons, including access to national networks and access to additional self-insured options. While HMO plans offer the ability to more tightly manage medical costs, there are also additional administrative costs associated with those plans which must be reflected in premiums and ASO fees.

Health Plans

We also agree with points B and C of the principal findings under *II. Health Plans.* There continues to be wide variation in provider total medical expenses across the Commonwealth and in smaller geographic areas. The growth in prices of medical services, not utilization, continues to be the primary cost driver for us and the other major carriers in the state.

In terms of point A ("Health plans continue to pay providers widely different amounts to care for patients of comparable health"), we agree that there continue to be significant differences in provider reimbursement rates. That said, we have observed that the sharp public focus on rising costs has made our negotiations with providers especially productive, and Harvard Pilgrim has negotiated contracts the large majority of which include prices that are growing below the rate of growth in Gross State Product. It is our hope that with sustained oversight of provider market power and consolidation and attention to the impact of rising prices, this trend will continue. And to the extent that certain providers in the past have been able to demand much larger increases than smaller or more efficient providers, we are hopeful that the new emphasis on provider rising costs will result in narrowing the gap.

Point D ("The design of health plan products affects risk selection - which types of consumers tend to purchase which types of products- total medical spending and care management.") is one that we largely agree with but have some concerns regarding the statement on risk selection. We agree that product design will influence self-selection to some extent. We have seen this self-selection with our Focus narrow network where members with lower utilization are more likely to choose this product. However, this is not a new issue in insurance and we do not believe that this is a bad thing if consumers are purchasing products that offer them value. As long as there are adequate disclosures concerning what the plan covers, standards for minimum essential coverage and network adequacy, adequate education and materials for consumers so that they understand what they are buying, and appropriate actuarial oversight by the plans themselves that extreme risk selection isn't occurring, any risk selection associated with these products should be manageable.

Providers

In terms of the provider findings, Harvard Pilgrim recognizes that not all providers have the same level of sophistication and vary in their ability to successfully take on risk. As a result, while we have alternative payment arrangements with integrated delivery systems that can handle partial or full capitation, our contracts with smaller, less sophisticated providers may be based on a fee-for-service platform with more familiar performance incentives that will not jeopardize their financial stability but reward them for achieving greater efficiency.

The dramatic and rapid change occurring in the provider community in terms of acquisitions, affiliations, mergers and other alignments of hospitals and other provider entities requires careful

monitoring by the Commonwealth. While the transition to more coordinated care is a major and understandable impetus for these changes, we remain concerned that consolidation in the industry could exacerbate the problem of provider market power that is now well documented as a key driver of health care cost increases in recent years. The Legislature has empowered the Health Policy Commission to closely monitor these changes, and thoughtful, rigorous oversight will be important to prevent this trend from working counter to the cost containment goals of C. 224.

The OAG Recommendations

Overall, Harvard Pilgrim agrees with the recommendations in the OAG report. There is one recommendation that we have concerns about if it were implemented in the near future. This is the recommendation that CHIA require quarterly reporting by private and public payers to track the effects of different health plan product designs and payment arrangements including the reporting of TME, utilization, cost, and quality by product design and payment arrangement. The health plans, including Harvard Pilgrim, expended time and resources in the last quarter of 2012 and the first 6 months of 2013 trying to implement a number of new APCD and other reporting requirements under C. 224. While CHIA staff worked hard with the plans to sort out the feasibility of providing different data and allow appropriate time to produce the various reports, it was still a large effort that involved significant IT work. Any consideration of expansion of reporting requirements should take into account whether it is feasible technically, the administrative costs associated with increasing or diverting staff to handle increasing amounts of reporting, the impact it may have on the ability of health plans to introduce new product designs and payment arrangements in a timely manner and the ultimate usefulness of the new reporting.

Harvard Pilgrim appreciates the opportunity to comment on this report.

Exhibit C: Instructions and OAG Questions for Written Testimony

Instructions:
On or before the close of business on September 16, 2013, electronically submit in both PDF and Microsoft Word format written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please submit any data tables included in your response in Microsoft Excel or Access format.

Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an `other-, `miscellaneous-, or similar category in any response, please explain what such a category includes.

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 questions regarding this process or regarding the following questions, please contact Courtney Aladro at Courtney.Aladro@state.ma.us or 617-963-2545:
Questions:

1. **Please submit a summary table 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 allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).**

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

   The impact of demographics on trend is -0.5% for 2010, 0.0% for 2011, and 0.2% for 2012. Benefit buy down affects the allowed trends via deterrence effect. The benefit buy down influencing the submitted actual trends are -1.0% for 2010, -0.7% for 2011, and -0.5% for 2012. These factors do not represent a portion of actual claims trend as requested. The buy down factors, do however, indicate that groups have changed their benefit plans from smaller member share to greater member share for each year. The effect of the change in health status is primarily incorporated in the demographic factors and is not developed separately at this time.

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

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

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)

Please refer to Section 2 Attachment 1 (OAG Exhibit C 2) for the tables containing the responses to questions a - f. At this time, we do not have any risk contracts for self-insured groups.

3. To the extent your membership in any of the categories reported 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 any such changes in membership.

The trends that Harvard Pilgrim sees in the movement of membership from 2009 to 2012 mirror earlier trends that we noted in last year's report. We continue to see a decline in fully-insured HMO/POS membership among large groups and an increase in self-insured membership. On the PPO side, we see increases in membership for both large and small groups. A more recent trend is the growth in membership, particularly in the small group market, in our limited and tiered network products that have been introduced largely since 2010. While these products are very new, they are generating a lot of interest.

The key reasons that we have observed for the increase in self-insured accounts are the following:

- Greater flexibility in developing plan benefit designs that meet the needs and desires of their employees
- Exemption from state mandated benefits
- Enhanced cash flow, as self-insured groups pay claims only after being billed by the health plan, whereas fully-insured premiums are paid in advance of rendered services
- Increased cost savings, as employers pay for actual claims incurred and not for administrative expenses levied by most health insurers

For PPO accounts, key reasons that we have observed for the increase in PPO membership are the following:

- Allows employers to offer their employees more choices in benefit packages that meet their needs and PPO products are particularly useful when a few employees may be located in other states and cannot use the Massachusetts network. Harvard Pilgrim has various arrangements to use provider networks outside of its service area so out-of-state employees can take advantage of the PPO option.
- Greater satisfaction among employees who are not limited to a closed network (e.g., HMO) and can see other providers of their own choice
- Provides an additional coverage option for dependents that live in other states

The increases in tiered and limited network membership are likely due to the following:

- Employers, particularly in the small group market, are becoming increasingly price-sensitive as premium increases that reflect increases in health care costs continue to outpace general inflation. Employers are seeking relief.
- Employee wage increases on average are not keeping up with increases in their share of the cost of insurance as employers shift more cost-sharing to their employees. As a result, employees are more cost-sensitive and more likely to consider a tiered or even a narrow network plan that offers lower premiums.
- Employers and employees are more willing to consider a tiered network plan that allows them the choice at point of service of going to particular providers with lower cost-sharing or going to a provider in the larger network but paying a higher copayment or coinsurance.

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, and insurance product populations to which your risk contracts apply (e.g., HMO, PPO, self-insured, fully insured).

Our portfolio of risk contracting models includes long established global payment and pay-for-performance programs and also a shared-savings model (structured similarly to CMS's shared savings model for Medicare ACO pilots) where participating provider groups are eligible to share in demonstrated savings when actual cost trends are below a pre-determined benchmark.

Harvard Pilgrim has been successful in transitioning many of our large- to mid-sized provider organizations from fee-for-service based agreements to either shared savings or risk-based global arrangements – with more planned for 2013. With each agreement, Harvard Pilgrim and the provider agree upon the appropriate level of risk for that group to initially assume. Harvard

Pilgrim has several financial models that are either shared savings (upside potential) or risk-based, including:

1. Full Capitation/Full Risk: Harvard Pilgrim pays the provider a direct capitation payment for all of their fully-insured Harvard Pilgrim HMO/POS members. The capitation payments are based on a negotiated percent of premium that Harvard Pilgrim collects from employer groups. The providers are at full risk for all medical and prescription drug claims expenses for these members.

2. Budgeted Capitation/Full Risk: The provider is at full risk for all medical and prescription drug claims expenses for all of their fully-insured Harvard Pilgrim HMO/POS members. Harvard Pilgrim pays the provider on a fee-for-service basis for the services he or she provided directly during the year. These capitations are based upon a negotiated budget reconciled and settled after the close of the year, or on managing the total medical cost compared to a blend of prior years' experience (a baseline "target").

3. Budgeted Capitation/Partial Risk: The same as the full-risk budgeted capitation model except that Harvard Pilgrim has shared risk with the provider (in surplus or in deficit beyond withhold).

4. Budgeted Capitation for limited services: Same budgeted capitation methodology as described above except the provider is at risk for the ambulatory and professional services, but is not at risk for inpatient and other institutional services or for prescription drug expenses. Also, the provider's maximum liability is limited to the claims withhold.

5. Shared Savings: Harvard Pilgrim pays the provider on a fee-for-service basis for the services he or she provided directly, and the provider has an opportunity to earn additional funding (upside only; no downside risk) based on managing the total medical cost compared to a blend of prior years' experience (a baseline "target") for all medical and prescription drug claims expenses for all of their fully-insured Harvard Pilgrim HMO/POS members.

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 members. 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.

Harvard Pilgrim does not currently offer financial risk models for our self insured membership. Our standard fully insured risk models have a number of mechanisms aimed at mitigating risk to providers participating in these models. These mechanisms include:

1) Reinsurance requirement - providers are required to purchase reinsurance from a company in order to participate in our risk models.
2) Predetermined caps/limits on deficits - in addition to reinsurance, the degree of risk is limited by specific caps on the losses a provider may incur.
3) Withhold requirements

4) Change in DxCG health status adjustment - Harvard Pilgrim reviews the provider's performance and risk pool in the previous year and makes any necessary health status adjustment for the following year.
5) High cost case truncation (typically $100,000) may be permitted by Harvard Pilgrim as part of the negotiation process with providers.
6) Out of area claims exclusions have been permitted by Harvard Pilgrim in the past, although these are very limited.

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.

One of Harvard Pilgrim's primary areas of focus is evaluating a provider's ability to bear risk. In carefully considering a group's capability to successfully participate in a risk contract, Harvard Pilgrim evaluates the following:

One of Harvard Pilgrim's primary areas of focus is evaluating a provider's ability to bear risk. In carefully considering a group's capability to successfully participate in a risk contract, Harvard Pilgrim evaluates the following:

- Demonstrated leadership—including alignment of member physicians, reporting structure, and communication programs
- Organizational accountability, infrastructure, and governance—including having the structure and systems in place to appropriately balance and manage the interests of various constituents in order to meet challenges and improve overall value of care for members
- Process and program capabilities—Including overall care coordination and population management
- Clinical integration—within the group and among specialists and hospital referral affiliations
- Assessment of Health Information Technology (HIT) infrastructure—including electronic medical record (EMR) capabilities and the existence of a data warehouse

For several years, we have helped groups develop processes so as to function with a common vision and objectives. These characteristics now form the backbone of their ability to come together as accountable care (and/or risk bearing) organizations, and include:

a. Health Information Technology: Harvard Pilgrim measures and rewards groups based on practice level surveys and their performance against an extensive set of quality metrics. In addition, we often award groups quality grants to promote practice transformation, which contain rigorous requirements to adhere to milestones. These initiatives have been in place and have evolved over the past ten years and have helped drive positive change in the market.
b. Leadership: Harvard Pilgrim requires committed clinical leadership to promote change within their groups. Harvard Pilgrim provides incentives to develop this leadership, and then offers reporting to monitor compliance and success in meeting targets. Medical leadership is also required to attend regular medical director meetings where objectives are developed, and results as well as any barriers encountered are discussed.
c. Communication vehicles: Harvard Pilgrim has developed a series of communication vehicles both within and between provider groups. These have provided Harvard Pilgrim with input (questions, concerns, etc.) to which we respond on a regular basis.

d. Patient centered care coordination: Care coordination is an essential element of practice transformation, and is a required element of Harvard Pilgrim's criteria. Requirements include the use of advanced directives, standards for MD-to-MD and patient-to-MD communication, and outcomes reporting to Harvard Pilgrim with documentation.
e. Internal programs based on recognition and/or financial incentives, the outcomes of which are reported to Harvard Pilgrim and shared with colleagues in the medical director meetings referenced above.

A growing key to a group's success is the ability to monitor, manage and improve performance, particularly when working to succeed within a risk arrangement. High value, timely, detailed information is therefore essential. Over the past decade, Harvard Pilgrim has developed sophisticated tools to support our provider partners. These include a range of solutions, such as on-line, self-service dashboards with detailed, user-directed drill-down pathways, as well as standard and ad hoc reporting. Analytics available include:

- Cost and utilization metrics across all sites and types of care
- Quality measures across domains such as HEDIS, gaps in care and pharmacy
- Patient characteristics that help orient care coordination efforts
- Consultative engagement to pinpoint areas of opportunity and interventions likely to generate improvement.

7. Please explain and submit supporting documents that show for each year from 2009 to 52013 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 network 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.

Our limited network product, called "FOCUS" was launched in January 2011 in the Worcester area and was subsequently expanded to our general service area in April 2012. Since the launch there has been about a 10% pricing differential between the FOCUS network and a comparable full network product (FOCUS is less expensive by 10%). The differential in pricing is due to higher cost providers being excluded from the market and that utilization shifting to lower cost providers. We did not assume any selection effect, where members with lower utilization would gravitate towards the limited network product.

Our tiered network product, called "ChoiceNet" was launched in July 2011. This product tiers the hospitals and physicians based on cost and quality measures. Since the launch there has been about a 7% pricing differential between the ChoiceNet network and a comparable full network product (ChoiceNet is less expensive by 7%). The differential in pricing is due to utilization shifting to lower cost providers where the member cost sharing is also lower. We did not assume any selection effect, where members with lower utilization would gravitate towards the limited network product. Note, Harvard Pilgrim also markets a tiered network product called "Hospital

Choice" which only tiers hospitals and not physicians. The pricing for this product is about 6% lower than the full network product.

In a recent study of the FOCUS network, we have discovered that in a dual option situation, where a limited network is offered alongside a broad network, that on average members with lower medical claims select the limited network product. This effect is even greater than a health risk measure (DxCG) would indicate. So there appears to be a self-selection effect of low-utilizing members selecting the limited network.

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.

Harvard Pilgrim's approach to wellness reflects our belief that supporting a healthy lifestyle is by far the simplest and most cost-effective way to protect and maintain health. We have both integrated and "buy-up" wellness program options for our employer groups.

Harvard Pilgrim believes wellness is a practice. It's not what a person is, it's what a person does. Anyone can do it, at any stage of life. Every choice made, even a small choice, that helps move the individual toward better health – whether that means physical, emotional, or spiritual health – is practicing wellness.

Wellness integrates physical, emotional and spiritual vitality; creates balance among relationships, family, work and community; and supports in us a sense of stability and harmony. Each person's wellness story is unique and evolving, changing over the course of a lifetime.

To that end, we offer our clients a robust wellness program, which includes an integrated wellness suite that carries no additional charges to the employer, as well as a menu of buy-up options for more flexibility and customization.

We have not conducted cost-benefit analyses of our suite of programs, but generally review the research literature in this area as well as listen to what our employer groups and members are asking for to choose our program offerings. We will measure relevant process and outcome metrics for a particular employer account to determine whether a program is meeting its objectives.

Please see Section 2, Attachments 2, 3 and 4 (OAG Exhibit C 3) for a description of our integrated suite of programs and "buy-up" options as well as sample analytic tools.

Exhibit C1 AGO Questions to Payers Total Allowed Medical Expenditure Trend by Year

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 2010	4.1%	-1.1%	0.0%	-0.8%	2.3%
CY 2011	4.5%	-0.7%	0.0%	-0.7%	3.1%
CY 2012	4.4%	-0.8%	0.0%	0.2%	3.7%
YE Q1 2012 (April 1, 2011 - March 31, 2012)					4.0%
YE Q1 2013 (April 1, 2012 - March 31, 2013)					1.6%

Notes:
1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix changes. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.
2. PROVIDER MIX is defined as the impact on trend due to the change in the types of providers. 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.

Exhibit D: Instructions and CHIA Questions for Written Testimony

Instructions:

On or before the close of business on September 16, 2013, electronically submit in both PDF and Microsoft Word format written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please submit any data tables included in your response in Microsoft Excel or Access format.

Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an `other-, `miscellaneous-, or similar category in any response, please explain what such a category includes.

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 questions regarding this process or regarding the following questions, please contact Steve McCabe at Steve.McCabe@state.ma.us or 617-988-3198:

Questions:

1. Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?

a. If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.

Harvard Pilgrim does not participate in the Massachusetts Medicare Pioneer Accountable Organizations initiative and has not analyzed information concerning this initiative. We do lead several Patient Centered Medical Homes initiatives and have done some analysis of the data, particularly for the Commonwealth of Massachusetts Group Insurance Commission. However, we are still in the early phases of these initiatives and have not yet performed the more comprehensive analysis described in this question.

Harvard Pilgrim's Patient Centered Medical Homes (PCMH) initiatives focus on developing different care delivery models that permit providers, with varying levels of sophistication and specialties to participate in outcomes-based payment frameworks that promote value (high quality/low cost). Currently, our active Harvard Pilgrim-led PCMH initiatives in Massachusetts are with Lahey Clinic (3,162 members), Beth Israel Medical Center's Health Care Associates (6,597 members) and Northeast Health Systems Physician Hospital Organization (3,524 members). We also support UMass Memorial Medical Center's PCMH (1,471 members). If Southern NH Health System, another Harvard Pilgrim-led PCMH, is added, close to 21,000 Harvard Pilgrim commercial members will be in PCMH programs.

Between July 1, 2011 and June 30, 2013, our overall Harvard Pilgrim network experienced an increase in its cost trend of approximately 3.1%. However, our Harvard Pilgrim-led PCMH initiatives experienced a decrease in their cost trend of approximately 1.6%. Utilization trends for the Harvard Pilgrim-led PCMHs were mixed. They decreased in the areas of pharmacy, hospital inpatient admissions and emergency visits. Moderate increases were seen for outpatient day surgery, primary care services and ancillary services.

Harvard Pilgrim's Informatics area has built an on-line dashboard and is starting to see good uptake with contracted groups. The current dashboard tracks costs, utilization and risk, and we will be adding quality metrics related to gaps in care by the end of 2013. As we build membership and data for our PCMH initiatives, we will be able to perform more comprehensive and reliable analyses that compare the performance of our Harvard Pilgrim-led PCMH initiatives against that of our overall network.

SECTION 2

ATTACHMENT 1

RESIDENCE	SEGMENT	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	15,513	19,087	19,045	17,928
MA	Commercial Large Group	475,282	472,787	456,806	452,156
MA	Commercial Small Group	110,694	131,118	141,103	143,773
MA	Medicare	31,983	36,111	24,801	34,809
TOTALS		**633,472**	**659,103**	**641,755**	**648,666**

NOTE: Reflects membership for MA residents on MA contracts in Core products only. HPI and United membership are not included here.

RESIDENCE	SEGMENT	CONTRACT TYPE	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	Risk Contract / Shared Savings	4,333	4,892	8,434	9,950
MA	Commercial Large Group	Risk Contract / Shared Savings	53,391	50,831	89,361	80,688
MA	Commercial Small Group	Risk Contract / Shared Savings	26,606	29,792	57,434	78,289
MA	Medicare	Risk Contract / Shared Savings	0	0	0	0
TOTAL			**84,330**	**85,515**	**155,229**	**168,927**

NOTE: Reflects membership for MA residents in MA contracts for Core products only.

RESIDENCE	SEGMENT	PRODUCT	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	FI HMO/POS	13,714	16,349	15,779	14,396
		FI PPO	1,799	2,738	3,266	3,532
		Commercial Individual Subtotal	**15,513**	**19,087**	**19,045**	**17,928**
MA	Commercial Large Group	FI HMO/POS	196,493	188,896	177,187	134,600
		FI PPO	15,638	19,519	19,487	25,353
		SI HMO/POS	188,778	185,493	191,214	216,980
		SI PPO	74,373	78,879	68,918	75,223
		Commercial Large Group Subtotal	**475,282**	**472,787**	**456,806**	**452,156**
MA	Commercial Small Group	FI HMO/POS	97,729	114,052	120,676	120,526
		FI PPO	12,965	17,066	20,427	23,247
		Commercial Small Group Subtotal	**110,694**	**131,118**	**141,103**	**143,773**
MA	Medicare	FI Medicare	27,641	31,504	19,290	28,840
		SI Medicare	4,342	4,607	5,511	5,969
		Medicare Subtotal	**31,983**	**36,111**	**24,801**	**34,809**
TOTAL			**633,472**	**659,103**	**641,755**	**648,666**

NOTE: Reflects membership for MA residents on MA contracts in Core products only. HPI and United membership are not included here.

RESIDENCE	SEGMENT	NETWORK TYPE	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	Tiered Network (broad definition)	1,265	3,376	6,482	7,100
MA	Commercial Large Group	Tiered Network (broad definition)	155,038	171,183	176,887	251,114
MA	Commercial Small Group	Tiered Network (broad definition)	1,845	2,045	3,316	4,960
MA	Medicare	Tiered Network (broad definition)	0	0	0	0
TOTAL			**158,148**	**176,604**	**186,685**	**263,174**

NOTE: Reflects membership for MA residents on MA contracts in Core products only. HPI and United membership are not included here.

A 'Tiered Network' product is defined in this exhibit one where . . .

(1) the network is stratified based on cost/quality (Choice Net, GIC, Hospital Prefer)

(2) the product on the network have a copay differential based on the type of provider rendering services to the member (PCP vs. Specialist)

(3) the network uses copay/deductible incentives to steer members to one particular facility over another (e.g., customzied products for hospital employer groups, such as BIDMC and Lahey).

RESIDENCE	SEGMENT	NETWORK TYPE	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	Limited Network	0	0	39	102
MA	Commercial Large Group	Limited Network	0	0	277	6,465
MA	Commercial Small Group	Limited Network	0	0	570	2,006
MA	Medicare	Limited Network	0	0	0	0
TOTAL			**0**	**0**	**886**	**8,573**

NOTE: Reflects membership for MA residents on MA contracts in Core products only. HPI and United membership are not included here.
The Limited Network membership reflected here is for two products only: HMO Focus (JA) and the BIDMC Limited Network HMO (JE).

RESIDENCE	SEGMENT	PRODUCT TYPE	DEC09	DEC10	DEC11	DEC12
MA	Commercial Individual	Qualified High-Deductible Plan (HSA)	809	1,585	2,198	2,585
MA	Commercial Large Group	Qualified High-Deductible Plan (HSA)	3,378	4,560	5,135	6,775
MA	Commercial Small Group	Qualified High-Deductible Plan (HSA)	4,884	6,601	8,747	11,248
MA	Medicare	Qualified High-Deductible Plan (HSA)	0	0	0	0
TOTAL			**9,071**	**12,746**	**16,080**	**20,608**

NOTE: Reflects membership for MA residents on MA contracts in Core products only. HPI and United membership are not included here.
The Qualified High-Deductible membership reflected here is for our PPO and HMO HSA products only.
(No other high-deductible membership is included here.)

ATTACHMENT 2

Harvard Pilgrim Wellness Programs and Resources

INTEGRATED SUITE

Personal assistance & support for members

- Lifestyle Management Coaching
- DecisionAssist
- Total PharmAssist
- Self-care and screening reminders
- Well Rx
- Health Links Finder

Building Community at Work

- Participation tracking for incentives

Getting Local

- Volunteering connections
- Your Health

Financial wellness – discount programs, making every dollar count

- *Your Member Savings*
    - Complementary and Alternative Medicine
    - Footwear @ Marathon
    - Weight Watchers
    - Diet.com
    - Care Scout
    - Mindfulness Based Stress Reduction
    - Senior Assist
- Fitness Reimbursement*
- Health Education classes

Self-Serve Tools for Members

Interactive self-help modules

- Health Questionnaire (HQ)
- My Way to Better
- Symptom Checker (through *Health Topics A-Z*)
- Action Sets (through *Health Topics A-Z*)
- Decision Points (through *Health Topics A-Z*)
- Mindfulness e-resources
- Smoking Cessation

Research & self-education

- Wellness Web site – identify tools/info/programs by life stage & need
- *Health Topics A-Z*
- Web Library
- Interactive Health Tools
- Access Healthywood

Managing personal healthcare & health information

- Personal Health Record (PHR)
- Preventive Care Recommendations
- WebMD Hospital Advisor

** In Massachusetts, beginning in January 2014, the fitness benefit is included in all merged market plans as part of the essential health benefits package under the ACA.*

BUY-UP Options for Employers

Worksite Programs: Harvard Pilgrim…At Work for You

For employers who want to invest in more customized programming. Multiple channels: On-site, mail, web/DVD, phone, videoconference

- Health screenings, flu clinics
- Biometric tracking
- Mindfulness training (on-site and soon online)
- Multi-session incentive programs
- Interactive workshops
- Face-to-face coaching
- Cooking demonstrations
- On the Go options for remote workforce and others
- The Full Yield
- Health Questionnaire enhancements (reporting, paper, non-member implementation)

PROGRAM DESCRIPTIONS

Lifestyle Management Coaching

Our Telephonic Lifestyle Management Coaching program provides personalized, telephonic support to help members make informed decisions about their lifestyle management opportunities. The Coaching program is available to all members over 18 and concentrates on:

- Blood pressure control
- Weight management
- Exercise
- Cholesterol management
- Nutrition
- Smoking cessation
- Stress reduction and life balance

Members are identified for inclusion of the Coaching program through the completion of a Health Questionnaire, on-site employer health fairs, care and disease management programs, and self-referral.

DecisionAssist

Harvard Pilgrim's *DecisionAssist* program offers members telephonic resources to help them make informed health care decisions for upcoming procedures and treatments. In an environment of increased cost sharing and health care complexity, *DecisionAssist* offers confidential, personalized decision-support services. *DecisionAssist* Nurse Care Managers empower members to participate more fully in their own health care decisions.

Total PharmAssist

Our pharmacists are available to answer members' questions about their elder loved one's medications, and will provide members with expert advice on interactions, taking them correctly, and more.

Self-care and Screening Reminders

Harvard Pilgrim regularly performs patient outreach to ensure routine preventive care and to improve early detection of disease and subsequent outcomes. Preventive health outreach efforts include mail and/or telephonic reminders to inform members they are due for preventive services such as mammograms, Pap smears, colorectal cancer screening, pediatric immunizations, diabetic eye exam, or influenza immunization.

Well Rx

Our Well Rx program can empower members to make healthy medication decisions. Our pharmacists will help members make safe, smart choices about medications, herbal supplements, vitamins and cough and cold products. The program's mission is to help members Be Well, Stay Well and Get Well!

Health Links Finder

Members can use this member-only service to receive personalized assistance in researching health topics online.

Participation Tracking for Incentives

Harvard Pilgrim can manage incentive tracking for our clients, and can also assist with an incentive plan design - we work collaboratively with employers to help define the particular approach and related incentives that are most effective for the group. Harvard Pilgrim has extensive experience in supporting employer-sponsored incentives for:

- Health questionnaires
- Walking program
- Biometric screenings

Member Newsletter: *Your Health*

Your Health, Harvard Pilgrim's member newsletter, arms members with actionable health and wellness information to help them improve their well-being. In addition to prevention-focused articles, the newsletter provides information on the latest programs and health improvement tools offered by Harvard Pilgrim, including online resources; benefit updates, and special events. Additionally, preventive screening guidelines and NCQA notices are published in the newsletter on an annual basis.

Health Education Classes

Harvard Pilgrim offers more health education programs than any other plan in New England. Approximately 1,000 classes per year are offered at Harvard Pilgrim provider and nearby community locations. These include standard risk reduction programs (such as smoking cessation and stress management), illness- or injury-related courses (such as asthma management, AIDS, diabetes management, and back care), and wellness classes (such as parenting and fitness). Most programs are available to our members at a discounted fee, and are also open to the community at large. In addition to on-site programs, we offer health information through other channels such as video, web and phone counseling. A listing of available programs is available on our Web site, *www.harvardpilgrim.org*.

Health Questionnaire - Harvard Pilgrim's Health Questionnaire (HQ) was developed in collaboration with the University of Michigan Health Management Research Center. The Harvard Pilgrim HQ is backed by more than 20 years of research and addresses 17 medical conditions, including mental health, productivity issues, major health risks, and biometric data. Members who complete an online HQ immediately receive an easy-to-read Individual Profile that offers a comprehensive picture of his or her health status, and identifies key risk factors. The individual is provided with actionable information on how to reduce risks by changing specific health behaviors in each health category. The report also offers action item to help individuals react to their HQ results, including prompts to speak with a physician or health care provider, and links to relevant educational materials.

My Way to Better

This engaging new online tool allows users to chart their own personalized roadmap to optimal living. *My Way to Better* is a short, fun, visual, interactive questionnaire that serves as a profiling tool to assess a user's attitudes and behaviors. It's not a health risk appraisal; in fact, most questions have nothing directly to do with health. Based on the user's responses to several such tailoring questions (e.g. sociability, active vs. passive personality, etc.), their profile is established. *My Way to Better* then showcases Harvard Pilgrim's top wellness hits, customized for the user based on that profile. People can print their results and refer to them later, or go back and create a new roadmap as their preferences change.

Symptom Checker

Members can use a clickable body map to access symptom topics that can help determine what to watch for or when to call their health professional (e.g. Chest Pain, Allergic reactions)

Action Sets

Actionable steps that can help manage a disease, or address early health concerns that can lead to lifelong problems (e.g. Taking charge of asthma, Preventing high blood sugar emergencies from diabetes)

Decision Points

Frameworks and information that consumers and their doctors can use to make wise health decisions (e.g. Which test should I have to screen for colorectal cancer? What should I do if I'm at high risk for breast cancer?)

Mindfulness e-Resources

In another example of programming innovation, Harvard Pilgrim offers cutting-edge programs that bring Mindfulness to the workplace as a stress management tool. Leverage Mindfulness techniques to manage stress, boost concentration, reduce blood pressure, and build the immune system. To make the programs accessible to any size employer group, we offer multiple delivery formats including online self-help resources at no charge. We also offer buy-up options for on-site instructor-led programs, and web-based interactive learning modules.

Smoking Cessation

Members trying to quit smoking can get the support they need. We offer free telephone or online counseling services, quit tips and much more through multiple channels, and translation services are available as well.

Wellness Web site

Harvard Pilgrim's wellness portal at www.harvardpilgrim.org/wellness uses a lifestyle-oriented approach to showcase our entire suite of wellness programs and resources for members. Our site guides members to resources that are timely and relevant for them, based on the life stage (or

stages) they most identify with. For example, members may be drawn to our "Work & Life Balance" page because they are juggling multiple work and home priorities - career, personal wellness, financial health, the care of loved ones both younger and older than themselves. This page will connect them with concrete, actionable information, such as how to sneak more physical fitness into a busy day, when to call a doctor for a particular symptom, or where to get member discounts on eldercare needs. Recognizing that our members access and use information in myriad ways, our wellness resources are practical, easy-to-use and varied. They include:

- Symptom Checker
- Interactive quizzes and tools
- Decision Points and Action Sets
- Discounts on health-related products and services
- Information about programs available in their own communities
- Member savings on wellness-related products and services
- And much more

Health Topics A-Z

Health Topics A-Z provides reliable and comprehensive online health information to help people make better health decisions. Members can use this feature, which is powered by the Healthwise® Knowledgebase, to research questions about health and wellness, medical conditions, tests and treatment options, and more. Easy-to-use, with interactive tools and helpful illustrations, *Health Topics A-Z* provides evidence-based health information in a consumer-friendly and printable format.

The Web Library

Our online web library offers a carefully selected collection of links to external peer-reviewed health Web sites.

Interactive Health Tools

Our online interactive tools available through *Health Topics A-Z* allow people to receive tailored health information by entering their personal data (e.g. Is Your Weight Increasing Your Health Risks? How to use a food record to track and improve your diet.)

Access Healthywood

With the help of a bunch of zany animated characters, our Access Healthywood videos will help parents partner with their children in separating real and naturally delicious foods from their phony, sneaky counterparts. These videos make picking the right kinds of food look really easy,

and that's because it is really easy, once a parent or child knows what to look for. We offer these videos free either online or in DVD format.

Personal Health Record (PHR)

The Personal Health Record helps members view and manage a complete picture of their personal health history. Features include medical history (i.e. immunizations, and procedures), provider visit summary, illness/conditions history, a health event record, social history, and a health tracker tool. Members can choose whether or not to permit their providers to view their PHR, and can export their PHR for easy portability.

Preventive Care Recommendations

Through our Web site, members can check Harvard Pilgrim's latest recommendations for screening tests and immunizations to keep them healthy.

***WebMD* Hospital Advisor**

Harvard Pilgrim members have access to a consumer decision-support tool, *WebMD* Hospital Advisor. *WebMD* Hospital Advisor compiles data that hospitals typically provide to government agencies and to organizations such as the Leapfrog Group and CMS. *WebMD* Hospital Advisor displays comparative hospital cost information and cost ranges for inpatient procedures. This tool also includes educational information about treatment options and what to expect for over a hundred and fifty different conditions and procedures. It allows consumers to rate the important importance of various convenience, safety, and quality characteristics of hospitals and receive a display of hospitals that best fit their preferences.

Worksite Employer Wellness Program: Harvard Pilgrim... *At Work for You*

Harvard Pilgrim's *...At Work for You* worksite wellness program is managed in house to provide the personal touch and flexibility necessary to deliver programs that are tailor-made for each worksite. Our dedicated team of health advisors reviews existing data with our clients, including utilization, demographics, special interests, and culture to create a worksite program series to address areas such as medical cost reduction, wellness, productivity, and absenteeism. Activities offered range from health risk screening programs and single session workshops to longer term, incentive-based behavior change programs that are available through multiple channels, including on-site and web-based programs. In addition to integrating these worksite events within our disease management programs, we also work with clients to ensure we optimize participation in other related employer-sponsored benefits (e.g., fitness discounts, smoking cessation initiatives, etc.). Here's a sampling of the types of programs we can offer:

- **Disease management:** heart health, gastrointestinal disorders, diabetes care, asthma care and cancer awareness
- **Prevention and screenings**: blood pressure, vision, body composition, diabetes, flu clinics, bone
- density and cholesterol

- **General health**: women's health, men's health, strategies to quit smoking, allergy workshop,
- weight management, pregnancy, nutrition, getting active, parenting of teens, ergonomics and understanding headaches
- **Balancing life and alternative complementary therapies (workshops, demos and courses)**: stress management, acupuncture, chiropractic, massage, t´ai chi, yoga and balancing work/family

A complete list and pricing information is available upon request.

Wellness Program Impact Analysis

Harvard Pilgrim works with its clients to determine meaningful expectations from clinical programs, including, when appropriate and when meaningful, ROI guarantees.

Harvard Pilgrim considers its Wellness and Disease Management programs essential to its members, working hard to keep members healthy, as well as to improve the health of those members with medical conditions. We are continuously working on innovative ways to demonstrate and measure the impacts of these programs, both qualitatively (member comments, surveys, etc) and quantitatively (medical & pharmacy claim impacts). We engage in this work with industry leading consultants, our research Institute at Harvard Medical School, and clients themselves. As current literature indicates, there are many factors influencing medical expense outcomes, from benefit designs to avoidance of unnecessary Emergency Room visits and Inpatient Admissions. Our mature Disease Management programs dealing with Common Chronic conditions (Asthma, Diabetes, Heart Disease, COPD, etc.) already have achieved low baseline Emergency Room and Inpatient utilization, making additional significant improvement guarantees problematic. Upon consultation with our customer, which includes an assessment of their unique goals and programs, we will develop a mutually agreed upon approach that evaluates the most appropriate and relevant metrics.

Please refer to Attachment DDD for a sample table of our Wellness Program Impact Analysis. Attachment CCC further demonstrates our Wellness Program Impact Methodology.

ATTACHMENT 3

Wellness Program Analysis (Methodology)

- Evaluated the relative risk of each member using a sophisticated, research-quality methodology reviewed by the Department of Population Medicine at the Harvard Pilgrim Health Care Institute
- Paired “Participants” and “Non-Participants” employees by demographic and clinical similarity
  - Came up with ### closely matched employees for each population
    - Removed Maternity & NICU, High Cost Claimants and Disease Management Program participants from both populations
  - Matched on multiple dimensions to ensure comparability
    - Age and sex
    - Similar constellation of clinical conditions (diagnoses on claims)
    - Chronic illnesses of a similar degree of severity
- **Main difference between populations is participation in Healthy Returns**
  - Differential outcomes can be attributed to the program
  - Projected cost differentials can reasonably be claimed as “savings”
  - Populations numbers are great enough to establish statistical significance

ATTACHMENT 4

Wellness Impact Analysis

Matched cohort study of Wellness Program participants, 2010-2012
Participants have min 1 biometric event in each of 2010-2012
Participants and non-participants were continuously enrolled in each meausurement year.
Participants and non-participants with > 50k or participation in DM program were dropped.

	Participants				Non-Participants			
	2010	**2011**	**2012***	**% Change**	**2010**	**2011**	**2012***	**% Change**
Members								
Member Months								
DxCG Age/Sex								
DxCG Concurrent								
DxCG Prospective								
Ancillary Services PMPM								
Behavioral Health PMPM								
Facility Based Physician PMPM								
Hospital Inpatient Facility PMPM								
Hospital Outpatient Facility PMPM								
Office Visit Physician PMPM								
Rx PMPM								
Total Medical Expense PMPM								
IP Admits/1000								
IP Days/1000								
IP ALOS								
ER Visits/1000								
OP Hospital Visits/1000								
Rx Scripts PMPM								

* 2012 claims dates of service1/2012- 10/2012, paid through 12/2012

ROI Calculation

Participant TME PMPM Diff	$0.00	
Non-Participant TME PMPM Diff	$0.00	
Par over Non-Par PMPM Reduction	$0.00	
Par Member Months (24 month peri	0	
Savings	$0.00	
Benefit Reimbursement Expense	$0.00	
ROI	**#DIV/0!**	**:1**