

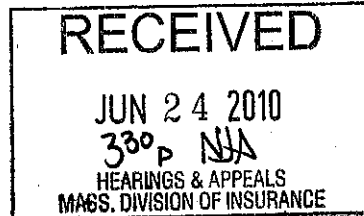


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COMMISSIONER OF INSURANCE

Harvard Pilgrim Health Care, Inc., Petitioner,
v.
Division of Insurance, Respondent

Docket No. R2010-02

FINAL AGENCY DECISION

I. PROCEDURAL HISTORY

Harvard Pilgrim Health Care, Inc. ("HPHC") on March 2, 2010, filed with the Division of Insurance ("Division") proposed rates for all small group products offered or renewed in the Massachusetts merged market on or after April 1, 2010. The filing was made pursuant to 211 CMR 43.00 *et seq.* as amended on an emergency basis on February 10, 2010 ("the Emergency Regulation").¹ The Commissioner of Insurance ("Commissioner") reviews rates for small group products offered or renewed in the Massachusetts market pursuant to G.L. c. 176G § 16, which provides in pertinent part as follows:

The subscriber contracts, rates and evidence of coverage shall be subject to the disapproval of the commissioner. No such contracts shall be approved if the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory. Classifications shall be fair and reasonable.

¹ All references and citations in this Decision to any section or subsection of 211 CMR 43.00 *et seq.* are to the Emergency Regulation that was promulgated on February 10, 2010. The Emergency Regulation governs all aspects of this hearing.

On April 1, 2010, after the Division deemed the filings complete (see 211 CMR 43.08), the Health Care Access Bureau ("Bureau") in the Division notified HPHC by letter that, with one exception, the rates for its small group products were disapproved ("Disapproval Letter").²

On April 2, HPHC requested a hearing on the disapproval pursuant to 211 CMR 43.08.³ The Bureau represented the Division in the hearing; the Office of the Attorney General participated as an intervenor. Susan L. Donegan, Esq., Jean F. Farrington, Esq. and Stephen M. Sumner, Esq. were designated as presiding officers for the hearing. The Commissioner delegated final authority for the Division's decision to Presiding Officer Donegan.

II. FINDINGS OF FACT, ANALYSIS, DISCUSSION AND CONCLUSIONS ABOUT THE REASONS FOR DISAPPROVAL STATED IN THE DISAPPROVAL LETTER

The Disapproval Letter enumerated several specific reasons for the Division's conclusion that HPHC's proposed rates were "unreasonable in relation to the benefits provided and excessive." G.L. c. 176G, § 16. Each reason specified was identified as an independent basis for disapproval of HPHC's proposed rates. HPHC's burden in this proceeding is to prove that each of the reasons for disapproving its rates as stated in the Disapproval Letter is incorrect.

References to the evidentiary record for the findings of fact that follow identify support for each finding, but are not necessarily exhaustive or exclusive.

A. Disapproval Letter Reason 1(a): Differing Rates of Reimbursement

"HPHC's Filing contains rates that are unreasonable and excessive because HPHC's Filing fails to demonstrate that HPHC is paying providers differing rates of reimbursement solely based on the criteria identified in 211 CMR 43.08(10). . . . a) HPHC's Filing fails to illustrate how HPHC is paying providers differing rates of

² HPHC's Core Coverage 1500 HMO product was deemed not disapproved. See page two of the Disapproval Letter.

³ Our jurisdiction over HPHC's appeal of the Disapproval Letter arises from the last paragraph of 211 CMR 43.08, which provides as follows:

If the Commissioner disapproves a filing, he shall notify the HMO in writing no later than the effective date of the rates or changes, and he shall state the reason(s) for the disapproval. The HMO may request a hearing on the disapproval to be held within 30 days of the notice by filing a written request with the Division of Insurance for a hearing within 15 days of its receipt of such notice. The Commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The HMO may not implement the disapproved rates, or changes at any time unless the Commissioner reverses the disapproval after a hearing or unless a court vacates the Commissioner's decision.

reimbursement solely based on (a) quality of care, (b) mix of patients, (c) geographical location at which care is provided, or (d) intensity of services provided, as identified in 211 CMR 43.08(10)." Exhibit 13, pp. 2-3.⁴

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 1(a)") was HPHC's failure to demonstrate that it pays different reimbursement rates to similarly situated providers ("differential reimbursement") based solely on quality of care delivered, mix of patients, geographical location at which care is provided, and intensity of services provided; four bases that are articulated in 211 CMR 43.08(10) ("the four articulated Regulatory bases"). 211 CMR 43.08(10) required HPHC to provide the following documentation in its filing (emphasis added):

(10) If the HMO intends to pay similarly situated providers different rates of reimbursement, a detailed description of the bases for the different rates *including, but not limited to:*

- (a) Quality of care delivered;
- (b) Mix of patients;
- (c) Geographic location at which care is provided; and
- (d) Intensity of services provided.

Findings of Fact:

1. HPHC's contracted reimbursement rates vary for providers of similar services. Exhibit 4, ¶ 10; Exhibit 14 (SERFF), Tab I. B. Attachment 2 Question 10; Tr. 177-178.⁵
2. HPHC's differential reimbursements are not based solely on the four articulated Regulatory bases. Tr. 177-178.
3. The cost structures of, and therefore the reimbursement payments to, hospital providers differ depending on whether they are tertiary and teaching hospitals or are "disproportionate share hospitals." Exhibit 6, p. 29.
4. HPHC's variations in reimbursement rates often are not attributable to the quality or complexity of the care provided. Exhibit 4, ¶ 10.

⁴ References to Exhibits are to the Final Exhibit List dated May 17, 2010.

⁵ All references to oral testimony in this proceeding (*viz.* "Tr.") are to pages of the transcript of May 5, 2010.

5. HPHC's variations in reimbursement rates are due primarily to the market power of certain providers, which derives from size, brand reputation or geographic location. Tr. 178-179; Exhibit 4, ¶ 10.

6. Some providers in geographic areas have been unwilling to contract with HPHC except at a level *they* deem appropriate. Exhibit 4, ¶ 11.

7. Some providers in certain provider specialties have been unwilling to contract with HPHC except at a level *they* deem appropriate. Exhibit 4, ¶ 11.

8. The Massachusetts health insurance merged market is competitive, with companies looking to expand their membership at the expense of other companies. Tr. 92.

9. If a provider is the sole provider in a geographic area, HPHC risks losing membership in that area unless it includes that provider in its network. Exhibit 4, ¶ 11; Tr. 225-226.

10. HPHC might risk not satisfying network adequacy requirements under 211 CMR 43.04(3)(i) unless a provider that is the sole provider in a geographic area is included in its network, and this would limit its ability to sell new business in the area. Exhibit 4, ¶ 11; Exhibit 14 Attachment 2.

11. Particularly in the Boston area, some providers have developed a "brand" in terms of the types of care or services that they provide, and employers and members expect such providers to be included in any HPHC network. Exhibit 4, ¶ 11; Exhibit 6, pp. 28-29.

12. Large employers have stated that they would leave HPHC for another carrier when HPHC proposed to exclude from its network providers who were charging what HPHC considered to be an excessive rate. Exhibit 1(X)(17), p. 3.

13. Surveys of employers undertaken by HPHC have shown that limited networks are not popular products in Boston. Exhibit 6, p. 29.

14. Employers expect well-known and highly respected facilities and physician groups to be in their HPHC network. Exhibit 6, p. 29.

15. The reputation of "branded" providers gives them a good deal of leverage in their contract negotiations with HPHC. Exhibit 4, ¶ 11; Exhibit 6, p. 29.

16. The primary foundation of market power is the size and magnitude of certain "branded" integrated delivery systems or their centrality in the medical community given the specialized care they provide. Exhibit 4, ¶ 11; Exhibit 6, pp. 29-30.

17. Market power enables “branded” providers to demand and receive reimbursement far in excess of that paid to other providers. Exhibit 4, ¶ 11.

18. Larger “branded” entities use their higher rates of reimbursement to successfully recruit physicians, both primary and specialty, from competing but smaller and less well-reimbursed entities. Exhibit 4, ¶ 11; Exhibit 6, p. 30.

19. The ability of larger “branded” entities successfully to recruit medical talent based on higher rates of reimbursement has an inflationary ripple effect on reimbursement unit costs because competing community-based providers, in response, demand higher rates of reimbursement so they can compete against the larger entities and retain their physician base. Exhibit 4, ¶ 11.

20. Another ripple effect on reimbursement unit costs comes from the geographical expansion into the suburbs of larger “branded” entities, because the rates that HPHC pays these suburban expansions are close to or the same as the rates for Boston academic medical centers. Exhibit 6, p. 27.

Analysis, Discussion and Conclusion

21. The Emergency Regulation does not characterize the four articulated Regulatory bases as the exclusive bases for justifying differential reimbursement; to the contrary, the Emergency Regulation explicitly acknowledges that the four articulated Regulatory bases constitute less than all the possible grounds for paying similarly situated providers different rates of reimbursement.

22. The Disapproval Letter, in disapproving HPHC’s rates for failing to base differential reimbursements solely on the four articulated Regulatory bases, overlooks the Emergency Regulation’s acknowledgment that other reasons may support such differential reimbursements.

23. Because of factors such as the economic realities of brand leverage, member and employer preferences, network adequacy requirements, and provider expansion into the suburbs, HPHC has no realistic option in the competitive small group health insurance market but to reimburse providers of similar services at different rates based on reasons beyond the four articulated Regulatory bases.⁶

⁶ HPHC stated that the Commonwealth’s existing regulatory structure presents few obstacles or financial disincentives for the expansion of the integrated systems tied to Boston academic medical centers into communities

24. *Conclusion:* HPHC has illustrated and proved that there are valid reasons that explain and justify its differential reimbursements to providers; accordingly, the disapproval of HPHC's rates based on Disapproval Letter Reason 1(a) is **REVERSED**.

B. Disapproval Letter Reason 1(b): Renegotiating Rates of Reimbursement

"HPHC's Filing contains rates that are unreasonable and excessive because HPHC's Filing . . . fails to show that HPHC has taken adequate steps to renegotiate rates of reimbursement to providers. . . . b) . . . The additional information provided to the Division does not demonstrate that HPHC has decreased its provider costs by renegotiating its existing contracts with providers." Exhibit 13, pp. 2-3.

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 1(b)") was HPHC's failure to demonstrate that HPHC had taken adequate steps to "renegotiate" rates of reimbursement to providers and had not demonstrated that it had decreased its provider costs by renegotiating its existing contracts with providers.

Findings of Fact:

25. Cost containment was not addressed by 211 CMR 43.00 *et seq.* prior to its amendment effective February 10, 2010.

26. The Emergency Regulation, *inter alia*, required HPHC to include in its filing "[a] detailed description of all cost containment programs of the HMO to address health care delivery costs and the realized past savings and projected savings from all such programs." 211 CMR 43.08(9).

27. One aspect of medical cost containment is control of provider reimbursements ("unit costs"). Exhibit 2, ¶ 22; Tr. 83.

28. The Division during a conference call on February 18, 2010, eight days after the promulgation of the Emergency Regulation, requested HPHC to "submit additional information" about its efforts to renegotiate its provider contracts. Exhibit 1(X)(8)(A), -(B), -(C), -(D), -(E); Exhibit 4, ¶ 20.

29. On March 2 and March 11, 2010, as requested, HPHC provided information on contract negotiations to the Division. Exhibit 14, Tab I.B Attachment 5 and Tab I.G.

30. A significant number of hospital contracts and contracts with large provider network organizations (*i.e.*, independent practice associations, physician-hospital organizations, integrated delivery systems, and large multi-specialty physician groups) are multi-year arrangements. Exhibit 4, ¶ 5.

31. The average length of a HPHC provider contract is one to three years. Exhibit 4, ¶ 5; Exhibit 14 Attachment 5.

32. All or most of HPHC's hospital and physician group contracts are renewed on a calendar year basis, with negotiations completed and new terms implemented for a January 1 effective date. Exhibit 4, ¶ 6.

33. Approximately one-third of HPHC's hospital and physician group contracts are up for renewal in a given year. Exhibit 4, ¶ 6.

34. 98% of HPHC's revenue that will flow through the claims system will be flowing through contracts that have finalized rates to which HPHC has committed. Tr. 249; Exhibit 1(X)(25).

35. As of the Division's April 1, 2010 rate disapproval, HPHC was committed contractually for 99% of its hospital and 82% of its physician group reimbursement rates for 2010. Exhibit 4, ¶ 6.

36. HPHC already is committed for 66% of its hospital and 58% of its physician group rates for multi-year provider agreements extending through 2011. Exhibit 4, ¶ 6.

37. HPHC is committed for 40% of both hospital and physician group rates for agreements extending through 2012. Exhibit 4, ¶ 6; Tr. 228-229.

38. The duration of a typical hospital or integrated delivery (or multi-provider) network contract negotiation ranges from two to five months and many of these negotiations can continue for as long as nine months or longer if the parties are far apart on rate increases or other financial terms. Exhibit 4, ¶ 9.

39. Some providers *in geographic areas* have been unwilling to contract with HPHC except at a level *they* deem appropriate. Exhibit 4, ¶ 11; Exhibit 14 I. B. Attachment 2.

40. Some providers *in certain provider specialties* have been unwilling to contract with HPHC except at a level *they* deem appropriate. Exhibit 4, ¶ 11; Exhibit 14 I. B. Attachment 2.

41. Particularly in the Boston area, some providers have developed a “brand” in terms of the types of care or services that they provide, and *members* expect such providers to be included in any HPHC network. Exhibit 4, ¶ 11; Exhibit 6, pp. 28-29; Exhibit 14 I. B. Attachment 2.

42. Particularly in the Boston area, some providers have developed a “brand” in terms of the types of care or services that they provide, and *employers* expect such providers to be included in any HPHC network. Exhibit 4, ¶ 11; Exhibit 6, pp. 28-29; Exhibit 14 I. B. Attachment 2; Tr. 180.

43. Large employers have stated that they would leave HPHC for another carrier when HPHC proposed to exclude from its network providers who were charging what HPHC considered to be an excessive rate. Exhibit 1(X)(17), p. 3.

44. Surveys of employers undertaken by HPHC have shown that limited networks are not popular products in Boston. Exhibit 6, p. 29.

45. Employers expect all of, or at least the well-known and highly respected facilities and physician groups, to be in their HPHC network. Exhibit 6, p. 29.

46. The reputation and market power of “branded” providers gives them a good deal of leverage in their contract negotiations with HPHC. Exhibit 4, ¶ 11; Tr. 184.

47. The primary foundation of market power is the magnitude of certain “branded” integrated delivery systems or their centrality in the medical community, based on the specialized care they provide. Exhibit 4, ¶ 11.

48. HPHC’s negotiation efforts with Massachusetts hospitals and large physician organizations with contract renewals occurring during the period October 1, 2009 through April 1, 2010 resulted in savings of approximately \$23 million when the providers’ initially proposed rate increases are compared with the final negotiated terms. Exhibit 1(X)(24); Exhibit 4, ¶ 14.

49. G.L. c. 176O, § 15(j) provides that: “No carrier shall make a contract with a health care provider which includes a provision permitting termination without cause. A carrier shall provide a written statement to a provider of the reason or reasons for such provider’s involuntary disenrollment.”

50. 211 CMR 52.12(5) provides that: "Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause."

51. 211 CMR 52.12(6) provides that "Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment."

52. HPHC does not have a contractual or other legal right unilaterally to reopen its provider agreements to obtain a reduction in the existing negotiated reimbursement rates. Exhibit 4, ¶ 7; Exhibit 14 Attachment 5.

53. HPHC's experience, contemporaneous with the Division's issuance of Emergency Regulation 211 CMR 43.08 on February 10, 2010, is that hospitals, physicians and other health care providers will not voluntarily accept a decrease in their reimbursement rates. Exhibit 4, ¶ 8.

54. Not one of the providers contacted by HPHC chose to propose a rate concession when HPHC during January and February of 2010, in connection with developing a limited network HMO product, contacted each of seven hospitals and physician groups whose cost structures prevented them from meeting criteria for participation and gave them the opportunity to respond with rate concession proposals that would allow them to participate. Exhibit 4, ¶ 8; Exhibit 14 Tab G, p. 5.

Analysis, Discussion and Conclusion

55. The Massachusetts Managed Care Reform Law of 2001, codified as G.L. c. 176O, and 211 CMR 52.12(5) require that all provider contracts contain a provision that the contract cannot be unilaterally terminated by a health plan or a provider without cause.

56. HPHC's provider agreements have been in compliance with 211 CMR 52.12(5) since its effective date.

57. The Emergency Regulation requires HPHC to describe its cost containment programs, but does not impose an obligation on an entity such as HPHC to *renegotiate* its existing contracts with medical providers.

58. The Division's interest in having HPHC renegotiate its provider rates does not, in and of itself, constitute an adequate cause that would allow HPHC to terminate or threaten to terminate its provider contracts.

59. *Conclusion:* HPHC has established the legal as well as practical barriers to reopening its existing provider contracts and the marketplace realities that limit its ability to do so, and has adequately described its efforts, despite these realities, to renegotiate rates of reimbursement to providers, and its inability to achieve results, despite its efforts, within the short time in which the Division expected results. Each of the following reasons constitutes, in itself, an independent and sufficient basis for reversing the disapproval of HPHC's proposed rates for Disapproval Letter Reason 1(b): (1) the time period within which the Division expected HPHC to secure reimbursement rate reductions from its providers in order to reduce its projected medical claim costs was unreasonable because it did not reflect the multi-year nature of provider contracts, the length of time required to negotiate contracts or the negotiating leverage of providers; (2) 211 CMR 52.12(5) imposes limits on amending or terminating provider contracts. Accordingly, the disapproval of HPHC's rates based on Disapproval Letter Reason 1(b), failure to renegotiate provider contracts, is **REVERSED**.

C: Disapproval Letter Reason 2(a): Rates Of Premium Increase

Compared With The Increase In The New England Regional Medical CPI

"HPHC's Filing contains rates that are unreasonable and excessive because HPHC's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the 2009 Consumer Price Index for medical care services for the New England Region ('Medical Care Services CPI'). Further, HPHC's overall assumed trend is not within 100% to 150% of Medical Care Services CPI, which the Division finds to be a reasonable range for this trend. . . . Medical Care Services CPI is 5.1%. HPHC's assumed trend increase is, at 8.6%, higher than Medical Care Services CPI. . . .

HPHC's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . . HPHC's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . .

a) HPHC's Filing indicates that HPHC's contracted rates of reimbursement to providers (also referred to as 'unit costs') have increased at a rate that is higher than the level of the increase in Medical Care Services CPI." Exhibit 13, pp. 3-4.

Introduction

The Disapproval Letter states that a reason for disapproval (“Disapproval Letter Reason 2(a)”) was that HPHC’s overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the 2009 Consumer Price Index for medical care services for the New England Region (“New England Regional Medical CPI”) and, furthermore, that HPHC’s overall assumed trend was not within 100% to 150% of the New England Regional Medical CPI, which the Division found to be a reasonable range for this trend.

Findings of Fact:

60. The overall cost of medical care in Massachusetts, compared with many other parts of the country, is higher because more people in Massachusetts are admitted to hospitals, more people undergo procedures, people who are sick see more specialists, more care goes into the last six months of life, and more radiology is done. Exhibit 6, p. 50.⁷

61. The cost structures of, and therefore the reimbursement payments to, hospital providers differ depending on whether they are tertiary and teaching hospitals or are “disproportionate share hospitals.” Exhibit 6, p. 29.

62. Boston has a preponderance of tertiary facilities, with more tertiary beds than cities of comparable size, and the cost structures of such facilities are higher; this cost gets passed along even when patients are getting relatively routine care. Exhibit 6, p. 50.

63. HPHC’s premium increases in recent years have been driven extensively by provider unit cost increases. Exhibit 6, p. 50; Tr. 222.

64. In some years, 75% of the increased cost of medical care has come from unit cost increases. Exhibit 6, p. 50; see Tr. 222.

65. Although in recent years provider unit cost increases have driven premium increases, utilization is a factor as well. Exhibit 6, p. 50.

66. The U. S. Bureau of Labor Statistics issues a Consumer Price Index for medical care services for the New England region, which, for purposes of this review, includes Boston,

⁷ At page 4 of *Harvard Pilgrim Health Care’s Memorandum in Support of Reversal of Rate Disapproval*, HPHC argues that “[t]he DOI has not demonstrated that increases in medical care costs in the New England Region are representative of increases in medical care costs in Massachusetts.” The burden of proof is not on the Division; HPHC has the burden of proof in this hearing, which it has met.

Massachusetts; Brockton, Massachusetts; Nashua, New Hampshire; Maine; and Connecticut ("New England Regional Medical CPI"). Exhibit 1(X)(2); Exhibit 2, ¶ 33.

67. The New England Regional Medical CPI is based on observations of price for a broad basket of both medical care commodities and medical care services in the New England region. Exhibit 2, ¶ 32.

68. The medical care expenditures category in the New England Regional Medical CPI includes out-of-pocket expenses paid by the consumer and what consumers spend on their health insurance premiums. Exhibit 2, ¶ 33; Tr. 143-144. See Exhibit 1(X)(2).

69. The New England Regional Medical CPI also provides information about what a consumer spends outside of his or her health insurance costs. Tr. 143-144.

70. The New England Regional Medical CPI includes certain costs that bear no relation to the services provided by HPHC, including the costs associated with services such as dental procedures, eyeglasses, nursing homes, and over-the-counter drugs. Exhibit 2, ¶ 32; Tr. 144-145.

71. The New England Regional Medical CPI includes consumers' premium payments for Medicare Part B, their payments for deductibles and copayments, their retail purchases of medical goods not covered by insurance, consumers' own purchases of commercial insurance, and the employee portion of employer sponsored health insurance. Exhibit 2, ¶ 33. See Exhibit 1(X)(2).

72. The New England Regional Medical CPI includes the cost of Medicare Part B premiums, and for people over the age of 65, Medicare Part B would be a very weighty percentage of their total out-of-pocket expenses. Tr. 144-145.

73. Whereas overall assumed trend accounts for both unit costs and utilization, the New England Regional Medical CPI reflects only unit costs and does not reflect any actual or expected changes in the level or intensity of medical services. Exhibit 2, ¶ 35.

74. There is not a close correlation, either now or in the recent past, between increases in the New England Regional Medical CPI and the increase of costs to health insurance plans. Tr. 145-146 and 152-153.

75. Existing data reflect the lack of correlation between the New England Regional Medical CPI and the appropriate rates for a health insurance plan. Exhibit 2, ¶ 37; Tr. 145-146.

76. The average annual change in the New England Regional Medical CPI during the period 2002-2006 was 4.5%. Exhibit 2, ¶ 37; Tr. 145-146 and 152-153.

77. In contrast, the change in the cost of medical care encountered by the Massachusetts health plans studied averaged *more than 11%* annually during the period 2002-2006 according to “Trends in Health Care Claims for Fully-Insured Health Maintenance Organizations in Massachusetts, 2002-2006,” an Oliver Wyman report to the Health Care Access Bureau of the Massachusetts Division of Insurance released on September 19, 2008 (“Wyman report”). Exhibit 2, ¶ 38; Tr. 145-146 and 166-167.⁸

78. HPHC has used the increase in the New England Regional Medical CPI, or a broader definition of inflation, as an element supporting its position in the course of contract negotiations with providers in order to bring the idea of inflation into the contract discussions. Exhibit 6, pp. 21-22; Tr. 231-232.

79. The New England Regional Medical CPI is relevant in a negotiating process for unit costs and is a reasonable look-back connected mostly to price, which is what HPHC is negotiating with providers. Tr. 231-232.

80. HPHC uses the New England Regional Medical CPI as an element in its negotiations with providers, but this is distinct from using it to develop a premium rate. Tr. 231-232.

81. HPHC sets its premium rates based upon expected future costs—specifically, the overall assumed trend of expected costs associated with both “unit cost” (the cost paid for a given service) and “utilization” (the level of services being provided to members). Exhibit 2, ¶ 34.

82. In contrast, the New England Regional Medical CPI is purely a backward-looking measure of past expenses and does not represent any forecast of future costs. Exhibit 2, ¶ 34.

83. HPHC’s actuary could not properly provide a certification of actuarial soundness if he were required to adhere to an external factor, such as the New England Regional Medical CPI, that does not correspond to HPHC’s costs. See Exhibit 2, ¶ 42; Tr. 104-105.

⁸ Whether the change in the cost of medical care encountered by Massachusetts health plans during the period 2002-2006 increase was 11.3% annually, as Mr. Topakian and the Bureau seemed to believe (Tr. 146-148), or 11.6%, as the Wyman report concludes, the pertinent fact is that the rate of change in the cost of medical care encountered by Massachusetts health plans was more than twice that of the average annual change in the New England Regional Medical CPI during the period 2002-2006 (4.5%).

84. The Division's methodology, focusing on a rate of increase rather than on actual base premium rates could result in not disapproving the proposed rate for a more expensive plan but disapproving the proposed rate for a similar, less expensive plan. Exhibit 2, ¶ 40.

Analysis, Discussion and Conclusion

85. G.L., c. 176G, §16, requires that a carrier's rates shall not be "inadequate."

86. The requirement of G.L. c. 176G, §16, that a carrier's rates shall not be "inadequate" means that rates must be adequate to meet the costs that a *particular* HMO, in this case, HPHC, can expect to actually occur.

87. Trend must be developed and evaluated for each HMO based on its own data; applying an external trend such as the New England Regional Medical CPI as the sole criterion for evaluating the overall assumed trend is improper from both actuarial and regulatory perspectives.

88. The New England Regional Medical CPI is backward-looking (*i.e.*, it looks at past costs) whereas rates are set prospectively; therefore, it is improper to use the New England Regional Medical CPI as a benchmark for determining whether a projected trend is reasonable because it does not accurately reflect the reasonably expected future costs to HPHC and therefore is an inappropriate metric for evaluating HPHC's proposed premium base rate increases.

89. Although the New England Regional Medical CPI may constitute some measure of the costs of medical care commodities and medical care services to consumers in the New England Region, it has no bearing or relevance to the actual or anticipated costs of health care claims to a Massachusetts HMO such as HPHC that has a specific group of consumers.

90. The New England Regional Medical CPI is inappropriate as a basis for evaluating HPHC's premium rates because it does not accurately reflect claim costs and administrative costs of Massachusetts HMOs such as HPHC.

91. The New England Regional Medical CPI is an inappropriate benchmark by which to evaluate HPHC's estimate of medical cost trend because the New England Regional Medical CPI measures increases in certain costs encountered by all consumers and therefore is not a relevant measure of the actual or anticipated costs of covered health care claims for members in HPHC's merged market health plans.

92. By using the rate of change of the New England Regional Medical CPI as a measure for allowed premium rate increases, the Division improperly focused on the rate of increase, rather than on the resulting actual premium base rate; the reasonableness of HPHC's proposed base rate increases cannot properly be evaluated solely from the rate of premium increase from the prior year.

93. *Conclusion:* HPHC has proved that using the increase of the New England Regional Medical CPI as the sole criterion for deciding whether to disapprove HPHC's rates is incorrect for the following reasons, each of which constitutes, in itself, an independent and sufficient basis for reversing the disapproval of HCHP's proposed rates for Disapproval Letter Reason 2(a): (1) the New England Regional Medical CPI is purely a backward-looking measure of past expenses and does not measure or forecast future costs; (2) the New England Regional Medical CPI does not measure costs that are comparable to the costs of HPHC's prospective claims, (3) focusing on the rate of increase, to the exclusion of the resultant premium number would permit anomalous results, with other companies' premiums that are higher than HPHC's proposed premiums for comparable products not being disapproved while HPHC's were disapproved; (4) using a metric external to HPHC as the sole factor to determine whether HPHC's proposed rates are excessive violates actuarial and regulatory principles and thereby contravenes the statutory requirement that rates must be adequate; accordingly, the disapproval of HPHC's rates based on Disapproval Letter Reason 2(a) is **REVERSED**.

D: Disapproval Letter Reason 2(b): Inadequately Controlling Utilization

"HPHC's Filing contains rates that are unreasonable and excessive because HPHC's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the 2009 Consumer Price Index for medical care services for the New England Region ('Medical Care Services CPI'). Further, HPHC's overall assumed trend is not within 100% to 150% of Medical Care Services CPI, which the Division finds to be a reasonable range for this trend. . . . Medical Care Services CPI is 5.1%. HPHC's assumed trend increase is, at 8.6%, higher than Medical Care Services CPI. . . . HPHC's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . ."

HPHC's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . .

b) HPHC's Filing fails to demonstrate that HPHC is adequately controlling utilization, or adjusting its practices in order to control utilization, in a manner that is sufficient to maintain claims costs at a reasonable level or that, when combined with unit cost, results in an assumed trend that is within a reasonable range, i.e. 100% to 150% of Medical Care Services CPI." Exhibit 13, pp. 3-4.

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 2(b)") was that HPHC's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the New England Regional Medical CPI and, furthermore, that HPHC's overall assumed trend was not within 100% to 150% of the New England Regional Medical CPI, which the Division found to be a reasonable range for this trend.

Findings of Fact:

94. Cost containment was not addressed by 211 CMR 43.00 *et seq.* prior to its emergency amendment effective February 10, 2010.

95. The Emergency Regulation, *inter alia*, required HPHC to include in its filing "[a] detailed description of all cost containment programs of the HMO to address health care delivery costs and the realized past savings and projected savings from all such programs." 211 CMR 43.08(9).

96. One aspect of medical cost containment is control of utilization. Exhibit 2, ¶ 22; Tr. 83.

97. HPHC's medical cost containment efforts are lead by the Provider Medical Cost Team ("PMCT"), which is responsible for tracking medical cost trends and identifying opportunities to address problematic areas of medical expenditure. Exhibit 4, ¶ 17.

98. The PMCT is chaired by HPHC's Senior Vice President of Health Services and its members include HPHC's Chief Financial Officer, Chief Medical Officer, Chief Information Officer, Chief Actuary, and Vice Presidents of Finance and Medical Management. Exhibit 4, ¶ 17.

99. The PMCT takes a multi-faceted approach that includes initiatives that span multiple HPHC business units as well as HPHC's external vendor arrangements. Exhibit 4, ¶ 18.

100. HPHC has realized the following first-year savings for a sample of the cost containment programs it has implemented over the past decade: Health Advance, \$20 million; Harvard Pilgrim Healthbeats, \$13 million; Advanced Imaging (NIA), \$11 million; Payment Policies, \$11 million; Your Care Champion, \$10 million; Claims Audit, \$7 million and ESRD, \$1 million. Exhibit 4, ¶ 20.

101. HPHC's medical cost containment programs for 2004 through 2010 have resulted in an estimated total savings of more than \$89 million in medical and pharmacy services that impact claims trend. Exhibit 4, ¶ 22.

102. In response to a request by the Division, HPHC provided details in its SERFF filing (see Appendix A attached to this *Decision*) concerning the medical cost containment and utilization review programs that it has instituted. Exhibit 14 Tab I. B.

Analysis, Discussion and Conclusion

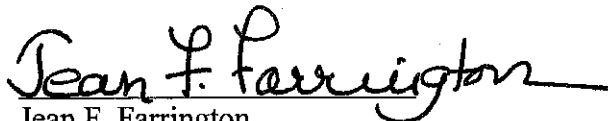
103. *Conclusion:* HPHC has demonstrated its cost containment programs (see Appendix A attached to this *Decision*), documented its realized cost savings from its cost containment efforts, and proved that its cost containment programs, including its utilization programs, are adequate in organizational structure, commitment by senior staff, scale, effectiveness and responsiveness; accordingly, the disapproval of HPHC's rates based on Disapproval Letter Reason 2(b), failure to adequately control utilization, is **REVERSED**.

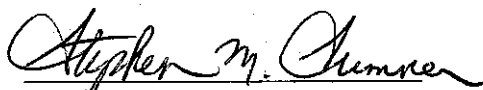
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III. ORDER

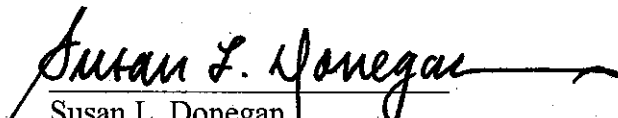
The disapproval in the April 1, 2010 Disapproval Letter is **REVERSED**; HPHC's proposed rates with effective dates on or after April 1, 2010 are **NOT DISAPPROVED**.

Filed: June 24, 2010


Jean F. Farrington
Presiding Officer


Stephen M. Sumner
Presiding Officer

AFFIRMED:
June 24, 2010


Susan L. Donegan
Designee of Commissioner of Insurance

This Decision constitutes the final agency decision of the Division of Insurance and may be appealed to the Superior Court pursuant to G.L. c. 30A, § 14.

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Appendix A

Harvard Pilgrim's Medical Cost Containment Programs and Initiatives

Harvard Pilgrim's medical cost containment programs and initiatives are described in the sections below.

a. Utilization Review

Harvard Pilgrim's Utilization Review program includes components designed to facilitate the appropriate utilization of health care resources. We use evidence-based clinical guidelines and criteria to evaluate the medical necessity and clinical appropriateness of selected elective inpatient and outpatient/ambulatory services, and work collaboratively with members and providers, as appropriate, to ensure member access to well-coordinated, appropriate, cost-effective, high quality care. Determinations of medical necessity are made by licensed clinical staff, and based on Harvard Pilgrim's definition of medical necessity. Clinical Staff review service requests to evaluate medical necessity of the proposed treatment plan and treatment site (e.g., inpatient vs. surgical day care), and may redirect care, when appropriate (e.g., for HMO members) to in-network providers. All potential denials of coverage decisions based on medical necessity are reviewed by a Utilization Management physician or other appropriately licensed physician designee (e.g., oral surgeon, psychiatrist, pharmacist), and discussed with the requesting provider before a final decision is made.

Prior Authorization is required for selected services; the list of services that require Prior Authorization is regularly reviewed by Harvard Pilgrim's Utilization Management & Clinical Policy Committee to ensure that resources are focused on those procedures, treatments, and modalities of medical care that are costly trend drivers, or subject to significant variation in utilization secondary to supply- and/or preference-sensitive issues. In-network providers are responsible for obtaining prior authorization when required. POS and PPO members accessing out-of-network benefits are responsible for notifying Harvard Pilgrim before elective admissions and surgical day care procedures, and for obtaining prior authorization when required.

Utilization Review staff use service-specific criteria and guidelines to facilitate fair and consistent decisions. All criteria and guidelines are based on relevant scientific evidence, and reviewed/updated at least annually to make certain they remain current and consistent with changing standards in medical care. Current guidelines include proprietary criteria (e.g., InterQual), and criteria developed internally with input from actively practicing in-network clinicians. All guidelines and criteria are made available to members and providers upon request.

Nurse Care Managers (RNs) provide concurrent utilization review at high volume acute rehabilitation hospitals, and selected in-network skilled/sub-acute nursing facilities. Concurrent review is used to ensure the appropriate utilization of inpatient services, and the timely and effective coordination of services for members receiving care at these facilities. Concurrent review is also utilized to identify potential discharge planning/care management opportunities.

Harvard Pilgrim determined in 2003 that high-end radiology was an appropriate candidate for utilization review given double-digit trends and literature suggesting unnecessary tests were commonly ordered. After a review of vendors, National Imaging Associates (NIA) was selected. Following several months of intensive provider communication and training, a prior consultation program was instituted that required ordering clinicians to contact NIA to obtain authorization.

Within the first year the trend that had exceeded 9% per year went basically flat and has remained there.

b. Case or Disease Management

Harvard Pilgrim is a nationally recognized leader in disease management. The results of this approach are reflected in Harvard Pilgrim's performance data. In November 2009 Harvard Pilgrim was again rated the #1 commercial health plan in America*. This was a joint ranking by the U.S News and World Report and the National Committee for Quality Assurance (NCQA). Harvard Pilgrim is the only health plan to earn the nation's top rating four years in a row. Our member-centered approach gets results because we provide clear, actionable information to both members and providers.

Harvard Pilgrim's philosophy for medical management is rooted in our mission – to improve the health of the people we serve and the health of society. Harvard Pilgrim has a strong commitment to continuously improve the quality of health care, and to effectively manage the cost of care provided to our members. We support:

- a clinical, multidisciplinary approach to care management through collaboration and consultation
- physician decision-making at the local level
- a care management focus, rather than episodic utilization review
- the availability of a selected network of providers and vendors who share Harvard Pilgrim's commitment to high-quality, accessible care.

The goals of the Disease and Care Management program are to provide

- coordination of care,
- resources that will prevent acute deterioration,
- improvement in utilization trends, and
- reduction in associated costs.

Program Components

All disease management programs include focused educational sessions conducted by specialized clinicians. Programs are available to all members with relevant diagnoses, and include combinations of the following components:

- Guidelines for effective clinical care
- Clinician education in these guidelines
- Patient identification and outreach to inform patients and their physicians of current programs, their benefits, and referral procedures
- Identification of high-risk patients who are most in need of intensive management
- Patient education emphasizing self-management skills
- Care management and outreach focused on support for high-risk patients
- Telemonitoring as appropriate based on patient severity class and symptoms

Member Identification

Members are identified for participation in disease management programs using:

- Referrals by patients' physicians or care managers
- Self-referrals
- Computerized algorithms that filter inpatient, outpatient, and pharmaceutical data
- Disease-specific high-risk registries
- Claims analysis (inpatient, outpatient, and pharmacy data to identify patients with specific diagnoses, omissions in care, and under- or overutilization of medications)

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- High-cost claimant lists
- Predictive modeling programs including DxCG

Outreach

Outreach to inform and encourage members to participate in these programs occurs through a variety of mechanisms, including:

- Clinician education programs to help clinicians identify patients appropriate for referral to disease management programs
- Case listings provided to physicians to identify patients who might benefit from follow-up/program enrollment
- Letters or phone calls to members from care managers and clinical educators
- Direct-to-member outreach through educational mailings, reminder letters, and community events
- Newsletters to members identified as at risk for these conditions
- Articles in the member newsletter Your Health

Our specific care and disease management programs are described below:

COMMON CHRONIC DISEASE MANAGEMENT SUITE

Program Name	Program Description
Asthma	Asthma management is Harvard Pilgrim's most mature disease management program and is available to both adults and children. The hallmark of the program is our asthma nurse who provides outreach, support, and care coordination to adults and children with asthma. A number of self-management tools are also mailed to members with asthma to help support and educate them in the management of their disease.
Chronic Obstructive Pulmonary Disease	Chronic obstructive pulmonary disease (COPD) is the 4th leading cause of death in the United States. Our COPD program is designed for members with lung disease who would benefit from coordinated resources that would enhance the quality of their lives and reduce the need for costly emergency room visits and periods of inpatient hospitalization. The program offers support and coordinated services that help the member better understand the disease in order to improve self-care management, including written patient information and access to nurse care managers.
Diabetes	Diabetes management is a multi-faceted program for all members with diabetes. Through the efforts of our certified diabetes educators, the program provides outreach, support and education to adults and children with diabetes. The program supports problem identification and prioritization, goal setting, and follow-up to assist providers in caring for patients with a chronic condition where outcomes are so heavily dependent on behavioral change.
Cardiac: HeartBeats	The cardiac disease management program is designed to improve quality of life for adult members with cardiovascular disease and to increase their ability to manage their condition. Specific program goals are to: <ul style="list-style-type: none"> - Improve coordination of care through early identification of members with cardiac diagnoses (i.e., ischemic cardiac disease, post-cardiac surgery, heart failure); - Improve health and quality of life through self-management, medication adherence, and secondary prevention; and - Reduce cost of care as measured by reduced avoidable utilization. Program components include direct-to-member educational materials and targeted outreach to high-risk members by nurse care managers.

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HIGH COST CONDITIONS

Predictive Modeling: <i>Health Advance</i>	Harvard Pilgrim's predictive modeling program, <i>Health Advance</i> , is specifically designed to identify and reach out to at-risk members before they require more intensive medical services, specifically those at risk for hospitalization or deterioration in their health within the next 12 months. These members typically have multiple diagnoses and psychosocial needs that can significantly diminish their quality of life. By intervening early, we are able to dramatically influence the health and well-being of this member group, which, while small in number, represents a significant percentage of overall medical costs. Uniquely member-centered, <i>Health Advance</i> strives to ensure coordination of medical care, increase self-reliance, enhance daily activity and fitness, and strengthen interdependence with family and friends. The program's core is nurse outreach and support. A designated Health Advance Care Manager works with the member, family, and providers to create a member-specific care plan. Members enrolled in Health Advance have shown a significant decrease in hospital admissions as well as reductions in per member per month costs.
Chronic Kidney Disease and End Stage Renal Disease (CKD)	The CKD Care Manager will work collaboratively with the member or "member" caregivers to ensure the most appropriate plan of care, reduce unnecessary utilization, and promote adherence to their care plan through member education. The HPHC CKD program demonstrates effective implementation of a care management program that empowers members through education while reducing overall costs and leading to optimal wellness. HPHC's CKD Care Management program realizes that the key to good renal outcomes is planning the care of CKD members and ensuring resources are effectively utilized.
Rare Diseases: <i>Your Care Champion</i>	Harvard Pilgrim's rare diseases program, <i>Your Care Champion</i> , is focused on providing support services to members with complex, chronic conditions. This interactive health management program, administered in conjunction with Accordant Health Services, combines personalized content, specialized education, disease-specific assessment tools and interaction with specially trained providers, to effectively deliver improved quality of life while reducing healthcare costs and improving outcomes to our members. In addition to Harvard Pilgrim care managers, members in <i>Your Care Champion</i> also have access to accordant.com , which features specialized resources, self-management tools, and access to specially trained nurses, medical experts, and interactive online communities. Currently the program offers support for members with the following progressive and chronic conditions: seizure disorders, multiple sclerosis, lupus, rheumatoid arthritis, Parkinson's disease, cystic fibrosis, Crohn's disease, hemophilia, myasthenia gravis, sickle cell disease, scleroderma, polymyositis, ALS, Gaucher disease, CIDP, and dermatomyositis.
Oncology	Our oncology care management program is designed to provide members with access to our oncology care managers, who work collaboratively with the members, their caregivers and their providers to develop the most appropriate plan of care, encourage adherence to it, and reduce unnecessary utilization. Members undergoing active chemotherapy and/or radiation treatment are eligible for this program. It offers a member-centered care plan that addresses both clinical and psychosocial issues, including support for family members.

ADDITIONAL DISEASE MANAGEMENT PROGRAM DESCRIPTIONS

Program Name	Program Description
Attention Deficit Hyperactivity Disorder	Harvard Pilgrim, in conjunction with our behavioral health partner, United Behavioral Health, has implemented a multifaceted program to help parents and providers better manage children with attention deficit/hyperactivity disorder (ADHD). We identify children who have filled a new stimulant medication and then target information to their parents and their providers. The goal of the program is to encourage providers to

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	provide appropriate follow-up and care coordination for members who are on stimulant medications. Additionally, it encourages providers to give parents more resources about behavioral counseling, medication management and working with schools and teachers.
Depression	Harvard Pilgrim, in conjunction with our behavioral health partner, has implemented a depression program that promotes the early detection and treatment of depression through screening and the discussion of results with health care providers. The goal is to increase the number of commercial adult members accessing services who are screened for depression and to increase the number of commercial members appropriately diagnosed with depression.
Flu/Pneumonia Prevention	Our flu prevention efforts target at-risk populations, particularly the <i>First Seniority Freedom</i> (our Medicare Advantage Plan) membership and our adult and pediatric commercial product members with chronic medical conditions. Annual influenza vaccination is the primary method for preventing influenza and its severe complications, such as pneumonia. The goal of the program is to increase influenza immunization rates among these populations as well as the general population. Direct phone outreach to members encourages flu vaccination by providing education as well as information on no-cost flu clinics in the member's area. We work with local retail pharmacies and community public health agencies to provide multiple flu clinic locations throughout our service area. If appropriate, members are also encouraged to discuss their need for a pneumococcal pneumonia vaccine with their primary care providers.
Pregnancy: Healthy Pregnancy Resources	<p>Harvard Pilgrim offers educational support for women who are pregnant or thinking of becoming pregnant. All women have access to our extensive educational material at www.harvardpilgrim.org/pregnancy. This site includes fact sheets on common issues during pregnancy, telephonic access to a maternal and child health nurse, and other resources. Preconception counseling is also available online, with information sheets on "Planning for a Pregnancy" and "Quick Guide to a Healthy Pregnancy." In addition, <i>Health Topics A-Z</i> provides reliable and comprehensive online health information to help people make better health decisions. Powered by the Healthwise® Knowledgebase, members can use this feature to find out how best to take care of themselves when planning a pregnancy.</p> <p>In addition, we remind women about the importance of timely post-delivery follow-up by proactively contacting women with postpartum visit reminders, as well as postpartum depression assessment and informational materials. Depending upon their assessment score, women may be encouraged to seek follow-up care.</p>
Pregnancy: Healthy & High-Risk Pregnancy Outreach	<p>We also offer Healthy Pregnancy Programs managed by our Maternal/Child Health Unit. The services include a nurse care management program for women wishing to become pregnant and for women with high-risk pregnancies. Members are triggered for identification via a proprietary algorithm, which considers maternal age, prenatal medications, the use of assisted reproductive technology and previous obstetrical claims history. The algorithm stratifies members into either a Healthy Pregnancy outreach or a High-Risk outreach program.</p> <p>For Healthy Pregnancy, obstetrical care management nurses provide education to ensure that the member can engage in optimal healthy behaviors before becoming pregnant and during pregnancy. The same nurse provides specific support and clinical collaboration between the care management team (nursing and social work) and the obstetrical care provider. The member's nurse is available throughout the pregnancy, providing ongoing follow-up, and may be contacted directly by the member if she or a family member has questions or needs additional assistance as the pregnancy progresses. After delivery, there is telephonic outreach for a minimum of six weeks.</p>

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	For High-Risk Pregnancy, the goal of the program is to proactively identify women with potential risk to maximize the length of their pregnancy. Through clinical collaboration with the member and provider, the care manager provides an anticipatory plan of care for the mother and baby. After delivery, if the baby is identified as high risk, our pediatric care managers continue to follow the member, baby and family for as long as care management services are needed.
Medication Safety	Harvard Pilgrim launched an innovative patient safety program designed to reduce medication errors. It includes three initiatives: <ul style="list-style-type: none"> - Medication reconciliation, which provides an assessment of medications after discharge from the hospital; - Anticoagulation management, a multi-faceted program designed to help reduce the risks associated with the use of warfarin; and - Polypharmacy, designed to help members 50 and over who are taking multiple medications, manage them safely.
RN 24/7	The RN 24/7 Program is a trusted source of information and support for a wide range of health concerns. Many of the options available to members are listed below: <ul style="list-style-type: none"> - 24x7 telephone access to a registered nurse - 24x7 access to an RN via the Web - Audio Health Information Library - HealthForum.com - Private labeled phone line program - Daily and quarterly reporting - Year 1 customized introductory brochure and postcard mailings during year - Year 2, 3 customized postcard mailings
Screening and Immunization Reminders	Harvard Pilgrim has developed preventive care reminder programs for breast cancer screening, cervical cancer screening, colorectal cancer screening, and pediatric immunization. Member outreach is routinely performed to maximize preventive care and to improve early detection of disease. The goals are to increase the percent of women ages 40-69 who have a mammogram every year; to increase the percent of women ages 21-64 who have a pap smear every three years; to increase the percent of members over age 50 who are screened for colorectal cancer; and to ensure that pediatric members under age 2 and adolescents under age 13 are receiving their required immunizations.
Smoking Cessation	Harvard Pilgrim continues its collaboration with the Massachusetts Department of Public Health and other local health plans and agencies to help members quit smoking. QuitWorks is a free, state-of-the-art smoking cessation service that offers providers a simple approach to identify patients who smoke and link them to the state's full range of tobacco treatment resources. The goals are to educate providers about the QuitWorks program; to enhance providers' referral rate of smokers to the QuitWorks tobacco treatment programs; to enhance members' awareness of the tobacco treatment programs; and to reduce rates of smoking among our membership and the overall population. (Although the QuitWorks provider referral program is currently available only to Massachusetts and Rhode Island residents, plans are underway to make 1-800-TRY-TO-STOP resources available to members in New Hampshire as well.) Members can access TRY-TO-STOP resources directly by calling 1-800-QUIT-NOW. Information about these smoking cessation services is also included in our mailings to members with chronic illnesses such as diabetes, asthma, and COPD.

**Source: Quality Compass® 2005, 2006, 2007 and 2008 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass is a registered trademark of NCQA. NCQA is a private, non-profit organization dedicated to improving health care quality. "America's Best Health Plans" is a trademark of U.S. News & World Report. Note that Harvard Pilgrim Health Care of New England, an affiliate of Harvard Pilgrim Health Care, is the #3 commercial health plan in America and the top-ranked plan in the Granite State for 2008.*

c. Health Promotion/Education

The goal of Harvard Pilgrim's health education efforts is to reach the largest number of members using innovative methods for the highest level of engagement. Harvard Pilgrim's philosophy is that an educated member, armed with the right information and questions, motivates his or her own behavior changes. To that end, Harvard Pilgrim has developed and continues to develop an extensive array of health education activities that includes general member-wide initiatives, such as the award-winning member newsletter and our website, as well as targeted messages that reach segments of our membership based on age, sex, risk profiles or disease history. Our programs are successful because we provide our members with clear, relevant and actionable health care information in a variety of mediums, including written brochures, personalized reminders and telephone outreach.

The array of member health education activities are listed here, with more detail below:

1. Members enrolled in disease management programs receive periodic educational mailings.
2. Members receive periodic telephone outreach on a range of preventive care measures.
3. Members receive mailed reminders for preventive screenings.
4. Members receive the newsletter quarterly.
5. Members have access to extensive internet-based resources on Harvard Pilgrim's web site, including health risk assessments and other tools and resources.
6. Harvard Pilgrim members can participate in community outreach events.

Members enrolled in disease management programs receive regular, detailed educational mailings. For example, members identified as having diabetes receive yearly reminders of tests they should be receiving and whether they may be overdue, plus a wallet card reminding them about routine monitoring. Patients with asthma receive the asthma action plan and an asthma passport (children) or the asthma action plan and a brochure on controlling asthma (adults).

Members receive periodic telephone outreach on a range of preventive care measures. Harvard Pilgrim uses innovative speech-recognition technology to call thousands of members and engage them in personalized conversations about particular health care issues. We have conducted campaigns on the following issues:

- Asthma
- Colorectal cancer screening
- Child and adolescent immunization reminders
- Flu immunization reminders

For all of these innovative calls, Harvard Pilgrim reminds and encourages members to take action, either scheduling a screening test, monitoring their blood pressure or immunizing their children. In addition, the calls explore barriers to care and offer diet, exercise or other lifestyle tips.

Members receive reminder letters or postcards for preventive screenings, including cervical cancer screening, breast cancer screening and immunizations. Parents of 12- to 14-month-olds and adolescents are also send postcard reminders to encourage them to schedule a well-child or adolescent visit with their doctors to complete all the age appropriate immunizations.

Harvard Pilgrim's member newsletter *Your Health*, mailed quarterly, is a key source of disease management information and health education for members. In 2008 the newsletter received a National Health Information award. Selected from among more than 1,000 entries representing

leading health care organizations, *Your Health* was deemed to be among the "best of the best" in materials developed for the consumer health care market.

Target population newsletters and educational materials are sent annually: *Health411*, our newsletter for women age 18-25, provides young women with pertinent health information, including chlamydia screening, substance abuse, nutrition, exercise and mental health issues.

Internet-based resources on Harvard Pilgrim's member Web site include health risk assessments, a web library, and risk calculators. *Health Topics A to Z*, powered by Healthwise, provides credible and comprehensive online information. Unique features include interactive health tools that can help members make more informed decisions about their health and health care. In addition, the following topics also have extensive web pages: Children with Special Health Care Needs, Attention Deficit-Hyperactivity Disorder (ADHD), Healthy Pregnancy and osteoporosis.

Harvard Pilgrim also sponsors a number of community outreach events, such as annual flu clinics held at Stop and Shop Pharmacies.

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). The classes reflect the needs of the diverse population Harvard Pilgrim serves, such as women in midlife, gay men and lesbians, adolescents, and senior citizens. Harvard Pilgrim has accommodations for disabled members and offers classes in languages other than English and in many different formats, including telephone counseling and self-help programs. Most programs are available to Harvard Pilgrim members at a discounted fee, and are also open to the community at large. A listing of available programs is publicized in the member newsletter and on the Web site, www.harvardpilgrim.org.

Employer Wellness Program: Harvard Pilgrim at Work for You

Harvard Pilgrim works closely with employers to determine ways to achieve a healthier workforce by providing preventive and targeted clinical activities at client employer work sites. Activities offered range from health risk screening programs and single session lectures to longer term behavior change programs, targeted health initiatives, and corporate consulting. Staff for these events are Harvard Pilgrim-associated health educators, nurses, registered dietitians, physical therapists, exercise physiologists, social workers, and psychologists. Typically, work site services are available to both members and non-members. The fee structure reflects a blend of participants.

d. Investigation of Fraud:

Harvard Pilgrim has adopted a zero tolerance policy against fraud and abuse and utilizes several methods of claims controls and fraud detection and prevention. Prior to claim payment, Harvard Pilgrim's claim editing software automatically audits claims to detect billing and coding errors. Software edits are developed utilizing various sources, including AMA CPT Guidelines, Specialty Society Recommendations, the CMS National Correct Coding Initiative (NCCI), and current medical practice standards. About 91% of Harvard Pilgrim's paid claims are evaluated by the editing software, and of that about 10% are adjusted. This pre-payment claims review accounts for roughly \$44M in annual claim savings. The claim editing software is primarily managed by certified professional coders and IT staff resources.

Harvard Pilgrim also evaluates claims post-adjudication, but prior to payment, using a prospective fraud and abuse program. This program is specifically designed to evaluate claims received from profiled providers that are in a "payable state." (i.e., after all benefits, contracts, and payment rules have been applied) for billing and coding issues. Select claims from these providers pend for further review and providers must submit additional medical records to support the level of service billed. These are claims that previously would have paid without intervention, but are now being more carefully scrutinized to ensure that they have been billed appropriately. This program is managed by Harvard Pilgrim's program vendor Ingenix and certified professional coding experts in the Payment Policy business area.

For claims that have already been paid, we have a number of audit methods that ensure Harvard Pilgrim recoups payments billed and paid in error. These provider audits may include on-site DRG Validation and Medical Bill Audit chart reviews, contract and payment policy data mining, on-site patient account system credit balance reviews and end-to-end contract compliance reviews. In total, these post-payment audits account for roughly \$25M in annual gross recoveries. The resources used to manage this program are a combination of internal claims audit resources and vended partners.

Harvard Pilgrim also has established a corporate Special Investigative Unit (SIU) to create and implement anti-fraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts. The SIU also uses data mining software to analyze claims data on a retrospective basis and is staffed by former law enforcement and clinical resources. As an operational matter, the SIU resides in Harvard Pilgrim's Legal Department, and collaborates with, and is supported by, the following departments: Claims, Medical Management, Payment Policy, Member Services, Account Services, Corporate Compliance Programs, Enrollment & Billing, Provider Relations, Credentialing and other internal Harvard Pilgrim departments on an "as needed" basis.

e. Coordination of Benefits (COB)

Harvard Pilgrim employs a number of controls to ensure that claims payments are recovered when it is determined that another insurer is involved and has an entire claims unit devoted to COB. Claims pre-payment screening and post-payment investigation occurs for Medicare eligibility, auto or workplace accidents and member retroactive termination. The COB process utilizes a number of pre and post-payment methods using the National Association of Insurance Commissioners (NAIC) guidelines along with federal guidelines and state mandates.

f. Provider Reimbursement Systems

Harvard Pilgrim's provider contracting mission is to maintain a comprehensive and stable provider network that provides the highest level of quality and efficient cost. Harvard Pilgrim employs an integrated and disciplined approach to evaluating the appropriateness of provider reimbursement levels to ensure that this mission is achieved. Harvard Pilgrim reviews reimbursement levels both relative to individual contract provisions and overall marketplace considerations. Our integrated approach looks beyond reimbursement levels; focusing also on appropriate financial models, quality incentive programs and administrative simplicity to encourage cost management and quality care delivery. Any changes to contracted provider reimbursement levels will be responsibly managed in respect to these considerations and will be market competitive.

g. Pharmacy Management Program

HPHC's pharmacy management department continually reviews pharmacy claim experience, current pharmacy protocols, and prescription benefit best practices in order to drive down the cost of prescription drugs for our members. Over the past decade, HPHC has reduced pharmacy

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expense by over \$50M. Since 2001, HPHC has been actively promoting the use of generic medications. Generic prescribing measures are a key component of the HPHC physician incentive program and a dedicated team actively works with the provider community to identify opportunities to move members to generic alternatives or to more efficient dosing of medications. These efforts have increased the generic percentage of prescription drug revenue from 46% in 2001 to 72% today.

HPHC aggressively negotiates with its prescription benefit manager for the lowest contract rates possible. Contract rate reductions since 2003 have resulted in over \$30M in savings. For example, combined savings for infertility/specialty care programs was \$5.6M. HPHC implemented a tiered formulary in January 2000, and active management of the tiers has produced \$10M in savings. The largest example is the move of Lipitor from tier 2 to tier 3 in 2007. Step edits to require preferred or generic alternatives before brand prescribing has yielded over \$10M in savings since 2003. Rebates received from brand drug manufacturers have also saved over \$30M annually.