Attached please find Tufts Health Plan's written pre-filed testimony for the 2016 Cost Trends Hearing. I am legally authorized and empowered to represent Tufts Health Plan and this testimony is signed under the pains and penalties of perjury.

Subscribed and sworn to, this second of September, 2016.

Thomas Croswell
President & Chief Executive Officer

Exhibit A: Notice of Public Hearing

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

Scheduled Hearing dates and location:

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

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

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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

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

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

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

Exhibit B: Instructions and HPC Questions for Written Testimony

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

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

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

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

Please note: Unless otherwise indicated, all responses below refer to Tufts Associated Health Maintenance Organization (TAHMO) and its commercial lines of business

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

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

      We are concerned about the state meeting the Health Care Cost Growth Benchmark for 2017 and beyond. Many of the same cost drivers from last year, when the state's total health care expenditures grew by 4.8% and exceeded the benchmark, persist in the market.

      The key area that could impact the state's ability to meet the benchmark is expected utilization trends. We believe that neither health plans nor providers can effectively control pharmaceutical pricing decisions. Unless pharmaceutical manufacturers are also held accountable in controlling health care costs, it will remain challenging for the Commonwealth to meet the cost growth benchmark. In addition to pharmacy trend, we are concerned about the overall utilization of medical services. We are experiencing a higher trend in 2016 than we had originally anticipated, and that may continue into 2017.

      We continue to receive proposals and requests from lower-paid providers who are seeking rate increases to make up ground relative to their peers. At the same time, higher-paid providers, often with greater and increasing market leverage, continue to seek rate increases.

      Lastly, we believe that provider consolidations impact our ability to meet the growth benchmark. We are concerned about growth in unit costs as smaller, less-leveraged physician groups or hospitals join forces with larger systems that have significant leverage and scale. Research suggests consolidation leads to increased market clout and, ultimately, higher prices as a result of bundled negotiations by systems.

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

      Looking forward, we expect pharmacy trend to continue to grow at a rate that exceeds the state's 3.6% cost growth benchmark. We also expect that medical trend will start to rise, after several years of lower observed levels. These factors, combined with an increasingly consolidated provider

market, will make meeting the state benchmark a significant challenge for carriers. We would propose the following measures to address some of these concerns:

1) Transparency of pharmaceutical pricing. At a minimum, the state should pursue policies that provide transparency regarding both the initial prices of drugs when they are released and the ongoing markup of drugs that have been on the market for years. We believe such action by the state is needed until a national policy is created to address this issue.

   We have seen the number of approvals for very expensive specialty drugs increase significantly in recent years, and we expect this trend to continue. It should be incumbent on pharmaceutical manufacturers to explain how these drugs are priced when they enter the market and whether that pricing has any relationship to the value that the drug is expected to provide to consumers. At the same time, we have also seen double-digit increases in the prices of some drugs, including generic drugs, which have been on the market for years or sometimes even decades. It is difficult to understand how such increases are related to value in any way, and we believe manufacturers that pursue such increases should also have to justify them.

   It is worth noting that Vermont has passed legislation around this issue, and that ballot initiatives will go before voters in Ohio and California later this year.

2) Addressing Price Variation. Report after report written by state agencies, including the Health Policy Commission and the Attorney General, have reached the same conclusions:

   - Prices charged by providers are driving health care costs higher
   - There is a significant gap between prices charged by the highest-paid and lowest-paid providers
   - The difference in prices charged does not relate to the quality of care being provided.

   The state should pursue policies to address price variation with two goals: 1) Reducing the price discrepancies paid to providers with no discernible differences in quality; and 2) Ensuring that total health care spending is not increased by providing rate increases to lower-paid providers without corresponding, or greater, decreases to higher-paid providers.

3) Addressing any inflationary consequences of provider consolidation. As evidenced by the number of Material Change Notices received by the Health Policy Commission, mergers, acquisitions and clinical affiliations continue to be prevalent in the provider market. While such changes often occur with the promise of greater care coordination and lower costs, there is little evidence to date to support these claims.

   We support policies that provide the Health Policy Commission with greater oversight of provider transactions. This would include the authority to conduct deeper, more longitudinal evaluations on cost, quality, and value. We would support a regular, ongoing process by which the HPC could evaluate and assess completed transactions to determine if the providers are meeting their stated goals for pursuing consolidation. Finally, we support policies that place more accountability on providers, such as taking steps to require providers who practice within the walls of a contracted facility/hospital to be contracted with the facility or in-network with the plan.

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

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

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

   ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*
   - ☒ Negotiating prices and discounts with drug manufacturers
   - ☒ Negotiating rebates with drug manufacturers
   - ☐ Developing and maintaining the drug formulary
   - ☒ Pharmacy contracting
   - ☒ Pharmacy claims processing
   - ☐ Providing clinical/care management programs to members

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

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	**13.1%**	**-1.4%**	**12.8%**	**22.9%**
Medicaid	**20.5%**	**1.8%**	**11.5%**	**46.1%**
Medicare	**5.1%**	**1.3%**	**2.2%**	**15.2%**

* Please note that Commercial trends are based on Tufts Health Plan's Commercial HMO, Medicare trends are based on Tufts Health Plan's Medicare Advantage HMO and Medicaid trends are based on Tufts Health Public Plans' MassHealth HMO.

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

   i. Risk-Based or Performance-Based Contracting
   Currently Implementing

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

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

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

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

   vi. Implementing programs or strategies to improve medication adherence/compliance
   Currently Implementing

   vii. Pursuing exclusive contracting with pharmaceutical manufacturers

Currently Implementing

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

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

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

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Does Not Plan to Implement in the Next 12 Months

xii. Other: Insert Text Here

3. **Strategies to Increase the Adoption of Alternative Payment Methodologies.**
Chapter 224 requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery. In the 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

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

Beginning in July, 2014, TAHMO expanded APMs beyond HMO products to include self-insured members in the Group Insurance Commission (GIC). Under this arrangement, value-based contracts were developed for POS and PPO membership. This was our first step into APMs for non-HMO products, and we will continue to expand our network of Integrated Risk Bearing Organization (IRBO) providers for our GIC business going forward.

In addition to the GIC IRBO, we continue to evaluate and explore value-based contracts for non-HMO membership. We are assessing the systematic approach, data and capabilities required to administer this model, as well as piloting this type of risk with a few select providers. We believe there is value in working with providers on a piloted basis in order to develop the reporting and systems necessary to support this expansion of risk.

Another way TAHMO is supporting an increase in the use of APMs is through bundled payments. We have pilots underway to explore bundled payments, particularly with certain specialty hospitals in order to better align cost and quality incentives. In addition to the pilots, we continue to have productive conversations with providers to assess who may be the right candidate for this type of APM.

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

One of the top barriers to increased use of APMs is related to the size and readiness of providers. For most of the providers remaining who are not in a value-based model, they are smaller and lack the infrastructure required to support APMs. There are considerable technical and administrative capabilities required to enter into an APM for both plans and providers.

As we reported last year, there is still a portion of our employer customers that prefer product designs with no gatekeepers. Without a gatekeeper or referrals to access care, providers are concerned about taking on risk for that population.

Additionally, there are challenges in pursuing APMs outside of an HMO product when groups use benefit carveouts or experience shifts in membership populations. Larger employer accounts can carve out certain services to other plans or vendors; therefore it is difficult to account for that change adequately within a value-based arrangement.

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

TAHMO supports smaller providers interested in pursuing value-based payment models with structures that includes outlier truncation and liability caps. Outlier truncation reduces a provider's exposure on high cost individual members by removing costs over a certain threshold, while liability caps provide protection in aggregate by limiting a providers exposure in a deficit on all claims for costs that are beyond a provider's control. In addition, groups can retain a portion of their fee schedule to attribute to any potential downside risk through a withhold capability.

Additionally, TAHMO's Provider Engagement Program delivers consultative support for providers in value-based payment models by sharing comprehensive data analysis. This encompasses cost and utilization data, referral pattern analysis, practice pattern analysis, quality performance measures and medical management data. We can also design additional custom analyses for individual providers based on analytical findings and provider areas of interest.

4. **Strategies to Align of Technical Aspects of APMs.**
In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.

a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

TAHMO currently utilizes industry standard quality measures, such as HEDIS and CMS measures, for value-based contracts and balances those measures on a provider by provider basis to identify opportunities for improvement. We believe quality needs to be a component of value-based contracts where improved efficiency is the desired outcome. These quality measures are integrated into our reimbursement methods and product designs to align providers with Tufts Health Plan's quality goals.

For risk adjustment, we currently leverage industry standard groupers that we believe are appropriate for the Commercial population.

As we reported last year, we have participated in a workgroup to facilitate a common member attribution methodology for PPO products. The workgroup has focused recent efforts on refining the model to allow for consistency across carriers and providers.

Lastly, we have developed a care management program for commercial members who are over the age of 65, modeled after similar programs currently in place for Tufts Medicare Preferred (TMP) (Medicare) members. We conduct outreach to this Commercial population using TMP-validated assessments and care plans when appropriate.

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

We have not encountered feedback that providers desire to align commercial contracts with Medicare or Medicaid. The commercial, Medicare and Medicaid populations all have unique demographics and needs. For example, Medicare characteristically has a larger portion of the population requiring higher intensity services and a significant amount of care management, whereas the commercial population typically has a lower percentage of its population requiring similarly intensive services. It would be difficult to try and fit each population into the same structure given that their requirements and participants are dissimilar. As a result, we currently contract with risk-based groups differently depending upon the populations they serve.

Overall, we believe providers are most successful in value-based contracts when moving elective, non-emergent care to high value, lower cost providers.

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.** Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.

a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

In January 2016, we implemented a specialty case management program in which we provide assistance to members impacted by Substance Use Disorder (SUD). As part of the program, a licensed behavioral health clinician reaches out to members shortly after detox discharges to assist with any barriers to adherence to their discharge instructions or aftercare plan; to advocate for participation in and assist with arranging of Medically Assisted Treatments (MAT) and other evidence-based treatments; and to coordinate care among the different providers involved in their care. In the future, we plan to expand this program to members identified in lower levels of care than an inpatient detoxification setting.

We also plan to create a new Navigator position to assist family members of those impacted by SUD. The Navigator will assist family members who call the health plan looking for information on how to get help for a loved one impacted by substance use. Such help will include assistance understanding benefits and coverage, assistance with identifying and locating the right resources, and ensuring that the needs of both the family and the member are being addressed. The Navigator will serve as a gatekeeper, helping direct members in need to available resources within the plan (such as our case management programs and services) and in the community, and will help coordinate the services, programs, and providers involved in the care of the member and family.

Prior to last year, methadone maintenance for the treatment of opioid addiction was not a covered benefit. In order to improve access to medication-assisted treatment, we initiated coverage of methadone maintenance and contracted with a network of federally-licensed methadone maintenance clinics to offer the service on an in-network benefit-covered basis. Neither primary care physician referral nor plan prior authorization are required to access coverage for methadone

maintenance. Office visits for management of suboxone are also covered, and likewise do not require referral or authorization.

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

1) Access to treatment due to lack of availability of providers certified to prescribe suboxone. Such a barrier may be addressed through newly created federal guidelines that increase capacity of providers from treating 100 patients concurrently to 250. There is also pending legislation that could allow prescribing nurses to become certified suboxone prescribers. Both of these solutions would improve access.

2) Reluctance on the part of some referring prescribers and members to accept pharmacological treatment of opioid addiction as valid. This barrier will only be overcome through education, engagement and a change in culture around SUD and MAT.

3) Access to culturally and linguistically competent care. Lack of providers that understand the various cultural issues members may face when dealing with SUD can be a barrier. Members also want to receive care in their native language. Increasing provider capacity (#1) may help resolve this.

6. **Strategies to Support Telehealth.**

In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.

a. Does your organization offer or pay for telehealth services? Yes

i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

TAHMO is participating in and developing pilot programs with select providers to implement payment for telemedicine in a way that improves care coordination and leads to better quality and value for members.

Some examples of the types of pilots we are supporting include: 1) Teleneurology, where stroke and care of other neurological disorders can stay in the community hospitals with a teleneurology service in one health system. This keeps the member near their family while providing high quality, specialized services; 2) With another health system, premature infants can stay in the Newborn Intensive Care Unit in the community while experts at an academic center review ophthalmological studies on a daily basis, keeping the infant in the same hospital as their mother and with the highest level of supports and monitoring; and 3) In the home setting, respiratory therapists visit children on ventilators and communicate with the pulmonary physician during the visit, eliminating the need for the inconvenience and cost of transport by ambulance to the doctor's office.

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

We reimburse telemedicine providers in these pilot programs on a FFS basis. General payment policies for telemedicine are still being developed. However, some key guidelines under

consideration to guard against potential overuse of telemedicine and to protect member privacy include the following:

· Protecting member privacy through requiring use of HIPAA compliant technology;

· Encouraging better coordination of care through requiring interactive video interfaces between the provider and member and follow-up reports to be sent to the member's PCP;

· Minimizing duplicative services by denying claims for same or similar services that have already been provided by an onsite provider;

· Minimizing changes in billing practices that may artificially increase utilization by only paying for visits where the member is present, thus discouraging providers to bill for informal consultations that often occur between providers during the regular course of business.

We also ask providers to bill telemedicine claims with a specific modifier, allowing us to monitor telemedicine claims and determine whether additional edits or guidelines need to be developed as the pilot programs progress.

iii. If no, why not?
n/a

7. **Strategies to Encourage High-Value Consumer Choices.**

In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No
    i. If yes, please describe the types of cash-back incentives offered.
    n/a

    ii. If no, why not?
    See below

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? No
    i. If yes, please describe the types of incentives offered.
    n/a

    ii. If no, why not?

TAHMO is currently evaluating products that reward consumers for making high-value choices for their care. However, several challenges exist for developing and implementing such products. These include:

- How to handle smaller providers who may not have sufficient member panels to properly evaluate cost or quality

- How to handle members of one family who select Primary Care Physicians (PCPs) from different provider organizations
- Such approaches would be likely limited to HMO/POS products
- The vast majority of employers use defined benefit models, which somewhat mute the impact of financial incentives for members to elect efficient providers

8. **Strategies to Increase Health Care Transparency.**
Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool."
   a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	7,302	69
	Q2	4,169	89
	Q3	5,895	78
	Q4	5,382	73
CY2016	**Q1**	12,021	77
	Q2	10,516	53
	TOTAL:	45,285	439

9. **Information to Understand Medical Expenditure Trends.**
Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).
See attached Tufts Health Plan_2016 Cost Trends Hearing_Exhibit 1

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.
Not Applicable

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

Exhibit C: AGO Questions for Written Testimony

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

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

HMO/POS	75%
PPO/Indemnity Business	25%

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

HMO/POS	56%
PPO/Indemnity Business	11%

    * Please note, these percentages include both fully-insured and self-insured business

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

HMO/POS	0%, no risk contracts carve out all pharmacy costs
PPO/Indemnity Business	0%, no risk contracts carve out all pharmacy costs

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

    Our standard risk-share model, which includes pharmacy, is based on HMO members' total health care costs managed by a provider's primary care physicians to an annual cost PMPM target (adjusted for the change in severity of members). Our HMO risk-share budgets are based on historical claims experience. Protections on risk have been considered, such as the incorporation of provider liability caps and the exclusion of high cost outliers and other costs that are beyond a provider's control.

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

    As noted in (d) above, our HMO risk-share budgets are based on historical claims experience and include pharmacy discounts. Any adjustments are reflected in network trend.

Exhibit # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Question: Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

Summary: Below is Tufts Health Plan's summary table showing actual observed allowed medical expenditure trends in Massachusetts for the specified time periods.

Response: On average, the aging of the population adds about 1% to trend annually, while the health status of the population increased by 1% to 2% per year. The impact of these changes (which are not normally exclusive) is seen primarily in the utilization trend. Other factors such as a slow economy, greater employee cost sharing and provider contracts encouraging quality over volume may have been factors in suppressing utilization trends during that time. Tufts Health Plan has observed a slight acceleration in the rate of benefit buy down over that period. Trends below reflect experience of Tufts Associated Health Maintenance Organiztion and Tufts Insurance Company

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured product lines

	Unit Cost	Utilization	Mix	Total
CY 2013	3.3%	1.2%	-0.1%	4.4%
CY 2014	3.1%	0.8%	2.5%	6.5%
CY 2015	3.0%	0.6%	-1.4%	2.2%

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. 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 provider. 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 C1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Trends below reflect experience of Tufts Health Public Plans

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2013	3.9%	3.4%	Unable to Determine	Unable to Determine	7.5%
CY 2014	-2.9%	2.5%	Unable to Determine	Unable to Determine	-0.4%
CY 2015	-2.4%	-1.1%	Unable to Determine	Unable to Determine	-3.5%

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.