MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 Pre-Filed Testimony

Payers

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission (HPC), 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:

Tuesday, October 16, 2018, 9:00 AM
Wednesday, October 17, 2018, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

The HPC will call for oral testimony from witnesses, including health care executives, industry leaders, and government officials. Time-permitting, the HPC will accept oral testimony from members of the public beginning at approximately 3:30 PM on Tuesday, October 16. Any person who wishes to testify may sign up on a first-come, first-served basis when the hearing commences on October 16.

Members of the public may also submit written testimony. Written comments will be accepted until October 19, 2018, and should be submitted electronically to HPC-Testimony@mass.gov, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 19, 2018, 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. The event will also be livestreamed on the HPC's homepage and available on the HPC's YouTube Channel following the hearing.

If you require disability-related accommodations for this hearing, please contact HPC staff at (617) 979-1400 or by email at HPC-Info@mass.gov 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 witnesses, testimony, and presentations, please check the Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Instructions for Written Testimony

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2018 Annual Cost Trends Hearing. On or before the close of business on **September 14, 2018**, please electronically submit written testimony to: HPC-Testimony@mass.gov. 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, 2015, 2016, and/or 2017 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 templates, 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@mass.gov or (617) 979-1400.

Pre-Filed Testimony Questions

1. STRATEGIES TO ADDRESS HEALTH CARE SPENDING GROWTH

To address excessive health care costs that crowd out spending on other needs of government, households, and businesses alike, the Massachusetts Health Policy Commission (HPC) annually sets a statewide target for sustainable growth of total health care spending. From 2013 to 2017, the benchmark rate was set at 3.6% growth. For the first time for 2018 and again for 2019, the HPC exercised its authority to lower this target to a more ambitious growth rate of 3.1%, the lowest level allowed by state law. Achieving this reduced growth rate in the future will require renewed efforts by all actors in the health care system, supported by necessary policy reforms, to achieve savings without compromising quality or access.

a) What are your organization's top areas of concern for the state's ability to meet the 3.1% benchmark? Please limit your answer to no more than three areas of concern.
As we have stated previously, including in our 2017 response, two areas of concern for BCBSMA remain shifting care from high-cost settings and reducing the growth in prescription drug spending. In addition to these areas, BCBSMA is concerned about the potential for government-mandated staffing for nurses or other professionals which may have a direct impact on Massachusetts's health care infrastructure and a negative impact on the state's ability to meet the benchmark for many years to come.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?
Under the current laws and environment, some providers are not interested in being included in a narrow network and some employers find that the current offerings do not meet the needs of their employees. A critical policy change that will advance this priority are needed reforms for out-of-network billing and costs. The next generation of innovation continues around value-based plan designs, including limited and tiered products, so out-of-network usage and increased costs will continue to be a problem. BCBSMA agrees with the Provider Price Variation Commission that in order to address out-of-network billing, there needs to be 1) consumer awareness of surprise billing scenarios, 2) patient protections to prevent balance-billing, and 3) a maximum reasonable provider reimbursements for out-of-network services. We were pleased to see the legislature take up this issue this session and hope that they continue to examine it in the next legislative session. For pharmacy costs, we have noted for the last few years that the larger health care community must tackle some difficult questions around pharmacy costs: What is the right price for new drugs and therapies? What is their appropriate use and who decides? How can we achieve a better balance between medical advancements and affordability? Data transparency from the pharmaceutical industry is necessary and the HPC should continue to provide analysis to aid policymakers in this discussion. Similar to the public reporting requirements of payers and providers, pharmaceutical companies should be required to submit data to the state and participate in the Annual Cost Trends Hearing with the HPC. This additional information will help policymakers reviewing the landscape to make informed decisions about pressing concerns since pharmaceutical costs will continue to be a large portion of health care cost growth. In terms of government-mandated staffing, we raise it as a central issue affecting all stakeholders in the Massachusetts health care system and pledge to continue to work collaboratively on the related issues.

c) What are your organization's top strategic priorities to reduce health care expenditures? Please limit your answer to no more than three strategic priorities.

BCBSMA's strategic priorities are in line with our areas of concern for the state's ability to meet the benchmark. Shopping for care, such as within a tiered or limited network, is a new approach for some of our accounts and members. We continue to engage with them and provide them with the tools to make informed decisions about where they will receive their care. For pharmaceutical costs, we have taken steps to mitigate the impact of these costs, including negotiating price and discounts with drug manufacturers, and negotiating rebates with drug manufacturers. We continue to pursue value-based contracting with our pharmacy benefit manager (PBM).

BCBSMA believes that changing the way we pay for health care is vital to addressing the cost burden felt by consumers and employers, so we continue to prioritize alternative payment methodologies – not only the adoption, but working closely with providers to make sure they excel under these models for the benefit of our members.

2. INFORMATION ON PHARMACY BENEFIT MANAGERS

The HPC, other state agencies, payers, providers, and others have identified increases in drug spending as a major driver of health care spending in Massachusetts in the past few years. Pharmacy benefit managers (PBMs) play a major role in the market, significantly impacting drug pricing and access. Furthermore, PBM policies that restrict the ability of pharmacies and pharmacists to share certain information with patients have been an increasing area of focus.

a) Please identify the name of your organization's contracted PBM(s), as applicable.
Express Scripts

b) 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
- ☐Other: Click here to enter text.

c) Briefly describe the Massachusetts member populations managed by your PBM (commercial, Medicaid, fully-insured, self-insured, etc.).
Commercial, self-insured, Medicare Advantage

d) Does your organization or any PBM with which you contract have policies that restrict the information a pharmacy or pharmacist can share with a covered person on the amount of the covered person's cost share for the prescription drug compared to self-pay (so-called "gag clause")? If yes, briefly describe this policy.
No

e) Does your organization or any PBM with which you contract have policies requiring a pharmacy to charge or collect a copayment from a covered person even if that amount exceeds the total charges submitted by the network pharmacy? If yes, briefly describe this policy.
No, BCBSMA and Express Scripts do not have such a policy since our members pay the lowest amount. In determining BCBSMA member cost share, a "lesser of" logic is used to compare negotiated discounted price, usual and customary, or member copay, to ensure that our members pay the least possible.

f) Does your organization or any PBM with which you contract have policies requiring a pharmacy to proactively disclose to a covered person if the total charges submitted by the network pharmacy are less than the required copayment? If yes, briefly describe this policy.
No, similar to the response in (e), BCBSMA members' cost share amount is the lowest amount.

3) STRATEGIES TO PROMOTE INNOVATIVE CARE DELIVERY THAT INTEGRATES BEHAVIORAL, SOCIAL, AND MEDICAL CARE

Public and private payers alike are implementing new policies to support the development and scaling of innovative, high-quality, and efficient care delivery, such as, for example, new billing codes for the collaborative care model and telehealth visits under Medicare Part B, reimbursement for services rendered by peers and community health workers, and incentives for patients and providers to engage in evidence-based treatment for substance use disorder.

Has your organization adopted policies related to any the following areas of care delivery improvement and innovation? [check all that apply, and describe your primary incentive related to the care delivery innovation in the fields below]

☒Readmissions Accounted for in Global Budget Payment
☒Avoidable emergency department (ED) visits Accounted for in Global Budget Payment
☒Behavioral health integration into primary care (e.g., collaborative care model) Accounted for in Global Budget Payment
☐Pharmacologic or other evidence-base therapies for substance use disorder Required Answer: Click Here
☐Peers and/or community health workers Required Answer: Click Here
☒Telehealth/telemedicine Fee-for-Service Reimbursement
☒Non-medical transportation Accounted for in Global Budget Payment
☐Supportive temporary or permanent housing Required Answer: Click Here
☐Other: Click here to enter text. Required Answer: Click Here

4) STRATEGIES TO INCREASE HEALTH CARE TRANSPARENCY

Chapter 224 of the Acts of 2012 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) In the table below, please provide available data regarding the number of individuals that sought this information:

Health Care Service Price Inquiries CY2017-2018			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In-Person
CY2017	Q1	11,547	78
	Q2	8,371	108
	Q3	8,703	100
	Q4	9,619	90
CY2018	Q1	10,767	76
	Q2	9,026	83
	TOTAL:	**58, 033**	**535**

b) What barriers do you encounter in accurately/timely responding to consumer inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

We work diligently with our members to provide this information on a timely and accurate basis. In terms of barriers, one of the greatest issues that we encounter is getting the necessary information from the provider in order to deliver an accurate cost estimate to our members. Currently, BCBSMA reaches out to the provider directly by phone or email to attempt to gather needed information to provide an estimate to a member. If we do not receive a response after the second request, we will ask our Network Management team to reach out to the provider. If we don't hear anything after additional intervention, we send a letter. We utilize our Network Management team to re-educate providers on the importance of responding timely to these requests. This re-education is often done on an individual basis when a provider has been non-responsive to our request.

Another barrier BCBSMA encounters is the member leaving out key information in the online request form. In those cases, BCBSMA reaches out to the member directly to get the needed information.

c) What barriers do you encounter in accurately/timely responding to provider inquiries for price information on admissions, procedures, and services? How have you sought to address each of these barriers?

BCBSMA generally does not receive provider inquiries for price information since they generally have access to pricing information in their contract and fee schedule.

5) INFORMATION TO UNDERSTAND MEDICAL EXPENDITURE TRENDS

Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2015 to CY2017 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2015 to 2017, the portion of actual observed allowed claims trends that is due to (a) changing demographics of your population; (b) benefit buy down; (c) and/or change in health status/risk scores of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend). To the extent that you have observed worsening health status or increased risk scores for your population, please describe the factors you understand to be driving those trends.
Please see attached Exhibit 1

6) INFORMATION ABOUT APM USE AND STRATEGIES TO EXPAND AND ALIGN APMS

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 2017 Cost Trends Report, the HPC recommended the Commonwealth continue to promote the increased adoption of alternative payment methodologies (APMs) from present levels of 59% of HMO patients and 15% of PPO patients in 2016. The HPC also called for an alignment and improvement of APMs in the Massachusetts market.

a) Please answer the following questions related to risk contract spending for the 2017 calendar year, or, if not available for 2017, for the most recently available calendar year, specifying which year is being reported. (Hereafter, a "risk contract" shall mean a contract that incorporates a budget against which claims costs are settled for purposes of determining the surplus paid or deficit charged to a provider organization.).

Reporting for 2017 calendar year

i) What percentage of your organization's covered lives, determined as a percentage of total member months, is HMO/POS business? What percentage of your covered lives is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)
   1. HMO/POS 46%
   2. PPO/Indemnity Business 54%

ii) What percentage of your HMO/POS lives is covered under a risk contract? What percentage of your organization's PPO/indemnity lives is under a risk contract?
   1. HMO/POS 77%
   2. PPO/Indemnity Business 36%

iii) What percentage of your organization's HMO/POS lives is covered under a risk contract with downside risk? What percentage of your PPO/indemnity lives is under a risk contract with downside risk?
   1. HMO/POS 77%
   2. PPO/Indemnity Business 0%

b) Please answer the following questions regarding quality measurement in APMs.

i) Does your organization plan to implement the core and menu quality measure set in all of your future global-budget based APM contracts, as applicable, with Accountable Care Organizations (ACOs) as defined by the Executive Office of Health and Human Services' Quality Alignment Taskforce (see Appendix A)?

(a) If yes, what is your timeline for implementing the measures in contracts? If no, why not?

BCBSMA views the quality measure set as an essential component of our global budget contracts. Because providers in these contracts accept accountability for the full continuum of care (from prenatal care to end-of-life care), it is important that the quality measure set encompass that full continuum to the greatest extent possible. While we are sensitive to concerns about provider burden, an even greater concern is ensuring the quality of care that our members receive. There is vast evidence that highlights the quality, safety and outcome failings in the current system – and we have seen important gains occurring through our combination of financial incentives and performance improvement support.

BCBSMA actively participated in the Taskforce and the development of the core and menu quality sets. Our current multi-year APM contracts, and renewals presently being negotiated, include the voluntary core measure set. The remainder of the

measures in these contracts draw almost entirely from the measures in the menu set defined through the Taskforce process, but there are a couple of exceptions. For example, there are certain measures that were not selected for the Taskforce menu set, but that are included in the AHIP/CMS core measure set for ACOs and that would be significant gaps if omitted. These include well visits for children ages 3-6 years old, Diabetes Hba1C testing, and Diabetes Nephropathy screening. While the Taskforce viewed performance on these measures as "topped out", we find that there is significant variation among our network providers and these domains are too important to exclude from provider accountability. A substantial evidence base has demonstrated erosion of performance that occurs when incentives and reporting on measures are removed.

(b) What are your organization's priority areas, if any, for new quality measures for ACOs?
BCBSMA's priority is to enable the transition from largely process-based measure sets to largely outcome-based measure sets. Outcome-based measure sets are advantageous for many reasons – including that they are more parsimonious. However, presently, there are few clinical areas for which there are established outcome measures that are ready for use in payment models. BCBSMA is not only committed to furthering the validation and testing of outcome measures for use in APMs, but we are co-leading a process with national stakeholders that seeks to further this aim. Among the highest priority areas for outcome measure development are conditions that are either high prevalence, high cost or both in a commercial population, and where current (process-based) measure sets have little or nothing to offer. This includes musculoskeletal conditions, behavioral health and substance use disorders, obstetric care, oncology care and cardiovascular care.

---- End of BCBSMA Responses ----

I affirm that the facts contained in the preceding responses are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that the facts stated with respect to such matters are true.

Sincerely,

Deborah Devaux

Deborah Devaux
Chief Operating Officer

Exhibit # 1 AGO Questions to Payers

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines - In state business

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	1.7%	0.8%	0.3%	0.3%	3.0%
CY 2016	1.8%	0.8%	0.3%	0.3%	3.2%
CY 2017	1.5%	0.7%	0.3%	0.3%	2.6%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND reflects the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends have not been adjusted for any changes in product, provider, demographic mix or partial coverage . In other words, these allowed trends are actual observed trends. These trends reflect total medical expenditures and include claims based and non claims based expenditures as well as member cost share.
2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services
4. Trend in non-fee for service claims (actual/estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) is reflected in Unit Cost trend as well as Total trend.
5. Estimated changes in benefit buydown and demographics have stayed fairly constant over the past couple of years.
6. Changes in health status were estimated using DxCG risk scores.
7. Overall health status deteriorated every year from 2015-2017

Change in health status can potentially impact all components of trend except unit cost

8. Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA
9. There is volatility in the components of trend due to macro and micro factors impacting health care trends including but not limited to economy, advances in medical technology a and treatment including new drugs, increased consumer engagement resulting from new product designs and transparency tools

NOTE: The Health Policy Commission trend methodology set forth in this question reflects benefit buy downs. In order to respond reliably for each year requested, in its response BCBSMA has used a consistent methodology to allocate all components of trend. It should further be noted that any stated unit cost component of trend is not an accurate reflection of BCBSMA's actual contracts. The reported information should instead be used as directional information only and not as an absolute measurement. Moreover, in light of the fact that preliminary data was used, it is noted that these numbers will likely change.