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.

Harvard Pilgrim has several concerns relating to the state's ability to meet the 3.1% cost growth benchmark:

- Unnecessary Hospital Utilization: In the *2017 Health Care Cost Trends Report*, the Health Policy Commission demonstrated that while utilization has declined in recent years, Massachusetts residents continue to utilize hospitals at a greater rate than the U.S. average. In 2015, hospital inpatient spending began to increase after years of decline as did readmission rates. Hospital outpatient spending, including in hospital emergency departments, increased by 5.5 percent between 2015 and 2016. This is up from 3.5 percent between 2014 and 2015.

  Massachusetts residents are continuing to seek care at higher cost hospitals even when a lower cost, more appropriate setting of care is available to them. Utilizing hospital resources for services that can and should be performed at a different setting of care only increases the total cost of health care in the state.

- Provider Reimbursement Rate Increases: One of our goals is to provide our members with a strong and diverse network of providers and facilities. We strive to enter into contracts with fair and appropriate payment terms. Our provider contracts standardly have annual fee-for-service reimbursement increases, which is another driver of underlying medical cost trends. In recent contract negotiations we are observing higher rate increase proposals from providers than in the recent past (provider's rationale for these requests include government shortfalls, relative position to more highly reimbursed provider organizations and increased labor costs).

- Drug Prices: The cost of prescription drugs is increasing at an unsustainable rate. Many of the new drugs coming to market are high cost, with no generic option available. And high drug prices are not limited to specialty or brand-name drugs. The costs of some generic drugs are also rising.

  In the *2017 Health Care Cost Trends Report*, the Health Policy Commission noted that "prescription drugs represented the highest growth sector of health care spending in 2016", with an increase of 6.1 percent between 2015 and 2016. This has only slightly improved from the increase of 7.2 percent between 2014 and 2015. In 2016 prescription drugs for Harvard Pilgrim's fully insured members accounted for 25 percent of total health care spend

net of rebates, manufacturer discounts, and refunds. This was an increase from 20 percent in 2011. The increase has translated into a per member per month increase from $81 in 2011 to $101 in 2016.

Health plans have a few tools to help lower drug prices, such as comprehensive utilization management programs, pharmacy benefit manager and specialty vendor management, rebates and manufacturer discounts. With rebates and manufacturer discounts, they are only available on a small subset of existing drugs. For example, rebates are not typically available for generic or some specialty drugs. Rather, they are utilized on more expensive brand name drugs and some specialty drugs with direct competition. In a July 2018 report by Milliman, *Prescription Drug Rebates and Part D Drug Costs*, it was reported that 81 percent of all Medicare Part D drugs analyzed do not offer rebates and drugs that did offer a rebate had a higher historical price trend than those where a rebate was not offered. Specifically for Harvard Pilgrim, rebates are offered on only 9.9 percent of covered prescription drugs.

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?

We would urge the legislature and our regulators to resist policies that would impact our ability to manage the care of our members. Health plans must be allowed to perform the function envisioned for them in the state's managed care law, to ensure that members have coverage for and access to appropriate, evidence-based care that is medically necessary. Utilization management can prevent unnecessary testing or undue medical procedures which may expose patients to potentially needless and ineffective care. Utilization management helps to improve care coordination and reduce cost.

Legislative and regulatory efforts to eliminate appropriate tools at our disposal will impact our ability to manage care and will increase costs for our members. That would include the elimination of prior authorization or step therapy policies, and mandating coverage of specific services or prescription drugs. The state must also resist any policies that would undermine valuable negotiations with providers around care coordination and alternative payment methodologies, which, if impacted, could lead to higher rates and financial strains or premium increases.

Specifically relating to prescription drug prices, we continue to recommend that the state consider drug price transparency legislation. Other states in our region have already passed some form of price transparency legislation. Vermont requires state officials to identify 15 drugs for which significant health care dollars are spent and list where prices rose by 50 percent or more over the previous five-year period. Similarly, in Connecticut drug manufacturers will need to provide justification for when the price of a prescription drug increases by 20 percent in one year or 50 percent over three years. Maine requires greater transparency on expenses related to prescription drug development and requires the Maine Health Data Organization to report on the 25 most frequently prescribed drugs in the state, the 25 most costly drugs in the state, and the 25 drugs with the highest year-over-year cost increase. Earlier this year, New Hampshire passed legislation requiring members of the government and key stakeholders to study greater transparency in prescription drug costs and how drug prices impact individuals and insurance premiums. Legislation was introduced in Massachusetts this session that would require drug manufacturers to report to the Department of Public Health drugs that had a wholesale acquisition cost increase of 15 percent or more over a 12-month period. However, it failed to pass.

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.

Harvard Pilgrim has several initiatives aimed at reducing health care expenditures. First, we see our role as an insurer as being more than just a payer of claims. We see it as part of our mission to guide our members to high quality, cost-effective, and affordable health care. We work directly with members, connecting them to contracted providers and specialty vendors, and other appropriate services to help them lead a happier, healthier life.

Part of providing our members more affordable health care is our continued focus on Population Health Management. Through Population Health Management, our Nurse Care Managers identify members who can benefit from care and disease management intervention. We use multiple data sources, including claims, electronic medical records, primary care provider referrals, and pharmacy data to identify members. We then further stratify our population into High Risk, Rising Risk and Working Well. For those members identified as a Risk, we work with them to establish a care plan with mutually agreed upon goals and objectives:

- We outreach to members who are being discharged from an acute care facility and work with them to reduce or avoid potential readmissions.
- We focus on members who have had multiple visits to the Emergency Department. Once contacted and engaged, we work with the members to select a Primary Care Provider if they don't have one or establish connection points with the member's primary provider and ensure that the member has alternative options to receive needed care at more appropriate setting.
- We review certain inpatient and outpatient services against evidence-based industry standard clinical criteria to ensure appropriateness and quality of care. The UM reviews help to prevent overuse, misuse and underutilization of services.

In addition to Population Health Management, we have implemented a number of initiatives to manage medical costs while ensuring quality of care for our members. Over the past year, we have implemented several key initiatives including expanding our utilization management program for medical drugs through CVS Health - NovoLogix and establishing new clinical initiatives to manage such conditions as musculoskeletal disorders and genetic testing.

Another priority is negotiating directly with pharmaceutical manufacturers for drugs included on our formulary. Traditionally these negotiations are held between a carrier's pharmacy benefit manager and the manufacturer. At Harvard Pilgrim, we negotiate contracts directly and have successfully agreed to outcomes-based contracts that include price protection components and direct discounts. These payment arrangements allow us to give our members access to newer therapies and pay for the value they provide. We currently have 10 value-based contracts with 5 manufacturers.

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.

MedImpact

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: Maintenance of the drug formulary and administration of the prior authorization process

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

The Massachusetts member populations managed by Harvard Pilgrim and MedImpact are: commercial fully-insured and self-insured, Medicare Enhance and Advantage, as well as our members enrolled in a Harvard Pilgrim plan through the Health Connector.

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.

MedImpact does not have any gag clauses or 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.

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.

MedImpact does not have any policies requiring a pharmacy to charge or collect a copayment from a covered person even when that amount exceeds the total pharmacy submitted charges.

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.

MedImpact does not prohibit its network pharmacies from disclosing to a covered person if the total charges submitted by the network pharmacy are less than the required copayment.

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 Payment Penalty or Non-Payment
☒Avoidable emergency department (ED) visits Payment Penalty or Non-Payment
☒Behavioral health integration into primary care (e.g., collaborative care model)
Other (please describe in a text box)

- Through our behavioral health vendor, Optum, we have a complex case management program that integrates medical and behavioral services.

☒Pharmacologic or other evidence-base therapies for substance use disorder
Co-Payment Reduction or Elimination

- Harvard Pilgrim has also eliminated prior authorization for any form of medication-assisted treatment (MAT) and has developed a robust MAT network in New England through Optum in an effort to reduce barriers to access.

☐Peers and/or community health workers
☒Telehealth/telemedicine Fee-for-Service Reimbursement
☒Non-medical transportation Payment Penalty or Non-Payment
☐Supportive temporary or permanent housing
☐Other:

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**	6,306	460
	Q2	559*	556
	Q3	1,849	528
	Q4	3,823	496
CY2018	**Q1**	3,131**	491
	Q2	2,328	487
	TOTAL:	17,996	3,018

*Due to technical problems with our online cost transparency tool, utilization of the tool substantially decreased in the second quarter of 2017. During this time, HPHC's website

redirected members to call our Member Services unit to ensure the continued availability of cost estimate information. Access to the online tool was restored in the third quarter. **Harvard Pilgrim introduced a new cost transparency tool on January 1, 2018. The tracking mechanism and search metrics may differ from the search metrics from our prior tool.

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

   One barrier that we have encountered is when the 270 / 271 eligibility transaction system has an outage. The 270 Transaction Set is used to transmit benefit eligibility inquiries and the 271 Transaction Set is the appropriate response mechanism for benefit eligibility inquiries. Together, the transparency tool uses the eligibility system to help provide our members with a more accurate estimate for the service selected. When these tools are not working properly, members are not able to get a cost estimate response and an error message is displayed to inform members of the system being down. In such cases, members will contact member services or reach out to the EDI team and the issue is resolved in less than one hour.

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

   When providers request price transparency, we generally provide base fee schedule rates and let them calculate their final allowed amount based on their contract. They are able to access sample fee schedules via the call center, Provider Relations, or Contracting and other more significant requests would come to Provider Reimbursement, generally through Contracting. There are processes in place for this to occur and we are not aware of any barriers that need to be addressed.

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 **<u>HPC Payer Exhibit 1</u>** 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 find Harvard Pilgrim Payer Exhibit 1 attached, which demonstrates the total allowed medical expenditure for CY2015 to CY2017.

(a) The impact of demographics on actual observed allowed trend is 0.7% for 2015, 0.6% for 2016, and 0.9% for 2017.

(b) The impact of benefit buy down on actual observed trend are -0.2% for 2015, -0.2% for 2016, and 0.0% for 2017. The buy down factors indicate that groups have changed their benefit plans from smaller member cost-share in each year.

(c) We do not measure health status as a separate factor at this time. The effect of the change in health status is primarily incorporated in the demographic factors.

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

In addition to the above, please also note:

- Historic annual trends are provided on an observed allowed basis for both fully insured and self-insured commercial business in the rating state of Massachusetts. Medicare products were excluded.

- Trends include non-claim based expenditures and are based upon actual observed claims and non-claim base trend.

- As specified, trends for non-claim based expenditures are reflected in Unit Cost Trend and Total Trend.

- Valuation Date: 7/31/2018, with IBNR completion factors for Medical only.

- Provider mix is not separately tracked at this time.

- Utilization represents admits per thousand for Inpatient Facility, services per thousand for all other Medical categories and 30-day supply count for all Prescription Drug categories.

- Self-insured commercial Pharmacy unit price trends assumed to be the same as for fully insured commercial Pharmacy.

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.)

   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 52%
      2. PPO/Indemnity Business 48%

   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 74%
      2. PPO/Indemnity Business 1%

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 70%
2. PPO/Indemnity Business 1%

Notes: The percentages reflect memberships for the state of Massachusetts only, all commercial lines of businesses as of December 31, 2017.

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?

Yes, Harvard Pilgrim plans to support the work of the EOHHS Quality Alignment Taskforce, as is applicable, as Harvard Pilgrim moves forward with new contracts on quality. Our timeline for implementing the measures within our contracts would be within the next 2-3 years to fully comply as there are existing contracts that extend to that point.

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?

Harvard Pilgrim has prioritized the standard HEDIS quality measures as they are required for NCQA accreditation.

HPC Payer Exhibit 1

*****All cells shaded in BLUE should be completed by carrier*****

Actual Observed Total Allowed Medical Expenditure Trend by Year

Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2015	2.9%	0.0%	N/A	2.1%	5.1%
CY 2016	2.3%	2.4%	N/A	-0.1%	4.7%
CY 2017	2.7%	0.1%	N/A	1.3%	4.1%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect 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 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 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. 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.