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.
Shift care from high-cost settings (e.g., academic medical centers) to lower-cost settings (e.g., community hospitals)
Reduce unnecessary hospital utilization (e.g., avoidable emergency department use, admissions, readmissions)

b) What are the top changes in policy, market behavior, payment, regulation, or statute would your organization recommend to address these concerns?
Reviewing exclusive provider arrangements and impact on members and providers; thoroughly reviewing hospital and physician consolidation and rate caps.

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.
Advance Consumer-Centric Benefits
Providing benefits that work for our customers and take hassles out of their lives.
• Examples: Navigate4Me, connected devices, UnitedHealthcare MotionTM and virtual reality to help with anxiety and pain management

Reinvent Health Care Delivery
Focus on the way people receive health care, putting the emphasis on more personal, effective, convenient care for patients and value-based payment models for providers.
• Examples: HouseCalls, e-visits, telemedicine, group models (e.g. Real Appeal, group prenatal care), and symptom analysis by Buoy Health

Transform Pharmacy Care Services
There are faster, more convenient, less expensive ways to get patients the medicines they need. We will work on changing the entire process.
• Examples: Synchronization, PreCheck MyScript, BriovaLive, and BriovaCommunity

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.
OptumRx, Inc.

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.).
Optum Rx, Inc. manages the following populations:: Fully Integrated Medicare/Medicaid, Senior Care Options, Medicaid, Commercial (which includes both FI and ASO).

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

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.
UHC does not have a "policy" requiring a pharmacy to proactively disclose to a member if the total charges submitted by the network pharmacy are less than the required copayment. However, UHC's benefits include a "lesser of three" logic for pharmacy. A member will pay the lower of the (1) copayment and/or co-insurance, (2) the network pharmacy's usual and customary charge (the amount a cash paying customer would pay), or (3) the contracted rate with the network pharmacy. While the pharmacy may not indicate which of the three was the lowest, the pharmacy would be required to charge the member the lowest.

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 Other (please describe in a text box)
☒Avoidable emergency department (ED) visits Other (please describe in a text box)
☐Behavioral health integration into primary care (e.g., collaborative care model)
Required Answer: Click Here
☐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 Required Answer: Click Here
☐Non-medical transportation Required Answer: Click Here
☐Supportive temporary or permanent housing Required Answer: Click Here
☒Other: Click here to enter text. Other (please describe in a text box)

Readmission:

Continuum-of-Care Integration- We have regular rounds of our functional areas where high risk members are reviewed and strategies recommended to make the care transition as seamless as possible for members

Readmission Prevention Program(RPP)- We identify a cohort of members age >70 with select diagnoses at high risk for readmission(Heart Failure, Septicemia, COPD, Renal Failure, Pneumonia). These members are then subject to following construct: Keeping members inpatient longer during the initial admission will decrease the members risk for readmission and increase quality of care during discharge.

Avoidable ED visits:

We work with our ACO in MA to give regular feedback on members with frequent ED utilization. We aim to ensure members with ED use have follow-up with their PCP in a timely manner.

Other:

Optum/UHC has Invested in a provider organization that utilizes medical, behavioral and pharmacy data to proactively identify members with chronic medical conditions and untreated behavioral health needs. Members are contacted and offered enrollment in a behavioral health therapy and coaching program that works in conjunction with their medical providers for integrated care.

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**	7,745	*We are not tracking these cost estimates inquiries. We track overall benefits/ coverage related calls and cost estimates are part of that category.*
	Q2	5,632	
	Q3	4,550	
	Q4	4,671	
CY2018	**Q1**	4,453	
	Q2	3,597	
	TOTAL:	30,648	

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?

While our tool covers nearly 800 common medical services in over 600 treatment/procedure journeys, the breadth and variety of services a member can receive makes it difficult to address all scenarios. Our tool highlights the most common journey a member may experience based on claims history analysis, and our data and clinical teams are regularly reviewing the estimate set-ups to ensure accuracy and exploring opportunities to expand the experience based on new needs and requests.

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?

N/A this is currently a member-focused tool.

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 refer to 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.)

   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 0%
      2. PPO/Indemnity Business 100%

   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 0%
      2. PPO/Indemnity Business 0%

   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 0%
      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?

      We are currently developing APM agreements in Massachusetts and will apply at minimum 2 quality measures in the core and menu measures, as applicable.

ii) What are your organization's priority areas, if any, for new quality measures for ACOs?
(a) Currently developing ACO quality measures for 2019.

CERTIFICATION

The foregoing statements, opinions and data were compiled from responses provided to me by employees of UnitedHealthcare and are true and correct to the best of my knowledge and belief.

I affirm that I am legally authorized and empowered to represent UnitedHealthcare Insurance Company for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury.

Dated this 14th day of September, 2018

UNITEDHEALTHCARE INSURANCE COMPANY

Signed:

Stephen J. Farrell
Health Plan CEO

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	-3.00%	25.30%	N/A	N/A	21.60%
CY 2016	-5.50%	15.30%	N/A	N/A	8.90%
CY 2017	5.90%	10.20%	N/A	N/A	16.70%

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.