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 2nd day of September, 2016

UNITEDHEALTHCARE INSURANCE COMPANY

Signed:

Stephen J. Farrell

Health Plan CEO

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.

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 see the three top areas of concern as the explosive trend in pharmaceutical costs, the demands of the local provider community for increased unit cost reimbursements and the annual growth rate in the Medical CPI. We definitely see Specialty Pharmacy as a trend driver in all of our markets and an impediment to providing an affordable benefit. These drugs are in both the Medical (Facility & Physician) and Retail Rx benefits and are at a high price point often over $50,000 per year and even much higher for certain rare conditions being treated. Another area where we are seeing high, unabated cost trends is in the ER – both the facility and physician pieces. We see facilities upcoding claims and there are few clear guidelines in existence that dictate proper coding for these claims. This is true of the Physician claims as well. On the Physician side, we are also seeing big ER Physician employer groups coming into markets, buying up ER practices and taking those groups out of our networks. Because of the dynamics in the ER, they are left unchecked to bill as they want with no recourse for us. This phenomenon is spreading into other HPB specialties as well – Anesthesiology and Radiology in particular.

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)

We would recommend the following changes:

- an auditable methodology for verifying the actual growth rate in the usage of Commercial members for inpatient care;
- a regulation that would support payment for value, not just procedures; and
- a policy that follows up upon the impact of organizations affiliated and merging in the name of 'cost containment' and 'efficiency' to determine if these objectives are achieved.

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.
   Optum Rx, Inc.

   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	**8.4%**	**6.9%**	**10.2%**	**7.3%**
Medicaid	**3.5%**	**4.3%**	**3.2%**	**2.4%**
Medicare	**2%**	**24%**	**4%**	**-9%**

Data Footnotes:

Commercial

1) Allowed w/HHE Mail and Retail
2) Allowed= Pre-Rebate Cost
3) Fully Insured Population in Massachusetts (Situs) not including PHS
4) No days content adjusted
5) HHE = Hepatitis C, Hemophilia, and Bulk Chemicals
6) The Allowed trends represent 2016 YTD experience (Jan-Jun) using paid through July financials.

Medicaid

1) Pre-Rebate, Pre-Reinsurance
2) Only membership is in a FIDESNP (Fully Integrated Dual Eligible Special Needs Plan).
3) We used Tiers to define Brand/Generic/Specialty as defined in PAPI
    a. Tiers 1 and 2 = Generic, Tiers 3 and 4 = Brand and Tier 5 = Specialty
4) The Allowed trends represent 2016 YTD experience (Jan-Jun) using paid through July financials.

Medicare

1) Pre-Rebate, Pre-Reinsurance
2) PDP trends are based on plans in Region 2 which includes MA, CT, RI and VT
3) MAPD trends include the Northeast Region RPPO plans which include MA, CT, RI and VT
4) For PDP trends we used Tiers to define Brand/Generic/Specialty
    a. Tiers 1 and 2 = Generic, Tiers 3 and 4 = Brand and Tier 5 = Specialty
5) The trends represent 2016 YTD experience (Jan-Jun) using paid through July financials.
6) United is providing the Medicare Advantage and/or Part D data requested by the

Massachusetts Health Policy Commission as a courtesy. The requirement to submit this data for Medicare Advantage and/or Part D plans is pre-empted by federal CMS law and regulations (Part C: 42 U.S.C. § 1395w-26(b)(3) and 42 CFR 422.402; Part D: 42 U.S.C. § 1395w-112(g) and 42 CFS 423.401).

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
   Currently Implementing
   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
   Currently Implementing
   xii. Other: Insert Text Here
   xiii. 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)

UnitedHealthcare is implementing value-based contracting models that include aligned financial incentives as a standard component of our agreements with network facilities and physicians. Examples of these approaches include accountable care agreements with shared savings, shared risk, and global risk (capitation). We also utilize episode-based payment models with incentives for quality performance and efficiency.

Optum has developed Pay-for-Performance (P4P) programs also known as ACE - ACE is a proprietary facility measurement and recognition program that acknowledges and rewards facilities for delivering both effective and efficient clinical care. ACE better allows Optum to understand how every facility can become a more effective and efficient provider, which in turn gives Optum the insight to help guide and encourage facilities to achieve the highest level health care delivery. We have implemented the program with several facilities in MA to reward hospitals for standard CMS measures, including but not limited to readmission rates, 7-day and 30-day follow-up after discharge. Facilities linked to P4P include Partners, GOSNOLD, Walden Behavioral Health, as well as others. In addition, we have a P4P for ambulatory practitioners, also known as ACE for Clinicians (ACE is a proprietary quality-focused measurement program that recognizes excellent service from our network clinicians and creates more transparency for care advocates and our members. Using nationally-based, regionally-adjusted metrics, Optum will identify clinicians and groups who deliver both effective and efficient care for Optum members. The results of this data-driven system will allow us to annually tier clinicians, and recognize and reward those providers who meet or exceed ACE benchmarks - Optum seeks to recognize and reward clinicians who consistently demonstrate effective and efficient clinical care. Our motive is to create an environment of better transparency and choice for Optum members and a more loyal patient population for our network providers. It is Optum's strong belief that patient outcomes are the most important indicator of quality health care service.

Rate increases are provided based solely on performance of our proprietary algorithms driven by member completed Wellness Assessments. These are an Outcome Measurement Tool that is used by members in collaboration with their provider during the initial visit and subsequent visits (usually between sessions 3 and 5) where a baseline is established at Session (1) and the patient is tracked through the subsequent sessions and submission of this tool. Based on the outcomes, provider may receive an annual inflator. ALERT is Optum's outpatient clinical risk management model. This innovative approach utilizes algorithms based on data from the member-completed Wellness Assessment and claims, to identify the member's individual treatment needs. In this way, Optum works in collaboration with providers to ensure a member receives evidence based treatment, tailored to their individual needs.

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)

We believe the top barriers to be:

- Providers that have not acquired the appropriate systems in order to track and trend care, volume, services and/or costs.
- Providers that are resistant to any form of risk that may replace the certainty of fee for service.
- The lag time to amend existing longer term agreements on renewal.

- These barriers could be addressed through provider education and experience.

Our objective in implementing value-based contracting models is to align incentives for providers to increase the value of the care our members receive. In doing so we acknowledge that not all value-based contracting models are suitable for some providers due to a number of factors including size, type, and infrastructure, and it is imperative that we implement reimbursement models that align with providers' sophistication and capabilities. We actively work with providers to develop those capabilities in order to adopt more advanced APMs over time. Unlike CMS, we do not have the ability to unilaterally amend all of our contracts and mandate that providers move to a new payment model.

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.

United is currently testing differing alternative payment methodologies with ancillary providers when associated with larger systems.

Optum has for the past few years initiated a P4P effort that rewards all providers based on the outcomes via the use of Optum's Outcome Measurement tool. Optum is also beginning to look into other types of programs such as bundled rates and retrospective payment methodologies.

Incentives that reward providers for providing high quality care is a feature included in each of our value-based reimbursement models for Medicare plans. However, limiting the degree of risk for smaller providers to a level commensurate with their size, experience and capabilities is essential to ensure success under any such model. As providers grow and develop accountable care capabilities we will work with them to graduate into reimbursement models that align with those capabilities, such as shared savings ACOs and capitation.

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).

United has adopted many of the Medicare and CMS methods of reimbursement and is translating them, where applicable, to the commercial population of members. United has aligned its Medicare and Commercial attribution methodologies and quality measures to follow HEDIS and other nationally recognized efforts.

Regarding our Medicare plans, UHC is a strong supporter of CMS and CMMI. Given that CMS is the largest payer in the country, we work diligently to align our incentives with them as much as possible to achieve maximum support and engagement from the provider community. Most prominently, we strive to align our quality and efficiency metrics with those established by CMS. We have found that when we use a common definition, like HEDIS, providers are much more comfortable with the incentive as they do not need to change their established processes or reporting practices. Another example of where we have been able to directly follow CMS is with the HACRP. We have incorporated both HAC and HAI measures into our performance based contract with our hospital partners.

We are currently an active participant in CMS' Comprehensive Primary Care initiative (CPCi) in three states, and will be participating in CMS' CPC+ initiative in six states starting in 2017 (five-year program). Additionally, many of the ACOs participating in CMS' MSSP and Pioneer programs are also contracted with us to help manage the health and total cost of care of our members.

Most recently, UHC has been integrally involved with CMS' pursuit of having 50% of health care payments in APMs by 2018. Several members of our organization have been involved in various work groups and steering committees on this topic.

On attribution and risk adjustment, we employ a dynamic and retrospective, primary care-based attribution model that combines a 24 month lookback at members' medical and pharmacy claims where applicable. A member attributed to an accountable care organization (ACO) physician is considered eligible. Utilizing the attributed population, conceptually, the design of our ACO agreements can be understood as follows:

- We establish the total cost of care of a provider in the form of a risk adjusted PMPM
- We then sets the target at a level that will result in medical cost savings
- Our share of the savings is subsequently passed on to fully-insured and self-insured purchasers through lower medical cost trends which are reflected in future premiums and prior year cost settlements

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)

For our commercial plans, a major barrier relates to administrative only customers that customize their health insurance offerings. Commercial insurance regulations differ by state resulting in methods being applicable in one state but contrary to regulation in another.

The biggest barrier for behavioral health is the limited number of APMs available for Mental Health and Substance Abuse (MHSA) across the industry, as well as the inability of providers to easily transition from a fee-for-service to an alternative payment methodology due to the huge disparity between provider's population and specialty. Unlike medical providers who have a unique specialty, behavioral health has providers that offer many sub-specialties with many noting expertise in many given areas making it difficult to build an Alternative Payment Methodology that can easily cover all.

For our Medicare plans:

Changing measures. Challenges arise given Medicare measures are often changing (removing measures, adding measures, changes in specifications). This could best be addressed by ensuring we have an appropriate amount of lead time to provide comment and feedback and ultimately adopt the changes on a timely basis.

Data collection. Measures that require information, other than what can be gathered from a claim submission, can be both time consuming and costly. This is especially the case when measures require a chart audit, as it can be a major inconvenience to the providers.

Contracting with providers. As mentioned in 3B above, the majority of our contracts require us to negotiate with the provider. This not only means coming to mutual agreement on which metrics will be included in the agreement, but also the threshold that needs to be met. Depending upon the complexity of the incentive and the dollars at risk, these negotiations can exceed 12 months.

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)

    For our medical plans, prior authorization requirements: Our prior authorization criteria are designed to ensure that medication assisted therapy is readily accessible. The criteria are based upon appropriate use as defined by the FDA label. This prevents inappropriate off-label use (e.g. for pain management) and reserves treatment for those with opioid use disorder. Understanding that this is a chronic condition, we do not place limits on duration of therapy. We monitor prior authorization turn around times routinely to verify that coverage decisions are made in a timely manner.
    Tier placement: We provide coverage of buprenorphine in our lowest cost tier similar to other generic medications. In addition, Zubsolv (a branded buprenorphine/naloxone product) is available in Tier 2, the lowest brand tier.

    Optum Behavioral Health, our behavioral health benefit manager, has removed prior authorizations for several Medicated Assisted Treatment (MAT) programs, MAT that occurs in a providers office does not require authorization and is considered routine. MAT that is facility based requires an administrative notification for approval of services for up to 6 months without clinical review.
    In addition, Optum has initiated some new contracting strategies for Bundled Rate programs in MA for agencies that provide not only MAT-like services, but also include counseling and drug testing in a monthly per diem – these include entities such as Column Health, CRC-Habit Management and Clean Slate. Optum has also created a Substance Use Disorder collateral communication plan that has been shared with members (Newsletter), Employer Accounts, HR Departments, EAPs, etc. regarding the value of these services.

    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)

    For our medical benefits, prior authorization requirements are sometimes viewed as a barrier to care; however, they are an important tool for ensuring appropriate use. Using prior authorization for buprenorphine products prevents their off label use and abuse, it provides a method to verify that only trained and waivered physicians are prescribing them, and it provides an opportunity to prepare opioid dependent patients to engage in treatment. Patients need to be in an actionable phase along the continuum of change readiness scale. Prior authorization criteria for medication assisted therapy not only ensure that the right patient is taking the right drug, but that the patient is engaged at the right time and with the right services that will help promote their recovery and remission. It will remain a priority for UnitedHealthcare to ensure quick turnaround for coverage decisions, to provide adequate coverage of buprenorphine, naloxone, and other products for the treatment of substance abuse, and to provide integrated care with our behavioral health partners.

For our behavioral health benefits, the biggest barrier to these services as it relates to substance abuse is the mandates under Chapter 258 that require immediate access to a detox/rehab facility in lieu of a MAT-like program – members go to ERs and tend to be immediately admitted into these higher levels of care programs when in reality they would benefit in most cases from a MAT-like service. The Regulation, although well-intended, has negatively impacted insurers in being able to re-direct (when medically appropriate) to this level of care by taking a "one-size-fits-all" mandated approach to treatment. Another issue is around Member education of these services which is something we are trying to address based on the information above.

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.)?

We pay for tele health services for primary care, tele behavioral medicine, Medicare (to address the elderly) and rural situations.

Our model emphasizes virtual clinics delivering medical services specifically focused on low acuity, non-emergent needs. Common issues often handled via virtual visits include such conditions as:
Allergies
Bladder infection
Bronchitis
Cough/cold
Diarrhea
Fever
Nausea
Pink eye
Rash
Seasonal flu
Sinus infection
Sore throat
Viral illness

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.)?

These services are paid for on an equivalent basis to fee for service for office visits with a GT modifier.

iii. If no, why not?

Not applicable

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.
   Not applicable

   ii. If no, why not?

   We do not currently offer cash back incentives; however, we do encourage the use of high value providers through lower co-payments, co-insurances and deductibles.

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? Yes

   i. If yes, please describe the types of incentives offered.

   United's Premium Designation program includes primary care which offers either lower premiums or lower deductibles for choosing a primary physician that is listed in the program.

   ii. If no, why not?
   Not Applicable

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**	5,616	We do not currently track for reporting purposes telephone or in person requests related specifically to cost estimates
	Q2	4,661	
	Q3	5,008	
	Q4	5,951	
CY2016	**Q1**	7,612	
	Q2	6,016	

	TOTAL:	34,864	

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 the attached HPC Payer 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.

We have no additional comments to provide at this time.

Exhibit C: AGO Questions for Written Testimony

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

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	0%
PPO/Indemnity Business	100%

    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	Not Applicable
PPO/Indemnity Business	None

    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	Not Applicable
PPO/Indemnity Business	Not Applicable

    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?
    Not Applicable

    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?
    Not Applicable

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 2013	-3.0%	-4.4%	N/A	N/A	-7.3%
CY 2014	5.1%	-5.2%	N/A	N/A	-0.4%
CY 2015	-1.8%	15.6%	N/A	N/A	13.5%

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.