Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the 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 6, 2014, 9:00 AM
Tuesday, October 7, 2014, 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 7. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 16, 2014 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 16, 2014, to the Health Policy Commission, Two Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website.

The HPC encourages all interested parties to attend the hearing. Visit the Suffolk Law School website for driving and public transportation directions. Suffolk Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school 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 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 Annual Cost Trends Hearing section of the HPC's website. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 8, 2014, electronically submit, **using the provided template,** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the template for submission of responses as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please begin each response with a brief summary not to exceed 120 words. The provided template has character limits for responses to each question, but 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**.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and 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 other questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Questions:

We encourage you to refer to and build upon your organization's 2013 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question (including Exhibit C questions from the Attorney General), please state it only once and make an internal reference.

1. Chapter 224 of the Acts of 2012 (c. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.

   SUMMARY: BCBSMA continues to aggressively negotiate our provider contracts with the Commonwealth's benchmark in mind. We take seriously our responsibility to meet the benchmark and take it into consideration in all areas of our business. BCBSMA has been vigorously pursuing a shared responsibility campaign with our providers to keep the total cost of care well below the 3.6% benchmark for overall medical cost growth.

   Under the AQC model, discussed in more detail below, a provider organization's financial success is highly dependent upon efficiently managing a patient's care across the continuum of services, while maintaining a focus on the quality of care. With 85% of our HMO membership having chosen a primary care physician in an AQC arrangement, our provider network is actively engaged in managing the total medical expense (TME) and improving the quality of care for our HMO population. We are developing a payment reform model for PPO and are planning to offer it for 2016.

   a. What actions has your organization undertaken since January 1, 2013 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

   BCBSMA has undertaken a series of actions, both before and since January 1, 2013 to help the Commonwealth meet the benchmark. Among those items and in specific reference to the timeline noted, BCBSMA has worked to bring additional ancillary providers, such as ambulance companies, into the BCBSMA network. BCBSMA added close to 2000 doctors to the network in 2013, which is discussed in more detail in Question 2. Maintaining a robust network of contracted providers helps to reduce overall medical expense.We have also responded to the medical cost issue by continuing to develop product offerings that allow individuals to take into consideration the cost impact of where they receive care, encouraging the use of high quality, lower cost facilities. Through medical and pharmacy management programs we have also encouraged our members to take affirmative measures to maintain and potentially improve their health status through coaching, wellness and other health management initiatives.

   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

BCBSMA plans to continue vigorously pursuing a shared responsibility campaign with our contracted providers to keep unit price increases, utilization, and mix of services well below the 3.6% benchmark for overall medical cost growth. It should be noted that cost growth is driven by factors other than provider price increases, such as utilization, provider mix, and severity. Our shared responsibility approach emphasizes how health plans, providers, employers and members all must work together to hold down the rising cost of health care. Each stakeholder has different ways that it can contribute to this effort and one of the ways in which we ask providers to help is to work with us to moderate unit cost increases. The approaches we have pursued with providers include negotiating contracts to lower or avoid unit cost increases, opening existing contracts to reduce contracted rates, and holding network-wide fee schedules flat. With providers facing growing revenue pressures from government payer reimbursement reductions, contract negotiations are a complicated and sometimes contentious process. However, for the most part, we have found providers to be receptive to working with us to moderate unit cost growth. Because of these collaborative efforts, over the last three years we have been able to significantly reduce our provider unit cost increases. We believe our current contracting efforts will lead to consistent results.

Other aspects of our shared responsibility efforts include working with employers and members to promote the use of lower cost care settings through product designs that incent members to use lower cost settings.

For our AQC providers, we will continue to offer an AQC support program which is a multi-faceted program through which we work with the clinical leadership of every AQC group to support their efforts to improve quality and reduce medical spending. We do this through a robust suite of data and analytic reports. These include a broad range of analytics to support both quality improvement (e.g., patient-level gaps in care) and to improve reduced medical spending (e.g., a wide range of results and benchmarks to inform both savings possible through use of lower cost care settings and through changes in utilization patterns). The AQC support model also includes a wide range of best practice forums and learning opportunities.

2. C. 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.

SUMMARY: As seen in the CHIA 2012 Alternative Payment Methods Report, BCBSMA has made considerable progress to reduce the use of fee-for-service (FFS) and is a leader in this area. The majority of our HMO members now receive care from providers with our Alternative Quality Contract (AQC) and participation continues to grow. The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. The twin goals of the AQC

are to significantly reduce health care spending growth while improving quality and health outcomes. Today, over 85% of our primary care physicians and over 89% of our specialist network are in an AQC arrangement. We are planning to provide incentives for quality and efficiency on our PPO products as well for 2016, and will continue our process for engaging providers in this between now and then.

a. Please describe your organization's efforts to date in meeting this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs)(payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-service basis, e.g., global budget, limited budget, bundled payment, and other non-fee-for-service models, but not including pay-for-performance incentives accompanying fee-for-service payments) on your (i) total medical expenses, (ii) premiums and (iii) provider quality.

   As noted above, the majority of our HMO members are now within an APM. As an illustration of the type of analysis we have conducted on these issues, attached please find a graph (HPC.Q2a.Exhibit1) that shows the trend of AQC over time. This trend represents Total Medical Expense changes, including claims and non-caims payments made to providers. As you can see, AQC trend is below the statewide benchmark of 3.6%.While allowed trend in the AQC is not equivalent to the state's cost growth benchmark, it supports meeting this overall goal.

b. What efforts does your organization plan between now and October 1, 2015 to increase your use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider types?

   BCBSMA's national leadership in the field of APMs continues and will continue beyond October 1, 2015. As you can see from the attached graph (HPC.Q2b.Exhibit2), BCBSMA added physicians to the AQC in 2013 and 2014. We will continue to offer the AQC to the small percentage of providers not participating today. Our focus is on applying APMs to PPO.

3. Please quantify your organization's experience implementing risk contracts across your provider network using the template below. For purposes of this question, "risk contracts" refers to contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to the provider, including contracts that subject the provider to limited or minimal "downside" risk.

   SUMMARY: Below please find the numbers of physicians in our network participating in a risk contract. The percentage fields would not allow decimal points. For accuracy, in 2012 we had 78.63% and in 2013 we have 86.59% of our physicians in our network participating in risk contracts.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	16724	78
CY2013	18570	86

4. Please identify and explain the principal factors considered in formulating risk adjustment measures used in establishing risk contracts or other APM contracts with providers, including how you adjust for changes in population health status over the contract term.

   SUMMARY: BCBSMA uses the DxCG family of risk adjustment tools in its APM contracts. Specifically, concurrent DxCG models using demographic and diagnosis input and outputs predicting total medical expense are used. Our AQCs use DxCG to adjust for a group's change in risk over time compared to the risk change in its benchmark population.

   a. Does your organization use a common approach to risk adjustment for all providers? If not, what factors support the need for the application of different measures or adjustments for different providers or provider organizations?

      Yes, BCBSMA uses a common approach to risk adjustment for all APM providers. Specific differences exist between contracts for differing approaches to stop loss protection, considerations of capped and uncapped health status adjustment, and benchmark population.

   b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of risk adjustment measures for use in contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

BCBSMA sees significant drawbacks in a statewide standardization of risk adjustment measures for use in contracts. With differing risk contracts, a standard risk adjustment could lead to detrimental results. For example, one key to our success in expanding APMs has been providing complete, transparent, timely and high quality data. Standard risk adjustment statewide is unlikely to be able to match what payers can do on these attributes. This could potentially lead to stalled expansion or contraction of APMs in the market. Risk adjustment is very technical and payers would need to control the data sources used. There is a substantial possibility that such standardization could increase premiums and variation among smaller payers.

c. What progress has your organization made to date regarding the development and implementation of population-based socioeconomic adjustments to risk budgets? What plans does your organization have in this area?

Using membership weighted census data, BCBSMA has developed a methodology to measure whether the presence of more vulnerable populations within an AQC group affects the group's performance. Based on a report titled "Socioeconomic Indicators That Matter For Population Health" from the Centers for Disease Control and Prevention, fourteen variables were selected to assess the level of socioeconomic deprivation. The list includes biological (4 variables), educational (3 variables), economic (6 variables), and social risk (1 variable) factors. A composite score was then calculated with membership weighted census data corresponding to the selected fourteen variables. This analysis showed that AQC groups with more vulnerable populations were able to equal or exceed quality scores of those with less vulnerable populations.

d. How do any such differences interact with other contract elements that materially affect risk budgets and performance-based payments, and what are the results of any analyses conducted by your organization regarding variation in provider performance under different measures and adjustments?

APMs are technical and complex arrangements where numerous contract features and adjustment mechanisms interact to create meaningful incentives for providers. Risk adjustment is just one of these elements and must be considered in light of the whole contract structure. Risk level, population size, stop loss protection, services at risk, and other elements must all be considered together with the risk adjustment mechanisms. BCBSMA has created a common core approach to APMs with the AQC but still allows for variation in the details to account for different situations in provider groups and populations managed.

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5. Please identify and explain the principal factors considered in selecting quality metrics used in establishing APM contracts with providers.

SUMMARY: BCBSMA uses quality metrics in two main provider contract incentive programs -- our Hospital Performance Incentive Program (HPIP) program and the AQC.

In both programs, BCBSMA uses a measure that includes nationally accepted, clinically important indicators of clinical quality ("process"), clinical outcomes and patient care experiences. As noted earlier, the AQC measures and rewards performance for hospitals, specialists, and primary care providers who participate in the AQC contract on a measure set that includes indicators of ambulatory and hospital performance. There are currently 17 medical groups participating in this program.

a. Does your organization use a common approach to quality measurement and associated payments for all providers? If not, what factors support the need for the use of different quality measures or performance targets for different providers or provider organizations?

   Yes, each of our incentive programs are based on a common set of measures that are nationally accepted, reliable, and valid for payment purposes. Providers receive reports on a regular basis to monitor and improve their performance.

   HPIP: Our HPIP program measures and rewards performance on outcomes, process, and patient experience measures for the majority of hospitals in our network. Under HPIP, hospitals have the potential to earn prospective performance based rate increases based on the level of performance above the minimum threshold in each component of the measurement program.

   AQC: The AQC measures and rewards both ambulatory and hospital performance for providers who participate in the AQC contract. For both settings, the contract includes measures of clinical process, outcomes, and patient care experiences. The ambulatory outcome measures are weighted three times more than other ambulatory or hospital measures to signal the importance of these measures for improving population health. Since the launch of the AQC (2009), performance on the quality measure set has represented significant earnings potential for AQC providers – one of the principal ways to do well under the contract. Beginning with 2011 contracts, the quality measure set has also served a second purpose: determining the amount of shared savings or deficit that the provider has each year. The higher the quality score, the more favorable the treatment of savings or deficit (that is, with a higher quality score, the provider retains a larger share of savings or owes a smaller share of deficit). This link was derived in order to encourage a more holistic approach to improving both quality and efficiency. Beginning 2011, quality incentive payments began to be paid on a per member per month (PMPM) basis (rather than as a percent of budget, which was the original approach). The PMPM approach means that AQC providers who achieve a given level of performance will be rewarded equally for that performance.

b. What values and/or drawbacks does your organization identify regarding potential statewide standardization of quality measures, such as the measures included in the Standard Quality Measure Set, for use in risk contracts and other APM contracts, both across providers and across payers? What are the values and/or drawbacks of differentiation?

The idea of a standard core measure set, such as what has been created for tiering, has some advantages, but also some risks. The advantages are that payers using a particular measure (e.g., mammography screening) will use the agreed upon standard measure specification rather than a variation on a standard measure. Limiting the variations on individual measures is important to gaining traction on quality improvement as well as for comparability across plans and providers. In addition, by drawing from a common core of measures, there might be some synergies and momentum gained as providers work to improve on a common set of priority quality topics. However, innovation on top of a common core set of measures will always be critical. There are significant gaps and deficits in the measures available today – entire conditions and specialties for which we have no good quality measures, and a particular deficiency of good outcome measures. Progress toward filling these gaps would be greatly hampered if all payers and providers had to move in "lock step" with an agreed upon measure set used by all for contracts and other purposes.

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6. C. 224 requires health plans to attribute all members to a primary care provider, to the maximum extent feasible.

SUMMARY: Due to the nature of the product, our HMO members already have a strong provider-based focus for their care. We strongly prefer our members to select a PCP to access their benefits. To this end, we regularly outreach to members who may be experiencing challenges selecting a PCP or have not yet selected one to help them understand the importance of having a regular, personal clinician.

Patient attribution is also an important step to ensure individuals with PPO products receive optimal care and can be included in alternative payment models. Attributing members to a primary care provider who provides their care and focusing on supporting that provider in care coordination is one way we are attempting to improve the quality of care and reduce costs as well as comply with C. 224.

a. Describe your current attribution methodology (or methodologies), identifying the purpose(s) for which it is (or they are) used, and include the following information:
    i. provider types considered for attribution (e.g., primary care physicians, specialist physicians, NPs/PAs)

        Currently we attribute members to a "primary care provider" as defined by the Commonwealth of Massachusetts as a doctor, nurse practitioner or physician's assistant with a primary care license.

    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)

BCBSMA has developed a claims-based plurality attribution methodology for PPO members that has been validated with selected providers, and we will be testing it with members.

iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)

The majority of members are attributed to a PCP through E&M medical claims. If E&M claims do not provide a PCP match, pharmacy data is added. In the future, we plan to include additional services provided by a PCP to the algorithm.

iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and

Currently, we look at the past 18 months of claims in our attribution methodology. We are planning to expand this to 24 months of claims. Specifically, the algorithm will look back 12 months and then, if a member is not attributed, it will look back at the preceeding 12 months (24 total).

v. whether patients are attributed retrospectively or prospectively.

Members are attributed based on their historical claims.

b. Please describe your efforts to develop a comprehensive attribution methodology, including the current status of your efforts to validate, pilot and implement a methodology for purposes of implementing risk contracts and other APM contracts for PPO insurance products. What resulting barriers or challenges has your organization faced?

Over the last several years, BCBSMA has been working to develop and validate an attribution methodology that maximizes accuracy, completeness and stability. This model has been validated with both members and providers and we are currently in the process of fine-tuning the algorithm based on stakeholder feedback. Most recently, we have participated in a multi-stakeholder effort to emprically evaluate some key feature of attribution models and seek alignment across payers on the approaches that appear to lead to the most accurate, complete and stable attribution results.

We plan to finalize testing and refinement of this model in a phased manner both to complete the validation of results and to assess member and employer feedback, before implementing fully. We used a similar phased process when we introduced the AQC.

c. What values and/or drawbacks does your organization identify regarding potential standardization of attribution methods, both across providers and across payers? What are the values and/or drawbacks of differentiation?

BCBSMA agrees to the value of alignment on overall principles and approaches for attribution across payer and provider organizations. This degree of standardization could enhance the ability of the greater Massachusetts community to make meaningful comparisons on quality and cost accountability metrics as well as reduce potentially unnecessary administrative waste. However, requiring absolute uniformity of methodology is likely operationally impossible, and also would add administrative complexity and significantly delay the timeline for adoption of payment reform in PPO products.

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

   In 2015 we will continue to move toward implementing payment reform models for our PPO members within Massachusetts. In addition, BCBSMA is committed to and is working closely with the Blue Cross Blue Shield Association to further capitalize on these innovative local contracts as part of a Blues-wide strategy for moving away from FFS payments and toward value-based models in the PPO marketplace. This strategy will have unparalleled advantages for large national accounts – enabling them to benefit from local innovation on a national platform.

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7. Describe your organization's efforts and results in developing insurance products that encourage members to use high-value (high-quality, low-cost) care and providers, including but not limited to tiered network and limited network products. Please attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending.

   SUMMARY: BCBSMA aligns the incentives it uses in its provider relationships with the incentives offered to members to encourage both the delivery and the receipt of high-value care. In addition to the response below, attached please find an example of the analyses we have conducted on these issues, specifically some qualitative analytics we have submitted to the Division of Insurance on limited, regional, and tiered network plan designs (HPC.Q7.Exhibits 3-6).

   ANSWER: On the member side, we couple benefit designs with member decision-support tools to encourage consumers to use high-value providers, specifically through Blue Options (our 3 tiered offering) and Hospital Choice Cost Sharing (HCCS) (our 2 tiered offering). Our tiered offering benefit stratifies primary care physicians and hospitals into three levels based on cost and quality. Member cost sharing varies for each tier for most services: members have the lowest cost sharing when they see lower cost, high quality providers and higher cost sharing when they see providers that are higher cost and lower quality. The HCCS benefit feature is also designed to offer better value for members and accounts by encouraging the use of high-quality care that is less costly. For

most services, HCCS offers members lower copays when they receive services at facilities that are high-value, as determined through the same methodology as the tiered benefit. This design also supports our overall affordability goal by creating a strong incentive for hospitals to lower their fees and increase quality. Each of these offerings results in an estimated premium discount of about five to fifteen percent, relative to products with comparable benefits. Lastly, we offer many consumer-driven health care products that feature high deductibles and cost sharing, so members are motivated to seek out high-value providers.

These benefit designs are still relatively new to the market so we are just beginning to assess relevant data. The receptivity of our customers to these plans already shows an intuitive understanding and acceptance of the principle of encouraging the use of high-value providers through benefit design incentives.

To ensure that our members are empowered to navigate these new benefit designs, we have a suite of member decision-support tools. These tools are available on our member portal and offer information on both the costs and quality of care across the system. We launched a new version of our Find a Doctor tool on February 1, 2013, which expanded our scope and capabilities for providing timely comparative quality information to all members, and cost information to our PPO members in a one-stop shopping manner. More detail on these transparency and decision support tools is included in Question 8.

On the provider side, as noted above, the AQC promotes the use of high-value providers and the AQC PCPs are encouraging consumers to make high-value choices as they exercise tighter focus on referral management. Providers are increasingly focused on providing care within a group's own system.

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8. C. 224 requires providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

SUMMARY: BCBSMA offered members access to cost information on-line and via telephone prior to C. 224. In response to the new mandate, we enhanced our offering to include written estimates. Between October 1, 2013 and June 30, 2014, BCBSMA received a total of 730 written estimate requests. The top 10 procedures requested are: (1) colonoscopy for diagnosis, (2) psychotherapy patient and/or family 45 minutes, (3) colonoscopy with biopsy, (4) septectomy submucos resection, (5) routine obstetrics care including post partum care; cesarean delivery, (6) psychiatric diagnostic evaluation, (7) knee arthroscopy, (8) limited exam, evaluation and/or treatment, office or outpatient department, (9) computed tomography bone mineral density study, (10) vasectomy complete or partial. Of the 730 requests, 379 did not contain enough information to

provide an estimate. BCBSMA provided a total of 351 written estimates. Data represents 4Q2013, 1Q2014, and 2Q2014. *The unit of time reported is in days.

Health Care Service Price Inquiries				
Year		Number of Inquiries via Website	Number of Inquiries via Telephone/In Person	Average (approximate) Response Time to Inquiries*
CY2014	Q1	125	25	1
	Q2	117	75	1
	Q3	268	120	0
	TOTAL:	510	220	

** Please indicate the unit of time reported.*

ANSWER: With the mandate not yet a year old and limited data available, a detailed analysis of how members utilize cost and quality data to make health care decisions is premature. Directionally, and based in part on years of Member Service interaction data, we have several general understandings: 1) members are looking for a guide to understand their potential out of pocket costs, which in many cases can be fulfilled with a better understanding of the member's benefit for the service and where the member stands with regard to deductibles and out-of-pocket maximums; 2) in many cases, providing a narrow range of costs that factors in multiple variables is sufficient; 3) as a whole, the industry is still early on as far as adoption and usage of cost/quality transparency resources by members with more basic plan understanding (e.g., benefits, how to use plan) continuing to take precedence at this time. In terms of estimate accuracy, BCBSMA conducts a quarterly review of all estimates provided to members (since inception on October 1, 2013) where historical claims are compared to completed estimates in an attempt to identify exact matches on provider, patient and service. Exact matches are then compared and contrasted with the estimate amounts to the claim amounts. To date, in only 10% (a total of 38 estimates) did the services data on which the estimate was based match the services actually rendered. These findings are not surprising given that there are many variables that can impact the overall cost of treatment when the service is actually rendered and billed by the provider. These variables, several of which are unknown until the service is actually rendered and billed, add a layer of complexity in generating an accurate estimate at the time the estimate is requested. The variables include the addition of modifiers for the service, number of units billed by the provider, changes in the member's deductible and out of pocket maximum accumulations, etc. Action plans to continually improve our process and accuracy include: 1) additional associate training to improve initial information capture from members; 2) improved workflows with providers to obtain more accurate service information.

9. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than national average utilization of inpatient care and its heavy reliance on academic

medical centers. Describe your organization's efforts to address these trends, including efforts to redirect appropriate care to lower cost community settings. Please attach any analyses you have conducted on such "outmigration," including specific estimates of cost savings that may be accrued through redirection of care.

SUMMARY: BCBSMA supports numerous efforts to ensure that members receive the right care, in the right place, at the right time. We offer the following comments as some initial commentary on the topic.

ANSWER: BCBSMA offers opportunities to address these trends, especially in our AQC and our tiered offerings. AQC providers have seen numerous areas of savings. For example, in 2011-2012, AQC groups prescribed generic drugs at an increased rate, leading to $49 million in lower spending and $4 million less in copays for members compared to the previous year. AQC providers also had a 9% drop in medical and surgical admissions, leading to $43 million in lower spending and $4 million in lower cost sharing for members. Lastly, high-tech radiology use dropped 4% for a $5 million cost reduction.

As mentioned in Question 7, we couple benefit designs with member decision-support tools to encourage consumers to use high-value providers. Our tiered offering and HCCS offers members lower costs when they receive services from lower cost, high quality providers. These benefit designs support our members to receive care in lower cost, high quality community and tertiary settings.

10. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2-2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

SUMMARY: BCBSMA understands the importance of the integration of behavioral health and medical care. We have instituted two innovative programs that offer services not traditionally provided or paid for by a health insurer in an effort to improve care coordination and resiliency for members with significant behavioral health and medical comorbidities.

a. Please describe any efforts your organization has made to effectively address the needs of these high-cost, high-risk patients in an integrated manner.

Developed in concert with researchers at Brigham & Women's Hospital, BCBSMA's Life Balance Program is designed to improve health outcomes for members with mental health problems and significant health conditions. It provides one-on-one coaching to help strengthen resiliency and teach the coping skills necessary for physical and psychological balance in the face of illness and to improve their ability to make effective decisions about their medical care. The goal is to help members

become more resilient in the face of major life stressors, improve their quality of life, and to make more effective health care choices resulting in improved affordability.

The program focuses on members with a recent behavioral health diagnosis with specifically targeted comorbidities. Early results demonstrate a reduction in anxiety by over 20% in members participating in the program.

In addition, this spring BCBSMA—in partnership with Beacon Health Strategies—launched the Recovery, Education, and Access to Community Health (REACH) program designed to improve care for certain members with serious mental illness or substance abuse issues who typically have difficulty engaging in traditional care plans. REACH provides focused care plan development and management, active coordination of behavioral health and medical services, as well as community-based, flexible supports to promote independent living such as peer support, life skills training, family support groups, and other support services including transportation to and from health care appointments. The goal of the REACH program is to help members live healthier, more stable lives in the community while reducing their health care costs.

b. If you contract with or otherwise use a behavioral health managed care organization or "carveout," please describe how you ensure that integrated treatment is provided for these high-cost, high-risk patients.

   BCBSMA manages its behavioral health benefits in-house, employing actively practicing clinicians with a range of behavioral health and medical specialties. These clinicians frequently collaborate on the integration of care for members with complex needs.

11. Please describe whether and how your organization provides financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. Attach any analyses your organization has conducted on the impact of PCMH implementation in your provider network on outcomes, quality, and costs of care.

SUMMARY: BCBSMA does not specifically provide financial support or incentives for a provider to achieve recognition or accreditation from a national organization as a patient-centered medical home (PCMH) or improve performance as a PCMH. BCBSMA believes that these incentives exist within our AQC model.

ANSWER: The AQC seeks to advance the twin goals of significantly improving quality and outcomes while significantly slowing the rate of health care spending growth. Broadly stated, the AQC combines the financial incentives of a global budget as the basis for provider payment, very modest annual inflation rates over a five year contract period, and robust performance-based incentives on a broad set of quality and outcome measures. Importantly, we are not prescriptive about the types of provider organizations that can engage in the AQC beyond a minimum patient panel size and having primary care at the

center of the organization. There is enormous diversity of organizational size, scope, and structure – with some AQCs consisting solely of well-organized primary care practices and others sharing risk and reward with a wide range of specialists and one or more hospitals. Regardless of structure, all AQC organizations are accountable for the full continuum of patient care and all rely on high functioning, well-coordinated primary care practices as central to their success. Many of the provider organizations that contract through the AQC are implementing PCMH models within their primary care settings. The current incentives within AQC reward results, not specific structures

12. After reviewing the Commission's 2013 Cost Trends Report and July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

SUMMARY: Overall, the findings are consistent with BCBSMA's experience. In general, premium trends are greatly influenced by trends in total medical expenses (TME). Some additional drivers of premium trend are noted below.

ANSWER:

- Overuse of medical services: Overuse of certain services increases costs unnecessarily. Examples include preventable hospital re-admissions and emergency room visits for avoidable or ambulatory sensitive conditions.
- Severity: Increase in trend resulting from services shifting from lower cost settings to higher cost settings. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.
- Regulatory and legislative changes: Regulatory and legislative actions impact costs and trends, such as assessments and administrative requirements on insurers. These include, but are not limited to, the significant expense incurred to implement the provisions of the federal ACA, in addition to expanding state provisions. Additionally, new mandated benefits also drive up health care costs and premiums

Exhibit C: Instructions and AGO Questions for Written Testimony

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2011 to 2013 according to the format and parameters provided and attached as AGO Payer Exhibit 1 with all applicable fields completed. Please explain for each year 2011 to 2013 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).

   Completed in Attachment AGO Payer Exhibit 1

   Please see attached AGO Exhibit 1.

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2. Please submit a summary table according to the format and parameters provided and attached as AGO Payer Exhibit 2 with all applicable fields completed showing your total membership for members living in Massachusetts as of December 31 of each year 2010 to 2013, broken out by:
   a. Market segment (Hereafter "market segment" shall mean commercial individual, commercial small group, commercial large group, Medicare, Medicaid MCO, MassHealth, Commonwealth Care, other government. "Commercial" includes fully-insured and self-insured.)
   b. Membership whose care is reimbursed through a risk contract by market segment (Hereafter "risk contracts" shall mean contracts that incorporate a per member per month 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.)
   c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity).
   d. Membership in a tiered network product by market segment (Hereafter "tiered network products" are those that include financial incentives for hospital services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)
   e. Membership in a limited network product by market segment (Hereafter "limited network products" are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
   f. Membership in a high cost sharing plan by market segment (Hereafter "high cost sharing plan" is any plan in which an individual deductible or copayment of $1,000 or more may apply to any in-network benefit at any tier level.)

   Completed in Attachment AGO Payer Exhibit 2

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3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2010 to 2013, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership (e.g., why membership in PPO is growing).

   Membership in BCBSMA PPO products has generally increased annually since 2005. In-state membership under BCBSMA ASC has stabilized over the last few years. Additionally, HMO/POS has declined, partially due to a movement to PPO products. A key factor in these developments has been an increase in large multistate accounts. Multistate accounts seek consistency in benefits across employee populations, which can generally be achieved on a self-funded basis and through a PPO product. For this reason, multistate accounts are frequently both PPO and self-insured. The increase in these accounts at BCBSMA over the years has driven growth in PPO and ASC product membership. In the same vein, new health care laws and mandates that only apply to fully insured business are another potential cause of the shift to ASC.

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4. Please explain and submit supporting documents that show for each year 2009 to 2013, (i) your total number of employer accounts and the total annual claim payments made for those employers; and (ii) the total number of such employers for whom you do not have arrangements to provide behavioral health network or management services and the total annual claim payments for such employers

   Please see attached Exhibit 3 (AGO.Q4.Exhibit3) for our total number of employer accounts and the total claim payments made for those employers, with behavioral health included and excluded.

– End Of Responses –

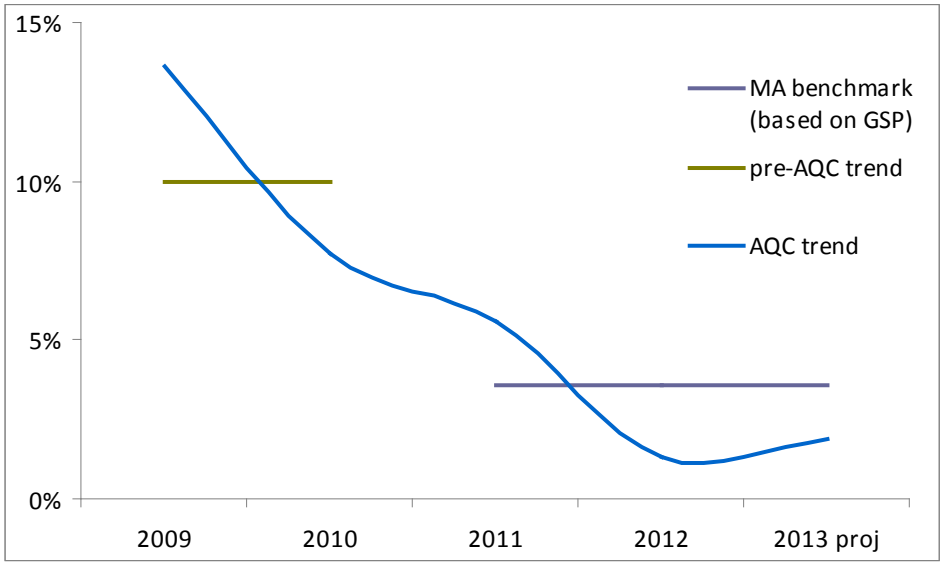
I affirm that the facts contained in the preceding response are true to the best of my knowledge. This document is signed under the pains and penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that facts stated with respect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

Sincerely,

Deborah Devaux
Senior Vice President, Consumer and Provider Solutions

HPC Cost Trends Question 2a – Exhibit 1

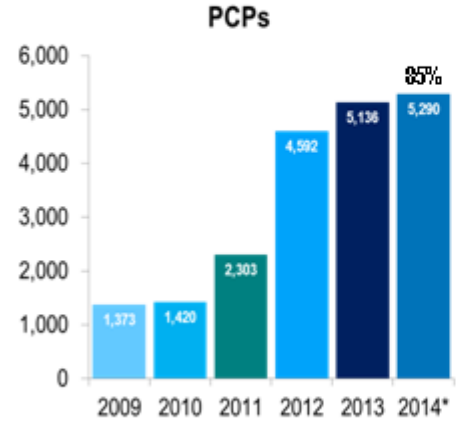
AQC Allowed Trend Comparison

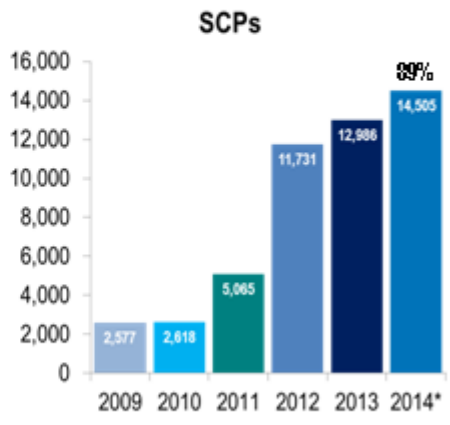


HPC.Q2b.Exhibit2

AQC Physician Participation
(Current as of August 2014)

MASSACHUSETTS





*2014 figures as of August

Massachusetts Division of Insurance's
Guidelines for Reporting Membership & Utilization Statistics
for Limited, Regional, and Tiered Provider Network Plans ("Data Guidelines")
as required under M.G.L. c. 176J, § 11 and 211 CMR 152.09

Version 3.0
Effective beginning with the calendar year 2012 Report

TABLE OF CONTENTS

I. INTRODUCTION

According to the provisions of 211 CMR 152.09, each Limited, Regional and Tiered Provider Network Plan shall file annual reports with the Massachusetts Division of Insurance ("Division") by April 30th for the prior year's membership information and utilization trends in the format specified by the Commissioner.

These Data Guidelines are intended to define the data carriers should submit to the Division. In addition, the Division created the attached data worksheets in Microsoft Excel® format to be used by carriers when developing the following report:

1. Annual Membership and Member Months
2. Inpatient Utilization for Limited/Regional Network or Tier 1 providers and Out-of-Network Providers
3. Outpatient Utilization for Limited/Regional Network or Tier 1 providers and Out-of-Network Providers
4. Inpatient Utilization Tier 2 Providers
5. Outpatient Utilization Tier 2 Providers
6. Inpatient Utilization Tier 3 Providers
7. Outpatient Utilization Tier 3 Providers
8. Non-Tiered Inpatient Utilization
9. Non-Tiered Outpatient Utilization
10. Out-of-Network Requests

II. GENERAL

All membership and utilization statistics should be reported in **which the risk of financial loss has been transferred to the carrier**. Since the Division is not responsible for the activities of self-funded groups, **carriers must ensure that these reports do not include statistics when the carrier is performing the duties of a third party administrator (TPA) or acting in a similar capacity for self-funded groups.**

Separate reports should be submitted for each separate Limited, Regional, or Tiered network product. If a product is a combination of two types of network products (e.g., a Regional Tiered network product), please default to reporting the product as a Tiered network product and follow the reporting guidelines that apply to Tiered network products.

Carriers must report statistics for members of all insured products regardless of the member's state of residence. Membership and utilization statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.*, where the member's employer or health care provider is located). **Utilization for care covered under Limited/Regional network products and care from Tier 1 providers in Tiered network products should be reported on worksheets 3-4 of the reporting template. Utilization for care from Tier 2 providers in Tiered network products should be reported on worksheets 5-6 of the reporting template. And utilization for care from Tier 3 providers in Tiered network products should be reported on worksheets 7-8 of the reporting template.**

Please note that the following definitions are intended to clarify definitions already part of NAIC guidelines and to use definitions in common usage, including what is defined in the most recent version of the Health Plan Employer and Data Information Set ("HEDIS®") technical specifications. HEDIS® is a registered trademark of the National Committee for Quality Assurance ("NCQA"). As used within the Data Guidelines, the "most recent version of HEDIS®" refers to the version applicable at the time this annual report is filed.

Limited Provider Network: A reduced or selective Provider Network, that is not a Regional Provider Network, and is smaller than a Carrier's General Provider Network.

Regional Provider Network: A Provider Network for a defined geographic area within Massachusetts that is smaller than the Carrier's General Provider Network and for a service area that is a geographic subset of the Carrier's General Provider Network.

Tiered Provider Network: A Provider Network in which a Carrier assigns Providers to different benefit tiers based on the Carrier's assessment of a Provider's relative cost and, where available, quality and in which Insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a Provider's assigned benefit tiers.

Tier 1 Provider: Tier 1 providers as identified by the carrier. In general, a covered person pays the lowest level of cost-sharing when receiving services from Tier 1 providers.

Tier 2 Provider: Tier 2 providers as identified by the carrier. In general, a covered person will usually pay a higher level of cost-sharing when receiving services from Tier 2 providers than from Tier 1 providers.

Tier 3 Provider: Tier 3 providers as identified by the carrier. In general, a covered person will usually pay the highest level of cost-sharing when receiving services from Tier 3 providers.

In accordance with NAIC guidelines, statistics should be reported for each of the following categories:

1. Group – members enrolled with the carrier through an entity (*e.g.*, employer, association, or trust) paying premiums to the carrier to cover eligible members of the entity. This category includes the following types of group members:

POS – members enrolled in so-called "dual certificate option" plans whereby a member receives two certificates and is covered by both an HMO, with a "closed network," and an indemnity carrier, with an "open network."

GIC – employees of the Massachusetts state government enrolled through the Group Insurance Commission.

Federal – employees of the federal government.

COBRA – members who receive their health coverage from the carrier pursuant to continuation of coverage protections guaranteed by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and members who receive their health coverage pursuant to M.G.L. c. 176J § 9 for groups with 2 – 19 eligible employees.

Merged Market – members enrolled in those merged small group/individual products (pursuant to Chapter 58 of the Acts of 2006) who belong to an entity (*e.g.*, employer, association, or trust) paying premiums to the carrier to cover eligible members of the entity.

Commonwealth Choice – members enrolled in the Commonwealth Choice contributory plan.

2. Individual – members who do not belong to a group and who directly contract with the carrier for coverage. Statistic includes those merged small group/individual product (pursuant to Chapter 58 of the Acts of 2006) members who enroll as individuals, and do not belong to a group. Statistic also includes Commonwealth Care members, and members enrolled in the Commonwealth Choice non-contributory plan. Statistic may include subscriber's formerly dependent divorced spouses following subscriber's remarriage. Statistic also includes members whose group coverage and COBRA coverage have expired and who have converted to an individual (conversion) policy. Statistic does not include (a) COBRA members (included in the Group category); or (b) self-employed small group members (included in the Group category).

III. MEMBERSHIP (see worksheet "Membership ")

Membership will be reported based upon a member's primary residence only, and not on any other factor (*e.g.*, where a member's employer or health care provider is located). The membership statistics will reflect information for the following categories:

1. Members residing in Massachusetts will be reported based on their county of residence and
2. Members residing outside Massachusetts will be in "Other States" Category.

When developing the statistics, the following definitions are to be used:

Member - Limited, Regional, or Tiered provider network subscriber or covered dependent of a subscriber (including divorced spouses covered under the carrier and newborns covered under the carrier) for whom the carrier has accepted the risk of financing necessary health services. A member is first counted as of his/her effective date of coverage. **When a member is "dually enrolled" (*e.g.*, covered by the carrier under the subscriber's and spouse's plans), the carrier should count this as one membership**. Membership should be reported by county according to the zip code of the member's primary residence listed on the member record (or subscriber record, if dependent's address is not available). If the member's primary residence is outside Massachusetts, then the member should be included in the "Other States" category.

Include:
1. All persons who receive health coverage from the reporting carrier regardless of where the member's employer or health care provider is located.
2. All group, individual, Commonwealth Choice, Commonwealth Care, and "conversion" members.
3. Members living outside of Massachusetts.

Exclude:
1. Individuals not enrolled in an insured product - *i.e.* self-funded plans for which the licensed carrier only acts as a third party administrator (TPA).
2. Fee-for-service patients seen at HMO-owned health centers.

Members at End Of Year - members enrolled in the carrier as of the close of business **on the last day of the calendar year.** A member is first counted as of his/her effective date of coverage. Dual enrollments should only be counted once.

Cumulative Member Months - Number of months of coverage **since the beginning of calendar year for which the carrier has recognized membership**. Figure should include adjustments to prior quarter member months to reflect retroactively reported additions or terminations to membership.

Example: A membership becomes effective on February 1, 2012. For purposes of the 2012 report, the report will include eleven member months (February thru December) to represent that individual enrollee.

IV. INPATIENT NON-BEHAVIORAL HEALTH UTILIZATION
(see worksheets "Tier 1 Inpatient," "Tier 2 Inpatient," and "Tier 3 Inpatient")

Inpatient utilization should be reported for the entire carrier, whether provided or arranged by the carrier or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**.

For reporting inpatient non-behavioral health utilization, include all paid claims incurred during the reporting period that were paid through March 31st. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the carrier has made payment to the provider of service.

Include: utilization of members for which the carrier is at least partially financially responsible (*e.g.* is the secondary or tertiary payer) regardless of where the inpatient care occurred.

Exclude: utilization of non-carrier members and **all member inpatient utilization that falls under inpatient behavioral health that is to be reported separately as described below**.

Acute Care - non-behavioral health care in a hospital licensed as an acute care facility by the state in which the facility is located.

Med./Surg. - medical and surgical care as defined in the most recent version of HEDIS®. Excludes well newborn days coincident with a maternity stay.

Maternity - as defined in the most recent version of HEDIS®.

Non-Acute - non-behavioral health care in an inpatient facility or ward of a facility licensed by the state in which the facility is located but not as an acute facility. This includes, but is not limited to, the following: skilled nursing home, long-term care; intermediate care; rehabilitation; and hospice.

Discharge - formal release of patient from a facility for any reason, including death.

Discharge Day - inpatient day associated with a discharge that occurred during the reporting period. All associated paid claim days are counted, even if those days occurred prior to the beginning of the reporting period.

Claim Costs – Total allowed claim costs incurred for the reported discharges and discharge days. The allowed claims costs should include member cost-sharing and be reported on a fee-for-service basis. Include all costs for the member during the admission (facility and professional costs, etc.). For maternity claims costs, include both mother and baby claim costs.

V. INPATIENT BEHAVIORAL HEALTH UTILIZATION
(see worksheets "Tier 1 Inpatient," "Tier 2 Inpatient," and "Tier 3 Inpatient")

Inpatient behavioral health utilization should be reported for the entire carrier, whether provided or arranged by the carrier or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**.

For reporting inpatient behavioral health utilization, include all paid claims incurred during the reporting period that were paid through March 31st. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the carrier has made payment to the provider of service.

Include: utilization of members for which the carrier is at least partially financially responsible (*e.g.* is the secondary or tertiary payer) regardless of where the inpatient care occurred.

Exclude: utilization of non-carrier members and **all member inpatient utilization that falls under inpatient non-behavioral health that is to be reported separately as described elsewhere in this document.**

Discharge - formal release of patient from a facility for any reason, including death.

Discharge Day - inpatient day associated with a discharge that occurred during the reporting period. All associated paid claim days are counted, even if those days occurred prior to the beginning of the reporting period.

Claim Costs – Total allowed claim costs incurred for the reported discharges and discharge days. The allowed claims costs should include member cost-sharing and be reported on a fee-for-service basis. Include all costs for the member during the admission (facility and professional costs, etc.).

Inpatient Behavioral Health Services – Includes Inpatient Detoxification; Inpatient Mental Health Services; and Inpatient Substance Abuse Services.

VI. OUTPATIENT NON-BEHAVIORAL HEALTH UTILIZATION
(see worksheets "Tier 1 Outpatient," "Tier 2 Outpatient," and "Tier 3 Outpatient")

Outpatient non-behavioral health utilization should be reported for the entire carrier, whether provided or arranged by the carrier or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**.

For reporting outpatient non-behavioral health utilization, include all paid claims incurred during the reporting period that were paid through March 31st. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the carrier has made payment to the provider of service.

Include: all primary care and referral encounters for members whether at in-plan health centers, in-network doctor offices, out-of-network locations, out-of-area claims or capitated provider visits; statistic should also include all visits to providers regardless of location at which treatment took place.

Exclude: utilization of non-carrier members; all inpatient care, lab/x-ray tests, and pharmacy transactions; **and all member outpatient utilization that falls under outpatient behavioral health that is to be reported separately as described elsewhere in this document**.

PCP Office Visit – non-behavioral health care encounters with a primary care physician that are not emergency room as defined below which are included in other groupings. Include office-based surgical procedures.

Specialist Office Visit – non-behavioral health care encounters with a specialist that are not emergency room as defined below which are included in other groupings. Include office-based surgical procedures.

Ambulatory Surgery – as defined in the most recent version of HEDIS®.

Observation Day – as defined in the most recent version of HEDIS®.

Emergency Room – as defined in the most recent version of HEDIS®.

Physicians – Medical Doctors and Doctors of Osteopathy providing other than behavioral health services.

Non-physicians – all other health professionals noted in the encounter section that provide health services to members other than behavioral health services.

Claim Costs – Total allowed claim costs incurred for the reported physician encounters and non-physician encounters. The allowed claims costs should include member cost-sharing and be reported

VI. OUTPATIENT NON-BEHAVIORAL HEALTH UTILIZATION (continued)

on a fee-for-service basis. Include all costs for the member during the encounter service date (facility and professional costs, etc.).

Encounter(s) – face-to-face visit with a provider who utilizes independent judgment in providing medical care to patients whether in a provider office, an inpatient facility, or at a patient's home. One encounter shall represent one unique member AND one unique calendar day AND one unique site of service. In cases where the patient sees a nurse practitioner (or similar clinician) and a physician in the same visit; this should be recorded as one encounter under the "physician" category. This statistic may be based on the most recent version of HEDIS® defined CPT™ codes for the following provider types:

Include visits with:	physicians, podiatrists, optometrists, audiologists, speech language pathologists, chiropractors, dentists, physician assistants, nurse practitioners, certified nurse midwives, therapists (speech, physical, occupational, rehabilitative), nutritionists, health educators, and Christian Science practitioners.
Exclude visits with:	registered nurses, nurse aides, x-ray technicians, lab assistants, pharmacists, and medical supply vendors, **and all behavioral health professionals that are to be reported separately as described below**.

VII. OUTPATIENT BEHAVIORAL HEALTH UTILIZATION
(see worksheets "Tier 1 Outpatient," "Tier 2 Outpatient," and "Tier 3 Outpatient")

Outpatient behavioral health utilization should be reported for the entire carrier, whether provided or arranged by the carrier or any delegated entity or contracting network. Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**.**

For reporting outpatient behavioral health utilization, include all paid claims incurred during the reporting period that were paid through March 31st. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the carrier has made payment to the provider of service.

Include: all behavioral health treatment for carrier members whether at in-plan health centers, in-network provider offices, out-of-network locations, out-of-area claims or capitated provider visits; statistic should also include all visits to providers regardless of location at which treatment took place.

Exclude: utilization of non-carrier members; all inpatient care, lab/x-ray tests, and pharmacy transactions; and **all member outpatient utilization that falls under outpatient non-behavioral health that is reported separately as described above**.

Physicians – Medical Doctors or Doctors of Osteopathy providing behavioral health services.

Non-physicians – the following licensed or otherwise certified health professionals who provide behavioral health services: psychologists; psychotherapists; independent clinical social workers; mental health counselors; nurse mental health clinical specialists; alcohol and drug counselors; marriage and family therapists; advanced practice registered nurses; registered nurse clinical specialists; nurse practitioners; and psychiatric clinical nurse specialists.

Encounter(s) – face-to-face visit with a physician or non-physician who provides behavioral health services who utilizes independent judgment in providing behavioral health care to patients whether in a provider office, inpatient facility, or at a patient's home. One encounter shall represent one unique member AND one unique calendar day AND one unique site of service. In cases where the patient sees a physician and non-physician in the same visit; this should be recorded as one encounter under the "physician" category.

Claim Costs – Total allowed claim costs incurred for the reported physician encounters and non-physician encounters. The allowed claims costs should include member cost-sharing and be reported on a fee-for-service basis. Include all costs for the member during the encounter service date (facility and professional costs, etc.).

Outpatient Behavioral Health Services – Includes Ambulatory Detoxification; Case Consultations; Crisis Intervention; Diagnostic Evaluations; Group Treatment/Counseling; Individual Treatment/Counseling; Intervention Services; and Mobile Assessment Team Services. Please note that a behavioral health professional must perform all services with an Evaluation and Management procedure code (CPT beginning with "99") in order to be included:

VIII. NON-TIERED PROVIDERS UTILIZATION
(see worksheets "Non-Tiered Inpatient" and "Non-Tiered Outpatient")

Outpatient utilization for non-behavioral health and behavioral health providers who participate in a limited, regional, or tiered network plan, but who are not classified into tiers for member cost-sharing purposes should be included within the "Non-Tiered" worksheet. Please use the above-noted definitions described in sections VI and VII.

IX. OUT-OF-NETWORK REQUESTS
(see worksheet "Out-of-Network Requests")

Number of Out-of-Network Requests: Total number of requests by insureds enrolled in Limited Provider Network plans for out-of-network coverage.

X. ATTACHMENTS

Data worksheets:

1. Annual Membership
2. Inpatient Utilization for Limited/Regional Network or Tier 1 providers and Out-of-Network Providers
3. Outpatient Utilization for Limited/Regional Network or Tier 1 providers and Out-of-Network Providers
4. Inpatient Utilization Tier 2 Providers
5. Outpatient Utilization Tier 2 Providers
6. Inpatient Utilization Tier 3 Providers
7. Outpatient Utilization Tier 3 Providers
8. Non-Tiered Inpatient
9. Non-Tiered Outpatient
10. Out-of-Network Requests

Limited, Regional and Tiered Provider Network Plans Report

Carrier Name:	**Blue Cross and Blue Shield of Massachusetts, Inc**
Product name & Form #:	
Hospital Choice	
Blue Care Elect Preferred Provider Plan Subscriber Certificate [Form # BCBS-PPO] with Hospital Choice Cost Sharing Rider:	
Rider 10-XXXX Basic (copayment version)	
Rider 10-XXXX Basic (coinsurance version)	
Type of Network:	Tiered Network
NAIC#:	**53328**
Reporting Period:	**Jan 2013 - Dec 2013**
Person completing report:	**Richard Massarelli**
Phone number:	**617.246.6737**
Email address:	**richard.massarelli@bcbsma.com**

Cost sharing for each tier (including copayment, deductible, and coinsurance):

See attached: Cost Sharing for Tiered Network Plans.doc

Membership in Plan as of December 31st

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Limited/Regional
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	0	0	0	0	0	0	2	0	2	0	0	0	0	0	14	4
6 through 12	0	0	0	0	0	0	3	1	0	0	0	0	0	0	27	4
13 through 18	0	0	0	0	0	0	1	1	0	0	4	0	0	0	14	6
19 through 25	0	0	0	0	0	0	6	0	0	0	3	0	0	2	25	11
26 through 64	0	1	0	0	0	0	22	6	3	0	7	0	1	1	166	41
65 +	0	0	0	0	0	0	2	0	0	0	2	0	0	1	5	5
Groups Total	0	1	0	0	0	0	36	8	5	0	16	0	1	4	251	71
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Limited/Regional**
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6 through 12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13 through 18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19 through 25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26 through 64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individual Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL CUMULATIVE MEMBER	0	1	0	0	0	0	36	8	5	0	16	0	1	4	251	71

Member Months in Plan

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Tiered
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	0	0	0	0	0	0	20	0	24	0	0	12	0	0	148	56
6 through 12	0	0	0	0	0	0	53	44	0	0	0	12	0	0	238	109
13 through 18	0	0	0	0	0	0	58	40	0	0	48	0	0	0	164	146
19 through 25	0	0	0	0	0	0	8	20	22	0	27	0	0	35	215	112
26 through 64	0	0	0	0	0	0	145	106	54	0	73	24	13	118	1628	533
65 +	0	0	0	0	16	0	0	0	12	0	24	0	0	12	50	64
Groups Total	0	0	0	0	16	0	284	210	112	0	172	48	13	165	2443	1020
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Tiered**
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6 through 12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13 through 18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19 through 25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26 through 64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65 +	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Individual Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL CUMULATIVE MEMBER MONTHS	0	0	0	0	16	0	284	210	112	0	172	48	13	165	2443	1020

Inpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 1 (or Limited/Regional) Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Med./Surg. Total	0	0	0	0	0	0
B. Maternity						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Maternity Total	0	0	0	0	0	0
II. Non-Acute Care						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Non-Acute Total	0	0	0	0	0	0
TOTAL UTILIZATION	0	0	0	0	0	0

Inpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
TOTAL UTILIZATION	0	0	0	0	0	0

Outpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 1 (or Limited/Regional) Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
PCP Office Visit Total	0	0	0	0	0	0
Specialist Office Visit						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Specialist Office Visit Total	0	0	0	0	0	0
Ambulatory Surgery						
1. Groups	0	0	0	0	0	0
5. Individual	0	0	0	0	0	0
Ambulatory Surgery Total	0	0	0	0	0	0
Observation Day						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Observation Day Total	0	0	0	0	0	0
Emergency Room						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
Emergency Room Total	0	0	0	0	0	0
TOTAL UTILIZATION	0	0	0	0	0	0

Outpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
TOTAL UTILIZATION	0	0	0	0	0	0

Inpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 2 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	0	0	0
2. Individual	0	0	0
Med./Surg. Total	0	0	0
B. Maternity			
1. Groups	0	0	0
2. Individual	0	0	0
Maternity Total	0	0	0
II. Non-Acute Care			
1. Groups	0	0	0
2. Individual	0	0	0
Non-Acute Total	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 2 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
PCP Office Visit Total	0	0	0
Specialist Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
Specialist Office Visit Total	0	0	0
Ambulatory Surgery			
1. Groups	0	0	0
5. Individual	0	0	0
Ambulatory Surgery Total	0	0	0
Observation Day			
1. Groups	0	0	0
2. Individual	0	0	0
Observation Day Total	0	0	0
Emergency Room			
1. Groups	0	0	0
2. Individual	0	0	0
Emergency Room Total	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 3 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	**Tier 3**		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	0	0	0
2. Individual	0	0	0
Med./Surg. Total	0	0	0
B. Maternity			
1. Groups	0	0	0
2. Individual	0	0	0
Maternity Total	0	0	0
II. Non-Acute Care			
1. Groups	0	0	0
2. Individual	0	0	0
Non-Acute Total	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Behavioral Health	**Tier 3**		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Tier 3 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
PCP Office Visit Total	0	0	0
Specialist Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
Specialist Office Visit Total	0	0	0
Ambulatory Surgery			
1. Groups	0	0	0
5. Individual	0	0	0
Ambulatory Surgery Total	0	0	0
Observation Day			
1. Groups	0	0	0
2. Individual	0	0	0
Observation Day Total	0	0	0
Emergency Room			
1. Groups	0	0	0
2. Individual	0	0	0
Emergency Room Total	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs

1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Non-Tiered Provider Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	4	7	49890.9	0	0	0
2. Individual	0	0	0	0	0	0
Med./Surg. Total	4	7	49890.9	0	0	0
B. Maternity						
1. Groups	1	3	12133.64	0	0	0
2. Individual	0	0	0	0	0	0
Maternity Total	1	3	12133.64	0	0	0
II. Non-Acute Care						
1. Groups	1	27	33675.47	0	0	0
2. Individual	0	0	0	0	0	0
Non-Acute Total	1	27	33675.47	0	0	0
TOTAL UTILIZATION	6	37	95700.01	0	0	0

Inpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
TOTAL UTILIZATION	0	0	0	0	0	0

Outpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts, Inc

Non-Tiered Provider Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	0	0	0	0	0	0
2. Individual	0	0	0	0	0	0
PCP Office Visit Total	0	0	0	0	0	0
Specialist Office Visit						
1. Groups	408	42	59817.61	0	0	0
2. Individual	0	0	0	0	0	0
Specialist Office Visit Total	408	42	59817.61	0	0	0
Ambulatory Surgery						
1. Groups	81	0	29401.57	0	0	0
5. Individual	0	0	0	0	0	0
Ambulatory Surgery Total	81	0	29401.57	0	0	0
Observation Day						
1. Groups	3	0	8461.77	0	0	0
2. Individual	0	0	0	0	0	0
Observation Day Total	3	0	8461.77	0	0	0
Emergency Room						
1. Groups	22	0	15825.54	0	0	0
2. Individual	0	0	0	0	0	0
Emergency Room Total	22	0	15825.54	0	0	0
TOTAL UTILIZATION	514	42	113506.49	0	0	0

Outpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	21	169	19406.93	0	0	0
2. Individual	0	0	0	0	0	0
TOTAL UTILIZATION	21	169	19406.93	0	0	0

Out-of-Network Requests

Blue Cross and Blue Shield of Massachusetts, I

	Total # of Requests
1. Groups	NA
2. Individual	NA
Total	0

Limited, Regional and Tiered Provider Network Plans Report

Carrier Name:	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**
Product name & Form #:	
Hospital Choice Cost Sharing	
Health Maintenance Organization Subscriber Certificate [Form # HMO] with Hospital Choice Cost Sharing Rider 10-XXXX Basic (copayment or coinsurance version)	
Preferred Blue PPO Preferred Provider Plan Subscriber Certificate [Form # HMO-PPO] with Hospital Choice Cost Sharing Rider 10-XXXX Basic (copayment or coinsurance version)	
Type of Network:	Tiered Network
NAIC#:	**12219**
Reporting Period:	**Jan 2013 - Dec 2013**
Person completing report	**Richard Massarelli**
Phone number:	**617.246.6737**
Email address:	**richard.massarelli@bcbsma.com**

Cost sharing for each tier (including copayment, deductible, and coinsurance):

See attached: Cost Sharing for Tiered Network Plans.doc

Membership in Plan as of December 31st

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Limited/Regional
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	98	27	363	9	553	48	127	71	1085	60	446	379	162	368	839	3796
6 through 12	158	42	590	20	886	63	164	94	1613	74	737	631	194	728	1250	5994
13 through 18	161	58	587	12	839	55	184	111	1623	79	751	575	179	716	1164	5930
19 through 25	226	72	757	19	1178	68	241	108	2213	79	922	683	438	817	1450	7821
26 through 64	1518	462	4870	185	6460	492	1385	804	12527	625	5253	4140	2991	4947	8986	46659
65 +	54	5	138	2	157	19	30	11	296	8	152	98	96	154	206	1220
Groups Total	2215	666	7305	247	10073	745	2131	1199	19357	925	8261	6506	4060	7730	13895	71420
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Limited/Regional**
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	25	10	25	8	48	3	15	10	151	14	92	46	43	41	2	531
6 through 12	30	14	37	17	102	2	16	25	258	9	154	79	33	85	2	861
13 through 18	28	15	37	12	93	8	11	16	325	5	146	89	29	60	1	874
19 through 25	30	28	43	20	156	9	25	14	348	8	159	73	60	64	11	1037
26 through 64	535	160	478	116	1019	84	221	180	2802	118	1178	699	764	628	76	8982
65 +	7	4	4	1	18	5	6	2	53	4	11	9	13	6	1	143
Individual Total	655	231	624	174	1436	111	294	247	3937	158	1740	995	942	884	93	12428
TOTAL CUMULATIVE MEMBER	2870	897	7929	421	11509	856	2425	1446	23294	1083	10001	7501	5002	8614	13988	83848

Member Months in Plan

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Tiered
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	1210	281	4188	100	6660	505	1444	958	13123	705	5330	4246	2106	4748	9510	45604
6 through 12	2030	468	6959	251	10676	730	1907	1209	19296	965	8707	6998	2428	8443	14337	71067
13 through 18	1821	645	6844	151	10131	669	2246	1360	19352	883	8587	6523	2202	8466	13547	69880
19 through 25	2627	773	8760	268	13927	728	2844	1345	25482	953	10421	7694	5117	9737	15864	90676
26 through 64	18424	5090	55738	2326	77307	5552	16252	9378	148051	7382	60974	46659	35697	58942	101226	547772
65 +	558	55	1526	17	1757	190	391	119	3326	81	1618	1154	1063	1692	2268	13547
Groups Total	26670	7312	84015	3113	120458	8374	25084	14369	228630	10969	95637	73274	48613	92028	156752	838546
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Tiered**
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	300	101	292	106	551	36	192	136	1814	175	1032	540	496	503	90	6274
6 through 12	371	174	464	198	1331	41	213	302	3338	92	1744	977	339	965	69	10549
13 through 18	331	178	470	148	1141	109	164	218	4002	66	1715	968	382	663	51	10555
19 through 25	367	352	589	209	1951	131	331	205	4200	98	1916	875	702	758	163	12684
26 through 64	6726	2032	6252	1390	12637	1072	2847	2328	34316	1451	14029	8441	9136	7510	1490	110167
65 +	82	52	46	21	178	34	70	26	674	40	142	76	135	54	29	1630
Individual Total	8177	2889	8113	2072	17789	1423	3817	3215	48344	1922	20578	11877	11190	10453	1892	151859
TOTAL CUMULATIVE MEMBER MONTHS	34847	10201	92128	5185	138247	9797	28901	17584	276974	12891	116215	85151	59803	102481	158644	990405

Inpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 1 (or Limited/Regional) Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	1330	4577	24170869.16	29	139	902592.62
2. Individual	153	591	3042748.18	8	37	475065.19
Med./Surg. Total	1483	5168	27213617.34	37	176	1377657.81
B. Maternity						
1. Groups	367	1140	4910816.33	1	2	12830.14
2. Individual	38	113	487370.84	0	0	0
Maternity Total	405	1253	5398187.17	1	2	12830.14
II. Non-Acute Care						
1. Groups	81	585	1064451.43	8	59	81221.2
2. Individual	11	118	205701.64	2	10	17486.18
Non-Acute Total	92	703	1270153.07	10	69	98707.38
TOTAL UTILIZATION	1980	7124	33881957.58	48	247	1489195.33

Inpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	67	252	385812.43	3	15	29178.34
2. Individual	8	23	29221.77	1	1	1225.75
TOTAL UTILIZATION	75	275	415034.2	4	16	30404.09

Outpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 1 (or Limited/Regional) Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	0	0	0	36	7	5027.92
2. Individual	0	0	0	1	0	162.4
PCP Office Visit Total	0	0	0	37	7	5190.32
Specialist Office Visit						
1. Groups	0	0	0	319	205	75176.58
2. Individual	0	0	0	68	42	12320.36
Specialist Office Visit Total	0	0	0	387	247	87496.94
Ambulatory Surgery						
1. Groups	3980	0	2000689.12	39	0	59249.95
5. Individual	477	0	261064.76	18	0	10471.13
Ambulatory Surgery Total	4457	0	2261753.88	57	0	69721.08
Observation Day						
1. Groups	1060	0	1997770.92	18	0	15643.47
2. Individual	99	0	229544.71	3	0	1644.16
Observation Day Total	1159	0	2227315.63	21	0	17287.63
Emergency Room						
1. Groups	8708	0	3901991.92	430	0	634263.08
2. Individual	791	0	369100.97	90	0	173691.62
Emergency Room Total	9499	0	4271092.89	520	0	807954.7
TOTAL UTILIZATION	15115	0	8760162.4	1022	254	987650.67

Outpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	0	0	0	35	99	14544.58
2. Individual	0	0	0	10	9	1774.91
TOTAL UTILIZATION	0	0	0	45	108	16319.49

Inpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 2 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	0	0	0
2. Individual	0	0	0
Med./Surg. Total	0	0	0
B. Maternity			
1. Groups	0	0	0
2. Individual	0	0	0
Maternity Total	0	0	0
II. Non-Acute Care			
1. Groups	0	0	0
2. Individual	0	0	0
Non-Acute Total	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 2 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
PCP Office Visit Total	0	0	0
Specialist Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
Specialist Office Visit Total	0	0	0
Ambulatory Surgery			
1. Groups	0	0	0
5. Individual	0	0	0
Ambulatory Surgery Total	0	0	0
Observation Day			
1. Groups	0	0	0
2. Individual	0	0	0
Observation Day Total	0	0	0
Emergency Room			
1. Groups	0	0	0
2. Individual	0	0	0
Emergency Room Total	0	0	0
TOTAL UTILIZATION	0	0	0

Outpatient Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 3 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 3		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	640	2860	18136875.31
2. Individual	68	395	1859498.15
Med./Surg. Total	708	3255	19996373.46
B. Maternity			
1. Groups	126	469	2133942.95
2. Individual	13	45	254618.3
Maternity Total	139	514	2388561.25
II. Non-Acute Care			
1. Groups	20	226	896440.24
2. Individual	3	40	70187.99
Non-Acute Total	23	266	966628.23
TOTAL UTILIZATION	870	4035	23351562.94

Inpatient Behavioral Health	Tier 3		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	15	47	63547.6
2. Individual	1	5	8157.27
TOTAL UTILIZATION	16	52	71704.87

Outpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 3 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
PCP Office Visit Total	0	0	0
Specialist Office Visit			
1. Groups	0	0	0
2. Individual	0	0	0
Specialist Office Visit Total	0	0	0
Ambulatory Surgery			
1. Groups	539	0	133118.12
5. Individual	65	0	17448.45
Ambulatory Surgery Total	604	0	150566.57
Observation Day			
1. Groups	370	0	1066033.09
2. Individual	63	0	164572.31
Observation Day Total	433	0	1230605.4
Emergency Room			
1. Groups	2117	0	1434481.29
2. Individual	254	0	187272.94
Emergency Room Total	2371	0	1621754.23
TOTAL UTILIZATION	3408	0	3002926.2

Outpatient Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs

1. Groups	0	0	0
2. Individual	0	0	0
TOTAL UTILIZATION	0	0	0

Inpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Non-Tiered Provider Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	363	1742	9480485.1	0	0	0
2. Individual	240	1165	5780248.08	0	0	0
Med./Surg. Total	603	2907	15260733.18	0	0	0
B. Maternity						
1. Groups	92	284	1458302.06	0	0	0
2. Individual	30	104	491823.92	0	0	0
Maternity Total	122	388	1950125.98	0	0	0
II. Non-Acute Care						
1. Groups	288	3005	3317854.26	0	0	0
2. Individual	131	1399	1773158.29	0	0	0
Non-Acute Total	419	4404	5091012.55	0	0	0
TOTAL UTILIZATION	1144	7699	22301871.71	0	0	0

Inpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	124	645	592318.59	0	0	0
2. Individual	45	194	256915.37	0	0	0
TOTAL UTILIZATION	169	839	849233.96	0	0	0

Outpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Non-Tiered Provider Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	123880	9002	18934601.44	0	0	0
2. Individual	13496	676	2106399.35	0	0	0
PCP Office Visit Total	137376	9678	21041000.79	0	0	0
Specialist Office Visit						
1. Groups	130922	19194	20838491.84	0	0	0
2. Individual	39948	4992	6386939.53	0	0	0
Specialist Office Visit Total	170870	24186	27225431.37	0	0	0
Ambulatory Surgery						
1. Groups	24506	0	12626862.83	0	0	0
5. Individual	6726	0	3240408.99	0	0	0
Ambulatory Surgery Total	31232	0	15867271.82	0	0	0
Observation Day						
1. Groups	329	0	722369.28	0	0	0
2. Individual	172	0	439946.55	0	0	0
Observation Day Total	501	0	1162315.83	0	0	0
Emergency Room						
1. Groups	2199	0	4036021.73	0	0	0
2. Individual	1322	0	1535069.72	0	0	0
Emergency Room Total	3521	0	5571091.45	0	0	0
TOTAL UTILIZATION	343500	33864	70867111.26	0	0	0

Outpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	15928	87839	10643926.48	0	0	0
2. Individual	9347	34415	4804308.37	0	0	0
TOTAL UTILIZATION	25275	122254	15448234.85	0	0	0

Out-of-Network Requests

Blue Cross and Blue Shield of Massachusetts H

	Total # of Requests
1. Groups	NA
2. Individual	NA
Total	0

Limited, Regional and Tiered Provider Network Plans Report

Carrier Name:	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**
Product name & Form #:	
Options (local and New England plans)	
Health Maintenance Organization Subscriber Certificate [Form # HMO] with HMO Blue Options Schedule of Benefits	
Preferred Blue PPO Preferred Provider Provider Subscriber Certificate [Form # HMO-PPO] with Preferred Blue PPO Options Schedule of Benefits	
Type of Network:	Tiered Network
NAIC#:	**12219**
Reporting Period:	**Jan 2013 - Dec 2013**
Person completing report:	**Richard Massarelli**
Phone number:	**617.246.6737**
Email address:	**richard.massarelli@bcbsma.com**

Cost sharing for each tier (including copayment, deductible, and coinsurance):

See attached: Cost Sharing for Tiered Network Plans.doc

Membership in Plan as of December 31st

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Limited/Regional
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	56	2	234	7	524	10	57	17	890	11	315	296	234	733	619	3386
6 through 12	86	6	384	2	788	30	106	28	1200	13	420	428	242	1030	871	4763
13 through 18	74	5	324	6	731	24	64	18	1292	6	446	477	213	1098	909	4778
19 through 25	122	6	416	11	946	24	110	23	1642	5	611	587	387	1483	1203	6373
26 through 64	700	56	2670	40	5476	207	722	217	9776	63	3269	2937	2730	7510	6547	36373
65 +	53	2	72	1	197	12	56	11	460	0	189	125	128	287	239	1593
Groups Total	1091	77	4100	67	8662	307	1115	314	15260	98	5250	4850	3934	12141	10388	57266
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Limited/Regional**
Member Age	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Members at End of Year	Massachusetts Only Members at End of Year
0 through 5	0	0	0	0	2	0	0	0	4	0	1	4	0	3	0	14
6 through 12	0	0	0	0	1	0	0	0	2	0	1	1	0	0	0	5
13 through 18	0	0	0	0	2	0	0	0	1	0	1	0	0	2	0	6
19 through 25	0	2	0	0	0	0	0	0	4	0	0	1	0	7	0	14
26 through 64	1	3	1	0	10	0	5	0	32	0	7	8	5	10	1	82
65 +	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	2
Individual Total	1	5	1	0	16	0	5	0	44	0	10	14	5	22	1	123
TOTAL CUMULATIVE MEMBER	1092	82	4101	67	8678	307	1120	314	15304	98	5260	4864	3939	12163	10389	57389

Member Months in Plan

Group	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester	Other States	Tiered
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	597	21	2781	76	6209	110	724	141	9867	128	3513	3450	2464	7788	7152	37869
6 through 12	971	72	4458	17	9289	323	1294	302	14200	144	4928	5015	2714	11147	10700	54874
13 through 18	855	64	3729	77	8477	232	857	233	15249	45	5240	5474	2318	12127	10790	54977
19 through 25	1353	79	5022	143	10919	253	1381	294	19043	88	7107	6769	4519	15573	13753	72543
26 through 64	7993	631	31015	470	63659	2246	9073	2435	112326	767	38170	33853	30882	80559	75893	414079
65 +	625	24	859	7	2190	129	693	112	4948		2086	1376	1342	2871	2629	17262
Groups Total	12394	891	47864	790	100743	3293	14022	3517	175633	1172	61044	55937	44239	130065	120917	651604
Individual	**Barnstable**	**Berkshire**	**Bristol**	**Dukes**	**Essex**	**Franklin**	**Hampden**	**Hampshire**	**Middlesex**	**Nantucket**	**Norfolk**	**Plymouth**	**Suffolk**	**Worcester**	**Other States**	**Tiered**
Member Age	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Cumulative Member Months	Massachusetts Only Cumulative Member Months
0 through 5	0	0	0	0	24	0	0	0	48	0	12	48	0	25	0	157
6 through 12	0	0	0	0	4	0	0	0	25	0	6	3	0	0	0	38
13 through 18	0	0	0	0	8	0	0	0	12	0	6	0	0	10	0	36
19 through 25	0	10	0	0	8	0	0	0	38	0	0	3	0	59	0	118
26 through 64	13	22	12	0	114	8	31	0	366	0	72	78	63	104	5	883
65 +	0	0	0	0	1	0	0	0	4	0	0	0	0	0	0	5
Individual Total	13	32	12	0	159	8	31	0	493	0	96	132	63	198	5	1237
TOTAL CUMULATIVE MEMBER MONTHS	12407	923	47876	790	100902	3301	14053	3517	176126	1172	61140	56069	44302	130263	120922	652841

Inpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 1 (or Limited/Regional) Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	1123	3955	21270603.06	24	147	1067212.5
2. Individual	0	0	0	0	0	0
Med./Surg. Total	1123	3955	21270603.06	24	147	1067212.5
B. Maternity						
1. Groups	311	980	4167743.03	2	25	23955.25
2. Individual	0	0	0	0	0	0
Maternity Total	311	980	4167743.03	2	25	23955.25
II. Non-Acute Care						
1. Groups	74	511	995560.74	5	44	182109.6
2. Individual	0	0	0	0	0	0
Non-Acute Total	74	511	995560.74	5	44	182109.6
TOTAL UTILIZATION	1508	5446	26433906.83	31	216	1273277.35

Inpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	44	148	328567.11	0	0	0
2. Individual	1	7	5593.03	0	0	0
TOTAL UTILIZATION	45	155	334160.14	0	0	0

Outpatient Utilization for Limited/Regional Network or Tier 1 Providers and Out-of-Network Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 1 (or Limited/Regional) Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	29368	7213	4562483.79	33	4	4410.37
2. Individual	7	5	1745.89	0	0	0
PCP Office Visit Total	29375	7218	4564229.68	33	4	4410.37
Specialist Office Visit						
1. Groups	13242	3862	1280758.28	168	105	36112.48
2. Individual	7	1	662.1	0	0	0
Specialist Office Visit Total	13249	3863	1281420.38	168	105	36112.48
Ambulatory Surgery						
1. Groups	2425	0	1464479.72	23	0	11014.95
5. Individual	1	0	733.46	0	0	0
Ambulatory Surgery Total	2426	0	1465213.18	23	0	11014.95
Observation Day						
1. Groups	894	0	1584226.35	9	0	14987.03
2. Individual	0	0	0	0	0	0
Observation Day Total	894	0	1584226.35	9	0	14987.03
Emergency Room						
1. Groups	6489	0	2840521.57	246	0	346243.22
2. Individual	2	0	1687.68	0	0	0
Emergency Room Total	6491	0	2842209.25	246	0	346243.22
TOTAL UTILIZATION	52435	11081	11737298.84	479	109	412768.05

Outpatient Behavioral Health	Tier 1 (or Limited/Regional) Providers			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	397	29	35383.4	12	39	6147.55
2. Individual	0	0	0	0	0	0
TOTAL UTILIZATION	397	29	35383.4	12	39	6147.55

Inpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 2 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	221	747	3302168.75
2. Individual	0	0	0
Med./Surg. Total	221	747	3302168.75
B. Maternity			
1. Groups	87	249	1144380.55
2. Individual	0	0	0
Maternity Total	87	249	1144380.55
II. Non-Acute Care			
1. Groups	10	53	112104.85
2. Individual	0	0	0
Non-Acute Total	10	53	112104.85
TOTAL UTILIZATION	318	1049	4558654.15

Inpatient Behavioral Health	Tier 2		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	18	64	78567.54
2. Individual	0	0	0
TOTAL UTILIZATION	18	64	78567.54

Outpatient Utilization for Tier 2 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 2 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	62391	171	9193357.91
2. Individual	49	0	6481.45
PCP Office Visit Total	62440	171	9199839.36
Specialist Office Visit			
1. Groups	3966	115	497990.61
2. Individual	1	0	212.09
Specialist Office Visit Total	3967	115	498202.7
Ambulatory Surgery			
1. Groups	1215	0	308528.43
5. Individual	1	0	145.3
Ambulatory Surgery Total	1216	0	308673.73
Observation Day			
1. Groups	279	0	570711.24
2. Individual	0	0	0
Observation Day Total	279	0	570711.24
Emergency Room			
1. Groups	2184	0	951367.96
2. Individual	0	0	0
Emergency Room Total	2184	0	951367.96
TOTAL UTILIZATION	70086	286	11528794.99

Outpatient Behavioral Health	Tier 2		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	38	0	5599.17
2. Individual	0	0	0
TOTAL UTILIZATION	38	0	5599.17

Inpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 3 Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Tier 3		
	Total Discharges	Discharge Days	Claim Costs
I. Acute Care			
A. Med./Surg.			
1. Groups	432	2039	13656927.52
2. Individual	0	0	0
Med./Surg. Total	432	2039	13656927.52
B. Maternity			
1. Groups	96	320	1571845.04
2. Individual	0	0	0
Maternity Total	96	320	1571845.04
II. Non-Acute Care			
1. Groups	22	278	909454.15
2. Individual	0	0	0
Non-Acute Total	22	278	909454.15
TOTAL UTILIZATION	550	2637	16138226.71

Inpatient Behavioral Health	Tier 3		
	Total Discharges	Discharge Days	Claim Costs
1. Groups	3	8	15104.46
2. Individual	0	0	0
TOTAL UTILIZATION	3	8	15104.46

Outpatient Utilization for Tier 3 Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Tier 3 Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit			
1. Groups	14511	825	2245083.74
2. Individual	8	0	942.26
PCP Office Visit Total	14519	825	2246026
Specialist Office Visit			
1. Groups	6522	599	610882.57
2. Individual	5	0	396.87
Specialist Office Visit Total	6527	599	611279.44
Ambulatory Surgery			
1. Groups	272	0	59323.97
5. Individual	0	0	0
Ambulatory Surgery Total	272	0	59323.97
Observation Day			
1. Groups	333	0	959343.64
2. Individual	0	0	0
Observation Day Total	333	0	959343.64
Emergency Room			
1. Groups	1925	0	1269752.45
2. Individual	1	0	961.91
Emergency Room Total	1926	0	1270714.36
TOTAL UTILIZATION	23577	1424	5146687.41

Outpatient Behavioral Health	Tier 3		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs

1. Groups	100	6	7418.78
2. Individual	0	0	0
TOTAL UTILIZATION	100	6	7418.78

Inpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Non-Tiered Provider Inpatient cost-sharing:

Inpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
I. Acute Care						
A. Med./Surg.						
1. Groups	86	733	2707609.92	0	0	0
2. Individual	1	7	2905	0	0	0
Med./Surg. Total	87	740	2710514.92	0	0	0
B. Maternity						
1. Groups	24	73	353212.81	0	0	0
2. Individual	1	2	11096.89	0	0	0
Maternity Total	25	75	364309.7	0	0	0
II. Non-Acute Care						
1. Groups	234	2290	2205369.12	0	0	0
2. Individual	8	67	82705.79	0	0	0
Non-Acute Total	242	2357	2288074.91	0	0	0
TOTAL UTILIZATION	354	3172	5362899.53	0	0	0

Inpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Discharges	Discharge Days	Claim Costs	Total Discharges	Discharge Days	Claim Costs
1. Groups	112	727	447441.07	0	0	0
2. Individual	2	11	11767.46	0	0	0
TOTAL UTILIZATION	114	738	459208.53	0	0	0

Outpatient Utilization for Non-Tiered Providers

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Non-Tiered Provider Outpatient cost-sharing:

Outpatient Non-Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
PCP Office Visit						
1. Groups	9304	875	1436486.35	0	0	0
2. Individual	2	0	290.4	0	0	0
PCP Office Visit Total	9306	875	1436776.75	0	0	0
Specialist Office Visit						
1. Groups	60519	8099	10395933.58	0	0	0
2. Individual	396	28	65271.2	0	0	0
Specialist Office Visit Total	60915	8127	10461204.78	0	0	0
Ambulatory Surgery						
1. Groups	15912	0	8739690.55	0	0	0
5. Individual	70	0	24184.09	0	0	0
Ambulatory Surgery Total	15982	0	8763874.64	0	0	0
Observation Day						
1. Groups	39	0	112810.18	0	0	0
2. Individual	2	0	8004	0	0	0
Observation Day Total	41	0	120814.18	0	0	0
Emergency Room						
1. Groups	344	0	2434963.64	0	0	0
2. Individual	16	0	16156.73	0	0	0
Emergency Room Total	360	0	2451120.37	0	0	0
TOTAL UTILIZATION	86604	9002	23233790.72	0	0	0

Outpatient Behavioral Health	Non-Tiered In-Network			Out-of-Network		
	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs	Total Physician Encounters	Total Non-Physician Encounters	Claim Costs
1. Groups	9242	58774	6669960.82	0	0	0
2. Individual	132	342	50066.12	0	0	0
TOTAL UTILIZATION	9374	59116	6720026.94	0	0	0

Out-of-Network Requests

Blue Cross and Blue Shield of Massachusetts H

	Total # of Requests
1. Groups	NA
2. Individual	NA
Total	0

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 2011	2.2%	0.8%	0.4%	0.1%	3.6%
CY 2012	0.3%	0.4%	0.2%	0.1%	1.0%
CY 2013	1.1%	0.7%	0.4%	0.1%	2.4%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends are not adjusted for any changes in product, provider or demographic mix. These trends include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the change in provider.

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 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) are reflected in Unit Cost trend as well as Total trend.

AGO Payer Exhibit # 2, Question #2
Total In-State Membership (for members living in Massachusetts)

a. In-State Membership by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	29,207	30,980	36,827	44,503
Commercial Small Group	201,288	193,356	204,690	231,791
Commercial Large Group	1,218,566	1,219,961	1,217,986	1,235,526
Medicare	257,647	252,135	252,948	248,181
Medicaid MCO				
MassHealth				
Commonwealth Care				
Other Government	310,570	310,323	364,838	368,843
Total	2,017,278	2,006,755	2,077,289	2,128,844

b. In-State Membership Whose Care Is Reimbursed Through a Risk Contract by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	17,201	16,900	17,263	20,151
Commercial Small Group	137,778	119,266	110,879	123,647
Commercial Large Group	376,493	352,195	368,837	388,892
Medicare	10,928	8,235	6,465	7,535
Medicaid MCO				
MassHealth				
Commonwealth Care				
Other Government	131,481	112,733	129,144	126,344
Total	673,881	609,329	632,588	666,569

c. In-State Membership by Commercial Market Segment and Product Line

Market Segment	Product Line		Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	HMO/POS	Fully-Insured	28,492	30,135	35,568	42,822
		Self-Insured	-	-	-	-
	PPO/Indemnity	Fully-Insured	715	845	1,259	1,681
		Self-Insured	-	-	-	-
Commercial Small Group	HMO/POS	Fully-Insured	197,528	189,199	199,611	225,008
		Self-Insured	-	-	-	-
	PPO/Indemnity	Fully-Insured	3,760	4,157	5,079	6,783
		Self-Insured	-	-	-	-
Commercial Large Group	HMO/POS	Fully-Insured	340,708	336,538	339,929	353,415
		Self-Insured	166,970	182,304	267,413	297,280
	PPO/Indemnity	Fully-Insured	86,691	87,934	79,565	83,633
		Self-Insured	624,197	613,185	531,079	501,198
			1,449,061	**1,444,297**	**1,459,503**	**1,511,820**

d. In-State Membership in Tiered Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	12,704	13,329	14,470	145
Commercial Small Group	71,261	67,417	62,731	11,041
Commercial Large Group	68,809	68,074	57,148	33,289
Total	**152,774**	**148,820**	**134,349**	**44,475**

e. In-State Membership in Limited Network Product by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	NA	NA	NA	NA
Commercial Small Group	NA	NA	NA	NA
Commercial Large Group	NA	NA	NA	NA
Total	NA	NA	NA	NA

f. In-State Membership in High Cost Sharing Plan by Market Segment

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	20,609	21,512	23,631	25,786
Commercial Small Group	159,651	150,652	151,840	156,868
Commercial Large Group	197,626	188,414	178,011	160,907

Total	**377,886**	**360,578**	**353,482**	**343,561**

* Other Government includes FEP, MSP, Municipal, and MIIA.

AGO Question 4

Group Employer Accounts

Excludes Host, FEP, and MSP

	(i) All	(ii) MH		(iii) No MH	
Date	Accounts	Accounts	Tot Claim Payments	Accounts	Tot Claim Payments
200912	37,245	37,240	$9,052,503,890	5	$194,402,387
201012	32,938	32,934	$8,715,642,411	4	$212,735,195
201112	30,074	30,072	$8,560,471,380	2	$201,648,189
201212	27,859	27,858	$8,588,133,032	1	$144,179,067
201312	27,366	27,365	$8,807,280,827	1	$91,225,808
201406	27,015	27,015	$4,338,657,117	-	$42,030,508