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: Fallon Health aggresively negotiates with providers; encourages provider groups to enter into alternative payment arrangements; continues to market a broad range of limited and tiered network plan designs; and contiues to implement Cost of Care Committee initiatives. These actions have resulted in Fallon Health having a Total Medical Expense (TME) below the 3.6% cost growth benchmark as evidenced in the Center for Health Information and Analysis September 2014 Annual Report on the Performance of the Massachusetts Health Care System.
   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?
      Fallon Health conducts all rate negotiations with the goal of having TME increases not to exceed 3.6% on an annual basis. We move providers, whenever feasible, to surplus sharing or full up and down risk arrangements.

      We continue to market our high-performing limited network products - Direct Care and Steward Community Care. We also contine to offer tiered network plans to our self-insured clients. These "Advantage Plans" are designed with provider tiering based on individual employer's claims experience and the geographic location of their employees, as well as data on the quality, cost and utilization efficiency of the providers in the network.

      Futhermore, Fallon Health's Cost of Care Committee continues to seek new and innovative ways to reduce the cost of care by utilizing a broad variety of tools to address not just price, but also the most appropriate utilization of services in the most appropriate settings. A recent Fallon Health Cost of Care introduction is the SmartChoice program administered by our medical cost management partner for high-tech radiology. The SmartChoice program is a high-tech radiology program (for MRIs and CTs only) designed to offer savings to members and to Fallon Health by encouraging providers to direct members to lower cost and often more convenient facilities. If a provider selects a higher cost facility, SmartChoice representatives will recommend a lower cost option to the provider. Depending on the provider's choice, SmartChoice will also outreach to the member to inform them of their options. Since this is a voluntary program members still retain the decision as to where they are most comfortable receiving their care.
   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

By October 1 Fallon Health will have a web-based cost transparency tool in place. The tool will provide members with a broad range of data readily available in real time to assist them in making informed decisions about their health care and its costs.

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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: Fallon Health continues to negotiate with providers to enter into alternative payment arrangments including shared savings, partial risk, and full risk arrangements.
    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.
    During 2014 we have put an even greater emphasis on negotiating alternative payment arrangments with provider groups. The models utilized include shared savings, capitation for primary care services, and global budgets with partial or full risk both up and down. To be successful, these arrangements have to focus on several variables including: utilization of primary care services and where these services are delivered; appropriate use of specialty services and the delivery site of these services; referral of assigned population to efficient and cost effective ancillary providers for services such as lab, outpatient therapies, and diagnostic imaging; and reduction of unnecessary hospital admissions, including hospital readmissions. We have found that at-risk providers can significantly reduce TME through coordination of care; referral management to lower cost providers; and the elimination of duplicative or unnecessary testing. Typically, these savings have been obtained with no decrease in patient satisfaction and no negative impact on patient outcomes.
    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?
    Between now and October 1, 2015 Fallon Health plans to negotiate additional alternative payment arrangements with at least four more integrated health systems. Several of these negotiations are already in the initial discussion phase. These models all apply to primary care providers, specialists, and hospitals. These arrangements will be a mix of shared savings, partial risk, and full risk. The commonality is that all three models will have global budgets and all three types of arrangments will involve planned efforts to reduce overall TME for the attributed patient population or to at least significantly reduce the year-over-year growth rate in TME.

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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: Fallon Health continues to implement risk contracts whenever possible. However, due to relatively small size of Fallon Health membership, there are many providers who do not have enough members for a statistically valid risk arrangement of any type.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012	300	2
CY2013	907	4.3

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: Fallon Health uses age/gender, product mix, benefit buy down, and a paid-to-allowed ratio factor. These four factors are updated quarterly for risk budgets. We also use catastrophic pooling methodology at time of risk settlement.
   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, Fallon Health does use a common approach to risk adjustment for all providers.
   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?
      At this time Fallon Health does perceive some value in the standardization of risk adjustment measures for use in contracts both across providers and across payer organizations. Having standard measures across payers should result in less provider anxiety and prolonged negotiation regarding risk adjustment measures. Having standard measures should also allow at-risk provider organizations to analyze their risk contracts across different payers and to better understand any differences or similarities with their assigned populations from different payers. Providers in risk arrangments could also find economies of scale when managing similar patient populations from different payers by using already developed infrastucture and staff. At this time we do not see any particular value to diffentiation in risk adjustment methdology by payer.

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?
Currently, Fallon Health does not include specific population based socioeconomic adjustments to its risk budgets. Fallon Health does not have any plans at this time to incorporate specific population based socioeconomic adjustments into its risk budgets.

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?
Risk budgets are severity adjusted so provider organizations with healthier populations receive lower PMPM budgets to cover the TME for their assigned member population. Provider organizations with higher risk populations receive higher PMPM budgets to cover the TME for their assigned populations. Receiving a lower than expected risk adjusted budget will often result in the at-risk provider group focusing more on their assigned population - analyzing what are the drivers of TME by service type and developing strategies specific to each medical service type to reduce cost while retaining or improving postive outcomes.

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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: Fallon Health uses quality metrics that are recommended by both state and nationally based quality organizations. We try to reduce administrative cost and complexity by choosing metrics that providers are already tracking and those metrics that will likely meet the needs of multiple payers.
    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, Fallon Health does use a common approach to quality measurement and associated payments to providers. Whenever possible, Fallon Health tries to use standard quality measures that are publically available at the state and national levels. We also work with providers whenever possible to use the same quality measures that the provider is already tracking for NCQA or other national quality organizations or that the provider is tracking for other payers. This approach allows providers to focus on core measures of quality with the greatest impact for patients and to keep their administrative costs lower since the same quality metrics can be used to satisfy the quality goals with many different payers.
    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?

At this time Fallon Health does not anticipate any significant drawbacks regarding the potential use of standardized quality measures across all payers. The potential value is that adoption of uniform measures will reduce administrative cost for providers and allow providers to more easily scale their efforts to improve quality measure across all their payer populations.

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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: Fallon Health's history as a health maintenance organization (HMO) incorporates the fundamental principal that members choose a primary care provider (PCP) to coordinate their care if they choose an HMO product.
   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)
         Fallon Health classifies internists, pedicatricians, and family practitioners as primary care providers. NPs and PAs may be primary care providers based on application and appropriate credentialing.
      ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
         N/A see below
      iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
         N/A see below
      iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
         N/A see below
      v. whether patients are attributed retrospectively or prospectively.
         N/A see below
   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?
      Only 4% of Fallon Health's commercial members are in PPO products, with many of these out of state. For this reason Fallon Health has not yet developed an attribution methodology for its PPO membership.
   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?
      A standard attribution methodology may be counterproductive to a plan that has already implemented a successful methodology.
   d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?

Fallon Health is primarily a managed care HMO, where 94% of our HMO members have chosen a PCP. We are considering methodologies to increase our PCP attribution rate.

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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: Fallon utilizes a number of strategies and techniques to drive membership into high-value limited and tiered network products, resulting in a 10% increase in membership in these products since 2010.

   ANSWER: Fallon Health has significant experience with strategies to steer and/or incentivize members and employers toward high-value care and providers in its limited and tiered network products. The most common is the pricing differential between Fallon Health's limited and tiered network products and Fallon Health's full network or un-tiered counterparts. In the past Fallon Health has also collaborated with large clients to offer a "premium holiday" or other incentives to encourage members to choose enrollment into a limited network, rather than the broad network HMO. Fallon Health also engages in significant education and outreach to its customers, brokers, and providers about the value of limited and tiered network products, as well as the lower cost sharing available for use of high-quality, lower cost providers within those tiered networks. Currently Fallon Health has approximately 61,000 members in commercial tiered and limited products which represents just over 46% of Fallon's commercial membership; up from 36% in 2010.

   Fallon has recently implemented the SmartChoice program administered by its medical cost management partner for high-tech radiology screening services. The SmartChoice program is designed to offer cost savings by encouraging providers to direct members to lower cost, and often more convenient, facilities. This is accomplished through both provider and member outreach and education. As this program is in its infancy stages, supporting cost data is not yet available.

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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: Complete data is not available, but based on the data that we do have, we have provided cost transparency information to members within two working days. The top service requests were for an MRI (3), followed by diagnostic lab (2), allergy testing (2) and dermatology vists (2). We are on track to meet Chapter 224 requirements to provide information in "real time" by October 1, 2014.

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			
	Q2			
	Q3			
	TOTAL:			

** Please indicate the unit of time reported.*

ANSWER: Fallon Health supports providing cost information to its members and is working to be compliant with all requirements within Chapter 224 as well as larger Federal and State Health Care Reform projects. We are taking a two tiered approach to addressing these provisions.

Fallon Health was compliant with the first part of the requirement, by providing cost information through our customer service toll-free telephone number and our member website, within 2 business days, effective October 2013. In certain circumstances, such as requests for costs for more complicated service types, codes and other detailed information must be obtained from providers, for a more thorough and accurate analysis. Upon receipt of this information, Fallon Health provides a detailed summary of the member cost for the requested services by the providers selected by the member.

To be compliant with the second part of the requirement, and more importantly, to provide education and incentives to members, Fallon Health is actively working through a detailed project plan with its contracted vendor. Fallon Health's solution will offer a broader range of detailed cost information online, available in real-time. Fallon Health plans to have this solution available effective October 2014.

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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: Fallon Health provides an array of products and programs whose goal is to have members receive care in the most cost effective setting.
ANSWER: Our limited network Direct Care and Steward Community Care products, through lower premiums and their network limitations, strongly encourage the use of community hospitals at the most appropriate level of care for non-tertiary services. Our tiered product encourages members to use cost effective physicians and hospitals through point of service copayment differentials. Our home infusion program focuses on moving members from the hospital to home for this service. We have recently implemented a high tech radiology program that proactively contacts members and helps direct them to less expensive settings. We have specialized programs that focous on oncology patients, sleep management studies, and members with drug addictions.

In our work with delivery systems under alternative payment arrangements, we provide those systems with information on their use of high cost hospitals and physicians and how community hospitals could be cost effective and quality alternatives. In the spring we introduced a consumer self-education program for members considering back surgery. This fall we will introduce a greatly enhanced cost tranparency program in accordance with Chapter 224 to assist and encourage members in making cost effective choices on cost of care.

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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: Fallon Health uses all of the approaches and strategies listed below to effectively address the needs of members with co-morbid behavioral health and chronic medical conditions, including leveraging our behavioral health vendor's breadth and depth of experience and expertise in managing behavioral health conditions.
    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.
    Weekly integrated rounds to discuss members from a biopsychosocial perspective; Monthly Trainings for Nurse Case Managers (CM) about Behavioral Helath (BH) diagnoses and Motivational Interviewing; Quarterly Trainings for BH staff about medical conditions; Modification of CM Social Workers role to triage members with BH needs and refer to BH vendor as appropriate, co-manage with BH vendor, co-manage with Nurse CMs; BH vendor staff sit on site at Fallon Health to promote staff-to-staff discussions about members; Nurse CMs and social workers or vendor staff co-managing members with medical and BH comorbidities; Weekly Integrated meeting with BH vendor Manager and CM Managers with BH Director to discuss training needs, policy development, etc.; Monthly integrated meeting with health plan Sr. Medical Director, Director of CM, Director of UM, BH Director, CM Managers, Disease Management Director, BH vendor Director and Manager to discuss integration issues, training needs, training curriculum, etc.; BH Oversight Committee with Fallon and BH vendor representatives meets eight times per year to discuss policy issues, updates on

programs vendor is doing on our behalf, quality initiatives that address BH and medical concerns, etc.

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.
In addition to the techniques and stragegies described above, on a quarterly basis we review behavioral health utilization with our behavioral health vendor. A monthly High Cost Member report is also produced to identify members with high-costs for co-management by Case Managers and our behavioral health vendor.

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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: Although Fallon Health does not directly fund provider groups that want to pursue PCMH designation, Fallon Health frequently does provide monies to fund physician organization infrastucture. Many providers use these funds to develop PCMH like capabilities.
ANSWER: Fallon Health does not have any program in place at the current time to directly fund groups who wish to apply for primary care medical home (PCMH) designation. However, for many large provider groups, PHOs and/or Independent Practice Associations, Fallon Health is paying monthly PMPM fees to support infrastucture improvements and MD and NP development. Many of these provider groups have not applied for formal PCMH designation but they have developed most of the features of a PCMH practice including: flexible scheduling; extended office hours; a team coverage approach (typically an MD and an NP or PA work as a team to manage the health of a specific subset of members); an electronic medical record that is integrated with other practices and the practice's primary admitting hospital; ready access to behavioral health services; low tech imaging; standard lab panels; case management for pateints with chronic conditions; and technological solutions for improving communication between patients and the group. Typically, these infrastucture fees and the activities they support are more common in groups that are interested in developing or already have risk arrangments with Fallon Health and other health plans.

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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: Fallon Health has observed many of the same trends that the Commission reported on in its 2013 report and 2014 supplement.
ANSWER: One particular observation relates to high-cost patients. We have seen an increasing number of members with multiple chronic conditions across all product lines. These members are much more difficult to manage both with respect to quality of care

and cost of care. Over the past two years Fallon Health has invested significant resources to improve its predictive modeling and case management functions. By leveraging our information system, our case management resources, and our provider partners we are beginnning to improve our ability to identify in advance those members who have the potential to have a negative life-altering or even life-threatening event and to reach out and offer those individual members education, support, and guidance so that they can take control of their chronic condition(s) and decrease the possibility of a major healthcare crisis. With at-risk provider groups Fallon Health is willing to partner in a variety of ways to help their members maintain wellness to the maximum extent possible for any given individual.

We continue to pursue the goals of Chapter 224: foster a value-based provider market; promote high-quality, cost-efficient healthcare delivery; increase the number of providers operating under alternative payment models; and increase the availability and quality of data to providers and patients so that both the provider and patient can make the right decision for the right care at the best price on the first try.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for hospitals. To the extent that a hospital submitting pre-filed testimony responses is affiliated with a provider system also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

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

   Attached is the summary table showing actual observed allowed medical trends. For the time frames requested we did not have specific studies to break mix between provider and service mix so all of the mix has been put into the Service Mix column. We do believe that this "Allowed" trend understates the true allowed trend if there were no benefit buy-downs. This is true even though we are looking at allowed trends that include both the payer and member share of the expense because as the member's share of the cost rises it has an impact on the underlying utilization. This understates the utilization and therefore the total trend in the table below.

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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).

There have been minor changes to Fallon Health's overall membership from 2010 to 2013. Generally, these minor changes are not attributed to any particular factor, rather, due to the expected fluctuations that exist in the insurance marketplace. We have noted a slight increase in limited network membership, with an overall commercial decline. The exception to this decline is within large group self-insured accounts, which is explained by our customizable, tiered "Advantage Plans." We have offered these plans to our large self-insured clients since 2010. To date, Fallon Health has built Advantage Plans for six large employer groups.

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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

Total All Accounts

Year	# of Account	Total Payments
2010	6,435	$592,576,187
2011	6,167	$574,696,977
2012	6,111	$595,756,326
2013	6,237	$627,160,913

Groups Carving Out Behavioral Health

Year	# of Account	Total Payments
2010	0	
2011	0	
2012	1	$4,222,489
2013	1	$3,422,350

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2011	3.9%	0.73%	n/a	-1.4%	3.24%
CY 2012	4.2%	1.07%	n/a	0.6%	5.94%
CY 2013	2.2%	-1.43%	n/a	1.5%	2.23%

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the change in provider. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

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	7,251	7,183	6,860	9,450
Commercial Small Group	39,830	38,510	37,472	39,894
Commercial Large Group	85,281	87,006	88,744	84,284
Medicare	27,576	29,204	29,022	30,205
Medicaid MCO	13,967	13,620	13,047	13,878
MassHealth	0	0	0	0
Commonwealth Care	3,842	4,150	4,979	6,019
Other Government	5,700	2,996	1,929	1,408
Total	183,447	182,669	182,053	185,138

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	1,639	1,337	1,332	1,977
Commercial Small Group	8,466	7,408	7,856	9,023
Commercial Large Group	24,768	21,823	23,740	24,538
Medicare	24,203	21,733	22,528	22,880
Medicaid MCO	11,138	11,825	11,499	12,206
MassHealth	0	0	0	0
Commonwealth Care	0	0	0	0
Other Government	0	0	0	0
Total	70,214	64,126	66,955	70,624

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	7,210	7,130	6,805	9,374
		Self-Insured	0	0	0	0
	PPO/Indemnity	Fully-Insured	41	53	55	76
		Self-Insured	0	0	0	0
Commercial Small Group	HMO/POS	Fully-Insured	36,471	35,787	35,403	37,975
		Self-Insured	0	0	0	0
	PPO/Indemnity	Fully-Insured	3,359	2,723	2,069	1,919
		Self-Insured	0	0	0	0
Commercial Large Group	HMO/POS	Fully-Insured	57,860	58,906	60,084	64,384
		Self-Insured	25,017	25,767	27,337	18,754
	PPO/Indemnity	Fully-Insured	1,300	1,237	1,323	1,146
		Self-Insured	1,104	1,096	0	0

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

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	0	0	0	0
Commercial Small Group	174	71	0	0
Commercial Large Group	25,489	26,865	24,914	11,574
Total	25,663	26,936	24,914	11,574

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

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	3,844	3,433	4,153	3,573
Commercial Small Group	10,908	10,323	8,440	10,333
Commercial Large Group	20,733	20,326	20,542	22,109

Total	35,485	34,082	33,135	36,015

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

Market Segment	Dec-13	Dec-12	Dec-11	Dec-10
Commercial Individual	6,152	5,516	4,886	6,240
Commercial Small Group	33,589	31,063	28,449	26,813
Commercial Large Group	19,887	19,211	17,928	15,449
Total	59,628	55,790	51,263	48,502

CERTIFICATION OF WRITTEN TESTIMONY FOR THE 2014 COST TREND HEARINGS FOR THE HEALTH POLICY COMMISSION AS AREQUIRED BY M.G.L. c. 6D, SECTION 8.

I, W. Patrick Hughes, am the President and CEO for Fallon Community Health Plan, Inc. (Fallon Health). I am legally authorized and empowered to represent Fallon Health for the purposes of this testimony. The responses contained in this submission were prepared by employees of Fallon Health who are subject matter experts in the questions that were asked. I have relied upon the information they have provided to me. I attest that the information contained in this submission is true and accurate to the best of my knowledge and belief.

Signed under the pains and penalties of perjury:

AUTHORIZED SIGNATORY:

Print Name: W. Patrick Hughes

Title: President and CEO

Date: September 8, 2014