Minuteman Health

Minuteman Health, Inc.
P.O. Box 120025
Boston, MA 02112-0025

September 8, 2014

Mr. David Seltz
Executive Director
Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz,

Enclosed please find Minuteman's written testimony in response to the Health Policy Commission's letter of August 1, 2014. If you have any questions, please do not hesitate to contact Susan Brown, General Counsel, at susanbrown@minutemanhealth.org or 857-265-3322.

As Chief Executive Officer of Minuteman, I am legally authorized and empowered to represent Minuteman for the purposes of this testimony. The enclosed responses are accurate to the best of my knowledge. I have relied on others in the company for information on certain matters not within my personal knowledge and believe that the facts stated with respect to such matters are true. I sign under the pains and penalties of perjury.

Sincerely,

Tom Policelli

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.

[Remainder of page intentionally left blank]

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: As a new, member-governed organization, Minuteman believes that long term and sustainable affordability of health care is a cornerstone of access and quality care.
   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?

      Minuteman has focused on creating a high quality, low cost network of providers in order to secure a low unit cost. To do this, Minuteman has partnered with Provider Network Alliance, LLC ("PNA"). PNA is a provider-owned network leasing company. By partnering with a provider-owned organization for its network services, Minuteman seeks to align the incentives of the payer and provider community to establish a highly efficient network with sustainable year over year unit price increases.
   b. What actions does your organization plan to undertake between now and October 1, 2015 to ensure the Commonwealth will meet the benchmark?

      Minuteman will continue to work with its network lessor, PNA, to identify additional opportunities to develop a low cost, high quality network of providers.

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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: Minuteman is a new entrant to the market. It received its HMO license in 2013, and began selling policies in October of 2013 for coverage effective January 1, 2014. As a new entrant, Minuteman had no existing member base on which to build an alternative payment methodology.
   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.

      Please see our introductory summary, above.
   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?

Minuteman does not anticipate that it will be able to offer risk-based payment contracts in 2015. Due to technical challenges faces by the Connector, consumers were unable to shop and purchase coverage through the Connector, and were instead either "fast tracked" into legacy carrier, or were place in "temporary" free state-sponsored coverage. As a result, Minuteman's actual member enrollment for 2014 was significantly lower than expected. Therefore, Minuteman does not have enough members or claims experience to pursue a risk-based contract starategy. Further, Minuteman will need to establish not only a sufficient base of members, but also sufficient claims history in order to support risk based contracts.

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: N/A. Minuteman was not yet covering members in 2012 or 2013.

Year	Number of Physicians in your Network Participating in Risk Contracts	Percentage of Physicians in your Network Participating in Risk Contracts
CY2012		
CY2013		

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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: Minuteman does not have any risk contracts, and therefore has not considered factors in formulating risk adjustment measures used to establish risk contracts.

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
b. measures or adjustments for different providers or provider organizations?
N/A
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?
So long as risk adjustment methodologies are non-standard, they present an opportunity for payers and providers to negotiate variable adjustment methodologies that create additional disparity in the rates paid between the lowest and highest cost providers. Further, standardized methodologies could pave the way for programs, such as the federal risk adjustment program, that have the goal of reallocating monies between payers so that payers are not rewarded for successfully attracting a healthier member population. However, risk adjustment is a complex, continually developing field, which is often more art than science, particularly with respect to issues such as adjustment for social or economic factors. By standardizing a risk methodology, the Commonwealth would halt innovation in the area of risk adjustment methodology.

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?
N/A

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?
N/A

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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: Minuteman does not have any risk contracts, and therefore has not considered factors in selecting quality metrics used to establish APM contracts with providers.
   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?
   Minuteman does not currently have any contracts that reimburse providers based on quality measurements.
   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?
   Values: A standardized quality measure set will provide the health care community with a consistent definition of quality, and providers will be able to focus their attention and resources on achieving excellence in a consistent manner, rather than chasing multiple conflicting quality measures established by a myriad of providers. Any standard measure set would necessarily need to align with NCQA, JC, and other national accreditation metrics, or else efficiencies would not be realized. Standardization may also provide consumers with a less confusing way to compare the quality of various providers. With the current proliferation of quality metrics in the marketplace, nearly every provider can be "#1" as measured by at least one reporting agency.

   Drawbacks: Standardization of quality measures will constrain quality metric innovation. Providers will only focus improvement initiatives on one set of metrics which means that other aspects of quality not being measured will be ignored. This is particularly worrisome because currently there isn't a perfect quality of care measurement set and metric innovation needs to be active and ongoing.

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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: All Minuteman products, HMO and PPO, require that all members that live in the Minuteman service area select a PCP at the time of enrollment. Unfortunately, the Connector does not currently support PCP selection at the time of enrollment, so while Minuteman's off-exchange members are enrolled with a PCP, Minuteman's Connector members are not enrolled with a PCP. The Connector requires that subsidized members be assigned a PCP shortly after enrollment.

Minuteman assigns a PCP to those subsidized members by matching the member to a PCP within the member's zip code. For non-subsidized Connector members, Minuteman retroactively assigns a PCP once sufficient claims information is available. Ideally, the Connector will develop a data field that enables members to select a PCP during the enrollment process to facilitate assignment of PCPs to members from day one.

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)
    Minuteman currently considers PCPs for attribution.
    ii. units used in counting services (e.g., number of claims, share of allowed expenditures)
    N/A
    iii. services included in a claims-based methodology (e.g., E&M, Rx, OP)
    Minuteman assigns PCPs retrospectively when it receives a claim for a visit to an in-network PCP.
    iv. time period for evaluation of attribution (e.g., 12 months, 18 months) and
    Minuteman assigns a PCP retrospectively based on the first claim it receives for a visit to a physician designated as a PCP.
    v. whether patients are attributed retrospectively or prospectively.
    PCPs are assigned prospectively for subsidized Connector members. PCPs are assigned retroactively for non-subsidized Connector members. All non-Connector members choose a PCP at the time of enrollment.

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?
    Minuteman requires that all members that live within the Minuteman service area have a PCP, including members that are enrolled in PPO products. We continue to work with the Connector in the hope that they can implement a PCP data field so that all Minuteman members, and not just those that enroll off-exchange, can have the benefit of a PCP from day one.

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?
    It is not clear to us that a standardized attribution methodology would provide substantial benefit to consumers, providers, or payors. It may be that variable methodologies are required to better accommodate different types of products or member populations. However, it would be helpful if state programs worked collaboratively with payers to support the PCP assignment process.

d. How does your organization plan to further extend the share of your members that are attributed to a primary care provider in 2015?
    Minuteman will continue to explore whether and how it is useful and/or possible to attribute members outside of Minuteman's service area to a PCP.

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: Minuteman has worked with its network parter, PNA, to create a select network of low cost, high quality providers. Because Miuteman's network is already very selective, resulting in a low premium price point, all of Minuteman's products are designed to provide members with a high-value care experience.

ANSWER: Due to Connector technical challenges outlined above, Minuteman has experienced low enrollment in its first year. In addition, Minuteman claims information is immature. Finally, Minuteman has a very low number of member hospitalizations to date. Therefore, Minuteman has not been able to do any robust claims analysis. The limited member demographics analysis that Minuteman has completed is attached for your information.

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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: Minuteman faces significant challenges in providing this information, as most vendors that offer price quoting services rely on historic claims data analysis in order to understand which services should be included in the quoted "bundle" of services. Nontheless, Minuteman has implemented a system for providing members with requested price information for admissions, procedures, and services.

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**	0	0	0

	Q2	0	0	0
	Q3	0	0	0
	TOTAL:	0	0	

** Please indicate the unit of time reported.*

ANSWER: To date, no members have requested a price quote of any type, through any channel.

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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: The majority of Minuteman's hospitals and affiliated physician/clinician networks are community based. The tertiary hospitals in MHI network, few in number but adequate to serve our member's needs, are among the lowest cost Massachuetts tertiary hospitals. This network design promotes out patient care, community based hospital care and cost effective tertiary care. The cost effectiveness of this provider network design is reflected in our low premiums. This select network design provides high quality care while keeping down costs.

   ANSWER: Due to the low volume and immaturity of data, Minuteman does not have an analysis of "outmigration."

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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: We recognize the vulnerability of this patient population and the impact they have on the cost of health care. We actively promote and sponsor provider initiatives, e.g. patient center medical home, that strive to provide integrated holistic care to all our members. Members with behavioral health conditions benefit by being in this integrated environment where all their health concerns can be addressed. As we continue to grow in membership, we will continue to promote and pay for services that ensure that patient's with behavioral health conditions have the outpatient and home support they need to function as best as possible and use health care resources in the most cost effective way.
    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.
       Minuteman has supported the development of a patient centered medical home that benefits many of its members.
    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.

Minuteman does not utilize a behavioral health managed care organization or "carveout."

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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: Minuteman has provided financial support for the New England Quality Care Alliance - the initial backbone of the Minuteman primary care network - to establishment, implement, and expand its PCMH.

ANSWER: Minuteman is a new entrant with a low member population. Therefore, Minuteman has been unable to conduct any analysis of the impact of PCMH implementation on our member outcomes, quality, and cost of care.

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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: Minuteman is a new entrant and does not yet have robust claims experience to analyze trends. Therefore, Minuteman cannot comment on the Commission's findings in light of its own experience. However, Minuteman aplauds the Commission's recommendations. In particular, Minuteman suggests that, in studying the impact of new insurance products, the Commission also consider the impact of increased alignment and/or affiliations between payers and providers in the marketplace on premium pricing, provider network make-up, product design, and financial accounting.

ANSWER: Minuteman is a new entrant and does not yet have robust claims experience to analyze trends. Therefore, Minuteman cannot comment on the Commission's findings in light of its own experience.

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

   Minuteman did not cover any members in 2011-2013. Therefore, it does not have any information responsive to this request.

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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).

Minuteman did not cover any members in 2011-2013. Therefore, it does not have any information responsive to this request.

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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

Minuteman did not cover any members in 2009-2013. Therefore, it does not have any information responsive to this request

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	NA	NA	NA	NA	NA
CY 2012	NA	NA	NA	NA	NA
CY 2013	NA	NA	NA	NA	NA

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	NA	NA	NA	NA
Commercial Small Group	NA	NA	NA	NA
Commercial Large Group	NA	NA	NA	NA
Medicare	NA	NA	NA	NA
Medicaid MCO	NA	NA	NA	NA
MassHealth	NA	NA	NA	NA
Commonwealth Care	NA	NA	NA	NA
Other Government	NA	NA	NA	NA
Total	NA	NA	NA	NA

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	NA	NA	NA	NA
Commercial Small Group	NA	NA	NA	NA
Commercial Large Group	NA	NA	NA	NA
Medicare	NA	NA	NA	NA
Medicaid MCO	NA	NA	NA	NA
MassHealth	NA	NA	NA	NA
Commonwealth Care	NA	NA	NA	NA
Other Government	NA	NA	NA	NA
Total	NA	NA	NA	NA

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	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA
	PPO/Indemnity	Fully-Insured	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA
Commercial Small Group	HMO/POS	Fully-Insured	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA
	PPO/Indemnity	Fully-Insured	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA
Commercial Large Group	HMO/POS	Fully-Insured	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA
	PPO/Indemnity	Fully-Insured	NA	NA	NA	NA
		Self-Insured	NA	NA	NA	NA

d. In-State Membership in Tiered 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

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	NA	NA	NA	NA
Commercial Small Group	NA	NA	NA	NA
Commercial Large Group	NA	NA	NA	NA
Total	NA	NA	NA	NA

Minuteman Health℠

JOIN THE REVOLUTION

Minuteman Plan Enrollment Report

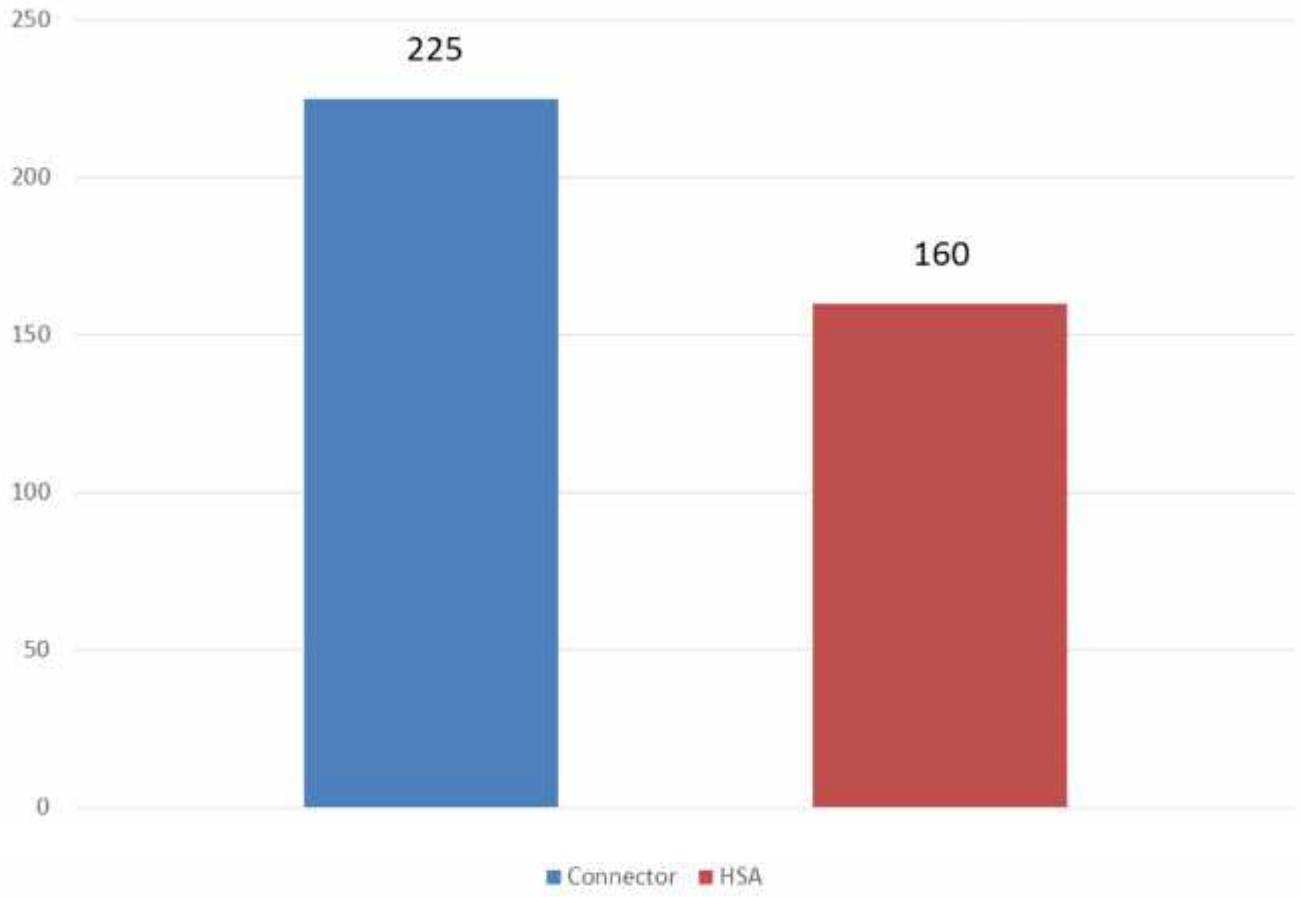
January 31, 2014

EXPLANATION OF DATA

- Data is as of January 28, 2014 from a report generated by Health New England that contains both Connector and HSA enrollments
- Data for Massachusetts and the Federal and State Based Exchanges comes from a report put out by HHS on January 13, 2014. The data in the report is from the period between October 1, 2013 through December 28, 2013

http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

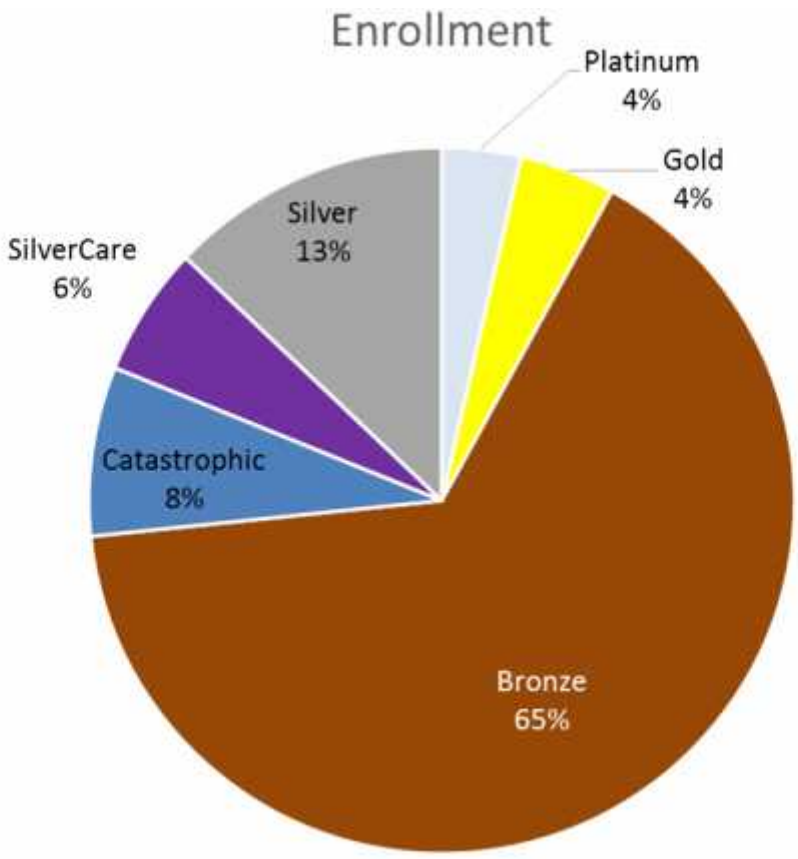
ENROLLMENT BY SOURCE



MHI data is as of January 28, 2014 from a report generated by Health New England

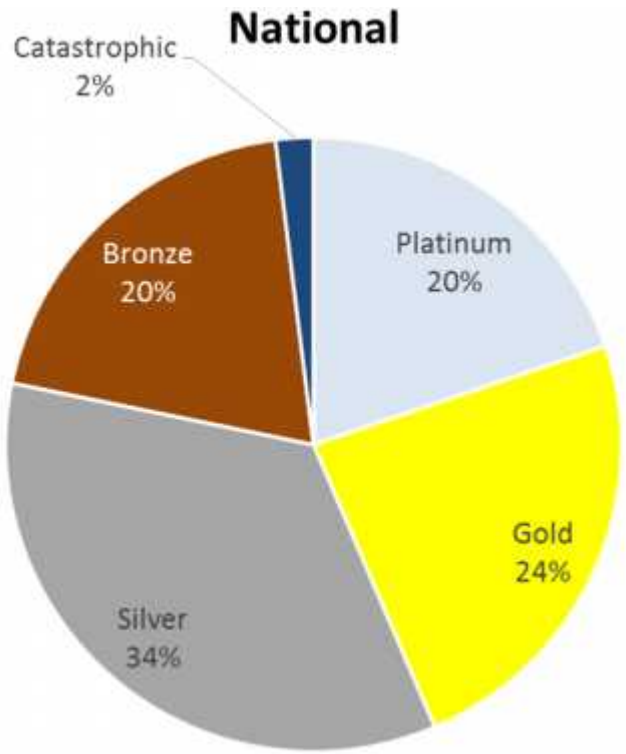
ENROLLMENT BY METALLIC TIER MHI

Metallic Level	Enrollment
Platinum	14
Gold	17
Silver	50
Bronze	253
Catastrophic	30
SilverCare	23



MHI data is as of January 28, 2014 from a report generated by Health New England

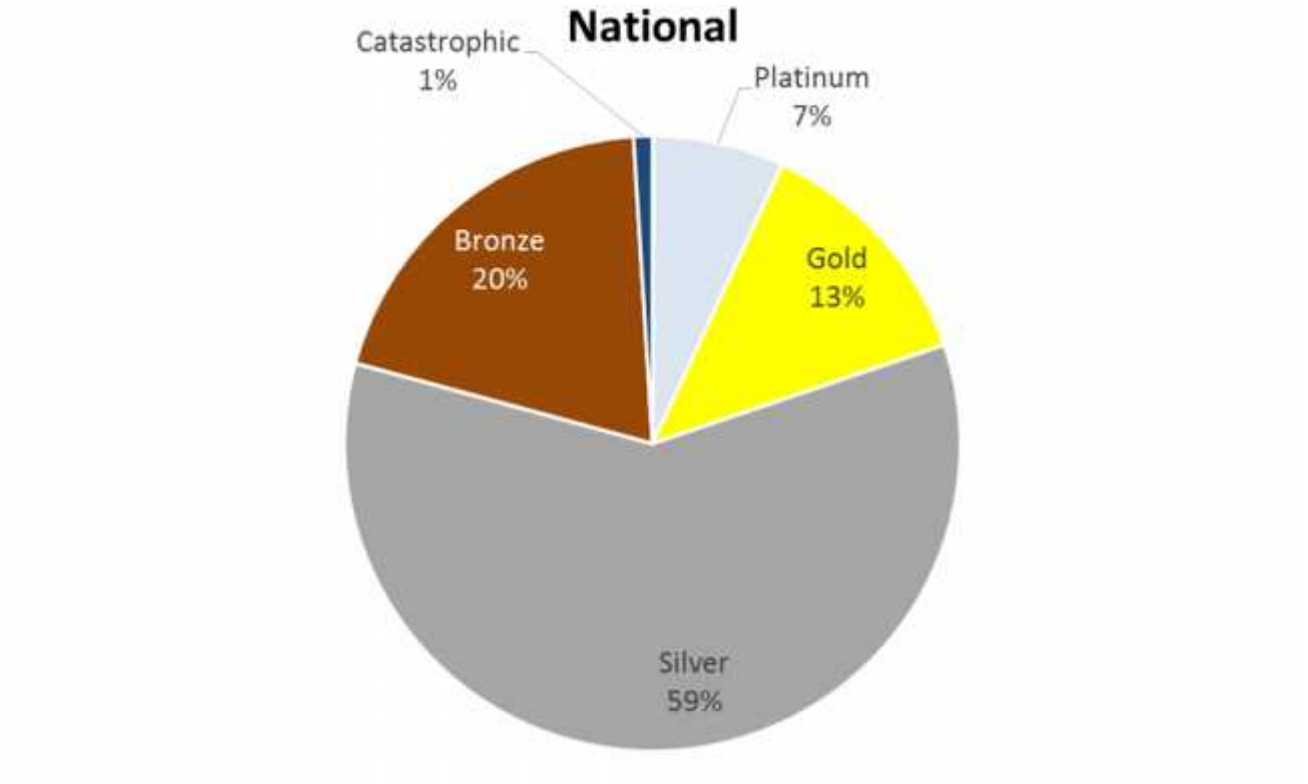
ENROLLMENT BY METALLIC TIER MASSACHUSETTS



As of December 28, 2013

Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

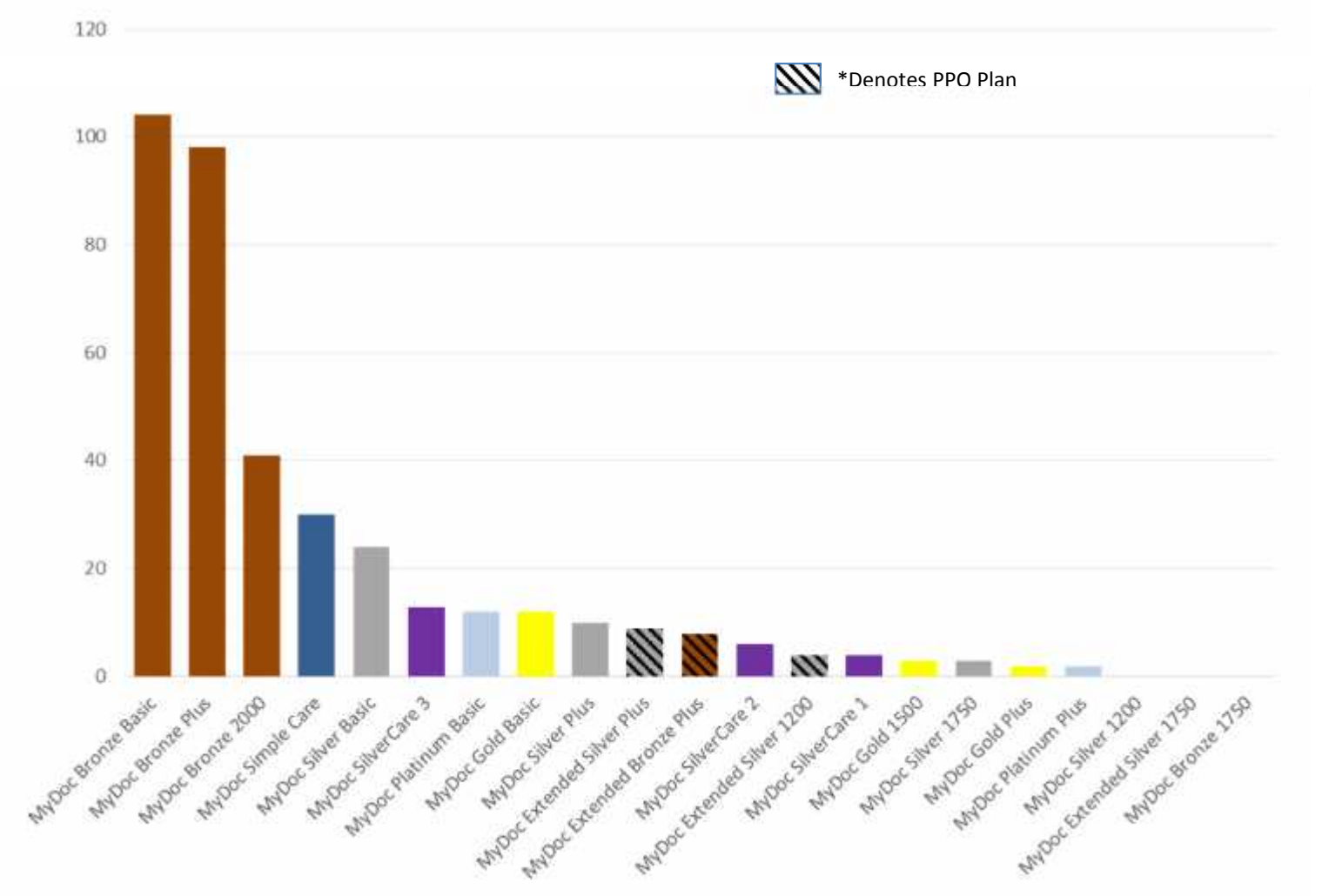
ENROLLMENT BY METALLIC TIER NATIONAL



As of December 28, 2013

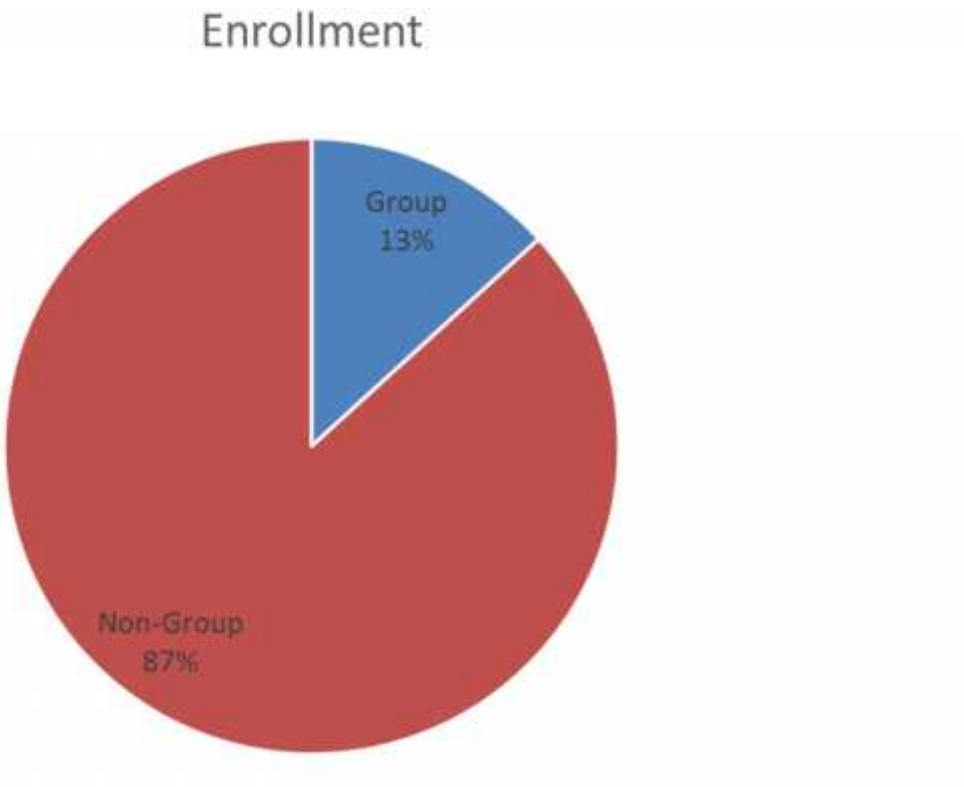
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

ENROLLMENT BY PLAN



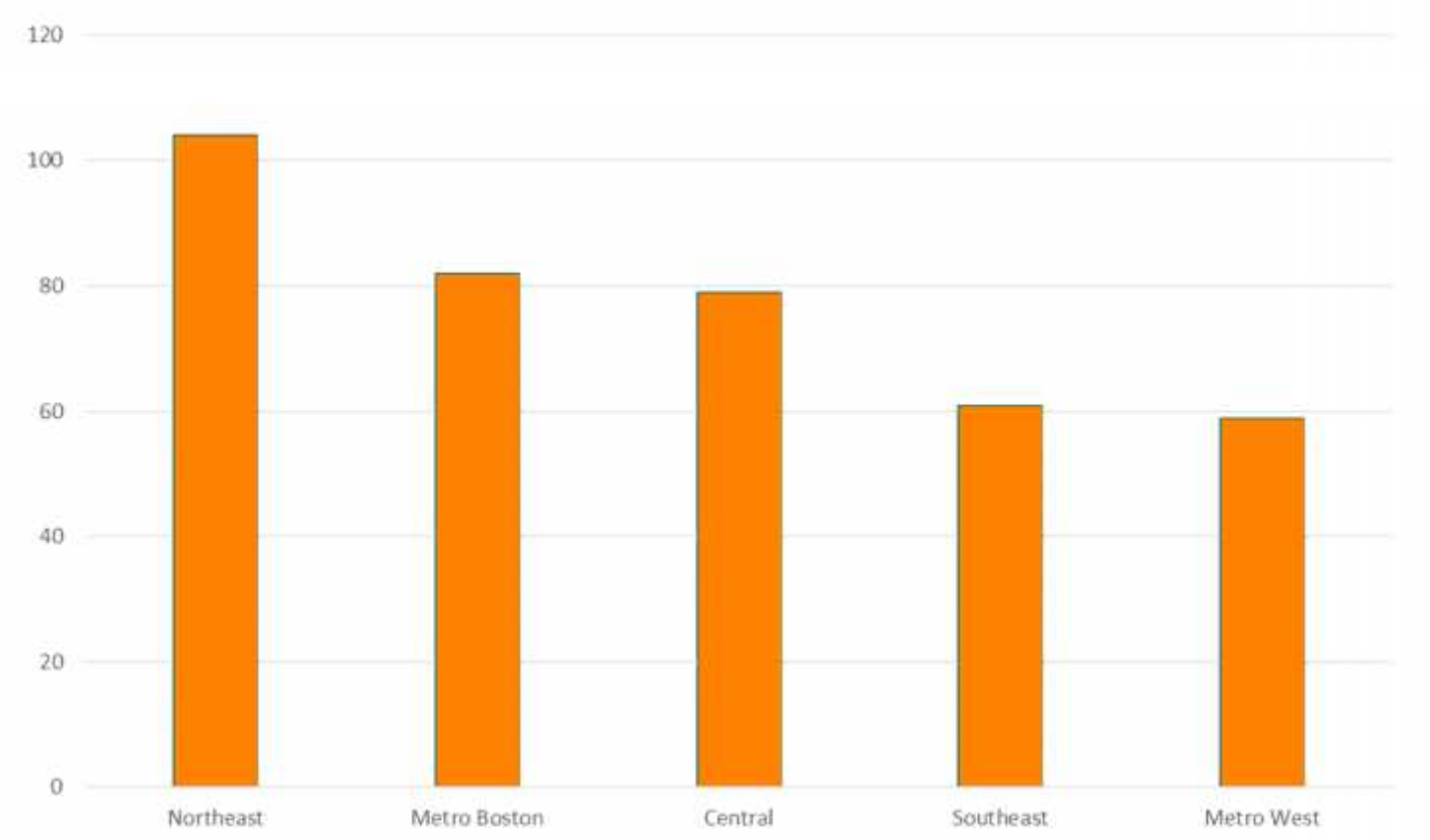
MHI data is as of January 28, 2014 from a report generated by Health New England

GROUP VS NON-GROUP PLAN ENROLLMENT



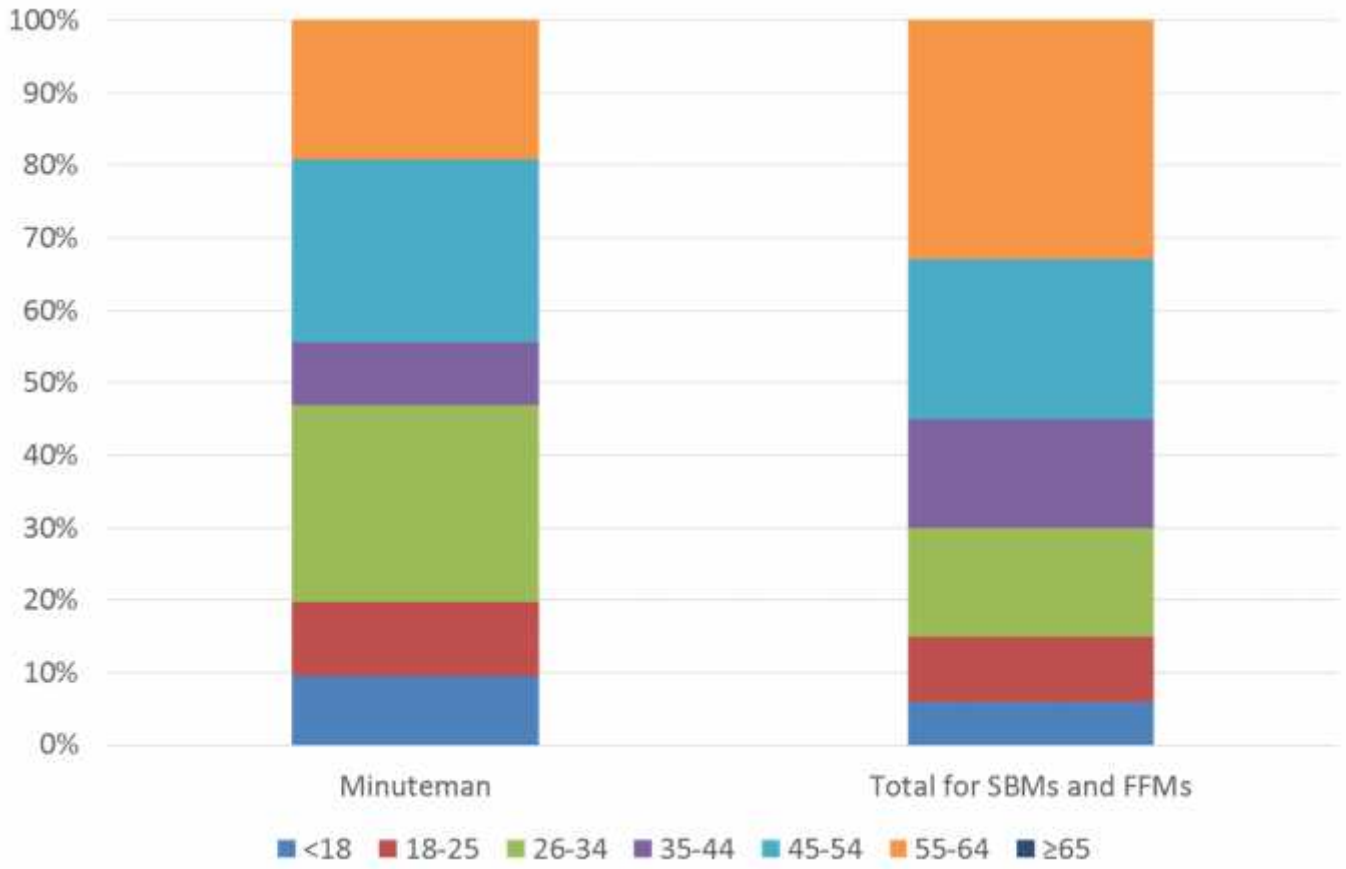
MHI Data is as of January 28, 2014 from a report generated by Health New England

ENROLLMENT BY GEOGRAPHIC REGION



MHI data is as of January 28, 2014 from a report generated by Health New England

ENROLLMENT BY AGE GROUP



MHI data is as of January 28, 2014 from a report generated by Health New England

National data for SBMs and FFMs is as of December 28, 2013

Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

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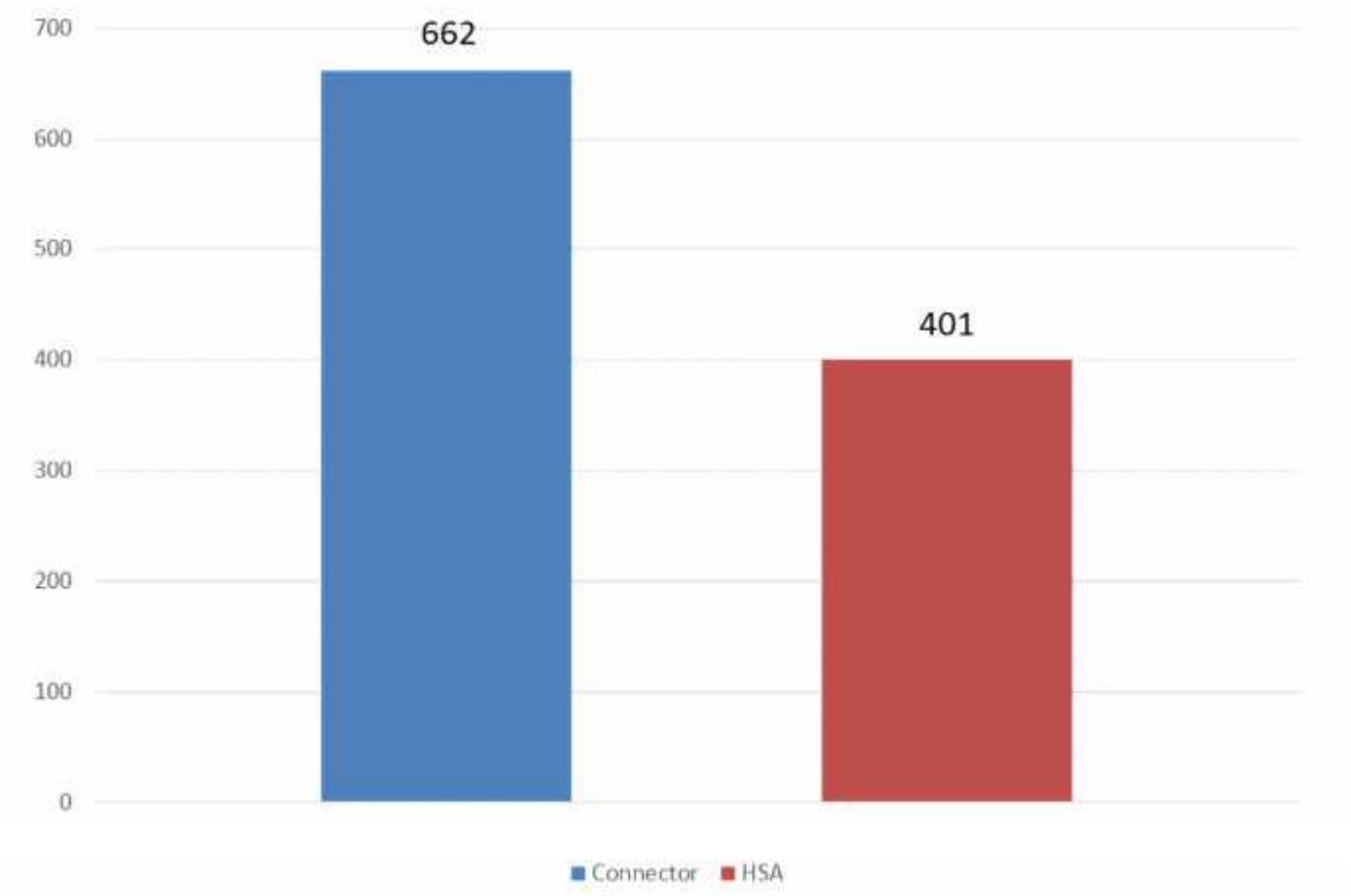
April 10, 2014

EXPLANATION OF DATA

- MHI data is as of March 28, 2014 from a report generated by Health New England that contains both Connector and HSA enrollments with effective dates through 5/1/14
- Data for Enrollment by Carrier is from a report put out by the Massachusetts Health Connector on March 24, 2014
- Data for Massachusetts and the Federal and State Based Exchanges comes from a report put out by HHS on February 12, 2014. The data in the report is from the period between October 1, 2013 through February 1, 2014

http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

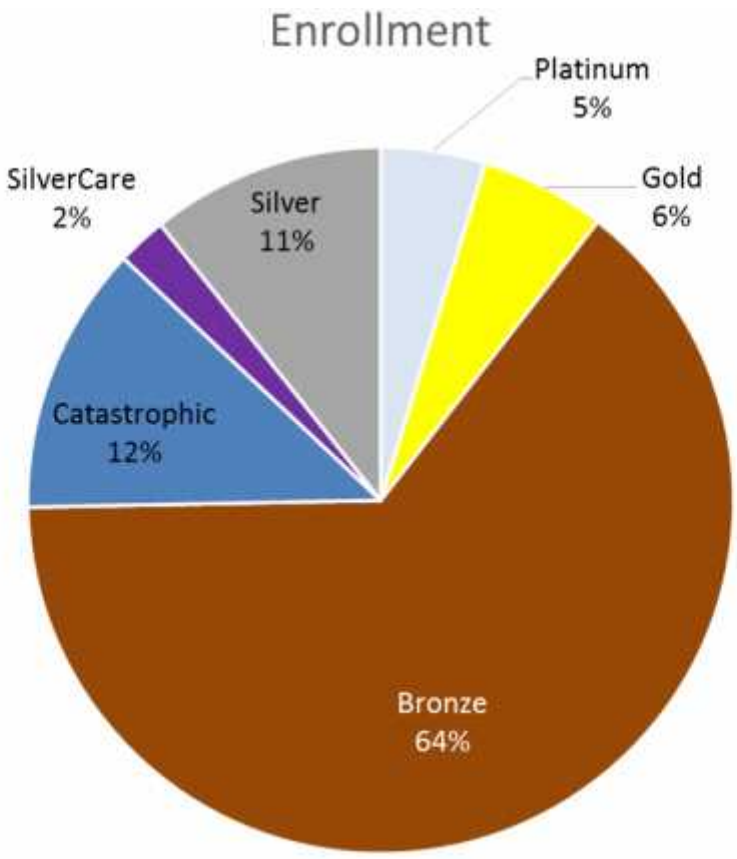
ENROLLMENT BY SOURCE



MHI data is as of March 28, 2014 from a report generated by Health New England

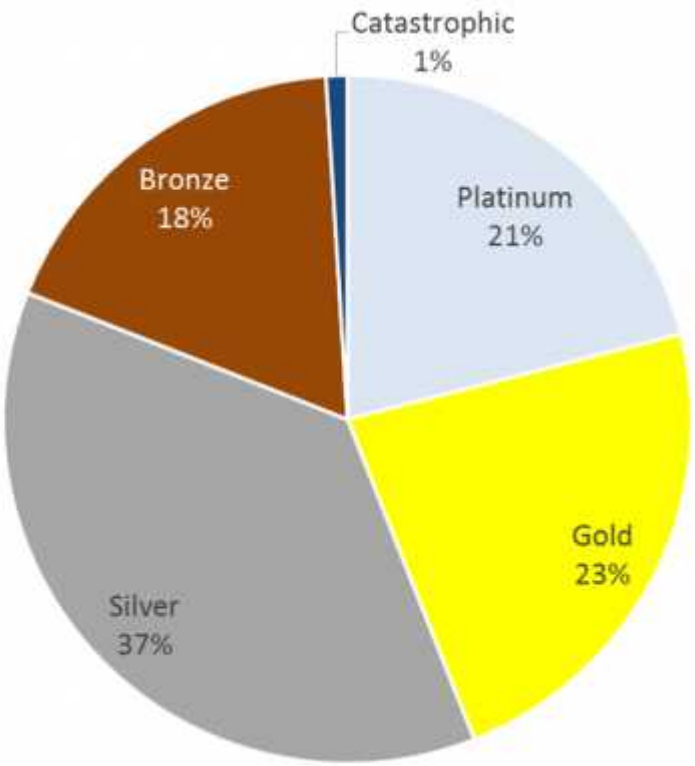
ENROLLMENT BY METALLIC TIER MHI

Metallic Level	Enrollment
Platinum	51
Gold	61
Silver	114
Bronze	682
Catastrophic	131
SilverCare	24



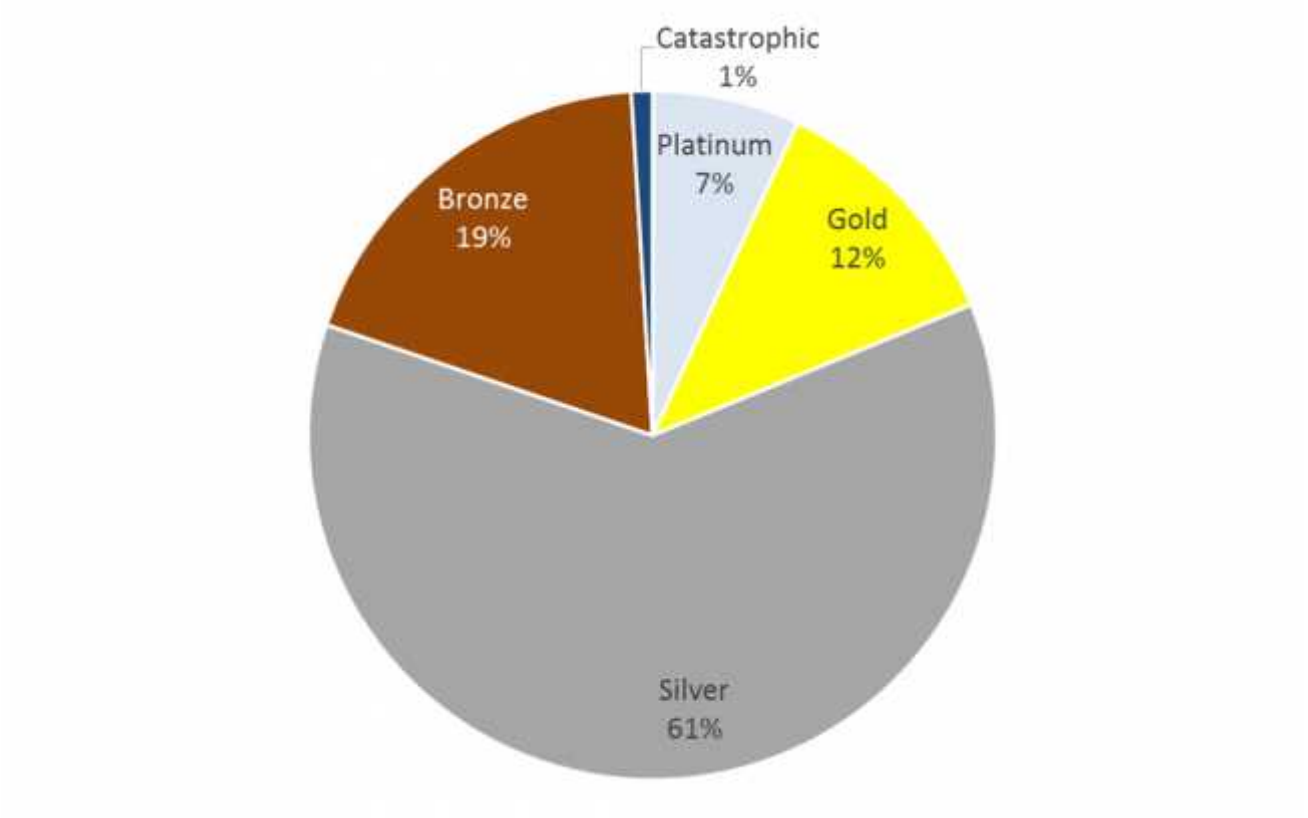
MHI data is as of March 28, 2014 from a report generated by Health New England

ENROLLMENT BY METALLIC TIER MASSACHUSETTS



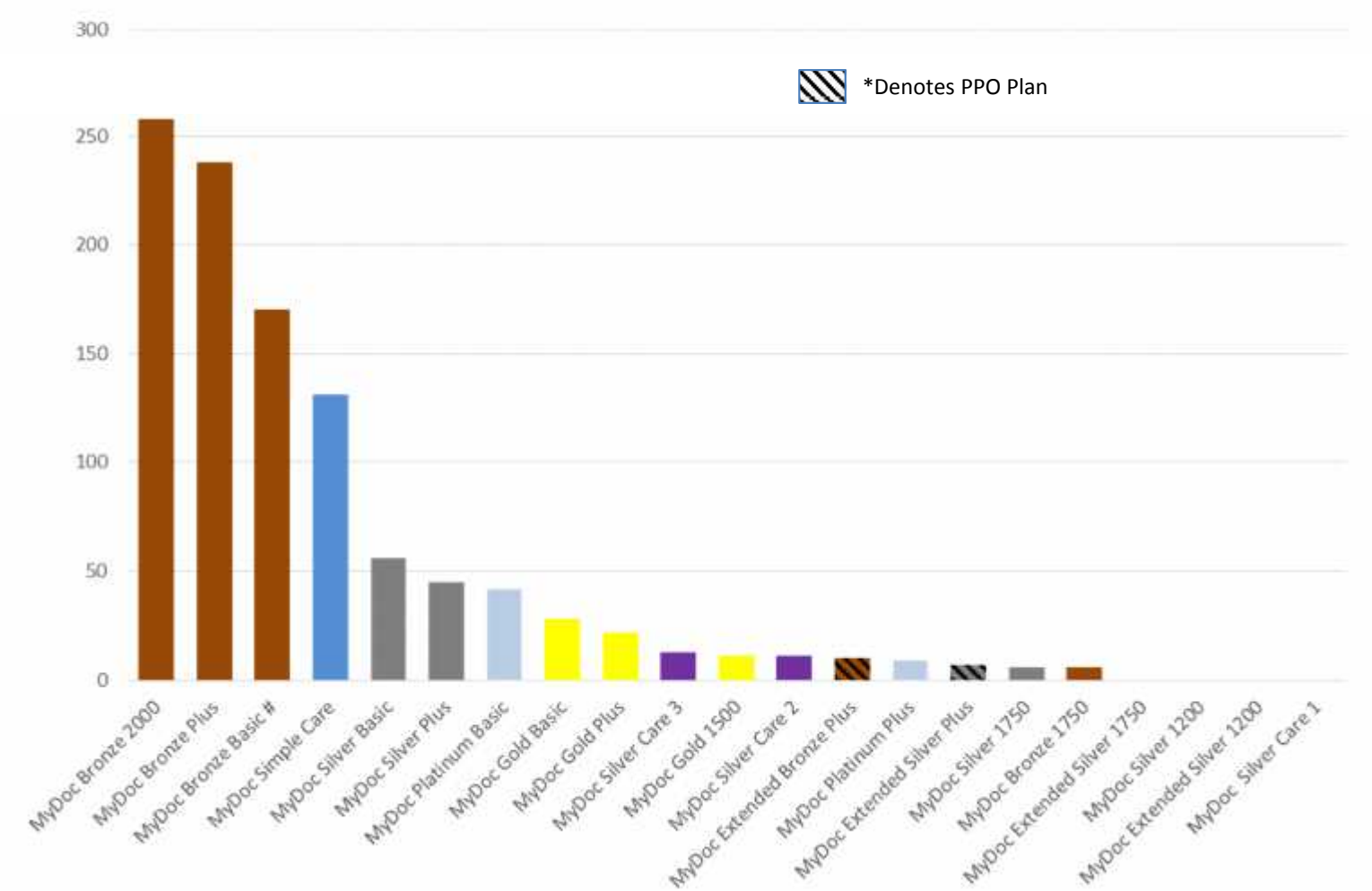
As of February 1, 2014
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

ENROLLMENT BY METALLIC TIER NATIONAL



As of February 1, 2014
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

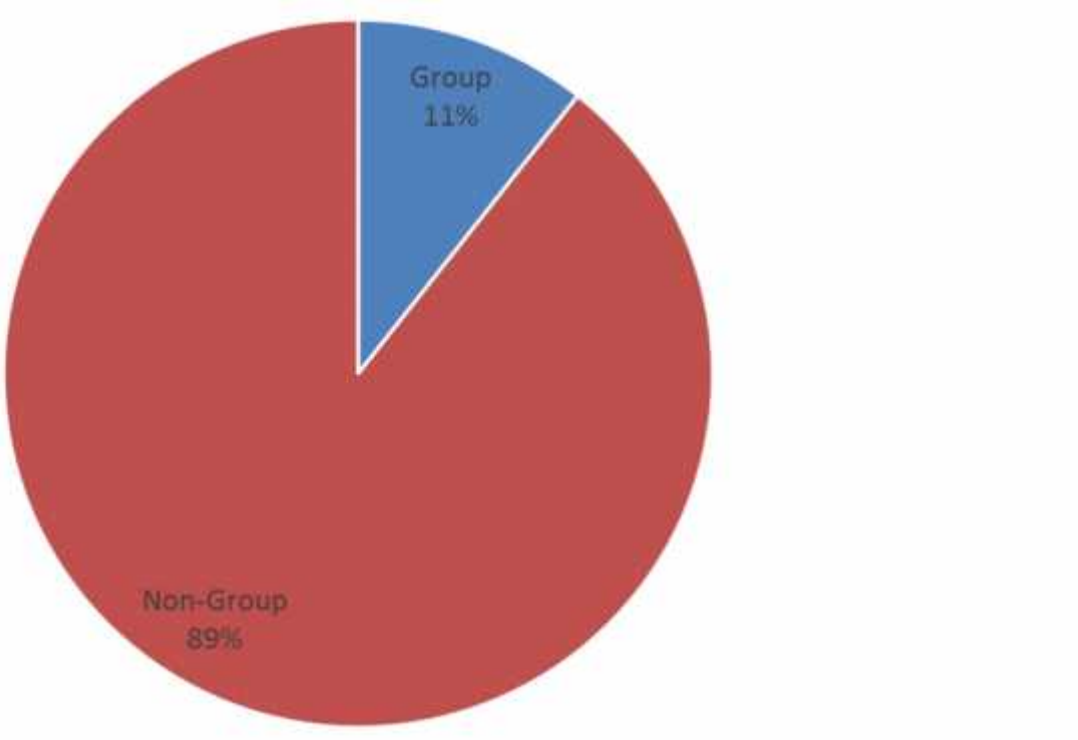
MHI ENROLLMENT BY PLAN



# Indicates that MyDoc Bronze Basic is an HDHP and is available with an HSA

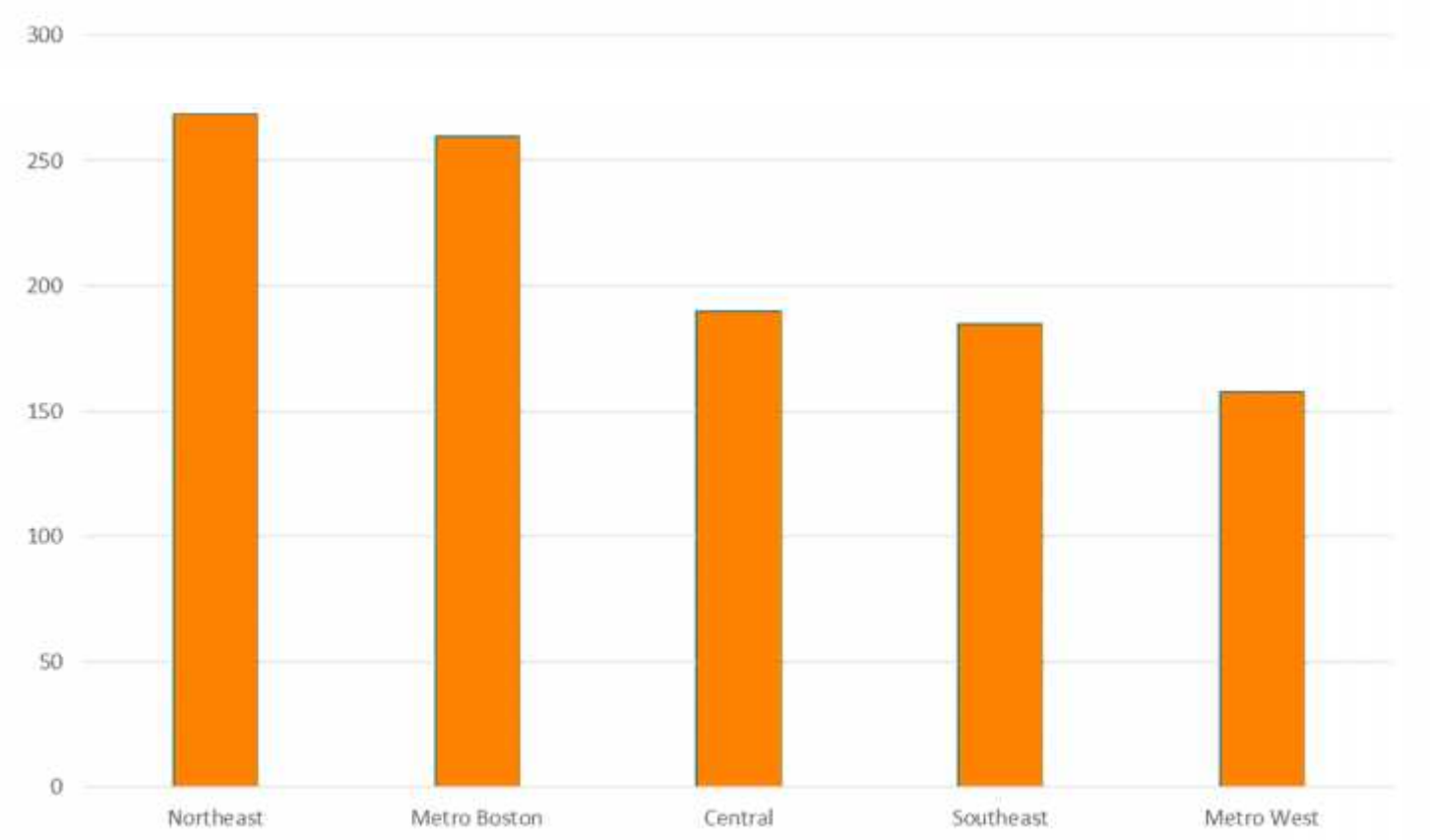
MHI data is as of March 28, 2014 from a report generated by Health New England

GROUP VS NON-GROUP PLAN ENROLLMENT



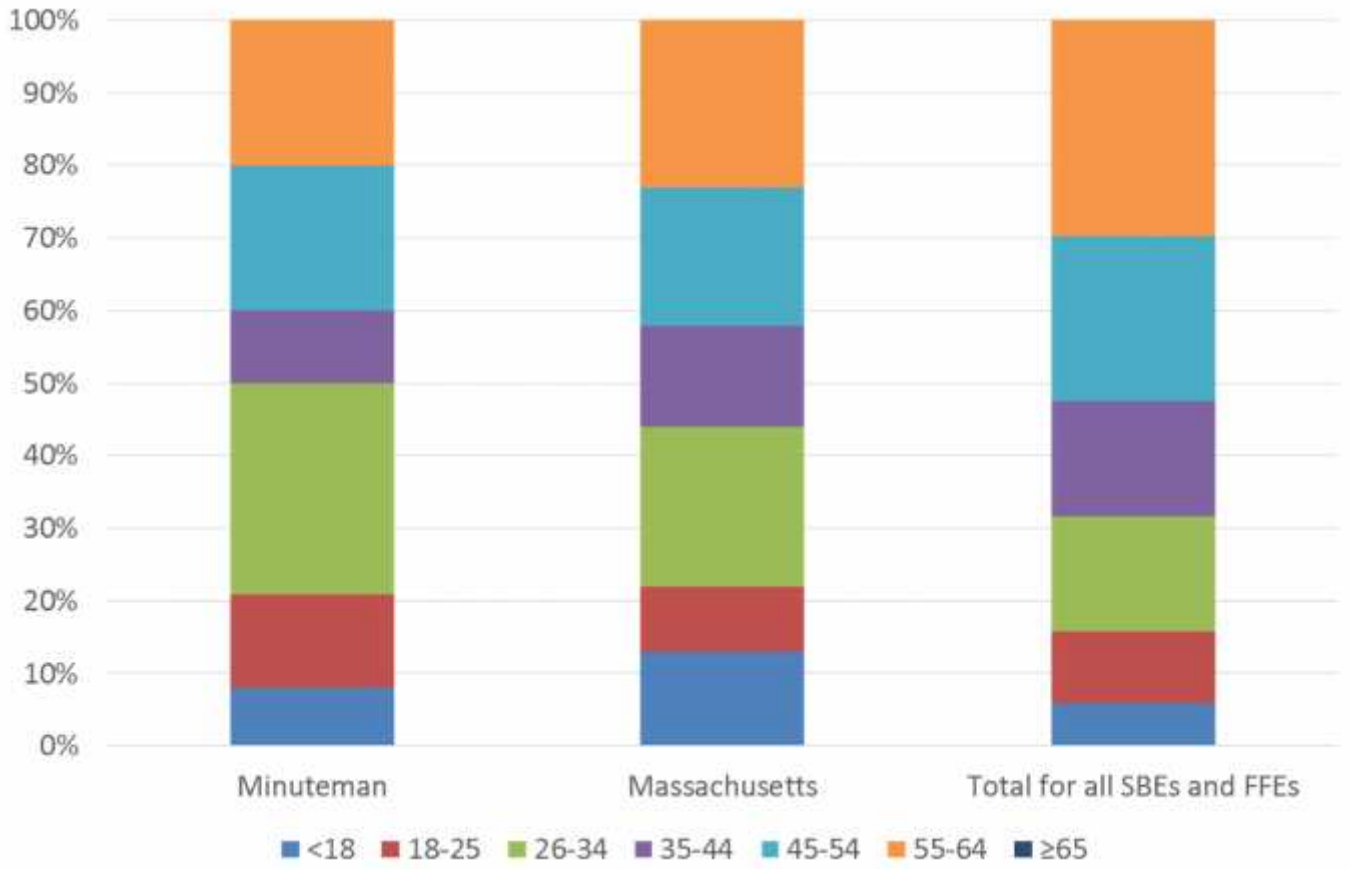
MHI Data is as of March 28, 2014 from a report generated by Health New England

ENROLLMENT BY GEOGRAPHIC REGION



MHI data is as of March 28, 2014 from a report generated by Health New England

ENROLLMENT BY AGE GROUP

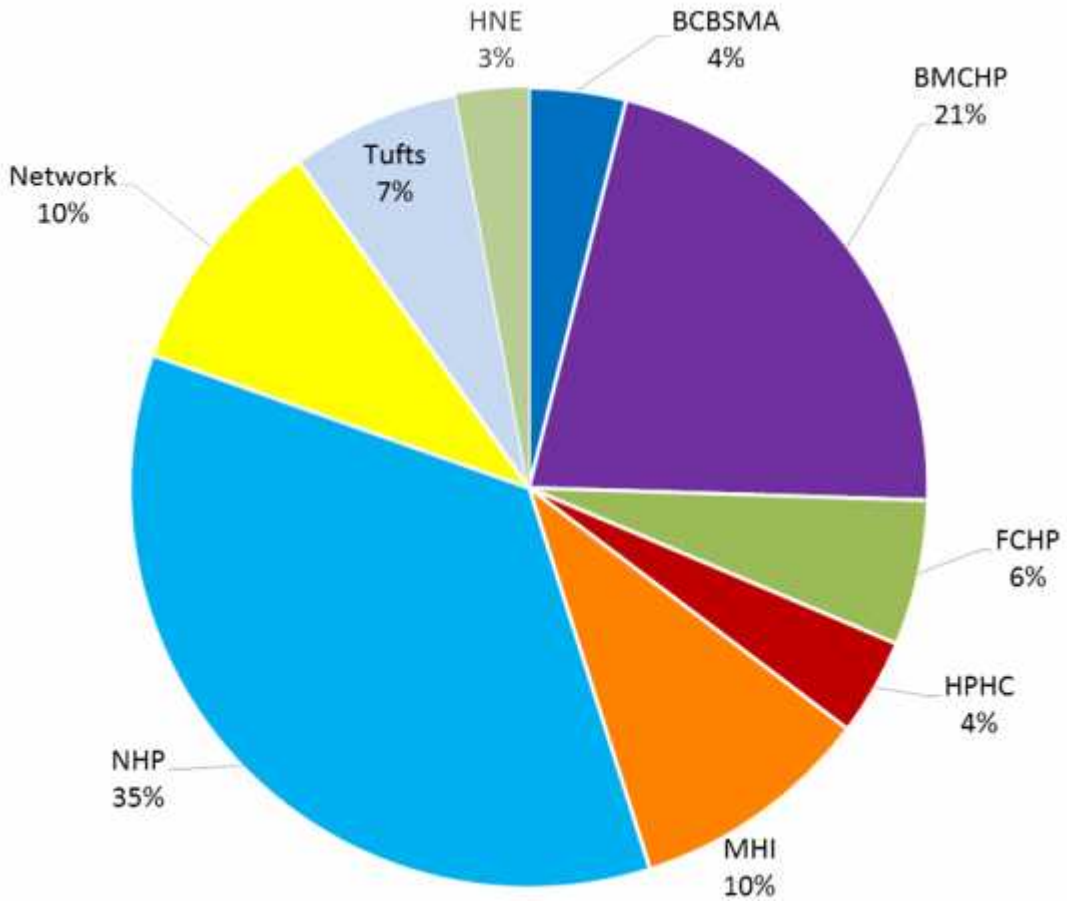


MHI data is as of March 28, 2014 from a report generated by Health New England

National data for SBMs and FFMs is as of February 1, 2014
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Feb2014/ib_2014feb_enrollment.pdf

ENROLLMENT ELIGIBLE FOR APTC

Carrier	Number of Enrollments
BCBS	4
BMCHP	22
FCHP	6
HNE	3
HPHC	4
MHI	10
NHP	36
Network	10
Tufts	7
Total	102



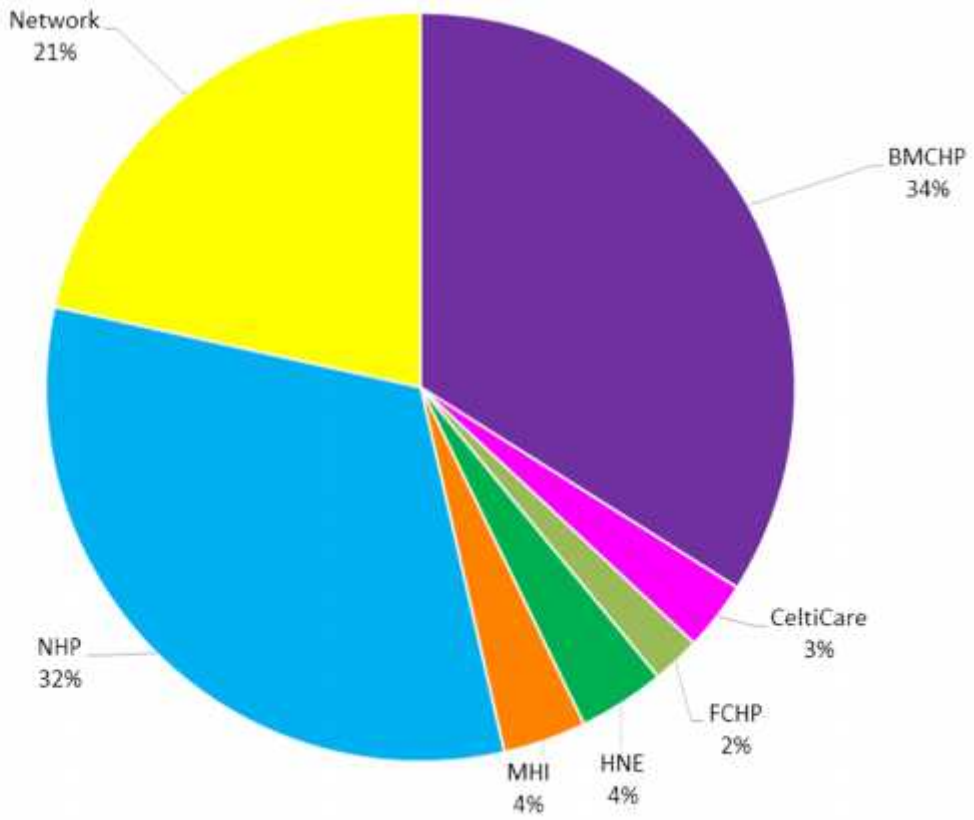
Represents enrollment by Massachusetts Health Connector as of March 25, 2014 with effective dates through May 1, 2014, less dental enrollments through Altus and Delta Dental

Total enrollment through the Connector for the ten health insurance carriers is equal to 22,986

Total number of APTC eligible enrollments is equal to 102

CONNECTOR CARE ENROLLMENT

Carrier	Number of Enrollments
BMCHP	227
CeltiCare	20
FCHP	14
HNE	25
MHI	24
NHP	214
Network	144
Total	668



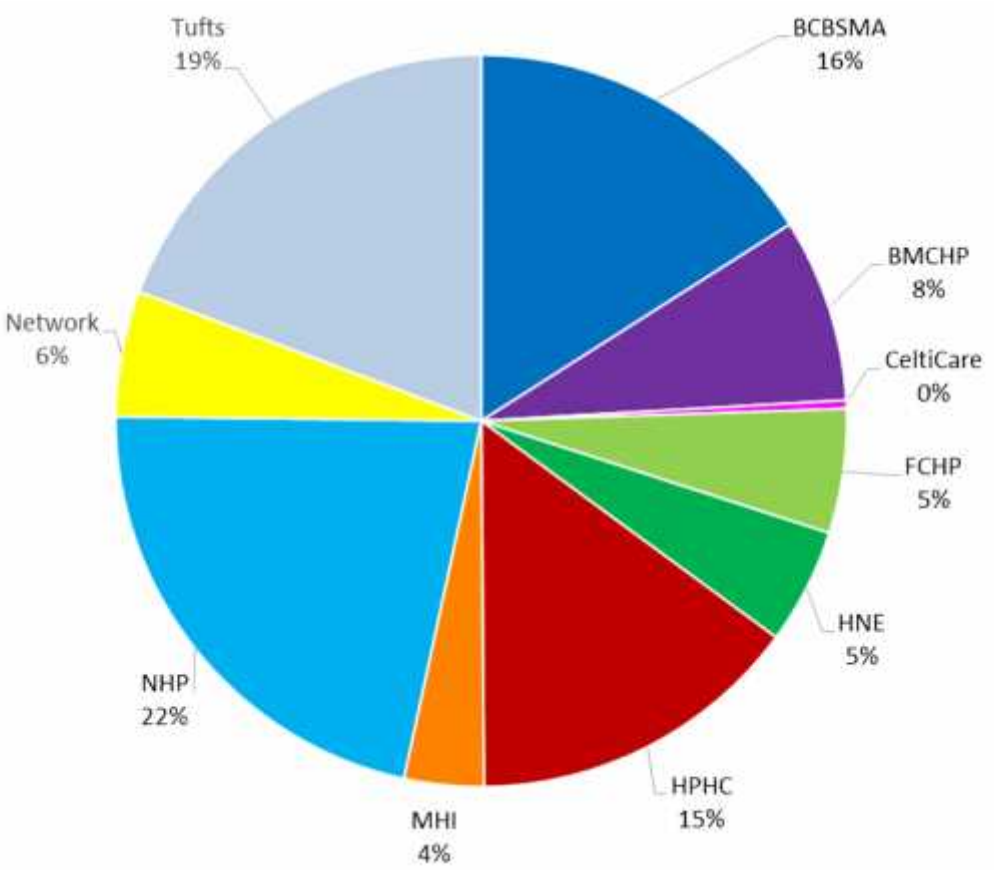
Represents enrollment by Massachusetts Health Connector as of March 25, 2014 with effective dates through May 1, 2014, less dental enrollments through Altus and Delta Dental

Total enrollment through the Connector for the ten health insurance carriers is equal to 22,986

Total number of Connector Care eligible enrollments is equal to 668

UNSUBSIDIZED ENROLLMENT

Carrier	Number of Enrollments
BCBSMA	2,753
BMCHP	1,398
CeltiCare	65
FCHP	944
HNE	881
HPHC	2,551
MHI	606
NHP	8,753
Network	956
Tufts	3,318
Total	22,225



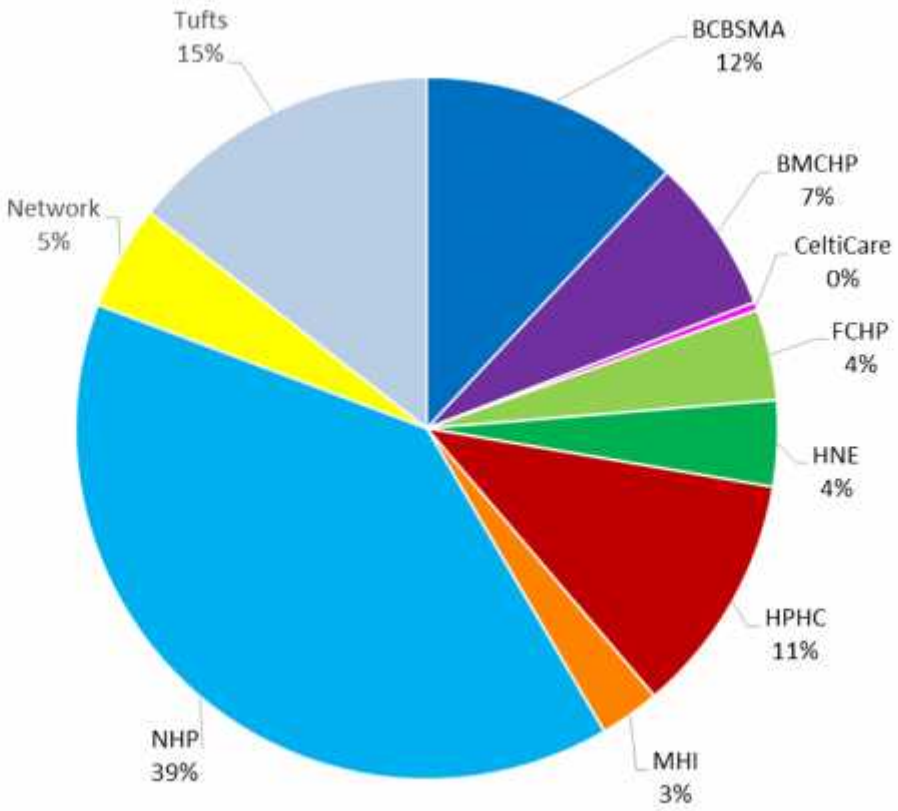
Represents enrollment by Massachusetts Health Connector as of March 25, 2014 with effective dates through May 1, 2014, less dental enrollments through Altus and Delta Dental

Total enrollment for the ten health insurance carriers is equal to 22,986

Total number of non-subsidy eligible enrollments is equal to 22,225

TOTAL ENROLLMENT

Carrier	Number of Enrollments
BCBSMA	2,757
BMCHP	1,645
CeltiCare	85
FCHP	964
HNE	909
HPHC	2,555
MHI	640
NHP	8,999
Network	1,107
Tufts	3,325
Total	22,986



Represents enrollment by Massachusetts Health Connector as of March 25, 2014 with effective dates through May 1, 2014, less dental enrollments through Altus and Delta Dental

Total enrollment for the ten health insurance carriers is equal to 22,986

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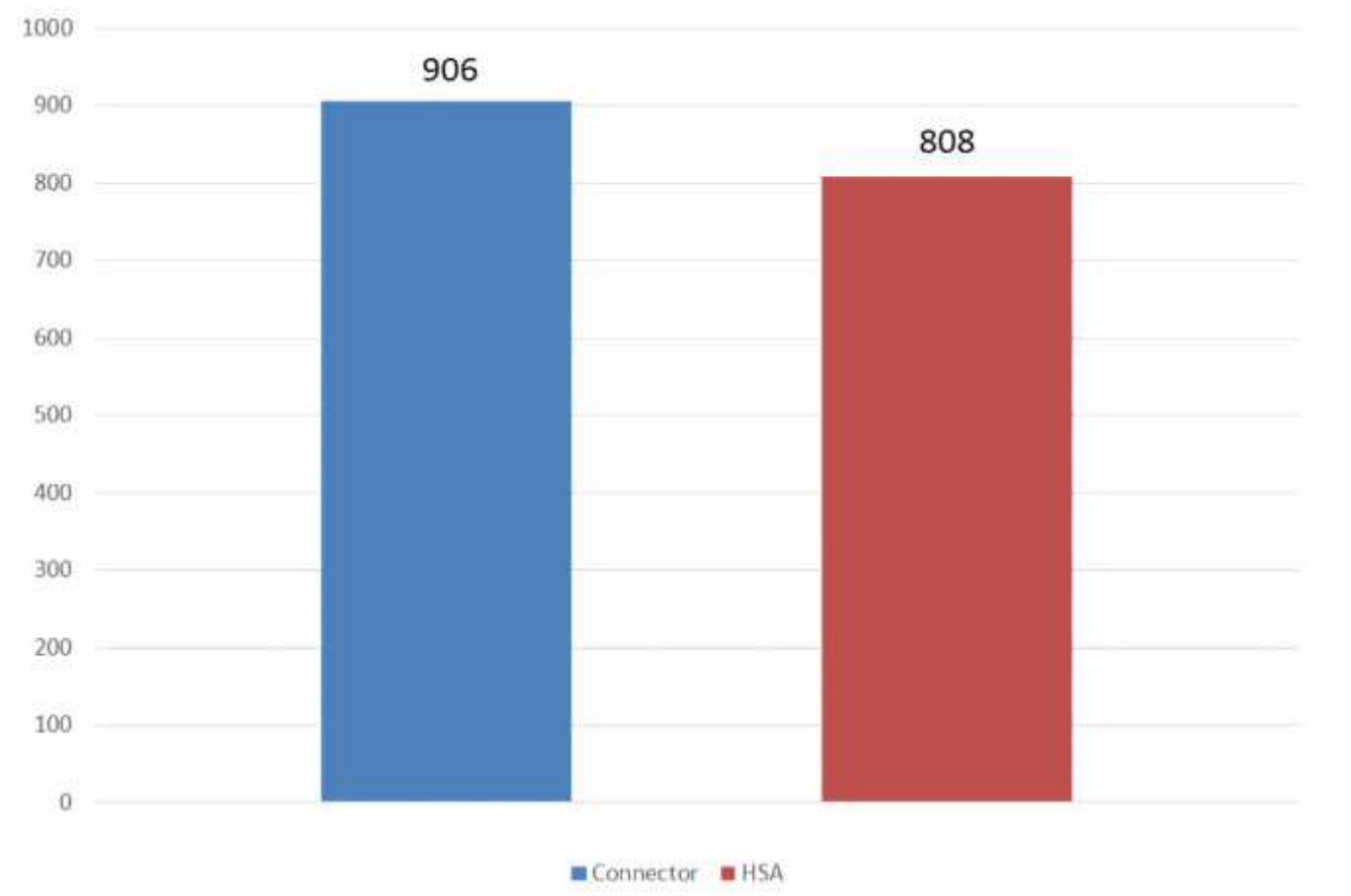
April 28, 2014

EXPLANATION OF DATA

- MHI data is as of April 24, 2014 from a report generated by Health New England that contains both Connector and HSA enrollments with effective dates through 6/1/14
- Data for Massachusetts and the Federal and State Based Exchanges comes from a report put out by HHS on May 1, 2014. The data in the report is from the period between October 1, 2013 through the April 19, 2014 Special Enrollment Period

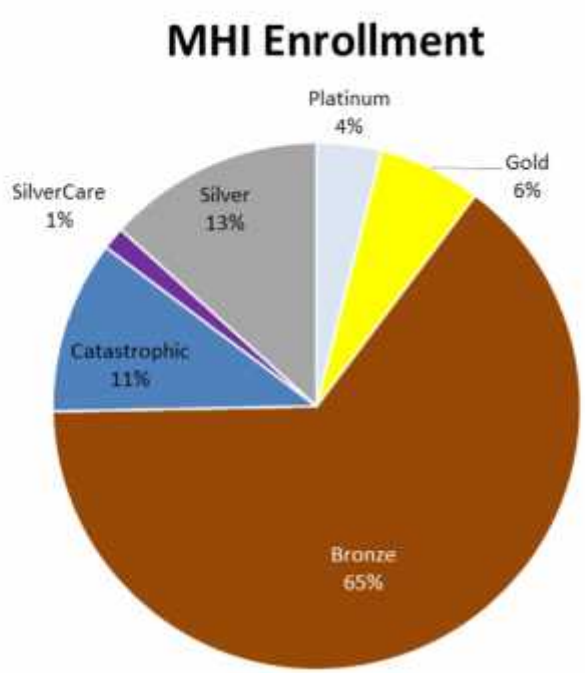
http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

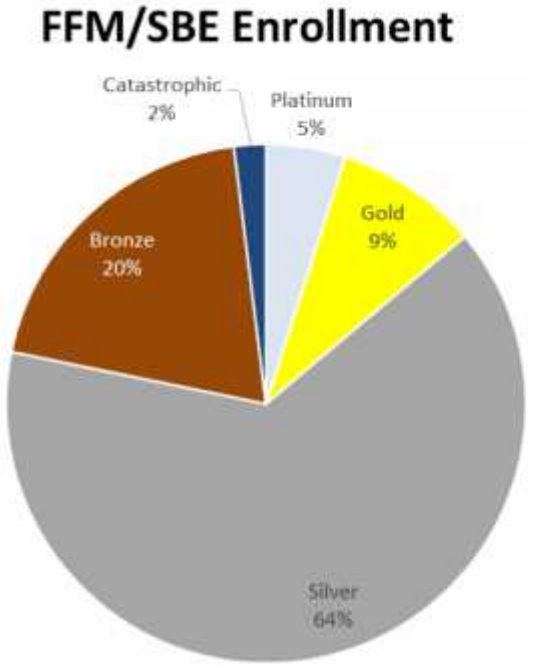
ENROLLMENT BY SOURCE



MHI data is as of April 24, 2014 from a report generated by Health New England

MHI ENROLLMENT BY METALLIC TIER

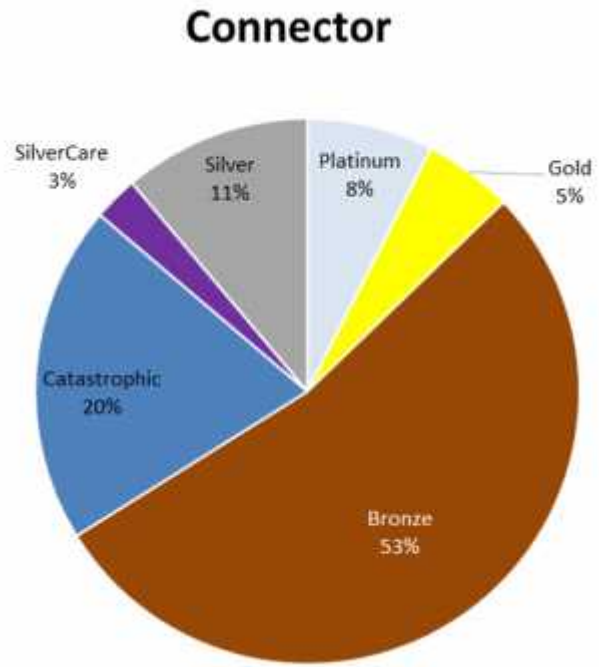


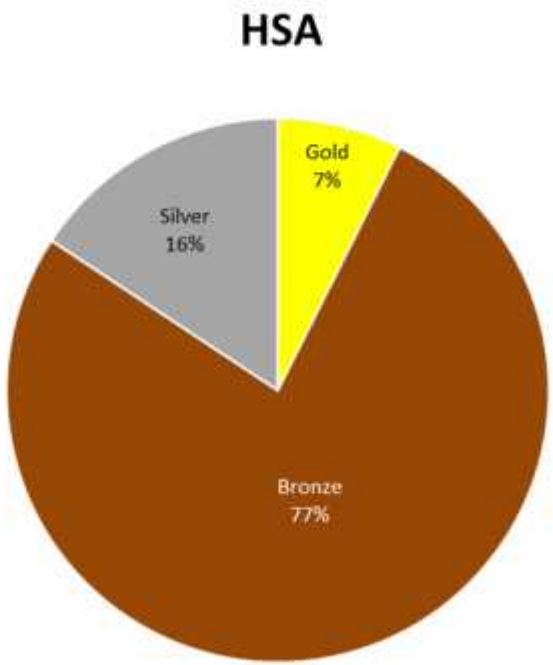


MHI data is as of April 24, 2014 from a report generated by Health New England

National data for SBMs and FFMs is as of May 1, 2014
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

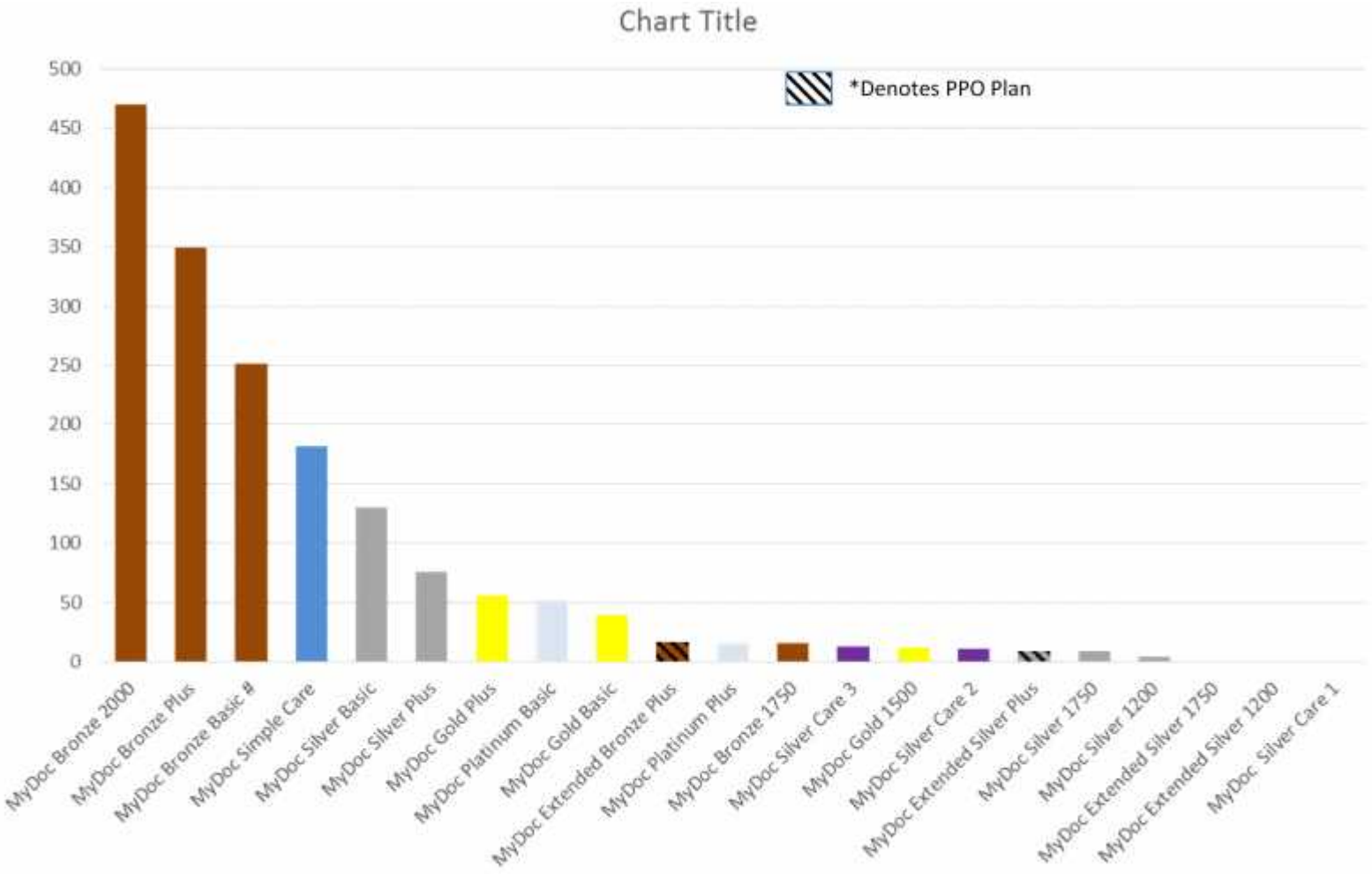
MHI ENROLLMENT BY METALLIC TIER HSA VS CONNECTOR





MHI data is as of April 24, 2014 from a report generated by Health New England

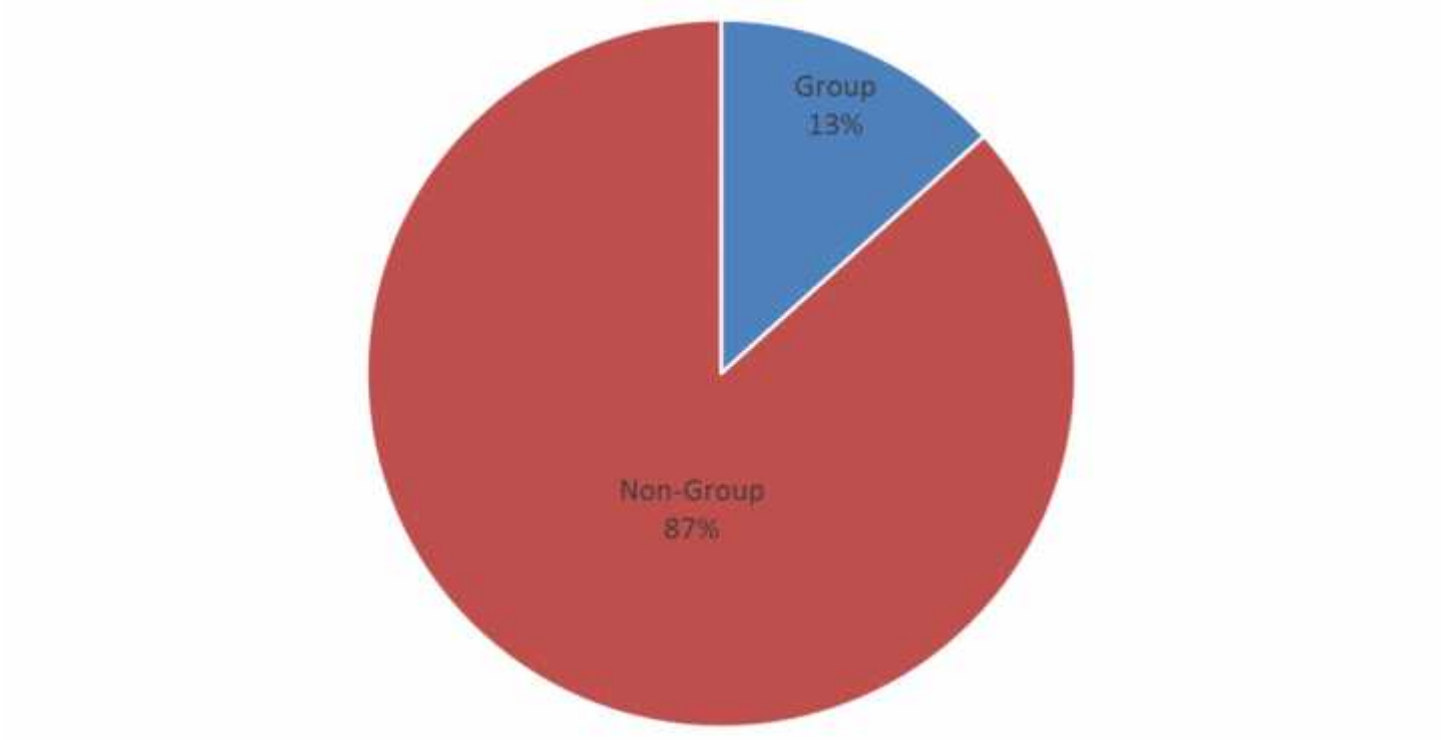
MHI ENROLLMENT BY PLAN



# Indicates that MyDoc Bronze Basic is an HDHP and is available with an HSA

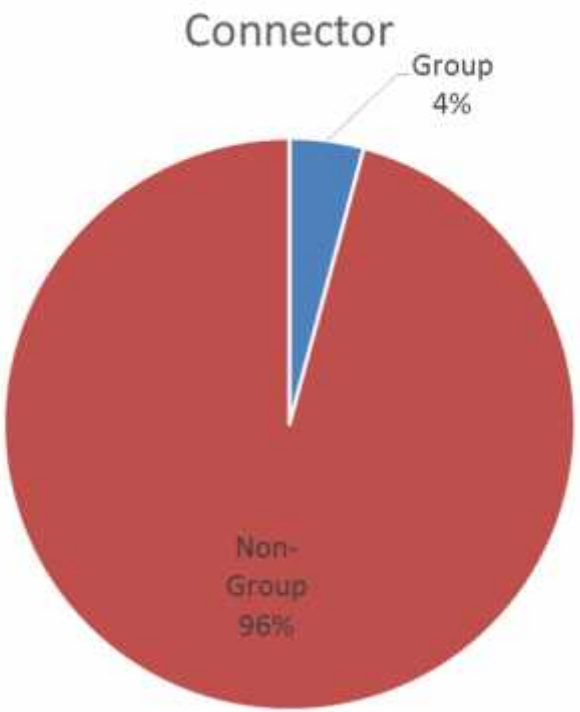
MHI data is as of April 24, 2014 from a report generated by Health New England

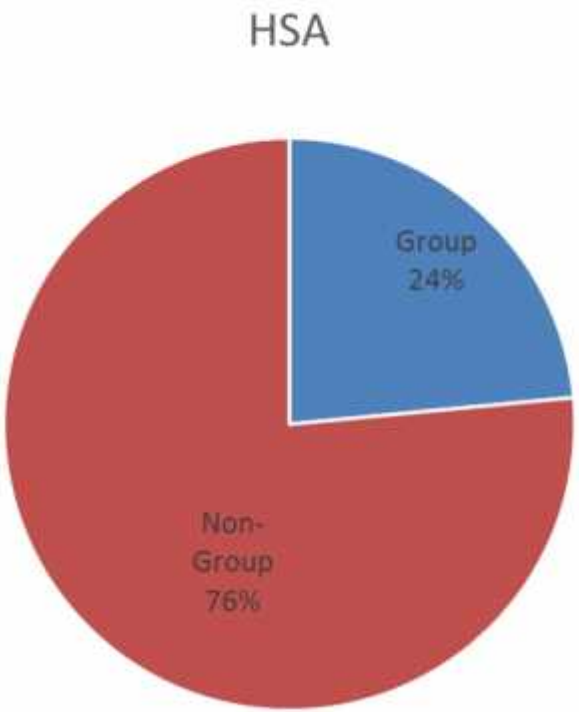
OVERALL GROUP VS NON-GROUP PLAN ENROLLMENT



MHI data is as of April 24, 2014 from a report generated by Health New England

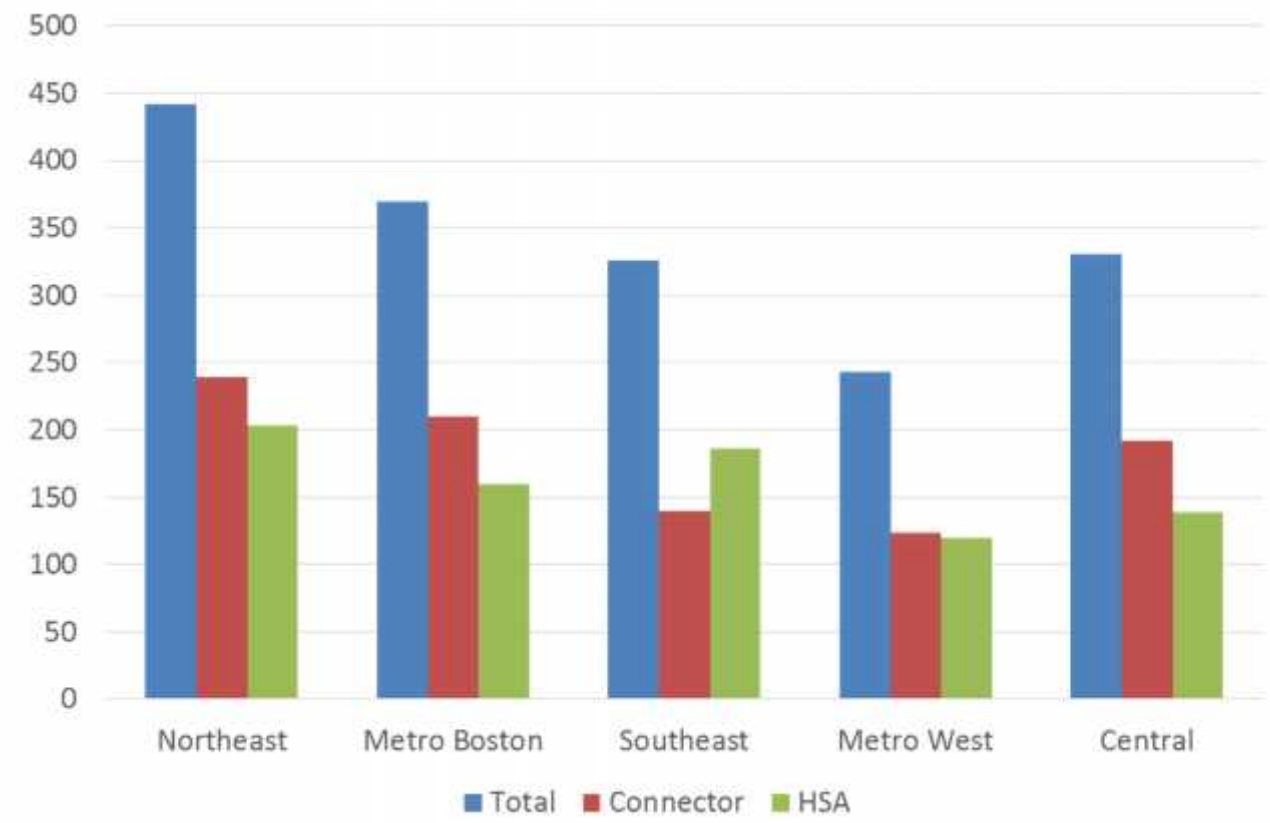
GROUP VS NON-GROUP PLAN ENROLLMENT BY SOURCE





MHI data is as of April 24, 2014 from a report generated by Health New England

ENROLLMENT BY GEOGRAPHIC REGION



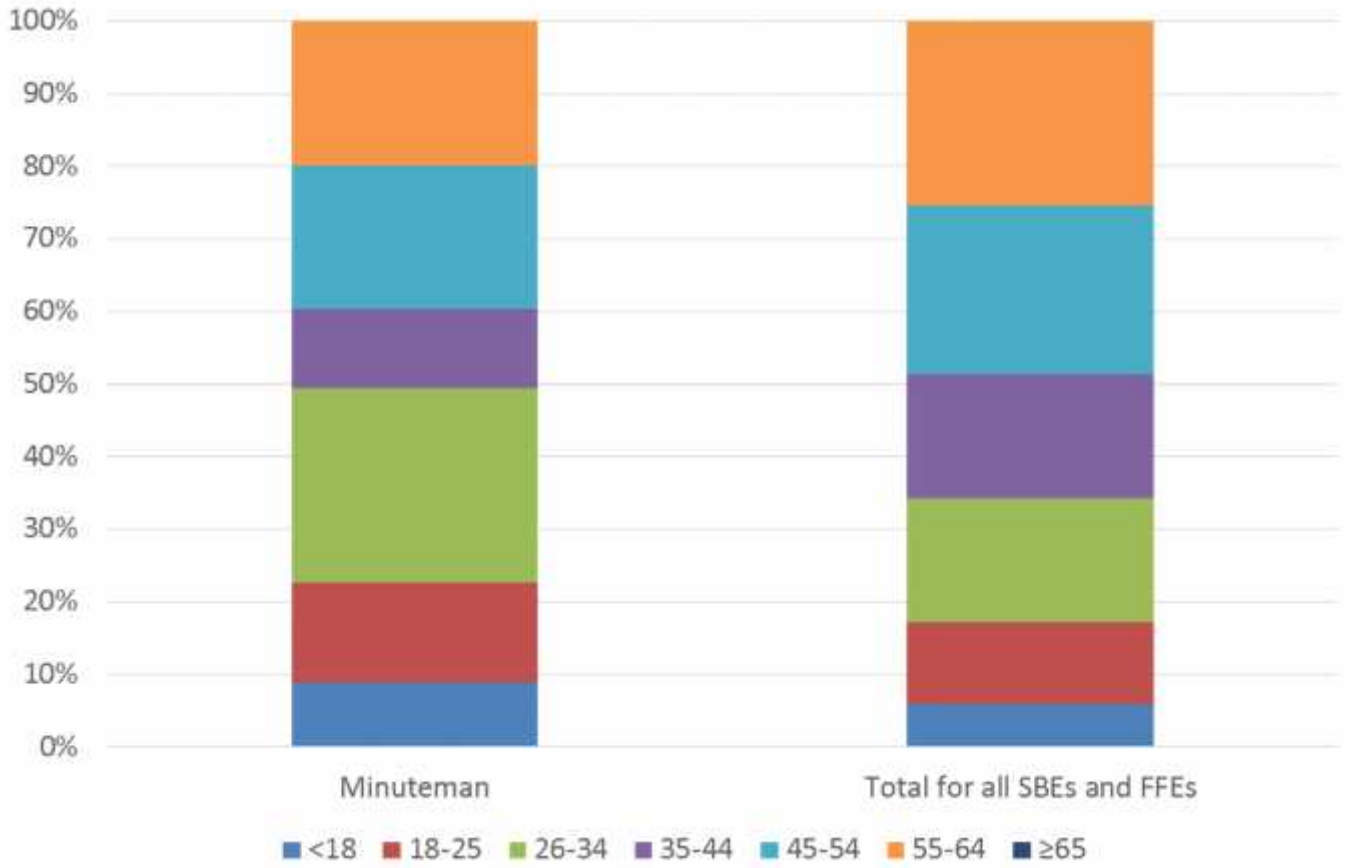
MHI data is as of April 24, 2014 from a report generated by Health New England

CITIES WITH THE MOST MHI MEMBERS

City	Enrollment
Worcester	98
Boston	54
Cambridge	38
Woburn	33
Beverly	28
Somerville	28
Winchester	26
Waltham	24
Lowell	23
Medford	22
Natick	22
Framingham	21
North Andover	21
Brockton	20
Methuen	20

MHI data is as of April 24, 2014 from a report generated by Health New England

ENROLLMENT BY AGE GROUP



MHI data is as of April 24, 2014 from a report generated by Health New England

National data for SBMs and FFMs is as of May 1, 2014
Source: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

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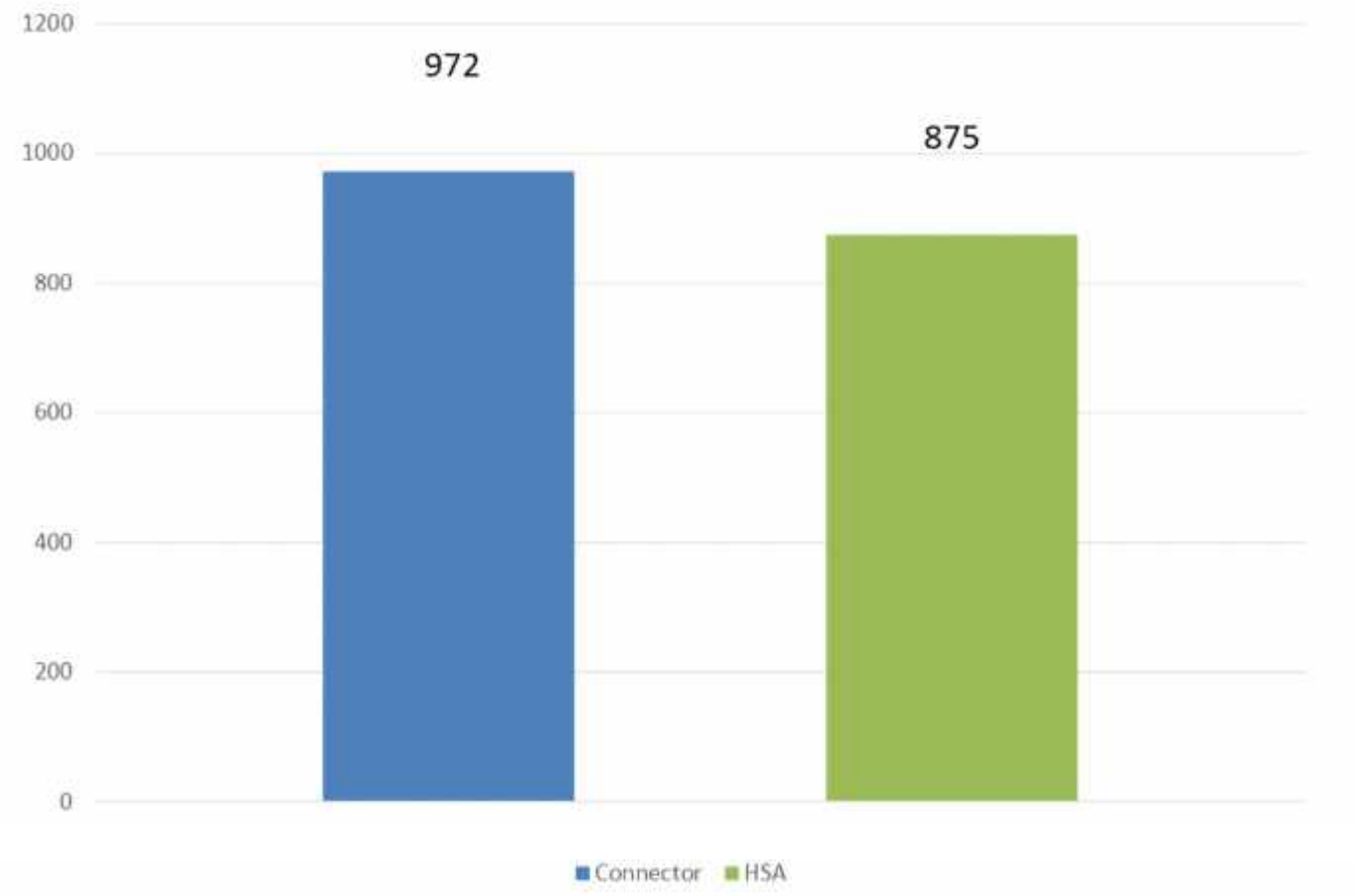
July 30, 2014

Explanation of Data

- MHI data is as of July, 2014 from a report generated by Health New England that contains both Connector and HSA enrollments

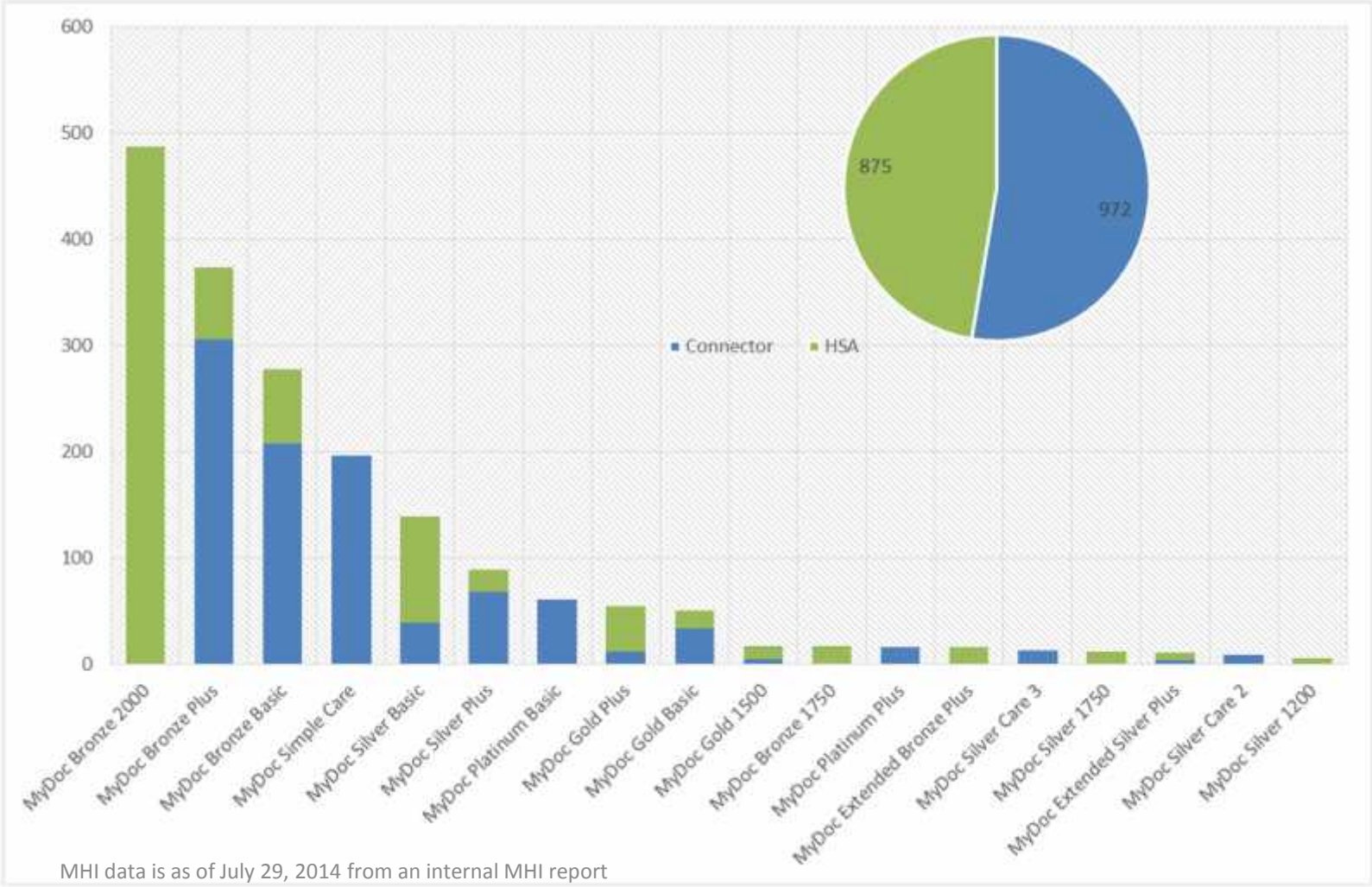
Enrollment by Source



MHI data is as of July 29, 2014 from an internal MHI report

MHI Enrollment by Plan

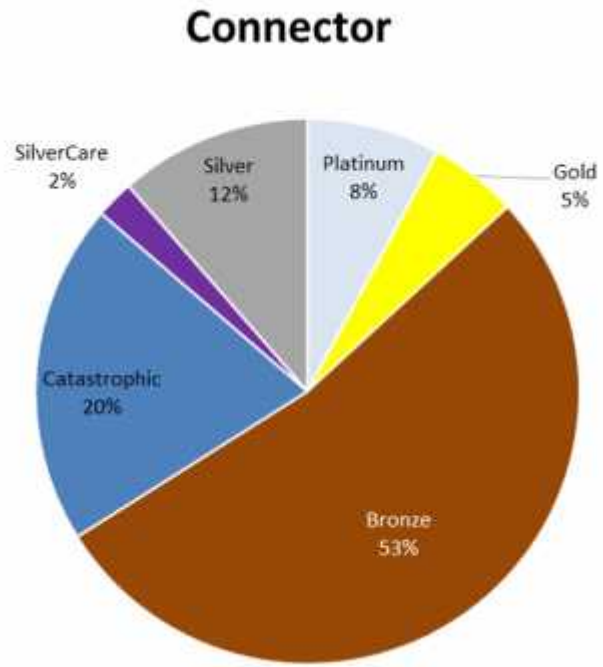
As of July 29, 2014

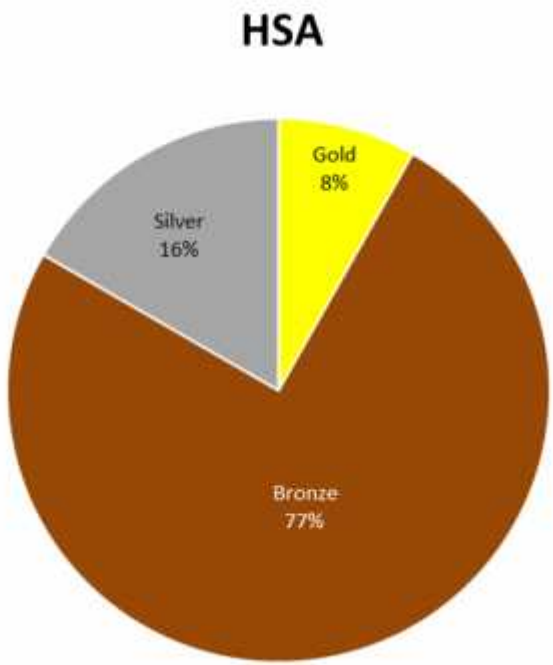


MHI data is as of July 29, 2014 from an internal MHI report

MHI Enrollment by Metallic Tier

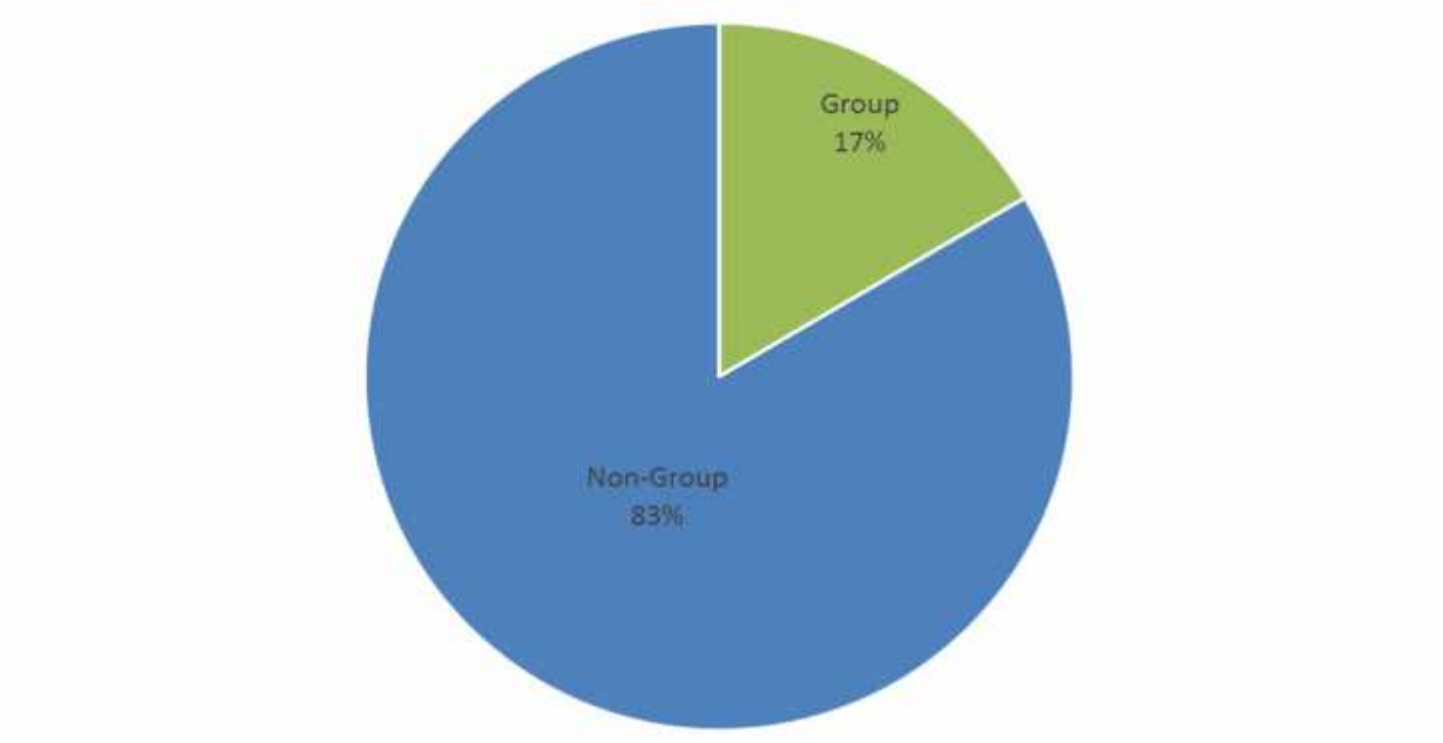
HSA vs Connector





MHI data is as of July 29, 2014 from an internal MHI report

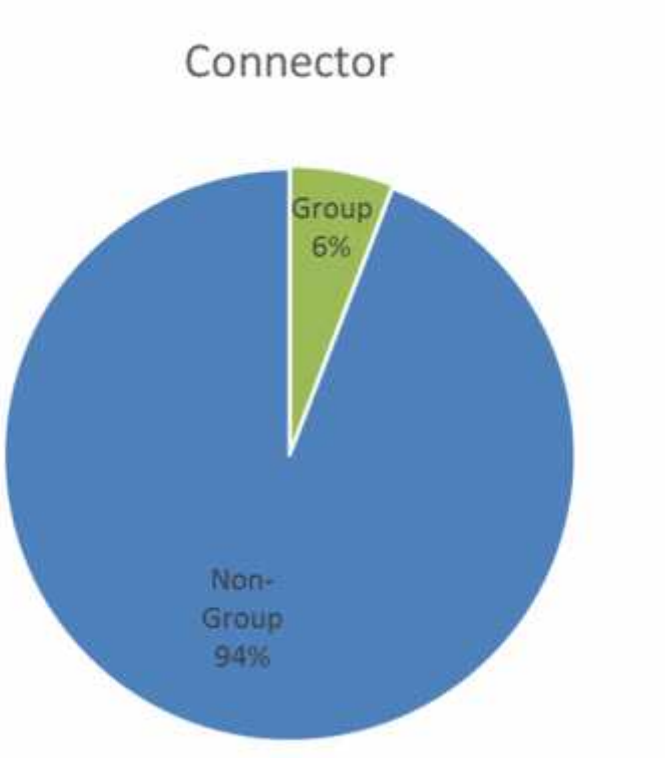
Overall Group vs Non-Group Enrollment

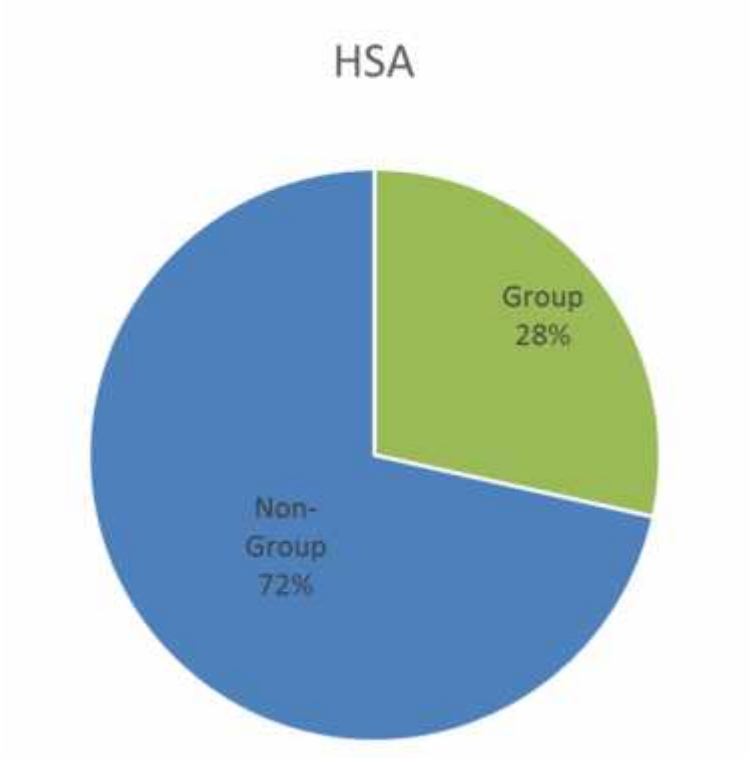


MHI data is as of July 29, 2014 from an internal MHI report

Group & Non-Group Enrollment

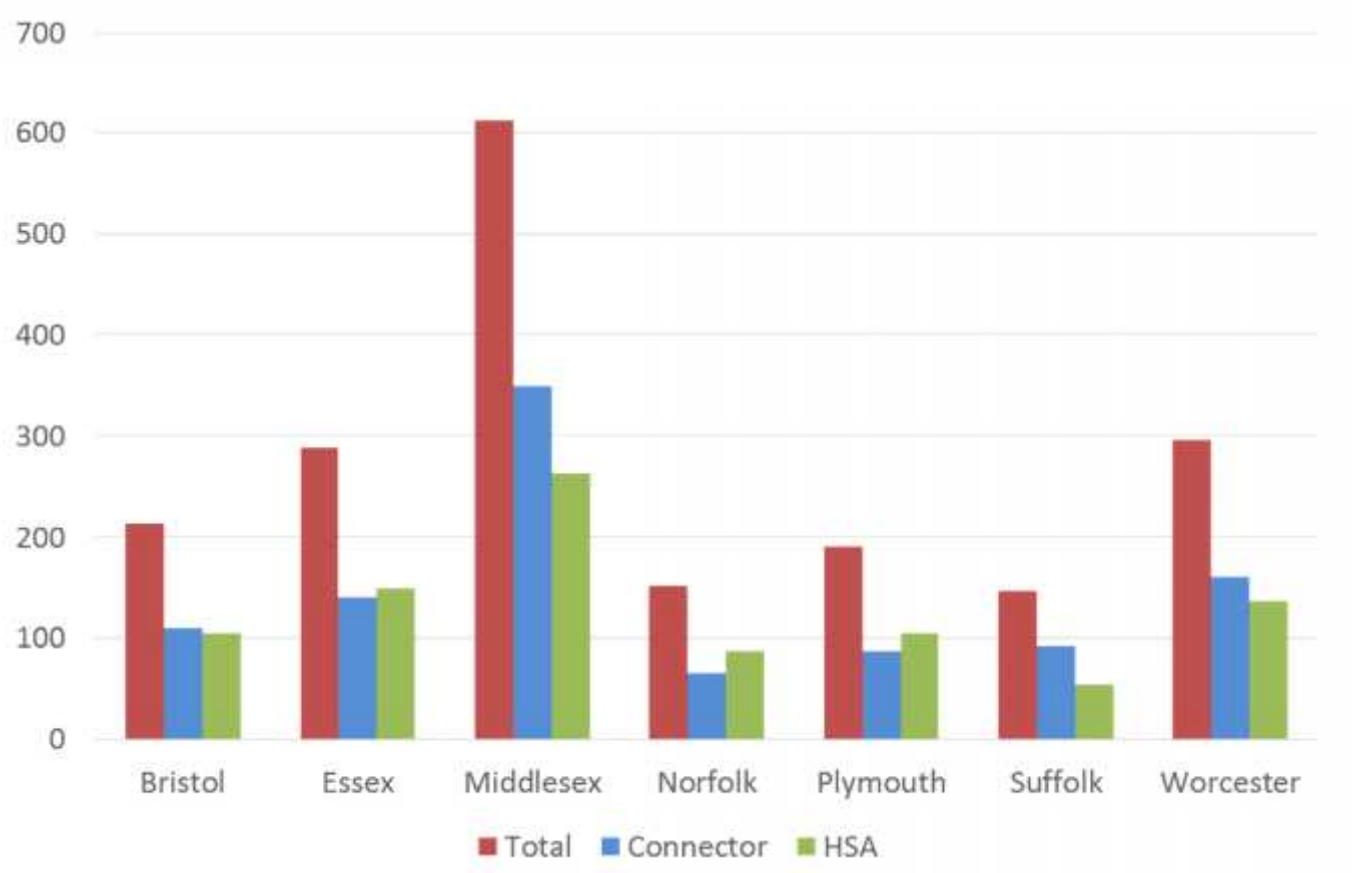
HSA vs Connector





MHI data is as of July 29, 2014 from an internal MHI report

Enrollment by Geographic Region



MHI data is as of July 29, 2014 from an internal MHI report

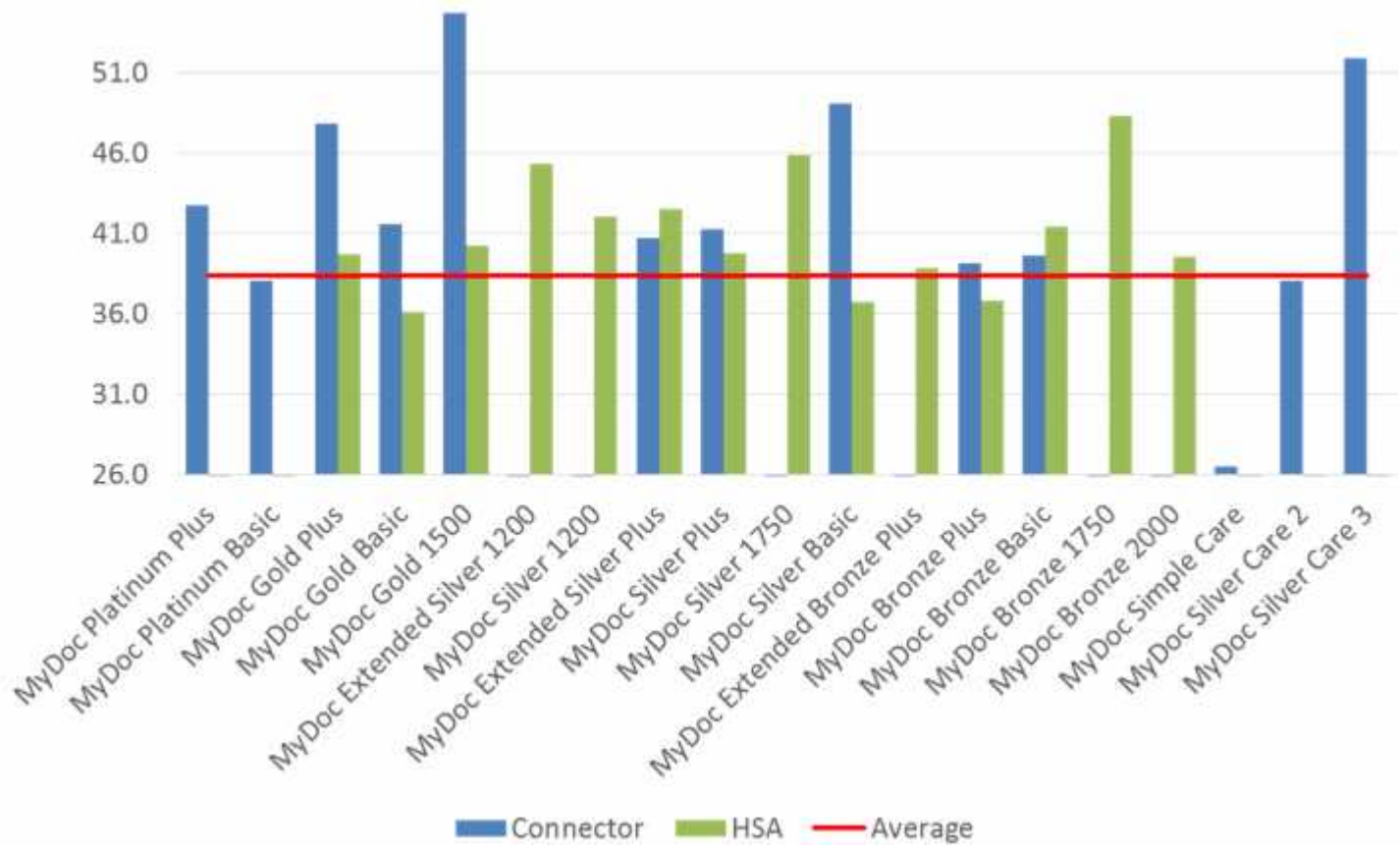
Cities with Greatest Membership

City	Enrollment
Worcester	67
Boston	60
Beverly	44
Cambridge	43
Woburn	39
Somerville	31
Haverhill	28
Lowell	27
Winchester	27
Natick	26
Waltham	25
Framingham	23
Brockton	22
Lakeville	20
Methuen	20

MHI data is as of July 29, 2014 from an internal MHI report

Average Age by Plan

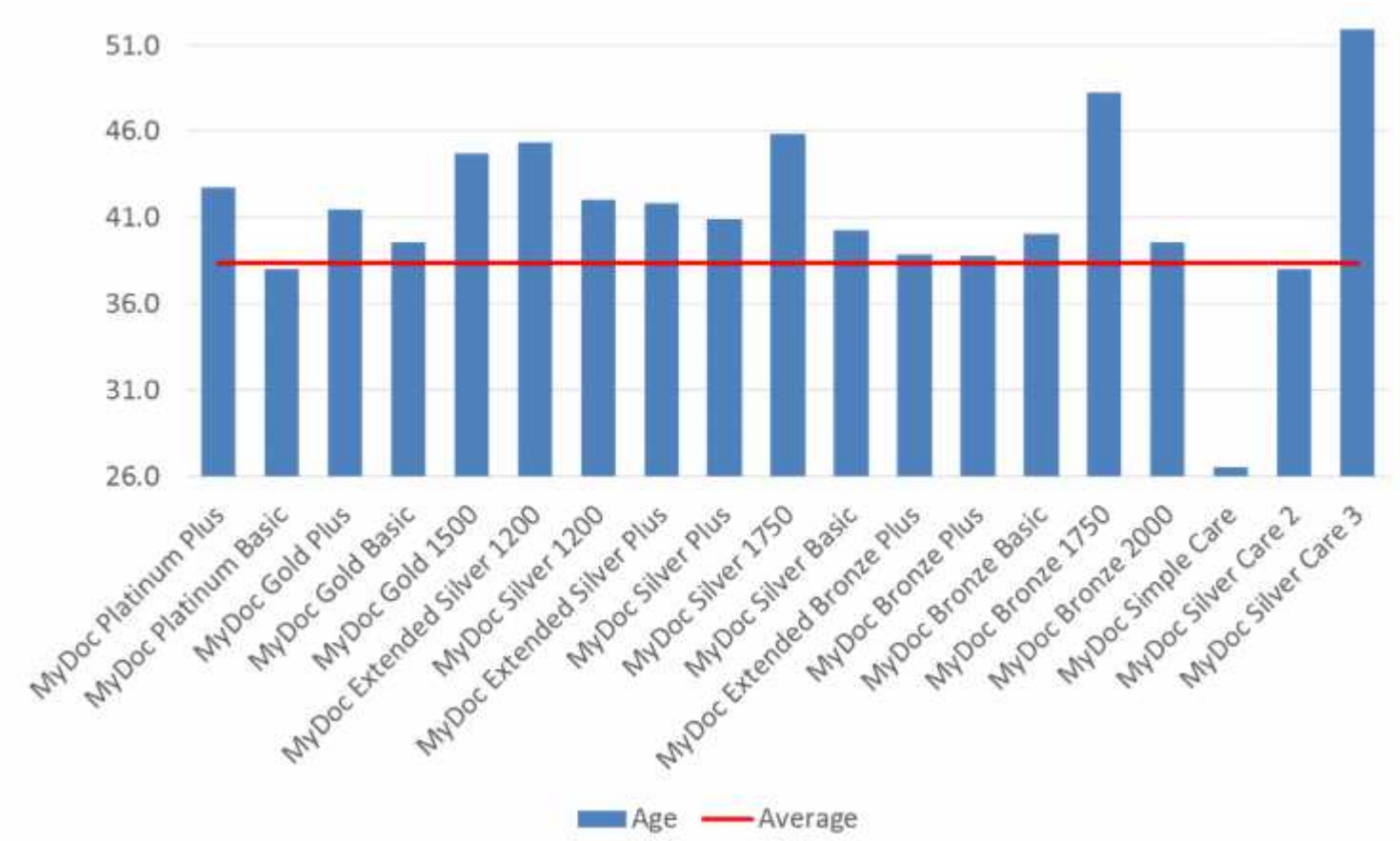
As of August 4, 2014



MHI data is as of July 29, 2014 from an internal MHI report

Average Age by Plan

As of August 4, 2014



MHI data is as of July 29, 2014 from an internal MHI report