Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), 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 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 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 both days. 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 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 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 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, 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: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at 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 at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment 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 complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement 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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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
    a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.

       BCBSMA is a national leader in payment reform and continues to reduce the use of fee-for-service (FFS) payment mechanisms. BCBSMA's contracting efforts have focused on our Alternative Quality Contract (AQC), a global budget model based on total medical expense (TME), quality and outcomes that encourages providers to coordinate all of the care a member needs. In fact, the majority of our HMO members now receive care from providers within our AQC and participation continues to grow. Moreover, BCBSMA has added physicians to the AQC over the last 12 months. Today, over 88% of our primary care physicians and over 92% of our specialists are in an AQC arrangement. Among the analyses of the AQC platform of which we are aware is Song Z et al., Changes in Health Care Spending and Quality 4 Years into Global Payment, *The New England Journal of Medicine* 2014 (analyzing 2009-2012 improvements). Additionally, please see response 1(c) below.

    b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.

       We believe that the AQC yields the most benefit compared to bundled payment models. Between now and October 1, 2016, we will continue to offer the AQC to the very small percentage of providers not participating today. Additionally, our main focus is on the implementation of APMs to PPO described in 1(c) below.

    c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.

       BCBSMA has already begun offering to our provider community a payment reform model for PPO with a 2016 effective date. As this model was designed, we took the elements of the AQC that have been most successful and did the hard work necessary to ensure that these elements worked within the PPO product design. As foundational work,

BCBSMA completed the methodology, systems and infrastructure development, and program design required to launch a global budget payment model for providers caring for our PPO members. The opportunity to participate in PPO Payment Reform is available to all providers with whom we currently have an AQC contract for our HMO members.

It is important to note that our PPO APM, once implemented, will apply to both fully insured and self-insured business.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and 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. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

   BCBSMA offers a number of approaches to encourage our members to use high value services, settings and providers. These approaches are premised on providing information and guiding members to make informed decisions about the best place to receive care and offering benefit designs that have embedded incentives to do the same. The following information provides a non-exhaustive summary of the major components of these efforts. Please also refer to response 3 below.

   Our tiered network offerings, *Options* and *Hospital Choice Cost Sharing*, encourage the use of providers that deliver higher quality and lower cost care by using differences in cost sharing. In the *Options* offering, primary care physicians and hospitals are placed into one of three tiers based on their cost and quality performance. Members pay lower out-of-pocket amounts when they use providers who deliver care effectively and efficiently. With *Hospital Choice Cost Sharing*, inpatient, ambulatory surgery, short term rehabilitation therapy, lab, x-rays and high tech radiology sites of service are tiered. This design uses two tiers rather than three tiers and has the flexibility to be paired with many types of plan designs, including high deductible plans, to strengthen member incentives for use of high quality, lower cost providers.

   BCBSMA also offers *Value Based Benefits* in which members can receive cost sharing reductions when adhering to recommended care for diabetes, asthma and heart disease. Member success with recommended care is increased by their knowledge and understanding of out-of-pocket costs, their condition, and management of their illness. This benefit design incents appropriate care by lowering applicable cost sharing amounts for specific medications and services while also providing members with advice and support in managing their condition.

BCBSMA continues to make available to all members our *BlueCare Line*, which enables a member to speak with a registered nurse 24/7 about urgent medical conditions or health questions, and if necessary receive advice in terms of self-care or when to seek urgent or emergency care. In addition, we strongly believe that telehealth, implemented appropriately, can be an additional tool for members that aligns with high-quality and affordable care. To that end, BCBSMA has implemented a pilot program to enable members to engage with their clinicians through online video. This pilot program, launched in 2014, provides benefits such as more efficient care and increased access, avoidance of unnecessary trips to the emergency room, convenient in-home medication management and adherence guidance, improved post-surgical outcomes and better integration of behavioral health into primary care practices to manage "whole person care." Building on this success, we plan on broadening the coverage for and availability of telehealth services beginning in 2016 in a coordinated way. We will continue to analyze additional opportunities that offer the potential to support our goals of improving care quality and affordability.

BCBSMA is also making available our *Smart Shopper Cost Sharing Program* as an option for our large PPO customers. The *Smart Shopper Cost Sharing Program* is a reference-based pricing benefit design for a wide range of MRI and CT scans. This benefit design creates incentives for members to shop for and use appropriate care by lowering cost sharing amounts. In the future, we look forward to enhancing this offering with additional services and incentives for members.

3. Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.

   BCBSMA members have been able to access cost information since 2011. In 2013, BCBSMA enhanced its cost transparency offerings in furtherance of member needs and in support of Chapter 224, specifically offering members new member-centric written estimates in addition to our existing web-based tools. In 2014, BCBSMA made further enhancements to our web-based tool to offer such cost information to members in real time.

   Our web-based tool, securely located in our member website portal, enables members to access costs for over 500 common medical services. Moreover, if a particular service is not available on-line, members can submit (via phone or web) a written estimate request.

   a. Using **HPC Payer Exhibit 1** attached**,** please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

      Please see attached HPC Payer Exhibit 1.

b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	☒	No	☐
Outpatient	Yes	☒	No	☐
Diagnostic	Yes	☒	No	☐
Office Visits (medical)	Yes	☒	No	☐
Office Visits (behavioral)	Yes	☒	No	☐

Our web-based tool enables access to over 500 common medical and behavioral health services across the inpatient, outpatient, diagnostic, and office visit category types. Cost data is helpfully presented at the episode level, factoring in claims from admission to discharge to provide a more realistic sense of cost. Cost data is updated twice a year, and is available for services and providers nationwide. We expect that major tool enhancements later in 2015 and 2016 will increase the number of services available for estimate to over 1,000.

c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.

Yes ☒ No ☐

Our methodology leverages historical claims data to develop the episodic treatment cost and the episode in most cases contains more than a single procedure code or claim. This approach integrates contracted rates into the cost calculation. Results are displayed based upon the average allowed amount, as well as the high and low points of the allowed amount range.

d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes ☒ No ☐

Yes: Some members already have access to actual out-of-pocket estimates that incorporate member-specific benefits and deductible status. The balance of members currently have access to total cost estimates based on average allowed amounts along with an estimate of their potential maximum out-of-pocket costs. Moreover, through ongoing IT implementation this year and next, we are planning for increasing numbers of members to have access to the actual out-of-pocket estimates noted above.

e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes ☒ No ☐

f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

There is growing anecdotal evidence of member desire for and use of cost information. Call volume related to costs and cost sharing continues to track at around 18% of annual total call volume; hits to our online provider search/cost estimation tool remain strong, averaging around 75,000 per month (YTD 2015); written estimate request volume is trending higher than 2014 (901 requests vs. 580 requests year over year as of the date of this response).

BCBSMA conducted quarterly reviews of all written estimates in 2013 and 2014, which are expected to result in major competitive enhancements to our integrated online provider search and cost estimation tools.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.

BCBSMA is closely monitoring the recent changes in the health care environment. We believe that the twin goals of improved quality of care and affordability should be the litmus test for any market changes. While it is too early to tell if or how any particular recent changes will impact cost and quality of care over the long-term, BCBSMA believes that some acquisitions and affiliations can be part of a healthy economy so long as such changes result in increased, demonstrated efficiencies, lower costs over time and higher quality care provided to members. Market analysis should not be restricted to any one region but rather should be viewed across the state and within submarkets of the state.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

    BCBSMA continually seeks to improve the quality of care our members receive through performance-based incentive contracts with network providers. Historically, in the Massachusetts market, prices have varied across the system (including within Medicare). The state has examined this concern previously and within the Special Commission on Provider Price Reform, a host of stakeholders came to the unanimous conclusion that

there are reasonable factors for variation. The Commission specifically noted within Recommendation No. 5 that, among other items, these factors could include quality, care coordination and community-based services. Consistent with these principles, BCBSMA believes that prices may, for example, vary across providers based on factors including clinical quality, efficiency, and improved health outcomes.

b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.

In addition to BCBSMA's leadership in value-based product design (previously outlined within response 2 above), BCBSMA also implemented the AQC with the goal of reforming the payment system by moving away from reimbursements merely based on the volume of the services delivered. Evaluations of the AQC show improvements in quality and reductions in claims spending, driven by a combination of shifting of care to less expensive providers and reducing utilization. See Song Z et al., Changes in Health Care Spending and Quality 4 Years into Global Payment, *The New England Journal of Medicine* 2014 (analyzing 2009-2012 improvements). As we engage in ongoing discussions with providers across the Commonwealth, we work to ensure that any resulting agreement promotes affordable, high-quality health care. Given the bilateral nature of such agreements, meaningful reform is best achieved through incremental, achievable targets met over time. Over the past seven years, we have seen a reduction in TME variation and a growing percentage of our members cared for by providers with essentially "average" TME. These shifts reflect the growing impact of payments based on quality and outcomes.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of- network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.

Out-of network charges continue to be a critical concern for the Massachusetts health care system. BCBSMA is proud that it has a broad and effective network of providers across the Commonwealth. In addition to the protections of that network for our members seeking care, BCBSMA has long had protections in place to ensure that out-of-network services, costs and charges are minimized in appropriate ways for the specific insurance product being utilized (HMO vs. PPO as one example). As examples, BCBSMA does not refer members for out-of-network services. BCBSMA continues to believe that in-network services are the most reliable source for affordable, high-quality care and actively promotes members receiving care within the network. BCBSMA also monitors authorization requests for out-of-network services. In addition, BCBSMA has conducted outbound calls to ensure that our members understand the impact of out-of-network costs as well as any alternatives that may be available to them.

In instances where the member receives out-of-network care prior to BCBSMA being involved, BCBSMA also utilizes a third party who can negotiate all PPO out-of-network claims above a certain dollar threshold. When a discounted rate is successfully arrived at, the member liability is based on the lower rate and the provider agrees not to balance bill the member.

Finally, we note that both HMO and PPO members are fully protected in emergent situations and receive their in-network benefit level for these services regardless of whether the provider is in-network.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.

   BCBSMA agrees it is not beneficial to members or the health care system for outpatient-based practices to bill a facility fee for a service appropriately delivered in an office setting. As a result, effective July 1, 2015, BCBSMA has implemented a new payment policy that prohibits reimbursement for any facility fees billed with routine Evaluation and Management (E&M) services. In our continued effort to make healthcare affordable and transparent, this payment policy change will reduce the confusion our members experience when they receive separate facility bills for physician office-based E&M visits off-campus. It also reduces member liability (for example, the impact from deductibles and coinsurance) since members will no longer have facility bills to pay in addition to the physician bill.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
   a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.

      BCBSMA has developed two key initiatives aimed at addressing patients with medical and behavioral health co-morbidities, and better integrating care.

      In 2014, we launched the *Recovery Education & Access to Community Health*, or *REACH Program*, designed to improve care for members with serious mental illness or substance use disorder issues who typically have difficulty engaging in traditional care plans. Our goal is to better address the psychological, medical and social needs of members with significant behavioral health needs to help them live healthier, more stable lives. *REACH* members have access to a series of traditional and non-traditional

treatments and interventions, such as: 24/7 access to a care manager, peer counseling, living skills training, family support groups, and transportation to and from health care appointments. While it is too early to draw conclusions, early member satisfaction results are promising.

We have also piloted the *Life Balance* program in the past two years. Developed in concert with researchers at Brigham & Women's Hospital, *Life Balance* is designed to improve health outcomes for members with mental health problems and significant health conditions such as cancer, heart disease or joint replacement. *Life Balance* provides one-on-one telephonic coaching to help strengthen resiliency and teach the coping skills necessary for physical and psychological balance in the face of illness. Cognitive behavioral coaching is monitored internally and measured by Brigham experts in the field. Early data supports significant improvements in coping and anxiety, reductions in ER usage and readmission rates. Final data review for *Life Balance* members completing the 12 week program is now underway.

b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.

We will be continuing our pursuit of the two programs noted in response 8(a) above, each focused on different subsets of the population. We expect to have more complete data on the *Life Balance* program in 2016. We will review these results with an eye to any appropriate program growth. We will also review the *REACH* program, which will take longer to evaluate.

On a broader public health scale, beginning in January 2016, all providers under our AQC will be responsible for costs associated with behavioral health services. This provides new incentives for physicians within our AQC network to screen patients for depression and adherence to antidepressant medications, helping to foster a total continuum of care. In fact, some AQC providers are already taking steps to imbed behavioral health clinicians directly in primary care settings.

We are also actively collaborating with several AQC providers to address how to improve fragmentation of care and the issue of individuals who have frequent readmissions. BCBSMA will continue to offer reports to our AQC groups to help them manage patients with behavioral health co-morbidities including the Daily Census and Discharge Reports (informing providers when patients are discharged or admitted for specific conditions) and the Medication Possession Ratio (MPR) Report (telling providers if patients are regularly filling their prescriptions, including antidepressants).

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and

attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).

Please see attached HPC Payer Exhibit 2.

----- End of BCBSMA Responses -----

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

Sincerely,

Andrew Dreyfus

President and Chief Executive Officer

HPC Pre-Filed Testimony - Payer Questions
BCBSMA Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		**Aggregate Number of Inquiries via Website**	**Aggregate Number of Inquiries via Telephone or In Person**	**Aggregate Average Time to Resolve Inquiries***
CY2014	**Q1**	117	75	<1 day
	Q2	268	120	<1 day
	Q3	428	70	<1 day
	Q4	405	178	<1 day
CY2015	**Q1**	346	129	<1 day
	Q2	299	127	<1 day
	TOTAL:	1863	699	

** Please indicate the unit of time reported.*

******In addition, payers <u>MUST</u> identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")******
All 3 tabs must be completed.

Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:

CY2014 Q1	**1**	PSYCHOTHERAPY PATIENT &/ FAMILY 45 MINUTES
	2	PSYCHOTHERAPY PT&/FAMILY W/E&M SRVCS 45 MIN
	3	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES
	4	VASECTOMY, UNILAT/BILAT; W/POST-OPERATIVE SEMEN EXAMINATION(S)
	5	VASECTOMY COMPLETE OR PARTIAL UNILATERAL OR BILATERAL IP
	6	PROFF SERVICES FOR ALLERGEN IMMUNOTHERAPY MULTI INJECT
	7	VASECTOMY,UNIL OR BILAT,INCLUDE POST OPT SEMEN EXAM(S)
	8	PROFF SERVICES FOR ALLERGEN IMMONOTHERAPY SINGLE INJECT
	9	NASOPHARYNGOSCOPY W/ENDOSCOPE (SEPARATE PROCEDURE)
	10	SEPTOPLASTY/SUBMUCOUS RESECT, W/ W/O CARTILAGE SCORING W/GRAFT
CY2014 Q2	**1**	COLONOSCOPY, FLEX, PROX TO SPLENIC FLEXURE; DIAG, COLON DECOMP
	2	NH SURGI CENTER PROCEDURE
	3	COLONOSCOPY,FLEXIBLE; DIAGN INCL COLLECTION OF SPECIMEN(S) BY
	4	COMPUTED TOMOGRAPHY BONE MINERAL DENSITY STUDY 1 OR MORE SITES
	5	DUAL-ENERGY X-RAY ABSORPTIOMETRY(DXA)BONE DENSITY STUDY 1&MORE
	6	DUAL ENERGY X-RAY ABSORPTIOMETRY (DEXA) BONE DENSITY STUDY
	7	LIMITED EXAM,EVALUATION AND/OR TREATMENT, OFFICE OR OPD
	8	ARTHROSCOPY, KNEE, SURG; W/MENISCECTOMY (MED/LAT, W/SHAVING)
	9	ROUTINE OB CARE INCL ANTE/POST PARTUM CARE; CESAREAN DELIVERY
	10	MRI SPINAL CANAL AND CONTENTS W/O MATERIALS
CY2014 Q3	**1**	THER PROC,1OR>AREAS,EA 15 MIN;THER EXER DEV STR,END,ROM,FLEX
	2	PELVIC DELIVERY WITH PRE AND POST-PARTUM CARE
	3	ROUTINE OBSTETRIC CARE W/ANTEPARTUM CARE, VAGINAL DELIVERY
	4	ROUTINE OB CARE INCL ANTE/POST PARTUM CARE; CESAREAN DELIVERY
	5	CAESAREAN DELIVERY ONLY
	6	COLONOSCOPY, FLEX, PROX TO SPLENIC FLEXURE; DIAG, COLON DECOMP
	7	COLONOSCOPY,FLEXIBLE; DIAGN INCL COLLECTION OF SPECIMEN(S) BY
	8	MANUAL THERAPY TECHNIQUES ONE OR MORE REGIONS, EACH 15 MINUTES
	9	ARTHROPLASTY, TOTAL KNEE REPLACEMENT, FASCIAL OR PROSTHETIC
	10	ULTRASOUND,PREGNANT UTERUS,FIRST TRIMESTER;SINGLE OR 1ST GESTA
CY2014 Q4	**1**	THER PROC,1OR>AREAS,EA 15 MIN;THER EXER DEV STR,END,ROM,FLEX
	2	THYROID STIMULATING HORMONE,(TSH)
	3	THYROID STIMULATING HORMONE (TSH)
	4	PELVIC DELIVERY WITH PRE AND POST-PARTUM CARE
	5	ROUTINE OBSTETRIC CARE W/ANTEPARTUM CARE, VAGINAL DELIVERY
	6	REDUCTION MAMMAPLASTY
	7	ANTIBODY;HIV-1,AND HIV-2,SINGLE RESULT
	8	MANUAL THERAPY TECHNIQUES ONE OR MORE REGIONS, EACH 15 MINUTES
	9	HEPATITIS B SURFACE ANTIGEN (HBSAG)
	10	MASTOPLASTY PLASTIC OPERATION ON BREAST REDUCTION ONLY UNIL IP

Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:

CY2015 Q1	1	NEUROPSYCHOLOGICAL TESTING PER HR.OF PSYCHOLOGIST'S OR PHYSICI
	2	PHYSICAL THERAPY EVALUATION
	3	MAGNETIC RESONANCE IMAGING,BRAIN INCLUDING STEM W//O CONTRAST
	4	MAGNETIC RESONANCE IMAGING-BRAIN-W/O CONTRAST MATERIAL
	5	MAGNETIC RESONANCE(PROTON)IMAGE, BRAIN; W/O CONTRAST MATERIAL
	6	NASOPHARYNGOSCOPY W/ENDOSCOPE (SEPARATE PROCEDURE)
	7	NH SURGI CENTER PROCEDURE
	8	FETAL ANEUPLOIDY 21 18 13 SEQ ANALY TRISOM RISK
	9	SEPTECTOMY SUBMUCOUS RESECTION
	10	APPLCTN OF INTERVERTEBRAL BIOMECHNCL DEV;LST SEP PRIMARY PROC
CY2015 Q2	1	ESOPHAGOGASTRODUODENOSCOPY, FLEX, TRANSORAL;DIAG, INCL COLLECT
	2	NEUROPSYCHOLOGICAL TESTING PER HR.OF PSYCHOLOGIST'S OR PHYSICI
	3	FAMILY PSYCHOTHERAPY(CONJOINT PSYCHOTHERAPY)(WITH PATIENT PRES
	4	PSYCHOTHERAPY PATIENT &/ FAMILY 45 MINUTES
	5	FAMILY MEDICAL PSYCHOTHERAPY
	6	ESOPHAGOGASTRODUODENOSCOPY, FLEX, TRANSORAL;W/BIOPSY,SNGL OR M
	7	REPAIR INGUINAL HERNIA/OVER AGE 5/IP
	8	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT
	9	PSYCHIATRIC DIAGNOSTIC EVALUATION
	10	REPAIR INITIAL INGUINAL HERNIA, AGE 5 YRS OR OVER; REDUCIBLE

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines - In state business

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	0.4%	0.3%	0.1%	0.1%	1.0%
CY 2013	0.7%	0.4%	0.2%	0.2%	1.5%
CY 2014	0.9%	0.8%	0.3%	0.3%	2.4%

Notes:

1. **ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND reflects the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends have not been adjusted for any changes in product, provider, demographic mix or partial coverage. In other words, these allowed trends are actual observed trends. These trends reflect total medical expenditures and include claims based and non claims based expenditures.**

2. **PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.**

3. **SERVICE MIX is defined as the impact on trend due to the change in the types of services.**

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

5. **Estimated benefit buydown has decreased over the past 3 years. This decrease has resulted in an increase to the utilization component of allowed claim trends.**

6. **The rate of increase of demographics has also slowed over the past years. Aging of the population can potentially impact all components of trend with the exception of unit cost.**

7. **Changes in health status were estimated using DxCG risk scores. Overall health status deteriorated every year from 2012-2014. Change in health status can potentially impact all components of trend except unit cost.**

8. **Note that the data and trends above are limited to claim experience for Massachusetts residents in Commercial plans whose primary coverage is with BCBSMA.**

9. **There is volatility in the components of trend due to macro and micro factors impacting**

health care trends including but not limited to economy, advances in medical technology and treatment including new drugs, increased consumer engagement resulting from new product designs and transparency tools.