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. .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.

a. Please specifically describe efforts related to bundled payment and similar payment methods;.

WE have made significant gains in our relationship with the Massachusetts HCPs through outreach and expansion of our contracting presence there. The Market medical Executive has reached out and met with many of the CMOs and to other leaders of the Provider community to explain and demonstrate the methodology we are proposing and have used with other CACs. Our market medical Executive and out Contracting leads have also met with the leadership of the State medical Society and plan to expand our relationships within the parameters and guidance of the Triple Aim to move to a value based structure.

b. 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.

Cigna has led efforts nationally and throughout New England regarding population attribution incentive based financing programs necessary for deployment of APM arrangements to PPO health plans. As mentioned above in 1.a, Cigna is committed to robust deployment of these capabilities in Massachusetts in keeping with our overall value proposition which has been remarkably well received and validated by our customers and their agents throughout the region. The majority of customers served by Cigna are covered under self-insured benefit plans, and accordingly, Cigna has and will continue to include such beneficiaries in APM arrangements.

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?

SUMMARY:

Cigna's advanced approach to integrated health coverage links people, information, plans, services, and incentives to create a more powerfully connected system of total health support. Our early efforts at connecting members with high-quality, cost-efficient doctors and hospitals that receive rewards for improving outcomes have provided promising results, but we are committed to doing more and achieving better results. Cigna is leveraging the value of health ownership by connecting our network solutions with personal coaching, plan coverage design, and member health participation.

ANSWER:

Our goal is to have the majority of members with high-cost conditions and complex medical needs receiving care from health care professionals who have an incentive relationship with Cigna. Our innovative solutions span the delivery system—from small to large doctor groups, hospital systems, specialist groups, and everything in between. CCC initiatives help health care professionals transition from volume-based reimbursement to value-based reimbursement. As we collaborate, we meet health care professionals wherever they are in the transition, and take them where they need to be to help improve quality, cost, and satisfaction. Our collaborative care reimbursement model is effective in lowering costs, and improving quality and member satisfaction. The highest performing doctor groups have demonstrated a 4-5 percent lower total medical cost trend compared to their market peers.

We have collaborative care arrangements with 125 large doctor groups in 29 states. These initiatives provide care to over 1,200,000 Cigna members, and over 41,000 physicians (over 24,000 primary care physicians and over 27,000 specialists). We have incentive arrangements with over 80 hospitals that promote quality, safety, and efficiency performance, and we continue to expand the number of hospitals with incentive arrangements nationally.

Our high-performance network strategy, Cigna Care Designation, guides members to select doctors in 21 specialties, including primary care, who meet quality and medical cost-efficiency standards. With the Cigna Care Network tiered benefit strategy, health care professionals who achieved Cigna Care

Designation are on a less expensive tier for member out-of-pocket costs. Cigna Care designated doctors are more compliant with evidence-based measures of quality, and have shown episode treatment costs on an average of 11 percent less than non-Cigna Care designated doctors. The collaborative care doctor groups that have matured and achieved the necessary standards of high quality and cost-efficiency receive Cigna Care Designation. Collaborative care doctor groups that have the best performance for cost and quality are included in the Cigna Care Network.

Cigna Care Designation is available in 71 markets across the U.S. Cigna Care Network tiered plans are projected to reduce total medical claims by 1-3 percent. Effective January 1, 2015 Cigna added new tiered physician network capabilities in eastern Massachusetts so Cigna now provides access across the entire Commonwealth.

LocalPlus is a local network solution designed to guide members to a select network of high-performing health care professionals and facilities in their area, to drive more savings for employers with employees located in certain geographies. In areas where collaborative care arrangements are available, LocalPlus includes health care professional groups and facilities that participate in collaborative care. The design of LocalPlus means our members have a financial incentive to seek care from doctors and facilities that receive an incentive to deliver better outcomes and are better motivated to improve health. On average, LocalPlus networks lowers costs by 4-15 percent.

Our innovative Centers of Excellence hospital program helps members make more informed health care decisions, providing them with hospital quality data that includes both outcome and cost comparisons for specific procedures via our online directory. In addition, Cigna provides a cost estimator tool for the 200 most common inpatient procedures, which allows members to see their projected costs based on the health care facility they choose.

Cigna piloted a reference-based pricing benefit for in-network commodity-type services with one national, multisite client since 2011. This pilot included colonoscopy screening, laboratory service, and MRI and CT scans.

Cigna's objective with this pilot was to learn, in a controlled manner, the value of a reference-based pricing benefit for our clients and members in terms of lower medical costs and better participation.
At this point our evidence shows that reference-based pricing, as a benefit lever alone, may not be effective at creating activated members.
At this time, Cigna is not expanding the reference-based pricing program will have other education, navigation, and motivation programs available that will help drive member activation, and ready the client population for other motivation solutions targeted for 2016.

Cigna recognizes the importance of providing our clients with Value Based Benefit Design (VBBD) solutions to help them manage costs and curb trends. As a result, we have developed a value based benefit design pilot that provides solutions to real challenges. The VBBD option addresses the issue of high utilization of the emergency room. Costs can be staggering. Combined, ER and UC claims represent approximately 10% of overall claim costs. Non-life threatening related ER claims represent 3% of total claim costs.

This pilot supports a consumerism approach that empowers customers to make thoughtful, well-informed decisions about their health care in order to maximize their health care benefits. Cigna has identified 54 common claim codes frequently associated with ER visits that can just as well be treated at an Urgent Care Center. All codes can be placed into 5 main categories, which include lower back pain, joint pain, minor respiratory symptoms, urinary tract infections and minor skin rashes.

Cigna created a benefit design that provides an incentive for customers to go to an Urgent Care Center for these five main categories. If customers visit the ER for true emergencies, then the plan will cover a percentage of the costs. However, if they visit an ER for any of the 54 avoidable codes, then the plan will pay a lesser percentage of the costs, generally 20% less.

The Avoidable ER benefit is designed to increase awareness of condition appropriate care and provides an incentive for customers to change their behavior.

However, the initial pilot results showed that customers were not responsive to ER penalties, which is consistent with findings of earlier studies. An ER 20% coinsurance increase is not associated with significantly higher Urgent Care utilization.

Cigna initiated efforts to develop a comprehensive telehealth strategy in 2012 with the goal of offering our customers online video or telephone consultations with board-certified internal medicine, family practice, and pediatric physicians. Cigna recognized that there has been an increased demand for access to quality and affordable care driven by changes in the healthcare environment: more people have difficulty finding non-emergency care on nights, weekends and holidays, average wait time for a new patient is 19 days, and there is a significant physician shortage in key specialties, including primary care. On 1/1/2014 Cigna launched a telehealth pilot to provide our

clients and customers the opportunity to have 24/7/365 access to affordable, convenient, and evidence based care. This pilot was launched only in our ASO book of business but with the intention to extend telehealth into existing and future products & services. At this point we have over 280 employers participating in the pilot, which has made telehealth available to approximately 1.7 million Cigna customers nationwide. We are just starting to analyze data from our first year experience. Utilization rate for telehealth for this pilot has been under 1% of all eligible customers, which makes outcome not statistically significant. We are working on increasing utilization levels to 2-5% to better assess ROI. The average age of customers accessing telehealth services was 36.1 y/o and the gender distribution was 61.4% females. The overall satisfaction rate for our customers has been consistently above 80%.

Cigna is moving forward expanding telehealth beyond a pilot phase to make it a standard offering across all products, all platforms, and all markets. The vision is for Cigna to support health care professionals [Hospitals, physicians, others] through system enablement, data sharing & reimbursement for telehealth services. Cigna will NOT be a supplier or distributer of the technology. Instead Cigna will support multiple vendor relationships to reduce business risk, enable more expansive service offerings and promote vendor competition. The end state of Cigna's telehealth offering will include both medical and behavioral health services. The target date for full implementation is 1/1/17. One of the barriers we have found on the implementation of a telehealth benefit has been lack of eligible customer engagement. To improve in this area Cigna is working with vendors on developing a variety of communication materials including hard copy welcome kits, electronic flyer, electronic welcome kits, and communication campaigns. Cigna is also collaborating with vendors on the expanded use of mobile apps for smartphones that could provide improved access and more convenience. Currently we do not have a unique telehealth solution for the state of Massachusetts. However once the Cigna's telehealth benefit is fully implements it will provide coverage to Cigna customers in the state.

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.

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.

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

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

Cost data for Cigna Behavioral Health is not available at this time.

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

Yes ***x*** ***No*** ☐

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

Yes ***x*** ***No*** ☐

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

Yes ***x*** ***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.***

We designed our cost and quality tool using multiple years of research, a year of pilot testing with a group of clients, guidance from consumer market research, and actual user feedback. We also held focus groups, in which we found that the majority of user transactions were on the "Find a Doctor," "Estimate Health Care Costs," and "View Your Coverage" pages. We incorporated focus group findings into our cost and quality tool to allow users to easily find information in one location.

This is why we became the first health service company to integrate our cost and quality tools into our health care professional directory in 2012. By integrating cost and quality information into every health care professional search, we were able to convert nearly 30 percent of doctor searches into cost views.

Cigna incorporates procedure-level cost information into the health care professional directory on myCigna for over 600 procedures, including labs, immunizations, office visits, radiology, outpatient procedures, and inpatient procedures.

For inpatient procedures, we calculate cost based on severity-adjusted average length of stay (ALOS) data for the procedure, as well as the hospital-specific average cost per day.

For outpatient procedures, the methodology ties together the estimated cost of the actual procedure and the doctor's estimated charges based on his or her specific practice patterns. By analyzing Cigna's own claims data for specific practice patterns, we are able to present an estimate of what the doctor tends to bill rather than a simple average.

Estimates are created based on 12 months of Cigna claims data, with the key data element of allowed charge amount (after discount and claim processing rules) by procedure. Truven Health Analytics creates estimates for other types of procedures, based on 12 months of Cigna claims data. Claims data is refreshed quarterly.

Before applying the claim methodology, claims data is reviewed to:

- ***remove claims with an ER place of service***
- ***exclude ineligible charges***
- ***ensure that claim adjustments are reflected in the final claim amount***
- ***group claims into plan coverage lines (PPO, HMO, Open Access Plus [OAP])***

This integration earned us recognition as a Top Technology Innovator by InformationWeek in 2012. We are proud of our accomplishments, but that does not mean we will rest on our laurels. Converting 30 percent of doctor searches into cost views is good, but we can do better.

As a result, we created a new health care professional directory. Listening to the feedback of our members, we used the fundamentals of our award-winning directory to build a new application—one with a revamped search engine, better navigation, and an updated look and feel to match our online branding.

Enhancements to the new directory include:

- ***region-specific cost estimates for the most common procedures performed by the type of specialist used in the search***

- ***an expansion of the number of procedures for which we provide cost estimates, more than doubling the previous number of procedures***
- ***a revised search engine that does not just autocorrect or give suggestions, but categorizes the suggestions to ensure members find exactly what they need***
- ***the addition of cost estimates for the most common procedures to the directory's landing page, giving members a sense of the cost variance before they conduct a single search***

We unveiled the new directory on www.cigna.com in August 2014. We launched the new directory at the end of 2014 on myCigna and integrated dental cost information into the directory in early 2015.

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.

Consolidation seems to be inevitable with the financial challenges that all elements of the Delivery system are facing. Our CAC model is based on the performance of the group in terms of quality and cost effectiveness. The size of the group obviously requires changes on the behalf of the delivery systems who are merging. Out model addresses quality and cost relative to the market and works very well in this environment. We are expanding our CAC presence in Massachusetts as stated above.

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?

The highly variable pricing for health care services in the Massachusetts market and elsewhere is the product of a health plans attempt to balance access to highly

leveraged delivery systems with discipline to unit cost increases. Based on this fact, it is our belief that market forces result in reasonable rates of reimbursement to any given provider entity.

a. 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.

Recognizing the impact of consolidation of health care delivery, Cigna is actively discussing alternative product and payment methodologies such as capitation and percent of premium arrangements within Massachusetts. These approaches would result in the delivery system partners distributing premium or premium equivalent to the actual provider of service in likely a more balanced way.

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.

Benefit Enhancement Policy

OVERVIEW

We recognize that there are situations when neither a customer nor their attending HCP is able to access a par facility or another par HCP. These situations include:

Emergencies

- ***We assume that a customer may not be able to get to a par facility's emergency department during an emergency.***

Authorized Services

- ***A customer may not have access to a par HCP or facility located within a reasonable distance, as determined by Cigna's Adequacy Provision.***
- ***The service was pre-certified at the customer's in-network benefit level, for reasons determined by clinical review or as a result of Cigna's pre-certification policy.***

Limited Non-Par HCP Services Rendered at a Par Facility

- ***Even in non-emergency situations, the customer and/or their HCP often do not have the discretion to choose the following HCPs who may be involved in the customer's care at a par facility;***

non-par anesthesiologists, radiologists, or pathologists.

non-par HCPs billing for consultant services at a par facility (limited to the 90000 series CPT codes).

- ***Compliance***

Circumstances where the enhancement of the claim is required by federal or state regulation.

In the above situations, Cigna will "enhance" the customer's benefit from their out-of-network benefit level to their in-network benefit level of copay/coinsurance and deductible.

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.

We have seen a shift to outpatient based practices in several instances. This is a common occurrence around the delivery of high cost Injectable drugs for example. Employers are concerned about significant costs associated with the purchase and administration of these drugs in these settings, rather than in setting such as the HCP office or the home. In situations where it is equally efficacious and safe to deliver these drugs in either setting many Clients are opting to develop benefit designs around utilizing the less costly setting and purchasing the drug from a preferred contracted vendor. In addition our CAC partners have been able to help their HCPs to understand the potential financial impact of these programs on the patient and the employers and to choose the site of service wisely.

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.

For the past three years Cigna has made behavioral health integration one of its top priorities to address the needs of our customers. Working with our Collaborative Accountable Care (private ACO model) partners Cigna has developed a suite of offerings to help meet our healthcare

provider's (HCP) integration needs. Cigna recognizes that every HCP has unique needs and is at a different stage of behavioral health integration. Cigna has developed a customized blueprint to guide behavioral health integration. Elements include:

1. ***Educating providers on screening techniques***
2. ***Engaging psychiatrists for primary care team consultation***
3. ***Supporting embedded behavioralist for treatment in the primary care setting***
4. ***Facilitating a relationship between the medical group and community- based behavioral providers***
5. ***Contracting for differentiated services***
6. ***Updating reimbursement guidelines to understand implications of integrated behavioral visits on the same day as a medical visit***

This year we are offering a direct 800 line for our CAC partners to call and get support for their patients that have behavioral health needs. Other services will include conducting network adequacy analysis, consultative services, develop solutions to pay for behavioral health services in the primary care setting, and develop analytic tools to demonstrate cost benefit of behavioral health integration.

Another way in which we are supporting integration is through contracting with behavioral health providers who are employed by a contracted medical group. As long as behavioral providers meet minimum credentialing guidelines a contract will be extended for consideration by the provider.

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.

In the next 12 months Cigna is planning to expand the offerings mentioned above to more providers in our network. Internally Cigna is upgrading its operating systems to increase integration of services and make referrals between our medical and behavioral teams seamless. This will help improve the ability of our care managers to refer customers to either behavioral or medical programs, like coaching programs. Cigna is now developing metrics to assess the impact of behavioral health integration in the primary care setting. Some of the possible data sources are readmission, ER utilization, use of screening tools , and impact on total medical cost.

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).

HPC Payer Exhibit 2 2015 submi...

I am 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.

Peter W. McCauley, MD 09/11/2015

Peter W. McCauley, M.D. Date
Senior Medical Director

HPC Pre-Filed Testimony - Payer Questions
HPC Payer 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*	Aggregate Number of Inquiries via Fax	Aggregate Number of Inquiries via Mail
CY2014	Q1	984,522	9,246,454	n/a	2,599	1,089,428
	Q2	882,854	8,583,541	n/a	419	1,215,610
	Q3	880,129	8,444,654	n/a	384	1,171,484
	Q4	769,598	8,546,325	n/a	994	1,150,030
CY2015	Q1	529,241	9,471,445	n/a	761	1,239,581
	Q2	841,229	8,364,354	n/a	725	1,115,147
	TOTAL:	4,887,573	52656773	n/a	5,882	6,981,280

** Please indicate the unit of time reported.*

Note--we do ot track average time to resolve inquiries

******In addition, payers MUST 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**	Colonoscopy	14604
	2	mamogram	8174
	3	mri	8103
	4	accupuncture	6303
	5	orthopedic surgery	5295
	6	Plastic Surgery	4681
	7	Vasectomy (unilateral or bilateral)	4390
	8	Ultrasound	3937
	9	Bariatric Surgery, (Gastric Bypass, Weight Loss Surgery)	3905
	10	Vaginal Delivery	3633
CY2014 Q2	**1**	Colonoscopy	12418
	2	mri	7935
	3	acupuncture	7290
	4	mamogram	6968
	5	Marriage counseling	6744
	6	Counseling	6121
	7	Laboratory Services	5304
	8	bariatric surgery	5155
	9	Plastic Surgery	4423
	10	Marriage And Family Therapy	4340
CY2014 Q3	**1**	Colonoscopy	15014
	2	Counseling	13152
	3	Marriage counseling	8734
	4	acupuncture	8435
	5	mri	8105
	6	mamogram	7905
	7	Laboratory Services	6317
	8	Marriage And Family Therapy	5767
	9	bariatric surgery	5614
	10	weight loss	4906
CY2014 Q4	**1**	Physical Therapy	11892
	2	mamogram	9883
	3	Colonoscopy	9065
	4	Colonoscopy	8105
	5	mri	8020
	6	Counseling	6992
	7	bariatric surgery	4402
	8	Ultrasound	4094
	9	Mammogram - Digital Screening (Routine)	3972
	10	weight loss	3954

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

CY2015 Q1	1	Mammogram, Digital Diagnostic (One Breast)	10,236
	2	Vasectomy (Unilateral or Bilateral)	6,530
	3	Back (Lower) MRI (without Dye)	5,941
	4	Gallbladder Removal, Laparoscopic	3,979
	5	Cataract Surgery or Repair	3,951
	6	Checkup-Adult	3180
	7	Bone Density Test	3093
	8	Vaginal Delivery	2030
	9	Hemoglobin A1cTest (HbA1c)	1999
	10	Ear Tube Insertion (with General Anesthesia)	1885
CY2015 Q2	1	Mammogram, Digital Diagnostic (One Breast)	9,203
	2	Checkup-Adult	7,652
	3	Back (Lower) MRI (without Dye)	5,308
	4	Vasectomy (Unilateral or Bilateral)	4,881
	5	Gallbladder Removal, Laparoscopic	3430
	6	Cataract Surgery or Repair	2960
	7	Bone Density Test	2581
	8	Ear Tube Insertion (with General Anesthesia)	1790
	9	Hemoglobin A1cTest (HbA1c)	1750
	10	Checkup-Child	1446

HPC Payer Exhibit 2

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 2012	3.7%	2.7%	*	-0.8%	5.6%
CY 2013	2.9%	4.8%	*	-0.7%	7.2%
CY 2014	1.2%	1.0%	*	0.7%	3.0%

*We did not think we could accurately normalize the impact of provider mix and report a distinct trend figure. The impact of provider mix is captured in unit cost and to a lesser extent service mix.

1. Actual Observed Medical Expenditure Trend Cigna OAP membership. Pharmacy is excluded.
   a. For 2012 through 2014, demographics of the population increased observed trend for MA residents by 0.7% in 2012, 2.1% in 2013, and 1.0% in 2014. Nationally, these figures 0.4%, 0.8%, and 1.9%
   b. Benefit buy downs decreased observed trend for MA residents by 1.3%, 0.4% and 2.1% for the years 2012-2014. Nationally these figures are 1.3%, 0.9%, 1.2%.
   c. We are defining change in health status as changes in risk. Year over year metrics imply the average impact of risk on trend is approximately +1.1% in 2012, +0.6% in 2013 and +0.05% in 2014.

Notes:

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

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

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

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