Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts 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 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 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 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, 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 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

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 Suffolk, 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 (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 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 2, 2016**, 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 from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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, 2014, and/or 2015 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 from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note 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 difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided 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. 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.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are the top areas of concern you would identify for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

The rising cost of health care continues to pose an unsustainable burden on consumers, employers and government. As part of our continuing work to address this pernicious problem, Blue Cross Blue Shield of Massachusetts (BCBSMA) has changed the way we pay for health care. The fee-for-service reimbursement model had unintended consequences, rewarding doctors and hospitals for the quantity and complexity of services provided instead of rewarding the quality and outcomes of care. However, with the framework of our Alternative Quality Contract (AQC) model in mind, BCBSMA knows that still more work needs to be done since medical costs are showing signs of increase after a period of historically low medical trends.

One key issue is the significant increase in pharmacy costs. As government and private payers are faced with these costs, we need to collectively analyze the impact of new and breakthrough therapies, technologies and drugs that hold so much promise for people with serious medical conditions. In addition to the increased costs associated with prescription drugs generally, we must specifically consider the high costs associated with specialty drugs and personalized medicine. As a community, we must be willing to tackle some very tough questions: What is the right price for new drugs and therapies? What is their appropriate use and who decides? How can we achieve a better balance between medical advancements and affordability?

We are concerned about cost growth in other areas impacting the Massachusetts Health Care Cost Growth Benchmark, including continuing cost drivers in the MassHealth program and the continuing nature of higher labor costs in Massachusetts compared to other parts of the country.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

There are many initiatives underway in both the public and private sector that merit commendation. In particular, BCBSMA is very pleased to see MassHealth implement alternative payment arrangements and delivery system reform. Commentators have noted the beneficial cost and quality improvements stemming from BCBSMA's AQC; we are anxious to see MassHealth and the Commonwealth benefit from similar alternative payment arrangements.

Importantly, state policymakers and regulators should guard against added costs from additional governmental mandates or assessments that do not have commensurate benefit. Additionally, policymakers at the Health Policy Commission and elsewhere should continue to consider the cost-

effectiveness and quality impact of any proposed policy and market solution, whether it is in the arena of cost and market impacts reviews, provider price variation or the HPC's newly available but still untested Performance Improvement Plan processes. These market-based tools are important features that should be employed in a manner consistent with their intended focus, now more than ever.

2. Strategies to Address Pharmaceutical Spending Trends.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising pharmaceutical prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Do you contract with a pharmacy benefit manager (PBM)? Yes

i. If yes, please identify the name of your PBM.
Express Scripts

ii. If yes, please indicate the PBM's primary responsibilities below *(check all that apply)*

- ☒ Negotiating prices and discounts with drug manufacturers
- ☒ Negotiating rebates with drug manufacturers
- ☐ Developing and maintaining the drug formulary
- ☒ Pharmacy contracting
- ☒ Pharmacy claims processing
- ☐ Providing clinical/care management programs to members

b. In the table below, please quantify your projected per-member-per-year (PMPY) rate of growth in pharmaceutical spending for different lines of business and drug types from 2015 to 2016.

Line of Business	Total Rate of Increase (2015-2016)	Rate of Increase for Generic Drugs Only (2015-2016)	Rate of Increase for Branded Drugs Only (2015-2016)	Rate of Increase for Specialty Drugs Only (2015-2016)
Commercial	15%	-4%	4%	35%
Medicaid	N/A	N/A	N/A	N/A
Medicare	8%	5%	2%	21%

c. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including pricing, purchasing, prescribing, and utilization. Using the drop down menu, please specify any strategies your organization is currently implementing, plans to implement in the next 12 months, or does not plan to implement in the next 12 months.

i. Risk-Based or Performance-Based Contracting
Currently Implementing

ii. Utilizing value-based price benchmarks in establishing a target price for negotiating with drug manufactures on additional discounts
Does Not Plan to Implement in the Next 12 Months

iii. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing).
Currently Implementing

iv. Monitoring variation in provider prescribing patterns and trends and conducting outreach to providers with outlier trends
Currently Implementing

v. Establishing clinical protocols or guidelines to providers for prescribing of high-cost drugs
Currently Implementing

vi. Implementing programs or strategies to improve medication adherence/compliance
Currently Implementing

vii. Pursuing exclusive contracting with pharmaceutical manufacturers
Currently Implementing

viii. Establishing alternative payment contracts with providers that includes accountability for pharmaceutical spending
Currently Implementing

ix. Strengthening utilization management or prior authorization protocols
Currently Implementing

x. Adjusting pharmacy benefit cost-sharing tiers and/or placement of certain drugs within pre-existing tiers
Currently Implementing

xi. Shifting billing for certain specialty drugs from the medical benefit to the pharmacy benefit
Currently Implementing

xii. Other: Insert Text Here
Click here

xiii. Other: Insert Text Here
Click here

NOTE: Responses reflect BCBSMA strategies and strategies undertaken by our PBM on behalf of itself, BCBSMA, and the other plans with which our PMB contracts.

3. **Strategies to Increase the Adoption of Alternative Payment Methodologies.**

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. In the 2015 Cost Trends Report, the HPC recommended that 80% of the state HMO/POS population and 33% of the state PPO/indemnity population be in alternative payment methodologies (APMs) by 2017.

a. What are the top strategies your organization is pursuing to increase use of APMs, including efforts to expand APMs to other provider types including hospitals, specialists (including behavioral health providers), and new product types (e.g., PPO)? (Please limit your answer to no more than three strategies)

Blue Cross Blue Shield has been a leader in the state in developing APM programs and working with our provider delivery systems to support implementation of these programs. We have recently expanded our APM suite to include both our PPO population as well as our Medicare Advantage population. Currently about 90% of the state's PCPs are participating in BCBSMA APM contracts. From a population perspective, 86% of our HMO patients and approximately 26% of BCBSMA's PPO population are currently enrolled in APM programs.

b. What are the top barriers to increased use of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

One critical challenge is that nearly all organizations who have accepted APM models continue to have a blend of traditional fee-for-service (FFS) incentives alongside their APM incentives. This has been described as the "Foot in 2 Canoes" problem for providers: – continuing to have one foot in the FFS revenue canoe while having the other foot in the global budget/population accountability canoe. Most organizations are still operating with two different sets of incentives -- the FFS incentives, under which a greater volume of services and greater complexity of services leads to more revenue – and the population-based payment incentives, where greater financial success results from managing the total

cost of care, quality and outcomes for a population. An organization's referral business is often part of this continued FFS revenue, where the organization's specialty physicians and/or hospital(s) are treating patients referred to them who are not part of their own APM population (and might be part of someone else's). In this case, the organization is operating under FFS incentives, rather than the APM incentives in which they feel accountability for the total cost of care, quality and outcomes for the patients being served. In addition, FFS revenue is still in play for that part of any provider's population that is covered by payers with whom the provider still has traditional FFS contracts. Thus, as APMs are incented by policymakers to grow across the marketplace this problem will decrease over time.

A second critical challenge is providers' need to focus on establishing infrastructure for population health management in advance of receiving earned incentives from APMs. It is centrally important that provider board and executive leadership understand the long-term nature of this process, and commit to leading the organizational changes required to be successful under new payment models. In BCBSMA's experience, these include developing and maintaining population health management capabilities in that were not core to success under FFS models, but that are core to success when providers assume accountability for a population's total cost of care, quality and outcomes. These include, for example, new staffing models, new types of data and information systems, new approaches to patient engagement and new ways of integrating care within and across settings. In addition, since 2009, BCBSMA has worked closely with all providers in our AQC model with additional elements that support their success in population health management. Central to the BCBSMA provider support model have been 4 core elements: (1) sharing data and actionable performance analytics and reporting, including benchmarks, to afford actionable data for improvement; (2) regular meetings with each organization's clinical leaders and staff to review performance results and offer expert consultative guidance on strategies for continued improvement; (3) convening organizational leadership and staff in regular and varied best practice sharing forums, and opportunities to learn from each other and from local and national experts; and (4) offering formal training and educational programs, including a 9-month curriculum on clinical leadership development. In our experience, this combination of partnership with the plan, together with the provider organization's commitment to develop and maintain the new population health management infrastructure are essential ingredients to the success of APMs.

Lastly, as is commonplace in APMs, BCBSMA's alternative payment models establish accountability and incentives at the organizational level for total cost of care, quality and outcomes. Each organization then chooses how to set incentives for its clinicians and staff. Available and emerging evidence on the topic of physician compensation reveals that nationally and in Massachusetts physician payments still largely emphasize volume over value. For systems to reach the next level of success in transformation, they need to align their provider compensation models to the incentives contained in the APMs they have in place with their payers. While many organizations have begun implementing models to create incentives for PCPs and occasionally for specialists that are more inclusive of quality and total cost of care, available evidence finds that the vast majority of organizations have compensation models where incentives related to productivity and volume of services are predominant. To be truly successful, greater alignment on these issues with the objectives of APMs is needed.

c. Please describe your organization's specific efforts to support smaller providers, including ancillary and community providers, who seek alternatives to fee-for-service payment models.

In considering this point, it is important to recognize that approximately 90% of physicians in our network (PCP and specialist) are contracted under an APM with BCBSMA. Thus, a very large share of small practices (<5 physicians in a site) are already part of our APM models – working as part of a larger organization. It is therefore useful to differentiate between small practices that are unaffiliated with a larger entity and those affiliated. The latter, through their affiliation arrangement, typically have the advantages of infrastructure support, leadership, resources for quality improvement and population

health management – all features that may not otherwise be feasible for small practices in isolation. In addition, BCBSMA provides performance improvement support to the organization (noted in response 3A above), and the organization itself commonly works with its constituent practices to monitor and improve performance. Patients receiving care in these settings have the experience of being in a small practice setting while being supported by infrastructure, along with the leadership and performance management of the organization to which the practice belongs.

For the small percentage of physicians in our network who are not in APMs, we have been supplying these physicians with data on their quality performance so they can better understand their current gaps in care. This data will allow these physicians to begin to migrate to a population-focused philosophy. We have also seen our larger care delivery systems begin to engage in a more integrated manner with particular specialties and partner with them to care for patients in new ways. Among other benefits of these collaborations, more clinicians are learning about population health and aligning their treatment protocols. Such protocols may include the increased use of telehealth, coaching of PCPs on behavioral health treatment, and complex care managers' work with particularly at-risk members.

Finally, in an effort to support smaller, standalone institutions like Behavioral Health Hospitals, we have recently launched a Behavioral Health Hospital Incentive program. This program supports smaller institutions who typically have been paid solely using fee-for-service payment models and have been generally outside of payment reform efforts to date.

4. Strategies to Align of Technical Aspects of APMs.

In the 2015 Cost Trends Report, the HPC called for an alignment and improvement of APMs in the Massachusetts market.

a. Please describe your organization's efforts to align technical aspects of APMs with Medicare and other plans in the Commonwealth, including specifically on quality measures, patient attribution methodologies, and risk adjustment (e.g. DxCG, HCC scores).

BCBSMA has played an important leadership role both locally and nationally to forge alignment among stakeholders on key technical aspects of APMs. Locally, we were part of a multi-stakeholder effort to establish a consensus model of claims-based attribution for PPO members. Nationally, BCBSMA continues to play a key leadership role, including the following recent activities that included our Chief Performance Measurement & Improvement Officer Dana Gelb Safran:

(1) Co-chairing the national Health Care Payment Learning and Action Network (LAN) workgroup on Population-Based Payment (PBP) tasked with setting core guidelines for global budget payment models to accelerate adoption of PBP models;
(2) Serving as a member of the Executive Committee of the Health Care Transformation Task Force (HCTTF), an industry consortium that brings together patients, payers, providers and purchasers, promoting the adoption and success of APMs nationally; and
(3) Participating in a CMS/AHIP collaborative that recently developed Core Quality Measure Sets for eight clinical specialties to promote alignment among payers in the measures used in APMs.

Throughout, BCBSMA has emphasized the value of alignment, while ensuring that alignment does not become a barrier to innovation and the continued improvement of APMs. For example, with regard to performance measurement, it is well understood that current measure sets need to progress to include more outcomes-oriented measures – including those that use clinical data sources and patient-reported outcome measures (PROMs). These innovations cannot occur if payers within and across markets are constrained to moving in lock-step. Rather, allowing mature payer-provider partnerships to push the

boundaries in testing measures that fill important gaps in current core measure sets serves an important common purpose, and can inform the continued improvement and evolution of APMs generally. Striking the right balance of alignment and latitude for innovation is critical for the long-term sustainability and success of APMs.

b. What are the top barriers to alignment on these technical aspects and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

As noted above, there are differences in the maturity of payer-provider partnerships both within and between markets. It is important to leverage these differences and allow innovation and testing of key technical aspects of APMs – for example, advancing new performance measures in high priority areas for which measures are currently lacking. We should be hesitant to lock into a single approach or to seek complete alignment among public and private payers.

In addition, key constituents and stakeholders served by public and private payers often have differing needs and expectations that impose constraints on alignment such that it must stop short of uniformity or standardization. Some of these differences stem from different needs of the populations being served (e.g., age and life stage, case mix).

5. **Strategies to Increase Access to Pharmacologic Treatment for Substance Use Disorder.** Despite a strong evidence-base, pharmacotherapy is underutilized to treat substance use disorder. Last year, several private payers committed to covering more pharmacologic treatment to address the increasing needs of patients.
   a. What are the top strategies your organization is pursuing to increase access, including affordability and provider availability, of pharmacologic treatment for your members with substance use disorder? Please include in your answer a description of any changes to coverage policies (e.g. cost-sharing, prior authorization, utilization review, duration of treatment limitations) or reimbursement strategies you have implemented or plan to implement with regard to pharmacologic treatment. (Please limit your answer to no more than three strategies)

One of our top strategies to increase access to appropriate pharmacologic treatment has been around access to methadone maintenance therapy to support individuals with SUD. In the fully insured market, BCBSMA has removed all member cost sharing as of July 1, 2016. Our self-insured plans are also being automatically enrolled in the new enhanced benefit as of January 1, 2017 with the ability to opt-out of this feature. Regrettably, federal law, which requires member deductible responsibility, continues to preclude the extension of this feature to high-deductible health plans. Once the deductible is met in these plans, there is no member cost share.

Moreover, BCBSMA presently anticipates that almost all federally-accredited methadone clinics in Massachusetts will join our network effective in January 2017. Lastly, BCBSMA does not apply any prior authorization requirements, service limitations or exclusions for methadone maintenance treatment.

BCBSMA covers naloxone at the lowest drug tier under a member's pharmacy benefit without a prescription at participating pharmacies, and we continue to encourage more pharmacies to participate in the collaborative practice program for naloxone.

b. What are the top barriers to increasing access to pharmacologic treatment for your members and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

Cultural. BCBSMA has seen that some programs continue to adhere to an abstinence / 12 step model framework rooted in alcohol support and recovery, where any use of medical/chemical treatment such as medication assisted treatment (MAT) is discouraged. BCBSMA has a trained addictionologist on staff

who works, alongside our psychiatrists, to educate these programs on a continuing basis. BCBSMA is seeing some early evidence that some programs are moving to wider acceptance of MAT.

Provider Capacity. The number of prescribers trained to dispense and monitor MAT is currently below the demand. Recent federal activity to increase patient capacity may help alleviate this shortfall and specifically BCBSMA also works with MAT treatment providers to address access.

Benefit Design. Please see our comments above concerning the methadone benefit enhancements. Moreover, while naloxone and methadone are generic drugs in the market for some time, BCBSMA is concerned about the increasing prices of these drugs as demand surges. As noted within response 1, collectively we need to consider developing a better balance between affordability and access to these critical treatments.

6. **Strategies to Support Telehealth.**

In its 2015 Cost Trends Report, the HPC recommended that the Commonwealth be a national leader in the use of enabling technologies to advance care delivery transformation.

a. Does your organization offer or pay for telehealth services? Yes
   i. If yes, in which scenarios or for which categories of care or specific populations do you pay for telehealth services (e.g. primary care, behavioral health, elderly, rural, etc.)?

      Effective on January 1 of this year, telehealth services are a core benefit for our fully-insured accounts, and are also available for self-insured accounts. This benefit includes access to both medical and behavioral health services as provided through our partnership with American Well and its Online Care Network of providers, as well as local network providers that offer telehealth services. As an example, local network providers can provide brief evaluation and management and behavioral health evaluation and psychotherapy visits via telehealth, provided that the services delivered fall within that provider's Massachusetts license.

   ii. If yes, how do you pay for these services (e.g. equivalent FFS rates as office visits, partial FFS rates, as part of a global budget, etc.)?

      BCBSMA uses a standard Resource Based Relative Value Units (RBRVU) methodology to pay for services and recognizes the efficiencies in delivering care via telehealth.

   iii. If no, why not?
      Click here to enter text.

7. **Strategies to Encourage High-Value Consumer Choices.**

In the 2015 Cost Trends Report, the HPC recommended that payers continue to innovate and provide new mechanisms that reward consumers for making high-value choices. The HPC highlighted strategies such as providing cash-back incentives for choosing high-value providers and offering members incentives at the time of primary care provider selection.

a. Do you currently offer cash-back incentives to encourage members to seek care at high-value providers? No
   i. If yes, please describe the types of cash-back incentives offered.
      Click here to enter text.

   ii. If no, why not?

      While we do not currently offer direct cash-back incentives and continue to evaluate the market as part of ongoing product development efforts, it is important to note that

BCBSMA's present tiered product design helps incent the selection of high-value providers. See response (b) below for further detail.

b. Do you currently offer incentives (e.g. premium differential) at the point of enrollment or the point of primary care provider (PCP) selection to encourage members to select high-value PCPs? Yes
   i. If yes, please describe the types of incentives offered.

Blue Cross Blue Shield of Massachusetts offers tiered network plans. With our Tiered Network plans, Massachusetts PCPs and acute-care hospitals are placed into one of three benefits tiers based on how they scored on cost and quality benchmarks. The tiered network drives value throughout the health plan because each time a member seeks care from a PCP or hospital, the member's out-of-pocket costs (deductibles, copayments, co-insurance) depends on the tier status of the provider. These plans help encourage members to consider the cost and quality of their PCP or hospital each time they receive care and rewards members for choosing high quality providers that are considered lower cost relative to the benchmark. These plans offer comprehensive coverage with lower premiums than plans with similar levels of benefits.

Blue Cross Blue Shield of Massachusetts also offers plans that include a tiered network feature called Hospital Choice Cost Sharing. Members in these plans will pay one of two different levels of cost share for certain services depending on the in-network general hospital they select. For most in-network general hospitals, members pay the lower cost sharing level. However, if members choose to receive certain covered services from network general hospitals that are considered higher cost relative to the benchmark, they will pay the higher cost sharing level. Members in these plans are empowered to become more engaged in health care decision making because they have a greater ability to control their own out-of-pocket costs based on the hospital they choose for care. These plans offer comprehensive coverage with lower premiums than similar plans without the Hospital Choice Cost Sharing feature.

   ii. If no, why not?
   Click here to enter text.

8. Strategies to Increase Health Care Transparency.

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."

a. Please provide available data regarding the number of individuals that seek this information in the following table:

Health Care Service Price Inquiries CY2015-2016			
Year		Aggregate Number of Inquiries via Website	Aggregate Number of Inquiries via Telephone or In Person
CY2015	**Q1**	346	129
	Q2	299	127
	Q3	286	110
	Q4	313	105
CY2016	**Q1**	7,949	100
	Q2	7,012	52
	TOTAL:	16,205	623

NOTE: We have offered a cost estimation function on our online "Find a Doctor" tool since February 2013. However, until recently, we did not have reporting and analytic capabilities that would allow us to identify all cost estimation search inquiries. We launched new online "Find a Doctor" and "Estimate Costs" tools on December 30, 2015. These tools include enhanced analytic functionality that allows us to identify cost estimation searches. The data above for the 1st and 2nd Quarters of 2016, therefore, reflects online cost estimation inquiries we were previously unable to track.

9. **Information to Understand Medical Expenditure Trends.**
Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2013 to CY2015 according to the format and parameters provided and attached as **HPC Payer Exhibit 1** with all applicable fields completed. Please explain for each year 2013 to 2015, 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 BCBSMA responses in blue attached as HPC.Payer.Exhibit.1.BCBSMA.Response.9.2.16

10. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) increase the adoption of APMs; c.) support alignment of APMs; d.) increase access to pharmacologic treatment; e.) support the adoption of telehealth; f.) encourage high-value consumer choices; and, g.) enhance consumer price transparency and utilization of transparency tools.
Click here to enter text.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please answer the following questions related to risk contracts and pharmaceutical spending for the 2015 calendar year, or, if not available for 2015, for the most recently available calendar year, specifying which year is being reported. (Hereafter, "risk contracts" shall mean contracts that incorporate a 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.)

    a. What percentage of your business, determined as a percentage of total member months, is HMO/POS business? What percentage of your business is PPO/indemnity business? (Together, HMO/POS and PPO/indemnity should cover your entire book of business.)

HMO/POS	56%
PPO/Indemnity Business	44%

    b. What percentage of your HMO/POS business is under a risk contract? What percentage of your PPO/indemnity business is under a risk contract?

HMO/POS	86%
PPO/Indemnity Business	26% (2016)

    c. What percentage of your HMO/POS business that is under a risk contract has carved out the pharmaceutical benefit? What percentage of your PPO/indemnity business that is under a risk contract has carved out the pharmaceutical benefit?

HMO/POS	12%
PPO/Indemnity Business	58%

    NOTE: BCBSMA includes pharmacy claims in our commercial risk contracts whenever BCBSMA has the pharmacy financial information. Our contracts do not explicitly carve out the pharmaceutical benefit from risk. The above percentages represent our business not at risk for pharmacy spending because BCBSMA does not have the pharmacy financial data, for example concerning our PPO Host members.

    d. For your risk contracts that include the pharmaceutical benefit, how is the provider's pharmacy budget set? How is the budget trended each year?

    Our providers have one budget across all medical and pharmacy claims. We set the budget by starting with the provider's claims in the year before risk starts. We then trend those claims into the current year using a negotiated budget trend that is indexed to how the network as a whole trends. We also take into account how the provider's overall health status and percentage of membership with pharmacy changes year-over-year, recognizing that if they increase their percentage of members with pharmacy coverage they will need a higher budget.

e. For your risk contracts that include the pharmaceutical benefit, how, if at all, are pharmaceutical discounts and/or rebates (e.g., from the manufacturer) incorporated into the provider's pharmacy budget?

   Pharmaceutical discounts and rebates guaranteed by our pharmacy benefit manager are reflected in the claims amounts that build up the budget, and that are charged against the budget in the performance periods.

---- 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 Payer Exhibit 1

All cells shaded in BLUE should be completed by carrier*

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

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2013	0.9%	0.4%	0.2%	0.2%	1.6%
CY 2014	1.2%	0.5%	0.2%	0.2%	2.2%
CY 2015	2.0%	0.9%	0.4%	0.4%	3.6%

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

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. Components of trend for CY 2012-2015 are based on a study done in 2015 . Study results have not been updated in 2016. BCBSMA has used a consistent allocation method for CY2013-CY2015 for all components of trend.

6. Estimated benefit buydown has been stable over the past three years

7. Changes to underlying demographics of the risk pool are not a major driver of trend in the data above

Aging of the population can potentially impact all components of trend with the exception of unit cost

8. Changes in health status were estimated using DxCG risk scores.

Trends in DxCG risk scores increased significantly over the 3 year period

Deteriorating health status can drive up utilization, severity and service/provider mix components of trend.

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

10. 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