



*The Commonwealth of Massachusetts
Health Policy Commission
Two Boylston Street
Boston, MA 02116*

August 16, 2013

Andrew Dreyfus, President and CEO
Blue Cross Blue Shield of Massachusetts, Inc.
Landmark Center, 401 Park Drive
Boston, MA 02215-3326

Dear Mr. Dreyfus:

The Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (OAG) and the Center for Health Information and Analysis (CHIA), is required by state law to hold annual public hearings concerning health care cost trends in the Commonwealth. (See the Notice of Public Hearing attached as “Exhibit A.”). G.L. c. 6D §8 requires the HPC to identify a representative sample of health care providers and payers as witnesses for the hearing. In accordance with these provisions, Blue Cross Blue Shield of Massachusetts, Inc. has been identified as a witness and is hereby requested to submit written testimony to the questions of the HPC in “Exhibit B”, questions of the OAG in “Exhibit C”, and questions of CHIA in “Exhibit D”.

While this testimony must be in writing, **you may also be called for oral testimony** on one or more dates of the hearing scheduled for October 1 and 2, 2013. You will be notified regarding oral testimony in a separate letter.

Your assistance and active participation in this hearing process will assist the HPC to prepare its annual report on statewide spending trends, including underlying factors contributing to growth and strategies to increase the efficiency of the Commonwealth’s health care system.

Blue Cross Blue Shield of Massachusetts, Inc. is required to:

1. electronically submit to HPC written testimony, signed under the pains and penalties of perjury, responding to the areas of inquiry identified on the attached “Exhibit B”, “Exhibit C”, and “Exhibit D” on or before the close of business on Monday, September 16, 2013; and
2. be prepared to appear at a public hearing to provide oral testimony at some time on October 1 and 2, 2013.

The written testimony should be submitted to HPC-Testimony@state.ma.us. Any and all written testimony will be a public record and will be posted on the HPC’s website.

Thank you for your attention to this important matter.

Sincerely,

A handwritten signature in blue ink, appearing to read "David Seltz". The signature is fluid and cursive, with the first name "David" and last name "Seltz" clearly distinguishable.

David Seltz
Executive Director

cc: Thomas O'Brien, Chief, Health Care Division, Office of the Attorney General
cc: Áron Boros, Executive Director, Center for Health Information and Analysis
cc: Michael Caljouw, Vice President, Government and Regulatory Affairs, Blue Cross Blue Shield of Massachusetts, Inc.

Enclosures:

Exhibit A: Notice of Hearing
Exhibit B: Instructions and HPC Questions for Written Testimony
Exhibit C: Instructions and OAG Questions for Written Testimony
Exhibit D: Instructions and CHIA Questions for Written Testimony

Exhibit A

NOTICE OF PUBLIC HEARING

Pursuant to M.G.L. c. 6D, §8, the Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Tuesday, October 1, 2013, 9:00 AM
Wednesday, October 2, 2013, 9:00 AM
University of Massachusetts Boston Campus Center
Third Floor, Ballrooms B and C
100 Morrissey Boulevard Boston, MA 02125

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Wednesday, October 2. 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 1.

Members of the public may also submit written testimony. Written comments will be accepted until October 11, 2013 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 11, 2013, to the Health Policy Commission, 2 Boylston Street, 6th floor, Boston, MA 02116, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.umb.edu/the_university/getting_here/directions. If you are driving, please park in the Bayside Lot, 200 Mt. Vernon Street at the former Bayside Expo site (cost: \$6). Free shuttle service runs every 5-7 minutes from the Bayside Lot to the Campus Center. If you are taking public transportation, UMass Boston runs a free shuttle service from JFK/UMass Station (which serves both the Red Line and Old Colony Line) to the Campus Center. The trip normally takes less than 10 minutes.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at 617-979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two weeks prior to the hearing so that we can accommodate your request.

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

Exhibit B: Instructions and HPC Questions for Written Testimony

Instructions:

On or before the close of business on September 16, 2013, electronically submit **in both PDF and Microsoft Word format** written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an 'other', 'miscellaneous', or similar category in any response, please explain what such a category includes.

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 questions regarding this process or regarding the following questions, please contact: Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

Questions:

1. C.224 sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY2012- CY2013 and CY2013-CY2014 is 3.6%.
 - a. What are the actions your organization has undertaken to ensure the Commonwealth will meet the benchmark?
 - b. What are the biggest opportunities you have identified at your organization to improve the quality and efficiency of care? What current factors limit your ability to address these opportunities?
 - c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?
 - d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?
2. The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of growth in prices on medical trend and what have been the results of these actions?
3. C.224 requires health plans, to the maximum extent feasible, to reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery. What actions has your organization undertaken to meet this expectation? What factors limit your ability to execute these strategies or limit their effectiveness?
4. C.224 requires health plans, to the maximum extent feasible, to attribute all members to a primary care provider. Please describe, by product line, how your organization is meeting this expectation, including, as of July 1, 2013, the number of members attributed to PCPs, attribution methodologies used, the purpose to which your organization makes such attribution (such as risk

payments, care management, etc.), and limitations or barriers you face in meeting this expectation.

5. Please describe programs you have implemented to engage consumers to use high value (high quality, low cost) providers. How effective have these efforts been? To what percentage of members and to which product lines does each program apply?
6. Please describe the impact on your medical trend over the last 3 years due to changes in provider relationships (including but not limited to mergers, acquisitions, network affiliations, and clinical affiliations). Please include any available documents providing quantitative or qualitative support for your response.
7. Please describe the actions that your organization has undertaken to provide consumers with cost information for health care services, including the allowed amount or charge and any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.
8. After reviewing the reports issued by the Attorney General (April 2013) and the Center for Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.

Exhibit C: Instructions and OAG Questions for Written Testimony

Instructions:

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Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an ‘other’, ‘miscellaneous’, or similar category in any response, please explain what such a category includes.

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 questions regarding this process or regarding the following questions, please contact Courtney Aladro at Courtney.Aladro@state.ma.us or 617-963-2545:

Questions:

1. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY 2010 to 2012, YE Q1 2012, and YE Q1 2013 according to the format and parameters provided and attached as AGO Exhibit C1 with all applicable fields completed. Please explain for each year 2010 to 2012 what portion of actual observed allowed claims trends is due to (a) demographics of your population; (b) benefit buy down; (c) change in health status of your population, and where any such trends would be reflected (e.g., utilization trend, payer mix trend).
2. Please submit a summary table showing your total membership for members living in Massachusetts as of December 31 of each year 2009 to 2012, broken out by:
 - a. Market segment
(Hereafter “market segment” shall mean Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)
 - b. Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, including contracts that do not subject the provider to any “downside” risk; hereafter “risk contracts”)
 - c. Within your commercial large group, commercial small group, and commercial individual membership, by product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)
 - d. Membership in a tiered network product by market segment
(Hereafter “tiered network products” are those that include financial incentives for inpatient and outpatient services (e.g., lower copayments or deductibles) for members to obtain in-network health care services from providers that are most cost effective.)

- e. Membership in a limited network product by market segment
(Hereafter “limited network products” are those that feature a limited network of more cost-effective providers from whom members can obtain in-network health care services.)
 - f. Membership in a high deductible health plan by market segment (“high deductible health plans” as defined by IRS regulations)
3. To the extent your membership in any of the categories reported in your response to the above Question 2 has changed from 2009 to 2012, please explain and submit supporting documents that show your understanding of the reasons underlying any such changes in membership.
 4. Please describe your models for risk contracting since 2009. Include, for example, the structure and elements of such contracts, the role of any non-claims based payments, the role of any trend factors or growth caps, the role of any adjustments to risk budgets, such as for changes in health status, unit price or benefits, the types of services carved out of your risk budgets, and insurance product populations to which your risk contracts apply (e.g., HMO, PPO, self-insured, fully insured).
 5. Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured members. Include in your response any adjustments for changes in health status, individual or aggregate stop loss insurance, claims truncation thresholds, distinction you make between performance and insurance risk, adjustments for risk due to socioeconomic factors, and any other ways in which you mitigate the transfer of insurance risk to providers.
 6. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider’s size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.
 7. Please explain and submit supporting documents that show for each year from 2009 to 2013 the average difference in prices for (1) tiered network products as compared to non-tiered network products; and (2) limited network products as compared to non-limited network products. Include an explanation of assumptions around these price differences, such as, (a) for tiered network products, expected utilization shift to tier 1 providers, unit price differences between tier 1 and tier 2 providers, and benefit differences between tiered network and non-tiered network products, and (b) for limited network products, unit price differences between limited network and non-limited network providers, and differences in benefit and member health status between limited network and full network products. In addition, please summarize any analysis performed on these products that validates or disproves the assumptions used.
 8. Please describe and submit supporting documents regarding any programs you offer purchasers and/or members (including your employees) that promote health and wellness (hereinafter “wellness programs”). Include in your response any analyses you have performed regarding the cost benefit of such wellness programs.

Exhibit C1 AGO Questions to Payers

****All cells shaded in BLUE should be completed by carrier****

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

	Unit Cost	Utilization	Provider Mix	Service Mix
CY 2010				
CY 2011				
CY 2012				
YE Q1 2012 (April 1, 2011 - March 31, 2012)				
YE Q1 2013 (April 1, 2012 - March 31, 2013)				

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year separated by utilization, cost, service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix changes. In other words, these allowed trends should be actual observed trend. **These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.**
2. PROVIDER MIX is defined as the impact on trend due to the change in the types of providers. 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, withhold, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

Exhibit D: Instructions and CHIA Questions for Written Testimony

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Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony or documentation in an Appendix. If your organization uses an 'other', 'miscellaneous', or similar category in any response, please explain what such a category includes.

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 questions regarding this process or regarding the following questions, please contact Steve McCabe at Steve.McCabe@state.ma.us or 617-988-3198:

Questions:

1. Do you analyze information on spending trends (e.g. TME) and clinical quality performance of the Massachusetts Medicare Pioneer Accountable Care Organizations and the providers that participate in the Patient Centered Medical Homes Initiative?
 - a. If so, please provide such information on the performance of these entities compared to other Massachusetts provider entities. If available, please provide the information with and without health status adjustment, and the number of member months associated with the identified and comparative providers.