September 16, 2013

David Seltz, Executive Director
Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02216

RE: *Blue Cross Blue Shield of Massachusetts' response to written testimony questions from the Health Policy Commission, the Office of the Attorney General, and the Center for Health Information and Analysis*

Dear Director Seltz:

On behalf of Blue Cross and Blue Shield of Massachusetts (BCBSMA), we are pleased to provide the following responses to the Health Policy Commission (HPC), Attorney General's Office (AGO), and the Center for Health Information and Analysis (CHIA) questions posed in Exhibits B, C and D respectively in a letter received August 20, 2013.

Health Policy Commission Questions (Exhibit B)

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?

BCBSMA Response:

BCBSMA continues to aggressively negotiate our provider contracts with the Commonwealth's benchmark in mind. We take seriously our responsibility to meet that benchmark and take it into consideration in all areas of our business. BCBSMA has been vigorously pursuing a shared responsibility campaign with our hospital providers to keep unit price and utilization well below the 3.6% benchmark for overall medical cost growth.

Under the AQC model, discussed in more detail below, a provider organization's financial success is highly dependent upon efficiently managing a patient's care across the continuum of services, while maintaining a focus on the quality of care. With 85% of our HMO membership having chosen a primary care physician in an AQC arrangement, our provider network is actively engaged in managing the total medical expense (TME) and improving the quality of care for our HMO population.

Landmark Center | 401 Park Drive | Boston, MA 02215-3326 | www.bluecrossma.com

In addition, BCBSMA has worked to bring additional ancillary providers, such as ambulance companies, into the BCBSMA network. Maintaining a robust network of contracted providers helps to reduce overall medical expense. We have also responded to the medical cost issue by developing product offerings that allow individuals to take into consideration the cost impact of where they receive care, encouraging the use of high quality, lower cost facilities. Through medical and pharmacy management programs we have also encouraged our members take affirmative measures to maintain and potentially improve their health status through coaching, wellness and other health management initiatives.

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?

BCBSMA Response:

An important opportunity to improve the quality and efficiency of care is the alignment of member and provider incentives. On the provider side, the Alternative Quality Contract (AQC), our global budget model, has led to the most significant improvements in the quality and efficiency of care that we have seen to date. The contract's goal is to align provider incentives with high quality care and a reduction in spending and to move away from the non-aligned fee-for-service (FFS) system.

In 2009, the first year of the AQC, participating groups made unprecedented improvements in the quality of patient care—greater than any previous one-year change measured in our provider network. Every AQC organization showed significant improvements in clinical quality, including in several dozen process and outcomes measures. In 2010 and 2011, provider groups that joined the AQC in 2009 continued to improve quality and outcomes—while groups that joined in 2011 made significant quality improvements in their first year. Participating groups exhibited exceptionally high performance for all clinical outcome measures, with many approaching performance levels believed to be the best achievable for chronic conditions, such as diabetes, heart disease, and hypertension. An independent, published evaluation of the AQC by researchers at Harvard Medical School found that the model was associated with a 2 percent slower growth in spending in the first year and a 3.3 percent slower growth rate in the second year. Savings were found in key areas such as reduced inpatient admissions, reduced use of high-tech radiology, and use of less costly settings of care.

We continue to innovate with product design and educational materials and campaigns to incent the member in the same ways that the AQC is incenting higher quality, more efficient care from providers. Some of these innovations are described further in response to Question 5. We believe the intersection of member/family and provider decision making about where and how to seek care is a critical lever for achieving truly high quality, affordable care.

c. What systematic or policy changes would help your organization operate more efficiently without reducing quality?

BCBSMA Response:

BCBSMA continues to monitor how Chapter 224 and the Affordable Care Act implementation affect our organization. The Commonwealth should continue to incent the voluntary adoption of alternative payment methodologies, and should move state-based contracts away from the FFS model. As BCBSMA has shown with the AQC, market-centric approaches can produce positive results with enough flexibility to account for differences.

BCBSMA is anticipating the results of increased monitoring of the market through the Health Planning Council under the Department of Public Health and the Cost and Market Impact Reviews through the Health Policy Commission. As the interest around tiered and limited networks grows, provider limitations and the impact of actual or potential provider opt-outs should be monitored and reviewed by the state. Moreover, as the Department of Public Health implements required changes to its Determination of Need processes, the state should review those changes through the dual lens of shared affordability and patient care coordination efforts.

As noted elsewhere in these responses, payers are under significant pressure implementing both state and federal changes. The Commonwealth should assess how those modifications affect the market before contemplating additional ones.

d. What steps have you taken to ensure that any reduction in health care spending is passed along to consumers and businesses?

BCBSMA Response:

BCBSMA premiums reflect projected reductions in health care spending resulting from improved provider contract terms, greater individual and group account product alternatives and improved quality and efficiency of care. Many of the improvements are the direct result of increased adoption of our AQC and overall contracting efforts. Moreover, there is a wide variety of care coordination efforts which continue to yield positive results. Our collective affordability efforts will continue to be tested over time as aspects of regulatory implementation and mandated requirements are phased in. BCBSMA also refers to its detailed responses to the other questions within this document as further context for these efforts.

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?

BCBSMA Response:

BCBSMA has been vigorously pursuing a shared responsibility campaign with our contracted providers to keep unit price and utilization well below the 3.6% benchmark for overall medical cost growth; it should be expressly noted that cost growth is driven by factors other than provider price increases, such as utilization. Our shared responsibility approach emphasizes how health plans, providers, employers and members all must work together to hold down the rising cost of health care. Each stakeholder has different ways that they can contribute to this effort and one of the ways in which we ask providers to help is to work with us to moderate unit cost increases. The approaches we have pursued with providers include negotiating contracts as they renew to lower or avoid unit cost increases, opening existing contracts to reduce contracted rates, and holding network-wide fee schedules flat. With providers facing growing revenue pressures from government payer reimbursement reductions, contract negotiations are a complicated and sometimes antagonistic process. However, for the most part, we have found providers to be receptive to working with us to moderate unit cost growth. Because of these collaborative efforts, over the last three years we have seen our network average provider unit cost increases fall to the lowest levels in a decade.

Other aspects of our shared responsibility efforts include working with employers and members to promote the use of lower cost care settings through product designs that incent members to use lower cost settings, tiered and limited provider networks that provide both incentives to use lower cost providers and increased transparency of lower cost providers, and active utilization management programs that help steer members to lower cost settings.

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?

BCBSMA Response:

As discussed above in Question 1b, the majority of our HMO members now receive care from providers with AQC contracts. The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. The twin goals of the AQC are to significantly reduce health care spending growth while improving quality and health outcomes. Today, over 80% of our primary care physicians and over 85% of our specialist network are in an AQC arrangement. We are working to reduce the use of FFS payments on our PPO products as well and will explore some factors affecting implementation.

The overarching barrier to moving the remaining 15-20 percent of our network onto the AQC model is the lack of provider infrastructure and inability to take on shared risk. A majority of these practices are solo or two physician practices that have abstained from the consolidation of the market over the past few years. We continue to support these practices with enhanced reporting to improve the quality of care by providing, for example, gaps in care lists and performance data on patient experience measures in addition to pay-for-performance contractual arrangements.

As stated earlier, we continue to implement payment reform concepts within our PPO lines. As that work continues, care must be taken to align and refine as appropriate with Medicare models and address operational considerations for providers, BCBSMA and our PPO members.

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.

BCBSMA Response:

Due to the nature of the product, our HMO members already have a strong provider-based focus for their care. While we will directly attribute HMO members to a primary care provider (PCP) when needed, we strongly prefer our members to select a PCP to access their benefits. To this end, we regularly outreach to members who may be experiencing challenges selecting a PCP or have not yet selected one to help them understand the importance of having a regular, personal clinician.

BCBSMA has developed a validated, plurality-based attribution methodology. The methodology aligns well with Medicare's attribution logic. Today, we attribute all members in our PPO product to a "primary care provider" as defined by the Commonwealth of Massachusetts – a doctor, nurse practitioner or physician's assistant with a primary care license. The purpose of attributing all members to a PCP is to develop our PPO payment reform model mentioned in Question 3 and to better understand the quality of care provided to our PPO members.

Below are our statistics on the number of members currently attributed to a PCP by product line.

Claims Based Attribution (plurality based attribution logic)

Anchor Date = 7/31/2013

Product	# Members Attributed
ACCESS BLUE (HMO product without a requirement to select a PCP to access benefits	2,475
All other HMO (HMO, POS)	33,571
PPO(PPO, SPPO)	**426,292**

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?

BCBSMA Response:

BCBSMA aligns the incentives it uses in its provider relationships with the incentives offered to members to encourage both the delivery and the receipt of high-value care.

On the member side, we couple benefit designs with member decision-support tools to encourage consumers to use high-value providers, specifically now through Blue Options (our tiered offering) and Hospital Choice Cost Sharing (HCCS), our cost-sharing offering. Our tiered offering benefit stratifies primary care physicians and hospitals into three levels based on cost and quality. Member cost sharing varies for each tier: members have the lowest cost sharing when they see lower cost, high quality providers and higher cost sharing when they see providers that are higher cost and lower quality. The HCCS benefit feature is designed to offer better value for members and accounts by encouraging the use of high-quality care that is less costly. HCCS offers members lower copays when they receive services at facilities that are high-value, as determined through the same methodology as the tiered benefit. This design also supports our overall affordability goal by creating a strong incentive for hospitals to lower their fees and increase quality. Each of these offerings results in an estimated premium discount of about five percent, relative to products with comparable benefits. Lastly, we offer many consumer-driven health care products that feature high deductibles and cost sharing, so members are motivated to seek out high-value providers.

These benefit designs are new to the market so we are just beginning to assess relevant data. The receptivity of these plans by our customers already shows an intuitive understanding and acceptance of the principle of encouraging the use of high-value providers through benefit design incentives.

To ensure that our members are empowered to navigate these new benefit designs, we have a suite of member decision-support tools. These tools are available on our member portal and offer information on both the costs and quality of care across the system. We launched a new version of our Find a Doctor tool on February 1, 2013, which expanded our scope and capabilities for providing timely comparative quality information to all members, and cost information to our PPO members in a one-stop shopping manner. More detail on these transparency and decision support tools is in Question 7.

On the provider side, as you have heard above, the AQC promotes the use of high-value providers and the AQC PCPs are encouraging consumers to make high-value choices as they exercise tighter focus on referral management. In fact, BCBSMA continues to witness shifts in referral patterns to high-value providers across our provider network and an increased focus on preventing leakage outside of a group's own system.

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.

BCBSMA Response:

The recent provider consolidation seen in the Massachusetts marketplace is not a new phenomenon. Since the 1990s when there were 111 independent acute care hospitals in Massachusetts, the provider landscape has changed dramatically. Hospital mergers and closings have left approximately 70 hospitals and many physicians have joined with each other to form independent physician associations (IPAs), or with hospitals to form physician-hospital organizations (PHOs) or other integrated delivery systems.

Within the past year, we have seen consolidations continuing and taking various shapes, including some independent practices going into large groups, and reconfigurations within large systems. BCBSMA believes that such changes can have a favorable impact on the marketplace when the following conditions are met: there are multiple networks in every market; there are aligned incentives between payers and providers and the government; consolidation promotes competition on cost and quality; and consolidation promotes integration and coordination of care. When consolidation merely serves to increase fee-for-service rates, it is not favorable.

Provider consolidation has the potential to generate benefits to the system, such as increased integration and coordination of care. However, our experience historically shows that more often, provider consolidation and the resulting market leverage of larger provider organizations can lead to increased prices, with very little of the intended integration of care achieved. Our response to this dynamic is to expand both the presence of the AQC across our provider network, and to develop innovative benefit options for employers. Both strategies create meaningful incentives for providers and patients to become engaged in reducing the total cost of care.

AQC providers are accountable for the cost of the care their patients receive, whether the care is delivered by a member of the AQC group or not. As a result, primary care providers have an incentive to look for specialists and facilities that provide high quality at a lower cost, so the AQC has the potential to drive value throughout the system. The AQC, together with new health insurance offerings that create strong incentives for members to choose high-value care, lead members to be active participants in discussions with their health care providers. One example noted earlier is our Hospital Choice Cost Sharing offering, in which the amount members pay for certain services depends on the hospital and affiliated facilities they choose. These and similar offerings align member incentives with the physician incentives in the AQC to create stronger support for delivery system change.

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 benefit as required under Chapter 224. Please describe the actions your organization has undertaken to inform and guide consumers to this cost information.

BCBSMA Response:

BCBSMA offers a suite of decision-support tools to help our members understand both the variations in both costs and quality of healthcare. At the center of this suite is our Find a Doctor tool, which enables members to search for health care providers nationwide and integrates with a variety of provider quality information to help members better understand how doctors and hospitals perform with regard to patient experience and clinical processes of care. For our PPO members, Find a Doctor also integrates the ability to search for cost information on a wide variety of common medical services. This feature couples facility and professional costs where applicable and presents results in an easy-to-understand way, enabling members to compare providers and help make decisions regarding where to get care. We promote these solutions broadly through employer, broker and member communications.

In order to address the requirements of Chapter 224, BCBSMA has developed a new solution that not only provides members with an estimate of their cost sharing responsibility, but also helps them better understand how that estimate relates to their benefits and overall plan experience. Rather than turn to an off-the-shelf solution from an outside vendor, we sought to leverage our strength in supporting members who have questions about claims and costs by creating a high-touch, member-centric user experience that will provide each member with the information that is most useful to his or her own unique situation. Such a solution will allow our members to get the personalized service they deserve and which we believe will be critical to guiding the member to the information that they truly need.

A significant advantage of our member-centric solution is its ability to provide actionable information about the types of services members are requesting estimates for, questions members are asking in relation to the estimates, and their overall experience. This information and feedback will assist BCBSMA in enhancing our future decision support offerings for our customers in a meaningful way.

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.

BCBSMA Response:

The findings are consistent with BCBSMA's experience. In general, premium trends are greatly influenced by trends in total medical expenses (TME). Some additional drivers of premium trend are noted below:

- Overuse of medical services: Overuse of certain services increases costs unnecessarily. Examples include preventable hospital re-admissions and emergency room visits for avoidable or ambulatory sensitive conditions.

- Severity: Increase in trend resulting from services shifting from lower cost settings to higher cost settings. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.

- Regulatory and legislative changes: Regulatory and legislative actions impact costs and trends, such as assessments and administrative requirements on insurers. These include, but are not limited to, the significant expense currently being incurred to implement both the provisions of the federal ACA and the new coding requirements of ICD-10 simultaneously. Additionally, new mandated benefits also drive up health care costs and premiums.

  BCBSMA has the following comments on the Total Medical Expenses results included in the report. We have noted these comments previously, but feel that they should be reiterated:

- The report places full value on relative TME for groups of any size and cuts a bright line at 1.00 to call a group high cost or not. We would apply a confidence interval based on the group's size before calling a group efficient, inefficient, or average. For BCBSMA TME data, 12 of the 36 groups reported in 2010 would be deemed "average" according to this method, instead of characterizing them as efficient or inefficient.

- The measure of disparity should also use this confidence interval concept. A smaller group with a high TME may be due to random fluctuation. We also would recommend a more robust measure such as interquartile range or 10-90th percentile range instead of the min to max range used in the report.

- The raw "Non-PCP required" TME trend 2011 to 2012 was lower than expectations, due to a change in the relative health status of our "Non-PCP required" membership. Members new to our "Non-PCP required" products in 2012 had a lower relative health status versus members who departed after 2011.

Attorney General Questions (Exhibit C)

1. Please submit a summary table showing your actual observed allowed medical expenditure trends in Massachusetts for CY2010 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).

BCBSMA Response:

Please see attached Exhibit C1.

Please note that BCBSMA is unable to provide partial year non-claim based payments. Specifically, we will be unable to provide this data for Q1 2012 and Q1 2013 as requested in the question. Non-claims payments are mostly efficiency and quality performance payments, based on a provider group's performance over an entire calendar year. We do not measure partial year performance so any partial year extrapolations of those dollars would be misleading.

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
   f. Membership in a high deductible health plan by market segment ("high deductible health plans" as defined by IRS regulations)

BCBSMA Response:

Please see attached Exhibit C2.

Please note that for this response, members reflects members living in Massachusetts.

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 this growth.

BCBSMA Response:

Membership in BCBSMA PPO products has increased annually since 2005. Membership under all BCBSMA ASC products increased annually from 2005 through 2008, and has been stable since 2008. A key factor in the growth of PPO and ASC products has been an increase in large multistate accounts. Multistate accounts seek consistency in benefits across employee populations, which can generally be achieved on a self-funded basis and through a PPO product. For this reason, multistate accounts are frequently both PPO and self-insured. The increase in these accounts at BCBSMA has driven growth in PPO and ASC product membership during the period.

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 budget, 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).

BCBSMA Response:

In 2009, BCBSMA introduced the AQC in an effort to moderate the unsustainable rate of increase in health care costs and improve the quality of patient care and health outcomes. Hospitals and physicians who enter into the AQC agree to take responsibility for the full continuum of care received by their patients —including the cost and quality of care— regardless of where the care is provided. The model combines a per-patient global budget with significant performance incentives based on nationally endorsed quality measures over a five-year period.

Although the AQC and its global budget have some likenesses to fixed models of the past, the AQC specifically addresses the most important limitations of historical capitation programs. In particular, the AQC incorporates significant financial incentives that encourage physicians and hospitals to meet high standards on a broad set of quality and outcome measures. Earlier efforts at fixed payments did not include such incentives – largely because the measures did not yet exist. In addition, starting budgets for organizations in the AQC are based specifically on each organization's historical rate of spending for its patient population and adjusted for changes in that population throughout the contract term. In contrast, previous fixed payment models set budgets based on regional norms or averages, and did not account for differences in resources required for physicians caring for sicker or needier patients.

AQC contracts are generally five-year agreements, in contrast to national and historical norms of one-year fixed payment arrangements. The five-year AQC time period enables physicians and hospitals to plan for use of health care services over the life of the contract. Finally, the AQC puts in place several features to mitigate financial risk for the groups, including a requirement that all groups carry reinsurance for high-cost cases (i.e., covers 70 to 90 percent of cost if medical expenditures exceed a threshold, such as $100,000), flexibility in the AQC model with respect to the degree of financial risk-sharing assumed by the provider organization based on performance on established quality metrics, and a budget trend anchored to network trend to account for network-wide changes beyond the providers' control.

Another distinguishing feature of the AQC is the ongoing data and information support provided by BCBSMA to the AQC groups. The broad set of data and reports – some daily, others monthly, quarterly, biannually and annually – is designed to support physicians' success at managing to both the quality and efficiency incentives of the AQC model.

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 plans. 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.

BCBSMA Response:

There are many factors that are evaluated through the course of negotiations with providers. With provider groups that are actively engaged in discussions and willing to explore a risk based contract model, factors that need to be reviewed include, but are not limited to, the groups' size, experience with risk arrangements, solvency, and infrastructure to effectively manage under a risk arrangement. These factors provide guidance to BCBSMA in negotiating the level of risk we are willing to shift to the provider groups.

Based on this analysis and discussion, several contract elements are used to vary the level and type of risk assumed by the provider. Some of the key elements include: overall risk share percentage, caps on the overall financial exposure, health status adjustments, and catastrophic claim adjustments. The overall goal is provide a meaningful incentive that focuses on factors of total cost within a provider's control and to limit factors outside that control or the impact of random variation.

BCBSMA developed the AQC in order to generate a responsible level of risk sharing between BCBSMA and providers. Risk sharing is tailored for individual providers using tools such as:

- Health Status Adjustment

- Minimum population size
- Risk Sharing (BCBSMA shares in the risk with providers)
- Risk Limits (typically BCBSMA is responsible for large losses on individual claims or across populations)
- Reinsurance
- Adjustment to global payment using broad network or regional trend to account for macro factors such as coverage mandates, flu season fluctuation, and economic conditions

Even in an AQC, BCBSMA always remains the ultimate risk bearing entity, and as such, we are required to keep a certain level of statutory reserves per the DOI and NAIC standards related to risk based capital calculations.

BCBSMA also includes numerous features in the AQC contracts to protect providers from accumulating a large deficit if expenses are outpacing budget targets. These contract features include:

- Interim settlement calculations to minimize cash flow volatility
- Claim withhold features both on physician and facility claims
- Physician and hospital fee for service claim offset to recoup unpaid deficits
- Quality and infrastructure payment offset to recoup unpaid deficits

The combination of all these features provides protections so that unpaid deficits are covered without requiring additional provider reserves.

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.

BCBSMA Response:

As BCBSMA enters into risk arrangements with provider groups the negotiations include discussions around withhold values, solvency, infrastructure, and prior risk experience. These discussions are intended to help determine a provider group's ability to absorb risk.

With a robust provider network across the Commonwealth, BCBSMA has often had a pre-existing contractual relationship with the organization looking to transition to a risk based model. In reviewing that historic relationship, BCBSMA can evaluate past performance on incentive programs with lower levels of risk to gauge the appropriateness of a risk model. In addition, BCBSMA often looks to the organization's infrastructure to assess the level of alignment across a group's constituency. Past experience has indicated that groups with strong infrastructure, analytic capabilities, and clinical leadership are able to manage within the constructs of a risk arrangement.

There are several factors that may come into play through these discussions that enable us to adjust the risk levels to maintain the focus on cost and quality while ensuring the applicability of a risk-based model for a specific provider group. Examples of these

factors may be the level of risk sharing both in a surplus and a deficit scenario, the presence of withholds, and possible caps on surplus and/or deficit levels. Adjusting these factors can minimize the potential deficit levels or anticipate possible deficit expenses while encouraging behavioral changes that drive quality, efficiency and ultimately success in a risk arrangement.

As noted in Question 5, BCBSMA always remains the ultimate risk bearing entity. BCBSMA also includes numerous features in the AQC contracts to protect providers from accumulating a large deficit if expenses are outpacing budget targets. These contract features include:

- Interim settlement calculations to minimize cash flow volatility
- Claim withhold features both on physician and facility claims
- Physician and hospital fee for service claim offset to recoup unpaid deficits
- Quality and infrastructure payment offset to recoup unpaid deficits

The combination of all these features provides protections so that unpaid deficits are covered without requiring additional provider reserves.

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 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.

BCBSMA Response:

Please see attached Exhibit C3.

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.

BCBSMA Response:

BCBSMA offers a variety of integrated wellness solutions to our members, including but not limited to a dedicated BCBSMA Wellness Consultant, health assessments, onsite health screenings, lifestyle telephonic coaching, online tools, and Health & Wellness discounts.

The BCBSMA Prevention & Wellness team provides innovative, customized solutions that empower members to build a healthy foundation through worksite wellness programs. This

approach to wellness provides our clients with the highest level of expertise, resources, and service to optimize the performance of employee wellness programs. Once an integrated approach is implemented, and there is a high level of engagement, significant participation in the program elements and a strong incentive strategy, we can begin to measure program impact by analyzing unique participants' health assessment and biometric data using a "time-1 time-2" methodology.

BCBSMA's *Wellness Opportunity and Savings Model*^{SM} uses the published works of Joseph Leutzinger, Ph.D., Ron Goetzel, Ph.D, and Ron Ozminkowski, Ph.D, leading researchers in Health Promotion Outcomes to demonstrate the impact of modifiable risk factors on medical costs. Our tool estimates the excess medical (and productivity) costs associated with the specific lifestyle risk profile of a population and monetizes the impact of changes in that profile. BCBSMA's methodology has been certified by Al Lewis, founder and president of the Disease Management Purchasing Consortium, and is the only health plan in the country to have earned that distinction.

The system method is driven primarily by:

- Population management
- Addressing the health and wellness of entire employee population regardless of geography or member status
- Incentive administration
- Working together to developed customized incentive strategies based on culture, budget and best practices
- Engagement solutions
- Multi-modal communication strategy
- Ease of access and assessment of readiness
- Program flexibility
- Tailored, modular wellness programs
- Integration
- Clinical and wellness programs are integrated resulting in a enhanced member experience
- Reporting & analytics
- Participation and engagement reporting
- T1/T2 clinical and fiscal measures

Center for Health Information and Analysis Questions (Exhibit D)

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?

BCBSMA Response:

No, while 5 of our AQC provider groups are also Pioneer ACOs and 10 of our primary care practices, representing 104 PCPs, participate in the PCMHI, we only evaluate the TME and clinical quality performance of those groups from a BCBSMA perspective under the AQC.

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.

Not applicable.

End of Responses

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

Sincerely,

Deborah Devaux

Deborah Devaux
Senior Vice President