HNE's Response to Health Policy Commission (HPC).

Please begin all responses with a brief summary not to exceed 120 words:

Overall Summary:
Health New England has used a number of strategies to help evolve care away from a fee-for-service, atomistic model to an integrated, collaborative and risk sharing model. This not only includes changes to payment models, but also: continued focus on enhancing care and case management; emphasis on outcomes and performance; the support and development of patient centered medical homes; health education and health promotion; and other strategies for improving care and quality while increasing value to the community.

Our past efforts have shown some success in providing value: HNE and its provider network have had excellent results for quality over a number of years. At the same time, data included in the Center for Health Information and Analysis (CHIA) Annual Healthcare Market Report shows that HNE has been one of the lowest cost sources of commercial health care coverage in the Commonwealth. In fact, according to the CHIA report, HNE had the lowest premiums per member per month (PMPM) among the major Massachusetts health plans during the period reported (2009-11). The same report showed that HNE had the second lowest overall medical costs PMPM among the plans mentioned.

EXHIBIT B – HPC Questions for Written Testimony

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.

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?

Summary:
HNE's efforts to control growth of healthcare costs include:
- **Evolution away from fee-for-service payment models**
- **Data analysis**
- **Network management strategies**
- **Utilization management; and**
- **Detection and prevention of fraud, waste and abuse.**

HNE uses a number of strategies to effectively control cost increases. Elsewhere in these responses, we discuss our evolution away from fee-for-service payment models. The expansion of risk and surplus sharing arrangements helps us to temper the increases in provider fee schedules and make such increases less relevant to total medical costs. HNE believes that as the percent of providers under these types of arrangements increase, providers will focus on better managing the care of their membership, which will decrease medical expenditures. HNE also makes use of DRG, case rates and Medicare fee based facility payment methodology for continued transition away from percent-of-charge methodologies.

We have invested in data analysis staff and supporting software capabilities to help us with a variety of tasks, such as improving our understanding of provider payments across our network and better understanding of how to

benchmark payments for similar provider types. We have also been very thoughtful about the participation of certain provider types such as standalone lab, radiology and ambulatory surgery facilities. While this may seem counter to the approach other health plans have taken, we believe that this has allowed us to negotiate lower rates with our network hospitals and has also resulted in lower, but appropriate, utilization of these services. We have also limited certain services in provider offices, such as CT and other diagnostic testing.

In response to increased emphasis on new risk models, and emphasis on quality and pay for performance, HNE and our providers are placing renewed emphasis of management of chronic conditions. Generally this is a collaborative effort between HNE and the practices, since HNE is in the position to identify members with chronic conditions through claims. The practices with electronic medical records (EMRs) or other appropriate systems are able to maintain their own registries of patients with chronic conditions. HNE has a number of disease management programs, but has generally not dictated to practices how to prioritize their own chronic disease management efforts. We believe that the practices are in the best position to address the needs of their patients. To that end, practices may concentrate, for example, on diabetes, on asthma or on COPD. These are just examples of chronic condition management. HNE also maintains a staff of nurses who assist with care management and coordination, especially for patients with complex cases or conditions. HNE has also supported development of care management capabilities within medical practices in our network.

In addition, HNE has been developing bundled payment programs for certain conditions such as CABGs (coronary artery bypass grafts), cardiac stent placement, joint replacement, bariatric surgery and certain common hospital conditions such as community acquired pneumonia. The hallmark of the management of these episodic conditions revolves around consistent physician ordering, timely provision of appropriate medical services and early discharge planning.

Some other examples of specific approaches that HNE has pursued to control health care costs include procedures and policies to monitor medical utilization and the accuracy and appropriate payment of provider claims, such as:

- Utilization management guidelines, including concurrent review of inpatient admissions based on clinical criteria
- Prior authorization for specific procedures prone to misuse
- Claims editing software
- A new care management system to identify gaps in care, including new predictive modeling capabilities
- Software and staff dedicated to analysis of claims data, including software specifically designed for detection of fraud, waste and abuse
- Dedicated claims audit personnel to review large and/or unusual claims and to detect fraud, waste and abuse
- Use of an external claim reviewer (Nurse Audit) to compare a facility bill to medical records
- Mandatory fraud, waste and abuse training for all HNE associates

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?

Summary:
Key opportunities are:

- **Development of patient centered medical homes**
- **Integrated care management strategies**
- **Care coordination.**

HNE has invested heavily in a patient-centered medical home (PCMH) initiative: approximately 50,000 HNE members, including both commercially insured and Medicare Advantage currently receive care in PCMHs in

over 20 practice sites. The addition of Medicare fee for service members will enhance practice transformation through the more rapid investment in practice infrastructure.

Working with network providers, HNE has launched an Integrated Health Care Program (IHC). This collaborative effort will have a shared budget with Medical Directors and a Nurse Director Team centralized at an HNE network PHO. Nurse care managers and care coordinators will be employed by the centralized organization and embedded in the PCMHs.

HNE plans to further refine the use of care managers in the PCMHs to help manage high risk cases and be an integral part of the health care teams that are important in practice transformation into medical homes. HNE is planning to aggressively expand the role of care management and care coordination in the practices through the IHC program.

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

Summary:
Desirable policy changes include:

- **Continued transformation of payment models**
- **Increased focus on collaboration, integration of care and care management**
- **Patient centered medical homes**
- **Increased use of electronic data exchange**
- **Fewer regulatory and legislative restrictions**
- **More attention to the cost impacts of legislative initiatives.**

From the perspective of HNE, we are pursuing the changes described elsewhere in these responses to evolve care away from a fee-for-service, atomistic model to an integrated, collaborative and risk sharing model. This includes continued focus on enhancing care and case management and emphasis on outcomes and performance. We also are continuing to consider how to increase consumer engagement through patient centered medical homes, health promotion, value-based benefit structures or other means.

From an external perspective, there are several systematic or policy changes which might help to improve HNE's ability to operate more efficiently without reducing quality. HNE has participated, with the Massachusetts Association of Health Plans, in collaborative efforts with providers to improve efficiency of health care administration and payment. It is difficult to achieve these efficiencies, but as more providers move to electronic medical records and as electronic data exchange becomes more widespread and more capable, additional progress should be feasible.

From a legislative and regulatory perspective, although the annual cost growth target is important, it can be misleading. A health plan that starts with a relatively low premium but has a higher than average percentage increase in a given year may be a better value than a relatively higher cost plan that happens to have a lower than average increase in a given year. Setting premiums and predicting costs are not exact sciences, so focusing on a plan's premium changes in any given year reflects a poor understanding of how health care coverage works. By extension, overly restrictive requirements concerning MLR, profit margins or other components of health care premiums make it difficult for plans to operate successfully, with very slim margins, over time. Asking health plans to continually improve efforts to improve quality and efficiency and to reduce costs is important, but allowing a reasonable amount of flexibility is necessary to permit those efforts to succeed. In addition, the

legislature should make a greater effort to consider the cost impacts of legislative initiatives such as mandated benefits, duplicative reporting requirements, etc.

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

Summary: HNE's comparatively low premiums, low financial margins and high percentage of premium devoted to medical care allow us to pass savings on to consumers and businesses.

The extent to which savings in health care spending are passed along to consumers can be measured by considering a carrier's profit margin, but also by examining the percentage of premium used to pay medical claims often called "Medical Loss Ratio' or "MLR." *Lower* profit margins and *higher* MLRs are indicators that the benefit of lower spending is received by consumers and not by carriers. HNE's profits are generally lower and our MLR is higher (i.e., better for consumers) than those of major national insurers, as shown in the following charts[1]:

Earnings Before Income Tax (EBIT) as % of Total Revenue			
Company	**2010**	**2011**	**2012**
HNE	**3.76%**	**3.89%**	**0.74%**
Aetna	7.72%	9.11%	6.95%
CIGNA	8.53%	8.58%	8.51%
Humana	5.21%	6.07%	4.88%
UnitedHealth	7.84%	7.81%	7.79%
Wellpoint	7.42%	6.52%	n/a

MLR Comparisons			
Company	**2010 MLR**	**2011 MLR**	**2012 MLR**
HNE	**86.40%**	**86.34%**	**89.23%**
Aetna	82.3%	79.6%	82.2%
CIGNA	66.9%	65.8%	68.4%
Humana	82.9%	82.1%	83.7%
UnitedHealth	80.6%	80.8%	80.4%
Wellpoint	83.2%	85.1%	n/a

In general, major health plans in Massachusetts tend to have lower profits and higher MLRs than the national carriers in the preceding comparisons. National Association of Insurance Commissioners (NAIC) data, however, shows that HNE's profits and MLR compare well to other Massachusetts Health Plans:

Comparisons Between Health Plans
From June 30, 2013 NAIC Reports

[1] For-profit companies' financial data sources: Aetna SEC filings (http://investor.aetna.com/phoenix.zhtml?c=110617&p=irol-sec#8639283); CIGNA annual reports (http://www.cigna.com/aboutus/financial-statements); Humana annual reports (http://phx.corporate-ir.net/phoenix.zhtml?c=92913&p=irol-irhome); UnitedHealth Group annual reports (http://www.unitedhealthgroup.com/investors/annualreports.aspx); Wellpoint statement of income (http://media.corporate-ir.net/media_files/irol/13/130104/wellpoint2011/consolidated-statement-of-income.html).

Income Statement –COMMERCIAL Line Business - PMPM									
	HNE	BC/BS	Fallon	HMO Blue	HPHC	Neighbor-hood	Tufts	BMC Health	Network Health
MLR	**89%**	91%	87%	89%	88%	83%	85%	104%	96%
Margin	**1%**	-1%	5%	2%	0%	8%	6%	-12%	-1%

To consider this from a different perspective, "payer retention," defined as "premium collection in excess of medical spending," is complementary to MLR. The higher the MLR, the lower the amount available for payer retention; the lower the percentage of payer retention, the greater the share of the premium devoted to health care spending (MLR).

The MLR figures cited above show that HNE's payer retention is reasonable on a percentage basis; it is also very low in terms of absolute dollars. The Center for Health Information and Analysis's (CHIA) Annual Healthcare Market Report data showed that HNE had one of the lowest dollar amounts of payer retention in the Commonwealth:[2]

FIGURE DA 12: MASSACHUSETTS PAYER RETENTION (2009-2011)

Payers	Reported Premium Collection in Excess of Medical Spending (in millions)			Change	
	2009	2010	2011	2009-2010	2010 - 2011
BCBS of MA"	$410,936,238	$441,453,118	$518,676,629	7.4%	17.5%
Fallon Community Health Plan"	$55,299,441	$92,765,318	$83,450,609	67.8%	-10.0%
Harvard Pilgrim Health Care"	$167,034,833	$220,105,087	$276,091,457	31.8%	25.4%
Health New England Inc.	$37,369,650	$46,835,322	$51,799,932	25.3%	10.6%
Neighborhood Health Plan Inc.	$21,620,326	$21,987,573	$43,261,089	1.7%	96.8%
Tufts Health Plan"	$104,454,720	$148,014,730	$199,798,671	41.7%	35.0%
Total	**$796,715,208**	**$971,161,148**	**$1,173,078,386**	**21.9%**	**20.8%**

' Premiums post-MLR rebates; "Consolidated

Source: Oliver Wyman analysis of data from Massachusetts payers for resident and non-resident insured lives

Given this data, is perhaps not surprising that other data included in the Center for Health Information and Analysis's Annual Healthcare Market Report showed that HNE has been one of the lowest cost sources of health care coverage in the Commonwealth. In fact, according to the CHIA report, HNE had the lowest premiums per member per month (PMPM) among the major Massachusetts health plans during the period reported (2009-11)[3]: Given the excellent quality performance of HNE and its provider network over the years, we believe this translates into real value for consumers.

[2] Commonwealth of Massachusetts, Center for Health Information and Analysis, *Annual Healthcare Market Report, Data Appendix,* August 2013, at page 8

[3] Commonwealth of Massachusetts, Center for Health Information and Analysis, *Annual Healthcare Market Report, Data Appendix,* August 2013, at page 3

FIGURE DA 3: PREMIUMS PMPM BY PAYER (2009-2011)

Insurers	Premiums PMPM'			Change	
	2009	2010	2011	2009 - 2010	2010 - 2011
BCBS of MA"	$383	$400	$422	4.6%	5.5%
Fallon Community Health Plan"	$357	$380	$393	6.3%	3.3%
Harvard Pilgrim Health Care"	$407	$414	$436	1.8%	5.2%
Health New England Inc.	$357	$367	$382	2.9%	4.0%
Neighborhood Health Plan Inc.	$386	$385	$385	-0.3%	-0.1%
Tufts Health Plan"	$379	$401	$426	5.8%	6.2%
Overall	**$384**	**$400**	**$421**	**4.3%**	**5.2%**

' Premiums are after rebates to consumers related to minimum loss ratio (MLR) requirements; member months exclude managed, self-funded employer groups

" Consolidated

Source: Oliver Wyman analysis of data from Massachusetts carriers for resident and non-resident insured lives

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?

HNE negotiates provider contracts in the way we believe will produce the best overall value for consumers. We have been working to increase the number of providers covered by risk sharing agreements, which help to put more emphasis on effective medical management and provide less reward for increases in price, volume or mix. Our success in using these and other techniques is reflected in data included in the Center for Health Information and Analysis's Annual Healthcare Market Report for 2013, mentioned in the preceding response. In addition to having the lowest premiums among the plans identified, HNE had the second lowest overall medical costs PMPM:[4]

[4] Commonwealth of Massachusetts, Center for Health Information and Analysis, *Annual Healthcare Market Report, Data Appendix,* August 2013, at page 8

FIGURE DA 11: TOTAL AND PMPM MEDICAL SPENDING (2010-2011)

Payers	Medical Expenses Totals (in millions)		Medical Expenses PMPM'	
	2011	Change: 2010-2011	2011	Change: 2010-2011
BCBS of MA"	$4,082.10	-1.7%	$375	3.5%
Fallon Community Health Plan"	$437	-7.5%	$330	3.8%
Harvard Pilgrim Health Care"	$1,760	3.3%	$377	2.7%
Health New England Inc.	$318	7.6%	$328	3.6%
Neighborhood Health Plan Inc.	$185	26.5%	$312	-6.8%
Tufts Health Plan"	$1,257	0.4%	$368	2.5%
Total	**$8,038**	**0.2%**	**$368**	**2.9%**

' Member months exclude self-funded employer groups; " Consolidated

Source: Oliver Wyman analysis of data from Massachusetts payers for resident and non-resident insured lives

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?

Summary: Changing the payment model is inherently difficult. HNE has been working to increase risk sharing and other methods of reducing the impact of fee-for-service payment models.

The central difficulty in evolving away from fee-for-service model is that it is a significant change which significantly changes both the mechanism and logic of financing health care delivery. It cannot be done instantaneously or easily. HNE's contracting strategy has included the following components:

Global and Other Risk Sharing Models: Approximately 50,000 HNE members in all of our products are in PCMH arrangements with global risk components. Our oldest global risk contract is over ten years old, and we are continuing to develop our approach to this model. These contracts may involve shared savings, or shared savings evolving toward shared risk, infrastructure or a payment based on historical costs with built in decreased premium contributions over the next several years. A "global" contract may include features such as fee-for-service payments for certain services such as laboratory, a monthly capitation for primary care services, or structures limiting fee-for-service prices for services within the overall financial model. HNE has supported the development of Patient Centered Medical Homes and has supported development of infrastructure and expertise needed for developing these models as core components of an integrated, risk sharing care delivery model. Several of the provider entities we deal with are exploring new models for internal compensation better suited to new approaches emphasizing population health management. We are also refining our provider contracting to reflect the IRBO initiative of the Group Insurance Commission.

Our risk contracting strategy has also included other components, such as:

Quality bonuses: HNE has had pay for performance (P4P) quality bonus incentives in place for key PHOs for many years. We have begun to enter into global risk contracts with Patient Centered Medical Homes (PCMHs) involving a more expansive quality program and more dollars are at risk on a PMPM basis, and which

may include HEDIS-like measures involving care processes and outcomes as well as initiatives around access and patient satisfaction or incentives around access and emergency room use related to ambulatory-sensitive ER visits. We believe that these initiatives are equally quality and utilization measures.

Bundles: HNE has worked on bundled payments initiatives involving total joint replacement, bariatric surgery and low back pain.

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.

Approximately 97% of HNE members are enrolled in an HMO or POS product and have a Primary Care Physician (PCP) assignment. As a result, attribution of almost all patients to a primary care physician is clear and prospective. HNE has not yet implemented an attribution model for PPO members.

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?

Summary: HNE's focus has been on efforts to increase development of new health care delivery models involving collaboration, coordination and shared risk, which in return requires new attention to population management and access to primary care.

As described in response to question 8, the health care delivery environment in Western Massachusetts is significantly different than in some other parts of the Commonwealth. A single hospital or physician specialty group may serve a fairly large geographic area. As a result, consumer engagement may require tactics other than tiered or selective provider networks. As noted elsewhere in these responses, HNE's focus has been on efforts to increase development of new health care delivery models involving collaboration, coordination and shared risk, which in return requires new attention to population management and access to primary care.

Population Management: As noted earlier, HNE has actively promoted the development of Patient Centered Medical Homes (PCMHs). Approximately 50,000 HNE members currently receive care in PCMHs in over 20 practices. A number of PCMH practices are involved in population management as part of the mission and vision of a new ACO, Pioneer Valley Accountable Care. These initiatives include embedded care management in the practices, plans for so-called development of hot spots to treat certain kinds of complex medical conditions in one location and continuing the development of practice guidelines to decrease care variation.

Access Management: Practices in HNE's network have taken different approaches to improving access to care, especially primary care. One practice has a program of offering appointments for any new patients within seven days. Another practice has begun an initiative to try to get new patients access for a visit within 14 days. Several practices have internet patient portals. Patients have access through these portals to schedule appointments, leave electronic messages and receive their test results.

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.

We have not performed a quantitative or qualitative analysis of such changes. The biggest challenge of this nature is that care provided at teaching hospitals in the Boston area is significantly more expensive than care provided in the four counties of Western Massachusetts. Consolidation or merger involving Western Massachusetts providers and Boston area providers has the potential to exacerbate these issues.

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.

Summary: Beginning October 1, 2013 Members will have the ability to submit a request for Cost of Care request using HNE's website, "HNEDirect.com".

HNE currently provides its Members with a toll-free telephone number to obtain, the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit. This allows our members the ability to speak with a customer service representative to submit a verbal request for Cost of Care. Beginning October 1, 2013 Members will have the ability to submit a request for Cost of Care request using HNE's website, "HNEDirect.com". Upon receipt of the request, HNE will contact the member via email or phone within two working days to provide the following information:

- Validation of Service – Medical necessity/covered benefit
- Facility fee
- Co-payment
- Deductible, and
- Co-Insurance (out of pocket)

8. After reviewing the reports issued by the Attorney General (April2013) 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.

Summary: Significantly altering the curve of health care cost growth in Western Massachusetts will require continued progress in developing new models for integrating the delivery and financing of health care, including further progress in development of patient centered medical homes and appropriate cooperation between providers and payors.

Western Massachusetts faces challenges that differ significantly from the challenges faced by health plans in other portions of the Commonwealth. It is less populous, and its distinctive demographics, geography and culture change the character of the provider community and the health care coverage market. As a result, the growth in PPO plans and in tiered and limited network plans reported in the Attorney General's report is not necessarily representative of Western Massachusetts. Creating a limited network offering limited to the four westernmost counties is difficult, if not impossible. PPO offerings are possible, but must reflect the significantly higher costs charged by providers in Eastern Massachusetts. Significantly altering the curve of health care cost growth in Western Massachusetts will require continued progress in developing new models for integrating the delivery and financing of health care, including further progress in development of patient centered medical homes and appropriate cooperation between providers and payors. It will also require willingness on the part of Boston area tertiary and quaternary referral providers to provide care for patients referred from Western Massachusetts at affordable rates.

EXHIBIT C – OAG Questions for Written Testimony

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:

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).

See Exhibit C1 and Attachment I.

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)

		Fully Funded Individual	Fully Funded Small Group	Fully Funded Large Group	Self Funded Group	Medicare	Medicaid
2009		1105	20235	51266	31562	838	0
2010		1368	21074	55368	31572	4271	6874
2011		1848	21245	56835	26274	5597	6277
2012		2378	23019	58528	25646	7590	10856

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")

		Fully Funded Individual	Fully Funded Small Group	Fully Funded Large Group	Self Funded Group	Medicare	Medicaid
2009		1105	20235	51266	31562	838	0
2010		1368	21074	55368	31572	4271	6874
2011		1848	21245	56835	26274	5597	6277
2012		2378	23019	58528	25646	7590	10856

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)

See Attachment I.

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.)

Our only tiered network is the plan offered to the Group Insurance Commission:

2009	17,178
2010	17,894
2011	19,055
2012	19,803

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.)

Not applicable.

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

	Fully Funded Individual	Fully Funded Small Group	Fully Funded Large Group	Self Funded Group	Medicare	Medicaid
2009	215	709	762	0	0	0
2010	182	1079	1027	0	0	0
2011	161	1128	984	0	0	0
2012	191	1398	1309	0	0	0

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.

Changes reflect normal loss and growth of membership over time.

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).

(The following answer is repeated from Exhibit B, Question 3)

Summary: HNE has been working to increase risk sharing and other methods of reducing the impact of fee-for-service payment models.

<u>Global and Other Risk Sharing Models</u>: Approximately 50,000 HNE members in all of our products are in PCMH arrangements with global risk components. Our oldest global risk contract is over ten years old, and we are continuing to develop our approach to this model. These contracts may involve shared savings, or shared savings evolving toward shared risk, infrastructure or a payment based on historical costs with built in decreased premium contributions over the next several years. A "global" contract may include features such as fee-for-service payments for certain services such as laboratory, a monthly capitation for primary care services, or structures limiting fee-for-service prices for services within the overall financial model. HNE has supported the development of Patient Centered Medical Homes and has supported development of infrastructure and expertise needed for developing these models as core components of an integrated, risk sharing care delivery model. Several of the provider entities we deal with are exploring new models for internal compensation better suited to new approaches emphasizing population health management. We are also refining our provider contracting to reflect the IRBO initiative of the Group Insurance Commission.

Our risk contracting strategy has also included other components, such as:

<u>Quality bonuses</u>: HNE has had pay for performance (P4P) quality bonus incentives in place for key PHOs for many years. We have begun to enter into global risk contracts with Patient Centered Medical Homes (PCMHs) involving a more expansive quality program and more dollars are at risk on a PMPM basis, and which may include HEDIS-like measures involving care processes and outcomes as well as initiatives around access and patient satisfaction or incentives around access and emergency room use related to ambulatory-sensitive ER visits. We believe that these initiatives are equally quality and utilization measures.

<u>Bundles</u>: HNE has worked on bundled payments initiatives involving total joint replacement bariatric surgery and low back pain.

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.

Summary: Methods to quantify and adjust risk include proper setting of medical budgets, reinsurance thresholds, risk pools and risk corridors.

Depending on the specific contract, HNE uses risk adjustment methods such as the following:

- Medical budgets on which the risk is based are set using factors such as product mix, demographics, known high-cost cases and case mix adjustment;
- Member-specific reinsurance thresholds are set and costs for any member beyond the threshold are allocated across risk pools;
- Providers are assigned to risk pools, and positive and negative experience within the risk pools offset to limit exposure based on random variation in patient experience;
- Upper and lower risk corridors are used to mitigate overall risk exposure.

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.

HNE has been developing risk sharing relationships with a relatively small community of providers, and has done so through a process specific to each provider grouping and based on ongoing dialogue. There is no "one size fits all" formula for these conversations, but a collaboration based on the providers capabilities and willingness to evolve to each more challenging step of risk sharing.

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.

HNE has no limited network products. Our only tiered network product is offered only to the Group Insurance Commission and cannot be compared effectively with our other commercial products.

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.

Summary: HNE has been involved in wellness initiatives for most of its history, using our internal resources, community-based consultants and expertise within our provider community.

The mission of the HNE Health Programs Department is to provide health education to our members and employer groups in order to improve the health of the communities we serve; to deliver superior value by promoting the health and wellness of members and potential members; and to act as a leading corporate citizen. As such, HNE places a high priority on wellness programs. Through these programs HNE assists employer groups in supporting its members in areas such as nutrition, physical activity, weight management, stress management, smoking cessation, osteoporosis, and diabetes and asthma management. HNE works with employers to identify potential incentive and reward programs that will drive participation in the programs.

HNE runs claims analysis to identify specific health program topics. For example, if an analysis shows that a certain number of members are seeking services for lower back problems, HNE will offer wellness programs on back care. HNE works to establish a working partnership with employers in order to optimally engage employees in health promotion programs and practice of healthy lifestyle behaviors. Each employer typically has one point of contact at HNE within the Health Programs Department. The HNE Health Programs contact person is asked to build the relationship with the employer as well as

tailor the programming for the specific needs and interests of the group. HNE works collaboratively with the employer and its employees to build a relationship based upon trust and upon programs focused on health improvement outcomes.

HNE has been involved in wellness initiatives for most of its history, using our internal resources, community-based consultants and expertise within our provider community. We have also begun an internal review of the extent and structure of our current efforts, and are continuing to consider new models for making effective wellness programs available to the population we serve. One of HNE's key strategies is to engage members in their health.

EXHIBIT C 1 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*	Total
CY 2010	4.0%	-2.0%			1.9%
CY 2011	3.5%	0.8%			2.6%
CY 2012	1.7%	0.5%			2.2%
YE Q1 2012 (April 1, 2011-March 31, 2012)	5.1%	-1.7%			3.3%
YE Q1 2013 (April 1, 2012-March 31, 2013)	1.0%	-0.6%			0.4%

**HNE does not break out service or provider mix from either cost or utilization trend calculations.*

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 actually 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 the utilization or cost trends.
3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.
4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

EXHIBIT D: Instructions and CHIA Questions for Written Testimony

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:

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.**

HNE does not perform such analysis.