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The AIS Report
on Blue Cross and Blue Shield Plans

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Blues Add Value-Based Reimbursement, Cost Sharing to MA, Medicare Part D Plans

Blue Cross and Blue Shield plans nationwide are reshuffling their Medicare Advantage (MA) and Part D offerings for 2015 to include more value-based networks and some additional cost sharing as they work to cope with reduced federal reimbursement to MA plans.

Some carriers — WellPoint Inc. and Blue Cross Blue Shield of North Carolina among them — are getting out of underperforming MA markets. Others, such as Highmark Inc., are building narrow-network products designed to lure cost-conscious Medicare consumers (see story, p. 6). Many are raising premiums both for MA and Part D, although some plans that have earned high MA star ratings have been able to mitigate premium increases due to the increased reimbursement paid to those high-performing MA plans.

Throughout the nationwide standalone Prescription Drug Plan (PDP) market, an analysis by Avalere Health LLC finds that fewer plans will be offered in 2015 — 1,001 compared to 1,169 in 2014. The reduction in plans is driven primarily by product consolidation in plans by a number of top plan sponsors, the analysis says. Meanwhile, according to Avalere, average monthly premiums for PDPs nationwide will decrease, but there remains huge premium variation between plans.

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Blues Form Alliances to Tap New Members, Encourage Existing Ones to Shop Again

Near the end of last year's open-enrollment period, a man clad in neon-yellow overalls showed up at an enrollment event sponsored by Philadelphia-based Independence Blue Cross. It turns out he was a baggage handler at the airport who decided to enroll in health coverage after his shift ended. Later that day, after the next shift ended, the room was full of men in neon-yellow overalls. "We learned firsthand that word of mouth is huge," says Paula Sunshine, vice president of sales and marketing for consumer business. For the 2014 plan year, she says Independence and its affiliate in New Jersey enrolled more than 285,000 people in individual policies sold through public exchanges.

Independence says its Silver Proactive three-tier-network plan was one of the more popular products last year. Enrollees have first-dollar coverage for hospitals and doctors listed on the "preferred tier." The benefit structure helps ensure that enrollees can afford to seek medical care. "It was fantastically successful," Sunshine says.

Beyond word of mouth, Blues plans tell *The AIS Report* that they will rely on a variety of strategies — including alliances with other companies — to extend their reach and drive more enrollees to public insurance exchanges during the upcoming enrollment period. They also are placing considerable emphasis on re-enrollment. But carriers must wait until Nov. 5 to begin marketing their exchange-based products. In a notice to carriers, CMS restricts insurers from marketing exchange products until user

agreements — the final products and rates — have been signed and approved. For the federally facilitated exchanges, that won't occur until at least Nov. 5.

Blues Plans Align With Outside Groups

Beginning on Nov. 15, more than 3,300 State Farm insurance agents and licensed team members in five states will sell individual Blue Cross and Blue Shield policies as part of an alliance with Health Care Service Corp. (HCSC). HCSC operates Blues plans in Illinois, Oklahoma, Montana, New Mexico and Texas. The State Farm team will market policies sold on and off of the exchanges.

"One of the goals of the Affordable Care Act is to reach the uninsured. But not all uninsured people are in large urban areas," says HCSC spokesperson Greg Thompson. "State Farm has storefronts throughout the country. It's a good way to broaden our reach."

Thompson says State Farm agents will go through "a pretty extensive" training process to get them up to speed with health insurance coverage and the exchanges. The program is an expansion of HCSC's relationships with its existing brokers and agents.

Arkansas Blue Cross and Blue Shield will host temporary enrollment centers in nine Goodwill Industries of Arkansas stores during the full enrollment period — Nov. 15, 2014, through Feb. 15, 2015. The self-contained kiosks will be staffed with licensed agents who will visit one-on-one with guests, explaining the health plan options available to them and providing onsite enrollment assistance, says spokesperson Max Greenwood. This will be the second year the Blues plan has partnered with Goodwill. The two groups will promote the locations through social media, digital media and in-store displays.

As it did last year, Independence partnered with CVS Health and will be present at its Project Health events this year. More than 350 Project Health events will be held at CVS/pharmacy locations across the country beginning in November. In addition to information about the exchange, participants will receive free health screenings, consultations with bilingual (English and Spanish) nurse practitioners or physician assistants and referrals to low- or no-cost medical facilities. "It's a great opportunity to talk to people about their health coverage… when they're already thinking about their health," says Sunshine. Independence also is printing messages on pharmacy receipts at CVS locations.

NC Blues Hits the Road

Blue Cross and Blue Shield of Kansas City says it has partnered with Wal-Mart Stores, Inc. The Kansas City Blues plan sells coverage in 30 counties in Missouri and two densely populated Kansas counties.

Along with promoting exchanges via its retail stores, Blue Cross Blue Shield of North Carolina redesigned its mobile unit to offer more information about coverage options. The mobile unit is already on the road and has been at NASCAR and other sporting events and community gatherings throughout the state. The unit is staffed by employee volunteers. It also has iPads loaded with information about plan offerings. To reach the Latino community, the North Carolina Blues plan intends to have a presence at ethnic festivals, church events and markets in Latino neighborhoods. To reach the so-called "young invincible" population, the Blues plan will hold events at community colleges and other places young people go.

Blues plan operator WellPoint, Inc. says it recently launched a member campaign to help educate individuals about the basics of navigating a health insurance plan. Among other things, it includes information about basic insurance terminology. As new Latino members signed up for coverage in late 2013, it became increasingly apparent that many of them were confused by new words and definitions associated with health insurance, says spokesperson Jerry Slowey. "They didn't understand what their new ID was used for or when to utilize it, how to access preventive care services offered to promote healthy living, how to understand the elements of an

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explanation of benefits or how to find a doctor through the member portal." WellPoint, which operates Blues plans in 16 states, also has invested in a new streamlined search tool that allows consumers to see if their doctor or local hospital is in a plan's network, and save their search results for later use.

Carriers Ramp Up Call Centers

Last year, the Kansas City Blues plan contracted with some of its brokers to head three outside call centers staffed with 52 representatives. This fall, about 80 reps will man the phones to answer questions. "We had a hard time keeping up with call volume last year, and this year it will be higher with current customers and prospects," says Ron Rowe, vice president of sales at the Kansas City Blues plan. The Blues plan also will have more sales staff working at its two retail locations. The carrier relies on a network of 3,000 independent brokers — about 1,000 of whom serve the individual market.

Independence says it will triple its telesales staff and double the number of customer service representatives who work directly with individual consumers. "We learned last year, when there is no human resources person standing between you and your coverage, folks have more questions and calls are more complex and longer," Sunshine says.

Premera Blue Cross says it is extending customer service hours and will operate from 8 am until 7 pm Monday through Friday and from 9 am until noon on Saturdays.

Is Re-enrollment More Critical Than Enrollment?

Blues plans say they are spending a great deal of energy determining how to ensure that existing members remain enrolled. CMS recently began sending out millions of re-enrollment notices to people who purchased coverage through federally facilitated exchanges. To ensure uninterrupted coverage, insured consumers have until Dec. 15 to choose a new plan with coverage that begins on Jan. 1

For the 2014 plan year, HCSC sold about 1.2 million policies on and off of the exchanges — between 80% and 90% of those enrollees were new HCSC customers. The company says those members will be encouraged to have their federal subsidy redetermined for the 2015 plan year.

Members who received federal premium subsidies will receive an identical subsidy if they opt to be automatically re-enrolled. That could mean substantially higher out-of-pocket costs if premiums for the existing product increase substantially. Members who actively shop for coverage will have their subsidy based on the second lowest-cost silver plan for 2015, Rowe explains. "In some cases, we'll be encouraging them to shop. We're introducing some new lower-cost products that might be a better deal for them. We're telling them that we basically have to start from scratch."

Rowe predicts that up to 20% of small employers in his market will move their employees to the public insurance exchange for 2015. This year, about 5% of employers dropped coverage and encouraged workers to find coverage on the exchange. Expected rate hikes in the small-group market will prompt more employers to drop coverage. "We are hearing about a lot of 40% rate increases from some competitors."

Through WellPoint's ChangeMyCoverage.com, current members can navigate through the renewal process with a "hands-on" approach led by a team of health plan advisors, says Slowey.

Independence Blue Cross has come up with a five-point pre-enrollment checklist to check off before logging on to HealthCare.gov. Points include ensuring they know their login name and password and have the most updated version of their computer browser before going online to find coverage.

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SERPs Remain Core Component of Blues Plan Executive Compensation

Despite occasional bad publicity that results when an executive gets a large payout, Supplemental Executive Retirement Plans (SERPs) remain popular among Blues plans and represent a core element of plans' executive compensation packages, according to a study by Reading, Pa.-based compensation consulting and research firm HR+Survey Solutions. SERP is a non-qualified retirement plan that allows companies to provide additional retirement benefits to executives who might have their pension benefits limited because of government restrictions on qualified retirement plans, according to California benefits firm Fringe Benefit Experts.

Nearly 80% of the 24 Blues plans that have participated in the firm's study over the past nine years say they provide SERPs to their executives. But SERPs' popularity may be declining slightly: Three Blues plans have eliminated them over the past nine years, and none has instituted a new SERP. And executive eligibility has remained flat, with seven Blues plans adding executives to their SERPs and seven plans reducing participation, the study shows.

continued

SERP benefits can be paid out to executives either as a lump sum or as an annual annuity. The participant chooses how to take the money, and due to low interest rates, many in recent years have chosen the lump-sum payout, says Judy Canavan, managing partner at HR+Survey Solutions.

"The whole concern over SERPs usually hits the news when an executive retires and takes a lump-sum payment," Canavan tells *The AIS Report*. "If that year [when the executive takes a lump-sum payout] isn't the best financial year for the company, it's a perfect storm — the company ends up in the media spotlight."

For example, former Excellus BlueCross BlueShield CEO David Klein received a $12.9 million payout in 2013. The company reported it in early 2014, and it followed a 2012 payout of $10.9 million to former CFO Zeke Duda, who retired in 2011. Together, the two payments led to questions about executive compensation for the Rochester, N.Y.-based Blues plan.

Despite some bad press, Canavan says SERPs "continue to be a very commonly used compensation vehicle." Blues plans surveyed over the past nine years as part of HR+Survey Solutions' research have an average of around 30 participants in their SERPs, she says; larger companies tend to have more people covered.

SERPs Sweeten the Pot

There's clearly a reason for SERPs at Blues plans, Canavan says. "What's at issue here is, companies still need to hire the best executives they can," she explains. "In order to get the best executives, it's going to be a challenge not to provide a supplement to their retirement income."

Median salaries for Blues executives over the past nine years have increased only 13%, while CEOs' median target annual incentive has increased from 60% to 85% of salary, representing a 40% increase in target incentives.

SERPs tend to "fill in the gap" between what the IRS allows companies to put into qualified retirement plans, and what top executives would accumulate in their positions if there weren't any limits in place, Canavan says.

Smaller SERP payouts of $2 million to $3 million tend not to raise as many eyebrows as Klein's payment of $12.9 million and Duda's payment of $10.9 million, Canavan says. "You can have a SERP without it being so large," she adds, although she notes that she's seen payments of up to $16 million. "It's obviously somewhat tied to pay."

Any bad publicity aside, Canavan maintains that Blues executives are paid less than their counterparts at large for-profit insurance companies, yet in many cases provide higher returns per dollar of CEO pay.

A study released last year by HR+Survey Solutions found that the average total direct compensation for the CEOs of Blues plans is only about 25% of the average level of pay reported in proxies for the large publicly held health insurance companies, even though they provide higher returns per dollar of CEO pay. The study showed executives return an average of $2,000 in premium revenue per dollar of CEO pay, while some Blues organizations' CEOs boast returns upwards of $4,000 per dollar of CEO pay.

Still, Canavan says, "it may be time for organizations to think about other ways to provide for longer-term retirement plans" than SERPs.

Long-term incentives (LTIs) have increased only about 20% for CEOs over the nine years of HR+Survey Solutions' Blues survey, Canavan says, adding that the plans may want to consider LTIs more often as part of their executive compensation packages.

Contact Canavan via HR+Survey Solutions spokesperson Candice Warltier at (312) 587-3105. ✧

FEP Enrollees to See Low Rate Hikes, More Incentives for '15

During this fall's open-enrollment period, federal workers and retirees who have coverage through the Blue Cross and Blue Shield Association's Federal Employee Program (FEP) will see smaller out-of-pocket costs and bigger financial incentives for enrollees who take steps to stay healthy, BCBSA says. Of the 8 million federal workers, dependents and retirees who have health coverage through the Federal Employees Health Benefits Program (FEHBP), more than 5.3 million are covered by one of two national FEP plans (see table, p. 5).

For the 2015 plan year, premiums for FEP's Basic Option increased by 4% (employees will contribute $63.40 every other week), while rates for the richer Standard Option grew by 3% (employees will contribute $91.03 every other week). By contrast, premium rates in the private sector are expected to increase by an average of 6% for 2015, according to PricewaterhouseCoopers.

That percentage increase for 2015 is lower than last year's average increase of 3.7% and represents the fourth consecutive year that FEHBP rate increases have been below 4%, according to the Office of Personnel Management (OPM). The largest percentage increase for the 2015 plan year was 36.2% from Coventry Health Plan of Florida, an Aetna Inc. subsidiary. Among products with more than 5,000 contracts, Lovelace Health Plan in New Mexico had the largest hike at 14.7%. Lovelace Insurance Co. was acquired by the New Mexico Blues plan last November *(The AIS Report 12/14, p. 6)*.

FEP Cuts Out-of-Pocket Costs

In 2015, FEP will help reduce out-of-pocket costs for its members and increase the financial incentives available to those who take steps to stay healthy. For example, out-of-pocket expenses for urgent care services in both the Basic and Standard options are being reduced by $15 in the Basic Option and $10 in the Standard Option.

"There's more focus on the wellness programs this year," says BCBSA spokesperson Eric Lail. Members who complete the health risk assessment can earn $40 on a health debit card. In the first quarter of 2014, BCBSA says about 150,000 members participated in that program. Members can earn an additional $35 for completing up to three lifestyle goals with the online health coach.

FEP also is increasing its focus on patient-centered medical homes (PCMHs). At the end of 2013, PCMHs covered more than 700,000 FEP members in 35 states and the District of Columbia. Of those, more than 400,000 are enrolled in medical homes that have achieved Level 2 and Level 3 recognition from the National Committee on Quality Assurance. Maryland-based CareFirst BlueCross BlueShield, which also sells coverage in Northern Virginia and Washington, D.C., operates the nation's largest single patient-centered medical home, according to BCBSA.

BCBSA's Blue Distinction Centers, which are available to employer benefit plans, are being incorporated into FEP for 2015. The Blue Distinction program is intended to help members identify high-quality institutions with better overall patient care outcomes. FEP members in need of a transplant, for example, can reduce their out-of-pocket costs by seeking care from a Blue Distinction Center for Transplants.

This year, FEP also partnered with WebMD to offer enrollees content as well as wellness tools, says Lail. A health risk assessment tool and online health coaching tool, for example, are part of FEP's "behavior-change platform."

Federal Workers Stay Put

While 257 health plans will be available through FEHBP during the upcoming enrollment period, surprisingly few people ever switch carriers. Overall, more than 90% of FEHBP enrollees are enrolled in products from just six carriers, and FEP has about 66% of those members.

Research conducted by Aetna Inc. over the summer determined that the overwhelming number of carriers available through the program creates anxiety rather than confidence, and that the vast majority of employees never switch carriers after they enroll in a plan, says Tom Bernatavitz, vice president of federal plans for Aetna. By retirement age, the typical federal worker has been with the same carrier for 25 years, he says.

In October, OPM issued a final rule that will allow some temporary and part-time federal workers to enroll in coverage through FEHBP and access a government contribution. Eligible employees must work at least 130 hours a months and at least 90 days during the year. Between 1% and 2% of federal workers would be eligible for the benefits, according to OPM.

See OPM's final rule on part-time federal workers at http://tinyurl.com/neta8cq.

Contact Kendall Marcocci for Bernatavitz at kmarcocci@aetna.com and Lail at Eric.Lail@bcbsa.com. ✧

Top 25 Health Plans Among Federal Employees, by Enrollment

For the 2014 plan year, 91 plans reported total membership in the Federal Employees Health Benefits Program (FEHBP) of 7.8 million, which represents almost a third of all large-group risk enrollment, 9% of all commercial risk enrollment, and almost 3% of all U.S. medical enrollment, according to *AIS's Directory of Health Plans: 2014*. Approximately 84% of FEHBP enrollment is via Blue Cross and Blue Shield entities.

Company	FEHBP Membership
WellPoint, Inc.	1,528,000
Blue Cross and Blue Shield of Illinois	782,787
CareFirst BlueCross BlueShield	637,052
Blue Cross and Blue Shield of Texas (BCBSTX)	416,785
Coventry Health and Life Insurance Company	329,160
Blue Cross and Blue Shield of Florida, Inc.	323,677
Blue Shield of California	282,365
Aetna Inc.	257,894
Highmark Blue Cross Blue Shield	232,774
Blue Cross and Blue Shield of North Carolina	159,804
Blue Cross and Blue Shield of Alabama	151,475
Premera Blue Cross	127,134
Horizon Blue Cross Blue Shield	126,694
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	123,267
UnitedHealthcare	123,188
Blue Cross Blue Shield of Massachusetts	117,734
Blue Cross Blue Shield of Michigan	107,667
Blue Cross Blue Shield of Arizona	102,174
BlueCross BlueShield of Tennessee	99,893
Blue Cross and Blue Shield of Minnesota	80,736
BlueCross BlueShield of South Carolina	80,058
Independence Blue Cross (IBC)	79,323
Regence BlueShield	77,348
Capital BlueCross	76,372
Blue Cross and Blue Shield of Louisiana	71,627

SOURCE/METHODOLOGY: *AIS's Directory of Health Plans: 2014*. Visit http://aishealth.com/marketplace/aiss-directory-health-plans for ordering information or call (800) 521-4323. Researched by AIS editorial staff. Includes health insurers operating as of Dec. 31, 2013.

PA Officials Sue Highmark Over Narrow Network MA HMO

The Pennsylvania attorney general, plus its departments of health and insurance, is suing to prevent Highmark Inc. from marketing a new narrow network Medicare Advantage (MA) HMO plan that does not include UPMC hospitals and providers.

The state, which filed its lawsuit on Oct. 10, is asking Commonwealth Court to enjoin Highmark from offering its lower-cost HMO plan. It also sent out letters to Pennsylvania insurance brokers warning that they could be subject to legal action for offering the plan. Results from a hearing in the case were not available as of press time.

In keeping with the trend toward narrower, lower-cost networks, Highmark announced its new narrow network Community Blue Medicare HMO in early October and set it to launch Oct. 15 in 23 western Pennsylvania counties for the 2015 benefit year.

The product includes 40 acute care hospitals, 9,040 primary care physicians and specialists at all western Pennsylvania Allegheny Health Network facilities as well as a variety of community hospitals. It does not include UPMC physicians and facilities.

Individuals who select the new Community Blue Medicare HMO have the option to choose between two plans, both of which include Part D benefits: Community Blue Medicare HMO Signature, a $0 premium plan with medium to high levels of cost-sharing, and Community Blue Medicare HMO Prestige, a $193 premium plan with minimal cost-sharing.

Members in the plan will have access to dedicated representatives who will help them find doctors, make medical appointments and coordinate the transfer of medical records and other health-related information between providers, according to Highmark.

Highmark also is launching a new tiered benefit product, Community Blue Flex PPO, that's based on the same network but hasn't raised concerns with the state and with UPMC.

The new MA HMO immediately drew fire from UPMC, whose hospitals were excluded from the HMO, and from state officials, who said it violated the consent decrees Highmark and UPMC reached with the state last June to protect consumers as the two companies severed their relationship.

The consent decrees granted Highmark members wider in-network access to UPMC hospitals, emergency rooms and oncologists, and also offered protections for access to care for Medicare patients, who were considered to be among "vulnerable populations."

"We have a longstanding commitment from both parties that vulnerable populations need the most protection and would not be impacted," Pennsylvania Insurance Department spokesperson Melissa Fox tells *The AIS Report*. According to the consent decree, that meant UPMC would contract with Highmark to cover Medicare

patients at in-network rates for Medicare Advantage products.

However, Highmark maintains that the consent decree allows the Blues plan to market an MA narrow network product that does not include UPMC. "The Commonwealth of Pennsylvania is now seeking to dictate product design under the auspices of the Consent Decree on a product that was previously approved by CMS for offering to seniors," the insurer said in a statement. "This is the wrong action and at the wrong time as seniors could reap the benefit of a lower cost product that may better suit their needs."

Highmark: No Plans to Pull Out

Highmark said it believes its new MA product does not violate the consent decree, since "Highmark Medicare Advantage members continue to have full access to a broad network through the Freedom Blue and Security Blue plans."

Highmark spokesperson Aaron Billger tells *The AIS Report* that Highmark does not plan to pull the new MA plan: "Highmark will continue to offer the product. The product had been approved by CMS and we're actively offering it in the marketplace. It is a choice — it is a low-cost choice."

UPMC Vice President and Chief Communications Officer Paul Wood characterizes the dispute as "an issue between the state and Highmark," and says his organization has not intervened in the latest court case, although UPMC "applauds" the state's decision to go to court.

"Highmark's new 'No UPMC' Medicare Advantage products were a betrayal of commitments Highmark made to the community, a bait-and-switch only intended to confuse a vulnerable population, and a direct violation of the July 1, 2014 Consent Decree," he asserted in a prepared statement.

Wood added in an interview that it's clear that Highmark's new MA plan does violate the part of the consent decree that calls for vulnerable populations, including seniors, to have access to UPMC providers. "Highmark is not a very ethical organization," Wood says. "They don't care about the law or about whatever anyone else says."

He adds that Highmark offered UPMC participation in the Community Advantage HMO products "through amendments to UPMC's existing Medicare Advantage contracts with Highmark."

At that time, Wood says, "UPMC advised Highmark that entering into these amendments with Highmark was not necessary since UPMC already participated in all of Highmark's Medicare Advantage products and that Highmark's proposed amendments, in any event, were not consistent with existing contracts. So, to be clear, UPMC did not decline participation in Highmark's new products — rather, UPMC declined the amendments since Highmark only offered these amendments by pretending the existing contract requirements and obligations do not exist."

Contact Fox at (717) 787-3289 or mefox@pa.gov or Billger at aaron.billger@highmark.com. ✧

Most Blues Plans Maintained or Improved Their CMS Star Ratings

Top Blue Cross and Blue Shield Medicare Advantage and Part D plans largely maintained or improved their CMS star ratings for 2015, according to an analysis by *The AIS Report*.

2015 star ratings for MA plans with prescription drug coverage (MA-PDs) include up to 44 quality and performance measures, while MA-only plans are rated on up to 33 measures and stand-alone Prescription Drug Plans (PDPs) are rated on up to 13 measures. The various measures look at outcomes, access to care and patient satisfaction.

Plans rated four stars or higher receive bonus payments of 5% from CMS, which must be used to boost benefits or lower premiums — perhaps making the difference between profit and loss on a MA or Part D plan. According to CMS, the average star rating weighted by enrollment for MA-PDs is 3.92 for 2015, compared to 3.86 in 2014, 3.71 in 2013, and 3.56 in 2012.

Just 11 MA plans — none of which is sponsored by a Blue Cross Blue Shield carrier — received the highest overall rating of five stars for 2015, according to an analysis of CMS data conducted by *The AIS Report*. Three PDPs — including the MedicareBlue Rx product operated by Blue Cross and Blue Shield plans in Minnesota, Montana, Nebraska, North Dakota and Wyoming and Wellmark BCBS in Iowa and South Dakota — received five stars, according to CMS.

Sixty-one MA plans received the second-highest 4.5 star overall rating, including plans sponsored by Blue Cross and Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Blue Cross of Idaho, HealthNow New York, Inc., Highmark Inc., Independence Blue Cross and WellPoint, Inc.

Another 86 MA plans received four stars overall, including plans sponsored by Blue Cross & Blue Shield of Rhode Island, Blue Cross Blue Shield of Arizona, Blue Cross Blue Shield of Michigan, Blue Shield of California, Excellus BlueCross BlueShield, Hawaii Medical Service Association, Health Care Service Corp. and WellPoint.

Only 25 MA plans received 2.5 stars, while just two received two stars for 2015, according to the CMS data. Capital Blue Cross and WellPoint's Amerigroup Com-

munity Care of New Mexico plans were the only Blues-sponsored plans to receive 2.5 stars from CMS. No Blues MA or Part D plans received two stars.

WellPoint Sees Stars

Here's how the top Blues MA and Part D plans are rated for 2015:

◆ ***WellPoint:*** With its multiple MA and Part D plans, WellPoint has nearly twice as many Medicare Advantage members as the next-highest Blues plan, Highmark.

According to an analysis from Credit Suisse, WellPoint earned an average star rating of 3.38 for 2015, with only 9% of its enrollment in plans with four stars or above, but no plans rated lower than 2.5 stars. The company's New Mexico MA plan received a 2.5 star rating. Some 89% of WellPoint's enrollment is in a 3 or 3.5 star plan, the analysis found.

"WellPoint made progress moving three plans to a four star rating, although most of the potential revenue benefit was offset by one plan [its CareMore Health Plan of Nevada] moving to a 3.5 star rating (from four stars)," the analysis said. "We estimate immaterial 2016 revenue/earnings per share impact from the updated ratings."

WellPoint spokesperson Doug Bennett Jr. touts 4.5-star ratings for the insurer's CareMore HMO plan in California and a PPO plan in New Hampshire, along with 4-star ratings for WellPoint plans in Connecticut, Virginia and Wisconsin.

"We had no plans with low-performing icons this year," Bennett tells *The AIS Report*. "Our New Mexico plan had 2.5 stars this year so we will be working hard to improve that plan along with our continuing efforts to increase the star rating of all our plans."

◆ ***Blue Cross Blue Shield of Michigan:*** The insurer continued its high level of performance for 2015, with its MA PPO product rated at four stars and its MA HMO product rated at 4.5 stars, says Jim McMahon, director of product development and strategy execution. The star levels stayed steady from 2014, he says.

"We're very proud of our star ratings and how we've maintained them," McMahon tells *The AIS Report*. "Plans that weren't able to maintain their star rating or to get to a four star rating are going to have a very hard time competing."

The Michigan Blues plan has been able to hold down MA premium increases in part because of the bonuses associated with its high CMS star ratings, McMahon says. The insurer's stand-alone Part D plan received 4.5 stars from CMS for 2015, up from four stars in 2014.

◆ ***Highmark:*** The Pennsylvania-based Blues plan saw a mixed bag of results for 2015 in its MA and Part D star ratings, with one MA plan jumping from a 3.5 star rating to a 4.5 star rating, two other MA plans holding steady at 3.5 and four, and its stand-alone Part D plan falling from a four to a 3.5 star rating.

◆ ***Blue Cross Blue Shield of North Carolina:*** The insurer fell from a four-star rating to a 3.5 rating on one MA plan, while holding steady at 3.5 stars for its other MA plan. Its PDP received four stars, up from 3.5 stars in 2014.

Download the CMS performance data from http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. Contact Bennett at doug.bennettjr@wellpoint.com and BCBSM spokesperson Stephanie Beres at sberes@bcbsm.com. ✧

Horizon Blue Invests in Oncology Firm for Patient-Centered Care

Horizon Blue Cross and Blue Shield of New Jersey is hoping that its recent investment in COTA, Inc., a technology company focused on oncology management, will help it transform the delivery of health care. The deal, says the Blues plan, will help it to assist physicians in providing patient-centered care that's focused on value and not volume.

The firm shares its name with its product, a cloud-based data platform that offers real-time clinical outcomes and cost-analysis data for cancer care. More than 100 practicing oncologists and national leaders in cancer biostatistics and reimbursement contributed data to it. The offering is able to sort patients according to very specific subsets of information and provide outcomes tracking in areas such as overall survival, progression-free survival and costs. When providers enter detailed information on their patients, they are able to see how that experience compares with other similar ones, which in turn allows them to make better treatment decisions by narrowing down the most effective approaches.

COTA — which stands for "Cancer Outcomes Tracking and Analysis" — "provides oncologists a number of actionable clinical and financial reports for the patients they are caring for," explains Kelly Choi, M.D., the firm's chief operating officer. "The key is that COTA can parse down to the finest of patient subtypes within a particular type of cancer. As an example, for a particular subtype of breast cancer, an oncologist who is running a practice of multiple oncologists can see if all of their oncologists are consistently using NCCN [i.e., National Comprehensive Cancer Network]-approved regimens as well as see his/her operational efficiency and margins for the services provided for that particular subtype of breast cancer patient. The specific actions of course are unique to the practice depending on what the data shows."

The company was founded in 2011 by hematologist/oncologist Andrew Pecora, M.D., who also serves as executive chairman. Pecora, who is vice president, cancer services, and chief innovation officer for the John Theurer Cancer Center in Hackensack, N.J., formed the company "when he saw the major gap in data tracking and analysis, particularly within oncology," says Choi.

In late September, COTA closed $3.7 million in a planned $7 million Series A funding round in which Horizon "was the lead investor," Choi says. "While we have been active in the oncology space working with oncologists as well as other customers and partners, our recent Series A funding will allow us to further expand the COTA platform." Prior to that, private sources and Regional Cancer Care Associates, a group with more than 100 oncologists, provided COTA with a seed round of funding.

Thomas Vincz, spokesperson for Horizon, says that his health plan "made a significant investment in COTA's business. Horizon is leading the effort to change the delivery of health care in New Jersey through patient-centered based practices that are focused on quality versus quantity of care." Horizon now has more than 500,000 of its 3.7 million members in patient-centered programs, with more than 3,700 participating physicians at 900 practice locations.

Glenn Pomerantz, M.D., vice president and chief medical officer of Horizon, will serve on COTA's board of directors, as will a second Horizon person who will be named later.

continued

WellPoint, Independent Blues Plans Dominate Markets in 39 States, D.C.

Blue Cross and Blue Shield plans lay claim to the largest market share in 39 states and the District of Columbia, according to a study from the American Medical Association (AMA). The study, released Oct. 9, is based on 2012 data from commercial enrollment in fully and self-insured health plans and consumer-driven health plans in 388 metropolitan markets.

The study was conducted in an effort to evaluate competition in the insurance industry and "to help researchers, lawmakers, policymakers and regulators identify markets where mergers and acquisitions among health insurers may cause competitive harm to patients, physicians and employers," according to AMA.

WellPoint, Inc. had the largest market share in 82 of the 388 markets, more than double that of the next two insurers combined. Health Care Service Corp. (HCSC), which operates Blues plans in Illinois, Montana, New Mexico, Oklahoma and Texas, had the largest stake in 37 markets. UnitedHealth Group led in 35 markets.

Blues plans accounted for more than half of the market share in 14 states (see table, below), claiming the largest portion (84%) in Alabama, with UnitedHealth (7%) second largest. The Blues also held a significant majority in Michigan, with Blue Cross Blue Shield of Michigan (67%) trouncing the next largest insurer, Spectrum Health (9%). In Pennsylvania, Blues plans were both the largest and second largest insurers, with Highmark, Inc. covering 31% of the market and Independence Blue Cross covering 19%.

For more information, visit http://tinyurl.com/pasv86e.

Top 10 States Where Blues Plans Have Biggest Market Share

State	Blues Plan	Market Share %	2nd Largest Insurer	Market Share %
Alabama	Blue Cross and Blue Shield of Alabama	84%	UnitedHealth Group	7%
Alaska	Premera Blue Cross	59%	Aetna Inc.	22%
Delaware	Highmark Inc.	62%	Aetna	20%
Hawaii	Hawaii Medical Service Association	65%	Kaiser Permanente	21%
Illinois	Health Care Service Corp. (HCSC)	61%	UnitedHealth	14%
Indiana	WellPoint, Inc.	56%	UnitedHealth	14%
Louisiana	Blue Cross and Blue Shield of Louisiana	62%	UnitedHealth	16%
Michigan	Blue Cross Blue Shield of Michigan	67%	Spectrum Health	9%
Nebraska	Blue Cross Blue Shield of Nebraska	56%	UnitedHealth	21%
South Carolina	Blue Cross and Blue Shield of South Carolina	61%	UnitedHealth	16%

SOURCE: American Medical Association, Market Competition Study, October 2014.

Amidst growing concerns over skyrocketing health care costs that may not provide comparable returns on investment, more stakeholders within the industry are implementing value-based care models. COTA, contends the company, will help oncologists transition from fee-for-service care to these value-based approaches.

"In the new value-based reimbursement world, oncologists will need to understand the population of patients they are managing to a very specific level in order to track progress, change treatment plans as needed, and understand and manage their costs at a much more granular level," Choi says. "COTA empowers users with the ability to sort cancer patients to the highest degree of specificity. Oncologists can thus glean a level of actionable and insightful analysis that no other system today can do."

Pricing for use of the platform "remains confidential at the moment," says Choi. "We charge the oncologists a nominal fee to use COTA, mainly to cover operating costs. We do not want to be a financial burden for the oncologists. We believe the payers have the most to gain from improved quality and lowering unnecessary costs, and we are pricing for health plans accordingly." She says COTA has "several pending" contracts with health plans. "We can't share any specific details at the moment, but [they] will be made public in the coming weeks," she adds.

According to Choi, "We are focused right now on scaling our company. Our goal is for COTA at a national level to enable higher quality care while reducing unnecessary expenditures so that patients now and in future generations will get the care they need."

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Expected MA and Part D Changes

continued from p. 1

Here's a rundown of major Blues players in MA and Part D plans, along with their expected changes for 2015:

◆ ***WellPoint*** — The Indianapolis-based Blues plan operator will expand its MA and Part D offerings next year to include plans with providers who are accepting value-based payment, and new Dual-Eligible Special Needs Plans (D-SNPs). D-SNPs — all of which are $0 premium with $0 copays — will be active in 145 counties in 12 states in 2015, according to WellPoint. The insurer also is introducing traditional HMOs in 67 new counties in nine states, and PPOs in two Missouri counties.

PEOPLE ON THE MOVE

Horizon Blue Cross Blue Shield of New Jersey said **Minal Patel, M.D.,** would rejoin the company as senior vice president and chief strategy officer. He had been president and chief operating office at Horizon Healthcare Insurance Company of New York. Most recently, Patel was executive vice president at iHealth Technologies….BlueCross BlueShield of Tennessee promoted **Trey White** to vice president, controller and chief accounting officer. White joined the Blues plan in 2011 and was promoted to director of financial reporting in 2012. Before joining the insurer, he was employed by Ernst & Young LLP as manager of assurance services. And Onlife Health, a wellness management subsidiary of the Tennessee Blues plan, named **Hayley Hines** regional vice president of sales. She previously worked at Viverae, a Dallas-based health and wellness management company….Blue Shield of California named **Todd Walthall** senior vice president for customer experience. He was most recently vice president of digital service integration at American Express Company….Premera Blue Cross promoted **John Espinola, M.D.,** to executive vice president of health care services. He has more than 15 years of experience in geriatric medicine in group and private practices and over 10 years working directly with health plans. Espinola most recently served as Premera's vice president for quality, medical management and provider engagement…HealthNow New York Inc. subsidiary BlueCross BlueShield of Western New York promoted **Chris White** to portfolio director, sales and marketing. The company also promoted **Katie Manetta** to portfolio director, health care services, network management and health care economics….**Bruce Bodaken,** who served as chairman and CEO of Blue Shield of California from 2000 until 2012, was appointed to the board of directors of molecular diagnostics firm AltheaDx, Inc. He also serves on the boards of Rite Aid Corp. and WageWorks, Inc., and is a visiting scholar at the Brookings Institution.

Meanwhile, WellPoint is dropping its Unicare Part D plans and is not replacing them, adds spokesperson Doug Bennett Jr. "In MA, we are non-renewing some plans, but far fewer than in the past," Bennett tells *The AIS Report*. "About 90% of these members will have the option of purchasing another WellPoint affiliated MA plan in their market." Since WellPoint is adding multiple D-SNPs at the same time as it discontinues some other MA plans, "I can't say how that shakes out in overall numbers," Bennett says. New benefits include vision and dental for most plans that didn't already include them, new preferred pharmacy networks, and the SilverSneakers fitness program. Finally, MA plans in 13 states will include WellPoint's Live Health Online, which allows members to visit a physician over the Internet (see brief, p. 12).

◆ ***Blue Cross Blue Shield of Michigan:*** The Michigan Blues plan will offer the same four MA PPO products as last year, says Jim McMahon, director of product development and strategy execution. Meanwhile, on the HMO side, the insurer dropped one plan but added another. Its new HMO, ConnectedCare, features doctors and hospitals affiliated with Oakwood Accountable Care Organization, a partnership between Oakwood Healthcare and affiliated physicians, and Together Health Network, an integrated group of physicians in partnership with Ascension Health Michigan and CHE Trinity Health, two of the largest health systems in Michigan. The three health systems participating in the partnership already contract with BCBSM on other value-based reimbursement arrangements. "With the local network we are able to offer really competitive benefits — $41 a month, with a $3,400 out-of-pocket maximum and $0 copay for primary care physician visits," says McMahon. Overall, premiums are staying fairly stable, with rates in the BCBSM Medicare Plus Blue Essential PPO dropping, and premiums in the BCBSM Medicare Plus Blue Vitality PPO rising just $1 per month.

◆ ***Highmark, Inc.:*** Although Pennsylvania insurance regulators are seeking an injunction to prevent Highmark from marketing its newest MA HMO plan, Highmark spokesperson Aaron Billger says the insurer has no plans to withdraw the product (see story, p. 6). Highmark's Community Blue Medicare HMO is a narrow network plan for 23 western Pennsylvania counties with a $0 premium option and Part D drug coverage for both options. It includes a provider network with 40 acute care hospitals and more than 9,000 physicians, plus multiple community hospitals, according to Highmark. The insurer also is launching a PPO built on the same network, Community Blue Flex PPO, which has a tiered benefit plan and a more comprehensive provider network. The Community Blue Medicare HMO offers a lower-cost option in a year when prices generally are rising, Billger tells *The AIS Report*. "We've had substantial rate increases across all our Medicare Advantage plans for a variety of reasons, including increases in the cost of providing care and reimbursement levels from the federal government." However, Highmark also is adding benefits to its plans, Billger says. The insurer has expanded preventive dental benefits to all its plans and has lowered copayments and cost-sharing for some services, he says.

◆ ***Blue Cross Blue Shield of North Carolina:*** The insurer has elected to discontinue two HMO products — Blue Medicare HMO Standard and Blue Medicare HMO Enhanced — in 11 of the state's 85 counties. The North Carolina Blues plan will continue to have "many options available in all the counties we serve," which still includes the entire state, spokesperson Darcie Dearth tells *The AIS Report*, adding, "we're hopeful that other offerings in these areas will meet the needs of our customers." The changes will not impact the insurer's provider network, nor will they impact Blue Medicare PPO plans, Dearth says. The insurer also has two statewide standalone Part D plans. Rates on those will be rising substantially, Dearth says: The Standard plan had been $41 per month, and will more than double to $83.80, while the Enhanced plan had been $78.60, and will increase to $109.10 for 2015.

◆ ***Excellus BlueCross BlueShield:*** The upstate New York insurer is eliminating one of its MA plans, and is joining other Blues plans in increasing premiums for the remaining four plans. It's also increasing some cost-sharing, the company says. Excellus' Medicare Blue Choice Value plan, formerly a $0 premium plan, now will cost beneficiaries $23 per month. The insurer's most expensive MA plan, Medicare Blue Choice Optimum, will see its premiums rise from $140 per month to $183, company spokesperson Jim Redmond tells *The AIS Report*. The three Blues plans in New York jointly offered a Part D Prescription Drug Plan in 2014, and that has been discontinued for 2015, Redmond says.

◆ ***Capital Blue Cross:*** Not all Blues plans are marketing their programs. In May, the Pennsylvania-based Blues plan was prohibited indefinitely by CMS from enrolling new members because it improperly denied some emergency services and prescription drug access (*The AIS Report 7/14, p. 12*). The carrier has since formed a task force to remediate issues CMS identified "as quickly as possible," Capital spokesperson Joe Butera tells *The AIS Report*.

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NEWS IN BRIEF

◆ **Regence BlueShield, the largest health plan operator in Washington state, agreed to pay $6 million in two class action lawsuits over its exclusion of therapies for neurodevelopmental disabilities such as autism,** the *Puget Sound Business Journal* reported on Oct. 15. While Washington is one of 16 states that does not require coverage for behavioral treatments, the cases follow similar suits previously brought against Premera Blue Cross and Group Health Cooperative in the state, the paper reported. The state's Supreme Court ruled that insurance carriers can't use blanket exclusions to deny mental health coverage. In letters sent to carriers Oct. 20, State Insurance Commissioner Mike Kreidler (D) said his office would be reviewing denied mental health claims going back as far as 2006. The settlement is awaiting approval from the judges. Read Kreidler's letter at http://tinyurl.com/keqk3mh.

◆ **Members whose pharmacy benefits are integrated with their employer-sponsored health plan — as opposed to being carved out to a separate employer-PBM agreement — incurred 11% lower per-member per-year (PMPY) medical costs,** according to a two-year study conducted by Prime Therapeutics LLC, which is owned by 13 Blue Cross and Blue Shield plans. Analyzing data from 2010 and 2011, the PBM estimated that patients with integrated pharmacy benefits had total PMPY medical costs of $3,176 vs. $3,506 for members with a separate drug benefit. Moreover, the company found that members with integrated pharmacy and medical benefits had 9% fewer hospitalizations and 4% fewer emergency room visits than did members with a separately administered pharmacy benefit. To conduct the study, the company used unidentifiable data from patients covered by 25 Blues plans and the Federal Employee Program (FEP) across the 48 contiguous states. The company on Oct. 10 presented its findings at the Academy of Managed Care Pharmacy conference in Boston. Download the study at http://tinyurl.com/mv7n322.

◆ **Blue Cross Blue Shield of Illinois, a division of Health Care Service Corp., won't negotiate reimbursement rates with hospitals that affiliate rather than merge,** *Crain's Chicago Business* reported Oct. 7. The insurer's stance comes on the heels of an affiliation between Silver Cross Hospital and Advocate Health Care, which owns 12 hospitals in the state. The two entities planned to negotiate jointly with BCBS of Illinois for higher reimbursement rates as a part of their deal, Crain's said. Advocate CEO Jim Skogsbergh told Crain's he thinks the insurer's decision will have a "chilling effect" in the industry. Visit http://tinyurl.com/p5az3l8.

◆ **Horizon Blue Cross Blue Shield of New Jersey is launching a new patient-centered Medicare Advantage (MA) health plan, expanding its move away from the fee-for-service payment model,** the insurer announced on Oct. 16. Among Horizon members who used patient-centered practices in 2013, Horizon says it saw a 14% higher rate in improved diabetes control and a 12% higher rate in cholesterol management, as well as a 4% lower rate in emergency room visits and a 4% decrease in total cost of care. Visit http://tinyurl.com/l748keg.

◆ **Highmark Inc. finalized terms with the Delaware Dept. of Health and Social Services (DHSS) to begin providing Medicaid to the state's residents,** the agency announced Oct. 15. Highmark replaces Aetna Inc., which could not agree on a reimbursement rate with DHSS for its Delaware Physicians Care, Inc. plan for 2015. Highmark joins UnitedHealth Group's United Healthcare, which will continue offering Medicaid plans in Delaware in 2015. Visit http://tinyurl.com/n8325hw.

◆ **Consumer Watchdog filed two class action lawsuits in Los Angeles against Cigna Corp. and Blue Shield of California, alleging they misled consumers about the size of their networks,** *Kaiser Health News* reported Sept. 25. The lawsuit accuses the insurers of advertising inaccurate lists of participating providers, which consumers did not realize until it was too late to switch companies. KHN reported that Consumer Watchdog filed a similar lawsuit against Anthem Blue Cross of California in July. Visit http://tinyurl.com/lxurwmm.

◆ **Anthem Blue Cross and Blue Shield of Nevada, a division of WellPoint, began offering telemedicine services to members in October.** LiveHealth Online offers members 24/7 access to doctors via teleconference. Patients can download the app, sign in and speak with a doctor who is on call. The physician can then perform certain tasks for simple diagnoses. WellPoint also offers the service to nonmembers for a fee. Visit http://tinyurl.com/llyk4g7.

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