The AIS Report
on Blue Cross and Blue Shield Plans

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Managing Editor
Steve Davis
sdavis@aishealth.com

Associate Editor
Lauren Clason

Executive Editor
Jill Brown

High Medical Costs, Corridor Pessimism Prompt Blues to Seek Big Rate Hikes

Bigger-than-expected claims, higher-then-projected prescription drug use, cancelled policies and pessimism about the so-called 3Rs (reinsurance, risk corridors and risk adjustment) risk-mitigation programs are prompting Blues plans in some markets to propose large rate increases for their 2016 individual policies, according to filing information some state insurance departments have made public.

For the 2016 plan year, BlueCross BlueShield of New Mexico, a subsidiary of Health Care Service Corp. (HCSC), is looking to boost average premiums for its qualified health plans (QHP) by 51.6%, according to preliminary rates filed with the New Mexico Office of the Superintendent of Insurance.

BlueCross BlueShield of Tennessee is seeking an average rate hike of 36% — the biggest proposed percentage increase among carriers in the state that sell individual coverage through HealthCare.gov. The company says it lost $141 million dollars on individual exchange-based plans. Based on the proposed rates, the Tennessee Blues plan could wind up with the state's highest-priced plans on the exchange, Scott Fidel, securities analyst for Deutsche Bank, wrote in a May 21 research note. A year ago, the Tennessee Blues plan was approved for a 19% rate hike. Humana Inc. filed for an average 15.8% rate increase, while Cigna Corp. proposed a mere 0.4% bump.

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Blues Don't Intend to Alter Coverage if Mammography Recommendations Change

A recently issued draft recommendation document potentially could result in coverage changes for one of the most widely used cancer screening tests. If the United States Preventive Services Task Force's (USPSTF) proposed recommendations for mammograms are finalized, this could result in the loss of guaranteed coverage for screening with no cost-sharing for 17 million women, notes a recent Avalere Health LLC analysis. And with mammograms shown to be the best way to screen women for breast cancer, this decision could reverse years of a declining trend in deaths from the disease (see box, p. 3), contend some industry observers. But a few Blues plans tell *The AIS Report* that they have no intention of scaling back coverage for the exams.

If finalized, the USPSTF's latest recommendations "will trigger a change to the standard established in the Affordable Care Act (ACA) on no cost-sharing for breast cancer screening, and will permit plans to eliminate or restrict coverage or require that women aged 40-49 share in the cost of a mammography," Sung Hee Choe, director at Avalere, points out. An Avalere analysis estimates that of the 17 million women in this age group who could lose guaranteed coverage, the bulk of that number — 13.4 million — are covered under employer-based plans.

Anthem, Inc. "continues to support breast screening as a covered benefit in women beginning at age 40," says spokesperson Lori McLaughlin. "Anthem also covers annual follow-up screenings. This is the same as it was in 2010 before the ACA requirements."

continued

According to McLaughlin, "Anthem medical policy recognizes preventive services recommendations from a number of national organizations that produce evidence-based guidelines. While our medical policy considers recommendations from the U.S. Preventive Services Task Force, it also considers policies from the American College of Obstetricians and Gynecologists and the American Cancer Society, among others. The 40-year-old baseline for screening and annual screening is part of current policy, which is in line with recommendations from the American College of Obstetricians and Gynecologists and the American Cancer Society. When recommendations differ, Anthem policy follows the preventive recommendations based on evidence-based guidelines that provide the most generous recommendation."

The medical policy at BlueCross BlueShield of Tennessee "allows for annual mammograms to begin at age 35 and to continue annually thereafter," says Barbara Easterling Smith, M.D., vice president and associate chief medical officer for the plan. In addition, she says, the insurer's age-related criteria are based on a state requirement, which "does not allow for an annual mammogram cut off age, so BlueCross allows for annual mammography screening beyond age 74." According to Smith, "We know that regular mammograms have been the best test available to assist doctors in finding early breast cancer. Our interest is to do what is required to support long, healthier lives for our members. Talking to a health care professional about any changes, symptoms or breast concerns will remain the choice action to take, even in the face of recommendation changes. Having the appropriate risk assessment is a key factor in the decision-making process between a patient and a provider on any screening option, for breast cancer as well as other conditions." Looking forward, Smith says the plan "can't speculate on potential changes to our mammogram policy if the USPSTF final recommendation is to maintain the C rating for screening women aged 40 to 49. Our policy has remained more liberal on screening than the USPSTF recommendations for many years."

"Blue Cross and Blue Shield of Kansas does not anticipate changing our benefits for mammography, and will continue to look to each member and her doctor to make the screening decision that is appropriate for her," says Mary Beth Chambers, a spokesperson for that plan. She tells *The AIS Report* that "Our ACA-compliant plans will continue to cover screening mammographies as a preventive service with no cost-sharing for women age 40 and older; likewise, our grandfathered plans — those that are not required to provide preventive services with no-cost sharing — will continue to cover screenings as deemed appropriate, but deductibles, copays and coinsurance might apply based on the member's specific benefits plan."

Law Reflects 2002 Recommendation

At the crux of the issue is the ACA mandate that many health plans cover certain preventive services at no cost to members. Those services are determined by the rating given to them by the USPSTF: If the USPSTF gives a service an "A" or "B" rating, then that would qualify the service for ACA-mandated coverage, while a lower-rated grade means the service wouldn't make the cut.

For much of the time the health reform legislation was being debated, the USPSTF recommendation was mammograms "every 1-2 years for women aged 40 and older." Issued in 2002, this recommendation had a "B" rating.

But in November 2009, only about four months before the ACA was signed into law in 2010, the USPSTF issued new recommendations for mammography: Biennial screening for women between 50 and 74 had a "B" rating, but for women younger than 50, screening mammograms were graded "C." The decision to have screening mammography by women younger than 50 "should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms."

The AIS Report on Blue Cross and Blue Shield Plans (ISSN: 1542-4790) is published 12 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Managing Editor, Steve Davis; Associate Editor, Lauren Clason; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon.

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Those recommendations provoked somewhat of an uproar, especially since many physician groups had been encouraging women to have annual mammograms starting at the age of 40.

Language based on a December 2009 Senate amendment aimed at countering those recommendations made it into the ACA: "[F]or the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009."

The current draft recommendations largely echo the 2009 ones. Mammography for women aged 40 to 49 still has a "C" rating, with the USPSTF noting the tests for women in this age group "may reduce the risk of dying of breast cancer, but the number of deaths averted is much smaller than in older women and the number of false-positive tests and unnecessary biopsies are larger." The draft document clarifies that this "is not a recommendation against mammography screening in this age group" and again stresses that the decision "must be an individual one."

Other Groups' Recommendations Vary

The comment period ended May 18. The USPSTF says that the "final Recommendation Statement will be developed after careful consideration of the feedback received and will include both the Research Plan and Evidence Review as a basis."

According to the American Cancer Society, "recent evidence has confirmed that mammograms offer substantial benefit for women in their 40s," although it adds that the tests "have limitations. A mammogram can miss some cancers, and it may lead to follow up of findings that are not cancer.…But despite their limitations, mammograms are still a very effective and valuable tool for decreasing suffering and death from breast cancer."

And although the recent recommendations have prompted similar outcries to those in 2009, weighing the risks vs. the benefits of mammograms, particularly in certain age groups, has led to varying opinions among industry groups on how often women should be screened. For example, the American Cancer Society recommends women have annual mammograms "starting at age 40 and continuing for as long as a woman is in good health."

Responding to the recommendations, the American College of Radiology maintained that the USPSTF "limited its consideration to studies that underestimate the lifesaving benefit of regular screening and greatly inflate overdiagnosis claims. They ignored more modern studies that have shown much greater benefit." The group cites an analysis of the 2009 recommendations that says "if women ages 40-49 go unscreened, and those 50-74 are screened biennially, approximately 6,500 additional women each year in the U.S. would die from breast cancer." In addition, says the group in a joint statement with the Society of Breast Imaging, "Thousands more women would experience more extensive and expensive treat-

Breast Cancer Rates Decline, but It's Still a Top Cancer in Women

Breast cancer diagnoses and deaths among women have dropped since the 1990s, according to data from the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) Program.

Still, according to the NCI, breast cancer is the most common cancer in women except for skin cancers, with more than 230,000 new cases estimated for 2015. More than 40,000 women are expected to die from it this year.

According to the American Cancer Society, breast cancer is behind only lung cancer as far as cancer-caused deaths in women. Overall it is the fourth most common cause of cancer deaths.

SEER data also show the following statistics about breast cancer in women:

- ***There were almost 3 million women living with breast cancer in 2012,*** the most recent year that data are available.
- ***The median age of diagnosis in women is 61.***
- ***One-quarter (25.6%) of breast cancer diagnoses in women are among those aged 55 to 64,*** which is the group with the highest frequency of diagnoses.
- ***21.9% of breast cancer diagnoses in women are in the age range of 65 to 74.***
- ***21.6% of diagnoses in women are among those aged 45 to 54.***

It is a portion of the women in this last age group whose guaranteed coverage of mammograms could be eliminated if draft recommendations from the United States Preventive Services Task Force are finalized (see story, p. 1).

ments than if their cancers were found early by a regular mammogram."

On the other hand, in an article published online May 19 in the *Annals of Internal Medicine,* the American College of Physicians says that "high-value care" should include clinicians discussing "the benefits and harms of screening mammography with average-risk women aged 40 to 49 years and order biennial mammography screening if an informed woman requests it." In addition, "clinicians should encourage biennial mammography screening in average-risk women aged 50 to 74 years."

"Each of these organizations has distinct processes for reviewing the evidence base in support of their recommendations, and the differences in the recommendations reflect different appraisals of the evidence," notes Choe. She says "USPSTF is just one of the inputs that plans can use in formulating their coverage policies. It's hard to say whether and how plans will change their policies based on this one recommendation."

Contact Danielson at mary_danielson@bcbst.com, McLaughlin at Lori.McLaughlin2@anthem.com, Chambers at Mary.Beth.Chambers@bcbsks.com and Choe through Frank Walsh at fwalsh@gymr.com. ✧

Two-Year-Old Payment Model Cuts Costs, Admissions, Anthem Says

Anthem, Inc., the nation's second-largest health insurer, says more than 37,000 network providers now participate in its two-year-old enhanced personal care program — a population health-based payment model that the Blues plan operator launched 24 months ago.

In its first year with the program, Anthem says it saw gross per-attributed-member-per-month savings of $9.51, and net savings of $6.62 PaMPM. That translated into a net savings of between $81 million and $102 million, according to a recent article in *The Wall Street Journal.* Members in the program had 7.8% fewer inpatient admissions when compared to a control group not in the program, and had 5.7% fewer inpatient days per 1,000. The company also reports a 5.1% PaMPM drop in outpatient surgery costs, and a 3.5% decrease in emergency room costs. By the end of the year, Anthem expects about 4.4 million members will be involved in the program.

Here's how it works: Anthem pays a monthly per-member fee for each member attributable to the primary care physicians in a group. The fee, which is risk-adjusted, ranges from $3 to $4 based on the complexity of the member's needs. The payment compensates providers for services not traditionally covered under a fee-for-service model, such as proactive outreach and expanded office hours so that members have around-the-clock access to care, explains Amy Cheslock, vice president of payment innovation. Prior to joining Anthem in 2005, she worked for UnitedHealth Group where she contracted with hospitals, doctors and ancillaries in New England.

Anthem has $38 billion tied to value-based contracts, representing 30% of its commercial claims and approximately 40,000 providers. These include ACOs, patient-centered medical homes, hospital quality and safety programs and other partnerships that offer rewards for keeping patients healthy and out of the hospital.

By 2018, HHS wants half of traditional fee-for-service Medicare payments to be tied to value or quality through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements, the agency said early this year. It wants 30% of payments under such models by the end of next year. Moreover, a group of health care providers and insurers — including several Blues plan operators — is pledging to put 75% of their business into value-based arrangements by 2020.

Industry Is Ready to Change Payment

In a conversation with *The AIS Report*, Cheslock said there is a strong willingness among providers to adopt new payment models that lead to improved care quality for patients. Here's what she said:

The AIS Report: ***What do you see as the future for the traditional fee-for-service payment model?***

Cheslock: The model is changing, and the industry as a whole is evolving. We definitely are evolving our payment models as an industry — either away from fee-for-service or on top of it — by incorporating things like care-coordination payments and opportunities for shared savings and bundled payments. There is tremendous innovation around fee-for-service and, in some instances, in lieu of it. I think we are going to have a future that reflects a variety of payment models that are more aligned around value than we have historically had.

The AIS Report: ***What is enhanced personal care?***

Cheslock: That is the name that we've given to our population health-based payment model and provider-collaboration model. It's the program we use to engage with organizations with a foundation in primary care. We work closely with large ACOs, integrated delivery systems as well as small, independent primary care practices under the umbrella of that program. It's a model where we align the incentives differently under a new payment model.

The AIS Report: ***What works and what isn't as effective when it comes to new provider payment models?***

Cheslock: I've been working with providers for a long time, and now — more than I've ever seen before — there is a strong willingness to engage in innovative models. The industry is ripe to innovate around the payment models. There is greater willingness on the part of

both the payer and the provider to engage differently. We think it's important to think beyond the payment model, which is a foundational element. We need a collaborative model supported by tools and resources, such as data and information, and how we are sharing that with the practices. Those are critical elements. It's a two-way collaboration that drives success.

The AIS Report: ***Are providers receptive?***

Cheslock: There is tremendous receptivity to new payment models that drive better value for the consumer. Not everyone is in that camp, but looking at the pace in which we've grown enhanced personal health care in 24 months…we've converted, through individual contracting practices at the group level, over 37,000 primary care physicians covered either under ACOs or small independent practices that are now contracting with us actively under this new arrangement. To do that as quickly as we did indicates a level of receptivity. We have scaled this across all 14 states where we operate.

The AIS Report: ***This model focuses largely on primary care?***

Cheslock: Yes. It's primary care focused. It is looking for organizations that can be broadly accountable, either through an ACO or patient-centered medical home. But it's not just primary care, it's also coordinating care and serving as that home for the patient.

The AIS Report: ***Where do the savings come from?***

Cheslock: We're seeing savings come from a variety of things. We are seeing fewer acute inpatient admissions. In the first year of the program, we saw 7.8% fewer inpatient admissions per 1,000 compared to doctors not in the program. We also are seeing a decrease in outpatient costs. Some of that is just using a more cost-effective site of services. We are seeing reductions in ER costs. We've also seen an increase in primary care visits for high-risk patients — almost 23 more visits per 1,000 among that population compared to patients not in one of these models.

The AIS Report: ***What sort of risk do the provider groups need to assume?***

Cheslock: The majority of providers are in a shared-savings model. They don't have risk in that model where they would pay money if costs go up. Essentially, a medical cost target is established and the population they have…they earn savings from that. We do have a full-risk model that more groups are moving into where they also are accountable for costs if they go up. And the benefit under that model is a provider group can earn more of the savings.

The AIS Report: ***Can less efficient provider groups be turned into highly efficient providers?***

Cheslock: The transformation of provider organizations starts within the provider organization. There has to be strong cultural and leadership alignment around adopting value-based practices. We feel as though we play a role in being a partner and assist through collaboration by providing [claims] data and by aligning the way we pay them so that the value-based practices are rewarded, and then supporting them with the resources we have in the field that are working with the practices.

The AIS Report: ***Where do you see this model going a few years from now?***

continued

Cheslock: This model will continue to evolve and we will continue to grow the number of providers that we collaborate with under it. We will continue to evolve the payment model. I think capitation will emerge as an opportunity for high-performing organizations. We're continuing to invest in and expand the tools we use to collaborate with providers,…the type of data and how we submit it and looking at ways that we might exchange care-planning information…more bi-directionally. And then we also are looking to pilot models that wrap around the primary care model that we call patient-centered specialty care, where you bring the specialists into the fold. We also are doing work on bundled payment that will sit alongside the primary care model.

Contact Lori McLaughlin for Cheslock at lori.mclaughlin2@anthem.com. ✧

Advocates Raise Concerns Over Blue Shield's Proposed Acquisition

On June 8, the California Dept. of Managed Health Care (DMHC) will hear public concerns about Blue Shield of California's proposed $1.25 billion acquisition of Care1st Health Plan, a California-based Medicaid managed care company. The future of Blue Shield's status as a not-for-profit company will also be discussed. However, industry observers tell *The AIS Report* that the acquisition is likely to go through and Blue Shield is unlikely to ever move to for-profit status. CEOs from Care1st and Blue Shield of California intend to offer comment at the hearing.

The Blues plan has come under close scrutiny from several state public advocacy groups after it was learned that the state had revoked the company's tax-exempt status last August. As a result, Blue Shield must pay about $40 million a year in state taxes retroactive to 2013. The Blues plan also has come under fire for boosting premiums despite holding $4 billion in financial reserves *(The AIS Report 4/15, p. 1).*

Blue Shield Could Be Medi-Cal Player

Blue Shield is protesting the tax board ruling and says it has no intention of considering a move to for-profit status. Moreover, the insurer says, the acquisition of a major Medicaid managed care company will give the Blues plan a way to serve low-income Californians through the Medi-Cal program. Blue Shield of California doesn't now participate in the state's Medicaid program, but the proposed purchase would make it a significant player in that space, says Blue Shield of California spokesperson Steve Shivinsky. He says his company has been criticized for not participating in Medi-Cal, which covers more than one-third of Californians (see box, p. 7).

Four advocacy groups — Consumers Union, Health Access, Western Center on Law & Poverty and the California Public Interest Research Group — are urging the state to pressure the insurer to move to for-profit status. They also want to know why the state's Franchise Tax Board (FTB) didn't make public its decision to revoke the Blues plan's tax-exempt status. In a letter to FTB's leaders last month, Consumer Watchdog notes that the agency has refused to respond to a Public Records Act request that would detail the agency's decision to revoke the tax-exempt status.

Blue Shield has taken the position that as one of the state's largest health insurance carriers, it should participate in the Medicaid market. The Blues plan, however, has had opportunities to get into that space in the past, according to one observer. Health Net, Inc. and Anthem, Inc. participate in Medi-Cal, but Kaiser Permanente is not a large participant in the program.

"I think the market would benefit from Blue Shield being in Medi-Cal, and I hope that it goes through," says Henry Loubet, chief strategy officer for Keenan, a California-based health care consulting and brokerage firm, and former CEO of UnitedHealthcare's Western operations. "From a competitive standpoint, I think the market would benefit significantly by having another large and well-regarded player in the market."

Contact Shivinsky at steve.shivinsky@blueshieldca.com and Jennifer Davis for Loubet at jdavis@Keenan.com. ✧

PEOPLE ON THE MOVE

Ken Goulet, executive vice president and president of Anthem, Inc.'s Specialty Business Division, will retire from the company this summer….Blue Cross and Blue Shield of Minnesota named Chief Financial Officer **Jamison Rice** senior vice president and chief transformational officer. The insurer appointed **Jay Matushak** to fill Rice's previous role. Matushak was most recently vice president of finance for Medicare and retirement and chief financial officer of national accounts and commercial operations for UnitedHealth Group.…Triple-S Management Corp. President and CEO **Ramon Ruiz-Comas** is retiring Jan. 1, 2016, after 25 years with the company. Chief Operating Officer **Roberto Garcia-Rodriguez** will succeed him….**Robert Morrow, M.D.,** was named president of Blue Cross Blue Shield of Texas (BCBSTX) Houston and Southeast Texas region. The Blues plan is one of five operated by Health Care Service Corp. Morrow previously was chief medical officer of the Houston and Southeast Texas region for BCBSTX.

AIS Databases Examine California Medicaid Market

Anthem Blue Cross of California, the only BCBS affiliate now participating in Medicaid in California, has 10.8% of the state's Medicaid HMO market and 3% of the small but growing market for Medicare-Medicaid dual eligible plans. In its bid to acquire Care1st Health Plan, Blue Shield of California would increase the Blues presence in those markets by 2.8% in the Medi-Cal program and 5.5% in the duals sector. Care1st Health Plan offers two CMS dual-eligible demo plans and four Special Needs Plans for dual eligibles (D-SNPs) in California and brings a total of 580,797 Medicaid lives and 16,528 dual-eligible lives as of the May 2015 update in *DUAL: Medicare-Medicaid Dual Eligibles Database,* AIS's new online subscription product. According to *DUAL*'s Monthly Enrollment Tracker, however, Care1st duals enrollment has declined each month during 2015 from 22,751 in January. The health plan's Medi-Cal enrollment is also declining.

Health Plans Participating in California's Medicaid and Dual-Eligibles Markets

	Enrollment*	
Health Plan	**Duals**	**Medi-Cal**
AIDS Healthcare Foundation		842
Alameda Alliance for Health		236,011
AltaMed PACE	1,272	
Anthem, Inc.	8,914	1,099,472
Brand New Day	1,980	
Brandman Centers for Senior Care	102	
CA Health & Wellness (Centene)		169,374
CalOptima	12,793	730,747
CalViva Health Medi-Cal		306,869
Care1st Health Plan	16,528	288,953
CenCal Health		153,945
Center for Elders Independence	546	
Central California Alliance for Health		319,271
Central Health Plan of California	8,783	
Chinese Community Health Plan	4,437	
Community Eldercare of San Diego	373	
Community Health Group	5,569	240,658
Contra Costa Health Plan		157,914
Family Mosaic Project Medicaid		46
Fresno PACE for Seniors	66	
Gold Coast Health Plan		186,744
Health Net, Inc.	51,684	1,633,028
Health Plan of San Joaquin		296,090
Health Plan of San Mateo	10,879	112,985
Humana, Inc.	650	
Inland Empire Health Plan	23,784	1,028,878
InnovAge	100	
Kaiser Foundation Health Plan, Inc.	79,537	111,329
Kern Family Health Care		192,241
L.A. Care Health Plan	17,573	1,612,523
Molina Healthcare, Inc.	20,297	405,004
On Lok Lifeways	1,202	
Partnership Health Plan of CA		526,107
Redwood Coast PACE	34	
San Francisco Health Plan		118,297
Santa Clara Family Health Plan	6,873	222,183
SCAN Health Plan	12,714	10,898
Sutter SeniorCare	220	
UnitedHealthcare	14	
WellCare Health Plans, Inc.	12,401	

*Dual eligible enrollment as of May 2015; Medi-Cal enrollment as of first quarter 2015.

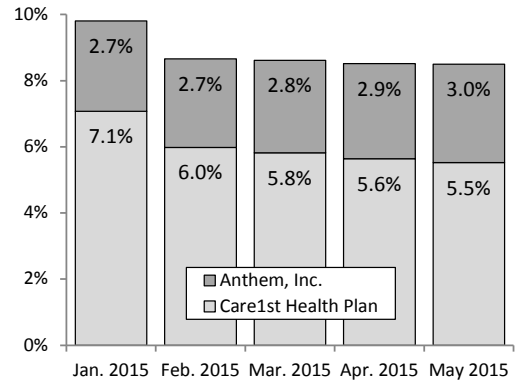
Medicare-Medicaid Dual Eligible Enrollees in California

BCBS Affiliation	Program Type	Jan. 2015	May 2015	Change
BCBS Entities	CMS D-SNP	832	498	-334
	CMS Duals Demo-CA	7,965	8,416	451
Non-Blues Entities	CMS D-SNP	179,036	167,375	-11,661
	CMS Duals Demo-CA	130,141	119,072	-11,069
	PACE	3,775	3,964	189

35% of California Insured Are In Medicaid or Dual-Eligible Plans

		Medicaid HMOs		Dual-Eligibles	
BCBS Affiliation	**Total Medical Enrollment**	**Enrollment**	**% of Medicaid**	**Enrollment**	**% of Duals**
Blues Plans	8,076,750	1,099,472	10.82%	8,914	2.98%
Care1st Health Plan	580,797	288,953	2.84%	16,528	5.52%
Other Non-Blues Plans	21,329,924	8,771,984	86.33%	273,883	91.4%

Anthem, Care1st Market Share in California Dual-Eligible Plans, Jan.-May 2015



SOURCES: Market share and impact calculated from the data in the following AIS databases: *AIS's Directory of Health Plans: 2015,* now available. Visit http://aishealth.com/marketplace/aiss-directory-health-plans to purchase or for more information. *AIS's Medicare and Medicaid Market Data: 2015,* shipping in June. Visit http://aishealth.com/marketplace/managed-medicare-and-medicaid-market-data for more information. *DUAL: Medicare-Medicaid Dual Eligibles Database,* an online subscription database and newsfeed from AIS. Visit http://aishealthdata.com/dual for more information.

Whistleblowers Target S.C. Blues Plan, Alleging MA Overcharges

A whistleblower lawsuit originally filed by the Department of Justice (DOJ) in conjunction with "relators" Jerald Conte and Catherine Brtva alleges that their former employer, Blue Cross and Blue Shield of South Carolina, and Medicare Advantage (MA) plans for which the Blues plan processes claims knowingly overcharged CMS via inflating risk-adjustment data. Specifically, the False Claims Act (FCA) suit in U.S. District Court in Columbia, S.C., charges that from 2006 to 2010 the defendants "improperly inflated the amounts" they were owed by millions of dollars per year.

The case is one of at least "a half dozen whistleblower lawsuits" filed since 2010 charging that MA plans are being overpaid because of inflated risk-adjustment scores, according to the Center for Public Integrity (CPI) news organization. DOJ no longer is pursuing this case directly.

S.C. Blues Denies Fraud

The South Carolina Blues, in its response to the suit late last year, acknowledged that there were some errors in submissions, but denied the fraud allegations and said that it has been working with CMS to correct the problems. The insurer's amended complaint, filed last July 30, has as defendants not just the South Carolina Blues, but also MA plan operators Instil Health Insurance Co. and Deseret Mutual Insurance Co. as well as the Blues plan's own Group and Individual Operations (G&I) unit. The Blues plan, which for many years has been a major claims processor for other insurers, submits diagnosis and procedure codes for eventual use in payment via CMS's controversial Risk Adjustment Processing System (RAPS).

The suit alleges "rampant fraud perpetrated by the Defendants" against Medicare "through the knowing submission, concealment and/or failure to correct member-related risk adjustment data." These actions, according to the complaint, led to CMS in February 2010 sending Deseret "a non-compliance email due to the alarming amount of RAPS duplicates" the Blues plan submitted on behalf of Deseret. That in turn led to Deseret asking the Blues plan to help it implement a corrective action plan within 14 days as CMS had requested, the suit said, and to findings of widespread risk-adjustment problems by the two relators, who had prominent roles in the South Carolina Blues' RAPS operations.

"In April 2010," the 71-page complaint alleged, "BCBS knew that the RAPS process was sending incorrect data to CMS, which would inflate the risk-adjustment scores for each Plan (G&I, InStil & Deseret) member." This then led CMS to assign higher risk-adjustment factors to the plans, resulting in "much higher government payments" than they were "entitled to receive," the suit added.

$20 Million in Inflated Payments Are Alleged

The relators said that "the defendants collected as much as 20 million dollars per year in improperly inflated payments from CMS" via these means. Conte and Brtva, according to the suit, informed their supervisors about the problems repeatedly, but the supervisors and the clients, which also received the information, did not inform CMS about the false data because they didn't want to have to reimburse large amounts of money. The defendants wanted to pay back just $2 million rather than $20 million, the suit alleged, and tried to change the data to support that.

When Conte acted himself to stop the inaccurate RAPS submission, "CMS became suspicious and began to notice an alarming amount of false submissions and duplicate entries submitted on behalf of Deseret," and sought reimbursement for all the erroneous submissions for 2009 and 2010, the complaint continued. Moreover, the Blues plan had not kept all the RAPS files it was supposed to under CMS rules and rejected Conte's recommendation to inform the agency about this, the suit contended.

The document also said that Conte was fired in December 2010 because of his "outspoken opposition to these illegal practices," while Brtva, like Conte a former Team Lead at the Blues plan and his successor in heading the RAPS project, was removed from the RAPS team and demoted. She resigned effective Aug. 5, 2011, the complaint added.

Their suit, which DOJ initially indicated it would join, seeks "the maximum amount" awardable to the relators under the FCA as well as treble damages and civil penalties for the federal government.

"We discovered some errors in the RAPS process, notified CMS and worked with CMS to identify and correct those errors," South Carolina Blues spokesperson Patti Embry-Tautenhan tells *The AIS Report* sister publication *Medicare Advantage News.* "In early 2014, we were contacted by the U.S. Attorney's office in connection with its investigation of this matter. We cooperated fully with the government's investigation and the government subsequently declined to take the case. The Relators chose to continue to pursue it and served us with an amended complaint last August. The discovery process is ongoing and trial is scheduled to take place per the court's order in January 2016. We deny the allegations and are vigorously defending the case."

She declines to comment further, but the Blues plan's 19-page response to the complaint filed with the court

last September said it "denies that it engaged in any unlawful or fraudulent conduct." The response said that Conte was just a contractor and never an employee of the plan. It added that the Blues plan "is not contractually required to determine whether codes are reimbursable, that codes are not submitted to RAPS based on whether they are reimbursable, and that risk-adjusted payment is not calculated on a per-code basis." Later the response said "it did not submit any RAPS submission claims."

The insurer "admits that Conte discussed potential RAPS problems with [his manager] Mark Buford and then unilaterally stopped all RAPS submissions on April 16, 2010, which Mark Buford subsequently approved…. BCBS further states that Conte did not know whether any customers but Deseret were affected when he stopped all RAPS submissions."

Insurer Said It Corrected All Errors Found

Trying to demonstrate that it also was attempting to fix the problems, the insurer's response contended that "multiple attempts were made to quantify any impact of the RAPS errors." The response added that the South Carolina Blues "expended significant resources to ensure that all erroneous submissions to CMS were corrected… and that CMS understood the basis for BCBS's later assessment of financial impact."

Then, focusing on the alleged violations of federal law, the response said, "BCBS further avers that Conte did not express to it any concern that the RAPS issues might implicate the False Claims Act." The insurer "admits that it addressed high numbers of duplicate submissions," the response said, but "duplicate submissions have no effect upon risk adjustments."

On the allegations about reprisals against the whistleblowers, the Blues plan said "Brtva was reassigned to another project in February 2011 because the work was more suited to her analytical skills and because her behavior as a team lead was disruptive." And "Conte's employer terminated him together with many other contractors due to budget reductions," the response asserted.

DOJ's lead attorney on the case, James Leventis, Jr. in Columbia, S.C., did not respond to two requests from *Medicare Advantage News* for an update about the case's status and the potential for a settlement before trial, and the plaintiffs' attorney, Jack Cordray, declined to comment to the newsletter.

Contact Leventis at james.leventis@usdoj.com, Embry-Tautenhan at patti.embry-tautenhan@bcbssc.com and Cordray at jack@cordraylawfirm.com. ✧

This article was reprinted from The AIS Report *sister publication* Medicare Advantage News. *For more information or to order, visit the MarketPlace at http://aishealth.com.*

Blues Plans Tap Technology for Televisits, Provider Search Tools

Blues plans contacted by *The AIS Report* are rolling out a wide variety of new provider payment models as well as improved technologies that allow members to do everything from comparing providers to making a doctor visit through a computer or mobile device. Here's a look at a few projects now in the Blue pipeline:

Anthem Touts Telemedicine

In late April, the Blues plan operator announced LiveHealth Online, a non-emergency telemedicine option for members in Connecticut. The program was launched late last year to certain segments of Anthem's membership. Participants can use their smartphone or computer to introduce a live video visit with a board-certified doctor. Doctors are available 24 hours, 365 days a year, including holidays, Anthem says. A LiveHealth Online visit costs $49 but because out of pocket expenses for Anthem member visits are calculated "real-time" at the start of the visit, many members will pay less, depending on their health plan benefits, according to a prepared statement. Moreover, Anthem is making a version of LiveHealth Online available to doctors in its provider network, starting with primary care organizations. ProHealth Physicians, Connecticut's largest independent primary care practice, will be the first medical group in the state to implement the Practice Edition. Anthem says it is in active discussions with several other large physician organizations across the state.

Capital Pilots Telehealth

The Harrisburg, Pa.-based company is piloting a remote monitoring system dubbed @home that can be used to track clinical changes in members with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and other chronic illnesses and intervene earlier to prevent unnecessary hospitalizations. Capital BlueCross recognizes that if given a choice, people would prefer to be home, so the company is focusing on meeting the needs of the consumer with technology that allows convenient connectivity through mobile devices where they are most comfortable. The pilot includes about 120 members. The Blues plan also has a telehealth program that allows members to securely connect with a licensed physician via web, mobile or telephone through a HIPAA-compliant tool, says Donna Lencki, senior vice president of consumer experience and chief marketing officer. Capital BlueCross also has launched a smartphone and tablet ready "search and save" function that members can use to access information about cost differentials between medical providers. Similar tools for dental and vision providers will be introduced later, she says. "Through

technology, it has become much easier for consumers to not only search for providers but also compare the costs of a procedure and find quality information. With widespread use of smartphones and tablets, fewer people are accessing such information through a laptop computer, so it is critical for us to provide this information in responsive design and in a way that speaks to customers across the age spectrum," she says. Members in their 20s, for example, want information quickly, but probably won't sift thought deep text. Baby boomers, by contrast, want more detailed information, but might want it in a larger font-size to make reading easier, she adds.

Arizona Blues Sees PCMH Results

Although the Blues plan says it works with a variety of accountable care organizations (ACOs) in the state, it's the company's patient-centered medical home (PCMH) care programs "that are making great strides," says Chief Medical Officer Vishu Jhaveri, M.D. Through the PCMHs, the health plan operator says it has seen reductions both in readmissions and multiple admissions. It also reports shorter hospital stays, increased primary care visits and higher adoption of preventive services. Among diabetic members, there has been a 27% reduction in emergency admits. More than 500 physicians participate now, and the Arizona Blues plan is looking to double the size of the network, says Jhaveri. The Arizona Blues plan also is gearing up to launch an enhanced suite of Web-based member tools designed to increase the understanding of health care costs and the choices available. The suite will consist of calculators, provider quality ratings, patient reviews and treatment timeline estimators, says Jhaveri.

Tennessee Offers New Wellness Tools

For the 2016 plan year, health plans sold inside and outside of HealthCare.gov will include access to new health and wellness services including online health risk assessments, self-directed health coaching and access to a 24/7 nurse line, says Kelly Paulk, director of product strategy. The company also is expanding and enhancing its BlueHealth Solutions suite of health and wellness products. For 2015, it launched telehealth, a lifestyle management mobile app and health management consulting. Through the year, it will release financial planning tools. For the 2016 plan year, the Tennessee Blues plan intends to introduce new wellness products and services including a diabetes prevention program. So far this year, it has released a number of new enhancements to its mobile-responsive website, BCBST.com, and its member mobile application, myBlueTN.

Contact Joe Butera for Lencki at joe.butera@capbluecross.com, Anne Christenson for Jhaveri at anne.christenson@azblue.com and Mary Danielson for Paulk at mary_danielson@bcbst.com. ✧

High Risk May Mean Rate Hikes

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With more complete demographic information about enrollees, and one full year of claims data, the Tennessee Blues plan says it is able to more accurately price its exchange-based products. The proposed rates would allow the carrier to operate on at least a "break-even basis" for those plans, meaning that the rate would cover only medical services and expenses, says spokesperson Mary Danielson.

Several factors drove the proposed rate increase:

◆ The number of young, healthy Tennesseans purchasing exchange-based coverage was less than projected to balance the risk pool.

◆ Many purchasers were much less healthy than expected, and the resulting medical care exceeded projections for this group.

◆ For every dollar received in premiums for individual coverage, BlueCross paid out $1.14 for medical care. When calculating for administrative costs and taxes, the company says it lost 35 cents on the dollar.

"In a very competitive business, we don't want to charge any more than is necessary. Even with this increase, we expect our premiums for 2016 to continue to be a very competitive option for consumers," Danielson says. For the 2015 plan year, the Tennessee Blues plan's rates for silver-tier PPO coverage ranged in price from $210 to $331 depending on the rating area, according to data compiled by AIS.

"We are not surprised to see significant proposed rate increases for 2016 given that next year will be the last year that carriers will have the full suite of 3R's protections to rely on and will likely be preparing for life without reinsurance and risk corridors in 2017," said Fidel.

A year ago, the Tennessee Blues plan enrolled about 135,000 people — nearly 90% of the state's exchange business. By the middle of 2014, however, the Blues plan's exchange business was running at an estimated loss of about $30 million, or a 110% medical loss ratio, including 3Rs protections, Fidel wrote. Without the 3Rs, losses would have been closer to $80 million for the first half of 2014. The company needed a rate increase of about 24% for 2015 to be profitable in the exchange, but settled on 19%.

The three-year risk-corridors program was designed to shield carriers that wind up with a disproportionate share of high-cost enrollees. Some conservative lawmakers labeled the program a bailout for health insurers. Tucked inside the so-called Cromnibus bill, which President Obama signed into law in December, was a provision requiring budget neutrality for the risk-corridors

program. CMS previously had indicated it would make up any shortfall. The loss of that financial cushion could translate to more conservative pricing for 2016 products.

CareFirst Seeks 26.7% Increase

For the 2016 plan year, CareFirst BlueCross BlueShield, which dominates Maryland's insurance market, is seeking an average 26.7% rate hike. CareFirst of Maryland Inc. and Group Hospitalization and Medical Services Inc. — both business units of CareFirst — requested an average 30.4% increase in the state, according to the Maryland Insurance Administration. By contrast, UnitedHealth Group's All Savers Insurance filed for a 3.2% rate reduction and Cigna filed for a 2.9% reduction. In Washington, D.C., CareFirst filed for a 7.8% rate reduction for its bronze-level HMO and is seeking an 18% increase for its gold-level HMO.

Wellmark: Costs Much Higher Than Expected

Wellmark Blue Cross and Blue Shield opted not to participate in public exchanges in Iowa and Nebraska, and will sit on the sidelines again in 2016. For individual ACA-compliant policies sold in Iowa outside of the exchange, the Blues plan operator is seeking to increase its average rate by between 26% and 28%. And in South Dakota, Wellmark is seeking a 43% rate increase, says spokesperson Traci McBee. The company says members who are enrolled in an Affordable Care Act (ACA)-compliant plan are using many more medical services for chronic and critical diseases than the company anticipated. The number of members with medical claims of more than $50,000 is 18% higher than anticipated. Moreover, the total volume of prescriptions is one-third higher than the baseline population, and the cost of prescriptions is nearly 50% higher than the baseline, according to Wellmark. The health plan operator notes that 135 people who enrolled in an ACA-qualified plan received "several million dollars in health care services" and then terminated coverage. The premiums received from those enrollees covered about 10% of the claims costs. Other members initially enrolled in a plan with rich benefits, but later dropped down to less expensive coverage after qualifying for a special enrollment period.

Iowa Insurance Commissioner Nick Gerhart last month said seven companies had applied to offer Iowans health insurance through the federal health insurance marketplace. Two health plan operators — Aetna Inc. subsidiary Coventry Health Care of Iowa, Inc. and Minnesota-based Medica Insurance Company have applied to sell their individual plans statewide. United Healthcare of the Midlands applied to sell its individual plans in at least 76 counties. Avera Health Plans and Gundersen Health Plan have applied to offer individual and small employer group plans for smaller regional markets, according to the insurance department.

Not All Blues Seek Big Hikes

Health insurers that intend to sell coverage through HealthCare.gov were required to submit rate proposals in May. Not all rate increases being sought by Blues plans are in the double digits, and proposed rates tend to be higher than those that ultimately are approved by the state. Premera Blue Cross, the largest player in Washington state with about 80,000 members, is seeking a 9.6% increase. Blue Cross Blue Shield of Vermont has requested an average annual rate increase of 8.4% above its 2015 rates, and Anthem, Inc.'s Connecticut subsidiary, which has nearly one-third of the market, requested a 6.7% increase.

Contact Traci McBee at mcbeets@wellmark.com, Fidel at scott.fidel@db.com and Danielson at mary_danielson@bcbst.com. ✧

NEWS IN BRIEF

◆ **While some health plan operators have blamed the Affordable Care Act (ACA) for financial problems, Arkansas Blue Cross and Blue Shield's 2014 revenue was more than 40% higher than in the previous year — from $1.4 billion to nearly $2 billion** — *Arkansas Business* said May 25. The health plan operator reported 206,000 new members who obtained coverage as a result of the ACA, Mark White, the Blues plan's CEO and president, told the newspaper. That pushed the Blues plan's overall membership up almost 40% to 626,471 in 2014, and allowed it to add about 200 jobs. See the article at http://tinyurl.com/k9ukagl.

◆ **CareFirst BlueCross BlueShield suffered a "sophisticated" cyberattack that compromised "limited personal information" of 1.1 million members,** the Maryland-based health insurer said May 20. The attack happened in June 2014, and was discovered as part of a general security review by Mandiant, a division of FireEye, Inc. CareFirst President and CEO Chet Burrell said in a statement on its website that hackers gained entry to a single database, accessing member names, birth dates, email addresses, subscriber ID numbers and website user names. But Burrell said the attackers did not access member passwords, Social Security numbers, medical claims,

NEWS IN BRIEF (continued)

or financial and employment information. Visit www.carefirstanswers.com.

◆ **Anthem, Inc. Chief Financial Officer Wayne DeVeydt said at the UBS Global Healthcare Conference that current economic conditions are favorable for the company to make an acquisition,** *Reuters* reported on May 19. The comment sparked more talk about the possibility of a major deal in the health insurance sector, which had recently centered around a possible purchase by Aetna Inc. "I like the pricing environment a lot and we have a lot of capacity to work with to do a cash transaction of meaningful size — and it would be transformative," DeVeydt said. Visit http://tinyurl.com/l5elazl.

◆ **A woman in California is suing Anthem for failing to cover the cost of expensive hepatitis C treatments,** the *Los Angeles Times* reported on May 18. Shima Andre alleges Anthem denied her request to pay the $99,000 Harvoni treatment because she did not have significant enough liver damage to warrant the drug. Visit http://tinyurl.com/lzrm46c.

◆ **A federal judge dismissed a class action lawsuit against Horizon Healthcare Services over a stolen laptop containing personal health information of more than 839,000 Horizon Blue Cross Blue Shield of New Jersey members,** according to a document published April 13 by Courthouse News Service. The judge said none of the defendants had demonstrated any injury stemming from the November 2013 theft and, as such, had no grounds to sue. Visit http://tinyurl.com/m7ffpdd.

◆ **Medicare star quality ratings have little impact on seniors' choices in Blue Cross Blue Shield plans,** according to data released by HealthPocket Inc. The April study found seniors paid little attention to star ratings, instead choosing plans based on brand familiarity, premiums, out-of-pocket costs and provider access. The Blues plans' branding power and wide variation in star ratings led HealthPocket to suggest seniors should be more aware of quality when selecting coverage. Visit http://tinyurl.com/prgseww.

◆ **The Indiana Supreme Court ruled that Anthem is entitled to coverage for the legal costs incurred while defending itself from challenges to its medical claims reimbursement practices,** according to a Law360 article on April 24. The decision mostly reverses a previous ruling for reinsurers Continental Casualty Co. and Twin City Fire Insurance Co. The original plaintiffs against Anthem alleged the carrier had purposely aimed to "systematically deny, delay, and diminish claim payments," which the court ruled are protected under Anthem's contract with the reinsurers.

◆ **Blue Cross of Northeastern Pennsylvania on May 18 said it will fund the distribution of naloxone, an anti-opioid, to local law enforcement.** Police officers can use the drug, which counteracts the effects of opioid overdose, in the field. The announcement comes on the heels of a report from the Pennsylvania State Coroner's Association, which found that nearly 2,500 people had overdosed in 2014. Visit http://tinyurl.com/m3pywqy.

◆ **UPMC claimed the loss of its contract with Highmark Health had little impact on its revenues,** the *Pittsburgh Post-Gazette* reported on May 14. UPMC reported $1.47 billion in patient services revenue, down from $1.48 billion for the same period the previous year. UPMC said it still plans to recover $143 million it claims Highmark owes for cancer services rendered to Highmark members. Highmark had previously agreed to pay all claims filed since January. Visit http://tinyurl.com/mnd9xet.

◆ **Anthem's reputation took only a slight hit following the massive data breach it announced earlier this year,** according to a May 11 article in the *Indianapolis Business Journal*. A survey conducted with more than 1,000 customers found 45% of respondents believed Anthem was a better brand than most other insurers, down from 51% before the breach was disclosed. Anthem managed to salvage the faith of 2% of respondents who favorably viewed Anthem's handling of the fallout. Visit http://tinyurl.com/lm5yo7u.

◆ **Blue Cross and Blue Shield of Illinois (BCBSIL), a unit of Health Care Service Corp., on April 29 unveiled four new accountable care organizations (ACOs).** The four ACOs incorporate more than 111,000 patients and nearly 3,000 physicians of Kane County Independent Physician Association, Alexian Brothers Health Systems, North Shore University Health System and Presence Health. BCBSIL now has nine ACOs. Visit http://tinyurl.com/l5b56n7.

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