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on Blue Cross and Blue Shield Plans

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Contents

3 BCBSNC Plans to Cut Already Low Admin. Costs 20% by 2014

4 *In Their Own Words:* BCBST CEO Says Focus Is on Individual Market

6 WellPoint's Net Income Up 4% in Second Quarter

7 In Setting Up ACOs, Hospital Contract May Be Sticking Point

7 IBC Gets a Facelift with Addition of Five Individual PPO Products

9 Four Blues Plans Turn to P4 Pathways Program to Reduce Cancer Costs

11 *Table:* Arizona, Wyoming Blues Plans Have Highest RBC Scores

12 *News in Brief*

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Report Assails Blues Plans' Giant Surpluses, Could Make Rate Hikes Harder to Justify

Framed by a setting of increasingly heavy regulatory scrutiny, Consumers Union (CU) released a report stating that nonprofit Blues plans have accrued billions of dollars in surpluses while simultaneously raising premium rates. As their sizeable reserves gain attention, Blues plans could run into even more difficulty justifying rate hikes, says one analyst. However, the insurers counter that financial reserves are not cash profits but rather a critical safety net for consumers — and even more critical in the wake of untested health reform laws that do little to reduce medical costs.

The report, *How Much Is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?*, released in July, states that seven of the 10 Blues plans surveyed "held more than three times the amount of surplus that regulators consider to be the minimum amount needed for solvency protection." At the end of 2008, nonprofit Blues plans held more than $32 billion in surplus, it states. The report further contends that some "financially strong" Blues plans with large surpluses are still seeking double-digit rate hikes.

And as capital levels are likely still growing, Carl McDonald, an analyst with Citigroup Investment Research, anticipates that Blues plans will make some changes to gain favor in the public eye. "[W]e think the Blues will lower forward rate increases, grant premium holidays, and make large charitable donations in order to help deflect public attention away from their sizeable reserves and try to mitigate any political fall-out."

continued on p. 10

Anthem's ACO Pilot Aims to Cut Costs and Improve Outcomes, but Hospitals Are Wary

While many are still struggling to get a handle on exactly what the designation "accountable care organization" (ACO) even means, WellPoint, Inc. subsidiary Anthem Blue Cross is putting the final touches on its own vision. The California insurer is collaborating with two medical groups/independent physician associations, Monarch HealthCare and HealthCare Partners, in a five-year ACO pilot project to be led by the Engelberg Center for Health Care Reform at Brookings and The Dartmouth Institute for Health Policy and Clinical Practice. While the insurer and provider groups are optimistic about the model, hospitals are apprehensive about such partnerships, which threaten to reduce admissions and take dollars out of their pockets.

The Anthem program is one of five such Brookings-Dartmouth pilots across the country.

Set to begin in January, the project aims to improve patient outcomes while lowering costs. Rome Walker, regional vice president and medical director of enterprise performance management at Anthem, explains that over the course of the five-year ACO pilot, groups of providers will transition to receiving a single global payment to cover health care for an entire population. He says the company is "taking things we learned in the HMO world and trying to apply them to the PPO world to better manage the health care of those PPO members."

continued

William Chin, M.D., executive medical director at HealthCare Partners, based in Torrance, Calif., says ACOs are created with three goals in mind:

◆ ***Reducing the cost trajectory for care,***

◆ ***Improving patients' clinical outcomes,*** and

◆ ***Improving patients' experiences.***

Achieving these three goals "requires a different care-delivery unit than the traditional office-based care we have had," he tells *The AIS Report*. Instead, hospitals, primary care physicians and specialists must work together to coordinate care.

According to Bruce Fried, a health care attorney at Sonnenschein Nath & Rosenthal who works on ACO legal issues, the current "business of medicine…too often does not value collaboration, coordination and efficiency." The ACO model "takes many of the behaviors that are valued and devalues them," he says. "So working in a stovepipe is not valued, doing unnecessary procedures is not valued, going at it your own way and not being part of a coordinated care system is not valued."

In the pilot programs with the two provider groups, members who already receive a significant portion of their care from one of the provider groups will be attributed — though not assigned — to that ACO. The outcomes of patients attributed to the ACO will be used to calculate shared savings.

Members can still see physicians outside the ACO and their benefits will not change at all. Anthem will send letters to members who have been attributed to an ACO in order to make them aware of the provider-insurer partnership. "In a perfect world," says Walker, "we would have a defined product and defined benefit plan for the ACO." But because the market moves so quickly, he says, the insurer for now will tailor the ACOs to existing benefits.

Each provider group will have more than 15,000 attributed members, which Walker says is regarded as the minimum needed for a successful ACO.

The risk for providers, says Walker, is that the ACO members stray from their ACO network. The outside-ACO visits will come out of the providers' payment, he explains.

Monarch and HealthCare Partners will run separate pilot programs, with distinct contracts and payment methods. Both groups are still in the process of finalizing their payment arrangements.

Providers' Risk to Increase Over Time

According to Jay Cohen, M.D., president and chairman of the board at Irvine, Calif.-based Monarch, his provider group will likely use a payment arrangement akin to a partial capitation system — meaning a portion of payments will be made on a traditional fee-for-service basis and a portion will be made to the ACO on a per-member per-month basis — for the first few years. The contract will move toward global capitation over the final years. The ACO will be eligible for bonuses based on performance metrics, as defined by Healthcare Effectiveness Data and Information Set (HEDIS) measurements. Cohen says this incentive arrangement has never been used in the PPO fee-for-service environment.

Cohen says he anticipates Monarch will take on a small portion of the risk for patients who go outside the ACO in the early years of the program. "In subsequent years, as we get more comfortable with this population, sharing data, and the ability to apply care coordination in the PPO environment, we'll take on additional risk," he says.

The attribution process will be fluid, he says. Patients who move out of the area or choose new providers will be attributed in and out as needed.

"We believe there will be substantial reductions in the cost trend from where we're currently running in the 8% to 10% range," says Cohen. "We think we can, over the course of the duration, take a percent or two or three out of that trend, toward the end of the project

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approaching CPI [i.e., the consumer price index], or slightly higher than CPI."

HealthCare Partners is still resolving payment issues with Anthem, Chin says, but it is not likely they will use a capitation arrangement in the first year. "The basic fee-for-service population is accustomed to doing what they want to do," he says. "To be at risk for that would presumptuous on our part." He asserts it is too early to comment on what the payment system will look like and how much risk the provider group will accept.

One major challenge, he notes, is that PPO patients may not be comfortable if they feel they are being directed to providers. And "individual fee-for-service doctors are kind of unaware of some of the things that are happening," says Chin. "There's a lack of understanding." Developing an effective communication strategy will be key, he says.

Stakeholders may not realize cost savings over the first year, says Chin. But down the road, better use of disease management and preventive care programs will lead to reduced hospitalizations and lengths of stay.

Chin says the provider group has been in "exploratory conversations" with several hospitals about being involved in the ACO, including Torrance Memorial Hospital in Torrance, Calif.

ACOs Could Shift Industry Paradigm

Considering the ACO model aims in part to reduce hospital visits, hospitals are understandably concerned (see story, p. 7).

Sally Eberhard, senior vice president of planning and development at Torrance Memorial, says, "There's a lot of promise without a lot of detail on how it will actually work. Overall we're encouraged that this might be an opportunity to reduce costs. We just lack details on how it will work, such as patient attribution and what choices patients will retain in the selection of physicians and hospitals."

Over the next five years, the pilot program could prove to be an indicator of monumental changes to come in the health care industry — or it could fizzle. Fried says the objectives behind the ACO model are lofty. "We're shifting the health care community from one paradigm to another," he says. "And that takes a lot of work."

"I think the key here is it's a pilot," says Chin. "There are multiple ACO pilots occurring throughout the country. We're trying to find the critical success elements for an ACO. It's evolving."

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BCBSNC Plans to Cut Already Low Administrative Costs 20% by 2014

Citing rising medical costs and increased competitive pressure, Blue Cross and Blue Shield of North Carolina unveiled plans to cut its administrative budget by 20% over the next three years. One analyst says a one-fifth trim is a "pretty high goal" considering the insurer's already low administrative cost percentage and high medical loss ratio.

BCBSNC President and CEO Brad Wilson circulated an internal memo about the companywide changes in July, stating 20% cuts were necessary by the end of 2014 "to keep us in the competitive ballpark." The company will take a number of steps to make the reductions, including "improving our processes, taking a careful look at our facilities and real estate, eliminating most open positions and carefully evaluating positions as turnover occurs."

Lew Borman, spokesperson for BCBSNC, confirms that the company is in the process of re-evaluating its real estate holdings. "We have considerable space in both Chapel Hill and Durham," he says. "We're looking at utilization — how much of that space do we use? Is there a way we can do things more efficiently?" Consolidation is not out of the question, he says. "We're putting literally everything on the table for discussion."

While layoffs are possible, Borman says it's too early to comment on the number of possible job cuts.

CEO Faults Reform Law

Shellie Stoddard, ratings analyst at Standard & Poor's, says a 20% cut seems like a "high figure." In early 2009, she says, "we saw some of the major companies doing reductions in force, taking employees out in order to save costs. And I don't think it was ever that high, at the 20% level."

For the first quarter of 2010, BCBSNC had a 7.07% administrative expense ratio, according to data collected by AIS from financial statements filed with the U.S. Securities and Exchange Commission and relevant state insurance departments. "That's really on the low side," says Stoddard, "so that would make me think that the 20% is going to be pretty tough." Many Blues plans had larger administrative expense ratios for the first quarter, such as WellPoint, Inc., which had a 15.82% ratio, and CareFirst BlueCross BlueShield, which had a 12.98% ratio. Of non-Blues plans surveyed, Coventry Health Care had the among the highest ratios, at 19.25%.

Despite its low current level of administrative spending, Wilson is "committed to the goal over several years," says Borman. "We will make it work."

continued

The memo also states that the health reform law's new insurance rules put greater pressure on the company's medical expenses and premiums. "Because of these rules, we face the prospect of a customer base that is less healthy and uses more services, with healthier people having an economic incentive to drop coverage," Wilson writes, though he does not specify the precise rules to which he is referring. The law does not do enough to address rising medical costs, he asserts. For that reason, another company goal is "to slow the increase in underlying medical costs by 2014 from the double digits to the rate of medical inflation, which was 4% last year."

Complying With MLR Will Be Easy

BCBSNC currently puts 87 cents on the premium dollar toward medical care, says Borman. Starting in 2011, the health reform law requires an 80% medical loss ratio for individual and small-group plans, and an 85% MLR for large-group plans. BCBSNC will not have a problem complying with that portion of reform, says Stoddard. That begs the question as to whether the memo was intended in part to make a political statement about the reform law, rather than outline the need for cutbacks. Stoddard says both explanations could apply.

A third company goal, according to the memo, is "for new, diversified business opportunities to account for 25% of our operating income by 2014." Last year, BCBSNC generated $17.5 million in operating income from diversified business; the target for 2014 is $85 million. Wilson mentions adding services such as vision coverage, payroll management and workers' compensation.

"We've seen other companies be pretty successful with diversified business," says Stoddard. "It's a common strategy among Blues plans." She notes that Highmark Inc. has done well by acquiring vision and dental companies, and that Health Care Service Corp. has a large life insurance business.

The North Carolina Blues plan's focus on administrative efficiency is not unique, says Borman. Most plans are heading in that direction, he says, but BCBSNC is "just saying that in a public manner."

Companies have been focusing on lowering administrative costs for several years now, says Stoddard. "The challenge will be when the tide reverses and employers begin hiring again." At that point, she says, keeping administrative costs at such low levels could be tough.

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In Their Own Words: BCBST CEO Says Focus Is on Individual Retail Market

The following interview is part of an occasional series by The AIS Report *that examines hot-button issues affecting Blues plans through the words of the industry's thought leaders. To suggest a topic or commentator, contact Liana Heitin at lheitin@aispub.com.*

The AIS Report caught up with Vicky Gregg, president and CEO of BlueCross BlueShield of Tennessee, to discuss challenges insurers are facing in light of the economy and heightened scrutiny, as well as where BCBST is headed in the post-reform climate.

The AIS Report: ***Where is the company focusing its efforts in terms of complying with health reform?***

Gregg: For us, like everyone else, it's been like drinking out of a fire hose. We're trying to take the bill and understand the pieces, and which one to do first. We're watching the regs as they're being formed to try to influence [them]. We've created our own office for health care reform. It's a team of seven people really dedicated to understanding what's in the bill, what the regulations are, what the issues are, what position to take on them.

We're directly working with various people through the NAIC [National Association of Insurance Commissioners], HHS and the Tennessee Department of Commerce and Insurance and through both the Blue Cross [Blue Shield] Association and AHIP [America's Health Insurance Plans] in terms of trying to influence how those [regulations] are ultimately propagated.

The AIS Report: ***What do you see as the major drivers of rising medical costs?***

Gregg: Technology is clearly one of the issues we deal with every day. There are new drugs, new procedures, new things coming out. It can be very good for people but it tends to add costs.

An underlying driver is unit price increases for hospitals, doctors and pharmaceuticals.…There are some instances [of cost drivers] on the utilization side, in particular the ancillary side and diagnostic [services].

It's interesting because the perspective in Washington is that it tends to be all about premiums. What we see is that a lot of businesses are self-funded — and premiums do not come into the equation.

And the economy has also been a problem.… As young people lose their jobs, they tend to go uninsured. People are staying on COBRA longer, which typically has claims costs of two to three times the average.

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The AIS Report: ***How are you addressing these rising costs?***

Gregg: In Tennessee, we're 44th overall for health status.…We tend to be overweight and smoke more than others nationwide. We're targeting those behaviors, trying to get people to be more active, make better choices in terms of lifestyle, what to eat and so forth. It's very important we work with physicians across the state. Primary care and medical homes are cornerstones in our perspective.

We're also embedding case managers into physicians' practices. It's a different model than you've seen in health plans historically. We work collaboratively with clinicians to do that.

And we're looking at our benefit designs to figure out how to use…[them] to reward people for the right things. We're doing a lot with consumer-driven health plans now — HSAs [health savings accounts] and HRAs [health reimbursement arrangements]. A significant portion of the population is moving into those arrangements, which make people more aware of what they're spending.

A lot has been talked about how we pay providers. Historically it's been all about volume. I'm married to a physician…and it's like a treadmill, trying to get patients through the office. That's fundamentally how the health system works.

We're doing a lot with pay for performance and moving into pay methods that reward quality over quantity.

The AIS Report: ***Are you experiencing increased scrutiny regarding premium increases? If so, how are you dealing with it?***

Gregg: In the individual and small group business, Tennessee is a file-and-approve state. So we've always gone through this type of procedure to file rates. The state engages outside actuarial consultants to look at the rates.…We continue to see that happening and obviously are getting more scrutiny now with all the visibility.

Over the last few years our department has done a good job questioning and pushing back and we'll continue to do so.

The rates filed with them [i.e., the regulators] are public information. The outside actuary reviews them, checks to make sure they're reasonable and looks for errors. We have an exchange back and forth and that's where we end up.

It's tough now. Even though everyone would love to have low single digits, that's not happening with the trends we're seeing now in the marketplace.

The AIS Report: ***How has health reform informed new product development? What kinds of new products are you considering?***

Gregg: There's incredible emphasis for us on retail in the individual market. Some of that is out of health care reform, and some, frankly, is what's happening in the economy. We see that more people, because they're self-employed or independent contractors, are looking for individual health insurance.

We're rolling out value-based benefits, and looking at targeting benefit design down to the individual. [For instance,] if I'm diabetic, I get a break on copayments and other things by showing compliance.

There's recognition of the importance and emergence of retail as opposed to the historical distribution through groups.…The exchange in 2014 will set up the ultimate retail market.

The AIS Report: ***How has technology played into your recent cost management and care coordination efforts?***

Gregg: We think the emphasis on administrative simplification, which is in the health care reform bill, has been somewhat overlooked. We became CORE [Committee on Operating Rules for Information Exchange] 2 certified and are beginning to try to take away some of the friction between providers and health plans.

We work with TriZetto, a technology company [in which BCBST holds a minority ownership stake], and frequently are their alpha to adopt lots of new products. We've been working for a while on real-time claims adjustments. We just put in the latest version of [the data exchange platform] CareAdvance, which gives us the ability to take the system and information, and have leverage at the point of care. As we integrate care management into the delivery site, we open up our information from CareAdvance to nurses and other clinicians caring for patients.

[BCBST's electronic health record platform] Shared Health has health records available on 3 million people — that's half the population here in Tennessee.…It aggregates information about our population. At the individual level it takes it to the point of care via the Internet. It has decision support, so when a patient shows up, the clinician can see …[the patient] may not have had a mammogram or colonoscopy or other preventive type of procedure.

It also gives physicians a population to use, so they can look at their population and how it's performing on HEDIS parameters. They know which patients are not compliant.

Contact Gregg through Mary Thompson at maryr_thompson@bcbst.com✧

WellPoint's Net Income Up 4% in Second Quarter

WellPoint, Inc.'s second-quarter financial results illustrate an "unanticipated upside" and emerging "steadiness" within the health insurance business that one analyst says have become a consistent trend across plans. But the strong financial results may have a political downside if insurers appear to be trying to reap excessive profits before many health reform provisions take effect.

The Indianapolis-based company reported July 28 that second-quarter 2010 net income rose 4% over the same period in 2009, to $722.4 million, or $1.71 per share. Net investment gains totaled $19.6 million after-tax, or 4 cents per share. WellPoint's per-share earnings were substantially higher than investment analysts' consensus estimate of $1.55.

For the second quarter of 2009, net income was $693.5 million, or $1.43 per share, with net investment losses of $38.0 million after-tax, or 7 cents per share.

Despite the strong results, WellPoint's share price fell 4% to $50.83 on July 28. Some analysts suggested that investors were disappointed by WellPoint's unwillingness to provide firm projections for 2011 financial results.

WellPoint President and CEO Angela Braly said the company's quarterly results exceeded expectations in part because claims from earlier quarters came in lower than expected, creating "favorable reserve development."

Operating revenue was $14.2 billion for the second quarter, a decrease of $1 billion, or 6.8%, from the previous year. The lower revenue figure was partly the result of the decision by one large municipal account with almost 900,000 members to convert from a fully insured to self-funded contract, noted Stifel Nicolaus analyst Thomas Carroll. Another factor was WellPoint's decision at the end of 2009 to transfer its non-Blues-branded Texas UniCare enrollment to Health Care Service Corp. *(The AIS Report 11/09, p. 5)*.

Joe Marinucci, ratings analyst with Standard & Poor's, says the results were "generally favorable," which is "consistent with the trend and consistent with what we've been hearing" from other insurers who've reported second-quarter results. "It continues with the theme of better-than-expected claims development."

WellPoint's medical membership totaled 33.5 million on June 30, 2010, down 343,000 members, or 1%, from the previous quarter. Last year at this time, membership totaled 34.2 million. Braly said in a July 28 conference call about earnings that the enrollment decline was in line with the company's expectation. The exit from the UniCare business caused some of the decline, as did in-group attrition at both the national and local group levels.

"There are still some pressures as compared with attrition over the past two years," says Marinucci, "but we're beginning to see some steadiness emerge."

Marinucci also points out that business has recently become more seasonal due to the increased prevalence of high-deductible products. Insurers perform better financially early on, because "consumers work through the deductible and become more claims-eligible toward the back end of the year," he says.

According to WellPoint's full-year 2010 outlook, net income is expected to be at least $6.30 per share, a 30-cent hike from the insurer's previous earnings target. Medical enrollment is expected to fall to 33.1 million at the end of the year, with 19.5 million self-funded members and 13.6 million fully insured members. WellPoint projected full-year 2010 operating revenue of $58 billion and a benefit expense ratio of 83.9%.

Federal and state regulators have targeted WellPoint for oversight in recent months. In late April, the California Department of Insurance found miscalculations in WellPoint, Inc.'s rate filing, and the insurer withdrew its up to 39% rate hike for individual plans *(The AIS Report 5/10, p. 1)*. The insurer re-filed for a 14% average premium increase in June.

According to a report by Carl McDonald, analyst with Citigroup Investment Research, "the lack of a rate increase in the California individual business negatively impacted earnings by about 15 cents per share this quarter."

The increased regulatory scrutiny was "impactful," says Marinucci. "In general, in states right now there's greater scrutiny overall. That's just part of being in a regulated business and partly due to the political environment."

McDonald says WellPoint was hit harder than any other publicly traded plan by the increased oversight. "The company's strong financial results probably won't help the situation, particularly given WellPoint's significant exposure to the individual business."

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In Setting Up ACOs, Hospital Contract May Be Sticking Point

Although accountable care organizations (ACOs) have won a lot of praise for their potential to improve outcomes and reduce costs, some industry insiders are skeptical about how they will work.

CMS is expected to issue regulations this fall for Medicare ACOs slated to start in 2012. But private-sector health plans and provider groups already have begun setting up global capitation models, shared-savings programs and other ACO-like entities (see story, p. 1).

"Everybody wants to be an ACO," said Joe Gifford, M.D., senior medical director at Regence BlueShield, the Washington state affiliate of The Regence Group, at a July 21 AIS webinar. "Accountable care sounds terrific, but from where I sit, I see big trouble."

He cited as a composite example a Seattle-area hospital system that failed in risk contracting in the 1990s and then returned to the comfort of costly fee-for-service arrangements, maximizing revenue in areas such as spine, oncology, transplant and robotic surgery services. Now, in 2010, the hospital wants to be an ACO. "I'm not sure how we'll get from here to there," Gifford said.

Regence today is in discussions with a few large provider groups over how to structure ACO contracts. One "sticking point," Gifford said, is how to include hospitals in the arrangement.

ACOs May Cut Hospitals' Revenue

The problem, he explained, stems from the principle that "there's no accountability if there's no downside risk." But that risk is a big issue for hospitals, since an "unspoken agenda" in many ACO structures is the need to achieve fewer hospitalizations and emergency department visits to succeed. ACOs need hospitals "to play" if objectives are going to be met, he asserted. But ultimately, Gifford claimed, the hospital CFO might say, "I'm gain-sharing because you've reduced hospitalizations of these sick people and I get a share of that, but wait a minute. Didn't I just lose the revenue from the hospitalization? How does this help me?" Gifford conceded, "I don't know how to answer him."

Another complication is that providers typically shy away from bundled payments. In theory, bundled payments provide downside risk, motivating the provider group to improve outcomes, Gifford said. "In all these discussions, I've never heard any entity think that bundled payments were any kind of a good idea unless they set the bar at or above the amount they're already getting." One option is to set up a bundled revenue-neutral payment for, say, bariatric surgery, and the hospital gets to keep the savings if they optimize care to encourage improvements. "It's a real baby step, but at least we go there," Gifford said.

Under Regence's working model, the population is segmented into four categories:

◆ ***The healthy or "walking well,"*** who receive targeted programs on wellness and acute needs.

◆ ***The chronically ill,*** who receive chronic condition management. Providers might receive an extra payment, say, $2 per-member per-month (PMPM), for additional care required for these patients.

◆ ***The "poly chronic,"*** who get a focus on intensive outpatient care. Regence might pay a larger PMPM for care management for these patients.

◆ ***The highly complex,*** who receive catastrophic care and case management.

Providers would receive the highest payment for keeping these patients relatively healthy.

"We think the real value is in keeping people from leaking from level to level," Gifford said, and in keeping patients at the top two levels out of the hospital.

Regence itself has launched a complex care medical home project that stemmed from a pilot with The Boeing Co. called the Intensive Outpatient Care Program (IOCP), Gifford said. The insurer pays a care-management fee to the medical group, which supplies care management, social work, pharmacy and other services to the sickest ambulatory patients. Savings (as compared against a control group) are shared 50%/50% with the provider.

The insurer also has begun adding gain-sharing provisions to hospitals contracts, under which the hospital, for example, would receive a bonus for reducing the complex imaging rate on certain procedures or for reducing ICU days while increasing palliative care days.

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IBC Gets a Facelift with Addition of Five Individual PPO Products

Facing erosion in the small-group market due to layoffs and employers reducing benefits, Philadelphia-based Independence Blue Cross added five new PPO plans July 1 to its individual product repertoire, which previously consisted of only HMO plans. One broker says IBC is reinventing itself in the wake of an

unrealized merger with Highmark Inc. But the new medically underwritten products will need alterations come 2014, when several market-changing provisions of the health reform law come into effect.

Brett Mayfield, vice president of sales for IBC, explains that there are three plan design options: copayment, deductible and health savings account (HSA). The plans are geared toward everyone under age 65, he says. Premiums for young males start at $75 per month. The plans include many of the same perks as group products, such as wellness incentives, fitness reimbursement and weight loss and smoking-cessation programs, he says.

"There's an option for everyone looking for first-dollar copay coverage or higher-deductible catastrophic coverage," Mayfield says. He adds that he thinks the HSA plan will be popular. "The lowest-priced product but with a savings account attached is an attractive one for the younger demographic," he says.

The PPO products differ from IBC's current HMO products in that they do not require referrals and include access to BlueCard, the nationwide network, making them "portable," says Mayfield.

IBC saw a clear gap in the market for the PPO plans to fill. Enrollment in group plans has decreased over the last couple years, says Mayfield. "The economy has had a significant impact on employers not being able to afford benefits," he says. Some employers are giving employees money to purchase their own insurance. People who are in between jobs, just out of college or coming off of COBRA coverage now that the federal subsidy is running out all need coverage as well. He notes that from June 2009 to June 2010, the company has seen almost 50% growth in individual products alone.

"We needed to have comprehensive products to offer those folks for a seamless transition" from a group plan to an individual plan, he says. "Obviously our competitors have these products as well."

IBC's only major competitor in the area is Aetna, Inc., says David Levy, employee benefits consultant with Leon L. Levy & Associates. Aetna recently overhauled its product line as well, says Levy. Over the last two years, IBC had been planning a merger with Highmark that did not pan out *(The AIS Report 2/09, p. 1)*. Levy says the insurer was likely going to come out with new products once the merger occurred, but given its failure the company "needed to reinvent themselves.…The same plans had been out there for five years now," he says.

The new plans are "health-reform compliant from a preventive care standpoint," Mayfield says, meaning preventive care costs nothing to subscribers for all three plan designs.

But come 2014, when the guaranteed-issue requirement and rating-band limits go into effect, the medically underwritten plans will need changing. "The way we price and rate will have to be different," Mayfield says. Under the reform law, rating variation can only be based

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on age — with a 3 to 1 ratio limit — and rating area, family composition and tobacco use — with a 1.5 to 1 ratio — in the individual and small-group markets, starting three years from now.

People with pre-existing conditions typically have had a 12-month waiting period for enrollment in IBC's individual plans. IBC recently added a few exceptions. Now, members transferring from another Blue Cross and Blue Shield plan will get a waiver on the pre-existing conditions waiting period. People coming from another carrier can have their exclusion period shortened, depending on how long they have had their current coverage. But that will change again in 2014 when the waiting period is limited to 90 days.

In 2014, state health insurance exchanges for individual and small-group plans will be up and running as well.

"We would obviously adapt [the plans] to whatever health reform requirements are necessary," says Mayfield. "I think the real change will be how they're marketed. If somebody has to go out to the exchange to purchase, I think it's set up perfectly for that." He says the plans are already being marketed on several different vendor sites, such as eHealth, that are similar to the upcoming exchanges.

Mayfield also points out that IBC already has a guaranteed-issue product because it's the state's insurer of last resort. And that puts the company in a better position to comply with reform than many others, he says.

So far, the plans are doing well, says Mayfield. "I don't have final numbers, but I can tell you we've probably almost exceeded expectations in terms of enrollment."

Contact Mayfield through Karen Burnham at (215) 241-3106 and Levy at (215) 875-8710. ✧

Four Blues Plans Turn to P4 Pathways Program to Reduce Cancer Costs

With an eye on providing its members cost-effective quality cancer care, BlueCross BlueShield of Tennessee has become the fourth health plan to adopt the P4 Pathways program. The other three plans using the program — Capital BlueCross, Blue Cross and Blue Shield of Michigan and CareFirst BlueCross BlueShield — are awaiting return on investment numbers but say preliminary estimates are promising, with savings stemming from improved patient outcomes, reduced emergency department and inpatient admissions and lower pharmaceutical spending.

The oncology treatment initiative standardizes care for certain cancers using evidence-based guidelines. P4 Pathways guidelines are "developed by regional physicians working together under P4 moderation," explains Jeffrey Scott, M.D., CEO of P4 Healthcare. The existing set of pathways is used as the "nucleus for each new payer regional pathways program," and then regional panels customize and update the guidelines, he tells *The AIS Report*'s sister publication *Specialty Pharmacy News.* They are subsequently updated quarterly.

Cardinal Health, Inc. in July completed the acquisition of Healthcare Solutions Holding, LLC — the parent company to P4 Healthcare, which is based in Ellicott City, Md. P4 says the acquisition is not likely to produce any material changes in how its programs are run.

Program to Expand in Years 2 and 3

"Cancer is the second leading cause of death in our state and has major health implications, physically as well as emotionally and financially, for our members," Terry Shea, Pharm.D., director of pharmacy services at BCBST, tells *SPN*. "Because there has historically been a large discrepancy between payment rates and the costs for acquisition of chemotherapeutic drugs, health care costs have risen exorbitantly." The P4 Pathways program "provides a way to deliver cost-effective quality health care without compromising the integrity or delivery of treatment."

For the first year the program is in place, it will provide pathways for breast, colon, lung and ovarian cancer and supportive care, all of "which represent nearly 85% of patients with a cancer diagnosis," Shea says.

In the second and third years, "the program will be expanded to several other solid and nonsolid tumors," he says. Ones under consideration, according to P4, include prostate cancer, multiple myeloma, chronic lymphocytic leukemia, mantle cell lymphoma, follicular lymphoma and large B-cell lymphoma.

Shea explains that physician participation is on a voluntary basis. "Practices will be measured not only on compliance but on a number of additional metrics that will be physician-driven."

Only patients starting chemotherapy or who have had a change in therapy will be eligible for the program.

In the first year of the program, treatment compliance — which is measured by data from claims and remittance files and is determined by the sum of all eligible patients — is considered 70%, with supportive care compliance at 80%. In the second year, compliance for both is 80%. Individual oncologists are judged on compliance, but it is the overall practice rate that is considered in determining reimbursement.

Noting the program has not yet begun, Shea declines to disclose estimated return on investment. However, he says, "We anticipate by encouraging providers to utilize

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generics according to evidence-based oncology pathways, significant savings will be assumed."

The insurer launched P4 on June 30 for providers who treat BlueCare Medicaid members, and will expand the program on Sept. 7 for providers treating BCBST commercial members.

CareFirst Was First Blues Plan to Use P4

The three other Blues plans using P4 Pathways have developed similar programs, starting with breast, lung and colon cancers and planning to expand to other types of cancer. All of the plans emphasize that physicians, not the insurers themselves, developed the guidelines based on medical evidence.

CareFirst spearheaded Blues plans' use of P4 Pathways just over a year and a half ago (*The AIS Report 2/10, p. 5*). Winston Wong, Pharm.D., associate vice president of pharmacy management at the plan, said at a Jan. 28 AIS webinar on oncology management that before the program started, the insurer was seeing 25% to 30% increases in oncology costs. Overall, CareFirst realized 12-month savings of $8.5 million using P4 Pathways. Asked if the insurer has realized a positive return on investment, Wong said "yes," the initial investment was less than $8.5 million. For the program's second year, five more cancer types were added, so Wong said he expects more savings to come.

Both Capital BlueCross and BCBSM adopted P4 Pathways in January.

Capital looked to Wong's P4 program at CareFirst in developing its own clinical pathways, according to Christopher Rumpf, M.D., vice president and chief medical officer for the insurer. "We took their early data as a sign. They were getting better patient outcomes, which resulted in reduced ER visits, reduced hospitalizations, reduced side effects from the chemotherapy and more savings on the drug side. That was enough for us," he says.

One of the challenges in developing a pathways program is "dealing with a diverse group of physicians," Rumpf says. "Not every physician agrees you can get to fairly specific guidelines around chemotherapy. It's always difficult having conversations with different groups of physicians and getting to an agreement on what's best practice." But in collaborating with P4, some of those physicians have come around, he says. As of now, about 60% of oncologists are involved in the program and the goal is to continue enrolling physician groups.

It's too early to calculate the return on investment, Rumpf explains. But down the line, "if we save 15%, we'll be happy with that."

BCBSM, unlike the other plans, does not contract with P4 directly but works with the physician-owned Oncology Physician Resource (OPR), which uses P4 Healthcare as a vendor.

Thomas Ruane, M.D., medical director for BCBSM, says one major reason for implementing the program was that historically "oncology fees have been related to a percentage of chemotherapy" administered, which incentivizes the use of expensive treatments. P4 helped the health plan "work on the fee schedule and produce the result that doctors would not lose money prescribing equally effective drugs that are less expensive."

The clinical pathways program was incorporated into BCBSM's physician group incentive program (PGIP). Ruane says BCBSM provided OPR with $2.5 million for administrative expenses and to distribute among participating physicians. "We realize you can't ask doctors to do a lot of work in the vague hope that someday they may save money.…We were willing to make that upfront investment as well as agree on future gain-sharing if the program does save money," he says.

Like executives at the other Blues plans, Ruane says it's premature to determine return on investment. "The very frustrating thing about these programs is that to genuinely track outcomes, it's a long-term process. Doctors have to believe what they're doing is the right thing for patient care and producing outcomes because it will be a while before they know for sure."

Oncology treatment is a challenge because it's "a moving target," says Ruane. "New drugs become available, old drugs go off patent protection and protocols change in more and less expensive ways." However, he says, the company is convinced "there's an opportunity for savings in terms of drug costs and improving treatment outcomes and decreasing treatment complications" through adherence to clinical protocols.

Contact Shea through Mary Thompson at maryr_thompson@bcbst.com, Rumpf through Joe Butera at joe.butera@capbluecross.com and Ruane through Debbie Reinheimer at dreinheimer@bcbsm.com. ✧

Blues Plans Defend Hefty Reserves

continued from p. 1

CU writes, "While maintaining sufficient capital on hand to deal with potential financial difficulties is universally acknowledged as an essential aspect of consumer protection, accumulating more surplus than is necessary may impose an unwarranted financial burden on subscribers."

McDonald's July 22 report reiterates how well Blues plans are faring. "By the end of this year, the nonprofit Blue Cross plans will hold more capital than ever before," it states. "By our calculation, the Blues now have a collective net worth more than $20 billion above regulatory requirements, which will make it difficult to justify rate increases next year that match cost trends,

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particularly since capital levels are likely to grow a lot more this year because of the favorable underwriting trends."

Bob Kolodgy, chief financial officer at the Blue Cross and Blue Shield Association, tells *The AIS Report* in a statement that Blues plans "maintain the appropriate reserves to provide a critical safety net" to members and ensure coverage during unforeseen disasters. "Because non-profit BCBS plans lack access to capital markets available to other companies, we rely on our own reserves to make the investments needed to increase efficiency and develop capabilities that help us better respond to increasing medical costs — a key driver of rising premiums," he says.

The National Association of Insurance Commissioners (NAIC) has implemented a system for regulating minimum surplus requirements but has not addressed maximum levels.

In particular, the CU report targets Blue Cross and Blue Shield of Arizona and Health Care Service Corp. (HCSC), saying the companies have surpluses that are seven and five times the regulatory minimum, respectively. It also states that both insurers have raised rates over the past three years.

According to the report, Blues plans "potentially could use portions of surplus to reduce the need for large rate increases, but evidence suggests that they do not use these large stores of capital to moderate premiums."

HCSC, a mutual insurer, claims that is a mischaracterization. "Although sometimes called 'surplus[es]' for accounting purposes, reserves are by no means extra cash or 'profits' that can be used for any purpose a company chooses," says HCSC spokesperson Ross Blackstone. "To the contrary, reserves are funds specifically set aside to cover risks and obligations for our member-owners."

Blackstone tells *The AIS Report* that HCSC's reserves total about $500 per customer. "That's less than the cost of an ambulance ride in many communities," he says.

BCBSAZ spokesperson Regena Frieden says the Arizona Blues plan has an amount in its reserve equal to six months of expenses. That is money set aside "to pay for unexpected health care claims and other expenses," she says, and is comparable to a family's savings account.

The CU report highlights Blue Cross Blue Shield of North Carolina as well, stating the insurer raised rates on some individuals and families more than 12% in 2010, while stockpiling about 4.5 times the regulatory minimum in surpluses. Lew Borman, spokesperson for BCBSNC, says financial reserves are necessary to allow the insurer to respond to a health crisis or natural disaster. "North Carolina State law *requires* reserve levels to be between three and six months of claims and administrative expenses, which is much larger than the regulatory minimum referenced in the report," he says. "Our 2009 year-end reserves represent 3.6 months of claims and administrative expenses."

CU recommends, among other things, that (1) states establish maximum ranges of surplus based on factors such as solvency risks, and (2) states analyze surplus as part of the review process for premium increases. The report says regulators should consider rejecting rate hike requests "when previously accumulated surpluses are sufficient to absorb potential underwriting losses." If a nonprofit plan's surplus is deemed "excessive," it states, the insurer should "spend the money for charitable purposes such as community health programs or affordable-coverage initiatives."

continued

Arizona, Wyoming Blues Plans Have Highest Risk-Based Capital Scores

Consumers Union looked at the surpluses, or financial reserves, amassed by 10 nonprofit Blues plans. The report notes that 200% of risk-based capital (RBC) is "commonly known as the minimum level of surplus that a health insurance company must hold." Below that level, the National Association of Insurance Commissioners (NAIC) takes regulatory action. The report also notes that BCBSA requires Blues plans to hold at least 375% RBC.

Blues Plan	Surplus in 2009 (in millions)	RBC score
Alabama	$694	497%
Arizona	$717.1	1,455%
Massachusetts	$723.9	724%
Michigan	$2,562.2	650%
Excellus BlueCross BlueShield (New York)	$965.1	542%
North Carolina	$1,423.8	911%
Regence BlueCross BlueShield of Oregon	$565.2	724%
Blue Cross of Northeastern Pennsylvania	$250.7	557%
Tennessee	$1,137.1	1,024%
Wyoming	$144	1,411%

SOURCE: Consumers Union, the nonprofit publisher of *Consumer Reports*. *How Much Is Too Much: Have Nonprofit Blue Cross Blue Shield Plans Amassed Excessive Amounts of Surplus?* Visit consumersunion.org.

Visit www.AISHealth.com/conflist.html to review a free, regularly updated six-month calendar with dozens of *Upcoming Health Business Meetings.*

Some contend that tampering with reserves right now could prove disastrous. "With the uncertain impact of guaranteeing coverage for these new individuals," says Blackstone, "now is not the time to consider cutting critical safety nets intended to protect consumers."

Kolodgy agrees. "To suggest that reserves should be reduced now, at a time when health care reform has created an untested and uncertain environment, would be reckless," he says.

Contact Kolodgy through Brett Lieberman at (202) 626-8625 or brett.lieberman@bcbsa.com, Blackstone at (972) 766-1735 or ross_blackstone@hcsc.net, Borman at (919) 765-3424 or lew.borman@bcbsnc.com and McDonald at carl.mcdonald@citi.com. ✧

NEWS IN BRIEF

◆ **Blue Cross and Blue Shield of Michigan will move 3,000 employees from Southfield, Mich., to downtown Detroit in 2011.** The BCBSM workers will relocate into 435,245 square feet in the GM Renaissance Center. According to the insurer's statement, the move will reduce BCBSM's real estate holdings by more than 400,000 square feet and save the company more than $30 million in real estate costs. The agreement by BCBSM, General Motors, the city of Detroit and other parties will also nearly double the downtown work force in Detroit. BCBSM will keep its Blue Care Network corporate headquarters in Southfield, but will sell its four-building campus in Southfield to a private firm. See the statement at tinyurl.com/2d2pggw.

◆ **Anthem Blue Cross and Blue Shield will refund $6 million to 45,000 members in Ohio after charging rates that were not consistent with those filed, according to the Ohio Department of Insurance.** The department's investigation, prompted by consumer complaints, determined that Anthem was charging policyholders rates that were inconsistent with those filed Nov. 6, 2009. Anthem entered into a consent order with the department at the end of June and also agreed to pay for expenses associated with the investigation and enforcement of the order. Erin Hoeflinger, president of Anthem's Ohio plan, said in a statement on the department's website, "Even though some members would have seen an increase in their premiums with this adjustment, Anthem has chosen not to issue those increases.…[W]e used the rates that we believed were in accordance with the new regulations." See the statement at tinyurl.com/2cflnxy.

◆ **The Missouri Health Insurance Pool (MHIP) contracted with Anthem Blue Cross and Blue Shield subsidiary RightChoice to run its new high-risk pool.** The federal government approved the state's proposal for such a pool, which will be subsidized by $81 million in federal funding under the health reform law, in July. To be eligible for the pool, Missouri residents must have a pre-existing condition and have been uninsured for at least six months. The pool will be available until 2014, when the guaranteed-issue health reform provision goes into place. This will be the second high-risk pool operated by MHIP in Missouri. See the Missouri Department of Insurance, Financial Institutions & Professional Registration statement at tinyurl.com/23wc74e.

◆ **PEOPLE ON THE MOVE: Leslie Margolin**, president of WellPoint, Inc. unit Anthem Blue Cross in California, resigned on July 20. She will lead Transforming Health Care, a coalition of health care providers, hospitals and consumer advocates. **Pam Kehaly**, a former Aetna Inc. executive, will take over for Margolin. Kehaly will start on Aug. 30. She had been Aetna's president of national accounts…. BlueCross BlueShield of Tennessee appointed **Jack Price** to the newly created position of chief security officer. Price joined the Blues plan in 2002 as a senior legal investigator. The Tennessee Blues plan also appointed **Hugh Kelley Riley, M.D.**, corporate medical director for the greater Nashville area. Riley is the former medical director for WellCare Health Plans Inc. in Tampa, Fla.…**Bryan Miller**, chief actuary for Blue Cross and Blue Shield of Kansas City, will serve on the board for the Missouri Health Insurance Pool, and.…**John DuMoulin** has joined the Blue Cross and Blue Shield Association's Federal Employees Program as executive director of the Office of Personnel Management and government relations. DuMoulin previously was a vice president at URAC.

◆ **CORRECTION:** The June 2010 issue of *The AIS Report* incorrectly cited Premera Blue Cross payments to the Blue Cross and Blue Shield Association during 2009. Premera's payments made specifically to BCBSA were not reported.

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