Efforts to Undo CSR Could Cause Blues to Increase Silver Rates, Enroll More in Gold

As the so-called insurers of last resort in many states, Blue Cross and Blue Shield plans could be hit especially hard if House Republicans are successful in eliminating federal cost-sharing reduction (CSR) payments, which reduce out-of-pocket costs for low-income people who buy health insurance through public exchanges. But the elimination of federal CSR payments could make richer coverage more affordable for those who qualify for advance premium tax credits (APTCs).

As of the end of 2015, more than half of those who purchased health coverage through a public exchange received CSRs, CMS says. According to the lawsuit (Case 1:14-cv-01967), which House Republicans filed in November 2014, the CSR program has illegally paid more than $5 billion in federal dollars to health insurers, which has been used to offset costs for their poorest members. On May 12, U.S. District Court Judge Rosemary Collyer — an appointee of George W. Bush — ruled in favor of House Republicans, who contend federal CSR payments to carriers have been funded without proper appropriation authority from Congress. Collyer’s decision came just one day after the May 11 deadline for submitting 2017 plan designs and rates for qualified health plans (QHPs) to be sold through HealthCare.gov.

Despite the ruling, nothing changes while this case is on appeal, notes Michael Adelberg, a former senior official in CMS’s Center for Consumer Information, now at

Focus on Customer Experience Could Help Blues Keep Members, Stay Off Front Page

High deductibles, tight provider networks and a substantial increase in non-group enrollment over the past few years all have contributed to members taking on a bigger role in their health care decisions. And that trend has pushed call volume higher, strained customer service departments and generated more complaints for some Blue Cross and Blue Shield plans. While executives tend to see customer service as an expense, it can be a health insurer’s most important point of contact with its customers.

A brief stroll through the Twitter-verse turns up a lengthy list of grumbles against Blues plans:

◆ “After 12 hours of attempts and several hours-long holds, I am finally on the phone with an actual human being at BCBS.”

◆ “Heading into hour 3 of this phone call w/ BCBS and I know 2 things for certain — the US health care system is broken & hold music is the devil.”

◆ “BCBS won’t approve my walker until I leave the hospital & see my [doctor], though he called it in.”

◆ “Just found out my Blue Cross plan will no longer cover the diabetic testing supplies I’ve been using for years.”

◆ “Ok BCBS, this pre-authorization for meds is getting insane. Why do you think the doctor prescribed it in the first place?”

continued
“I’ve come to expect so little in the way of customer service that whenever I actually receive it, I’m blown away.”

Being told that coverage for a medication or procedure has been denied after being prescribed by a doctor, or that authorization is needed, “is one of the most confounding things to a consumer,” says Ingrid Lindberg, a consultant and speaker, who previously was Prime Therapeutics, LLC’s first customer experience officer — a title she says she pioneered a decade ago at Cigna Corp. “If you are serious about fixing things for the consumer, you have to look at the drivers of these huge call volumes, which then end up on the front page when people start complaining about wait times.” Prime is a pharmacy benefit manager owned and operated by 13 not-for-profit Blues plans. Lindberg says most Blues plans are just beginning to change their philosophies around customer service.

‘One and Done’

Improving customer service isn’t difficult once the senior management team decides to do it. But there typically needs to be a sizable investment in time and staff, and a commitment from the top. A carrier’s chief financial officer (CFO) will want to know what it’s going to cost and they don’t like rough estimates. But you don’t know what it will cost to turn around a customer service department until you dive into the process, says Bob McVey, former vice president of contact center operations at Prime. While such a transformation can take several years, it can pay for itself over time either through an improved customer experience or increased first-contact resolution, which means a company eventually needs fewer reps, he explains.

The first step is to determine the type of service currently being delivered, rather than the service that the insurer wants to offer. And that step alone can take several months. While at Prime, McVey says he listened to a lot of phone calls and determined that the customer service department was making the customer do the work. “The customer should only call us once. Our mission statement was ‘one and done.’” He adds that it’s important to have educated reps who have access to tools that can help them quickly answer member questions. And reps must have a certain level of empathy.

To reduce incoming calls, sometimes outbound calls need to increase. Rather than telling a member that they need authorization from their doctor for a prescription, Prime’s customer service team now contacts the member’s doctor, then notifies the patient once it has approval. That change helped push first-call resolution from 60% to almost 80% and saved the company nearly $2 million last year. “It was a huge change, and we saw almost an immediate improvement in customer satisfaction,” says McVey.

Blue Cross Blue Shield of Vermont has the same philosophy. “In every instance, we aim to take the member out of the middle and resolve their inquiry on first contact in a compassionate and knowledgeable way,” says Catherine Hamilton, Ph.D., vice president of consumer services and planning. The entire company, not just the customer service department, is focused on the member experience, she says. “It’s a mission commitment to putting members first that permeates everything that we do as a company,” she explains.

BCBSVT Gets ‘World Class’ Ranking

The Vermont Blues plan’s call center handles more than 250,000 calls a year. Early this year, it was recognized for having the nation’s best performing call center among small/mid-sized member service organizations. The award, from the consulting firm Service Quality Measurement (SQM) Group, evaluates first-call resolution and employee satisfaction and engagement. The insurer also received World Class Certification, which is available if 80% of surveyed customers indicate their issue was resolved with one call, and that they were very...
satisfied with the customer service representative with whom they spoke and were very satisfied with their overall experience, according to a prepared statement from the Blues plan.

The Blues plan manages its resource allocation to account for the volume of calls to avoid extended wait times. “We use a composite work mix to determine call-center representative resource needs and monitor that on a regular basis,” she says. “We also have technology in place for real-time holds so people don’t have to wait in queue. Instead they can get an estimated hold time and the option to receive a call back while keeping their place in line.”

The Vermont Blues plan touts a 12% turnover for its customer service staff — about half the industry average. A modest retention bonus — based on performance metrics that focus on consumer satisfaction — is paid out twice a year. Reps go through a one-hour-long coaching session each month along with weekly staff meetings that offer coaching and development. Individual coaching sessions include customer survey feedback as well as results from listening to calls.

**Five Questions for Ingrid Lindberg**

After leading the transformation of Cigna’s consumer experience division more than a decade ago, Lindberg says there was interest from several Blues plans that wanted her to do the same thing for them. She wound up being hired by Prime, which works with its owner plans, as well as with employers, managed care plans and other PBMs, to coordinate care for more than 26 million members. As a Prime employee, all 13 Blues plans could benefit from her expertise. Lindberg spent three years with Prime before becoming an independent consultant full time. McVey calls her “the best in the business.”

เพชร The AIS Report: Customer service is an area where Blues plans, as well as most other insurance carriers, tend to fall down. Is that changing?

**Lindberg:** Most Blues plans are just starting to really attack these deep-seated problems. I actually received an email from my Blues plan today reminding me to go in for my annual check-up and to call if I needed anything. But I had my annual check-up more than 60 days ago. This is a perfect example of how insurers can over-communicate because they don’t have their data streams lined up correctly. Health plans spend a lot of time pushing information out, but it’s not actionable or usable. And sometimes that generates a phone call to a customer service agent who doesn’t know anything about that information or why it was sent. That just causes more confusion on the part of the consumer. When we use the term customer service, we generally mean just the contact center and the people who answer the phone. I see this as more of a customer experience issue, which includes all of the different channels.

**The AIS Report: There are so many ways for health plans to connect with the consumer today. Does that improve customer service or just create more challenges?**

**Lindberg:** I spoke with someone on an airplane who had been on hold for an enormous amount of time with a Blues plan. While listening to the hold music, he got an auto-prompt notifying him that there was no wait time on Snapchat. A customer who can’t find the answers online, waits 45 minutes on the phone and then is told the insurer is offering something like Snapchat….That flies in the face of all things rational. Social media is there to answer rapid-fire questions. It’s not there to supplement your basic channels of communication. And many plans are skipping that.

**The AIS Report: Is customer service still viewed as a cost center?**

**Lindberg:** Think about the ecosystem of customer experience. It’s all the communication channels (web, paper, contact center). The call center is still seen as a cost lever in a lot of cases. People immediately ask why we can’t just push customers to go online. But you can’t force people to go online if you’re not investing in your online resources to make it easy to find an answer.

Health insurance is a negative service industry. Nobody cares to interact with a health plan until something goes wrong. When they have to have an interaction, there is an opportunity to make a positive impression, and perhaps ensure that the consumer will choose you again next year. Why on Earth would you blow it? I’m fascinated by how few plans have done the work around customer lifetime value so they understand how long they have to retain a customer before they become profitable. If you look at a contact center as a cost-cutting opportunity, it is one of the most narrow-minded decisions that you can possibly make as a CFO. But we’re getting to a point where leaders within these plans are starting to understand that enrollment is what covers their paycheck. That is new. For so many years, health plan executives saw employers as paying their paycheck.

**The AIS Report: When a health plan contacts you, what are they hoping you can fix?**

**Lindberg:** A lot of health plans are trying to become customer centric. That is the top call I get. The work we did at Cigna was transformational. I explain that it is a five-year business transformation journey as well as a cultural transformation journey. It’s not a matter of changing your mission statement and slapping it on the wall.

**The AIS Report: Is there anything that Blues plans can learn from retail companies such as Zappos or Amazon?**

continued
Highmark Sues, Says Feds Owe $223M in Corridors Payments

On May 17, Pennsylvania-based Highmark, Inc. became the first Blues plan operator to sue the federal government over money owed through the risk-corridors provision of the Affordable Care Act (ACA). According to the complaint, which was filed in the U.S. Court of Federal Claims, Highmark and its subsidiaries should have collected $222.9 million in risk-corridors payments for the 2014 calendar year. To date, CMS has paid $27.3 million of that total. After filing the suit, Highmark President and CEO David Holmberg told the Pittsburgh Post-Gazette that he has since been contacted by other carriers about the case. Highmark sells coverage in Delaware, Pennsylvania and West Virginia.

The three-year risk-corridors program is part of the so-called 3Rs — along with risk adjustment and reinsurance — and was designed to shield insurance carriers that wind up with a disproportionate share of costly enrollees through the public insurance exchanges. The program was designed to be funded by carriers that wound up with a healthier mix of enrollees. But health insurers contributed just $362 million for the 2014 calendar year. About one-eighth of the $2.87 billion that carriers requested. Some insurers assumed CMS would make up any shortfalls, but a catch-all budget bill passed by Congress and signed by President Obama in late 2014 required the program to be budget-neutral. Some observers say carriers could have a case if they can show the government knew the program wouldn’t be budget-neutral when they entered it. The risk-corridors and reinsurance programs sunset at the end of 2016.

Before filing the suit, Highmark pursued “all avenues to enforce the government’s obligations,” according to spokesperson Lynn Seay. Those efforts included meeting with Obama administration officials, CMS leaders and federal legislators. The company also sent a formal demand letter requesting payment. “We are committed to having the government honor its statutory, regulatory and contractual obligations to Highmark and its health insurance affiliates that agreed to offer plans on the exchanges as set forth in our complaint,” she tells The AIS Report.

On April 1, the Pennsylvania-based company reported a 2015 operating loss of $565 million, which it attributes primarily to higher-than-anticipated medical costs among people enrolled in its exchange products. Highmark’s exchange members are an average of seven years older than its commercial members, and many have multiple comorbidities, according to the company.

As of Feb. 25, Highmark says 195,000 people in three states signed up for individual coverage on or off the public exchanges — down from about 350,000 (The AIS Report 5/16, p. 4).

CO-OP Was First to Sue

Early this year, Oregon-based Health Republic Insurance Co., which is winding down operations, filed a $5 billion proposed class-action lawsuit against the federal government for violating section 1342 of the ACA, which established the risk-corridors program. Health Republic, a Consumer Operated and Oriented Plan (CO-OP), had about 15,000 group and individual members before it was forced to close last fall. The insurer determined it is owed more than $7 million through the risk-corridors program for 2014, and estimates it is owed at least $15 million more for the 2015 plan year. Twelve of the 23 CO-OPs that received funding through the ACA have been liquidated or are winding down operations. The 11 that remain collectively lost nearly $400 million in 2015, according to a March 3 research note from Credit Suisse.

Many CO-OPs collapsed last fall after CMS disclosed it would pay carriers just 12 cents for every dollar they requested via the risk-corridors program. Health Republic’s lawsuit goes beyond CO-OPs because hundreds of carriers were negatively impacted by the risk-corridors program. The suit was filed in the U.S. Court of Federal Claims by the law firm Quinn Emanuel Urquhart & Sullivan, LLP. All carriers that sold QHPs and had allowable costs that exceeded 103% of their target amounts could be a part of the class.
Seay notes that the Health Republic case is distinct from Highmark’s case because the CO-OP is no longer operating.

On May 3, Iowa Insurance Commissioner Nick Gerhart filed suit against HHS and CMS in U.S. District Court in Iowa. The suit contends the agencies “unlawfully withheld millions of dollars owed to CoOportunity,” a CO-OP that went into liquidation in early 2015. That company is owed $130 million through the risk-corridors program.

The Iowa Insurance Division had discussions with the federal government over several months, but was told by the Dept. of Justice that “further negotiations would be futile,” Gerhart said in a prepared statement. The federal government loaned $147 million to CoOportunity to capitalize the new entry, which sold coverage in Iowa and Nebraska. The disagreement centers on the federal government’s position that they have “super-priority” ahead of all other creditors, including those with federal government over several months, but was told by the Dept. of Justice that “further negotiations would be futile,” Gerhart said in a prepared statement. The federal government loaned $147 million to CoOportunity to capitalize the new entry, which sold coverage in Iowa and Nebraska. The disagreement centers on the federal government’s position that they have “super-priority” ahead of all other creditors, including those with

Seay says the money owed to Highmark through the risk-corridors program hasn’t negatively impacted premium rates for Highmark’s ACA products. But she says the company has changed some of its product offerings for 2017 to offset the risk of exchange enrollees. Those changes include fewer products, narrower networks, higher premiums and lower reimbursement for certain providers.

“Unlike previous years, we now have access to information that better informs our predictions. Based on this information and further actuarial insight, we have made a number of decisions to account for the reality of rising costs in the ACA market. This move is in no way related to Highmark’s current financial situation or the content of the litigation, but a key component of our goal to stabilize this marketplace,” she explains.

For more information about Highmark’s complaint, visit http://tinyurl.com/hbg8fma.

Contact Seay at lynn.seay@highmarkhealth.org.

Minn. Blues Fined $90K for Not Explaining Single vs. Family Costs

Blue Cross Blue Shield of Minnesota says it is taking corrective action to ensure two-person families understand the potential out-of-pocket cost differences between family policies that include a shared deductible and single-coverage high-deductible plans.

On May 4, Minnesota Commissioner of Commerce Mike Rothman ordered the Blues plan to pay a $90,000 penalty for not adequately explaining that two-person families might be better off financially with separate individual policies, which cost the same, include identical coverage, but have substantially lower annual deductibles. An investigation was launched after a married couple complained that their policy required them to pay more than $3,000 more to meet the annual deductible than they would have if they had been covered by single-person individual policies.

In his consent order, Rothman said 1,526 two-member households had enrolled in individual family policies — with either a $9,000 or $10,400 annual deductible — through the Minnesota Blues plan. Annual deductibles for single-person plans are half as much, $4,500 or $5,200. Of the two-member households that obtained family coverage last year, only 144 had a change in family size.

In response to a query from The AIS Report, the Minnesota Blues plan says it has reviewed the consent order and intends to work with customers who decide to switch from family coverage to individual plans.

As part of the agreement, 352 two-member households will be reimbursed the difference in deductibles between family coverage and the combined deductible they would have paid under two single-deductible plans. The Blues plan also must identify two-person households that purchased family coverage for 2016, and notify them that they have the option of switching to two single-deductible plans with the same benefit levels. In agreeing to the consent order, Blue Cross does not admit wrongdoing.

Coverage for two-person families represents a “very small subset of our individual business,” according to the Blue plan. “The circumstances leading to plan selection vary depending on each situation, and there are situations under which a non-embedded deductible is preferred for families of two,” according to the company.

See the consent order by visiting the May 25 From the Editor entry at The AIS Report’s subscriber-only Web page: www.aishealth.com/newsletters/bluecrossblueshield.

Contact Laura Kaslow for the Minnesota Blues plan at laura.kaslow@bluecrossmn.com or Ross Corson at the Minnesota Dept. of Commerce at ross.corson@state.mn.us.
Wellmark Partners With Systems For Exchange; NM Blues to Re-enter

After sitting on the sidelines for the past three years, Wellmark Blue Cross and Blue Shield will sell individual and small-group coverage through HealthCare.gov when the open-enrollment period begins Nov. 1. For its new exchange products, the Blues plan operator collaborated with local health systems — Mercy Health Network and University of Iowa Health System — to create two separate insurance companies. Both collaborations will offer individual and small-group HMO plans on and off the exchange in Iowa with coverage beginning in 2017, explains spokesperson Traci McBee. Members will use each respective health system’s local network for health care services, she tells The AIS Report. While Wellmark also sells coverage in South Dakota, it will not operate on that state’s exchange.

For existing individual Affordable Care Act (ACA)-compliant policies in Iowa, the Blues plan operator is seeking to increase premiums by 38% to 43% for the 2017 plan year. The proposed increase would impact 30,000 people. Last year, Wellmark says it spent an average of $1.27 on health care for every dollar in premiums it took in for that group. About 10 percentage points of the proposed rate increase is tied to just one member who is receiving $1 million in care each month to treat a severe genetic disorder. “These life-saving drugs are making a difference in the life of this member, as well as many others, however they come at a cost we all must absorb,” McBee says.

Another 90,000 Wellmark customers covered by non-ACA-compliant “grandmothered and grandfathered plans” will likely see smaller increases. The company will file those rates on June 8. McBee says the medical trend for that group is “notably lower” than for its individual ACA-compliant group.

N.M. Blues Jumps Back In

After dropping out for the 2016 plan year, Blue Cross Blue Shield of Mexico, a subsidiary of Health Care Service Corp. (HCSC), filed to sell coverage through the state-run exchange for the 2017 plan year, according to the New Mexico Office of Superintendent of Insurance (OSI). The Blues plan filed to sell individual HMOs, a catastrophic plan and an individual multi-state plan — as well as small-group PPOs and HMOs, Lisa Reid, director of OSI’s Life and Health Division, tells The AIS Report. The weighted percentage increase request for the individual HMOs is 83%, according to OSI.

But that increase is from the 2015 rate, notes HCSC spokesperson Mark Spencer. Looking only at the percentage increase, he says, can be misleading without looking at the actual premium amounts. “It’s the actual dollar amounts that people will pay [in premiums and out of pocket] that’s most relevant.”

OSI will have to approve the submissions before they can be offered on the exchange, she says. He cautions that no final decisions have been made about the

Network Wars: Health Plan Strategies to Protect and Defend In-Network Contracts

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Blues plan’s 2017 offerings, but says the company expects them to be competitively priced.

The New Mexico Blues plan was unable to reach an agreement on rate increases with the OSI last summer and decided to discontinue its exchange products. The Blues plan, which covered about 35,000 people through the exchange, said it lost $19.2 million on that product line and sought an average 51.6% premium increase for its 2016 Qualified Health Plans (QHPs).

Under the ACA, once a carrier leaves a market, it must wait five years before being allowed to re-enter. While the Blues plan stopped selling coverage through New Mexico’s exchange last year, it continued to offer an individual bronze option outside of the exchange, so it was not considered to have left the individual market, Reid explains.

Contact Reid at lisa.reid@state.nm.us, McBee at mcbeets@wellmark.com and Spencer at Mark_D_Spencer@bcbsil.com.

Blues Plans Seek Big Rate Hikes For Public Exchange Plans in 2017

State insurance departments are just beginning to release rate proposals from carriers that intend to sell coverage on public exchanges for 2017. So far, Blues plans, along with the majority of other carriers, are seeking rate hikes, often in the double digits.

In Virginia, 10 carriers proposed 2017 rates, with average increases ranging from 9% to 37%, according to information released April 27 by the Bureau of Insurance. CareFirst, Inc., which operates Blue Cross and Blue Shield plans in Maryland, northern Virginia and Washington, D.C., requested an average increase of 32.6%, ranging from a low of 2% to a high of 91.9%.

In Washington, D.C., CareFirst cut its individual product offerings from 15 this year to seven for 2017. The company requested that rates for its PPO plans remain flat and proposed a 13.3% increase for its HMO plans. On the small-group side, CareFirst is seeking average rate decreases of 4.4% for its PPO products and no overall change for its HMO plans.

In Maryland, CareFirst BlueChoice Inc. is seeking a 12.4% increase for its individual products and a 2.9% increase for its small-group products. CareFirst of Maryland Inc. and Group Hospitalization and Medical Services Inc. proposed a 16% rate increase for its individual products and a 7.4% hike for its small-group products.

Here’s a rundown of rate requests from Blues plans in other states:

◆ New York: Insurance carriers are looking to boost premiums for individual products by an average of 17%, and by 12% for small-group, according to the New York Dept. of Insurance Services. Empire BlueCross BlueShield is looking to boost premiums for its HMO by 24%, while Excellus BlueCross BlueShield filed for a 15.9% increase for its individual products and a 12.3% increase for its small-group products.

In a May 18 statement, the New York Health Plan Association called the increases “necessary to maintain financial stability of New York’s market,” adding that the rates are justified based on the particular circumstances of each plan.

◆ Oregon: An analysis of 2015 financial results determined that Oregon’s seven largest insurers lost $171 million on the exchanges, according to Jake Sunderland, spokesperson for the Oregon Insurance Division. Bridgespan Health Co., a subsidiary of Blues plan operator Cambia Health Solutions, Inc., is seeking an 18.9% rate increase for its individual products. Regence BlueCross BlueShield, also part of Cambia, requested a 17.9% rate increase for its individual products, but wants to reduce its small-group premiums by 2.9%. Premera Blue Cross subsidiary LifeWise Health Plan is pulling out of Oregon after doing business in the state for more than two decades, the company said April 21. The carriers that sold 2016 coverage through Oregon’s state-run insurance exchange collectively signed up 147,000 people, according to preliminary data compiled by AIS.

◆ Vermont: On May 11, Blue Cross Blue Shield of Vermont said it asked the Green Mountain Care Board to allow it to boost rates for its individual products by 8.2%. The Blues plan said the increase was primarily driven by higher medical expenses among people who bought coverage through the state’s exchange and the rising costs of pharmacy and medical care. Following its review, the Green Mountain Care Board is expected to issue a final decision on QHP rates in mid-August.

◆ Washington state: Health plan operators that intend to sell individual coverage in Washington this fall have proposed an average rate increase of 13.5%, the Office of the Commissioner of Insurance reported May 16. Thirteen carriers collectively filed 154 individual health plans for 2017 coverage to be sold inside and outside of the Washington Healthplanfinder exchange. Nine of the 13 insurers intend to sell individual plans inside the exchange.
Illinois Blues Plan and Oncology Group Form Intensive Medical Home

Two long-time partners recently launched a new oncology program to better manage patient care. Blue Cross and Blue Shield of Illinois (BCBSIL) and Illinois Cancer Specialists (ICS) are collaborating on what they say is the first oncology intensive medical home pilot program in that state. The Illinois Blues plan is part of Health Care Services Corp., which operates Blues plans in five states.

ICS, which is in The US Oncology Network, “has been a partner of ours for a long time,” says Lee McGrath, senior director, provider network strategy for BCBSIL, and the group has provided “excellent quality of care for our members.”

For its part, “ICS chose to work with BCBS because the organizations were very aligned in improving community-based oncology care,” says Brian Field, director of managed care for The US Oncology Network. “We approached them because they were already working on a medical home project in another specialty. We also pursued this with BCBS because of the influence in the Chicago market, as well as their place in our practice market share, [where] they are second behind only Medicare. We feel in an era to drive quality, outcomes and value that the specialist market, specifically oncology, can drive improvement. After sharing our program and resources available to us, BCBS felt we could make that difference as well.”

Crohn’s Pilot Has Promising Early Results

The Blues plan has other intensive medical homes, and its first specialty one was a pilot for Crohn’s disease with the Illinois Gastroenterology Group that was launched in late. Early results have been promising: Cost of care declined by 10% over the first 10 months of the program, and there was a 57% reduction in hospitalization payments and a 53% drop in emergency room payments.

McGrath clarifies that the “goal of a patient-centered medical home and an intensive medical home are the same: managing and coordinating the care of a patient.”

But with a patient-centered medical home, “there is a governing body that says you have to do these 10 things, and now you’re a PCMH.”

BCBSIL members eligible for the oncology intensive medical home are those who are receiving chemotherapy or hormone therapy and have a diagnosis of breast, colon, lung, pancreatic or prostate cancer or non-Hodgkin’s lymphoma. Those conditions were selected because they “are the most prevalent at that practice,” explains McGrath. BCBSIL “looked at our claims” and is partnering with ICS “based on who they are seeing...We want to make sure we’re covering as many patients as we possibly can.”

The groups are hoping to enroll 150 to 200 patients per year. Enrollment is not automatic, though. According to Field, “We must first educate the patient about the program, and secure a signed consent and share that with BCBS.” Enrolled patients will be in the program for six months at a time and will be treated at one of the 10 ICS locations. If treatment needs to be provided for a longer period of time, McGrath says those members can continue in the program. “We want to support patients in any way possible.”

McGrath says that BCBSIL has been talking with other oncology practices about other pilots. In fact, in April the plan signed an agreement with one that she did not disclose at this point.

‘Very, Very High Compliance’

At ICS, “our goals are quite simple,” Field tells AIS sister publication Specialty Pharmacy News. “The program is designed to help meet the needs of patients, payers, and providers. We have sought to improve efficiency and quality by following evidence-based medicine, leading to the development of a patient-centered, value-based cancer care program.” The providers are following the National Comprehensive Cancer Network’s NCCN Guidelines. “Our goal is to provide evidence-based validated, outcome-driven patient care,” says Field.

McGrath says the Blues plan is looking for a “very, very, very high” percentage of compliance with the guidelines, but she notes that it will never be 100%. A “big differentiator” between care provided through the pilot and care that a member normally would receive is ICS’s use of a nurse care manager (NCM), says McGrath. This is an oncology certified nurse who can proactively manage patients.

According to Donna Krueger, clinical services administrator at ICS, “There is one care manager for all sites, and she is an employee of ICS.” The NCM, also known as a supportive care nurse (SCN), “is responsible for following up with all patients receiving chemotherapy (IV or oral) for the six major disease types chosen.
Krueger says that “If the patient is having a problem that the SCN feels needs additional medical attention, she contacts the patient’s primary care site for further intervention. Examples include dehydration, fevers, inability to eat or protracted nausea or vomiting. These patients are brought into the office for intervention, which can often eliminate the need for an ED visit or an inpatient hospitalization. Education is also a high priority to help patients from getting into these situations — for example, discussing the need for good hand washing and staying away from sick people when their white blood cell counts are low, calling with fevers greater than 100.5 degrees, etc.”

Contact McGrath through Kristen Cunningham at kristen_cunningham@bcbsil.com and Field and Krueger through Christy Sullivan at christy.sullivan@usoncology.com.

This article was excerpted from the May 2016 issue of Specialty Pharmacy News. For more information or to order, visit the MarketPlace at www.AISHealth.com.

**AIS Survey Data Finds Individual Membership Up for Blues**

BCBS plans reported membership in individual (non-group) commercial plans of 9.07 million, and non-Blues plans reported individual membership of 7.59 million, in the just-completed survey conducted for AIS’s Directory of Health Plans: 2016, now available online. This represents a 3% and 6% increase, respectively, over individual enrollment reported in the 2015 edition of the Directory*. In the small-group market, Blues membership totaled 7.45 million and non-Blues plans reported 6.9 million, a 5% and 11% increase, respectively, over small-group membership reported in the 2015 edition. However, about a third of plans did not provide small-group enrollment data in the 2015 edition. Among plans reporting in both years, 42% of Blues plans reported lower small-group enrollment in 2016, for a 25% net decrease, while 27% of non-Blues plans reported lower small-group enrollment, for a 7% net decrease over 2015.

**Change in Individual, Small-Group Membership, Blues vs. Non-Blues, 2015–2016**


BCBSA: Specialty Drug Spending Jumped 26% From 2013-2014

In the commercial insurance market, about $450 billion was spent on prescription drugs in 2014, according to a report released by HHS in March. Between 2013 and 2014, drug spending jumped 12.6%, the highest annual increase in a decade. Much of the increase is due to specialty pharmacy, which increased 26% ($87 per member, per year) between 2013 and 2014, according to a report released May 12 by the Blue Cross and Blue Shield Association. The findings are based on a sample of 70.5 million commercially insured Blues plan members.

Currently, there are no data to show whether the higher spending on specialty pharmacy has reduced medical costs in other areas, such as shorter hospital stays. “We are very interested in exploring how pharmacy might be able to do something along value-based payment… so that we can see utilization patterns,” says Trent Haywood, chief medical officer for BCBSA.

The report also found that drug spending was 17% higher in the non-group market when compared to members with employer-sponsored coverage. As a group, Haywood says members who purchased coverage through the public insurance exchange were sicker than anticipated.

Hep C Spending Spiked 400%

Spending on drugs to treat hepatitis C spiked 400% between 2013 and 2014 with the introduction of Sovaldi and Harvoni. Treatments for that condition accounted for one-third of the overall increase in specialty pharmacy. Since 2014, competing drugs have hit the market, which has helped drive down costs. “Drug pricing for hepatitis C [drugs] is still pretty high overall. But in that situation, having competition did allow for some negotiation around how you come up with pricing that is much more affordable,” Haywood tells The AIS Report.

The report also determined that the use of oral and self-injectable specialty medications has been on the rise due to advancements in technology. Also boosting spending is an increase in “pharmatization” of specialty drugs where health plans move existing medications typically billed through the medical benefit to the pharmacy benefit to improve the management of those medications.


Contact Robert Elfinger for Haywood at robert.elfinger@bcbsa.com.

Loss of CSR Would Impact Rates

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FaegreBD Consulting in Washington, D.C. He says the timing of the ruling suggests the judge was “looking to contain the market upset of this decision as the higher court considers the merits of the case and her opinion.”

The case highlights another legal question: whether the House has legal standing to file suit against the administration.

While APTCs are mandatory under the Affordable Care Act (ACA), the language of the statute appears to indicate that CSRs must be funded by a specific act of Congress each year, explains Christopher Condeluci, a principal at CC Law & Policy in Washington, D.C. Condeluci worked for the Senate Finance Committee during the drafting of the ACA. While Congress never appropriated funds for CSR, the Treasury Dept. still made payments to carriers, which could prove troublesome for the administration if the appeals court and/or the Supreme Court chooses to decide the case on the merits, he adds.

House Energy and Commerce Committee Chairman Fred Upton (R-Mich.) on May 4 subpoenaed HHS, demanding the agency turn over documents regarding the CSR program. The documents, according to Upton and House Ways and Means Committee Chairman Kevin Brady (R-Texas), have been sought for more than one year.

Subsidies Would Increase

The ACA established APTCs to help offset the cost of premiums for people with annual incomes of between 100% and 400% of the Federal Poverty Level (FPL). Similarly, CSR dollars are paid directly to insurance carriers and used to reduce out-of-pocket expenses (e.g., deductibles, copayments, coinsurance) for members who purchase silver-tier plans and have annual incomes of between 100% and 250% of the FPL. But health plans must provide CSR protections to their poorest members regardless of whether the carriers are reimbursed by the federal government.

By cutting out-of-pocket costs, CSR payments increase the actuarial value (A/V) of silver plans from 70% to 73% for enrollees with incomes between 200% and 250% of poverty; to 87% for those with incomes between 150% and 200% of poverty; and to 94% for individuals with incomes between 100% and 150% of poverty, according to Tim Jost, an emeritus professor at the Washington and Lee University School of Law. For someone earning 100% to 150% of the FPL, CSR payments reduce the annual deductible for a silver plan from about $3,000 to just $221, according to research from the Kaiser Family Foundation.

Web addresses cited in this issue are live links in the PDF version, which is accessible at The AIS Report’s subscriber-only page at http://aishealth.com/newsletters/bluecrossblueshield.
APTCs are pegged to the second-lowest-cost silver plan in each market. A ruling to stop federal CSR funding would prompt carriers to increase premiums for silver-tier plans by an average of $1,040 per person, according to estimates from The Urban Institute. The higher premiums would translate to larger APTCs for all exchange enrollees up to 400% of the FPL, not just those who qualify for CSRs. The higher premiums would mean silver-tier plans, which must have an A/V of 70%, could wind up being more expensive than richer gold-tier plans, which must have an A/V of 80%, explains Linda Blumberg, a senior fellow at the Urban Institute. Such a ruling could add 400,000 newly insured to the exchanges by making richer gold-level coverage more affordable.

“Some of those who decide not to enroll in a silver-tier plan with a 70% A/V because the deductibles and co-insurance seem too high for them would be willing to spend the same percentage of their annual income to enroll in gold-level coverage that has lower cost-sharing requirements,” she explains. “It could increase enrollment among the uninsured with annual incomes between 200% and 400% of the FPL.” An additional $3.6 billion in federal dollars would need to be spent on APTCs per year, she estimates. On net, however, enrollment in the exchanges would decrease by about 1 million people, since some of those not eligible for APTCs would start purchasing coverage outside the exchanges instead of inside them, she adds.

**Ruling Isn’t Likely to Stand**

Industry observers contacted by *The AIS Report* expect the ruling will be overturned by an appeals court. If it’s not, it likely would head to the Supreme Court. If the court decides to hear the case, the court would probably overturn it, given the existing make-up of the court’s judges.

Blumberg says the *House v. Burwell* case doesn’t have the potential to cataclysmically disrupt the insurance markets the way that the *King v. Burwell* case would have if the Supreme Court had ruled against the administration (*The AIS Report* 7/15, p. 12). Such an outcome would have led to a potential collapse of the non-group insurance market.

However, the uncertainty created by another legal case tied to the insurance exchanges could cause Blues plans and other carriers to consider leaving a market that continues to be plagued by uncertainties, she adds.

Contact Jost at jostt@wlu.edu, Condeluci at chris@cclawandpolicy.com, Adelberg at michael.adelberg@faegrebd.com and Blumberg at lblumber@urban.org.

**NEWS IN BRIEF**

- Independence Blue Cross is offering a college tuition benefit to employer clients, the insurer said on May 18. By registering children, stepchildren, grandchildren, nieces and nephews, workers can accrue rewards that are applicable to up to one year of tuition at more than 350 institutions nationwide. The credits are supplied by the schools themselves and members do not incur any costs. Visit http://tinyurl.com/z6ept25.

- Anthem, Inc. on May 18 revealed a 6,500-square-foot “Innovation Studio” in Atlanta. The new space is open-concept and will feature a “multi-disciplinary team” focused on leveraging data and technology to improve consumer experience, advance quality of care and reduce costs. The insurer said it has a “sophisticated method” for advancing innovative ideas through workshops and “pitch days.” Promising ideas will be developed through the Innovation Studio. For more information, visit http://tinyurl.com/jolh4nn.

- Highmark Health is working to integrate behavioral health through a partnership with Quartet, the insurer said on May 13. The tech company will help primary care physicians identify members who might be in need of mental health services, and provide doctors with resources in connecting those patients with appropriate care. Highmark is piloting the program in Western Pennsylvania before rolling it out to its entire network. For more information, visit http://tinyurl.com/jx1kh3.

- Triple-S Management Corp. is attempting to withdraw from the U.S. Virgin Islands but might be obligated to stay, at least temporarily, the *St. Croix Source* reported on May 13. Lt. Gov. Osbert Potter said he won’t approve the withdrawal until the company finds another insurer to assume its debts and take over for its policyholders. The Virgin Islands Blues licensee will stop offering health insurance plans Aug. 1, after physicians began refusing to accept the company’s insurance due to long delays in payment. The *Source* reported that the problem worsened when Triple-S was forced to upgrade its systems last year. Triple-S also agreed to a $3.5 million HIPAA settlement with HHS in November. Visit http://tinyurl.com/zyxnkbq.
NEWS IN BRIEF (continued)

♦ An Oklahoma patient and his proton therapy cancer treatment facility are suing Blue Cross Blue Shield of Oklahoma (BCBSOK) for denying care for his prostate cancer, NewsOK reported on May 11. The facility claims the Health Care Service Corp. unit owes it more than $75,000 and says that the treatment had been covered prior to April 2015. The patient, Randy Farland, says he would be cancer-free if he had been provided coverage. BCBSOK declined to comment. For more information, visit http://tinyurl.com/h4gpqet.

♦ Blue Shield of California is taking action against the country’s opioid problem, Southern California-based radio station KPCC reported on May 10. The insurer is employing prior authorizations to prevent patients from getting dangerous dosages of the painkillers, and is also lowering the dosage that requires doctors to seek approval before prescribing. The new dosage was identified by the Centers for Disease Control and Prevention as the threshold that puts patients at a higher risk of overdose. Visit http://tinyurl.com/jxrdj6f.

♦ Cigna Corp. cautioned investors on May 6 that its proposed acquisition by Anthem, Inc. may not close until next year. In its first-quarter earnings report, the company said that “in light of the complexity of the regulatory process and the dynamic environment, it is possible that such approvals may not be obtained in 2016.” Anthem CEO Joe Swedish has maintained that the deal is on track to be completed in the expected timeframe. Visit http://tinyurl.com/jqxxs5l.

♦ Anthem struck a deal with Sequenom, Inc. for in-network coverage of its prenatal genetic tests for certain plans in some states, Sequenom said on May 3. The tests will be covered for expecting mothers with average-risk or high-risk pregnancies in Georgia, Indiana, Kentucky, Missouri, Ohio, Virginia and Wisconsin. The company said that its non-invasive tests provide “early patient management information” to doctors and families. Visit http://tinyurl.com/z3vgnjl.

♦ Highmark is offering up to $5.5 million in compensation for physicians addressing the problem of unconfirmed diagnosis codes, the insurer said on May 3. The funds are an extension of Highmark’s previous diagnostic code initiative, which pushes primary care physicians to complete documentation for a certain percentage of their patient panel in Medicare Advantage or exchange plans. The program applies to 2,800 Pennsylvania doctors and 200,000 Highmark members. Visit http://tinyurl.com/z5kedgd.

♦ California regulators last month hit Anthem Blue Cross in California with a $415,000 fine for customer service violations and failure to respond to inquiries from the Department of Managed Health Care (DMHC). The department cited the insurer for failures in responding to consumer grievances and explaining claims denials, and also for failing to respond to DMHC’s requests for information in a timely manner. In a letter, the agency said it had accepted Anthem’s corrective action plan. Visit http://tinyurl.com/hdunyb4.

♦ An investigation into customer complaints by the North Carolina Dept. of Insurance (DOI) could result in substantial fines for Blue Cross Blue Shield of North Carolina, The Charlotte Observer reported May 4. The investigation was triggered by more than 1,000 formal customer complaints and thousands of calls (The AIS Report 3/16, p. 3). Many of the complaints are related to overbilling and an inability to confirm coverage, particularly among those who signed up for coverage through the state’s federally run insurance exchange. The DOI, which is expected to conclude its investigation by the end of May, could fine the carrier up to $1,000 per day for each customer wronged, according to the newspaper. The Blues plan will then have 30 days to respond. Contact Ryan Vulcan for the North Carolina Blues plan at ryan.vulcan@bcbsnc.com.

♦ Anthem Blue Cross of California was fined $415,000 for failing to identify, process and resolve enrollees’ grievances, the California Department of Managed Health Care (DMHC) said May 4. DMHC says it identified 40 cases involving 83 violations where Anthem deprived members of their grievance and appeal rights. Anthem has 90 days to provide a detailed report about the corrective actions it has taken to resolve the issues. Grievance programs are supposed to assist consumers in resolving issues with their health plans. To resolve those issues, Anthem has provided additional training to its staff and has implemented a new tracking system to reduce delays with the grievance and appeals system, says spokesperson Darrel Ng. Contact Ng at darrel.ng@anthem.com.
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