Welcome to the
Spring HMO
Administrative Forum
2013
Welcome and Introduction to the Program

Margaret Scott
Sr. Manager, Network Management
Federal Government Relations Update

Jill Wolowitz
Federal Government Relations
## Affordable Care Act - Regulations

<table>
<thead>
<tr>
<th>Key Regulations</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Health Benefits (EHBs)</td>
<td>Issued; additional guidance required</td>
</tr>
<tr>
<td>Actuarial Value (includes AV calculator and methodology)</td>
<td>Issued; HHS clarification needed</td>
</tr>
<tr>
<td>Insurance Market Rules</td>
<td>Issued; additional guidance required</td>
</tr>
<tr>
<td>Rate Review</td>
<td>Issued</td>
</tr>
<tr>
<td>QHP Certification Templates</td>
<td>Issued</td>
</tr>
<tr>
<td>OPM Multi-state Plan</td>
<td>Issued</td>
</tr>
<tr>
<td>Payment Notice (3Rs and other payment-related provisions)</td>
<td>Issued</td>
</tr>
<tr>
<td>Employer and Individual Mandate/Rules</td>
<td>Proposed</td>
</tr>
<tr>
<td>Federal Exchanges (FFE and state partnerships)</td>
<td>Proposed; additional guidance expected</td>
</tr>
</tbody>
</table>

Health Care Reform: Are You Ready?
Affordable Care Act - Exchanges

- 3 flavors of Exchange:
  - State-run (17 States + DC)
  - Federally Facilitated (26 States)
    - Partnership (7 States)
- Key features
• Medicaid Expansion
  • Last week, federal officials approved a limited number of States to allow low-income earners to receive Medicaid funds to buy health insurance from private plans as long as it does not cost the government more than the traditional Medicaid program (versus expanding government-run Medicaid, the health program for the poor)

• Impact on Premium for Some
Affordable Care Act – Blue Cross and Blue Shield

• We intend to offer a broad array of products on and off Exchanges.

• All on-Exchange plans will also be available off-Exchange.

• Additional plans will be offered Off Exchange to providing a variety of competitive options for consumers-
  • Each state will have a selection of unique plans to fill out the specific portfolio needs of that state.
  • We will also develop additional plans to minimize member migration disruption.
• State of the State
  February 6, 2013

• Budget Address
  March 6, 2013
Welcome to the Big Top!

98th General Assembly
January 9, 2013
Health Care Reform: Are You Ready?

D - r

40 - 19
D - r
71 - 47
Legislative Highlights to Date

- General
  - Guns
  - Budget
  - Same Sex Marriage
  - Pensions

- Health care
  - Medicaid Expansion
  - Exchanges
Spring HMO Admin Forum
Sales & Marketing Outlook
3 April 2013

J. Todd Phillips
Vice President - Local Markets
IL Sales & Marketing Leaders

Karen Atwood  
President  
BCBS of Illinois

Kevin Cassidy  
National Accounts

J. Todd Phillips  
Local Markets

## Net Growth Results

<table>
<thead>
<tr>
<th></th>
<th>Feb 2012 – Jan 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Group</td>
<td>14,000</td>
</tr>
<tr>
<td>Large Group</td>
<td>35,000</td>
</tr>
<tr>
<td>National</td>
<td>200,000</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>249,000</strong></td>
</tr>
</tbody>
</table>
## YoY Growth performance

<table>
<thead>
<tr>
<th>Membership</th>
<th>as of 12/31/2010</th>
<th>as of 12/31/2011</th>
<th>as of 12/31/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Group</td>
<td>744,000</td>
<td>710,000</td>
<td>727,000</td>
</tr>
<tr>
<td>Large Group</td>
<td>1,240,000</td>
<td>1,216,000</td>
<td>1,219,000</td>
</tr>
<tr>
<td>Municipals</td>
<td>375,000</td>
<td>382,000</td>
<td>380,000</td>
</tr>
<tr>
<td>Labor</td>
<td>1,022,000</td>
<td>1,042,000</td>
<td>1,049,000</td>
</tr>
<tr>
<td>National</td>
<td>2,551,000</td>
<td>3,128,000</td>
<td>3,190,000</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>5,932,000</strong></td>
<td><strong>6,478,000</strong></td>
<td><strong>6,565,000</strong></td>
</tr>
</tbody>
</table>
2013 Sales & Marketing Priorities

- Continued growth
- Transactional efficiency
- Consultative partnership
HCSC Corporate Strategy

Group

Government

Retail
What are our customers asking?

- Why is healthcare so expensive?
- How can I lower my healthcare spend?
- How can I make my employees more productive?
- What impact will the ACA have on my business?
- What is my role in the ACA?
What else is happening in the marketplace?

- Provider consolidation
- Distribution uncertainty
- Old competitors want to grow
- New competitors are nipping at our ankles
- Employers are more knowledgeable than ever
- Members don’t know who to trust
Worry not – BCBSIL will win!

- Stable, experienced team
- Industry-leading solutions
- Strong partners that support our efforts
- Dedication to the community at large
- Commitment to doing what’s right for our members
HMO Network Management Update
April 3, 2013

PRESENTED BY: Donna Levigne,
Divisional Vice President
Network Management

This presentation is a high-level summary and for general informational purposes only. The information in this presentation is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.
Beyond the Horizon
Agenda

- Blue Medicare Advantage
- Medicare/Medicaid Alignment Initiative (MMAI)
- Exchange
- Commercial HMO 2014
• Launched Blue Medicare Advantage HMO effective January, 2013
  ▪ Narrow Network in 4 counties

• Fine tuning MA operations

• Focus on Plan performance
  ▪ Care Management
  ▪ Documentation and Coding
  ▪ Quality Performance

• Exploring 2015 PPO product offering
Medicare/Medicaid Alignment Initiative (MMAI)

Provide coordinated care to 136,000 Medicare-Medicaid enrollees in the Chicagoland area and throughout central Illinois beginning October 2013

- Innovative payment and service delivery model to improve coordination of services for Medicare/Medicaid enrollees
- Enhance quality of care and reduce cost for both the State and Federal Government

Voluntary Enrollment – October, 2013
Passive Enrollment – January 1, 2014
Health Plan Funding

Capitated Model
- Prospective, blended Medicare-Medicaid payment to provide coordinated care to enrollees

Savings percentage deduction
- Year 1: 1%
- Year 2: 3%
- Year 3: 5%

Risk Adjustment
- Medicare CMS - HCC
- Medicaid rate cells - stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care

Quality Withhold
- Year 1: 1%
- Year 2: 2%
- Year 3: 3%

Examples of Year 1 measures include:
- Encounter submission
- Assessment performance
- Customer service
- Getting Appointments and Care Quickly
Health Plan Responsibility

- Assessing enrollees’ medical, behavioral health, long-term services and supports, and social needs.
- Stratifying enrollees into three risk groups based on need using assessment data and analysis of available data.
- Establishing an interdisciplinary care management team to work with enrollees and their caregivers in developing person-centered, individualized care plans.
- Developing and operating specialized programs to assist with transition of care and to reduce avoidable hospital and nursing facility admissions.
- Ensuring enrollees will have 24-hour telephonic access to medical professionals.
- Ensuring continuity of care which allows enrollees to continue to see their current providers and can continue their current course of treatment for 180 days.
- Administering established quality measures relating to the enrollee and caregiver which includes:
  - Overall experience of care
  - Care coordination
  - Fostering and supporting community living
Program Implementation

- Care Model Development
- Preparing for Readiness Review
- Medical and LTSS Network Development

**Reimbursement Model**
- Fee for Service with additional payments for:
  - Care Coordination
  - Care Plan Participation
  - Annual Health Assessment
  - Quality Improvement
  - Shared Savings
Exchange
2014 Exchange participation

- Open enrollment for 2014 plan year begins October 1, 2013 and runs until March 31, 2014.
- Effective date is January 1, 2014.
- In subsequent years, open enrollment begins October 1 and ends December 7.

Blue Precision - HMO offering

- Same participation and program requirements as Blue Advantage
  - Capitation
  - Incentives including Quality, RX and UM Fund
  - Reinsurance program
- Stand alone performance for Blue Precision
- Amendment to MSA
Exchange - 2014

ACA requires states establish the exchanges for the individual and small group market (called a Small Business Health Options Program or SHOP).

Small Group for Illinois is defined as

- 1-50 employees for plan year 2014
- IL could change small group to 1-100 for plan year 2015 (states get to choose 1-50 or 1-100)
- 1-100 employees for plan year 2016
- 100+ employees for plan year 2017+ if a state allows it

Starting in 2014, small employers with less than 25 full-time equivalent employees who purchase coverage through the exchange can receive a tax credit.

- For Profit businesses: up to 50 percent of their contribution for 2014
- For Non-Profit organizations: up to 35 percent of their contribution for 2014

ILLINOIS FAST FACTS

- Estimated 1.8 million Illinois residents are uninsured
- Nearly 486,000 Illinois residents will get coverage from commercial insurers via the exchange in 2014
- This number to grow to 1 million by 2016

- Approximately 209,000 small businesses with fewer than 50 employees in Illinois and 1/3 offer health insurance to their workers
- No projections on the number of small businesses likely to participate in the exchange

SOURCE
Enhanced benefit structure includes Essential Health Benefits

10 Broad Categories
At minimum, all plans must include benefit coverage of items and services in the following 10 broad categories:

- Hospitalization
- Emergency services
- Laboratory services
- Maternity and newborn care
- Mental health, substance abuse disorder services, behavioral health treatment
- Prescription drugs
- Habilitative and rehabilitative services and devices
- Preventive and wellness services, chronic disease management
- Ambulatory patient services
- Pediatric services including oral and vision care
Metal Levels

The key difference between the “metallic” plans is the expected percentage of medical expenses shared between the health plan and the member.
People who buy coverage on their own through an exchange and have household income up to four times the poverty level may be eligible for premium and cost-sharing subsidies.

- The premium subsidies are based on household income and the premium of the second lowest cost silver plan in an exchange.
- Low and modest income people buying insurance on the exchange may be eligible for coverage with a higher actuarial value and lower out-of-pocket maximum.
## The Federal Poverty Level

2013 poverty guidelines for the 48 contiguous states and the District of Columbia

<table>
<thead>
<tr>
<th>SIZE OF FAMILY UNIT</th>
<th>100% FPL</th>
<th>150% FPL</th>
<th>200% FPL</th>
<th>250% FPL</th>
<th>300% FPL</th>
<th>400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>$17,235</td>
<td>$22,980</td>
<td>$28,725</td>
<td>$34,470</td>
<td>$45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510</td>
<td>$23,265</td>
<td>$31,020</td>
<td>$38,775</td>
<td>$46,530</td>
<td>$62,040</td>
</tr>
<tr>
<td>3</td>
<td>$19,530</td>
<td>$29,295</td>
<td>$39,060</td>
<td>$48,825</td>
<td>$58,590</td>
<td>$78,120</td>
</tr>
<tr>
<td>4</td>
<td>$23,550</td>
<td>$35,325</td>
<td>$47,100</td>
<td>$58,875</td>
<td>$70,650</td>
<td>$94,200</td>
</tr>
<tr>
<td>5</td>
<td>$27,570</td>
<td>$41,355</td>
<td>$55,140</td>
<td>$68,925</td>
<td>$82,710</td>
<td>$110,280</td>
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<tr>
<td>6</td>
<td>$31,590</td>
<td>$47,385</td>
<td>$63,180</td>
<td>$78,975</td>
<td>$94,770</td>
<td>$126,360</td>
</tr>
</tbody>
</table>

**SOURCE:**
Premium Tax Credits

The Premium Tax Credit Is:

- Available for eligible individuals who purchase individual coverage on the exchanges, also known as health insurance marketplaces, with household incomes between 100-400% of the federal poverty level
- On a sliding scale
- Applied to the health insurance PREMIUM payments of a plan at any metallic level, and will most likely be applied monthly
- Advanced to the consumer upon enrollment in an exchange plan
- Based on the consumer’s income the previous year
Individual Premium Contribution Based on Income

<table>
<thead>
<tr>
<th>Individual Income</th>
<th>Minimum Premium Contribution</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>FPL</td>
</tr>
<tr>
<td></td>
<td>Annual Income</td>
</tr>
<tr>
<td></td>
<td>Annual % of Income</td>
</tr>
<tr>
<td></td>
<td>Annual $ amount</td>
</tr>
<tr>
<td>FPL</td>
<td>Annual Income</td>
</tr>
<tr>
<td>100-150%</td>
<td>$11,490 - $17,235</td>
</tr>
<tr>
<td></td>
<td>2-4%</td>
</tr>
<tr>
<td></td>
<td>$229.80 - $689.40</td>
</tr>
<tr>
<td>150-200%</td>
<td>$17,235 - $22,980</td>
</tr>
<tr>
<td></td>
<td>4-6.3%</td>
</tr>
<tr>
<td></td>
<td>$689.40 - $1,447.74</td>
</tr>
<tr>
<td>200-250%</td>
<td>$22,980 - $28,725</td>
</tr>
<tr>
<td></td>
<td>6.3-8.05%</td>
</tr>
<tr>
<td></td>
<td>$1,447.74 - $2,312.36</td>
</tr>
<tr>
<td>250-300%</td>
<td>$28,725 - $34,470</td>
</tr>
<tr>
<td></td>
<td>8.05-9.5%</td>
</tr>
<tr>
<td></td>
<td>$2,312.36 - $3,274.65</td>
</tr>
<tr>
<td>300-400%</td>
<td>$34,470 - $45,960</td>
</tr>
<tr>
<td></td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>$3,274.65 - $4,366.20</td>
</tr>
</tbody>
</table>

Premium Tax Credit Case Studies (dollar amounts are annual)

<table>
<thead>
<tr>
<th>FPL</th>
<th>Annual Income</th>
<th>2nd Lowest Cost Silver Level Plan Premium</th>
<th>Individual Minimum Contribution</th>
<th>Federal Premium Tax Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>150%</td>
<td>$17,235</td>
<td>$4,500</td>
<td>$689.40</td>
<td>$3,810.60</td>
</tr>
<tr>
<td>300%</td>
<td>$34,470</td>
<td>$4,500</td>
<td>$3,274.65</td>
<td>$1,225.35</td>
</tr>
</tbody>
</table>

SOURCE
**Cost-Sharing Subsidies**

**Enhanced Actuarial Value Cost-Sharing Subsidy**

Designed to help those at lower incomes with costs at the point of service by enrolling them in health plans with higher actuarial values.

**This Cost-Sharing Subsidy Is:**

- A federal payment to the insurer that reduces the eligible member’s costs (deductible, coinsurance or copayment)
- Based on the consumer’s income the previous year
- For those enrolled in an exchange plan with household incomes 100-250% of FPL
- Applied when members select a Silver level plan

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Plan Original Cost-Share</th>
<th>Member Original Cost-Share</th>
<th>Plan NEW Cost-Share</th>
<th>Member NEW Cost-Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>250-400% of FPL</td>
<td>70%</td>
<td>30%</td>
<td>70% (same)</td>
<td>30% (same)</td>
</tr>
<tr>
<td>200-250% of FPL</td>
<td>70%</td>
<td>30%</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>150-200% of FPL</td>
<td>70%</td>
<td>30%</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>100-150% of FPL</td>
<td>70%</td>
<td>30%</td>
<td>94%</td>
<td>6%</td>
</tr>
</tbody>
</table>

**SOURCE:**
Cost-Sharing Subsidies

Out-of-Pocket Maximum

- An out-of-pocket maximum cost-sharing subsidy is available to those that select a silver plan and have a household income of 100-400% of FPL. This subsidy limits the maximum out-of-pocket expenses for individuals.

- Without any federal subsidies, ACA limits out-of-pocket maximums to those established for Health Savings Accounts. Those limits, which include deductibles and copayments, are $6,250 for individuals and $12,500 for families for 2013.

- In 2014, this subsidy considerably reduces the out-of-pocket maximum.

<table>
<thead>
<tr>
<th>Income Level</th>
<th>OOP Maximum Without Subsidy (Individual)</th>
<th>Reduction in OOP Liability</th>
<th>OOP Maximum With Subsidy (Individual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-200% FPL</td>
<td>$6,250</td>
<td>2/3 of the maximum</td>
<td>$2,083</td>
</tr>
<tr>
<td>200-300% FPL</td>
<td>$6,250</td>
<td>1/2 of the maximum</td>
<td>$3,125</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>$6,250</td>
<td>1/3 of the maximum</td>
<td>$4,166</td>
</tr>
</tbody>
</table>
How Subsidies Work

**Premium Tax Credits**
Available to people with income between 100-400% of FPL

**Application**
Person applies for premium tax credits and cost-sharing subsidies during open enrollment

**Cost-Sharing Reductions**
Available to people with income between 100-250% of FPL (for AV Upgrade)

**Premium Tax Credits**
Payments are monthly and paid directly to the health plan.

**Cost-Sharing Reductions**
Plans pay a greater amount of the covered costs. Cost-sharing subsidies are paid directly to the health plan.

**Reconciliation**
Because premium tax credits are based on the previous year’s income, underpayments or overpayments are reconciled when people file tax returns

**Reconciliation**
No consumer reconciliation

SOURCE
Adverse Selection Protection

Large, diverse risk pool

- Spreads costs across more enrollees
- Less vulnerable to destabilization by large or catastrophic medical claims

3Rs Program

Ensures that insurance plans compete on the basis of quality and service and not on attracting the healthiest individuals

1. Reinsurance
2. Risk Corridors
3. Risk Adjustment
Temporary program (2014-2016) designed to stabilize premiums for coverage in the individual market due to the potential of newly insured individuals having high-cost medical care needs.

- All health care insurers and self-insured group health plans will make reinsurance contributions
- Reinsurance payments will be made to insurers for non-grandfathered individual health insurance coverage.
- HHS established the Reinsurance Fee at a per capita contribution rate of $5.25 per member, per month for the 2014 benefit year.
Temporary program (2014-2016) that is intended to protect against rate setting uncertainty by Qualified Health Plans sharing losses/gains

- Insurers with QHP (Qualified Health Plans) gains greater than 3% of target remit charges to HHS
- HHS makes payments for QHPs with losses greater than 3% of target
Risk Adjustment

Permanent program that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees

- States that run their own exchange can establish own risk adjustment program; otherwise HHS will operate program
- Calculation of risk adjustment payments involves methodology that includes plan’s average actuarial risk
- Risk adjustment applies to non-grandfathered health insured plans in individual and small group markets
- Health plans retain their own data and do not submit PHI to a state or HHS
- Concurrent Model – 2014 diagnosis predicting 2014 cost
- Plan level risk score (individual and SM on and off the exchange) compared to weighted average risk score
Possible Performance Impact for Illinois:

- Measuring clinical performance of all exchange plans across a set of standardized quality metrics
- Making plan-level performance scores publically available
- Limiting number of health plans available by allowing only the highest quality plans to be available
- Requiring standardized quality metrics for plans offered on and off the exchange
Network Development
## Expanding Provider Partnerships

### Care to all our Members

#### Triple Aim
- Low Cost
- High Quality of Care
- High Member Satisfaction

#### Administrative
- Performance of Delegated Functions
- Quality and Timeliness of Data

<table>
<thead>
<tr>
<th></th>
<th>MA</th>
<th>MMAI</th>
<th>Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Performance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cost Improvement</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Care Management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Encounter reporting</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Access to Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Compliance</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
HMO Cost and Quality Analysis
Risk Adjusted Total Cost & Star Rating
Average # of Days

- DOS to BC received  127 (4 months)
Quality and Cost of Care

Access to Primary Care

Risk Scores
- Documentation and Coding

Delegated activity compliance

Encounter submission requirements

Care Management
- CCM/ICM
- Chemical Dependency management
  - Retooling Magellan partnership
Questions
2013 Cultural Competence
Physician Education
QI Fund Project

HMO Administrative Forum

April 3, 2013
Carol Wilhoit, MD, MS
Cultural Competence Physician Education Project

• The 2013 QI Fund includes a new payment for a Cultural Competence education program.

• The payment will be based upon the percentage of IPA PCPs who complete the Quality Interactions for Physicians continuing medical education program offering up to 2.5 hours of CME credit.

• The deadline for completion of the CME program is September 30, 2013.

• To receive credit, IPAs will need to submit copies of physicians’ certificates documenting completion of the program.
Cultural Competence
Physician Education Project

• BCBSIL plans to continue this program in 2014, so the IPA will receive credit in both 2013 and 2014 for physicians who complete the program by September 30, 2013.

• The percentage of physicians will be calculated using the IPA’s credentialed physicians, as documented in BCBSIL credentialing records as of May 1, 2013.

• The IPA should be working with Credentialing and the Network Consultant to be certain that credentialing records are current by May 1, 2013.
Availability of Discount for the Quality Interactions CME Program

• A discount is now available to physicians who register for the CME program using the following Plan Promo Code: BCBS_Illinois2

• Enter this code in the Promo Code area of the credit card section to receive the 20% discount.
Version of the Program
With a Pediatric Focus

• A version of the CME program with a pediatric focus is available.

• To enroll for the pediatric version, the physician should register for the Specialty Pediatric program instead of the Doctor program.

• The price and discount are the same for both the Doctor program and the Specialty Pediatric program.
Updated Documents

• Updated project instructions will be sent to IPAs today.

• The updates to the instructions include:
  – The Promo Code
  – How to enter the Promo Code
  – How to enroll for the Pediatric program
Contact Information

• Technical questions on Quality Interactions Program or Website:
  – Diane Blake dblake@qualityinteractions.org

• Quality Interactions Program/Product Questions:
  – Evelyn Barahona ebarahona@qualityinteractions.org

• BCBSIL QI Fund Project:
  – Donell Banyard 312.653.5007  donell_banyard@bcbsil.com
  – Marvisene Cohill 312.653.7535  cohillm@bcbsil.com
Closing Remarks
Thank You for Attending!