Spring HMO
Administrative Forum

Presented by:
Network Management
Provider Relations

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Welcome and Introduction

Steve Hamman
VP Network Management
# Agenda

- **QI Fund Project Attestation Forms**
  - Dr. Carol Wilhoit
  - Medical Director, Quality Improvement

- **Best Practices**
  - "Managing Physicians Prescribing Habits"
    - Rami Rihani
    - Pharm.D, Dreyer Medical Clinic

**Break**

- **The HMOs of BCBSIL, “Well Positioned for the Future”**
  - Ana Shay
  - Director, Account and Sales Management

- **Hospitalist and Medical Home Programs**
  - Sandra Sloan
  - Senior Director, Professional Provider Network
  - Richard Gayes
  - Medical Director, Network Management

- **Legislative Updates**
  - Harmony Harrington
  - Manager, Legislative and Policy Management

**Closing Remarks**
QI Fund Project
Attestation Forms

Dr. Carol Wilhoit
Medical Director, Quality Improvement
Accuracy of QI Data

- It is imperative that BCBSIL clinical QI project data is accurate and complete because it is used for:
  - IPA payment
  - Public reporting in the Blue Star Medical Group/IPA Report
  - Employer reporting
  - HEDIS reporting
Since 2000, BCBSIL has required each IPA to send an attestation of completeness and accuracy signed by the IPA Administrator or Medical Director with each QI Fund Project submission.

For several years, this process seemed to work fairly well. However, as the projects have become more complex, more clinical oversight is required.

- Some services appear to be under-reported.
- Some services appear to be over-reported.

When incorrect/incomplete information is submitted, the Data Request Forms are returned to the IPA, requiring IPA re-work, which is inefficient and delays reporting of results.
Examples of Incorrect Data Submitted to BCBSIL

- **All Projects**
  - Entering dates of service for which there is no documentation of service
  - Entering a different date of service than the date on the supported documentation submitted by the IPA

- **Childhood Immunization**
  - Confusing HepB and Hib
  - Confusing HepA and HepB
  - Combination vaccines: entering date of service for only one of the antigens included in the vaccine
Examples of Incorrect Data Submitted to BCBSIL

- **Diabetes**
  - Indicating that an ACE/ARB was given, when the drug prescribed is not an ACE or ARB
  - Entering date of service for a retinal eye exam when a patient had eye care such as measurement of intraocular pressure or refraction only
  - Entering services not tracked on a flowsheet
  - Entering date of service and value for a hemoglobin instead of HbA1c
  - Entering date of service for a creatinine or urinalysis instead of a microalbumin
Examples of Incorrect Data Submitted to BCBSIL

- BCBSIL has noted a few instances in which medical records appear to have been altered to meet project requirements.
IPA Oversight of QI Data Submissions

- Therefore, for the 2010 QI Fund projects, BCBSIL will require the IPA Medical Director to review the information being submitted for a sample of at least ten members per project and to attest that the data being submitted accurately reflects the care provided.

- The attestation is not to be taken lightly; it should not be signed unless the IPA Medical Director can truthfully attest to the contents of the submission.
Recommendations

- The IPA Medical Director needs to understand the basic project requirements and to provide oversight for the data collection process to be certain that the correct information is being submitted and that it is being accurately documented.

- When non-clinical staff are involved in data collection, it is imperative that there be adequate clinical supervision to ensure that the correct data elements are being captured.
Interventions to Improve Generic Prescribing

April 14, 2010

Dreyer Medical Clinic

Advocate
Medical Group Profile

• Established 1922 by John Dreyer
• Affiliate of Advocate Healthcare
• 150 physicians, 26 specialties, 11 sites
• 60 allied health professionals
• 500,000 patient visits / year
• 120,000 unique patients in 2009
• EPIC EMR since 2002
• 35% of business is managed care
Recent History

- 1996 Affiliation with Advocate Health Care
- 2003 – EPIC as a decision resource
- 2009 E-Prescribing
  - SureScripts / Rxhub
Prescribing Volume

- 620,000 Rx orders in 2009
- Generics have always been important at Dreyer

**Monthly Generic Utilization Percentage**

<table>
<thead>
<tr>
<th>Month</th>
<th>Generic Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/2006</td>
<td>50.00%</td>
</tr>
<tr>
<td>02/2006</td>
<td>55.00%</td>
</tr>
<tr>
<td>03/2006</td>
<td>60.00%</td>
</tr>
<tr>
<td>04/2006</td>
<td>65.00%</td>
</tr>
<tr>
<td>05/2006</td>
<td>70.00%</td>
</tr>
<tr>
<td>06/2006</td>
<td>75.00%</td>
</tr>
<tr>
<td>07/2006</td>
<td>80.00%</td>
</tr>
<tr>
<td>08/2006</td>
<td>50.00%</td>
</tr>
<tr>
<td>09/2006</td>
<td>55.00%</td>
</tr>
<tr>
<td>10/2006</td>
<td>60.00%</td>
</tr>
<tr>
<td>11/2006</td>
<td>65.00%</td>
</tr>
<tr>
<td>12/2006</td>
<td>70.00%</td>
</tr>
<tr>
<td>01/2007</td>
<td>75.00%</td>
</tr>
<tr>
<td>02/2007</td>
<td>80.00%</td>
</tr>
<tr>
<td>03/2007</td>
<td>50.00%</td>
</tr>
<tr>
<td>04/2007</td>
<td>55.00%</td>
</tr>
<tr>
<td>05/2007</td>
<td>60.00%</td>
</tr>
<tr>
<td>06/2007</td>
<td>65.00%</td>
</tr>
<tr>
<td>07/2007</td>
<td>70.00%</td>
</tr>
<tr>
<td>08/2007</td>
<td>75.00%</td>
</tr>
<tr>
<td>09/2007</td>
<td>80.00%</td>
</tr>
<tr>
<td>10/2007</td>
<td>50.00%</td>
</tr>
<tr>
<td>11/2007</td>
<td>55.00%</td>
</tr>
<tr>
<td>12/2007</td>
<td>60.00%</td>
</tr>
<tr>
<td>01/2008</td>
<td>65.00%</td>
</tr>
<tr>
<td>02/2008</td>
<td>70.00%</td>
</tr>
<tr>
<td>03/2008</td>
<td>75.00%</td>
</tr>
<tr>
<td>04/2008</td>
<td>80.00%</td>
</tr>
<tr>
<td>05/2008</td>
<td>50.00%</td>
</tr>
<tr>
<td>06/2008</td>
<td>55.00%</td>
</tr>
<tr>
<td>07/2008</td>
<td>60.00%</td>
</tr>
<tr>
<td>08/2008</td>
<td>65.00%</td>
</tr>
<tr>
<td>09/2008</td>
<td>70.00%</td>
</tr>
<tr>
<td>10/2008</td>
<td>75.00%</td>
</tr>
<tr>
<td>11/2008</td>
<td>80.00%</td>
</tr>
<tr>
<td>12/2008</td>
<td>50.00%</td>
</tr>
<tr>
<td>01/2009</td>
<td>55.00%</td>
</tr>
<tr>
<td>02/2009</td>
<td>60.00%</td>
</tr>
<tr>
<td>03/2009</td>
<td>65.00%</td>
</tr>
<tr>
<td>04/2009</td>
<td>70.00%</td>
</tr>
<tr>
<td>05/2009</td>
<td>75.00%</td>
</tr>
<tr>
<td>06/2009</td>
<td>80.00%</td>
</tr>
<tr>
<td>07/2009</td>
<td>50.00%</td>
</tr>
<tr>
<td>08/2009</td>
<td>55.00%</td>
</tr>
<tr>
<td>09/2009</td>
<td>60.00%</td>
</tr>
<tr>
<td>10/2009</td>
<td>65.00%</td>
</tr>
<tr>
<td>11/2009</td>
<td>70.00%</td>
</tr>
<tr>
<td>12/2009</td>
<td>75.00%</td>
</tr>
</tbody>
</table>
Current Performance

• 74.5% overall generic prescribing rate
• 88% generic statin
• 80% generic PPI
• 78% nasal steroids
• 77% generic oral contraceptives
How did we achieve these results?

• The Electronic Medical Record (EMR)
• An internal Pharmacy and Therapeutics (P&T) Committee
• Dreyer has a “No Prescription Medication Sampling Policy”
• Limited pharmaceutical representative access
• Education and counter-detailing by a clinical pharmacist
EMR Interventions

- Generic synonyms
- Point of care messaging regarding generic equivalents or alternatives
Internal Pharmacy & Therapeutics Committee

- Tasked with
  - Evaluating new drugs
  - Developing an internal formulary
  - Considering and communicating formulary changes by payers
  - Disseminating best practices
Eliminate Samples & Restrict Pharmaceutical Rep Access

- Summer 2003 we eliminated samples and Pharmaceutical Representative Access due to
  - Regulatory Concerns with Sampling
  - Patient Complaints
  - Staff and Physician Productivity
Education / Counter Detailing

• Clinical Pharmacist provide updates on new drugs, safety alerts, upcoming generics, formulary changes, etc

• One-on-one counter detailing
Final Thoughts

• Need organizational commitment and leadership buy-in
• No single intervention will get you where you want to be.
• Leverage technology as a decision resource
• Do your best to eliminate incongruent messages
Break
The Value of the HMOs | Well Positioned for the Future
January 2010 Results

HCSC January 2010
12.4 million members
4.5 Texas
6.9 Illinois
327,000 New Mexico
629,000 Oklahoma

Illinois Division by Product

Traditional (8716)
PPO (319,556)
POS (3818)
HMO (4946)
Top Challenges for 2009/2010

1. Dependent Age
2. National Consolidation
3. Economy
4. Unexpected Membership Gains from Unicare
January 2010; HMO

Some Large Group HMO Cancels that resulted in losing over 20,000 members
HMO Product Historical Numbers

12/31/06 862,673
12/31/07 848,730
12/31/08 821,634
12/31/09 829,741
1/31/10 824,795
2/28/10 822,350

Net Impact of Unicare members; 31,000 +

*Jan. 2009 through Feb. 2010
Managing Care helps Manage Costs

Employers are looking for options to manage costs

Terms prevalent in the marketplace:

Patient Centered Medical Home

Accountable Care Organization

Evidence Based Medicine

Value Based Plan Design
An HMO by any other name.......
Health Care Reform

Features of Health Care Reform already in HMO Product:

- Dependent Age
- No Pre-existing Conditions
- No Lifetime Maximums
- Wellness Coverage
2011 Challenges

Financial Uncertainty; unemployment rates high

Medical Trends; costs and utilization going up

Health Care Reform
The HMOs of Illinois
Well positioned for the future

Illinois HMO Market Share

Blue Cross and Blue Shield of Illinois has more than **800,000 HMO members** – that’s almost half of the Illinois HMO market share.

Sources: Blue Cross Blue Shield of IL and Western Wats
We Share Commitment to Service Quality and Member Satisfaction

**Satisfaction** among BCBSIL members is **significantly higher** than the competition in health plan value and overall service.

BCBSIL members are also **more loyal** to their health plan than competitor members.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Call Survey Satisfaction Score</td>
<td>93.8%</td>
</tr>
<tr>
<td>Member Touchpoint Measures</td>
<td>96.4%</td>
</tr>
<tr>
<td>Member Loyalty Score</td>
<td>87.6%</td>
</tr>
<tr>
<td>Member Loyalty Differential</td>
<td>+7.2%</td>
</tr>
</tbody>
</table>

Source: 2009 Continuous Tracking Program, BCBSIL & DSS Research. IL, all products.
The Value of BCBSIL HMOs

BCBSIL HMOs deliver cost advantages and improved quality of care

- Strong HMO membership growth, with more than 800,000 members
- Unique and stable capitation model delivers significant cost advantages
- Innovative network solutions
- Quality improvement and condition management programs embedded in the HMO product

Per member per month costs of the HMOs of BCBSIL are **27.6% lower** than PPO
## HMO and PPO Cost Comparison

<table>
<thead>
<tr>
<th>Cost Categories</th>
<th>HMO PMPM</th>
<th>PPO PMPM</th>
<th>Cost Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Plan Cost</strong></td>
<td>$223.40</td>
<td>$274.90</td>
<td>$51.50</td>
<td>18.7%</td>
</tr>
<tr>
<td><strong>Member Monthly Out-of-Pocket Cost</strong></td>
<td>+ $14.36</td>
<td>+ $53.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Cost of Care</strong></td>
<td>= $237.76</td>
<td>= $328.58</td>
<td>$90.82</td>
<td>27.6%</td>
</tr>
<tr>
<td>+ Demographic Risk Adjustment</td>
<td>+ $15.55</td>
<td></td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>+ Geographic Adjustment</td>
<td>$0.00</td>
<td>+ ($7.48)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Plan Costs Normalized</strong></td>
<td>=$253.31</td>
<td>= $321.10</td>
<td>$67.79</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

Relative Value of HMO: **21.1%**
The Power of Blue
The Value of the HMO Model

• The HMOs of Blue Cross and Blue Shield are the original patient-centered medical home model

The growing accountable care movement is born of the member-focused successes of HMO PCP-driven care

– Demonstrated care management model delivers verifiable results in improving members’ health

– Capitation model is built around savings – and has been proven to contain costs and improve members’ health outcomes

– Our HMOs have always featured as a foundation of our care philosophy elements such as preventive care coverage, standard dependent age, no lifetime maximums, and no pre-existing condition exclusion
Care Management

## Utilization Management
Member’s doctor determines medical need and health care treatment decisions.

Medical Groups (MGs) and Independent Practice Associations (IPAs) review/approve their own referrals, planned surgical procedures and inpatient care.

## Condition Management
Members are identified to receive information and outreach to assist in improved self-management.

Physician manages member’s care and MG/IPAs are incented to work with the physician to optimize the management of chronic illness.

## Quality Improvement
Pay-for-performance and public recognition programs have been successful in motivating physicians to improve delivery of preventive services and management of chronic conditions.

## Preventive Care/Wellness
Personal Health Manager provides programs and tools to help members manage their health and make good health care decisions.

Members receive targeted communications to engage them in preventive care and wellness activities.

---

### Transparency — Public Reporting and Decision Making Tools

Blue Cross and Blue Shield of Illinois was one of the first health plans to evaluate hospital quality and patient safety. Pay-for-performance programs, combined with public recognition, succeed in motivating physicians to improve both delivery of preventive services and management of chronic health conditions.

Providing feedback allows hospitals and physicians to compare their performance to their peers.

Information on hospital and Medical Group/Independent Practice Association quality and safety is made publicly available to members for more informed decision-making.
Asthma Program
Condition Management

Asthma Program Objective:
Motivate physicians to:
- Give asthmatic members written asthma action plans to help them better manage their condition
- Assess the level of asthma control, using a validated tool or structured approach

Asthma Program Outcomes:
Asthmatics who have received at least 3 asthma action plans over 5 years do better than those who received 0-2 asthma action plans.

8 Year Results:
+54 percentage point increase in compliance

Percentages of HMO Members with Asthma Who Received Written Asthma Self-Management Plan

- 2000: 21%
- 2001: 36%
- 2002: 55%
- 2003: 59%
- 2004: 69%
- 2005: 75%
- 2006: 80%
- 2007: 74%
- 2008: 74%
- 2009: 75%

QI Fund Project
Public Reporting Begins
Plan Within 1 Year
Assessment of Control Added as a Requirement
5-Year Outcomes:

There has been a **dramatic reduction in asthma ER visits and asthma inpatient admissions** for 1,051 asthmatics who have received at least 3 written asthma action plans from their physician over a five-year period.

**Increase**

- **21%**
- **75%**

2000 - 2008 Asthma Action Plan Rate
Recommended by the American Lung Association, Asthma Action Plans are a critical component to successful asthma care outcomes—helping employer groups contain costs more effectively.

BCBSIL received a Silver Award in URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Awards competition for The Positive Impact of Written Asthma Action Plans.

“Simple low technology interventions with proven efficacy … that can be adopted by physician practices to improve quality. By incorporating action plans into its QI fund, BCBSIL successfully increased use of this simple but important intervention.”

For more information on BlueWorks visit:
Diabetes Program
Condition Management

**Diabetes Program Objective:**
Promote improvements in diabetic care by encouraging physicians to track and trend diabetes care on a flowsheet, which can help physicians better manage diabetes.

**Diabetes Screenings** (percentage points improvement)

- **2000 - 2008 HbA1c Testing Rate**
  - Testing increased +16
  - 74% to 90%

- **2000 - 2008 LDL Screening Rate**
  - Screenings increased +16
  - 72% to 88%

- **2000 - 2008 Medical Attention for Nephropathy**
  - Services increased +47
  - 37% to 84%

- **2000 - 2008 Eye Exam**
  - Screenings increased +19
  - 46% to 65%

*Source: HEDIS report*
Diabetes Program Condition Management

Diabetes Program Results:

**Decrease** of poor control rate is desired

- **2000 - 2008 HbA1c Poor Control Rate**
  - 46%
  - 28%
  - 18% Improvement

- **2006 - 2008 Blood Pressure Control (<140/90)**
  - 60%
  - 69%
  - +9 Control increased

- **2003 - 2008 LDL-C Control Rate (<100 mg/dL)**
  - 32%
  - 43%
  - +11 Control Increased

Source: HEDIS report

(percentage points improvement)
Diabetes Program
Outcomes

ER Visit Rate/1,000 Diabetics by the number of years HbA1c was < 9 %

5-Year Outcomes:
For the 8,959 diabetic patients enrolled each year from 2003-2008, those whose diabetes was more consistently controlled achieved better health outcomes.

Inpatient Admission Rate/1,000 Diabetics by the number of years HbA1c was < 9 %
The Impact of Reporting
Blue Star℠ Medical Group/IPA Report Impact Analysis

The HMOs of BCBSIL evaluate and publicly report the performance of contracting providers, which has **positively impacted provider performance** and **improved outcomes** for our members.

Some of our standard information initiatives include:

- Blue Star℠ Hospital Report
- Blue Star℠ Medical Group/IPA Report
- Blue Ribbon Report
- Care Comparison®
- Treatment Cost Advisor

These reports are published in member materials and on our Web site @ www.bcbsil.com
Blue Star Hospital Report

94 contracting, urban Illinois hospitals reported in 2009 report

- **Hospital performance** is measured annually by BCBSIL. Each year, hospitals that meet defined levels of performance can earn up to ten “Blue Stars”

- Up to two Blue Stars are awarded in each of five categories: Structure, Process, Outcomes, Efficiency and Member Survey

- Results are then made available to all consumers, publicly reported @ [www.bcbsil.com/member/blue_star_report.htm](http://www.bcbsil.com/member/blue_star_report.htm)

The Blue Star Hospital Report helps consumers make educated decisions about where to seek the medical care they need.
Impact of the BCBSIL Hospital Profile

- The number of Illinois hospitals publicly reporting to Leapfrog has increased from 1 in 2003 – when the first Profiles were sent to hospitals – to 71 in January 2010.

- Hospital electronic claims submission rates have increased from 89% in 2003 to 93% in 2009.

- Of the more than 9,500 members who responded to the 2009 BCBSIL HMO member survey, 9% reported having seen the Blue Star Hospital Report, and 94% of these members found the information to be useful.

- Of the 1,136 PCPs responding to the 2009 HMO PCP survey, 32% were familiar with the Blue Star Hospital report, and 94% rated the report as Excellent, Very Good or Good.
Blue Star℠ Medical Group/IPA Report

Blue Star MG/IPA Report

115 Illinois MG/IPAs reported in the 2009 report

- Medical group performance is measured annually by BCBSIL in accordance with nationally based clinical practice and preventive care guidelines
- Groups earn a “Blue Star” each time they meet the target care goal
- Results are then made available to all consumers, publicly reported @ www.bcbsil.com/member/hmo/hmo_bluestar.htm

BCBSIL was the first (2003) HMO in Illinois to publish condition-specific provider data to members
Blue Ribbon Report
Member Feedback on Contracting Medical Groups/IPAs

Members of the HMOs of BCBSIL are surveyed annually to evaluate their experiences and satisfaction with contracting medical groups/IPAs.

Results are then made available to HMO Members, publicly reported @ www.bcbsil.com/pdf/bluestar_mg_report.pdf.

2009 Results:
91% of eligible groups earned a Blue Ribbon*

*Percentage based on members rating “excellent”, “very good” and “good”.
Based on medical groups/IPAs with sufficient response to survey.
Our mission is to
promote the health and wellness
of our members and communities through accessible, cost-effective, quality health care.
Patient Centered Medical Home / Accountable Care Office Program

Sandra Sloan
Sr. Director, Professional Provider Network
Current PCMH / ACO program for PPO patients

3 Partners:
- DuPage Medical Group
- Elmhurst Clinic
- Pronger Smith Medical Care

PPO enrollment approximately 75,000, HMO enrollment approximately 75,000
To be considered as a PCMH/ACO site, an office must:

- have an EMR
- be accredited by Joint Commission, NCQA, other accreditation organization (or equivalent) – primary focus based on patient access and communication, ability to use clinical data for population management, care coordination, patient self management and support
- use hospitalists
- use cost effective hospitals, outpatient surgery (or office based surgery providers when available), cost effective specialists
- use Quest, LabCorp or other independent reference lab under contract with BCBSIL, or bill BCBSIL directly for services
- high tech imaging pre-certified by AIM
The office at a minimum must:

- Identify & close gaps in care at the time of the patient visit
- Perform outreach on chronic care patients
- Perform case management on sickest patients

**BCBSIL** supplies patient information to the sites to assist them in these activities, **via D2**

**3 Areas of Focus**
Should BCBSIL expand PCMH/ACO?

If so, where are opportunities to expand?

1) Expand within HMO model

2) Expand within PPO model

3) Use as foundation for new product, yet to be developed
BCBSIL is willing to provide Blue Advantage IPAs with a “PCP pass thru incentive” to offices that meet PCMH/ACO criteria, in order to expand model and facilitate adoption of criteria such as use of hospitalist programs, use of data to close gaps in care, use of cost effective labs.
Expand within the PPO model:

Blue Advantage PCP offices that meet criteria would also participate for their PPO patients via a direct contract with BCBSIL.
BCBSIL is very likely to begin to develop a new product to be competitive under healthcare reform. This product will most likely be sold to individuals, and will need to be extremely competitive. If there is enough participation by PCPs in the PCMH/ACO model, these PCPs would likely be the foundation of this new product.
HMO Utilization Management 2010

Richard Gayes, MD MBA
Medical Director, Network Management
HMO vs PPO: Acute Inpatient Days/k
HMO vs PPO: Acute Inpatient ALOS
HMO vs PPO: Acute Inpatient ALOS

Milliman Model C
HMO vs PPO: Acute Inpatient Admits/k
MG Days/k vs Census (6/2009)

Excludes Outliers, Sick newborns, Transplants, Substance Abuse
MG Days/k vs Census (6/2009)
Excludes Outliers, Sick newborns, Transplants, Substance Abuse
MG ALOS Over Mil C vs Census

Excludes Outliers, Sick newborns, Transplants, Substance Abuse
MG ALOS Over Mil C vs Admits/k (6/2009)

Excludes Outliers, Sick newborns, Transplants, Substance Abuse
Managing Admission Rate

- Emergency Room
- Readmissions
- Case Management (Dual- or Multiple-Chronic Illness, Catastrophic, End of Life)
- Ambulatory-Care-Sensitive Admissions
- Preference-Sensitive Admissions
- Patient-Centered Medical Home
- Accountable Care Organizations
Managing Length of Stay

- Hospitalists
- Discharge Planners
- SNF / Subacute / Home health
MG ALOS Over Mil C vs Admits/K
Excludes Outliers, Sick newborns, Transplants, Substance Abuse

HMO-Approved Hospitalist Programs
Hospitalists say:

- Professional, “career” hospitalists
- Full-time in the hospital; Manageable census
- “Crackerjack” Discharge planners
- Leadership, Daily rounds at the hospital
- Communication & Discharge process is key
- Pay actual hospitalists case rate (with incentives)
- Utilization efficiency is a priority and a passion
PCPs say (about Hospitalists):

- Professionalism of the Hospitalist is paramount
- Communication & Discharge process is key
- Importance of a peer Champion
- Financial impact typically very manageable
- Lifestyle improves a lot!
Let’s Do This Together!

HMO Medical Directors Workgroup
HMO Hospitalists Workgroup

Contact Richard Gayes MD
312-653-5065
gayesr@bcbsil.com
Navigating the Patient Protection and Affordable Care Act

Harmony Harrington
Manager, Government and External Relations

Please note that this presentation is for informational purposes only – The information contained in this presentation does not constitute legal advice. Participants should consult their own attorneys, actuaries and tax advisers for guidance.
And Then Came Reform

1. Nov 4, 2008
   Obama wins presidency

2. Feb 3, 2009
   Sebelius named as HHS Secretary

3. Mar 5, 2009
   Obama launches reform effort

4. Aug 2009
   Congress fails to meet Obama’s deadline for passing legislation

5. Sept 9, 2009
   Obama addresses joint session of Congress

   House passes HR 3962 – includes public option

7. Dec 24, 2009
   Senate passes HR 3590, PPACA

8. Jan 19, 2010
   Brown wins special Senate election in MA

9. Feb 22, 2010
   Obama unveils his own health care proposal

10. Feb 25, 2010
    Bipartisan Health Care Reform Summit

11. Mar 4, 2010
    Sec. Sebelius and Pres. Obama meet with Insurance CEOs

12. Mar 21, 2010
    House Passes PPACA and Reconciliation Bill

    President signs PPACA into law

14. Mar 26, 2010
    Reconciliation bill passes both House and Senate

15. Mar 30, 2010
    President signs final piece of reform legislation
Patient Protection and Affordable Care Act

• President signed:
  – Senate HCR bill March 23 (P.L. 111-148)
  – “Fix it” Reconciliation bill March 30

• Administration will soon issue rules/guidance on implementation over the next several years
  – Some guidance imminent

Some HIGHLIGHTS:
• Largely maintains employer-based system
• No new government-run plan
• ERISA protections maintained
• Maintains state regulation under federal framework of rules for insured business
HUH?
Estimated Coverage Levels in 2019 – Expansion of Coverage (CBO Data)

Current Law
- Uninsured: 54M
- Medicaid: 35M
- Individual: 30M
- Employer: 162M

Reform (PPACA)
- Uninsured: 23M
- Medicaid: 51M
- Individual: 25M
- Exchanges (paid by employer): 24M
- Exchanges (paid by employer)

Gains are largely in Exchange and Medicaid coverage
Important Notes Regarding PPACA Requirements

• Many of the requirements are for plan years beginning six months after enactment.

• The requirements may apply to new plans or grandfathered plans. The

• PPACA (the Act) defines a grandfathered plan as a “group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the Act.”

• Insured plans are generally subject to state regulations and mandates.

• Certain states may have already enacted provisions that are similar to those included in PPACA.

• Self-insured plans have significantly greater freedom with their benefit design and plan provisions but still must comply with the provisions of PPACA.
Key Provisions: Insurance Reforms/Plan Requirements

- Review of “unreasonable” rates
- National high risk pool
- HHS web portal
- Temporary employer reinsurance
- No pre-ex for kids*
- Dependent coverage to 26*
- Limits on rescissions
- Internal/external appeals*
- MLRs (80% individual/small group; 85% group)
- No lifetime limits*
- No preventive cost-sharing*
- Patient protections*
- GI/CR
- Age band (3:1)
- Risk adjustment
- Exchanges

* Impact all plans


PPACA imposes several significant new requirements effective plan years 6 months after enactment

<table>
<thead>
<tr>
<th>New Plans</th>
<th>Grandfathered Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
</tr>
<tr>
<td>Indiv.</td>
<td>Group</td>
</tr>
</tbody>
</table>

| Lifetime Limits: Prohibits lifetime dollar limits | ✓ | ✓ | ✓ | R | R | R |
| Annual Limits: Restricts annual dollar limits on essential health benefits to HHS-defined amount until 2014; prohibited in 2014 | ✓ | ✓ | ✓ | R | R | R |
| Children’s Pre-Ex: Prohibits pre-existing condition waiting periods for children under age 19 | ✓ | ✓ | ✓ |   |   |   |
| Dependent Age: Requires allowing dependents to remain on coverage until age 26 | ✓ | ✓ | ✓ | R | R* | R* |
| Preventive Care: Requires specified preventive care services and immunizations set by USPSTF and others | ✓ | ✓ | ✓ |   |   |   |
| Rescissions: Prohibited unless fraud or intentional misrepresentation | ✓ | ✓ | ✓ | R | R | R |

* For plan years before 2014, grandfathered group plans only would have to offer extended coverage if the dependent was not eligible for other group coverage
## "6-Month" Reforms: Impacting Group Benefit Programs  
(For Plan Years Beginning On or After Six Months After Enactment)

PPACA would impose several significant new requirements including:

This chart is not intended to be actuarial, legal or other advice. To accurately understand how the Act may impact your plan, please consult your actuary, lawyer, insurance carrier, or other consultant. This chart is intended to provide an estimate of the financial impact of the required changes.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Applies to New Plans</th>
<th>Applies to Grandfathered Plans</th>
<th>Estimated Financial Impact</th>
<th>Self Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Limits:</strong> Prohibits lifetime dollar limits.</td>
<td>✓</td>
<td>✓</td>
<td>1% 0.0% 0.0% 1% 1%</td>
<td>Approximately 1% based on common lifetime limits.</td>
</tr>
<tr>
<td><strong>Annual Limits:</strong> Restricts annual dollar limits on essential health benefits to HHS-defined amount until 2014; prohibited in 2014.</td>
<td>✓</td>
<td>✓</td>
<td>0.5% 0.0% 0.5% 0.5% 0.5%</td>
<td>Approx 0.5% based on common plan provisions.</td>
</tr>
<tr>
<td><strong>Children’s Pre-Ex:</strong> Prohibits denying coverage due to pre-existing condition for children under age 19, and limits waiting periods to 90 days.</td>
<td>✓</td>
<td>✓</td>
<td>0.0% 0.0% 0.0% 0.0% 0.0%</td>
<td>Minimal to no impact due to HIPAA</td>
</tr>
<tr>
<td><strong>Dependent Age:</strong> Requires allowing dependents to remain on coverage until age 26</td>
<td>✓</td>
<td>✓</td>
<td>0.0% 0.0% 0.25% 1.0% 0.25%</td>
<td>Approximately 1.0% for age limits of child to age 19, student to age 26. More generous definitions will have smaller financial impact.</td>
</tr>
<tr>
<td><strong>Preventive Care:</strong> Requires full coverage of preventive care services.</td>
<td>✓</td>
<td></td>
<td>0.5% 0.5% 0.5% 0.5% 0.5%</td>
<td>Impact will vary based on preventive services currently covered.</td>
</tr>
<tr>
<td><strong>Emergency Services:</strong> Requires same cost-sharing in/out of network, coverage w/o pre-auth, and prudent layperson.</td>
<td>✓</td>
<td></td>
<td>0.0% 0.0% 0.0% 0.0% 0.0%</td>
<td>Plan likely already has these provisions.</td>
</tr>
<tr>
<td><strong>OB/GYN Access:</strong> Requires direct access to OB/GYNs for female enrollees.</td>
<td>✓</td>
<td></td>
<td>0.0% 0.0% 0.0% 0.0% 0.0%</td>
<td>Little to no impact for plans that do not already have this provision.</td>
</tr>
<tr>
<td><strong>PCP/Pediatrician Choice:</strong> Requires choice of any participating PCP accepting new patients; choice of pediatrician</td>
<td>✓</td>
<td></td>
<td>0.0% 0.0% 0.0% 0.0% 0.0%</td>
<td>Little to no impact for plans that do not already have this provision.</td>
</tr>
</tbody>
</table>

*For plan years before 2014, grandfathered group plans only would have to offer extended coverage if the dependent was not eligible for other group coverage.*
**"6-Month" Reforms: Implementation Example**

### New Lifetime Limits Requirements

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Months following Enactment</th>
<th>Dependencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Bill signed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Plans assess language &amp; requirements</td>
<td>2</td>
<td>A</td>
</tr>
<tr>
<td>C</td>
<td>Plans develop/file contract language &amp; rates</td>
<td>3</td>
<td>A</td>
</tr>
<tr>
<td>D</td>
<td>State DOIs review/approve policy/rate filings*</td>
<td>4, 5</td>
<td>C</td>
</tr>
<tr>
<td>E</td>
<td>Plans develop/finalize communications</td>
<td>6</td>
<td>D</td>
</tr>
<tr>
<td>F</td>
<td>Plans print/mail materials</td>
<td>7</td>
<td>D, E</td>
</tr>
<tr>
<td>G</td>
<td>Plans begin quoting new rates/renewals</td>
<td>8, 9</td>
<td>D, F</td>
</tr>
<tr>
<td>H</td>
<td>Plans develop/finalize systems requirements</td>
<td>10, 11, 12</td>
<td>A, D</td>
</tr>
<tr>
<td>I</td>
<td>Plans program benefits</td>
<td>11, 12</td>
<td>D, H</td>
</tr>
<tr>
<td>J</td>
<td>Plans test programming</td>
<td>12</td>
<td>I</td>
</tr>
</tbody>
</table>

*Volume of state filings will be unprecedented as all plans being sold in the market will need to be modified prior to new sales. Approval time could be longer in some cases.*
Coverage of Preventive Health Services (PPACA: SEC. 2713)

- Requires coverage of preventive services (all markets) with no cost sharing; effective plan year 6 months after enactment

- Coverage must follow recommendations by:
  1. United States Preventive Services Task Force “A or B”
  2. Advisory Committee of Immunization Practices (CDC)
  3. HRSA Guidelines for Preventive Care & Screenings for Infants, Children and Adolescents
# Preventive Services Recommended by the USPSTF A and B recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Aortic Aneurysm Screening (one time age 65-75 if ever smoked)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Alcohol Misuse Screening and Behavioral Counseling Intervention</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Y²</td>
</tr>
<tr>
<td>Aspirin for the Prevention of Cardiovascular Disease</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Men 45-79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women 55-79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymptomatic Bacteriuria in Adults, Screening</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Breast Cancer Screening (Biennial 50-74)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing Based on Family Risk Factors</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>
## Preventive Services Recommended by the USPSTF

### A and B recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding, Primary Care Interventions to Promote</td>
<td></td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅²</td>
</tr>
<tr>
<td>Cervical Cancer Screening if Sexually Active</td>
<td></td>
<td>✅</td>
<td></td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Chlamydial Infection, Screening</td>
<td></td>
<td>✅</td>
<td>✅</td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (Beginning at 50 and continuing to 75)</td>
<td></td>
<td>✅</td>
<td>✅</td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Fecal occult blood testing: annual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy: every 5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy: every 10 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Hypothyroidism Screening (Newborns)</td>
<td></td>
<td></td>
<td>✅</td>
<td></td>
<td>✅</td>
</tr>
<tr>
<td>Dental Caries in Preschool Children, Prevention (prescribe oral fluoride if deficient in water)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✅</td>
</tr>
</tbody>
</table>

¹ Based on group market. Coverage of preventive services varies in the Individual market and if offered, is sometimes capped or has a waiting period.

² Would typically be part of a normal wellness office visit.
## Preventive Services Recommended by the USPSTF A and B recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (Adults) Screening</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y²</td>
</tr>
<tr>
<td>(When staff-assisted depression care supports are in place)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet, Behavioral Counseling in Primary Care for Adults with Hyperlipidemia and</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Other Risk Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Gonorrhea, Prophylactic Eye Medication, (Newborns)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Hearing Loss in Newborns, Screening</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>Y²</td>
</tr>
<tr>
<td>Hepatitis B Virus Infection, Screening</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>Y</td>
</tr>
</tbody>
</table>

¹ Typically Covered: Coverage varies by state and insurance plan.
## Preventive Services Recommended by the USPSTF

**A and B recommendations**

Typically Covered¹

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure Screening (18 and older)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y²</td>
</tr>
<tr>
<td>HIV Screening (At Risk and All Pregnant Women)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Y</td>
</tr>
<tr>
<td>Iron Deficiency Anemia, Prevention (At Risk 6 to 12 Month Old Babies)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Iron Deficiency Anemia, Screening</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Lipid Disorders in Adults, Screening</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Men</strong>: 35+ / <strong>Women</strong>: 45+ &lt;br&gt;<strong>Men at risk for CAD</strong>: 20-35 / <strong>Women</strong>: 20-45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Depressive Disorders in Adolescents, Screening</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>
## Preventive Services Recommended by the USPSTF

### A and B recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity in Adults Screening and Intensive Counseling and Behavioral Interventions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Osteoporosis in Women, Screening: 65+ / 60+ If At Risk</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Phenylketonuria, Screening Newborn</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Rh (D) Incompatibility, Screening</td>
<td></td>
<td>✔</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections, Counseling (at risk adolescents and adults)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>Y²</td>
</tr>
<tr>
<td>Sickle Cell Disease, Screening Newborn</td>
<td></td>
<td>✔</td>
<td></td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

¹Typically Covered indicates that the service is covered by health insurance plans, but coverage can vary. 
²Coverage for sexually transmitted infections counseling can vary depending on the risk of exposure.
# Preventive Services Recommended by the USPSTF

## A and B recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Adult Men</th>
<th>Adult Women</th>
<th>Children</th>
<th>Pregnant Women</th>
<th>Typically Covered¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis Infection Screening (At Risk and All Pregnant Women)</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td>Y</td>
</tr>
<tr>
<td>Tobacco Use and Tobacco-Caused Disease, Counseling</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>Counseling is done but not sure all cessation is covered</td>
</tr>
<tr>
<td>Type 2 Diabetes Mellitus in Adults, Screening with sustained blood pressure</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Visual Impairment in Children Younger than 5 Years, Screening</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Discuss Chemoprevention When at High Risk for Breast Cancer</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Daily Supplement of Folic Acid</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>
Medical Loss Ratios
(Insurer Spending for Medical Care)

• Reimbursement for clinical services/activities that improve healthcare quality must equal:
  – Large Group: 85%
  – Individual/Small Group: 80%
  – States can set higher percentages
• Federal and state taxes, licensing and regulatory fees excluded
• Grandfathered plans must be included
• Insured Groups only

Key Dates
• Loss ratio reporting effective for plan years starting 6 months after enactment
• NAIC provides definitions and methodology by 12/31/10 – HHS this week reached out to NAIC asking for information by June 1, 2010
• Rebates to enrollees apply beginning 2011
• MLRs based on three years of data starting 2014
## Rate Review

HHS in conjunction with States must establish process for annual review of “unreasonable” premium increases starting 2010 plan year in all insured markets.

<table>
<thead>
<tr>
<th>Insurers</th>
<th>States</th>
<th>HHS</th>
</tr>
</thead>
</table>
| • Must send justifications for unreasonable rate increases to HHS and States  
• Must post justifications online  
• Applies to all insured markets | To obtain federal grants, must:  
• Review and, if appropriate under state law, approve premium increases (2010)  
• Provide HHS with information on premium trends (2010)  
• Make recommendations to Exchange whether to exclude insurers based on excessive/unjustified increases (2014) | • Develops process with states for review of unreasonable increases  
• Ensures insurer justifications made public  
• Makes grants (up to $5M) to states for rate review (2010-2014)  
• For 2014 plan years, monitors, with States, premium increases inside/outside Exchanges |

### Additional Considerations

- President’s proposal for HHS to have approval/denial authority on rates was not included in the Reconciliation Bill; however, there likely will be continued risk of stand-alone legislation in coming months
- Potential for HHS “bully pulpit” enhanced with new information disclosure requirements
- Risk that HHS could take expansive view on new rate “review” authority

*Massachusetts Rate Review Example – Denial of 234 out of 274 proposed rates in the individual and small groups markets*
High Risk Pool Program

HHS is required to create a temporary high risk pool program within 90 days of enactment, until guaranteed issue and exchanges go into effect (2014)

<table>
<thead>
<tr>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HHS (directly), state, or nonprofit private entity</td>
</tr>
<tr>
<td>• State must do maintenance of effort if it receives an HRP contract</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pre-existing condition defined by HHS</td>
</tr>
<tr>
<td>• No creditable coverage in last 6 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No pre-ex exclusion</td>
</tr>
<tr>
<td>• 65% actuarial value, OOP at HDHP limits</td>
</tr>
<tr>
<td>• Standard rate premiums with age (4:1), geography, no gender</td>
</tr>
<tr>
<td>• HHS sets other requirements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>• $5B in federal funds for claims and administration</td>
</tr>
<tr>
<td>• HHS could cap enrollment if insufficient funds</td>
</tr>
<tr>
<td>• 375,000 estimated enrollment in 2010, but funding exhausted by 2012 (CMS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“Anti-Dumping”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employers and insurers must reimburse for enrollee costs if they “dump” into HRPs</td>
</tr>
<tr>
<td>• HHS anti-dumping criteria must include payment of financial incentives to disenroll and private premiums higher than HRP due to non-actively marketed coverage, durational rating, and re-underwriting</td>
</tr>
</tbody>
</table>

While most states have risk pools, eligibility and benefit changes needed to meet new HHS contracting standards
“6-Month” Patient Protections

PPACA imposes several new requirements effective plan years 6 months after enactment

<table>
<thead>
<tr>
<th>New Plans</th>
<th>Insured*</th>
<th>Self-Funded</th>
<th>Grandfathered Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image.png" alt="Table" /></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Note: Many states already have similar patient protection requirements for insured plans
## Key Provisions: Individual Responsibility

| **Individual Mandate (2014+)** | All individuals must purchase minimum coverage  
Penalty (with exceptions) is lower of:  
• National average premium, **or**  
• Greater of: % income (up to 2.5%), **or** $95 (2014), $695 (2016) |
|-------------------------------|--------------------------------------------------|
| **Subsidies (2014+)** | Sliding scale, up to 400% FPL ($88,000/year for family of 4)  
– Only available thru exchanges |
| **Medicaid (2014+)** | Expanded to 133% FPL in all states  
– Mandatory enrollment under 100% FPL |
### Key Provisions: Employer Responsibility

<table>
<thead>
<tr>
<th>Requirement: “Play” (2014+)</th>
<th>Employer with &gt;50 FTEs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers &gt;50 FTEs must offer minimum coverage:</td>
<td>• Not offering coverage and at least one FTE receives tax credit</td>
</tr>
<tr>
<td>• Part-time are included on FTE basis in calculating &gt;50 FTE</td>
<td>• Offering coverage at least one FTE receives tax credit but actuarial value &lt; 60% or employee cost is &gt; 9.5% of household income</td>
</tr>
<tr>
<td>• Full-time employee is 30+ hours/week</td>
<td>• Lesser of $2000 x total FTEs or $3000 x number of employees receiving tax credit</td>
</tr>
<tr>
<td>• No minimum contribution</td>
<td></td>
</tr>
<tr>
<td>• Must provide “essential coverage” with 60% actuarial value minimum</td>
<td></td>
</tr>
</tbody>
</table>
| Free Choice Voucher (2014+) | Employers must provide for use in exchange if:  
  • Employee premium cost sharing is 8-9.5% of household income (>400% FPL) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-Enrollment</td>
<td>Employers &gt;200 employees must auto enroll FTE into health plan (employee may opt out)</td>
</tr>
<tr>
<td>Treasury Reporting</td>
<td>Employers required to submit annual coverage reports</td>
</tr>
<tr>
<td>W-2 Reporting</td>
<td>Must disclose cost of coverage</td>
</tr>
<tr>
<td>Early Retiree Reinsurance (2010)</td>
<td>Temporary reinsurance for retirees 55-64</td>
</tr>
</tbody>
</table>
### Key Provisions: Employer Responsibility (Tax)

| **Small Group Tax Credit (2010+)** | Employers < 25 employees and < $50,000/year average wages contributing > 50% of premium  
| | • 2010-2013: sliding scale credit up to 35% of employer costs (25% if tax exempt)  
| | • 2014+: credit up to 50% of employer costs (35% if tax exempt) for first 2 years; limited to exchange only |
| **Retirees Drug Subsidy (2013+)** | Eliminate tax exclusion for Part D subsidy payments |
| **High Cost Plan Excise Tax (2018+)** | 40% nondeductible tax  
| | • $10,200 individual; $27,500 family coverage  
| | • Excludes dental and vision |
## Key Provisions: Exchanges

<table>
<thead>
<tr>
<th>Exchanges (2014+)</th>
<th>States must establish exchanges for individuals/small employers (federal fallback)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Small employer (1-100 workers) (state option 1-50 workers until 2016)</td>
</tr>
<tr>
<td></td>
<td>• Employee choice</td>
</tr>
<tr>
<td></td>
<td>• Subsidies and small employer credits only available through exchange</td>
</tr>
<tr>
<td></td>
<td>• Options limited to 4 “actuarial value” benefit packages</td>
</tr>
<tr>
<td></td>
<td>• Bronze 60%, Sliver 70%, Gold 80%, Platinum 90%</td>
</tr>
<tr>
<td></td>
<td>• Insurers must offer Silver and Gold</td>
</tr>
<tr>
<td></td>
<td>• Catastrophic plan offering available to individuals &lt;30 or financial hardship</td>
</tr>
<tr>
<td></td>
<td>• State mandates required only if state pays added costs</td>
</tr>
<tr>
<td></td>
<td>• Participating plans must meet extensive requirements</td>
</tr>
</tbody>
</table>
Key Provisions: Exchanges (cont’d)

<table>
<thead>
<tr>
<th>Exchanges (2014+)</th>
<th>Grants to “navigators” for education and enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside Exchange</td>
<td>Individual and group coverage can be sold</td>
</tr>
<tr>
<td></td>
<td>– Must meet “essential benefits”</td>
</tr>
<tr>
<td></td>
<td>– Follow cost sharing limits</td>
</tr>
<tr>
<td></td>
<td>– Apply state benefits mandates</td>
</tr>
</tbody>
</table>
### Key Provisions: Benefits

<table>
<thead>
<tr>
<th>Benefits (2014+)</th>
<th>Must meet 3 elements:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Include “essential benefits” (HHS to define)</td>
</tr>
<tr>
<td></td>
<td>2. Limit cost-sharing</td>
</tr>
<tr>
<td></td>
<td>3. Meet minimum actuarial values (60%)</td>
</tr>
</tbody>
</table>

| Preventive Health (2010+) | Must provide w/out cost sharing |

| Wellness | Discounts allowed for group plans under certain circumstances |

| Grandfathered Policies (enrolled or dates of enactment) | • Existing coverage exempted from many new rules |
|                                                       | • Certain new benefit mandates apply (e.g., lifetime limits, pre-ex) |
|                                                       | • May add/delete employee/dependents |
# Key Provisions: New Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| Co-ops (2014+)                  | Creates non-profit, member-run health insurance companies to be offered in exchanges  
  - Provides grants for start-up |
| Multi-State Plans (2014+)        | OPM contracts w/insurers to offer at least two multi-state plans in exchanges  
  - One must be non-profit     |
| Basic Health Plan (2014+)        | States may create Basic Health Plan for uninsured individuals between 133-200% FPL                                                     |
# Key Provisions: Medicare

| Medicare Advantage (2012) | • Reduces payments relative to county FFS levels (CBO: $206B)  
  | |  
  | |   – Lowest FFS, payments = 115% FFS  
  | |   – Quality bonus payments up to 5%  
  | | • 85% MLR starts 2014  |
| Part D Prescription Drug Program | • 2011: $250 rebate if member hits doughnut hole  
  | | • 2012-2019 close hole  
  | | • Means-test Part D premium similar to Part B  |
| Medicare Parts A & B (2010+) | • No Medicare doc fix  
  | | • Reduces other FFS provider pay rates (CBO: $196 B) |
## Key Provisions: Other Medicaid/CHIP

<table>
<thead>
<tr>
<th>Provision</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Access (2013)</strong></td>
<td>• States must pay Medicaid primary care providers at Medicare levels</td>
</tr>
<tr>
<td></td>
<td>• 100% federal funding for increases in 2013 and 2014</td>
</tr>
<tr>
<td><strong>Medicaid Drugs (2010+)</strong></td>
<td>• Increases required discounts that drug manufacturers provide to states (CBO: $38B)</td>
</tr>
<tr>
<td><strong>CHIP Extension (2014+)</strong></td>
<td>• $40B in additional funding in FY 2014 and FY 2015 for the Children’s Health Insurance Program (CHIP)</td>
</tr>
<tr>
<td></td>
<td>• 2016: States can enroll CHIP kids in exchange plans</td>
</tr>
</tbody>
</table>
### Key Provisions: Other

<table>
<thead>
<tr>
<th>Independent Payment Advisory Board (2014+)</th>
<th>Recommends Medicare savings for expedited congressional action (until 2020 exempts hospitals, others)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative Effectiveness Center (2010+)</td>
<td>New independent center, all-payer funded</td>
</tr>
</tbody>
</table>
### Key Provisions: Financing

<table>
<thead>
<tr>
<th><strong>FSA Limits</strong> (2011+)</th>
<th>Limited to $2,500/year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax on Rx/Devices (2011)</strong></td>
<td>$47 B in new taxes</td>
</tr>
</tbody>
</table>
| **Increased Medicare Tax (2013+)** | Increases tax on income and investments for high income people  
  - Additional .9% HI tax for individuals >$200,000 and joint filers >$250,000 |
| **Insurance Tax (2014+)** | $60 B tax on insured products; $8 B in 2014 |
| **Cadillac Tax (2018+)** | Tax on high value plans ($10,200 single/ $27,500 family) |
“Grandfathering” from new requirements applies as long as coverage is “renewed”

- New employees and family members can enroll in grandfathered coverage
- PPACA does apply some requirements to grandfathered plans; the Reconciliation Bill (if enacted) would make additional requirements binding on grandfathered plans
Passage Would Be Only the Beginning

“The Secretary Shall...”
State Attorneys General File Lawsuits to Block Federal Health Reform Law

- Attorneys general from 19 states filed a lawsuit in the U.S. District Court for the Northern District of Florida challenging the Patient Protection and Affordable Care Act ("Act")
  - Argument centers on two elements:
    1) the Act's individual mandate is an unconstitutional expansion of Congress' ability to regulate interstate commerce; and
    2) the penalties for non-compliance with the individual mandate violate the taxation powers provided to Congress under the U.S. Constitution.
  - Lawsuit asks the court to:
    1) declare that the Act is unconstitutional and that the defendants have violated the attorneys general's rights as "sovereigns and protectors" of the health, freedom, and welfare of their citizens; and
    2) enjoin any federal agency or employee from enforcing the Act in the 13 states; and 3) award reasonable attorney's fees and costs, as the court finds proper.

- Virginia Attorney General Ken Cuccinelli (R) filed a separate lawsuit in the U.S. District Court for the Eastern District of Virginia challenging the individual mandate as unconstitutional.
  - Because the individual mandate is an "essential, non-severable" provision of the Act, Virginia's lawsuit asks the court to invalidate the entire Act. Virginia's lawsuit lists Secretary Sebelius as the sole defendant.
Current “Hot” Topics

• Implementation
• GOP talk of Repeal
• Extender Bills: Medicare “fix” for docs
• Access to Care: Shortage of primary care, general practitioners
• Medicaid Funding in the States
State of Illinois – State of the State

Potential Managed Care Medicaid

State Budget Crisis

State Impact of Federal HCR – Baton passes to the states...

State Bond Rating (2nd to California)

General Election – November
96th General Assembly 2010 Spring Legislative Session

- Runs January through May
- All legislation from 2009 still in play and new bills introduced

Some Issues under Consideration:

- Hearing Aid and Cochlear Implants
- Smoking Cessation $500 credit for treatment
- Glucose Strips as DME rather than pharmacy
- Guarantee Issue
- Non-Participating Providers/Member Balance Billing
- Network Regulation
- Cancer Clinical Trials – Routine Care
- State Mental Health Parity
- Rescission Regulation
- Psoriasis Mandate
- Mandated Maternity Care on Individual Policies
- State Response to Federal PPACA

Exchanges
Medicaid Expansion
High-Risk Pool Administration
Review of “Unreasonable Rates
Establishing Rules for Reinsurers
Looking Ahead: Implementation

• Passage of reform just the beginning
• Focus now on implementing new requirements
• HHS, DOL, Treasury, NAIC guidance forthcoming
• Want to work closely with stakeholders to identify/address key issues

Questions?
Closing Remarks