

# THE AIS REPORT

## on Blue Cross and Blue Shield Plans

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## WellPoint Under Fire For Errors in Rate Filing; Shrapnel Could Hit Other Insurers

WellPoint, Inc. has drawn the ire of federal and state lawmakers once again — this time over math errors that led to an inflated rate hike request. The California Department of Insurance found “significant” miscalculations including double counting in WellPoint’s rate filing, which one actuary calls “unusual.” The insurer withdrew its proposal for an up to 39% rate hike for individual plans on April 29, but regulators at all levels have continued to focus on the errors, indicating that scrutiny of rates could soon be up across the states.

WellPoint says the errors were inadvertent and that it will resubmit a filing that adheres to the health reform legislation’s call for an 80% medical loss ratio ahead of the 2011 implementation deadline.

Byron Tucker, the deputy insurance commissioner for the California Department of Insurance, says, “From the very beginning WellPoint submitted the rate filing, we had our reservations about the accuracy of the data....Commissioner [Steve] Poizner felt something was askew and asked Anthem to voluntarily withhold implementing the increase.”

*continued on p. 9*

## Blues May Implement Reform Provisions Early but With Loose Interpretation of Regs

Blues plans are getting a jump on required health reform changes by implementing provisions regarding young adult coverage and rescissions ahead of their Sept. 23 deadlines. The regulations for young adult coverage were released May 10, while those for rescissions have yet to be published. But the implications of early implementation are still hazy, experts say, because insurers are not bound to the federal regulations until the law goes into effect.

The Blue Cross and Blue Shield Association said April 20 all 39 independent Blues plans will extend coverage for young adults, who typically are cast off their parents’ policies upon graduating from college or high school, up to age 26 starting June 1. The implementation applies to fully insured plans only — self-insured clients may choose whether to extend coverage. The U.S. Office of Personnel Management announced that the Federal Employees Health Benefits Program (FEHBP) will not accelerate the effective date for young adult coverage. BCBSA administers the Federal Employee Program, which provides coverage for 60% of FEHBP members.

Yet for the next few months, insurers can pick and choose which regulations they comply with. Robert Laszewski, president of Health Policy and Strategy Associates, Inc. in Alexandria, Va., says, “Generally, because they are doing things voluntarily, they’ve got a lot of flexibility.” The health reform legislation, as it is written, is broad and applies to all young adults, regardless of whether they are married, employed or have dependents of their own, Laszewski says. Insurers implementing the provision early “could do it just for children graduating from college,” he points out, because they are not

bound to comply with the law until plan years beginning on or after Sept. 23. For the majority of health plans, the rules will take effect Jan. 1, 2011.

Under the regulations, young adults who qualify can join their parents' coverage during an open-enrollment period. But Bob Meehan, vice president of consumer and senior markets for Horizon Blue Cross Blue Shield of New Jersey, says, "For a lot of companies, [the early extended coverage] only applies to young adults who are currently covered. If someone dropped out a couple of months ago, most plans are not allowing that person back on until the federal government kicks in."

Laszewski emphasizes that the logistics of early implementation will vary from company to company.

Enrollees will have to weigh premium costs for dependent coverage, says Meehan. In some cases, staying on a parent's plan may not be the cheapest option. If a parent has more than one child, the cost of adding a dependent is usually nominal. "The trickier issue is if you and your spouse only have one child and that one child is about to age out," he says. The incremental cost of add-

ing a single dependent may be more than the cost of buying individual coverage. Or in states like New Jersey that already are guaranteed issue, the state coverage might be a little cheaper. "As a subscriber, you do have to look and see what all your options are," Meehan says.

Keeping young adults on their plans by implementing the policy early is beneficial for insurers, says Dean Hatfield, a health practice leader for Sibson Consulting. "That's additional premiums being paid and it helps them with loss ratios. It does make a lot of sense to do it." For the most part, these young adults tend to be healthier. "It comes down to risk-sharing," he says.

HHS says on its website that early implementation will also "save on insurance company administrative costs of dis-enrolling and re-enrolling [young adults] between May 2010 and the start of the plan or policy year beginning on or after September 23, 2010."

### WellPoint First to Stop Rescissions

A number of Blues plans also said they will stop rescinding policies immediately, except in cases of fraud or intentional misrepresentation. Insurers emphasize that rescission is used rarely and is an important tool in the fight against fraud. The health reform legislation mandates that insurers provide advance notice of their intention to retroactively cancel an insurance policy in plan years beginning on or after Sept. 23.

HHS Sec. Kathleen Sebelius called on insurers to stop the practice after *Reuters* reported that WellPoint, Inc. was using algorithms to target women with breast cancer and cancel their coverage. WellPoint denied the accusation in a letter to Sebelius, calling the *Reuters* story "inaccurate and grossly misleading." Five days later, on April 27, WellPoint became the first insurer to announce it would implement the rescission reforms early.

On May 8, President Obama reiterated the *Reuters* account in his weekly radio address. WellPoint lashed back with a letter to Obama the next day, stating that "WellPoint does not single out women with breast cancer for rescission. Period."

Over the last three years, California regulators have fined insurers, including WellPoint subsidiary Anthem Blue Cross and Blue Shield of California, as much as \$15 million for issuing rescissions in violation of state laws (*The AIS Report* 2/09, p. 9).

According to Laszewski, companies were previously engaging in "rescission abuse" by canceling policies for inadvertent omissions on insurance applications. For instance, a 40-year old woman who forgot to write that she briefly sought treatment for back pain when she was 25 could face rescission after a breast cancer diagnosis, "which is just outrageous," he says.

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Under the new health reform law, “you can still rescind when someone intentionally commits fraud and leaves material information off [of an insurance application],” Laszewski explains. For instance, failing to report that you had treatment for breast cancer two months ago “is certainly material and they can rescind the policy,” he says. But leaving off immaterial information, such as having seen a doctor about an unrelated condition 15 years ago, is no longer grounds for rescinding, says Laszewski.

BCBSA did not respond to request for comment prior to *The AIS Report’s* deadline.

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## **BCBSF Pushes Single Vendor on ASCs, but Keeps Docs Happy**

Blue Cross and Blue Shield of Florida is requiring ambulatory surgery centers (ASCs) to order surgical implants through a single device vendor — a move that might be expected to rile surgeons and physician groups but so far hasn’t ruffled many feathers. Implantable Provider Group (IPG) says it is able to save the insurer at least 10% to 15% without limiting physicians’ choices. But while ASCs and insurers have seen early benefits, one major manufacturer has taken exception to the program and is refusing to deal with IPG.

Insurers face continuous challenges trying to control the cost of implants. Barry Schwartz, M.D., vice president of network management at the Florida Blue plan, says prices for implants “are all over the place.” For instance, he says, an artificial hip can cost anywhere from \$2,000 to \$15,000, depending on the vendor and the type of material used.

ASCs sometimes negotiate rebates from manufacturers that can reduce an implant’s cost by up to 30% — but that rebate may or may not be passed on to the payer, says Robert Phipps, vice president of payer programs for IPG. Coding for implants is inconsistent as well, with some ASCs even using miscellaneous codes. By the time the bill gets to the insurer, it’s not often clear what items the plan is being asked to pay for, Phipps explains.

With prices for implants on the rise, cost control is only getting harder. Jay Ethridge, the CEO of IPG, explains that normal medical cost trends are increasing between 4% and 6% a year, while the trend for implants is 8% to 10%. The implant market is “one-third the size

of the pharmaceutical market. It’s a significant spending area for the plans,” he says.

The BCBSF program with IPG took effect in April. As of now, 150 ASCs are involved; the remaining ASCs can choose to opt in or wait until their anniversary rolls around to begin using IPG.

Previously, ASCs ordered implants from the manufacturer and then sent a bill to the health plan. Under the new program, IPG plays the middleman: ASCs contact IPG to request implants, and IPG deals with the manufacturer and then bills the insurer. The ASC no longer has to do any of the billing, Schwartz explains.

The hitch would seem to be that IPG only deals with a limited number of manufacturers, right? Wrong. Robert Phipps, the vice president of payer programs for IPG, explains that IPG is currently under contract with about 65 manufacturers and the list is growing. If a physician or ASC wants an implant from a manufacturer that IPG is not under contract with, IPG will reach out to the manufacturer to set up an agreement. “If the manufacturer says they don’t want to deal with this, it’s simple. We’ll just write the ASC a check,” he says, though this policy is only temporary. “The goal is to make sure that physicians and ASCs have a choice about what [implants] they want to use in their surgeries,” Phipps says.

Michael Wasylik, M.D., a Tampa, Fla.-based orthopedic surgeon and chair of the Florida Medical Association’s Managed Care Committee, says, “We’re always suspicious when managed care is doing something. But so far, it’s really turned out to be OK... [Physicians] have been able to get the implants they want, which is very good. That was one of our concerns.”

One downside he sees is that ASCs charging mark-ups on implants could lose some money. “But it seems to be working out better than what the centers had before. The IPG people seem to be helping them out,” Wasylik says. “They’re getting implants by dealing with one group rather than dealing with 25 or 26 vendors.”

### **Arthrex Refuses to Contract with IPG**

However, IPG says it will not continue reimbursing ASCs for implants from manufacturers that don’t sign a contract for much longer. And one major manufacturer — Arthrex, Inc. in Naples, Fla. — has refused to sign with IPG and does not seem to be budging. Wasylik says Arthrex offers some of the most cutting-edge technology on the market. Their holdout is significant, he says, “because going down there for a physician is like a little kid going to Willy Wonka’s candy shop.”

Phipps says Arthrex takes “issue with how our model works. They believe it takes control out of their hands and puts it in the payer’s hands.” He notes that IPG has

had accounts with Arthrex in the past without any problems. But in this case, "so far they've been extremely resistant to deal with us or have dialogue with us." Arthrex did not return *The AIS Report's* request for comment.

According to Phipps, IPG has not yet decided what it will do about Arthrex long term. As for now, the company will keep cutting checks to the ASCs. Etheridge says IPG is already contracting with all of Arthrex's competitors. "It will be difficult for them to not be part of the program," he says.

While IPG does have agreements with other insurers, the BCBSF deal is the only one that requires ASCs to use IPG rather than giving them the choice to continue billing the payer for implants, says Phipps. An IPG competitor, Access MediQuip, is doing similar programs with WellPoint, Inc. in some states, says Etheridge, but the Florida program "is innovative in terms of the approach."

### Deal Keeps Surgeries at ASCs

Many payers in Florida and nationwide are beginning to include implant costs in the technical fee for surgery, says Phipps. This tends to drive surgeries to hospitals, which is more expensive for the insurer and often less desirable for the patient than the ASC outpatient setting. "Blues is the first one to say, 'We're not going to go that way.' They'll do what they can to keep it in the ASC. It's a novel concept considering what other payers are doing out in the marketplace," he says.

Schwartz would not comment on how much money the Florida Blues plan is hoping to save through the deal. Etheridge did not offer exact figures either, but says, "Typically we can conservatively estimate 10% to 15% in savings expected the first year as far as implementing our program."

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## IBC, CareFirst, Highmark Eye Ways to Reform Physician Payment Methods

Several Blues plans are making changes to the way they pay primary care physicians — with two plans focusing on the medical home model and another with a menagerie of options on the table — in an effort to reduce health care costs.

Philadelphia-based **Independence Blue Cross** will launch a new version of its decade-old Quality Incentive Payment System (QIPS) on July 1. Richard Snyder, M.D., IBC's chief medical officer, says the two major drivers of the new program were the rising cost of care

and the need to improve the primary care physician network.

IBC will invest \$47 million in primary care, both to boost payment levels for primary care physicians in return for improved quality and efficiency and to support the medical home model. One major change is that the company will increase physicians' base reimbursement levels by 10%, Snyder says. "Last year, we spent \$32 million on the QIPS program in incentive payouts. And that number is doubling," Snyder says. "A physician with 850 patients could earn up to \$150,000 in extra revenue in a year... This is serious money to providers."

IBC will continue to use Healthcare Effectiveness Data and Information Set (HEDIS) measures, such as standards for blood sugar testing and cholesterol screenings, to determine quality of care. However, the company will no longer include member satisfaction surveys as part of the measurement because, according to Snyder, there "was not statistical variation between providers." Patients tend to be positive about their physicians, he says, because if they have a negative experience they will find a new doctor.

Physicians will be reimbursed as patient-centered medical homes based on tiers, Snyder says. "The expectation of a medical home is there's more electronic connectivity, more timely access... and more coordination of care," he explains. The program is "intended to be a bridge to help providers to make that transition [to becoming medical homes]. It's an expensive transition in hours and human effort and resources." IBC will also incentivize physicians to manage medical costs. Snyder says that using a team approach to delivering care can help keep people healthier and keep costs down.

### CareFirst Ups Provider Fee 12%

Under **CareFirst BlueCross BlueShield's** new HealthyBlue product, primary care medical homes (PCMHs) that are most effective in reducing costs and improving quality could see their base rates for care double. CareFirst, which operates in Maryland, Washington, D.C., and northern Virginia, hopes to launch the product in the third quarter, CEO Chet Burrell tells *The AIS Report's* sister publication *Health Plan Week*.

The foundation of HealthyBlue will be a group of community-based medical homes. Group practices that include five or more primary care physicians will be able to build their own PCMHs, while small and solo practices will be able to join with others to form a medical home panel. Network providers who join will see an immediate fee increase of at least 12%. In exchange, they must agree to coordinate patient care,

develop treatment plans, maintain electronic connectivity with CareFirst and consider the most cost-effective specialists when referring patients.

Rather than spending 10 minutes with each patient, physicians in the program might need to take as much as an hour to evaluate the patient's needs and develop a care plan. For such in-depth visits, CareFirst says its reimbursement could be approximately \$200.

Based on prior claims data, CareFirst will establish a "global expected cost of care" benchmark based on the number of patients in a medical home as well as their age, sex and risk characteristics. CareFirst will divide its region into 18 subregions and will provide local community support, which likely will be headed by a registered nurse.

At the end of the year, the PCMHs will be evaluated based on a variety of criteria including prescription patterns, patient compliance, follow-up care and referrals. They also will be evaluated against HEDIS quality measures, preventable hospital readmissions and documentation of patient engagement.

A PCMH that scores in the second quartile on quality and comes in 5% below the "global expected costs" for the year could see a reward of between 40% and 50% of its base fees. If quality and cost improvements continue in subsequent years, top-performing medical homes might see their base reimbursement levels double.

"There could be some significant dollars. It's enough to get them to pay attention to cost, outcomes and quality," Burrell says.

**Highmark, Inc.** has been discussing alternate payment methodologies with regional health systems as well. "The concerns we have are cost and quality," says Michael Weinstein, spokesperson for Highmark. "Nationwide, there is a lot of discussion about alternate payment approaches. Incentives as they are today encourage higher pay based on volume."

Weinstein would not confirm details about the types of payment reform being discussed. However, the *Pittsburgh Post-Gazette* reported April 1 that Highmark "has been exploring reinstating a form of medical reimbursement called 'capitation.'" Insurers, including Highmark, began moving away from flat-rate per-patient fee reimbursement for physicians and hospitals years ago, under criticism that such plans encouraged providers to avoid treating the sickest patients. The *Post-Gazette* and other news sources stated that Meadville Medical Center and Heritage Valley Health System were in discussions with Highmark, but Weinstein says to "mention those is probably premature."

Despite the media hubbub, "there's nothing concrete, nothing specific," says Weinstein. "All approaches being talked about are on the table.... We're trying to

## **The Regulation of Medical Loss Ratios: Major Changes Health Plans Should Design Now**

- How is HHS likely to define MLR in terms of what qualifies for medical costs?
- What would be the impact of measuring MLR on a state-by-state basis versus plan-wide or company-wide, and using a one-year versus three-year measurement period?
- What is likely to be the impact of MLR provisions on commercial and Medicare insurers' earnings?
- What effect does reclassifying administrative costs (such as like disease management and medical policy) have on an insurer's MLR profile?
- How much flexibility do insurers typically have to adjust broker commissions? How would that affect the already difficult individual market?
- How does New Jersey define MLR, and what has been the impact of the MLR reporting and rebate law on insurers, brokers and others in that state?

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determine if there's shared mutual interest with health systems to explore alternate payment methodologies."

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## Slew of HIPAA Security Breaches Could Tarnish the Blues Brand

Companies that have been involved in widespread privacy and security breaches can attest to the fact that not all press is good press. In the past year, Blue Cross and Blue Shield plans have been involved in at least four major breaches of protected health information, one of which affected more than 1 million people. And based on the new federal security breach notification regulations, public awareness of breaches is growing. Employee benefits experts say consumers are learning to ask questions about information privacy when choosing a health plan, and that breaches by local Blues affiliates and their business associates do reflect on the overall Blues brand. But the Blue Cross and Blue Shield Association says breaches are not unique to the Blues and that the name will not suffer.

### Breaches Stem From Theft, Human Error

One story that's repeatedly made headlines is the October 2009 breach at a BlueCross BlueShield of Tennessee training facility, in which 57 small hard drives were stolen out of a data closet (*The AIS Report 10/09, p. 1*). Nearly 1 million people had information, including their Social Security numbers, exposed as a result of the break-in and theft.

Two months prior to the Tennessee breach, a laptop containing approximately 850,000 physicians' Social Security numbers and tax identification numbers was stolen from a BCBSA employee's car (*The AIS Report 10/09, p. 1*). The incident, which was announced by BCBSA in late September, involved an employee who had proper access to the data but downloaded an unencrypted version of the information onto a personal laptop.

In a bewildering turn of events in April 2010, Blue Cross and Blue Shield of Minnesota printed a woman's confidential health information in a handbook that was mailed to 95,000 insurance subscribers (*AIS Report 3/10, p. 12*). The claims form, which BCBSMN said was published as a result of a "human error," included the woman's name, the medical services she received over a one-month period and their cost. BCBSMN discovered its own error and alerted the affected woman, who has since filed a lawsuit against the insurer.

And just this month, Blue Cross & Blue Shield of Rhode Island gave away a filing cabinet containing

12,000 members' information. The insurer donated the cabinet to a nonprofit before removing Medicare health surveys, which included members' names, Social Security numbers, Medicare identification numbers and medical information.

These days, security breaches are garnering both local and national attention. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was signed into law in February 2009, ordered that HIPAA covered entities self-report security breaches affecting more than 500 people to local news media and HHS. The HHS Office for Civil Rights (OCR) posts these breaches on its website for public viewing ([www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/postedbreaches.html](http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/postedbreaches.html)).

### Pattern of Problems Emerges

Combing the OCR list, most of the breaches appear to have been at hospitals and medical centers, but a pattern of Blues-related breaches does emerge. Harry Rhodes, director of practice leadership for the American Health Information Management Association (AHIMA), says, "Blues [plans] have got some of the biggest numbers in terms of the total number of people affected.... That's why they're getting a lot of attention."

He says that average consumers who only watch "every second news spot on TV" and see the Blues brand mentioned repeatedly may not differentiate between local Blues affiliates. "I think it will hurt their business," Rhodes says.

However, BCBSA says this is not much of a concern. According to Jeff Smokler, spokesperson for BCBSA, "Any instance of a security breach is unfortunate, but it's certainly something that's not unique to the Blues. In fact, I think the Blues have an impressive track record when it comes to complying fully with HIPAA and other laws that impact personal health information."

The OCR website also lists breaches that were caused by business associates, but categorizes them under the HIPAA covered entity's name. BCBSA is listed twice for breaches in which business associates were involved — one disclosure in October 2009 affecting 15,000 individuals and another affecting 3,400 individuals the same month. Both were the result of paper mailings. Rhodes says consumers are likely to focus on the Blues name and may not recognize that the business associate was responsible for the error.

Michael Vittoria, president of the Rhode Island Business Group on Health, says that people in Rhode Island tend to understand that BCBSRI is an independent entity. "That said, we're dealing with a brand," he explains. "If you're a multi-state employer, as many of us are, the reason you buy the brand is so employees who live and

work around the country can access health care through the local Blue Cross network. By extension, other Blues [plans] having problems with data privacy has to reflect on the local affiliates."

Even so, Vittoria believes the Rhode Island breach "probably will not result in the loss of business for Blue Cross." For one, the Rhode Island Blues plan has the majority of the state's health insurance market (a study by the American Medical Association released in February put their market share at 68%). Vittoria says the health plan also has a "good reputation for privacy. It's much more an embarrassment than an indication of a systemic problem."

Smokler says, "We take very seriously any kind of breach of a member's privacy and security. In each of the rare instances where there has been a security breach, whether with the association or an individual plan, we've acted swiftly and fully to rectify the situation."

Consumers do consider information privacy in choosing plans, says Dean Hatfield, a New York-based health practice leader for Sibson Consulting. During the bidding process, it's "routine now to ask a number of questions around privacy," he says. "If there's been any sort of broadcasted news there was a breach in that area, that's something to add into the script to ask various reference checks." He recommends clients ask for 10 references rather than the typical five when looking into an insurer that has experienced a major breach.

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## Physicians Storm Out of Ratings Talks with Blue Shield of California

A small blue icon — or the absence of one — is causing much turmoil between physicians and Blue Shield of California. The insurer says its Blue Ribbon rating system, scheduled to begin June 1, is intended to reward physicians with a positive track record, but members of the California Medical Association (CMA) argue it unfairly penalizes physicians for their patients' decisions and is based on faulty data.

Michael-Anne Browne, M.D., the medical director for quality at Blue Shield of California, explains that the company has been working with the California Physician Performance Initiative (CPPI) for three years to develop a system to measure the quality of patient care. CPPI was formed under the California Cooperative Healthcare Reporting Initiative, a collaborative of health plans, providers and consumers. "We were attempting to look at claims data to see if one could get a quality read at the individual doctor level," Browne says. Blue Shield of

California partnered with Anthem Blue Cross, United-Healthcare and the Pacific Business Group on Health for the CPPI negotiations.

The group decided to use the Healthcare Effectiveness Data and Information Set (HEDIS), the industry standard for measuring the quality of health plans, to score physician quality. HEDIS examines such criteria as whether women get annual pap smears for cervical cancer screenings and people with diabetes have their blood sugar and lipid levels checked. Blue Shield of California determined it would use claims data to gather evidence and come up with physician ratings.

"The CPPI project decided the results were directionally informative," says Browne, meaning they would indicate which doctors were generally performing better. In order for a physician to receive a score at all, he or she had to have at least 30 patients with a particular condition that was being measured, such as diabetes. Physicians who met the criteria would have a blue ribbon next to their name on the Blue Shield website, under "Find a Provider."

Physicians in primary care, cardiology, gynecology and endocrinology are all subject to scores, but those in vascular surgery and orthopedic surgery are not. Browne says there is currently no way to indicate on the website whether a physician received a score. That is, the absence of a ribbon could mean either a low quality score or insufficient data.

### CMA: Error Rate Is 'Ridiculously High'

The insurer mailed its first set of physician report cards at the end of July, says Browne. Physicians were "able to request patient lists and find out which patients were attributed to them, and which had evidence for needed care. We encouraged [physicians] to pull patient charts and submit corrections if corrections were needed," she says.

According to Andrew LaMar, spokesperson for CMA, that first set of report cards was rife with problems. "What doctors were seeing in looking at the ratings was that a bunch of patients who didn't get screened for cervical cancer, it was because they had hysterectomies in the past," he says. "Those kinds of problems are inherent in the rating system as we have it now.... The error rate is ridiculously high," says Lamar.

And though physicians were offered the opportunity to correct the mistakes, Lamar says "it would literally take them and their staff hours, even days to correct the records.... That's an administrative nightmare — to be in the position that to protect your reputation you have to take time out of caring for patients."

Browne says physicians were given over a month to request corrections, but admits that "for some docs it didn't get to their attention for a few weeks. Perhaps they

or their office staff didn't understand what the report card was." She says the project is looking for ways to streamline the reconciliation process, so that doctors with hundreds of patients needing cervical cancer screenings do not have to pull every patient's chart.

Another major problem, according to CMA, is that the system holds physicians 100% accountable for their patients' actions. "The physician-patient relationship is a dynamic one; it's certainly not an autocratic one," LaMar says. "Many dedicated physicians follow up with patients...but ultimately how can a physician be blamed if the patient says 'I don't want to do that?'"

Blue Shield of California sees accountability from another angle. "We think that there is a difference in some physicians' abilities to actively engage patients in taking care of their health...and that's worth shining a light on," says Browne.

CMA is also dissatisfied that physicians have no way to opt out of the rating program. "We feel strongly that until you can guarantee the accuracy and fairness of these ratings they should be voluntary," says LaMar. The controversy is akin to what is happening

in schools with teacher rating systems and performance pay, he contends.

CMA pulled out of the negotiations with CPPI and Blue Shield, stating that their concerns were not being addressed. "Unfortunately physicians are portrayed as being obstructionist about this," says LaMar. "We wholeheartedly support the notion of transparency and providing vital information to patients — but we've got to do this right." In the short term, CMA is hoping Blue Shield will at least postpone the implementation — as Browne says they did at the end of last year — and make the program voluntary.

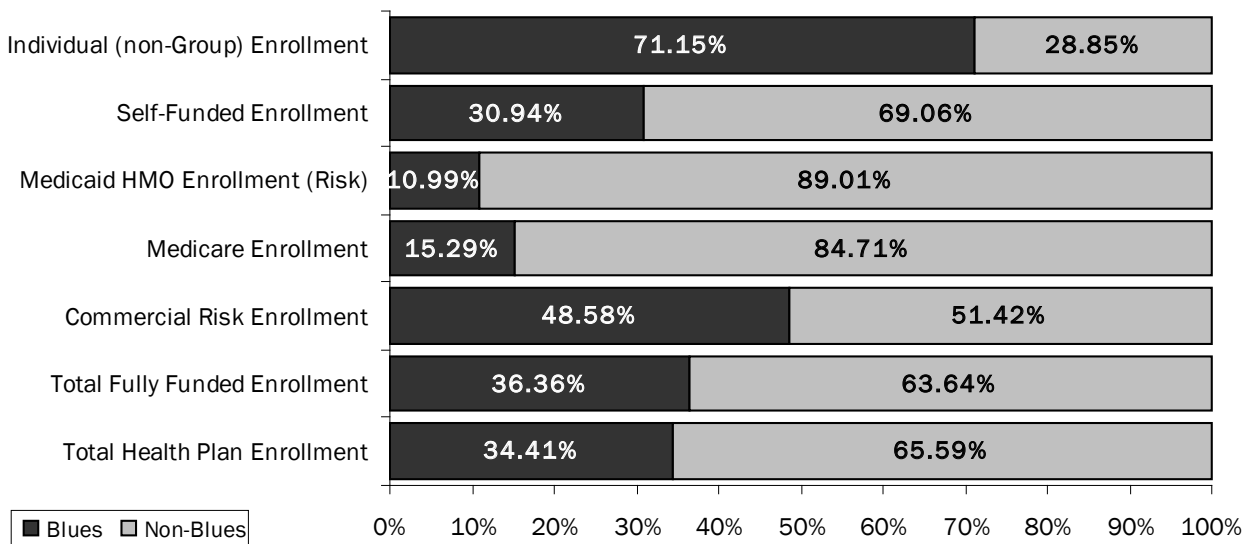
"Their decision was to withdraw," says Browne, "which perhaps makes sense since they couldn't see a way to suggesting a path forward...The project does continue to live and progress. I think the door is open to CMA at whatever point they wish to rejoin the discussion."

The program is set to begin on June 1, and California Blue Shield says it will commence with or without CMA's support.

Contact Browne through Johnny Wong at (415) 229-6321 or johnny.wong@blueshieldca.com and Andrew LaMar at (916) 551-2881 or alamar@cmanet.org. ✧

### Blues Medical Enrollment as Percentage of Total, by Sector

Blue Cross and Blue Shield plans cover just over one-third of all insured people in the U.S., according to analysis of AIS's *Directory of Health Plans: 2010* data. Nationally, Blues plans represent the majority of individual (non-group) members, and almost half of all commercial risk members—e.g., employer-sponsored HMO/POS/PPO plans. Blues plans cover only 15% of Medicare Advantage beneficiaries and only a small fraction of Medicaid recipients, according to the AIS data.



SOURCE: AIS's *Directory of Health Plans: 2010*. For ordering information visit [www.aishealth.com/Products/dhp.html](http://www.aishealth.com/Products/dhp.html) or call (800) 521-4323. METHODOLOGY: Researched by AIS editorial staff via survey and publicly available sources. Survey included health insurers operating as of Jan. 1, 2010. Enrollment data are current as of fall 2009 and include insured and ASO managed medical enrollment only, not pharmacy or other specialty enrollment. Blues enrollment may include some non-branded membership of BCBS affiliates.

## Michigan Temporary High-Risk Pool Could Prove a Boon for BCBSM

The Michigan insurance commissioner announced April 30 the state will partner with the federal government to set up a temporary high-risk pool for uninsured individuals. Blue Cross Blue Shield of Michigan, which is the insurer of last resort in the Great Lakes State, may serve to gain from the arrangement — both because the new plan could take some of the sickest members out of the BCBSM pool and because the insurer could be selected to administer the plan.

The high-risk pool program was included in the federal reform legislation to assist individuals who've been denied insurance coverage due to serious pre-existing conditions. Jason Moon, spokesperson for the Michigan Office of Financial and Insurance Regulation, explains that it's a temporary three-and-a-half-year program "designed to be a bridge until implementation of the other coverage provisions [including the health insurance exchange] take place in January 2014."

Under the reform legislation, to be eligible for the federal high-risk pool an individual must have a pre-existing condition and must not have had coverage for the previous six months. The law appropriates \$5 billion to the program, which will be available starting July 1. Michigan will receive \$144 million and, like all other states, will not have to contribute any state funds.

### New Pool Could Diffuse Costs

While the logistics still need to be ironed out, the program could prove advantageous for BCBSM. As the insurer of last resort, the Michigan Blues plan must accept members who've been denied by other insurers, regardless of their health conditions. The state has no high-risk pool in operation now. BCBSM receives tax-exempt status but bears the burden of managing people with high-risk conditions (*The AIS Report 6/09, p. 7*). The new high-risk pool could diffuse the costs of sicker members across two plans.

The Michigan Blues plan might also be offered the chance to administer the plan since the law requires HHS to contract with a not-for-profit entity. Insurance Commissioner Ken Ross wrote a letter to HHS Sec. Kathleen Sebelius announcing the state's intent to implement the program, saying, "Michigan would likely subcontract with a health carrier or insurer in the health market to deliver subsidized coverage to the eligible high risk population." Helen Stojic, spokesperson for the Michigan Blues plan, told *The AIS Report* in an e-mail that "the state is approaching BCBSM, along with a number of others, to help them determine how best to move forward. But again, it is too early to judge as more guidance is needed from the Department of Health and Human Services."

Moon says the high-risk pool will not affect BCBSM's status as the insurer of last resort. The federally run program and the BCBSM individual plans will differ in premiums and benefit designs, he says, though he could not offer details on how.

Stojic emphasizes that the new pool will have an impact only on a small percentage of the population. "Until all carriers are required to accept anyone, regardless of health status — as BCBSM already does — people rejected by other carriers for pre-existing conditions that will not qualify them for the risk pool will only have Blue Cross Blue Shield of Michigan as an option," she writes. "This is why we continue to advocate for change in Michigan legislation now in order to ensure everyone has broad access and choice."

See the HHS fact sheet on the high-risk pool program at [www.hhs.gov/ociio/initiative/hi\\_risk\\_pool\\_facts.html](http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html). Contact Moon at (517) 335-1700 and Stojic at (313) 225-8113 or [hstojic@bcbsm.com](mailto:hstojic@bcbsm.com). ♦

## Rate Filing Error Brings Scrutiny

*continued from p. 1*

The insurer complied and the department hired a team of four outside actuarial consultants to review the filing. That review, completed by Axene Health Partners, LLC, found errors including "double counting of aging in the calculation of underlying medical trend for the projection of total lifetime loss ratio" and overstatement of "the initial medical trend used to project claims for September 2009 for known risk factors." According to the report, the review demonstrated that "Anthem Blue Cross could reduce their average rate increase by 10.2% and still achieve the Lifetime Loss Ratio they forecasted in their rate filing, once their methodology was corrected."

California is a file-and-use state, meaning the commissioner does not have the authority to reject a rate hike request. However, the state requires insurers to use a 70% or higher medical loss ratio (MLR). Once the methodological errors in WellPoint's filing were fixed, the insurer's SmartSense product did not meet the 70% MLR compliance standard. Tucker says the next step would have been a legal hearing, but there was no need for one because WellPoint voluntarily withdrew its proposal within 48 hours of the finding.

A WellPoint press release states the insurer will "revise rate requests as soon as possible, likely sometime in May."

David Tuomala, an actuary at Ingenix Consulting, says when it comes to calculating a rate increase, companies "have protocol to follow. It's a rote exercise to some

degree. Major errors in calculation seem to be an unusual thing." State regulators often have their own staff review rate increases, he says, but to go to an external firm for a review "sounds unusual" as well.

In his experience, Tuomala says, "for something that's a relatively large increase or something that might be viewed as being politically sensitive, there are several layers of review to make sure everyone is happy and comfortable with it" before the rate request is submitted. Any premium increase "in excess of 20% or 25% is going to get a hard look at from the regulator, and from the company" beforehand, he says.

According to the WellPoint press release, in refiling the rate requests, the insurer will use "updated and real-time medical utilization information as well as address inadvertent miscalculations related to the way in which we estimated our future medical costs in our initial filings."

In addition, the statement notes that the health care reform legislation requires insurers to use an 80% MLR for individual products. "As such, Anthem will resubmit its individual rate filings in California to meet our current understanding of this requirement in advance of the effective date of January 1, 2011," it states.

### Mild Flu Drives Up First-Quarter Earnings

WellPoint, Inc. and Triple-S Management Corp. were among several publicly traded health insurers that benefited from the mild flu season in their first-quarter 2010 financial results.

WellPoint said April 28 that it had first-quarter 2010 net income of \$876.8 million (\$1.96 a share), up 51% from \$580.4 million (\$1.16 a share) in the year-ago period and topping Wall Street's consensus by about 30 cents. Revenue remained virtually unchanged at \$15.1 billion. The company's medical loss ratio, aided by lower-than-expected utilization, was 81.8%, down from 82.5% in the first quarter of 2009.

Chief Financial Officer Wayne DeVeydt told investors that "our adjusted earnings increased by 7.8% in the quarter, due in part to a less severe flu season than we expected." The mild flu season drove down first-quarter medical loss ratios across the commercial, Medicare and Medicaid business lines.

DeVeydt added that since there is no claims code for the flu, it is "very difficult" to accurately estimate costs associated with the flu. But he said flu-related costs may have fallen by \$35 million to \$50 million compared with the previous year. He added that Well-

Point is assuming a return to "normal flu levels" for the third and fourth quarters of 2010.

As of March 31, WellPoint had 33.9 million members — a decline of 724,000 from the same date a year ago. Much of the decline was in the small-group and individual markets.

Meanwhile, Puerto Rico-based Triple-S Management Corp., the parent of Blue Cross and Blue Shield of Puerto Rico, said adjusted first-quarter 2010 net income rose 32% to \$10.8 million, or 37 cents per share.

Although Triple-S incorporated the projected impact of the H1N1 swine flu in premiums, CEO Ramon Ruiz-Comas said the insurer has seen little impact from the flu so far in 2010.

Although many Blues plans are scrambling to meet the challenges of the federal health reform law (see story, p. 1), Ruiz-Comas told investors that "while there is still uncertainty surrounding many of the legislation's specifics, because our business is concentrated in Puerto Rico, our initial assessment is that for the next two years key components will not affect us in the same way as our U.S. peers." He added that "additional funding is anticipated for Medicaid, which would be of significant benefit to our population."

	WellPoint, Inc.		Triple-S Management Corp.	
	1Q2010	1Q2009	1Q2010	1Q2009
Total premium and fee revenue	\$14.9 billion	\$15.3 billion	\$519.1 million	\$472.8 million
Net Income	\$876.8 million	\$580.4 million	\$11.2 million	\$3.9 million
Earnings per Share	\$1.96	\$1.16	\$0.38	\$0.13
Medical Loss Ratio	81.8%	82.5%	90.0%	91.5%
Administrative Cost Ratio	14.8%	14.6%	15.2%	14.8%
Membership	33.8 million	33.7 million	1,364,881	1,209,463

SOURCE: Company financial statements, compiled by Atlantic Information Services, Inc.

WellPoint spokesperson Jon Mills says the company has “no further comment” beyond the press release.

### Sebelius Pushes for State Scrutiny

On May 5, HHS Sec. Kathleen Sebelius elevated the California conversation to a national level. She wrote a letter urging governors and insurance commissioners to re-examine WellPoint rate increases in their states “to determine whether any mistaken assumptions similar to those made in California were made.” Sebelius has been coming down on WellPoint for months now, since it first requested the rate hikes of 20% to 39% for individual plans (*The AIS Report 3/10, p. 1*).

A report from investment bank Cowen and Co. on WellPoint’s rate filing states that “scrutiny on such filings is likely to continue to intensify given the blunder and the current political and legislative environment.” A Stifel Nicolaus analyst echoes that prediction, saying “this issue is likely to expand as insurance commissioners in other [WellPoint] markets open formal investigations of recent underwriting practices in their states.” The report says the incident is “terrible timing,” because it happened after pro-reform lawmakers used WellPoint’s requested rate hike “to reignite the healthcare debate and pass legislation.”

Poizner announced May 5 that the California Department of Insurance is investigating WellPoint’s claims payment systems to make sure the underlying information used to justify future rate filings is “fair and accurate.” Poizner (R) is a candidate in the June 8 gubernatorial primary in California.

Tuomala says a new federal review requirement — part of the health reform legislation that would give federal regulators the authority to disapprove rate hikes — “could potentially lead to more scrutiny” as well. The legislation states that the HHS secretary “shall review the rating areas established by each State...to ensure the adequacy of such areas...If the Secretary determines a State’s rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.” HHS has not issued guidance on how it plans to implement this reform provision.

WellPoint CEO Angela Braly sent a memo to 40,000 employees May 5 stating that the company will do the following to ensure “greater accuracy moving forward”:

- ◆ *Update the internal peer review processes* to include third-party actuaries;
- ◆ *Ask the insurance commissioner to allow Axene to help* the company prepare an updated filing;
- ◆ *Implement third-party reviews of all 2010 filings* across the company’s 14 states;
- ◆ *Reach out to state regulators* to answer questions about rate filings; and
- ◆ *Investigate why the miscalculations were not discovered* in the original filing.

According to Tuomala, “One of the challenges insurers face in the individual market is that even had [WellPoint] done everything correctly, the calculations were 100% correct, and they needed a 40% increase, in many cases it’s politically untenable to get that 40% increase.”

Contact Mills at [jon.mills@anthem.com](mailto:jon.mills@anthem.com) and Tuomala at [david.tuomala@ingenixconsulting.com](mailto:david.tuomala@ingenixconsulting.com). ✧

## NEWS IN BRIEF

◆ **Blue Cross & Blue Shield of Rhode Island reported a \$100 million loss for 2009.** The insurer says it earned premium revenue of \$1.7 billion but had total expenses of \$1.8 billion for the year. BCBSRI’s reserves fell to \$558 per member in 2009, from \$713 in 2008, and according to the company’s statement are projected to decrease to \$479 per member by the end of 2010. The insurer says reimbursement increases to hospitals, which account for one-third of claims, “pose an ongoing challenge.” Prescription drug costs and utilization increased by between 10% and 12% for both 2008 and 2009 and are expected to increase at that level again for 2010, according to the statement. Go to [www.bcbsri.com](http://www.bcbsri.com).

◆ **The Regence Group is warning members in Oregon, Washington, Idaho and Utah to beware of**

**a scam involving vitamin coverage.** Members who have purchased nutritional supplements are seeing claims for services they did not receive on their explanations of benefits (EOBs). The companies from which they bought the products advertise that consumers can be “reimbursed up to 100% through your insurance provider.” According to the Regence statement, an investigation showed the companies filing for reimbursement submitted fraudulent claims from providers who were also involved in the scheme. “The fraudulent claims are coded for legitimate covered services such as consultations, lab and x-ray, which members did not receive.” See the statement at [http://news.regence.com/article\\_display.cfm?article\\_id=4573](http://news.regence.com/article_display.cfm?article_id=4573).

**NEWS IN BRIEF (continued)**

◆ **Health Care Service Corp., which operates Blue Cross and Blue Shield plans in four states, says it has launched a new tool to help physicians and health care facilities identify health risks among enrollees.** The CareProfile is an electronic health record (EHR) created with input from MEDdecision, Availity and HCSC's Illinois, New Mexico, Oklahoma and Texas Blues plans. HCSC says the EHR is the first to include a health status measure in addition to information relevant to a patient's care. Contact Ross Blackstone at ross\_blackstone@hsc.net.

◆ **Blue Cross Blue Shield of Arizona launched an online service that allows members to research facility options and learn about costs associated with specific conditions and treatments.** Care Comparison currently provides information on 39 procedures, including childbirth, mammography and knee replacement surgery. Members can search facilities that provide a particular type of care by ZIP code and find the average minimum and maximum cost for the treatment or procedure. For more information, visit [www.azblue.com](http://www.azblue.com).

◆ **Capital BlueCross launched an oncology case management program to provide additional care during all phases of cancer treatment, the insurer announced April 26.** Under the voluntary program, nurses with oncology expertise and certification collab-

orate with a medical director who is board certified in internal and palliative medicine. Care managers assist members with treatment options, symptom management and life care planning. Members are identified for potential participation through hospital admissions, physician referrals and self-referrals. Go to [www.cap-bluecross.com](http://www.cap-bluecross.com).

◆ **Horizon Blue Cross Blue Shield of New Jersey will become the sole owner of AtlantiCare Administrators Inc. (AAI), a third-party administrator that already serves 200,000 Horizon members, the companies announced April 26.** AAI was a joint venture between Horizon and AtlantiCare, an Egg Harbor Township, N.J., regional health system. About half of AAI's employees will be offered positions at Horizon BCBSNJ, according to a prepared statement about the acquisition. The remaining AAI staff members will be considered for employment at other AtlantiCare businesses. Go to [www.horizon-bcbsnj.com](http://www.horizon-bcbsnj.com).

◆ **PEOPLE ON THE MOVE:** Regence BlueCross BlueShield of Utah appointed **Robert Hatch** president. Hatch will replace **Scott Ideson**, who is retiring, on June 1. Hatch formerly served as president and CEO of Wells Fargo Utah... **Michael Guyette**, former senior vice president of Blue Cross Blue Shield of Florida's diversified business unit, was named a region head for Aetna, Inc.

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