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To: Health Care Committee

From: Mark F. Schafer, Health Insurance Administrator

RE: Highmark and Independence Blue Cross Merger Withdrawn – Recommendation Regarding 2010 Legacy Managed Care Organization Plans

Date: March 2, 2009

Highmark Inc. and Independence Blue Cross announced January 21, 2009 that they have withdrawn their applications to the Pennsylvania Insurance Department to merge.

At the August 22, 2008 Special Board Meeting, the Highmark Medicare Advantage and pre-65 managed care plans were adopted as the sole managed care plan options to the HOP Medical and Pre-65 Medical Plans for new participants effective January 1, 2009. While this action was not contingent upon the Highmark/Independence Blue Cross merger, the merger was a distinct possibility at that time.

Effective January 1, 2009, new enrollments were frozen in seven managed care organization plans; now referred to as “legacy” plans. When the Highmark proposal was approved, the Board considered moving HOP participants enrolled in legacy plans to the Highmark plans. This action was to take place no sooner than January 1, 2010.

Attached to this memo is an analysis and recommendation from the Segal Company regarding the transfer of participants from legacy plans to Highmark. Staff agrees with their recommendation to allow legacy plan participants the option of remaining in their legacy plans through December 31, 2010. The Segal Company and staff will bring this issue back to the Board in early 2010 as part of the planning phase of the 2011 plan year.

The Segal Company will be prepared to answer questions concerning their recommendation at the March 12, 2009, Health Care Committee meeting.
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MEMORANDUM

To: Mark Schafer - PSERS

From: J. Richard Johnson

Date: February 18, 2009

Re: MCO Legacy Plans Recommendation

This memo provides Segal's review and recommendation regarding continuation of the legacy Medicare Advantage plans provided to existing HOP participants through a variety of managed care organizations (MCOs). ***We recommend that PSERS continue the current legacy MCOs through 2010, one additional year beyond the current Board policy***.

Current Board Policy

In 2008, the PSERS Board approved a contract with Highmark Blue Cross and Blue Shield to become the sole managed care vendor for the Health Options Program for 2009 and subsequent years. Also, the Board decided to allow HOP participants who had elected any of the managed care plans offered by various Managed Care Organizations (MCOs) that were in place prior to 2009 to continue in their current coverage for 2009. If a participant chooses to move from a legacy MA plan to HOP or to the Highmark MA plan, then the previous legacy MCO plan would no longer be open to them. According to the Board's action, for 2010, all participants in managed care plans other than Highmark would be transitioned into the plans offered by Highmark with the option of electing instead the corresponding HOP self-insured plan (HOP Medical Plan plus the HOP Basic or Enhanced Medicare Prescription Drug Plan, or the HOP Pre-65 Medical Plan plus Prescription Drugs for pre-65 participants). This transition would be accomplished during the regular 2010 Option Selection Period in October-November 2009.

Analysis

Highmark – IBC Merger Developments

One of the factors weighed by the Board in making its decision to retain the legacy MCO plans through 2009 was the pending merger request of Highmark Blue Cross and Blue Shield with Independence Blue Cross and Blue Shield (IBC). That merger would have given Highmark full access to every county in the Commonwealth and would have facilitated transfer of participants from existing MCOs into a single Medicare Advantage carrier with full networks throughout the Commonwealth. The consolidation strategy was, to a large extent, based on the expected improved provider access and combined leverage over provider pricing that the new combined BCBS entity would posses within the Commonwealth. On January 21, 2009, Highmark and IBC mutually decided to withdraw their applications to merge.

The withdrawal of that merger request means that IBC will continue in its five-county Philadelphia area market and that Highmark will not offer negotiated networks in the Southeastern region of Pennsylvania. For 2009, Highmark continues to be the only HOP program MCO open for new participants in the Southeastern region. Existing HOP participants in that region were offered the Highmark MA-PPO plan during the 2009 Option Selection Period with an out-of-network benefit design exactly the same as the in-network benefits offered to Highmark MA-PPO participants elsewhere in the Commonwealth. PSERS retirees residing in the five-county area around Philadelphia who become eligible for HOP participation during 2009 will see the Highmark MA-PPO with out-of-network benefits at the same level as in-network benefits as the only Medicare Advantage plan choice available to them if they desire that benefit platform instead of the HOP Medical Plan Medicare supplement program. Had the merger gone through, Highmark would have offered the same benefits as now, but the delivery system would have allowed those benefits for Southeastern region participants to be through networked doctors and hospitals.

Highmark – Blue Cross and Blue Shield Association Developments

Highmark has also notified PSERS that the Blue Cross and Blue Shield Association (BCBSA), the association that coordinates and guides the 39 participating Blues plans nationally, has mandated that its members coordinate for a national Medicare Advantage provider network to meet the new Medicare requirements that all MA-Private Fee for Service (MA-PFFS) plans have a negotiated network in place beginning January 1, 2011. According to Highmark, BCBSA has further mandated that all of its participating plans be fully operational with this national cooperative network by January 1, 2010, one year ahead of the federal requirements.

This national network will be based on BCBSA's current BlueCard national network, which allows a commercial Blues plan participant to receive in-network care from a participating BCBS doctor or hospital anywhere there is a participating Blues plan. The Blues organization for the area in which the care is delivered adjudicates the claim according to its discounts and then internally passes the claim back to the participant's home Blues plan, which settles the cost according to agreed association protocols and pricing. The new network for Medicare Advantage plan participants will operate in a similar fashion.

According to Highmark, a pilot test of this "Medicare Advantage BlueCard" network is already under way during 2009 with a handful of state plans. Highmark expresses confidence that the system will be operational nationally for 2010 and that all of the Pennsylvania Blues plans that offer an MA-PPO or MA-PFFS will be participating. This means that under the current HOP plan structure, participants in the Philadelphia area would have their claims paid by IBC, which would then pass the claims through the Medicare Advantage BlueCard system back to Highmark, resulting in in-network care in the HOP Southeastern region.

However, the relatively seamless operation from the participant's perspective of this Medicare Advantage BlueCard program described by Highmark and BCBSA has not yet been tested on retirees in Pennsylvania and that program will not begin actual operation until 2010. Adopting an as yet untested approach to a statewide Medicare Advantage plan network as the sole option may raise concerns over potential member disruption. As a result, consideration should be given to delaying full replacement to all legacy Medicare Advantage plan options for a year to allow the new Medicare Advantage BlueCard system to become operational and stable.

Medicare Plan Market

The current Medicare Advantage plan market is undergoing significant change as MCOs compete for market share of the senior population. The individual policy Medicare Advantage market is particularly volatile, with some carriers significantly cutting the premium cost for one or more plan design options to capture more Medicare retirees, even if the carrier incurs a loss on the coverage for the first few years.

Typically, benefit plans that are rated on a "group" basis taking into account the specific membership of the plan sponsor's group produce lower rates for a given plan design than do "individually rated" products available for purchase outside of a group arrangement. Economies of scale from group plans should result in lower marketing costs and lower underwriting charges which typically means that a group plan such as the HOP is able to provide the same benefit as an individually rated policy at a reduced cost to plan participants. In addition, as a group grows in size, further savings can be achieved by converting to self insured funding arrangements. Larger group plans have more predictable claim experience and can build up self insured reserves. Converting to self insured allows groups to avoid insurance premium taxes and insurance company risk/underwriting charges.

Despite these advantages, HOP members participating in managed care plans available through the HOP from time to time call to say they can purchase the same coverage outside of HOP for a lower premium. When these situations are researched, the outcome is almost always that the policy offered on an individual retail basis at lower cost also has a lower benefit level than the plan offered through HOP.

For 2009, at least one of the MCOs participating in the HOP program – Capital Blue Cross – has begun offering their individually rated products at a lower premium cost than the very same plan provided through a group rated contract. This inversion of group and individual pricing in the market has caused confusion among some HOP participants. Discussions with Capital Blue Cross to rectify their rates for HOP have been unsuccessful, as there is no Commonwealth

contract to support strong negotiation of rates for the HOP group. This anomaly, we believe, can not be sustained overtime. Insurers can temporarily mask true cost disadvantages by subsidizing one insurance product or market (individual market rates in a distinct location) with reserves or surpluses from other areas within the insurer. However, fundamentally the advantages of a group product, over time, will produce the best long term value to the members of HOP.

Segal has also noted similar "upside down" pricing between group and individual MCO products with other clients both in Pennsylvania and outside the Commonwealth, indicating that the pricing issue may be more widespread than just one carrier.

Discussion of Alternatives

PSERS should consider the following in its analysis of whether to extend the transition of the legacy MCO plan participants into Highmark from the 2010 to the beginning of 2011.

More Orderly Transition in Southeastern Region

By continuing the legacy MCOs through 2010, PSERS will postpone and possibly eliminate provider disruption of as many as 5,000 HOP participants residing in the five-county Philadelphia area (HOP's Southeastern Region). If the current MCO participants are forced to move to Highmark for 2010, the participants in the Philadelphia area would be moving from a fully networked carrier (IBC, Keystone East, Aetna) to a carrier where all or most of their benefits will be considered out-of-network, even though the actual benefit provided is the same as the in-network benefit. With the Highmark/IBC merger now off the table, it is possible that some HOP participants in the five Philadelphia area counties might face losing the availability of their current doctor because that provider happens not to accept the Highmark BCBS card on an out-of-network basis. We understand that almost all doctors in the Philadelphia area currently accept the Highmark card, but there are likely some that will not accept the transition to Highmark at this time.

The BCBSA Medicare Advantage BlueCard national network would provide the ability to assure that HOP members in any location in the country (including the five-county Philadelphia area) would have the ability to elect a Medicare Advantage plan option under Highmark with full network provider coverage. That network availability is mandated by the Centers for Medicare and Medicaid Services (CMS) for 2011. Once the national network is available, HOP participants in the Independence Blue Cross and Aetna MCO plans would be able to transition to Highmark's Medicare Advantage product without losing the availability of their network doctors and hospitals, since IBC is a participating plan.

Viability of the BCBSA "Medicare Advantage BlueCard"

While the information presented by Highmark regarding their ability to implement the Medicare Advantage BlueCard system effective January 1, 2010 is compelling, we believe it would be prudent for PSERS to hold off one year pushing MCO participants into that payment system. That additional year would help us make certain that the BCBSA system is operating

successfully for some months prior to eliminating other options. A 2011 implementation of the transition would also coincide with CMS' mandated changes, which would provide more justification for reducing the non-national plan options.

A 2011 transition date is attractive for another reason. HOP provides an MA-PFFS plan option for HOP participants that reside outside of Pennsylvania. To continue offering an MA plan option for these HOP participants, PSERS must meet the CMS mandate that all MA-PFFS plans must have a provider network in place by January 1, 2011. With the implementation of the BCBSA Medicare Advantage BlueCard network, Highmark will be able to meet the CMS requirement for 2011.

PSERS may need to convert its out-of-state participants from an MA-PFFS plan to the same MA-PPO plan offered to HOP participants residing within Pennsylvania, but that change could be primarily a change of carrier payment platform, since the HOP program already offers the same benefit plan to out-of-state participants through the MA-PFFS that it does to in-state participants through the MA-PPO. In addition, most HOP participants reside in areas where Highmark expects the BCBSA Medicare Advantage BlueCard network to be available.

By waiting the additional year to 2011 to make the transition from the legacy MCOs, PSERS would be able to bring all Medicare eligible managed care participants into a single national program at the same time, providing the same benefits anywhere in the country the participant may live or obtain services.

Continued Reduction of Legacy MCO Plans

The number of frozen MCOs in the HOP program declined for 2009 as a couple of existing MCOs eliminated plans or dropped out entirely. Pacificare/United HealthCare dropped all HOP participation due to their unwillingness to offer a companion plan for pre-65 dependents and retirees. Aetna dropped its MA-PFFS plan being piloted in Florida because they attracted only one HOP participant into the plan. In addition, Aetna dropped plan coverage in a few counties in Pennsylvania where they had no remaining participants in legacy plans. We anticipate that other MCOs will consider dropping coverage for 2010 as the number of HOP participants remaining in the frozen legacy plans dwindles. Even postponing the full transition to Highmark from 2010 to 2011, we expect a continued and perhaps increased flow of participants back into the HOP Medical Plan and Highmark managed care plans as some carriers continue to increase their premiums and make the individual's transition a financial imperative.

However, extending the remaining legacy MCO plans for an additional year allows PSERS to keep the door open for other potential MCOs that may be willing to offer another competitive and viable group plan with formal contracts. If a regional player within the state can demonstrate cost competitiveness and access on a sustained basis, there may be pockets where a few legacy plans may warrant another look in the future.

Continued Program Structure Complexity

If the elimination of the legacy MCO plans is postponed until 2011, the HOP program will retain its current plan complexity for one additional year. There are currently six MCOs (Aetna, Amerihealth/IBC, Capital Blue Cross, Humana, Independence Blue Cross, and UPMC) other than Highmark with existing participants from prior years. Some of these carriers provide unique participant rates by county of residence, making the development and maintenance of premium rate tables complex and adding to the overall administration required for the program.

Lack of Commonwealth Contracts

The legacy MCO plans continue to operate outside of a Commonwealth contract. This is the situation PSERS originally addressed by putting the MCO services out to bid, resulting in the Highmark contract. The lack of a Commonwealth contract for the six remaining legacy carriers complicates the administration and reduces PSERS' leveraging ability to obtain the best rates and service for HOP participants. By postponing the transition, we expect to continue this condition for one additional year.

Recommendations and Next Steps

Segal recommends the following regarding continuation of the current MCO legacy plans:

1. PSERS should extend the date for eliminating all legacy Medicare Advantage plans by one year from December 31, 2009 to December 31, 2010.

2. Current participants in legacy Medicare Advantage plans for 2009 should continue to have the option to remain in those same legacy plans for 2010, provided the MCO agrees to continue offering that specific plan, premium rates remain competitive and the MCO continues to operate in accordance with the requirements and guidelines established for all MCOs in the program.

3. For 2009 and 2010, the HOP Medical Plan (and the companion HOP Pre-65 Medical Plan) and the HOP Managed Care Plan/Highmark FreedomBlue MA-PPO (and the companion HOP Pre-65 Managed Care/Highmark PPOBlue), should continue to be the only medical plan options open to new participants in the Health Options Program, and to current participants who desire to change their elected plan option.

4. The benefit features for each of the current HOP and Highmark plans should continue to be updated each year to compete favorably in the market, and new plan designs should be offered through HOP and Highmark, as approved by the Board, to help keep the program attractive to new participants.

5. PSERS and Segal should continue to monitor the development of the Medicare Advantage and managed care plan marketplace in the Commonwealth and take market developments into account in planning for the 2011 plan offerings, including the group contracting of a few legacy MA plans where the value is clearly demonstrated.

6. PSERS and Segal should continue to monitor the development of the national BCBSA Medicare Advantage BlueCard program to assure that it is working well during the pilot test in 2009 and the first year of operation in 2010.

7. If feasible, the Medicare Advantage BlueCard program should be implemented for current Highmark MA-PPO participants in the Philadelphia area as well as for any new participants entering the Highmark plan in the five-county Philadelphia area during 2010.

8. PSERS and Segal should begin the process of evaluating the cost/benefit implications of converting the National Medicare Advantage PPO offering contracted through Highmark to a self insured group contract to generate additional savings to participants.

We believe that extending the current legacy MCOs one additional year will allow more of the market components to be in place prior to forcing HOP participants to move away from their current Medicare Advantage plans.

We would be glad to discuss any questions you have regarding this recommendation.

cc: Ed Kaplan

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PSERB Resolution 2009-10
Re: Health Options Program - Legacy Managed Care Organization Plans
March 12, 2009

RESOLVED, that Public School Employees' Retirement Board allow HOP participants enrolled in managed care organization plans frozen to new enrollments, the option of remaining in these legacy plans through December 31, 2010, as recommended by the Segal Company in their memo to Mark F. Schafer, Health Insurance Administrator dated February 18, 2009.