



The Marketplace Consumer: Understanding the Marketplace Population Through Two Years' Worth of Data



Health Insurance [Marketplace](#) [HealthCare.gov](#)

Lessons Learned from The Individual Marketplace

Horizon Blue Cross Blue Shield of New Jersey



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VP, Consumer, Small Group and Mid-size Markets

Ed Lara

VP, Marketing and Product Development

June 9, 2016



Health Insurance Marketplace

HealthCare.gov

Discussion Points

- Horizon's Learnings in the Individual Segment
 - Key environmental/market factors
 - Product and pricing actions
 - Consumer engagement and go-to-market strategies

Horizon BCBSNJ Individual Market – Lessons Learned

Market Factors

Pre-ACA Marketplace

- **Horizon had the leading market share pre-ACA:** Horizon entered the ACA world with a large block of members in the Basic and Essential (B&E) plan. Biggest challenge was how to retain these members with the withdrawal of the B&E, with new plans at higher premiums.

High Risk and Uninsured Population

- **High risk consumers had access to specific plans (NJ Protect) prior to ACA.** However, with ACA, they became part of the same risk pool as the rest of direct consumer buyers.
- **Pre-ACA uninsured rate was about 12%, or 1.2 million residents.** Of these, we expected about 161K would come into the exchange.

Transitional Plans

- **We decided against offering transitional plans,** meaning we did not offer the “old” products as an alternative to the new products. We have a single risk pool.
- Many other plans (outside of New Jersey) decided otherwise and had more than one risk pool, resulting in adverse selection.

Pre-ACA testing

- Given all the uncertainties, we conducted a significant amount of consumer research prior to ACA to refine our product line up, pricing, membership forecasts and marketing messaging.
- Research included product simulations to test our proposed product line-up and pricing vs. the projected competitive set, conjoint analysis to determine primary drivers of product selection and understand trade-offs between specific features and premium pricing, and focus groups with uninsured and insured to better understand consumer needs and motivations.

Horizon BCBSNJ Individual Market – Lessons Learned

Product & Pricing Factors

Prudent Pricing

- **We intentionally went with conservative assumptions about morbidity and priced for a reasonable margin in 2014.** Our conjoint and product/pricing simulation research helped us in guiding our pricing decisions.

Simple Product Offerings

- For 2015, our posture was “competitive but not reckless.”
- **We offered 5 products in 2014, under a philosophy of “keep it simple.”** Product simulation testing again helped us determine our final product portfolio, including not offering a Platinum product in either 2014 or 2015, and only offering a Gold tiered network plan in 2014.
- In contrast, some other NJ plans offered 50 or more products, only to withdraw many of them, forcing consumers to shop around.

Use of Tiered Networks

- **We developed tiered network products and offered them as a lower-premium alternative to traditional broad networks.** Note that these tiered products still offered access to Horizon’s broad managed care network.

Off Exchange Presence

- **We offered our products both on and off exchange.** Our competitors play either exclusively or primarily on the exchange.

Horizon BCBSNJ Individual Market – Lessons Learned

Consumer Engagement/Go-to-Market

Consumer Analytics

- We leveraged our consumer analytics to develop a segmentation model and an approach for identifying potential uninsured segments.
- We used a multi-channel marketing strategy to not only build awareness but to directly target likely uninsured populations.

Integrated Marketing

- Outdoor, transit and social were used primarily to build awareness for Horizon products.
- Direct mail, targeted digital and email were focused on specific segments.
- We developed a simplified enrollment process and more consumer-friendly welcome kits patterned after credit card welcome letters.

Latino Market Focus

- We recognized that the Latino market was underserved and comparatively healthy; we launched a Spanish website and a grass roots effort to sign them up.
- We ran separate Spanish language marketing campaigns using transit, direct mail and digital.
- We grew from 8,000 Latino members to 30,000 by OEP 2016.

Retail Presence

- We set up a retail center in South Jersey and also deployed pop-up retail kiosks in major NJ malls during open enrollment. We also deployed our Blue to You vans at community events.
- In 2015, we also launched a Hispanic retail center in a major NJ city with a high percentage of Hispanic residents.

Retention

- We stepped up our retention efforts beginning 2015, including addressing major consumer pain points in enrollment and billing, outbound welcome calls to new members, handing off “at risk” members from CSRs to sales, and targeted marketing to reinforce benefits (beyond access to doctors) to demonstrate more value for monthly premiums.

Horizon Outdoor and Transit Ads



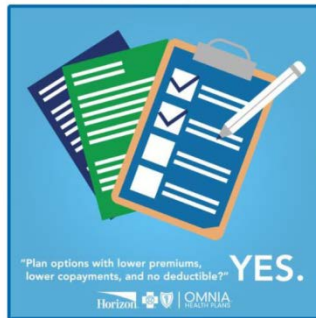
Horizon Social, Digital and Direct Mail

SOCIAL MEDIA

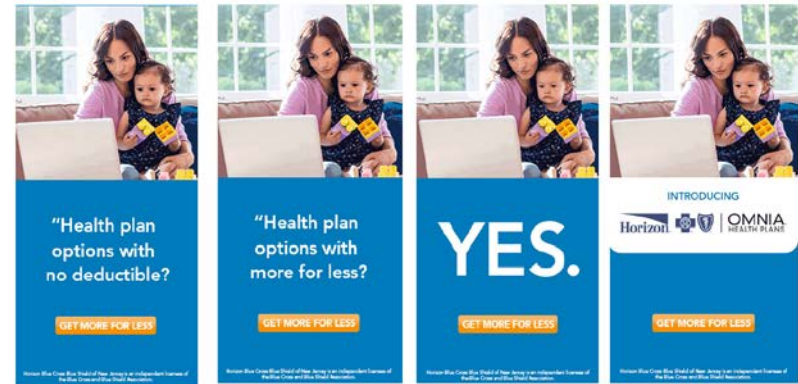
Horizon BCBSNJ @HorizonBCBSNJ · 11 Dec 2015
 "Plan options with lower premiums, lower copayments, and no deductible?" YES.
[shout.it/bl6vm](https://www.facebook.com/HorizonBCBSNJ) #OMNIANJ



Horizon BCBSNJ @HorizonBCBSNJ · 9 Nov 2015
 "Plan options with lower premiums, lower copayments, and no deductible?" YES.
[shout.it/bhKWN](https://www.facebook.com/HorizonBCBSNJ) #OMNIANJ



DIGITAL

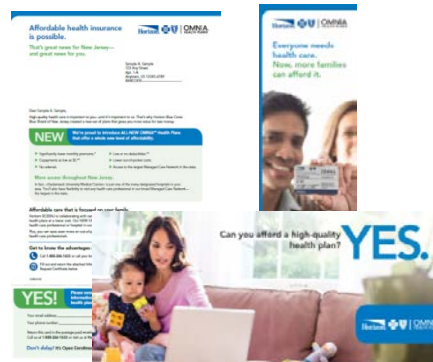


DIRECT MAIL

YOUNG INVINCIBLES



FAMILIES



EMPTY NESTERS



Spanish Language Campaign



"¿Opciones de planes con tarifas más bajas, copagos bajos y sin deducible?"

¡Claro que SÍ!

PRESENTAMOS

Horizon OMNIA HEALTH PLANS

Nuestros nuevos Planes de salud OMNIA ofrecen tarifas más bajas para obtener acceso a nuestra red completa de doctores y hospitales, la más grande en New Jersey. Además, usted y su familia pueden ahorrar aún más en gastos de bolsillo cuando utilizan a ciertos doctores, hospitales y otros profesionales del cuidado de la salud de OMNIA. Todo sin necesidad de ser referido y con una docena de beneficios en bienestar para usted y su familia.

Es otra forma en la que decimos, ¡Claro que Sí!
a la reducción en costos en atención médica en New Jersey.

HorizonAzul.com/OMNIA • 888-765-7061

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"¿Un mejor cuidado de la salud puede costar menos?"



Sí.

Horizon OMNIA HEALTH PLANS

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Sí.

Horizon OMNIA HEALTH PLANS

[Leer más](#)

PRESENTANDO

Horizon OMNIA HEALTH ALLIANCE

EL PODER DEL SÍ

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Retail Presence

Mall Pop Up Retail Kiosks



Blue 2 You Travelling Van



Horizon BCBSNJ Individual Market – Lessons Learned

Membership Trends

2014 – 2016 Individual Business Highlights

Year	Enrollment
2013	120,000
2014	128,000
2015	168,000
2016 est.	200,000



Marketplace Consumers

SelectHealth

Rachel Reimann & Russ Elbel

June 9, 2016



Health Insurance Marketplace

HealthCare.gov

Enrollment and Outreach Strategies for the Marketplace Population

Rachel Reimann
June 9, 2016

Who We Are



HEADQUARTERS: Salt Lake City, UT
ESTABLISHED: 1984
EMPLOYEES: 1,500
PRESIDENT/CEO: Patricia R. Richards
SERVICE AREA: Utah and Idaho
OWNED BY: Intermountain Healthcare®



Who We Serve

SelectHealth covers more than 880,000 members in Utah and Idaho—more than 780,000 of those are in Utah.



Annual Open Enrollment Themes

- Year One — Get Educated
- Year Two — Get Covered
- Year Three — We'll Come to You

Year One—Get Educated

Healthcare Reform.

We don't make the laws. But we do make sense of them.

selecthealth.org/reform



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Most people are confused about healthcare reform.

Don't be one of them.

selecthealth.org/reform



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The ABCs

Healthcare Coverage ABCs

Maybe you've never had health insurance before, or maybe you're just buying it on your own for the first time. No matter the case, we can help you find the best way to choose and pay for your family's healthcare—every step of the way.

Because of the Affordable Care Act (ACA), **everyone** qualifies for coverage, even if you have pre-existing health issues.



The government is offering a tax credit (sometimes called a "subsidy") to help you pay for your health insurance. Depending on your age and income, your subsidy might cover your *entire* monthly payment.

We have online tools that make it easy to see if you qualify for a tax credit and, if so, how much it will pay for.



selecthealth.org/calculator

Healthcare Coverage 123s

1 I picked a plan on healthcare.gov—now what? > Pay your premium.

- We recommend that you pay your first month's premium through healthcare.gov. This will give you the quickest access to your plan and your materials.
- If you are unable to make your payment through healthcare.gov, you may call us, bring payment to our building in Murray, or mail us your payment. You will not be enrolled or receive any plan materials until your premium has been paid.
- We will contact you for future payment options that will be paid directly to us.

2 I paid my premium—what happens next? > You will receive your member materials.

- You will receive your ID Card within two weeks of paying your premium.
- You will also receive a copy of your Contract that describes your benefits in detail.

3 I need to use my benefits but don't have my materials—what should I do? > Call us or visit our website.

- You can find a doctor, learn about preventive care, or find a pharmacy on selecthealth.org.
- If your ID Card doesn't arrive before you need to receive care, you may call us to get your subscriber ID# and a copy of your card.
- Once you have your ID#, you may log in to *My Health*, our secure member website at selecthealth.org/myhealth. This site allows you to send secure messages and provides you with access to a copy of your ID Card.

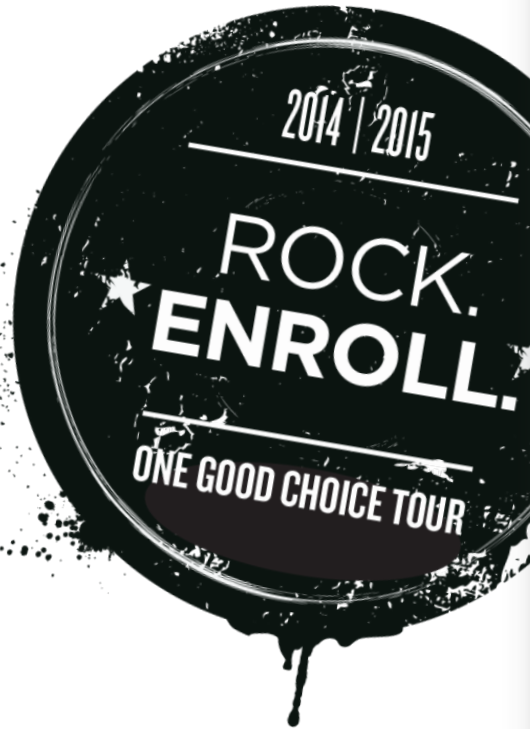
Member Services is available during extended hours to answer questions. Call **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. TTY/TDD users should call 711.



selecthealth.org/reform

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Year Two—Get Covered



✓ Boots
✓ Helmet
✓ Goggles
✓ Health Plan

Get the coverage you **really** need.
Enroll by February 15.

2014 | 2015
ROCK. ENROLL.
ONE GOOD CHOICE TOUR

You've still got time for a few more ski runs, but the chance to sign up for health insurance coverage is running out. **To get coverage for this year, you must enroll by February 15.*** We can help you find the right plan, answer your questions, *and* chat about the weather—faster than you can navigate the bunny hill.

Walk in with questions, walk out with a plan.

LAST CHANCE ENROLLMENT FAIRS:

Red Lion Hotel Canyon Springs
Oak Room, 1357 Blue Lakes Boulevard North
Twin Falls, ID 83301
Friday, February 6 | 2:00 p.m. to 6:00 p.m.

The Village at Meridian
3600 East Fairview Avenue, Fountain Square
Meridian, ID 83642
Saturday, February 7 | 10:00 a.m. to 3:00 p.m.

selecthealth.org

*Outside of open enrollment, coverage is only available with certain special enrollment periods. For a list of qualifying events and to learn more about SEPs, read our blog at selecthealth.org/blog/SEP.

Event Venues



Last Chance Events

- Events were better attended near the deadline.
- Online enrollment was difficult for new insurance purchasers.
- Consumers appreciated one-on-one assistance.



OPEN ENROLLMENT ENDS FEBRUARY 15

Get your ticket to healthcare for 2015. **Rock. Enroll.**

 selecthealth.org

The banner features a green background with a pattern of small white dots. On the right side, there is a graphic of a green and white ticket stub with the SelectHealth logo and the word "selecthealth" printed on it.



The image shows two vertical banners for the "Rock, Enroll." event. The banners have a green background with a pattern of small white dots. The left banner lists the event details and the right banner lists the benefits of enrolling.

Left Banner:

- Enroll on-site—walk in with questions, walk out with a plan
- Talk to an independent insurance agent
- Find out if you qualify for a reduced premium price
- Avoid possible tax penalties
- Enjoy games, fun, and prizes

ROCK. ENROLL.

Remember when you listened to albums from beginning to end? Sometimes a song you barely noticed at first became your favorite tune. Don't settle for just the hits. Get the full album—coverage for everything you need—in one place. If you want insurance for 2015, you need to enroll by February 15. Think of it as a limited-release party, and you're invited.

LAST CHANCE ENROLLMENT FAIR:

SelectHealth
5381 South Green Street
Murray, UT 84123

Friday, February 13
2:00 p.m. to 6:00 p.m.

Saturday, February 14
10:00 a.m. to 3:00 p.m.

Right Banner:

MOSH PITS
Rock.
MONEY PITS?
Do not Rock.

STANDING ROOM ONLY
Rocks.
EMERGENCY ROOM ONLY?
Does not Rock.

AFFORDABLE COVERAGE
Rocks.
TAX PENALTIES?
Do not Rock.

Know what else rocks? Access to great doctors. Preventive care. Coverage when you're out of town. A health plan that cares about its members. We've got an entire album of benefits—hear the full set list at a Rock, Enroll. event near you.

2014 | 2015
ROCK. ENROLL.
ONE GOOD CHOICE TOUR

Get the coverage you *really* need.
Enroll by February 15.

Affordable Coverage Promotion

Affordable
healthcare



is
no
longer
out
of
reach.



"Health insurance is
too expensive for me."

"I applied years ago
and I didn't qualify."

"I can't get coverage
for my family."

Think health insurance
is out of reach? **Think again.**

Affordable Care Act (ACA) changes may help you
qualify for and afford health insurance coverage:

- **Coverage is guaranteed** — You won't be turned down for insurance based on your health status, age, gender, or a pre-existing condition when you apply during the annual enrollment period.
- **Tax credits are available** — The government may help pay for your plan with a tax credit (also known as a subsidy). For some, these tax credits cover their entire payment! Learn more and see if you qualify for these or other medical assistance programs at selecthealth.org/calculator.

Great benefits
are within
your reach...



You already know that you get great care at Intermountain Healthcare®. And no other health plan works as closely with Intermountain as SelectHealth.

So what are you waiting for? Health insurance is within reach. Visit selecthealth.org/plans or call us at 855-442-0220.



Year 3—We'll Come to You

- Community Centers
- Grocery Stores
- Personal Appointments
- Expert Phone Bank
- News Stories



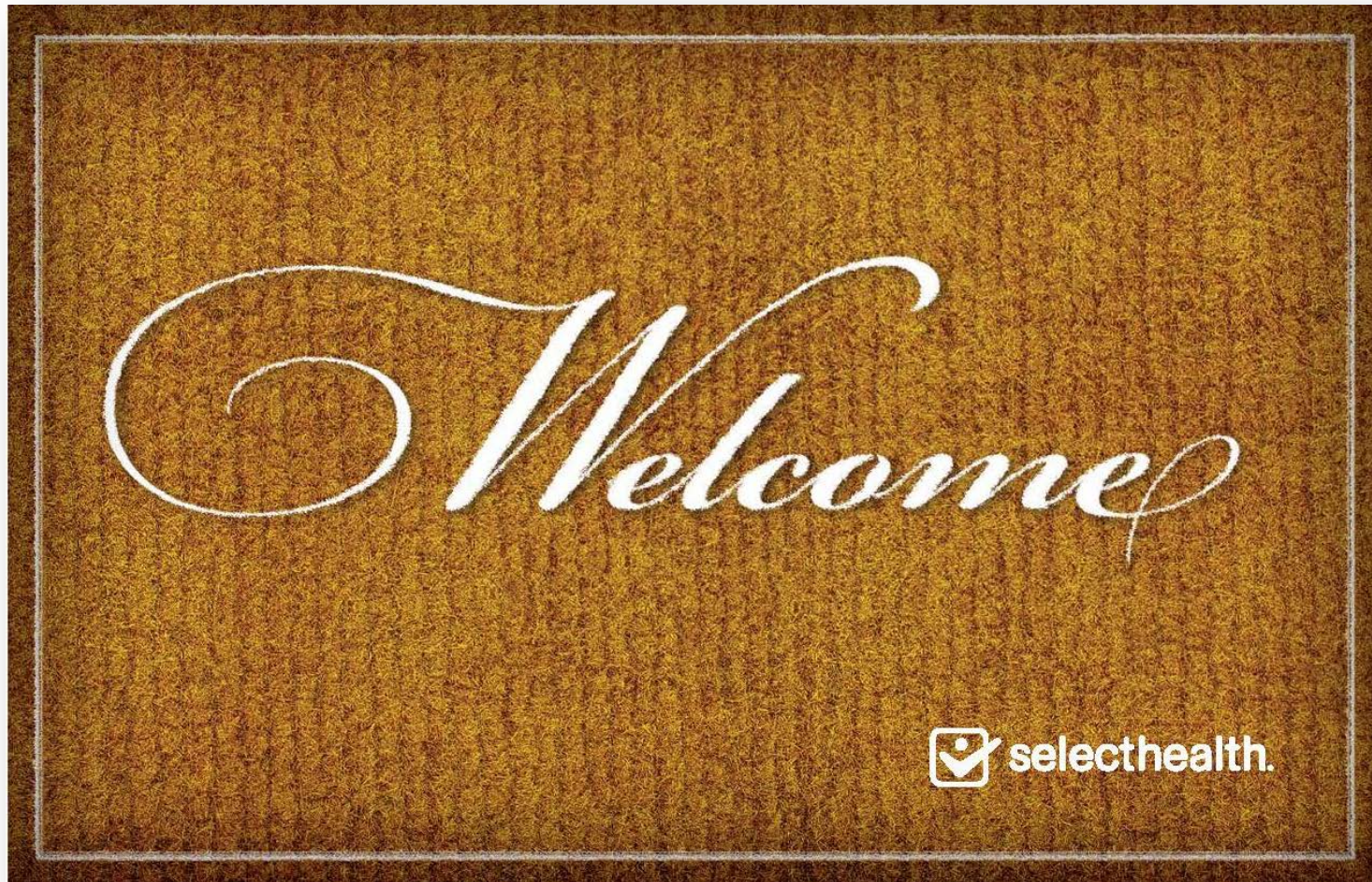
Community Centers



Ask the Expert



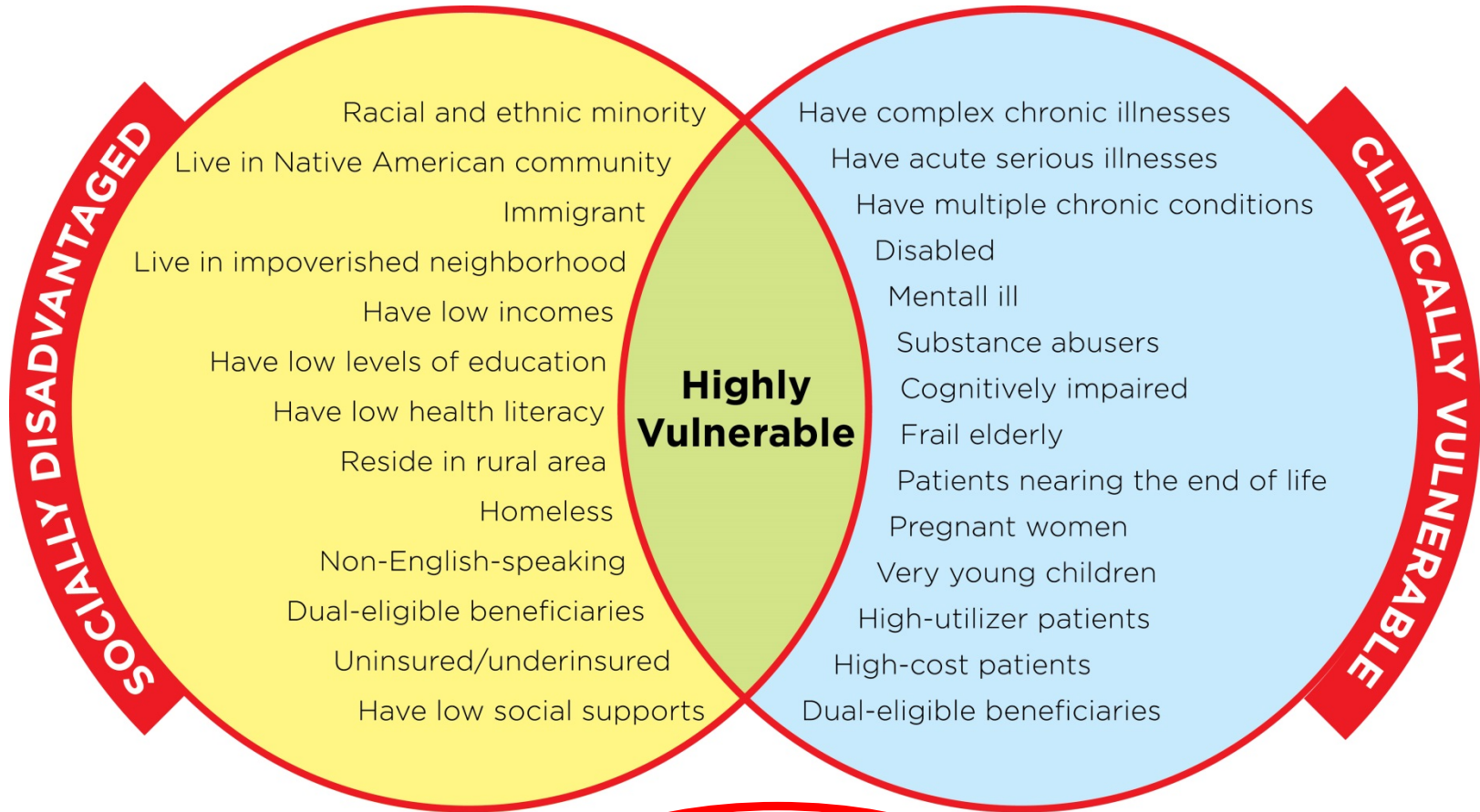
Simplified Communication



Integration and Coordination with the Delivery System and Community Services

Russ Elbel
June 9, 2016

Categories and Overlap of Vulnerable Populations



IMPORTANT CHARACTERISTICS:

Geographic concentration
High use of social services
Health care concentrated in low-performing health care systems

IMPORTANT CHARACTERISTICS:

Social needs exacerbate clinical needs
Greatest opportunity to reduce cost, improve quality, and reduce disparities

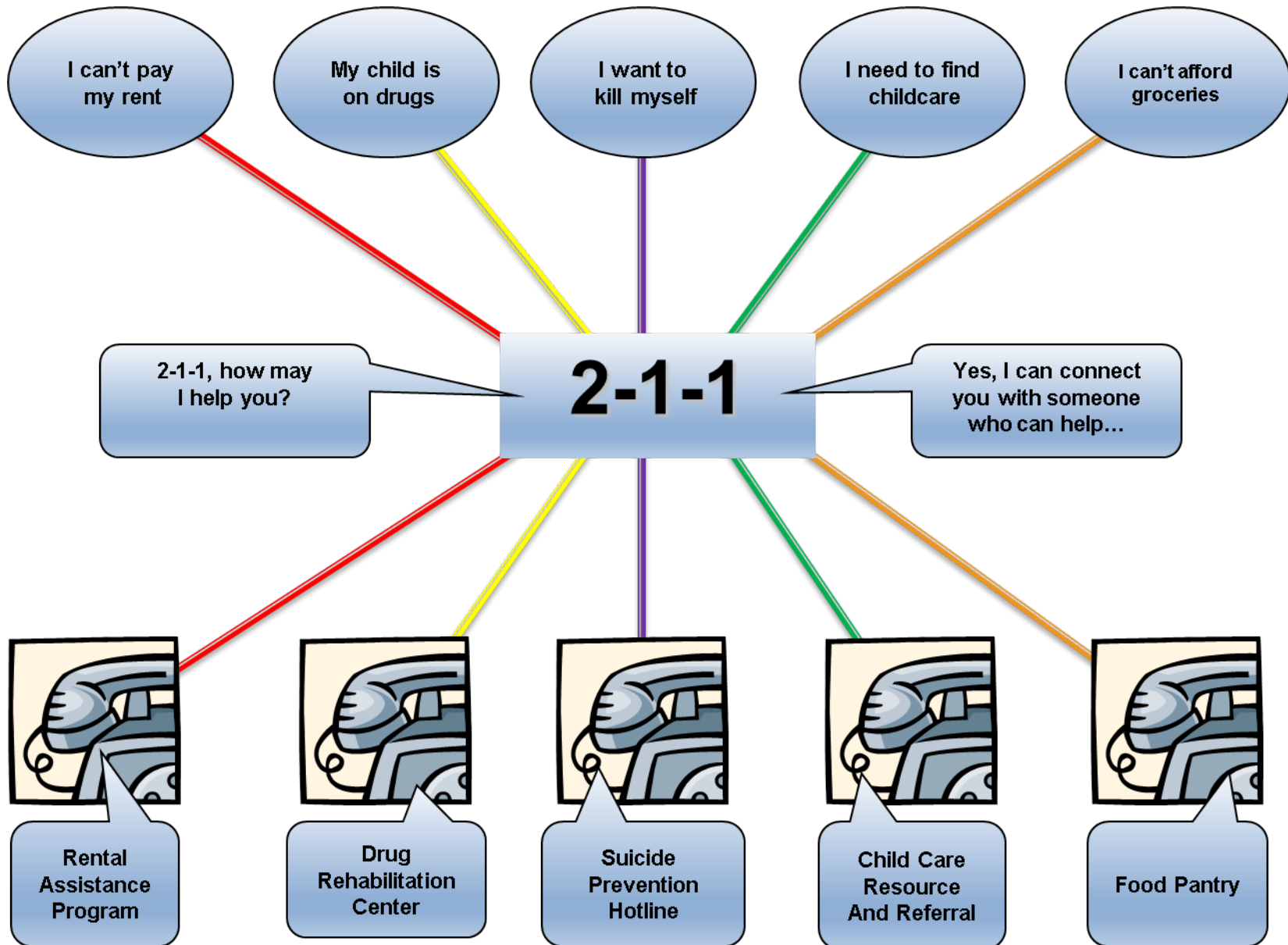
IMPORTANT CHARACTERISTICS:

Geographically dispersed
High use of clinical care
All socioeconomic groups affected

Member Engagement

- Early Innovations
 - Comprehensive Care Clinic
 - Community Care Management
- Recent Innovations
 - Telehealth
 - Community Health Workers

People Need Help Finding Help



2-1-1 Search

[Clinical](#)[Pay & Personal](#)[Workplace Tools](#)

Intermountain.net

Search...

Elizabeth Craig

Integrated Care Management

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[Search by Service Topics »](#)
Use our service tree to find resources.

[Add a resource to this directory »](#)

MY RESOURCE GROUPS

- [Chronic Disease- Stroke »](#)
- [Dental »](#)
- [Food »](#)
- [Housing »](#)
- [Interpersonal Violence »](#)
- [Respite Care »](#)
- [Support Groups »](#)
- [Transportation »](#)
- [Utilities »](#)
- [Manage resource groups...](#)

Continuum of Care



CARE MANAGEMENT



**EMERGENCY BEHAVIORAL
HEALTH SERVICES (EBHS)**



MOBILE CRISIS SERVICES (MCS)



ACUTE INPATIENT SERVICES



SUB-ACUTE TREATMENT



RESIDENTIAL SERVICES



**PARTIAL HOSPITALIZATION
(DAY TREATMENT)**



**INTENSIVE OUTPATIENT SERVICES
(IOP)**



OUTPATIENT SERVICES



COMMUNITY SOCIAL SERVICES

TACO

NOT THIS



THIS

Total Accountable Care Organization (TACO)

A health care system where all physical health, behavioral health, long-term services and supports (LTSS), and elements of public health and social services are integrated for targeted high-need populations

CHCS, Jan. 2014, and Health Affairs blog, Jan. 23, 2014.
Introducing Total Accountable Care Organizations:
[Thhttp://www.chcs.org/media/Introducing-Totally-Accountable-Care-Organizations_Nov2014.pdf](http://www.chcs.org/media/Introducing-Totally-Accountable-Care-Organizations_Nov2014.pdf).

Profiling Marketplace Enrollees

Rebecca Owen FSA, MAAA
June 9, 2016



Health Insurance Marketplace

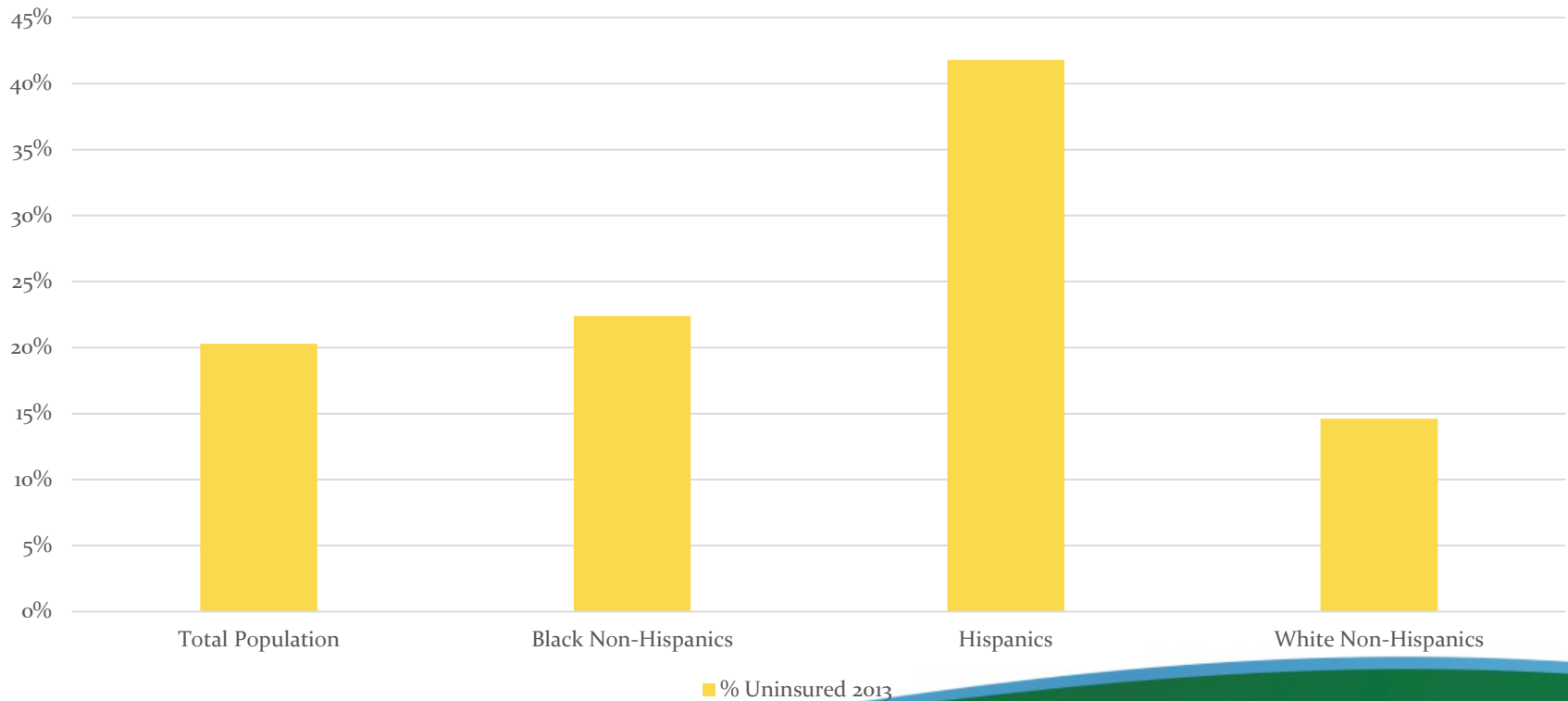
HealthCare.gov

Content

- Summary Statistics
- State Variations
- Plan Experience
- Member Profiles
- Thinking about the information

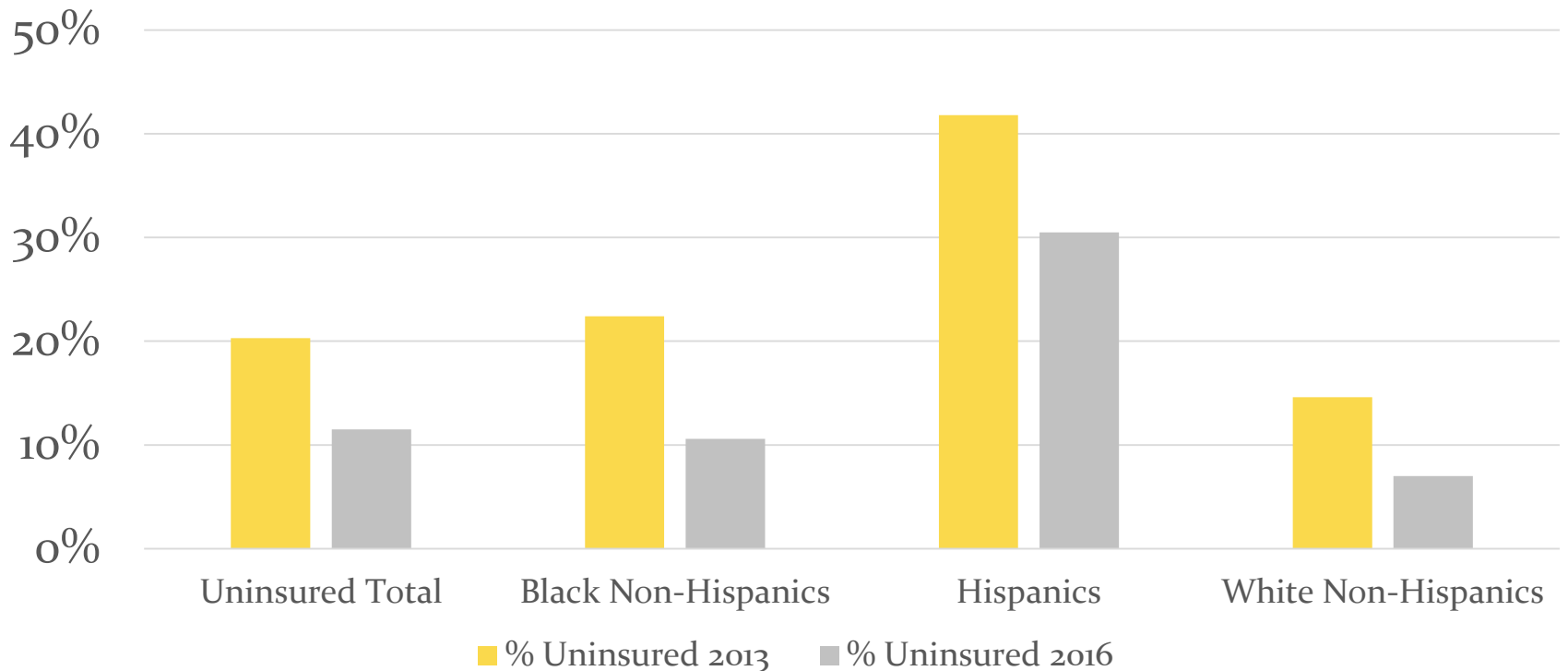
Before the ACA

Uninsured Rate for Non-Elderly Adults (2012-2013)
ASPE Issue Brief March 3, 2016



After the ACA

Gains in Coverage for Non-Elderly Adults
ASPE Issue Brief March 3, 2016



Who obtained coverage?

- Steady increase in coverage:
NCHS reported people with private coverage increased from 6.7 million in (Q4 2014) to 9.1 million (Q4 2015).

Enrollee Financial Assistance

- 85% of enrollees on the Federally Facilitated Marketplace qualified for Financial Assistance
- 77% for the State/Federal Marketplaces
- 89% in California (2014)

Age Distributions

Enrollment Distribution by Age Group	
<18	9%
18-25	11%
26-34	17%
35-44	16%
45-54	21%
55-64	25%
>-65	1%

Variation by State

Each state had a different starting point.

And no two implementations were the same.

Transition Plans

- Transition plans allowed people to re-enroll and renew plans that did not comply with ACA protections. These can be maintained through December 31, 2017.

Medicaid Expansion

2013	Expansion	Non Expansion
Uninsured	18.4%	22.7%
Public	17.7%	15.6%
Private	65.2%	63.2%
2015	Expansion	Non Expansion
Uninsured	9.8%	17.5%
Public	21.5%	14.7%
Private	70.0%	69.0%

Choosing a health plan

- Cost sharing insulated some members from making price based decisions.
- Familiarity with plans is an important part of the decision and Medicaid plans have name familiarity among lower income groups.
- Networks were important for both cost and access.

Special Enrollment Periods

- Loss of health coverage
- Changes in household size
- Changes in residence
- Life circumstances

Moral hazard

- Purchase health insurance for non-chronic emergent care and terminate insurance after the procedure.
- Providers choosing to help with premiums in order to get higher reimbursement.
- Self insured plans purchasing individual coverage for expensive members
- Nonpayment of premium while retaining coverage.

Information about the health status of newly insured

- Plans reported that newly insured members tended to have more conditions as well as more complex conditions.
- There was some evidence of pent-up demand.
- Chronic disease prevalence was evident.

Specialty Pharmacy

- Hepatitis C
- HIV medication
- Cancer Care
- Drugs for Chronic Diseases

Thinking about the numbers

Prevalence of Chronic Disease by Income Category

Prevalence of two or more of nine selected chronic conditions in 45 + year olds by income category

Below 100 %	33%
100-199%	30%
200-299%	21%
400% or more	16%

Looking forward

- **There are still 11.5% uninsured.**
- **Transition plans will enter the pool.**
- **Plans will enter and exit the market.**
- **Recovering economy may mean more people receive coverage through employers**
- **Experience will drive better understanding**
- **There will continue to be variation from market to market.**

Thank you

Rebecca Owen, FSA MAAA

Health Research Actuary

Society of Actuaries

847.273.8846

rowen@soa.org

@owenfsa

Innovation in Provider Contracting



Health Insurance [Marketplace](#) [HealthCare.gov](#)



MASSACHUSETTS

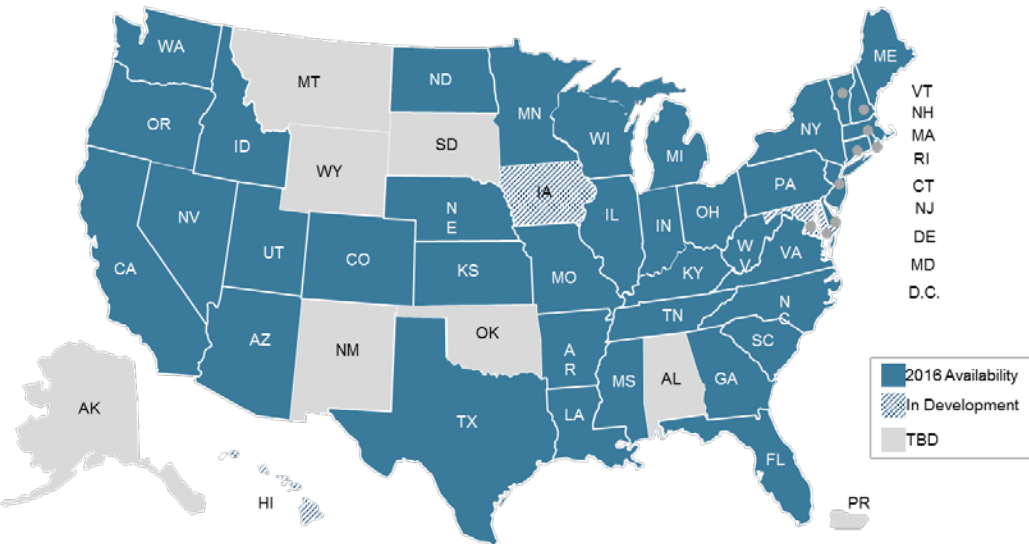
OUR
Quality care
advantage

Innovation in Payer / Provider Partnerships

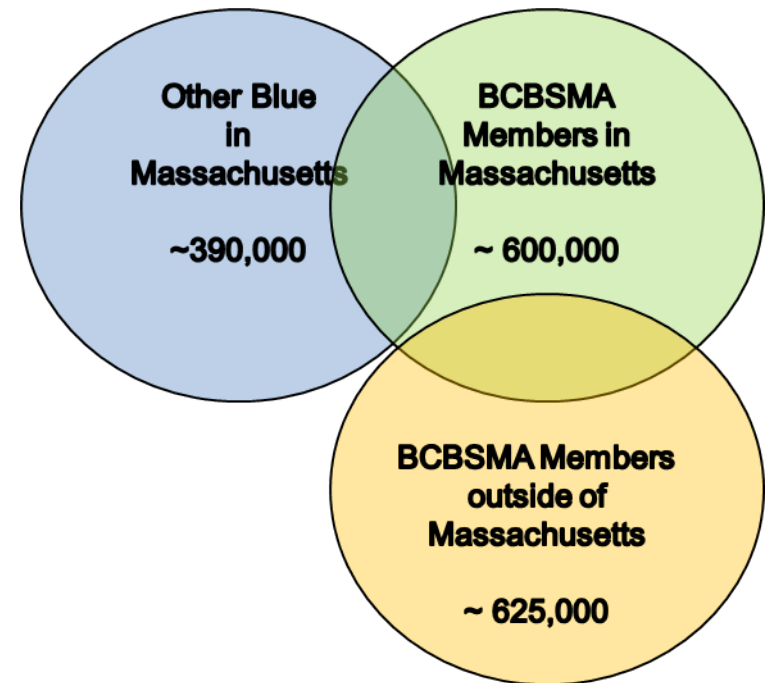
**Andreana Santangelo, FSA, MAAA
SVP, Business and Financial
Analytics and Chief Actuary**

Blue System Collaboration Supports Payment Reform Expansion

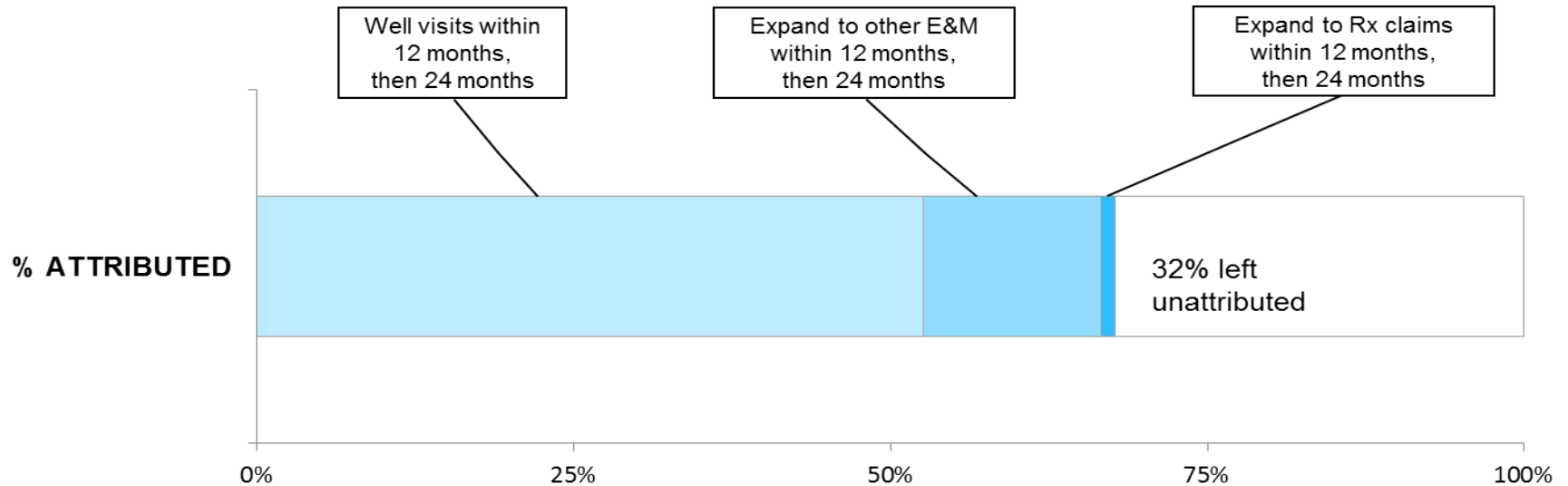
National Presence



PPO Member Populations



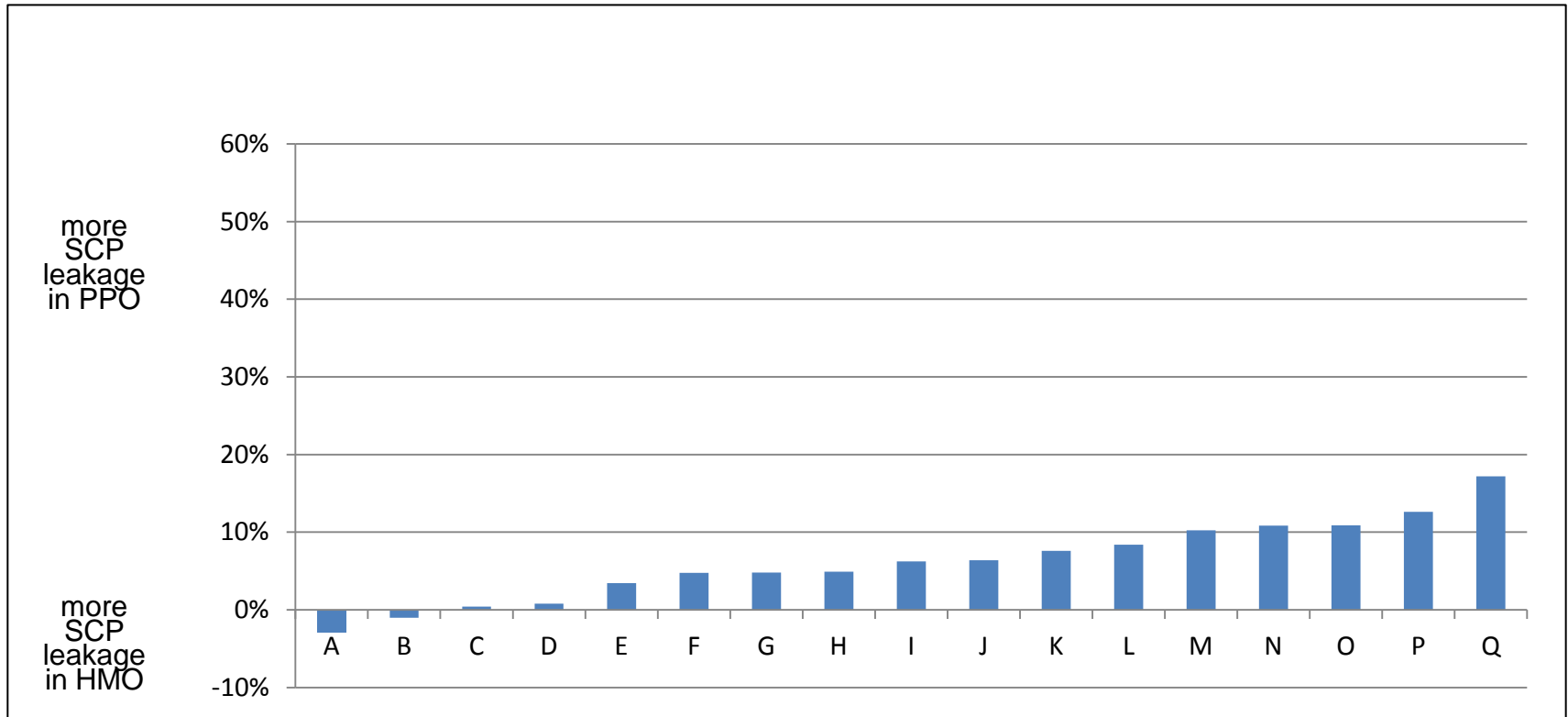
Attribution Methodology



Note: BCBSMA attribution algorithm is based on a hierarchy (e.g., once a member is attributed the logic stops)

- Reflects local, multi-stakeholder workgroup consensus
- BCBSMA tested attribution logic resulting in a 99% accuracy rate. Such test also resulted in limited calls from members regarding the attribution process.
- Indicates that PPO Members have a doctor that they primarily utilize

PPO Members Look to Their PCP for Guidance



- PPO members had their specialist use align with the affiliation of their PCP only 3% less than in HMO
- Illustrating some opportunity for improvement but overall little differences across product lines in patient approaches to accessing care

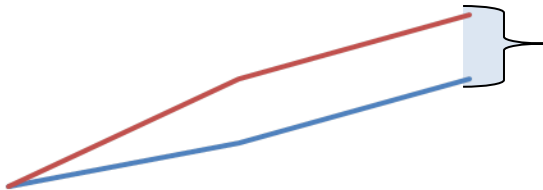
The Model

Core to Value Based Models

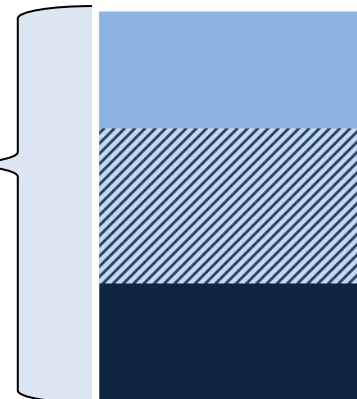


Unique to PPO Model

Savings = provider (risk adjusted) trend better than average



Savings are shared based on quality



30% returned to accounts (minimum ROI)


40% shared (account & provider) based on quality


30% paid to providers

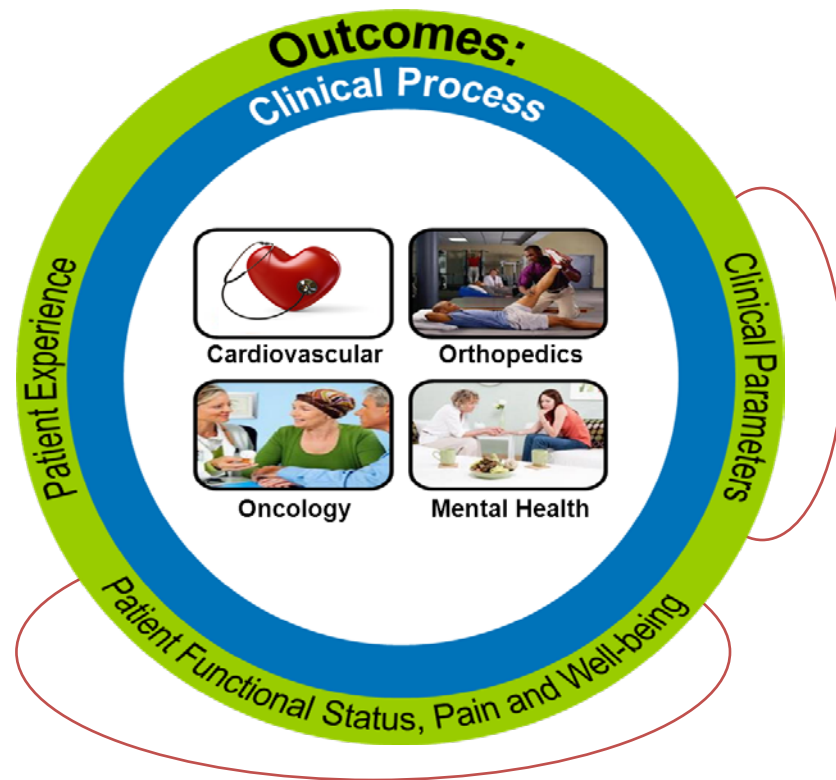
AQC Measure Set for Performance Incentives

	AMBULATORY	HOSPITAL
PROCESS	<ul style="list-style-type: none"> • Preventive screenings • Acute care management • Chronic care management <ul style="list-style-type: none"> • Depression • Diabetes • Cardiovascular disease 	<ul style="list-style-type: none"> • Evidence-based care elements for: <ul style="list-style-type: none"> • Heart attack (AMI) • Heart failure (CHF) • Pneumonia • Surgical infection prevention
OUTCOME	<ul style="list-style-type: none"> • Control of chronic conditions <ul style="list-style-type: none"> • Diabetes • Cardiovascular disease • Hypertension <p>*** <i>Triple weighted</i> ***</p>	<ul style="list-style-type: none"> • Post-operative complications • Hospital-acquired infections • Obstetrical injury • Mortality (condition –specific)
PATIENT EXPERIENCE	<ul style="list-style-type: none"> • Access, Integration • Communication, Whole-person care 	<ul style="list-style-type: none"> • Discharge quality, Staff responsiveness • Communication (MDs, RNs)
EMERGING	Up to 3 measures on priority topics for which measures lacking	

Expanded Quality Measure Set

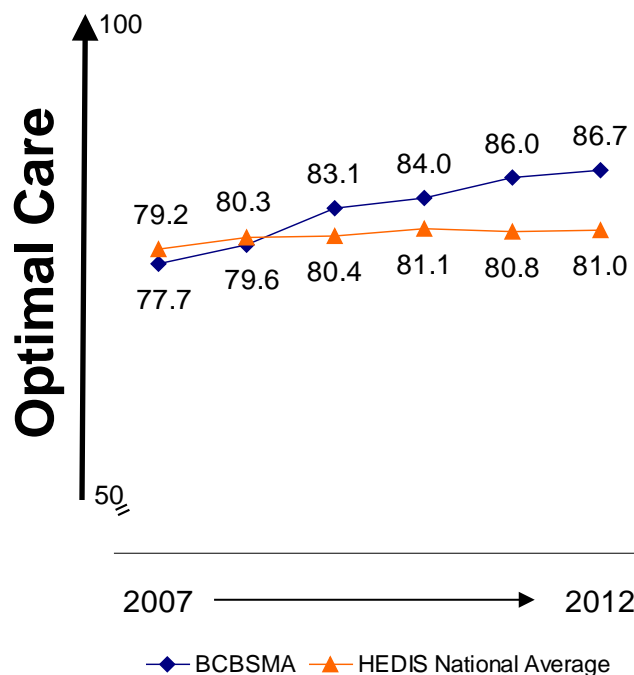
 Ambulatory Measures	
Ambulatory Measure Set	
Clinical Process Measures	
Depression	
Acute Phase Rx	
Continuation Phase Rx	
Diabetes	
HbA1c Testing (2x)	
Eye Exams	
Nephropathy Screening	
Cancer Screening	
Breast Cancer Screening	
Cervical Cancer Screening	
Colorectal Cancer Screening	
Preventive Screening/Treatment	
Chlamydia Screening	
Ages 16 - 20	
Ages 21 - 24	
Adult Respiratory Testing	
Acute Bronchitis	
Pediatric Respiratory Testing	
Upper Respiratory Infection	
Pharyngitis	
Pediatric Well Visits	
< 15 months	
3 - 6 years	
Adolescent Well Care	
Clinical Outcomes Measures	
Diabetes	
HbA1c in Poor Control	
Blood Pressure Control	
Hypertension	
Controlling High Blood Pressure	
Patient Experience - Adult	
Communication Quality	
Knowledge of Patients	
Integration of Care	
Access to Care	
Patient Experience - Pediatric	
Communication Quality	
Knowledge of Patients	
Integration of Care	
Access to Care	

 Hospital Measures	
Hospital Measure Set	
Hospital Clinical Process Measures	
Immunization	
Influenza Immunization	
Stroke	
Venous Thromboembolism (VTE) Prophylaxis	
VTE	
Venous Thromboembolism Prophylaxis	
Intensive Care Unit Venous Thromboembolism Prophylaxis	
Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	
Hospital Outpatient Surgery and Cardiac Care	
Median Time to Transfer to Another Facility for Acute Coronary Intervention (mins)	
Aspirin at Arrival	
Median Time to ECG (mins)	
Hospital Outcome Measures	
Iatrogenic Pneumothorax - Adult	
Post-operative Respiratory Failure	
Peri-operative PE/DVT	
Accidental Puncture or Laceration	
Birth Trauma Injury to Neonate	
OB Trauma - Vag with Instrument	
OB Trauma - Vag without Instrument	
Heart Failure Mortality Rate	
Acute Stroke Mortality Rate	
Hospital Wide Readmission (HWE) 30 Day All Cause Unplanned Readmission	
Hospital Patient Experience (H-CAHPS) Measures	
Communication with Nurses	
Communication with Doctors	
Responsiveness of Staff	
Pain Management	
Communication about Medicines	
Discharge Information	

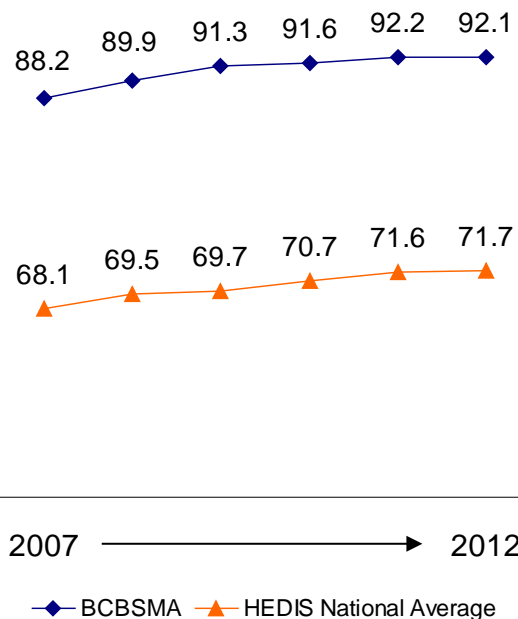


Quality & Health Outcome Results Under the AQC: Improvements by the 2009 Cohort of AQC Groups from 2007-2012

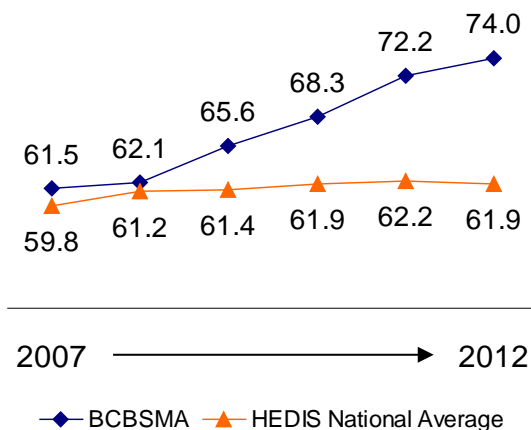
Adult Chronic Care



Pediatric Care



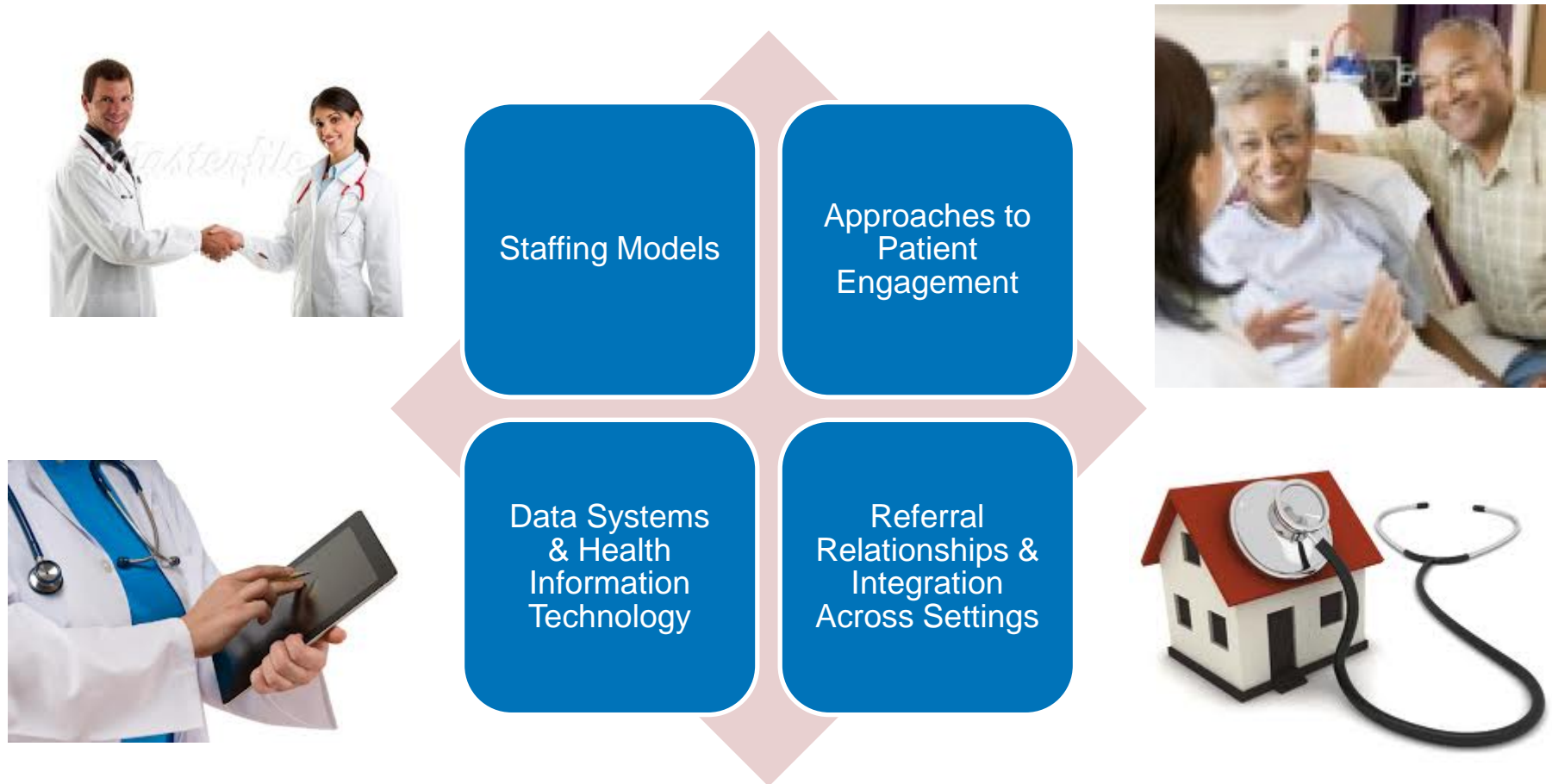
Adult Health Outcomes



These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first two scores are based on the delivery of evidence-based care to adults with chronic illness and to children, including appropriate tests, services, and preventive care. The third score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC's pioneering achievements.

Delivery System Innovation: Four Themes

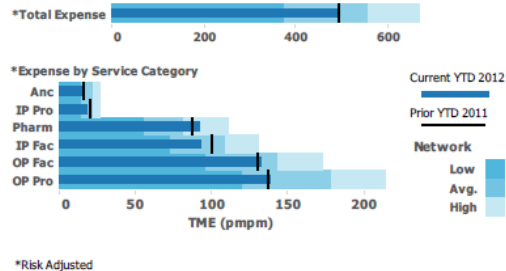
There are four domains in which we see AQC Groups innovating to improve quality and outcomes while reducing overall spending.



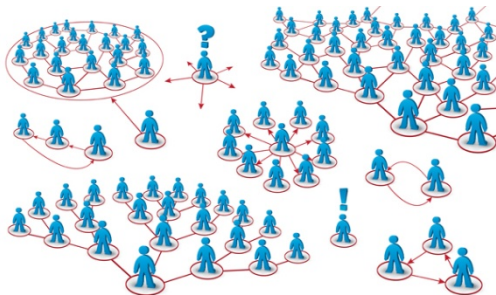
Payer Provider Partnership for Management of Care

Our four-pronged support model designed to help provider groups succeed in the AQC is now expanded across the PPO Population

Data and Actionable Reports



Consultative Support



Best Practice Sharing and Collaboration

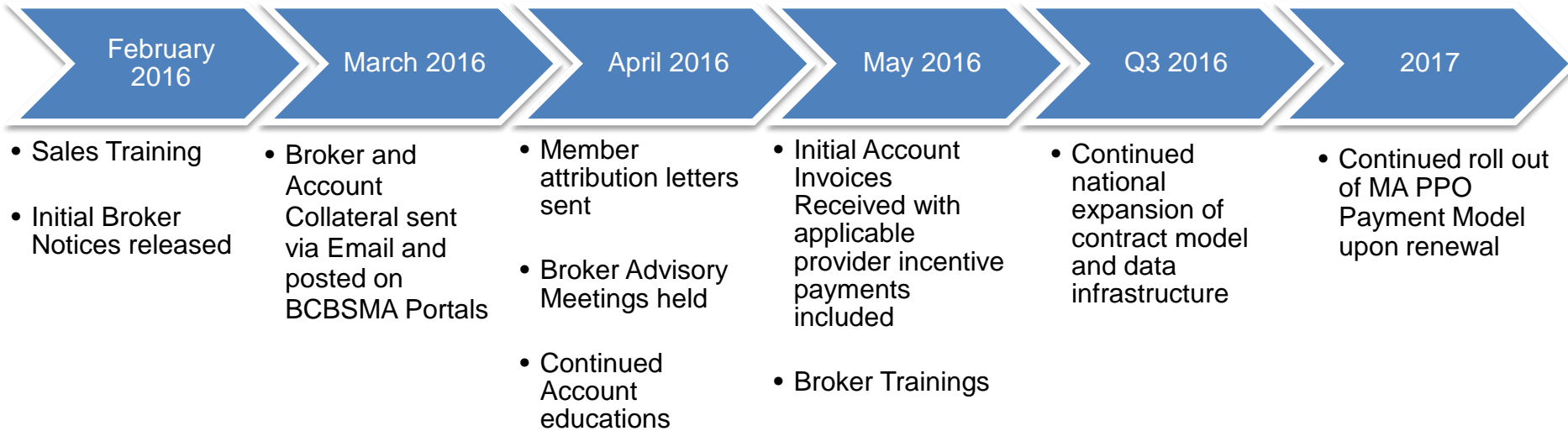


Training and Educational Programming

The AQC has been transformative. It has allowed us to innovate because it enables us to think like a system rather than individuals doctors.

- Leslie Sebba, MD, Medical Director
Northeast Physician Hospital Organization

Constituent Roll Out



Frequent and multi-layered communication is key to buy-in

OUR MODEL IN ACTION

Mary has diabetes.

If it goes unchecked, she could cost her employer **more than \$16,000^{1,2}** annually in health care and lost productivity.

Actionable data

Sustained partnerships and support

Care coordination by providers

Total cost accountability

High impact quality incentives

BCBSMA provides reports that indicate Mary is not filling her prescription.

AQC's Analyst identifies opportunity & informs her doctor prior to her visit

Mary visits her Primary Care Physician.

Provider educates Mary on treatment plan & refers to Provider Care Manager

Mary remains adherent to medication and keeps condition under control

¹ American Diabetes Association, People with diabetes incur \$13,700 per year in total expenses on average: <http://care.diabetesjournals.org/content/36/4/1033.full>

² Value in Health Journal, Value in Health study: 20% of diabetics miss 15 hrs of work / month, resulting in \$2300 of lost productivity per person per year <http://www.disabled-world.com/health/diabetes/missing-work.php>



Innovation + Solutions = Results

We're ***the*** pioneer
in health care
payment reform.

Our model works,
proven by three
major studies.



MASSACHUSETTS

Building a healthier world

Health care transformation through
accountable care



Agenda

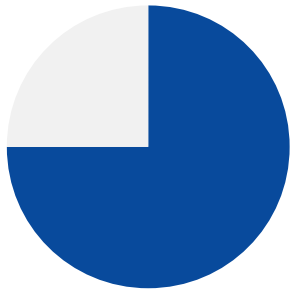
1) The Aetna approach

2) Consumers Benefit from value-based contracting

3) Lessons learned

Our commitment – build a healthier world by paying for value not volume

AETNA'S GOAL



75% of spend
flowing through
VBC models by
2020

WHERE WE ARE TODAY

40%+ of medical spend
through value-based contracts

6.2 million members with
value-based care providers

We're changing how health care is delivered

Our accountable care approach is unique:



Includes more feet-on-the-street enablement with programs and technology



Supports an innovative product – Aetna Whole Health



Not just data, but advanced analytics and collaboration for more intense population health



Holds providers accountable with more rigorous efficiency and quality measures

By transforming care we can:



Reduce waste:

8-15% savings targeted compared to Aetna broad network plans*



Improve quality:

Focus on targeted quality metrics



Improve member/patient satisfaction:

Establish baseline and increase year-over year

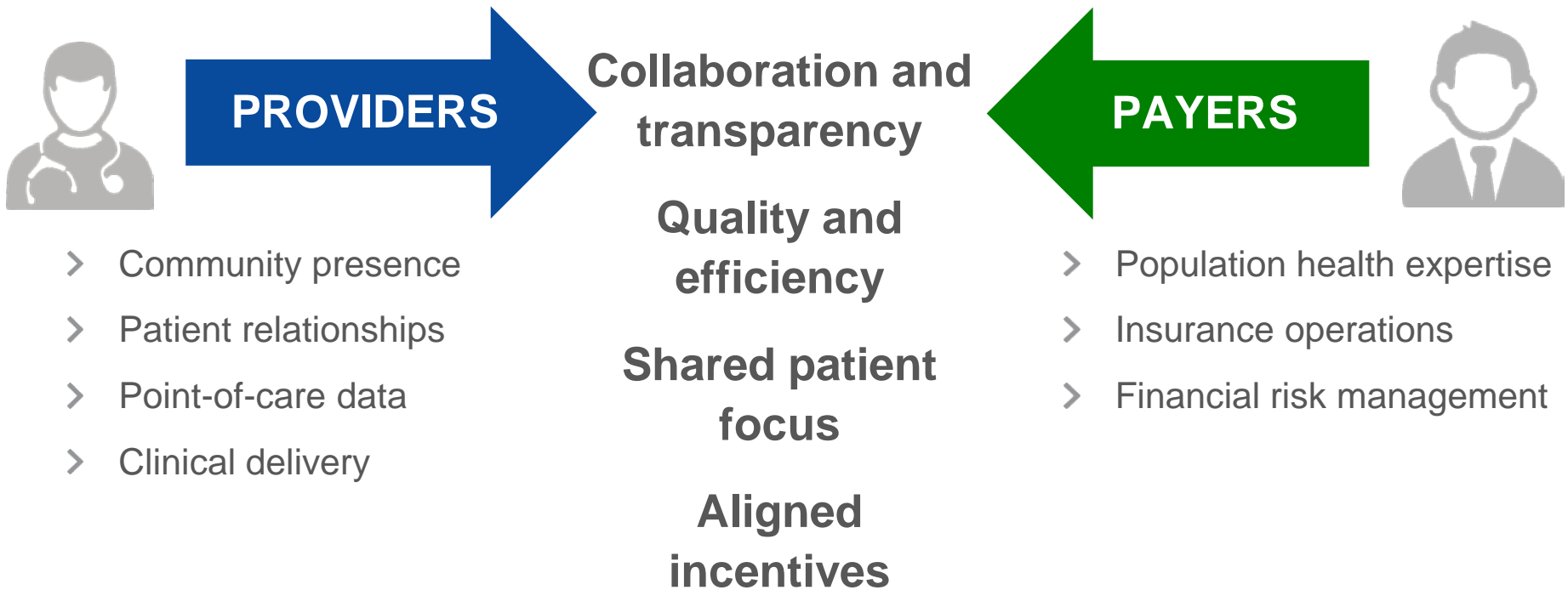


Improve the overall health and productivity of members and their families

* Actual results may vary, savings may be less when compared to other value-based or narrow network plans.

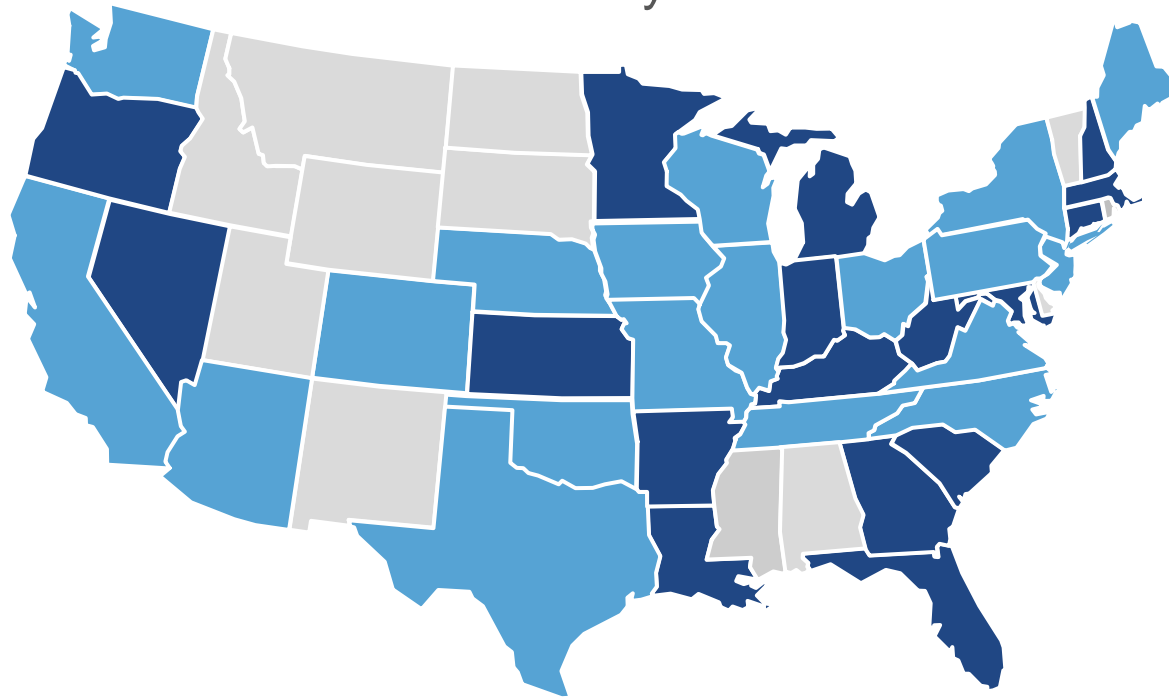
The value of payer and provider collaboration

Building on strengths of both players creates a bright future based on shared goals




Creating a national value-based care network

Aetna has 77 ACOs, and talks are underway with hospital systems across the U.S.



800+
Value-based
contracts

77 ACOs
275 that meet the broader
industry ACO definition¹

 States projected to have
provider collaboration
product or plan by 1/1/17
(may also have other value-
based products)

 States with other Aetna
value-based contracts

¹<http://leavittpartners.com/2013/10/really-aco/>

above data as of February 7, 2016

Agenda

1) The Aetna approach

2) Consumers benefit from value-based contracting

3) Lessons learned

This is a new model, not an old-style HMO

A **win-win-win** for patients, doctors and employers

Old-style HMO (not value-based)

Where many providers are today

Little, if any, health IT or analytics

Limited changes in patient behavior

Provider payment contingent on volume of services

Patient frustration with lack of coordination

New paradigm

Providers that want to transform

▶ **Earlier identification of at-risk patients** with richer information

▶ **Enhanced patient engagement** through proactive, doctor-driven outreach

▶ **Improved cost and quality effectiveness** by aligning financial incentives

▶ **A more satisfying experience** when providers coordinate care more effectively

Our value based systems are improving the patient experience by helping patients....

Navigate the system

- Proactive outreach to help patients select a primary care doctor to lead their care team
- Smoother care transitions from provider to provider and facility to facility
- A dedicated, toll-free Aetna Whole Health member services number
- Welcome calls and kits to ensure a smooth onboarding process
- New hospital case managers to explain discharge instructions and new medications to patients
- New nurse care coordinators to support doctors and their patients with personalized care plans



Get better access

- Same-day primary care appointments
- Extended weekday and weekend clinic hours
- Reserved appointments for patients with chronic conditions or acute care needs



Manage their health

- A free online health risk assessment
- Online emergency room check-in to reduce waiting times and provide support
- Telemedicine option



Patients are benefiting from improved best practices versus existing approach



Increased generic dispensing of top 4 drug groups



Decreased impactable surgical admits per 1,000



Overall reduction in medical costs versus expected costs for the local area



Baseline period: 1/1/13 – 12/31/13; Performance period: 1/1/14 – 12/31/14. Paid through 3/2015; Results for ACOs effective as of 1/1/2014 and in place for at least one year.

Keeping consumers healthy benefits them – and the economy

Productivity losses related to health problems cost U.S. employers **\$1,685** per employee per year*

TRADITIONAL EXPERIENCE

“**I missed hours of work** driving back and forth to the lab to get my blood drawn.”

“I had a test to see if my cholesterol was high but **never heard anything. Then I had a heart attack.**”

“**I can’t concentrate on work** because of rheumatoid arthritis flair-ups and multiple joint replacement surgeries.”

ACCOUNTABLE CARE EXPERIENCE

“I went to the lab once when my physician wanted blood drawn. **My specialist had all the information on his computer.**”

“**A whole team watches my cholesterol problem.** A nurse coaches me on my diet. I get educational e-mails, and they get me in for regular checkups.”

“**My doctor’s care team made special arrangements** so I get the tests and medications needed to avoid flair-ups. I feel great.”

*2015 National Center for Chronic Disease Prevention and Health Promotion

Agenda

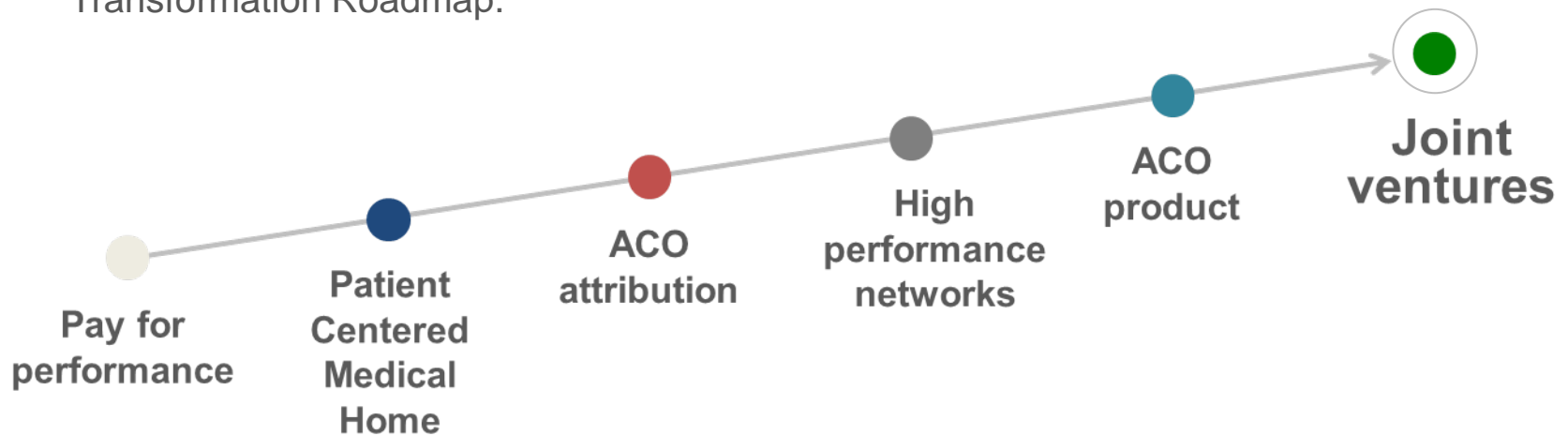
1) The Aetna approach

2) Consumers benefit from value-based contracting

3) *Lessons learned*

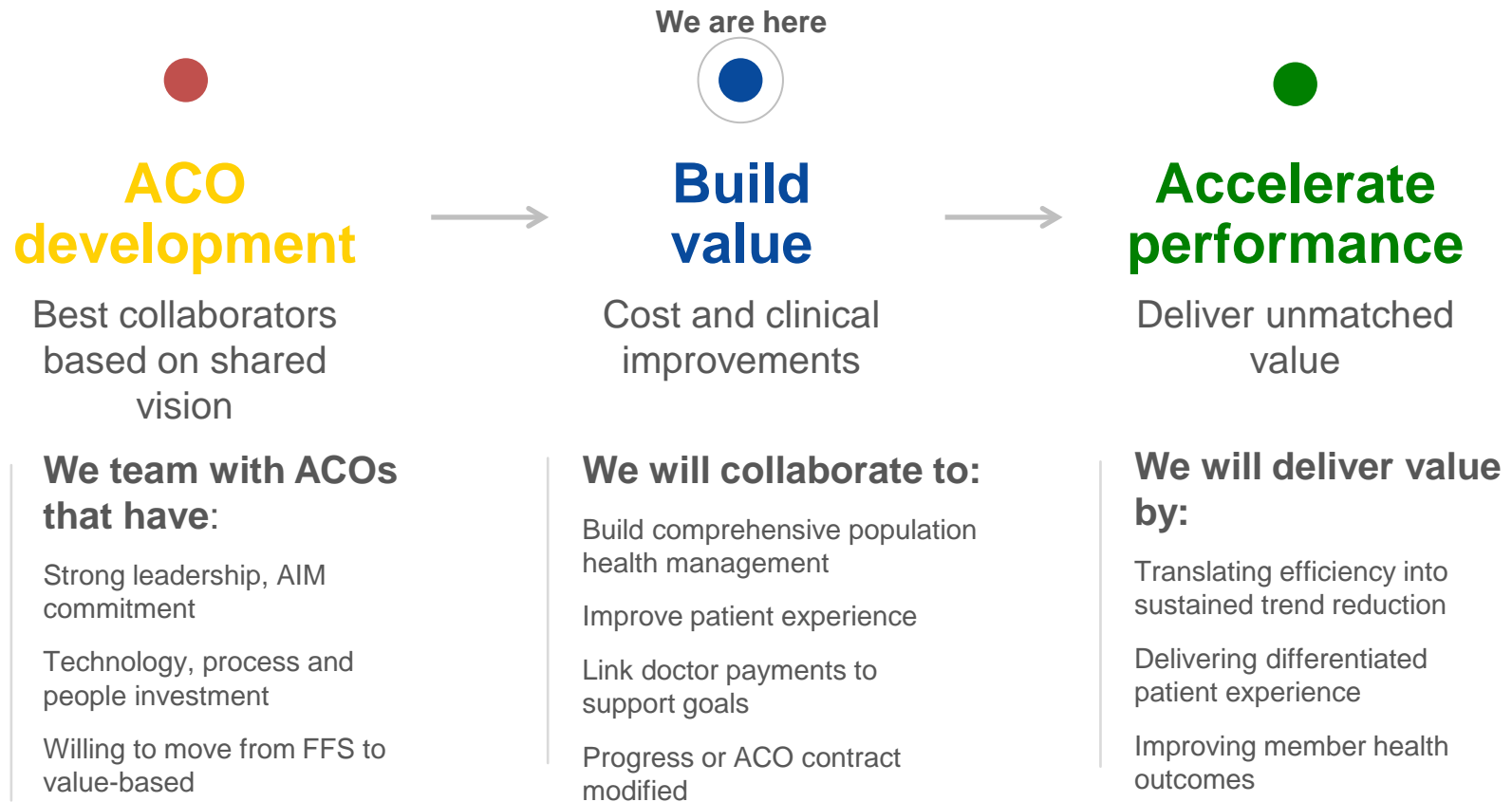
We need to meet providers where they are

- After providers enter the continuum, we help them progress to models with more risk and more reward.
- We guide ACO providers with a comprehensive “Transformation Roadmap.”






Accountable care is a journey – not a destination

PRINCIPAL PHASES:



Population health

	Today	Future
MODEL 	Provider-centric model Payer-led care management telephonic model	Member-centric model Provider-led care management activity at the point of care
PEOPLE 	Focus on sick patients only Lack of comprehensive care coordination	Focus on population health Robust care coordination across the continuum of care Patient engagement through digital technology
TECHNOLOGY 	Early stages of Clinically Integrated Network (CIN)	Data-driven clinical decision making: <ul style="list-style-type: none">• Standardized evidence based medicine• Predictive analytics at the ACO level and the primary physician level• Smart segmentation across the population• Improved care coordination workflows



Thank you

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company (Aetna) and its affiliates.

This material is for information only. Health benefits and health insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.





Care Coordination



Health Insurance [Marketplace](#) [HealthCare.gov](#)

Innovation In Care Coordination

Scott Streator

SVP, Market & Product Group

Chris Turner

SVP, New Business Integration & Member Care

CareSource

June 9, 2016



Health Insurance **Marketplace**

HealthCare.gov

October 31, 2013



Agenda

- Who is CareSource
- What We Learned
 - Enrollment Snapshot
 - Success Factors
- Care Coordination of Newly Insured
- Innovation in Care Coordination





**Non-profit, founded in
1989 in Dayton, OH**

**Comprehensive,
member-centric health
and life services**

**Regionally based-
serving multiple states
and products**

MISSION FOCUSED:

To make a lasting difference in our members' lives by improving their health and well-being.

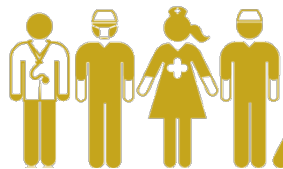
Product Lines

- Medicaid
- Marketplace
- Duals Demo
- Medicare Advantage

1.52M
members



100k



Marketplace
Enrollment Growth



Marketplace
Coverage

Why We Were an Early Adopter



**Commitment to uninsured
&
vulnerable populations**

Enrollment Snapshot



Common Diagnoses

- Hypertension
- Lipid Disorders
- Low Back Pain
- Obesity
- Diabetes



60%

Silver Plan



20%

Prior Medicaid



87%

Receive Subsidies



41.9

Average Age

18% are under age 35



46% Male / Female **54%**

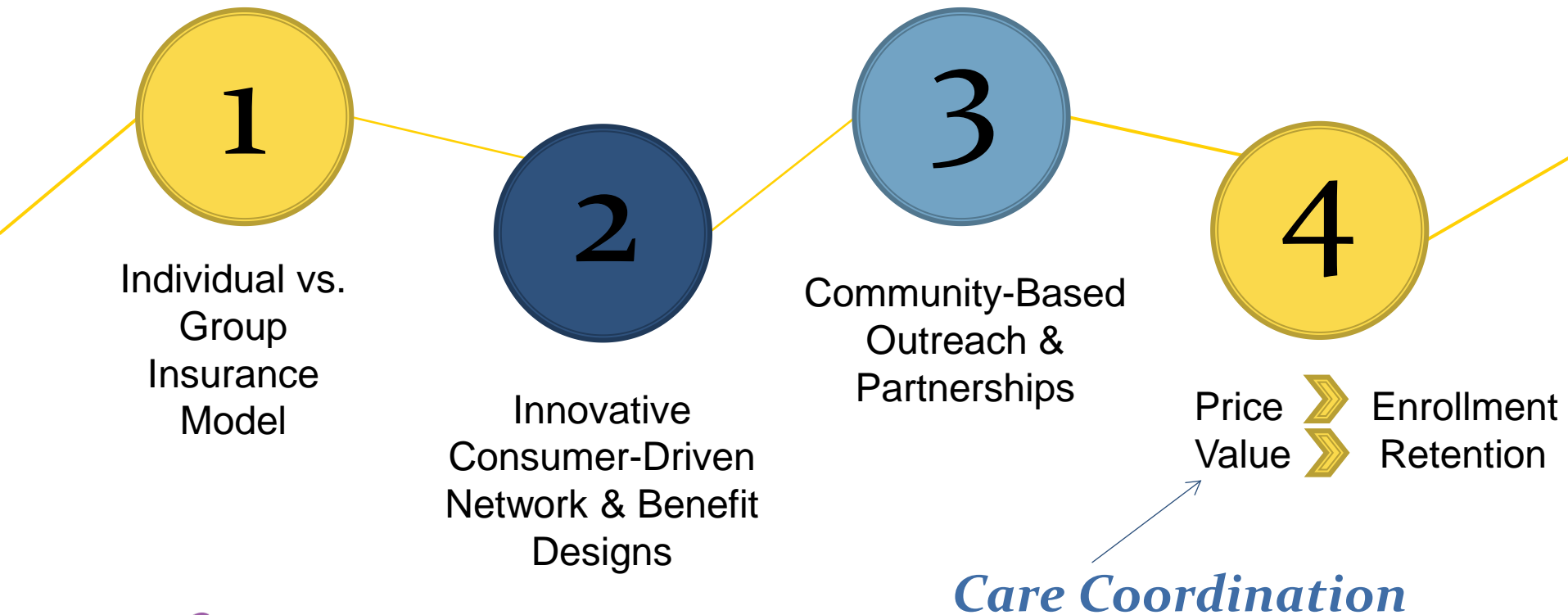


47-63%

Previously Uninsured



Marketplace Success Factors



Care Coordination Case Studies



Welcome Call

- Vulnerability Index
- Health Risk Assessment



Identify Members for Care Coordination



Our Care Model



Population Health Approach



Nine Clinical Personas

Actionable Insight to Slow Member Progression

Who manages member's health?

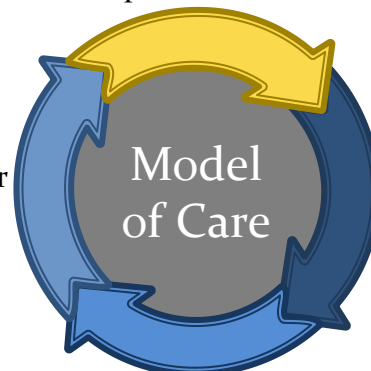
Health Self Partner 1:1 Care Coordination

Monitoring	✓			
Low	✓			
Medium	✓	✓		
High	✓	✓	✓	
Intensive	✓	✓	✓	✓
Complex	✓	✓	✓	✓



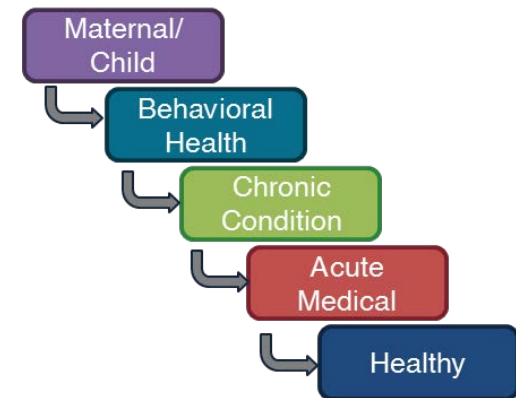
Population Risk

Member Risk



Triggers

- Life
- Coordination
- Evidence-based

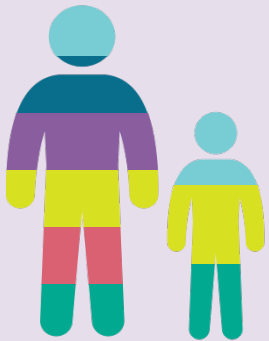


Life Services:

Managing Social Determinants of Health

HEALTH-RELATED SOCIAL NEEDS

+ HEALTH



Health-related social needs are found where people live, learn, work and socialize; they impact health outcomes.



ECONOMIC STABILITY

- ACCESS TO LONG-TERM EMPLOYMENT
- ACCESS TO FINANCIAL LITERACY
- ACCESS TO ADULT EDUCATION & JOB TRAINING
- INCREASED ASSETS SUCH AS HOME OWNERSHIP



HOUSING & NEIGHBORHOODS

- ACCESS TO HEALTHY FOODS
- INCREASED QUALITY OF SAFE & AFFORDABLE HOUSING
- IMPROVED ENVIRONMENTAL CONDITIONS



EDUCATION

- EARLY CHILDHOOD EDUCATION & DEVELOPMENT
- ACCESS TO EXTRACURRICULAR ACTIVITIES & MENTORING
- INCREASE HIGH SCHOOL GRADUATION
- ENROLLMENT IN JOB TRAINING OR POST SECONDARY EDUCATION

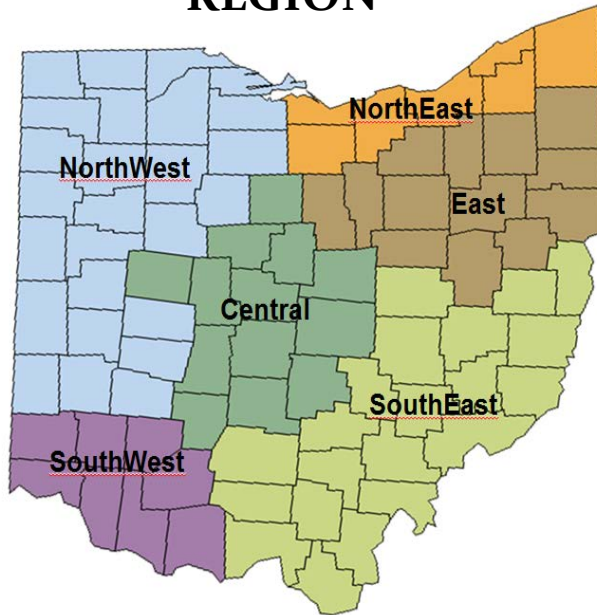


FOOD & NUTRITION

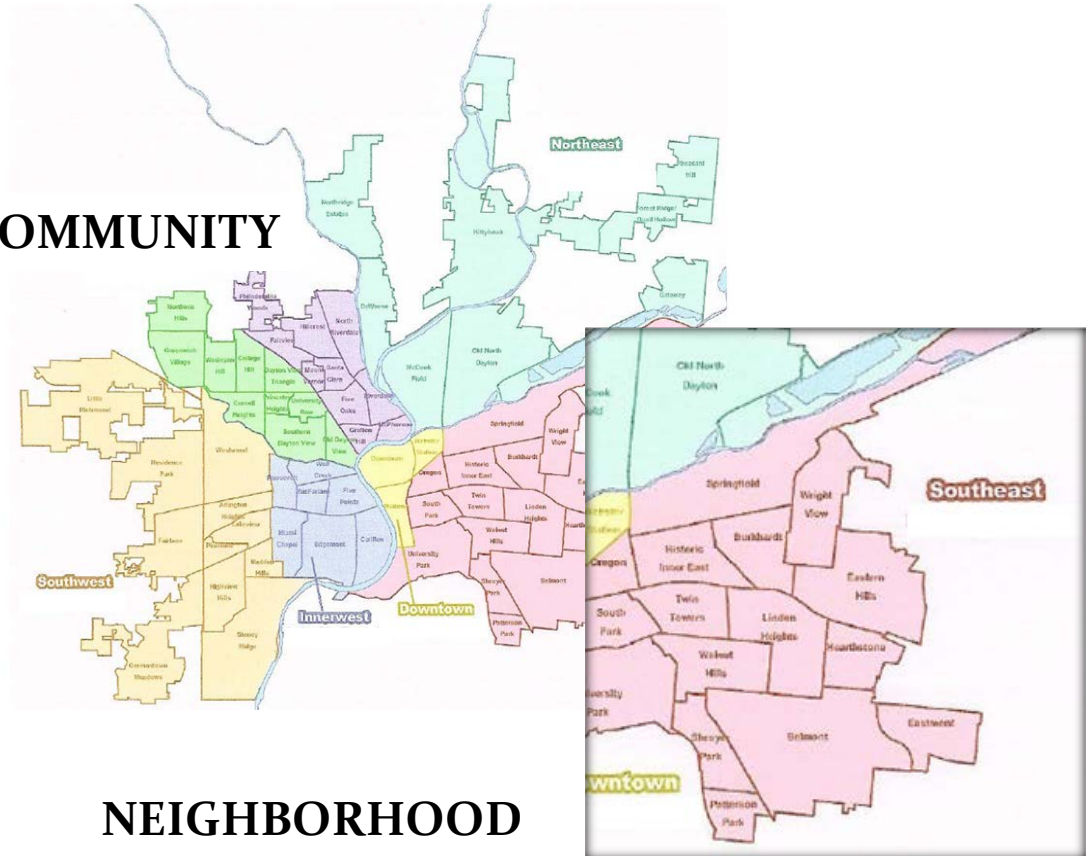
- REGULAR & CONSISTENT ACCESS TO HEALTHY FOODS
- EDUCATION ON NUTRITION & OVERALL HEALTH IMPACTS
- ADDRESSING FOOD DESERTS & INEQUALITIES

Neighborhood Centered Member Care

REGION



COMMUNITY



NEIGHBORHOOD



Innovation Supports Improved Outcomes

- Health, Wellness and Care Plans
- Health Risk Assessment
- Member Engagement
- Tailored Interactive Member Experience
- Service Access and Utilization
- Overall Cost Per Member / Month Cost



Conclusion

- Innovate
- Population Health
- Care for Everyone
- Care is Local
- Relationships
- Rising Risk
- Social Determinants





Place of Delivery Care Model

A collaborative approach for high-risk patient care

Deborah Stewart, M.D.
Regional Medical Director
Florida Blue
June 9, 2016



Health Insurance Marketplace

HealthCare.gov

Innovative Solutions/Customer



GuideWell Emergency Doctors

Free-standing ERs staffed by board-certified emergency physicians billing at urgent care (not ED) fees



CliniSanitas

Culturally relevant, comprehensive care addressing needs of Central and South Americans



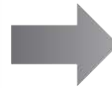
Florida Blue Retail Centers

Retail centers that engage, educate, enroll, provide health assessments and in several locations attached to care providers

Transforming our Medical Management Model

Historically

- Disease-Centric Approach
- Moderate Array of Support Services
- Non-Scalable Care Model
- Post-Event Care Interventions
- Limited Engagement Channels
- Almost Exclusively English-Based
- Average Quality Ratings



Future State

- Member-Centric Approach
- Robust Continuum of Services
- Model Scaled to Support Product/Network Arrangements
- Real Time and Prospective Care Support
- Leveraging Most Effective Engagement Channels for Population
- Culturally Competent to Serve Target Markets
- Competitive Results on all Quality Standards

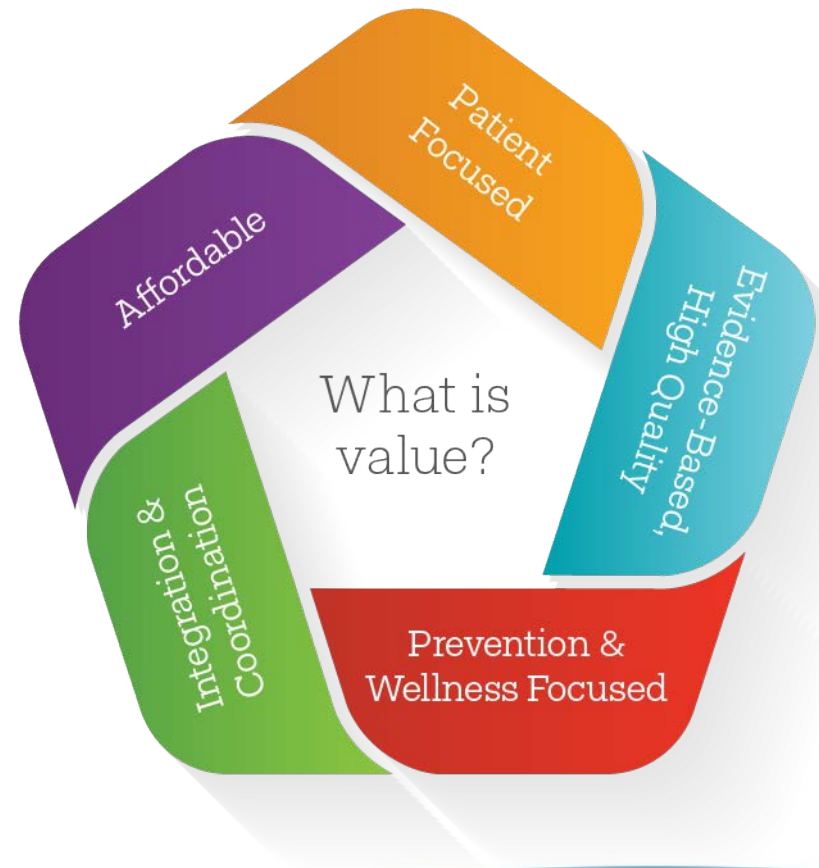
Progress

80%

Future State

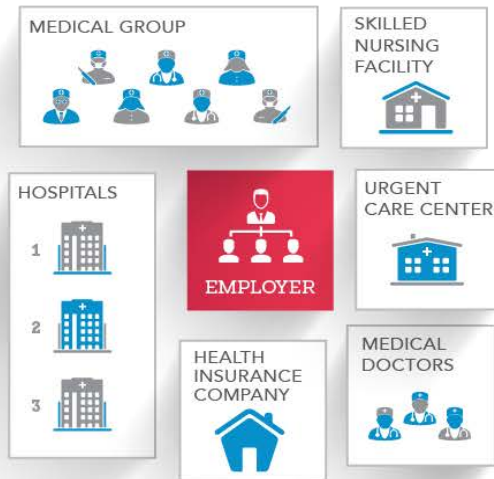
Why the POD Model?

- Improve quality, utilization and cost outcomes for members.
- Coordinates care for high-risk members in the community where they receive their services.
- Builds and improves relationships with members and their medical provider.
- Leverage national best practices.



Current Environment

“Old World”



- Employer-based coverage
- Large open provider networks
- Self directed care management

“Future World”



- Consumer-centric care
- Geo-and product specific networks
- Collaborative care management (ACOs, PCMHs, CCMs)
- Population care management model

How We Make the Greatest Impact

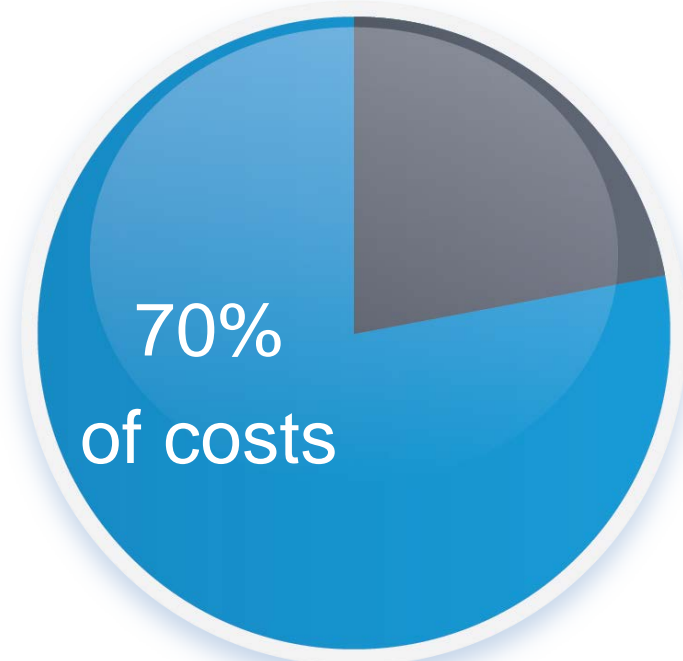
PODs focus on complex-care members who drive 60% to 70% of costs.

This breaks down to:

- 1% of the fully insured
- 5% of Affordable Care Act (ACA)/individuals under 65
- 10% of Medicare Advantage members

=

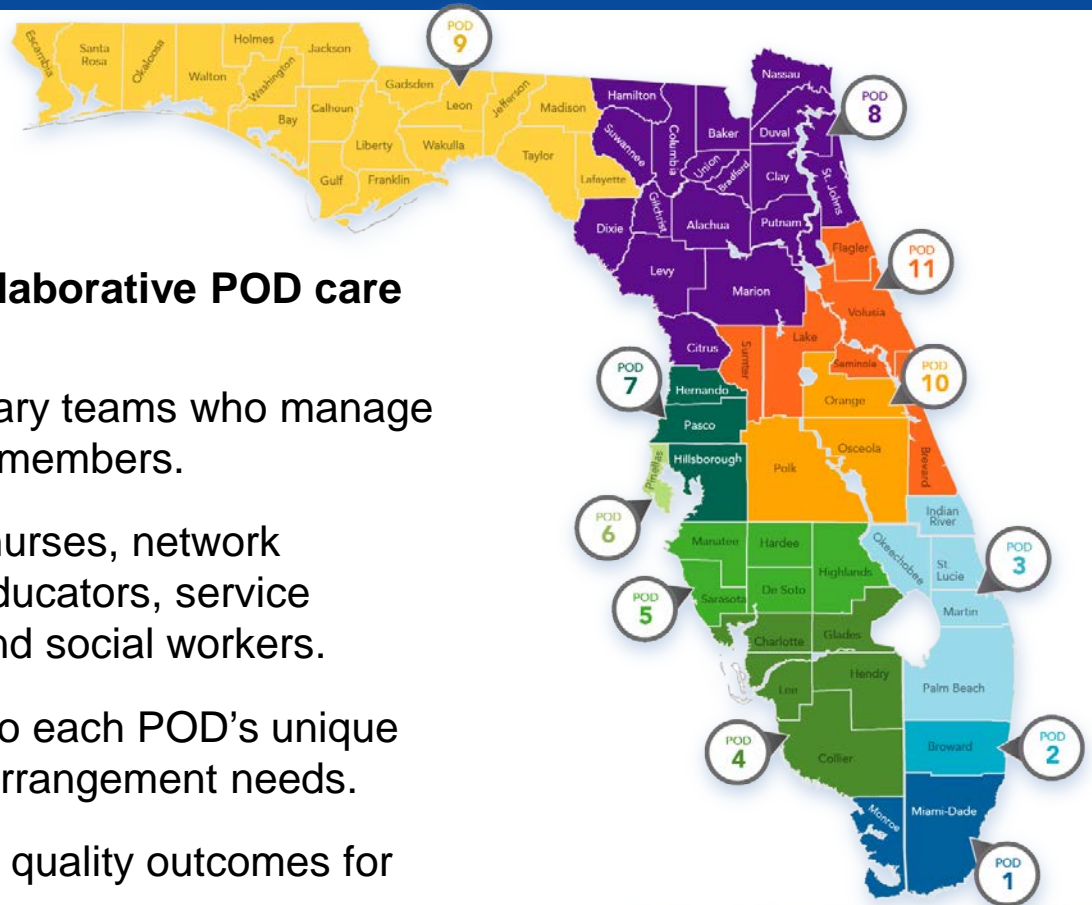
**Complex-Care
Membership Cost**



POD Design and Implementation

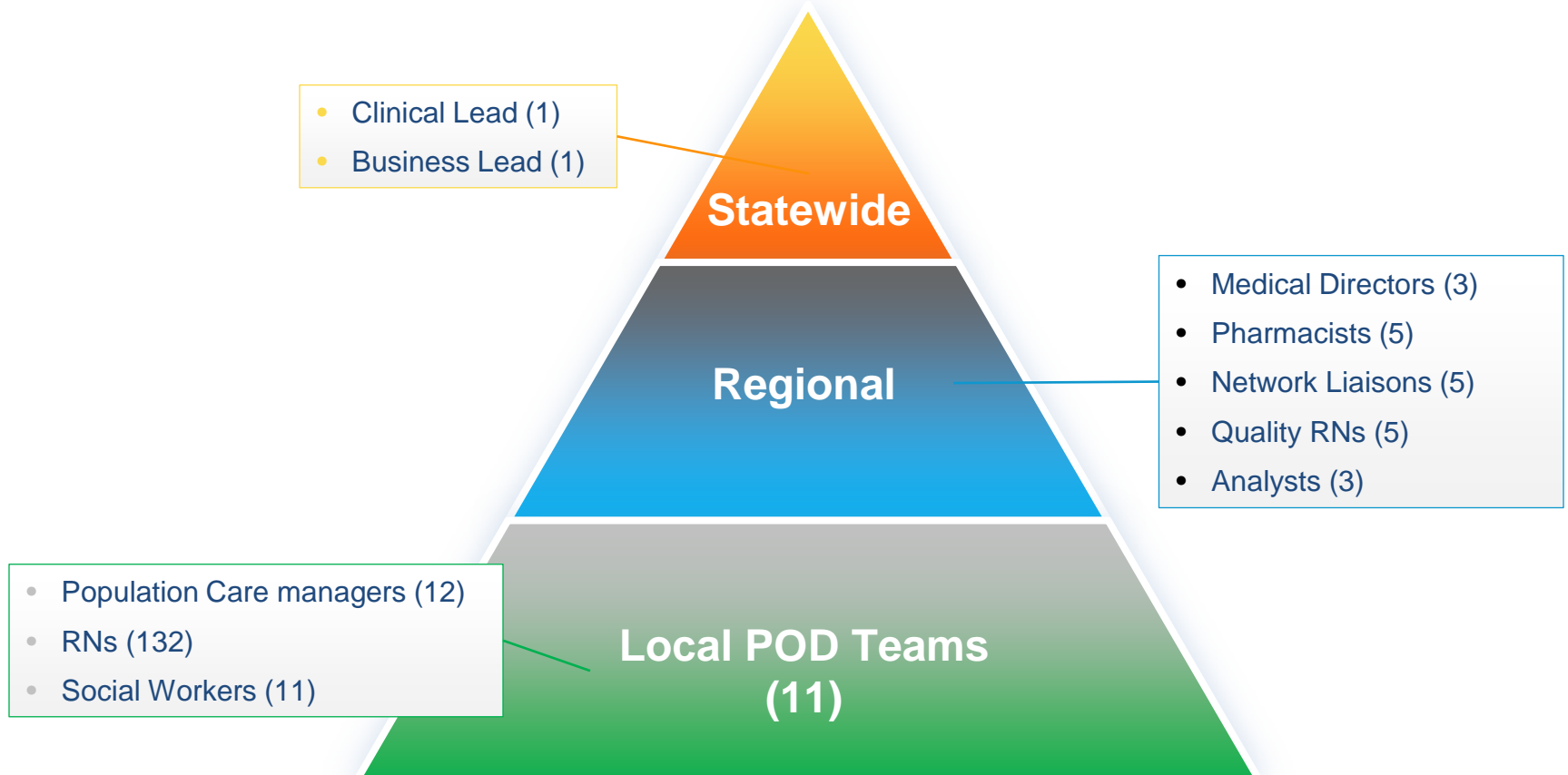
Eleven (11) locally based, collaborative POD care models:

- Geo-specific, inter-disciplinary teams who manage the care needs of high-risk members.
- Florida Blue staff includes nurses, network liaisons, analysts, coding educators, service consultants, pharmacists and social workers.
- Staffing levels customized to each POD's unique membership and provider arrangement needs.
- Accountable for clinical and quality outcomes for target population.

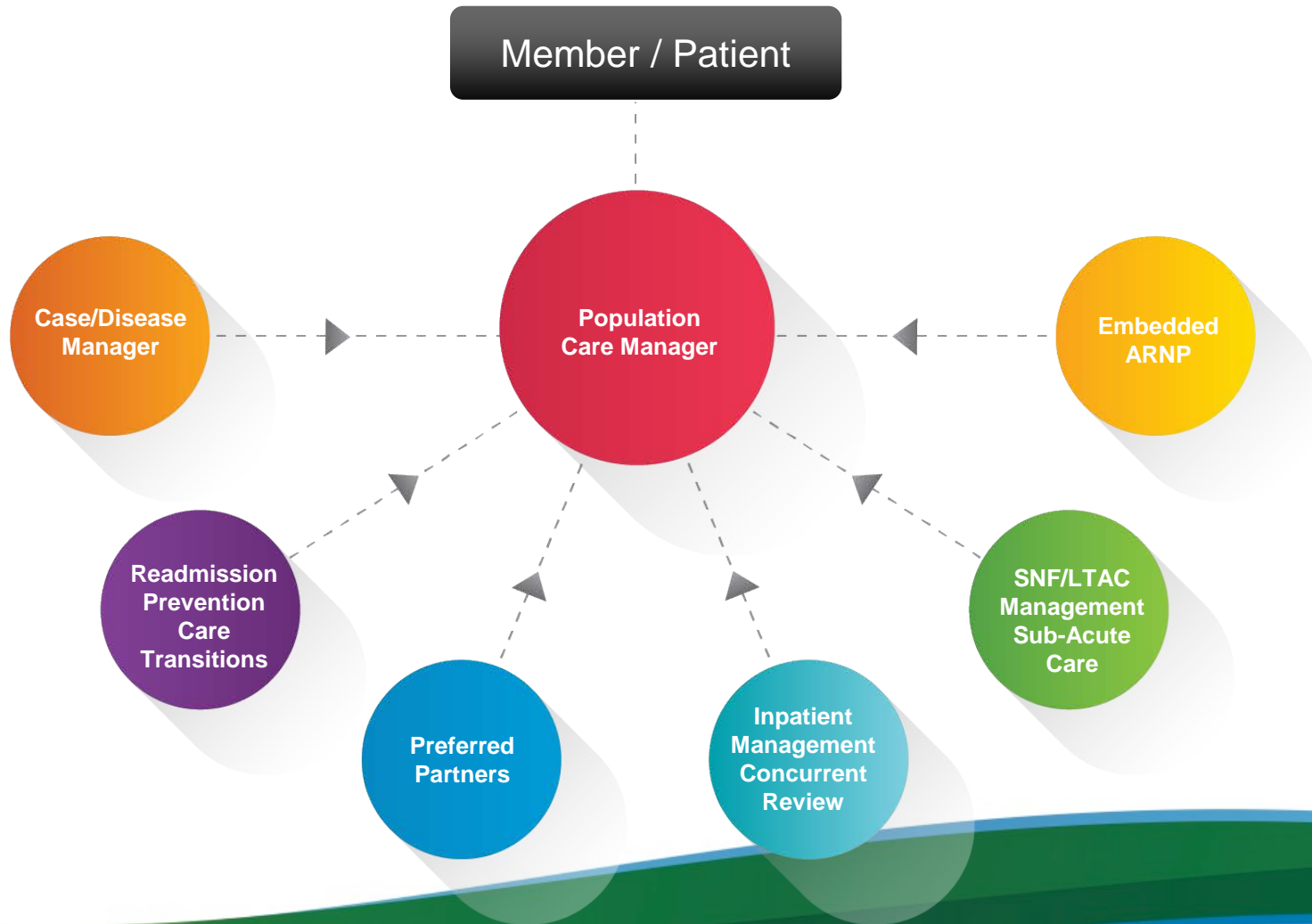


POD Design and Implementation

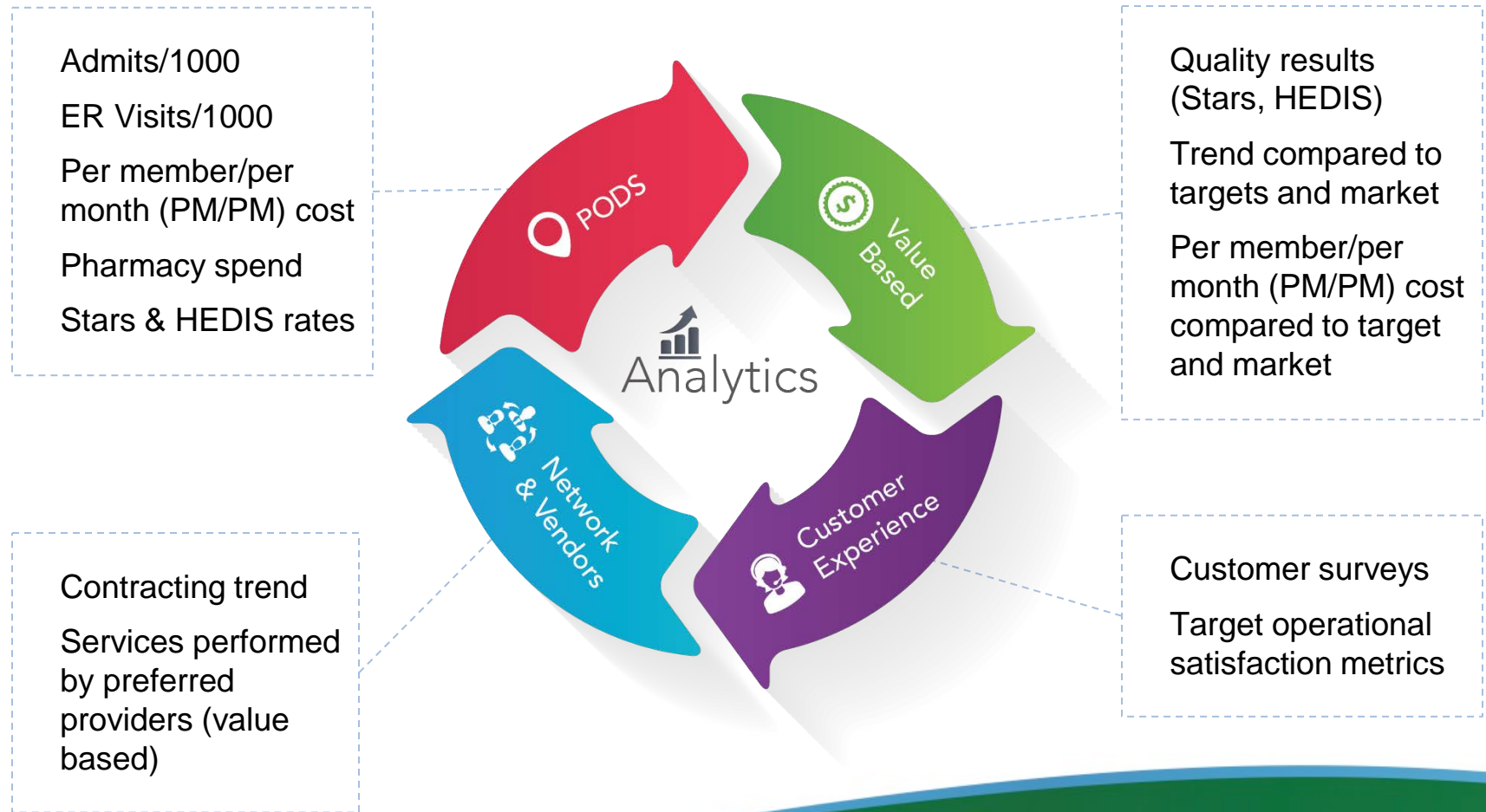
POD Clinical Support by Vicinity



POD Population Care Manager and Team



POD Model Success Measures



ACA Inpatient Admits, Readmits

Admissions

Jan. 2015	Jan. 2016
93 admits/1,000	76 admits/1,000

Readmission Rates

Jan. 2015	Jan. 2016
11.5%	10.7%

PODs fully implemented Sept. 2015

CMS Marketplace Forum Care Coordination

UPMC Health Plan

Adam Pittler, MBA Director Consumer Products

Roseanne Degrazia, Associate VP Clinical Affairs

June 9, 2016



Health Insurance Marketplace

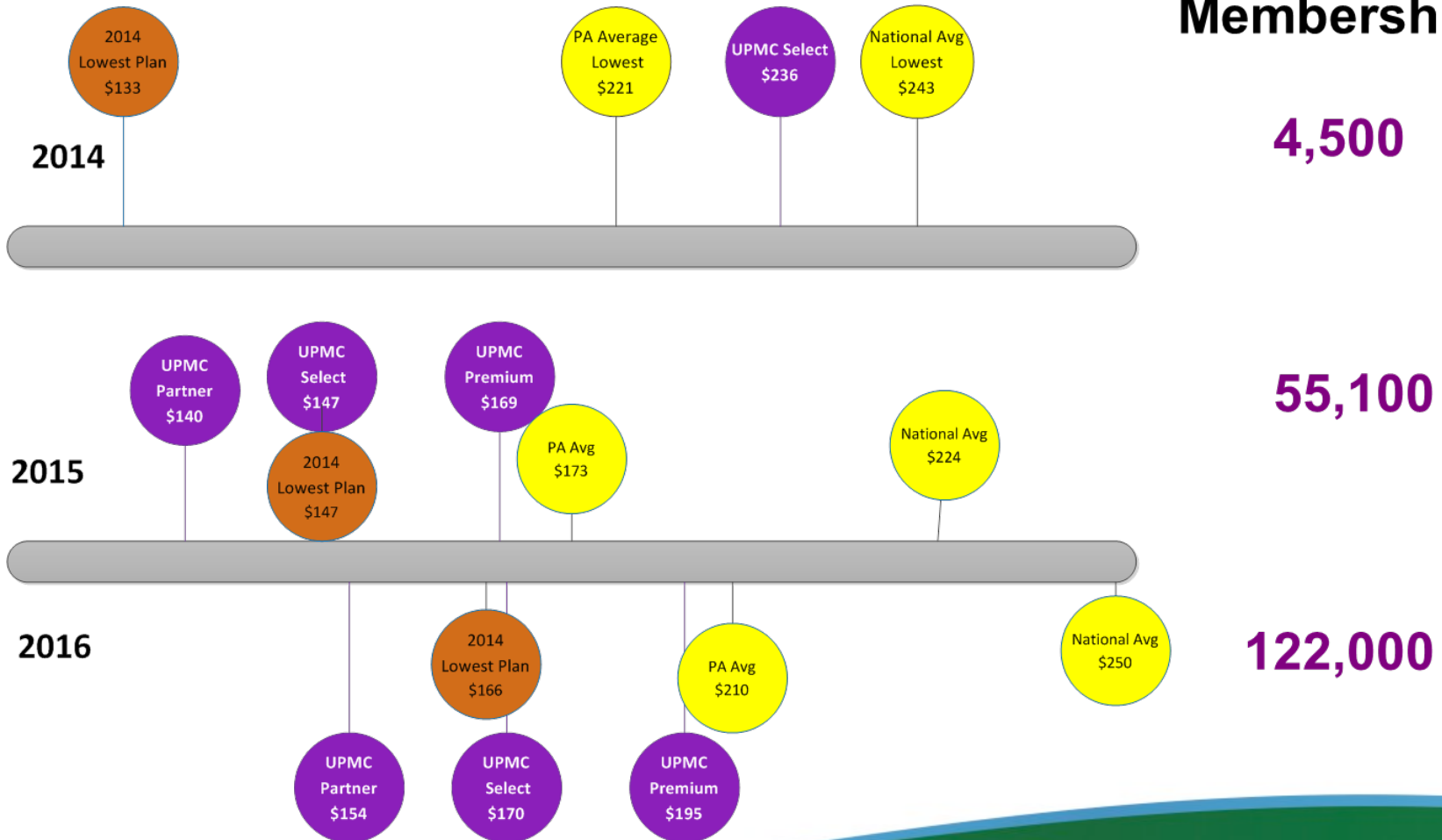
HealthCare.gov

UPMC's Integrated Delivery and Financing System Approach

- **UPMC Has Been An IDFS Since 1998** We're committed to improving the health of our members and community, implementing cost-effective solutions, creating innovative product offerings, service excellence, and leveraging our unique structure to partner with community providers, our patients, our members, and our purchasers.
- **Provider-focused, integrated systems are best positioned** to create innovative clinical models that improve care and reduce expenses – the imperative we must embrace in order to thrive in the future.
- **Continued support of physicians coupled with investments** in our systems and infrastructure enables the ongoing success of our integrated delivery and financing model.
- UPMC, through its Integrated Delivery and Financing System, is **partnering with community hospital systems and physicians** to create the highest quality, cost effective care to improve the health of the communities we serve.

UPMC's Individual Market Experience

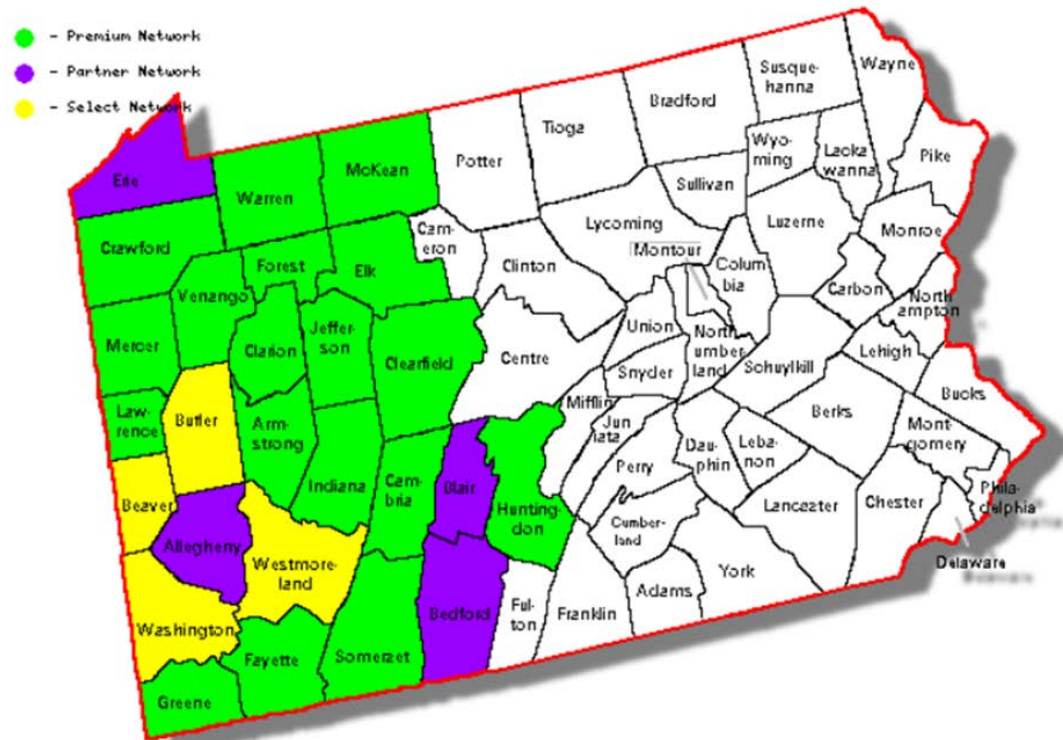
Health Plan Membership



UPMC's Individual Market Network Strategy

Develop High Quality/Low Cost network options at the local level

- **Premium Network**
 - Traditional Commercial Network
 - Full 29 County Service Area
- **Select Network**
 - UPMC + Local Community Hospitals
 - 80%+ Shared Savings/PCMH PCPs
- **Partner Network**
 - UPMC Focused
 - Available in counties where UPMC has a hospital presence

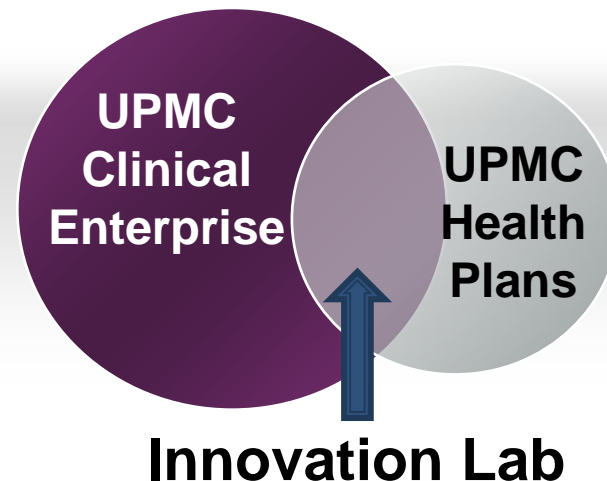


Aligning Plan and Provider Effectiveness

Integrated Delivery and Financing System Innovation Lab

Advantages

- Creates synergistic provider and payer business growth and development strategies
- Combines provider and payer expertise to drive improved outcomes
- Aligns clinical and financial incentives to create value
- Creates administrative efficiencies

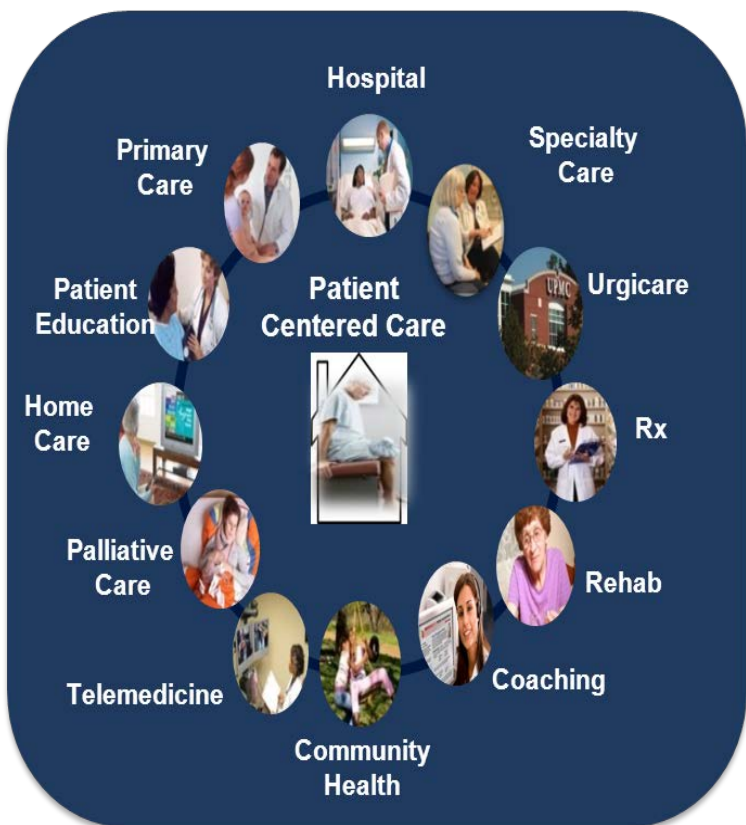


UPMC Health Plan Medical Home



UPMC Continues to Focus on People, Process and Technology to Unleash the Power of an Integrated System

Value Network



Right Infrastructure

- People
- Process
- Technology

Right Clinical Model

- Standardized Protocols & Registries
- Care Transition Programs
- Patient Centered Services
- Chronic Care Management Models
- Lifestyle Coaching & Education

Right Consumer/Patient Supports

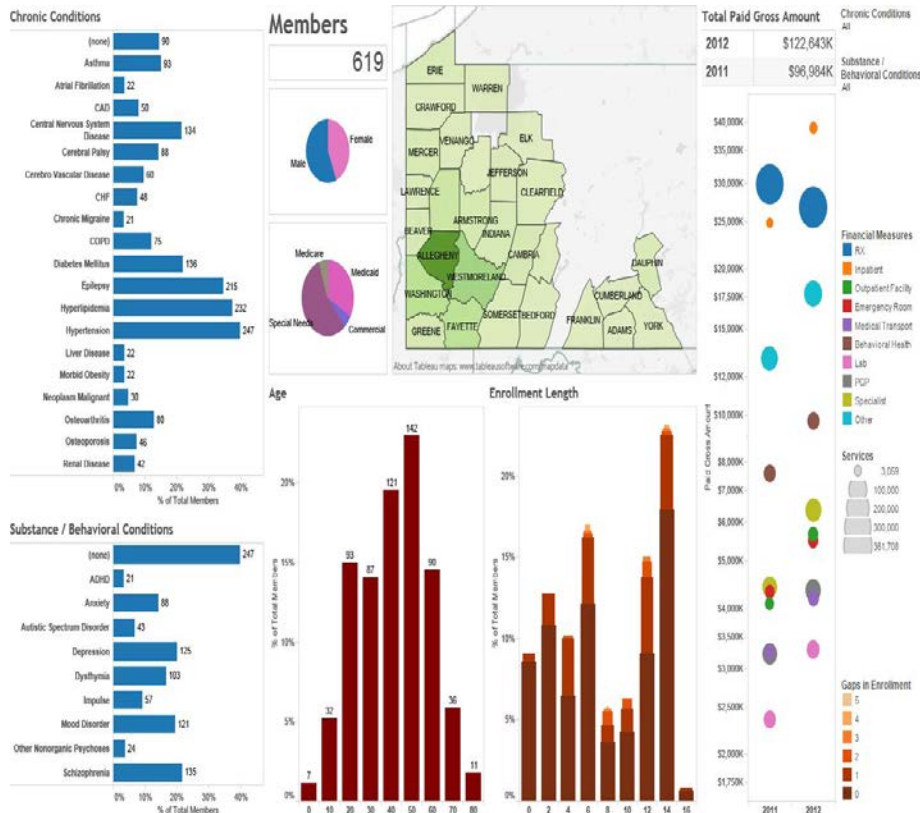
- Consumer Incentives
- Transparency: Cost/Quality
- Shared Decision Support Tools

Right Economic Incentives

- Gainsharing
- Capitation and Bundled Payments
- Care Management Payment
- Performance Payment
- Benefit Designs

Improved
Quality
and
Cost
and
Patient
Experience

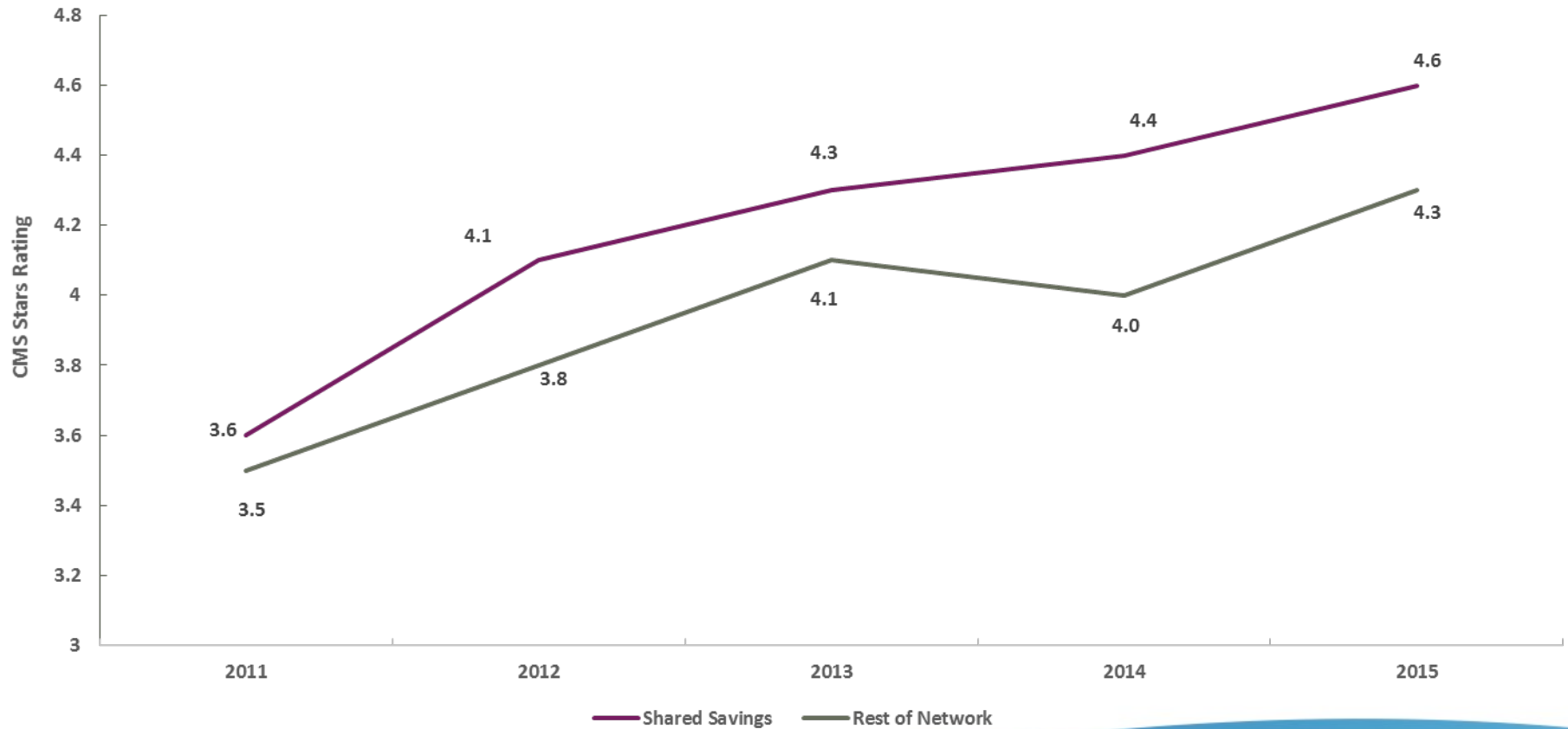
UPMC Health Plan 5th Year of Medical Home Transforming Care Delivery



- UPMC Health Plan 422 active sites in Medical Homes
- ~1,000 primary care physicians participating
- Improved care coordination and quality outcomes
- Data and physician report cards drive results
- Integrated primary care and Health Plan coaching teams

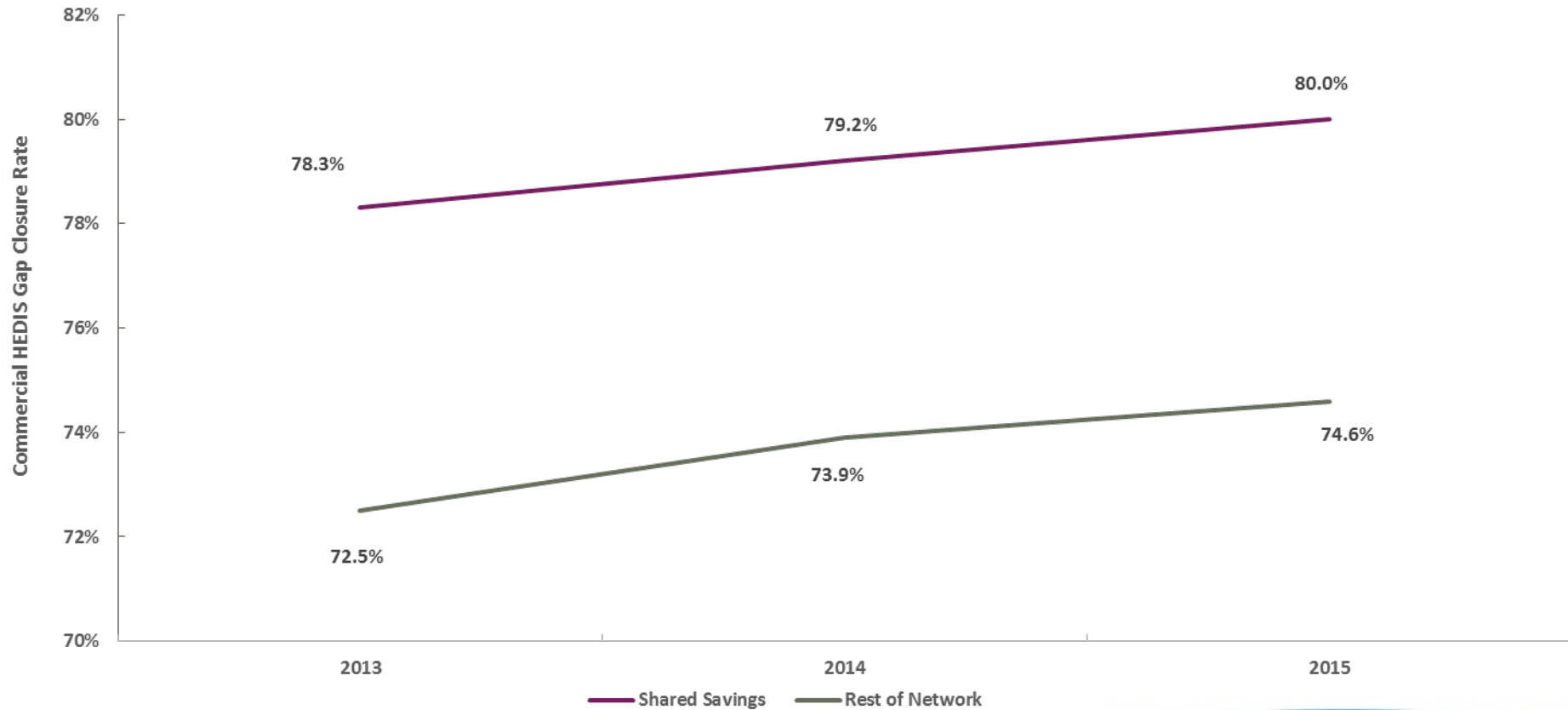
Shared Savings Quality Trend – Medicare/SNP: 2011-2015

UPMC Health Plan Stars Ratings -
Shared Savings Program v. Rest of Network
2011 - 2015



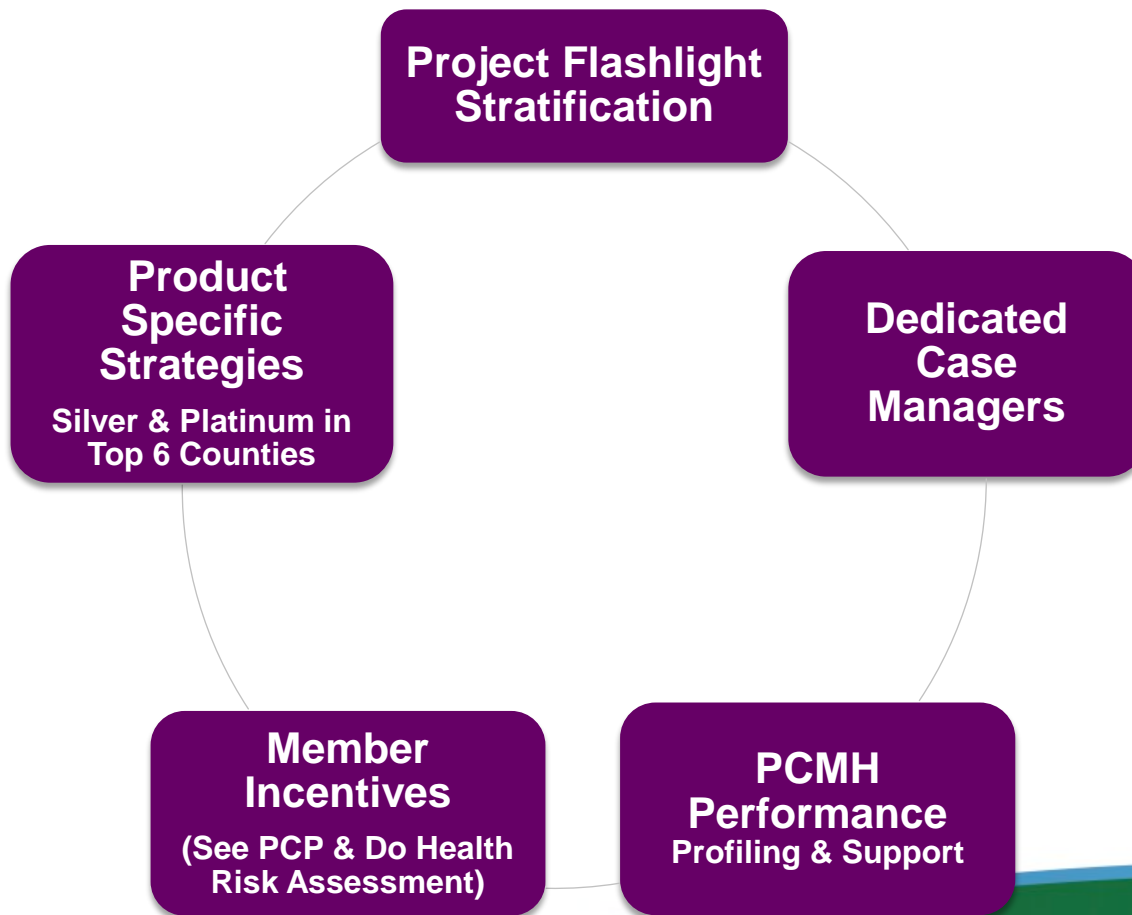
Shared Savings Quality Trend – Commercial: 2013-2015

UPMC Health Plan Commercial HEDIS Gap Closure Rates -
Shared Savings Program v. Rest of Network
2013 - 2015



Marketplace Population Health and Care Management

Improving Strategies for CY16



Proactively Identifying this Population

Data sources & Risk Factors – continuous stratification using cost experience

Lifestyle Preferences & Demographics

- Acxiom Marketing Data
- Member Demographic Data

UPMC Doctor's Office Information (EPIC)

History of Complex Conditions

Medipac Data Extraction of Inpatient and ER Encounters at UPMC Facilities

MARS Data

Pharmacy Utilization

Pharmacy weekly claims data

Prior Medicare Data

14 medical diagnoses

Cancer	Hemophilia
Hepatitis C	Sickle Cell
HIV	Multiple Sclerosis
Diabetes	Atrial Fibrillation
CHF	Transplant
CKD	Obesity
COPD	Premature delivery

14 medications

Anti-rejection drugs	Hemophilia
Depression combination therapy	Hepatitis C
Polypharmacy DUR meds	Inflammatory bowel disease
Long acting injectable antipsychotics	Multiple sclerosis
Chronic Kidney Disease	Oral chemotherapy
HIV	Sickle cell
> 9 medications	17P (maternity)

Proactively Identifying this Population

Individual Market Model Example:

- What creates the initial & early prediction?

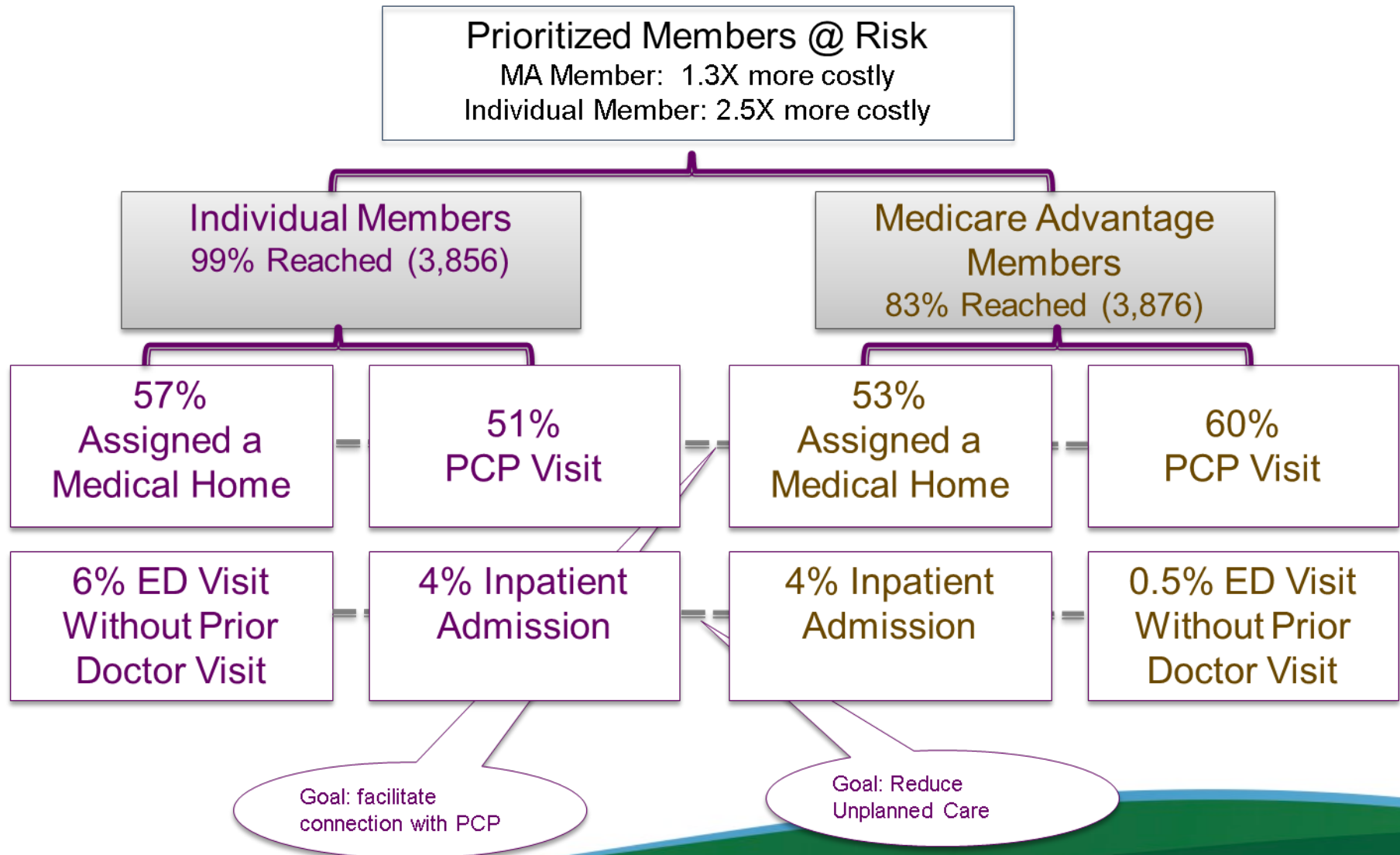
Metal Level	Subsidy	Area Deprivation Index	Product
Geographic Region	Property Type	Length of Residence	Network
Age	Sex	Marital Status	NULL

- Risk Categories / Rules

Predicted TCOC Risk Category	% Exchange Population	Median TCOC PMPM
Low	59.4%	\$232.86
Medium	30.9%	\$482.55
High	9.6%	\$733.97

- Validation
 - Vendor Risk Score Model – Uses claims data to predict future risk.
 - DOHE new Individual Exchange Member model

What happened in CY15 with members identified at risk?



Project Flashlight

December 2015 Initial **RISK** Review of New Individual & Medicare Advantage Product Enrollees

CY2016 Individual Product enrollee pool

- Currently indicating higher predicted risk mix than CY2015 enrollee pool with net impact (to-date):
 - 3.7% increase in high risk member share**
 - 2.2% increase in medium risk member share**
 - 5.8% decrease in low risk member share**

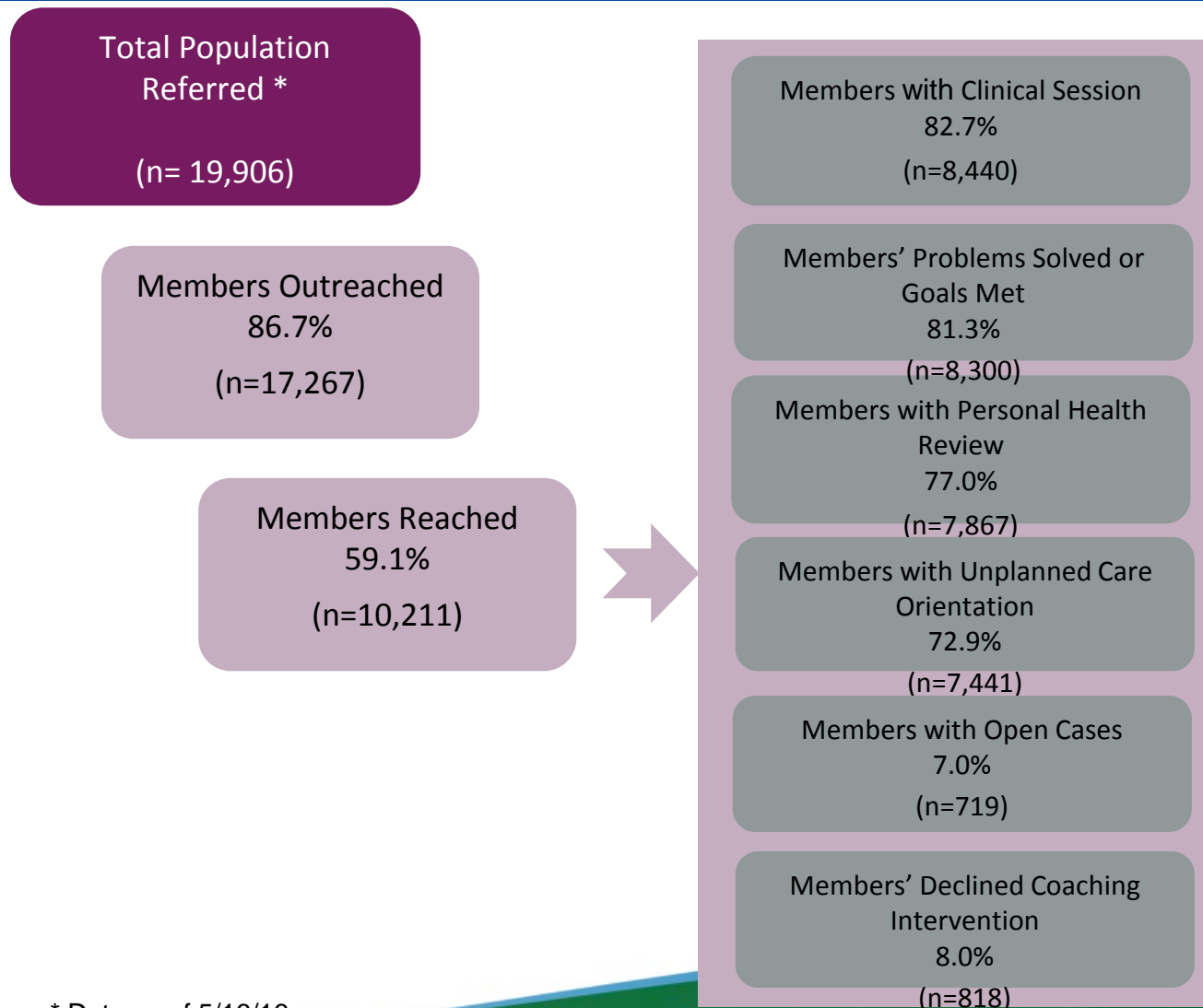
Enrollment Period	Enrollees	High Risk	Medium Risk	Low Risk
CY2015 Final	60,562	9.6% (n=5,814)	30.9% (n=18,714)	59.4% (n=35,974)
CY2016 (enrolled-to-date)	18,864	21.3% (n=3,984)	40.7% (n=7,613)	37.5% (n=7,011)

CY2016 Medicare Advantage Product enrollee pool – **Stable Mix**

- Currently indicating similar predicted risk mix as CY2015 enrollee pool.

Enrollment Period	Enrollees	High Risk	Low Risk
CY2015 Final	NULL	24.9%	75.1%
CY2016 (enrolled-to-date)	6,819	26.7% (n=1,821)	73.3% (n=4,998)

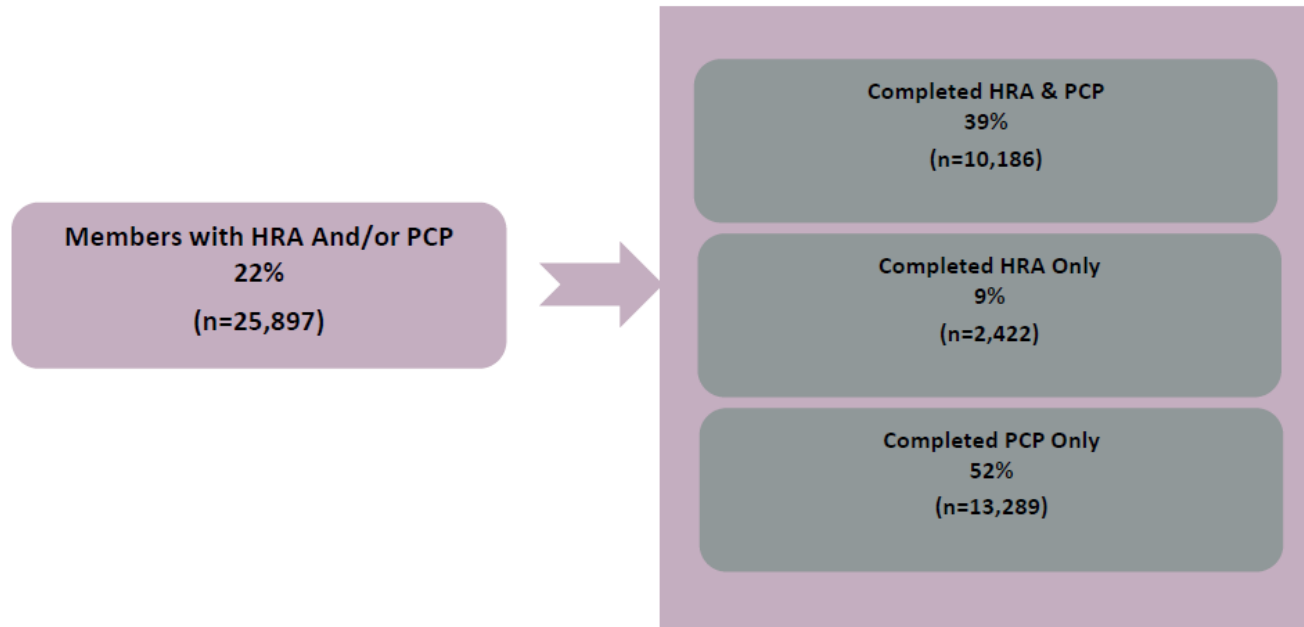
2016 New Member Clinical Outreach – Project Flashlight



* Data as of 5/16/16

ACA UPMC Advantage New Member

- **22%** of total 2016 membership have completed some portion of the incentive



- **45%** of 2016 membership targeted by members services has completed an HAS (8,477)
 - 21% (1,780) referred over to HM based on triggers

Cross Functional Team: New Member Case Referrals

Member Services Welcome call

- 5 Q HRA Individual
- Medicare Getting to Know You Survey including 5 Q Predicative HRA questions
- Selecting a PCP

Clinical Team

- Provide early intervention and care management assistance.
- Assist member in selecting a PCP and schedule PCP appointments
- Provide a direct point of contact between the Provider, Health Plan and member/caregiver(s)
- “Unplanned Care School”
- Facilitate member engagement into health management & wellness programs
 - ✓ *Engage the care coordination team early including the Provider, Case Manager, Social Worker to build relationships*