

ST. LOUIS HEALTH CARE INDUSTRY OVERVIEW

2017

Volume 1: Health Plan Quality and
Financial Overview





MESSAGE TO THE COMMUNITY.....1

SECTION ONE: FINANCIAL PERFORMANCE

Health plan medical loss ratios 2
 Graph: National Health Plans, Missouri Medical Loss Ratios, 2015

Overall, plans remain profitable despite losses on the exchanges 3
 Graph: National Health Plan Operating Margins, 2014 – 2015
 Graph: National Health Plan Profit Margins, 2014 – 2015

St. Louis commercial payers on path to value-based provider payment 4
 Graph: National Provider Payment Models, Current and Future

SECTION TWO: QUALITY PERFORMANCE

Health plan customer service 5
 Graph: Percent of enrollees who rated their health plan a top score of 8, 9 or 10, St. Louis Area Health Plans, 2013 - 2015

Medicare Advantage savings spill over to traditional Medicare 6
 Graph: St. Louis Metropolitan Area, Medicare Advantage Plan Star Ratings, 2016 – 2017

Fewer patients have blood pressure in control 7
 Graph: Commercial vs. Medicare Advantage Plans, % of Patients with Blood Pressure in Control, 2015

Medicare Advantage outperforms commercial plans on diabetes care 8
 Graph: Commercial and Medicare Advantage Plans, % of Diabetic Patients with Blood Sugar Controlled, 2015

Medicare Advantage plans continue to outperform FFS on readmissions 9
 Graph: Plan All-Cause 30-Day Readmission Rates, St. Louis Medicare Advantage Plans, 2014 – 2015

About the BHC and this report Inside Back Cover



In 2015, the U.S. hit two milestones:

- **Federal spending on health care programs exceeded Social Security costs**, for the first time.
- The percentage of **uninsured Americans dropped to 9%**, the **lowest point in recorded history** according to the U.S. Census.

Nationally the number of insured in the U.S. grew via expansion of Medicaid, adult children added to parents' plans, and an increase in commercial insurance coverage. Health plans purchased directly by consumers saw the largest gain in enrollment of nearly 46%, but still accounted for only 5% of the health plan market. While the Affordable Care Act (ACA) has supported the decrease in uninsured, it has not tamed health care inflation. To afford coverage, 75% of customers purchasing on the public exchanges required subsidies. **Today, affordability is the most serious health care problem facing the nation.**

Health spending accelerated in 2015 increasing 6%, up from 5.3% the prior year, and medical loss ratios increased (p. 2). Still, **Medicare costs grew at a slower pace than private health insurance**. Recent research suggests **Medicare Advantage** plans may be playing a role. These plans are more likely to include value-based compensation that lead to savings which are “spilling over” to traditional Medicare (p. 6).

Carriers lost money on individual products, both on and off the public exchanges. Narrower network plans fared better on the public exchanges with lower claims and better margins. Premium stabilization payments were created by the ACA to cover losses on high-cost, high-risk populations. Payments fell short of insurer requests and most of the Consumer Operated and Oriented Plans (CO-OP) failed. The CO-OPs were established by the ACA to offer more affordable coverage and increase competition among carriers. For 2017, the Department of Health and Human Services granted rate increases on public exchange plans resulting in a 25% average increase in premiums. Yet, Aetna and UnitedHealth Group stopped selling individual plans on the ACA's public exchanges for 2017 in all but a few states due to losses, plans said (p. 3). In St. Louis, **Anthem and CIGNA are the only plans offering coverage on Missouri's federally-facilitated exchange.**

In 2015, **national carriers maintained secure financial positions**, despite losses on individual products, which are a small segment of their business and have a limited impact on profitability. In Securities and Exchange Commission filings, insurers reported income growth was driven by **enrollment gains in government and commercial products and rate increases on private plans that offset higher medical costs**. Mergers and acquisitions also bolstered revenue and negotiating leverage. In late January 2017, court rulings decreased the likelihood that the proposed Anthem-CIGNA and Aetna-Humana deals would go through, unless something changes with an appeal.

For the **second consecutive year, fewer commercial customers gave their health plan the top score** in 2015. Nationally, only 75% gave their plan a top score at the 90th percentile. No St. Louis plan performed at this level and scores varied. **Why do plans continue to lag behind other industries in customer service?** It may be how they communicate. A recent study found when members contact the call center, coverage information is not always specific enough to be useful and the plan did not tell them how to reduce costs (p. 5).

As noted earlier, **Medicare Advantage may be playing a role in reducing fee-for-service (FFS) Medicare costs**. For years, the Medicare Advantage (MA) program administered by commercial insurers has been criticized for being more costly than FFS Medicare. A recent national study found the opposite. Counties that experienced the largest increase in MA enrollment had the largest drop in FFS Medicare cost growth. Savings were greater in counties with higher baseline MA penetration and more primary care physicians per capita. Nationally and locally, **financial incentives in MA plans are more likely to include quality bonuses or other gain sharing relationships which reward clinicians for results**. This suggests the combination of managed care penetration and the growing use of incentives may be measurably changing the way care is delivered in MA plans (p. 6).

The Centers for Medicare and Medicaid Services pay private health plans financial incentives to ensure MA members receive high quality care. The **Star Ratings program rewards plans for care quality** with an emphasis on prevention and health outcomes for members. **In St. Louis, more plans earned a 4-star rating or higher and were eligible for a bonus, as compared to MA plans nationally.**

St. Louis MA plans outperform commercial insurers on standard quality metrics and health outcomes. For example, the percentage of **patients with blood pressure in control declined to 53% in 2015 for members of private health plans**, down from 61% the previous year. In comparison, **73% of patients enrolled in St. Louis MA plans had their blood pressure in control**. The gaps in performance between MA and commercial plans were as wide as 30 percentage points. Similar gaps were seen in control of blood sugar for diabetics among MA and the privately insured (pgs. 7, 8). **It is important to ask why. What can we learn from those managing care in the over-65 population?**

In 2015, **readmission rates were 11% on average nationally for Medicare Advantage plans**, up from 10% the previous year. This is **dramatically lower than the 15.6% average for FFS Medicare**. In St. Louis, readmissions for MA plans held at 10%, about the same as in 2014. Anthem's MediBlue and United Healthcare's Special Needs plans were the top performers (p. 9).

Employers have taken note of the better chronic care management in Medicare Advantage plans and the use of value-based provider payments. To learn more about insurers' use of financial rewards in commercially insured products, BHC surveyed St. Louis health plans. The survey found **all local carriers are on the path to paying providers based on value** (p. 4). Currently, all of the insurers pay quality bonuses to some providers, however, fee-for-service is still predominant. Shared savings and bundled payment arrangements exist, but are rare. No carrier offers reference pricing.

In 2015, record numbers of Americans became insured. The U.S. also saw the largest increase in health benefits costs in a decade. Few could have afforded coverage without financial help from ACA subsidies or its rule changes. While many benefitted, affordability was not improved. Early learnings from the Medicare program demonstrate that care quality can be improved while reducing overall expenditures. The responsibility is incumbent upon us all, including patients, payers and providers, to eliminate excess and adopt best practices in insurance and care delivery. Improving health care affordability is paramount to any new reform proposal – and to the financial well-being of our nation.



SECTION ONE: Financial Performance

In 2015, the U.S. hit two milestones. First, the percentage of Americans who were uninsured dropped to 9%, the lowest point in recorded history, the U.S. Census found. Since the Affordable Care Act (ACA) enacted guaranteed issue and expanded Medicaid, enrollment in private health coverage purchased directly by consumers grew 46% and Medicaid increased 14%. Second, for the first time federal spending on health care programs exceeded Social Security. Nationally, medical costs increased about 6%, faster than the 5.3% growth in the prior year.¹

Refunds to customers decreased 15% to \$396.7 million as medical loss ratios (MLR) increased, down from \$469 million the prior year, the Medicare Center for Consumer Information & Insurance Oversight said. The ACA requires insurers to spend a certain percentage of premiums on health care. Plans must pay 80% of premium dollars for individual and small group coverage and 85% for large group plans on medical and quality improvement expenses. Insurers with MLRs below this amount must repay the difference to customers. This was the fourth year insurers were required to pay refunds to customers under the MLR rule. Unlike national trends, customers in Missouri received nearly \$21 million in refunds in 2015, up 55% compared to the previous year. In Missouri more customers received a refund and the average payment increased to \$116 per family, up from \$109 in 2014. Nationally 12% fewer customers received refunds, and the average payment increased to \$138 per family, up from \$129 the prior year.

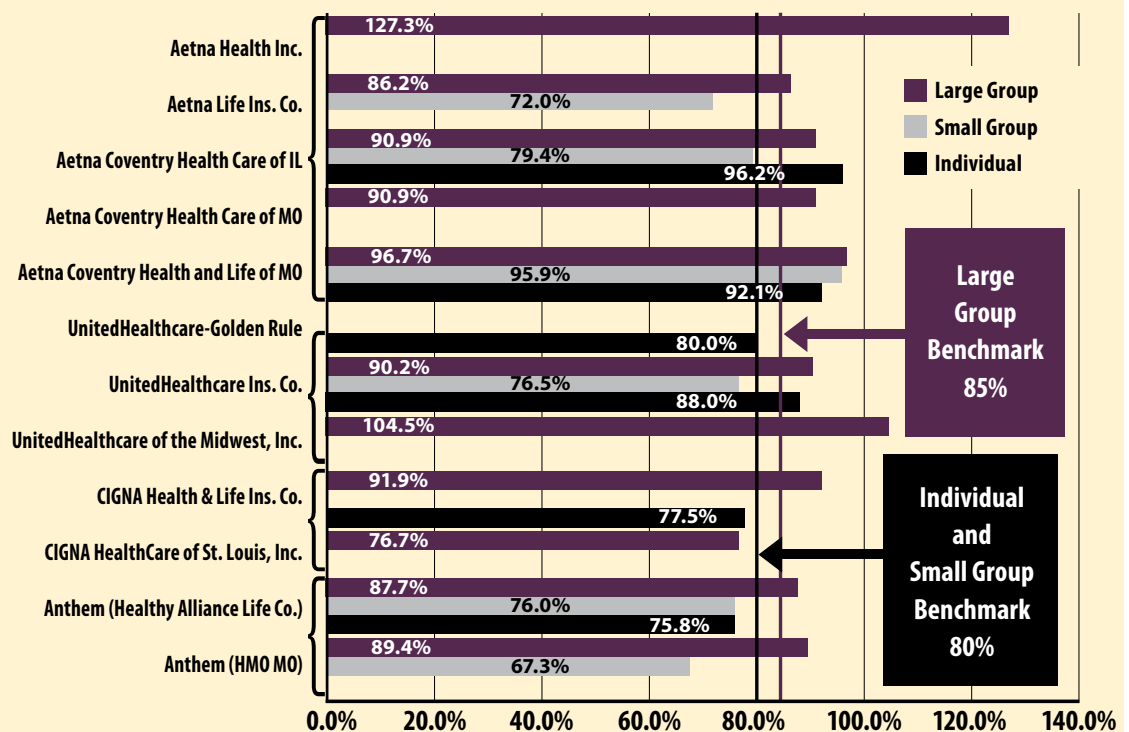
Carriers lost money in the individual market both on and off the public exchanges in 2015, and only 25% had positive margins, initial reports said. Narrow network plans tended to have lower claims and better margins than broad-network plans on the public exchanges.² Broad networks tend to attract sicker people who are willing to pay extra for greater choice of providers. For 2017, the Department of Health and Human Services granted carriers' requests for rate increases on public exchange plans which resulted in a 25% average increase in premiums. Since 75% of exchange customers qualified for subsidies, this cost will be shouldered by taxpayers. In 2016, Aetna and UnitedHealth Group announced they would stop selling individual plans on the ACA's public exchanges in 2017 in all but a few states due to losses (see p. 3). Anthem and CIGNA are now the only carriers offering coverage in the St. Louis region on the federally-facilitated exchange.

Consumer Operated and Oriented Plans

The ACA's non-profit Consumer Operated and Oriented Plans (CO-OP), designed to provide more affordable individual and small group coverage and to increase competition on the exchanges, largely disappeared.

In the first year, some CO-OPs priced aggressively, gaining high enrollment yet exposing them to greater financial risk.³ Federal premium stabilization payments were expected to help CO-OPs make up for losses on high-cost, high-risk enrollees (p.3), yet payments fell short and many failed. By the end of 2016, only five of the original 23 CO-OPs offered coverage.

National Health Plans - Missouri Medical Loss Ratios, 2015



Source: The Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight (CCIIO). Medical loss ratios for 2015 do not reflect the credibility adjusted 3-year average used to determine rebates.

In 2015, Missouri enrollment decreased 4% overall for health plans operating in St. Louis. Small group plans had the largest decline in enrollees (8%) and three out of four carriers saw decreases. Membership declined (6%) in individual and (1%) in large group plans yet varied across plans individually. Aetna's Coventry health plans saw a 7% increase in individual members, while UnitedHealthcare saw a 6% increase in small group enrollees. Nearly every carrier saw an increase in large group membership. In aggregate, premium revenue per enrollee grew 8% while claims costs increased at a slower rate of 3%. Medical loss ratios increased 2% for individual plans, 4% for large groups and decreased (6%) in the small group market. Local plans paid over \$20 million in rebates to customers, up from \$11.2 million in 2014, a 20% increase.

- Anthem paid more than \$13.8 million in refunds to individual and small group market customers in 2015, more than double the amount compared to the previous year, the largest for any plan in the region. Refunds accounted for 1.2% of earned premiums.
- UnitedHealthcare paid over \$6 million in refunds to small group members, up from \$4.2 million in 2014, or 0.6% of earned premiums.
- CIGNA paid over \$249 thousand in refunds to large group consumers which represented 0.40% of premiums.

¹ J Hancock, "Big Companies Expect Moderate Increases in 2017 Employee Health Care Costs," *Kaiser Health News*, August 6, 2016.

² E Coe, et al. "Exchanges three years in: Market variations and factors affecting performance," *McKinsey Center for U.S. Health System Reform*, May 2016.

³ S Corlette, et al. "The Affordable Care Act CO-OP Program: Facing Both Barriers and Opportunities for More Competitive Health Insurance Markets," *The Commonwealth Fund*, March 12, 2015

Overall, plans remain profitable despite losses on the exchanges

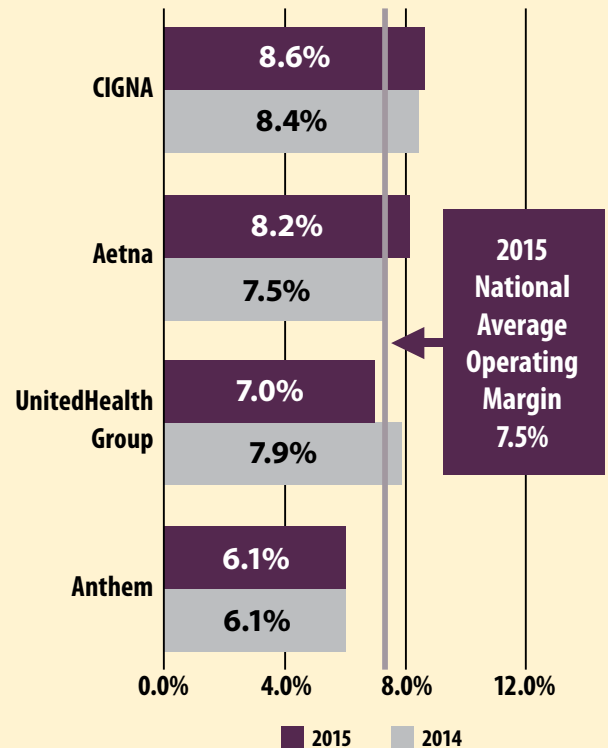
In 2015, operating revenues nationally increased 13% on average for the four large carriers doing business in St. Louis. This was driven in part by growing enrollment in Medicare, Medicaid and Exchange plans and rate increases on commercial products to cover higher medical costs, plans said in Securities and Exchange Commission filings. Better cost management improved margins. Three of the four carriers posted operating margins close to or above the national average of 7.5%, as shown in the graph to the right.

As mentioned earlier, Aetna and UnitedHealth Group announced they would exit the public exchanges in 2017 in all but a few states due to losses. For United, in most markets the company offered products with broader networks that had higher premiums as compared to other plans, an Urban Institute study found. This may have discouraged the healthier, more price sensitive customers from enrolling, which would balance the risk of enrollees with health problems. The individual market is small, accounting for only 5% of the commercially insured population, including plans sold on the public exchanges. While losses on individual plans were large, they had a limited impact on the profitability of national carriers.

Locally, Aetna's Coventry plans offered on Missouri's exchange also tended to have broader provider networks. Aetna's plans saw the largest increase in medical loss ratios in 2015 (p. 2). The large national carriers operating in St. Louis received nearly \$82 million in premium stabilization payments established by the ACA to cover higher-cost and higher-risk populations. Coventry received \$37 million, the largest share among local plans. Still, Aetna and United exited the exchange in 2016 which left 96 of Missouri's 114 counties with only one insurance carrier.¹

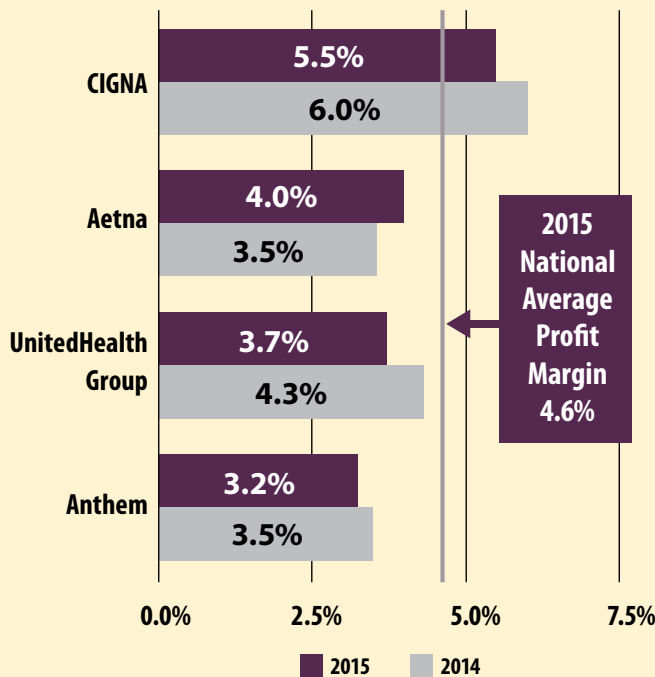
¹ S Liss, "A broader look at Missouri's insurance exchange and what Aetna's exit means," *St. Louis Post-Dispatch*, August 20, 2016

National Health Plan Operating Margins 2014 - 2015



Source: SEC Health Plan 10-K Statements and CSI Markets national statistics

National Health Plan Profit Margins 2014 - 2015



Source: SEC Health Plan 10-K Statements and CSI Markets national statistics

Nationally, the average health plan profit margin increased to 4.6% in 2015, up from 4.3%. For the fourth consecutive year, CIGNA was the most profitable and the only carrier posting a profit margin above the national average, shown in the graph to the left. Aetna was the only plan with a profit margin increase.

Merger Mania In 2015, mergers and acquisitions provided plans with an increasing revenue stream and enhanced negotiating leverage in response to the changing health care landscape. **UnitedHealth Group bought Catamaran Corporation**, a fast-growing competitor, to bolster OptumRx, its pharmacy benefit manager. Yet the **highest profile deals were Anthem's proposed acquisition of CIGNA and Aetna's bid for Humana**.

The Anthem merger with CIGNA would combine the second and fifth largest health insurers by revenue and would create a company with a huge footprint in commercial insurance. Combined annual revenue is expected to be \$117 billion and cover 53.2 million people. Aetna's bid for Humana would merge the third and fourth largest national carriers. Annual revenue for the combined company is expected to be \$115 billion and more than 18 million members. The acquisition of Humana would significantly increase Aetna's presence in Medicare Advantage across markets nationally.

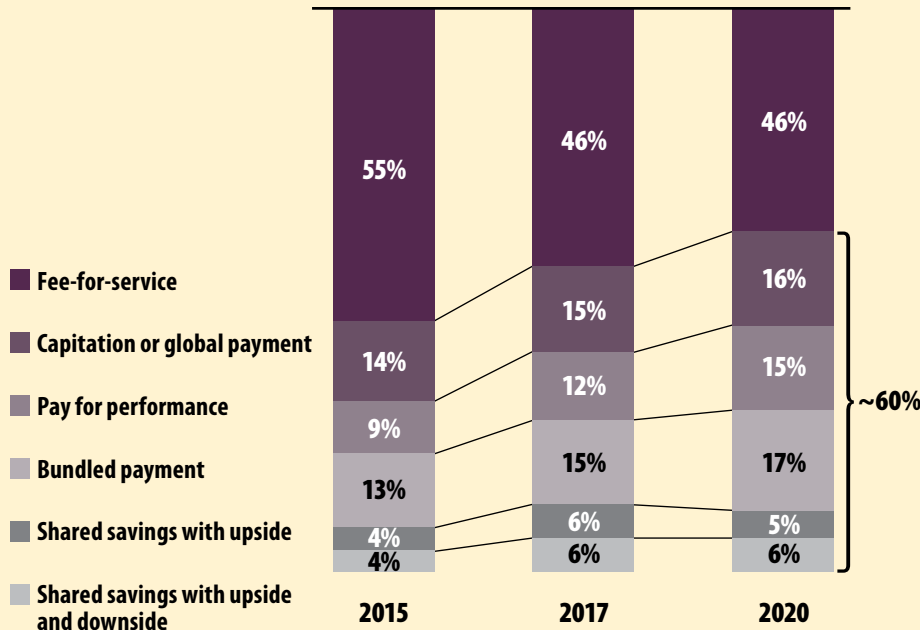
In late January 2017, court rulings decreased the likelihood the proposed Anthem-CIGNA and Aetna-Humana deals would go through. Unless something changes with an appeal, Anthem is at risk for a \$1.85 billion break-up fee with CIGNA and Aetna will have to pay Humana a \$1 billion fee.



St. Louis commercial payers on path to value-based provider payment

Nationally, health plans and providers are early on the road toward value-based reimbursement. In 2015, an overwhelming **97% of commercial payers and 91% of hospitals and physicians reported deploying a complex mix of value-based reimbursement and fee-for-service**. That is up 7% for payers and a jump of 10% for providers compared to the previous year, a recent survey found.¹ These value-based arrangements cover a range of payment models designed to drive higher quality, more affordable and coordinated care.

National Provider Payment Models Current & Future



In 2015, providers nationally reported that **45% of commercial payments were value-based** across a mix of capitation, quality bonuses, bundled payment and shared savings models (see graph at left). **In five years, payments based on value will increase to nearly 60%. Bundled payment, the fastest growing model, will increase to 17% of reimbursement.**² This may be a reflection of the growing participation among providers in public and private “bundled” payment arrangements. This includes Medicare’s recent Comprehensive Care for Joint Replacement bundled payment program.

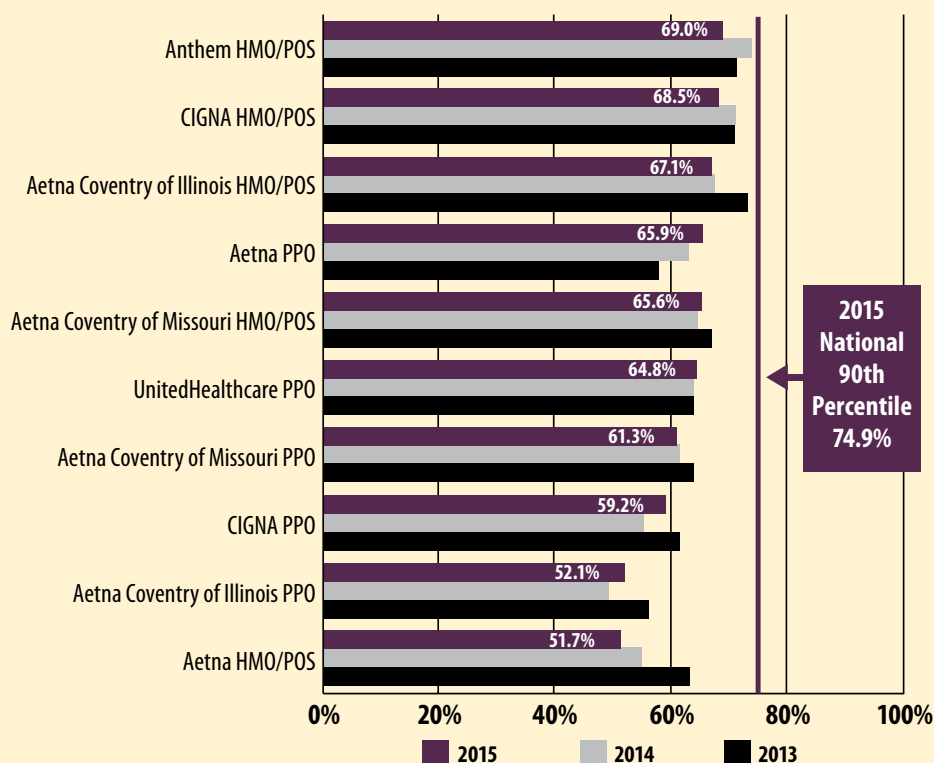
^{1,2} “Journey to Value: The State of Value-Based Reimbursement in 2016,” McKesson Health Solutions National Survey, June 13, 2016.

In St. Louis, the mix of value-based payment methods ranged widely across commercial insurers in 2015, based on a recent St. Louis Area Business Health Coalition (BHC) survey. The BHC requested information from the four largest carriers operating in the region regarding current use of value-based contracts with local hospitals and physicians. Survey categories for value-based payment were somewhat comparable to the national study mentioned above, which are outlined in the table below. Insurers continue to use fee-for-service payments to administer the programs, often holding providers to a budget, from which retrospective adjustments are made.

St. Louis Commercial Health Plan Value-Based Payment Survey

Payment Model	Description
Fee for Service (FFS)	The most common provider payment method locally and nationally for hospital and physician providers. This model rewards quantity over quality and is often held out as a key reason for the high level of health care spending.
Medical home, Primary Care PMPM or Management Fee	Medical homes focus on preventive care, the patient relationship, and care coordination. Management fees are often made to providers in addition to FFS payments to cover care over time and outside of the traditional office visit such as coordination and management of patients with chronic conditions.
Quality Bonus	Medical groups and hospitals are rewarded for performance on quality and/or efficiency relative to benchmarks, such as improved performance, or performing better than peers. This payment model is common among plans locally and nationally.
Bundled Payment	A bundled or “episode-based” payment is a single payment to providers, health care facilities, or jointly to both for all services to provide a procedure or to treat a condition as well as costs associated with preventable complications.
Reference Pricing	While this option is not offered by St. Louis health plans, it has been used successfully by payers on the West Coast and elsewhere. The plan determines a fair price for the procedure. Any amount above this price is the patient’s responsibility.
Accountable Care Organization	Health care providers who assume responsibility for the overall health and care of a defined patient population. Providers may be paid fee-for-service and held to a budget or paid a monthly capitation fee.

Percent of enrollees who rated their health plan a top score of 8, 9 or 10, St. Louis Area Health Plans, 2013-2015



Source: National Committee for Quality Assurance (NCQA) Quality Compass 2014, 2015 and 2016, St. Louis Metropolitan Area. NCQA Quality Compass metrics represent data from the prior year. For example, NCQA Quality Compass 2016 reports data for 2015.

For the second consecutive year, a slightly smaller percentage of customers rated their health plan an “8, 9 or 10.” **Nationally, only 75% gave their health plan the top score in 2015, as compared to 76% the previous year.** In St. Louis, performance improved for roughly half of the plans, scores were low and varied widely as shown in the graph above. None of the local carriers performed at or above the 90th percentile. **Anthem scored the highest among local plans, although their performance declined as compared to the year before.**

Why do few customers give their health plan a top score? It may be how plans communicate. The nature of insurance requires documents. Outbound communications in the form of paper documents are usually the only interactions customers have with a carrier. In today’s rapidly evolving market, **customers expect communications that are fast, convenient and in an understandable format** delivered to the customer’s channel of choice such as mobile devices or interactive websites. However, a recent white paper found most communications are exactly the opposite. **Often communications are slow, poorly formatted, full of jargon** and delivered through the payers’ channel of choice, usually a portable document file (pdf) on a website. Few plans offer mobile delivery, and if they do, it has static text, no interactive elements and there is limited personalization.¹

Health plans are complex products and not all customers are proficient at understanding their benefits. In addition, rising costs have prompted purchasers to modify benefit designs to encourage more cost conscious use of services. These modifications, such as tiered benefits and cost sharing, have increased plan complexity. Customers expect carriers to educate them about their benefits and give them accurate information. A recent survey found when members contacted the customer call center, coverage information was not always specific enough to be useful and the plan did not tell them how to reduce costs.² Many purchasers now provide cost transparency tools to enrollees to help fill this gap.

¹ “Healthcare Payers: engaging members in an evolving and competitive market,” A White Paper by GMC Software, 2015.

² “Customer Communications Are Critical for Healthcare Payers,” America’s Health Insurance Plans, August 30, 2016.

What can health plans learn from top-rated industries?

In 2015, health insurance companies were rated poorly by their customers, scoring toward the bottom among 43 industries in the American Customer Satisfaction Index (ACSI). The ACSI rates industries on a different, yet similar set of metrics as compared to the National Committee for Quality Assurance.

High premiums, deductibles, and co-pays, as well as slow claims processing, keep health insurance customer satisfaction below other types of insurance the ACSI survey said.

Credit unions are among the top-rated industries. They have worked for decades to better understand, segment and communicate with their customers. Credit unions stood out on the courtesy of staff, the speed of transactions and more competitive interest rates.¹

What can health plans learn? Health plan customers span generations, income ranges, education levels, and life stages. Plans can start by tailoring benefits to suit the needs of different customer segments, find the best channel of communication to reach them, and deliver the kind of support they require.

¹ ACSI Finance and Insurance Report 2015, November 17, 2015



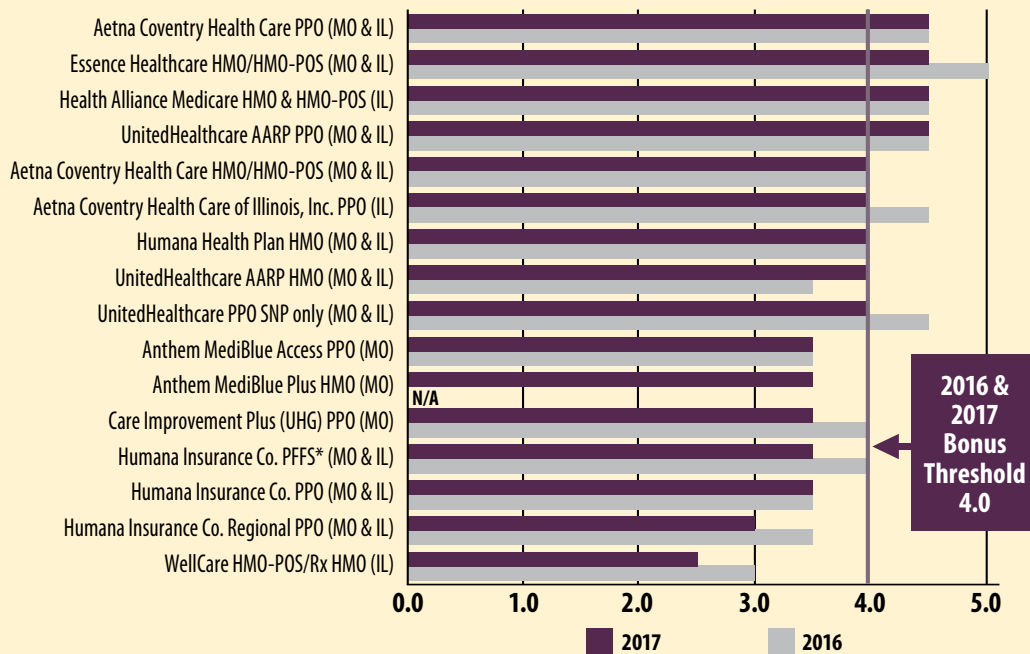
Medicare Advantage savings spill over to traditional Medicare

Nationally, nearly **one in three Medicare beneficiaries is enrolled in a Medicare Advantage (MA) plan** administered by a private insurer. Members generally receive more covered benefits in MA plans as compared to fee-for-service (FFS) Medicare. The government pays carriers monthly per capita payments adjusted for the disease burden of the patient population they enroll. Any difference between payments and expenses is kept as profit, thus plans have an incentive to control costs.

Medicare publishes Star Ratings to improve care quality and to make it easier for members to compare MA plans. Ratings are based on nearly 50 quality metrics (see box to the right). Plans may earn one to five stars and a 4-star rating or higher is eligible for a bonus. If a plan is rated less than three stars over a 3-year period, it is terminated from the program.

In Missouri, **29% of Medicare members have signed up for Medicare Advantage.**¹ **Similar to the prior year, more than half of St. Louis MA plans were rated four stars or higher.** Local plans improved the percentage of patients that received preventive screenings for breast and colon cancer and continued to outperform commercial plans on outcomes such as controlling blood sugar in diabetics, keeping blood pressure in control and avoiding readmissions to the hospital (see pgs. 7, 8 and 9).

St. Louis Metropolitan Area Medicare Advantage Plan Star Ratings, 2016-2017



Source: The Centers for Medicare and Medicaid Services. * Private Fee-for-Service (PFFS).

For 2017, nearly half of MA plans nationally received a 4-star rating or higher, the same as in 2016. Quality improved on most metrics including screenings for breast and colon cancer, obesity, and monitoring patients' mental health. Nationally and locally, an increasing number of MA plans have value-based reimbursement agreements with physicians. Recently, **Humana reported roughly 63% of MA members are affiliated with physicians engaged in its value-based program which had better health outcomes and lower costs** compared to patients with providers that did not have these additional incentives.¹

In recent years the Medicare Advantage program has been under scrutiny because it costs more than FFS Medicare. Research by government and non-profit think tanks has suggested some of the cost difference may be driven by the fact that MA plans attract healthier patients and, by the nature of the payment incentives, risk scores are inflated compared to FFS Medicare.² In response, Congress has reduced payments to MA plans since 2010. Enrollment was expected to decline. Instead, participation surged and there was a simultaneous slowdown in FFS costs. Some experts worried that MA growth was concentrated in wealthier areas with fewer sick patients. A recent study found the opposite. **Counties that experienced the largest decrease in FFS Medicare cost growth had the largest increase in MA enrollment and were poorer with larger minority populations.** The spillover effect on FFS Medicare costs was stronger in counties with higher baseline MA penetration and more primary care physicians per capita. **This suggests there may be a threshold of managed care penetration above which providers change measurably the way they deliver care.**³

¹ G Freeman, "Value-based MA Plan Spikes HEDIS Scores 19%," *HealthLeaders Media*, November 16, 2016

² Report to Congress, *Medicare Payment Advisory Commission*, March 2016

³ G Johnson, et.al, "Recent Growth in Medicare Advantage Enrollment Associated With Decreased Fee-For-Service Spending in Certain US Counties," *Health Affairs*, September 2016

Medicare Advantage Plan Star Rating Metrics

Improvement Metrics (wt. 5)

- Health Plan Quality
- Drug Plan Quality

Outcomes of Care (wt. 3)

- **HEDIS (NCQA)**
 - Diabetes: Blood sugar control
 - Blood pressure control
 - All-cause readmissions
 - Improving or maintaining physical health (HOS)*
 - Improving or maintaining mental health (HOS)*
- **Drug Plan**
 - High-risk medication
 - Medication Adherence
 - Diabetes
 - Hypertension
 - Cholesterol

Patient Experience (wt. 1.5)

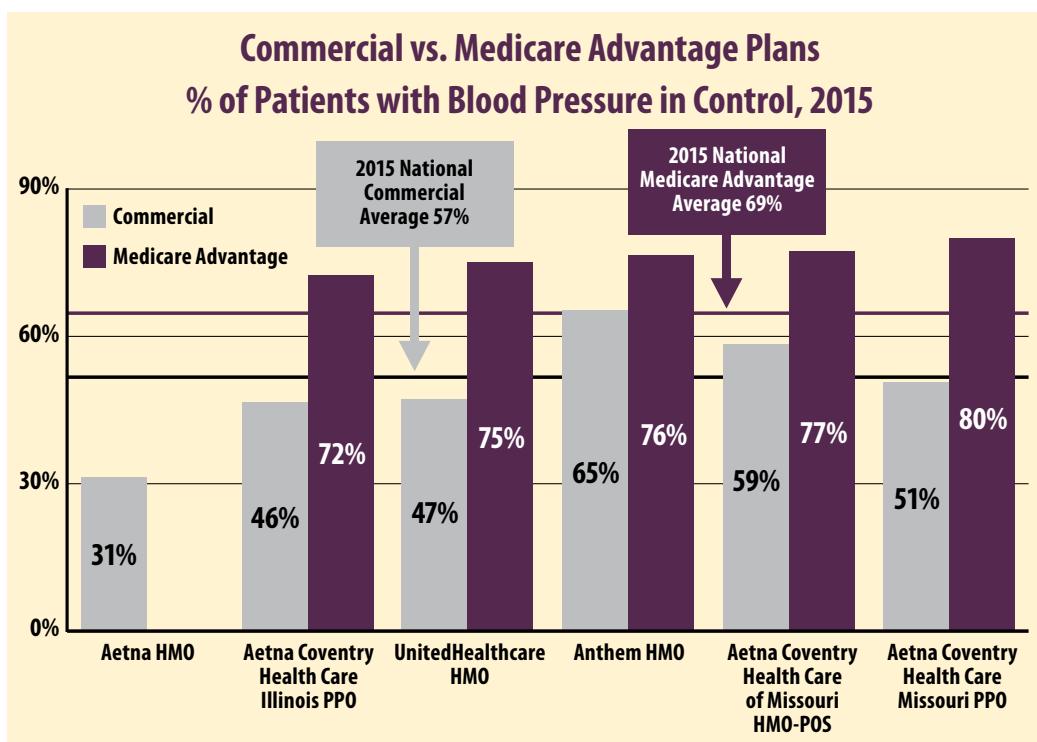
- **HEDIS CAHPS (NCQA)**
 - Getting needed care
 - Get appointments & care quickly
 - Customer Service
 - Rating Health Care Quality
 - Rating of Health Plan
 - Care Coordination
- **Other**
 - Health Plan Complaints
 - Members Choose to Leave Plan
 - Timely appeals decisions
 - Appeal review decisions
 - Call Center Foreign Interpreter
- **HEDIS CAHPS-Drug Plan**
 - Rating of drug plan
 - Getting needed prescriptions
- **Other Drug Plan**
 - Drug Plan Complaints
 - Call Center Foreign Interpreter
 - Appeals Auto-Forward
 - Appeals upheld
 - Members Choose to Leave Plan
 - Plan Finder Price Accuracy

Process Metrics (wt. 1)

- **HEDIS (NCQA)**
 - Screening
 - Breast Cancer
 - Colorectal Cancer
 - Care for Older Adults
 - Medication Review
 - Functional Status Assessment
 - Pain Assessment
 - HEDIS CAHPS-Flu Vaccine
 - Diabetes Care:
 - Eye Exam
 - Kidney Disease Monitoring
 - Adult BMI assessment
 - Osteoporosis mgt.
 - Rheumatoid Arthritis mgt.
 - Monitor physical activity (HOS)*
 - Reduce the risk of falling (HOS)*
 - Access & Performance Issues
 - Special Needs Plan Care Mgt.
- **Drug Plan:**
 - Access & Performance Issues
 - Drug Review Completion Rate

* Health Outcomes Survey (HOS)

Fewer patients have blood pressure in control



Health Threats of High Blood Pressure (Hypertension)

Hypertension damages the blood vessels. Left uncontrolled or undetected, high blood pressure can lead to:

- Heart attack
- Stroke
- Heart failure
- Kidney disease or failure
- Vision loss

Source: American Heart Association

Source: National Committee for Quality Assurance (NCQA) Quality Compass 2016 and Centers for Medicare and Medicaid Services. Coventry of Illinois' service area includes counties in the central part of the state and the St. Louis metro east county of Macoupin. Aetna did not offer a Medicare Advantage HMO equivalent plan in the St. Louis market.

About 80 million Americans — one out of every three adults — have high blood pressure, the American Heart Association says. The condition rarely has symptoms and often goes undiagnosed, silently damaging the blood vessels leading to heart, kidney and other vascular diseases. It is easily detected and treated with regular primary care visits. Treatment and lifestyle changes can prevent further damage and reverse some disease processes. Blood pressure below 140/90mg/Hg is considered controlled.

Nationally, blood pressure control in commercially insured patients decreased to 57% in 2015, down from 61% the previous year. St. Louis plans saw an even steeper decline to 53%, also from 61% the previous year. Four out of five St. Louis plans saw a decrease and scores ranged from 31% for Aetna to 65% for Anthem. This marks a sharp reversal in performance compared to recent years.

Medicare Advantage (MA) plans continued to outperform commercial insurers. As illustrated in the graph above, there were wide gaps in performance between commercial and MA plans. For example, the gap between Aetna's Coventry of Missouri Medicare Advantage PPO plan and its commercial equivalent was nearly 30 percentage points. Similar differences were seen among other local carriers. This trend toward better performance on standard quality measures among people enrolled in Medicare Advantage plans compared to members of commercially insured plans has been an increasingly common occurrence. **It is important to ask why. What can those managing care or contracting for the under-65 population learn from their colleagues working with the over-65 population?**

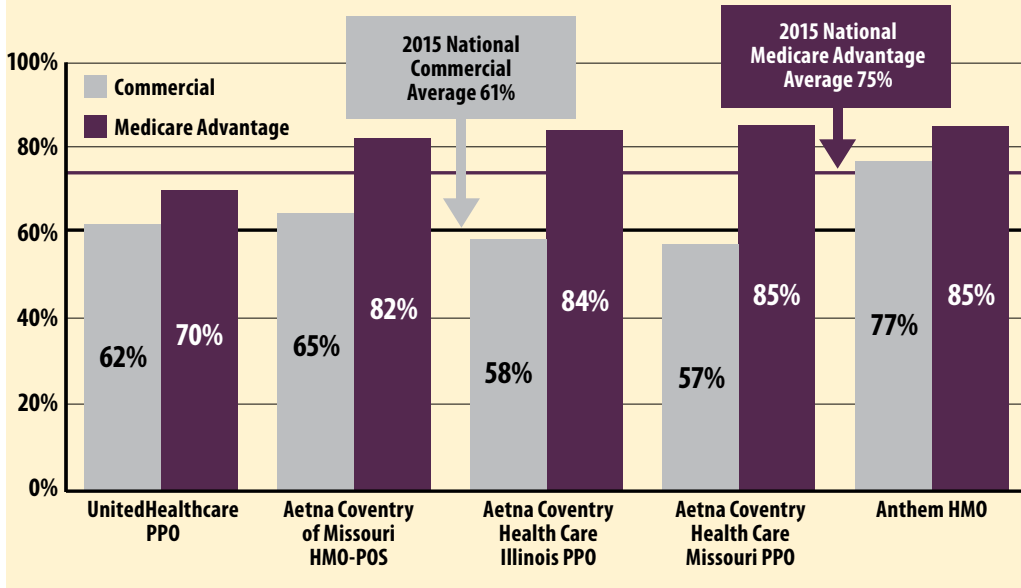
The leading cause of poor blood pressure control among people with hypertension is non-adherence to taking prescribed medication. To encourage health plans to support improved adherence for specific medications, such as antihypertensives, the Centers for Medicare and Medicaid Services has included medication adherence quality measures in the Medicare Advantage Star Ratings program. Plans work to improve their results by using interventions such as medication therapy management programs to review beneficiaries' medication regimens and follow up with those who are nonadherent.¹

Financial incentives in Medicare Advantage plans are notably more likely to include quality bonuses or other gain sharing relationships which reward clinicians for results, such as keeping blood pressure under control, than commercial plans. For example, patients who experience complications and end up in the emergency department or admitted to the hospital are more likely to result in lower payments to their clinical team. Therefore, providers are invested in keeping their patients as healthy and complication free as possible.

¹ M Ritchey, et al., "Vital Signs: Disparities in Antihypertensive Medication Nonadherence Among Medicare Part D Beneficiaries – United States, 2014," *Centers for Disease Control and Prevention*, September 13, 2016



Commercial and Medicare Advantage Plans % of Diabetic Patients with Blood Sugar Controlled, 2015



People with diabetes either do not make enough insulin (Type 1) or cannot use insulin properly (Type 2). Insulin converts blood sugar (glucose) to energy. A lack of insulin causes glucose to build up in the blood. When blood glucose is persistently high, it damages blood vessels and increases the risk of heart attack, stroke, kidney failure, blindness and amputations. Timely diagnosis, lifestyle changes and adherence to treatment can prevent or delay complications.

Source: National Committee for Quality Assurance (NCQA) Quality Compass 2016 and Centers for Medicare and Medicaid Services. Coventry of Illinois' service area includes counties in the central part of the state and the St. Louis metro east county of Macoupin.

In the U.S., more than 29 million people have diabetes, or **9.3% of the population**, which includes 8.1 million people who are undiagnosed. In Missouri, the percentage is much higher at 15%.¹

Nationally, the economic burden of diabetes is estimated to be \$322 billion, with \$244 billion in direct costs and \$78 billion in indirect costs due to lower productivity and missed days of work.¹ In private health plans, national per capita spending for insured people with diabetes was 3.6 times higher than for insured people without diabetes.²

In 2015, fewer privately insured patients with diabetes had blood sugar in control compared to the previous year. Nationally, 61% of patients with diabetes had blood sugar in control, down from 66% in 2014. **St. Louis plans saw a steeper decline in 2015** dropping to 58%, compared to 67% the prior year.

This trend did not occur in Medicare Advantage (MA) plans. Nationally, 75% of MA members with diabetes had blood sugar under control in 2015, about the same as the previous year. In St. Louis, in MA plans **blood sugar control for diabetics has improved while performance by commercial plans lags** (see graph above). Locally, the high penetration of financial incentives in MA plans is what is keeping people healthier and their chronic conditions in control.

Anthem members with diabetes saw the greatest improvement in blood sugar control in both Medicare Advantage and commercial health plans in 2015. The Anthem Medicare Advantage HMO saw a 9% increase and the commercial HMO/POS product saw a 4% increase in performance. Anthem's MA plan reports that its network of providers made meaningful improvements in care over the past three years as it aligned incentives toward greater value-based care (see p. 9). The plan provides timely data to physicians on their patient population with diabetes, identifying those with uncontrolled blood sugar and/or frequent emergency department use. Providers target therapy to improve blood sugar control and the health consultant team ensures patients get timely follow-up visits and coordinate other care services the patient may need. Anthem shares savings with providers who meet quality goals.

In St. Louis, Aetna's Coventry Medicare Advantage plans had comparable performance on blood sugar control in patients with diabetes in 2015. Coventry's MA scores decreased slightly compared to the prior year, however they were higher than their commercial counterparts and the gap in performance widened further. Aetna offers financial incentives to MA network providers to promote value-based care such as care management fees, quality bonuses and capitation for primary care services.

¹ B Drees, S Yun, "Reducing the Burden of Diabetes Mellitus in the State of Missouri: A Call to Action," *Missouri Medicine*, September/October 2016

² 2014 Diabetes Health Care Cost and Utilization Report, *Health Care Cost Institute*, June 2016

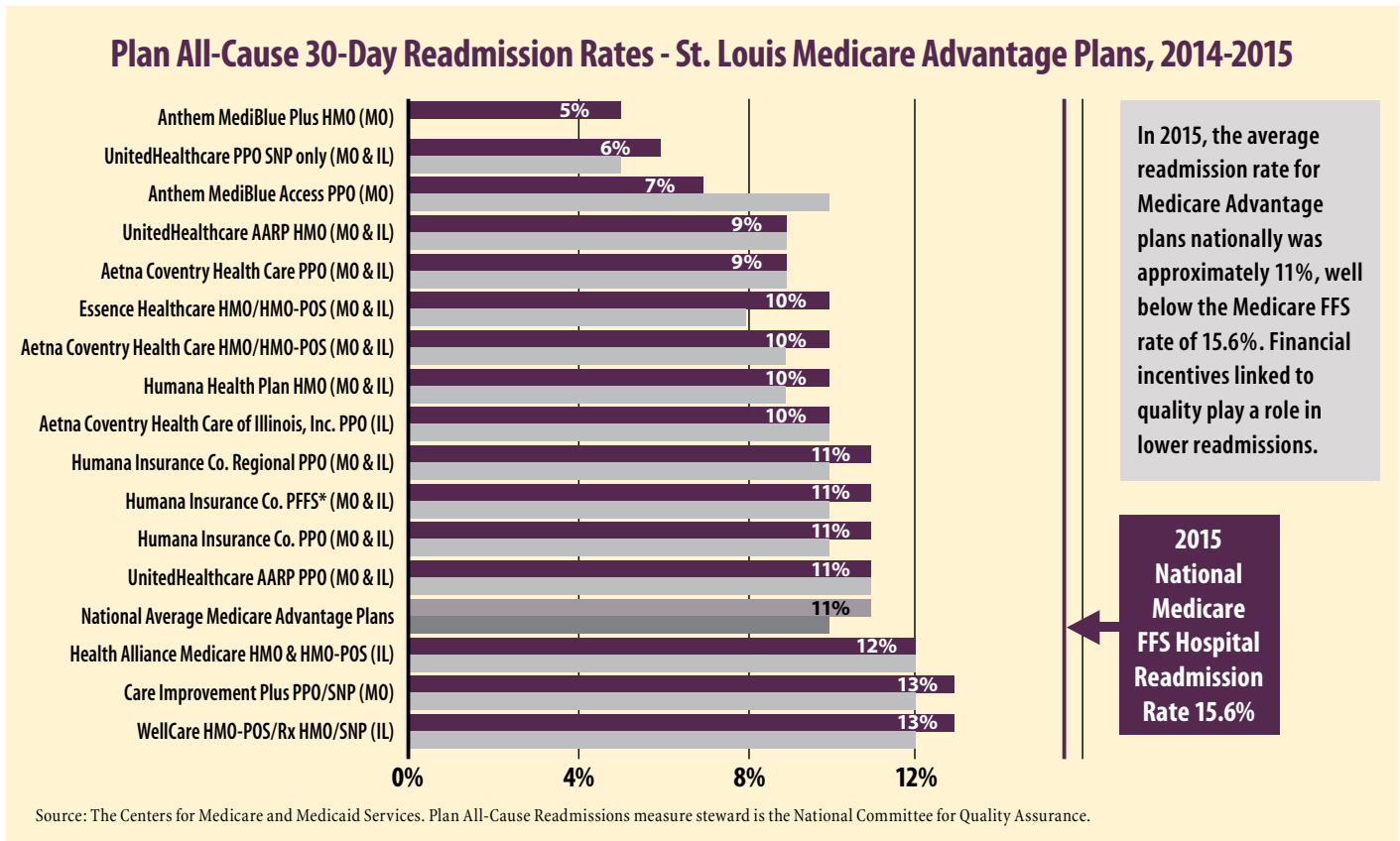
Medicare Advantage plans continue to outperform FFS on readmissions



When a patient must return to the hospital shortly after a previous stay, it is considered a poor outcome and a sign of lower quality care. Readmissions cost taxpayers billions in additional costs each year. In 2015, readmission rates were 11% on average nationally for Medicare Advantage (MA) plans, up from 10% the previous year. This is dramatically lower than the 15.6% average for fee-for-service Medicare. In St. Louis, average readmissions for MA plans held at 10%, about the same as in 2014. Yet more plans were at or below average, as shown in the graph below. Anthem's MediBlue and United Healthcare's Special Needs (SNP) plans were the top performers.

Medication non-adherence and errors are common when patients transition between health care settings. Adverse drug events, often attributable to medication non-adherence, are associated with up to 66% of readmissions. Medication reconciliation can significantly decrease adverse drug events. A care transition program based on medication reconciliation for a population at moderate to high risk reduced the relative risk for all-cause 30-day readmission by 50%.¹

Collaborative relationships with providers and aligned financial incentives are key to driving better care quality. Nationally, more than 40% of MA health care dollars are paid to providers participating in incentive-based arrangements, a recent study found. These include risk-based patient-centered medical homes, bundled payments and other value-based arrangements to promote high quality, coordinated care.²



Anthem's MediBlue Plus HMO and PPO are also Special Needs Plans (SNP) that cover patients dually eligible for Medicare and Medicaid in the St. Louis and Southwest Missouri regions. SNPs are paid higher capitation rates due to their more complex patient populations. **“Building collaborative relationships with providers has been key to improving outcomes for patients and reducing readmissions,”** said Dr. Michael Smith, Chief Medical Officer-Anthem Central Region. The plan partners with physicians to educate them about value-based care focusing on three critical elements to manage the patient population:

- Identify and document the burden of illness using claims and supplemental data from the medical record
- Close the gaps in care
- Allocate resources and redesign benefits to drive better outcomes

“If congestive heart failure patients are frequently using the emergency department, we know care is not being effectively managed,” said Kerry Sheridan, Quality Director Medicare-Anthem Central Region, “there is a tremendous focus to engage physicians.” For example, Anthem provides timely data and on-going feedback on patients with chronic illness so providers can more pro-actively manage their conditions. Health Promotion Consultants engage the population directly, ensuring patients have regular visits and follow-up with their primary care provider, identify gaps and coordinate care. Geo-mapping connectivity tools help the team identify resources in the community to better serve patient needs.

Plan **value-based financial incentives help improve health outcomes.** Physicians are incented to do comprehensive annual exams at the beginning of the year to identify health problems early to allow more time to meet care goals. Anthem is also actively moving physicians into risk arrangements such as shared savings based on quality performance. “This is the future. Medicare is moving MA plans to a value-based insurance design model so that benefits can be tailored to specific populations,” said Pritpal Virdee, Anthem Plan president.

¹ J Polinski, et al, “An Insurer’s Care Transition Program Emphasizes Medication Reconciliation, Reduces Readmissions and Costs,” Health Affairs, July 2016.

² “Measuring Progress: Adoption of Alternative Payment Models In Commercial, Medicare Advantage And State Medicaid Programs,” HCP LAN, October 25, 2016.



About the BHC and this report

Board of Directors

Carolyn Plummer*
Monsanto Company

Ed Strouth*
Barry-Wehmiller Cos, Inc.

Tim Sutter*
Caleres

Kevin Supple*
Francis Howell School District

Debbie Hanlon*
ESCO Technologies, Inc.

Marla Langenhorst*
Ameren

Beth Biggs
Charter Communications

Dolores Ennico
Olin Corporation

Judy Faires
Emerson

Andrew Fondow
Concordia Plan Services

Gail Frye
Panera, LLC

Bruce Hanson
The Boeing Company

Kirk McCarley
Saint Louis County

Mark Mispagel
Spire, Inc.

Kristine Schuster
Mississippi Lime Company

Dave Toben
Bi-State Development/Metro

John Ziegler
Arch Coal, Inc.

Bob Knowles
Ex-Officio

Bob Wald
Ex-Officio
* BHC Foundation Executive
Committee member

Report Author

Karen Roth, RN, MBA, CPA
Director of Research
For more information, contact
kroth@stlbhc.org

BHC Members

AAF International
Aegion
Ameren Corporation
Anheuser-Busch InBev
Arch Coal, Inc.
TheBANK of Edwardsville
Barry-Wehmiller Cos, Inc.
Bass Pro Shops, Inc.
Bi-State Development/Metro
The Boeing Company
Bunzl Distribution USA, Inc.
Caleres
Charter Communications
City of St. Louis
Concordia Plan Services
Cushman & Wakefield
Daikin Applied Americas, Inc.
Diocese of Springfield in Illinois
The Doe Run Company
Drury Hotels Company, LLC
Edward Jones
Emerson
Emmaus Homes
ESCO Technologies Inc.
Ferguson-Florissant School District
Francis Howell School District
Global Brass and Copper, Inc.
Graybar Electric Company, Inc.
Laird Technologies, Inc.
Maines Paper & Food Service, Inc.
McCarthy Holdings, Inc.
Millipore Sigma
Mississippi Lime Company
Monsanto Company
North American Lighting, Inc.
Northwest R-1 School District
Olin Corporation
Panera Bread, LLC
Parkway School District
Peabody Energy
Rockwood School District
Saint Louis County
Saint Louis Public Schools
Schnuck Markets, Inc.
Shelter Insurance
Spire, Inc.
St. Louis Graphic Arts
Sulzer USA Inc.
Sunnen Products Company
Tucson Electric Power
Watlow
WestRock Co.
World Wide Technology, Inc.

Sustaining Members

Aon Hewitt
Lockton Companies, LLC
Mercer
Willis Towers Watson

Health Care HR Partners

Centene Corporation
Express Scripts, Inc.
Mallinckrodt Pharmaceuticals
Saint Louis University
University of Missouri

About the BHC

The St. Louis Area Business Health Coalition (BHC) represents leading St. Louis employers in their efforts to improve the well-being of their employees and enhance the overall value of their health benefit investments. BHC employers seek a transparent health care market where comparative information about quality, cost and outcomes is used to achieve high-quality, patient-centered, and affordable care for all people in the region.

The BHC Foundation is a separate non-profit subsidiary organization to the BHC. The BHC Foundation's purpose is to provide pertinent health care information to the community.

About this Report

This report analyzes, summarizes, and presents information and trends on St. Louis area health plans that include data from fiscal year 2013 through 2015. The report includes data from the following sources: U.S. Department of Health and Human Services HealthCare.gov, the Centers for Medicare and Medicaid Services, Health Plan 10-K reports filed with the Securities and Exchange Commission, the Kaiser Family Foundation, and the National Committee for Quality Assurance (NCQA) Quality Compass, as well as additional information voluntarily submitted by health plans. This report may be downloaded from the BHC website, at www.stlbhc.org.

Data Limitation and Cautions

BHC has made every effort to provide accurate information. Each health plan was given the opportunity to verify its data. As with any analysis of industry data, a note of caution is advised. BHC depends upon the accuracy of the data sources and cannot guarantee the complete accuracy of all the data in this report. For example, NCQA Quality Compass data may not always report rates from year to year and rates may also be affected by small sample sizes. In this case, data inaccuracies that may remain for individual health plans would have minimal impact on weighted average values and virtually no impact on the overall conclusions.

Please read and become familiar with the technical discussion while reviewing or interpreting the data detailed in this report.

Acknowledgments

BHC would like to acknowledge the health plan representatives who voluntarily provided BHC with health plan data. Health plan representatives and their staff worked extensively with BHC to verify the accuracy of the data. The additional time and effort spent analyzing and verifying the data was invaluable to the project's success.

BHC especially thanks its members that provided funding to the BHC Foundation to make this publication possible.



St. Louis Area

bhc

BUSINESS HEALTH COALITION

employer partners in healthcare

8888 Ladue Road, Suite 250 | St. Louis, Missouri 63124

(314) 721-7800 | www.stlbhc.org