Welcome

to the

2008 Broker Forum

2007 Top Producers (1 - 50 Market)

1. **Gregory Mayer,** Group Insurance Solutions, Inc.
2. **John Gardiner,** Potomac Basin Group Associates, Inc.
3. **Rodger Bayne,** The Agency LLC
4. **Corporate Coverage LLC**
5. **PSA Financial, Inc.**
6. **Jack W. Abel,** The Meltzer Group

2007 Top Producers (51+ Market)

1. **John Kelly,** Kelly Benefit Strategies
2. **Jack W. Abel,** The Meltzer Group
3. **Michael Marchini,** CBIZ Benefits & Insurance Services
4. **Mark McWright,** Group Insurance Solutions, Inc.

CareFirst BlueCross BlueShield

Sarah Smith

Fulfillment Manager, Benefitfocus

Presentation available in Brokers & Agents section of www.carefirst.com under CareFirst Connect

CareFirst BlueCross BlueShield

BlueFund
CONSUMER DIRECTED HEALTH PLANS

CDH Update

Cindy Otley
Director, Strategic Marketing & Product Development

2008 CDH Initiatives

- Continuing Operational Improvements
- Argus Enhancements
    - Debit Cards for HRAs
    - Emphasis on Communication and Education
    - New HRA Options for MSGR, with Combined Deductibles
    - Automated Provider Payments
- Health Statements
- Improved Consumer Tools
- Multiple PBMs
- Multiple Trustees

Introducing……. Contract Year Benefits!

Effective February 1, 2008, all standard benefits can be offered on either a Calendar Year or Contract Year basis.

- Launched December 21, 2007 for accounts with February 1, 2008 effective dates;
- Business sold with 1st of the month effective dates can choose to have benefits on **either** a Contract Year basis or Calendar Year basis;
  - 15th of the month groups (new business) will only have Calendar Year available
- All Existing business on Calendar Year can move to Contract Year **upon renewal**

Contract Year Benefits – Who's Impacted?

- **Small Group**
  - Maryland Small Group Reform (MSGR)
  - Maryland Parity
  - Virginia
  - District of Columbia

- **Large Group**
  - Maryland
  - Virginia
  - District of Columbia

Out-of-Scope

- Individual Market - Over 65 and Under 65
  - All IMD business will continue to only be offered on a Calendar Year basis

Quoting Systems

PC Rate Quote Updates

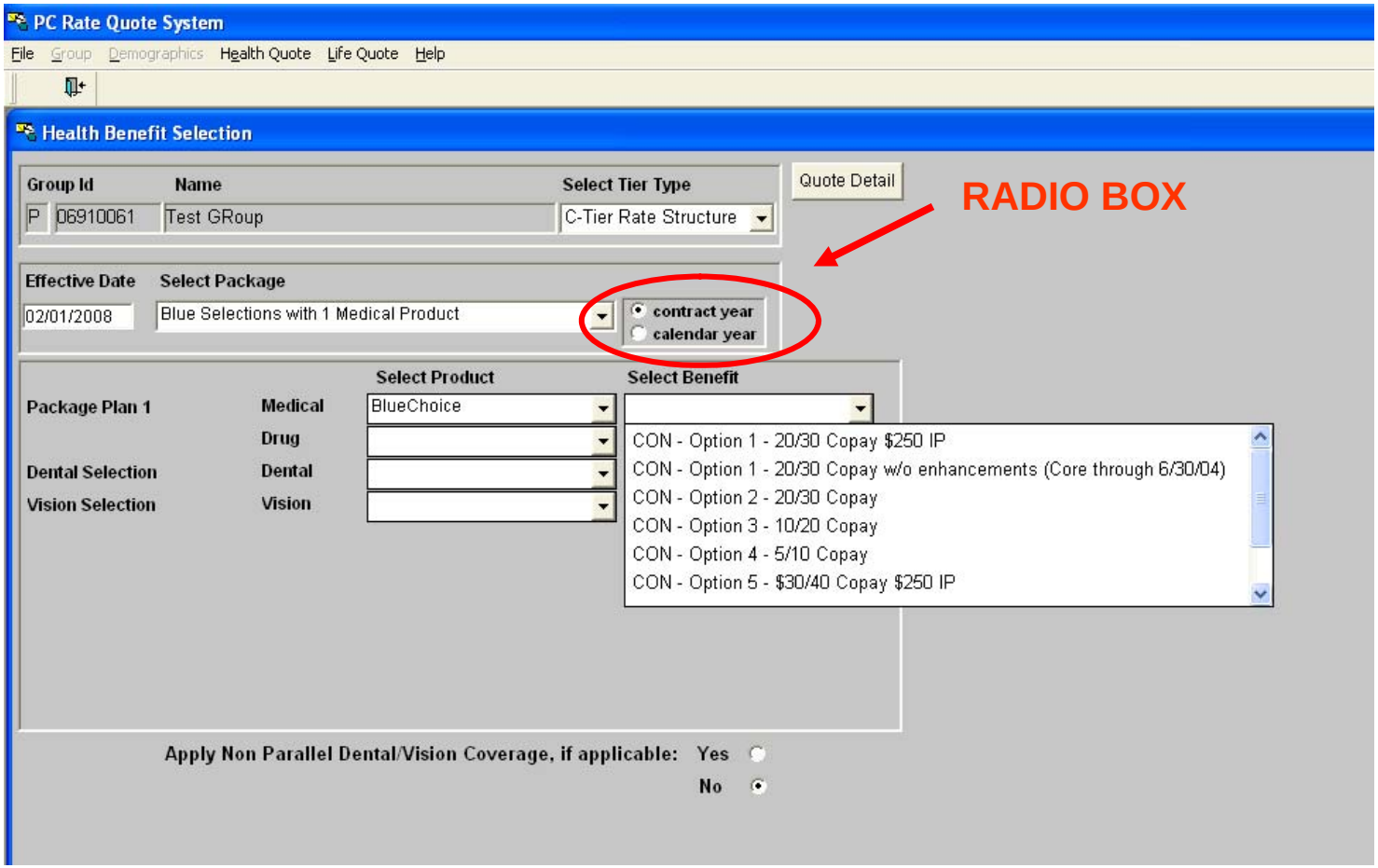
- A newly created indicator box “radio button” allows a user to select benefits on either a Contract or Calendar Year basis

- The **default** for **existing** groups will be **current benefit period**
  - If a group wants to change from their existing benefit period upon renewal, they should use the radio button to indicate their new selection
  - When the group is installed they will be migrated to the new benefit period indicated

- The **default** for **prospects** will be **Contract Year**
  - If a group wants to change from Contract Year, they will need to select the Calendar Year radio button
  - When the group is installed the group will be loaded into the system based on the radio button selection

- Note that the Benefit period will be indicated clearly on the group’s quote/renewal

Revised Rate Quote Screen Shot



Revised Rate Quote Screen Shot

Name: Sample Renewal
Group Location: Maryland MSGR - MO
Proposed Effective Date:12/01/2007
Total Enrolled:47
Quote Number:18

Group Number:12345
Rep Code:
Rate Invalid After:12/31/2007
Average Age:37
SIC Code:7999 Page 1 of 4

RENEWAL RATES AND BENEFITS - - PARALLEL - - CONTRACT YEAR

BlueChoice In-Network	**H1**	**17**	Option 1 - $20/30 Copay - Contract Year $250 Inpatient Copay per Admission $30 Copay for Plan Provider Urgent Care Facility $35 Copay for Hospital Emergency Room or Non-Plan Urgent Care Center
Drug	**RH**	**V5**	$0 Deductible - Contract Year Non-Maintenance: $15 Generic $25 Brand Formulary $50 Brand Non-Formulary 34 Day Supply Maintenance: $30 Generic $50 Brand Formulary $100 Brand Non-Formulary 35-90 Day Supply

	Individual	Ind/Child(ren)	Ind/Adult	Family	Medicare
BlueChoice	$224	$414	$515	$627	$191
Drug	$75	$139	$173	$210	$64
Total Rate	$299	$553	$688	$837	$255

Contract Year or Calendar will be indicated here

Off-Cycle Benefit Changes

Business Rules - 1-50 Segment

- All new rules will be in place for one year (2/1/08 – 1/31/09)
- By that time, we will have gone through a complete renewal cycle so most groups would have had the opportunity to change their benefit period if they so desired and high volumes would no longer be expected

Business Rules - MSGR Market

- No off-cycle changes will be allowed for the sole purpose of changing benefit periods
  - This applies to Calendar Year to Contract Year, or vice versa
- Off-cycle **benefit** changes are allowed (following *normal* rules) and these changes may also include a benefit period change
- If an MSGR account wants to make a change to the benefit period only, they will have to make this change upon renewal
  - Again, this applies to movement from Calendar Year to Contract Year or vice versa

Business Rules - MD Parity, VA & DC Markets

- No off-cycle benefit changes will be allowed with the exception of ancillary changes (i.e., pharmacy, dental, vision) that are done "short plan year" and do not alter the "renewal month“

- Benefit changes will only be allowed upon renewal

Deductible Credit

How Deductible Credit Works Today

- **Medical Deductible and Out of Pocket Credit is available**
  - For new business
    - Manual Process
  - For existing business
    - Within same benefit period (automated on FLEXX)
  - Deductible credit (CDH) expected on existing CareFirst accounts changing to new benefit effective periods
- **Manual process when a group changes benefit effective periods**
- **Rx Deductible Credit is not a CareFirst business or industry practice**

New Deductible Credit Business Rules

New Business

Group	Before 2/1/08	After 2/1/08
Calendar	Yes	Yes*
Contract	Yes	No
15th of Month (Calendar)+	Yes	No

Renewing Business

Group	Before 2/1/08	After 2/1/08
Off Cycle Change	Yes	Calendar – YES Contract - No
Moving Calendar to Contract (vise versa)	Yes	No
Remaining Calendar Year – changing benefits	Yes	Yes

* Must currently be calendar year plan with competitor -- ensures we are not extending their deductible period longer than 12 months, thus making the plan out of compliance with the IRS

\+ 15th of the Month Contract Year Not Available

Non-CDH Products sold stand alone or not offered with CDH as part of Blue Selections:
Existing Deductible Credit Rules Apply

Bottom Line: When a CDH Product is offered standalone or as part of Blue Selections, Deductible Credit is ONLY ALLOWED on Calendar Year New or Renewing Business

New ACS/Mellon HSA Process

New ACS/Mellon HSA Process

- CareFirst has implemented an expedited Process which accelerates the activation of HSA accounts
- Purpose is to make it possible for members to have their HSA opened and ready to receive deposits on their plan's effective date
- Members will no longer need to wait for their Welcome Kit to establish their HSA which could save several weeks
- Instructions and necessary forms, including the new HSA application, are available in the Brokers & Agents section of www.carefirst.com

New ACS/Mellon HSA Process

Expedited Process:

- Members who select a health plan with a HSA option complete the new Health Savings Account Application.
- Applications are then collected and faxed to FlexAmerica; applications must be received by FlexAmerica prior to the enrollment feed from CareFirst.
- FlexAmerica activates HSA accounts for those members who appear on the eligibility file and have completed HSA Applications.
- Members who complete the HSA application will receive a *modified* welcome kit that includes a paper signature card (needed to order checks) and beneficiary form. These forms should be completed and returned following directions on the forms.

Note:

Members who do not complete an HSA application OR whose HSA application is not submitted on-time, will receive the Standard Welcome Kit in the mail and will open their accounts based on the Current Process.

CDH Issues and Resolution

Ken Barrette

Director, Operations Support Services

Work Request Summary

Root Causes of Work Requests closed during 3 months in 2007 show that **72% are non-system issues.**

Summary of Root Causes for Requests Closed September-November								
Root Cause Theme	September		October		November		Total	
	Requests	%	Requests	%	Requests	%	Requests	%
Benefit Selection Error or Change / Enrollment / Retroactivity	20	39%	30	41%	23	41%	73	40%
CareFirst or Argus System Issue	19	37%	19	26%	13	23%	51	28%
Policy or Education	10	20%	16	22%	7	13%	33	18%
Timing (e.g. Voids)	2	4%	9	12%	11	20%	22	12%
Other	0	0%	0	0%	2	4%	2	1%
Total	**51**	**100%**	**74**	**100%**	**56**	**100%**	**181**	**100.0%**

Of the incoming new work requests in the first half of January, **60% were retroactivity requests.**

Work Request 1/1 - 1/16/08	47	100%
Retros	28	60%
Contract Year Issues	12	26%
2007 Calendar Year Issues	5	11%
Deductible Reset Issue	2	4%

CDH Member Pain Points

CareFirst BlueCross BlueShield

Current State	Fixes
Timing issues between pharmacy claims, and medical claim processing may cause deductible balances to be out of synch. For example: • Member pays for Rx. Argus has claim immediately. CareFirst receives batch file sent daily from Argus. • Members leave Rx at pharmacy due to sticker shock. Rx already processed at Argus and sent to CareFirst. Argus must send void which CFI handles manually.	--Enhancing medical claim system to support improved deductible tracking **1st Q/2008** --Increasing frequency method of claim data sharing with pharmacy benefit administrator **4th Q/2008** -Implementing daily deductible file coordinate deductible balance view **1st Q 2008**
Retroactive transactions require manual adjustments and impacts to members and providers. For example: • If an existing group has HMO and as of 1/1 renews, but then submits HSA HMO renewal change 2/1 effective back to 1/1. CareFirst has to adjust claims to be member liable for charges, and manual verify that pharmacy and medical deductible accumulations are in synch. Also, member will not receive debit card until 3-4 weeks from implementing change.	-Developed business policies for retroactive changes and deductible credit **4th Q/2007** -Working with brokers to educate, and if necessitated, follow a rigid quality assurance process to handle retroactive changes **4th Q/2007** -Implementing automated business rules to improve handling of retroactivity transactions **2008**
Member doesn't know what they owe before and after receiving care so they pay provider in full (not at discounted fee). Possible outcomes •Provider overcharged, member must ask for refund once they receive EOB •Provider is made whole so does not file the claim. If member didn't pay, provider must chase member.	-Evaluating and implementing new consumer tools **4th Q2008/09** -Real Time Adjudication - **Future**
Member confusion when their HSA/HRA custodian balance does not match the deductible balance with CareFirst. This is due to receiving services that don't accumulate toward their deductible (e.g. vision services or OTC drugs). Member has different member service numbers to call (CFI and Administrator/Trustee) and may get different answers.	-Developing member service and support model to provide service end to end **4th Q2007 and 2008** -Designing and implementing multiple Trustees Model **2008/09**
Groups are changing from calendar year to contract year. This creates deductible credit accumulation challenges. For example: •Group is calendar year PPO, and as of August 1, selects HSA PPO contract year. This is a new product/benefit so deductibles reset. •Broker/accounts/members want deductible credit for new twelve month period, but IRS regulations on providing deductible credit with actuary concern of crediting 7 months into a new 12 month period	-Evaluating business policies for deductible credit **4thQ/2007** -Implementing contract year/calendar year options for brokers **1st Q/2008**

Continuing CDH Improvements

- **Centralizing CDH end-to-end service and operational support organization**
  - To handle pharmacy, medical, and BlueFund inquiries, as well as CDH education and member assistance
- **Additional Argus enhancements to improve near real-time data sharing, and single point of deductible balance inquiry for determining benefits and service inquiry**
- **Transaction management – Manage transactions impacting accumulators and deductibles**
  - Improve void handling (when a member does not pick up a prescription)
  - Deductible credit handling, including IRS formula application
  - Ability to automate full file refresh and reconciliation at account level

Continuing CDH Improvements

- **Expand customer service tools**
  - Add transparency such as debit card bank transaction detail
  - Evaluate current customer service tools and develop additional reporting and automated analytical function tools to allow CSRs to better assist members at point of service

- **Reporting - Establish core set of standard file extracts and account reports for 3rd party fund administrators or accounts who need additional data to address employee issue:**
  - Show that basic claims met approved HSA guidelines for validating the deductible balance against the debit balance at the administrator custodian level
  - Develop claims adjustment and transaction reports and make available to brokers and administrators. Improve formats/criteria to better reflect the rules of operating under the new paradigms of the HSA and HRA environment

We are Starting to See Results

2007	# CDH Calls Answered	% Change since Oct.
Oct, 2007	10,780	N/A
Nov, 2007	9,176	-15%
Dec, 2007	8,544	-21%

CDH Service Calls have decreased by 21% since October

2007	New Requests	% Change since August
August	199	N/A
September	147	-26%
October	143	-28%
November	91	-54%
December	76	-62%

Incoming Work Requests have decreased by 62% since August

2007 Week of:	# of Requests Reviewed	% Change since 11/26
11/26	80	N/A
12/3	80	0%
12/10	79	-1%
12/17	46	-43%
12/24	No Meeting	N/A

Retroactivity Requests have decreased by 43% since November

Service Concierge Program

- **Recognizing CDH products require a different level of support, CareFirst Member Service has implemented a Concierge Program.**

- **The Concierge Program identifies members to proactively call and provide support based on:**
  - Utilization of healthcare – i.e., members who are reaching deductible balance
  - Diagnosis/condition
  - Frequent callers

- **CareFirst is empowering and supporting members through online investments, consumer tools, and adaptive service models.**
  - Adapting a proactive model of member service aimed towards guiding members to the right information, at the right place, at the right time
  - Preventing escalating service issues
  - Providing value add information for members to make informed decisions about their healthcare
  - Investing in a suite of consumer tools to improve service and empower members to make informed health management decisions

Actuarial Pricing Update

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Visual Presentation Only