IAI

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MASSACHUSETTS

MARCH 2007

HEALTH CARE REFORM UPDATES

The following updates concern the health care reform law in Massachusetts (Chapter 58 of the Acts of 2006).

Health Care Reform Plans Receive Connector's Seal of Approval

We are pleased to announce that seven Blue Cross Blue Shield of Massachusetts plans were awarded a Seal of Approval by the Board of the Commonwealth Health Insurance Connector Authority (the Connector) on Thursday, March 8, 2007.

Included are two new plans, each with two options:

- Essential Blue YA (Young Adult)—with and without pharmacy coverage
- HMO Blue® Basic Value—with and without pharmacy coverage

In addition to these four new options, you are already familiar with three other plans:

- HMO Blue® Value
- Access Blue® Enhanced Value
- HMO Blue® $10

These products cover all three of the Connector's price bands and the 19-26-year-old segment. The plans offer a range of member cost-sharing levels and price points, but do share some common features.

- No deductibles on physician, diagnostic, or hospital services
- Copayments for preventive, primary care, specialist, and emergency room visits
- Co-insurance (for certain plans) for most other services with an out-of-pocket maximum
- Access to our HMO Blue network of providers
- Three tier copayments for drugs
- No annual or per-illness benefit maximums

The open enrollment period for these plans begins May 1, 2007, for effective dates starting July 1, 2007.

Below are highlights for each of the young adult, basic, value, and premier plans awarded the seal of approval. For details on these plans, please visit **www.bluecrossma.com**, or contact your Account Executive.

Young Adult Plans for 19-26-Year-Old Individuals

Essential Blue YA (with or without pharmacy coverage)

Essential Blue YA is a no-deductible plan that features a tiered network. Members choose a primary care physician (PCP) from one of two tiers. The tier of their PCP determines the member's cost share for all services. This means that if a member selects a PCP from the Enhanced Benefit Tier, they will have lower cost share for all services; if they select a PCP from the Standard Benefit Tier, they will have greater cost share for all services.

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Overview:

- No deductible on any service
- $10 copayment for all preventive care office visits for members with an Enhanced Benefit Tier PCP ($50 for Standard Benefit Tier PCP)
- $25 copayment for all other PCP and Specialist office visits for members with an Enhanced Benefit Tier PCP ($50 for Standard Benefit Tier PCP)
- $15/$30/$50 copayment for retail pharmacy
- $30/$60/$150 copayment for mail-service pharmacy
- 30% co-insurance for inpatient hospital and day surgery admissions for members with an Enhanced Benefit Tier PCP (60% co-insurance for Standard Benefit Tier PCP)
- $250 copayment for emergency room (ER) visits for members with an Enhanced Benefit Tier PCP ($350 for Standard Benefit Tier PCP)
- Preventive dental coverage through our Dental Blue® PPO network
- No annual or per-illness benefit maximum
- $5,000 annual out-of-pocket maximum for all co-insurance
- Healthy Blue—programs, discounts and savings, resources, and tools to help members manage their health and health plan

Basic Level Plan (Lowest Price Tier)

HMO Blue Basic Value (with or without pharmacy coverage)

HMO Blue Basic Value contains no deductibles on any services, with copayments for office visits, and inpatient and surgery co-insurance to provide a lower price point.

Overview:

- Access to the extensive statewide HMO Blue provider network
- No deductible on any service
- $15 copayment for all preventive care office visits
- $25/$40 copayment for PCP/Specialist office visits
- $15/$30/$50 copayment for retail pharmacy
- $30/$60/$150 copayment for mail-service pharmacy
- 35% co-insurance for inpatient and day surgery
- $150 copayment for ER visits
- $5,000/$10,000 out-of-pocket maximum per year for all copayments and co-insurance except pharmacy
- No annual or per-illness benefit maximum
- Healthy Blue—programs, discounts and savings, resources, and tools to help Members manage their health and health plan

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Value Level Plans (Middle Price Tier)

HMO Blue Value

HMO Blue Value offers coverage for doctor visits, hospital services, surgical care with no deductible, benefits for preventive care, well-child care, and other medical services. Prescription drugs are covered with a small deductible.

Overview:

- Access to the extensive statewide HMO Blue® provider network
- $25 copayment for all preventive care office visits
- $25 copayment for PCP/Specialist office visits
- $10/$20/$35 copayment for retail pharmacy
- $20/$40/$70 copayment for mail-service pharmacy
- $100 copayment for ER visits
- $250 day surgery copayment
- $500 inpatient hospital copayment
- $2,000/$4,000 out-of-pocket maximum per year for all inpatient, day surgery, and ER copayments
- No annual or per-illness benefit maximum
- Healthy Blue—programs, discounts and savings, resources, and tools to help Members manage their health and health plan

Access Blue Enhanced Value

Access Blue Enhanced Value provides no-referral access to doctors, low copayments, no deductible, and pharmacy coverage.

Overview:

- Access to the extensive statewide HMO Blue® provider network
- No deductible
- $0 copayment for PCP/network physician preventive care office visits
- $20/$30 copayment for PCP/Specialist office visits
- $15/$30/$50 copayment for retail pharmacy
- $15/$30/$50 copayment for mail-service pharmacy

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- $75 copayment for ER visits
- $250 day surgery copayment
- $500 inpatient hospital copayment
- $2,000/$4,000 out-of-pocket maximum per year for inpatient, day surgery, and ER copayments
- No annual or per-illness benefit maximum
- Healthy Blue—programs, discounts and savings, resources, and tools to help Members manage their health and health plan

Premier Level Plan (Top Price Tier)

HMO Blue® $10

HMO Blue $10 includes benefits for preventive care, well-child care, prescriptions, and other medical services.

Overview:

- Access to the extensive statewide HMO Blue® provider network
- No deductible
- $10 copayment for all preventive care office visits
- $10 copayment for PCP/Specialist office visits
- $10/$25/$45 copayment for retail pharmacy
- $10/$25/$45 copayment for mail-service pharmacy
- $50 copayment for ER visits
- No annual or per-illness benefit maximum
- Healthy Blue—programs, discounts and savings, resources, and tools to help Members manage their health and health plan

Employer Premium Contribution Date Change

The effective date of the health care reform law's employer premium contribution provisions has changed from January 1, 2007, to July 1, 2007. Thus, beginning July 1, 2007, health carriers are only permitted to renew or enter into insured group health benefit plan contracts with employers that (1) offer such coverage to all full-time employees who live in Massachusetts; and (2) do not make greater premium contribution levels to higher-paid employees than the employer makes to lower-paid employees. These provisions do not apply to premium contribution differentials for employees covered by collective bargaining agreements.

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Special One-Time Open Enrollment for "Opt-Out" Employees

Open Enrollment Effective Date: July 1, 2007

Accounts with 1–50 Eligible Employees

Existing accounts with 50 or fewer employees that offer our products to all full-time employees and decide to allow current "opt-out" employees to join their plans on July 1, 2007—and only on that date—will be allowed to do so and will be permitted to keep the same anniversary date and current rates.

Accounts with More Than 50 Employees

Existing accounts with more than 50 employees that offer our products to all full-time employees and decide to allow current "opt-out" employees to join their plans on July 1, 2007—and only on that date—will be allowed to do so and will be permitted to keep the same anniversary date and current rates. We expect this new membership will not exceed the 10-percent threshold referenced in our account agreements, and therefore a re-rate may not be necessary.

Accounts that change their eligibility criteria effective July 1, 2007, (i.e., from hourly/salary, management only, etc., to all full-time employees) and request approval for the above-mentioned, additional open enrollment on July 1, 2007, will have to be reviewed and re-rated in Underwriting.

Dependent Eligibility Changes

Beginning January 1, 2007, eligibility for dependents, including adoptive children and newborns, has been extended to age 26, or for two calendar years after the dependent is no longer claimed on the subscriber's or spouse's federal tax return, whichever occurs first. The two-year extension of eligibility period begins on January 1 of the calendar year in which the dependent is no longer being claimed on the subscriber's or spouse's federal tax return.

Division of Insurance Bulletin on Dependent Coverage

On January 18, 2007, the Division of Insurance issued a bulletin to clarify new dependent coverage requirements that went into effect on January 1, 2007, under the Health Care Reform Act. For your information, the bulletin is attached to this *IAI*.

If you have any questions about the health care reform law, please refer to the December 2006 *IAI*, or contact your Account Executive.

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Enrollment Management: How to Update Dependent Coverage

As reported in the December 2006 edition of the *IAI*, employers can use the BlueLinks℠ Enrollment Management to enroll dependents in coverage. Instructions for performing the update follow.

(Not all accounts are subject to this provision. For details, refer to the attached *IAI* article on health care reform.)

For accounts that do qualify, the process typically involves two transactions.

If the Dependent's Current Status Is "Canceled"

Transaction 1

1. From the **Coverage** tab, select the appropriate dependent name from the dropdown list. Enter 01/01/2007 for the effective date, and click the **Go** button.
2. Click either the **Reenroll** or **Reinstate** button.
   - **Reenroll** will appear if the cancel date is prior to 1/1/2007 (indicating a break in coverage).
   - **Reinstate** will appear if the cancel date equals 1/1/2007 (indicating no break in coverage).
3. Select **Open Enrollment** from the **Qualifying Event Reason** dropdown.
4. Verify and submit the transaction.

Transaction 2

1. From the **Personal Information** tab, select the appropriate dependent name from the dropdown list. Click the **Go** button.
2. If the **Relationship** indicates Student, change the status to Dependent. (If the **Relationship** already indicates Dependent, no further action is required.)
3. Enter 01/01/2007 for the effective date, and click the **Next** button.
4. Verify and submit the transaction.

If the Dependent's Current Status Is "Active"

Check the **Relationship** of the member on the **Personal Information** tab. If it indicates "Student," and he/she is no longer a full-time student, but is within the Dependent Eligibility provisions, simply follow Transaction 2 above.

Changing the member's status to Dependent is very important, not only for reporting purposes, but also to ensure that the enrollment is administered properly. In addition, it is important that you not use the **Add Spouse/Dependent** function, since the dependent (although currently canceled) was previously enrolled as a member.

If you ever need help with Enrollment Management, please contact the BlueLinks Help Desk at **1-800-650-9808**, Monday through Friday between 8:00 a.m. and 5:00 p.m. ET, or via email at **bluelinks@bcbsma.com**.

Medicare Part D Retiree Drug Subsidy Updates

The following information concerns the Retiree Drug Subsidy (RDS) program offered by the Centers for Medicare and Medicaid Services (CMS) to employers that sponsor their own retiree prescription drug plans.

Fees

Under the RDS program, Express Scripts, Inc. (ESI), our third-party pharmacy-benefits administrator, charges us fees for the administration of monthly claim files submitted to CMS. These fees are per-member-per-month (PMPM) based on the number of members an employer has enrolled in its retiree prescription drug plan.

Effective January 1, 2007, we will begin charging accounts for this administrative service undertaken on behalf of their organizations. The initial rate set by ESI is $0.84 PMPM, subject to change with prior notice to accounts.

Beginning in March 2007, accounts will receive invoices for RDS fees on a monthly basis. The initial invoice will be for fees associated with January 2007 claim files submitted to CMS, and the next month's invoice will be for February 2007 fees. RDS fees will appear on a separate invoice from medical coverage, and will be payable on or before the due date listed on the invoice.

Prior to sending the initial invoice, we will send accounts an amendment to their *Agreement to Provide Administrative Services for the Retiree Drug Subsidy Program* document, which outlines the terms and conditions of RDS program administrative services.

If you have questions or would like additional information, please contact your Account Executive.

Actuarial Services

We provide actuarial support and services for accounts filing for the RDS program through CMS. These services include:

- Evaluation of current benefits to determine creditable coverage status required for employers' annual notifications to retirees
- Reports showing "gross" level of actuarial equivalence to Standard Part D benefit
- Actuarial attestation as required for RDS applications (for non-complicated benefit/contribution accounts)
- Discounted services through Milliman for actuary attestations (for complicated or non-standard benefit/contribution accounts)

If accounts would like to use any of our services, they should contact us 150 days prior to the RDS application submission date.

Please contact your Account Executive for details.

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Alternatives to RDS Application Filings

Instead of filing for the RDS, accounts have other ways to save on their retiree plans without the administrative burden of the application filings and maintenance. In many cases, these alternative plans offer little to no disruption to current benefits and member access to services and pharmacies, and can result in greater savings than the 28 percent subsidy from the RDS program.

If you are interested in these options, please contact your Account Executive.

Coverage for Mastectomy-Related Services

As required by the Women's Health and Cancer Rights Act of 1998, individuals who are covered for a mastectomy and elect breast reconstruction in connection with a mastectomy will receive benefits for the mastectomy-related services listed below. This is the case even if the individual was not covered by Blue Cross Blue Shield of Massachusetts at the time of the mastectomy.

Benefits are provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Coverage is provided as determined in consultation with members and their attending physician.

If you have any questions, please contact your Account Executive.

HIPAA Update: National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services (HHS) adopt a standard, unique, health identifier for health care providers. The National Provider Identifier (NPI) is the result of this mandate. Covered entities, including Blue Cross Blue Shield of Massachusetts and other providers who conduct business electronically, are required to implement this new standard by May 23, 2007.*

What We Are Doing

We began preparing for the NPI mandate in 2005. The NPI replaces current legacy provider numbers issued today by each payer for the purpose of claims adjudication. With this new standard, providers must request their own NPIs, and health plans must adapt their systems to process claims using the new NPIs. We are working to complete all internal system changes in preparation for the May 23, 2007, deadline, and anticipate being in full compliance by that time. In addition, we are working closely with the provider community to educate them on the mandate requirements.

Please contact your Account Executive for further information.

*Small health plans have an additional year to implement this standard or by May 23, 2008.

New Standard Deductible for HSA-Compliant Plans Increasing

As of July 1, 2007, the standard deductible level for our health savings account (HSA)-compliant Access Blue™ Saver and Blue Care® Elect Saver plans will increase to $1,500 from its current $1,100 level.

- Access Blue Saver is an open-access, high-deductible HMO plan with no referrals that offers employers an attractive price point, while engaging members in their care and its costs.
- Blue Care Elect Saver is a high-deductible PPO plan that features no referrals for care, out-of-network coverage, and choice of provider, while engaging members in their care and costs.

Why We Are Making This Change

This deductible shift will make it easier for employers to comply with federal HSA regulations in future years. Annually, the federal Department of Treasury sets minimum deductible standards for plans to qualify as compliant with HSA regulations. This has meant that employers have had to increase the deductible levels on their plans to meet those minimum standards.

By shifting the standard deductible to $1,500, employers who select our HSA-compliant plans will be able to maintain a consistent deductible level for several years, making it easier for their employees to understand and plan for health care expenses.

Additionally, we expect the deductible change to decrease premiums for employers.

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What the Change Means

For current Access Blue Saver and Blue Care Elect Saver plans and plans sold before July 1, 2007, the increase will take effect at the next anniversary date. There will be no change to plans during the plan year. New plans sold after July 1, 2007, will carry the new standard deductible level.

In both cases, employers with more than 50 employees have additional flexibility in choosing deductible levels for their Access Blue Saver and Blue Care Elect Saver plans.

If you have questions about your current plan or about offering an HSA-compliant plan in the future, please contact your Account Executive.

Blue Options™/Blue Precision™ Plans Now Available

We are pleased to announce the launch of Blue Options/Blue Precision plan designs with tiered provider networks. These plans include a self-funded, national, PPO plan and fully-insured and self-funded HMO Blue® and HMO Blue® New England network plans. These products can deliver lower costs for employers, and help engage employees in their health and health care costs by encouraging them to use providers who have met our cost and quality benchmarks.

About Our Strategy

At the heart of these plans are provider tiers driven by these key concepts:

- Statistical rigor. Our process for tiering providers leverages the claims from more than one million members that we analyze for measurable differences among provider performance. The tiers then help members make informed health care decisions.
- Collaboration with providers. Our tiering methodology, which uses both cost and quality data where available, is closely aligned with our Pay-For-Performance programs.
- Transparency for members. By giving members access to cost and quality data, our plans help them make informed choices about their providers.

Our Approach to Tiering Providers in Massachusetts

In developing our plans, we chose to tier acute-care hospitals and primary care physicians (PCPs). Together, these provider types represent 50 percent of our total claims, and significantly impact the care our members receive.

Members of our Blue Options/Blue Precision plans pay different levels of copayments for care depending on which PCPs and hospitals they select for care in Massachusetts.

- Tier 1 carries a lower copayment and includes Massachusetts providers whose cost and quality scores met or exceeded the benchmarks, and certain providers who have been included to ensure geographic access for members.
- Tier 2 carries a higher copayment and includes Massachusetts providers whose cost and/or quality scores did not meet the benchmarks.

Note: All acute-care hospitals passed the quality benchmark. PCPs without sufficient quality data, and certain specialty hospitals, were measured on cost alone for their overall tier rating.

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Though we do collect and report cost and quality data for individual physicians, for most providers for the purposes of the Blue Options tiering, the scores are aggregated, or averaged, by the entire physician group with which a provider is associated. Alternatively, we calculated scores based on the geography and referral patterns with which a provider is associated.

Specialists were not tiered and carry a copayment equal to Tier 2 providers.

National Tiered-Network Option

Employers who are looking for a national PPO tiered network solution can choose the Blue Precision option. The plan features a single, unified, two-tier, in-network benefit design that members can use in 26 states and the District of Columbia where a Blue Cross Blue Shield of Massachusetts Blue Precision network exists based upon locally collected and analyzed data.

In states where no Blue Precision network exists, members have access to the full, nationwide Blue Cross and Blue Shield network for tier-1-level care, allowing for an all-Blue solution to coverage.

Availability

Our PPO Blue Options plan is currently available and the national Blue Precision plan is available May 1, 2007 for larger self-insured employers.

Our HMO Blue Options™ and HMO Blue New England Options™ plans will be available on April 1, 2007, for fully insured or self-insured employers with 51 or more employees, and on July 1, 2007, for fully insured employers with 50 or fewer employees.

To learn more about our Blue Options/Blue Precision tiered-network plan designs, please contact your Account Executive.

Specialty Pharmacies Designated for Oncology Medications

As of June 1, 2007, in order to obtain pharmacy benefit coverage for certain medications, members currently receiving medications most commonly used for oncology will need to have their pharmacy prescription filled through one of the specialty pharmacies listed in the table below.

Designated Retail Pharmacy Network for Oncology Prescriptions		
Caremark®, Inc. Phone: 1-800-237-2767 Fax: 1-800-323-2445 **www.caremark.com**	**CuraScript™ Pharmacy, Inc.** **A subsidiary of Express Scripts, Inc.** Phone: 1-888-823-9070 Fax: 1-888-773-7386 **www.curascript.com**	**SpecialtyScripts Pharmacy** Phone: 1-800-218-5688 Fax: 1-800-830-5292 **www.specialtyscripts.com**

This change will not affect medications provided and administered in a physician's office, a hospital, an outpatient clinic, or by a home-infusion provider.

How This Affects Members

If members are currently receiving one of the medications, listed on the next page, through one of these specialty pharmacies, they need not take any action at this time. If they are currently receiving medications through the Mail Service Pharmacy via Express Scripts, Inc., or another retail pharmacy, they will need to transfer their prescription to Caremark, CuraScript, or SpecialtyScripts.

As an accommodation, members will be allowed one courtesy refill of their medication at their current pharmacy. This one-time accommodation is only available through September 1, 2007. After this final refill, they must fill their prescription through Caremark, CuraScript, or SpecialtyScripts. Because these designated network providers are retail pharmacies, members' current retail cost-sharing amount will apply. The mail-service benefit will not apply for these medications after June 1, 2007 (with the exceptions stated on page 15). Once this network change goes into effect, members who choose to receive their oncology medications through any pharmacy not in the specialty pharmacy network will be responsible for the full out-of-pocket costs.

How to Get the Next Supply of Specialty Medication(s)

Members should contact one of the designated retail specialty pharmacies listed above. If they have questions about one of the designated pharmacies or the specialty network change, they can contact our Member Service Department at the number printed on the front of their ID cards.

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Oral Medications	Intravenous and Injectable Medications			
Alkeran®	Abraxane™	Elspar®	Methotrexate*	Toposar®
Cytoxan®	Adriamycin PFS®	Epirubicin	Mitomycin	Trelstar™ LA
Etoposide	Adrucil®	Ethyol®	Mitoxantrone	Trelstar™ Depot
Gleevec®	Alferon® N	Etopophos®	Mustargen	Velcade®
Leucovorin Calcium	Aredia®	Etoposide	Mutamycin®	VePesid®
Mesna	BiCNu®	Floxuridine	Mylotarg®	VinBLAStine
Mesnex®	Blenoxane®	Fludara®	Navelbine®	VinCRIStine
Nexavar®	Bleomycin Sulfate	Fludarabine phosphate	Neosar®	Vinorelbine
Revlimid®	Busulfex®	Fluorouracil	Nipent®	Vumon®
Sprycel™	Campath®	FUDR®	Novantrone®	Zanosar®
Sutent®	Camptosar®	Gemzar®	Oncaspar®	Zinecard®
Tarceva®	Carboplatin	Herceptin®	Ontak®	Zoladex®
Temodar®	Cerubidine®	Hycamtin®	Onxol®	
Thalomid®	Cisplatin	Idamycin PFS®	OTN Pamidronate	
VePesid®	Cladribine	Idarubicin	Paclitaxel	
Xeloda®	Cosmegen®	Ifex®	Pamidronate disodium	
Zolinza™	Cytarabine	Ifex®/Mesna®	Paraplatin®	
	Cytoxan®	Ifosfamide	Photofrin®	
	Dacarbazine	Ifosfamide/Mesna	Proleukin®	
	Daunorubicin HCL®	Intron® A	Rituxan®	
	DaunoXome®	Leucovorin Calcium	Roferon-A®	
	Depocyt®	Leuprolide Acetate**	Sandostatin®	
	Doxil®	Leustatin®	Sandostatin-LAR®	
	Doxorubicin HCl	Lupron Depot®**	Taxol®	
	DTIC-Dome®	Lupron Depot-Ped®**	Taxotere®	
	Ellence®	Lupron®**	TheraCys®	
	Eligard®	Mesna	Thiotepa	
	Eloxatin®	Mesnex®	Thyrogen®	

*Methotrexate oral dosage forms will continue to be available at retail pharmacies in the ESI network, and at mail order. Only the injectable forms of Methotrexate will be included in the designated retail specialty pharmacies.

**Leuprolide, Lupron, and Lupron Depot will be available only through the following pharmacies: Caremark, Inc.; CuraScript Pharmacy, Inc; Freedom Fertility Pharmacy; ivpcare; SpecialtyScripts Pharmacy; or Village Fertility Pharmacy.

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Exceptions to the Network Change

There are two exceptions to this network change:

1. The implementation date for the network change will be January 1, 2008, for members who:
   – are receiving medications for oncology, AND
   – have a co-insurance benefit for retail pharmacy combined with a copayment benefit for mail service (e.g., 20%/50% retail co-insurance, combined with a $10/$25/$40 mail-service copayment).
2. The network change does not apply to Medex®, Blue MedicareRx℠, Blue Health Plan for Kids™, or Medicare Advantage plans that include prescription drug coverage. Members with these health plans do not need to obtain their oncology medications through our specialty pharmacy network.

A Full Range of Services

Caremark®, CuraScript, and SpecialtyScripts all provide specialized support and delivery services that are available at no additional cost. These services include:

- All necessary medications and supplies needed for administration.
- Delivery of medications to members' home or designated location.
- When medically necessary, overnight delivery is available at no additional delivery cost.
- Access to nurses and pharmacists specializing in the treatment of the applicable condition, and who are available 24 hours a day, seven days a week, to provide support and educational information about medications.
- Telephone consultation to answer questions related to medication administration needs.
- Educational resources regarding medication use, side effects, and injection administration. Instructions are available in both English and Spanish, and translation services are available in other languages.

If you have any questions about these pharmacies, please contact your Account Executive.

Blue Care®Connection Update

Programs to Address Seizure Disorder and Chronic Obstructive Pulmonary Disease (COPD)

We recently expanded the Blue Care®Connection *for Select Conditions* health management program to support eligible members identified with a seizure disorder.

We estimate that approximately 4,000 members will participate in this program, which is managed by Accordant Health Services, Inc. The program goals are to:

- reduce seizure-related trauma
- reduce frequency of seizures
- improve medication adherence
- promote safe pregnancies
- develop patient-coping skills

In addition, in April 2007 we will begin offering a Blue Care®Connection program for COPD, the fourth leading cause of chronic morbidity and mortality in the U.S. This program is designed to improve members' quality of life and support the physician-patient relationship and plan of care. Like our other disease management programs, it will provide educational tools that allow members to take a more active role in their own health.

The COPD program, managed by Healthways, Inc. is designed to help members:

- prevent or lessen the severity of COPD exacerbations to include the proper use of maintenance and/or exacerbation medications
- prevent upper-airway infections
- foster adherence to a medication regimen and treatment plan
- enhance their functional status

The support and information members receive through these programs is not intended to replace the care of a physician, and members should continue to follow their physicians' treatment plans.

Healthways to Manage Blue Care®Connection for a Healthy Heart

In March 2007, we will transition management of our Blue Care®Connection *for a Healthy Heart* program to Healthways, Inc., an organization with over 20 years experience in providing health management support to physicians and their patients.

We already deliver many Blue Care®Connection programs in collaboration with Healthways.

This program provides valuable heart-health resources to help members lead healthier lives. Members will be contacted by registered nurses and dieticians at Healthways, who will offer confidential guidance and helpful tips on heart-health topics, ranging from cholesterol control to stress reduction. Members will also continue to receive educational materials in the mail about heart-health topics.

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Protecting Members' Privacy

Both Accordant and Healthways adhere to the same important confidentiality guidelines as Blue Cross Blue Shield of Massachusetts. Further, all Blue Care®Connection programs fully comply with the Health Insurance Portability and Accountability Act (HIPAA), a U.S. law that addresses the obligations of health care providers and health plans to protect personal health information.

If you have any questions, please contact your Account Executive.

Bariatric Privileging Program

Medical research has shown that bariatric (weight loss) surgery, when performed under safe circumstances, can be an appropriate treatment for certain individuals diagnosed as clinically obese.

As reported in the December edition of the *IAI*, we are implementing a Bariatric Surgery Privileging Program in the second quarter of 2007. The implementation date of this program will be June 1, 2007. For accounts that offer this benefit, this privileging program will only affect members in our HMO Blue, Blue Choice® plans 1 and 2, Network Blue™ plans, Blue Care Elect, and indemnity plans.

Beginning June 1, 2007, members who are candidates for this surgery must choose a hospital that has been privileged through Blue Cross Blue Shield of Massachusetts in order to be eligible for coverage.

The privileging program will require that medical facilities in Massachusetts meet the quality and safety standards established by a panel of experts convened by the Massachusetts Department of Public Health and the Betsy Lehman Center for Patient Safety and Medical Error Reduction. Facilities that do not meet the standards will not be eligible for reimbursement for bariatric surgery on our members. We will honor all pre-authorizations approved before June 1, 2007.

In June 2007, members can find information on privileged hospitals by calling Member Service at the number on their ID cards or by going to **www.bcbsma.com** and clicking on Find a Doctor.

Incentive Program for Skilled Nursing Facilities to Launch

We are launching an incentive program in 2007 to recognize skilled-nursing facilities (SNFs) that meet specified benchmarks for selected state and federal quality measures. SNFs that meet the criteria as of August 2007 will be eligible for increased inpatient per diem rates during the 2008 calendar year for services rendered in 2008.

To determine an SNF's eligibility for incentives, we will review publicly available data from the Massachusetts Department of Public Health (DPH) and the Centers for Medicare & Medicaid Services (CMS). By using these sources, we can measure SNFs objectively and audit quality-related results with minimal effort by providers.

This incentive program will apply to HMO Blue®, Blue Care® Elect, PPO, and Medicare Advantage (Medicare HMO Blue® and Medicare PPO Blue™). It will exclude indemnity, Managed Blue for Seniors™, and Medex®.

As we continue to evaluate base rates for SNFs, it is our intention over time to move from standard, base-rate increases to outcome-driven incentive payments that focus on quality and safety. Following our initial program rollout for the first year, additional incentive opportunities will be presented in subsequent years.

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