Senate Committee on Health and Welfare

and

Senate Committee on Insurance

Oversight Report

on the

Proposed Acquisition of Blue Cross Blue Shield of Louisiana

Submitted to the Louisiana Department of Insurance

Commissioner Tim Temple

February 8, 2024

Senate
State of Louisiana

P. O. Box 94183
Baton Rouge, Louisiana 70804
(225) 342-2040

February 8, 2024

Commissioner Tim Temple
Louisiana Department of Insurance
1702 N. Third Street
Baton Rouge, LA 70802

Re: Legislative Hearing to Discuss the Proposed Acquisition of Blue Cross and Blue Shield of Louisiana – Summary of Findings

Commissioner Temple,

On Monday, February 5, 2024, the Senate Committee on Health and Welfare and the Senate Committee on Insurance ("Committee") convened to hold a joint legislative oversight hearing on the proposed reorganization and sale of Blue Cross Blue Shield of Louisiana ("Blue Cross") to Elevance Health. The sale of a locally owned and operated insurance company with a well-respected reputation and a value of $3.4 billion to a multi-state insurance company worth more than $115 billion represents one of the most profound business transactions that will ever occur in this state. It will have direct and lasting effects on the lives of our people for years to come.

For nearly eight hours, the committee conducted an in-depth examination of the proposal and engaged in a robust dialogue with several witnesses. At the conclusion of the hearing, we find ourselves left with more questions and concerns than we had at the outset.

While our ability to intervene in this matter may be limited at this time, the laws that we have enacted in the Louisiana Insurance Code vest within the commissioner the authority to determine whether this reorganization and sale properly protects, serves the best interests of, and is fair and equitable to policyholders and members.

This correspondence serves as a summary of findings based on concerning information amassed in the weeks leading up to and throughout the hearing that should be of importance to the regulatory body charged with overseeing this process. While not intended to be exhaustive, noted below are several problematic issues and occurrences brought to our attention during the course of the committee hearing. For ease of reading, this correspondence sets forth three main areas of concern captioned "regulatory process," "Elevance Health," and the "Accelerate Louisiana Initiative."

Testifying as witnesses before the committee were David Caldwell representing the Louisiana Department of Insurance; Dr. Steven Udvarhelyi, Darrell Langlois, and Korey Harvey representing Blue Cross; Morgan Kendrick representing Elevance Health; Dr. Christy Valentine Theard representing Healthy Blue Louisiana (Elevance); and Tim Barfield, Blue Cross Board member, representing The Accelerate Louisiana Initiative (Foundation/Trust).

REGULATORY PROCESS

The regulatory and voting process involved in the proposed reorganization and $2.7 billion sale of Blue Cross generated much discussion throughout the hearing. Special attention was given to the procedural timeline and sequence of events that could occur within the next thirty days and the integrity of the voting process, especially vote steering and lack of unbiased information provided to voters. Throughout the hearing, the committee made several concerning findings regarding timelines and voting:

Timeline

1. **Scheduled timeline.** While the proposed reorganization/sale has been in the public view for more than a year in one form or fashion, the current timeline for public hearing, voting, and final determination appear to be compressed. There are several steps in this process that current timelines suggest could all be resolved within thirty days. It was admitted during the testimony that there is an urgency by the parties involved to get this resolved prior to the start of the 2024 Legislative Session, which is set to convene on March 11, 2024. There was also concern expressed that having the public hearing the day after Mardi Gras could prevent some interested members of the public from participating.
2. **Prematurely collecting votes.** Votes are already being solicited and collected prior to the public hearing. It appears that the voting policyholders do not have the benefit of all sides and positions prior to casting their votes.

Voting Confusion

3. **Widespread public confusion on who gets to vote on the reorganization/sale.** While nearly 1.9 million Louisiana residents have Blue Cross cards in their wallets, pay Blue Cross premiums, and are Blue Cross policyholders, only 95,000 of them are "eligible policyholders" who have a vote in this matter. This very small percentage of policyholders are the only ones with an opportunity to vote on a transaction that will affect almost half of the population of Louisiana, nearly every healthcare provider in the state, and several thousand Blue Cross employees. In addition, the committee discussed the more than 200,000 government employees, retirees, and their dependents who are covered by Blue Cross through the Office of Group Benefits who have no vote in this matter.

Vote Steering

4. **No unbiased information being provided to voters.** All information being shared with the voting policyholders is coming directly from Blue Cross and is all in support of the proposed reorganization/sale. No independent assessments of the proposal has been shared with the voting policyholders and efforts by those who oppose the proposal were thwarted under the auspices of a HIPAA violation.
5. **Ballot influence techniques.** An actual ballot shared with the committee shows the option "For" in bigger bold font as opposed to the option to vote "against." The ballot lacks any real explanation of what the individual is voting on and lacks clarity on how and when a policyholder can change their vote.
6. **$3000 offer for a vote.** On printed material shared with the committee, Blue Cross touts as the first of seven benefits of casting a "For" vote, a "Cash payment to Eligible Members of approximately $3,000 per Eligible Policy."
7. **Telephone proxy votes.** Blue cross is allowing telephone proxy voting but could not assure the committee on how the vote was being verified or recorded.

8. **Same call to promote the plan and solicit a vote.** The committee received testimony that in the same call to confirm receipt of voting materials and promote "A Better Blue for You," the soliciting caller will also ask if the voting policyholder would like to cast their vote during the same conversation.
9. **Misleading Blue Cross fact sheet influencing voters.** The committee was shown a document titled "Facts about the Proposed Blue Cross and Blue Shield of Louisiana Acquisition by Elevance Health." This document identified "myths" and countered with "truths" according to Blue Cross. Some of the "myths" included concerns about losing access to doctors and hospitals, premium increases, and the loss of jobs. The fact sheet states as truths that these things will not happen. During testimony, it was stated several times throughout the day that neither Blue Cross nor Elevance intended for any of these things to happen, but they could not guarantee them. The document also included a "myth" that policyholders are not getting any portion of the sale proceeds. While it is a "truth" that policyholders are getting *a portion* of the sale, the full "truth" is that it is limited to a very few policyholders and they are only getting 9% of the sale proceeds.

Voting Integrity

10. **Blue Cross board vote influence raises ethics concerns.** Several concerns were brought during the hearing about the fiduciary responsibilities of the Blue Cross board to protect the policyholders. The board members have a vested financial interest in the reorganization/sale taking place so their urging yes votes could have ethics consequences.

ELEVANCE HEALTH

A very thorough analysis of Elevance Health was conducted throughout the hearing and many questions arose regarding their integrity and business practices. The committee discussed whether this information was available to the Louisiana Department of Insurance and was pleased that Mr. Caldwell stayed present for the duration of the entire hearing to listen to all of the testimony and discussion. It should be noted that the witnesses representing Blue Cross, Elevance, and the Accelerate Louisiana Initiative did not stay to hear public testimony. In the course of analyzing Elevance Health the committee made several concerning findings regarding their fines, penalties, litigation, claims denial, and employee retention:

Fines/Penalties/Lawsuits

11. **Incomplete data on administrative actions and fines.** The committee was provided with a Louisiana Department of Insurance document titled "Administrative Actions and Fines Above $250,000.00 for the past 5 years." This document is apparently a component of the resources being considered in the evaluation process and it is a public document. The administrative fines listed on this document total just over $27 million. However, the committee quickly identified several problems with the document that could render this number grossly under calculated. First, Anthem, the predecessor of Elevance, has a long history of incurring fines and penalties so it seems arbitrary to limit this data to just five years. In addition, it also seems arbitrary to limit the data to just fines over $250,000. It is possible that Anthem/Elevance incurred any conceivable number of fines under $250,000.
12. **Unreported or confirmed fines.** Information regarding significant fines were shared with the committee by constituents and obtained through cursory research that were not reflected on the department's document. For instance, $16 million owed to HHS Office of Civil Rights for a record HIPAA data breach violation was not included. One constituent shared with the committee that

the more accurate total of fines in other states since 2000 equals nearly $1 billion for a staggering 476 penalties.

13. **Significant civil litigation.** Through information provided by constituents and cursory research, the committee was made aware of the fact that Elevance has been involved in significant litigation. None of this was reflected on the department's document, but warrants attention and further discussion. For example, there appears to have been a $23.6 million settlement for a breach of fiduciary duty on 401(K) management, $594 million class action antitrust settlement regarding BCBS, settlement in a lawsuit brought by Valley Health over $11.4 million in past due claims, and settlement in a lawsuit brought by Bon Secours over $93 million in unpaid claims.
14. **Significant federal litigation.** Elevance is currently involved in significant federal litigation as a defendant in a US federal civil fraud action in the US District Court for the Southern District of New York. In this case, they are accused of submitting false diagnosis code claims to Medicare to generate tens of millions of dollars in fraudulent revenue. This concerned the committee greatly as it goes directly to the integrity of this company.

Claims Denial

15. **High rate of claims denial.** Several constituents who are members of reputable health provider trade associations contacted their counterparts in other states to discuss their experience with Elevance. The committee learned that the experience has not been good and that Elevance has a higher than usual rate of claims denials. In fact, the committee learned that the Georgia Office of Inspector General found that their rate of claim denial was 33.7%, more than twice as high as the rates of the other managed care organizations that they reviewed.
16. **Impact on state employees, retirees, and dependents.** Based on the information the committee received regarding claims denials and other challenges of working with Elevance, there was discussion about the current Office of Group Benefits contract with Blue Cross and whether Elevance was assuming that contract as a successor or if there would be an opportunity to renegotiate.

Workforce reductions

17. **The impact to the 2,500 Blue Cross employees.** During the hearing, multiple assurances were given that Elevance would retain the 2,500 Blue Cross employees. However, their own 2023 3rd Quarter earnings report indicates that they use staff reduction, relocation, and office closure to improve financial standing.

CMS Star Rating Decline

18. **Elevance has a declining star rating.** The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure the experiences Medicare beneficiaries have with their health plan and health care system. Health plans are rated on a scale of 1 to 5 stars, with 5 being the best. Blue cross currently has a 4.5 star rating. Elevance has experienced a decline from 4.5 stars to 3.5 stars due to poor performance in metrics including member access to appointments and care.

ACCELERATE LOUISIANA INITIATIVE

The Accelerate Louisiana Initiative, referred to throughout the hearing as the foundation or trust, proved to be one of the more controversial components of the reorganization/sale proposal discussion by the committee. It is included as a condition of the sale and sees $3 billion from the sale redirected from the

policyholders to the control of a nonprofit organization presently controlled by four men who are current Blue Cross board members. Aside from funding it, Blue Cross and the foundation/trust took great measure to distance themselves from each other. In fact, it was stated during the testimony that the Blue Cross Foundation would continue to operate and function in its same capacity after the sale as it does today. This new foundation/trust is something completely different. Throughout the hearing, the committee engaged in an extremely detailed discussion relative to the proposed redirecting of funds, legal formation, mission and purpose, and management of the foundation/trust, all of which yielded even more questions that warrant continued scrutiny by the legislature and any other regulatory body with authority and jurisdiction of charitable orgainizations/trusts:

Redirecting Funds to the Foundation/Trust

19. **$3 billion from the sale is being redirected from the policyholders to the foundation/trust.** Understanding how the $3 billion is generated was the initial point of discussion, especially since the sale price is $2.7 billion. According to the Rector & Associates analysis commissioned by the department, the current value of Blue Cross is $3.4 billion. Blue Cross is proposing to make a $667 million contribution to the foundation/trust before the sale. After the sale, from the proceeds received from Elevance, Blue Cross will contribute an additional $2.4 billion to the foundation/trust, which will result in a trust worth more than $3.1 billion.
20. **The policyholders are being asked to vote on the reorganization, but not whether they want to donate 91% of the value of their investment.** Extensive discussions were had regarding why the money wasn't just being returned to the policyholders either outright or in the form of a person specific health savings account or by development of a trust that benefits the total 1.9 million Blue Cross policyholders to cover medical expenses such as deductibles, co-pays, or denied services.

Legal Formation of the Foundation/Trust

21. **Much uncertainty on the legal formation of the foundation/trust.** Throughout the hearing there was extensive fluidity in the entity being a 501(c)(3) without a trust, 501(c)(4) without a trust, or 501(c)(4) with a trust. The committee was told by the witness during the hearing that the addition of the special charitable trust to hold the funds came at the direction of the Governor and his staff. The committee had extensive questions regarding the legal parameters of each of these United States Internal Revenue Code designations, especially as it relates to political activity and expenditure of funds.
22. **New legal designation the legislature "must" give them.** One of the more surprising components in "The Foundation & The Trust" provisions of the "Member Information Statement" that generated a lot of discussion was regarding proposed legislation. The committee reviewed the language which purports to impose a requirement on the legislature to enact a new law exactly as the foundation/trust wants it to read. It states in part that the legislation "must provide for delegation of authority," certain "limitations on liabilities," and "must also permit the trust instrument to be amended by the trustees without court involvement." It goes on to say that the proposed legislation "must not (i) change the purpose of the Trust, (ii) require amounts be paid to specific recipients or causes or (iii) change the board of trustees of the Trust." It concludes by stating "Finally, no amendments to the Proposed Legislation that are enacted that materially alter the terms above would be allowable." Extensive discussion ensued relative to the purported inability to comply with the current laws regarding nonprofits or trusts in Louisiana. The committee had several questions regarding the need for a new type of trust that would operate outside of the scope of current laws governing non-profits and trusts while having nonprofit rights and protections.

23. **No defined beneficiary of the trust.** There was much discussion regarding the use of a trust and how a trust is typically established for an identified beneficiary or class of beneficiaries. In this case, the beneficiary of the trust is the "people of Louisiana." In discussing how the trust is being redirected from the policyholders, the committee noted that the trust beneficiaries are not the Blue Cross policyholders, but the broadly identified "people of Louisiana."

Mission and Purpose of the Foundation/Trust

24. **Mission of the foundation/trust is extremely broad.** The foundation/trust's mission is to "improve the health and lives of the people of the State of Louisiana," which the committee noted is admirable but is very broad and could lend itself to a litany of funded and supported causes.
25. **Purpose of the foundation/trust is extremely generic.** The foundation/trust's four focus areas were described by the witness as "bold and transformative." The committee noted that the focus areas are all things that several other state agencies, institutions, charities, and foundations are already committed to working on. Three of the four focus areas include moving "Louisianans from dependence to independence," "improving health outcomes," and "healthcare workforce development." The fourth focus area is "optimizing government performance" to "supercharge agency performance and program optimization," which appeared to the committee to potentially be providing for government consulting contracts.
26. **"Relatively small" portion of resources.** The foundation/trust generated extensive discussion regarding the intent to "allocate a relatively small portion of its resources to innovation, research and development, and pilot programs designed to improve the health, health outcomes, and social determinants of health in Louisiana." The committee had several questions regarding what is considered a "small portion" of $3.1 billion and why these particular initiatives were being relegated to a "small portion."
27. **No one but Pennington.** The foundation/trust favors only Pennington by stating in their plan "other than Pennington Biomedical Research Center, educational institutions and institutions of higher education shall not be eligible to receive these resources." This generated a thorough debate as each member of the committee could name an institution in their district that could contribute to advancing the stated purpose of the foundation/trust, especially workforce development. The committee was told by the witness during the hearing that the exclusion of all entities other than Pennington came at the direction of the Governor and his staff.

Management of the Foundation/Trust

28. **Blue Cross board placement and compensation.** According to the Rector & Associates analysis commissioned by the department, the current Blue Cross board members will either move to the BCBSLA Advisory Board where they will be compensated "at least" $105,000 annually for "at least" ten years. Separate from the BCBSLA Advisory Board will be the board of the foundation/trust, which currently has only four members who are Blue Cross board members and is expected to increase to nine to eleven members with one member appointed by the Governor. The witness testified that they had provided the Governor with the list of candidates they were pursuing for the remaining board seats but could not share it with the committee. The board salaries are still being assessed by a consultant, but the chief executive office is expected to have a salary of around $500,000 to $700,000. The committee had extensive questions about compensation and selection of board members.
29. **Good "intentions" and "hopes."** Throughout the hearing the witnesses on behalf of all parties involved, but particularly the foundation/trust, used phrases like "we intend" or "we do not intent" or "hopefully." This gave the committee significant concerns since the legislature operates in terms of what you can and cannot do, not what you intend to do. From lobbying to political

influence to salaries to rate cuts and premium increases, the committee was very concerned with the use of non-concrete parameters and rules of engagement.

30. **Change is always possible and inevitable.** The foundation/trust witness stated to the committee several times that the governing documents established by the foundation/trust, including the Articles of Incorporation and Bylaws, could not be changed. This was intended to give the committee comfort, but several lawyers on the committee and lawyers who observed the entire day's hearing and testified in opposition said that there is nothing absolute and with a proper vote and legal compliance anything can be changed. The trust itself may be irrevocable, but all of the terms and conditions may be revisited.

Upon conclusion of the witness testimony, several members of the public either submitted a card in opposition to the proposed reorganization/sale or offered testimony before the committee. Those members of the public include Mariah Bowen with the Louisiana State Medical Society, Tut Kinney, John Bradford, Bryan Gautreaux, Kevin Landreneau, Chris Alexander, Brian Albrecht, Coleman Brown, and Bridgette Gilbert. All of the members of the public present opposed the proposed reorganization/sale and concurred with many questions and concerns expressed by the committee throughout the hearing. All of the written materials submitted by the public are included with this correspondence.

This was not an exercise taken lightly by the members of the Senate Committee on Health and Welfare and the Senate Committee on Insurance. Extensive research was conducted by the members in anticipation of the meeting to be prepared for an informed and thorough discussion. All of the materials reviewed by the committee before and during the hearing are included with this correspondence. In addition, the committee hearing in its entirety can be viewed at Hearing Part 1 and Hearing Part 2.

We take seriously our responsibility to provide oversight on matters of such importance that nearly every family in this state will be impacted in some form or fashion by this proposal. We will continue to have hearings on this matter regardless of what transpires within the next thirty days because whether the proposal advances or not, clearly Blue Cross believes it needs additional resources to continue to serve the people of Louisiana.

The responsibility for approval is ultimately within your control. As stated by your executive counsel during the hearing, your staff is doing research to prepare for the public hearing and decision-making that soon follows. We understand that you may approve the proposal, reject the proposal, or apply your own conditions for approval. We request that you consider the information contained in this correspondence as there are significant questions and concerns that have not been properly addressed regarding the integrity of the voting process, the quality of Elevance, and the positioning of the Accelerate Louisiana Initiative as an integral part of the entire proposal.

Sincerely,

Senator Patrick McMath
Health and Welfare, Chairman

Senator Kirk Talbot
Insurance, Chairman

Blue Cross Blue Shield of Louisiana
Reorganization and Acquisition Timeline

Reorganization/Demutualization

February 14 - 15:

Department of Insurance Public Hearings on the Reorganization/Demutualization of BCBSLA

February 21:

BCBSLA Policyholder Meeting to vote on the Plan of Reorganization/Demutualization

- 2/3 of voting members must approve the conversion of BCBSLA from a mutual insurance company to a stock insurance company

Between February 21 and 29:

Commissioner makes determination regarding the reorganization in accordance with R.S. 22:72

- "A. No domestic insurer may convert from a stock to a mutual, or from a mutual to a stock insurer, or from any type insurer to any other type insurer, except as provided in R.S. 22:71 unless a plan of conversion is submitted to and approved by the commissioner of insurance.
  B. The commissioner of insurance shall not approve any such conversion unless in his opinion after a full investigation the best interests of the policyholders of any such insurer will be served."

Acquisition

February 29:

Department of Insurance Public Hearing on the BCBSLA Acquisition

- The proposed public hearing on the acquisition will not be held if the Commissioner and/or the Policyholders do not approve the Plan of Reorganization/Demutualization of BCBSLA.

Within 30 days after the public hearing:

The commissioner shall make a determination regarding the acquisition in accordance with R.S. 22:691.4.

*Prepared by Senate Health & Welfare Staff based on information available on the Department of Insurance's public website: https://ldi.la.gov/public-hearing-and-rulemaking-notices

Cover Letter to Member Information Statement

See attached.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY
D/B/A BLUE CROSS AND BLUE SHIELD OF LOUISIANA
5525 Reitz Avenue, Baton Rouge, Louisiana 70809

Dear BCBSLA Policyholder:

On January 23, 2023 (the "**Adoption Date**"), the Louisiana Health Service & Indemnity Company (d/b/a Blue Cross and Blue Shield of Louisiana) (referred to herein as "**BCBSLA**") Board of Directors adopted a Plan of Reorganization. The Plan of Reorganization was approved in connection with an agreement and plan of acquisition with Elevance Health, Inc. (formerly known as Anthem, Inc. and referred to herein as "**Elevance Health**") under which Elevance Health proposes to acquire BCBSLA. The Plan of Reorganization was subsequently amended upon approval by the Board of Directors by Amendment No. 1 effective as of July 18, 2023, Amendment No. 2 effective as of August 23, 2023, and Amendment No. 3, effective as of December 12, 2023.

This Member Information Statement refers to a public hearing on the Plan of Reorganization to be held by the Louisiana Department of Insurance on [•], 2024 (the "**Public Hearing**"), and provides notice of a special meeting of BCBSLA policyholders (the "**Special Meeting**") to be held at 9:00 a.m. Central Time on [•], at the offices of BCBSLA located at 5525 Reitz Avenue, Baton Rouge, Louisiana 70809.

As a BCBSLA policyholder as of [•], the new record date for the Special Meeting (the "**Record Date**"), you are entitled to vote on this transaction. The BCBSLA Board of Directors has determined that the Proposed Reorganization is in the best interests of BCBSLA and its policyholders and members and is seeking your vote in favor of the Plan of Reorganization.

Please note that any proxy previously granted in 2023 (whether online, by mail or by phone) will be disregarded. Therefore, if you have previously granted your proxy (whether online, by mail or by phone), and you wish to grant your proxy at the Special Meeting, you *must* grant your proxy again on the proposed Plan of Reorganization using the instructions on your enclosed proxy form, so that we can maintain an accurate and current list of proxies granted for the Special Meeting.

To help with your consideration of the vote, the following documents are enclosed:

- A Member Information Statement containing a detailed summary of the transactions contemplated by the Plan of Reorganization;

- A summary of the proposed reorganization of BCBSLA from a mutual insurance company into a stock insurance company pursuant to Louisiana law, which is necessary for BCBSLA to be acquired by Elevance Health, Inc.;

- Certain financial information of BCBSLA; and

- A proxy form that you may use to grant your proxy on the proposed Plan of Reorganization instead of voting in person at the upcoming special meeting.

We thank you for being a BCBSLA policyholder and look forward to continuing to serve you as Anthem Blue Cross and Blue Shield of Louisiana under the umbrella of Elevance Health, Inc. following the completion of the Proposed Reorganization.

Sincerely,

I. Steven Udvarhelyi, M.D.

President and Chief Executive Officer

Summary of Member Information Statement

See attached.

<u>MEMBER INFORMATION STATEMENT SUMMARY – PLEASE READ</u>

You are receiving the attached "Member Information Statement" because you have been identified as a Voting Member of Louisiana Health Service & Indemnity Company (d/b/a Blue Cross and Blue Shield of Louisiana and referred to herein as "**<u>BCBSLA</u>**") as of [•], which is the new record date for the Special Meeting (the "**<u>Record Date</u>**"). Voting Members (Policyholders with In Force Policies as of the Record Date) are eligible to vote on the proposed Plan of Reorganization. Eligible Members (Policyholders whose In Force Policies were in effect as of January 23, 2023, the date the BCBSLA Board of Directors approved the Plan of Reorganization (the "**<u>Adoption Date</u>**"), and continue to be in effect as of the date the Proposed Reorganization is completed (each an "**<u>Eligible Policy</u>**")) are eligible to receive their fair and equitable allocation of the Eligible Member Payment.

As explained in the attached Member Information Statement, BCBSLA's Board of Directors recommends that you vote in favor of the Plan of Reorganization, which, if approved by the required number of Voting Members and the Commissioner of Insurance for the State of Louisiana and, subject to other customary closing conditions, if completed, will result in (i) BCBSLA converting from a mutual insurance company to a stock insurance company, (ii) a payment to you, if you are an Eligible Member, of over $3,000 for each Eligible Policy as consideration for the extinguishment of your Membership Interest; and (iii) funding of approximately $3 billion for a new nonprofit foundation or trust (as explained below- See "*The Foundation*" on page 33) dedicated to improving the health and lives of the people of the State of Louisiana. Completion of the Plan of Reorganization will not change the terms, conditions or coverage provided by any insurance policy issued by BCBSLA. Completion of the Proposed Reorganization will not result in increased premiums or reduced coverage under your In Force Policy in the Policy year, the duration of which is governed by the terms of the Policy.

Upon the conversion of BCBSLA from a mutual insurance company to a stock insurance company as provided for by the Plan of Reorganization, all of the authorized shares of capital stock of BCBSLA will be issued to ATH Holding Company, LLC ("**<u>Purchaser</u>**"), an Indiana limited liability company and a wholly owned subsidiary of Elevance Health, Inc. (**"<u>Elevance Health</u>"**). This indirect acquisition of BCBSLA by Elevance Health is subject to approval by the Commissioner of Insurance for the State of Louisiana and should, among other things, create meaningful economies of scale, provide BCBSLA with greater resources and enhanced access to technology to improve the experience for members, customers, providers and other stakeholders, and support improvements in BCBSLA's products, services and capabilities.

If the Plan of Reorganization does not receive approval by the required number of Voting Members or the Commissioner of Insurance for the State of Louisiana or otherwise is not completed, BCBSLA will remain a mutual insurance company, you will not receive the over $3,000 payment for each Eligible Policy referred to above, and the new nonprofit foundation will not be funded. BCBSLA's Board of Directors recommends that you vote in favor of the Proposed Reorganization.

THE FOREGOING IS A SUMMARY ONLY AND IS INTENDED TO BE READ IN CONJUNCTION WITH THE ENTIRETY OF THE ATTACHED MEMBER INFORMATION STATEMENT.

Capitalized terms used but not otherwise defined herein have the meanings given to such terms in the Glossary of Key Terms below.

The Member Information Statement contains important information about:

(1) A proposed reorganization of BCBSLA from a mutual insurance company to a stock insurance company;

(2) A proposed issuance of 100% of the newly issued shares of common stock of BCBSLA as a converted stock insurance company to Purchaser;

(3) How the Proposed Reorganization with Purchaser and Elevance Health would affect Voting Members;

(4) How Voting Members can vote for or against the Plan of Reorganization; and

(5) How Eligible Members may receive payment in connection with the Proposed Reorganization.

The Member Information Statement describes a proposed reorganization of BCBSLA from a Louisiana mutual insurance company into a Louisiana stock insurance company pursuant to a Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company (as amended, the "**Plan of Reorganization**," and the transactions contemplated by such Plan of Reorganization, the "**Proposed Reorganization**").

As part of the Plan of Reorganization, each Eligible Member will be entitled to receive their share of the Eligible Member Payment.

If the Proposed Reorganization is completed, the Membership Interests of Policyholders will be extinguished as part of the reorganization. The Membership Interests that are to be extinguished are all rights and interests of the Policyholders of BCBSLA under law and BCBSLA's governing documents, namely the Policyholders' right to vote on certain matters.

Demutualization laws of the State of Louisiana (LSA-R.S. § 22:72, LSA-R.S. §§ 22:236 *et seq.)* and the other applicable provisions of the Louisiana Insurance Code (collectively, the "**Louisiana Demutualization Law**") control the Proposed Reorganization and, together with the BCBSLA Articles of Incorporation and Bylaws, define the Policyholders entitled to vote on the Proposed Reorganization and the Policyholders entitled to receive consideration from the Proposed Reorganization.

BCBSLA is responsible (i) for identifying who Voting Members are and identifying Eligible Members who will receive consideration from the Proposed Reorganization, and (ii) ensuring each Eligible Member is paid their fair and equitable allocation of the Eligible Member Payment for the extinguishment of their Membership Interests.

"**Voting Members**" *are Policyholders with In Force Policies as of the Record Date. Only Voting Members are permitted to vote on the Plan of Reorganization. Policyholders with In Force Policies as of the Adoption Date and on the date of the closing of the Proposed Reorganization*

*are "***Eligible Members***." Your Policy must remain In Force from the Adoption Date through the date the Proposed Reorganization is completed in order for you to remain an Eligible Member.* ***Only Eligible Members will receive their fair and equitable allocation of the Eligible Member Payment*** (as defined below).

As part of the Proposed Reorganization and as required by Louisiana law (LSA-R.S. § 22:236.3), BCBSLA has determined that consideration in the amount of approximately $307,755,241 in total is fair to the Eligible Members as a group, from a financial point of view (the "**Eligible Member Payment**"). This amount remains subject to adjustment, which may result in a higher or lower Eligible Member Payment, that will occur as a result of the final reconciliation of the total number of member months by including the member months from the Adoption Date through the effective date of the Reorganization as well as the amount of BCBSLA's surplus at the time of Closing. This determination was supported by and is consistent with a fairness opinion that the Board of Directors of BCBSLA obtained from Chaffe & Associates, Inc. ("**Chaffe**" or the "**Qualified Investment Banker**"). The methodology used to calculate the Eligible Member Payment is described in more detail in the "*Questions and Answers About the Proposed Reorganization and the Vote*" section on page 6.

Subsequent to the filing of the proposed Plan of Reorganization with the Department on January 23, 2023, BCBSLA was able to conduct an exhaustive search of all available records, including records located in archived systems and files, in order to prepare an updated estimate of the aggregate Eligible Member Payment of $307,755,241, or over $3,000 per policy held by an Eligible Member from the Adoption Date until the effective date of the Reorganization. This updated estimate of the aggregate Eligible Member Payment was reflected in the Amendment No. 1 to the Plan of Reorganization which was approved by the Board on July 18, 2023. This amount remains subject to adjustment, which may result in a higher or lower Eligible Member Payment, that will occur as a result of the final reconciliation of the total number of member months by including the member months from the Adoption Date through the effective date of the Reorganization as well as the amount of BCBSLA's surplus at the time of Closing.

It is anticipated that if certain conditions are satisfied, as outlined further below (see "*The Foundation*" on page 33), the Foundation would donate or contribute the funds it receives in connection with the Proposed Reorganization to a newly established special charitable trust (as referred to herein, the "**Trust**"). The Trust would be established under the laws of the State of Louisiana and it is intended that the Trust will be exempt from federal income tax as an organization described in Section 501(c)(4) of the Code. The Trust would have the same general purpose as the Foundation of improving the health and lives of the people of the State of Louisiana. However, until the earlier of the initial twelve years of its existence or the achievement of certain milestones or criteria, the Trust would have primary areas of focus within that general purpose. As outlined further below (see "*The Foundation*" on pages 33-34), the primary areas of focus would be related to

- efforts to transition people who are using public assistance programs to independence through methods that adequately and sustainably provide for their needs and dignity,

- improving health outcomes by addressing chronic illnesses, disabilities and health concerns through a focus on diabetes, maternal/infant health, and mental health,

- health care workforce development through programs designed to match the demand for the health care work force in Louisiana while addressing the excess demand on training institutions and risk of out-of-state migration, and

- optimizing government performance (in particular, state health care, workforce, and social services agencies).

The Plan of Reorganization does not change the terms, conditions or coverage provided by any insurance policy issued by BCBSLA. Completion of the Proposed Reorganization will not result in increased premiums or reduced coverage under your In Force Policy in the Policy year. However, premiums and policy coverage are frequently adjusted upon renewal. In fact, BCBSLA has already filed with the Department proposed rate changes for the Policy years beginning in 2024.

The Plan of Reorganization is the result of careful deliberation by the BCBSLA Board of Directors. The BCBSLA Board of Directors determined that the Plan of Reorganization serves the best interest of Policyholders and members and is consistent with BCBSLA's mission as set forth in its governing documents. The BCBSLA Board of Directors approved the Plan of Reorganization.

As set forth above, the Plan of Reorganization will not be completed unless (among other closing conditions that must be satisfied or waived) the Plan of Reorganization is approved by: (i) at least two-thirds of the votes cast by Voting Members in person or by special ballot or special proxy; and (ii) the Commissioner of Insurance for the State of Louisiana.

There are conditions to the Proposed Reorganization that may be material to your decision whether to vote for or against the Plan of Reorganization. These conditions are described below.

This document provides a brief overview of the Plan of Reorganization and Acquisition Agreement. The Member Information Statement that follows includes key transaction documents and provides detailed information about how the Plan of Reorganization will affect your interests in BCBSLA as follows:

- a glossary of key terms (page 1);

- questions and answers about the Proposed Reorganization and vote (page 6);

- the benefits and risks of the Proposed Reorganization (pages 8-9);

- financial information regarding BCBSLA (page 50, Annex A);

- a background discussion of the Plan of Reorganization, including the Board of Directors' reasons for approving the Plan of Reorganization and its recommendation to Voting Members (page 22);

- in connection with the Proposed Reorganization, information regarding the Foundation and/or a new trust which may be established (page 33)

- an explanation of the Special Meeting, including the rules governing it and instructions on how to vote (page 36);

- summaries of the fairness opinion of Chaffe and the actuarial opinion by Deloitte Consulting LLP (page 38);

- risks and considerations relating to the Plan of Reorganization (page 41);

- certain U.S. federal income tax considerations relating to the Plan of Reorganization (page 43);

- a cautionary statement concerning forward-looking information (page 48); and

- a summary of the Plan of Reorganization and Acquisition Agreement (page B-1, Annex B).

Voting Members are strongly encouraged to vote in favor of the Plan of Reorganization. You may cast your vote in one of four ways: (1) submit your proxy online using the instructions on the enclosed proxy form; (2) submit your proxy by phone using the instructions on the enclosed proxy form; (3) complete and return the enclosed proxy form by mail to Blue Cross and Blue Shield of Louisiana c/o First Coast Results, PO Box 3672, Ponte Vedra Beach, FL 32004-9911; or (4) vote in person at the Special Meeting. Please note that the submission of your proxy online, by mail or by phone must be received no later than 11:59 p.m. Central Time on [•] to be counted for purposes of the Special Meeting. A postage prepaid envelope preprinted with the above address is enclosed for your use.

Please note that any proxy previously granted (whether online, by mail or by phone) will be disregarded for purposes of the rescheduled Special Meeting. Therefore, if you have previously granted your proxy (whether online, by mail or by phone), and you wish to grant your proxy at the Special Meeting, you *must* grant your proxy again on the proposed Plan of Reorganization using the instructions on your enclosed proxy form, so that we can maintain an accurate and current list of proxies granted for the Special Meeting.

The Board of Directors of BCBSLA recommends voting FOR the approval of the Plan of Reorganization.

If you have questions or need assistance voting, please call MacKenzie Partners, Inc. at 1 (800) 356-8906 from 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday.

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Member Information Statement

See attached.

Louisiana Health Service & Indemnity Company
D/B/A Blue Cross and Blue Shield of Louisiana

Member Information Statement

[•]

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GLOSSARY OF KEY TERMS

The following are brief explanations of certain terms used in this Member Information Statement.

Term	Definition
Acquisition	The acquisition by Purchaser of 100% of the shares of Common Stock of BCBSLA pursuant to the transactions completed under the Acquisition Agreement.
Acquisition Agreement	The Agreement and Plan of Acquisition dated January 23, 2023, by and among BCBSLA, the Foundation, Purchaser and Elevance Health, as it may be amended from time to time. A summary of the Acquisition Agreement is included herein as part of Annex B.
Adoption Date	January 23, 2023, the effective date of the Board's adoption of the Plan of Reorganization.
Affiliate	An "Affiliate" of any particular Person means any other Person controlling, controlled by or under common control with such Person, where "control" means the possession, directly or indirectly, of the power to direct the management and policies of a Person whether through the ownership of voting securities, contract or otherwise.
Alternative Transaction	Any transaction or series of related transactions, whether or not proposed in writing, pursuant to which any Third Party or group of Third Parties would, directly or indirectly, (i) acquire or participate in a merger, consolidation, or other business combination involving BCBSLA, directly or indirectly, (ii) acquire a substantial equity interest in BCBSLA, including the right to vote 25% or more of the capital stock (following a reorganization or conversion) of BCBSLA or a resulting parent company of BCBSLA Inc., (iii) acquire 25% or more of the assets of BCBSLA, other than in the ordinary course of business, (iv) acquire in excess of 25% of the outstanding capital stock (following a reorganization or conversion) of BCBSLA or a resulting parent company of BCBSLA Inc., other than as contemplated by the Acquisition Agreement, (v) acquire control of BCBSLA, or (vi) effect any transaction similar to the above.
Amended and Restated Articles of Incorporation	The amended and restated articles of incorporation of BCBSLA as of the Reorganization Effective Time.
Amended and Restated Bylaws	The amended and restated bylaws of BCBSLA as of the Reorganization Effective Time.
Antitrust Law	The Sherman Act, 15 U.S.C. §§ 1-7, as amended; the Clayton Act, 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53, as amended; the HSR Act; the Federal Trade Commission Act, 15 U.S.C. §§ 41-58, as amended; and all other federal, state and foreign laws, orders, administrative and judicial doctrines, and other laws that are designed or intended to prohibit, restrict, or regulate actions having the purpose or effect of monopolization or restraint of trade.
Approved Excess Surplus	An amount equal to the statutory capital of BCBSLA in excess of 500% of the authorized control level risk based capital of BCBSLA as of the Closing Date, or such other amount as approved by the Commissioner.

Term	Definition
BCBSLA	Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana.
BCBSLA Records	The books, records and accounts of BCBSLA.
BCBSLA Subsidiaries	The subsidiaries of BCBSLA.
Board	The Board of Directors of BCBSLA.
Board Recommendation	The Board's recommendation to the Voting Members that they approve the Proposed Reorganization and approve and adopt the Plan of Reorganization at the Special Meeting.
Business Day	Any day other than a Saturday or Sunday or any other day on which commercial banks in Baton Rouge, Louisiana, or New York, New York, are authorized or required by Law to close.
Closing	The closing of the transactions contemplated by the Acquisition Agreement.
Closing Date	The date of the Closing of the Acquisition.
Code	The Internal Revenue Code of 1986, as amended.
Commissioner	The Commissioner of Insurance for the State of Louisiana.
Company Entities	BCBSLA and each BCBSLA Subsidiary.
Department	The Louisiana Department of Insurance.
Eligible Member Payment	The total consideration to be paid to Eligible Members for the extinguishment of their Membership Interests.
Eligible Members	Each Policyholder of an Eligible Policy.
Eligible Policy	Any Policy that is In Force on the Adoption Date through to the Reorganization Effective Time.
Foundation	The Accelerate Louisiana Initiative, Inc., a newly formed Louisiana nonprofit non-stock corporation organized to work to improve the health and lives of the people of the State of Louisiana which has qualified as a Code Section 501(c)(4) social welfare organization.
In Force	A Policy will be deemed to be "In Force" as of any date if, as shown in the BCBSLA Records as of such date, the effective date of such Policy occurs on or prior to such date, and as of such date the required premium has been received by BCBSLA and such Policy, as shown on BCBSLA's records on such date, has not expired or otherwise been surrendered or terminated; provided that a Policy will be deemed to be In Force during any applicable grace period for non-payment of premiums as administered by BCBSLA if the applicable premium is paid prior to expiration of such grace period; provided, further, however, that such Policy will not be deemed to be In Force following the last day for which premiums have been paid if such grace period expires without the applicable premium having been paid.

Term	Definition
Indemnified Parties	Each person who is now, or who has been at any time before Closing, a member of the Board.
Insurance Regulators	All Governmental Authorities regulating the business of insurance under applicable federal and state insurance laws.
IRS	Internal Revenue Service.
Louisiana Demutualization Law	LSA-R.S. § 22:72, LSA-R.S. §§ 22:236 *et seq.*, and the other applicable provisions of the Louisiana Insurance Code.
Membership Interests	All of the rights and interests of Policyholders of BCBSLA arising under and provided by law and by BCBSLA's then-effective articles of incorporation and then-effective bylaws.
Paying Agent	Epiq Corporate Restructuring, LLC, who shall serve as paying agent pursuant to the terms of the Paying Agent Agreement.
Paying Agent Agreement	The paying agent agreement to be entered into by and among Purchaser, BCBSLA and the Paying Agent, in the form mutually agreed to by the parties to the Acquisition Agreement prior to the Closing.
Person	An individual, partnership, firm, association, corporation, joint-stock company, limited liability company, trust, government or governmental agency, state or political subdivision of a state, public or private corporation, board, association, estate, trustee, or fiduciary, or any similar entity.
Plan of Reorganization	The Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company (including all its schedules and exhibits), as originally adopted, as amended by that Amendment No. 1 effective as of July 18, 2023, that Amendment No. 2 effective as of August 23, 2023, that Amendment No. 3 effective as of December 12, 2023, and as may be from time to time further amended, supplemented or modified as legally permitted under Louisiana law (including the Louisiana Demutualization Law). The Plan of Reorganization is the legal document that governs the Proposed Reorganization. A summary of the Plan of Reorganization is included herein as part of Annex B.
Policy	Any individual insurance policy or group health care benefits contract that has been issued by BCBSLA and under which the Policyholder holds Membership Interests.
Policyholder	The Policyholder of an In Force Policy as of any date specified in the Plan of Reorganization will be determined by BCBSLA on the basis of BCBSLA's records as of such date in accordance with the following provisions: • The Policyholder of a Policy that is an individual insurance policy is the Person who signed the application for the Policy or, in the case of applications made on behalf of minor children, the Person who signed the application. • The Policyholder of a group insurance policy is the Person or Persons sponsoring the group health care benefits plan. For the avoidance of doubt, certificates or other evidences of insurance issued under a group Policy are not and shall not be treated as Policies.

Term	**Definition**
	• In no event may there be more than one Policyholder of a Policy, although more than one Person may be entitled to health benefits under a Policy. • Self-funded or administrative services-only contracts are not contracts of insurance and do not create Membership Interests for the contract holders or participants of such groups. • Except as otherwise set forth in the Plan of Reorganization, the identity of the Policyholder is determined by BCBSLA without giving effect to any interest of any other Person in such Policy. For the avoidance of doubt, certificates or other evidences of insurance issued under a group policy are not and shall not be treated as Policies. • In any situation not expressly covered by the above provisions, or as to which application of the above provisions is unclear, the Policyholder reflected on the records of BCBSLA and determined in good faith by BCBSLA, will be presumed to be the Policyholder for purposes of the Plan of Reorganization, and, except for administrative errors, BCBSLA will not be required to examine or consider any other facts or circumstances. • The mailing address of a Policyholder as of any date for purposes of the Plan of Reorganization will be the Policyholder's last known address as shown on the records of BCBSLA as of such date. • Any dispute as to the identity of a Policyholder or the right to vote or receive consideration will be determined in accordance with the above and the relevant provisions of the Louisiana Demutualization Law, applicable provisions of the Louisiana Insurance Code or such other procedures as may be acceptable to the Commissioner.
Proposed Reorganization	Collectively, the proposed reorganization of BCBSLA from a mutual insurance company into a stock insurance company contemplated by the Plan of Reorganization (in the form approved by the Commissioner and pursuant to the Louisiana Demutualization Law), the Acquisition and the transactions related thereto and contemplated thereby.
Purchaser	ATH Holding Company, LLC, an Indiana limited liability company.
Record Date	[•], the record date for Voting Members entitled to vote on the Plan of Reorganization at the Special Meeting.
Reorganization Effective Time	The effective time of the Plan of Reorganization.
Special Meeting	The special meeting to be held at 9:00 a.m. Central Time on [•], of the Voting Members to vote on the Plan of Reorganization and any adjournment thereof.
Superior Proposal	A bona fide written proposal made to BCBSLA by any Third Party which did not result from a breach of the non-solicitation and negotiations with other parties provisions of the Acquisition Agreement with respect to any Alternative Transaction, (a) that is on terms that the Board determines in good faith (after consultation with its financial advisors and outside legal counsel) would result in a transaction that, if completed, is (i) more favorable to the Eligible Members, as a group, and (ii) no less favorable to the Foundation, in each case of (i) and (ii), from a financial point of view, than the Proposed Reorganization and the Acquisition Agreement (taking into account any proposal by Purchaser to amend the terms of the Acquisition

Term	Definition
	Agreement), (b) with respect to which the cash consideration and other amounts (including costs associated with the Proposed Reorganization) payable at closing are subject to fully committed financing from recognized financial institutions, and (c) which is reasonably likely to receive all required governmental approvals, including by the Department and Voting Members, on a timely basis and otherwise reasonably capable of being completed within a reasonable period of time on the terms proposed, taking into account all financial, regulatory, legal and other aspects of such proposal, as is the Proposed Reorganization and the Acquisition Agreement.
Third Party	Any Person other than BCBSLA, Purchaser, or any of their respective subsidiaries or Affiliates.
Transaction Documents	The Plan of Reorganization, the Acquisition Agreement and the documents related thereto and contemplated thereby.
Voting Member Approval	The approval of the Plan of Reorganization by no less than two-thirds of the Voting Members present or represented by special ballot or special proxy at the Special Meeting pursuant to Louisiana law (§ 236.5 of the Louisiana Insurance Code (LSA-R.S. § 22:236.5)).
Voting Members	Policyholders whose Policies are In Force as of the Record Date.

QUESTIONS AND ANSWERS ABOUT THE PROPOSED REORGANIZATION AND THE VOTE

Unless otherwise indicated, any references to "we" or "us" refer to BCBSLA and any references to "you" refer to Voting Members. This Member Information Statement has been sent to you because BCBSLA Records indicate that you are a Voting Member because you are a Policyholder of an In Force Policy as of the Record Date.

Capitalized terms used but not otherwise defined herein have the meanings given to such terms in the Glossary of Key Terms above.

Questions and Answers About the Plan of Reorganization

Q1. What is the Plan of Reorganization?

A1. The Plan of Reorganization is the document describing the reorganization of BCBSLA from a mutual insurance company to a stock insurance company and, immediately thereafter, the issuance of 100% of the newly issued common stock of BCBSLA to Purchaser in accordance with the Acquisition Agreement.

The Plan of Reorganization includes the Plan of Reorganization itself, the Acquisition Agreement and other exhibits. A summary of the Plan of Reorganization and Acquisition Agreement is included herein as Annex B.

Q2. What are Eligible Members entitled to receive in the Proposed Reorganization?

A2. Eligible Members are Policyholders with any Policy that was In Force on the Adoption Date and remains In Force through the Reorganization Effective Time. The Eligible Members are entitled to receive a fair and equitable allocation of the Eligible Member Payment for the extinguishment of their Membership Interests. Only Eligible Members are permitted to receive their fair and equitable allocation of the Eligible Member Payment. Your Policy must have been In Force on the Adoption Date and remain In Force from the Adoption Date through the date the Proposed Reorganization is completed in order for you to remain an Eligible Member and receive your fair and equitable allocation of the Eligible Member Payment.

The Proposed Reorganization and payment to the Eligible Members depends on, among other things, approval of the Plan of Reorganization by the Commissioner and by the Voting Members at the Special Meeting, and the satisfaction or waiver of certain other conditions described in the Acquisition Agreement. If the Plan of Reorganization is not approved, the Acquisition by Purchaser will not be completed and Eligible Members will not receive any portion of the Eligible Member Payment.

Subsequent to the filing of the proposed Plan of Reorganization with the Department on January 23, 2023, BCBSLA was able to conduct an exhaustive search of all available records, including records located in archived systems and files, in order to prepare an updated estimate of the aggregate Eligible Member Payment of $307,755,241, or over $3,000 per policy held by an Eligible Member on the Adoption Date and through the

effective date of the Reorganization. This updated estimate of the aggregate Eligible Member Payment was reflected in the Amendment No. 1 to the Plan of Reorganization which was approved by the Board on July 18, 2023. It remains subject to adjustment, which may result in a higher or lower Eligible Member Payment, that will occur as a result of the final reconciliation of the total number of member months by including the member months from the Adoption Date through the effective date of the Reorganization as well as the amount of BCBSLA's surplus at the time of Closing.

Q3. What is the Proposed Reorganization?

A3. The Proposed Reorganization involves a reorganization, or demutualization, of BCBSLA (demutualization is the process by which an insurance company converts from a mutual company owned by policyholders into a stock company owned by one or more shareholders) and, among other things, upon conversion, the issuance of 100% of the newly issued common stock of BCBSLA to Purchaser in accordance with the Acquisition Agreement.

Q4. How can Eligible Members receive their share of the Eligible Member Payment?

A4. Following the Closing, the Paying Agent or BCBSLA will mail, by first class mail, a return envelope, an IRS Form W-9, along with instructions on how to receive their portion of the Eligible Member Payment. Upon receipt of appropriate instructions, sent by the Eligible Member, including an IRS Form W-9 (or appropriate Form W-8, as applicable) verifying their address and certifying, under penalties of perjury, their correct taxpayer identification number or any required certifications for tax purposes, the Paying Agent shall make payment of the portion of the Eligible Member Payment attributable to such Eligible Member, less any applicable tax withholding, by the mailing of a check (by first class mail) or such other payment method as mutually agreed to by BCBSLA and the Paying Agent.

Q5. What was the basis for determining the amount of the Eligible Member Payment?

A5. Consistent with Louisiana law (LSA-R.S. § 22:236.3(A)) and the Plan of Reorganization, and in consultation with and reliance upon advisors, the Board determined that consideration in the amount of approximately $307,755,241 is fair to the Eligible Members as a group, from a financial point of view. This amount is subject to adjustment, which may result in a higher or lower Eligible Member Payment, that will occur as a result of the final reconciliation of the total number of member months by including the member months from the Adoption Date through the effective date of the Reorganization as well as the amount of BCBSLA's surplus at the time of Closing. To help determine this amount and as required by Louisiana law, the BCBSLA Board of Directors obtained a fairness opinion from Chaffe & Associates, Inc. ("**Chaffe**" or the "**Qualified Investment Banker**").

Q6. Why is BCBSLA proposing the Plan of Reorganization?

A6. The Plan of Reorganization is the result of careful deliberation by the Board of the best interests of BCBSLA and its Policyholders and members. The Board and management team of BCBSLA conducted detailed strategic assessments of how BCBSLA could improve to better serve its Policyholders and members. As part of that assessment, the Board considered possible business combination strategies that may have been available to BCBSLA, a demutualization of BCBSLA on a stand-alone basis and the viability of remaining independent, with or without acquiring other businesses. The Board regularly discussed and considered presentations from various financial advisors, third-party consultants and legal counsel evaluating the advantages and disadvantages of the various strategic alternatives. The Board also consistently monitored recent and ongoing developments in the health insurance and health care industry. Consequently, when considering BCBSLA's long-term strategic opportunities and prospects, the Board was cognizant and took into consideration broader trends in the health insurance and health care industry, including the challenges facing the health insurance and health care industry over the last decade to provide Policyholders and members with the highest quality of care and service. Based on the above and the terms of the Plan of Reorganization, the Board determined that the Plan of Reorganization is in the best interests of BCBSLA's Policyholders and other members. The Proposed Reorganization allows Eligible Members to receive cash for the extinguishment of their Membership Interests and to continue to be insured by an industry-leading health insurer. The Board approved the Plan of Reorganization and entering into the Acquisition Agreement with Purchaser and Elevance Health and recommends that the Voting Members approve the Plan of Reorganization. See "*The Proposed Reorganization – Background of the Proposed Reorganization Provided by BCBSLA*" on page 22.

Q7. What are the advantages of the Proposed Reorganization to Policyholders?

A7. In addition to providing Eligible Members with the opportunity to receive their fair and equitable allocation of the Eligible Member Payment for the extinguishment of their Membership Interests, the Board:

- believes the Plan of Reorganization serves the best interests of Policyholders and members;

- considered BCBSLA's position as an independent company in the highly competitive environment for health care insurers and believes that BCBSLA's ability to pursue its strategic objectives and further its mission will be enhanced by the Plan of Reorganization;

- believes the Plan of Reorganization and ownership by Elevance Health will create meaningful economies of scale and will provide BCBSLA with greater resources and enhanced access to technology to improve the experience of members, customers, providers and other stakeholders, and support advancement in BCBSLA's products, services and capabilities to help improve the affordability and quality of care provided to Policyholders and members;

- considered that Elevance Health has a history of successfully integrating past acquisitions and investing substantial resources in such companies, resulting in the steady growth and expansion of such insurers over time; and

- received the opinion of the Qualified Investment Banker as to the fairness from a financial point of view of the total consideration to be received by the Eligible Members as a group in the Plan of Reorganization.

Q8. What are the potential disadvantages of the Plan of Reorganization to Policyholders?

A8. The Plan of Reorganization will:

- extinguish Policyholders' Membership Interests, which includes all rights and interests of Policyholders of BCBSLA under law and its governing documents, namely the Policyholder's right to vote; and

- result in BCBSLA becoming an indirect subsidiary of Elevance Health, a publicly traded company, which has a shareholder base to which it is accountable and whose interests may be different than those of the members of BCBSLA.

Q9. Will the Proposed Reorganization change the Membership Interests of Policyholders?

A9. **Yes**. Policyholders of a mutual insurance company with policies that are In Force have certain rights and interests, including the right to vote on various matters (including certain extraordinary transactions, such as a conversion), and the right to participate in meetings of policyholders. If the Proposed Reorganization occurs, all Membership Interests of the Policyholders in BCBSLA will be extinguished.

The Proposed Reorganization does not change the terms, conditions or coverage provided by any insurance policy issued by BCBSLA. Completion of the Proposed Reorganization will not result in increased premiums or reduced coverage under your In Force Policy in the Policy year.

Q10. Who is eligible to receive a portion of the Eligible Member Payment?

A10. Each Eligible Member is entitled to receive their fair and equitable allocation of the Eligible Member Payment. In general, Policyholders of an Eligible Policy will be Eligible Members and will be eligible to receive their share of the Eligible Member Payment. Under the Louisiana Demutualization Law, a Policyholder who did not own a Policy on the Adoption Date is not an Eligible Member. In addition, Policyholders who terminate their Policies *after* the Adoption Date and *prior* to the Reorganization Effective Time are not Eligible Members.

Q11. When will the Eligible Member Payment be distributed?

A11. The Eligible Member Payment will be distributed by the Paying Agent promptly following receipt of the documents and information referred to in A4 above.

Q12. Can an Eligible Member sell, assign or transfer their right to receive their share of the Eligible Member Payment?

A12. **<u>No</u>**. An Eligible Member Payment will not be transferable except, in specific circumstances, to (i) the personal representative or heirs of a deceased individual or (ii) the successor to the business of a corporation or other business entity. Documentation of a transfer exception must be provided to and accepted by the Paying Agent.

Q13. What conditions must be met in order for the Proposed Reorganization to occur?

A13. The Proposed Reorganization cannot be completed unless the following conditions are met:

- the Commissioner approves the Plan of Reorganization;
- approval of the Plan of Reorganization by at least two-thirds of Voting Members who are actually present or represented at the Special Meeting by special proxy or special ballot; and
- all of the other conditions to the closing of the Acquisition Agreement are met or waived in accordance with their terms.

Q14. Is the receipt of the Eligible Member Payment taxable?

A14. The receipt of the Eligible Member Payment in accordance with the Plan of Reorganization is a taxable transaction for U.S. federal income tax purposes. See "U.S. Federal Income Tax Considerations" on page 43.

Q15. Will the Proposed Reorganization adversely affect the coverages under a Policy that is In Force?

A15. **<u>No</u>**. Completion of the Proposed Reorganization will not result in increased premiums or reduced coverage under your In Force Policy in the Policy year.

Q16. Who are Purchaser and Elevance Health?

A16. Elevance Health, through its subsidiaries, is a health benefits company in the United States serving more than 48 million medical members through its affiliated health plans. Elevance Health is an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans, and currently serves its members as the Blue Cross and/or Blue Shield licensee for all or portions of fourteen states: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New

York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin.

Q17. What does Elevance Health do and how can a transaction with Elevance Health result in future benefits to BCBSLA Policyholders?

A17. Elevance Health has developed a portfolio of whole health solutions and capabilities with over $4 billion in investments in recent years. This portfolio of whole health solutions is designed to support members' physical, mental and social health in an integrated fashion. It is designed to provide solutions for a wide variety of member needs, ranging from wellness and preventative care to condition-specific needs for illnesses such as diabetes, cancer and heart conditions. Having condition-specific solutions that complement the care delivered by health care providers enables members to focus on what will improve their health and lives. Increasingly, health care is being delivered digitally and outside of the traditional physician's office when appropriate, especially in rural parts of Louisiana where health care services can be located hours away from a member's home or work. Elevance Health's digital platforms and health care delivery assets dramatically improve access via mobile devices, internet, and phone at the convenience of members. These whole health capabilities have shown success in improving Elevance Health members' health. Elevance Health has recently developed a 'whole health index', a dynamic model to better understand drivers of health and measure the impact of its various solutions on health outcomes in a community. This index also helps identify the most promising future opportunities to improve the health of members and their communities. Further, Elevance Health plans to invest annually over $1 billion in building new capabilities – capabilities that the Board desires to bring to BCBSLA members. Among the whole health solutions that Elevance Health offers are:

(1) Elevance Health's Cancer Care Navigator and Concierge Care solutions to support members with cancer and their families with personalized one-to-one support as they navigate the complex landscape of cancer care. Examples include connecting and aligning with the appropriate health care providers, matching with appropriate clinical trials, traveling to a center of excellence, and getting second opinions when needed. These solutions already serve members in Elevance Health's existing segments and ensure that Elevance Health members understand their options, get high quality care, and minimize unnecessary hospital visits.

(2) Personalized care programs for diabetes patients, including remote patient monitoring and AI-powered coaching that recommends specific actions members can take to better manage their health. These solutions help diabetic members maintain the right nutrition and activity levels to proactively minimize any disease complications. As a testament to the effectiveness of these tools, Elevance Health's Medicare Advantage members have 19% lower A1C (blood sugar levels) than diabetic Medicare seniors nationally.

(3) Maternal health solutions focused on maternal morbidity and pre-natal and postpartum care, with a goal to reduce health disparities in Louisiana such as low birth weight and pre-term births, especially among Black women. Examples of whole health solutions include incentives for pregnant women for timely pre-natal visits, postpartum depression screening and follow-up, dedicated clinical liaisons who collaborate with health care providers and advocate for the right care for the member, and a comprehensive suite of digital tools to support future moms as they journey through their pregnancies. Together, these solutions among current Elevance Health members have helped reduce the number of pre-term births by 25% and decrease the number of low birthweight babies by 26%, metrics in which Louisiana currently ranks 50th among all states.

(4) A full suite of industry-leading behavioral health services through a broad network of experts that already serve one out of every six people in the United States. Elevance Health is committed to bring to BCBSLA members enhanced access to clinical mental health support, substance use disorder treatment, specialty programs such as autism and depression, crisis programs, support for children in foster care, virtual counseling, 24-hour chat service and more. These services are integrated into medical product design. Through improved data and analytics capabilities, BCBSLA will be able to proactively identify members at risk and in need of health interventions. The behavioral health capabilities of Elevance Health will complement the behavioral health capabilities currently available to BCBSLA members. Purchaser is a wholly owned subsidiary of Elevance Health.

The future benefits of the Proposed Reorganization include: (1) BCBSLA would have the financial resources to improve the performance of its existing business, develop new business opportunities and enhance its competitive position in the health benefits industry by becoming part of Elevance Health, a company with more than $100 billion in market capitalization and one of the most diversified asset portfolios in the entire industry; (2) as part of Elevance Health, BCBSLA could in the future better improve service to customers and grant members the ability to utilize tools already available to customers of Elevance Health and its affiliates. These tools enhance the availability of health care services and allow members to better manage their own health. Such tools include Elevance Health's digital platforms and products which give members 24-hour digital support and includes text and video visits with integrated health care providers, integrated pharmacy support, at-home diagnostics solutions, and care navigation. BCBSLA anticipates gaining access to Elevance Health's services and capabilities in as little as two years, services and capabilities that it otherwise could not develop on its own over the span of a ten-year period; (3) Elevance Health's scores for quality outcomes for patients are higher than BCBSLA's, as measured by nationally recognized standards; (4) with more than 47 million members, Elevance Health can reduce increases in administrative costs for BCBSLA and its customers more than if BCBSLA remained independent; (5) Elevance Health has developed a portfolio of whole health solutions, and capabilities through investments of over $4 billion in recent years. This portfolio provides solutions for a variety of member needs, including condition-specific needs regarding diabetes, cancer, heart conditions, and several others. Having

condition-specific solutions that complement the care delivered by health care providers enables members to focus on what will improve their health and lives; (6) increasingly, health care is being delivered digitally and outside of the traditional physician's office when appropriate, especially in rural parts of Louisiana where health care services can be located hours away from a member's home or work. Elevance Health's digital platforms and health care delivery assets dramatically improve access via mobile devices, internet, and phone at the convenience of members; (7) these whole health capabilities have shown success in improving the health of Elevance Health's members. Elevance Health has recently developed a 'whole health index', a dynamic model to better understand the drivers of health and measure the impacts of its various solutions on health outcomes in a community. This index also helps identify the most promising future opportunities to improve the health of members and their communities; (8) in total, access to these capabilities and services will allow BCBSLA to better improve the health of its members, and to better manage health care costs than if BCBSLA had remained independent; and (9) further, Elevance Health plans to invest annually over $1 billion in maintaining, enhancing and expanding these capabilities – capabilities that BCBSLA strives to bring to members, but that to date have been challenging.

Q18. Who is the Foundation?

A18. It is The Accelerate Louisiana Initiative, Inc., a newly formed nonprofit non-stock corporation organized to work to improve the health and lives of the people of the State of Louisiana which has qualified as a Code Section 501(c)(4) social welfare organization. The Foundation was originally formed in the State of Delaware and redomiciled to the State of Louisiana on November 30, 2023. It is anticipated that if certain conditions are satisfied, as outlined further below (See "*The Foundation*" on page 33), the Foundation would donate or contribute the funds it receives in connection with the Proposed Reorganization to a newly established special charitable trust (as referred to herein, the "**Trust**"), which would have the same purpose of improving the health and lives of the people of the State of Louisiana. In the event that the conditions are not satisfied, the Foundation would retain the funds consistent with its purpose and intends to requalify as an organization exempt under Code Section 501(c)(3). See "*The Foundation*" on page 33.

Q19. Are there any conditions to the distribution of Eligible Member Payment?

A19. **<u>Yes</u>**. The obligation to pay the Eligible Member Payment depends on:

- the approval and completion of the Proposed Reorganization according to the Acquisition Agreement, Plan of Reorganization and the Louisiana Demutualization Law;

- the approval of Elevance Health's indirect acquisition of BCBSLA by the Commissioner; and

- the satisfaction or waiver of the other conditions that must be met as required in the Acquisition Agreement and the closing of the transactions in the Acquisition Agreement.

Q20. When do you expect the Proposed Reorganization to be completed?

A20. The Proposed Reorganization will be completed when the conditions of the Acquisition Agreement described in Annex B hereto are met or waived and the transactions under the Acquisition Agreement are completed. It is currently anticipated that the Proposed Reorganization will be completed in the first quarter of 2024. However, there is no assurance that the Proposed Reorganization will be completed.

Q21. What happens if the Commissioner requests modifications to the Plan of Reorganization after the Public Hearing?

A21. If the Commissioner requests modifications to the Plan of Reorganization, BCBSLA's Board may be required to approve an amended Plan of Reorganization by at least two-thirds of the Board, unless the Acquisition Agreement is terminated under the relevant provisions in the Acquisition Agreement (as described in more detail in the summary of the material terms of the Plan of Reorganization and Acquisition Agreement attached as Annex B hereto).

Q22. What happens if the Proposed Reorganization is not completed?

A22. If the Proposed Reorganization is not completed, BCBSLA will not convert to a stock insurance company and will remain an independent mutual insurance company. If BCBSLA remains an independent mutual insurance company, the Eligible Member Payment will not be paid.

In addition, BCBSLA may have to pay Elevance Health a termination fee of $75,000,000 if the Proposed Reorganization is terminated under certain circumstances including:

- the Board amends, withdraws or modifies the Board Recommendation;
- the Board takes action to pursue an Alternative Transaction, or does not confirm the Board Recommendation after BCBSLA receives a proposed Alternative Transaction;
- BCBSLA terminates the Acquisition Agreement before the Voting Members vote on the Proposed Reorganization in order to enter into an agreement for an Alternative Transaction that is a Superior Proposal; or
- Elevance Health terminates the Acquisition Agreement before the Voting Members approve the Proposed Reorganization at the Special Meeting (as scheduled or adjourned for no more than 30 days), and an Alternative Transaction has been publicly proposed and not withdrawn before the Special

Meeting and BCBSLA agrees to or closes such Alternative Transaction within 12 months of the termination of the Acquisition Agreement.

Q23. What will happen to the Board of BCBSLA as a result of the Proposed Reorganization?

A23. In considering the Board Recommendation that Voting Members vote to approve the Plan of Reorganization, you should be aware that BCBSLA's Board and executive officers have interests in the Proposed Reorganization that are in addition to the interests of members. As is typical in change of control transactions such as the series of transactions contemplated by the Plan of Reorganization, all of the current directors on the Board, except for the President and Chief Executive Officer of BCBSLA (who is also a member of the Board), will resign immediately prior to the Closing. Under Louisiana law, the President of BCBSLA must remain a director on the BCBSLA Board. Certain of the resigning directors are currently directors of the Foundation or will become directors of the Foundation at or prior to the Closing, and such directors will continue as directors of the Foundation following the Closing (and if applicable, trustees of the Trust - See "*The Foundation*" on page 33). Other resigning directors of the BCBSLA Board will become members of the Advisory Board (as defined in the Acquisition Agreement) of BCBSLA effective as of the Closing. Except for service in the capacities described above, no director of BCBSLA will receive any fee, commission, or other valuable consideration, other than his or her usual regular salary, compensation and benefits, that depends on the Plan of Reorganization becoming approved or completed or is based upon aiding, promoting, or assisting in the approval or completion of the Plan of Reorganization. It is anticipated that compensation for members of the Advisory Board and directors of the Foundation will be no greater than what they receive today as members of the BCBSLA Board, and in many cases it will be less than the current compensation they receive. If the transactions contemplated by the Plan of Reorganization are not completed, the directors on the Board will continue to receive the compensation and benefits that they currently receive as directors on the Board. The Advisory Board's charter provides that a member of the Advisory Board will be deemed removed from the Advisory Board at the expiration of the term during which such member attains the age of 75.

In addition, as allowed by Louisiana law, Purchaser shall, and shall require BCBSLA and each BCBSLA Subsidiary to, indemnify, defend and hold harmless the Indemnified Parties against all claims in which an Indemnified Party is, or is threatened to be made, a party or witness in whole or in part on or arising in whole or in part out of the fact that such person is or was a director, officer, manager, employee or holder of an equity interest of BCBSLA or a BCBSLA Subsidiary, if such claim pertains to any matter of fact arising, existing or occurring at or before the Closing, regardless of whether such claim is asserted or claimed before, or after, the Closing, to the fullest extent BCBSLA is permitted under applicable law and consistent with BCBSLA's or any BCBSLA Subsidiary's organizational documents as in effect as of the date of the Acquisition Agreement.

At the Closing, Purchaser shall, or shall require BCBSLA to, obtain, maintain in effect for a period of six years thereafter, and fully pay for irrevocable "tail" directors' and officers' liability insurance policies naming all Persons who are covered on the date of the Acquisition Agreement by the Company Entities' existing policies as direct beneficiaries. The directors' and officers' liability insurance will be in an amount and scope that, in total, is at least as beneficial as the Company Entities' existing policies covering matters existing or occurring at or prior to the Closing Date.

Q24. Will any officers of BCBSLA receive any compensation in connection with, or on an accelerated basis due to, the Proposed Reorganization?

A24. Certain officers and key employees of BCBSLA have previously entered into, or are expected to enter into, employment, retention, and/or severance agreements that provide for compensation and other terms of employment. As is typical in change of control transactions such as the transactions contemplated by the Plan of Reorganization, certain employment and retention agreements provide for payment of retention bonuses that become payable based on continued employment in good standing through specific dates, and certain of those retention bonuses will become payable in connection with, or payable early due to, the Closing. Certain employment and severance agreements provide for severance pay and benefits in the event of a qualifying termination of employment and include enhanced severance pay and benefits if such termination occurs during a specified period following the Closing. Except as described above, no officer, agent, or employee of BCBSLA will receive any fee, commission, or other valuable consideration, other than their usual regular salary and compensation that is contingent upon the Plan of Reorganization becoming approved or completed or is based upon aiding, promoting, or assisting in the approval or completion of the Plan of Reorganization.

If the transactions required by the Plan of Reorganization are not completed, certain officers and key employees of BCBSLA will continue to receive retention bonuses and other compensation under agreements or arrangements made with BCBSLA according to the dates and on the terms set forth in those agreements, and severance pay and benefits without an enhancement as described above in the event of a qualifying termination.

If the Plan of Reorganization is approved and the transactions required by the Plan of Reorganization are completed, certain officers and key employees of BCBSLA will receive retention bonuses that may become payable early due to the Closing (as described above) and may receive enhanced severance pay and benefits (as described above) in the event of a qualifying termination.

Voting on the Plan of Reorganization

Q25. What is the Plan of Reorganization?

A25. The Plan of Reorganization is the document that details the terms and conditions of the Proposed Reorganization. It identifies who is an Eligible Member and a Voting

Member and it establishes how the Eligible Member Payment is to be paid to the Eligible Members for the extinguishment of their Membership Interests in BCBSLA. The Plan of Reorganization also includes, among other items, the proposed Amended and Restated Articles of Incorporation and proposed Amended and Restated Bylaws, which will become effective upon completion of the Proposed Reorganization.

Q26. Has the Board approved the Plan of Reorganization?

A26. **Yes**. The Board, after careful deliberation, approved the Plan of Reorganization effective as of the Adoption Date. In addition, the Board approved (1) the Amendment No. 1 to the Plan of Reorganization effective as of July 18, 2023, to reflect, among other things, the increase in the Eligible Member Payment as discussed in more detail above, (2) the Amendment No. 2 to the Plan of Reorganization effective as of August 23, 2023, to provide for the new Record Date for the Special Meeting, and (3) the Amendment No. 3 to the Plan of Reorganization effective as of December 12, 2023, to provide for the potential establishment of a newly established special charitable trust, as described below in "*The Foundation*" (page 33).

Q27. Who can vote on the Plan of Reorganization?

A27. If you were a Policyholder on the Record Date, you are a Voting Member and are entitled to vote on the Plan of Reorganization. Voting Members will be allowed to vote at the Special Meeting in person or by special ballot or special proxy.

Q28. How many votes are needed to approve the Plan of Reorganization?

A28. In order for the Plan of Reorganization to become effective, the Louisiana Demutualization Law requires that it be approved by at least two-thirds of Voting Members actually present or represented at the Special Meeting by special proxy or special ballot. See "*Eligibility to Vote*" on page 36.

Q29. What are Voting Members voting on?

A29. Voting Members are voting to approve or disapprove the Plan of Reorganization.

Q30. What should Voting Members do now?

A30. Voting Members may attend the Special Meeting to vote in person, or grant their special proxy with instructions on how to vote using the instructions on the enclosed proxy form by telephone or internet or by completing and returning the enclosed proxy form in the accompanying postage prepaid reply envelope. Please note that the submission of your proxy online, by mail or by phone must be received no later than 11:59 p.m. Central Time on [•] to be counted for purposes of the Special Meeting.

The Board recommends that you vote **FOR** approval of the Plan of Reorganization.

Q31. Can a Voting Member revoke a proxy?

A31. **Yes**. A Voting Member can revoke a proxy at the Special Meeting or before the Special Meeting by contacting MacKenzie Partners, Inc. at 1 (800) 356-8906 or via email at proxy@mackenziepartners.com or by attending the Special Meeting in person and revoking a previously furnished proxy.

Q32. What do I do if I have questions about the Plan of Reorganization or voting process or want additional copies of this Member Information Statement, enclosed proxy or voting instructions?

A32. If you have any questions regarding the Plan of Reorganization or the voting process, or if you need additional copies of this Member Information Statement or the enclosed proxy or voting instructions, please contact MacKenzie Partners, Inc. at 1 (800) 356-8906 or via email at proxy@mackenziepartners.com.

Q33. What do I do if I hold multiple Policies with BCBSLA?

A33. If you hold multiple In Force Policies with BCBSLA, you will only receive one copy of this Member Information Statement and enclosed proxy form. Your vote or the proxy you grant pursuant to the enclosed proxy form will cover all such In Force Policies you may hold with BCBSLA. You will receive a separate share of the total Eligible Member Payment for each Eligible Policy you hold. If you have any questions or need assistance with respect to multiple Eligible Policies you may own, please contact MacKenzie Partners, Inc. at 1 (800) 356-8906 or via email at proxy@mackenziepartners.com.

Risks and Uncertainties Associated with the Plan of Reorganization

Q34. Are there any risks with respect to the Plan of Reorganization?

A34. There are risks with respect to the Plan of Reorganization. The risks are discussed in "*Certain Risks and Considerations Relating to the Proposed Reorganization*" on page 41. The Board considered the benefits of the Plan of Reorganization as well as the risks and approved the Plan of Reorganization and the Proposed Reorganization.

Q35. What impact will the Proposed Reorganization have on providers?

A35. Elevance Health does not plan to make changes to existing BCBSLA provider networks. BCBSLA's and its Subsidiaries' current provider networks will remain intact following the Closing and the contractual relationships with providers will not be impacted as provider contracts are between the respective providers and the relevant BCBSLA entity. Louisianans will maintain access to their local healthcare providers and gain the support of a national network and benefits. Elevance Health also has no intention of reducing provider reimbursements, nor would such reductions be in line with its strategic needs, as multiple large national insurance companies compete for companies' business and many customers prefer to have broad networks and choices. BCBSLA has a long tradition of partnering with the provider community to ensure that patients receive the right care at the right time, and the Proposed Reorganization will not change that. Elevance Health intends to become the partner of

choice for providers by providing service differentiation, and its provider satisfaction scores are a testament to this commitment. Elevance Health will give providers the tools and technology to allow them to better perform their jobs and focus on providing high quality care at a low cost. Additionally, Elevance Health intends to invest in provider partnerships and assets in Louisiana, and to support independent primary care and further enable BCBSLA's existing provider MSO strategy, and help independent primary care providers maintain their independence (when they choose to do so).

The Regulatory Approval Process, including the Plan of Reorganization Public Hearing

Q36. What regulatory approvals are required in connection with the Plan of Reorganization?

A36. The Plan of Reorganization has been filed with and requires the approval of the Commissioner. In addition, the Plan of Reorganization must receive approval or have the applicable waiting period expire pursuant to applicable Antitrust Laws prior to Closing.

Q37. What is the Plan of Reorganization Public Hearing?

A37. The Commissioner is required by law to hold a public hearing on the Plan of Reorganization. You may attend this hearing and participate pursuant to any procedures set forth by the Commissioner. The public hearing on the Plan of Reorganization will be held by the Department, beginning at [10:00 a.m]., Central Time, on [•]. Information regarding the public hearing on the Plan of Reorganization was provided to Voting Members in a Notice of Public Hearing separately mailed to you by BCBSLA on or before [•]. Further information related to the public hearing will be available on the Department's website at https://www.ldi.la.gov/public-hearing-and-rulemaking-notices.

Q38. What are the standards that the Commissioner needs to find have been met to approve the Plan of Reorganization?

A38. Pursuant to Louisiana law (LSA-R.S. § 22:236.4), the Commissioner needs to find that:

- the Plan of Reorganization properly protects the interests of Policyholders and members;
- the Plan of Reorganization serves the best interests of Policyholders and members; and
- the Plan of Reorganization is fair and equitable to Policyholders and members.

Q39. Why was the Special Meeting rescheduled?

A39. The Special Meeting was rescheduled to [•], because the Louisiana Demutualization Law requires that the Special Meeting to approve the Plan of Reorganization be held after the Public Hearing on the Plan of Reorganization. Because the Public Hearing dates were rescheduled to [•], the Special Meeting was rescheduled to a date following the Public Hearing.

Q40: What do I do if I have previously granted my proxy on the Plan of Reorganization?

A40: Please note that any proxy previously granted (whether online, by mail or by phone) will be disregarded for purposes of the Special Meeting. Therefore, if you have previously granted your proxy (whether online, by mail or by phone), and you wish to grant your proxy at the Special Meeting, you must grant your proxy again on the proposed Plan of Reorganization using the instructions on your enclosed proxy form, so that we can maintain an accurate and current list of proxies granted for the Special Meeting.

Q41: If I have received this Member Information Statement and am entitled to vote at the Special Meeting, does that mean I am entitled to a share of the Eligible Member Payment if the transaction closes?

A41: Not necessarily. This is because in order to receive an allocable share of the Eligible Member Payment, you must be an Eligible Member, which means you must have held an In Force Policy as of the Adoption Date, which was January 23, 2023, and continue to hold such In Force Policy as of the effective date of the Reorganization. Accordingly, because the Record Date for determining the Voting Members was [•], there may be some Voting Members who obtained an In Force Policy prior to or on the Record Date but after the Adoption Date (which would prevent them from qualifying as an Eligible Member), and there may also be some Voting Members whose In Force Policy was held as of the Adoption Date and the Record Date, but is no longer In Force as of the effective date of the Reorganization (which would prevent them from qualifying as an Eligible Member).

SUMMARY FINANCIAL INFORMATION

A copy of the summary financial information for the years ended December 31, 2021, and 2022, and the quarter ended September 30, 2023, is attached as Annex A hereto. The summary financial information has been derived from the financial statements of BCBSLA prepared in conformity with statutory accounting principles prescribed or permitted by the Insurance Regulators consistently applied. See "*Available Information*" on page 46 and "*Incorporation of Certain Documents by Reference*" on page 47.

THE PROPOSED REORGANIZATION

Background of the Plan of Reorganization

BCBSLA Background and Recent Developments

Founded in New Orleans in 1934 as a charitable, nonprofit organization, BCBSLA today is a tax-paying not-for-profit mutual health insurer. BCBSLA is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent health benefit plans. BCBSLA is committed to its mission to improve the health and lives of Louisianians. BCBSLA, including through its subsidiaries, covers 1.9 million members and offers a diverse product plan range to both individuals and businesses that include Preferred Provider Organization ("**PPO**"), Point of Service ("**POS**"), Health Maintenance Organization ("**HMO**"), select network, dental, vision, cancer and serious disease, Medicare Advantage, Medicare Supplement, and life insurance, among others. BCBSLA also acts as a third-party administrator for self-funded health plans established by employers and associates. BCBSLA operates only in Louisiana, while two of its subsidiaries operate in Arkansas and Mississippi.

BCBSLA invests both time and money in the health and wellbeing of Louisiana communities by supporting more than 200 charitable organizations through volunteer service, board participation, employee giving and focused grantmaking. BCBSLA's commitment to corporate citizenship has been recognized for the past five years by Points of Light. BCBSLA was named in 2019, 2020, 2021, 2022, and 2023 as an honoree of the Civic 50, a list of the 50 most community-minded companies in the United States.

BCBSLA is dedicated to transforming the health care industry in Louisiana into one that delivers high-quality health outcomes for its customers, with top-notch service at more affordable costs. BCBSLA's reputation for exceptional service and prompt payments, as well as the hard work of its 200 plus in-house doctors, nurses, pharmacists, social workers and dietitians, keeps both customer and provider satisfaction high.

BCBSLA is consistently honored as a "Best Place to Work" and recognized for its wellness initiatives, excellence in customer service, superior digital design and content, advertising and public relations excellence and support for diversity, including employee and supplier diversity. BCBSLA was honored with the large business 2019 Diversity Star Award by the Baton Rouge Area Chamber.

BCBSLA has proudly managed to improve the health and lives of Louisianans while being a good steward of its finances. Despite the challenges over the last few years, BCBSLA navigated through the COVID-19 pandemic and all its uncertainty and continues through the ongoing economic fallout and related inflation caused by the COVID-19 pandemic. During this timeframe, BCBSLA fully integrated with Vantage Holdings, Inc., and its health plans, including expansion of its health plans into Mississippi and Arkansas. The Medicaid partnership with Healthy Blue, jointly owned with Elevance Health, has recorded the most growth of any of the Managed Medicaid Plans in the state of Louisiana.

In addition to these major strategic successes, BCBSLA continued to record positive gains from operations and membership growth. BCBSLA currently serves approximately 1.9 million

members, and is well-capitalized with reserves of approximately $1.8 billion, with risk-based capital that is over four times the amount required by the Department. In January 2023, Standard and Poor's gave BCBSLA its 26th consecutive "A" rating. Being well-capitalized has allowed BCBSLA to react quickly and impactfully to the numerous catastrophes over the last few years, including hurricanes, floods and the COVID-19 pandemic. BCBSLA continues to perform well in all quality metrics scoring well above average annually on the Member Touch Point Measure program of the Blue Cross and Blue Shield Association. It is the goal of BCBSLA's management to continue to execute on BCBSLA's mission to improve the health and lives of Louisianans while achieving its long term financial and operational goals.

BCBSLA believes that the Proposed Reorganization is consistent with the mission set forth in its charter, which includes, among other things, the promotion of the welfare of Policyholders and members and the general public by (i) entering into and issuing contracts for health care services and health, accident and life insurance, (ii) responding to community needs of the people of the State of Louisiana, (iii) driving leadership to influence the efficient and innovative delivery of quality health care services, (iv) implementing measures designed to control the cost of health care services delivery and (v) protecting the best interests of Policyholders and members with regard to matters relating to all kinds of insurance authorized by law in BCBSLA's area of operation.

Elevance Health Background

The following section contains a summary of the background of Elevance Health that has been prepared based on information contained in the public filings referenced below. More detailed information regarding Elevance Health and its subsidiaries is included in its Securities and Exchange Commission ("**SEC**") reports and the above discussion is qualified by reference to the financial information included in such reports. Elevance Health files annual, quarterly and current reports, proxy statements and other information with the SEC. You may read and copy any document Elevance Health files at the SEC's public reference room at 100 F Street, N.E., Washington, D.C. 20549. You may obtain additional information about the public reference room by calling the SEC at 1-800-SEC-0330. In addition, the SEC maintains a website (www.sec.gov) that contains reports, proxy and information statements and other information regarding issuers that file electronically with the SEC, including Elevance Health. Elevance Health also publishes its public SEC filings as soon as reasonably practicable after the report is electronically filed with, or furnished to, the SEC. These SEC filings can be found on the Elevance Health website (www.elevancehealth.com). The information contained at the Elevance Health website is not incorporated by reference in this Information Statement, and you should not consider it a part of this Information Statement.

Elevance Health, through its subsidiaries, is a health benefits company in the United States serving more than 48 million medical members through its affiliated health plans as of December 31, 2022. Elevance Health is an independent licensee of the Blue Cross and Blue Shield Association and serves its members as the Blue Cross and/or Blue Shield licensee for all or portions of fourteen states: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (in the New York City metropolitan area and upstate New York), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service

areas, Elevance Health's affiliated health plans do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, and Empire Blue Cross Blue Shield or Empire Blue Cross. Elevance Health, through its subsidiaries, also serves customers in numerous states and Puerto Rico as AIM Specialty Health, Amerigroup, Aspire Health, Beacon, Carelon, CareMore, Freedom Health, HealthLink, HealthSun, MMM, Optimum HealthCare, Simply Healthcare, Unicare and/or WellPoint. Elevance Health also provides pharmacy benefits management services through its subsidiary, CarelonRx. Elevance Health is licensed to conduct insurance operations in all 50 states, the District of Columbia and Puerto Rico through its subsidiaries.

Elevance Health believes in working together to achieve its mission of improving lives and communities, simplifying health care and expecting more. As Elevance Health seeks to accomplish these goals through a collaborative focus on execution and delivering for those it serves, Elevance Health's vision is to be a lifetime, trusted health partner. With an unyielding commitment to meeting the needs of its diverse customers, Elevance Health is guided by the following values: leadership, community, integrity, agility and diversity. In pursuing its strategy and becoming a lifetime, trusted health partner, Elevance Health intends to transform health care by taking a whole health approach and providing trusted and caring solutions, delivering quality products and services that give customers access to the care they need and removing barriers to health.

Elevance Health offers a broad spectrum of network-based, managed care, risk-based plans to individual, group, Medicaid and Medicare markets. In addition, Elevance Health provides a broad array of managed care services to fee-based customers, including claims processing, stop loss insurance, provider network access, medical management, care management and wellness programs, actuarial services and other administrative services. Elevance Health also provides services to the federal government in connection with its Federal Health Products & Services business, which administers the Federal Employees Health Benefits Program. Elevance Health provides an array of specialty services to its subsidiary health plans and also unaffiliated health plans, including pharmacy benefit management services and dental, vision, life, disability and supplemental health insurance benefits, as well as integrated health services.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population, other demographic characteristics and the COVID-19 pandemic continue to contribute to rising health care costs. Elevance Health's managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of its innovative medical management services, quality initiatives and financial incentives.

Elevance Health believes that health care is local and that it has the strong local presence required to understand and meet local customer needs with regard to any product they are enrolled in with Elevance Health. Further, Elevance Health believes it is well positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care.

Elevance Health believes that its local presence, combined with its national expertise, creates opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. Elevance Health feels that its commitment to health improvement and care management provides added value to customers and health care professionals.

Elevance Health believes that practical and sustainable improvements in health care must focus on improving health care quality while managing costs for total affordability. Elevance Health has implemented initiatives driving payment innovation and partnering with providers to lower costs and improve the quality of health care for its members, and continues to develop new and innovative ways to effectively manage risk and engage its members.

In addition, Elevance Health continues to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through digital technology and improving internal operations. Elevance Health's approach includes not only sales and distribution of health benefits products through digital technology, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

Health Insurance and Health Care Industry Background and Recent Developments

The health insurance and overall health care industry has seen significant shifts and evolution over the last several years. As the cost of health care continually rises faster than other components of the economy, health care companies are forced to find strategies that allow them to remain competitive. The most prevalent strategy across all health care companies (health insurers and health systems) to achieve cost savings for members and make health care more affordable is achieving sufficient growth opportunities across all operations. Another major strategy is the use of digital innovation and shifting care to the home. Introducing care at home and utilizing digital innovation is another approach to keep cost in check to address affordability. In the early days of this strategy, capital investment in capabilities is extensive and undercapitalized health care companies are at a disadvantage when they lack growth opportunities. The overall industry is moving fast to find the optimal point of growth, capabilities, and experience that positions them to be competitive and valued by their customers. This is likely to continue to take place over the next decade.

Background of the BCBSLA and Elevance Health Transaction

The Board and BCBSLA's senior management have met periodically and regularly to review and evaluate BCBSLA's long-term strategy and opportunities and options to protect and enhance value for all constituencies of BCBSLA, including its Policyholders, members, employees, agents, providers and the communities in which BCBSLA and its respective subsidiaries and affiliates operate. These reviews have included consideration of possible business combination strategies that may be available to BCBSLA. In addition to considering the BCBSLA and Elevance Health transaction, the Board considered a demutualization of BCBSLA on a stand-alone basis as well as the viability of remaining independent, with or without acquiring other businesses. At these meetings, the Board has regularly discussed and considered presentations from third-party consultants, financial advisors and legal counsel in which the advantages and disadvantages of various strategic alternatives were outlined. In addition to these periodic and regular reviews of BCBSLA's long-term strategy and opportunities and options, the Board regularly monitored recent and ongoing developments in the health insurance and health care industry. Consequently, when considering BCBSLA's long-term strategic opportunities and options, the Board was cognizant and took into consideration broader trends in the health insurance

and health care industry, including the challenges facing the health insurance and health care industry over the last decade.

During the course of calendar years 2021 and 2022, senior management and the Board, as part of the Board's ongoing and ordinary practice of reviewing and monitoring BCBSLA's strategy, and informed by developments in the health insurance and health care environment, discussed a number of factors impacting BCBSLA and its business, including: the highly competitive and increasingly complex environment in which BCBSLA operates, the associated competitive pressures from larger, more diversified insurers, the increasing costs of acquiring and maintaining capabilities and technology, the consolidation of BCBSLA insureds into better capitalized or more diversified entities and the resulting impact on BCBSLA, uncertainties inherent in the estimates of medical cost trends and associated reserves, increased costly regulatory requirements, senior management succession, the ability to retain and recruit employees, the ability to successfully execute on acquisitions and the inherent risks of acquisitions and entering into new segments. The Board also discussed strategic alternatives, which included the possibility of a sale transaction, a merger of mutual insurance companies, an affiliation with another insurance company, and remaining independent. As part of its consideration of BCBSLA's strategic alternatives, including a possible sale transaction, the Board preliminarily approved engaging McKinsey & Company ("**McKinsey**"), a global management consulting firm to assess BCBSLA's strategic strengths and weaknesses, and to provide detailed, independent, third-party analysis regarding both the trends in the health insurance and health care industry and their likely effect on BCBSLA. McKinsey also assessed the strategic fit for BCBSLA of potential affiliations or partnerships with a wide range of other insurance companies.

The Board identified numerous factors that were considered in the evaluation of any organization that was potentially a party to a transaction or partnership proposal. These factors included:

- An organization with a strong, demonstrable focus on offering the best outcomes for Policyholders and members;
- An organization that has a strong focus on collaborative and progressive relationships with physicians and other providers;
- A demonstrable commitment to serving health care well into the future;
- A commitment to taking the best parts of both companies to create an organization that neither readily could have developed alone;
- Financial strength and stability;
- Long-term strategy and viability;
- Complementary geographic footprint;
- Product diversity;
- Ease of integration (effect and impact on operations, management and employees);
- Regulatory process and timing;
- Risk appetite;
- Underwriting, rate/pricing and claims handling philosophy;
- Commitment to innovation; and
- Potential transaction structure.

The Board, with the assistance of McKinsey, reviewed the strategic fit of possible strategic partners with the above factors in mind, and after preliminary discussions with multiple organizations concluded that aligning with either Elevance Health or another party ("**Party A**") were the two best potential options to improve BCBSLA's ability to meet its strategic objections.

The law firm of Morgan, Lewis & Bockius, LLP ("**Morgan Lewis**") was retained to advise the Board and management on various matters related to potential transactions. Management presentations were scheduled with Elevance Health and Party A. The Board also engaged Cain Brothers, a Division of Keybanc Capital Markets ("**Cain Brothers**") and a nationally known and highly reputable investment bank with broad health care experience, as a financial advisor in the context of any transaction or partnership proposal.

Discussions and management meetings with each of Elevance Health and Party A were held in 2021. During these meetings, Elevance Health and Party A were informed that the Board had not yet determined to pursue a transaction and that the meetings were exploratory in nature. These meetings included Board members and members of the senior management team.

BCBSLA communicated bid instructions to Elevance Health and Party A. Initial indications of interest ("**Bids**") were submitted by each of Elevance Health and Party A on November 26, 2021, and December 8, 2021, respectively. Each remained interested subject to diligence, including, among other things, confirmation of BCBSLA's reserves.

The Board discussed factors that suggested that a transaction that combined BCBSLA with either Elevance Health or Party A would be in the best interests of the Policyholders and members, including, but not limited to, a changing medical provider and customer environment, the increased growth that is needed to provide for Policyholder and member needs and regulatory requirements, the need for financial strength and stability to weather cyclical changes in the health insurance and health care marketplace, improved financial and business strength and diversity that could be achieved by increased product diversity, the changing models of distribution and a concern that the current competitive strengths of BCBSLA could be eroded due to industry changes. The Board also concluded that staying as an independent company, although a viable option, would likely lead to BCBSLA becoming competitively weaker over time. Cain Brothers discussed potential next steps with the Board.

At the December 2021 Board meeting, Cain Brothers presented a preliminary view on valuation to the Board utilizing multiple industry standard valuation methodologies. Based on the Bids, the Board concluded that a sale of BCBSLA to Elevance Health was the superior option to a sale of BCBSLA to Party A, based on several factors: (1) it provided BCBSLA with greater financial strength than the proposal by Party A; (2) it provided BCBSLA access to a broader and more comprehensive set of capabilities and technology than what could be provided by Party A, at a lower cost and more quickly; and (3) the structure of the Proposed Reorganization with Elevance Health would create a new "game changing" nonprofit foundation (the Foundation) that would continue the historic mission of BCBSLA as set forth in its charter for generations (including responding to community needs of the people of Louisiana and driving leadership to influence the efficient and innovative delivery of quality health care services), while a potential reorganization with Party A would not provide this type of benefit for the people of Louisiana (specifically because the transaction proposed by Party A would not include the payment of any

financial consideration and thus would not provide for the funding of the Foundation nor would it involve payment of any consideration to Policyholders).

Following this conclusion, the Board instructed senior management to work with its outside advisors (including Chaffe and Deloitte, as further summarized in "Reports of Financial Advisors" below) to negotiate the definitive terms of a transaction with Elevance Health in which (1) the Foundation would be funded and become dedicated to improving the health and lives of the people of the State of Louisiana, (2) BCBSLA would convert from a mutual insurance company to a stock insurance company, and (3) BCBSLA's newly created shares of capital stock would be issued to ATH Holding Company, LLC ("**Purchaser**") (thereby making BCBSLA an indirect wholly owned subsidiary of Elevance Health), upon which each Eligible Member would be entitled to receive their share of the Eligible Member Payment on a fair and equitable basis. The Board determined that the creation and funding of the Foundation was justified based on applicable Louisiana law, the history and mission of BCBSLA as set forth in its charter, and its history of issuing insurance policies that are non-participating, pay no dividends and provide no rights to surplus, shares of stock or liquidation proceeds to Policyholders. Based on these factors the Board determined that it was reasonable, fair and appropriate to allocate a portion of the substantial value that would be achieved upon the completion of the Proposed Reorganization to the Foundation. The Foundation was formed on December 2, 2022, and its initial directors were C. Richard Atkins, D.D.S.; Thomas A. Barfield, Jr.; Jerome K. Greig and Charles Brent McCoy.

Throughout the latter part of 2021 and well into 2022, Elevance Health continued its diligence review, including meetings with senior management and Cain Brothers, and continued negotiations over the terms of a Proposed Reorganization. Updates were provided to the Board by senior management regarding the diligence process, timing and discussions with Elevance Health. Cain Brothers provided feedback on the methodologies used by Elevance Health to arrive at its Bid. Cain Brothers and senior management continued to engage in discussions and negotiations with Elevance Health to further improve their offer.

During the time period in which Elevance Health continued its due diligence process, senior management of BCBSLA and Cain Brothers engaged in multiple discussions regarding the purchase price. In March 2022, Cain Brothers and Elevance Health discussed a counter-proposal to the original proposal provided by Elevance Health to BCBSLA. In May 2022, Elevance Health shared its valuation methodologies with Cain Brothers which resulted in a subsequent call to discuss Elevance Health's valuation methodologies.

Beginning in July 2022, the CEOs of BCBSLA and Elevance Health discussed the timing of a revised purchase price. On August 16, 2022, Elevance Health confirmed its original purchase price of $2.4 billion prior to any excess capital distributions. Subsequent to Elevance Health's confirmation of purchase price, BCBSLA and Cain Brothers continued to discuss an increase to the purchase price. In October 2022, Elevance Health increased its purchase price to $2.5 billion prior to any excess capital distributions.

BCBSLA and Elevance Health and their respective advisors began drafting and negotiating the Acquisition Agreement and the Plan of Reorganization following lengthy and involved due diligence. The parties negotiated the definitive terms of the Acquisition Agreement and the Plan of Reorganization during March-December 2022. Cain Brothers delivered a fairness opinion to the

Board assessing Elevance Health's revised Bid in December 2022 (the "**Cain Fairness Opinion**"), which Cain Fairness Opinion concluded that, as of the date of such opinion and subject to the terms and conditions set forth therein, the total consideration to be paid by Purchaser under the Acquisition Agreement is fair, from a financial point of view, to BCBSLA. BCBSLA agreed to pay Cain Brothers a reasonable customary fee and reimburse Cain Brothers for its expenses related to the Cain Fairness Opinion. BCBSLA also agreed to indemnify Cain Brothers for certain liabilities that may arise in connection with the rendering of the Cain Fairness Opinion.

At a meeting of the Board held on January 13, 2023, which meeting included numerous presentations from BCBSLA management and outside legal advisors and other consultants, the Board approved the Plan of Reorganization (with more than two-thirds of Board members voting to approve the Plan of Reorganization, consistent with applicable Louisiana law), including the terms of the Acquisition Agreement, with an effective date of January 23, 2023. The Board also approved the recommendation that the Voting Members vote to approve the Plan of Reorganization. On January 23, 2023, BCBSLA, Elevance Health, Purchaser and the Foundation entered into the Acquisition Agreement and publicly announced the Proposed Reorganization. On January 23, 2023, BCBSLA filed the Plan of Reorganization with the Department.

Reasons for the Proposed Reorganization and Considerations of the Board; Recommendation of the Board[1]

The Board considered a number of factors relating to the Proposed Reorganization including the advantages and disadvantages. With regard to what the Board considered in terms of advantages and disadvantages, the Board primarily focused on two possible paths forward: (1) maintaining the current situation as an independent, single-state Blue Cross Blue Shield plan (without a demutualization and transaction with Elevance Health); and (2) pursuing a demutualization and transformative transaction with Elevance Health to become part of a larger Blue Cross Blue Shield organization.

As the Board thoroughly vetted the disadvantages of maintaining the current situation, the following issues were considered: (1) consolidation within the Blue Cross and Blue Shield system moving forward appears inevitable for multiple reasons, including the need for growth, efficiencies and access to capital to invest in new capabilities at an increasingly rapid pace to maintain a competitive market position against larger national insurers. These new capabilities include customer-facing and provider-facing digital capabilities, which are expensive to create, maintain and update, and additional capabilities to improve the health of members and to improve the affordability of health care; (2) the ability of BCBSLA to maintain competitive pricing (affordability) for its customers will be diminished over time without access to increased growth and to new capabilities, which requires access to capital; (3) the continued increase in the cost of administration and to maintain compliance federal and state regulations and requirements highlights the need for greater volumes to defray costs; and (4) the historical core market for BCBSLA, which is insured commercial business, is shrinking, while self-funded commercial business and government business (e.g., Medicare Advantage and Medicaid) are growing.

[1] For more information on the advantages and potential disadvantages of the Proposed Reorganization, see Question and Answer Q/A7 and Q/A8, respectively, of the "*Questions and Answers About the Proposed Reorganization and the Vote*" section of this Member Information Statement on pages 8-9.

BCBSLA's historic strengths do not position it well for future success and growth and BCBSLA has already shown the need to enter into partnerships with other organizations to serve these growth market segments. However, the Board does not view these multiple partnership arrangements as sustainable for the long term.

Overall, the Board concluded that, while maintaining the current situation would provide the benefit of allowing BCBSLA to continue to be locally governed and managed, the potential disadvantages outweigh this benefit and would negatively impact policyholders, members and the communities in Louisiana that BCBSLA serves. Specifically, BCBSLA would not be able to invest enough to maintain industry-leading services and capabilities, compared to better-capitalized national competitors. Further, maintaining the current situation would ultimately result in a relative inability to manage rising health care costs and rising administrative costs, resulting in higher costs and premiums compared to its competitors. The tools and programs that health insurers have established to maintain affordable price points for customers are costly to create and maintain, adding to the need for significant long-term capital beyond what is needed as reserves against future claims. From the perspective of health care providers, maintaining the current situation could also result in providers working preferentially with national competitors who have greater ability to invest in innovative partnerships. This has already occurred in selective places in Louisiana and is likely to accelerate moving forward.

The Board carefully weighed the potential disadvantages of a demutualization and Proposed Reorganization with Elevance Health and considered the following: (1) the potential impact of conversion from a legal nonprofit mutual insurance company to a subsidiary of a publicly-traded for-profit company (BCBSLA is a nonprofit mutual from the perspective that it does not pay dividends, but it is not tax-exempt as it fully pays state and federal taxes); (2) certain decisions regarding BCBSLA's strategy and operations may no longer be made exclusively by a local, community board and a management team based solely in Louisiana; (3) local plan priorities could compete with national priorities of a larger, multi-state company; (4) the possible consolidation of some local operations into other out-of-state locations, with corresponding job loss; and (5) whether the culture of Elevance Health is consistent with the culture of BCBSLA.

After extensive review, senior management and the Board of BCBSLA determined that the long-term potential disadvantages of remaining independent far outweighed any limited potential disadvantages of the Proposed Reorganization. Moreover, the conclusion was that all Policyholders and members of BCBSLA, as well as the State of Louisiana as a whole, would be better off after the Proposed Reorganization in a number of ways. These future benefits of the Proposed Reorganization include: (1) BCBSLA would have the financial resources to improve the performance of its existing business, develop new business opportunities and enhance its competitive position in the health benefits industry by becoming part of Elevance Health, a company with more than $100 billion in market capitalization and one of the most diversified asset portfolios in the entire industry; (2) as part of Elevance Health, BCBSLA could in the future better improve service to customers and grant members the ability to utilize tools already available to customers of Elevance Health and its affiliates. These tools enhance the availability of health care services and allow members to better manage their own health. Such tools include Elevance Health's digital platforms and products which give members 24-hour digital support and includes text and video visits with integrated health care providers, integrated pharmacy support, at-home diagnostics solutions, and care navigation. BCBSLA anticipates gaining access to Elevance

Health's services and capabilities in as little as two years, services and capabilities that it otherwise could not develop on its own over the span of a ten-year period; (3) Elevance Health's scores for quality outcomes for patients are higher than BCBSLA's, as measured by nationally recognized standards; (4) with more than 47 million members, Elevance Health can reduce increases in administrative costs for BCBSLA and its customers more than if BCBSLA remained independent; (5) Elevance Health has developed a portfolio of whole health solutions, and capabilities through investments of over $4 billion in recent years. This portfolio provides solutions for a variety of member needs, including condition-specific needs regarding diabetes, cancer, heart conditions, and several others. Having condition-specific solutions that complement the care delivered by health care providers enables members to focus on what will improve their health and lives; (6) increasingly, health care is being delivered digitally and outside of the traditional physician's office when appropriate, especially in rural parts of Louisiana where health care services can be located hours away from a member's home or work. Elevance Health's digital platforms and health care delivery assets dramatically improve access via mobile devices, internet, and phone at the convenience of members; (7) these whole health capabilities have shown success in improving the health of Elevance Health's members. Elevance Health has recently developed a 'whole health index', a dynamic model to better understand the drivers of health and measure the impacts of its various solutions on health outcomes in a community. This index also helps identify the most promising future opportunities to improve the health of members and their communities; (8) in total, access to these capabilities and services will allow BCBSLA to better improve the health of its members, and to better manage health care costs than if BCBSLA had remained independent; (9) further, Elevance Health plans to invest annually over $1 billion in maintaining, enhancing and expanding these capabilities – capabilities that BCBSLA strives to bring to members, but that to date have been challenging; and (10) please see Section C of the "Affirmations" in the Summary of the Proposed Plan of Reorganization attached as Annex B for a description of whole health solutions that Elevance Health offers.

Certain members of the Board were designated and selected to serve on either the Advisory Board or as directors on the board of the Foundation prior to the Board's approval of the Proposed Reorganization, and it was determined that the employment of certain management-level employees of BCBSLA would continue unchanged following the completion of the Proposed Reorganization. The purpose of the Advisory Board is generally to review and consult with BCBSLA and Elevance Health management regarding materials provided from time to time to the Advisory Board, including but not limited to, (1) strategic plans and other strategies relevant to BCBSLA, (2) financial performance, (3) operational performance reports (4) customer satisfaction reports, (5) provider satisfaction reports, (6) employee engagement satisfaction reports, and (7) status reports on adherence to the commitments made by Elevance Health in the Acquisition Agreement and the information required for a Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed by Elevance Health, which commitments include the following: (i) the Board will appoint a local plan president subject to Elevance Health's approval; (ii) Elevance Health and Purchaser will maintain average total employment levels in Louisiana at or above current employment levels for two years, which shall include offering future employment opportunities for open positions at Elevance Health that can be based in Louisiana or fully remote, offering greater room for growth for BCBSLA's employees; (iii) Elevance Health and Purchaser will explore the establishment of a Center of Excellence (e.g., MSO, analytics) in Louisiana that serves Elevance Health corporate-wide and addresses local needs; (iv) Elevance Health and Purchaser will explore the development of specific whole health solutions in Louisiana (please see

Section C of the "Affirmations" in the Summary of the Proposed Plan of Reorganization attached as Annex B for a description of whole health solutions that Elevance Health offers); (v) Elevance Health will establish (a) operational objectives and timelines that enable growth operations, increased competitiveness in Medicare Advantage and ASO and (b) a unique management structure, providing a strong local market with key leadership contacts to retain the competitive advantage it currently enjoys; and (vi) Elevance Health is committed to establishing the Advisory Board comprised of Louisiana residents and will provide BCBSLA with advice, support and insight on matters relating to BCBSLA's business and operations in Louisiana, including monitoring integration with Elevance Health and its enterprise-wide operations. The new Advisory Board to be formed is to provide BCBSLA and Elevance Health management with market information, stakeholder input and feedback (including from members/policyholders, providers, members of the community, public officials, etc.) and other information regarding the performance, market position, market perception, competitive landscape, community relations, government relations and other relevant matters affecting BCBSLA.

The Board also determined, in consultation with Chaffe and Deloitte, the most appropriate way to allocate the Eligible Member Payment among the Eligible Members consistent with applicable Louisiana law and the charter and historic mission of BCBSLA.

Based on the above factors, the Board and BCBSLA management believe that the Proposed Reorganization satisfies the requirements of La. R.S. 22:236.4 in properly protecting the interests of Policyholders as such and as members, serves the best interests of Policyholders and members, and is fair and equitable to Policyholders and members. Furthermore, the Board has determined that the Proposed Reorganization is consistent with and satisfies the purpose and principles specifically identified in BCBSLA's charter "to promote the welfare of the members of the Corporation ***and the general public***."

The Board recommends that Voting Members vote FOR approval of the Plan of Reorganization.

THE FOUNDATION & THE TRUST

General

The Accelerate Louisiana Initiative, Inc. is a newly formed nonprofit non-stock corporation organized to work to improve the health and lives of the people of the State of Louisiana which has qualified as a Code Section 501(c)(4) social welfare organization. The Foundation was originally formed in the State of Delaware and redomiciled to the State of Louisiana on November 30, 2023. It is anticipated that if certain conditions are satisfied, as outlined further below, the Foundation would donate or contribute the funds it receives in connection with the Proposed Reorganization to a newly established special charitable trust (as referred to herein, the "**Trust**"). The Trust would have the same general purpose as the Foundation of improving the health and lives of the people of the State of Louisiana. The Trust would be established under the laws of the State of Louisiana and it is intended that the Trust will be exempt from federal income tax as an organization described in Section 501(c)(4) of the Code. The Trust concept was created to address concerns raised by various stakeholders.

New Charitable Trust

As outlined above, the Trust would have the same general purpose as the Foundation of improving the health and lives of the people of the State of Louisiana. However, until the earlier of the initial twelve years of its existence or the achievement of certain milestones or criteria (to be established by the board of trustees of the Trust, after consultation with the Louisiana Department of Health and the Louisiana Department of Children & Family Services, and other such state departments as appropriate to properly develop milestones and criteria), the Trust would have primary areas of focus within that general purpose, which would be related to:

- helping move Louisianians from dependence to independence, with a priority of assisting individuals and families to move from depending on government programs to a life of independence through jobs, coaching, and assistance in the transition,
- improving health outcomes by addressing chronic illnesses, disabilities and health concerns through a focus on diabetes, maternal/infant health, and mental health,
- health care workforce development through programs designed to match the demand for the health care workforce in Louisiana while addressing the excess demand on training institutions and risk of out-of-state migration, which may include, without limitation, marrying training for Certified Nurse Assistants (CNAs) with high school curricula and graduation schedules to expedite the process of earning CNA qualifications, balancing the demand for nurses with the limited pipeline of nurses from Louisiana universities, creating more practical and flexible ways for nursing capacities to be increased, augmenting dedicated resources to attract high quality faculty to university nursing programs, and exploring ways to increase funding, commitment, and employment opportunities for in-state health care jobs, and
- optimizing government performance (in particular, state health care, workforce, and social service agencies), which may include, without limitation, providing expertise and structured training academies for senior level executives in specific state agencies, providing bench training for the future leaders of Louisiana state government, providing technical resources to assist state agencies in integrating eligibility systems and

modernizing customer-facing interfaces through mobile devices, and surfacing best practices and technical assistance to supercharge agency performance and program optimization.

For each of the Priority Areas outlined above, the Trust may allocate a relatively small portion of its resources to innovation, research and development, and pilot programs designed to improve the health, health outcomes, and social determinants of health in Louisiana. Other than Pennington Biomedical Research Center, educational institutions and institutions of higher education shall not be eligible to receive these resources. The Trust would comply with the restrictions that apply to public charities described in Code Section 501(c)(3) with respect to influencing legislation and participating in political campaign activity.

The board of trustees of the Trust would consist of nine to eleven members, which would include the existing four board members of the Foundation (C. Richard Atkins, D.D.S., Thomas A. Barfield, Jr., Jerome K. Greig and Charles Brent McCoy), one member selected by the Governor of the State of Louisiana (which will not be an employee or official of the government of the State of Louisiana unless the Trustees consent to the appointment of such individual), and the remaining board members would be selected by the then current members of the board of trustees (i.e. self-perpetuating board members). It is also expected that the Commissioner would be offered an observer role on the board of the Trust (which would be a non-voting and non-compensated position).

It is expected that new legislation in the State of Louisiana will be needed to create this special charitable trust, as existing laws in Louisiana do not provide sufficient flexibility for a private charitable trust of this magnitude to operate in a commercially reasonable manner. In particular, including that existing trust law does not allow for sufficient delegation of organizational management to traditional governance structures such as committees, executives, and employees, nor does it provide for market-standard indemnification of board-level leadership, which are crucial to recruiting appropriate personnel to the organization in trustee and management roles.

It is further expected that if the Closing occurs, the Foundation would retain as a custodian the funds it receives in connection with the Plan of Reorganization until the date that is 12 months from the Closing (the "**Expiration Date**"). During that period, the Foundation will not make any grants and will only deploy funds for the purposes of recruiting staff, initiating start-up operations, and paying for applicable taxes and other expenses. It is expected that during this 12-month period, the conditions below will be satisfied; however, if they are not satisfied, then the Foundation will seek to convert from an organization exempt under Code Section 501(c)(4) to an organization exempt under Code Section 501(c)(3), and upon such conversion, the Foundation would be free to operate in accordance with its organizational documents. If the conditions are satisfied by the Expiration Date, the Foundation would donate or contribute to the Trust all of the funds it has received in connection with the Plan of Reorganization (less any amounts paid as required by applicable law for taxes or otherwise paid pursuant to the Acquisition Agreement or as operating expenses).

Conditions related to funding of the New Charitable Trust

The obligation of the Foundation to donate to the Trust the funds it has received in connection with the Plan of Reorganization (less any amounts paid as required by applicable law for taxes or otherwise paid pursuant to the Acquisition Agreement or as operating expenses) shall be subject to the following conditions: (a) the Trust will adopt and have in place a trust agreement and bylaws containing the material terms and conditions that are summarized below under "Summary of Material Terms of Trust"; (b) the initial Board of Trustees of the Trust will include those individuals identified above, and the remaining trustees will be selected as described above; (c) the Trust will have received an affirmative determination from the U.S. Internal Revenue Service (the "**IRS**") of the Trust's status as exempt from federal income tax under Code Section 501(c)(4); (d) the Trust will have agreed to assume all debts and liabilities of the Foundation; and (e) new legislation will be enacted and in force in the State of Louisiana ("**Proposed Legislation**") that is in substantial conformance with the summary set forth below under "Proposed Legislation."

As referenced above, in the event that each of the above conditions are not satisfied by the Expiration Date, the Foundation will be free to retain the funds and deploy them in accordance with its organizational documents and will be obligated to seek to convert from an organization exempt under Code Section 501(c)(4) to an organization exempt under Code Section 501(c)(3), and to take such other actions as shall be necessary and advisable to achieve said result, as soon as reasonably practicable following the Expiration Date.

Summary of Material Terms of Trust

The Trust will be organized and operated exclusively for the social welfare purpose of improving the health and lives of the people of Louisiana. The Trust will provide for the composition of the Board of Trustees of the Trust as outlined above. The Trust will also be prohibited from the amendment of certain provisions regarding government oversight and the purpose and disposition of the assets of the Trust without the consent of a court of competent jurisdiction.

Proposed Legislation

The Proposed Legislation, as enacted, must provide for delegation of authority of the Board of Trustees of the Trust to officers, employees, and agents, the indemnification of trustees, officers, agents and third parties, limitations on the liabilities of trustees, officers, and agents, and the assumption of liabilities in connection with or related to donations or contributions, in each case in a manner that is no less than the corresponding standards under Louisiana law for nonprofit corporations. The Proposed Legislation, as enacted, must also permit the trust instrument to be amended by the trustees without court involvement, except certain provisions regarding government oversight and the purpose and disposition of the assets of the Trust. In addition, the Proposed Legislation, as enacted, must not (i) change the purpose of the Trust, (ii) require amounts be paid to specific recipients or causes or (iii) change the board of trustees of the Trust. Finally, no amendments to the Proposed Legislation that are enacted that materially alter the terms above would be allowable.

ELIGIBILITY TO VOTE

General

In general, policyholders of a mutual insurance company with policies that are in force as of a particular record date have membership interests that give such policyholders the right to vote on various matters, including certain extraordinary transactions such as conversions. The rules described below explain who is entitled to vote on the Plan of Reorganization and receive payment pursuant to the Proposed Reorganization.

Membership Interests are derived from being a Policyholder. In order for you to be entitled to vote on the Plan of Reorganization (i.e., be a "**Voting Member**"), you must have been a Policyholder of an In Force Policy as of the Record Date.

Voting

In accordance with applicable Louisiana law (LSA-R.S. § 22:236.5(A)), Voting Members shall be entitled to vote on proposals to adopt and approve the Plan of Reorganization. To become effective, the Plan of Reorganization must be approved by at least two-thirds vote of Voting Members actually present or represented at the Special Meeting by special ballot or by special proxy.

In accordance with LSA-R.S. § 22:236.5(D), a quorum for the Special Meeting consists of the Voting Members present or represented at the Special Meeting by special ballot or by special proxy.

The Plan of Reorganization by its terms, including the Amended and Restated Articles of Incorporation and Amended and Restated Bylaws, if adopted, will be effective only upon the closing of the Proposed Reorganization. If the Commissioner does not approve the Plan of Reorganization or requires modifications to the Plan of Reorganization following the Public Hearing, the date of the Special Meeting may change to a later date or be extinguished.

Voting Members may use the PROXY FORM enclosed in this package. Voting Members may vote in person or by proxy.

Please note that any proxy previously granted (whether online, by mail or by phone) will be disregarded for purposes of the rescheduled Special Meeting. Voting Members' proxy forms should be returned by using the internet or phone in accordance with the instructions on the proxy form or by mail to Blue Cross Blue Shield of Louisiana c/o First Coast Results, PO Box 3672, Ponte Vedra Beach, FL 32004-9911 by 11:59 p.m., Central Time, on [•]. A postage prepaid envelope preprinted with the above address is enclosed for your use. Voting Members may also deliver their proxy forms to us at any time prior to the Special Meeting. If you need instructions regarding voting by proxy, please call MacKenzie Partners, Inc. toll-free at 1 (800) 356-8906 from 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday.

Your proxy form is to be marked with a vote of either "FOR" approval of the Plan of Reorganization or "AGAINST" approval of the Plan of Reorganization.

The Board voted to adopt the Plan of Reorganization and found the Plan of Reorganization to be in the best interests of Policyholders. ***The Board recommends that Voting Members vote FOR approval of the Plan of Reorganization.***

REPORTS OF FINANCIAL ADVISORS

In reaching its decision to adopt the Plan of Reorganization and recommend its approval by the Policyholders at the Special Meeting, the Board considered, among other things, whether: (i) the total consideration that Elevance Health would pay in connection with the Proposed Reorganization is fair; (ii) the allocation of total consideration between the Foundation and the Eligible Members was fair; and (iii) the allocation of consideration among the Eligible Members was fair. In reaching its conclusions, the Board carefully selected and retained expert financial advisors to assist in its evaluation. Below is a summary of the fairness opinions and each respective financial advisors work in determining the allocation of the Eligible Member Payment.

Fairness Opinion of Chaffe & Associates, Inc.

BCBSLA, with the assistance of Chaffe and other advisors retained in connection with the Proposed Reorganization, structured the Proposed Reorganization to provide that consideration paid to the Eligible Members for the extinguishment of their Membership Interests as of the Reorganization Effective Time is fair to the Eligible Members, as a group, from a financial point of view, as provided for in the Plan of Reorganization. In that regard, the Board received a written fairness opinion from Chaffe (the "**Chaffe Fairness Opinion**") confirming, subject to the limitations and qualifications in such opinion, that the method for the payment of consideration to the Eligible Members upon the extinguishment of their Membership Interests under the Plan of Reorganization is fair to the Eligible Members, as a group, from a financial point of view consistent with Louisiana law (LSA-R.S. § 22:236.3(A)).

The Chaffe Fairness Opinion was rendered based upon Chaffe's review of the draft Acquisition Agreement, draft Plan of Reorganization, BCBSLA's then-effective articles of incorporation and then-effective bylaws, and other documents and records deemed material and relevant by Chaffe in connection with its rendering of the Chaffe Fairness Opinion. In particular, the Chaffe Fairness Opinion noted that BCBSLA's then-effective articles of incorporation grants BCBSLA members the right to vote, but provide that they shall receive no dividends, and are silent with regard to any right of BCBSLA members to participate in BCBSLA's surplus or proceeds of liquidation. The Chaffe Fairness Opinion also noted that Chaffe, to the extent it deemed relevant in accordance with the standards of the investment banking industry, considered other factors in rendering its opinion, including, without limitation, the rights associated with a membership interest in BCBSLA, which do not include a right to dividends or surplus. The Chaffe Fairness Opinion included customary limitations, qualifications and assumptions appropriate for a transaction of this nature, and did not contain any opinion other than the opinion noted above, including that it did not opine with respect to such matters as (i) the value or range of values of BCBSLA, and the fairness from a financial point of view of such value, range of values, any point within such range, and the value of a member month; (ii) the total amount of consideration to be paid in the Proposed Reorganization or its fairness from a financial point of view; (iii) the accuracy or completeness of the information used by BCBSLA to compute the total member months of all members since BCBSLA's formation and of the number of member months attributable to existing Eligible Members individually or as a group, and the accuracy of and methodology underlying such calculations; (iv) the methodology and underlying assumptions for the allocation of consideration among Eligible Members; and (v) the decision by BCBSLA to employ the

methodology stated in the Plan of Reorganization for the allocation of the transaction consideration to the Eligible Member group as compared to any other methodology.

Chaffe's compensation for the Chaffe Fairness Opinion is not dependent or contingent upon the completion of the Proposed Reorganization and is not related to or based upon the nature of the findings made therein. BCBSLA agreed to pay Chaffe a reasonable customary fee and reimburse Chaffe for its expenses related to the Chaffe Fairness Opinion. BCBSLA also agreed to indemnify Chaffe for certain liabilities that may arise in connection with the rendering of the Chaffe Fairness Opinion.

Actuarial Opinion of Deloitte Consulting LLP

The Board received a written actuarial opinion (the "**Actuarial Opinion**") from Brian Collender of Deloitte Consulting, LLP ("**Deloitte**") consistent with Louisiana law (LASA-R.S. § 22:236.3(B)) as to the reasonableness and appropriateness of the methodology and underlying assumptions used to allocate the Eligible Member Payment among Eligible Members and stating that the resulting allocation is fair and equitable. The method or formula for allocating the Eligible Member Payment among the Eligible Members is to make a uniform payment of consideration, a "fixed component" under Louisiana law (LASA-R.S. § 22:236.3(B)(1)), to each Eligible Member. In the event that an individual or entity is an Eligible Member pursuant to multiple In Force Policies, such Eligible Member shall receive the uniform payment of consideration for each In Force Policy. Each Eligible Member will be allocated a cash amount equal to a portion of the Eligible Member Payment (as described in more detail in the Plan of Reorganization), which such allocation has been determined as fair and equitable in the Actuarial Opinion.

The Actuarial Opinion was rendered based upon Deloitte's review of the draft Plan of Reorganization, BCBSLA's then-effective articles of incorporation and then-effective bylaws, sample BCBSLA member contracts and other documents and records deemed material and relevant by Deloitte in connection with its rendering of the Actuarial Opinion. The Actuarial Opinion noted that the Proposed Reorganization is unique in that none of BCBSLA's policies provide for dividends to be paid (i.e., none are participating insurance policies), in contrast to what is typically seen in mutual insurance companies. Furthermore, the Actuarial Opinion stated that BCBSLA determined that since all of its policies are non-participating, paying no dividends and providing no rights to surplus, shares of stock or liquidation proceeds, there is no variable component to the allocation of consideration among Eligible Members. Thus, BCBSLA determined that the allocation of consideration among Eligible Members should consist of only a fixed component on a per policy basis to compensate Eligible Members for the extinguishment of voting rights.

The Actuarial Opinion noted that practices commonly used by actuaries for the allocation of the fixed component of consideration compensate policyholders for the extinguishment of membership rights associated with owning an in-force policy (e.g. voting rights) and, as outlined in the Plan of Reorganization, BCBSLA's allocation method for the Proposed Reorganization includes a fixed component to compensate policyholders for the extinguishment of voting rights, and that the same amount will be allocated to each Eligible Member for each available vote.

The Actuarial Opinion noted that Actuarial Standards of Practice (ASOP) No. 37 notes that in determining the reasonableness of the allocation, the actuary may consider the company's voting policy and that the actuary may determine that the fixed component can be allocated based on each eligible policy (regardless of the size of the policy) or each eligible policyholder (regardless of the number of policies or size of policies). The Actuarial Opinion concluded that the allocation methodology utilized by BCBSLA conforms to this guidance as the fixed component is allocated based on each policy that has a voting right.

The Actuarial Opinion also noted that under BCBSLA's methodology, there is no variable portion of consideration being allocated to Eligible Members, and that, according to the American Academy of Actuaries Practice Note titled, "Distribution of Policyholder Equity in a Demutualization," a variable portion is generally allocated to each holder of a policy that is participating on its face. The Actuarial Opinion went on to state that since BCBSLA's policies are all non-participating, it is reasonable that there is not a variable portion being allocated.

BCBSLA agreed to pay Deloitte a reasonable customary fee and reimburse Deloitte for its expenses related to the Actuarial Opinion. BCBSLA also agreed to indemnify Deloitte for certain liabilities that may arise in connection with the rendering of its Actuarial Opinion.

The Actuarial Opinion assessed only the allocation of consideration among Eligible Members and was not intended to offer comments or recommendations regarding the exact number of BCBSLA members eligible to receive a portion of the Eligible Member Payment, the form of the consideration to be distributed to Eligible Members, nor the proposed methodology for valuation of the total Eligible Member Payment to be distributed, including any calculations or components related to the development of the total consideration amount. Additionally, the Actuarial Opinion was rendered from an actuarial perspective only and provided no recommendation with regard to whether or not Voting Members should vote to approve the Plan of Reorganization. The Actuarial Opinion contained no analysis of the adequacy of policy reserves, future policy benefits, other policyholder funds or any other related actuarial financial statement items, all of which were outside of the scope of the opinion.

CERTAIN RISKS AND CONSIDERATIONS RELATING TO THE PROPOSED REORGANIZATION

The Proposed Reorganization involves some potential risks. As set forth in the Plan of Reorganization filed with the Commissioner, BCBSLA did not identify any material risks resulting from the Proposed Reorganization. However, there are other considerations and consequences of the Proposed Reorganization. You should consider carefully, in addition to the other information contained in the Member Information Statement (in particular, (1) the information in "Important Information", (2) Answer 32 and (3) the advantages and disadvantages discussed in "Reasons for the Proposed Reorganization and Considerations of the Board; Recommendation of the Board" (pages 29-32)), the following factors before voting on the Proposed Reorganization.

As a consequence of the Proposed Reorganization, Policyholders of BCBSLA will lose their Membership Interests and control over BCBSLA will be exercised exclusively by Elevance Health.

A mutual insurance company is generally operated for the benefit of its policyholders. The Proposed Reorganization will result in one shareholder, Purchaser (and, indirectly, Elevance Health), gaining control of BCBSLA. Shareholder interests in a converted BCBSLA might differ from the interests of Policyholders.

BCBSLA's management and Board may have interests in pursuing the Proposed Reorganization that are in addition to the Policyholders' interests.

BCBSLA's Board and members of its management may have interests in the Proposed Reorganization that are in addition to the interests of members. Some of these interests are related to improving the communities at large that BCBSLA serves and ensuring that BCBSLA remains optimally competitive in the state's insurance segment. For more information, see Question and Answer Q/A22, of the "Questions and Answers About the Proposed Reorganization and the Vote" section of this Member Information Statement on pages 14-15.

BCBSLA could face adverse reactions to the Proposed Reorganization.

Policyholders may respond negatively to the Proposed Reorganization by canceling or declining to renew Policies.

BCBSLA, whether or not it converts to a stock insurance company, would remain subject to changes in state and/or federal law.

Changes in law and regulations, or changes in interpretations thereof, could reduce BCBSLA's profitability. Furthermore, such changes could have an adverse impact on the insurance business generally. No assurance can be given that any future legislative or regulatory developments would benefit, or would not harm, a converted BCBSLA. Similar risks exist for BCBSLA if it does not convert.

The reserves of BCBSLA for future Policy benefits and claims could prove to be inadequate, whether or not it converts to a stock insurance company.

BCBSLA maintains reserves so it can cover expenses associated with unknown future risks. Example of such risks include hurricanes and the recent COVID-19 pandemic. While the transaction will result in BCBSLA having somewhat lower reserves than it does today (with some of the reserves going to the Foundation (or the Trust, as applicable)), it would still have at least 2.5 times the required regulatory minimum risk based capital amount. Further, the financial strength of the Elevance Health organization is substantially greater than BCBSLA on its own today. In the event that additional capital is needed to strengthen the solvency of BCBSLA in the future, Elevance Health maintains cash and/or investments that can be contributed to its subsidiaries if necessary.

Litigation and regulatory investigations may adversely affect BCBSLA.

BCBSLA faces risks of litigation, regulatory investigations and enforcement actions in connection with BCBSLA's activities as an insurer, employer, investor and taxpayer, as well as in connection with the Proposed Reorganization. These types of lawsuits and regulatory actions may be difficult to assess or quantify and may seek recovery of very large or indeterminate amounts, including punitive or other special damages. The existence and magnitude of these risks may remain unknown for substantial periods of time. A substantial legal liability or a significant regulatory action against BCBSLA could have a material adverse effect on BCBSLA. Except with respect to risks of litigation related to the Proposed Reorganization, the same risks exist for BCBSLA if it does not convert.

Failure to complete the Proposed Reorganization could negatively impact the consideration, if any, Eligible Members might receive in a future demutualization, if any.

If the Proposed Reorganization is not completed and the Board determines to seek another acquisition, affiliation or sponsored demutualization transaction, there can be no assurance that BCBSLA will be able to find an equivalent strategic acquirer or an acquirer willing to pay an equivalent or more attractive price than that which would be paid in the Proposed Reorganization.

Indemnification obligations under the Acquisition Agreement.

Under the Acquisition Agreement, the Foundation will be obligated to indemnify the Purchaser under certain circumstances, which could result in the Foundation being required to return certain amounts to the Purchaser. These indemnification obligations will not result in any decrease in or clawback of any Eligible Member Payment. These indemnification obligations would be assumed by the Trust, if applicable.

U.S. FEDERAL INCOME TAX CONSIDERATIONS

The following is a summary of the material U.S. federal income tax consequences of the receipt of their shares of the Eligible Member Payment pursuant to the Plan of Reorganization by Eligible Members who are U.S. Members (as defined below) and that hold their Membership Interests as capital assets within the meaning of Section 1221 of the Code. This summary is for general informational purposes only. It is not intended to be a complete discussion of all tax consequences that may be relevant to a particular Eligible Member. This summary does not address federal estate, gift, Medicare or alternative minimum tax consequences, or any state, local, or non-U.S. tax consequences of the Plan of Reorganization or any other transaction. This summary is not tax advice. Eligible Members should consult a tax advisor to determine how the Proposed Reorganization and other transactions described in the Member Information Statement will affect them in their particular circumstances, including how the application of federal estate, gift, Medicare or alternative minimum tax, and any state, local, and non-U.S. tax consequences of the transactions may affect them.

For purposes of this summary, the term "**U.S. Member**" means an Eligible Member who is, for U.S. federal income tax purposes:

(i) an individual who is a citizen or resident of the United States; or

(ii) a corporation (or other entity taxable as a corporation for U.S. federal income tax purposes) created or organized under the laws of the United States, any state thereof, or the District of Columbia.

This summary is based on the provisions of the Code, U.S. Treasury regulations promulgated thereunder, judicial authorities, and administrative rulings, all of which are subject to change, possibly with retroactive effect. There can be no assurance that the IRS or a court will agree with the positions and U.S. federal income tax consequences described below. This summary does not apply to Eligible Members who may be subject to special treatment under U.S. federal income tax law (including, without limitation, insurance companies, retirement plans, certain former citizens or residents of the United States, partnerships or other pass-through entities, trusts, and tax-exempt organizations). This summary does not address the U.S. tax consequences of any Eligible Member who is not a U.S. Member, such as a non-resident alien individual, foreign corporation, foreign partnership, or foreign estate or trust. This summary assumes that each U.S. Member's tax basis in his or her Membership Interest is zero. See "*Tax Basis in Membership Interests*" below for additional information.

Eligible Member Payment

The receipt of a share of the Eligible Member Payment by a U.S. Member will be a taxable event for U.S. federal income tax purposes. In general, a U.S. Member should recognize capital gain in an amount equal to their share of the Eligible Member Payment. This capital gain will be long-term capital gain if the U.S. Member's holding period in its extinguished Membership Interest exceeds one year. This period should include the period during which a U.S. Member holds his or her Membership Interest prior to the Proposed Reorganization. Long-term capital gains of non-corporate U.S. Members are eligible for reduced rates of taxation. Short-term capital gains are

subject to U.S. federal income tax at the same rates as ordinary income. Each U.S. Member should consult with such U.S. Member's tax advisor as to the proper treatment of such gain based on such U.S. Member's particular situation.

Tax Basis in Membership Interests

In the case of the transfer of property, gain or loss generally is determined by subtracting the cost basis of the property from the amount of consideration realized from the transfer of the property. The legal precedents regarding whether a Policyholder has a tax basis in membership rights of a mutual company such as BCBSLA are complex and conflicting, and may depend upon the facts applicable to the particular situation. Nonetheless, in accordance with the historic position of the IRS, a U.S. Member will recognize gain in connection with the Proposed Reorganization equal to the full amount of their allocable share of the Eligible Member Payment received, because the basis of the property transferred by the U.S. Member in the Proposed Reorganization is derived by reference to such U.S. Member's basis in its Membership Interest, and the IRS's position has been that the basis of a membership right in a mutual company is zero. You should be aware, however, that in a 2008 decision affirmed on appeal, the U.S. Court of Federal Claims rejected the IRS's position, applying instead the "open transaction" doctrine to a taxpayer's receipt of consideration in a mutual company conversion transaction similar in certain respects to the Proposed Reorganization. The IRS continues to litigate this issue, however, and prevailed in a separate U.S. Court of Appeals case.

Withholding

The Paying Agent will require that you submit a properly executed IRS Form W-9 (if you are a U.S. Member) certifying (i) your correct social security number or other applicable taxpayer identification number, and that (ii) (a) you are exempt from backup withholding, (b) you have not been notified by the Internal Revenue Service that you are subject to backup withholding, or (c) the Internal Revenue Service has notified you that you are no longer subject to backup withholding, and (iii) you are a "U.S. person" as defined in IRS Form W-9. Failure to provide such information would generally result in the Paying Agent's need to withhold on your receipt of your allocable share of the Eligible Member Payment at the applicable U.S. federal backup withholding statutory rate (currently, 24%). An IRS Form W-9 and associated instructions may be obtained from the IRS at its website: www.irs.gov. Backup withholding is not an additional tax. Rather, the amount of the backup withholding may be credited against the U.S. federal income tax liability of the person subject to the backup withholding, provided that the required information is timely provided to the IRS. If backup withholding results in an overpayment of tax, a refund can be obtained by the Policyholder by timely providing the required information to the IRS.

If you are not a U.S. Member, the Paying Agent will require you to submit an appropriate and properly completed Form W-8BEN, W-8BEN-E, W-8ECI, W-8EXP or W-8IMY, as the case may be, signed under penalties of perjury attesting to your exempt (or reduced) withholding status for U.S. federal income tax purposes. Such forms and instructions may be obtained from the IRS at its website: www.irs.gov. Failure to provide such information would generally result in the Paying Agent's need to withhold on your receipt of your allocable share of the Eligible

Member Payment (at the applicable withholding statutory rate (currently a maximum rate of 30%)).

AVAILABLE INFORMATION

BCBSLA is subject to the laws and regulations of the State of Louisiana applicable to health and life insurance companies, and, as required by those laws, files financial reports and other information with the Department. Publicly available information regarding BCBSLA and relevant to the Plan of Reorganization can be inspected at BCBSLA's principal office, located at 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, between 10:00 a.m. and 4:00 p.m., Central Time, Monday through Friday until [•], except days on which BCBSLA is closed for business, by calling us toll-free at (225) 295-2294 from 9:00 a.m. to 4:00 p.m., Central Time, Monday through Friday to arrange an appointment. Certain information can also be requested from the Department pursuant to the Louisiana Public Records Law. For information and instructions regarding submitting such a request, please see the Department's website at www.ldi.la.gov.

INCORPORATION OF CERTAIN DOCUMENTS BY REFERENCE

The financial statements of BCBSLA, prepared in conformity with statutory accounting principles prescribed or permitted by the Insurance Regulators consistently applied, for the years ended December 31, 2021, and December 31, 2022, and the quarter ended September 30, 2023, which have been filed with the Department, are incorporated by reference into this Member Information Statement. Copies of these documents and all other documents referred to in this Member Information Statement can be inspected by Voting Members at BCBSLA's principal office, 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, between 10:00 a.m. and 4:00 p.m., Central Time, Monday through Friday until [•], except days on which BCBSLA is closed for business, by calling us toll-free at (225) 295-2294 from 9:00 a.m. to 4:00 p.m., Central Time, Monday through Friday to arrange an appointment.

Statements contained in this Member Information Statement and in documents summarized or incorporated by reference into this Member Information Statement regarding the contents of any other document are not necessarily complete. In each instance where reference is made to the Plan of Reorganization, the Acquisition Agreement or to any public or other document, each such statement is qualified in all respects by the more complete information contained in the referenced document. For the purposes of this Member Information Statement, each of the documents referred to in this Member Information Statement is deemed incorporated by reference in its entirety.

CAUTIONARY STATEMENT CONCERNING FORWARD-LOOKING INFORMATION

This Member Information Statement contains information that is forward-looking. Forward-looking statements involve known and unknown risks, uncertainties and other factors, which may cause actual results to differ materially from the forward-looking statements. Words such as "anticipates," "expects," "intends," "plans," "believes," "seeks," "estimates," "may," "will," "continue," "project," and similar expressions, as well as statements in the future tense, identify forward-looking statements. These forward-looking statements are not guarantees of our future performance and are subject to risks and uncertainties that could cause actual results to differ materially from the results contemplated by the forward-looking statements. These risks and uncertainties include:

- the inability to consummate the Plan of Reorganization (including obtaining necessary regulatory and Voting Member approval and satisfaction or waiver of the other conditions to the closing of the Acquisition) and to realize the benefits of the Plan of Reorganization;
- the impact on BCBSLA of a failure to complete the transactions contemplated by the Plan of Reorganization;
- the validity of assumptions and methodologies used by management in analyzing the Proposed Reorganization and in predicting BCBSLA's further capital and liquidity needs and the inability to predict with certainty any future scenarios;
- changes in law and accounting principles;
- changes in general economic conditions, including the impact of inflation or deflation and unemployment;
- risks arising from BCBSLA's investment strategy, including risks related to the market value of investments, fluctuations in interest rates and our need for liquidity;
- developments in financial markets that could affect BCBSLA's investment portfolio;
- the competitive environment in which BCBSLA operates and associated pricing and other pressures;
- changes in the availability, cost, quality or collectability of insurance/reinsurance;
- consolidation of BCBSLA's members into or under better capitalized or more diversified entities which may be insured by competitors, or may not have a risk profile that BCBSLA's our underwriting criteria or which may not use external providers for insuring or otherwise managing substantial portions of their liability risk;
- uncertainties inherent in the estimate of BCBSLA's loss and loss adjustment expense reserve and reinsurance recoverables;

- changes to the ratings assigned by rating agencies;
- changes in BCBSLA's organization, compensation and benefit plans;
- the ability to retain and recruit senior management;
- loss of the services of any of BCBSLA's key employees;
- BCBSLA's ability to achieve continued growth through expansion into new segments or through acquisitions or business combinations;
- expected benefits from completed and proposed acquisitions may not be achieved or may be delayed longer than expected due to business disruption, loss of customers, employees or key agents, increased operating costs or inability to achieve cost savings, and assumption of greater than expected liabilities, among other reasons;
- the results of litigation, including pre- or post-trial motions, trials and/or appeals BCBSLA may undertake;
- the availability, integrity and security of BCBSLA's technology infrastructure or that of third-party providers of technology infrastructure, including any susceptibility to cyber-attacks which might result in a loss of information or operating capability;
- the impact of a catastrophic event, as it relates to both BCBSLA's operations and insured risks;
- changes in the ability of the U.S. government to meet its obligations that may affect the U.S. economy and our business; and
- the impact of epidemics, pandemics, acts of terrorism and acts of war.

The effects of these factors are difficult to predict. New factors emerge from time to time and BCBSLA cannot assess the financial impact of any such factor on its business or the extent to which any factor or combination of factors may cause results to differ materially from those described in any forward-looking statement. Any forward-looking statement speaks only as of the date of this Member Information Statement and BCBSLA does not undertake any obligation to update any forward-looking statements to reflect events or circumstances after the date of such statement or to reflect the occurrence of unanticipated events.

ANNEX A

Summary Financial Information

See attached.

Louisiana Health Service & Indemnity Company and Subsidiaries

Consolidated Statements of Operations
(In Thousands)

	Year Ended December 31	
	2022	**2021**
Revenue:		
Premiums:		
Local underwritten	**$ 3,955,753**	$ 3,721,218
Federal Employee Program	**502,217**	504,697
Claims processing fees earned	**198,741**	172,282
Patient services revenue	**47,028**	46,008
Investment (loss) income, net	**(123,579)**	112,020
Other	**3,280**	531
Total revenue	**4,583,440**	4,556,756
Expenses:		
Claims:		
Local underwritten	**3,252,324**	3,100,000
Federal Employee Program	**464,556**	468,465
Administrative expenses	**1,016,676**	837,274
Total expenses	**4,733,556**	4,405,739
(Loss) income before income taxes	**(150,116)**	151,017
Income tax (benefit) expense	**(11,417)**	49,995
Consolidated net (loss) income	**(138,699)**	101,022
Net loss attributable to noncontrolling interest	**(229)**	(2,646)
Net (loss) income attributable to Louisiana Health Service & Indemnity Company	**$ (138,470)**	$ 103,668

Louisiana Health Service & Indemnity Company and Subsidiaries

Consolidated Statements of Operations
(In Thousands)

	Year to Date September 30, 2023
Revenue:	
Premiums:	
Local underwritten	**$3,144,408**
Federal Employee Program	**415,668**
Claims processing fees earned	**153,489**
Patient service revenue	**39,660**
Investment income, net	**81,688**
Other	**9,264**
Total revenue	**3,844,177**
Expenses:	
Claims:	
Local underwritten	**2,619,895**
Federal Employee Program	**385,006**
Administrative expenses	**713,366**
Total expenses	**3,718,267**
Income before income taxes	**125,910**
Income tax expense	**40,467**
Consolidated net income	**$85,443**

ANNEX B

Summary of Plan of Reorganization and Acquisition Agreement

See attached.

ANNEX B

Summary of Plan of Reorganization and Acquisition Agreement

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY D/B/A
BLUE CROSS AND BLUE SHIELD OF LOUISIANA

a mutual insurance company organized
and existing under the laws of the State of Louisiana

SUMMARY OF PLAN OF REORGANIZATION
REGARDING THE CONVERSION
FROM A MUTUAL INSURANCE COMPANY
TO A STOCK INSURANCE COMPANY

under LSA-R.S. §§ 22:72 and 22:236 *et seq.*

Proposed and adopted by the Board of Directors of
Louisiana Health Service & Indemnity Company d/b/a
Blue Cross and Blue Shield of Louisiana on
January 23, 2023

and amended by that Amendment No. 1 effective as of
July 18, 2023, that Amendment No. 2 effective as of August 23, 2023, and that Amendment
No. 3 effective as of December 12, 2023

Explanatory Note*: This document is a summary of the material terms and conditions of the Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company that was approved and adopted by the Board of Directors of Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, a mutual insurance company organized and existing under the laws of the State of Louisiana, on January 23, 2023 and amended by that Amendment No. 1 effective as of July 18, 2023, that Amendment No. 2 effective as of August 23, 2023, and that Amendment No. 3 effective as of December 12, 2023.*

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY
D/B/A
BLUE CROSS AND BLUE SHIELD OF LOUISIANA

SUMMARY OF PLAN OF REORGANIZATION REGARDING THE CONVERSION FROM A MUTUAL INSURANCE COMPANY TO A STOCK INSURANCE COMPANY

The Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company (the "Plan") has been adopted and is being proposed by the Board of Directors (the "Board") of Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, a mutual insurance company organized and existing under the laws of the State of Louisiana ("BCBSLA"), by resolutions of the Board duly adopted and effective as of January 23, 2023 (the "Adoption Date"). Capitalized terms used herein have the meanings set forth in Article XII. The Plan was amended upon approval by the Board by that Amendment No. 1 effective as of July 18, 2023, that Amendment No. 2 effective as of August 23, 2023 and that Amendment No. 3 Effective as of December 12, 2023.

Affirmations Related to the Proposed Reorganization

A. The Plan provides for:

(1) the conversion/reorganization of BCBSLA from a mutual insurance company into a stock insurance company pursuant to Louisiana law (LSA-R.S. § 22:72, LSA-R.S. § 22:236 *et seq.* and the other applicable provisions of the Louisiana Insurance Code (such statutory provisions are referred to herein collectively as the "Louisiana Demutualization Law"));

(2) prior to the effectiveness of the Reorganization (as defined below) and in furtherance of the purposes and policies set forth in the currently existing Second Amended and Restated Articles of Incorporation of BCBSLA (the "Current Articles") (including promoting the health and welfare of the constituencies to be served pursuant to such Current Articles), the contribution by BCBSLA of the Approved Excess Surplus to The Accelerate Louisiana Initiative, Inc., a newly formed nonprofit nonstock corporation organized to work to improve the health and lives of the people of the State of Louisiana which has qualified as a Code Section 501(c)(4) social welfare organization (the "Foundation") and, in connection therewith, the issuance by BCBSLA of a funding agreement which requires the Foundation, subject to the satisfaction of certain conditions, to donate the amounts it receives pursuant to the Reorganization (less amounts for applicable taxes and expenses) to the Trust (as defined herein), as further provided for in Section 1.2 hereof;

(3) prior to the effectiveness of the Reorganization, and in furtherance of the purposes and policies set forth in the Current Articles (including promoting the health and welfare of the constituencies to be served pursuant to the Current Articles), the issuance by BCBSLA to the Foundation of a note payable (the "Note").

The amount of the Note (the "Note Amount") is equal to:

- $2,500,000,000 *minus*

- the Eligible Member Payment plus
- A portion of BCBSLA's surplus (not including any Approved Excess Surplus) in an amount to be determined prior to Closing, subject to adjustment for indebtedness and transaction expenses (which adjustments will be determined prior to Closing).

The Note shall be paid immediately following the closing of the transactions contemplated by the Acquisition Agreement (the "Closing") in accordance with the terms of the Acquisition Agreement and the Plan;

(4) contemporaneously with the effectiveness of the Reorganization, the issuance of 100% of the shares of Common Stock to be issued pursuant to the Plan to ATH Holding Company, LLC, an Indiana limited liability company ("Purchaser"), which is a wholly owned subsidiary of Elevance Health, Inc., an Indiana corporation ("Elevance Health"), such that, following such issuance upon the effectiveness of the Reorganization, Purchaser shall directly own (and Elevance Health shall indirectly own) 100% of the issued and outstanding shares of Common Stock; and

(5) contemporaneously with the effectiveness of the Reorganization, the deposit by Purchaser with the Paying Agent (for distribution to the Eligible Members) of the Eligible Member Payment as consideration for the extinguishment of the Membership Interests of the Eligible Members;

in each case, in accordance with the Plan, the Acquisition Agreement and the Louisiana Demutualization Law, as applicable. The transactions set forth in clauses (1) through (5) above are collectively referred to herein as the "Proposed Reorganization" and, in the form approved by the Commissioner, the "Reorganization".

B. The Board believes that the Proposed Reorganization will not, in any way, adversely impact policy premiums or health care benefits to Policyholders or members.

C. The Board believes that the Proposed Reorganization will provide BCBSLA with greater financial resources and flexibility. The Board believes that this financial flexibility will improve BCBSLA's access to capital to permit BCBSLA to expand existing business, develop new business opportunities and enhance its competitive position in the health benefits industry through Elevance Health's more than $100 billion market capitalization and one of the most diversified asset portfolios in the entire industry. The Board believes that the Proposed Reorganization will permit BCBSLA to continue to improve service to customers and grant BCBSLA members in the future the ability to utilize tools already available to Elevance Health and its affiliates that will enhance the availability of health care services and benefits to members, including Elevance Health's digital tools which give members 24-hour digital support and includes text and video visits with integrated health care providers, integrated pharmacy support, at-home diagnostics solutions, and care navigation. Elevance Health has developed a portfolio of whole health solutions, and capabilities with over $4 billion in investments in recent years. This portfolio provides solutions for a variety of member needs, including condition-specific needs regarding diabetes, cancer, heart conditions, and several others. Having condition-specific solutions that

complement the care delivered by health care providers enables members to focus on what will improve their health and lives. Increasingly, health care is being delivered digitally and outside of the traditional physician's office when appropriate, especially in rural parts of Louisiana where health care services can be located hours away from a member's home or work. Elevance Health's digital platforms and health care delivery assets dramatically improve access via mobile devices, internet, and phone at the convenience of members. These whole health capabilities have shown success in improving Elevance Health members' health. Elevance Health has recently developed a 'whole health index', a dynamic model to better understand drivers of health and measure the impacts of its various solutions on health outcomes in a community. This index also helps identify the most promising future opportunities to improve the health of members and their communities. Further, Elevance Health plans to continually invest over $1 billion annually in building new capabilities – capabilities that the Board desires to bring to BCBSLA members. Among the whole health solutions that Elevance Health offers are:

(1) Elevance Health's Cancer Care Navigator and Concierge Care solutions to support members with cancer, and their families, with personalized one-on-one support as they navigate the complex landscape of cancer care. Examples include connecting and aligning with the appropriate health care providers, matching with appropriate clinical trials, traveling to a center of excellence, and getting second opinions when needed. These solutions already serve members in Elevance Health's existing industries and ensure that Elevance Health members understand their options, get high quality care, and minimize unnecessary hospital visits.

(2) Personalized care programs for diabetes patients, including remote patient monitoring and artificial intelligence-powered coaching that recommends specific actions members can take to better manage their health. These solutions help diabetic members maintain the right nutrition and activity levels to proactively minimize any disease complications. As a testament to the effectiveness of these tools, Elevance Health's Medicare Advantage members have 19% lower A1C (blood sugar levels) compared to diabetic Medicare seniors nationally.

(3) Maternal health solutions focused on maternal morbidity and pre-natal and postpartum care, with a goal to reduce health disparities in Louisiana such as low birth weight and pre-term births, especially among Black women. Examples of whole health solutions include incentives for pregnant women for timely pre-natal visits, postpartum depression screening and follow-up, dedicated clinical liaisons who collaborate with health care providers and advocate for the right care for the member, and a comprehensive suite of digital tools to support future moms as they journey through their pregnancies. Together, these solutions for current Elevance Health members have helped reduce the number of pre-term births by 25% and decrease the number of low-birth weight babies by 26%, metrics in which Louisiana currently ranks 50th among all states.

(4) A full suite of industry-leading behavioral health services through a broad network of experts. Elevance Health is committed to bringing to BCBSLA members enhanced access to clinical mental health support, substance use disorder treatment, specialty programs for autism and depression, crisis programs, support for children in foster care, virtual counseling, 24-hour chat service and more. These services are integrated into medical product design. Through improved data and analytics capabilities, BCBSLA will be able to proactively identify members at risk and in need of health interventions. The behavioral health capabilities of Elevance Health will complement the behavioral health capabilities currently available to BCBSLA members.

The Board, therefore, has determined that (1) the Plan properly protects and serves the best interests of all BCBSLA members, and is fair and equitable to all BCBSLA members, (2) there are no material risks associated with the Proposed Reorganization and (3) the financial condition of BCBSLA will not be diminished upon the effectiveness of the Proposed Reorganization.

D. The Board believes that the benefits of the Proposed Reorganization to Eligible Members and Voting Members are plentiful and that all BCBSLA members and covered persons, not just Eligible Members and Voting Members, will be able to access a portfolio of solutions and capabilities developed by Elevance Health and its affiliates, including its health care services organization, Carelon. As described in more detail above, these solutions have shown success in improving members' health while reducing costs and complexity. The Proposed Reorganization will result in the delivery of these more effective and efficient solutions, such as integrated pharmacy, care navigation, and member advocacy, which would help improve member health outcomes while working to lower the cost trend of care. The large and continual investment in expanding capabilities simultaneously improves member experience and reduces the inflationary rise in health care costs and health insurance premiums.

E. The Board has not identified any risks of the Proposed Reorganization that would outweigh the benefits described in clauses "C" and "D" above.

F. The Board believes that the expansion of capabilities and services to be made available to BCBSLA members and other covered persons as a result of the Proposed Reorganization will materially improve the member experience, including improving the likelihood that health coverage offered by BCBSLA after the effectiveness of the Proposed Reorganization will be more effective at improving the health and lives of BCBSLA members, which is the purpose of BCBSLA as espoused in the Current Articles. BCBSLA expects that the availability of certain capabilities can occur shortly after the effectiveness of the Proposed Reorganization, and will be followed in the medium or long term with additional improvements such as expanded care management programs and further integration of health care information, analytics and clinical insights to improve the health outcomes of BCBSLA members. In addition, there will be greater resources available to grow, refine and improve analytics following the effectiveness of the Proposed Reorganization. The Proposed Reorganization ultimately ensures that BCBSLA members receive more value for their premium dollars.

G. Following the effectiveness of the Proposed Reorganization, BCBSLA will be in a strong financial position as part of the well-capitalized Elevance Health holding company system. Further, BCBSLA will continue to exceed the minimum statutory requirements for capital and surplus and will maintain an authorized control level risk-based capital ratio of at least 375% immediately following the Reorganization.

ARTICLE I.
Manner of Reorganization

The manner in which the Proposed Reorganization will occur, and the insurance and other companies that will result from or be directly affected by the Proposed Reorganization, are as follows:

Section 1.1. Reorganization to a Stock Insurance Company. In accordance with the Acquisition Agreement and the Louisiana Demutualization Law, BCBSLA will as of and following the Effective Date become a stock insurance company, organized and existing under the laws of the State of Louisiana. The Articles of Incorporation of BCBSLA, and Bylaws of BCBSLA, as amended and effective upon the Effective Date, will contain customary terms and conditions appropriate for a Louisiana stock insurance company. The transaction set forth in Affirmation A(1) of the Plan is intended to qualify as a tax-free reorganization described in Section 368 of the Internal Revenue Code of 1986, as amended (the "Code").

Section 1.2. Establishment and Funding of the Foundation. The Foundation has been formed by BCBSLA in connection with the Proposed Reorganization. Prior to the effectiveness of the Reorganization, in furtherance of the purposes delineated in the Current Articles to work to improve the health and lives of the citizens of the State of Louisiana, and in accordance with the Louisiana Demutualization Law and subject to the approval of the Commissioner, and in exchange for the right to become a stock insurance company under the Louisiana Demutualization Law with the approval of the Commissioner, BCBSLA shall (a) pay or transfer the Approved Excess Surplus to the Foundation and (b) issue the Note to the Foundation. Immediately following the Closing, Purchaser shall (i) contribute, or cause to be contributed, to BCBSLA an amount equal to the Note Amount, and (ii) cause BCBSLA to donate to the Foundation the Note Amount and thereby satisfy its obligations under the Note. In connection with the payment of the Note Amount and the payment or transfer of the Approved Excess Surplus to the Foundation, BCBSLA will issue a funding agreement which requires the Foundation, subject to the satisfaction of certain conditions, to donate the amount it receives in connection with the Proposed Reorganization (less amounts for applicable taxes and expenses) to a newly established special charitable trust (the "Trust"), which would be established under the laws of the State of Louisiana and would have the same purpose of improving the health and lives of the people of the State of Louisiana.

Section 1.3. Purchase and Sale of BCBSLA Shares. At the Closing, all of the shares of BCBSLA's Common Stock will be issued to Purchaser such that, following the Effective Date, BCBSLA will be a direct wholly owned subsidiary of Purchaser and an indirect wholly owned subsidiary of Elevance Health (the "Acquisition"). Further, following the Effective Date, BCBSLA shall be a continuation of the existence of BCBSLA as it existed prior to the effectiveness of the Reorganization and shall be treated as such pursuant to the applicable provisions of the Louisiana Demutualization Law (including, LSA-R.S. § 22:236.9(A)).

(a) On the Effective Date, the Eligible Members will be entitled to receive the Eligible Member Payment as further described in Article V.

(b) The Reorganization will be completed through the following structure or series of transactions in the following order:

(i) BCBSLA will reorganize, or convert, from a Louisiana mutual insurance company into a Louisiana stock insurance company and issue to Purchaser all of the shares of its Common Stock being issued.

(ii) Purchaser shall pay to the Paying Agent, for distribution to the Eligible Members in full consideration for the extinguishment of their Membership Interests, the Eligible Member Payment, by wire transfer of immediately available funds to the account designated in the Paying Agent Agreement.

(iii) The transaction set forth in Affirmation A(1) of the Plan is intended to qualify as a tax-free reorganization within the meaning of Section 368 of the Code.

(c) Common Stock. The Common Stock will not be registered under the Securities Act or applicable state securities laws (collectively, the "Securities Laws"), and Purchaser agrees not to sell, encumber or otherwise transfer shares of Common Stock unless (i) there is an effective registration statement under the Securities Laws covering the transaction, (ii) Purchaser receives an opinion of counsel satisfactory to Purchaser that such registration is not required under the Securities Laws, or (iii) Purchaser otherwise satisfies itself that registration is not required under the Securities Laws. Each certificate (if any) representing shares of Common Stock shall bear a legend substantially to the above effect. Neither BCBSLA nor Purchaser will have any obligation to provide a procedure for the disposition of shares of Common Stock, except as expressly stated in the Plan.

Section 1.4. Effectiveness of the Plan. The Plan and the amendment and restatement of the Current Articles contemplated by Section 1.1 (the "Articles Amendment") will become effective upon the date and time of filing of appropriate Articles of Amendment by the Recorder of Mortgages for the Parish of East Baton Rouge, Louisiana, and a Certificate of Compliance with the Louisiana Department of Insurance as provided in the Louisiana Demutualization Law unless a later date and time are specified in the Articles Amendment, in which event the Plan and the Articles Amendment will become effective and take place at the later date and time (which shall not be later than the tenth day after the Articles Amendment is recorded in accordance with Louisiana law (LSA-R.S. § 22:236.8(C))). The effectiveness of the Plan is conditioned upon, among other things, (1) approval of the Plan, which includes the Acquisition, by the Commissioner, (2) approval of the Plan by the Voting Members at the Special Meeting, as further described in Article X below, and (3) the satisfaction or waiver of the conditions set forth in Article VI of the Acquisition Agreement (a summary of which is set forth in Exhibit A).

Section 1.5. ERISA Plans; Tax-Qualified Policies.

(a) To the extent necessary, BCBSLA shall engage an independent fiduciary to (i) exercise the vote with respect to the Plan for any Eligible Members which are affiliates of BCBSLA, and (ii) determine how to allocate any consideration received under the Plan with respect to any employee benefit welfare plan among plan participants and the sponsoring employer identified in proviso (i) herein.

(b) There are no Policies issued by BCBSLA that are part of tax-qualified retirement funding arrangements or individual retirement annuities described in Sections 401(a), 403(a), 403(b), 408 or 408A of the Code.

Section 1.6. Continuation of Corporate Existence. Upon BCBSLA's Reorganization from a mutual insurance company into a stock insurance company pursuant to the Plan, BCBSLA shall continue its corporate existence as a stock insurance company as provided by Louisiana law (LSA-R.S. § 22:236.9).

ARTICLE II.
Extinguishment of Membership Interests

All Membership Interests will be extinguished and will cease as of the Effective Date. The extinguishment of Membership Interests will occur by operation of law under the Louisiana Demutualization Law on the Effective Date. All other contractual rights and obligations under every Policy will continue in force under the terms of the Policy.

ARTICLE III.
Distribution of Consideration

The Eligible Members will, upon the extinguishment of their Membership Interests, become entitled to receive consideration equal to each Eligible Member's equitable share of the Eligible Member Payment as provided in Article V of the Plan.

ARTICLE IV.
Determination of the Equitable Consideration for Extinguishment of Membership Interests

BCBSLA has, with the assistance of its Qualified Investment Banker and other advisors retained in connection with the Proposed Reorganization, structured the Proposed Reorganization to provide that consideration paid to the Eligible Members for the extinguishment of the Membership Interests of the Eligible Members as of the Effective Date is fair to the Eligible Members, as a group, from a financial point of view, as provided in Article V. In that regard, the Board has received a written fairness opinion from the Qualified Investment Banker (the "Fairness Opinion") confirming, subject to the limitations and qualifications in such opinions (which opinions will be reaffirmed to the Board as of the Effective Date), that the method for the provision of total consideration to the Eligible Members upon the extinguishment of the Membership Interests under the Plan is fair to the Eligible Members, as a group, from a financial point of view consistent with Louisiana law (LSA-R.S. § 22:236.3(A)).

The Fairness Opinion was rendered based upon the Qualified Investment Banker's review of the draft Acquisition Agreement, draft Plan, BCBSLA's Current Articles and Current Bylaws, and other documents and records deemed material and relevant by the Qualified Investment Banker in connection with its rendering of the Fairness Opinion. In particular, the Fairness Opinion noted that BCBSLA's Current Articles grant Voting Members the right to vote, but provide that they shall receive no dividends, and are silent with regard to any right of Voting Members to participate in BCBSLA's surplus or proceeds of liquidation. The Fairness Opinion also noted that the Qualified Investment Banker, to the extent it deemed relevant in accordance with the standards of the investment banking industry, considered other factors in rendering its opinion, including

without limitation the rights associated with a membership interest in BCBSLA, which do not include a right to dividends or surplus. The Fairness Opinion included customary limitations, qualifications and assumptions appropriate for a transaction of this nature, including a statement that the Qualified Investment Banker did not opine as to any values or range of values, the total consideration being distributed in the Reorganization or the rationale underlying the business decision to effect the Reorganization. The Qualified Investment Banker's compensation for the Fairness Opinion is not dependent or contingent upon the completion of the Reorganization and is not related to or based upon the nature of the findings made therein. BCBSLA has agreed to pay the Qualified Investment Banker a customary fee and reimburse the Qualified Investment Banker for its expenses related to the Fairness Opinion. BCBSLA has also agreed to indemnify the Qualified Investment Banker for certain liabilities that may arise in connection with the rendering of the Fairness Opinion.

ARTICLE V.
Form and Amount of Consideration to be Distributed

The Board has received the Fairness Opinion confirming the fairness of the method for the provision of total consideration to the Eligible Members, as a group, from a financial point of view, consistent with Louisiana law (LSA-R.S. § 22:236.3(A)). The total consideration to be distributed to the Eligible Members in exchange for the extinguishment of their Membership Interests will be cash in an amount equal to approximately $307,755,241, subject to adjustment in respect of the reconciliation of the member months in from the Adoption Date and through to the Closing Date and the methodology and conditions described below in this Article V (the "Eligible Member Payment"). The total value of the Eligible Member Payment was determined by tabulating the total number of months that an Eligible Member was covered by an insurance policy issued by BCBSLA (for group policyholders, the number of member months of employees), divided by the number of member months of all BCBSLA members and all members of BCBSLA's subsidiaries since BCBSLA's corporate formation in 1975. The tabulation does not take into account the member months attributable to self-insured customers, which currently constitute a majority of BCBSLA's members and customers and related member months, and are a significant contributor to the value of BCBSLA. The exclusion of self-insured customer member months in the tabulation increases the value that is attributable to Eligible Members to the benefit of the Eligible Members (as compared to the value if the self-insured customer member months were included).

ARTICLE VI.
Method or Formula for the Allocation of Consideration

The Board has received a written actuarial opinion from the Actuary (the "Actuarial Opinion") as to the reasonableness and appropriateness of the methodology or formula and underlying assumptions used to allocate the Eligible Member Payment among Eligible Members and stating that the resulting allocation is fair and equitable, consistent with Louisiana law (LSA-R.S. § 22:236.3(B)). The method or formula for allocating the Eligible Member Payment among the Eligible Members is to make a uniform payment of consideration, a fixed component under Louisiana law (LSA-R.S. § 22:236.3(B)(1)), to each Eligible Member. In the event that an individual or entity is an Eligible Member pursuant to multiple Policies, such Eligible Member(s) shall receive the uniform payment of consideration for each In Force Policy. The payment of uniform, fixed consideration for each In Force Policy is fair and equitable because each In Force

Policy furnishes an Eligible Member with a Membership Interest that is identical for each Eligible Member. Each Eligible Member will be allocated a cash amount equal to a portion of the Eligible Member Payment referred to in Article V, which such amount has been determined as reasonable and appropriate in the Actuarial Opinion.

The Actuarial Opinion was rendered based upon the Actuary's review of the draft Plan, BCBSLA's Current Articles and Current Bylaws, sample BCBSLA Policies and other documents and records deemed material and relevant by the Actuary. The Actuarial Opinion noted that the proposed Reorganization is unique in that none of BCBSLA's Policies provide for dividends to be paid (i.e., none are participating insurance policies), in contrast to what is typically seen in mutual insurance companies. Furthermore, the Actuarial Opinion stated that BCBSLA has determined that since all of its Policies are non-participating, paying no dividends and providing no rights to surplus, shares of stock or liquidation proceeds, there is no variable component to the allocation of consideration among Eligible Members. Thus, BCBSLA has determined that the allocation of consideration among Eligible Members should consist of only a fixed component on a per policy basis to compensate Eligible Members for the extinguishment of voting rights.

The Actuarial Opinion noted that Actuarial Standards of Practice (ASOP) No. 37 provides that in determining the reasonableness of the allocation, the actuary may consider the company's voting policy and that the actuary may determine that the fixed component can be allocated based on each eligible policy (regardless of the size of the policy) or each eligible policyholder (regardless of the number of policies or size of policies). The Actuarial Opinion concluded that the allocation methodology utilized by BCBSLA conforms to this guidance as the fixed component is allocated based on each Policy that has a voting right.

The Actuarial Opinion assessed only the allocation of consideration among Eligible Members and was not intended to offer comments or recommendations regarding the exact number of Voting Members eligible to receive a portion of the Eligible Member Payment, the form of the consideration to be distributed to Eligible Members, or the proposed methodology for valuation of the total Eligible Member Payment to be distributed, including any calculations or components related to the development of the total consideration amount.

ARTICLE VII.
BCBSLA Pays No Dividends

The Current Articles prohibit the payment of dividends and since BCBSLA's incorporation, its articles of incorporation, as amended (and the articles of incorporation, as amended, of all relevant predecessors), have never included provisions providing for the payment of dividends. BCBSLA has no Policies that provide for the payment of dividends and, heretofore,

no dividends have been paid. Accordingly, no method or procedure need be established to provide for the determination and preservation of dividends.

ARTICLE VIII.
Address and Telephone Number of BCBSLA

The address and telephone number of BCBSLA will be unchanged by the Proposed Reorganization, and each Member of BCBSLA will receive notification of such information along with a notice of hearing outlined in Section 9.2 and by Louisiana law (LSA-R.S. § 22:236.4).

ARTICLE IX.
Approval by the Commissioner

Section 9.1. Commissioner's Public Hearing on the Plan; Commissioner's Order. The Plan and the Proposed Reorganization, which includes the Acquisition, are subject to the approval of the Commissioner. The Commissioner will hold a public hearing on these matters pursuant to Louisiana law (LSA-R.S. § 22:236.4) (the "Public Hearing").

Section 9.2. Notice of Public Hearing. Written notice of the Public Hearing, in a form satisfactory to the Commissioner, will be mailed to Voting Members by first class mail at BCBSLA's expense at least 30 days prior to the Public Hearing. Such notice will be mailed to the address of each Member of BCBSLA as such address is shown on BCBSLA's records on the Record Date (or such other address as may be provided in writing to BCBSLA by the Member within a reasonable period of time prior to the mailing of the notice). Such notice of Public Hearing will include a brief statement of the subject of the Public Hearing, the date, time and location of the Public Hearing, and such additional information as the Commissioner may require.

Section 9.3. Findings Required for Approval. Pursuant to Louisiana law (LSA-R.S. § 22:236.4(B)), the Commissioner shall approve the Plan and the Proposed Reorganization if the Commissioner is satisfied, following the Public Hearing: (a) that the interests of the Eligible Members and the other members of BCBSLA are properly protected; (b) that the Plan serves the best interests of the Eligible Members and the other members of BCBSLA; and (c) that the Plan is fair and equitable to the Eligible Members and the other members of BCBSLA.

Section 9.4. Notice of Approval Order. In the event that the Commissioner approves the Plan and the Proposed Reorganization, which includes the Acquisition (such approval, the "Commissioner's Order"), notice of the Commissioner's Order will be mailed by first class mail following the issuance of the Commissioner's Order to Voting Members. Such notice will be mailed to the address of each Member of BCBSLA as such address is shown on BCBSLA's records on the Record Date (or such other address as may be provided in writing to BCBSLA by the Member within a reasonable period of time prior to the mailing of the notice).

ARTICLE X.
Approval by Voting Members

Section 10.1. Voting.

(a) BCBSLA will hold a special meeting of Voting Members (the "Special Meeting") within a time period that complies with Louisiana law (LSA-R.S. § 22:236.5), which shall occur after the Public Hearing. At the Special Meeting, the Voting Members will be entitled to vote in person or by proxy on the Plan. The Members eligible to vote at the Special Meeting (the "Voting Members") will be the Members of BCBSLA entitled to vote as of the record date for the Special Meeting established by the Board pursuant to the Current Articles and currently effective Amended and Restated Bylaws of BCBSLA (the "Record Date").

(b) The Plan shall be approved at the Special Meeting by a vote of not less than two-thirds of the Voting Members present or represented by special ballot or special proxy at the Special Meeting. The Voting Members will vote as a single class.

(c) A quorum for the Special Meeting shall consist of the Voting Members present or represented by special ballot or special proxy at the Special Meeting.

Section 10.2. Notice of Special Meeting.

(a) BCBSLA will mail or cause to be mailed notice of the Special Meeting by first class mail at BCBSLA's expense to all of the Voting Members. The notice will comply with the Current Articles and Louisiana law (LSA-R.S. § 22:236.5) and set forth the date, time and place of the Special Meeting. Such notice will be mailed, at least 30 days prior to the Special Meeting, to the address of each Voting Member as it appears on the records of BCBSLA on the Record Date (or such other address as may be provided in writing to BCBSLA by the Voting Member within a reasonable period of time prior to the mailing of the notice). The notice will be in a form satisfactory to the Commissioner.

(b) Such notice of the Special Meeting will be accompanied by a proxy form and a copy or summary of the Plan as required by Louisiana law (LSA-R.S. § 22:236.5) and approved by the Commissioner.

ARTICLE XI.
Additional Provisions

Section 11.1. Policyholders. The Policyholder of a Policy as of any date specified in the Plan will be determined by BCBSLA on the basis of BCBSLA's records as of such date in accordance with the following provisions:

(a) The Policyholder of a Policy that is an individual insurance policy is the Person specified in such Policy as the policyholder, unless no policyholder is so specified, in which case the Policyholder will be deemed to be the Person that signed the application for the Policy or, in the case of applications made on behalf of minor children, the Person who signed the application.

(b) The Policyholder of a group insurance policy is the Person or Persons specified in such Policy as the policyholder unless no policyholder is so specified, in which case the Policyholder is the Person sponsoring the group health care benefits plan. For the avoidance of doubt, certificates or other evidences of insurance issued under a group Policy are not and shall not be treated as Policies.

(c) In no event may there be more than one Policyholder of a Policy, although more than one Person may be entitled to health benefits under a Policy.

(d) Self-funded or administrative services-only contracts are not contracts of insurance and do not create Membership Interests for the contract holders or participants of such groups.

(e) Except as otherwise set forth in this Section 11.1, the identity of the Policyholder is determined by BCBSLA without giving effect to any interest of any other Person in such Policy. For the avoidance of doubt, certificates or other evidences of insurance issued under a group policy are not and shall not be treated as Policies.

(f) In any situation not expressly covered by the above provisions of this Section 11.1, or as to which application of the above provisions is unclear, the Policyholder reflected on the records of BCBSLA and determined in good faith by BCBSLA, will be presumed to be the Policyholder for purposes of this Section 11.1, and, except for administrative errors, BCBSLA will not be required to examine or consider any other facts or circumstances.

(g) The mailing address of a Policyholder as of any date for purposes of the Plan will be the Policyholder's last known address as shown on the records of BCBSLA as of such date.

(h) Any dispute as to the identity of a Policyholder or the right to vote or receive consideration will be determined in accordance with the above and the relevant provisions of the Louisiana Demutualization Law, applicable provisions of the Louisiana Insurance Code or such other procedures as may be acceptable to the Commissioner.

Section 11.2. In Force. A Policy will be deemed to be in force ("In Force") as of any date if, as shown on BCBSLA's records on such date, the effective date of such Policy occurs on or prior to such date, and as of such date the required premium has been received by BCBSLA and such Policy, as shown on BCBSLA's records on such date, has not expired or otherwise been surrendered or terminated; provided that a Policy will be deemed to be In Force during any applicable grace period for non-payment of premiums as administered by BCBSLA; provided further however that for the avoidance of doubt such Policy will no longer be deemed to be In Force if such applicable grace period expires without the applicable premium having been paid.

(a) Any dispute as to whether a Policy is In Force will be resolved in accordance with the above or such other procedures as may be acceptable to the Commissioner.

Section 11.3. Confidentiality. BCBSLA will request the confidential treatment of documents in accordance with the Louisiana Insurance Code (Title 22) and the Louisiana Public Records Law (Title 44).

Section 11.4. Additional Acquisitions of Ownership. Except for the Acquisition, for five years following the Effective Date, no Person or Persons acting in concert (other than BCBSLA, Purchaser, any other company that is directly or indirectly wholly-owned by Elevance Health, or any employee benefit plans or trusts sponsored by BCBSLA, Purchaser or Elevance Health) may directly or indirectly acquire, or agree or offer to acquire, in any manner the beneficial ownership of five percent (5%) or more of the outstanding shares of any class of a voting security of BCBSLA or Purchaser, other than in compliance with Louisiana law (LSA-R.S. § 22:236.6 or any regulations promulgated thereunder).

Section 11.5. Director and Officer Compensation. As is typical in change of control transactions such as the series of transactions contemplated by the Plan of Reorganization, all of the current members of the BCBSLA Board, except for the President and Chief Executive Officer of BCBSLA (who is also a member of the BCBSLA Board), are expected to resign immediately prior to the Closing. Certain of the resigning directors (C. Richard Atkins, D.D.S., Thomas A. Barfield, Jr., Jerome K. Greig and Charles Brent McCoy) are currently directors of the Foundation or will become directors of the Foundation at or prior to the Closing, and such directors will continue as directors of the Foundation following the Closing. The Foundation has not yet determined the compensation structure for the members of its board of directors following the Closing and intends to engage a compensation consultant to advise the board of directors of the Foundation on this and other matters. It is intended that any compensation of members of the board of directors of the Foundation will comply with all provisions of applicable law, including any regulations promulgated thereunder applicable to organizations organized and operated for charitable purposes. Other resigning directors of the BCBSLA Board (Judy P. Miller, Stephanie A. Finley, Michael B. Bruno, Robert T. Lalka, J. Kevin McCotter, Thad Minaldi and Carl Luikart, M.D.) will become members of an advisory board to the BCBSLA Board (the "Advisory Board") to become effective as of the Closing. The Advisory Board is to be comprised of Louisiana residents and provide the BCBSLA Board with advice, support and insight on matters relating to BCBSLA's business and operations in Louisiana, including monitoring integration with Purchaser and its enterprise-wide operations. The members of the Advisory Board will receive compensation in an initial amount not in excess of the amount they currently receive as compensation for serving as members of the BCBSLA Board, which amounts may be adjusted during the term of the Advisory Board's existence in accordance with the provisions of an agreed upon charter specifying the duration, governance and responsibilities of the Advisory Board. Except as described above, no director, officer, agent or employee of BCBSLA will receive any fee, commission, or other valuable consideration, other than his or her usual regular salary and compensation, that is contingent upon the Plan of Reorganization becoming approved or completed or is based upon aiding, promoting, or assisting in the approval or completion of the Plan of Reorganization. If the transactions contemplated by the Plan of Reorganization are not completed, the members of the BCBSLA Board will continue to receive the compensation and benefits that they currently receive as members of the BCBSLA Board. All directors of the Foundation will also become members of the board of trustees of the Trust pursuant to the organizational documents of the Trust.

Section 11.6. Amendment or Withdrawal of the Plan. The Plan may be amended or abandoned only as provided by the Louisiana Demutualization Law and by action of two-thirds of the members of the BCBSLA Board in accordance with the Acquisition Agreement. The Plan shall be promptly abandoned upon any valid termination of the Acquisition Agreement. The Plan may not be amended after the Public Hearing referred to in Article IX unless the Commissioner

determines that the amendment is not materially disadvantageous to BCBSLA members. If the Commissioner determines that the amendment is materially disadvantageous to BCBSLA members, another Public Hearing must be held regarding the Plan as amended.

Section 11.7. Corrections. BCBSLA may, until the Effective Date and in accordance with the Acquisition Agreement, by an instrument executed by its President and Chief Executive Officer, the Senior Vice President, Strategy and Business Development, Chief Legal Officer or Chief Financial Officer, attested by its Secretary or Assistant Secretary under BCBSLA's corporate seal and submitted to and approved by the Commissioner, make such modifications as are appropriate to correct clerical errors, clarify existing items or make additions to correct manifest omissions in the Plan so long as such corrections or modifications do not materially disadvantage BCBSLA members. BCBSLA may in the same manner also make such corrections or modifications as may be required by the Commissioner before or after the Public Hearing as a condition of approval of the Plan. No such corrections or modifications will require approval by the Voting Members unless such corrections or modifications materially disadvantage BCBSLA members or such approval is otherwise required by the Board or the Commissioner.

Section 11.8. Notices. Pursuant to Louisiana law (LSA-R.S. § 22:236.5(C)), if BCBSLA complies substantially and in good faith with the Louisiana Demutualization Law with respect to any required notice to BCBSLA members, the failure of any Person to actually receive any such notice that such Person was entitled to receive will not impair the validity of any action taken under the Louisiana Demutualization Law or the Plan.

Section 11.9. Costs and Expenses. BCBSLA will pay the expenses of any accountants, actuaries, attorneys, and other experts hired by the Commissioner to review any matter under the Louisiana Demutualization Law with respect to the Plan.

Section 11.10. Captions and Headings. The captions and headings of the Plan have been inserted for convenience of reference only and will not affect the meaning or interpretation of the Plan.

Section 11.11. Governing Law. The terms of the Plan will be governed by and construed in accordance with the laws of the State of Louisiana.

Section 11.12. Judicial Review. Pursuant to Louisiana law (LSA-R.S. § 22:236.4), all petitions for judicial review of, and any action challenging the validity of or arising out of the approval or disapproval of or any action proposed to be taken under any order or determination of the Commissioner in connection with the Plan or the Reorganization must be filed not later than 30 days after the order or determination is issued by the Commissioner.

ARTICLE XII.
Definitions

Section 12.1. General Terms. For all purposes of the Plan, except as otherwise expressly provided or unless the context otherwise requires:

(1) The terms defined in this Article XII will, when used in the Plan, have the meanings assigned to them in this Article XII and include the plural as well as the singular.

(2) The words "herein," "hereof," "hereunder" and other words of similar import refer to the Plan as a whole and not to any particular article, section, subsection or other subdivision.

Section 12.2. Specific Terms. For all purposes of the Plan, except as otherwise expressly provided in the Plan, the following terms will have the meanings set forth below:

"Acquisition" shall have the meaning set forth in Section 1.3.

"Acquisition Agreement" shall mean that certain Agreement and Plan of Acquisition, dated as of January 23, 2023, by and among BCBSLA, Purchaser, Elevance Health and the Foundation, as it may be amended from time to time in accordance with the provisions thereof. A summary of the material terms of the Acquisition Agreement is set forth in Exhibit A.

"Actuarial Opinion" shall have the meaning set forth in Article VI.

"Actuary" shall mean Brian M. Collender, FSA, MAAA associated with the firm of Deloitte Consulting LLP.

"Adoption Date" shall have the meaning specified in the first paragraph of the Plan.

"Advisory Board" shall have the meaning set forth in Section 11.5.

"Approved Excess Surplus" shall mean an amount equal to the statutory capital (i.e., admitted assets over liabilities) of BCBSLA in excess of 500% of the authorized control level risk based capital of BCBSLA as of the Closing Date, or such other amount as approved by the Commissioner.

"Articles Amendment" shall have the meaning set forth in Section 1.4.

"BCBSLA" shall have the meaning specified in the first paragraph of the Plan.

"Board" shall have the meaning specified in the first paragraph of the Plan.

"Closing" shall have the meaning specified in Affirmation A(3) of the Plan.

"Code" shall have the meaning specified in Section 1.1.

"Commissioner" shall mean the Commissioner of Insurance of the State of Louisiana, his deputy or the Louisiana Department of Insurance, as appropriate.

"Commissioner's Order" shall have the meaning specified in Section 9.4.

"Common Stock" shall mean the common stock of BCBSLA, par value $0.01 per share, following the effectiveness of the Reorganization.

"Current Articles" shall have the meaning specified in Affirmation A(2) of the Plan.

"Effective Date" shall mean the date on which the Reorganization contemplated by the Plan becomes effective in accordance with the Louisiana Demutualization Law and Section 1.4.

"Elevance Health" shall have the meaning specified in Affirmation A(4) of the Plan.

"Eligible Member" shall mean a Person who is a Member of BCBSLA on the Adoption Date and continues to be a Member of BCBSLA on the Effective Date.

"Eligible Member Payment" shall have the meaning set forth in Article V.

"ERISA" shall mean the Employee Retirement Income Security Act of 1974.

"Fairness Opinion" shall have the meaning set forth in Article IV.

"Foundation" shall have the meaning specified in Affirmation A(2) of the Plan.

"In Force" shall have the meaning specified in Section 11.2.

"Louisiana Demutualization Law" shall have the meaning specified in Affirmation A(1) of the Plan.

"Member" shall mean as of any specified date any Person who, in accordance with the records, BCBSLA's Current Articles and then-effective Amended and Restated Bylaws of BCBSLA, is the Policyholder of an In Force Policy.

"Membership Interests" shall mean all of the rights and interests of Policyholders as members of BCBSLA as arising under and provided by law and by BCBSLA's Current Articles and then-effective Amended and Restated Bylaws, which rights include, but are not limited to, the rights, if any, to vote and the rights, if any, with regard to the surplus of BCBSLA.

"Note" shall have the meaning specified in Affirmation A(3) of the Plan.

"Note Amount" shall have the meaning specified in Affirmation A(3) of the Plan.

"Paying Agent" shall mean the paying agent appointed pursuant to the Paying Agent Agreement.

"Paying Agent Agreement" shall mean a paying agent agreement to be entered into by and among Purchaser, BCBSLA and the Paying Agent, in the form mutually agreed to pursuant to the Acquisition Agreement prior to Closing.

"Person" shall mean an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, a limited liability company, a limited liability partnership, a government or governmental agency, a state or political subdivision of a state, board, estate, trustee or fiduciary, or any other legal entity.

"Plan" shall have the meaning specified in the first paragraph of the Plan.

"Policy" shall mean any individual insurance policy or group health care benefits contract that has been issued by BCBSLA and under which the Policyholder thereof is a Member with Membership Interests.

"Policyholder" shall mean the Person or Persons specified or determined pursuant to Section 11.1.

"Proposed Reorganization" and "Reorganization" shall have the meaning specified in Affirmation A of the Plan.

"Public Hearing" shall have the meaning specified in Section 9.1.

"Purchaser" shall have the meaning specified in Affirmation A(4) of the Plan.

"Qualified Investment Banker" shall mean Chaffe & Associates, Inc.

"Record Date" shall have the meaning specified in Section 10.1(a).

"Securities Act" shall mean the Securities Act of 1933, as amended.

"Securities Laws" shall have the meaning specified in Section 1.3(c).

"Special Meeting" shall have the meaning specified in Section 10.1(a).

"Trust" shall have the meaning specified in Section 1.2.

"United States" shall mean the States of the United States, the District of Columbia, the Commonwealth of Puerto Rico and Territories of the United States within the meaning of Section 2(6) of the Securities Act.

"Voting Member" shall have the meaning specified in Section 10.1(a).

EXHIBIT A

The following is a summary of certain material terms of the Acquisition Agreement. Terms used and not defined herein shall have their meanings as set forth in the summary of the Plan of Reorganization set forth above or the "Glossary of Key Terms" section of the Member Information Statement, as applicable.

Acquisition; Closing

Unless the Acquisition Agreement is terminated, subject to the satisfaction or waiver of the conditions set forth in the Acquisition Agreement, the closing of the Acquisition shall take place on the third Business Day following the satisfaction or waiver of all conditions to each party's obligation to consummate the transactions contemplated by the Acquisition Agreement (other than the conditions which by their nature are to be satisfied at the Closing, but subject to the satisfaction or waiver of such conditions at the Closing), or at such other place or on such other date as is mutually agreeable to Purchaser and BCBSLA.

Pursuant to the Acquisition Agreement, Elevance Health and BCBSLA will mutually agree upon the Paying Agent for purposes of effecting the distribution and payment of the Eligible Member Payment to the Eligible Members.

Consideration

Immediately prior to the effectiveness of the Reorganization and in exchange for the right to operate as a stock insurance company following the Reorganization in accordance with the Louisiana Demutualization Law and subject to approval of the Commissioner and in furtherance of the purposes of the constituencies to be served pursuant to the Amended and Restated Articles of Incorporation of BCBSLA, BCBSLA shall (i) pay or transfer, as applicable, to the Foundation the Approved Excess Surplus and (ii) issue to the Foundation the Note, to be repaid immediately following the Closing in accordance with the terms thereof and the Plan of Reorganization. The amount payable to the Foundation pursuant to the Note shall consist of a $2,500,000,000 base purchase price, less the Eligible Member Payment, and subject to adjustment for BCBSLA's surplus (other than any amounts in respect of the Approved Excess Surplus), indebtedness and transaction expenses. In addition, the Paying Agent will distribute the Eligible Member Payment to the Eligible Members.

Representations and Warranties

BCBSLA makes customary representations and warranties in the Acquisition Agreement on behalf of itself and its subsidiaries that are subject, in some cases, to certain qualifications (including qualifications as to knowledge, materiality, time and dollar amount) and are further modified and limited by a disclosure schedule provided by BCBSLA to Purchaser at the time the Acquisition Agreement was executed. These representations and warranties relate to corporate, financial and operational matters and include, among other things:

- the corporate organization, good standing and similar corporate matters of BCBSLA, including its qualification to do business under applicable laws and authority to enter into the Acquisition Agreement;
- certain financial statements of BCBSLA and BCBSLA's Subsidiaries;
- the absence of certain changes to BCBSLA and BCBSLA's Subsidiaries since December 31, 2021;
- litigation against BCBSLA or BCBSLA's Subsidiaries;
- compliance with applicable law and regulatory matters and possession of necessary licenses;
- the computation of BCBSLA's insurance reserves;
- reinsurance agreements; and
- the due authorization of the Acquisition Agreement and the transactions contemplated therein.

Purchaser and Elevance Health also make customary representations and warranties in the Acquisition Agreement that are subject to certain qualifications (including qualifications as to knowledge, materiality, time and dollar amount). These representations and warranties relate to, among other things, certain corporate and regulatory matters.

Several of the representations, warranties and covenants contained in the Acquisition Agreement relating to BCBSLA and its subsidiaries refer to the concept of a "Material Adverse Effect." For purposes of the Acquisition Agreement, a "Material Adverse Effect" with respect to BCBSLA generally means a material adverse effect on the business, results of operations, assets, liabilities, or financial or other conditions of BCBSLA and its subsidiaries, taken as a whole, or on the ability of BCBSLA to perform its obligations under the Acquisition Agreement or to consummate the transactions contemplated thereby, subject to certain customary exceptions.

BCBSLA Interim Operating Covenants

BCBSLA is subject to certain affirmative covenants in the Acquisition Agreement relating to the conduct of its business prior to the Closing. BCBSLA has agreed that it will, among other things:

- conduct its and its subsidiaries' business in the ordinary course and consistent with past practices in all material respects (except as otherwise expressly provided for by the Acquisition Agreement);

- use commercially reasonable efforts to (i) conduct its business, and cause its subsidiaries to conduct their respective operations, in compliance, in all material respects, with applicable laws, and (ii) maintain relationships with key employees, suppliers, customers and other Persons with whom BCBSLA or any of its subsidiaries has material commercial dealings; and

- maintain and preserve intact, in all material respects, its and its subsidiaries' (i) business organization and (ii) books and records and accounts in accordance with past practices.

BCBSLA has also agreed to certain negative covenants in the Acquisition Agreement customary for a transaction of this nature relating to the conduct of its and its subsidiaries' business prior to the completion of the Reorganization, including among other things restrictions on amending organizational documents, authorizing or issuing shares of stock, increasing compensation or hiring employees (subject to certain permitted thresholds), consummating acquisitions or dispositions, incurring liens or indebtedness (subject to certain permitted thresholds), and settling legal actions (subject to certain permitted thresholds).

Regulatory Matters

Each of Purchaser and BCBSLA are required to make all filings and notifications with all governmental authorities that are necessary in order for the Reorganization to be effective. Such regulatory approvals include approval of the Plan by the Commissioner.

Restrictions Relating to Other Transactions

The Acquisition Agreement provides that BCBSLA shall not, and shall cause its subsidiaries and representatives to not, directly or indirectly solicit, initiate or knowingly encourage or facilitate any inquiries that would reasonably be expected to lead to, or otherwise propose, offer, approve, recommend, discuss, negotiate or agree to any alternative transaction, or enter into any agreement requiring it to abandon, terminate, or fail to consummate the Reorganization.

Notwithstanding the above, if BCBSLA receives a bona fide written proposal from a Person for an alternative transaction that was not solicited after the date of the Acquisition Agreement and is not otherwise prohibited by the Acquisition Agreement, BCBSLA may, at any time prior to receipt of the approval of the Plan at the Special Meeting, furnish information to, and negotiate or otherwise engage in discussions with such Person, if and so long as the Board determines in good faith after consultation with its outside legal counsel that failure to provide such information or engage in such negotiations or discussions is reasonably likely to be inconsistent with the Board's fiduciary duties under applicable law and determines in good faith that such a proposal is, or would reasonably be expected to lead to, a superior proposal.

Conditions to Closing

Mutual Closing Conditions

The obligations of each of the parties to consummate the transactions contemplated by the Plan and the Acquisition Agreement shall be subject to the satisfaction of customary closing conditions including that:

- no order, injunction or decree issued by any governmental authority of competent jurisdiction or other legal restraint or prohibition preventing the effectiveness of the Plan or any of the transactions contemplated by the Acquisition Agreement shall be in effect and no statute, rule, regulation, order, injunction or decree shall have been enacted, entered, promulgated or enforced by any governmental authority which prohibits, materially restricts or makes illegal the effectiveness of the Plan, including the transactions contemplated by the Acquisition Agreement;

- all waiting periods under any applicable antitrust law shall have expired or been terminated;

- the Plan shall have been approved by the requisite affirmative vote of the Voting Members of BCBSLA; and

- BCBSLA has been converted from a mutual insurance company to a stock insurance company in accordance with the Louisiana Demutualization Law and the Plan and the shares of BCBSLA capital stock issued in connection therewith shall be duly authorized and validly issued.

Conditions to Obligations of Purchaser

The obligations of Purchaser to consummate the transactions contemplated by the Plan and the Acquisition Agreement shall be subject to the satisfaction or waiver by Purchaser of additional customary closing conditions including that:

- the representations and warranties of BCBSLA that are set forth in the first sentence of Section 2.11 of the Acquisition Agreement or are fundamental representations shall be true and correct in all respects on and as of the date of the Acquisition Agreement and as of the Closing Date. The fundamental representations of BCBSLA shall be true and correct in all material respects on and as of the date of the Acquisition Agreement and as of the Closing Date. All other representations and warranties of BCBSLA shall be true and correct on and as of the date of the Acquisition Agreement and as of the Closing (disregarding any qualification as to "materiality" or Material Adverse Effect) except where the failure of any such other representations and warranties to be true and correct would not reasonably be expected to have, individually or in total, a Material Adverse Effect on BCBSLA;

- BCBSLA shall have performed in all material respects all obligations required to be performed by it under the Acquisition Agreement at or prior to the Closing;

- all required regulatory approvals shall have been obtained and shall remain in full force and effect and shall not, individually or in total, reasonably be expected to have a material adverse effect on Purchaser and its affiliates, taken as a whole, or a Material Adverse Effect, or be reasonably likely to have a material impact on the benefits expected to be derived by Purchaser in connection with the transactions, taken as a whole (other than an acceptance by Purchaser of a prior notification and approval provision required by a governmental authority to secure a required approval and such action is expressly conditioned upon the closing of the transactions (collectively, a "Burdensome Term or Condition"));

- the Plan shall have been approved by the Blue Cross and Blue Shield Association without the imposition of a Burdensome Term or Condition;

- the Plan shall have been approved by the Commissioner without the imposition of a Burdensome Term or Condition; and

- BCBSLA shall not have suffered a Material Adverse Effect and there shall have been no occurrence, circumstance or combination thereof, which, as of the Closing, is reasonably likely to result in a Material Adverse Effect on BCBSLA.

Conditions to Obligations of BCBSLA

The obligation of BCBSLA to consummate the transactions contemplated by the Plan and the Acquisition Agreement is also subject to the satisfaction or waiver by BCBSLA of certain conditions including that:

- the representations and warranties of Purchaser and Elevance Health contained in the Acquisition Agreement shall be true and correct as of the date of the Acquisition Agreement and as of the Closing except where the failure of any such representations and warranties to be true and correct would not reasonably be expected to have, individually or in total, a Material Adverse Effect on the ability of Purchaser to consummate the transactions.

- Purchaser shall have performed in all material respects all obligations required to be performed by it under the Acquisition Agreement at or prior to the Closing;

- all required regulatory approvals (including approval by the Commissioner) shall have been obtained and shall remain in full force and effect; and

- the Plan shall have been approved by the Blue Cross and Blue Shield Association.

Termination

The Acquisition Agreement may be terminated prior to the Closing under certain circumstances including:

- by mutual written consent of Purchaser and BCBSLA;

- by Purchaser upon written notice to BCBSLA if there has been a breach of any covenant or agreement by, or inaccuracy of any representation or warranty of, BCBSLA set forth in the Acquisition Agreement, which would result in the failure of the conditions in the Acquisition Agreement relating to no breach of representations and warranties and performance of covenants to be satisfied (so long as Purchaser has provided BCBSLA with written notice of such breach or inaccuracy and the breach or inaccuracy has continued without cure until 30 days following the date of such notice of breach);

- by BCBSLA upon written notice to Purchaser if there has been a breach of any covenant or agreement by, or inaccuracy of any representation or warranty of, Purchaser set forth in the Acquisition Agreement, which would result in the failure of the conditions in the Acquisition Agreement relating to no breach of representations and warranties and performance of covenants to be satisfied (so long as BCBSLA has provided Purchaser with written notice of such breach or inaccuracy and the breach has continued without cure until 30 days following the date of such notice of breach or inaccuracy);

- by either Purchaser or BCBSLA upon written notice to the other party if the Reorganization has not been completed by a specified outside date (subject to certain customary exceptions, one extension of the Outside Date exercisable by either party, and a second extension of the Outside Date that must be mutually agreed-upon);

- by either Purchaser or BCBSLA upon written notice to the other party if any injunction or order related to antitrust laws restraining, enjoining or otherwise prohibiting the effectiveness of the transactions shall become final and non-appealable;

- by either Purchaser or BCBSLA upon written notice to the other party if (i) any governmental authority which must grant a required regulatory approval has denied approval of such required regulatory approval as herein contemplated, and such denial has become final and non-appealable or any governmental authority of competent jurisdiction shall have issued a final non-appealable order permanently enjoining or otherwise prohibiting the effectiveness of the transactions;

- by Purchaser upon written notice to BCBSLA if the BCBSLA Board (i) fails to recommend that Voting Members approve the Plan, (ii) changes their recommendation that Voting Members approve the Plan, (iii) authorizes, approves or recommends to the Commissioner, the Voting Members, or otherwise authorizes, approves or publicly recommends, an alternative transaction, or (iv) shall fail to publicly confirm the Board's recommendation that Voting Members approve the Plan within ten Business Days after a written request by Purchaser that it do so following BCBSLA's receipt of a proposal concerning an alternative transaction, if, in each case, following such termination BCBSLA pays to Purchaser a termination fee of $75,000,000 (the "Company Termination Fee");

- by BCBSLA, provided that BCBSLA has complied with its obligations under the relevant provisions of the Acquisition Agreement relating to nonsolicitation of

alternative proposals, at any time prior to obtaining the approval of the Plan by the Voting Members at the Special Meeting, in order to concurrently enter into a binding agreement for an alternative transaction that constitutes a superior proposal, and concurrently with such termination, BCBSLA pays to Purchaser the Company Termination Fee;

- by either Purchaser or BCBSLA upon written notice to the other party if, subject to any adjournment of the Special Meeting to a date no later than 30 days following the date for which the Special Meeting is initially scheduled, the approval of the Plan by the Voting Members at the Special Meeting shall not be obtained at the Special Meeting and BCBSLA pays to Purchaser the Company Termination Fee if an alternative transaction has been publicly announced and not withdrawn prior to the date of the Special Meeting, and BCBSLA enters into an agreement with respect to, or consummates, such alternative transaction within 12 months of termination of the Acquisition Agreement.

Additional Termination Fees

Mutual Termination Fee

If the Acquisition Agreement is terminated due to an uncured covenant breach or material breach of a representation and warranty, in each case causing the conditions to Closing under the Acquisition Agreement to not be met, then the non-terminating party shall pay to the terminating party a $25,000,000 termination fee.

Purchaser Termination Fee

If the Acquisition Agreement is terminated by Purchaser or BCBSLA because the outside date (as the same may have been extended) has passed, the transactions have become prohibited under applicable antitrust law, or the required regulatory approvals are not received, and Purchaser has, after the signing of the Acquisition Agreement, taken certain additional actions, then Purchaser shall pay to BCBSLA a $75,000,000 termination fee.

RECTOR & ASSOCIATES, INC.

REPORT TO THE LOUISIANA DEPARTMENT OF INSURANCE REGARDING LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY (D/B/A/ BLUE CROSS AND BLUE SHIELD OF LOUISIANA

Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company and Purchase of Louisiana Health Service & Indemnity Company (d/b/a) Blue Cross and Blue Shield of Louisiana Common Stock

August 14, 2023

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Rector & Associates, Inc. **("R&A")** is pleased to present the Report of its findings and recommendations to the Louisiana Department of Insurance **("Department")** with respect to the services requested by the Department in connection with the following:

- The Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company with respect to Louisiana Health Service & Indemnity Company (D/B/A/ Blue Cross And Blue Shield of Louisiana) **("Plan of Reorganization")**; and
- The acquisition of 100% of the outstanding shares of capital stock of BCBSLA (BCBSLA Purchase) **("BCBSLA Acquisition").**

The following describes the actions that have been taken and the proposed actions to be taken to effectuate the Plan of Reorganization and the BCBLS Acquisition (collectively, the **"Transactions")**:

First, the Board of Directors of Louisiana Health Service & Indemnity Company (D/B/A/ Blue Cross and Blue Shield of Louisiana) **("BCBSLA")** approved the Plan of Reorganization pursuant to Board resolutions that were adopted on and effective as of January 23, 2023. The transactions contemplated by the Plan of Reorganization would result in the reorganization of BCBSLA from a mutual insurance company to a stock insurance company in accordance with LSA-R.S. § 22:72, LSA-R.S. § 22:236 et seq. and the other applicable provisions of the Louisiana Insurance Code (collectively, the **"Demutualization Statutes")**.

In addition, an Agreement and Plan of Acquisition **("Acquisition Agreement")** was entered into effective January 23, 2023 by and among BCBSLA, Elevance Health, Inc., an Indiana corporation **("Elevance")**, ATH Holding Company, LLC, an Indiana limited liability company and wholly owned subsidiary of Elevance **("Purchaser")**, and The Accelerate Louisiana Initiative, Inc., a newly established Delaware nonprofit nonstock corporation organized by BCBSLA to work to improve the health and lives of the people of the State of Louisiana and intended to qualify as an Internal Revenue Code Section 501(c)(4) social welfare organization **("Foundation").** (BCBSLA, Elevance, Purchaser and the Foundation are, collectively, the **"Parties")**.

At or shortly following the effectiveness of the Transactions (the **"Closing Date")**, the following would occur: Elevance would indirectly acquire 100% of the BCBSLA issued and outstanding shares of capital stock **("BCBSLA Shares")**, subject to the terms and conditions set forth in the Transactions. In addition, eligible members of BCBSLA, as determined by BCBSLA and approved by the Louisiana Commissioner of Insurance **("Eligible Members")** would receive Eligible Member Payments as consideration for the extinguishment of the Eligible Members' rights and interests as BCBSLA policyholders and members of BCBSLA. Finally, BCBSLA would make payments to the Foundation to fund its future operations.

I. EXECUTIVE SUMMARY

A. Summary of Key Economic Aspects of the Transactions

The following is a high-level summary of the key economic aspects of the Transactions. This summary was prepared using dollar estimates developed by BCBSLA based on data on or approximately as of 12/31/2022. The amounts below are general, informational estimates only. The actual amounts would be based on BCBSLA's financial statements as of the Closing Date.

1. Elevance (through Purchaser) is to make the following payments, totaling $2.746 billion:
   - $307 million paid to the Eligible Members (via a paying agent) ($3,027 per policy);
   - $2.435 billion contributed to the Foundation (via BCBSLA); and
   - $4 million paid to cover various indebtedness and transaction expenses.

2. In addition to the amounts above (which are to be funded by Elevance), BCBSLA is to contribute $667 million to the Foundation from its existing funds.
   - Following this contribution and the other aspects of the Transactions, BCBSLA would have statutory surplus of approximately $1 billion (compared to $1.652 billion as of 12/31/2022) and an Authorized Control Level Risk-Based Capital **("ACL RBC")** ratio of 500% (compared to 838% as of 12/31/2022);

3. Following the Transactions, it is estimated that the Foundation would have assets of $3.102 billion, consisting of:
   - the $2.435 billion payment originating with Elevance (Item 1 above, second bullet), and
   - the $667 million payment originating with BCBSLA (Item 2 above).

4. For purposes of determining the amount of consideration to be paid to Eligible Members, the "value of" BCBSLA[1] was determined by the Parties to be $3.413 billion.[2]
   - As noted in Item 1 above, first bullet, the payment to Eligible Members would be $307 million, which is approximately 9% of BCBSLA's $3.413 billion valuation.

B. Benefits of the Transactions

In the Plan of Reorganization—and especially in clauses "C" and "D" of the section titled "Affirmations Related to the Proposed Reorganization"—BCBSLA describes many of the benefits it believes the Transactions would provide to BCBSLA and its members and other customers. Those benefits include such things as improving BCBSLA's access to capital, improving the delivery of health care digitally, and allowing BCBSLA to use Elevance's wide-ranging portfolios of whole health solutions. Although it is outside of the scope of our engagement to perform more than a general review of these various anticipated benefits, the benefits of the Transactions claimed

[1] Within the meaning of La. Rev. Stat. 22:236.3.A.

[2] This consists of the base purchase price of BCBSLA on a debt-free basis assuming an ACL RBC of 375% ($2.5 billion) plus BCBSLA's surplus above an ACL RBC ratio of 375% ($913 million) (i.e., $2.5 billion + $913 million = $3.413 billion).

by BCBSLA appear to us to be reasonable and to be the types of benefits we anticipate transactions such as those contemplated here would provide.

In addition to the anticipated benefits to BCBSLA's members and other customers, the funding of the Foundation should also benefit residents of Louisiana more broadly—even those who are not members or other customers of BCBSLA—since the stated mission of the Foundation is "to improve the health and lives of the people of Louisiana."

C. Items Requiring Particular Consideration by the Department

To be balanced against these many benefits are two items arising from our analyses and conclusions that we believe the Department should give particular consideration to as it decides whether to approve the Transactions. These items are in addition to any that may be raised by the other Department-contracted specialists or advisors.

1. ***Very little of substance is currently known about how the Foundation would operate or how it would use the more than $3 billion it would receive as part of the Transactions.***
   - The expectation is that the Foundation would benefit Louisianians since its mission is "to improve the health and lives of the people of Louisiana." These benefits should inure not only to BCBSLA's members and other customers, but, also, to Louisianians more broadly. However, very little is currently known about what the Foundation would actually do to accomplish its mission. Currently, the Foundation's expressed plans are quite general in nature. For example, one of the responses provided to our questions about the Foundation's plans was, "[t]he Board [of the Foundation] has had many discussions about the many areas of need within the state, intends to conduct a needs assessment for health and the social determinants of health in Louisiana to assist in narrowing its focus and identify and develop specific projects and initiatives that potentially will be transformational within the state." In other words, the Foundation plans to study the issue and to make decisions later about what problems to address and how to address them. Other descriptions provided by the Parties as to the Foundation's plans are set out in the body of our report below. Those descriptions are similarly general in nature.
   - Questions also remain regarding who the officers and directors of the Foundation would be. Currently, the board of directors of the Foundation consists of four initial directors (all currently board members of BCBSLA). The Foundation intends to add more directors as well as (presumably) officers and other staff, but it is not currently known who those persons would be.
   - Another somewhat open question pertains to the activities of the Foundation relative to its planned operation as a social welfare organization that is tax-exempt pursuant to section 501(c)(4) of the Internal Revenue Code. The Parties indicated that the Foundation is expected to satisfy the requirements needed to be such an organization; however, the Foundation does not plan to seek a "determination letter" from the Internal Revenue Service **("IRS")** to confirm that status until after the Closing Date. Also, as discussed further in the body of the report, 501(c)(4) social welfare organizations (unlike 501(c)(3) charitable organizations) are allowed to engage in wide-ranging political activity, including lobbying and engaging in political campaigns on behalf of or in opposition to candidates

for public office.[3] As discussed in the body of our report, the Foundation's Certificate of Incorporation prohibits the Foundation from engaging in such political activity—restricting its activities in this area to those permitted of a 501(c)(3) organization. However, it would be possible for the Foundation to amend its Certificate of Incorporation in the future to modify or remove this restriction so long as the amendment has the approval of two-thirds (2/3) of the total number of directors then in office.

- In some ways, it is understandable that specifics about the Foundation's plans are not yet known. The Foundation is in its early stages, and (understandably, and responsibly) it would like to take a methodical approach to fulfilling its mission. However, this is probably the only opportunity for the Department and the Eligible Members to evaluate the Foundation's plans. Once/if the Transactions are approved, the Department and the Eligible Members would likely not have any jurisdictional oversight of the Foundation, its operations, or its use of the funds being contributed to it. Accordingly, the Department and the Eligible Members are being asked to approve Transactions that would include the contribution to the Foundation of approximately $667 million of BCBSLA's current assets, in addition to the contribution through BCBSLA of approximately $2.435 billion in assets funded by Elevance, even though very little of substance is known as to what the Foundation would do with the funds it would receive or as to who would control the decisions to be made regarding them.
- **Recommendations**:
  - We recommend that the Department decide whether additional information pertaining to the Foundation's plans is needed before the Department and the Eligible Members can make an informed decision regarding the Transactions.
  - We recommend that the Department consider whether the Foundation's current limitation as to its engagement in political activity is sufficient (given that it may be removed from the Foundation's Certificate of Incorporation with the vote of 2/3 of the total number of directors at the time of the vote) or whether further steps are needed to assure that the Foundation will not engage in political activity at some point in the future.
- **Conclusion:** We have no conclusions regarding this matter separate from our recommendations.

2. ***The Transactions would cause BCBSLA's liquid assets[4] to go from 116% of its liabilities as of 12/31/2022 to 53% of its projected liabilities as of 12/31/2023.***
   - In addition to the impact such a reduction in liquidity would have on BCBSLA's financial condition generally, there is a concern it could also impact decisions made at BCBSLA in the future as to whether, when, how often, and by how much to increase rates to its customers.
   - The Parties have identified a number of protections relative to this reduction in liquidity: (1) BCBSLA would become part of Elevance, a publicly-traded Fortune 500 company and

[3] According to the IRS, 501(c)(4) organizations "may engage in an unlimited amount of lobbying, provided that the lobbying is related to the organization's exempt purpose," and "may engage in political campaigns on behalf of or in opposition to candidates for public office provided that such intervention does not constitute the organization's primary activity." *See* Political Campaign and Lobbying Activities of IRC 501(c)(4), (c)(5), and (c)(6) Organizations, by John Francis Reilly and Barbara A. Braig Allen, p. L-2. https://www.irs.gov/pub/irs-tege/eotopicl03.pdf.

[4] Investments in cash, bonds, and non-affiliated common stocks.

financially strong health insurer and provider group, (2) BCBSLA has developed and submitted cash flow projections that show it having positive cash flow through at least the period of the projections (the end of calendar year 2026), (3) Elevance intends to provide a form of financial guarantee to protect the "customers" of BCBSLA and HMO Louisiana, Inc. [5] **("HMO Louisiana")** in the event of financial insolvency at either entity, (4) Elevance has indicated that it is willing to commit to the Department that it will maintain ACL RBC ratio levels of at least 375% at both BCBSLA and HMO Louisiana, and (5) BCBSLA has stated that it will not need to increase rates due to any aspect of the Transactions, including its reduced liquidity.

- **Recommendations:** We recommend the following as conditions to any approval of the Transactions by the Department:
  - That the Department ensure that Elevance issues the referenced forms of guarantee that protect the "customers" of BCBSLA and HMO Louisiana;
  - That the Department require Elevance to formally document that it will ensure that BCBSLA and HMO Louisiana each maintain an ACL RBC ratio of at least 375% (as it has committed to do);
  - That the Department require BCBSLA to agree not to pay any shareholder dividends (whether "ordinary" or "extraordinary" dividends) without prior Department approval prior to 2027, which is consistent with the cash flow projections submitted by BCBSLA (which show no dividends through 2026); and
  - That the Department carefully monitor BCBSLA's adherence to the submitted cash flow projections.
- **Conclusion:** We would be concerned by the reduction in BCBSLA's liquidity if it occurred in a vacuum, without any countervailing protections. However, we believe the protections identified by the Parties, coupled with the implementation of our recommendations, would adequately address the concerns presented by the reduction in liquidity.

[5] HMO Louisiana, Inc. is a Louisiana domestic HMO that is a wholly-owned subsidiary of BCBSLA.

II. SCOPE OF WORK

In connection with our engagement by the Department, we were asked to perform the following services and analyses:

R&A will review various documents filed in connection with the Transactions and provide comments to the Department, Randall Stevenson[6] and Butler Snow LLP **("Butler Snow")**[7], as appropriate, regarding matters R&A believes would be relevant as the Department decides whether to approve the Transactions. R&A will focus on certain financial and regulatory issues. In particular, R&A will:

1. Review documents filed with the Department for the purpose of identifying key "big picture" financial issues R&A believes the Department should consider as it decides whether to approve the Transactions.

2. Assist Mr. Stevenson in his review in several ways, including:
   - Asking the Parties generally about the process used by BCBSLA/Elevance in determining what they believe to be "the value of" BCBSLA for the purposes of determining what consideration to pay to Eligible Members, reviewing (along with Mr. Stevenson) the December 22, 2022 correspondence from Cain Brothers (a Division of KeyBanc Capital Markets) **("Cain Brothers")** to the BCBSLA Board of Directors relative to that determination of "value" (the **"Cain Brothers Opinion")** and providing comments regarding such matters that it believes the Department should consider as it decides whether to approve the Transactions.
   - Sharing thoughts and comments R&A has regarding the January 12, 2023 correspondence from Chaffe & Associates, Inc. to the Board of Directors (the **"Chaffe Opinion")** and the January 12, 2023 Deloitte Consulting LLP Statement of Actuarial Opinion – Allocation of Policyholder Consideration for Proposed Demutualization, as issued by Brian M. Collender, FSA, MAAA (the **"Deloitte Opinion")**, as well as asking the Parties general questions R&A has regarding the Chaffe Opinion and the Deloitte Opinion.
   - Sharing other thoughts/comments/questions/concerns that R&A believes Mr. Stevenson should consider as he performs his work.

3. Evaluate, generally, whether R&A believes the Transactions would leave BCBSLA in a financial position that should be of concern to the Department as it decides whether to approve the Transactions.

4. Ask the Parties various questions pertaining to the Foundation, including questions about proposed compensation to officers and board members of BCBSLA.

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[6] Randall A. Stevenson, ASA MAAA MSc, is the President of & Consulting Actuary with Hause Actuarial Consulting, Inc. **("HAC")**. It is our understanding that HAC and Mr. Stevenson were engaged by the Department to perform actuarial, valuation, and related services in connection with the Department's review of the Transactions.

[7] Butler Snow LLP is a law firm that we understand was engaged by the Department to perform legal services in connection with the Department's review of the Transactions.

5. Ask the Parties questions regarding their proposed compliance with La. Rev. Stat. 22:236.3.D. pertaining to dividend expectations and protections.

6. Determine whether and how BCBSLA's current board members and executive officers would financially benefit if the Transactions are approved.

7. Provide any additional comments/thoughts R&A has after reviewing the documents and communicating with the Parties to the extent R&A believes such thoughts/comments would be helpful to the Department as it decides whether to approve the Transactions.

For sake of clarity, among the things R&A was not tasked with doing are the following:

- Determining what is an appropriate "value" of BCBSLA;
- Evaluating whether the consideration BCBSLA proposes to pay to Eligible Members—whether in the aggregate or in the allocation of that aggregate amount among Eligible Members—constitutes amounts equal to Eligible Members' "equitable share" of BCBSLA's value; or
- Determining whether BCBSLA's decisions as to who are and who are not Eligible Members are appropriate.

As part of our services and analyses, R&A requested information and documents from the Parties in the form of correspondence to Ronnie L. Johnson, Esq. of the McGlinchey Stafford PLLC law firm, legal counsel for BCBSLA. We requested information and documents in correspondence dated June 22, 2023, July 10, 2023, July 20, 2023, August 7, 2023, August 11, 2023, and August 13, 2023 (collectively, the **"R&A Requests for Information")**. Mr. Johnson responded to the R&A Requests for Information in the form of correspondence to R&A dated July 7, 2023, July 17, 2023, August 2, 2023, August 7, 2023, and August 13, 2023 (collectively, the **"Responses")**.

III. ANALYSIS AND RECOMMENDATIONS

Following this list is a description of our work and findings relative to each of the tasks.

A. Task 1 – Document Review and Identification of Key "Big Picture" Financial Issues

Task: Review the documents filed with the Department for the purpose of identifying key "big picture" financial issues that R&A believes the Department should consider as it decides whether to approve the Transactions.

We reviewed the documents filed in connection with the Transactions, focusing on those that most impacted the specific tasks we were asked to perform. Although there are numerous issues presented by transactions as complex as these, we identified three "big picture" financial issues that we believe are the most critical ones for the Department to consider as it decides whether to approve the Transactions. Those issues, and a brief discussion as to how they have been dealt with, are as follows:

1. **"Big Picture" Financial Issue # 1: What is "the value of" BCBSLA?**

   Analysis: La. Rev. Stat. 22:236.3.A provides, in part, that "each eligible member shall be entitled to consideration in an amount equal to his or its equitable share of the value of the reorganizing mutual…." (emphasis added). A key part of the analysis, therefore, is for there to be a determination of what constitutes "the value of" BCBSLA. As noted above, we were not tasked with determining "the value of" BCBSLA. However, we were tasked with assisting Mr. Stevenson in his analysis of that issue.

   It was not easy to ascertain from the documents themselves the amounts that are to be paid by the Parties in connection with the Transactions or how those payment amounts might relate to "the value of" BCBSLA.[8] Accordingly, part of our work pertained to sorting through the complexity in the documents and working with BCBSLA to obtain estimates of the various amounts to be paid in connection with the Transactions. A further part of our work was presenting that information in an understandable format, such as in Section I.A. – Executive Summary, Summary of Key Economic Aspects of the Transactions, above.

[8] For example, the largest payment to be made by Elevance, via Purchaser, is set out in Section 1.6(f) of the Acquisition Agreement, which requires Purchaser to contribute to BCBSLA, and to cause BCBSLA to contribute to the Foundation, something called the "Note Amount." The "Note Amount" is defined in the Acquisition Agreement as "an amount equal to the Closing Foundation Amount." The "Closing Foundation Amount" is defined as "an amount equal to (i) the Foundation Amount, plus (ii) the Estimated Closing Surplus (which may be a negative number), minus (iii) the Estimated Company Transaction Expenses to the extent not included in the calculation of the Estimated Closing Surplus, minus (iv) the Estimated Closing Indebtedness to the extent not included in the calculation of the Estimated Closing Surplus." Each of those capitalized terms is further defined in the Acquisition Agreement. The most important of those terms relative to the analysis here is the "Foundation Amount," which is defined as "an amount equal to (i) the Base Purchase Price, minus (ii) the Eligible Member Payment. The Base Purchase Price is defined as $2.5 billion.

A related complication was that the documents contained differing amounts that appeared, at first blush, to be what the Parties had determined to be "the value of" BCBSLA. For example, the Acquisition Agreement references a "Base Purchase Price" of $2.5 billion. An initial reaction, therefore, was that Elevance would be paying an amount close to the $2.5 billion Base Purchase Price and that what Elevance would pay was approximately "the value of" BCBSLA. However, Exhibit E – Eligible Member Payment Methodology – of the Plan of Reorganization listed the "Transaction Valuation" at $3.413 billion.

In response to questions posed, we learned that the "Base Purchase Price" ($2.5 billion) was what the Parties believed the debt-free value of BCBSLA would be if BCBSLA only had enough surplus to support an ACL RBC ratio of 375%. BCBSLA's ACL RBC ratio as of 12/31/2022 was actually 838%, though, well above the 375% ACL RBC level used to determine the $2.5 billion Base Purchase Price valuation. Accordingly, the Parties determined "the value of" BCBSLA to be $3.413 billion, as follows: the $2.5 billion Base Purchase Price (the debt-free value of BCBSLA as of 12/31/2022 up to a 375% ACL RBC level) + $913 million (the amount of statutory surplus BCBSLA actually had as of 12/31/2022 that exceeded the 375% ACL RBC level) = $3.413 billion.

It should be noted that, although the total value of BCBSLA is deemed to be $3.413 billion, Elevance would be paying only $2.746 billion,[9] which is $667 million less than the total valuation. The reason for this difference is the $667 million contribution that would be made by BCBSLA to the Foundation. After that contribution, the value of BCBSLA would be $2.746 billion ($3.413 billion - $667 million), which is the amount that would be paid by Elevance in connection with the Transactions.

In connection with our work relative to "the value of" BCBSLA, we also reviewed the Cain Brothers Opinion, which concluded that, as of the date thereof, "the Base Purchase Price is fair, from a financial point of view, to [BCBSLA]." Our review included a review of the financial projections and selected other materials relied on by Cain Brothers in issuing the Cain Brothers Opinion.

Conclusion: Consistent with the scope of our task, we performed various review procedures to assist Mr. Stevenson in determining "the value of" BCBSLA, including a review of the Cain Brothers Opinion and the projections underlying it, and we shared our thoughts and observations regarding these matters with Mr. Stevenson.

Recommendations: None.

2. **"Big Picture" Financial Issue # 2: Assuming the claimed "value of" BCBSLA is appropriate, are the Eligible Members receiving their equitable share of the overall amount?**

Analysis: As noted above, we were not tasked with evaluating whether the consideration BCBSLA proposes to pay to Eligible Members—whether in the aggregate or in the allocation

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[9] See Section 1.A – Executive Summary, Summary of Key Economic Aspects of the Transactions, Item 1, second bullet.

of that aggregate amount among Eligible Members—constitutes amounts equal to the Eligible Members' "equitable share" of BCBSLA's value. We also were not tasked with determining whether BCBSLA's decisions as to who are and who are not Eligible Members are appropriate. However, we were tasked with assisting Mr. Stevenson in his analysis relative to these issues.

As part of our work, we explored with BCBSLA various factual matters and BCBSLA's reasoning in connection with a number of items, including such things as (1) why consideration to Eligible Members should consist solely of a "fixed" payment in exchange for the Eligible Members' governance (voting) rights and not also a "variable" payment in exchange for any economic rights they might have, (2) why it is "equitable" (within the meaning of La. Rev. Stat. 22:236.3.A) for Eligible Members, who hold 100% of the governance rights, to receive only 9% of what the Parties believe "the value of" BCBSLA to be, and (3) why the Parties selected the methodologies they did in determining the amount of consideration to be paid to Eligible Members.

The Parties' decisions regarding these matters were incorporated into the analyses that led to the Chaffe Opinion (pertaining to the methodology pursuant to which the aggregate amount of consideration to be paid to the Eligible Members as a group was determined) and the Deloitte Opinion (pertaining to the methodology pursuant to which the aggregate consideration is to be allocated among Eligible Members). We also reviewed and asked questions pertaining to those opinions.

Conclusion: Consistent with the scope of our task, we performed various review procedures to assist Mr. Stevenson in determining whether the Eligible Members are receiving their "equitable share" of the value of BCBSLA, including a review of the Chaffe Opinion and the Deloitte Opinion, and we shared our thoughts and observations regarding these matters with Mr. Stevenson.

Recommendations: None.

3. **Big Picture" Financial Issue # 3: Would BCBSLA, post-Transactions, have sufficient funds to be able to be a financially strong and viable company?**

Analysis: Our work here consisted of a number of items, including reviewing BCBSLA's financial statements, reviewing materials pertaining to the financial condition of Elevance, reviewing financial projections pertaining to BCBSLA's financial condition post-Transactions, and reviewing and evaluating the Responses.

As set out above in Section I.C – Executive Summary, Items Requiring Particular Department Consideration, the Transactions would have several negative financial impacts on BCBSLA. Most significantly, BCBSLA's investment in cash, bonds and non-affiliated stocks is projected to decline from approximately 116% of its liabilities as of 12/31/2022[10] to approximately 53%

[10] As of 12/31/2022, BCBSLA reported approximately $1.246 billion in common stocks (of which $736 million consisted of "affiliated" common stocks), plus approximately $665 million in bonds, plus approximately $209 million in cash, for a total of $1.384 billion (excluding "affiliated" common stocks), or 116.7% of its total liabilities of $1.185 billion.

of its projected liabilities as of 12/31/2023.[11] Further, BCBSLA's statutory surplus is projected to decline from $1.652 billion as of 12/31/2022 to approximately $1 billion as of the Closing Date. BCBSLA's ACL RBC ratio is also projected to decline, going from 838% as of 12/31/2022 to approximately 500% as of the Closing Date. In addition to how such matters would impact BCBSLA's financial condition generally, there is also a concern they could impact decisions made at BCBSLA in the future as to whether, when, how often, and by how much to increase rates to its customers. These negative impacts result, in significant part, from the plan for BCBSLA to contribute approximately $667 million of its existing assets to help fund the Foundation.

Notwithstanding these negative impacts, BCBSLA (post-Transactions) would have a number of strengths pertaining to its financial condition. For example, the Transactions would cause BCBSLA to become a member of a financially strong and viable group with access to capital.[12] The Transactions would also allow both BCBSLA and HMO Louisiana to have parental guarantees and other commitments as to maintenance of specified ACL RBC ratio levels to support those entities financially should they need such support. (BCBSLA and HMO Louisiana do not have either of these protections currently.) Further, even without the support of Elevance or without parental guarantees/ACL RBC ratio maintenance commitments, BCBSLA would continue to have approximately $1 billion in statutory surplus and an ACL RBC ratio of approximately 500%, both of which significantly exceed Louisiana required amounts.[13]

Of the negative impacts described above, the one that gives us the greatest pause is the projected reduction in BCBSLA's liquidity. However, BCBSLA provided various materials regarding how it plans to manage its liquidity risk post-Transactions, including cash-flow projections through calendar year 2026. Its plans in this regard appear to be reasonable and consistent with past historical experience. Further, the existence of the proposed financial guarantees and of the ACL RBC ratio maintenance commitments from Elevance provide additional comfort that BCBSLA (and HMO Louisiana) would be able to access additional

[11] As of 12/31/2023, BCBSLA projects approximately $744 million in common stocks (of which $736 million would be a reasonable estimation of "affiliated" common stocks), plus approximately $509 million in bonds, plus approximately $122 million in cash, for a total of $639 million (excluding "affiliated" common stocks), or approximately 53% of the projected 12/31/2023 total liabilities of $1.199 billion.

[12] Elevance is a publicly-traded Fortune 500 health managed care company. According to its Audited Consolidated Financial Statements as of 12/31/22 (as contained in its SEC Form 10-K as of 12/31/22 and 12/31/21), the Elevance group had $6.02 billion of net income; $155.66 billion of total operating revenue; $102.77 billion of total assets; and $36.39 billion of total equity. According to Elevance's Form A Statement, Elevance's financial strength ratings as of January 23, 2023 were:

- Standard & Poor's Rating Services: AA- (Very Strong)
- A.A. Best Company: A (Excellent)
- Moody's Investor Services, Inc.: A2 (Good)
- Fitch, Inc.: A+ (Strong)

[13] A Louisiana domestic insurer with similar licensing attributes as BCBSLA is required to maintain a minimum of $3.0 million in capital and surplus. *See* La. Rev. Stat. 22:82.A. As to RBC, a Louisiana domestic insurer would be required to submit to the Department a risk-based capital plan if its ACL RBC ratio falls below 200% (or below 300%, if certain "trend tests" are also triggered). The consequences to the insurer potentially become greater if its ACL RBC ratio drops further below 200%. *See* La. Rev. Stat. 22:611 et. seq.

capital, if needed.[14] It should be noted that the ACL RBC ratio maintenance commitment relative to BCBSLA is of particular importance, and that it indirectly covers all of the companies directly or indirectly owned by BCBSLA, because BCBSLA's ACL RBC ratio would be negatively impacted by poor results arising from any of those other companies.

Although the Transactions would result in a number of items that would enable BCBSLA to be a financially strong and viable company, we recommend several items below to further protect customers and other creditors.

Conclusion: The Transactions would have some negative financial impacts on BCBSLA (with the reduction in BCBSLA's projected liquidity giving us the greatest pause). However, if our recommendations to the Department are implemented, we believe those protections, coupled with the protections identified by the Parties, would be sufficient to allow BCBSLA to continue to be a financially strong and viable company post-Transactions, including that it should have access to additional capital to support operations and to protect customers and other potential creditors, if needed.

Recommendations: We recommend the following as conditions to any approval of the Transactions by the Department:

a. BCBSLA has developed and submitted materials as to how it will manage its liquidity risk post-Transactions, including providing cash-flow projections.

   We recommend that the Department carefully monitor BCBSLA's adherence to the submitted cash-flow projections.

b. Elevance has indicated it intends to provide a form of financial guarantee to protect the "customers" of BCBSLA and HMO Louisiana in the event of financial insolvency at either entity. We note, however, that those documents do not provide direct protection for creditors of the entities other than those entities' "customers" (policyholders, certificate holders, administrative-only clients, etc.). Further, those documents do not guarantee that BCBSLA will maintain capital equal to any specified ACL RBC ratio level. Accordingly, in response to questions raised in the R&A Requests for Information, Elevance expressed a willingness in the Responses to commit to the Department that it will maintain an ACL RBC ratio of at least 375% in both BCBSLA and HMO Louisiana.

   We recommend that the Department ensure that Elevance issues the referenced forms of guarantee that protect the "customers" of BCBSLA and HMO Louisiana.

   We recommend that the Department require Elevance to formally document that it will ensure that BCBSLA and HMO Louisiana will each maintain an ACL RBC ratio of at least 375%.

[14] Additional sources of capital might also be available should a liquidity event occur. For example, the Notes to the BCBSLA Financial Statement indicate that BCBSLA could borrow up to $200 million from the Federal Home Loan Bank of Dallas.

c. The submitted cash-flow projections do not show any dividends being paid by BCBSLA through at least 2026.

   We recommend that the Department require BCBSLA to agree not to pay any shareholder dividends (whether "ordinary" or "extraordinary" dividends) prior to 2027, unless it receives prior approval from the Department to allow such dividends to be paid.

B. Task 2 – Assistance with Stevenson Review and Analysis

Task: Assist Mr. Stevenson in his review in several ways, including:

- **Asking the Parties generally about the process used by BCBSLA/Elevance in determining what they believe to be "the value of" BCBSLA for the purposes of determining what consideration to pay to Eligible Members, reviewing (along with Mr. Stevenson) the Cain Brothers Opinion and providing comments regarding such matters that it believes the Department should consider as it decides whether to approve the Transactions.**
- **Sharing thoughts and comments R&A has regarding the Chaffe Opinion and the Deloitte Opinion, as well as asking the Parties general questions R&A has regarding the Chaffe Opinion and the Deloitte Opinion.**
- **Sharing other thoughts/comments/questions/concerns that R&A believes Mr. Stevenson should consider as he performs his work.**

The work we performed relative to these items is described above, in connection with Section III.A. – Analysis and Recommendations, Task 1 – Document Review and Identification of Key "Big Picture" Financial Issues with respect to the first two "big picture" financial issues.

C. Task 3 – Evaluation of BCBSLA Financial Position After Occurrence of the Transactions

Task: Evaluate, generally, whether R&A believes the Transactions would leave BCBSLA in a financial position that should be of concern to the Department as it decides whether to approve the Transactions.

The work we performed relative to this item is described above, in connection with Section III.A. – Analysis and Recommendations, Task 1 – Document Review and Identification of Key "Big Picture" Financial Issues with respect to the third "big picture" financial issue.

D. Task 4 – Requests for Information Regarding the Foundation and BCBSLA Management Compensation

Task: Ask the Parties various questions pertaining to the Foundation, including questions about proposed compensation to officers and board members of BCBSLA.

Analysis: In the R&A Requests for Information, we asked BCBSLA a number of questions pertaining to the Foundation.

The Responses indicated that the Foundation is a nonprofit nonstock corporation formed for social welfare purposes within the meaning of Section 501(c)(4) of the Internal Revenue Code and that its mission is "to improve the health and lives of the people of Louisiana." The Responses indicated that the Foundation meets the eligibility requirements of a 501(c)(4) entity. However, the Responses also indicated that the Foundation "does not plan to file for a determination letter from the Internal Revenue Service until after the [Transactions]."

Many of the questions we asked in the R&A Requests for Information pertained to how the Foundation planned to use the more than $3 billion it would receive as part of the Transactions. The answers we were provided in the Responses were general in nature, evidencing that few of the specifics about these matters appear to be currently known. Rather than providing specifics, the Responses indicated that the Foundation plans to study the issue and to make decisions later about what problems to address and how to address them.

For example, as noted in Section I.C.1. – Executive Summary, Items Requiring Particular Consideration by the Department, the Responses included the following in response to our questions about the Foundation's plans:

> The Board [of the Foundation] has had many discussions about the many areas of need within the state, intends to conduct a needs assessment for health and the social determinants of health in Louisiana to assist in narrowing its focus and identify and develop specific projects and initiatives that potentially will be transformational within the state.[15]

Examples of other descriptions in the Responses of the Foundation's anticipated activities were:

> The Foundation's principal activity will be making grants to fund programs and activities that will further its mission of improving the health and lives of the people of Louisiana. The Foundation anticipates that a significant portion of these grants will be focused on searching for innovative and scalable solutions to address the healthcare needs of residents of the state, including access to care and the social determinants of health, as well as more general issues such as poverty and education. The Foundation may also engage in direct charitable programs and activities, although this may not occur during the first few years of its operation.

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[15] The Responses further described this anticipated process as follows: "the Board [of the Foundation] intends to commence a robust 'Needs Assessment' executed by a world-class firm to achieve the following expected objectives:

- Comprehensive understanding of state performance across health outcomes and their underlying drivers (e.g., SDoH);
- Identification of potential root causes of performance, cross-walking outcomes to potential drivers (and therefore creating visibility into how to potentially address underlying issues) for prioritized areas;
- Qualitative view to provide additional context and perspective (while also creating an inclusive process that enables Louisiana voices to be heard);
- Inventory of existing philanthropy and not-for-profit landscape of efforts and focus across the state (both LA- and non-LA-based);
- case study profiles identifying how other foundations have attempted [to] address similar outcomes and root causes, including lessons learned from successes and failures;
- initial perspective of balancing feasibility and impact across various challenges; and
- an initial view of potential gaps to prioritize (as an input to subsequent strategy development)."

and

> The Foundation's mission is to improve the health and lives of the people of Louisiana, which the Foundation plans to pursue by addressing the health inequities and strengthening local communities, focusing both on issues relating directly to healthcare and on more holistic community issues such as poverty, education, and the social determinants of health. … Upon the closing of the [Transactions], the Foundation expects to be funded with a significant investment portfolio that will allow it to devote critically needed support to projects concerning health, education, poverty, and other social welfare issues affecting the residents of Louisiana.

In the R&A Requests for Information, we also inquired regarding the officer and board structure at the Foundation, including asking questions about the proposed compensation of such officers and directors. The answers provided were similarly general, also evidencing that not many specifics are known yet about these matters.

In response to our inquiries, BCBSLA indicated that four members of BCBSLA's current board currently comprise the board of the Foundation and are expected to remain on the Foundation's board. Those four initial members of the board of directors of the Foundation are:

- Jerome Greig
- C. Richard Atkins, DDS
- Charles "Brent" McCoy
- Thomas A. Barfield, Jr.

The Responses indicated that these are the members of the board of BCBSLA "who had the interest and made the commitment to serve as the founding Board of Directors of the Foundation and lead its start-up and operational phases. These Board members volunteered for this role and have passion for the mission of the Foundation."

The Responses further indicated that:

> "[d]uring the start-up phase, the expectation is for additional directors to be elected by the Board [of the Foundation]. The Board intends to conduct a national search for exceptional additional directors who have the background, experience, and proficiency in strategy and planning to help advise the Foundation during its critical start-up phase and when it becomes fully operational."

The Responses further described the planned engagement of a national search firm to help identify and select candidates for additional board members, indicating that it is in the final stages of selecting the search firm it will use. Further, "[w]hile the search for Board members will be nationwide to identify the widest pool of candidates available and there is no requirement that Board members be residents of Louisiana, the Board will be looking for directors who have connection to the state and who are familiar with the needs and concerns of Louisianians and expects that a majority of the Board members will be residents of Louisiana."

As to compensation, BCBSLA indicated that the initial (current) directors are serving without compensation. However, the expanded board is expected to consider whether compensation is appropriate. To help it sort through these issues, "the Board [of the Foundation] has engaged a compensation consultant to recommend a level of compensation that meets the applicable legal requirements for organizations described in Sections 501(c)(3) and 501(c)(4) of the [Internal Revenue Code] (i.e., the compensation must be reasonable based on comparable market data for board compensation at comparably-sized foundations)."

The Responses further provide that "[n]o person shall receive compensation in multiple capacities as no member serving on the Advisory Board [of BCBSLA] may serve on the Foundation's board." And "[t]here are no arrangements to offer BCBSLA Board members or executive officers of BCBSLA compensated roles as executive officers of or advisors to the Foundation."

As mentioned in the Executive Summary, another somewhat open question pertains to the activities of the Foundation relative to its planned operation as a social welfare organization that is tax-exempt pursuant to section 501(c)(4) of the Internal Revenue Code. The Responses indicated that the Foundation is expected to satisfy the requirements needed to be such an organization. However, the Responses further indicated that the Foundation does not plan to seek a "determination letter" from the IRS to confirm that status until after the Closing Date. Accordingly, we do not have available to us how the Foundation would describe itself and its planned activities to the IRS when seeking tax-exempt status.

Another item we questioned pertained to the fact that 501(c)(4) social welfare organizations (unlike 501(c)(3) charitable organizations) are allowed to engage in a wide range of political activity, including to engage in "an unlimited amount of lobbying, provided the lobbying is related to the organization's exempt purpose," and "in political campaigns on behalf of or in opposition to candidates for political office provided that such intervention does not constitute the organization's primary activity."[16] Although the Foundation is intended to be a 501(c)(4) organization—and, thus, would typically have the ability to engage in political activity[17]—the Foundation's Certificate of Incorporation restricts that ability and imposes limits pertaining to political activity that would be the same as if the Foundation were a 501(c)(3) organization. In this regard, Article "Sixth" of the Foundation's Certificate of Incorporation provides:

> "Restrictions. Provisions for the regulation of the activities and affairs of the [Foundation], are as follows:
> …
> (b) The [Foundation] shall be subject to the restrictions that apply to Section 501(c)(3) public charities with respect to influencing legislation and participating in political campaign activity. Accordingly, no substantial part of the activities of the [Foundation]

[16] *See*, Political Campaign and Lobbying Activities of IRC 501(c)(4), (c)(5), and (c)(6) Organizations, by John Francis Reilly and Barbara A. Braig Allen, p. L-2. https://www.irs.gov/pub/irs-tege/eotopicl03.pdf

[17] Examples of well-known 501(c)(4) organizations include AARP, the American Cancer Society Cancer Action Network, the American Civil Liberties Union (ACLU), the National Association for the Reform of Marijuana Laws (NORML), the National Rifle Association (NRA), No Labels, Planned Parenthood Action Fund, and Tea Party Patriots.

> shall be the carrying on of propaganda, or otherwise attempting, to influence legislation. The bylaws of the [Foundation] may set forth additional restrictions regarding lobbying activity by the [Foundation]. Additionally, the [Foundation] shall not participate or intervene in (including the publication or distribution of statements concerning) any political campaign on behalf of or in opposition to any candidate for public office."

We note that it would be possible for the Foundation to amend its Certificate of Incorporation in the future to modify or remove this restriction, although doing so would require the vote of two-thirds (2/3) of the total number of directors then in office.[18] However, it appears that the intention of the Foundation is not to engage in political activities. The Responses indicated "there are no plans to engage in lobbying or political campaigns even to the extent as would be permitted for a 501(c)(3) organization."

To summarize:

- The funding of the Foundation is a significant part of the Transactions. Not only would the vast majority of what Elevance would pay be used to fund the Foundation, but, in addition, a substantial amount of BCBSLA's current assets (approximately $667 million) would be contributed to the Foundation. As described above,[19] these payments would have a negative financial impact on BCBSLA, including causing a reduction in BCBSLA's liquidity.

- Notwithstanding the very substantial role of the Foundation in the Transactions, very little of substance is currently known about how the Foundation would operate, including such things as how the Foundation would use the more than $3 billion it would receive as part of the Transactions, who would constitute its officers and directors, and how those officers and directors would be compensated. It should also be noted that, once/if the Transactions are approved, the Department and the Eligible Members would likely no longer have any jurisdictional oversight of the Foundation, its operations, or its use of the funds being contributed to it.

Conclusion: In some ways, it is understandable that specifics about the Foundation's plans are not yet known. The Foundation is in its early stages, and (understandably, and responsibly) it would like to take a methodical approach to fulfilling its mission. However, this is probably the only opportunity for the Department and the Eligible Members to evaluate the Foundation's plans. Once/if the Transactions are approved, the Department and the Eligible Members would likely not have any jurisdictional oversight of the Foundation, its operations, or its use of the funds being contributed to it. Accordingly, the Department and the Eligible Members are being asked to approve the Transactions, which include the contribution to the Foundation of approximately $667

[18] Article "Eighth" of the Foundation's Certificate of Incorporation provides as follows:

> "Amendment of Certificate of Incorporation and Bylaws. In furtherance and not in limitation of the powers of the members conferred by law, subject to any limitations contained elsewhere in this certificate of incorporation or the bylaws, the board of directors is authorized to make, repeal, alter, amend or rescind the bylaws of the [Foundation] or to amend this certificate of incorporation; provided, however, that an amendment to section (b) of Article Sixth of this certificate of incorporation shall require a two-thirds (2/3) vote of the total number of directors then in office."

[19] Section III.A. – Analysis and Recommendations, Task 1 – Document Review and Identification of Key "Big Picture" Financial Issues with respect to the third "big picture" financial issue.

million of BCBSLA's current assets (in addition to the contribution through BCBSLA of approximately $2.435 billion in assets funded by Elevance), even though very little of substance is currently known as to what the Foundation would do with the funds it would receive.

Recommendations:

We recommend that the Department decide whether additional information pertaining to the Foundation's plans is needed before the Department and the Eligible Members can make an informed decision regarding the Transactions.

We recommend that the Department consider whether the Foundation's current limitation as to its engagement in political activity is sufficient (given that it may be removed from the Foundation's Certificate of Incorporation with the vote of 2/3 of the total number of directors at the time of the vote) or whether further steps are needed to assure that the Foundation will not engage in political activity at some point in the future.

E. Task 5 – Questions Regarding Dividend Expectations and Protections

Task: Ask the Parties regarding proposed compliance with La. Rev. Stat. 22:236.3.D. pertaining to dividend expectations and protections.

Analysis: Although the task of asking the question presented was within our scope, the task of analyzing the response and determining whether or how the matter should impact the Department's decision pertaining to the Transactions was not. Rather, the substantive analysis of these issues was within the scope of other Department-contracted specialists and advisors.

Conclusion: We asked BCBSLA questions pertaining to the task and relayed the responses to the Department, Mr. Stevenson, and Butler Snow.

Recommendations: None.

F. Task 6 – Determination of Financial Benefits to BCBSLA Management from the Transactions

Task: Determine whether and how BCBSLA's current board members and executive officers would financially benefit if the Transactions are approved.

Analysis: In response to the R&A Requests for Information, we obtained information regarding the anticipated employment and compensation arrangements, post-Transactions, relative to each of the current members of BCBSLA's board of directors and relative to each of BCBSLA's "Officers" (its five most senior executive officers), both categories as listed on the Jurat page of BCBSLA's Financial Statements.

BCBSLA's Current Board of Directors: BCBSLA currently has 12 board members. Only one of the current board members—Dr. Steven Udvarhelyi—is expected to remain on BCBSLA's board after the Closing Date. Of the other 11 board members, seven are to become

members of the BCBSLA "Advisory Board"; the other four are the initial members of the board of directors of the Foundation. Accordingly, all 12 of the existing members of the BCBSLA board of directors are expected to have continuing association with entities that are part of the Transactions (either BCBSLA or the Foundation).

The following are the seven members of BCBSLA's existing board who are expected to become members of BCBSLA's "Advisory Board":

- Michael B. Bruno
- Stephanie A. Finley
- Robert T. Lalka
- Carl Luikart, MD
- Joseph Kevin McCotter
- Judy Price Miller
- Thad Minaldi

The purpose of the Advisory Board would be to advise BCBSLA and Elevance as to various matters in the years ahead. According to the Advisory Board's Charter, the following are to be its principal duties and responsibilities:

> "(a) Review and advise upon strategies relevant to [BCBSLA], an affiliate of Elevance.
>
> (b) Review and consult with [BCBSLA] and Elevance management regarding materials provided from time to time to the Advisory Board, including but not limited to, (i) strategic plans, (ii) financial performance, (iii) operational performance reports (iv) customer satisfaction reports, (v) provider satisfaction reports, (vi) employee engagement satisfaction reports, and (vii) status reports on adherence to the commitments made in the Plan of Reorganization Regarding the Conversion from a Mutual Insurance Company to a Stock Insurance Company governing [BCBSLA's] demutualization approved by the Louisiana Department of Insurance on [●], 2023 and the Form A (Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer) filed by [BCBSLA] on [●], 2023.
>
> (c) Perform such other functions and duties as may reasonably be delegated to the Advisory Board by Elevance from time to time.
>
> (d) Provide [BCBSLA] and Elevance management with market information, stakeholder input and feedback (including from members/policyholders, providers, members of the community, public officials, etc.) and other information regarding the performance, market position, market perception, competitive landscape, community relations, government relations and other relevant matters affecting [BCBSLA].
>
> (e) Provide additional guidance as requested by Elevance."

Consistent with its name, the Advisory Board would give advice only; it would not have the power to take action. The Advisory Board's Charter specifically provides that "the Advisory Board will not have any power or authority to bind, act for or on behalf of [BCBSLA],

Elevance or their respective affiliates and no Advisory Board Member shall have any such power or authority as a result of being an Advisory Board Member."

The Responses indicated that Elevance has agreed that each member of the Advisory Board would receive "an annual retainer of not less than $105,000" (the Chair of the Advisory Board would receive "an additional amount of not less than $25,000 per year" for the years served as Chair). Elevance has further agreed that the Advisory Board would "remain intact for a period of at least 10 years" from the Closing Date.

The annual compensation for board members currently ranges from approximately $119,000 - $165,000 (not including that of Dr. Steven Udvarhelyi, who is BCBSLA's President and Chief Executive Officer as well as a member of BCBSLA's board of directors). As such, the anticipated compensation for members of the Advisory Board would be less than, but similar to, their current compensation as members of the board of BCBSLA. However, their participation on the Advisory Board would also guarantee that compensation for at least 10 years (if the person wished to remain with the Advisory Board for that period of time). Of course, no such guarantee of board membership or compensation exists currently for the members of the board of BCBSLA. Further, the members of the Advisory Board would receive that income for providing "advice" rather than for being in positions of authority that could require them to take action after making difficult decisions.

We noted that the agreement as to the compensation for the members of the Advisory Board describes the annual retainer of $105,000 as a "not less than" amount. In response to questions posed in the R&A Requests for Information, the Responses indicated that "there have been no discussions, agreements or understandings regarding increases in compensation above the 'not less than amounts." Similarly, we noted that the agreement indicates that the Advisory Board would continue for "at least" 10 years. In response to our questions as to whether the duration might be extended, the Responses indicated that "there have been no … discussions, agreements, or understandings regarding the existence of the Advisory Board past its 10th anniversary date."

To summarize as to the Advisory Board:

- Seven existing members of the board of directors of BCBSLA plan to serve on the BCBSLA Advisory Board;
- Those persons would receive an annual retainer of "at least" $105,000 (with the Advisory Board Chair receiving "at least" $125,000 annually);
- The amounts specified ($105,000 and $125,000) are less than, but similar to, the compensation currently paid to members of the board of BCBSLA;
- The Advisory Board would continue in existence for "at least" 10 years;
- The Responses indicated that there have been no discussions, agreements or understandings about either increasing the compensation paid to members of the Advisory Board or extending the duration of the Advisory Board beyond the 10 years discussed.

As noted above, the other four board members of BCBSLA are the initial members of the board of directors of the Foundation. As discussed above in connection with Task # 4, these persons

are currently serving in an unpaid capacity. However, as also noted there, we were told that the board of the Foundation "has engaged a compensation consultant to recommend a level of compensation that meets the applicable legal requirements for organizations described in Sections 501(c)(3) and 501(c)(4) of the [Internal Revenue Code] (i.e., the compensation must be reasonable based on comparable market data for board compensation at comparably-sized foundations)." Accordingly, it cannot currently be known how the compensation (if any) of the members of the board of the Foundation would compare to their current compensation as members of the board of BCBSLA.

BCBSLA's Five Most Senior Executive Officers: Following are the five senior executive officers listed as "Officers" on the Jurat page of the BCBSLA Financial Statement as of March 31, 2023:

- Dr. Steven Udvarhelyi, President and Chief Executive Officer
- Adam Short, Senior Vice President, Chief Financial Officer
- Bryan Camerlinck, Executive Vice President, Chief Operating Officer
- Louis Patalano, Senior Vice President, Chief Legal Officer
- Korey Harvey, Vice President, Deputy General Counsel

It is anticipated that each of these five persons will remain with BCBSLA in their existing capacities (or in similar capacities). It is also anticipated that their compensation arrangements post-Transactions will not materially differ from their existing compensation arrangements. However, three items should be noted.

First, these executive officers (and others), except for Mr. Patalano, have retention agreements with BCBSLA. The Responses indicated that these agreements are currently in effect, regardless of the Transactions.

- The retention agreements for Messrs. Short and Harvey provide that lump sum payments will be paid upon the earlier of: (a) a vote by BCBSLA's board of directors not to pursue a transaction like the Transactions, (b) the date final regulatory approvals for a transaction like the Transactions are not granted, (c) the date a transaction like the Transactions closes, or (d) December 31, 2024. In other words, if the employee stays with BCBSLA through the triggering date, that employee will receive the lump sum retention agreement payment even if the Transactions are not effectuated. The lump sum payments to be paid pursuant to these retention agreements range from $50,000-$200,000.
- The Responses indicated that retention agreements for Dr. Udvarhelyi and Mr. Camerlinck were executed in 2020, before any consideration of a transaction like the Transactions. Payments pursuant to those agreements are to be made on fixed dates if the executive continues to be employed by BCBSLA through the specified dates. The Responses indicated that, under their retention agreements, there is no provision for payment related to any events associated with a transaction like the Transactions.

Second, these executive officers (and others) have severance agreements with BCBSLA. The Responses indicated that these agreements are also currently in effect, regardless of the Transactions. The severance agreements would provide severance pay and benefits if a

specified termination of employment[20] occurs within two years of the Closing Date. The specifics as to how much compensation is to be provided depends on the position of the executive. The range of such compensation is between 52-104 weeks of base pay plus other items (for example, the target amount of the executive's participation in BCBSLA's incentive plan, a year's worth of COBRA premium, etc.) The Responses indicated that there are no understandings or expectations as to whether any terminations that would trigger the severance agreements would occur.

Third, if BCBSLA is acquired by Elevance, BCBSLA's executive management would be eligible to participate in Elevance's "Total Rewards" benefits program, which includes equity-based rewards (stock options) as well as other forms of compensation. The Responses indicated that the Elevance Total Rewards program would replace BCBSLA's existing long-term incentive compensation program (which is cash-based), that eligibility in the Total Rewards program would be based on the existing provisions of the Total Rewards program, and that eligibility or rewards under the Total Rewards program would not be related to or contingent on any executive management team member's involvement in the Transactions. The Responses also indicated that Elevance plans to have the total amount of compensation paid pursuant to the Total Rewards program be approximately equal to the amounts currently paid under BCBSLA's cash-based long-term incentive plan. In the words of the Responses, "[t]he effect of this is not additional compensation as a result of the [Transactions], but rather a different form (i.e., equity v. cash) as Elevance … will largely target long-term incentive compensation consistent with that provided by BCBSLA prior to the Closing [Date]."

Conclusion:

Directors: All of the existing directors of BCBSLA are expected to have continuing association with entities that are part of the Transactions (either BCBSLA or the Foundation). Dr. Steven Udvarhelyi is expected to remain on BCBSLA's board. Of the other 11 existing directors, seven are expected to become members of BCBSLA's Advisory Board; the other four are the initial members of the board of directors of the Foundation. The Advisory Board members would receive compensation that, at least initially, would be less than (but similar to) their existing compensation. However, unlike now, the members of the Advisory Board would be guaranteed that compensation for at least 10 years. Moreover, the amount and/or duration of the payments could increase (although the Responses indicated that there are no plans or agreements to do so). Further, they would receive that income for providing "advice" rather than for being in positions of authority that could require them to take action after making difficult decisions. The members of the board of the Foundation are not currently compensated. However, the Foundation has engaged a compensation consultant to recommend a level of compensation to be paid to the members of the Foundation's board. It is not known how the level of compensation (if any) to be paid to the Foundation board members would compare to the compensation they currently receive as members of BCBSLA's board.

Senior Executive Officers: The senior executive officers of BCBSLA are expected to remain with BCBSLA in their same (or similar) capacities. Although the form of some aspects of

[20] An involuntary termination by BCBSLA without cause or a termination by the executive for what is defined in the severance agreement as a "good reason" (such as a material diminution of the executive's duties or compensation).

their compensation would change from cash to equity if the Transactions are effectuated, it is anticipated that the amount of their compensation would not materially differ from what they receive under their existing compensation arrangements (subject to standard increases over time, etc.).

Recommendations: None.

G. Task 7 – Additional Analysis and Comments

Task: Provide any additional comments/thoughts R&A has after reviewing the documents, communicating with the Parties, etc. to the extent R&A believes such thoughts/comments would be helpful to the Department as it decides whether to approve the Transactions.

Analysis: Throughout the course of our work, we relayed various thoughts and comments to the Department and to the other Department-contracted specialists and advisors. The bulk of that work, and those thoughts and comments, pertained to the various issues identified above.

However, one item as to which we performed some work but that is not discussed above pertains to the possible impact of the Transactions on Elevance. As noted above,[21] the Elevance group is a strong, viable and highly rated group. Elevance indicated in its Form A Statement that it expects to be able to pay the consideration pursuant to the Transactions with available cash on hand and amounts available under its existing credit facility and commercial paper program and that none of the payments would be contingent on the issuance of new debt or other new financing arrangements. Nevertheless, $2.746 billion is a significant amount of money, even for a group of the size of Elevance.

We brought this issue to the attention of the Department and recommended that the Department contact the lead insurance regulator for the Elevance group to discuss the issue with them and to make sure that the lead regulator would not be concerned by the Transactions (should they be effectuated) or by their financial impact on the Elevance group. It is our understanding that the Department has done so.

Conclusion: Consistent with our tasks, we provided thoughts and comments regarding a number of matters to the Department and to the other Department-contracted specialists and advisors, including identifying the issue of the impact of the Transactions on Elevance's financial condition.

Recommendations: None (other than the recommendation already made that the Department contact the lead regulator of the Elevance group to discuss the Transactions with that regulator).

[21] *See*, e.g., Footnote 12 above.

ADMINISTRATIVE ACTIONS AND FINES ABOVE $250,000.00 FOR THE PAST 5 YEARS

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
1	Anthem Blue Cross & Blue Shield	KY	$321,118.80	August 2023	Kentucky Dept. for Medicaid Services	Medicaid Market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office. C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format. E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
2	Anthem Blue Cross & Blue Shield	KY	$354,024.70	October 2022	Kentucky Dept. for Medicaid Services	Medicaid market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office. C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format. E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
3	Anthem Blue Cross & Blue Shield	KY	$311,230.00	March 2022	Kentucky Dept. for Medicaid Services	Medicaid market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office. C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
4	Anthem Blue Cross & Blue Shield	KY	$262,555.65	June 2022	Kentucky Dept. for Medicaid Services	Medicaid market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office. C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format. E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
5	Anthem Blue Cross & Blue Shield	KY	$267,109.26	May 2020	Kentucky Dept. for Medicaid Services	Medicaid market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office. C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format. E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
6	Anthem Blue Cross & Blue Shield	KY	$278,489.57	December 2019	Kentucky Dept. for Medicaid Services	Medicaid market	A. Anthem failed to submit timely encounter files. B. Anthem failed to resubmit erroneous files that were identified by the Medicaid office.

ADMINISTRATIVE ACTIONS AND FINES ABOVE $250,000.00 FOR THE PAST 5 YEARS

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							C. Anthem's threshold error for encounter files exceeded percentage required by the Medicaid office. D. Failed to submit encounter data in the required format. E. Failed to submit required attestations. F. Failed to timely submit encounter files from adjudication date.
7	Anthem Blue Cross Partnership Plan	CA	$265,000.00	December 2022	California Dept. of Health Care Services	Medicaid market	A. Failure to meet minimum performance levels.
8	Anthem Blue Cross Partnership Plan	CA	$323,000.00	December 2023	California Dept. of Health Care Services	Medicaid Market	A. Failure to meet performance measures. • The scope of violations is determined by the number of insured impacted by the quality-of-care violation. B. Failure to provide preventative services. Preventative measures include: • Child and adolescent well care visits • Immunization for children and adolescents • Lead screening in children • Well child visits • Reproductive health and cancer prevention o Breast cancer screening o Cervical cancer screening o Chlamydia screening for women o Prenatal and postpartum care and timeliness of prenatal care • Chronic disease management o Comprehensive diabetes care o Controlling high blood pressure • Behavioral healthcare o Follow up after emergency department visits for mental illness

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							○ Follow up emergency department visits for substance use
9	Anthem Health Plans Inc.	CT	$320,000.00	February 2022	Connecticut Dept. of Insurance	Commercial – Individual Market – Small Group Market – Large Group Market	The Connecticut Dept. of Insurance examined Anthem's market conduct practices and procedures from January 2016 through December 2018. Anthem failed as follows: A. Failed to utilize licensed producers. B. Utilizing producers without required appointments. C. Failure to take corrective action regarding producer licensing and appointments as required under prior administrative action against Anthem on June 11, 2015, D. Failure to pay claims without conducting a reasonable investigation. E. Failure to pay claims in a timely manner. F. Failure to maintain sufficient controls for the handling of policyholder co-payments and co-insurance for emergency room claims. G. Failure to maintain proper controls for the payment of out of network claims. H. Failure to maintain sufficient procedures relative to policyholder service. I. Failure to take corrective action for the prompt payment and investigation of claims as required under prior administrative action against Anthem in 2015. J. Failure to properly investigate claims for certain preventive services including 3D mammograms. K. Failure to maintain sufficient controls to ensure claims are properly investigated and sufficiently documented.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							L. Failure to pay interest on claims not paid in a timely manner. M. Failure to maintain proper controls for the loading and adjudication of policyholder deductibles and coinsurances. N. Failure to implement proper control for payment of autism services.
10	Anthem Health Plans of Virginia Inc.	VA	$300,000.00	June 2023	Virginia Dept. of Insurance	Commercial Market – Individual Market – Small Group Market – Large Group Market	Failure to pay clean claims to contract providers and failed to pay claims in a timely fashion.
11	Anthem Life Insurance Company	CT	$54,500.00	February 2022	Connecticut Dept. of Insurance	Commercial Market – Individual Market – Small Group Market – Large Group Market	A. Failure to establish proper procedures to ensure that sufficient documentation is available to demonstrate that individuals negotiating or effecting insure on Respondent's behalf are properly licensed and appointed as required by law. B. Failure to take corrective action regarding producer licensing as required under prior administrative action from 2015. C. Use of unlicensed individuals to solicit, negotiate, or effecting insurance on Policyholder's behalf and producers acting as agents without proper appointment as required by law. D. Anthem failed to provide documentation sufficient for regulatory review.
12	Blue Cross Blue Shield Healthcare Plan of GA., Inc.	GA	$5 million Consent agreement and corrective action plan	2015 - 2021	Georgia Dept. of Insurance	Commercial Market – Individual Market – Small Group Market –	A market conduct examination conducted by the Georgia Department of Insurance provided that: A. Anthem failed to adopt and implement procedures for the prompt investigation and payment of claims for policyholders and providers from 2018 to 2021.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
						Large Group Market	B. Anthem had numerous provider complaints and processing errors regarding claims from in network providers processing as out-of-network and rejecting claims for unknown reasons. o Anthem entered into a consent agreement and corrective action plan. o Anthem not allowed to pay any ordinary dividend above $100 million or any other dividends while under departmental supervision without first obtaining commissioner approval. The corrective action plan is in effect until March 2023. Anthem is subject to periodic examinations by a qualified individual or firm of the department's choosing. Anthem is ordered to be monitored by a single appointed contact to ensure compliance and to assist the Georgia healthcare providers. Anthem is required to take action within 15 days of initial complaints and inquires filed with the department. Anthem will adhere to all prompt payment requirements.
13	Blue Cross of California	CA	$2.8 million	corrective actions required by July 31, 2019	California Dept. of Managed Health Care	Commercial Market – Individual Market – Small Group Market – Large Group Market	A. Failure to adequately consider a grievance/appeal and/or to initiate the grievance process required by law. B. Failure to provide an enrollee with written acknowledgment of its receipt of a grievance/appeal within 5 calendar days of receipt as required by law. C. Failure to resolve enrollee grievances/appeals within 30 calendar days of receipt as required by law. D. Failure to issue clear and concise written resolution of a grievance/appeal as required by law.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							E. Failure to provide the appropriate notification within 3 days of receipt of a grievance/appeal concerning imminent and serious threat to the health of the patient as required by law. F. Failure to include appropriate language in an appeal-related communication as required by law. G. Failure to timely provide info to the department as required by rule or regulation. **$2.8 million administrative penalty assessed against Anthem and entered into a corrective action plan.**
14	Blue Cross of California dba Anthem Blue Cross	CA	$725,000 and corrective action plan	December 2022	California Dept. of Managed Health Care	Commercial Market – Individual Market – Small Group Market – Large Group Market	A. Failure to timely reimburse providers or enrollees after receiving independent medical review decisions that overturn Blue Cross's denial of claim. B. BCBS denied healthcare services that were medically necessary and improperly denied claims for experimental or investigational coverage. C. BCBS improperly denied coverage of healthcare services included in their health insurance policy. o The group of violations is not an isolated incident. They were fined in 2020 and 2021. • **In 2020 they were fined $20,000 administrative penalty.** • **In 2021 they were fined $70,000 administrative penalty.**
15	Blue Cross of California dba Anthem Blue Cross (Plan)	CA	$360,000 and corrective action plan	March 2022	California Dept. of Managed Health Care	Commercial Market – Individual Market – Small Group Market – Large Group Market	A. Violation of the Knox-Keen Act of 1975 • The Knox-Keen Act requires plans to provide coverage for seven broadly defined categories of "basic health care services," which include: Physician services, including consultation and referral. Hospital inpatient and ambulatory care services. Diagnostic laboratory and diagnostic and therapeutic radiologic services.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							The plan reported that approximately 2,047,077 claims involving 362,877 enrollees were impacted. Explanation of benefits had not been issued to enrollees. An EOB is issued to the insured to inform them of the processing of the claim and to advise the insured of any amounts that the plan did not cover and any liability for payment for which the enrollee is responsible.
16	Blue Cross of California dba Anthem Blue Cross (Plan)	CA	$750,000 And corrective action plan	2015-2020	California Dept. of Managed Health Care		A. Violation of the Knox-Keen Act of 1975 • The Knox-Keen Act requires plans to provide coverage for seven broadly defined categories of "basic health care services," which include: Physician services, including consultation and referral. Hospital inpatient and ambulatory care services. Diagnostic laboratory and diagnostic and therapeutic radiologic services. Anthem's audit determined that 59,443 individual claims were applied incorrectly. Anthem initiated remediation efforts, which resulted in $8,558,138.88 in reprocessed claims. Additionally, Anthem issued a total of $600,836.05 in interest payments, using a 10% per annum interest rate. In total, Anthem issued $9,158,975.93 total repayments to impacted members.
17	Blue Cross of California Partnership Plan	CA	$1 million and corrective action plan	October 2020	California Dept. of Managed Health Care	Commercial Market – Individual Market – Small Group Market – Large Group Market	A. Violation of the Knox-Keen Act of 1975 • The Knox-Keen Act requires plans to provide coverage for seven broadly defined categories of "basic health care services," which include: Physician services, including consultation and referral. Hospital inpatient and ambulatory care services. Diagnostic laboratory and diagnostic and therapeutic radiologic services. B. Enrollee was denied a health care service and subsequently appealed it to an Independent Medical Review (IMR). The IMR overturned the denial of the health care service and authorized that the health care service be provided to the enrollee.

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
							• 200 days elapsed between the date the plan was required to authorize the service and the day it was actually authorized by Blue Cross of California.
18	Anthem Blue Cross Partnership Plan	CA	$11,408,600.00	April 2019	California Dept. of Health Care Services	Medicaid Market	Anthem Blue Cross Partnership Plan was sanctioned for 48,551 noncompliant grievance/appeal notices.
19	Elevance Health, Inc. and affiliated health plans (Please note this is an action of a rating taken by CMS and is not considered a fine or administrative action.)						CMS-Medicare has reduced Elevance's rating from a 4.5 to a 3.5 on a scale (with rating of a 1 being worse and rating of 5 being best). As a result of this rating reduction, Elevance could potentially lose a $500,000,000 Dollar Bonus, one of the major reasons for the reduction of complaints against Elevance. On October 13, 2023, the Centers for Medicare & Medicaid Services ("CMS") released its 2024 Star Ratings for Medicare Advantage ("Medicare Part C") and Medicare Part D prescription drug plans. Based on the newly released 2024 Star ratings, the percentage of Medicare Advantage members of Elevance Health affiliated health plans in 4 Star or higher-rated plans is expected to drop to approximately 34% as compared to approximately 64% based on the 2023 Star Ratings result. This will impact both the Star quality bonus payments and the plan level rebates in 2025.
20	HealthPlus HP, LLC	NY	$289,067.00	August 2023	New York Dept. of Health	Medicaid Market	A. Failed to submit patient specific medical information and claims including encounter data to the New York office of Medicaid to allow oversight of quality assurance for compliance of state and federal law.
21	HealthPlus HP, LLC	NY	$376,791.44	2022-2023	New York Dept. of Health	Medicaid Market	A. Failed to submit patient specific medical information and claims including encounter data to the New York office of Medicaid to allow oversight of quality assurance for compliance of state and federal law.
22	Healthy Blue of Louisiana	LA	$250,000.00	July 2019	Louisiana Dept. of Health	Medicaid Market	Healthy Blue's pharmacy benefit manager (PBM) IngenioRx improperly steered enrollees to certain network providers in violation with its contract with the Louisiana Department of Health (LDH).

	Entity	State	Fine Amount/ Admin Action	Date	Entity Who Issued Fine	Insurance Market	Violation Description
23	Healthy Blue of Louisiana	LA	$1,186,420.24	December 2019	Louisiana Dept. of Health	Medicaid Market	A. Failure to meet quality performance measures regarding: • Follow up after hospitalization after mental illness within 30 days of discharge • Comprehensive diabetes care

Louisiana

Grant your Proxy **FOR** our Plan of Reorganization

Change Blue Cross and Blue Shield of Louisiana from a Mutual Insurance Company to a Stock Insurance Company

- Cash payment to Eligible Members of approximately $3,000 per Eligible Policy.
- Creation of a new, billion dollar foundation funded by proceeds from the transaction with Elevance Health focused only on improving Louisiana.
- Blue Cross and Blue Shield of Louisiana will remain a local Blue Cross and Blue Shield company with local customer service, the same network of healthcare providers, and the same offices and employee base in the state.
- The plan of reorganization does not change your plan benefits or increase the cost of your insurance for the current plan year. Upon renewal of any health insurance policy, the law and/or policy terms, unrelated to the plan of reorganization, allow for changes in plan benefits and premiums.
- The plan of reorganization will not change the doctors and hospitals in our Blue Cross networks for the current plan year. At any time, unrelated to the plan of reorganization and in the ordinary course of business, providers may join or leave the network.
- Blue Cross will be a part of Elevance Health, which already owns 14 Blue Cross companies across the United States.
- Blue Cross will have access to greater financial resources to introduce and maintain market-leading customer services and programs.

Explanatory Note: *The following information is only a summary of certain results anticipated to be achieved by the proposed Plan of Reorganization. Please refer to the enclosed Member Information Statement for more information on the proposed transaction.*

26GN1157 R12/23

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

Help us build a

A BETTER BLUE FOR YOU

Act Now to Grant your Proxy **FOR** our Plan of Reorganization

A BETTER BLUE FOR YOU

We recently mailed you a packet of information about our plan of reorganization, which will **change Blue Cross and Blue Shield of Louisiana from a Mutual Insurance Company to a Stock Insurance Company**. This move will enable us to be acquired by Elevance Health, a company that can bring you and all of our customers exciting innovations, products, capabilities and services – and at a faster pace than we could alone.

The packet gives you a PIN number and tells you how to grant your proxy online, by phone or through the mail. So do your part to help us create a Better Blue. Grant your proxy **FOR** our plan of reorganization. **Here's why:**

- Cash payment of approximately $3,000 to eligible policyholders, if the transaction is approved.
- The plan of reorganization does not change your plan benefits or increase the cost of your insurance for the current plan year. Upon renewal of any health insurance policy, the law and/or policy terms, unrelated to the plan of reorganization, allow for changes in plan benefits and premiums.
- The plan of reorganization will not change the doctors and hospitals in our Blue Cross networks for the current plan year. At any time, unrelated to the plan of reorganization and in the ordinary course of business, providers may join or leave the network.
- Local customer service, the same offices and employee base in the state – we will still be the same Blue Cross and Blue Shield Louisianians have known for almost 90 years.

To grant your proxy by phone, please call **1-866-402-3905**.

bcbsla.com/betterblue

01MK7918 R01/24 Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

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U.S. DEPARTMENT OF JUSTICE
Antitrust Division

JONATHAN S. KANTER
Assistant Attorney General

Main Justice Building
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001
(202) 514-2401 / (202) 616-2645 (Fax)

August 23, 2023

Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70802

Re: Conversion of Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana from a mutual insurance company to a stock insurance company pursuant to La. R.S. 22:236.4(C).

Dear Mr. David Caldwell:

At the request of the Louisiana Department of Justice ("LADOJ"), dated August 11, 2023,[1] the Antitrust Division of the U.S. Department of Justice ("Division") respectfully submits this statement to encourage the Louisiana Department of Insurance ("LDI") to consider competitive effects of Elevance Health's f/k/a Anthem Health proposed acquisition of Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") in its October 5–6, 2023, public hearings.

I. Background and the LADOJ's request

In January, Elevance Health f/k/a Anthem Health and BCBSLA announced that Elevance Health plans to acquire BCBSLA.[2] The LADOJ subsequently opened an investigation into this acquisition. Given that the investigation is ongoing, the LADOJ requested that the Division consult on the matter.[3] The LADOJ also invited the Division

[1] Letter from Jeff Landry, Louisiana Attorney General, Louisiana Dep't of Just., to Jonathan Kanter, U.S. Dep't of Just., Antitrust Div., Competition Pol'y & Advoc. Sect. (Aug. 11, 2023).

[2] Blue Cross & Blue Shield of Louisiana, *Elevance Health to Acquire Blue Cross and Blue Shield of Louisiana* (Jan. 23, 2023).

[3] Note, the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR Act") mandates parties to report certain mergers and acquisitions to the Division and the Federal Trade Commission (collectively, "Agencies") and must wait before closing the transaction so that the Agencies may investigate any potential competitive impact of the merger or acquisition. Conclusion of the HSR process and inaction by the Agencies do not reflect formal approval of the transaction and no such inferences should be drawn. *See* 15

to submit a public comment for the LDI's consideration in the October 5–6, 2023, public hearings on the transaction[4] and emphasize the importance of competition.

II. The importance of healthcare competition, and the Division's interest and experience in the healthcare industry.

Competition is a core organizing principle of America's economy.[5] The Division works to promote competition through its own enforcement efforts and through competition advocacy before federal and state authorities (*e.g.*, comments on legislation, discussions with regulators, court filings, and regulatory proceedings).

Healthcare competition has long been a priority for the Division due its significant impact on the public. The Division has accrued deep expertise in healthcare from its own enforcement and by engaging in competition advocacy with federal and state authorities across the entire healthcare sector.[6] We have investigated and litigated antitrust cases across the country involving mergers and unlawful business practices by healthcare insurers, hospitals, pharmaceutical companies, physicians, and other providers of healthcare goods and services.[7] The Division has, over the years, through its publication of research, reports, and public events, provided guidance to the community on competition. Our antitrust enforcement and advocacy work enables us to recognize competitive forces that impact cost, price, quality, and innovation in the healthcare sector.

U.S.C. § 18a (i)(1) ("Any action taken by . . . the Assistant Attorney General or any failure of . . . the Assistant Attorney General to take any action under this section shall not bar any proceeding or any action with respect to such acquisition at any time under any other section of this Act or any other provision of law"); *see also* California v. American Stores Co., 495 U.S. 271, 296 (1990); Steves & Sons, Inc. v. JELD-WEN, Inc., 988 F.3d 690, 716–19 (4th Cir. 2021).

[4] Press Release, Louisiana Dep't of Ins., *Louisiana Department of Insurance to Hold Public Hearing BCBSLA Conversion Plan* (June 30, 2023).

[5] *See, e.g.*, N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, (2015) ("Federal antitrust law is a central safeguard for the Nation's free market structures."); Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy has long been faith in the value of competition."); National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978) (noting that the antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services . . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain-quality, service, safety, and durability-and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[6] *See generally*, *Healthcare*, U.S. DEP'T OF JUST., ANTITRUST DIV., (Aug. 14, 2023) (providing an overview and links to the Division's many healthcare-related activities in enforcement, advocacy, and written publications).

[7] *E.g.*, United States v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017); United States v. Aetna, Inc., 240 F. Supp. 3d 1 (D.D.C. 2017); VDA Plea Agreement, United States v. Hee, No. 2:21-cr-00098 (D. Nev. Oct. 27, 2022), ECF No. 106; Press Release, U.S. Dep't of Just., Antitrust Div., *Pharmaceutical Company Admits to Price Fixing in Violation of Antitrust Law, Resolves Related False Claims Act Violations* (May 31, 2019).

III. Competitive effects of mergers and acquisitions in the healthcare industry

Given the importance of competition, the Division encourages the LDI to consider the importance of competitive and vibrant free markets when evaluating BCBSLA's plan of conversion. Specifically, we encourage the LDI to consider the following factors:

1. *When evaluating a merger or an acquisition, the LDI should consider the risk of the transaction resulting in a reduction in competition.*

An assessment of a merger or acquisition should start out by evaluating how competition in a relevant market occurs in the present and the likelihood of the transaction to lessen that competition. Today, that competition likely occurs on several fronts. Insurers may compete for individuals and employers who need to purchase health insurance. They may compete to contract with healthcare providers and facilities on favorable terms. And they may compete to participate in state-administered programs such as Medicaid. Importantly, the Division encourages the LDI to assess the proposed acquisition of BCBSLA for its potential long-term competitive effects in the healthcare sector. Transactions may limit rivals' access to markets or raise barriers to entry for new or expanding health insurers.[8] In such cases, the LDI is encouraged to consider the transaction's impact on price to the consumer, the quality of healthcare services, access to care, reduction of costs, and innovation. Moreover, the Division encourages the LDI to evaluate whether the incentives of the acquiring firm to be accountable to patients, physicians, and BCBLA's plan members will be altered because of the transaction, thereby causing harm to both existing and future health care competition.

2. *Antitrust scrutiny is not limited to horizontal transactions.*

The Division encourages the LDI to consider whether the transaction may substantially lessen competition by giving a firm control over access to a product, service, or customers that its rivals use to compete. Where access to products, services, or customers are important for rivals to compete, competition concerns may arise even in markets that do not reflect traditional vertical supply and distributor relationships, such as in connected ecosystems. The healthcare industry is one example of a connected ecosystem. Insurance companies put together networks that connect patients to providers, but providers also set up their own system of relationships through referrals and contracting for privileges at certain facilities. Similarly, many health insurance companies rely on pharmacy benefit managers to help assemble formularies, pharmacy networks, and mail-order and specialty pharmaceutical delivery. In mergers involving connected ecosystems, the Division assesses whether the merger changes ownership or alters incentives in the merged firm, which may result in higher barriers to entry or switching costs, or foreclosing or raising rivals' costs. In other words, the Division analyzes the risk that the merged firm would have the ability and incentive to make it

[8] Ford Motor Co. v. United States, 405 U.S. 562, 571 (1972).

harder for rivals to compete, thereby harming competition.[9] Any of these would present a competitive harm of the merger, even if the merging firms were not previously in a horizontal or vertical relationship.

The Division also encourages the LDI to consider whether Elevance Health or BCBSLA already maintains a dominant position[10] in the health insurance markets. If either merging party has a dominant position in the market, such position could be used to (1) entrench their dominant position in the health insurance market using various mechanisms to prevent rivals from competing in the market rather than through improvements from efficiency[11] or (2) extend that dominant position into another market. A merger that entrenches or extends a firm's dominant position may violate Section 1 or Section 2 of the Sherman Act. *See, e.g.*, United States v. Grinnell Corp., 384 U.S. 563 (1966) (acquisitions among the types of conduct that may violate the Sherman Act).

3. Antitrust scrutiny should cover any relevant market where the merger or acquisition may impact competition.

The Division encourages the LDI to consider how Elevance Health's proposed acquisition of BCBSLA may affect not only insurance markets but also the labor markets for healthcare workers. Some transactions between competitors have the potential to impact industry participants in both upstream and downstream markets. With respect to the healthcare insurance industry, a merger or acquisition may affect not only the costs and quality of services, or of patients' experience, but also the wages and working conditions to which physicians, nurses, and other healthcare professionals are subject. Furthermore, markets for healthcare services may differ from labor markets because each has a distinct geographic scope. Therefore, the Division encourages the LDI to consider the impact of the transaction not only on the harm to competition affecting patients, but also that affecting healthcare workers.

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[9] *E.g.*, in United States v. UnitedHealth Grp. Inc., the Division sued to block the merger of UnitedHealth Group's acquisition of Change Healthcare, Inc. Although the merging parties were in different levels of the healthcare insurance supply chain, the Division argued that the proposed transaction would substantially lessen competition because post-acquisition, the merged entity would be able to gain access to a vast amount of its rival health insurers' competitively sensitive information and to use its rivals' information to gain an unfair advantage and harm competition in health insurance markets. Plaintiffs' Pretrial Brief, United States v. UnitedHealth Grp. Inc, No. 1:22-cv-00481-CJN, (D.D.C. 2022), ECF No. 101.

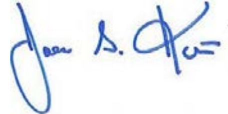
[10] To identify whether one of the merging firms already has a dominant position, the Division looks to whether (i) there is direct evidence that one or both merging firms has the power to raise price, reduce quality, or otherwise impose or obtain terms that they could not obtain but for that dominance, or (ii) one of the merging firms possesses at least 30 percent market share.

[11] These mechanisms include, but are not limited to, increasing barriers to entry, increasing switching costs, interfering with the use of competitive alternatives, depriving rivals' scale economics or network effects, or eliminating a nascent competitive threat.

IV. Conclusion

The Division recognizes that competition is only one of the many policy objectives LDI must consider in its evaluation of the Elevance Health-BCBSLA transaction. The Division encourages the LDI to carefully consider the competitive impacts of this transaction when evaluating the BCBSLA's current plan of conversion in the upcoming hearing and in future hearings.

Sincerely,



Jonathan S. Kanter

Testimony of Dr. Steven Udvarhelyi
before the Joint Session of
the Senate Health and Welfare Committee and
the Senate Committee on Insurance

February 5, 2024

Chairman Talbot, Chairman McMath, and members of the Committees, thank you for the opportunity to provide testimony related to the proposed Plan of Reorganization for Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana. My name is Steven Udvarhelyi, and I am the president and CEO of Blue Cross and Blue Shield of Louisiana, a role I have had the privilege to serve in since 2016. I am also trained as a board-certified internal medicine physician. With me today are Mr. Tim Barfield who is representing the Accelerate Louisiana Initiative, Mr. Morgan Kendrick, Executive Vice President of Elevance Health, Dr. Christy Valentine, President of Healthy Blue (our Medicaid company that is jointly owned by BCBSLA and Elevance Health), and finally, Mr. Darrell Langlois, the Chief Strategy Officer of BCBSLA.

Let me start by saying that BCBSLA is proposing the Plan of Reorganization to better serve its policy holders, and all of its members in general. As I am sure everyone is aware, health care is expensive, especially in Louisiana. We have close to the highest per capita health care costs in the country according to analyses done by the federal government (CMS). On top of that, Louisiana has

billion and Humana has $90 billion. And they are actively deploying billions of dollars of capital in Louisiana, something that BCBSLA cannot compete with financially. When we are a part of Elevance Health, we will be part of a company that has over one hundred and seventy billion dollars in revenue, almost one hundred thousand employees and the capacity to invest over a billion dollars each year in new capabilities, products and services. On a stand-alone basis, we just don't have the resources to make the investments that our competitors are making, including recent investments that total billions of dollars in Louisiana.

I am sure you are all aware that a number of years ago United Health Care acquired Peoples Health in New Orleans, and more recently they acquired LHC in Lafayette for $5.5 billion and they in the process of acquiring Amedysis in Baton Rouge for close to $3.5 billion. Humana is building CenterWell clinics across the state to serve their Medicare Advantage members, and Aetna, part of CVS Health, is taking advantage of every CVS pharmacy location across the state.

The Plan of Reorganization we have put forth will make us a better company, a Better Blue, by giving us access to resources, services and capabilities at a scale that is much more affordable for our customers. For example, we just invested in a multimillion-dollar contract with Epic to interact with providers in a way that can automate data exchange and simplify administrative work. Epic has been operational at Elevance Health for years. Compared to executing a multi-million dollar contract with Epic and doing all the implementation ourselves, we could be operational more quickly and at a fraction of the cost as part of Elevance Health

part of Elevance Health. Rather, being part of a larger organization with greater scale and capabilities will allow us to make health care more affordable in Louisiana, as Elevance Health has done in other states.

As I believe you all know, we sought out a partner to help BCBSLA be a better company, which is how we arrived at this proposed transaction.

I joined BCBSLA in 2016. The year before that, BCBSLA was only offering commercial insurance policies, and had no presence in government business, such as Medicare Advantage and Medicaid. In fact, BCBSLA was the least diversified Blue Cross Blue Shield plan in the country in terms of sources of revenue. This is important, because the employer sponsored insurance market – historically our core business - is shrinking, and within that the insured group commercial business is shrinking the most. Let me restate that – our core business was shrinking. And the year before I joined, the company had significant financial losses.

We needed to reposition the company so that it could be successful moving forward. This repositioning included entry into the government lines of business and the execution of a strategy focused on improving the health of our members, making health care more affordable, and improving the experience for our members. We are proud to say that we are the only health insurance company in the state that offers a product in every parish for every constituency: individuals, groups, Medicare beneficiaries and Medicaid enrollees. We have done a lot in the last 8 years – but we don't think that is enough.

helped assess how the general environment and the health insurance marketplace were evolving, and whether BCBSLA was positioned for long term success. That assessment concluded that while we were competitive in the individual and small group markets, we had material opportunities for improvements in government business and in serving larger commercial customers. It also confirmed three other themes: 1) the pace required for deploying new capabilities was accelerating, 2) the cost of acquiring these capabilities was increasing, and 3) the cost and complexity of complying with increasing regulation of our industry were increasing as well.

The Board and management team concluded that the company should identify a partner to help ensure our long-term success moving forward, while the company was still in a strong position, rather than wait until we fell behind BCBSLA's better resourced competition. In searching for a partner, the Board was committed to remaining a locally based Blue plan and focused on looking at other Blue plans as potential partners. In addition to getting further assistance from McKinsey on this, the company also engaged the services of Cain Brothers, an investment banking firm specializing in health care.

After analyzing the merits of virtually every other Blue Plan in the country as a potential partner, the company that was the best partner for us strategically was our existing partner in Medicaid, Elevance Health. Elevance Health is also the parent company of the local Blue Cross and Blue Shield plan in fourteen states. The Plan of Reorganization that has been proposed is the result of what is required for us to combine with the best partner for our long-term success.

To be clear, we are not a company that is in desperate trouble. But it is my belief, and our Board's belief, that at some point down the road there is a substantial risk that the Company will be at a material disadvantage to larger companies that have the capability to offer a broader range of health insurance products and services at a lower cost than we can. Let me be clear that we are in a very price sensitive business. Health insurance is typically the second highest cost for businesses after the salaries of their employees. If we become more expensive than our competitors, we will lose business. That already happens today.

We are also aware of those in our communities who believe this change is not a good idea. We have heard many misperceptions about what this transaction will do. We have heard that changing from a non-profit to a for profit company will cause premiums to go up, that payments to providers will go down, that we will eliminate providers from our networks, and that we will cease to be a local company and will lay off most of our employees. Those things simply are not true. As I just commented, we believe health care will be more affordable in Louisiana because of this transaction and I'd like to clear up these misperceptions. First, while we are a nonprofit mutual, we are not exempt from paying any federal or state taxes. We are fully taxed and there will be no additional taxes we need to pay after the transaction. We are considered a nonprofit mutual because we pay no dividends to our policyholders – we never have. Second, BCBSLA needs to make a margin on its business to stay viable, and the company targets a 2-4% margin, give or take, which is industry standard and within acceptable bounds for regulators and federal laws governing premiums. In fact, all successful insurers,

Elevance will adapt a different strategy in Louisiana, and I am sure Mr. Kendrick will further explain this.

On the topic of Elevance being problematic from a provider perspective, to me that is really based on hearsay and rumor. Most providers in Louisiana have never interacted with Elevance Health. Those providers in Louisiana who have had experience in working with both BCBSLA and Elevance in other markets have shared that their experience with Elevance is at least as good as with BCBSLA. On Friday, I received a very positive letter from a provider in Lafayette, Louisiana (VieMed) and I'd like to share that letter with members of the Committee. VieMed has worked with Elevance in 19 states, and candidly they believe Elevance Health is better to work with than all of Elevance Health's competitors. The letter comments that Elevance has a track record of integrity, being transparent and predictable in prior authorizations and paying claims. They simplify administrative processes. Their technology is superior and helpful to providers. They have excellent customer service. And they retain a local focus in working with providers. So, the facts in those other 19 states tell a different story that what we are hearing from people with no experience with Elevance Health.

Finally, on the issue of BCBSLA laying off employees and ceasing to be a local company, we have committed to maintaining the level of our workforce in Louisiana, and that is in our agreement with Elevance. Maintaining a local workforce and presence is how Elevance runs its operations in other states. When we previously came before this legislature last fall, there was misinformation circulating that Elevance's office in Georgia only had 600 people.

Louisiana, it will not be good for our employees, and it will not be good for the people and communities of Louisiana.

One thing we have heard consistently throughout the last year, since we announced the transaction, is that the people of Louisiana, and the providers in Louisiana, like and value Blue Cross and Blue Shield of Louisiana. We are grateful and humbled to hear that – and we want to keep it that way - which is why we are pursuing the transaction. The people of Louisiana have trusted us for 90 years to do the right thing for their health insurance needs. We ask that they trust us now – because this is a right move for the right reasons for our policy holders and for the people of Louisiana.

Thank you again for the opportunity to speak with you today, and I am happy to answer any questions you may have.

INVESTING IN THE HEALTH AND LIVES OF LOUISIANIANS

2022

WELCOME

We are pleased to share with you ***Investing in the Health and Lives of Louisianians.*** This report chronicles our initiatives and efforts in 2021 and throughout the pandemic to create a sustainable enterprise, support communities and meet our corporate mission.

As you will see in this report, everything we do at Blue Cross and Blue Shield of Louisiana is ultimately focused on our mission to improve the health and lives of Louisianians.

We work in partnership with providers and community organizations to transform the health care industry by reducing costs and improving health outcomes, accessibility and the patient experience. We operate with ethics and integrity, and in support of our core values of collaboration, accountability and excellence.

Blue Cross is dedicated to the communities we serve and to diversity, equity and inclusion efforts within our organization, in our supplier and provider communities, and in the world at large. Going forward, we plan to continue building on our efforts as we work to create a better, healthier Louisiana.

I. Steven Udvarhelyi
President and CEO

ABOUT BLUE CROSS AND BLUE SHIELD OF LOUISIANA

Founded in New Orleans in 1934, Blue Cross and Blue Shield of Louisiana is the oldest and largest Louisiana health insurer. We provide coverage to more than 1.9 million people.

For almost 90 years, we've been committed to improving the health and lives of Louisianians. We've weathered storms of all kinds with our customers and communities. Our dedication to our state and its people has never wavered.

OUR MISSION

To improve the health and lives of Louisianians

OUR VISION

To serve Louisianians as the statewide leader in offering access to affordable health care by improving quality, value and customer experience

THE NUMBERS AT A GLANCE

3,674 employees enterprise-wide

30,000 employee volunteer hours (2021)

2,500 agents & brokers at 529 agencies statewide who work with us

1.9 million members (1/3 of Louisianians)

34,000+ network doctors, hospitals & other providers

200+ charitable organizations supported

ECONOMIC IMPACT

At Blue Cross and Blue Shield of Louisiana, we keep our business in Louisiana and make a **$6 billion impact** on the state's economy through:

- billions in claims paid
- millions in taxes
- employee salaries
- advertising
- buying from Louisiana suppliers
- community sponsorships and grants

We invest a substantial portion of our portfolio in **Louisiana-based securities**.

Our company has received **25 consecutive "A" ratings** for financial strength from Standard & Poor's.

We maintain a **reserves** fund to protect our policyholders.

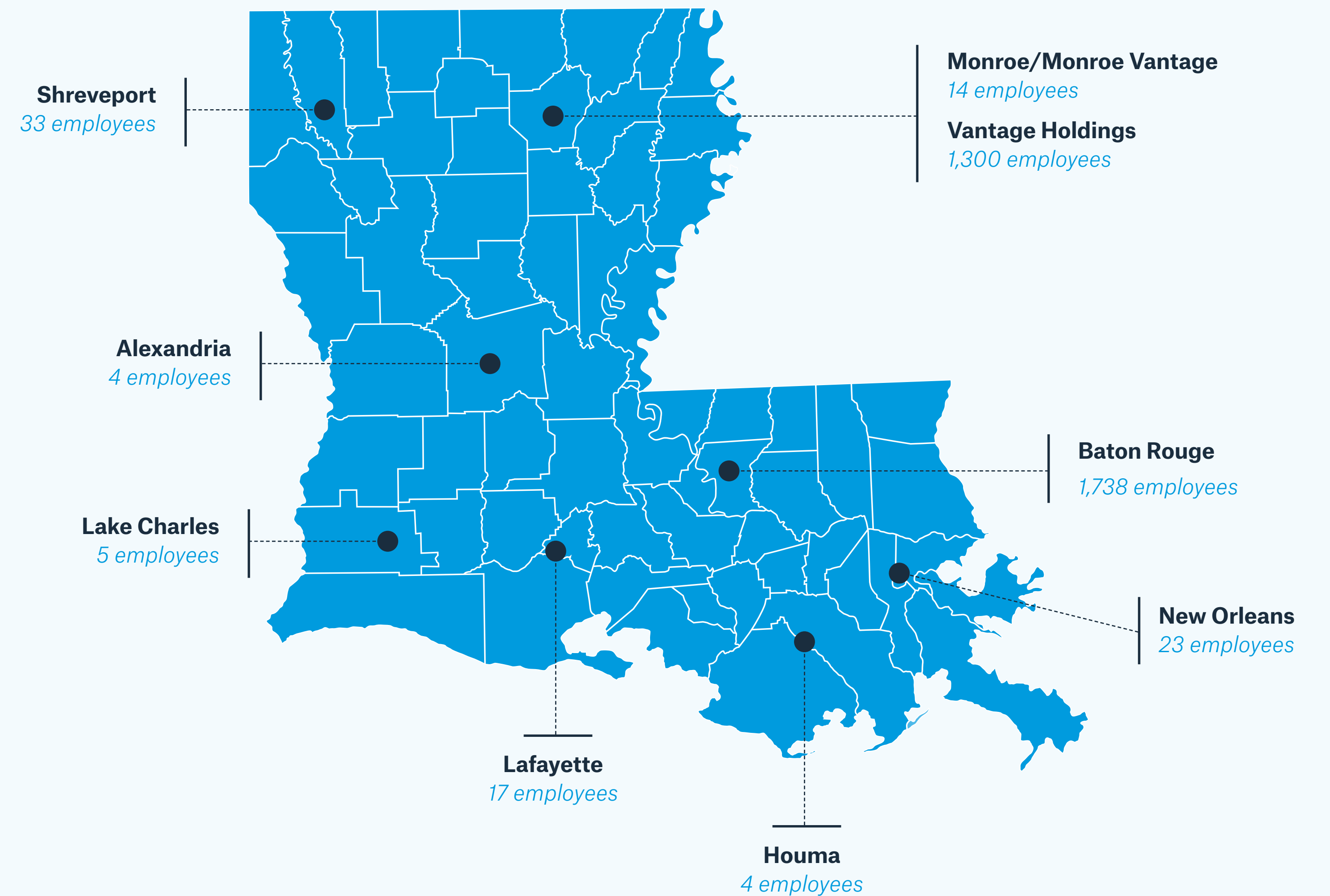
We invest in our communities, spending **millions each year** in sponsorships and project funding for Louisiana nonprofits.

Our Foundation **gives millions annually in grants** for health- and education-related programs within Louisiana.

WE ARE LOUISIANA TRUE.

Operating solely in Louisiana, Blue Cross is a nonprofit, fully taxed mutual company, owned by policyholders – not shareholders. We are also an independent licensee of the Blue Cross Blue Shield Association. Our company is homegrown and run by an independent Louisiana board of directors. Because we operate only in Louisiana, our focus is local – on our home. All of our business decisions are made here in Louisiana, by Louisiana-based employees.

3,674 ENTERPRISE-WIDE EMPLOYEES*



*includes 536 employees working in other states

COVERAGE THAT'S MADE FOR LOUISIANA

Blue Cross has developed a wide variety of plans and products in every parish and ZIP code in the state, so Louisianians have options to find quality, affordable coverage with access to top providers that best meets their families' needs. Louisianians of any age and income level can find a product from Blue Cross.

We offer a full line of health insurance products for individuals and groups, including:

- both fully insured and self-insured (administrative services only) products for **groups**;
- a range of coverage plans for **individuals**, including healthcare.gov options;
- **life insurance**;
- a suite of **voluntary group benefit options**, including life, dental and disability coverage;
- **Medicare Supplement and Medicare Advantage** (HMO and PPO) plans for individuals, plus Medicare Advantage Employer Group Waiver Plans (EGWP) for group retirees; and
- **Medicaid** managed care plans offered through a partnership with Healthy Blue.

Blue Cross was recognized in 2022 as one of the 50 most community-minded companies in the nation for the fourth year in a row.

The award is an initiative of the Points of Light Foundation, an organization founded by George H.W. Bush, who, in his inaugural address, invoked the vision of a "thousand points of light" as an invitation to Americans to serve their fellow citizens.

The Civic 50 list includes much larger corporations with national footprints. Last year, we were selected from among all 50 honorees as **2021's Volunteer Champion**.

This year we were recognized as the **top company in the country for integration**, which, according to the Points of Light Foundation, is:

> *how a company integrates its community engagement and social impact programs throughout its business functions and interests.*

OUR STRATEGY

It takes a strong strategy to support our mission of improving the health and lives of Louisianians. Our mission is the WHY that informs our strategies.

Our strategic plan features five core pillars:

- HEALTH
- AFFORDABILITY
- EXPERIENCE
- SUSTAINABILITY
- FOUNDATIONS

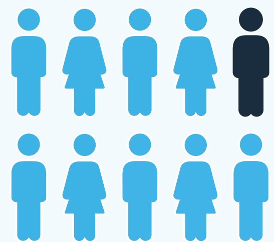
HEALTH

As the oldest and largest health insurer in Louisiana, we are making investments to improve health outcomes, keep costs in line and reverse our state's historically poor health rankings.

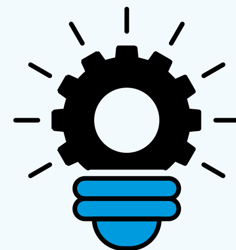
We start with our own members. Through our clinical programs and services, Blue Cross is leading a data-driven population health management strategy to close gaps in care, address disparities and focus on social/community-based determinants of health.

PROVIDER PARTNERSHIPS IMPROVE HEALTH

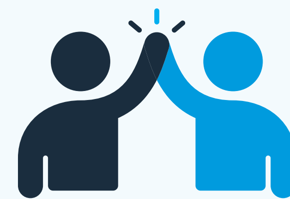
At Blue Cross, we have broader and deeper partnerships with health care providers than any other insurance carrier in Louisiana. And we work closely with our network providers to get better health outcomes and keep costs in line for our mutual customers – their patients, our members.



34,000+ network doctors, hospitals & other providers



Through partnerships with providers, we offer **innovative network products** built to offer considerable cost savings and high-touch, high-quality, coordinated care.



Our providers are both **highly satisfied** and **likely to recommend** Blue Cross to other providers, according to annual research.

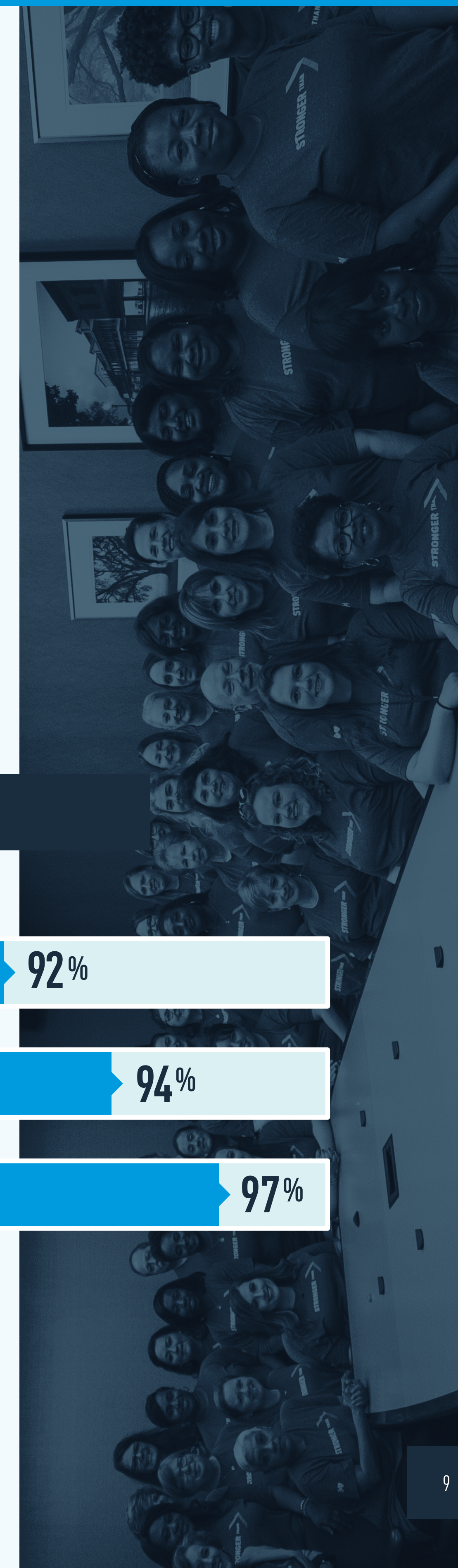
STRONGER THAN EVER:
OUR CARE MANAGEMENT PROGRAMS

Blue Cross has an in-house care team of more than 200 clinicians – physicians, nurses, pharmacists, social workers, dietitians – who help their fellow Louisianians through our best-in-class **Care Management** programs. Our clinicians offer ongoing support, personalized education and empowerment to members dealing with long-term conditions and serious illnesses or injuries. They also work with members on cost-effective drug choices, medication adherence and more.

Eligible members can join these free programs themselves, or they can be referred by their doctors, by immediate family members or even by their group leaders.

MEMBER RATINGS FOR CARE MANAGEMENT*

Rating	%
ACHIEVEMENT OF GOALS	92%
PROGRAM SATISFACTION	94%
STAFF SATISFACTION	97%



*Source: CMDM Member Experience Survey, Q1 2021

INVESTING IN DATA TO IMPROVE HEALTH OUTCOMES

In 2017 Blue Cross began using real-time data and artificial intelligence (AI) to identify members at risk for increased hospital admissions and emergency room visits. Our focus was on members with coronary artery disease, congestive heart failure and diabetes.

We used AI to predict precisely which members with these conditions could get the most benefit from our Care Management services. These interventions succeeded in reducing hospital admissions and emergency room visits for members with these three chronic conditions compared to the previous year. Additionally, members identified through AI were three times more likely to engage with population health interventions.

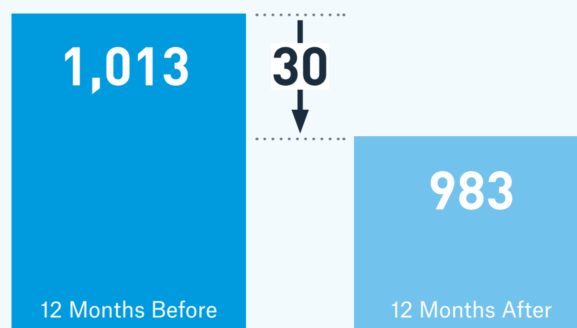
SUCCESSFULLY REDUCED ADVERSE EVENTS

An evaluation of the two predictive models used to manage clinical needs of a large commercial group

NUMBER OF ADMISSIONS

For members in risk of hospitalization approach

Estimated 30 fewer admits per year

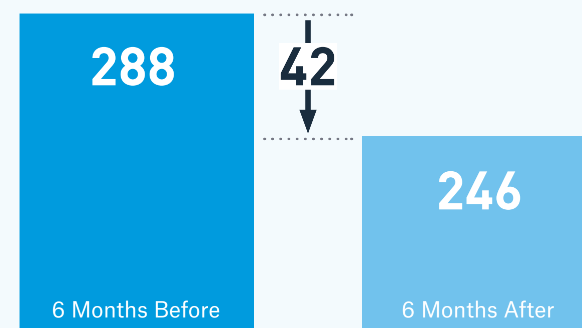


Calculation: Admits/member month over 12 month period

NUMBER OF ER VISITS

For members in risk of emergency department visits approach

Estimated 42 fewer ER visits per 6 months



Calculation: ER visits/member month over 6-month period

VALUE-BASED CARE THROUGH QUALITY BLUE

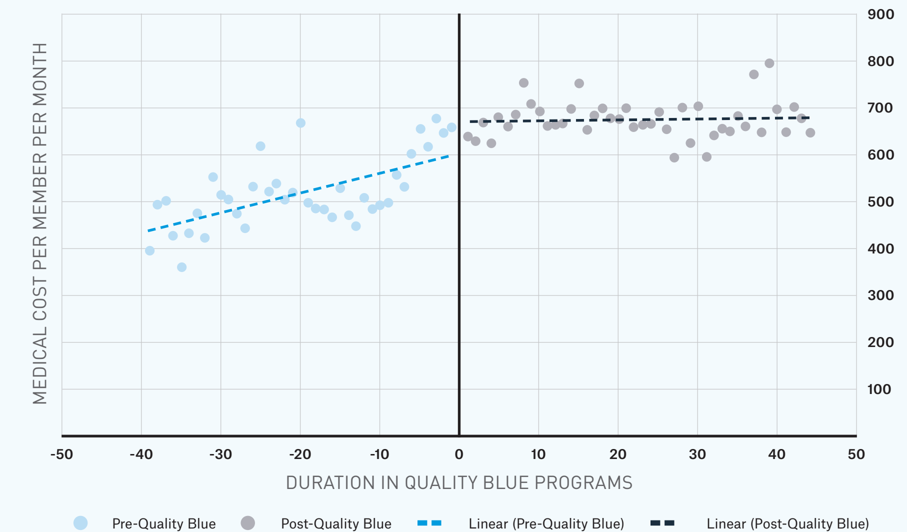
With our **Quality Blue** programs, we work with doctors, hospitals and clinics around Louisiana to give members an easier, better health care experience. Quality Blue ties reimbursement to how well providers are keeping patients healthy and out of the hospital. It's a shift away from fee-for-service toward value-based reimbursement.

Launched in 2013, the program has achieved ongoing health improvements, especially for members with chronic conditions. And we've seen that tying providers' reimbursement to value can lower costs.

Since 2013 Quality Blue has slowed medical cost increases from **4 dollars to only 20 cents per month.**

QUALITY BLUE: SLOWING THE MEDICAL COST TREND

Data validated by Tulane University's School of Public Health

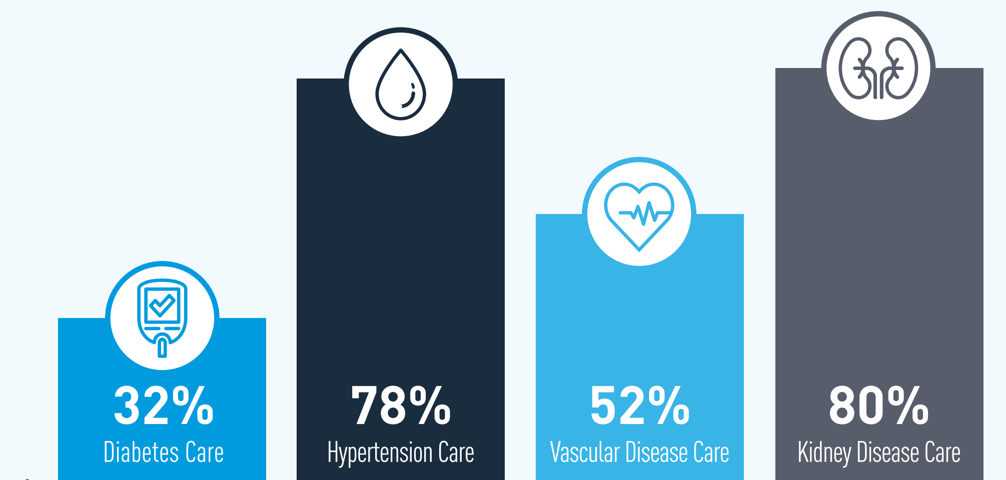


Blue Cross continues to build on Quality Blue's proven successes. This year we are:

- moving to nationally recognized clinical quality measures and comparing providers' performance nationally, not only within their peer group
- opening the program up to more providers and more members, and
- **securely sharing data** with our Quality Blue providers to help them improve patient care and achieve better outcomes.

QUALITY BLUE RESULTS

Driving Improvements in Health Outcomes



Improvement over time on care quality measures for each targeted chronic condition from program years 2013-2021.

Source: Quality Blue program data through October 2021

HEALTH

INCREASING ACCESS THROUGH TELEHEALTH

In 2016 Blue Cross rolled out BlueCare, our signature telehealth platform, to give members access to care outside of doctor's office hours for non-emergencies.

BlueCare is available 24/7 in all 50 states and works on any device with internet and a camera. It costs less than urgent care and ER visits and is an easier way to treat routine illnesses. Telehealth doctors can write or refill prescriptions to treat most conditions.

Since 2020 Blue Cross added network dietitians, chiropractors, behavioral health providers, dentists, and occupational, speech and physical therapists to our network of telehealth providers.

FIGHTING OBESITY

Obesity increases the risk of several debilitating and deadly diseases, including diabetes, heart disease and some cancers. **In Louisiana, 38.1% of our population is considered obese.*** We've made several investments to help conquer this challenge.

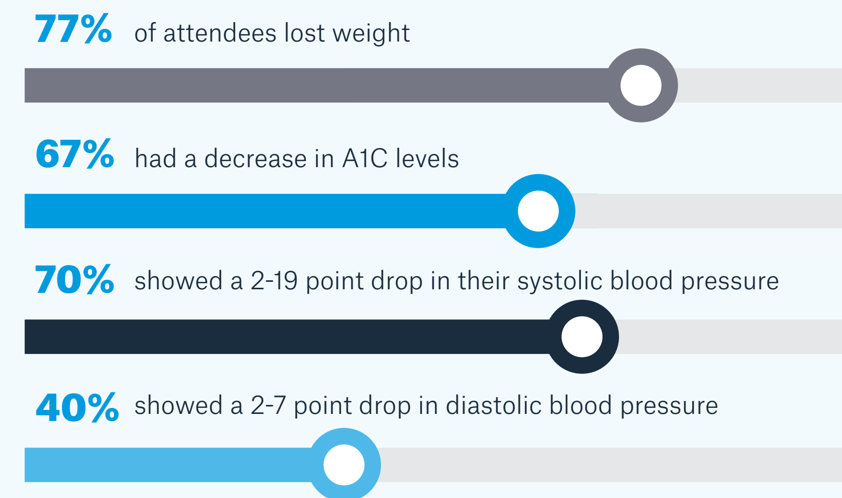
Children's health: Blue Cross added to its policies an obesity and weight management benefit that provides reimbursement for children ages 3 to 18 diagnosed with obesity for up to 52 visits for intensive treatment with eligible health and behavioral programs and professionals.

Research: Blue Cross is a co-investigator in Pennington Biomedical Research Center's TEAM UP, which studies the effectiveness of family-centered obesity treatment in primary care. The trial uses an evidence-based intervention delivered by specialists that targets diet, activity, behavior strategies and parenting support to promote weight loss and maintenance.

*Source: Robert Wood Johnson Foundation, 2021

Family health: In 2019 we piloted a program with Baton Rouge provider partners. Their patients – our members – with chronic health issues took part in a 12-week class at Louisiana Culinary Institute to learn healthy grocery shopping and cooking techniques.

We saw high engagement in this program, with all 35 participants sticking to the 12 weeks of classes. Results showed that:



Prediabetes care program: Omada is a 16-week program combining data-powered human coaching, connected devices and curriculum tailored to members who have prediabetes or are at high risk for type 2 diabetes. The program is designed to help individuals lose weight, reduce their risk of type 2 diabetes and heart disease, and build healthy patterns for life. **Since its inception, this intensive behavioral intervention has shown results:**

11,879 — Total members enrolled in Omada

79,278 — Pounds lost by our members

87% — Participant satisfaction rate

$0 DRUG COPAY PROGRAM

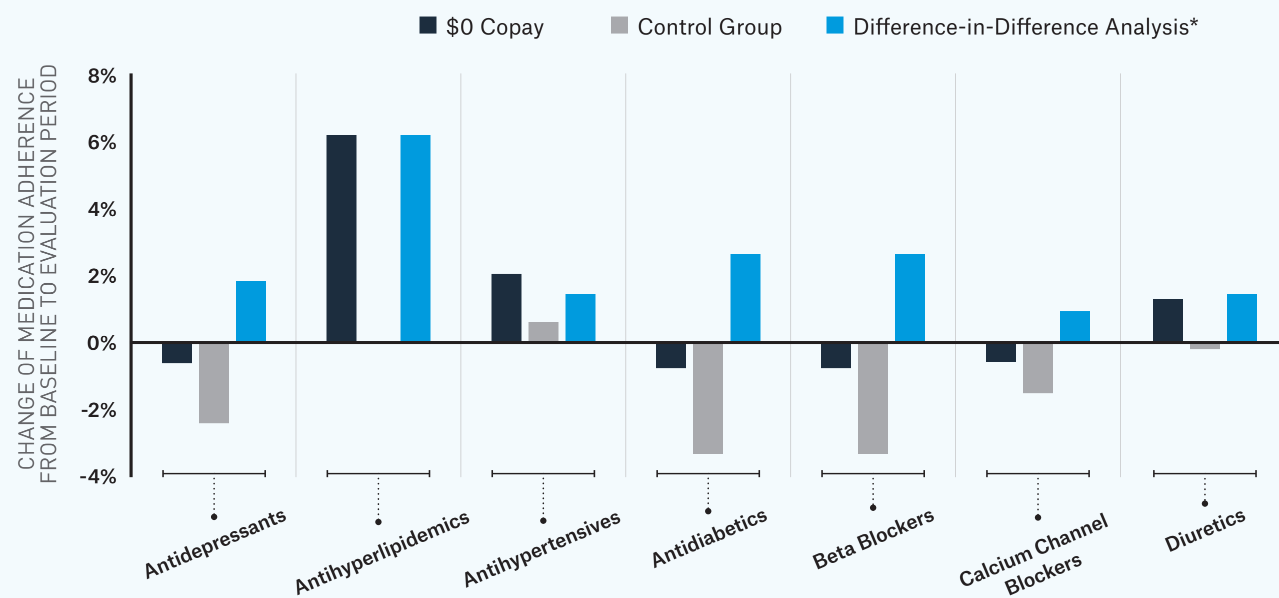
In 2013 Blue Cross launched a **$0 Drug Copay program** designed to encourage and support members with certain chronic diseases, including depression, in sticking to their prescribed medications.

Because cost is a common reason people do not take medication as directed, the program removed out-of-pocket cost barriers by providing certain members with a widely used set of medications to treat their conditions for a $0 copay. This program has documented success.

Our $0 Drug Copay program achieves something unusual in health care: It enhances patient access to medications and reduces their total health care spending significantly. The decrease is primarily in medical spending rather than pharmacy spending.

$0 DRUG COPAY PROGRAM IMPROVES ADHERENCE

Medication Adherence Rate Changes of Top Prescribed Medications



*Difference-in-Difference measurement compares the change of the $0 treatment group to the change of the control group.

ADVANCING HEALTH EQUITY IN LOUISIANA

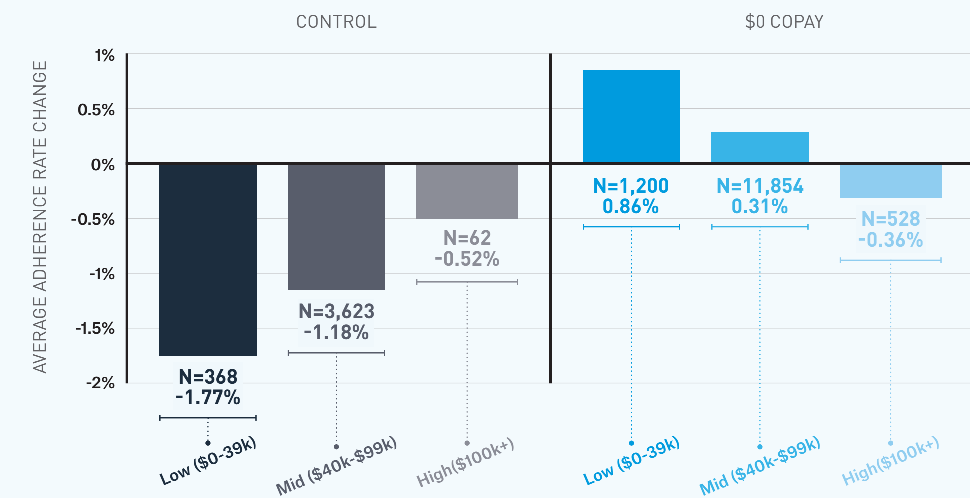
Lack of access to care, transportation barriers, high poverty and unavailability of nutritious food options are some of the key reasons Louisiana ranks at the bottom of most national health rankings.

As the state's largest insurer, we touch most stakeholders in the health care system – providers, members, employers and others – and this makes us uniquely positioned to work with them to improve health outcomes, keep costs in line and reverse Louisiana's historically poor health rankings. In recent years, we've increased our focus on working with others to address these social determinants of health.

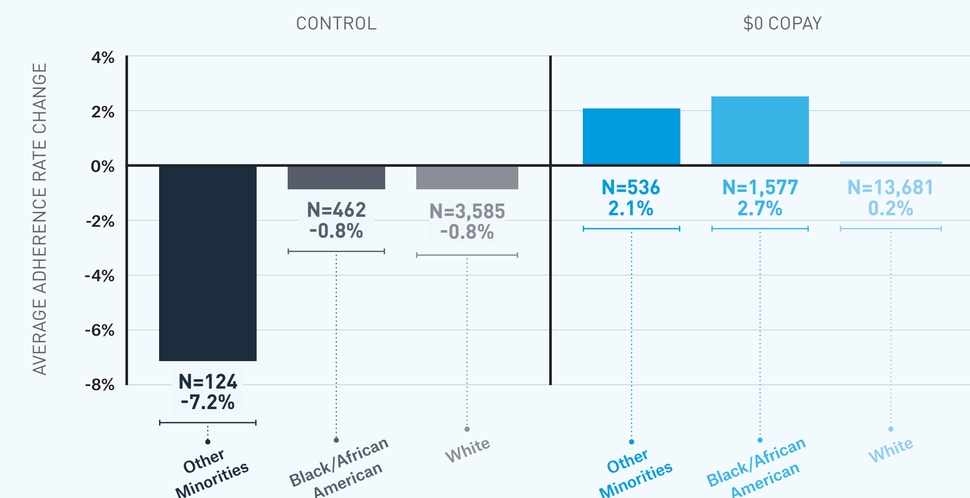
DRIVING HEALTH EQUITY: $0 DRUG COPAY PROGRAM

Income-based barriers were removed, which improved compliance among low- and mid-income populations. This greatly benefited Black/African American, Hispanic/Latino and Asian populations.

MEDICATION ADHERENCE BY INCOME LEVELS



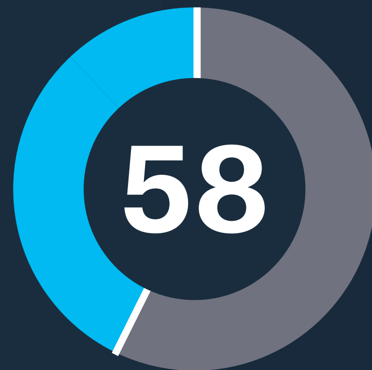
MEDICATION ADHERENCE BY RACE/ETHNICITY



HEALTH

MATERNAL HEALTH EQUITY STRATEGY

Louisiana has one of the highest maternal mortality rates in the country.



Out of every **100,000** Louisianians who give birth, **58** of them will die as a result of childbirth.*

4x

Black women are dying from pregnancy-related complications at **over four times the rate of white women.**

This is why Blue Cross and Blue Shield of Louisiana has joined the Blue Cross Blue Shield Association's **National Health Equity Strategy**. The purpose is to confront racially based health disparities, with the goal of reducing racial disparities in maternal health by 50% in five years.

We understand that medical care is only one piece of overall health and well-being. Other factors play a significant role – income and education levels, where you live, transportation options, social support, access to health care providers, and availability of nutritious food. We must address the whole picture to make our state a better place to have a baby and raise healthy, happy families.

At Blue Cross we're committed to working with providers, state health officials, community groups and others to build bridges that close these gaps in care and ensure the future is brighter for Louisiana parents and families.

**Source: World Population Review, Maternal Mortality Rate By State 2022*

BIKE SHARE

To address transportation barriers and offer a healthy, green alternative for getting around metropolitan areas, Blue Cross sponsors bike share programs in New Orleans and Baton Rouge.

Blue Bikes promotes healthy exercise and gives residents an easy way to get to work or school, go to medical appointments or shop at grocery stores and farmers markets. Blue Bikes meets transportation needs in the New Orleans community.

Dr. I. Steven Udvarhelyi
President and CEO

ALL OF US

Blue Cross does extensive work to promote the National Institutes of Health's ***All of Us*** research program. *All of Us* is an ambitious effort to gather health data from

1 million individuals

who reflect our country's diverse population.

The goal is to build the most diverse health database in history, which will provide the data researchers need to study how our biology, lifestyle and environment affect our health.

Outcomes from this research will enable health care treatments to be based on what works for each individual instead of what works on the "average" person.

SPOTLIGHT

ANALYTICS AND DATA CAPABILITIES

Blue Cross' Analytics & Data Division uses our nationally recognized capabilities and proprietary technology to turn health care data into timely, actionable insights that improve the health and lives of Louisianians. **The robust program we offer today rests on five critical pillars:**

- INTEGRATED DATA SOURCES FOR ANALYSIS
- DATA-DRIVEN POPULATION HEALTH STRATEGIES
- PREDICTIVE MODELS
- HIGH-TOUCH CLINICAL ENGAGEMENT
- RIGOROUS OUTCOMES EVALUATION

BETTER DATA, BETTER OUTCOMES

The program uses traditional data from claims, lab results, pharmacy benefits and other clinical information, and nontraditional data such as social attributes and Customer Service and Care Management interactions. **We use this information for actionable data insight. For instance, we can:**

- identify at-risk members and connect them to our Care Management team before they suffer adverse health events;
- drive effective coordination, internally and externally, to enhance patient clinical outcomes and lower the total cost of care;
- create effective programs with AI-based targeting combined with robust outcomes evaluation; and
- compare models to industry benchmarks and standards to continually improve performance.

PI PLATFORM

To drive business insights and value, Blue Cross uses its cloud-based proprietary analytics platform, **Pi**.

With **Pi**, clinicians, providers and groups also can track disease states over time, where disease states are located geographically and whether affected members are participating in the Blue Cross Care Management program.

AI: ARTIFICIAL INTELLIGENCE MODELS DRIVE BETTER OUTCOMES

Blue Cross' class-leading AI capabilities are very accurate, tailored for Louisiana residents and – most importantly – integrated and acted upon to make a difference for members. The Blue AI predictive models empower members' doctors and other providers, our Blue Cross care team and members themselves to make changes to improve outcomes through the appropriate care channels.

Our five foundation models are:

- **01** **Risk of hospitalization**
- **02** **Risk of ER visits**
- **03** **Risk of hospital readmission**
- **04** **Prediction of high-cost claimants**
- **05** **Customer Service complaints**

With each of these models, we can make predictions six months out or more with incredible accuracy, sometimes up to 10 times more accurately than commercial models.

Why is this important? Identifying at-risk members in advance enables members' doctors and our Blue Cross clinical staff to intervene sooner with health coaching, education and self-care support. It allows each member's care to be much more precise, prescriptive and efficient at applying resources. These proactive efforts can potentially mitigate a clinical event like a hospitalization, save lives and reduce costs.

Next-generation models are allowing us to further solve health challenges across key areas. These models predict risk drivers, rising risks, risk of ER visits and readmission. They enable us to understand the best actions to take to reduce the risks. The models also enable us to improve customer experience and better aid in helping our senior members find the products that best meet their health care needs. Plus, they can help members follow their prescription drug regimen.

AFFORDABILITY

Blue Cross is committed to ensuring Louisianians have access to affordable, quality health care. We work to keep costs down and to be good stewards of our members' health care dollars.

2021 PREMIUM DOLLAR BILL

Blue Cross is a not-for-profit insurer and a Louisiana-based company, so premium dollars stay in our state's health care system. In 2021 we received $3.8 billion in premium payments from our at-risk, fully insured members. **Here is where those premiums go:**

2021 PREMIUM DOLLAR

59% Doctors and Hospitals

26% Prescription Drugs[1]

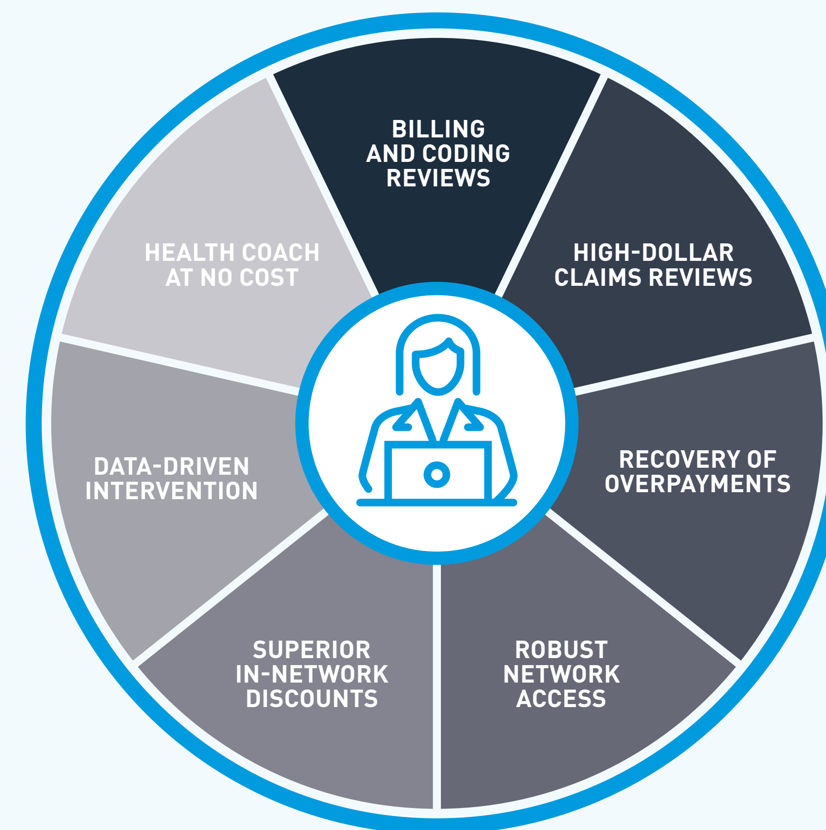
15% Administrative Costs*

CORE COST-CONTAINMENT SERVICES

We understand the importance of managing medical costs for our members. Our internal, multidisciplinary team monitors and manages medical costs through a formalized process of trend analysis, claims evaluation, claims billing practices and monitoring industry cost trends.

* Covers operating costs, commissions, taxes/fees and reserves.
Source: All figures are estimates based on Blue Cross and Blue Shield of Louisiana actuarial, claims and membership data.
Represents fully insured group and individual members of both Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc.
[1]Includes the cost of prescription drugs administered in physician offices and for outpatient hospital care. Drug costs are net of all discounts and rebates.

COST CONTAINMENT AT A GLANCE



In 2021 our pre-pay avoidance and recovery totaled more than ***$53 million.***

Blue Cross and Blue Shield of Louisiana Health Services Division

Product portfolio: We make sure Louisianians have access to a variety of health plans that fit all budgets for groups and individuals. When **healthcare.gov** launched, we were the only insurer to offer plans in every parish and every ZIP code in the state. Through the years, other insurers have come and gone. But we have stayed because of our commitment to ensuring our fellow Louisianians have access to health care at an affordable price.

Provider networks: With our highly competitive, locally negotiated contracts, we keep costs fair by driving high in-network access and superior discounts.

Select networks for quality at a lower cost: Select network plans offer members high-quality, coordinated care at a savings. Our select network products, available in the greater New Orleans, Baton Rouge, Lafayette, Monroe and Shreveport areas, are just one innovative way Blue Cross is working with our strong provider partners to transform health care.

BLUE CROSS CORE CLAIMS SERVICES

Data and insights: Blue Cross uses data insights, care coordination and Care Management programs to help ensure members get the right care, while also containing costs.

Fraud and abuse: We work to identify and correct fraud, waste and abuse.

Payment integrity: We are committed to strong cost management. Activities include:

- **Fraud prevention** and recovery

- **Care coordination**, Care Management and medication adherence programs to help members manage their chronic conditions and health challenges

- **Utilization Management** and medical policies to ensure our members are getting the right care in the proper settings

- **Cost-containment** recovery services

- **Audits** to validate the appropriateness of provider billings and payments

- **Work to recover medical expenses** that were a third party's responsibility

SPOTLIGHT

OUR COVID-19 RESPONSE

Well before the pandemic hit Louisiana, Blue Cross and Blue Shield of Louisiana's Analytics & Data team recognized that the cloud-based technology they had developed to drive targeted care interventions for members had the potential to provide critical insight to state leaders throughout the crisis.

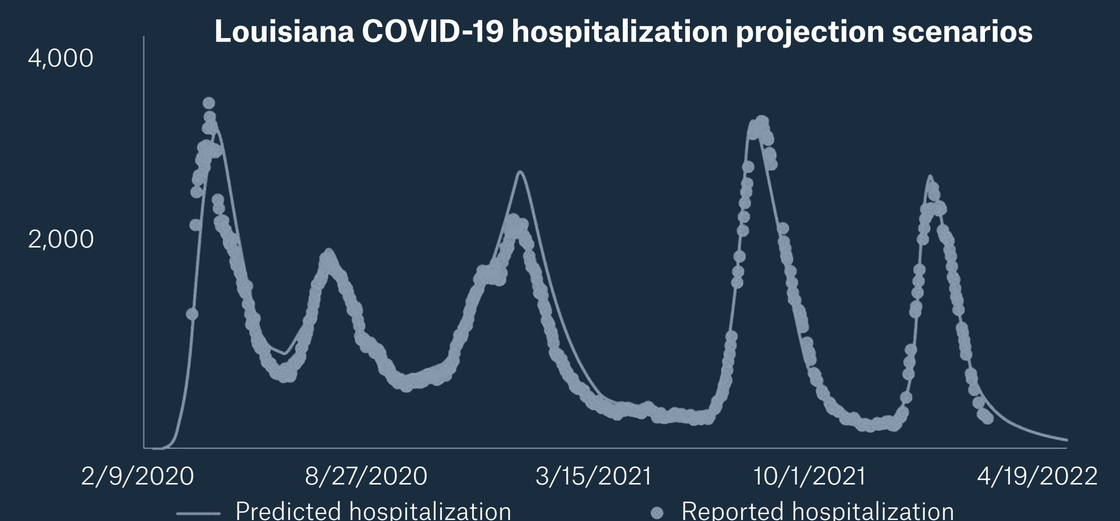
PUBLIC-PRIVATE PARTNERSHIP WITH STATE OF LOUISIANA

In early 2020, living out our mission to improve the health and lives of Louisianians, Blue Cross partnered with the State of Louisiana to share our team's technological and analytical capabilities and to build what would become known as the COVID-19 Outbreak Tracker.

Even before the state's first COVID-19 case was identified, Blue Cross team members and state officials were using the tracker to monitor the novel coronavirus' spread in Louisiana. They aggregated, analyzed and modeled diverse data for both Blue Cross members and members of state Medicaid plans.

The COVID-19 tracker gave the state information on projected rates of hospitalizations, deaths, health care facilities' capacity and more.

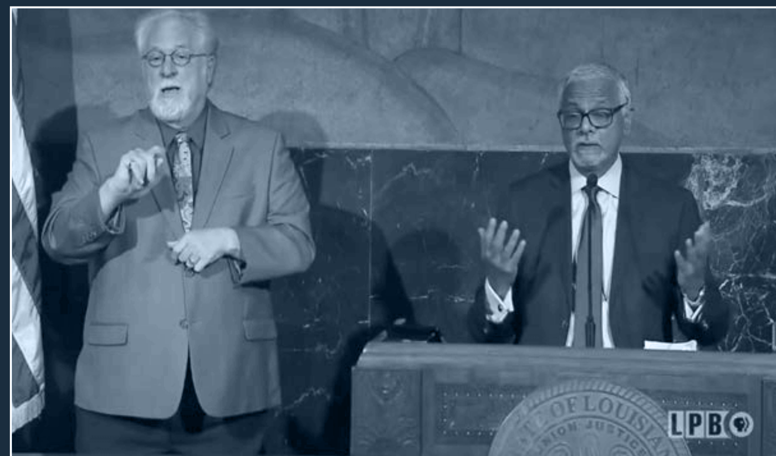
The state used this information to allocate crucial medical resources and implement mitigation measures that ultimately saved lives.



SPOTLIGHT

OUR COVID-19 RESPONSE

This public-private partnership continues, as Blue Cross works with the Louisiana Department of Health to provide analyses that can assist not only with COVID-19 responses, but with other public health initiatives.



Somesh Nigam, former chief analytics and data officer for Blue Cross, speaks at the governor's press conference in July 2020. Nigam was named among Modern Healthcare's 2022 class of Top Innovators, recognizing leaders from around the country who are instituting innovation and leading transformative programs that improve care.

SUPPORTING OUR MEMBERS

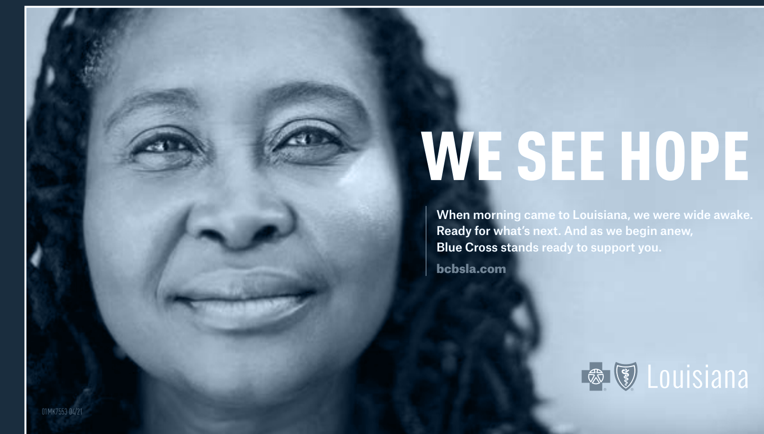
Blue Cross voluntarily implemented steps to support our members through this crisis on March 6, 2020, well before most federal and state rules and regulations were mandated. **These included:**

Waiving member cost-sharing for COVID-19 services and in-network telehealth visits

Adding more in-network providers who can deliver care via telehealth and adding behavioral health services to our telehealth platform, BlueCare

Relaxing several requirements to ensure members had **increased access to prescription medications**

OUTREACH AND ENGAGEMENT



Since 2020 Blue Cross has developed and disseminated messages to give all Louisianians vital COVID-19 information, promoting safety and good health while mitigating anxiety.

In addition to our "Hope" brand campaign, we used radio, print and TV advertising to promote programs and services related to the pandemic and to remind the public to #MaskUp and "Get the Facts, Get the Vax." We used press releases, original videos, livestream broadcasts, social media, media interviews and more to share this important information with our communities.

With the understanding that COVID-19 affected minority populations disproportionately, Blue Cross also worked with key partners, particularly those focused on Black, Hispanic and other minority communities, to build trust, expand access and encourage vaccination.

PARTNERING WITH PROVIDERS

Blue Cross voluntarily implemented several non-mandated benefit changes to assist network providers during the public health emergency and during the recovery following hurricanes Laura and Ida. **They included:**

Increasing reimbursements
Providing bridge funding
Delaying plans to increase eligible hospital readmissions from 15 days to 30 days
Relaxing and delaying several requirements for credentialing and recredentialing

For providers participating in Quality Blue, our signature value-based care program, we

Made early shared-savings payments
Adjusted tiering levels that determine six-month payment rates so they could drop only one level at most
Waived reporting requirements for some measures

EXPERIENCE

As a Louisiana company, we believe we are well-positioned to meet the unique needs and challenges of our members. Our customer experience efforts are focused on improving the health and lives of Louisianians by building intentional experiences for our members.

A FOCUS ON SIMPLICITY

The three imperatives of our customer experience program are:

3
- MAKE IT EASY.
- MAKE IT HAPPEN.
- SHOW YOU CARE.

This simplicity is showing up in the systems and programs we are building for our members, including our dynamic website and cost-saving tools.

Our online member portal allows members to manage their account, find a doctor, download ID cards, see claims, see deductible and maximum out-of-pocket amounts, see HSA balances and more. This is also available on any mobile device via Google Play or the App Store.

Health is complicated, and health insurance is even more so. We believe we have a duty to our members to provide timely, accurate and clear information. Blue Cross targets a 7th-grade reading level as the standard for member communications.

We have a local, dedicated enrollment team and local Customer Service representatives who are available from 8 a.m. to 8 p.m. Monday-Friday from our offices in Baton Rouge and Shreveport.

Customer Experience is about looking into the moments that matter for people and taking time to understand what it's like to be in their shoes, and then figuring out how you can make that experience better.

Shane Bray
SVP, Chief Experience Officer

CUSTOMER SERVICE

The customer experience relies on advisors who handle incoming calls and correspondence from our 1 million commercial members and their health care providers. Inquiries for benefit information comprise the largest category of call volumes. Here's what they did in 2021.

ADVISORS

1.06 MILLION
Calls Answered

310,502
Written Inquiries

1.7 MILLION
Tasks Completed

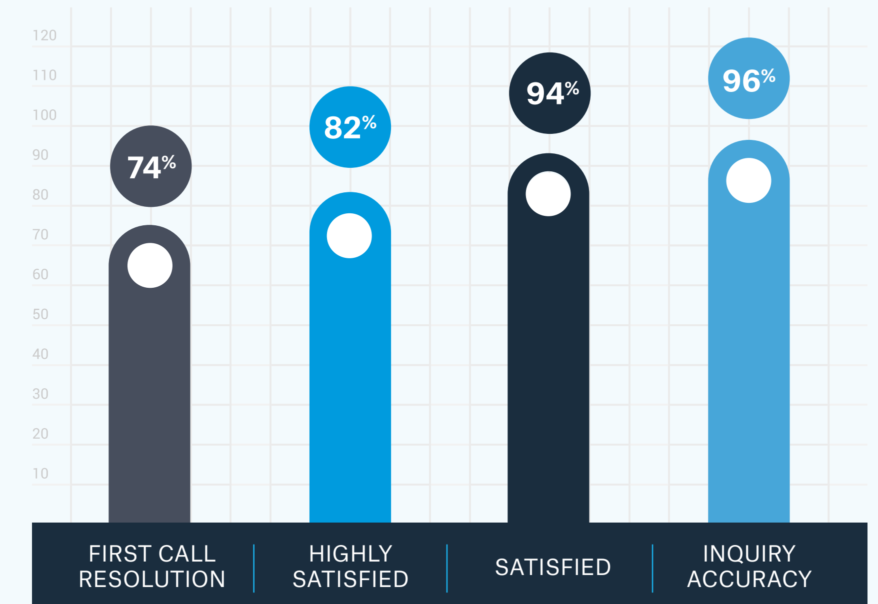
SELF-SERVICE

295,211
Registered Active Users of Member Portal

384,443
IVR Self-Service

593,483
Member Portal Logins

An important part of serving our customers is knocking the basics out of the park. Here's how we did last year:



MEMBERSHIP AND CLAIMS

The Membership and Claims teams are responsible for the successful enrollment, renewal and maintenance of our group and individual members and for all claims-processing activities of our commercial lines of business.

87%	Claims Process Automatically
95%	Claims Process Within 10 Days
$5.8B	In Benefits Paid
1M	Members Enrolled and Renewed Each Year
95,325	Claims Received Daily
24,021,872	Claims Processed Annually
99%	Claims Submitted Electronically

SUSTAINABILITY

To live out our mission, it's imperative that we are stable and strong financially. This strength enables us to grow, invest, innovate and provide even greater value to our members when they need us.

FINANCIAL STABILITY AND SECURITY

We are financially strong and stable, with **25 consecutive 'A' ratings** from Standard & Poor's.

Blue Cross pays millions in premium taxes each year and returns billions to the Louisiana economy through claims paid. We do not have shareholders. **Just 5.9% of our overall premium dollar each year is used to pay for operating costs.**

Blue Cross maintains **strong financial reserves**, providing security against the unknown. Following Hurricane Ida in 2021, Hurricane Laura in 2020 and the 2016 Baton Rouge floods, our reserves gave us the ability to implement immediate policy changes to support our members and providers.

URAC ACCREDITATION

Blue Cross earned re-accreditation from URAC, the leading nonprofit organization promoting health care quality through measurement against rigorous national standards. **URAC is the independent leader in promoting health care quality through leadership, accreditation, measurement and innovation**. By achieving this status, Blue Cross has demonstrated a comprehensive commitment to quality care, improved processes and better patient outcomes.

CODE OF BUSINESS ETHICS

Blue Cross' Compliance and Ethics Department is more than 25 years old, and its 18 team members hold graduate degrees and various certifications in the audit, compliance and ethics fields. Our Compliance and Ethics programs are audited by federal regulators, state regulators and external parties. **These audits consistently show that the company addresses integrity and ethics as one of its highest priorities.**

The Compliance and Ethics Department follows the seven elements of an effective compliance program, which were established by the federal government and are recognized as a standard in the industry.

PRIVACY AND DATA SECURITY

Led by our strong IT security team, all of us at Blue Cross work together to protect our members' health data and privacy. We follow state and federal laws, our own robust internal policies and all "minimum necessary" guidelines. All employees receive intense, mandated annual training. And our "Cyber Shield" Security Team distributes weekly all-employee educational reminders to keep security top of mind.

SPOTLIGHT

DIVERSITY, EQUITY AND INCLUSION

In 2006 Blue Cross and Blue Shield of Louisiana created a **Diversity and Inclusion program** and team to train and encourage employees to recognize, respect and celebrate the rich cultural differences in Louisiana and within our company.

We also built a structure for **increasing the numbers of women, veterans and people of color competing** for management-level positions.

We introduced our **supplier diversity program** for partnering with businesses owned by women, veterans and minorities.

In 2021 we formally added the word "**EQUITY**" to our program to celebrate the fact that we each have unique perspectives and gifts.

Throughout the years, our DE&I program has earned recognition as one of the best in our area. Our **Diversity, Equity and Inclusion Task Force**, which includes members of our Senior Management Team, helps drive our DE&I initiatives in many ways:

- All employees and all board members are required to participate in unconscious bias training during their first six months with the organization.
- We provide regular programs and communications to increase understanding, celebrate our diversity and create equity.
- We recognize cultural observances and plan awareness activities within our multicultural workforce.
- We do not shy away from the hard topics, hosting frequent town halls to encourage discussion on racism, social justice and violence.

*Our supplier diversity program has grown since its inception. In 2006 our diversity spend was **$8.1 million**. By 2020 it had grown to **$26.1 million**. In 2021 **71%** of leadership hires were people of color, women and/or veterans.*

EMPLOYEE RESOURCE GROUPS

One of our latest successful endeavors was the creation of our **employee resource groups (ERG)**. In the past five years we have grown this program from a single ERG for veterans to nine different ERGs, each of which is open to all employees.

9

- BOOTS TO BLUE (VETERANS)
- AFRICAN AMERICANS
- HISPANIC AMERICANS
- ASIAN AMERICAN AND PACIFIC ISLANDERS
- BETTER FOR BLUE (LGBTQ+)
- WOMEN OF BLUE
- PARENTS OF BLUE
- EMERGING LEADERS
- (DIS)ABILITIES

RECRUITING & RETAINING TOP TALENT

We recognize that to be successful, our workforce should not only be diverse but should also reflect the communities we serve. Our **Talent Acquisition** team works with community partners to ensure our employee and intern candidates represent diversity of race, background, gender, ability and thought. **And it's working. In addition to our workforce being 74% women, our current breakdown by racial demographics is:**

8	American Indian or Alaska Native
96	Asian
980	Black or African American
36	Hispanic or Latino
28	Non-Identified
24	Two or more races
1,204	White
2,376	Total*

*Does not include employees of Vantage Health Plan.

FOUNDATIONS

To achieve our mission, we must invest in a strong foundation.
At Blue Cross, that starts with our culture.

OUR CULTURE

Blue Cross employees are driven by our mission — to improve the health and lives of Louisianians. The past few years have taught us that the best way to live out our mission is through unity, hope and compassion. Like all of Louisiana, our Blue culture of caring is stronger than any pandemic, hurricane or flood.

Our employees have gone the extra mile to care for our members — rolling up their sleeves to clean and rebuild, making food and clothing donations, and giving thousands of hours of time and talent to nonprofits. We're selected for our skills and experience and embraced for our diversity. Even as we have been forced apart, we continue to be united in our shared experiences and in our drive to serve our members, our state and each other.

TOP EMPLOYER RECOGNITION

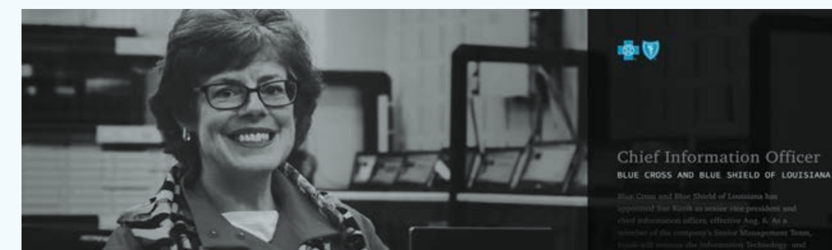
We are consistently recognized as one of the top employers in Louisiana, earning "Best Places to Work" designations in each of our major markets. These designations generally include both submitted answers and surveys of randomly selected employees. In addition, we have received national recognition both for our diversity practices and initiatives and for our commitment to our communities. In 2021 we were honored with eight of these designations.

THOUGHT LEADERSHIP

Blue Cross is fortunate to have leaders with the experience, passion and expertise to fundamentally improve health, make quality care more affordable and enhance our members' experience.

These leaders are:

- developing creative partnerships with providers and community leaders to improve health care;
- using big data and new tools to draw insights that can solve big health care issues;
- embracing modern technology solutions to help Louisianians make the best decisions to improve their overall health; and,
- preparing the organization to drive these innovations.



We call them Thought Leaders, and their messages about how our programs and initiatives are showing results and improving health care have been featured around the state and the country.

PUBLISHED RESEARCH 2020-2021

Blue Cross data scientists, along with pharmacists, nurses and other members of our in-house care team, have had their health and wellness research published in national and international journals.

This published research includes evaluations of integrated pharmacy benefits, COVID-19 Emergency Department utilization, the $0 Drug Copay program, Care Management programs and the model for risk of unplanned hospital admission.

EMPLOYEE PROGRAMS

Benefits and services Blue Cross provides its employees:

Rewards and recognition	**Development and growth**
Rich benefits package	**Employee Assistance Program**
All-encompassing wellness program	**Work-life balance, including PTO, holidays and paid-time off for volunteering**

FOUNDATIONS

THE BLUE CROSS AND BLUE SHIELD OF LOUISIANA FOUNDATION

The Blue Cross and Blue Shield of Louisiana Foundation is a separate 501(c)(3) nonprofit organization that invests in the health and well-being of Louisianians through grant programs, sponsorships and company matches of employee giving.

Blue Cross is the only health insurer in the state with a foundation focused exclusively on Louisiana.

THE 2021 NUMBERS

Impact
24 MILLION
points of service to more than 2.4 million people

Corporate Giving
$1.3 MILLION
in sponsorships, matching grants & corporate support

Foundation Grants
$8.4 MILLION
in grants made to Louisiana nonprofits

Employee Volunteering
30,000+
hours of employee volunteerism

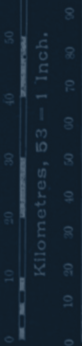
Employee Giving
$983,727
in charitable gifts reported by employees

Pro Bono Services
$175,200
in skills-based volunteering & pro-bono services

Community Crisis Grants
$15 MILLION
to support people affected by COVID-19 & natural disasters since 2020

Food Insecurity
$2.8 MILLION
to address food insecurity

Health Screenings and Services
51,000+
health screenings, including biometric screenings and mental health sessions



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www.viemed.com

625 East Kaliste Saloom Road
Lafayette, LA 70508

February 2nd, 2024

The Honorable Tim Temple
Commissioner of Insurance
Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804-9214

Commissioner Temple:

I am writing to express my strong support for the proposed acquisition of Blue Cross and Blue Shield of Louisiana ("BCBSLA") by Elevance Health. As the CEO of VieMed Healthcare, Inc. ("VieMed"), I and my company have extensive experience working with a number of health insurance companies, including both BCBSLA and Elevance. Based on that experience, I believe that this acquisition will significantly benefit patients across Louisiana.

VieMed is a leading provider of home disease management, with a particular focus on respiratory care. We help patients manage a broad range of respiratory conditions, including COPD, neuromuscular diseases such as ALS, and obstructive sleep apnea. We are headquartered in Lafayette, Louisiana, and have served tens of thousands of patients within our home state. Our strong local ties give us a unique and useful perspective on the proposed acquisition.

We have provided care to Elevance insureds in at least 19 states. We have found Elevance to be deeply committed to our shared mission of ensuring the highest-quality healthcare for our patients. Recently investments have positioned Elevance as an industry leader in technology and efficiency, to the benefit of both patients and providers. Areas where Elevance consistently excels include the following:

Elevance Has a Proven Track Record of Transparency and Predictability

Like many of its competitors, Elevance consistently publishes its medical necessity criteria. Unlike some of its competitors, however, Elevance consistently abides by its published medical necessity criteria. This empowers providers and patients to confidently navigate the insurance landscape, leading to smoother care delivery and reduced administrative overhead for all involved. For this reason, we find that our "success rate" on claims submitted to Elevance is significantly higher—in some cases, two to four times higher—than that of most of its competitors. Remember that every claim denied reflects an item or episode of care that a physician or

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provider thought was appropriate for a patient, and the insurance company disagreed. More transparency leads to the right care getting to the right patients—usually more quickly, as well.

Elevance Streamlines Its Processes

Just about everyone who has interacted with our healthcare system has a story about needless bureaucracy interfering with patient care and satisfaction. It seems at times as though insurance companies are intentionally creating obstacles in hopes that patients and providers will lose their nerve and go without needed care. This has not been our experience with Elevance. For example, some other companies (including BCBSLA) will deny a claim for one reason and then, when that reason has been overturned on appeal, they will deny the claim again for a different reason. Going through multiple rounds of appeals is costly enough as an administrative matter; when our critically ill patients are waiting for a decision on whether their insurance company will cover their life-sustaining therapy, the cost of any delay is far greater. By contrast, Elevance provides all of its reasons for denial with its initial determination. This permits all issues to be addressed in a single appeal, leading to significant time and administrative savings, and better outcomes for patients.

Elevance's Investments in Technology Have Paid Major Dividends

As I noted above, we have been impressed with Elevance's commitment to leveraging technology to create a better experience for providers and patients. Elevance's online provider portal is easy to navigate and simplifies document submission. Elevance also has an excellent "chat" feature in their provider portal, allowing our collection team to communicate with a representative without long phone hold times and limited representative availability. This gets more care to patients more quickly and affordably. Compared to other insurers, including BCBSLA, I would put the Elevance provider portal at the very top of the class.

Elevance Has a National Reach but a Local Focus

It is natural to worry that a national healthcare company based elsewhere will not be as invested in serving our community as one based in Louisiana. In my experience, Elevance has exhibited a remarkable commitment to understanding and addressing local needs. They actively engage with providers and patient groups, demonstrating a commitment to building strong relationships beyond pure market share. We believe this approach will benefit patients in our state who may feel overlooked by larger, national insurers.

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For example, Humana has entered into agreements whereby effectively all of its patients across the nation must use one of just two designated durable medical equipment ("DME") companies for respiratory care. The two chosen DME companies are named Rotech and Adapt. Neither company has sufficient operations in Louisiana to satisfy the patient need. As a result, we and other companies operating in Louisiana have had to pick up the slack—uncompensated by Humana—to ensure that patients are not left without critical therapy. By contrast, we have found that Elevance demonstrates a commitment to working with a broad range of companies in each of the communities where it operates in order to ensure that the options afforded to patients and providers are better than adequate.

Elevance Has Excellent Customer Service

Time and again, our encounters with Elevance's customer service representatives have been positive. Their staff boasts in-depth knowledge of policies and procedures, enabling them to address our concerns efficiently and effectively. Moreover, we have observed that Elevance's representatives give us consistent guidance across the board, giving us confidence that we are receiving well-thought-out responses that we can rely on in shaping our own policies and procedures. Elevance's customer service compares favorably with many other insurers, where the answer we receive may depend on who answers the phone and our internal procedures must change frequently.

In conclusion, we strongly believe that the acquisition of BCBSLA by Elevance Health will greatly benefit patients in our state. Where other companies may merely pay lip service, Elevance truly is a patient-centric company. We urge you to carefully consider these factors and approve the approval of this acquisition.

Thank you for your time and consideration. I would welcome the opportunity to discuss this matter further at your convenience.

Sincerely,

Casey Hoyt
CEO
VieMed Healthcare, Inc.

CC:
David Caldwell, General Counsel, Louisiana Department of Insurance
Steven Udvarhelyi M.D., President and CEO, Blue Cross and Blue Shield of Louisiana
editorialpage@theadvocate.com

Facts about the Proposed Blue Cross and Blue Shield of Louisiana Acquisition by Elevance Health

Some Louisianans have raised questions about the proposed acquisition of Blue Cross and Blue Shield of Louisiana (BCBSLA) by Elevance Health. This process is dictated by Louisiana state law and includes a public hearing by the LDI and must also have the approval of approximately 92,000 BCBSLA policyholders with voting rights. **The following information is intended to answer some of those questions and address any misunderstanding about this transaction and the benefits it will bring to Louisiana healthcare consumers.**

Myth 1 I will lose access to my doctor or hospital.

TRUTH

Blue Cross and Blue Shield of Louisiana's members will continue to have the same access to their doctors, hospitals, and care providers in Louisiana. In addition, for those members who have benefits that allow them to see healthcare providers in other states, that benefit will not change.

Myth 2 My premiums will increase because Elevance Health is a for-profit company.

TRUTH

No, premiums are not significantly impacted by the profit margin of a mutual company (like BCBSLA today) versus a for-profit company. The profit margin of health insurers are reviewed in detail by state insurance departments and operate within a standard range. The cost of health insurance is largely a result of the cost and amount of healthcare services used, not profit margins. Compared to 14 states where Elevance Health does business as Anthem, premiums are lower in 13 of Anthem's states than in Louisiana, and in one state are less than half of what they are in Louisiana.

Myth 3 BCBSLA will no longer be a local company with local leadership.

TRUTH

Healthcare in Louisiana must be local, and BCBSLA and Elevance Health share that philosophy. Everything you have come to expect when you reach out to a BCBSLA employee to ask a question about coverage or a claim, or for a doctor to connect to a local team member --- will not change. Elevance Health has a hyperlocal focus, and all of its affiliated health plans have leadership teams and staff based in the local markets where they serve healthcare consumers.

Myth 4 This deal will result in the loss of jobs at BCBSLA.

TRUTH

Elevance Health has committed that aggregate employment levels will be maintained at or above the current level of employment. Upon closing, BCBSLA will become part of the parent company, Elevance Health. It has been Elevance Health's experience in other markets that overall employment has increased.

TIMELINE

BCBSLA refiled its transaction with the Louisiana Department of Insurance (LDI)

Public hearing on Plan or Reorganization

Special BCBSLA Policyholder Meeting

Public Hearing on Change of Control

Decision by the Commissioner of Insurance

Myth 5 BCBSLA policyholders are not getting any portion of the sale proceeds

TRUTH

All eligible policyholders, as defined by BCBSLA's corporate charter and consistent with state law, will receive their allocated portion of the proceeds. The amount of the proceeds going to policyholders has been analyzed by experts using investment banking principles and insurance actuarial principles.

bcbsla.com/betterblue

A Better Blue for You

Blue Cross and Blue Shield of Louisiana is committed to improving the health and lives of Louisianians.

And to making Blue even better for *you*.

Learn more about how we're building a better Blue.

Positioned for Future Success: Blue Cross and Blue Shield of Louisiana Enters Into Definitive Agreement to be Acquired by Elevance Health

Feedback

Deal will result in $3 Billion foundation focused on improving Louisiana

Blue Cross and Blue Shield of Louisiana recently announced that it has entered into a definitive agreement to be acquired by Elevance Health, subject to customary closing conditions and regulatory approval.

This acquisition will unite two organizations deeply rooted in the communities they serve and aligned in a mission to improve whole health. Together they will continue to prioritize what is best for Louisiana's members and customers by improving access, quality, affordability, and the experience that Louisianians have trusted for almost 90 years.

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Yes No

The purchase price is $2.5 billion. In addition to the purchase price, there is an agreement between the two companies that some of Blue Cross' existing reserves will go toward establishing a $3 billion private foundation aimed at addressing health inequalities across Louisiana. Called the Accelerate Louisiana Initiative, the foundation will focus only on the unique and complex needs of Louisianians. It will do this by addressing health inequities and broader community needs across our state, which continues to lag the nation in many important health metrics.

Letter to Members from Dr. I. Steven Udvarhelyi, M.D.,
President and Chief Executive Officer, Blue Cross and Blue Shield of Louisiana

Letter to Members

Frequently Asked Questions About the Acquisition

Will there be any changes in member benefits?
At this time, there will be no changes to our members' current benefits.

Can members still see their doctor/healthcare provider?
The Blue Cross and Blue Shield of Louisiana network is not changing. Members can continue to access the same providers as they do now under their current benefit plan.

Do members have the same choice of services?
Yes. At this time, there will be no changes to Blue Cross and Blue Shield of Louisiana's services.

Feedback

Will Blue Cross and Blue Shield of Louisiana continue to provide Medicare Advantage products for seniors?
Yes. Our current Medicare Advantage products are not changing at this time.

Following the close of the transaction, Elevance Health will enhance the competitive Blue offering in the Medicare Advantage space. In doing so, BCBSLA can bring seniors in Louisiana more robust benefits and additional product offerings that are available with Elevance Health.

Who should BCBSLA members contact for questions about their benefits?
Members should continue to call the customer service number on the back of their membership ID card or access our website at **www.bcbsla.com** as they always have.

Are authorization/pre-approval rules changing?
Nothing related to benefits is changing at this time. In accordance with our provider and state/federal contracts, we will notify members of any changes well in advance of their implementation.

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Yes No

Will BCBSLA members be required to move to an Elevance Health-affiliated health plan now?
No, there will be no immediate changes to our member's current benefits.

Will members have access to new products and services as a result of this transaction?
Yes, after the transaction closes, Blue Cross and Blue Shield of Louisiana members will be able to access a portfolio of solutions and capabilities developed by Elevance Health and its healthcare services organization, Carelon.

Elevance Health has made more than $4 billion in investments over the past several years such as behavioral health, complex and chronic care programs and innovative digital models.

These solutions have demonstrated success nationally in improving members' health and keeping them healthier.

What kinds of products and services will be available?
We will bring more effective and efficient solutions such as integrated pharmacy, care navigation, and member advocacy, which would help improve member health outcomes

Will Elevance Health continue to invest in Louisiana?
Yes, Elevance Health is committed to continued investment in broadening its breadth of services to advance the whole health of its members

Why is Elevance Health acquiring BCBSLA?
Blue Cross and Blue Shield of Louisiana is a financially strong and vibrant company, serving Louisiana for almost 90 years. As the leading health insurer in the state, we have a deep understanding of the unique needs of our members, our customers, the providers we work with and the communities we serve. To meet those needs, we have had to evolve over time, and in the rapidly changing healthcare environment, the need to evolve and adapt is more important today than ever.

Feedback

Across healthcare, scale has become increasingly important. That is why the BCBSLA board, the CEO and members of senior management initiated a formal process to identify a partner with the ability to help us secure a strong future for our company, and specifically a partner that could provide leading innovations, products, capabilities and services at a faster pace, and more comprehensively, than we could alone. We believe that aligning with a large, trusted organization will allow us to accelerate our mission of improving the health and lives of Louisianians.

What is Elevance Health?
Elevance Health is no stranger to us or Louisiana. BCBSLA and Elevance Health formed the Healthy Blue joint venture, where we have partnered together since 2017 to offer a Blue option to Louisiana's Medicaid population.

Since forming Healthy Blue, it has become clear that our **missions and cultures** are aligned, with a focus on community, volunteerism, diversity, equity and inclusion.
Elevance Health is the parent company of 14 Blue Cross Blue Shield plans across the country and has a broad portfolio of whole health solutions.
More information on Elevance Health can be found at **www.elevancehealth.com.**

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Yes No

Will there still be Blue Cross and Blue Shield offices in Louisiana?

Yes, our headquarters will remain in Baton Rouge, and regional sales offices will still be located across the state, including the recently announced Medicare Advantage Center of Excellence in Monroe.

When will the transaction close?

We do not know the date for closing, but we anticipate it will occur in the fourth quarter of 2023.

What are the details of the new foundation?

The Accelerate Louisiana Initiative is being created to address the unique and complex needs of the people of Louisiana. Its mission - like ours - will be to improve the health and lives of the people of Louisiana. The foundation will focus on strengthening communities by addressing health inequities and broader community needs in Louisiana, which continues to lag the nation in many important health metrics.

Will the foundation only be focused on Louisiana?

Yes, the Accelerate Louisiana Initiative foundation will focus only on the unique and complex needs of Louisianians.

How can I find out more about the Accelerate Louisiana Initiative Foundation and apply for funding?

More information on the Accelerate Louisiana Initiative foundation will be shared following the close of the transaction.

Feedback

Approving the Acquisition

The Elevance Health acquisition requires several levels of approvals, not only from regulatory bodies and the Blue Cross Blue Shield Association, but also from certain eligible policyholders who must vote to approve the Plan of Reorganization, which converts BCBSLA from a mutual insurance company to a stock company.

This reorganization needs to happen before Elevance Health can complete the acquisition.

In early August, Blue Cross and Blue of Louisiana mailed eligible policyholders an information packet that explained the plan of reorganization and included the option of granting their proxy to the company by mail, online, by phone or in person at a Special Policyholder Meeting on Sept. 6, 2023.

Please note that who is considered an eligible policyholder is well defined in this situation. In fact, most of our members did not receive an information packet because they're not eligible to vote under that definition.

Who is an eligible policyholder?

An eligible policyholder is an individual or company who has purchased a fully insured health, vision, and/or dental policy with Louisiana Health Service & Indemnity Company, which is the legal holding company of Blue Cross and Blue Shield of Louisiana. In addition, to be an

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Yes No

eligible policyholder, they must have actively held one or more of the above policies on January 23, 2023 – the date the plan was adopted – and must be an active eligible policyholder on the date the transaction closes, which we expect to be by year end.

Those members who purchased eligible individual BCBSLA policies – Medicare Supplemental, Medicare Advantage, ACA and non-ACA – are eligible policyholders. Their dependents on these policies are not eligible policyholders. Group customers who purchased eligible BCBSLA group policies for employees are considered the eligible policyholder and would be represented by their group leader on record. Their covered employees and dependents are not eligible policyholders. Administrative Services Only (ASO) policyholders and people who hold policies with subsidiaries of BCBSLA's holding company are not eligible to vote.

HMO Louisiana, Southern National Life or Vantage policyholders are not eligible to vote.

What to do if you receive an information packet in the mail.

If you're an eligible policyholder, you should have received a packet of information that gives you instructions on how to grant your proxy to the Blue Cross and Blue Shield of Louisiana Board of Directors. You can do this by mail, online, phone or at a Special Policyholder Meeting scheduled on Sept. 6, 2023.

There are several ways to grant your proxy:

- You can grant your proxy online at www.fcrvote.com/BCBS
- You can grant your proxy using a touchtone phone, by calling 1-866-402-3905
- You can grant your proxy by returning the proxy form via mail in the postage-paid envelope that was included in your information packet
- You can present your proxy at the Special Policyholder meeting on September 6, 2023

Feedback

ALL proxies must be received by 11:59 p.m. Central Time on Sept. 1, 2023, in order for your proxy to be valid.

Someone called me about this? Is that call legitimate?

In addition to the mailing, you may receive a phone call from Dial America. This is a courtesy to make it easier for you to vote. Dial America will not ask you for financial information. As always, never give your financial information over the phone.

How will I know if I'm an eligible policyholder?

If you are an eligible policyholder, you will have received an information packet and a proxy ballot in the mail in early August.

Why didn't I get an information packet?

We sent packets to all eligible policyholders in early August. There are a few reasons why you didn't receive a packet, the most likely is that you're not an eligible policyholder as defined in this situation. However, if your address has changed recently, you can call the customer service number on the back of your ID card.

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Yes No

Will eligible policyholders receive a payment as result of the transaction?

Yes. Once the transaction is approved and finalized, eligible policyholders will receive a payment of approximately $3,000 per eligible policy.

Is the payment taxable?

The payment is taxable for US federal income tax purposes.

Feedback

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Yes No

An Open Letter to Louisianans Regarding Elevance Health and Blue Cross and Blue Shield of Louisiana Coming Together as One Company

Blue Cross and Blue Shield of Louisiana (BCBSLA) has a rich and storied history serving its customers in every corner of the state for the last 90 years, and we will continue that noble mission for the next 90 years and beyond to improve the lives of Louisianans and the health of our communities.

Together, BCBSLA and Elevance Health will make healthcare more affordable for individuals and employers, improve health outcomes across the state, and bring innovation more rapidly to customers and healthcare providers. We will become Anthem BCBSLA — the same Blue you have come to trust, bolstered by a brand and an organization that will commit more to this market tomorrow than Blue is able to today.

Unfortunately, some special interest groups have been sharing misleading or even false information about our partnership. **You deserve the facts.**

Current BCBSLA benefit plans won't change, but customers will gain access to new and enhanced services. BCBSLA customers will keep the same doctors and hospitals you know and trust. The BCBSLA team will stay the same too, keeping jobs in our communities and providing customers with local support. What will change is the access customers will gain to additional tools and technologies that will help them take more control of their health, and access care where and when they need it. This includes intuitive and personalized services to support the unique needs customers have in virtual health, behavioral health, chronic conditions, palliative care, pharmacy, and much more.

Elevance Health is continually reducing administrative burdens for doctors and simplifying their experiences with us, so they have more time to focus on patient care. Doctors and hospitals are widely satisfied with their partnerships with Elevance Health, as our affiliated health plans across 14 states process 98% of claims within 30 days and 99.8% of claims within 90 days. We are also able to credential new providers faster than ever, often in less than 30 days, enabling them to get to work with their patients more quickly. Our customers are satisfied too; we continue to be highly rated for how easy customers say we are to work with, at levels higher than the average of our peers.

Together with BCBSLA, Elevance Health will continue to promote increased affordability for Louisiana families and employers, without any compromise on outcomes. BCBSLA customers will gain access to a portfolio of solutions and capabilities that have demonstrated success nationally in both improving members' health and keeping care affordable. With Louisianans struggling under the weight of an already high-cost health market, we see nothing but opportunities to make a positive impact. The trust we've earned from our customers, employers, and provider partners across all the other states where our plans operate are the best testament to how we talk the talk, and walk the walk.

We welcomed BCBSLA's invitation to partner with Elevance Health because we knew it was the right match at the right time. We are big enough to make the investments Louisiana needs and deserves in its dynamic healthcare market; nimble enough to ensure Louisianans get the best health experience possible; and innovative enough to provide both customers and providers with access to the best technologies and capabilities anyone has to offer. All while maintaining the benefits of BCBSLA's local experience, relationships and presence.

Taken together, this translates to more affordable care, a better overall experience for members, providers, and employers in the

state, and improved health outcomes for Louisianans. Together, we will build a better Blue — one that will serve Louisiana long into the future and do more to improve the lives of Louisianans and the health of our communities.

Morgan Kendrick
Executive Vice President
Elevance Health

To learn more, visit: **BetterHealthForLouisiana.com**

Elevance Health's 2023 in 10 headlines

Elevance Health named new leadership, planned acquisitions and settled lawsuits in 2023.

Here are the 10 most-read stories about Elevance Health *Becker's* reported this year.

1. In October, employees with Elevance Health and its subsidiaries took to social media regarding an unknown number of job cuts they say occurred across the company. Elevance confirmed "recent changes" with *Becker's*. Elevance is one of several payers to implement workforce reductions in 2023.

2. Elevance Health sued to block a former regional Medicare president from taking a similar role at Molina Healthcare, alleging the former executive was in possession of trade secrets that would inevitably be disclosed to Molina. The companies eventually agreed to settle the case out of court.

3. In January, Elevance Health announced plans to acquire BCBS Louisiana in a $2.5 billion deal. The deal has faced a series of regulatory hurdles — the two companies paused the acquisition in September before submitting a new request to merge to Louisiana regulators in December.

4. Former Elevance CFO John Gallina retired from his role in November and was replaced by Mark Kaye, former CFO of Moody's Corp.

5. In August, Cincinnati-based Bon Secours Mercy Health sued Elevance subsidiary Anthem Blue Cross Blue Shield of Virginia for $93 million, alleging the payer owed the system millions in unpaid claims. The suit came in the midst of a contract dispute that left nearly 50,000 Anthem Medicaid beneficiaries in Ohio and 11,000 Anthem Medicare Advantage members in Virginia out of network with Bon Secours. The two systems reached an agreement in September, and the lawsuit was dismissed.

6. The percentage of Elevance Health Medicare Advantage members enrolled in contracts rated at four stars or higher declined from 64% in 2023 to 34% for 2024. Three of the company's largest MA contracts by enrollment will decline from 4.5 or four stars to 3.5 stars in 2024. The company said it was "disappointed" with its performance on certain metrics, especially declines in members' reported satisfaction with access to appointments and care.

7. Elevance Health and Health Care Service Corp. are vying for Cigna's Medicare Advantage business, a deal that could be worth more than $3 billion, according to *Bloomberg*.

8. Elevance Health planned to expand its AI-concierge care program to 40,000 members by the end of 2023. Anthony Nguyen, MD, former chief clinical officer at Elevance Health, told *Becker's* more about the program in April.

9. Elevance Health achieved a drastic reduction in youth and young adult suicides through predictive modeling and clinical outreach.

10. Bill Beck, Elevance Health's chief marketing officer, told *Becker's* how the company transformed from Anthem to Elevance Health.

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EARNINGS RELEASE

ELEVANCE HEALTH REPORTS THIRD QUARTER 2023 RESULTS

- **Third quarter GAAP net income was $5.45 per share, including net negative adjustment items of $3.54 per share. Adjusted net income was $8.99* per share.**
- **Operating gain, excluding adjustment items, grew 12.6% year-over-year to $2.5 billion.**
- **Operating cash flow was $2.6 billion.**

Indianapolis, Ind. - October 18, 2023 - Elevance Health, Inc. (NYSE: ELV) reported third quarter 2023 results reflecting strong financial performance across the enterprise.

"Elevance Health delivered another quarter of solid performance reflecting the strength and balance of our diversified portfolio of businesses, our continued investments in innovation and growth, and our relentless focus on affordability, simplicity, and customer experience," said Gail K. Boudreaux, President and CEO. "With affordability a paramount concern for all payors and a more uncertain forward-looking operating environment, we took action during the third quarter that will enhance our ability to act nimbly and operate efficiently. Along with the earnings power of our Health Benefits and Carelon businesses, we are well-positioned to meet our commitments to all of our stakeholders while continuing to advance our whole health strategy."

As a result of outperformance year-to-date, the Company now expects GAAP net income to be greater than $26.40 per share in 2023, and adjusted net income to be greater than $33.00 per share.

*Refer to GAAP reconciliation tables on page 14.

CONSOLIDATED HIGHLIGHTS

Earnings Per Share: GAAP net income was $5.45 per share in the third quarter, including net negative adjustment items of $3.54 per share. Adjusted net income was $8.99* per share.

*Please refer to the GAAP reconciliation tables on page 14.

Membership: Medical membership totaled approximately 47.3 million as of September 30, 2023, an increase of 42 thousand, or 0.1 percent year-over-year, driven primarily by growth in BlueCard, Affordable Care Act health plans, and Medicare Advantage membership, partially offset by attrition in Medicaid due to the resumption of eligibility redeterminations and a new entrant into one of our state Medicaid programs in the third quarter, as well as declines in our Employer Group risk-based business.

During the third quarter of 2023, medical membership decreased by 664 thousand driven by attrition in Medicaid due to the aforementioned dynamics.

Operating Revenue: Operating revenue was $42.5 billion in the third quarter of 2023, an increase of $2.9 billion, or 7.2 percent year-over-year. The increase was primarily driven by higher premium revenue in our Health Benefits business and growth in pharmacy product revenue in CarelonRx due to growth in external pharmacy members served and the acquisition of BioPlus in the first quarter of 2023.

Benefit Expense Ratio: The benefit expense ratio was 86.8 percent in the third quarter, an improvement of 40 basis points year-over-year. The improvement was driven by premium rate adjustments in recognition of medical cost trend.

Medical claims reserves established at December 31, 2022 developed within the range of the Company's expectations as of the third quarter of 2023.

Days in Claims Payable: Days in Claims Payable was 48.6 days as of September 30, 2023, an increase of 2.1 days from June 30, 2023 and an increase of 0.9 days compared to September 30, 2022.

Operating Expense Ratio: The operating expense ratio was 12.9% in the third quarter of 2023, an increase of 150 basis points from 11.4% in the third quarter of 2022. The increase was due to a business optimization charge recognized in the quarter.

In the third quarter, we completed a strategic review of our operations, assets, and investments to enhance operating efficiency, refine the focus of our investments in innovation and optimize our physical footprint. This resulted in a net charge of $697 million, comprised of the write-off of certain information technology assets and contract exit costs, a reduction in staff including the relocation of certain job functions, and the impairment of assets associated with the closure or partial closure of data centers and offices.

Operating Cash Flow: Operating cash flow was approximately $2.6 billion, or 2.0 times net income in the third quarter of 2023, a decrease of $2.3 billion as compared to the prior year quarter. The year-on-year decrease was driven by the receipt of an additional month of CMS payments in the third quarter of 2022.

Share Repurchase Program: During the third quarter of 2023, the Company repurchased 1.1 million shares of its common stock for $480 million, at a weighted average price of $451.68. Year-to-date, as of the end of the third quarter, the Company repurchased 3.8 million shares of its common stock for $1.7 billion, at a weighted average price of $462.42. As of September 30, 2023, the Company had approximately $5.1 billion of Board-approved share repurchase authorization remaining.

Cash Dividend: During the third quarter of 2023, the Company paid a quarterly dividend of $1.48 per share, representing a distribution of cash totaling $348 million.

On October 17, 2023, the Audit Committee of the Company's Board of Directors declared a fourth quarter 2023 dividend to shareholders of $1.48 per share. The fourth quarter dividend is payable on December 21, 2023, to shareholders of record at the close of business on December 6, 2023.

Investment Portfolio & Capital Position: During the third quarter of 2023, the Company recorded net losses of $124 million. During the third quarter of 2022, the Company recorded net losses of $57 million. These amounts are excluded from adjusted earnings per share.

As of September 30, 2023, the Company’s net unrealized loss position in the investment portfolio was $2.4 billion, consisting primarily of fixed maturity securities. As of September 30, 2023, cash and investments at the parent company totaled approximately $1.7 billion.

REPORTABLE SEGMENTS

Elevance Health has four reportable segments: Health Benefits (comprised of Individual, Employer Group risk-based, Employer Group fee-based, BlueCard, Medicaid, Medicare, and Federal Health Products & Services businesses); CarelonRx; Carelon Services; and Corporate & Other (comprised of businesses that do not individually meet the quantitative thresholds for an operating division as well as corporate expenses not allocated to our other reportable segments).

Elevance Health, Inc.
Reportable Segment Highlights
(Unaudited)

(In millions)	Three Months Ended September 30			Nine Months Ended September 30		
	2023	2022 (Restated)	Change	2023	2022 (Restated)	Change
Operating Revenue						
Health Benefits	$36,744	$35,065	4.8 %	$112,024	$103,488	8.2 %
Carelon[1]	11,892	10,403	14.3 %	35,135	30,088	16.8 %
Corporate & Other	242	211	14.7 %	780	799	(2.4)%
Eliminations	(6,398)	(6,054)	5.7 %	(20,184)	(18,382)	9.8 %
Total Operating Revenue[2]	$42,480	$39,625	7.2 %	$127,755	$115,993	10.1 %
Operating Gain (Loss)						
Health Benefits	$1,847	$1,634	13.0 %	$6,154	$5,266	16.9 %
Carelon[1]	650	641	1.4 %	2,003	1,831	9.4 %
Corporate & Other[2]	(741)	(24)	NM[4]	(942)	(73)	NM[4]
Total Operating Gain[3]	$1,756	$2,251	(22.0)%	$7,215	$7,024	2.7 %
Operating Margin						
Health Benefits	5.0 %	4.7 %	30 bp	5.5 %	5.1 %	40 bp
Carelon[1]	5.5 %	6.2 %	(70) bp	5.7 %	6.1 %	(40) bp
Total Operating Margin[2]	4.1 %	5.7 %	(160) bp	5.6 %	6.1 %	(50) bp

1. Operating Revenue and Operating Gain for Carelon for the three months ended September 30, 2023 included $8,518 and $477 for CarelonRx; $3,374 and $173 for Carelon Services, respectively. Operating Revenue and Operating Gain for Carelon for the three months ended September 30, 2022 included $7,249 and $516 for CarelonRx; $3,154 and $125 for Carelon Services, respectively. Operating Revenue and Operating Gain for Carelon for the nine months ended September 30, 2023 included $25,008 and $1,485 for CarelonRx; $10,127 and $518 for Carelon Services, respectively. Operating Revenue and Operating Gain for Carelon for the nine months ended September 30, 2022 included $21,003 and $1,393 for CarelonRx; $9,085 and $438 for Carelon Services, respectively.
2. Operating gain for Corporate & Other for the three and nine months ended September 30, 2023 included a business optimization charge of $697.
3. See "Basis of Presentation" on page 6 herein.
4. "NM" = calculation not meaningful.

Health Benefits: Operating gain in the Health Benefits segment totaled $1.8 billion in the third quarter of 2023, an increase of $213 million from $1.6 billion in the third quarter of 2022, representing growth of 13.0%. The increase was primarily driven by premium rate adjustments to cover medical cost trend on higher levels of post-pandemic care.

Carelon: Operating gain in the Carelon segment was $650 million in the third quarter of 2023, an increase of $9 million from $641 million in the third quarter of 2022. The increase was primarily driven by the continued expansion of our post-acute care services business, the acquisition of BioPlus in the first quarter of 2023, and improved performance in our Behavioral Health business, partially offset by the non-recurrence of out of period fee-based revenue recognized in the third quarter of 2022 in CarelonRx.

Corporate & Other: The Company reported an operating loss of $741 million in the Corporate & Other segment for the third quarter of 2023, a decrease of $717 million from an operating loss of $24 million in the third quarter of 2022, driven by business optimization charges.

Basis of Presentation

1. Operating revenue and operating gain/loss are the key measures used by management to evaluate performance in each of its reporting segments, allocate resources, set incentive compensation targets and to forecast future operating performance. Operating gain/loss is calculated as total operating revenue less benefit expense, cost of products sold and operating expense. It does not include net investment income, net gains/losses on financial instruments, interest expense, amortization of other intangible assets, gains/losses on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management. Refer to page 14 for the GAAP reconciliation tables.

2. Operating margin is defined as operating gain divided by operating revenue.

Conference Call and Webcast

Management will host a conference call and webcast today at 8:30 a.m. Eastern Daylight Time ("EDT") to discuss the company's third quarter results and outlook. The conference call should be accessed at least 15 minutes prior to the start of the call with the following numbers:

888-947-9963 (Domestic)	866-405-7293 (Domestic Replay)
312-470-0178 (International)	203-369-0605 (International Replay)

The access code for today's conference call is 3972058. There is no access code for the replay. The replay will be available from 11:30 a.m. EDT today, until the end of the day on November 17, 2023. The call will also be available through a live webcast at www.elevancehealth.com under the "Investors" link. A webcast replay will be available following the call.

Elevance Health Contacts:

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About Elevance Health, Inc.

Elevance Health is a lifetime, trusted health partner fueled by its purpose to improve the health of humanity. The company supports consumers, families, and communities across the entire care journey – connecting them to the care, support, and resources they need to lead healthier lives. Elevance Health's companies serve approximately 117 million people through a diverse portfolio of industry-leading medical, digital, pharmacy, behavioral, clinical, and complex care solutions. For more information, please visit www.elevancehealth.com or follow us @ElevanceHealth on Twitter and Elevance Health on LinkedIn.

Elevance Health, Inc.
Membership and Other Metrics
(Unaudited)

Medical Membership (in thousands)	September 30, 2023	September 30, 2022	June 30, 2023	Change from September 30, 2022	Change from June 30, 2023
Individual	999	800	949	24.9 %	5.3 %
Employer Group Risk-Based	3,754	3,988	3,765	(5.9)%	(0.3)%
Commercial Risk-Based	4,753	4,788	4,714	(0.7)%	0.8 %
BlueCard®	6,756	6,453	6,737	4.7 %	0.3 %
Employer Group Fee-Based	20,166	20,184	20,160	(0.1)%	— %
Commercial Fee-Based	26,922	26,637	26,897	1.1 %	0.1 %
Medicare Advantage	2,064	1,969	2,059	4.8 %	0.2 %
Medicare Supplement	928	945	926	(1.8)%	0.2 %
Total Medicare	2,992	2,914	2,985	2.7 %	0.2 %
Medicaid	11,018	11,319	11,759	(2.7)%	(6.3)%
Federal Employees Health Benefits	1,640	1,625	1,634	0.9 %	0.4 %
Total Medical Membership	47,325	47,283	47,989	0.1 %	(1.4)%
Other Membership (in thousands)					
Life and Disability Members	4,611	4,796	4,686	(3.9)%	(1.6)%
Dental Members	6,775	6,655	6,728	1.8 %	0.7 %
Dental Administration Members	1,708	1,577	1,694	8.3 %	0.8 %
Vision Members	9,861	9,628	9,850	2.4 %	0.1 %
Medicare Part D Standalone Members	261	274	263	(4.7)%	(0.8)%
Other Metrics (in millions)					
CarelonRx Quarterly Adjusted Scripts	77.3	76.9	77.4	0.5 %	(0.1)%
Carelon Services Consumers Served	104.8	105.3	103.6	(0.5)%	1.2 %

Elevance Health, Inc.

Consolidated Statements of Income

(Unaudited)

(In millions, except per share data)	Three Months Ended September 30		
	2023	2022	Change
		(Restated)	
Revenues			
Premiums	$ 35,259	$ 33,722	4.6 %
Product revenue	5,177	3,972	30.3 %
Service fees	2,044	1,931	5.9 %
Total operating revenue	42,480	39,625	7.2 %
Net investment income	493	371	32.9 %
Net losses on financial instruments	(124)	(57)	NM
Total revenues	42,849	39,939	7.3 %
Expenses			
Benefit expense	30,606	29,421	4.0 %
Cost of products sold	4,648	3,437	35.2 %
Operating expense	5,470	4,516	21.1 %
Interest expense	259	213	21.6 %
Amortization of other intangible assets	212	225	(5.8) %
Total expenses	41,195	37,812	8.9 %
Income before income tax expense	1,654	2,127	(22.2) %
Income tax expense	354	529	(33.1) %
Net income	1,300	1,598	(18.6) %
Net (income) loss attributable to noncontrolling interests	(11)	5	NM
Shareholders' net income	$ 1,289	$ 1,603	(19.6) %
Shareholders' net income per diluted share	$ 5.45	$ 6.62	(17.7) %
Diluted shares	236.5	242.2	(2.4) %
Benefit expense as a percentage of premiums	86.8 %	87.2 %	(40)bp
Operating expense as a percentage of total operating revenue	12.9 %	11.4 %	150 bp
Income before income tax expense as a percentage of total revenue	3.9 %	5.3 %	(140)bp

"NM" = calculation not meaningful

Elevance Health, Inc.
Consolidated Statements of Income
(Unaudited)

(In millions, except per share data)	Nine Months Ended September 30		
	2023	2022	Change
		(Restated)	
Revenues			
Premiums	$ 107,716	$ 99,583	8.2 %
Product revenue	14,058	10,841	29.7 %
Service fees	5,981	5,569	7.4 %
Total operating revenue	127,755	115,993	10.1 %
Net investment income	1,296	1,112	16.5 %
Net losses on financial instruments	(358)	(439)	NM
Total revenues	128,693	116,666	10.3 %
Expenses			
Benefit expense	92,996	86,447	7.6 %
Cost of products sold	12,456	9,389	32.7 %
Operating expense	15,088	13,133	14.9 %
Interest expense	771	622	24.0 %
Amortization of other intangible assets	668	520	28.5 %
Total expenses	121,979	110,111	10.8 %
Income before income tax expense	6,714	6,555	2.4 %
Income tax expense	1,554	1,544	0.6 %
Net income	5,160	5,011	3.0 %
Net (income) loss attributable to noncontrolling interests	(29)	18	NM
Shareholders' net income	$ 5,131	$ 5,029	2.0 %
Shareholders' net income per diluted share	$ 21.56	$ 20.67	4.3 %
Diluted shares	238.0	243.3	(2.2) %
Benefit expense as a percentage of premiums	86.3 %	86.8 %	(50)bp
Operating expense as a percentage of total operating revenue	11.8 %	11.3 %	50 bp
Income before income tax expense as a percentage of total revenue	5.2 %	5.6 %	(40)bp

"NM" = calculation not meaningful

Elevance Health, Inc.
Consolidated Balance Sheets

(In millions)	September 30, 2023	December 31, 2022
Assets	(Unaudited)	(Restated)
Current assets:		
Cash and cash equivalents	$ 10,919	$ 7,387
Fixed maturity securities	27,811	25,952
Equity securities	165	953
Premium receivables	7,883	7,083
Self-funded receivables	3,756	4,663
Other receivables	5,293	4,298
Other current assets	5,358	5,281
Total current assets	61,185	55,617
Long-term investments:		
Fixed maturity securities	816	752
Other invested assets	6,118	5,685
Property and equipment, net	4,248	4,316
Goodwill	25,291	24,383
Other intangible assets	10,491	10,315
Other noncurrent assets	2,329	1,687
Total assets	$ 110,478	$ 102,755
Liabilities and equity		
Liabilities		
Current liabilities:		
Medical claims payable	$ 16,176	$ 15,596
Other policyholder liabilities	5,681	5,933
Unearned income	4,332	1,112
Accounts payable and accrued expenses	5,983	5,607
Short-term borrowings	—	265
Current portion of long-term debt	799	1,500
Other current liabilities	10,366	9,683
Total current liabilities	43,337	39,696
Long-term debt, less current portion	24,045	22,349
Reserves for future policy benefits	807	803
Deferred tax liabilities, net	1,779	2,015
Other noncurrent liabilities	1,971	1,562
Total liabilities	71,939	66,425
Shareholders' equity		
Common stock	2	2
Additional paid-in capital	8,830	9,084
Retained earnings	32,103	29,647
Accumulated other comprehensive loss	(2,512)	(2,490)
Total shareholders' equity	38,423	36,243
Noncontrolling interests	116	87
Total equity	38,539	36,330
Total liabilities and equity	$ 110,478	$ 102,755

Elevance Health, Inc.
Consolidated Statements of Cash Flows
(Unaudited)

(In millions)	Nine Months Ended September 30	
	2023	2022
		(Restated)
Operating activities		
Net income	$5,160	$5,011
Adjustments to reconcile net income to net cash provided by operating activities:		
Net losses on financial instruments	358	439
Equity in net earnings of other invested assets	70	(304)
Depreciation and amortization	1,321	1,202
Deferred income taxes	(361)	(183)
Impairment of property and equipment	446	—
Share-based compensation	217	191
Changes in operating assets and liabilities:		
Receivables, net	(727)	(678)
Other invested assets	(46)	46
Other assets	(936)	(465)
Policy liabilities	333	1,588
Unearned income	3,220	2,548
Accounts payable and other liabilities	1,717	598
Income taxes	257	(41)
Other, net	3	(35)
Net cash provided by operating activities	11,032	9,917
Investing activities		
Purchases of investments	(24,337)	(19,612)
Proceeds from sale of investments	7,830	9,402
Maturities, calls and redemptions from investments	14,531	7,606
Changes in securities lending collateral	55	(677)
Purchases of subsidiaries, net of cash acquired	(1,570)	(623)
Purchases of property and equipment	(970)	(854)
Other, net	(82)	(91)
Net cash used in investing activities	(4,543)	(4,849)
Financing activities		
Net proceeds from commercial paper borrowings	—	375
Net proceeds from (repayments of) short-term borrowings	(265)	(10)
Net proceeds from (repayments of) long-term borrowings	666	304
Changes in securities lending payable	(54)	685
Changes in bank overdrafts	(523)	181
Repurchase and retirement of common stock	(1,748)	(1,748)
Cash dividends	(1,049)	(924)
Proceeds from issuance of common stock under employee stock plans	112	152
Taxes paid through withholding of common stock under employee stock plans	(99)	(91)
Other, net	5	16
Net cash used in financing activities	(2,955)	(1,060)
Effect of foreign exchange rates on cash and cash equivalents	(2)	(16)
Change in cash and cash equivalents	3,532	3,992
Cash and cash equivalents at beginning of period	7,387	4,880
Cash and cash equivalents at end of period	$10,919	$8,872

Elevance Health, Inc.
Reconciliation of Medical Claims Payable

	Nine Months Ended September 30		Years Ended December 31		
	2023	2022	2022	2021	2020
(In millions)	(Unaudited)	(Unaudited)			
Gross medical claims payable, beginning of period	$ 15,348	$ 13,282	$ 13,282	$ 11,135	$ 8,647
Ceded medical claims payable, beginning of period	(6)	(21)	(21)	(46)	(33)
Net medical claims payable, beginning of period	15,342	13,261	13,261	11,089	8,614
Business combinations and purchase adjustments	—	133	133	420	339
Net incurred medical claims:					
Current year	91,058	84,177	113,414	100,440	85,094
Prior years redundancies[1]	(1,342)	(901)	(869)	(1,703)	(637)
Total net incurred medical claims	89,716	83,276	112,545	98,737	84,457
Net payments attributable to:					
Current year medical claims	77,048	70,453	98,997	88,156	74,629
Prior years medical claims	12,097	11,219	11,600	8,829	7,692
Total net payments	89,145	81,672	110,597	96,985	82,321
Net medical claims payable, end of period	15,913	14,998	15,342	13,261	11,089
Ceded medical claims payable, end of period	4	3	6	21	46
Gross medical claims payable, end of period	$ 15,917	$ 15,001	$ 15,348	$ 13,282	$ 11,135
Current year medical claims paid as a percentage of current year net incurred medical claims	84.6 %	83.7 %	87.3 %	87.8 %	87.7 %
Prior year redundancies in the current year as a percentage of prior year net medical claims payable less prior year redundancies in the current year	9.6 %	7.3 %	7.0 %	18.1 %	8.0 %
Prior year redundancies in the current year as a percentage of prior year net incurred medical claims	1.2 %	0.9 %	0.9 %	2.0 %	0.8 %

1. Negative amounts reported for net incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated.

Elevance Health, Inc.
GAAP Reconciliation
(Unaudited)

Elevance Health, Inc. has referenced "Adjusted Net Income" and "Adjusted Net Income Per Share," which are non-GAAP measures, in this document. These non-GAAP measures are not intended to be alternatives to any measure calculated in accordance with GAAP. In addition to these non-GAAP measures, references are made to the measures "Operating Revenue" and "Operating Gain." Each of these measures is provided to further aid investors in understanding and analyzing the company's core operating results and comparing Elevance Health, Inc.'s financial results. A reconciliation of Operating Revenue to Total Revenue is set forth in the Consolidated Statements of Income herein. A reconciliation of the non-GAAP measures to the most directly comparable measures calculated in accordance with GAAP, together with a reconciliation of reportable segments operating gain to income before income tax expense, is reported below. Prior amounts may be grouped differently to conform to current presentation. Net adjustment items per share may not sum due to rounding.

	Three Months Ended September 30			Nine Months Ended September 30		
(In millions, except per share data)	2023	2022	Change	2023	2022	Change
Shareholders' net income - As reported	$ 1,289	$ 1,618	(20.3)%	$ 5,131	$ 5,076	1.1 %
Impact of Accounting Standards Update 2018-12 Adoption	—	(15)		—	(47)	
Shareholders' net income - Restated	$ 1,289	$ 1,603	(19.6)%	$ 5,131	$ 5,029	2.0 %
Add / (Subtract):						
Net losses on financial instruments	124	57		358	439	
Amortization of other intangible assets	212	225		668	520	
Business optimization charges	697	—		697	—	
BCBSA litigation settlement	—	(24)		—	(24)	
Transaction and integration related costs	73	13		154	36	
Litigation expenses	2	6		5	11	
Tax impact of non-GAAP adjustments	(270)	(72)		(470)	(261)	
Net adjustment items	838	205		1,412	721	
Adjusted shareholders' net income	$ 2,127	$ 1,808	17.6 %	$ 6,543	$ 5,750	13.8 %
Shareholders' net income per diluted share - As reported	$ 5.45	$ 6.68	(18.4)%	$ 21.56	$ 20.86	3.4 %
Impact of Accounting Standards Update 2018-12 Adoption	—	(0.06)		—	(0.19)	
Shareholders' net income per diluted share - Restated	5.45	6.62	(17.7)%	21.56	20.67	4.3 %
Add / (Subtract):						
Net losses on financial instruments	0.52	0.24		1.50	1.80	
Amortization of other intangible assets	0.90	0.93		2.81	2.14	
Business optimization charges	2.95	—		2.93	—	
BCBSA litigation settlement	—	(0.10)		—	(0.10)	
Transaction and integration related costs	0.31	0.05		0.65	0.15	
Litigation expenses	0.01	0.02		0.02	0.05	
Tax impact of non-GAAP adjustments	(1.14)	(0.30)		(1.97)	(1.07)	
Net adjustment items	3.54	0.84		5.93	2.96	
Adjusted shareholders' net income per diluted share	$ 8.99	$ 7.46	20.5 %	$ 27.49	$ 23.63	16.3 %

	Full Year 2023 Outlook
Shareholders' net income per diluted share	Greater than $26.40
Add / (Subtract):	
Net losses on financial instruments	$1.50
Business optimization charges	$2.93
Transaction and integration related costs	$0.65
Litigation expenses	$0.02
Amortization of other intangible assets	$3.69
Tax impact of non-GAAP adjustments	Approximately $(2.19)
Net adjustment items	$6.60
Adjusted shareholders' net income per diluted share	Greater Than $33.00

	Three Months Ended September 30			Nine Months Ended September 30		
(In millions)	2023	2022 (Restated)	Change	2023	2022 (Restated)	Change
Income before income tax expense	$ 1,654	$ 2,127	(22.2)%	$ 6,714	$ 6,555	2.4 %
Net investment income	(493)	(371)		(1,296)	(1,112)	
Net losses on financial instruments	124	57		358	439	
Interest expense	259	213		771	622	
Amortization of other intangible assets	212	225		668	520	
Reportable segments operating gain	$ 1,756	$ 2,251	(22.0)%	$ 7,215	$ 7,024	2.7 %

Forward-Looking Statements

This document contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements reflect our views about future events and financial performance and are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan" and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various risks and other disclosures discussed in our reports filed with the U.S. Securities and Exchange Commission from time to time, which attempt to advise interested parties of the factors that affect our business. Except to the extent required by law, we do not undertake to update or revise any forward-looking statements to reflect events or circumstances occurring after the date hereof. These risks and uncertainties include, but are not limited to: trends in healthcare costs and utilization rates; reduced enrollment; our ability to secure and implement sufficient premium rates; the impact of large scale medical emergencies, such as public health epidemics and pandemics, including COVID-19, and other catastrophes; the impact of new or changes in existing federal, state and international laws or regulations, including healthcare laws and regulations, or their enforcement or application; the impact of cyber-attacks or other privacy or data security incidents or breaches or our failure to comply with any privacy or security laws or regulations, including any investigations, claims or litigation related thereto; information technology disruptions; changes in economic and market conditions, as well as regulations that may negatively affect our liquidity and investment portfolios; competitive pressures and our ability to adapt to changes in the industry and develop and implement strategic growth opportunities; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon; our ability to maintain and achieve improvement in Centers for Medicare and Medicaid Services Star ratings and other quality scores and funding risks with respect to revenue received from participation therein; a negative change in our healthcare product mix; costs and other liabilities associated with litigation, government investigations, audits or reviews; our ability to contract with providers on cost-effective and competitive terms; failure to effectively maintain and modernize our information systems; risks associated with providing pharmacy, healthcare and other diversified products and services, including medical malpractice or professional liability claims and non-compliance by any party with the pharmacy services agreement between us and CaremarkPCS Health, L.L.C.; risks associated with mergers, acquisitions, joint ventures and strategic alliances; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; possible restrictions in the payment of dividends from our subsidiaries and increases in required minimum levels of capital; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; the potential negative effect from our substantial amount of outstanding indebtedness and the risk that increased interest rates or market volatility could impact our access to or further increase the cost of financing; a downgrade in our financial strength ratings; the effects of any negative publicity related to the health benefits industry in general or us in particular; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; intense competition to attract and retain employees; risks associated with our international operations; and various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. ANTHEM, INC., Defendant.	20 Civ. 2593 (___) **COMPLAINT** JURY TRIAL DEMANDED

The United States (the "Government"), by its attorney, Geoffrey S. Berman, United States Attorney for the Southern District of New York, alleges for its Complaint as follows:

PRELIMINARY STATEMENT

1. This is a civil fraud action brought by the Government against defendant Anthem, Inc. ("Anthem") to recover treble damages sustained by, and civil penalties and restitution owed to, the Government as result of Anthem's violations of the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq*. As set forth below, Anthem knowingly disregarded its duty to ensure the accuracy of the risk adjustment diagnosis data that it submitted to the Centers for Medicare and Medicaid Services ("CMS") for hundreds of thousands of Medicare beneficiaries covered by the Medicare Part C plans operated by Anthem. By ignoring its duty to delete thousands of inaccurate diagnoses, Anthem unlawfully obtained and retained from CMS millions of dollars in payments under the risk adjustment payment system for Medicare Part C.

2. As a Medicare Advantage Organization ("MAO"), Anthem was responsible for covering the cost of services rendered by healthcare providers like hospitals and doctors' offices for the Medicare beneficiaries enrolled in Anthem's Part C plans. Anthem, in turn, received monthly capitated payments from CMS for providing such coverage. *See infra* ¶¶ 21-39.

3. Anthem understood that CMS calculated the payments to Anthem pursuant to a risk adjustment system, under which the amounts of those payments were based directly on the number and the severity of the diagnosis data — in the form of ICD diagnosis codes — that Anthem submitted to CMS. *See infra* ¶¶ 27-44. In most cases, Anthem submitted the diagnosis codes reported by providers in the claims and data that the providers submitted to Anthem to seek payments for treating Medicare beneficiaries enrolled in Anthem's Part C plans.

4. Anthem knew that, because the diagnosis codes it submitted to CMS affected payment directly, it had an obligation to ensure that its data submissions were accurate and truthful, including by complying with the ICD coding guidelines adopted by CMS regulations. *See infra* ¶¶ 45-50. Indeed, Anthem expressly promised CMS that it would "research and correct" any "discrepancies" in its "risk adjustment data" submissions and that it would comply with CMS's regulatory and contractual requirement that diagnosis codes for risk adjustment purposes must be substantiated by beneficiaries' medical records. *See infra* ¶¶ 79-82. In addition, Anthem repeatedly attested to CMS that its risk adjustment diagnosis data submissions were "accurate, complete, and truthful" according to its "best knowledge, information and belief." *See infra* ¶¶ 83-90. As Anthem knew, the promises and attestations it made to CMS placed on Anthem an obligation to make good faith efforts to delete inaccurate diagnosis codes. *See infra* ¶¶ 56-61, 70-78, 130-133.

5. Anthem's actual practices between early 2014 and early 2018 (the "relevant period"), however, were in direct contravention of its promises and attestations to CMS.

Specifically, Anthem implemented a "retrospective chart review" program using a vendor, pursuant to which they obtained medical records from providers concerning services they provided to beneficiaries enrolled in Anthem's Part C plans and the vendor then reviewed those medical records to identify all the diagnosis codes supported by the records.[1] This process was "retrospective" because it typically occurred at least several months after Anthem had submitted to CMS the diagnosis codes reported by providers. Anthem knew that the results of chart review could indicate whether or not the diagnosis codes Anthem previously submitted to CMS were accurate. More specifically, Anthem knew that the diagnosis codes it previously submitted to CMS, but which could not be substantiated by Anthem's retrospective chart review, had likely been reported inaccurately. *See infra* ¶¶ 114-127.

6. To persuade providers to supply records for review, Anthem told providers that Anthem's chart review process was an "oversight activity" that "will help ensure that the ICD9 codes have been reported accurately" and in accordance with "proper coding guidelines." *See infra* ¶¶ 108-113. That was not true. Instead, Anthem used chart reviews only to submit additional diagnosis codes to CMS while turning a blind eye to negative results where chart reviews could not substantiate the diagnosis codes that Anthem had previously submitted to CMS.

7. More specifically, although the Medicare Revenue and Reconciliation ("Medicare R&R") group at Anthem could have readily written a computer algorithm to find inaccurately reported diagnosis codes by comparing previously-submitted codes against chart review results, Anthem made no effort to do so during the relevant period. This was because Anthem viewed its chart review program only as a means to find "new revenue generating [diagnosis] codes" so that Anthem could obtain higher Medicare payments. Finding and deleting inaccurate diagnosis

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[1] In 2018, Anthem made significant changes to its chart review procedures. Specifically, it began comparing the diagnosis codes it previously submitted to CMS against the chart review results to identify potential inaccuracies.

codes, by contrast, would have reduced Anthem's revenue from Medicare. *See infra* ¶¶ 114-127.

8. Anthem made "revenue enhancement" the sole purpose of its chart review program, while disregarding its obligation to find and delete inaccurate diagnosis codes, because Anthem prioritized profits over compliance. Specifically, Anthem's one-sided chart review program, *i.e.*, focusing solely on finding additional codes to submit to CMS without also identifying and deleting inaccurate codes, often generated $100 million or more a year in additional revenue for Anthem. Indeed, as the head of the Medicare R&R group at Anthem recognized, the one-sided chart review program was "a cash cow" for Anthem because it consistently produced a "return on investment" of up to 7:1. *See infra* ¶¶ 135-146.

9. Ultimately, the extraordinary profits that Anthem obtained through its one-sided chart review program came at the expense of the public fisc. By knowingly breaching its promises and attestations to CMS, and by knowingly disregarding its regulatory and contractual obligation to correct inaccuracies in its diagnosis data submissions, Anthem improperly obtained or retained millions of dollars from CMS in violation of three FCA provisions — 31 U.S.C. §§ 3729(a)(1)(A), (a)(1)(B), and (a)(1)(G) – and under the common law. *See infra* ¶¶ 152-170.

THE PARTIES

10. Plaintiff is the United States. Through its Department of Health and Human Services ("HHS"), and more specifically through CMS, a component agency within HHS, the Government administers the Medicare Program, including, as relevant here, the risk adjustment payment system for Medicare Part C.

11. Defendant Anthem, Inc., formerly known as WellPoint, is an Indiana corporation with its headquarters at 220 Virginia Avenue in Indianapolis, Indiana. During the times relevant to this action, Anthem maintained three geographic divisions — East, Central, and West. Further, Anthem, through its subsidiaries and affiliates, operated dozens of Medicare Part C

plans across the United States. In New York, for example, Anthem operated Empire MediBlue Plus (the "Empire MediBlue Plan") – a Medicare Part C plan with the contract number H3370 – through its subsidiaries Empire HealthChoice HMO, Inc. and Empire HealthChoice Assurance, Inc. (collectively *d/b/a* Empire BlueCross BlueShield). A table of the plans operated by Anthem that are relevant to this action, the contract numbers for those plans, and the Anthem subsidiaries involved with those plans is attached as Exhibit 1 hereto.[2]

JURISDICTION AND VENUE

12. This Court has jurisdiction over the claims under the FCA pursuant to 31 U.S.C. § 3730(a) and 28 U.S.C. §§ 1331 and 1345, and it has jurisdiction over the common law claims pursuant to 28 U.S.C. § 1345.

13. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) because Anthem transacted business in this District and because a substantial part of the events giving rise to the claims herein occurred within this District. For example, Anthem operated a Medicare Part C plan, Empire MediBlue Plus, that enrolled numerous patients who reside in this District. *See supra* ¶ 11.

14. This Court may exercise personal jurisdiction over Anthem pursuant to 31 U.S.C. § 3732(a), which provides for nationwide service of process.

THE FALSE CLAIMS ACT

15. The False Claims Act was originally enacted in 1863 to address fraud on the

[2] The subsidiaries and affiliate that Anthem used to operate the Medicare Part C plans at issue and during the relevant period include, but are not limited to: Anthem Blue Cross Life & Health Insurance Co., Anthem Health Plans, Inc., Anthem Health Plans of New Hampshire, Inc., Anthem Health Plans of Kentucky, Inc., Anthem Health Plans of Maine, Inc., Anthem Health Plans of Virginia, Inc., Anthem Insurance Companies, Inc., Blue Cross of California, Blue Cross Blue Shield of Georgia, Community Insurance, Co., Compmore Health Services Insurance Corp.; Empire Healthchoice HMO, Inc., Empire Healthchoice Assurance, Inc., Healthkeepers, Inc., HMO Colorado, Inc., HMO Missouri, Inc., Rocky Mountain Hospital & Medical Services, Inc., and Unicare Life & Health Insurance Co.

Government in the midst of the Civil War, and it reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." *See* S. Rep. No. 99-345, at 1 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266.

16. As relevant here, the FCA establishes treble damages liability to the Government where an individual or entity:

> i. "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval[;]"
>
> ii. "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim[;]" or
>
> iii. "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government[.]"

31 U.S.C. §§ 3729(a)(1)(A), (a)(1)(B), and (a)(1)(G).

17. "Knowingly," within the meaning of the FCA, is defined to include a defendant acting in reckless disregard or deliberate indifference of the truth or falsity of information, as well as actual knowledge of such falsity by the defendant. *See id.* § 3729(b)(1). Further, "no proof of specific intent to defraud" is required to establish liability under the FCA. *Id.*

18. For purposes of section 3729(a)(1)(B), the FCA defines "material" as "having a natural tendency to influence, or capable of influencing, the payment or receipt of money or property." *Id.* § 3729(b)(4).

19. The FCA also defines "obligation" in section 3729(a)(1)(G) – the reverse false claims provision – to include any "established duty, whether or not fixed, arising from an express or implied contractual … relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of an overpayment." *Id.* § 3729(b)(3). This broad definition reflects Congress's intent for the reverse false claims provision to apply to non-fixed duties to

pay or repay the Government. *See* S. Rep. 111-10 at 14 (2009). In 2010, Congress further reinforced the duty on Medicare program participants like MAOs to return overpayments in a timely manner. Specifically, as part of the Patient Protection and Affordable Care Act of 2010, *see* 124 Stat. 119, 753-56 (2010), Congress added a provision to the Social Security Act that obligates MAOs like Anthem to report and return overpayments made by Medicare within sixty days of the identification of the overpayments. *See* 42 U.S.C. § 1320a–7k(d)(2). Under this provision, if an MAO makes a late report or repayment—that is a report or repayment after 60 days—it is still liable to pay treble damages and penalties under the FCA.

20. Finally, in addition to treble damages, the FCA also provides for assessment of a civil penalty for each violation or each false claim.[3] *See* 31 U.S.C. § 3729(a)(1).

THE MEDICARE ADVANTAGE PROGRAM AND ITS RISK ADJUSTMENT PAYMENT SYSTEM

A. Medicare Advantage and the Role of Part C MAOs

21. Medicare is a federally-operated health insurance program administered by CMS benefiting individuals 65 and older and the disabled. *See* 42 U.S.C. § 1395c *et seq*.

22. Parts A and B of the Medicare Program are commonly known as "traditional" Medicare. Part A covers inpatient and institutional care, while Part B covers physician, hospital, outpatient, and ancillary services and durable medical equipment. Under Medicare Parts A and B, CMS reimburses healthcare providers (*e.g.*, hospitals and physicians' offices) directly using a fee-for-service system. Specifically, healthcare providers submit claims to CMS for medical services actually rendered. CMS, in turn, pays the providers directly for each service based on payment rates established by the Government.

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[3] As adjusted by applicable laws and regulations, the range of civil penalties for FCA violations occurring between September 29, 1999, and November 1, 2015, is $5,500 to $11,000, *see* 28 U.S.C. § 2461 (notes); 64 Fed. Reg. 47,099, 47,103 (1999); and the range of civil penalties for FCA violations occurring after November 1, 2015, is $10,781 to $21,563, *see* 82 Fed. Reg. 9,131–9,136 (2017).

23. On the other hand, Medicare Part C, which is at issue in this case, involves Medicare beneficiaries who have elected to receive Part A and Part B benefits through a Medicare Advantage plan ("Part C plan" or "MA plan"). *See* 42 U.S.C. §§ 1395w-21 to 1395w-28. The MA plans, in turn, are operated and managed by MAOs, which are private insurers like Anthem. *See* 42 C.F.R. §§ 422.2, 422.503(b)(2).

24. Under Medicare Part C, beneficiaries receive healthcare services managed by those plans. More specifically, when a healthcare provider furnishes medical services to a Medicare beneficiary enrolled in an MA plan, the provider submits claims and encounter data to the MAO that operates the MA plan in order to receive payment from the MAO, instead of CMS.

25. Congress expressly delegated authority to CMS to issue rules to implement and regulate Medicare Part C. *See* 42 U.S.C. § 1395w-26(b). Pursuant to that delegation, CMS has promulgated regulations that, *inter alia*, define the MAOs' obligations and responsibilities. *See generally* 42 C.F.R. Part 422. As discussed more fully below, *see infra* ¶¶ 57-60, CMS's Part C regulations require MAOs like Anthem to implement compliance procedures and programs and to make annual attestations.

26. In addition to issuing regulations, CMS also has defined the MAOs' obligations contractually. For example, in order to participate in Medicare Part C, MAOs must execute a written agreement or a renewal of the written agreement with CMS on an annual basis for each of the Part C plans they operate. As relevant here, Anthem executed such agreements or renewals annually for all of the Part C plans it operated from 2013 to 2018.[4] Further, the terms and conditions in the Part C annual agreements/renewals that are relevant here have remained the same during that period.

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[4] Examples of such agreements are the annual Part C agreements executed by Anthem in 2014 and 2015 for its Empire MediBlue Plan, which are attached here as Exhibits 2 and 3.

B. Medicare Part C's Risk Adjustment Payment System and the Role of ICD and HCC Codes in CMS's Calculation of Risk Adjustment Payments

27. A central and distinguishing feature of Medicare Part C is how CMS determines the amount of the payments to which each MAO is entitled for providing healthcare coverage to a beneficiary enrolled in one of the MAO's Part C plans. Instead of compensating an MAO on a fee-for-service basis for specific medical services for a beneficiary, CMS makes monthly payments to the MAO in a fixed, capitated (per beneficiary enrollee in each Part C plan) amount for providing coverage for each of the Medicare beneficiaries enrolled in the Part C plan.

28. Unlike under Parts A and B, the per-member, per-month payments that CMS makes to MAOs under Medicare Part C do not depend on the amount of services provided to a specific beneficiary. Instead, the capitated rate is determined based on how the bid submitted by an MAO compares to an administratively set benchmark established under the Part C statute. *See* 42 U.S.C. § 1395w-23(a)(1)(B); 42 C.F.R. §§ 422.254, 425.304.

29. Within this system, which Congress has mandated since 2000, *see* 42 U.S.C. § 1395w-23(a)(1)(C) (directing CMS to adjust the capitated payments for each MA plan enrollee based on each enrollee's demographic factors and health status), CMS uses its risk adjustment payment system to determine the capitated payments based on the expected risk of each beneficiary.[5]

30. More specifically, CMS calculates, for each beneficiary enrolled in a Part C plan, a risk score – also known as the risk adjustment factor or "RAF" — which acts as a multiplier for

[5] Because CMS calculates and makes the monthly capitated payments to MAOs in a given payment year before CMS necessarily has received all the diagnosis data relevant to the risk-adjustment calculation, CMS also engages in a "reconciliation process" *after* the conclusion of each payment year. *See* 42 C.F.R. § 422.310(g)(2).

Through this process, CMS may conclude that "adjustments to payments are necessary" based on subsequently-submitted diagnosis data, which may result in CMS making an additional reconciliation payment to an MAO or seeking a reconciliation refund from the MAO. *See id.*

purposes of determining the capitated payment for that enrollee. *See* 42 C.F.R. § 422.308(e).[6] In other words, CMS pays MAOs more for beneficiaries with certain serious illnesses or chronic medical conditions and, thus, higher risk scores, than for beneficiaries without those conditions and, thus, lower risk scores.

31. Since 2004, CMS has employed a hierarchical condition category ("HCC") model to calculate the risk score for Medicare beneficiaries enrolled in Part C plans. As directed by Congress, the HCC model takes into account both the demographic factors and health status of Medicare beneficiaries. *See* 42 C.F.R. § 422.2.

32. Clinically, HCCs are categories of related medical diagnoses including major, severe, and/or chronic illnesses. *See id*. Between 2004 and 2013, there were 70 HCCs in CMS's Part C risk adjustment model. Starting in 2014, and after CMS revised its model, the number of HCCs increased to 79.

33. Each HCC correlates with the marginal predicted cost of medical expenditures for that set of medical conditions based on CMS's data from administering the traditional Medicare Fee-For-Service program. Some examples of HCC codes are HIV/AIDS (HCC 1), metastatic cancer and leukemia (HCC 8), congestive heart failure (HCC 80), and ischemic stroke (HCC 100).[7] Higher relative values (also sometimes referred to as relative factors, or coefficients) are assigned to HCCs that include diagnoses with greater disease severity and treatment costs.

34. A single Medicare beneficiary may have none, one, or multiple HCCs, which

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[6] To determine the *base* monthly payment amount for Medicare beneficiaries enrolled in a specific Part C plan, CMS uses a bidding process in which each Part C Plan, through its MAO, submits a bid amount. That bid is then compared to an administratively set benchmark set by CMS. *See* 42 C.F.R. Part 422, subparts F and G.

[7] HCC numerical codes changed between the 2004–2013 model (known as Version 12) and the 2014 model (known as Version 22). The numerical examples of HCC codes cited herein are from the Version 22 model.

affect the risk adjustment payment calculated by CMS according to the relative values of those HCCs and the base payment amount for a specific Medicare beneficiary.

35. To illustrate, assume that adding HCC 8 (metastatic cancer and leukemia) to a hypothetical Medicare beneficiary's list of HCCs in 2014 would have increased that beneficiary's overall risk score from 0.7 to 2.77, *i.e.*, by 2.07; and further assume that the base payment amount for this beneficiary was $10,000. In these circumstances, adding HCC 8 would have caused CMS to pay out $20,700 more in risk adjustment payments for that beneficiary in 2014.

36. To determine which HCCs are applicable to each Medicare beneficiary, CMS's HCC model relies on the diagnoses – more specifically ICD diagnosis codes – documented by medical encounters that Medicare beneficiaries have with authorized healthcare providers (*e.g.*, a visit to a doctor's office or an inpatient stay at a hospital). In other words, the ICD diagnosis codes submitted by MAOs are used by CMS to calculate the risk adjustment payment.

37. HHS has adopted the ICD Guidelines for Coding and Reporting as the standard for medical record documentation. *See* 45 C.F.R. § 162.1002(c)(2) and (c)(3) ("The Secretary [of HHS] adopts … the official ICD-10-CM Guidelines for coding and reporting"). CMS regulations, therefore, required MAOs to "submit data that conform to" the ICD coding guidelines. *See* 42 C.F.R. § 422.310(d)(1) (requiring MAOs to submit data in conformity with "all relevant national standards").

38. Practically, the ICD coding and classification system allows healthcare providers, insurance carriers and public health agencies to use alphanumeric codes to represent diagnoses. Each disease, injury, infection and symptom has its own ICD code. During the relevant times, the applicable standards for ICD coding have been set forth in two systems — first, up to October 1, 2015, the International Classification of Diseases, Ninth Revision, Clinical

Modification ("ICD-9"); and thereafter, the International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10").

39. Finally, the HCC model is prospective, meaning that it relies on risk-adjusting diagnosis codes from dates of service by a provider in one year (the "DOS year" or "date of service year") to determine payments in the following year (the "payment year"). In other words, CMS calculates the risk score for each Medicare beneficiary enrolled in Part C anew for each payment year based on the ICD codes from medical encounters that occurred in the immediately preceding year. As illustrated by the hypothetical example in paragraph 35 above, the higher a Part C beneficiary's risk score, the higher the payments by CMS to the MAO operating that beneficiary's Part C plan.

C. CMS's Risk Adjustment Payment Process and Its RAPS and EDPS Risk Adjustment Data Reporting Systems

40. In most cases, the ICD diagnosis codes reported to CMS for risk adjustment purposes originate from healthcare providers who treat Part C beneficiaries. In this scenario, the risk adjustment data is typically generated and reported in five steps.

41. First, based on a face-to-face encounter between a healthcare provider and a Part C beneficiary, the provider (the physician or a nurse) would document the encounter in the beneficiary's medical records, including the characteristics of the beneficiary's illnesses or medical conditions. Next, the provider – or, often, a coder working for the provider – would assign the diagnosis codes reflecting the beneficiary's illnesses or medical conditions in the provider's records for the beneficiary. Third, MAOs like Anthem would receive diagnosis codes from the provider. Healthcare providers can transmit diagnosis codes to an MAO when they submit claims for payment from the MAO for treating the beneficiary, in encounter records reporting the services rendered, or by alternative means (for purposes of this Complaint, diagnosis codes reported by providers to MAOs like Anthem are referred to as "provider-

reported codes"). Fourth, the MAO would in turn submit those diagnosis codes to CMS using the risk adjustment data reporting systems provided by CMS.

Finally, CMS maps each beneficiary's diagnosis codes to HCCs and then calculates each beneficiary's risk score to apply to the payment calculation.

42. During the years relevant to this action, CMS utilized two electronic systems for collecting risk adjustment diagnosis data — the Risk Adjustment Processing System ("RAPS") and the Encounter Data Processing System ("EDPS"). Up to 2014, CMS calculated risk adjustment payments based solely on the RAPS-submitted diagnosis data. Starting in 2015, CMS has calculated risk adjustment payments using a combination of RAPS and EDPS-submitted diagnosis data. The RAPS data submissions (and, after 2015, the EDPS data submissions) were claims for payment from CMS because the reported diagnosis codes factored directly into CMS's risk adjustment calculations.

43. More specifically, the data that MAOs submit through the RAPS system have several components. For example, the component known as AAA identifies the submitter, while the component known as BBB identifies the MAO. As relevant here, the CCC component contains the Medicare identification number for a particular beneficiary as well as up to ten diagnostic clusters for that beneficiary. Each cluster, in turn, contains the date on which the medical treatment occurred, the type of provider, a diagnosis code from the medical encounter, and a "Delete Indicator."[8] Because each diagnostic cluster includes a distinct diagnosis that can increase a beneficiary's risk score, each cluster is, for purposes of the FCA, a separate claim for payment.[9]

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[8] As discussed more fully below, this indicator allows MAOs to correct or withdraw a false cluster by advising CMS to delete the inaccurate diagnosis code in that cluster.

[9] In the EDPS system, MAOs similarly submit data with a number of components, known as "loops." ICD diagnosis codes are among the data that MAOs are required to submit to CMS

44. During the relevant period, CMS calculated the risk adjustment payments to be made to MAOs in three phases. First, CMS made an initial calculation based on the diagnosis data reported by MAOs for the 12-month period ending in the June before a given payment year (*e.g.*, diagnosis data from July 2011 through June 2012 for payment year 2013). *See* 42 C.F.R. § 422.310(g) (requiring MAOs to submit such diagnosis data by September). This initial calculation determined the interim monthly payments that CMS made to MAOs in the first six months of the payment year. Next, CMS recalculated the risk scores for beneficiaries enrolled in an MAO's plans based on diagnosis data for medical encounters during the year immediately preceding the payment year (*e.g.*, diagnosis data from January and December 2012 for payment 2013). Based on that recalculation, CMS would make retroactive adjustments to payments made in the first half of the payment year and also update the interim payments for the second half of the payment year. Finally, after the payment year ended, CMS provided a further opportunity for MAOs like Anthem to submit or correct the diagnosis data. Based on the additional submissions or corrections, CMS recalculated the risk scores again "to determine if adjustments to payments are necessary." 42 C.F.R. § 422.310(g)(2). If such adjustments were necessary, CMS would make the adjustments as part of the annul reconciliation process to ensure that the final payments to the MAOs were accurate. This might involve CMS making an additional payment to an MAO if the MAO submitted additional diagnosis data by the final submission deadline or involve CMS seeking a recoupment from the MAO if the MAO deleted inaccurate diagnosis codes.

D. CMS Required MAOs to Follow the "Medical Record Documentation" Standard for Part C Risk Adjustment Diagnosis Data Submissions

45. Because the accuracy and integrity of CMS's calculation of Part C risk adjustment

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using EDPS. Further, like the RAPS system, the EDPS system has mechanisms designed for MAOs to notify CMS to delete certain diagnosis codes so that CMS would not use those codes for purposes of calculating risk-adjustment payments.

payments depend on the accuracy of the diagnosis codes MAOs submit to CMS, CMS promulgated regulations regarding the coding and medical record documentation standards for risk adjustment diagnosis data. More specifically, as noted above, CMS required MAOs to "submit [diagnosis] data that conform to" the ICD coding guidelines. *See* 42 C.F.R. § 422.310(d)(1) (requiring MAOs to submit data in conformity with "all relevant national standards," which, pursuant to 42 C.F.R. § 162.1002(c), included the ICD coding guidelines); *accord* Medicare Managed Care Manual ("MMC Manual"), Chap. 7, Ex. 30 (Aug. 2004) (instructing MAOs to follow the ICD coding guidelines in submitting diagnosis codes).[10]

46. As relevant here, the ICD coding guidelines consistently provided that "accurate coding cannot be achieved" in the absence of "complete documentation in the medical record." *See*, *e.g.*, ICD-10-CM Official Guidelines for Coding and Reporting FY 2014 (the "2014 ICD-10 Coding Guidelines") at 1. This coding standard is widely understood by MAOs like Anthem, and they commonly refer to it as the risk adjustment "medical record documentation" requirement. Under this standard, a diagnosis code can be considered accurate and valid for risk adjustment purposes if it is documented in and supported by medical records for a particular encounter between a patient and a healthcare provider. *See* 2014 ICD-10 Coding Guidelines at 112 ("For accurate reporting of ICD-10[] diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses, as well as symptoms, problems, or reasons for the encounter").

47. In addition, the ICD coding guidelines also specified that a diagnosis code should not be applied if a condition is documented in the medical records as only "probable," "suspected," "questionable," one that the provider is trying to "rule out," or characterized by

[10] As noted below in paragraph 64, the annual contracts that Anthem signed with CMS each expressly required compliance with the MMC Manual. *See*, *e.g.*, Ex. 2, Art. II.A (requiring Anthem to comply with CMS policies, including, specifically, the MMC Manual).

"other similar terms indicating uncertainty." *See id*. at 113.

48. CMS has repeatedly provided training and instructions to MAOs on how to implement the medical record documentation requirement under the ICD coding guidelines. For example, CMS issued public guidance to emphasize to MAOs that they were responsible for submitting "risk adjustment data that are substantiated by the physician or provider's full medical record," *see* MMC Manual Chap. 7, § 111.8 (Aug. 2004), and to ensure that "[a]ll diagnosis codes submitted [are] documented in the medical record," *see* MMC Manual Chap. 7, § 40 (June 2013). Likewise, provisions in the MMC Manual advised MAOs that they should not submit diagnosis codes for risk adjustment purposes if the condition at issue was only probable or suspected, or questionable. *See* MMC Manual Chap. 7, Ex. 30 (Aug. 2004).

49. In addition, CMS offered trainings to MAOs on how to implement this regulatory requirement starting as early as 2003. *See* 2003 Regional Risk Adjustment Training for MAOs Participant Guide § 4.1 (MAOs "must submit risk adjustment data that are substantiated by the patient's medical record). To emphasize the importance of this requirement, and to ensure that MAOs understood it, CMS continued to provide training on this regulatory requirement in 2004, 2005, 2006, 2007, 2008, 2012, 2013, and 2014. *See* 2004 Regional Risk Adjustment Training for MAOs Participant Guide, §§ 5.1, 5.5, 6.1.3; 2005 Risk Adjustment Data Basic Training Participant Guide §§ 4.1, 5, 5.1, 5.5, 8.7.3, 9.1, 9.2; 2006 Risk Adjustment Data Basic Training for MAOs Participant Guide §§ 5.1, 5.4, 5.5, 7.7.3, 8.1, 8.2; 2007 Risk Adjustment Data Training for MAOs Participant Guide §§ 6.1, 6.4, 7.1, 7.2, 8.7.3; 2008 Risk Adjustment Technical Assistance Participant Guide §§ 5.6, 6, 6.1, 6.4, 6.5, 7.1, 7.2; 2012 Regional Technical Assistance Participant Guide § 2.2; Risk Adjustment 101 Participant Guide §§ 3.2.4; 4.3 (2013);

Risk Adjustment Webinar at p. 48 (July 1, 2014).[11]

50. Further, as MAOs do not directly provide medical care to Part C beneficiaries directly, CMS trained them to "take steps to ensure that they have, or have access to, the proper medical documentation to support diagnoses being submitted for risk adjustment." *See* 2005 Risk Adjustment Data Basic Training for MAOs § 8.7.3. More specifically, CMS explained that MAOs "are responsible for the accuracy of the data they submit to CMS" and "[w]here necessary, should obtain the proper documentation to support diagnoses and maintain an efficient system for tracking diagnoses back to medical records." *Id*. CMS reiterated those instructions to MAOs regarding their responsibility for ensuring proper medical record documentation during trainings conducted in 2005, 2006, 2007, 2008, and 2012.

E. CMS Required MAOs to Delete Diagnosis Codes That Were Not Supported by Medical Record Documentation

51. CMS recognized that MAOs may subsequently obtain information showing that diagnosis codes that the MAOs previously submitted were not valid for risk adjustment purposes, such as because such codes are not supported by medical record documentation. The duties imposed by the risk adjustment regulations, including the duty to exercise due diligence and good faith in ensuring data accuracy, 42 C.F.R. § 422.504(l), and the duty to detect and correct non-compliance with CMS's program requirements, id. § 422.503(b)(4)(vi), required MAOs to delete unsupported diagnosis codes.

52. CMS also recognized that, unless such codes were deleted or withdrawn, the inclusion of the inaccurate diagnosis codes would cause CMS to calculate – and make – higher risk adjustment payments to MAOs that it would not have made but for the submission of the inaccurate data. This, in turn, would result in the MAOs violating their regulatory and

[11] These trainings are available at: https://www.csscoperations.com/internet/cssc4.nsf/docsCatHome/CSSC%20Operations (last visited March 11, 2020).

contractual obligations, as well as attestations, to ensure the accuracy of their risk adjustment data submissions. *See infra* ¶¶ 58-90. Accordingly, CMS implemented a function in each of the risk adjustment data reporting systems – RAPS and EDPS – for MAOs to use to delete inaccurate diagnosis codes.

53. In addition to implementing the delete functions in RAPS and EDPS to enable MAOs to fulfill their regulatory obligation and attestations, CMS also provided instructions and training to MAOs on their responsibility to use this function to delete inaccurate diagnosis codes that they had submitted for risk adjustment purposes. For example, CMS instructed MAOs that if "upon conducting an internal review of submitted diagnosis codes," they "determine[] that any ICD[] diagnosis codes that have been submitted do not meet risk adjustment submission requirements," they are "responsible for deleting the submitted ICD[] diagnosis codes as soon as possible." MMC Manual, Chap. 7 § 40 (June 2013).

54. CMS also repeatedly emphasized the obligation to delete inaccurate diagnosis codes that had been submitted during trainings for MAOs. For example, in 2003, CMS provided training to MAOs that if they "identif[y] incorrect or invalid information that has been submitted, [they] must delete that information." Likewise, in 2005, CMS trained MAOs on their "responsibilities for deletions." Specifically, CMS explained that the "reasons to delete" includes where any of the "data fields" in a diagnosis code cluster submitted to RAPS "are incorrect." *See* 2005 Risk Adjustment Data Basic Training for MAOs Participant Guide §§ 4.12 to 4.16. CMS also told the MAOs that they "must delete a diagnosis [data] cluster [in RAPS] when any data in that cluster are in error." *Id*. To ensure that MAOs understood their responsibilities for making deletions, CMS provided similar trainings for MAOs in 2006, 2007, 2008, and again in 2014. *See* 2006 Risk Adjustment Data Basic Training for MAOs Participant Guide §§ 4.12 to 4.16; 2007 Risk Adjustment Data Training Participant Guide §§ 4.12 to 4.16; 2008 Risk

Adjustment Technical Assistance Participant Guide §§ 4.12 to 4.16; CMS June 2014 Risk Adjustment Webinar.[12]

55. More specifically, and as CMS explained to MAOs like Anthem, it is important for the MAOs to timely report deletions of inaccurate diagnosis codes because deletions can directly affect the accuracy of CMS's final reconciliation calculation for each payment year. As noted above, *see supra* ¶ 44, as part of its reconciliation process, CMS may make an additional payment to an MAO based on additional diagnosis codes reported before the final submission deadline or seek a recoupment if the MAO deleted inaccurate diagnosis codes.

56. Finally, to ensure that MAOs can fulfill their obligation to delete inaccurate diagnosis code submissions, CMS also promulgated regulations and configured its risk adjustment data reporting systems to allow MAOs to submit deletions both before and after the final deadline for RAPS and EDPS data submissions. *See* 42 C.F.R. § 422.310(g)(2)(ii). In other words, while MAOs ordinarily were required to make final risk adjustment diagnosis data submissions by a specific deadline prior to receiving their final reconciliation payments for a given payment year, CMS required MAOs to delete inaccurate diagnosis codes that had been previously submitted even *after* that deadline. This, in turn, enabled CMS to recover risk adjustment payments associated with the deleted diagnoses as part of CMS's risk score rerun processes. In the Medicare Part C context, diagnosis deletions reported before the deadline are known among the MAOs as "open-period deletes," while diagnosis deletions reported after the deadline are known as "closed-period deletes."

[12] These trainings are available at: https://www.csscoperations.com/internet/cssc4.nsf/docsCatHome/CSSC%20Operations (last visited March 11, 2020).

TO ACCURATELY CALCULATE PART C RISK ADJUSTMENT PAYMENTS, CMS IMPOSED REGULATORY AND CONTRACTUAL OBLIGATIONS ON PART C MAOS – INCLUDING ANTHEM – TO ENSURE THE ACCURACY OF THEIR DIAGNOSIS CODES AND TO DELETE INACCURATE CODES

57. CMS promulgated regulations and annual agreements to define the obligations of MAOs under Medicare Part C. As set forth below, among the most important regulatory and contractual obligations of the MAOs are those pertaining to their responsibilities for ensuring the accuracy of the risk adjustment diagnosis data that they submit to CMS and for deleting inaccurate data that they previously submitted.

A. CMS Regulations Required MAOs Like Anthem to Implement Compliance Procedures to Ensure the Accuracy of Their Risk Adjustment Diagnosis Data Submissions

58. Throughout the relevant period, CMS required MAOs to implement effective compliance programs and defined this requirement as a prerequisite to MAOs obtaining and retaining payments under Part C. *See* 42 U.S.C. § 422.503(a). As CMS explained as early as June 2000, one purpose of requiring MAOs to implement compliance programs is to ensure that the information they submit to CMS is accurate and truthful. *See* 65 Fed. Reg. 40170-01 at 40264 (June 29, 2000).

59. At the outset, CMS's Part C regulations require MAOs – including Anthem – to "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [] program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi).

60. CMS's Part C regulations specify that the compliance program that MAOs like Anthem are required to implement "must, at a minimum, include [certain] core requirements," which include, as relevant here:

- To establish and implement "an effective system for routine monitoring and identification of compliance risks," which "should include internal monitoring and audits and, as appropriate, external audits," to evaluate the MAO's

"compliance with CMS requirements and the overall effectiveness of the compliance program."

- To establish and implement "procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements."

Id. § 422.503(b)(4)(vi)(E)-(F).

61. In the event that an MAO like Anthem uncovers "evidence of misconduct related to payment," CMS's Part C regulations require the MAO to "conduct a timely, reasonable inquiry into that conduct" and to undertake "appropriate corrective action," including "repayment of overpayments" in response. *Id.* § 422.503(b)(4)(vi)(G). CMS's Part C regulations also required Anthem and other MAOs to "have procedures to voluntarily self-report potential fraud or misconduct related to [the Part C] program to CMS or its designee." *Id.*

B. <u>Anthem and Other MAOs Assumed the Obligation to Ensure the Accuracy of Their Risk Adjustment Data Submissions and to Delete Inaccurate Data by Executing Part C Annual Agreements with CMS</u>

62. In addition to being subject to regulatory requirements, MAOs like Anthem also agreed in their Part C annual agreements to be responsible to CMS for ensuring the accuracy of their risk adjustment diagnosis data submissions.

63. As relevant here, each time Anthem executed a Part C annual agreement, it affirmatively accepted the obligation to ensure that "the risk adjustment data it submits to CMS [for Part C purposes] are accurate, complete, and truthful." *See* Ex. 2, Art. IV.D.2; *see also* Ex. 3, Art. IV.D.2 (same). Relatedly, and in accordance with CMS regulations, *see* 42 C.F.R. § 422.510, the Part C annual agreement also specified that CMS could terminate Anthem's participation in Medicare Part C if CMS determined that Anthem had submitted false data or

"fail[ed] to provide CMS with valid risk adjustment data." *See* Ex. 2, Art. VIII.B.1(a).

64. By executing Part C annual agreements, Anthem and other MAOs also agreed to comply with CMS's requirements relating to the submission of diagnosis codes.[13] Specifically, Anthem agreed to operate its MA plans "in compliance with the requirements of [] applicable Federal statutes, regulations, and policies" and to "implement a compliance plan in accordance with [42 C.F.R.] § 422.503(b)(4)(vi)." *See*, *e.g.*, Ex. 2, Art. II.A and Art.III.F. The Part C annual agreements further define the applicable federal policies as including, among other things, the "Medicare Managed Care Manual." *Id*. Art. II.A

65. In other words, by executing its Part C annual agreements, Anthem affirmatively assumed the obligation not only to follow CMS regulations requiring compliance with the ICD coding guidelines, including the medical record documentation standard, but also to comply with the requirement that MAOs affirmatively assess the accuracy of their diagnosis data submissions against the ICD coding guidelines and the medical record documentation standard.

66. During the relevant period, Anthem was well aware of its contractual obligation to submit diagnosis data in accordance with CMS's requirements. For example, in August 2010, Anthem distributed an "outreach and education" bulletin to physicians and other healthcare providers entitled "Risk Adjustment 101."[14] In that bulletin, Anthem explained that "CMS uses documentation from [beneficiary's] medical record to validate that the appropriate ICD-9 code has been assigned" and that "[i]f the medical record does not support the reported ICD-9 code, CMS may adjust [] payments" to the Part C plans. *See* Ex. 4. Anthem further explained that

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[13] In this regard, the Part C annual agreement further specified that"[a]s a condition of receiving a monthly payment under" the agreement, MAOs like Anthem would "request payment … on the forms attached" to the contract, including "Attachment B," which required the MAO to certify the "accuracy, completeness, and truthfulness" of the risk adjustment data submitted to CMS. *See* Ex. 2, Article IV.C.

[14] A copy of this bulletin is attached here as Exhibit 4.

providers could "help [it] meet [its] reporting requirements and obligations to CMS" by "supplying Anthem with the most accurate and complete diagnosis coding[.]" *Id.*

67. Anthem also understood that relevant sections of the MMC Manual and CMS's trainings reflected the controlling requirement for risk adjustment diagnosis coding. When it issued an internal coding manual in 2015, for example, Anthem instructed its staff that "when coding medical records on behalf of Anthem (formerly WellPoint) for Medicare Advantage Risk Adjustment purposes," they should "refer to" the "Official ICD … Coding Guidelines," "CMS 2008 Risk Adjustment Participant Guide," CMS's 2013 "Risk Adjustment 101 Participant Guide," "Chapter 7 [of] the Medicare Managed Care Manual," and one other training as the sources of "official coding rules and regulations." *See* Medicare Advantage Risk Adjustment Programs (the "2015 Anthem Coding Manual") at 4 (relevant excerpts from this internal Anthem manual are attached here as Exhibit 5).

68. More specifically, Anthem knew that the ICD coding guidelines required particular types of evidence in the medical records to support specific medical conditions like diabetes with complications or active forms of cancer. For example, because providers "may document cancer in historical terms," proper coding requires a determination of "whether the malignancy should be coded [as] history, using a V-code, or [as] current." *See* 2015 Anthem Coding Manual (Ex. 5) at 18. To "code current malignancy," therefore, required medical record documentation that "show clear presence of current disease." *Id.*

69. Similarly, the 2015 Anthem Coding Manual also specified that "in order to select a code from HCC categories 15-18," which represent diabetes with various types of complications, there "must be a documented cause-and-effect relationship between diabetes and the associated manifestation." *Id.* at 21. Accordingly, if the medical record "documentation

does not properly link the two conditions," a coder must "default to diabetes without complication code 250.0x (HCC 19)." *Id.*

70. In addition, by executing the Part C annual agreements, Anthem agreed to abide by CMS's requirement for MAOs to delete inaccurate diagnosis codes that they previously submitted. *See* Ex. 3, Art. II.A. As discussed above, *see supra* ¶¶ 51-56, CMS issued public guidance to Anthem and other MAOs that, as part of their regulatory obligation to ensure the accuracy of risk adjustment data, they were "responsible for deleting the submitted ICD[] codes as soon as possible" whenever they "determine[] that any IC[] diagnosis codes that have been submitted do not meet risk adjustment submission requirements." *See* MMC Manual, Chap. 7 § 40 (June 2013).

71. Anthem, in turn, understood both how to use the delete function in the RAPS and EDPS reporting systems and when it was appropriate for Anthem to delete diagnosis codes.

72. In the first regard, Anthem implemented procedures that allowed it to implement deletions of previously-submitted RAPS and EDPS diagnosis data submissions and to track the status of such deletion efforts. For example, as described in a report from Anthem's Internal Audit department, the "management" of the Medicare R&R group at Anthem "created delete files for submission [to CMS]" when they decided to make certain deletes in response to an audit by CMS in 2013.

73. In the second regard, and as Anthem's chief compliance officer acknowledged, Anthem understood that it would "be appropriate to submit deletes" of diagnosis codes previously submitted to CMS "if Anthem became aware that one of the codes … was not supported by the medical record."

74. More specifically, based on trainings from CMS as well as its own experience as a major health insurance company, Anthem was well aware of several circumstances that could

lead to the presence, in the claims that Anthem received from providers, of inaccurate diagnosis codes that were unsubstantiated by medical record documentation.

75. For example, Anthem knew that many of the diagnosis codes in the claims data it received from providers were likely to be inaccurate due to the high frequency of provider coding errors. In a November 2012 e-mail, for example, a compliance manager in Anthem's Medicare R&R group explained to a senior Anthem executive that "we also know that physicians do not always code accurately" and that "the assignment of improper dx [diagnosis] codes" was one of the "[c]ommon errors."

76. Further, Anthem's own coding policies and procedures identified a number of specific medical conditions as ones that were generally known to be subject to frequent inaccurate coding. In an internal policy from 2014, for example, Anthem referred to several conditions and HCCs – including, for example, "Cancer (HCC 7/8, 8/9, 9/10, 10/11, 11/12)" and "DM [diabetes mellitus] with Complication" – as "Red Flag HCCs." According to Anthem, this classification was applied because those "are conditions targeted by CMS or that have a high probability of coding error."

77. In addition, Anthem also had so-called "capitated reimbursement" relationships with certain healthcare providers during the relevant period. Under these arrangements, which also are known as "revenue-sharing" or "profit-sharing" relationships, Anthem shared a percentage of its Medicare Part C risk adjustment payments with the contracted providers. To illustrate, if Anthem had a capitated relationship with a physicians' group with a 50-50 revenue split, and Anthem received $100,000 in risk adjustment payments from CMS based on the diagnosis codes submitted by the physicians' group, Anthem would then pay $50,000 to that physicians' group pursuant to their arrangement.

78. Anthem understood that its "capitated" or "profit-sharing" relationships with providers created a strong financial incentive for those providers to over-report diagnosis codes both in terms of the number and the severity of reported medical conditions for Part C beneficiaries. Thus, Anthem's internal risk assessments during the relevant period – such as the "2015 Risk Chart" for its Medicare R&R group – identified the "capitated" provider relationships as a "key" reason for classifying the risk of Anthem's "submitting diagnosis data for risk adjustment that is not accurate and/or supported in the medical record" as "High."

C. Pursuant to Their EDI Agreements with CMS, MAOs Like Anthem Agreed to Comply with the Obligation to "Research and Correct" Risk Adjustment Data Discrepancies

79. As a condition for using the RAPS and EDPS systems to submit risk adjustment diagnosis data to CMS for risk adjustment payments, MAOs must execute Electronic Data Interchange ("EDI") agreements with CMS.

80. In these agreements, Anthem and other MAOs expressly agree to assume a number of specific obligations relating to their risk adjustment data submissions, including the obligation to "research and correct risk adjustment data discrepancies." *See* EDI Enrollment Form stamped May 23, 2004 ("A. The Eligible Organization Agrees: … 11. That it will research and correct risk adjustment data discrepancies.") (attached as Exhibit 6).

81. During the relevant period, executives at Anthem executed multiple EDI agreements in which Anthem expressly agreed to "research and correct risk adjustment data discrepancies." *See* EDI agreement dated October 11, 2013; EDI agreement dated December 2, 2015 (attached as Exhibits 7 and 8).

82. Further, according to its chief compliance officer, Anthem understood that the types of "data discrepancies" that it was responsible for researching and correcting pursuant to its EDI agreements included situations where medical record review indicated Anthem had submitted a diagnosis code that inaccurately depicted a beneficiary's medical condition, such as

a mis-transcription resulting in switched digits in an ICD code (*e.g.*, 250 vs. 205).

D. MAOs Like Anthem Submitted Annual Attestations to CMS to Certify That Their Risk Adjustment Diagnosis Data Submissions Were "Accurate" to Their "Best Knowledge, Information, and Belief"

83. Medicare Part C regulations require MAOs like Anthem to submit annual attestations to CMS for each of their Part C plans that, among other things, certify the accuracy of the risk adjustment diagnosis data they submitted for the relevant payment year. *See* 42 C.F.R. § 422.504(l). The Part C regulations further specify that the MAO's submission of their annual attestations is "a condition for receiving the monthly [capitated] payment" from CMS. *Id.*

84. In addition to being a regulatory requirement, the MAOs' obligation to submit annual attestations regarding the accuracy and truthfulness of their risk adjustment diagnosis data is also specified in the Part C annual agreements that they execute with CMS. *See*, *e.g.*, Ex. 3, Art. IV.D.2

85. Here, Anthem understood that its receipt of risk adjustment payments from CMS was conditioned on its submission of the annual attestations to CMS in compliance with the Part C regulations and the annual agreement provisions.

86. In 2015, for example, the director of regulatory compliance for Anthem's Medicare R&R group approved a policy to "document the process related to the submission of the annual Risk Adjustment Attestation as required by [CMS]." The policy explained that "CMS requires that each MAO attest to the validity and accuracy of [its] Risk Adjustment Data for the previous Payment Year." This Anthem policy also recognized that submission of the attestation is a prerequisite "[i]n order for [Anthem's] Risk Adjustment data to be included in CMS's run of the Risk Adjustment Model," which determines the final payment to Anthem.

87. During the relevant period, senior Anthem executives – including the then-President of Anthem's Medicare business – signed and submitted annual attestations to CMS

each year for the Part C plans operated by Anthem. Anthem submitted those annual attestations after the final submission deadline for reporting diagnosis data for each payment year.

88. In each of these annual attestations, the executives certified that Anthem understood that the risk adjustment information it submitted to CMS "directly affects the calculation of CMS payments to [Anthem]" and that "misrepresentation to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution." *See* Attestation of Risk Adjustment Data dated June 26, 2015 (attached hereto as Exhibit 9). Having "acknowledge[d]" that understanding, the Anthem executives further certified that "all information submitted to CMS" by Anthem for risk adjustment payment purposes "is accurate, complete, and truthful" according to Anthem's "best knowledge, information, and belief." *Id.*

89. As CMS repeatedly notified MAOs since June 2000, the purpose of the annual attestation requirement is to place the responsibility on MAOs like Anthem to make "good faith efforts to certify the accuracy" of the risk adjustment data they submitted. *See* 65 Fed. Reg. 40,170, 50,268 (June 29, 2000); *see also* MMC Manual Chap. 7, § 111.7 (2004) ("CMS expects [MAOs] to design and implement effective systems to monitor the accuracy, completeness, and truthfulness of risk adjustment data and to exercise due diligence in reviewing the information provided to CMS").

90. Anthem, in turn, understood its obligation to make "good faith efforts" and "exercise due diligence" to ensure the accuracy of its risk adjustment diagnosis data submissions to CMS. In July 2010, for example, Anthem distributed a "provider announcement" to hospitals and physicians acknowledging that "CMS requires that we [Anthem] perform oversight activities related to the collection and reporting of [beneficiary] diagnosis data which must be supported by medical record documentation."

THE GOVERNMENT'S EXTENSIVE EFFORTS TO ENSURE THE INTEGRITY AND ACCURACY OF MEDICARE PART C RISK ADJUSTMENT PAYMENTS

A. CMS Sample Audits of Risk Adjustment Data Submissions

91. Since the early 2000s, CMS has conducted audits of diagnosis codes submitted by MAOs, known as Risk Adjustment Data Validation ("RADV") audits.

92. In 2001, CMS alerted MAOs that they were "required to submit medical records for validating encounter data" and that "[m]edical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information." *See* MMC Manual, Chapter 7, § 110.3 (October 2001). In 2004, CMS updated its public guidance to MAOs by explaining that "[a] sample of risk adjustment data used for making payments may be validated against hospital inpatient, hospital outpatient, and physician medical records to ensure the accuracy of medical information. Risk adjustment data will be validated to the extent that the diagnostic information justifies appropriate payment under the risk adjustment model." *See* MMC Manual, Chapter 7, § 111.8 (August 13, 2004).

93. To facilitate its audit of risk adjustment diagnosis data, CMS promulgated a regulation to require MAOs as well as healthcare providers who render care to Part C beneficiaries to supply the underlying medical records to CMS for use in RADV audits of risk adjustment diagnosis code submissions. *See* 42 C.F.R. § 422.310(e).

94. For each audit, CMS selected a *sample* of enrollees in an MAO's Part C plans and reviewed the medical records for those enrollees to determine if the diagnosis codes submitted by the MAOs were supported by those records.

95. For the payment year 2007 audits, CMS calculated the amounts by which the Part C MA plans were overpaid as result of the inaccuracies and sought refunds from the plans. *See*, *e.g.*, Medicare Advantage RADV Audits Fact Sheet at 1 ("CMS recouped $13.7 million in

overpayments associated with sampled beneficiaries" as result of its RADV audits of Part C MA plans for payment year 2007).[15]

96. As relevant here, CMS has conducted RADV audits of Part C MA plans operated by Anthem. For payment year 2007, RADV audits of four such MA plans resulted in Anthem refunding CMS more than $800,000 in overpayments. S*ee id*. at 2 (refunds associated with plans H0540, H0564, H1849, and H3655).[16]

97. In addition to allowing CMS to recoup overpayments, the RADV audits also highlighted for Anthem and other MAOs that a material percentage of the diagnosis codes they submitted to CMS were inaccurate. For example, as an internal Anthem report shows, CMS's payment year 2012 RADV audits showed Anthem that its risk adjustment diagnosis code submissions to CMS had an error rate of 9.6%, which was higher than the national error rate.

B. <u>The Government Has Actively Enforced the Requirement for Accurate Risk Adjustment Diagnosis Data Submissions</u>

98. Further, because the accuracy of risk adjustment diagnosis data submissions directly impacts the integrity of the risk adjustment payment system, the Government has sought to enforce the requirement for data accuracy by actively pursuing legal remedies against both MAOs that have knowingly submitted inaccurate and untruthful diagnosis data to CMS and healthcare providers that knowingly caused MAOs to submit inaccurate and untruthful diagnosis data to CMS.

99. In August 2012, for example, the Government obtained $3.82 million in settlement from SCAN Health Plan, a Long Beach, California-based managed care company,

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[15] This fact sheet is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Fact-Sheet-2013.pdf (last visited March 11, 2020).

[16] As noted above, CMS selected a *sample* of diagnosis codes for each RADV audit. RADV audits did not, and are not intended to, review all or significant percentage of the diagnosis codes submitted by MAOs to CMS.

based on allegations that SCAN had used outside vendors to review medical charts of SCAN's Part C beneficiaries to identify new diagnosis codes for SCAN to submit to CMS, but had failed to disclose to CMS that chart review results also indicated that some of the previously-submitted diagnosis codes might need to be deleted, which enabled SCAN to improperly obtain higher risk adjustment payments from CMS.

100. Further, in May 2017, the Government obtained a $32.5 million settlement from Freedom Health, Inc., a Tampa-based MAO, in connection with a *qui tam* action involving allegations that Freedom Health had submitted unsupported diagnosis codes to CMS on behalf of two Part C plans and thereby obtained inflated risk adjustment payments. In addition to paying the Government to settle these allegations, Freedom Health also agreed to be subject to a Corporate Integrity Agreement that included procedures for "determin[ing] whether Freedom properly submitted risk adjustment eligible diagnoses to CMS in accordance with CMS's rules and criteria under the Medicare Advantage Program." *See* Corporate Integrity Agreement, App. C at 1 (available at https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp).

101. In addition, in October 2018, the Government obtained a $270 million settlement from DaVita Medical Holdings LLC, a healthcare provider. This settlement was based in part on allegations that DaVita had given improper coding guidance to its employees so that they would record inaccurate diagnosis codes to MAOs in order to boost its payments under revenue-sharing or capitated arrangements with MAOs and that DaVita had hired coding companies to perform retrospective chart reviews to identify new diagnosis codes to report to MAOs for submission to CMS, but did not take corrective action with respect to previously submitted codes that could not be substantiated by chart review. More specifically, DaVita's alleged misconduct caused CMS

to overpay the MAOs based on inaccurate diagnosis codes from DaVita and, in turn, enabled DaVita to receive higher cost-sharing payments from the MAOs.

102. Likewise, in August 2019, the Government obtained a settlement against Beaver Medical Group, L.P., a California-based physician group, based on allegations that, to increase its payments from MAOs pursuant to revenue-sharing arrangements, Beaver had knowingly submitted diagnoses that were not supported by the medical records, and thereby caused CMS to calculate risk adjustment payments based on inaccurate diagnosis data.

ANTHEM USED ITS CHART REVIEW PROGRAM SOLELY TO OBTAIN HIGHER PAYMENTS FROM CMS AFTER HAVING MISREPRESENTED THAT PROGRAM AS AN "OVERSIGHT ACTIVITY" THAT WOULD IMPROVE THE ACCURACY OF ANTHEM'S RISK ADJUSTMENT DATA SUBMISSIONS

A. Anthem's Procedures for Submitting to CMS the Diagnosis Codes That It Collected from Providers' Claims

103. Anthem relied on the diagnosis codes contained in the insurance claims submitted by healthcare providers who treated Anthem's Part C beneficiaries as the primary source of the diagnosis data it submitted to CMS for risk adjustment purposes.

104. During the relevant period, the Medicare R&R group at Anthem referred to the provider-reported diagnosis codes as the "internal source data." Within Anthem, the data team in the Medicare R&R group was responsible for collecting these diagnosis codes after they had been uploaded electronically to a shared site by the three geographic business divisions at Anthem — East, Central and West.

105. Once the data team in Anthem's Medicare R&R group received the diagnosis code uploads from the business divisions, it would run computer algorithms to compare the newly-uploaded data against diagnosis data that Anthem previously submitted to CMS, to look for duplicative entries. If the computer algorithms found exact duplicates, the data team would remove those entries. The data team also was responsible for configuring the diagnosis data submissions in formats that would be accepted by the RAPS and, starting in 2012, the EDPS

systems.

106. After those steps, the data team in Anthem's Medicare R&R group submitted electronic data files, which contained the provider-reported diagnosis codes, to CMS using the RAPS and, starting in 2012, the EDPS systems.

107. During the relevant period, and as discussed above, Anthem not only understood that providers "do not always code accurately" as a general matter, but also had specific notice that its own diagnosis code submissions contained a significant percentage of inaccuracies. *See supra* ¶¶ 74–78. Yet, Anthem did not implement any regular procedure or process during the relevant period to audit, review, or monitor whether the diagnosis codes it was submitting to CMS were in fact supported by the underlying medical records. More specifically, Anthem did not check the accuracy of its diagnosis code submissions before sending them to CMS, and Anthem did not have any regular procedure for checking those codes after they were submitted.

B. To Encourage Providers to Supply Records for Chart Review, Anthem Asserted That Its Chart Review Program Would Be an "Oversight Activity" Designed to Verify the Accuracy of Previously-Submitted Diagnosis Codes Based on Provider Claims

108. From 2007 to 2010, Anthem had operated a limited chart review program. In 2010, Anthem decided to significantly expand its chart review program. To that end, Anthem retained a vendor called Medi-Connect and tasked it with contacting healthcare providers to obtain the medical records to review as well as reviewing and coding these records.

109. To induce healthcare providers to supply records for chart review, executives at Anthem's Medicare R&R group created "FAQs" (frequently asked questions), "talking points," and "provider announcement" flyers in late June 2010. In these communications, Anthem informed providers that its chart review program was "an oversight activity" and that a key purpose of this program was to verify the accuracy of the "ICD9 codes [that] have been reported by the provider[s]."

110. For example, the FAQs told providers that Anthem's chart review program would serve *two functions* within the Part C risk adjustment framework – one, to identify diagnosis codes that providers may have missed so that Anthem would "submit all ICD 9 codes for [its] Medicare Advantage members"; and, "in addition," to "ensure that ICD9 codes have been reported by the provider correctly," meaning that there was "medical record documentation support" and that "proper coding guidelines were followed." *See* FAQ's Regarding Retrospective Medical Record Review and Medi-Connect Global at 1 (attached as Exhibit 10).

111. To underscore Anthem's representation that its chart review program would involve verifying the *accuracy* of provider-reported ICD9 codes, the FAQs also characterized the chart review program as "an oversight activity related to" whether "the collection and reporting of [Part C beneficiaries'] diagnosis data" were "supported by medical record documentation as required by CMS." *Id*.

112. Anthem's FAQs further asserted that providers were "required to comply with [Medi-Connect's] request for medical records" pursuant to CMS's policies. *See id*. at 3. Specifically, Anthem reiterated that "the [chart] review process will help ensure that ICD9 codes have been reported *accurately*." (emphasis added).

113. The "provider announcement" flyers that Anthem distributed to providers about its chart review program likewise touted the program as an "oversight activity" designed to improve the accuracy of diagnosis data. Specifically, the flyers represented that Anthem "engaged Medi-Connect [as a vendor] to perform retrospective review of [] medical records" to fulfill the "CMS require[ment] that [Anthem] perform oversight activities related to" whether diagnosis data reported to CMS were "supported by medical record documentation." *See* Provider Announcement dated July 1, 2010 (attached hereto as Exhibit 11). The flyers further

advised providers that cooperating with Medi-Connect's "record retrieval" requests would "help[] Anthem ensure risk adjustment payment integrity and accuracy." *Id.*

C. In Practice, Anthem Treated Chart Review Solely as a "Revenue Enhancement Program" and Chose Not to Use Chart Review Results to Verify the Accuracy of Previously-Submitted Diagnosis Codes Based on Provider Claims

114. Contrary to what it communicated to healthcare providers in the FAQs and flyers, Anthem did not use the results of its chart review program to verify that "ICD9 codes have been reported accurately," *see* Ex. 10 at 3, or to "ensure risk adjustment payment integrity and accuracy," *see* Ex. 11. Instead, Anthem treated chart review only as a "revenue enhancement program." More specifically, Anthem used this program *solely* to find additional diagnosis codes to submit to CMS and thereby obtaining higher risk adjustment payments, and *not* – as it had told providers – to determine whether previously-submitted diagnosis codes had been reported accurately or inaccurately.

115. For example, Anthem instructed Medi-Connect to focus its chart review and coding efforts on finding "all possible new revenue generating codes" for Anthem.

116. Once Medi-Connect obtained medical records from providers to review, its instruction from Anthem was to have its certified coders conduct an initial round of "cold coding" – meaning that the coders would review the medical records and extract ICD codes without knowing what ICD codes Anthem had previously sent to CMS – of all the records.

117. What Medi-Connect did next with the codes extracted during this initial round of coding depended entirely on whether a given code could be submitted to CMS to generate an additional risk adjustment payment for Anthem. Specifically, for the "newly identified ICD codes which are new revenue-generating," Anthem directed Medi-Connect to have its coders conduct a second round of review of the relevant medical records.

118. The purpose of this further review, as Anthem told Medi-Connect, was to check that "the initial coders did in[]fact identify all mapped HCCs." In other words, Anthem did not want to leave out any diagnosis code that could lead to a revenue-generating HCC for itself.

119. In addition, while Anthem allowed Medi-Connect's coders to use "issue flags" to identify documentation mistakes in the medical records they reviewed, whether those issue flags served any function again depended wholly on whether they could benefit Anthem financially for risk adjustment purposes.

120. Specifically, when "new revenue generating" codes were at stake, Anthem told Medi-Connect to conduct a second round of review of the flagged records with the goal of finding "all possible new revenue generating codes" that met the medical record documentation standard set forth in the ICD coding guidelines.

121. By contrast, if the "issue flags" did not implicate "new revenue generating codes," Anthem did not ask Medi-Connect to take any step to determine whether the flagged records supported or would not support the diagnosis codes that Anthem had already reported to CMS for risk adjustment purposes. As Anthem was well aware, deleting inaccurate diagnosis codes that had been submitted to CMS previously not only would generate no new revenue, but also could lead CMS to lower risk adjustment payments or even seek recoupment from Anthem.

122. Besides how it defined the scope of Medi-Connect's responsibilities within Anthem's chart review program, Anthem also configured its internal procedures to ensure that chart review would be used solely for revenue generation purposes.

123. Specifically, as they received the chart review results from Medi-Connect, the data team in Anthem's Medicare R&R group would run a computer algorithm in the SAS software system to compare the diagnosis information in Medi-Connect's results against the diagnosis information that Anthem had previously submitted to CMS. This comparison enabled

the data team to gather all of the newly-identified diagnosis codes that could generate additional risk adjustment payments for Anthem. Anthem then had its internal coding teams review those new diagnosis codes to ensure that they satisfied CMS's submission requirements. Finally, Anthem submitted to CMS the codes that its internal coding terms found to be consistent with CMS's requirements.

124. By contrast, Anthem did *not* have any process during the relevant period to compare the diagnosis codes that Anthem previously submitted to CMS against Medi-Connect's chart review results for the same visits by the same patients, so as to identify diagnosis codes that had previously been submitted but were not identified by Medi-Connect (and thus were likely inaccurate). Anthem did not run this comparison during the relevant period even though, as the director of the data team at Anthem's Medicare R&R group admitted under oath, Anthem's programmers were fully capable of writing an SAS database algorithm to do such a comparison.

125. As Anthem understood, taking the simple step of running this comparison would have shown which of Anthem's previously-submitted diagnosis codes could not be substantiated through the chart review process. For example, such a comparison would have revealed instances where Anthem submitted to CMS diagnosis codes in provider claims that were inaccurate due to transcription errors, including when someone had mistakenly entered ICD code 250 (diabetes) as 205 (leukemia). As Anthem's Chief Compliance Officer recognized, identifying such errors would have fulfilled the promise that Anthem made to CMS in EDI agreements to "research and correct risk adjustment data discrepancies."

126. Similarly, by taking the simple step of comparing its previously-submitted codes against chart review results, Anthem would have identified instances where a diagnosis of diabetes with complications was inaccurate because the underlying medical record "d[id] not properly link" the patient's diabetes with the supposed complications, *see* Ex. 5 at 21 (Anthem'

internal coding manual instructing coders to "default to diabetes without complication code" if the medical records do not show such a link), *see also infra* ¶ 148.a (example where Medi-Connect's results identified an inaccurate diagnosis of diabetes with complications. Such a comparison also would have identified, for example, situations where an active form of cancer diagnosis in a provider claim was inaccurate because the underlying medical records did not "show clear presence of current disease," rather than a history of cancer, *see* Ex. 5 at 18, *see also infra* ¶ 148.b (example where Medi-Connect's results identified an inaccurate diagnosis of active cancer).

127. As Anthem knew, identifying and deleting such inaccuracies in its diagnosis code submissions could lead CMS to calculate lower risk adjustment payments to Anthem. So it did not make an effort to do so. Instead, Anthem allowed inaccuracies to remain in its diagnosis code submissions. For example, and as Anthem understood, in the scenario where a medical assistant mistakenly typed ICD9 code 250 (diabetes) as 205 (leukemia) into a claim, and where Medi-Connect's coders correctly identified code 250, instead of 250, as the correct diagnosis, Anthem's practice during the relevant period was to report both 205 and 250 for the same patient, instead of checking to see which code was accurate. This practice inevitably led to inflated risk adjustment payments for Anthem because caused CMS was making its calculations based on inaccurate diagnosis data.

ANTHEM KNOWINGLY DISREGARDED ITS OBLIGATION TO DELETE INACCURATE DIAGNOSIS CODES BECAUSE IT PRIORITIZED PROFITABILITY OVER COMPLIANCE

128. Anthem's failure to comply with its contractual and regulatory obligations was not due to ignorance or mistake. As detailed below, Anthem understood the structure of the risk adjustment payment system and its responsibilities as an MAO, including, specifically, (a) the direct impact that diagnosis data has on CMS's risk adjustment payment calculations, (b) Anthem's obligation to ensure the accuracy of its diagnosis data submissions to CMS, (c) the

presence of substantial numbers of inaccuracies in the diagnosis codes that Anthem was submitting to CMS based on provider claims, (d) Anthem's obligation to research and correct data discrepancies, and (e) Anthem's duty to delete previously-submitted diagnosis codes that proved to be inaccurate. *See infra* ¶¶ 130–134.

129. Rather, Anthem intentionally chose to structure chart review in contravention of the representations it made to healthcare providers and its regulatory and contractual obligations because it decided to prioritize profits over its compliance obligations. Anthem saw its chart review program not as an "oversight activity" — as it had told providers —but rather as "a cash cow" for Anthem itself. *See infra* ¶¶ 135–146.

A. <u>Anthem's Understanding of Its Obligation to Identify and Delete Inaccurate Codes</u>

130. During the relevant period, Anthem was well aware of the direct effect that diagnosis data had on the risk adjustment payments that Anthem received from CMS. For example, the 2015 Anthem Coding Manual used formulas to describe the relationship among diagnosis codes, the patient's risk score, and the risk adjustment payment amount. Specifically, it explained that the risk score was calculated using "disease data … in the form of diagnosis codes" as follows:

Risk Score = (demographics) + (disease) + (disease) + (disease)

The manual further explained that CMS, in turn, calculated the payment to Anthem using the risk score and a base payment rate:

Total Payment = Base Payment x Risk Score

131. Anthem also understood that, as an MAO, it had the obligation to ensure the accuracy of the diagnosis data that CMS used to calculate the risk adjustment payments. For example, Anthem unequivocally acknowledged that it had the obligation to "perform oversight activities" and to "ensure risk adjustment payment integrity and accuracy" in the FAQs and

flyers it created in 2010 to encourage providers to supply medical records to Medi-Connect, *See* Ex. 10 at 3, Ex. 11; *see generally supra* ¶¶ 108–113.

132. Further, Anthem was aware of the high frequency of provider coding errors. In 2012, for example, one of Anthem's Medicare compliance managers observed that "we all know that physicians do not always code accurately" and that "improper [diagnosis] codes" are one of the "[c]ommon errors." *See supra* ¶ 75. During the relevant time, RADV audit results also gave Anthem specific notice that a significant percentage of its diagnosis code submissions to CMS were inaccurate. Anthem's self-assessment, moreover, concluded that the "risk level" for its "submitting diagnosis data for risk adjustment that is not accurate and/or supported in the medical record" was "high" in 2015.

133. In addition, Anthem recognized that, in accordance with the EDI agreements it executed, it had an obligation to "research and correct" any "discrepancies" in its "risk adjustment data" submissions. *See* Exs. 6, 7, 8. Specifically, as Anthem's chief compliance officer acknowledged, the types of "data discrepancies" that Anthem would be responsible for researching and correcting pursuant to its EDI agreements with CMS would include situations where medical record review suggests that a diagnosis code previously submitted to CMS was incorrect, for example due to a mis-transcription.

134. Finally, Anthem knew that it was obligated to delete inaccurate diagnosis codes. As an MAO, Anthem was familiar with the CMS trainings on this requirement. Further, as its chief compliance officer admitted, it was understood at Anthem that one of the situations where it would "be appropriate to submit deletes" was "if Anthem became aware that one of the codes had been submitted [to CMS] was not supported by the medical record." Indeed, during the relevant period, Anthem routinely submitted deletes for the diagnosis codes that RADV audits had determined to be inaccurate.

B. Anthem's Internal Records and Communications Show That It Treated the Chart Review Program as a "Cash Cow," Instead of as an "Oversight Activity"

135. Although Anthem told providers in 2010 to supply medical records to Medi-Connect for chart review because it would be an "oversight activity" that verified the accuracy of diagnosis codes already submitted to CMS, *see* Ex. 10 at 3, internal records show that Anthem treated chart review solely as a means to obtain more risk adjustment payments from CMS.

136. For example, both before and during the relevant period, Anthem classified chart review as one of its "revenue enhancement programs." Further, according to a 2013 internal audit report, Anthem stated the purpose of its chart review program as "to collect additional data to submit to CMS."

137. Consistent with that goal, Anthem assessed its chart review program not on the basis of whether it enabled Anthem to improve the accuracy of its diagnosis code reporting, but instead based on how effectively it generated revenue for Anthem. Specifically, analysts in Anthem's Medicare R&R group were tasked with constantly looking for ways to increase the return on investment ("ROI") rate for chart review, which was calculated by dividing the amount of additional revenue generated by chart review by the cost of operating the program.

138. For example, in 2015 and 2016, Anthem had its analysts engage in a "predictive model analysis" to "predict[] which retrospective chart chases will be valuable" to Anthem. As one of the analysts explained in an e-mail to the data team, having such a model would give Anthem a "methodology" to "improve the retrospective [chart review] ROI with little or no impact on total revenue."

139. Anthem also closely tracked the ROI for its chart review program. According to an actuarial director in Anthem's finance department, calculating the ROI for chart review required several of Anthem's finance staff working together using data and algorithms in several computer programs. As result of those efforts, Anthem found that in 2015, for example, its chart

review program generated over $112 million in additional revenue while costing Anthem just under $19 million in expenses, yielding an ROI of 6.00. *See* 2015 ROI Analysis (attached here as Exhibit 12).

140. The fact that chart review was generating five, six, or seven million dollars in revenue in return for each million dollars of expenditures was not lost on Anthem's senior executives. For example, when there was discussion within Anthem in early 2016 about changing the chart review program, the head of the Medicare R&R group promptly raised a concern about making such changes. According to that executive, she told two of her peers in March 2016 that she was "not inclined to change" chart review in any way because "[chart review] is a cash cow" for Anthem by virtue of its having "a high ROI."

141. A key reason that chart review was "a cash cow" was because of Anthem's one-sided use of chart review results — only looking for additional diagnosis codes to submit and not, as Anthem had told providers and promised CMS, also to identify inaccurate codes that needed to be deleted. Anthem's internal discussions underscore the magnitude of the financial impact that Anthem anticipated if it made the switch to using chart review to look for both additions and deletions.

142. In 2017, for example, finance executives at Anthem had a series of discussions about this topic. According to one of Anthem's finance vice presidents at that time, he made an estimate in October 2017 that making a switch from one-sided chart review to two-way chart review could reduce the value of chart review for Anthem by 72%, which translated to an $86 million reduction to Anthem's "chart revenue" forecast for 2017.

143. Further, the 72% estimate was not an outlier within Anthem. Specifically, earlier in 2017, another finance vice president at Anthem had suggested in discussions that making the

switch from one-sided chart review to two-way chart review would reduce Anthem's revenue from its chart review program by about two thirds.

144. Anthem's strong focus on the profitability of the chart review program came at the direct expense of its compliance with its obligations as a Medicare MAO. For example, according to Anthem's 2015 internal compliance plans, the head of the Medicare R&R group was primarily responsible for mitigating the compliance risks for submitting inaccurate risk adjustment diagnosis data. Yet, Anthem never notified this executive that she had been assigned such a role. Thus, that executive believed that it "would be unreasonable" to have expected her to be responsible for ensuring that Anthem did not submit inaccurate risk adjustment diagnosis data to CMS.

145. Further, even though this executive – the head of Anthem's Medicare R&R group since 2015 – was a member of Anthem's Medicare Compliance committee, she not only never received training on Anthem's obligation to research and correct discrepancies in risk adjustment data under its Part C EDI agreement with CMS, but also had never seen a copy of an EDI agreement until August 2019.

146. Nor was the lack of attention to compliance at Anthem limited to its Medicare R&R group. The President of Anthem's Medicare business from 2013 to 2019, who also served on Anthem's Medicare Compliance committee, was likewise unfamiliar with Anthem's EDI agreements with CMS. In addition, even though he personally signed dozens of Anthem's Part C annual attestations to CMS, this executive was not aware of any training from CMS regarding when MAOs like Anthem had the obligation to delete inaccurate diagnosis codes.

ANTHEM'S KNOWING DECISION TO DISREGARD ITS REGULATORY AND CONTRACTUAL OBLIGATIONS RESULTED IN THE SUBMISSIONS OF THOUSANDS OF FALSE CLAIMS AND AVOIDANCE OF ITS OBLIGATION TO REPAY THE GOVERNMENT

147. As set forth above, Anthem understood its obligation to submit accurate diagnosis data to CMS and to delete inaccurate diagnosis code submissions that could not be validated by the medical records. Anthem also was aware of significant rates of errors in the diagnosis codes it was submitting to CMS based on the provider claims. Further, Anthem knew that the chart review results from Medi-Connect could help it verify the accuracy of the previously-submitted diagnosis data. Finally, Anthem understood that it both had the ability and the obligation to compare the chart review results from Medi-Connect against the diagnosis codes it previously submitted to find and delete the codes that could not be validated based on the medical records.

148. Anthem, however, chose to prioritize profitability over compliance. *See supra* ¶¶ 135-146. As result of that choice, until 2018, when it finally began to use chart review results to identify both codes to delete and additional codes to submit, Anthem knowingly caused CMS to calculate the risk adjustment payments it made to Anthem on the basis of thousands, and likely tens of thousands, of inaccurate diagnosis codes. Examples of those instances include:

a. Patient A: In connection with a visit to a provider by this beneficiary on May 13, 2014, Anthem submitted an ICD-9 diagnosis code for diabetes with ophthalmic manifestations for this beneficiary – which mapped to HCC 18 – for payment year 2015. Anthem's chart review program did not substantiate the diabetes with ophthalmic manifestations diagnosis, but instead determined that the patient had diabetes without complications, which mapped to HCC 19, instead of 18. Further, no other provider reported the diabetes with ophthalmic manifestations diagnosis (or any other diagnosis that mapped to HCC 18) during 2014.

   Anthem did not submit a delete for the diagnosis code for diabetes with ophthalmic manifestations, replace that diagnosis code with one for diabetes without complications, or otherwise notify CMS not to rely on that code for

risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit four additional ICD-9 codes to CMS for Patient A's visit on May 13, 2014. Due to this course of conduct, CMS used HCC 18, instead of HCC 19, to calculate Anthem's risk adjustment payment for Patient A in payment year 2015, resulting in an overpayment of $1,680.32 to Anthem.

b. Patient B: In connection with a visit to a provider by this beneficiary on June 23, 2014, Anthem submitted an ICD-9 diagnosis code for active lung cancer (*i.e.*, malignant neoplasm of the bronchus or lung) for this beneficiary – which mapped to HCC 8 – for payment year 2015. Anthem's chart review program did not substantiate the active lung cancer diagnosis. Further, no other provider reported such a diagnosis (or any other diagnosis that mapped to the same HCC) during 2014.

Anthem did not submit a delete for the diagnosis code for active lung cancer or otherwise notify CMS not to rely on that code for risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit three additional ICD-9 codes to CMS for Patient B's visit on June 23, 2014. Due to this course of conduct, CMS used HCC 8 to calculate Anthem's risk adjustment payment for Patient B in payment year 2015, resulting in an overpayment of $7,080.74 to Anthem.

c. Patient C: In connection with a visit to a provider by this beneficiary on May 15, 2014, Anthem submitted an ICD-9 diagnosis code for chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction for this beneficiary – which mapped to HCC 31 – for payment year 2015. Anthem's chart review program did not substantiate that diagnosis. Further, no other provider reported such a diagnosis (or any other diagnosis that mapped to the same HCC) during 2014.

Anthem did not submit a delete for the peptic ulcer diagnosis code or otherwise notify CMS not to rely on that code for risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit four additional ICD-9 codes to CMS for Patient C's visit on May 15, 2014. Due to

this course of conduct, CMS used HCC 31 to calculate Anthem's risk adjustment payment for Patient C in payment year 2015, resulting in an overpayment of $2,519.18 to Anthem.

d. Patient D: In connection with a visit to a provider by this beneficiary on May 17, 2012, Anthem submitted an ICD-9 diagnosis code for bipolar disorder for this beneficiary – which mapped to HCC 55 – for payment year 2013. Anthem's chart review program did not substantiate the bipolar diagnosis. Further, no other provider reported such a diagnosis (or any other diagnosis that mapped to the same HCC) during 2012.

   Anthem did not submit a delete for the bipolar diagnosis code or otherwise notify CMS not to rely on that code for risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit six additional ICD-9 codes to CMS for Patient D's visit on May 17, 2012. Due to this course of conduct, CMS used HCC 55 to calculate Anthem's risk adjustment payment for Patient D in payment year 2013, resulting in an overpayment of $2,693.27 to Anthem.

e. Patient E: In connection with a visit to a provider by this beneficiary on August 1, 2012, Anthem submitted an ICD-9 diagnosis code for colostomy for this beneficiary – which mapped to HCC 176 – for payment year 2013. Anthem's chart review program did not substantiate the colostomy diagnosis. Further, no other provider reported such a diagnosis (or any other diagnosis that mapped to the same HCC) during 2012.

   Anthem did not submit a delete for the colostomy diagnosis code or otherwise notify CMS not to rely on that code for risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit five additional ICD-9 codes to CMS for Patient E's visit on August 1, 2012. Due to this course of conduct, CMS used HCC 176 to calculate Anthem's risk adjustment payment for Patient E in payment year 2013, resulting in an overpayment of $6,394.41 to Anthem.

f. Patient F: In connection with a visit to a provider by this beneficiary on October 15, 2012, Anthem submitted an ICD-9 diagnosis code for chronic respiratory failure ("COPD") for this beneficiary – which mapped to HCC 79 – for payment year 2013. Anthem's chart review program did not substantiate the COPD diagnosis. Further, no other provider reported a COPD diagnosis (or any other diagnosis that mapped to the same HCC) during 2012.

Anthem did not submit a delete for the COPD diagnosis code or otherwise notify CMS not to rely on that code for risk adjustment purposes. In the meantime, Anthem relied on chart review results to submit four additional ICD-9 codes to CMS for Patient F's visit on October 15, 2012. Due to this course of conduct, CMS used HCC 79 to calculate Anthem's risk adjustment payment for Patient F in payment year 2013, resulting in an overpayment of $4,769.37 to Anthem.

g. Patient G: In connection with a visit to a provider by this beneficiary on August 16, 2012, Anthem submitted an ICD-9 diagnosis code for osteopathy resulting from poliomyelitis of the lower log for this beneficiary – which mapped to HCC 37 – for payment year 2013. Anthem's chart review program did not substantiate that diagnosis. Further, no other provider reported such a diagnosis (or any other diagnosis that mapped to the same HCC) during 2012.

Anthem did not submit a delete for the osteopathy resulting from poliomyelitis of the lower log diagnosis code or otherwise notify CMS not to rely on that code for risk adjustment purposes. Due to this course of conduct, CMS used HCC 37 to calculate Anthem's risk adjustment payment for Patient G in payment year 2013, resulting in an overpayment of $5,137.89 to Anthem.

In these and thousands of other instances, Anthem's misconduct had a direct and foreseeable impact on CMS. Specifically, Anthem's misconduct not only enabled it to obtain and retain higher risk adjustment payments from CMS, it also adversely affected the integrity and accuracy of CMS's risk adjustment payment system. In addition, by knowingly failing to delete these and

thousands of other inaccurate diagnoses, Anthem knowingly and improperly avoided its obligation to repay CMS for payments it received for these inaccurate diagnoses.

149. Further, for each payment year in the relevant period – 2013, 2014, 2015, and 2016, Anthem submitted Part C annual attestations for its MA plans, which certified to CMS that all of the risk adjustment diagnosis data Anthem had submitted for those MA plans were "accurate" based on Anthem's "best knowledge, information, and belief." *See* Ex. 9.

150. As Anthem knew, each of those Part C attestations was false. Specifically, Anthem had information in its possession – the chart review results it received from Medi-Connect – that Anthem could have used to uncover numerous inaccuracies like the seven examples enumerated in paragraph 148 above.

151. Anthem also knew that its ongoing submission of the false annual attestations to CMS had a direct and unforeseeable impact on CMS. Specifically, as Anthem's internal policy recognized, CMS's procedures required MAOs like Anthem to submit Part C annual attestations before CMS would proceed with the final reconciliation phase of the risk adjustment payment process. *See supra* ¶ 86. Thus, the false attestations submitted by Anthem caused CMS to move forward with final reconciliation for Anthem's Part C plans and disburse reconciliation payments to Anthem during the relevant period.

FIRST CLAIM

Presentation of False or Fraudulent Claims

31 U.S.C. § 3729(a)(1)(A)

152. The Government incorporates by reference paragraphs 1 through 151 above as if fully set forth in this paragraph.

153. The Government seeks relief against defendant Anthem under section 3729(a)(1)(a) of the FCA, 31 U.S.C. § 3729(a)(1)(A), because Anthem knowingly presented, or

caused to be presented, false or fraudulent claims for payment or approval to CMS.

154. Specifically, on account of its choice to operate its chart review program in deliberate ignorance or reckless disregard of its regulatory and contractual obligation to delete inaccurate diagnosis codes, Anthem knowingly submitted false Part C annual attestations to CMS in connection with seeking final reconciliation payments from Medicare.

155. By reason of the false annual attestations that Anthem knowingly presented, or caused to be presented, for payment or approval, the Government has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM

Making and Using False Statements in Violation of the FCA

31 U.S.C. § 3729(a)(1)(B)

156. The Government incorporates by reference paragraphs 1 through 151 above as if fully set forth in this paragraph.

157. The Government seeks relief against Anthem under Section 3729(a)(1)(B) of the FCA, 31 U.S.C. § 3729(a)(1)(B), because Anthem knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim.

158. Specifically, on account of its choice to operate its chart review program in deliberate ignorance or reckless disregard of its regulatory and contractual obligation to delete inaccurate diagnosis codes, Anthem knowingly made, used, or caused to be made or used, false Part C annual attestations in relation to seeking final reconciliation payments from Medicare.

159. By reason of these false records or statements, the Government has been damaged in a substantial amount to be determined at trial and is entitled to recover treble damages plus a civil monetary penalty for each false record or statement.

THIRD CLAIM

Reverse False Claims — Knowingly and Improperly Avoiding an Obligation to Repay the Government

31 U.S.C. § 3729(a)(1)(G)

160. The Government incorporates by reference paragraphs 1 through 151 above as if fully set forth in this paragraph.

161. The Government seeks relief against Anthem under Section 3729(a)(1)(G) of the FCA, 31 U.S.C. § 3729(a)(1)(G), both because Anthem knowingly made or used a false record or statement material to an obligation to repay the Government and because Anthem knowingly concealed or knowingly and improperly avoided an obligation to repay the Government.

162. Specifically, on account of its choice to operate its chart review program in deliberate ignorance or reckless disregard of its regulatory and contractual obligation to delete inaccurate diagnosis codes, Anthem knowingly made, used, or caused to be made or used, false Part C annual attestations that enabled it to evade its obligation to refund CMS under the Medicare Part C's final reconciliation process.

163. Further, by deliberately or recklessly disregarding its regulatory and contractual obligation to delete inaccurate diagnosis codes, Anthem knowingly concealed its obligation to refund CMS.

164. By reason of these false records or statements, as well as Anthem's knowing concealment and avoidance, the Government has been damaged in a substantial amount to be determined at trial and is entitled to recover treble damages plus a civil monetary penalty for each false record or statement.

FOURTH CLAIM

Unjust Enrichment

165. The Government incorporates by reference paragraphs 1 through 151 above as if

fully set forth in this paragraph.

166. Anthem has received money from the Government to which it was not entitled, which unjustly enriched Anthem, and for which it must make restitution. Anthem received such money by claiming and retaining Medicare Part C risk adjustment payments based on inaccurate and invalid risk adjustment data. In equity and good conscience, such money belongs to the Government and to the Medicare Program.

167. The Government is entitled to recover such money from Anthem in an amount to be determined at trial.

FIFTH CLAIM

Payment by Mistake

168. The Government incorporates by reference paragraphs 1 through 151 above as if fully set forth in this paragraph.

169. The Government paid money to Anthem as a result of a mistaken understanding. Specifically, the Government paid Anthem's claims for risk adjustment payments under the mistaken understanding that such claims were based on accurate and valid risk adjustment data. Had the Government known the truth, it would not have paid such claims. Those payments was therefore by mistake.

170. As result of such mistaken payments, the Government has sustained damages for which Anthem is liable in an amount to be determined at trial.

PRAYER FOR RELIEF

WHEREFORE, plaintiff, the Government, requests that judgment be entered in its favor as follows:

(a) on the First, Second, and Third Claims for relief (violations of the FCA, 31 U.S.C. §§ 3729(a)(1)(A), 3729(a)(1)(B), and 31 U.S.C. §§ 3729(a)(1)(G)), a judgment against Anthem for treble the Government's damages, in an amount to be

determined at trial, plus a civil penalty in the maximum applicable amount for each violation of the FCA by Anthem, as well as an award of costs incurred by the Government against Anthem pursuant to 31 U.S.C. § 3729(a)(3);

(b) on the Fourth Claim for relief (unjust enrichment), a judgment against Anthem in an amount equal to the monies that Anthem obtained from the Government without right and by which Anthem has been unjustly enriched, plus costs, pre- and post-judgment interest;

(c) on the Fifth Claim for relief (payment by mistake), a judgment against Anthem in an amount equal to the Government's damages, plus costs, pre- and post-judgment interest; and

(d) such further relief as is proper.

Dated: New York, New York
March 26, 2020

GEOFFREY S. BERMAN
United States Attorney

By: *_/s/ Li Yu_*

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Exhibit I

Plan Number	Plan Name	Anthem Subsidiaries
H0147	HealthKeepers (Medicare-Medicaid Plan)	Healthkeepers, Inc.
H0564	Anthem MediBlue Plus (HMO) d/b/a Blue Cross Senior Secure Plan I	Blue Cross Of California.
H1394	Anthem MediBlue Dual Advantage	HMO Colorado, Inc..
H1517	Anthem Medicare Preferred Core	Anthem Insurance Companies, Inc..
H1607	Anthem MediBlue Access Plus (PPO)	Anthem Insurance Companies, Inc..
H1849	Anthem MediBlue Plus d/b/a Anthem Senior Advantage Value	Anthem Health Plans Of Kentucky, Inc..
H1894	Amerivantage Classic (HMO)	Amerigroup Washington, Inc..
H2836	Anthem MediBlue Preferred Standard	Anthem Health Plans, Inc..
H3342	Empire MediBlue Access (PPO) d/b/a Empire MediBlue Freedom II	Empire Healthchoice Assurance, Inc..
H3370	Empire MediBlue Plus (HMO)	Empire Healthchoice Hmo, Inc..
H3447	Anthem MediBlue Plus (HMO) d/b/a Anthem MediBlue Local	Healthkeepers, Inc..
H3536	Anthem MediBlue Plus (HMO d/b/a Anthem MediBlue Select	Matthew Thornton Health Plan, Inc..
H3655	Anthem MediBlue Essential (HMO) d/b/a Anthem Senior Advantage Plus	Community Insurance Company.
H4036	Anthem MediBlue Access (PPO) d/b/a Anthem Medicare Preferred Core	Anthem Insurance Companies, Inc..
H4211	Amerivantage Classic	Amerigroup Georgia Managed Care Company, Inc.
H4909	Anthem MediBlue Access (PPO) d/b/a Anthem Medicare Preferred Core	Anthem Health Plans Of Virginia, Inc..
H5422	Anthem MediBlue Plus (HMO) d/b/a BCBSHP Dual Advantage	Blue Cross Blue Shield Of Georgia.
H5529	Anthem Medicare Preferred Standard	Community Insurance Company.
H5530	Anthem MediBlue Access d/b/a Anthem Medicare Preferred Standard	Anthem Health Plans Of Kentucky, Inc..
H5854	Anthem MediBlue Select (HMO) d/b/a Anthem MediBlue Select	Anthem Health Plans, Inc..
H6229	Anthem Blue Cross Cal MediConnect	Blue Cross Of California Partnership Plan Inc..
H6786	Anthem MediBlue Access (PPO)	Anthem Health Plans Of Maine, Inc..
H7728	Anthem Medicare Preferred Premier	Anthem Health Plans Of New Hampshire, Inc..
H8417	Empire BlueCross BlueShield HealthPlus FIDA Plan (Medicare-Medicaid Plan)	Amerigroup New York, Llc.

Exhibit 1

Plan Number	Plan Name	Anthem Subsidiaries
H8432	Empire MediBlue Plus (HMO); Anthem Dual Advantage	Anthem Health Plans Of Maine, Inc.
H8552	Anthem MediBlue Access (PPO); Anthem Medicare Preferred Standard	Anthem Blue Cross Life And Health Insurance Co..
H9525	Anthem MediBlue Plus (HMO)	Compcare Health Services Insurance Corporation.
H9525	Anthem MediBlue Select	Compcare Health Services Insurance Corporation.
H9886	Anthem MediBlue Plus (HMO)	Hmo Missouri, Inc..
H9947	BCBSGa MediBlue Access (PPO)	Blue Cross Blue Shield Of Georgia.
H9954	Anthem MediBlue Dual Advantage	Anthem Insurance Companies, Inc. (Hmo).
Hl517	Anthem Medicare Preferred Core	Anthem Insurance Companies, Inc..
Hl607	Anthem Medicare Preferred Standard	Anthem Insurance Companies, Inc..
Hl849	Anthem Senior Advantage Value (HMO)	Anthem Health Plans Of Kentucky, Inc..
R5941	Anthem MediBlue Access (Regional PPO)	Anthem Insurance Companies, Inc..

CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H3370)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

EMPIRE HEALTHCHOICE HMO, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2014, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2013 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2013 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2013 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV
CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also*attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(l)]**

Article V
MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations.**[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.**[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII
Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644.**[422.506(b)]**

Article VIII
Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article.**[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in subparagraph 1 (a) of this paragraph, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX
Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X
Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

ATTACHMENT A

ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

LEEBA LESSIN

____

Contracting Official Name

8/29/2013 1:42:51 PM

____

Date

EMPIRE HEALTHCHOICE HMO, INC.

____

Organization

1 Liberty Plaza
165 Broadway
New York, NY 10006

____

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

____

Danielle R. Moon, J.D., M.P.A
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

9/26/2013 11:18:12 AM

____

Date

H3370

CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H3370)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

EMPIRE HEALTHCHOICE HMO, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2015, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2014 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2014 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2014 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV
CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also*attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(l)]**

4. The MA Organization must certify based on best knowledge, information, and belief, that the information provided for the purposes of reporting and returning of overpayments under 42 CFR §422.326 is accurate, complete, and truthful. The form for this certification will be determined by CMS. **[422.504(l)]**

Article V
MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS' contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, to related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations.**[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.**[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII
Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42

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CFR §422.644.**[422.506(b)]**

Article VIII
Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article.**[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the following occur:

(i) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(ii) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(iii) substantially failed to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(iv) failed to provide CMS with valid data as required under 42 CFR §§422.310.

(v) failed to implement an acceptable quality assessment and performance improvement program as required under 42 CFR Part 422 Subpart D.

(vi) substantially failed to comply with the prompt payment requirements in 42 CFR §422.520.

(vii) substantially failed to comply with the service access requirements in 42 CFR §422.112.

(viii) failed to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(ix) substantially failed to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(x) Failed to comply with regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xi) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xii) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years.

(xiii) Has failed to report MLR data in a timely and accurate manner in accordance with 42 CFR §422.2460.

(c) Notice. If CMS decides to terminate a contract, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(d) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(b)(i) or (b)(ii) of this paragraph or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX
Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X
Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

ATTACHMENT A

ATTESTATION OF ENROLLMENT INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

MARC RUSSO

____

Contracting Official Name

8/27/2014 3:17:12 PM

____

Date

EMPIRE HEALTHCHOICE HMO, INC.

____

Organization

1 Liberty Plaza
165 Broadway
New York, NY 10006

____

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

____

Kathryn A. Coleman
Acting Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

9/11/2014 1:10:21 PM

____

Date

H3370

Medicare Advantage
Outreach and Education Bulletin

August, 2010

To: Medicare Advantage Physicians and Practitioners

Risk Adjustment 101

Did you know that Medicare Advantage plans, like Empire Blue Cross and Blue Shield ("Empire") are required to report member diagnoses to the Centers for Medicare and Medicaid Services ("CMS")? This information is used to risk adjust payments received by the health plan from CMS. This is referred to as the ***CMS HCC Risk Adjustment Payment Methodology***.

What is the CMS-HCC Risk Adjustment Payment Methodology?

It is the payment methodology used by CMS to adjust its payments to the plan based on the health status and demographic characteristics of a member. The result is higher payments from CMS for members who are at risk for being sicker and lower payments for members who are predicted to be healthier.

You Play a Critical Role

You, as the provider, play a critical role in facilitating the risk adjustment process. How?

- ICD-9 codes recorded on claims and encounters are reported to CMS and used to determine the risk adjusted payment;
- CMS requires that providers use the most specific code available (including secondary codes when appropriate);
- CMS uses documentation from the member's medical record to validate that the appropriate ICD-9 code has been assigned, and may review this data at any time, including annually;
- If the medical record does not support the reported ICD-9 code, CMS may adjust health plan payments.

Your assistance and commitment to this process is critical. By supplying Anthem with the most accurate and complete diagnosis coding and medical record documentation, you will help us meet our reporting requirements and obligations to CMS.

Our goal is to help you better understand how the risk adjustment process impacts Anthem, you, as the provider, and our members. For more information related to this important subject, please contact your provider engagement representative.

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Medicare Advantage Risk Adjustment Programs

Rev: May 29, 2015

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Part 1: Diagnostic Coding Guidance

This manual provides coding guidance to be used when coding medical records on behalf of Anthem (formerly WellPoint) for Medicare Advantage Risk Adjustment purposes. This manual was created based on specific coding guidance from the following reputable resources:

- Official ICD-9 and ICD-10 Coding Guidelines
- AHA Coding Clinic
- CMS 2008 Risk Adjustment Participant Guide
- Risk Adjustment 101 Participant Guide (2013 National Technical Assistance)
- Chapter 7 Medicare Managed Care Manual

Please refer to these resources for official coding rules and regulations. This manual is intended to address common coding topics seen in the Medicare Advantage population. This manual is not all inclusive; it will be reviewed and updated annually.

Coders should also utilize (current and up-to-date) references such as:

- Medical dictionaries
- Drug references
- AMA and other Anatomy/clinical references (i.e., Merck Manual)
- AHA, AAPC, and AHIMA approved coding and billing education references (e.g., Faye Brown's Coding Handbook, Coder's Desk Reference)
- Internet access for coding and clinical research

Part 2: Overarching Guidance

The intent of all Anthem programs is to report to CMS all conditions that are properly documented and addressed in the member's medical record for each date of service. The information contained in this manual provides parameters and guidance to help achieve this ultimate goal.

Part 3: What Is Medicare Risk Adjustment?

Medicare risk adjustment is the method used to adjust bidding and payment from CMS (Centers from Medicare & Medicaid Services) to Medicare Advantage plans based on demographics (i.e., age and sex) as well as actual health status of enrollee. Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs and adjust payment.

The purpose of risk adjustment is to allow CMS to pay Medicare Advantage (MA) plans for the risk of the beneficiaries enrolled. By risk adjusting plan payments, CMS is able to make appropriate and accurate payment for enrollees with differences in expected costs.

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3.1 Risk Score

A risk score is created in order to determine how an average member in the population compares to another member in the population. Risk score is based on a combination of demographic and disease data. The demographic data is provided to CMS by the Social Security Administration, while the disease data is submitted by the MA Organization in the form of diagnosis codes.

The formula reads:

Risk Score = (demographics) + (disease) + (disease) + (disease)

CMS uses the following demographic factors when calculating a risk score:

- Age
- Sex
- Frailty
- Disability
- Original Reason for Entitlement (OREC)
- Institutionalization
- Medicaid Status

Total risk adjusted payment starts with the base payment calculated by the MA Plan that is submitted to CMS for approval as part of the Plan's annual bid process. The total payment calculation is:

Total Payment = Base Payment x Risk Score

3.2 HCC/ Diagnosis Groups

The Hierarchical Condition Category (HCC) is a diagnosis grouping with a single relative factor assigned to it for each model segment. The diagnosis grouping consists of clinically related ICD-9 codes that have similarly projected costs. MA plans are paid based on the member's diagnoses codes that map to an HCC. These HCC-related diagnosis codes must be reported at least once during each calendar year for risk adjusted payment. Codes are reported to CMS via the Risk Adjustment Processing System (RAPS). RAPS will be replaced with Enterprise Data Processing System (EDPS) in the near future.

Over 3,100 ICD-9 codes map to 2013 CMS-HCC and/or 2014 CMS-HCC risk adjustment model. There are over 8,700 ICD-10 codes that map to the 2014 CMS-HCC risk adjustment model.

2013 & 2014 CMS-HCC Model Spreadsheet
Preliminary ICD-10-CM Mapping to CMS-HCC Model

3.3 CMS-HCC Risk Adjustment Model

For 2014 payment year, CMS implemented an updated, clinically revised CMS-HCC risk adjustment model. The risk scores for payment year 2014 and 2015 were calculated by blending the 2013 CMS-HCC model and the revised 2014 CMS-HCC model.

For 2016 payment year (2015 dates of service), CMS fully implemented the 2014 CMS-HCC Risk Adjustment Model. For more details on the CMS-HCC models, please refer to CMS' Advance Notice and Final Call Letters.

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3.4 Provider Types

For risk adjustment purposes, MA organizations must collect data from the following provider types:

- Hospital outpatient facilities
- Hospital inpatient facilities
- Physicians (refer to table below for acceptable physician specialty types)

Acceptable Physician Specialty Types for 2015 Payment Year (2014 Dates of Service) Risk Adjustment Data Submission

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	25	Physical Medicine And Rehabilitation	67	Occupational Therapist
2	General Surgery	26	Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	27	Geriatric Psychiatry	72*	Pain Management
4	Otolaryngology	28	Colorectal Surgery	76*	Peripheral Vascular Disease
5	Anesthesiology	29	Pulmonary Disease	77	Vascular Surgery
6	Cardiology	33*	Thoracic Surgery	78	Cardiac Surgery
7	Dermatology	34	Urology	79	Addiction Medicine
8	Family Practice	35	Chiropractic	80	Licensed Clinical Social Worker
9	Interventional Pain Management (IPM)	36	Nuclear Medicine	81	Critical care (intensivists)
10	Gastroenterology	37	Pediatric Medicine	82	Hematology
11	Internal Medicine	38	Geriatric Medicine	83	Hematology/Oncology
12	Osteopathic Manipulative Medicine	39	Nephrology	84	Preventive Medicine
13	Neurology	40	Hand Surgery	85	Maxillofacial Surgery
14	Neurosurgery	41	Optometry	86	Neuropsychiatry
15	Speech Language Pathologist	42	Certified Nurse Midwife	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	43	Certified Registered Nurse Anesthetist	90	Medical Oncology
17	Hospice And Palliative Care	44	Infectious Disease	91	Surgical Oncology
18	Ophthalmology	46*	Endocrinology	92	Radiation Oncology
19	Oral Surgery	48*	Podiatry	93	Emergency Medicine
20	Orthopedic Surgery	50*	Nurse Practitioner	94	Interventional Radiology
21	Cardiac Electrophysiology	62*	Psychologist	97*	Physician Assistant
22	Pathology	64*	Audiologist	98	Gynecologist/Oncologist
23	Sports Medicine	65	Physical Therapist	99	Unknown Physician Specialty
24	Plastic And Reconstructive Surgery	66	Rheumatology	C0	Sleep Medicine

* Indicates that a number has been skipped.

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Part 4: Medical Record Documentation

Medical record documentation is the historical account of the patient/provider encounter and serves as the basis for coding of all diagnoses and services provided to patients. The medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The documentation should be clear and concise to communicate the condition(s) and treatment rendered to the patient.

Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time. It is also the basis for collecting data and coding for risk adjustment.

Carefully review the medical record to ensure the following guidelines are met for HCC validation:

- Each coded date of service (DOS) should be able to stand on its own.
- CMS recommends that the patient's name and DOS appear on each page of the record.
    - If the patient's name and DOS do not appear on each page of the record, it is acceptable for coding as long as it is evident that each page of the record is for the same patient and DOS. Coders should carefully review the entire record for context using their best judgment.
- Diagnosis must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility.
- Diagnosis must be supported by appropriate medical record documentation that demonstrates TAMPER (refer to section 5.15, Status/Status Post codes, for exceptions).
- Diagnosis must be submitted at least once during a reporting period.
- The provider's signature and credential must comply with CMS requirements (refer to section 5.5, Physician Signature and Credentials, for more details)
- Conditions coded must be stated in the medical record using text. Conditions documented using only numerical ICD-9 codes are not acceptable for risk adjustment per CMS (refer to section 5.16, ICD-9-CM Codes Only, for more details).

The entire medical record should be reviewed at the time of coding to ensure complete code capture of the condition(s) documented by the provider in accordance with the Official Coding Guidelines.

There are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient's diagnosis, condition and/or problem. It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes. (AHA Coding Clinic for ICD-9-CM, 2012, Q1, Volume 29, Number 1, pg 6)

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Part 5: Physician/ Outpatient Records

5.1 Hospital Outpatient

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization. Covered and non-covered hospital outpatient facilities are listed below.

Covered Facilities
- Short-term (general and specialty) Hospitals
- Medical Asst. Facilities/Critical Access Hospitals
- Community Mental Health Centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Rural Health Clinic (Free-standing & Provider-based)

Non-Covered Facilities*
- Free-standing Ambulatory Surgical Centers
- Home Health Care
- Free-standing Renal Dialysis Facilities

Non-Covered Services
- Laboratory Services
- Ambulance
- Durable Medical Equipment
- Prosthetics
- Orthotics
- Supplies
- Radiology Services**

* These are examples of non-covered facilities and are not a comprehensive list.
** Regardless of the type of diagnostic radiology bill (outpatient department or physician component), this hospital outpatient service is not acceptable for risk adjustment because it typically does not contain confirmed diagnoses.

5.2 Coding Exclusions

Documentation acceptable for risk adjustment purposes must be from a face-to-face visit with an acceptable provider type (reference section 3.4 for listing). Do not code the following from Table 5A.

Table 5A Coding Exclusions List, Do Not Code

Lab	Phone calls	Dialysis
Radiology	Physician orders	Prosthetics/orthotics
Ambulance	Charge slips/ Superbills	Ambulatory surgery center
DME/Supplies	Rx scripts	Letters not for a face-to-face visit
Diagnostic/Electro-diagnostic Reports	Nursing notes/Nurse Only Visits	Consultation requests
Chemotherapy only	Infusion Therapy	Visits between provider and family
Skilled Nursing Facility (SNF)		

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5.3 Date of Service

The Date of Service (DOS) defines when a beneficiary received medical treatment from a physician or medical facility. For outpatient and physician services, the DOS has to be clear and legible including the month, day, and year. The DOS submitted to CMS must be within the data collection year.

Do not guess or use a default date. Do not interpret the signature date, Date Dictated (DD), Date Transcribed (DT), vitals date or finalized date as the DOS. Exercise extreme caution with progress notes. Do not code the record if the DOS is missing or illegible.

5.4 Date of Birth

The Date of Birth (DOB) does not have to be listed on each date of service. Look for conflicts in comparison that would invalidate the medical record. It is important that coders use their best judgment when reviewing the medical record for DOB. Implement the following best practices when the member's DOB is missing on the date of service:

- Look for patient's age to subtract from the year in the medical record. If the total corresponds with the DOB year in Chart Navigator (based on calculation), the record may be coded.
  - For example: For DOS 05/01/2014, the record states patient's age is 78. Subtract patient's age from the year in the date of service, 2014-78= 1936. The DOB in Chart Navigator is 02/01/1936.
- If the DOB is referenced in other documents within the medical record (e.g., lab or x-ray), the coder may use that DOB for validation. If DOB corresponds, the record may be coded.
- If there is no reference to DOB throughout the entire medical record and the patient's age is not listed, allow the record and code as usual.

Conflicts:

- If there is a modest conflict (i.e., one or two digits, one or two days) in either the DOB or age calculation, allow the record and code as usual.
- If there is a major conflict in the DOB or the member age, do not code the record.

5.5 Physician Signature and Credentials

For risk adjustment purposes, the provider of service for face-to-face encounters is appropriately identified on the medical record via signature and physician specialty credentials.

Examples of acceptable physician signature, including credentials, are:

- Handwritten signature or initials
- Electronic signature with authentication by the respective provider

If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," and "Validated

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by" including the practitioner's name, credentials, and date of authentication. If the provider signature is missing at the time of audit, CMS allows for submission of a completed CMS-Generated Attestation for the specific encounter date for an outpatient/physician record. Flag missing signatures appropriately in Chart Navigator.

5.6 Format of Records

Conditions can be coded from *any* part of the medical record provided the condition is documented and appropriately supported with TAMPER (see section 5.8). The two most common documentation formats are:

SOAP

- **S**ubjective - HPI, chief complaint (patient's own words), ROS, reason for the visit
- **O**bjective – physical exam, review of systems, vitals, weight etc.
- **A**ssessment – final impression, symptoms, relevant concurrent problems
- **P**lan - refill meds, order test, refer to specialists, order lab work, treatment plan

CHEDDAR

- **C**hief Compliant – presenting problem(s) in patient's own words
- **H**istory – social, medical, surgical, family histories
- **E**xam – physical examination of the patient
- **D**etails of Problem – details of the complaints or symptoms
- **D**rugs/ Dosages – current medications and dosages
- **A**ssessment – assessment of the diagnostic process and final impressions
- **R**ecommendations – return to clinic, refer to specialist, treatment plan

Keep in mind, not all records follow these formats. Category titles in the medical record vary. For instance, a category titled "History" may indicate past medical history (PMH) or history of present illness (HPI). The main goals are to verify that each encounter is a face-to-face visit with an acceptable provider and that each condition coded has supportive documentation.

5.7 Unconfirmed Diagnosis

For physician and hospital outpatient records, do not code conditions documented as "consistent with," "probable," "possible," "questionable," "rule out," "likely," "suspected," "suspicious for," "working," or other uncertain language. Rather, code the condition(s) to the highest degree of certainty for that encounter such as symptoms, signs, abnormal test results, or other reason for the visit. Refer to the Official ICD-9-CM Guidelines for Coding and Reporting Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services for additional guidance.

The Official Guidelines for Coding and Reporting for Outpatient Services, state, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."

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5.8 TAMPER/Coding Guidelines per Section

Coders will apply TAMPER guidelines when analyzing each diagnosis and deciding whether that diagnosis meets reporting criteria for each DOS. Coders will look for evidence of treatment as explained by the TAMPER guidelines below.

Treatment: Can be, but not limited to, the following:
- Considered to be Medications
- Education

Assessment: Can be, but not limited to, the following:
- Included as part of the final assessment
- Part of the Assessment with other notation (i.e., “stable”, “active”, “present”)

Monitoring: Can be, but not limited to, the following:
- Laboratory Orders/Results
- Routine follow up visits
- Home monitoring

Plan Can be, but not limited to, the following:
- Decrease medication/increase medication
- Routine follow up visits
- Home monitoring
- Case Management
- Disease Management

Evaluate: Can be, but not limited to, the following:
- Evaluation of current medical regimen
- Physical Examination
- Evaluation for treatment
- Vaccine Titers
- Diagnostics for effectiveness of care and resolution of disease
- Monofilament testing for disease detection

Referral Can be, but not limited to, the following:
- Referral to specialist for treatment
- Referral to dietician

If any one of the above actions is documented, coders should capture and report the diagnosis code(s). Every diagnosis and date of service must stand alone. See below for coding guidelines pertaining to each section of the medical record.

HPI (History of Present Illness) and Chief Complaint

- Conditions documented under HPI or as the chief complaint should be coded as long as there is evidence that the condition is current and confirmed by the provider (i.e, not documented as probable or as hearsay from the patient).

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PMH (Past Medical History)/Problem Lists

- Chronic conditions in these areas require TAMPER in order to be extracted for risk adjustment. If no TAMPER exists then the code should not be extracted.

ROS (Review of Systems)

- Conditions documented under ROS should be coded as long as there is evidence that the condition is current and confirmed by the provider (i.e, not documented as probable or as hearsay from the patient). Conditions(with the exception of status codes) in these areas require TAMPER in order to be extracted for risk adjustment.

Physical Exam

- The physical exam is considered TAMPER. Current conditions documented here should be captured as they are the objective findings from the face-to-face encounter with the patient. Conditions here should only be coded if they are documented as a confirmed diagnosis and not just a description (i.e., patient appears hypoxic).

Assessment/Plan

- All conditions listed here are considered to meet TAMPER and should generally be coded. Chronic conditions listed under the assessment/plan are considered to meet TAMPER and should be coded. Keep in mind that some conditions, such as cancer, require current treatment in order to be coded as active and not history of. Acute conditions (e.g., stroke, fracture, MI, etc.) will always require TAMPER.

5.9 Chronic Conditions

Below are examples of chronic conditions that can be extracted from HPI, ROS, Physical Exam, and Assessment/Plan.

Table 5B Chronic Conditions (not an all inclusive list)

Atrial Fibrillation	Chronic Osteomyelitis	End Stage Liver Disease	Peripheral Vascular Disease
Bipolar Disorder	Chronic Pancreatitis	Epilepsy	Pulmonary Heart Disease
Cardiomyopathy	Chronic Resp. Failure	HIV/AIDS	Quadriplegia
Cerebral Palsy	Chronic Skin Ulcer	Ischemic Heart Disease	Rheumatoid Arthritis
Chronic Bronchitis	Cirrhosis of the Liver	Major Depressive Dis.	Schizophrenia
Chronic Hepatitis	Congestive Heart Failure	Multiple Sclerosis	Systemic Lupus Erythem.
Chronic Kidney Disease	Crohn's Disease	Muscular Dystrophy	Ulcerative Colitis
Chronic Nephritis	Cystic Fibrosis	Paraplegia	
Chronic Leukemia	Diabetes Type 1 & 2	Parkinson's Disease	
COPD	Emphysema	Peripheral Neuropathy	

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Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition. (2013 National Technical Assistance, RA 101 Part Guide, Pg 17)

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5.10 Acute/Emergency Conditions in Physician's Office

Patients with life threatening conditions are not likely to be treated in the physician's office. Upon review, it is often discovered that documentation is describing the historical event rather than a current (acute) condition. Use the following list as a guide if it appears that an acute, emergent event has been documented in the office visit. Keep in mind that historical conditions that have no bearing on current care are not coded. TAMPER applies to all acute conditions.

Table 5C Coding Acute Conditions (not an all-inclusive list)

Code	Acute Condition(s)	Coder Action
411.1	Unstable Angina, Acute Coronary Syndrome	Assign a code for the underlying condition if documentation supports, such as CAD.
434.xx 436	Occlusion of cerebral arteries Acute, but ill-defined, cerebrovascular disease	Assign code V12.59 for history of CVA if no residual conditions remain. If the provider documents a late effect and cause (e.g., hemiplegia due to CVA) then use the late effects category 438.xx.
410.x1 410.x0	Acute Myocardial Infarction (initial episode of care) Acute Myocardial Infarction (unspecified episode of care)	Look for the date of the event. If the patient is ≤ 8 weeks status post MI, it is acceptable to code 410.x2 for subsequent follow up care. Assign code 412 if the patient had an MI > 8 weeks ago.
518.5 518.81 518.82 518.84	Pulmonary insufficiency following trauma and surgery Acute respiratory failure Other pulmonary insufficiency, NOS Acute on chronic respiratory failure	Assign a code for the underlying pulmonary condition with supporting documentation, such as COPD.

5.11 Specialists

For specialist (Cardiologist, Ophthalmologist, Endocrinologist, etc.) encounters, all confirmed conditions documented in the HPI, ROS, Exam, and/or assessment that pertains to the specialist's field should be captured as long as there is no evidence of contradiction in the medical record. The specialist is following up on conditions that the PCP does not. They perform specific examinations and tests that would constitute as TAMPER for those conditions related to the specialist's field. It would also be appropriate to code co-existing conditions as long as there is supportive documentation for that condition. As a reminder, do not code from PMH alone without TAMPER.

5.12 Inferring a Diagnosis

Coder's must be careful to not infer a diagnosis that has not been stated by the provider. For example, Coumadin is listed as a current medication but the condition for which Coumadin is being taken is not stated. It would be incorrect for the coder to infer that the patient has atrial fibrillation based solely on the medication. Also, coders must not assign diagnoses based solely on findings (lab, x-ray, etc.). **The provider must specifically state the condition in the documentation in order for it to be coded.**

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5.13 "History of"

According to ICD-9-CM, the phrase "history of" means the patient no longer has the condition and the diagnosis often indexes to a V-code not in the HCC models. However, physicians often use this phrase to indicate the length of time for which a member has been treated for a condition. Use the context of the entire medical record to determine whether the condition is active with current treatment or historically resolved.

5.14 Problem Lists

Problem lists rarely contain the required elements as described by CMS. In general, it is felt that they should be avoided as a source of diagnosis coding. **Do not code from the problem list or PMH unless there is TAMPER that can be attributed to the condition.** Carefully review the documentation, including dates (if listed) to ensure that the condition is not historically resolved.

Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender. (2008 Risk Adjustment Participant Guide, 7-17, p172).

5.15 Status/ Status Post Codes

Per ICD-9 Guidelines, "Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing a person's health status. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition." The status code may not affect the course of treatment indicating an exception to the TAMPER criteria.

Status codes may be coded from *any* part of the medical record as long as there is evidence of the condition. Coders are again cautioned with coding from PMH alone; validate that the condition and/or presence of device is a current status and not historical when able. Typically ostomies, amputations, and devices are documented in the physical exam for confirmation of current status.

Listed below are status/status post codes that link to an HCC:

- organ transplant status such as lung, liver, stem cell, etc.
- HIV status
  - *Note: Per ICD-9 Guidelines, "V08 Asymptomatic human immunodeficiency virus [HIV]*

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infection is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive;' "known HIV;' "HIV test positive:' or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any: HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08."

- heart assists devices/artificial heart
- renal dialysis
  - *Note: Must be documented as <u>currently</u> receiving dialysis in order to code V45.11 for renal dialysis status. Assign the renal dialysis status code for the presence of an AV (arterial-venous) shunt only when documentation specifies it is for dialysis.*
- ventilator status
- long term use of insulin
  - *Note: Use only as secondary to type II diabetes.*
- old Myocardial Infarction (refer to Table 7B for common terms associated with MI)
- artificial/stoma openings such as tracheostomy, gastrostomy, etc.
  - *Note: Must be documented as currently present. Look for words such as "takedown" or "reanastomosis" to indicate the ostomy no longer exists.*
- amputations of lower extremity such as toe, BKA, and AKA
  - *Note: Traumatic amputation should only be coded for acute treatment. If the patient had a traumatic amputation of the lower extremity in the past, correct coding would fall under the V49.7x category*
- hemiplegia/ hemiparesis
  - Note: *If late effect of CVA, must be documented with linking verbiage*

5.16 Legibility

Documentation should be clear and legible. Do not assume or guess a diagnosis. Only code the conditions that are clearly documented and supported in the medical record.

At a minimum the following items must be clear and legible:

- DOS including month, day, and year
- Member's first and last name
- Diagnosis
- Supportive TAMPER

If in doubt, please have another coder/supervisor review the record for legibility.

5.17 ICD-9-CM Codes Only

Some physician records contain only ICD-9-CM codes without the code's description. For risk adjustment purposes, there must be documentation of the condition elsewhere on that DOS. If the record does not document the condition (other than just listing the ICD-9-CM code), do <u>not</u> code.

Remember: The clinician must document the <u>condition</u> in the medical record in order for code assignment. Refer to ICD-9 coding guidelines and other reputable resources previously listed for further guidance.

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Part 6: Inpatient

6.1 Hospital Inpatient

Hospital inpatient services include those for which the patient is admitted to the facility for at least one overnight stay. Covered and non-covered hospital inpatient facilities are listed below.

Covered Facilities:
- Short-term (general and specialty) Hospitals
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Medical Assistance Facilities/ Critical Access Hospitals

Non-Covered Facilities*:
- Skilled Nursing Facilities (SNFs)
- Hospital Inpatient Swing Bed Components
- Intermediate Care Facilities
- Respite Care
- Hospice

** These are examples of non-covered facilities and not a comprehensive list.*

6.2 Inpatient Records

In order to code an encounter as an inpatient record there must be a valid discharge summary containing both the admission and discharge dates. Per ICD-9-CM Inpatient Coding Guidelines, "*If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis*." Additionally, diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

Listed below are a few rules to consider when coding for Inpatient Records:

- A discharge summary is considered a valid document to code for an inpatient record if both the admission and discharge dates are listed. Use inpatient coding guidelines.
- CMS has strict guidelines for submitting History & Physical (H&P) as stand-alone documentation. Refer to 2008 CMS Risk Adjustment Participant Guide section 6.4.3.1 History and Physical (H&P), and Lab and Pathology Reports- Guidance for more details.
- Emergency room visits on the day of admission, operative reports, inpatient consults, H&P, and inpatient progress notes may be coded:
  - In combination with a valid discharge summary using inpatient coding guidelines, *or*
  - Separately using outpatient coding guidelines

Inpatient Coding Advise: Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. (AHA Coding Clinic for ICD-9-CM, 2007, 3Q, p14).

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Part 7: Condition Specific Coding Guidance

7.1 Cancer

If documentation is not clear whether a neoplasm is benign or malignant, use the alphabetic index to find the morphological term used to describe the behavior of the neoplasm. For example, the term leiomyosarcoma is indexed to malignant neoplasms while lipoblastoma is indexed to benign neoplasms in the ICD-9-CM code book.

7.1.1 Current Cancer vs. History

Clinicians may document cancer in historical terms. Coders must refer to the entire document for each DOS to determine whether the malignancy should be coded history, using a V-code, or current. **Documentation must show clear presence of current disease to code current malignancy.** Instances in which the malignancy should be coded as current are noted below.

1. Document indicates either the patient or physician chose not to treat the cancer (e.g. choosing not to continue treatment of a terminal disease) OR

2. Document shows evidence of current/ongoing treatment of the disease:
   - Chemotherapy (e.g. antineoplastic medications)
   - Radiation therapy (e.g. including radioactive seed implantation to provide continuous ambulatory radiation)
   - Suppressive therapy (e.g. hormonal therapy, like Lupron for advanced prostate cancer)
   - Surgical treatment (e.g. a preoperative examination prior to colectomy)
   - Immunotherapy/Biological therapy (e.g. Herceptin therapy for breast cancer)
   - Other Adjuvant therapies

3. Documentation shows that current treatment is being temporarily stopped for the following reasons :
   - To determine an appropriate or alternate treatment plan for the patient's cancer
   - To allow the patient to rest clinically from the effects of treatment (chemo/radiation)
   - To transfer of care where treatment is to be continued by another provider

For coding purposes, cancer is considered "history of" after definitive surgical treatment and/or completion of treatment regimen **unless there is documented evidence of residual disease/ treatment.** Reference chapter 2 of the ICD-9 Coding Guidelines for more specific details for coding neoplasms.

> *Per RADV Medical Record Checklist and Guidance, "Pay special attention to cancer diagnoses. A notation indicating 'history of cancer,' without an indication of current cancer treatment, may not be sufficient documentation for validation."*

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7.1.2 Primary vs. Secondary

Metastatic from = Primary

For Example: Malignancy of the colon metastatic from prostate.
- Prostate cancer is primary.
- Colon cancer is secondary.

Metastatic to = Secondary

For Example: Breast cancer with metastasis to the mediastinal lymph nodes.
- Breast cancer is primary.
- Mediastinal lymph nodes cancer is secondary.

If the documentation only states "metastatic" assign the primary malignancy along with code 199.1 for secondary malignancy of unspecified site. (Faye Brown's ICD-9-CM Coding Handbook 2011, pg. 381)

For coding purposes, if a malignancy is not specified as primary or secondary it is assumed to be primary. The following sites are exceptions; they are classified as secondary when not otherwise specified in the documentation:

- Bone
- Brain
- Diaphragm
- Heart
- Liver
- Lymph nodes
- Mediastinum
- Meninges
- Peritoneum
- Pleura
- Retroperitoneum
- Spinal cord

The liver has 3 possible morphological designations:

- Liver, primary – code 155.0 (HCC 8/9*)
- Liver, secondary – code 197.7 (HCC 7/8)
- Liver, not specified as primary or secondary – code 155.2 (HCC 8/9)

* Note: HCC 2013/HCC 2014

7.1.3 In Remission

The following definitions of "remission" are provided by the National Cancer Institute:

- Remission – a decrease in or disappearance of signs and symptoms of cancer
- Partial Remission – some, but not all, signs and symptoms of cancer have disappeared
- Complete Remission – all signs and symptoms of cancer have disappeared, although cancer may be in the body

Lymphoma patients who are "in remission" are still considered to have lymphoma and should be assigned the appropriate code from categories 200-202 (AHA Coding Clinic for ICD-9-CM, 1992, 2Q, p3).

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When coding cancer, ICD-9 guidelines state that there must be current treatment aimed at the malignancy in order to assign a current cancer code. Lymphoma "*in remission*" represents an exception to that rule. Lymphoma stated as "*in remission*" is coded as current from categories 200-202 per AHA Coding Clinic reference above. It is inappropriate to assign a history code for lymphoma when specified as "*in remission*."

Do not to confuse lymph node metastasis with lymphoma. Physicians may document lymph node involvement in a patient with lymphoma. It is incorrect to assign category 196 (secondary and unspecified malignant neoplasm of lymph nodes) in this case.

When coding other hematopoietic neoplasms/malignancies classified to codes 203-208 (i.e. plasma cell leukemia) assign the correct fifth digit to indicate the appropriate stage of the disease based on documentation in the medical record.

Table 7A Fifth Digit Classification

Fifth digit	For use with ICD-9 categories 203-208
0	Without mention of having achieved remission
1	In remission
2	In relapse

7.1.4 In-Situ

A neoplasm described as in-situ (codes 230-234) has not metastasized or spread to any other area of the body. The ICD-9-CM coding guidelines offer specific guidance via the index. **A neoplasm described as both in-situ and secondary, represents a conflict in the medical documentation.** Use sound coding judgment and context to determine the appropriate behavior of the neoplasm based on past medical history and treatment (surgical/ radiation/ chemotherapy) documented along with TAMPER to support the chosen code.

- **Dysplasia** – earliest form of pre-cancerous lesion recognizable in a biopsy by a pathologist. Dysplasia can be low grade or high grade. The risk of low-grade dysplasia transforming into cancer is low. Per ICD-9 index reference the term dysplasia, followed by the correct anatomical site.
- **Carcinoma in situ** – neoplasm that has stayed in the place where it began and has not spread to neighboring tissues (e.g., squamous cell carcinoma in situ). The term is synonymous with high-grade dysplasia in most organs.

7.2 Myelodysplastic Syndrome/Myelodysplasia

Myelodysplasic Syndrome, code 238.75 (HCC 44/46), is sometimes confused with congenital myelodysplasia of the spine, code 742.59 (HCC 69/72), a birth defect. Myelodysplasic syndrome (MDS, myelodysplasia) is a group of blood disorders associated with low blood count; it is more common among the elderly population versus the congenital spine defect. Use context and coding judgment to determine correct code.

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7.3 Diabetes

Coding for diabetes is a four-step process in which coders must have key pieces of information in order to make accurate code selections:

- Type of Diabetes – type 1 (juvenile) or type 2 (adult onset)
  - Default is type 2 if unspecified
- Status of Control – controlled vs. uncontrolled
- Associated Manifestations – complications or manifestations of diabetes must be documented with linking verbiage to display causality
- Insulin Use – code *only* as secondary to type II diabetes
  - Code as secondary to type I DM, if desired. Type 1 diabetics must use insulin because their pancreas does not produce insulin naturally. Thus, unnecessary to assign V58.67.

Note: *Coder's should never assign a code for diabetes 250.xx when the physician documents abnormal glucose, impaired fasting glucose, or impaired glucose tolerance test. A laboratory test showing one reading of high blood sugar is not considered sufficient "clinical evidence" of diabetes. These conditions are laboratory findings and have designated codes for reporting 790.21 – 790.29. Additionally, the diagnosis of "pre-diabetes" also falls under code 790.29.*

7.3.1 Demonstrating Causality

Conditions listed with a diagnosis of diabetes mellitus or in a diabetic patient are not necessarily complications of the diabetes (AHA Coding Clinic, 1991, Q3, p7-8).

Diabetic complications require two or more codes to fully describe the conditions. **Assign a code for both "diabetes with ___ manifestation" in addition to the specific diabetic complication as instructed by ICD-9 coding guidelines.**

There must be a documented cause-and-effect relationship between diabetes and the associated manifestation in order to select a code from HCC categories 15-18. If documentation does not properly link the two conditions, default to diabetes without complication code 250.0x (HCC 19).

Look for linking verbiage such as:

- Diabetic coma
- Gastroparesis in diabetes
- Foot ulcer associated with diabetes
- Nephropathy due to diabetes
- Blindness of diabetes

** This is not an all-inclusive list of terms. The cause-and-effect relationship must be clearly documented with supportive TAMPER*

Gangrene and osteomyelitis are exceptions to the cause-and-effect rule above. ICD-9-CM assumes a causal relationship between osteomyelitis/gangrene and diabetes when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis or gangrene is totally unrelated to the diabetes (AHA Coding Clinic, 2004, Q1, p 14-15).

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7.3.2 Diabetes "with"

Question: What are the code assignments for a diagnostic statement of diabetes with neuropathy? Answer: Assign code 250.6X, Diabetes with neurological manifestations, and code 357.2, polyneuropathy in diabetes, for diabetes with neuropathy. Words such as "with," "with mention of," "associated with," and "in" indicate that both elements in the title must be present in the diagnostic statement or procedural statement. Although they do not necessarily indicate a cause-effect relationship, they occur together much of the time and the classification system indicates this relationship. (AHA Coding Clinic, 2008, Q3)

In ICD-9-CM's Alphabetic Index, the subentry term "with" means associated with or due to. For example: if the provider documents "diabetes with neuropathy," assign codes 250.6X (diabetes with neurological manifestations) and 357.2 (polyneuropathy in diabetes). (AHA Coding Clinic, 2009, Q2)

Coders need to be cautious with vague terms such as "with" ensuring that the medical record supports a diabetic manifestation. The Coding Clinic question pertains to the diagnostic statement of diabetes with neuropathy.

- If HPI states, "diabetes with CKD, CAD, and hypertension" this would not be considered linked as it is not the diagnostic statement. Additionally, it is unclear as to whether CKD is a manifestation of diabetes since there are multiple conditions included in the sentence.
- If Assessment states, "diabetes with CKD- follow with nephrologist." This would be considered linked since it is the diagnostic statement and there is supportive documentation for the diabetic manifestation.

The Coding Clinic examples of "with" is between diabetes and a specific condition, neuropathy. Diabetes with neurological, ophthalmic, renal, or peripheral circulatory manifestation/complications must include the specific condition that falls under that category in order to additionally code the manifestation.

For instance, the diagnostic statement reads, "diabetes with renal manifestations." What renal manifestation?

- Chronic Kidney Disease
- Diabetic Nephropathy
- Diabetic Nephrosis
- Intercapillary Glomerulosclerosis
- Kimmelstiel-Wilson Syndrome

If it is unclear as to what the specific diabetic manifestation is, default to diabetes without complication code 250.0x (HCC 19).

7.3.3 Diabetic Examinations

If the patient is being seen for a *diabetic* eye or foot exam, it would be appropriate to code the confirmed diabetic manifestation.

- During the diabetic eye exam, the patient is diagnosed with PDR (proliferative diabetic retinopathy). It would be appropriate to code 250.50 and 362.02 for this encounter as instructed by ICD-9 guidelines (code first diabetes).

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- During the diabetic foot exam, the patient is diagnosed with Diabetic Peripheral Neuropathy. It would be appropriate to code 250.60 and 357.2 for this encounter as instructed by ICD-9 guidelines (code first underlying disease).

Common forms of TAMPER for diabetes include, but are not limited to:

- A1C – blood test checks how well your diabetes has been recently controlled
- Oral Glucose Tolerance Test or Plasma Glucose Test – a blood test given after more than 8 hours of fasting followed by a dose of glucose, additional testing is then performed to determine the level of glucose that remains in the blood.
- Documenting the review of home blood sugars
- Insulin – currently used or prescribed (code V58.67 in addition to diabetes type II)

7.4 Peripheral Neuropathy

Peripheral neuropathy, code 356.9 (HCC 71/no HCC) is a result of nerve damage, often causing numbness and tingling in the hands and feet. One of the most common causes of peripheral neuropathy is diabetes.

Assign code 356.9, Polyneuropathy unspecified, for peripheral neuropathy of both extremities. Because the disease is affecting multiple nerves, this would be classified as a polyneuropathy. (AHA Coding Clinic, 2013, Q1)

7.5 Morbid Obesity/Body Mass Index (BMI)

Morbid obesity, code 278.01 (no HCC/22), is defined in ICD-9-CM as a BMI of 40 or greater (based on WHO criteria). BMI codes V85.4x (no HCC/22) should only be assigned as a secondary diagnosis when a clinical condition has been stated by the provider. According to the ICD-9-CM codebook, when coding for overweight and obesity an additional code should be used to identify the BMI, *if known*. Ensure that the BMI supports the corresponding diagnosis of morbid obesity.

Individuals who are overweight, obese, or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. (AHA Coding Clinic, 2004, Q3)

If the BMI has clinical significance for the patient encounter, the specific BMI value may be picked up from the dietitian's documentation. The provider must provide documentation of a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet the criteria for a reportable secondary diagnosis, the BMI would need to have some bearing or relevance in turns of patient care. For reporting purpose, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring: Clinical evaluation; or Therapeutic treatment; or Diagnostic procedures; or Extended length of hospital stay; or Increased nursing care and/or monitoring. Once the provider has provided documentation of the clinical condition, such as obesity, the coder can use the dietitian's note to assign the appropriate BMI codes from category V85 (AHA Coding Clinic, 2008, Q4)

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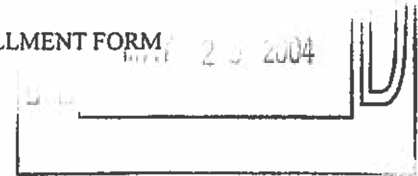
Medicare+Choice Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM



ONLY for the Collection of Risk Adjustment Data and/or

With Medicare+Choice Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees:**

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness
4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.
6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.
7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.
8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
11. That it will research and correct risk adjustment data discrepancies.
12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To:**

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.
2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.
3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's

Name: ANTHEM BLUE CROSS BLUE SHIELD

Title: ANTHEM SENIOR ADVANTAGE

Address: 1351 WILLIAM HOWARD TAFT

City/State/ZIP: CINTI, OHIO 45206

By: [signature]

Title: Manager, reconciliation Date: 5-19-04

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

M+CO EDI Enrollment

P.O. Box 100275, AG-570

Columbia, SC 29202-3275

Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

H9886

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees:**

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct risk adjustment data discrepancies.

H9886

12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To:**

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

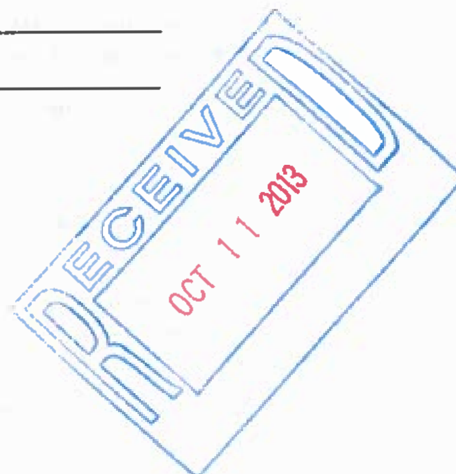
Eligible Organization's Name: The WellPoint Companies, Inc.

Contract Number: H9886

Signature: [signature]

Name: J. Camille Welch

Title: Director, Medicare Risk & Recovery



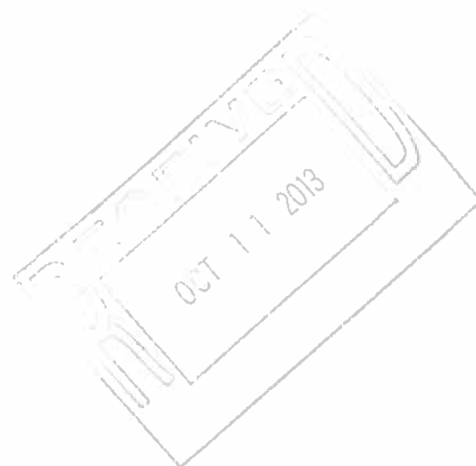
MEDICARE
CSSC OPERATIONS

Dial up / Modem ________________

GENTRAN ________________

Please return the completed submitter application, EDI Agreement and CONNECT:DIRECT dataset specifications, if applicable, to CSSC Operations at the address below.

Palmetto GBA
CSSC Operations, AG-570
2300 Springdale Drive, Bldg. One ■ Camden, South Carolina ■ 29020
www.cssoperations.com
A CMS Contracted Intermediary and Carrier



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Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. **The Eligible Organization Agrees:**

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.

3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness

4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.

5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.

6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.

7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.

8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

11. That it will research and correct risk adjustment data discrepancies.

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12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agrees To:**

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.

2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.

3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.

4. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. **Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name: HMO COLORADO, INC.

Contract Number: H1394

Signature: [signature]

Name: Jeff Deshay

Title: Director, Reporting & Data Analysis

RDD 15343C23100003 15343 0007

Address: 700 Broadway

City/State/ZIP: Denver CO 80273

Phone: (724)996-5258

Email: jeff.deshay@anthem.com

Date: 12/2/2015

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

Medicare Advantage EDI Enrollment
CSSC Operations AG-570
2300 Springdale Drive Bldg. One
Camden, SC 29020-1728

Phone (877) 534-2772
www.csscoperations.com

Review and Certify Risk Adjustment Data Confirmation - Payment Year 2014 (Dates of Service 2013)

Confirmation #: 1172

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and ANTHEM HEALTH PLANS, INC. (H5854), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage and Medicare Advantage-Prescription Drug plans 005, 801, 803, 805, the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentation to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2013, to December 31, 2013, all risk adjustment data (INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, AND PHYSICIAN) available to the MA Organization as of January 31, 2015, with respect to the above-stated MA and MA-PD plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

MARC RUSSO on behalf of

ANTHEM HEALTH PLANS, INC. (H5854)

6/26/2015

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Review and Certify Risk Adjustment Data Confirmation

Confirmation #: 530

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

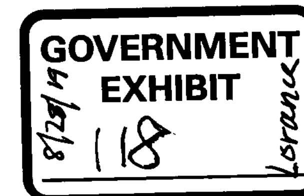
Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC. (H4211), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage and Medicare Advantage-Prescription Drug plans 001, 003, the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentation to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2012, to December 31, 2012, all risk adjustment data (INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, AND PHYSICIAN) available to the MA Organization as of January 31, 2014, with respect to the above-stated MA and MA-PD plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

MARC RUSSO on behalf of

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC. (H4211)

4/30/2014



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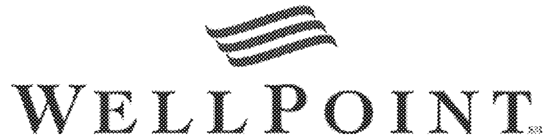

FAQ'S REGARDING RETROSPECTIVE MEDICAL RECORD REVIEW AND MEDICONNECT GLOBAL

Question: **Who is MediConnect?**

Answer: MediConnect is a leading document management company, located in South Jordan, Utah, that provides medical record retrieval services for health and life insurance companies and law firms. In addition, MediConnect provides other medical record management and coding services as part of its record retrieval services.

Question: **What services is MediConnect performing on behalf of WellPoint?**

Answer: MediConnect is assisting WellPoint in retrieving Medicare Advantage member medical records from physicians throughout the WellPoint regions and from a select number of hospitals. Like last year, CV Infosys, another WellPoint vendor, will be retrieving record summaries from all other hospitals.

Once the records are retrieved from the provider, MediConnect will perform a record review to capture diagnosis data from the record for submission to CMS as part of WellPoint's risk adjustment data submissions.

This review is referred to as the retrospective medical record review.

Question: **Why is MediConnect assisting in performing the retrospective medical record review?**

Answer: CMS ***requires*** Medicare Advantage health plans to submit all ICD9 codes for all Medicare Advantage members in order to ensure adequate and accurate risk adjusted payment to the Medicare Advantage health plan. While WellPoint collects all submittable ICD 9 codes from available encounter data (e.g. claim files and encounter files), WellPoint also collects ICD9 codes from medical record documentation in order to ensure that it is meeting its CMS obligations concerning the submission of ***all*** member diagnosis data.

In addition, CMS requires that medical record documentation support the ICD9 code selected and substantiate that proper coding guidelines were followed. Therefore, the retrospective medical record review will ensure that ICD9 codes have been reported by the provider correctly.

Question: **Is the retrospective medical record review an audit?**

Answer: No, this is not an audit. This is an oversight activity related to the collection and reporting of member diagnosis data which must be supported by medical record documentation as required by CMS.

Question: **Does the retrospective medical record review process apply to all medical records?**

Answer: No, under the CMS-HCC model of payment, Medicare Advantage health plans may only submit diagnosis data that is obtained from physicians and IP or OP hospital visits or encounters. This means that we will be collecting records from physicians and hospitals only.

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MediConnect is assisting WellPoint in collecting medical records from ***all*** physicians and select hospitals. WellPoint is using another vendor, CV Infosys, to assist in collecting record summaries from all other hospitals.

Question: **Is WellPoint asking for medical records for all dates of service?**

Answer: No. We are asking that providers supply medical records having a date of service of January 1, 2010 to current date.

Question: **Are we collecting medical records for all Medicare Advantage members?**

Answer: No. WellPoint will be targeting Medicare Advantage members who are flagged using an algorithm that has been developed based on claims and pharmacy data. The flagged member names will be compiled into a chase list that will be supplied to MediConnect to initiate the retrieval process.

Question: **What is the provider notification process?**

Answer: Beginning on May 16, 2011, MediConnect will initiate the record retrieval process. The process begins with telephonic outreach to the provider which is followed by a written request. The written request addresses the role of MediConnect, the purpose of the medical record retrieval request, the action being requested (i.e. submission of the entire medical record), the name of the member and the dates of service being requested. A sample of the provider record request letter is attached at the end of this document.

Question: **When does the provider need to submit the requested medical records?**

Answer: The provider should supply the medical records within 2 weeks following receipt of the request.

Question: **What should the provider do if the information being requested does not appear in the medical record (e.g., the provider did not actually see the patient during the requested date(s) of service)?**

Answer: The provider should return the request to MediConnect with an explanation that no information relative to the request appears on the patient's medical record.

Question: **How does the provider submit a medical record? Are there different submission options?**

Answer: The medical record(s) may be returned to MediConnect using the following methods:

1. Secure Fax: 800-391-1807
2. Mail: Prepaid Postage
3. EMR Integration
   a. Remote access to Provider's EMR system by MediConnect
   b. Print to file and (1) electronic upload or (2) save to encrypted CD, DVD or thumb drive
   c. Implement secure FTP with Provider
4. Secure FTP Transfer
5. Provider Portal Upload
   a. www.submitrecords.com/
   b. Password: secure62
   c. Click select and select records to upload from provider's Windows Explorer.
   d. Records (PDF or TIF) can be uploaded individually or in batch.
6. Onsite Scanning

Question: **Once the medical record is submitted to MediConnect, what happens?**

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Answer: Upon receipt of the medical record, it will be imaged and uploaded into MediConnect's web-based medical record management system. A MediConnect coder will review the medical record and the medical conditions reported on the record will be assigned a diagnosis code in the web-based medical record management system. Diagnoses codes identified in the record will be extracted into a file and provided to WellPoint.

Question: **What happens with the ICD9 codes collected from the medical records?**

Answer: MediConnect will provide to WellPoint a file of all ICD9 codes extracted from the medical record. This information will then be submitted to CMS through the CMS risk adjustment data processing system. This system is designed for the submission of member diagnosis data collected from all Medicare Advantage health plans.

Question: **Is the provider required to comply with the request for medical records?**

Answer: Yes. CMS requires that the MA health plan submit to CMS **all** acceptable diagnosis codes for a Medicare Advantage member. The medical record is used for purposes of extracting ICD9 codes that were not reported on the member's claim or encounter file. In addition, CMS requires that medical record documentation support the ICD9 code selected and substantiate that proper coding guidelines were followed. Therefore, the review process will help ensure that the ICD9 codes have been reported accurately.

Also, in accordance with the language in the provider agreement/terms and conditions of payment, ***all providers*** are required to comply with WLP's request for medical records to facilitate WellPoint's review of risk adjustment data.

Question: **Does the provider need a HIPAA authorization or release in order to supply the medical records?**

Answer: No. The HIPAA Privacy Rule allows for the disclosure of protected health information without a HIPAA authorization form or release of information when such information is being disclosed for payment, treatment and health care operations (45 CFR 164.506). The release of medical records for purpose of the Medicare Advantage health plan extracting diagnosis data to be submitted to CMS for risk adjustment purposes is considered a health care operation activity.

Question: **Will the provider be reimbursed for supplying the medical records?**

Answer: No, the provider will not be paid for producing the record. CMS requires that MA health plans support their member diagnosis data with medical record documentation. This requirement, as well as the provider agreement/terms and conditions of payment, mandate that ***all providers*** comply with WellPoint's request for medical records to facilitate WellPoint's review of risk adjustment data.

Question: **Who can I contact if I have questions?**

Answer: Matt Cogdill, Manager of Retrospective Risk Adjustment Programs
(614)880-6268
brian.cogdill@wellpoint.com

Question: **What is the timeline for the medical record retrieval process?**

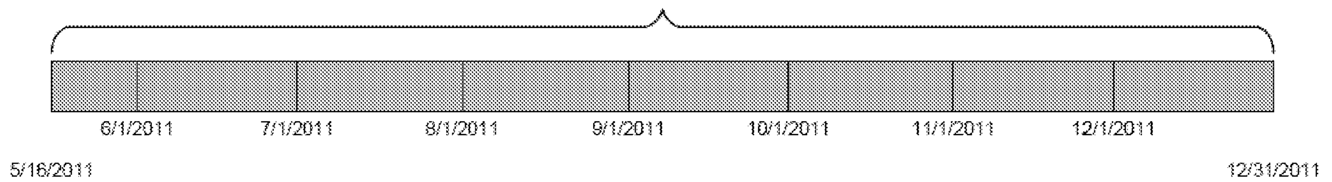
Answer: See below.

MediConnect Record Retrieval Timeline

5/16/2011 - 12/31/2011

MediConnect begins to request records starting 5/16/11 and continues requesting or pursuing records through 12/31/11. Providers mail, fax or upload records to MediConnect throughout this period.
As records are received, records are imaged and uploaded into record management system. Diagnosis codes are extracted from record and populated into data file.
Produces data file 2 x month for submission to CMS.

Note: 5/16/2011 is a tentative begin date



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Provider Announcement

Empire Blue Cross Blue Shield Teams With MediConnect Global, Inc.

July 1, 2010

Empire Blue Cross Blue Shield (Empire) is pleased to announce its collaboration with MediConnect Global, Inc. ("MediConnect"), a leading records retrieval and electronic document management company that specializes in medical records retrieval, digitization, coding and delivery via the internet. MediConnect's web based workflows will help reduce time and improve efficiency and costs associated with record retrieval, coding, and document management.

CMS requires that we perform oversight activities related to the collection and reporting of member diagnosis data which must be supported by medical record documentation. As such, Empire has engaged MediConnect to perform retrospective reviews of our Medicare Advantage member medical records. MediConnect's role in record retrieval, review and coding will be instrumental in helping Empire ensure risk adjustment payment integrity and accuracy.

If you have any questions regarding MediConnect Global, Inc., or this record retrieval process contact your Provider Services Representative.

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

MediConnect Global, Inc. is an independent company providing medical record retrieval services.

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ANTHEM_DOJ_00046576

US-12-B

Excludes Simply

Membership	
Program	2015 Program Actual

Program Expense Aligned to Revenue Payment Year

Program	2015 Unit Cost	2015 Volumes	2015 Actual
Housecalls			
In Office			
Retro Charts[1]	$ 37	511,190	$ 18,811,606
Non-HDC Total[2]			**$ 66,081,057**

Program Revenue Aligned to Expense Year

Program	2015 Unit Revenue	2015 Volumes	Revenue on 2015 Actual
Housecalls			
In Office			
Retro Charts	$ 170	**$ 511,190**	$ 112,929,769
Non-HDC Total			

Program Revenue ROI (i.e. Revenue/Expense)

Program	Revenue on 2015 Budget
Housecalls	**3.77**
In Office	**1.31**
Retro Charts	**6.00**
Non-HDC Total	**3.25**

Notes

[1] *2015 include $1.3M of re-code of 2014 charts; 2016 include $2.4M of targeting improvement benefits (i.e. worth $5/chart cost impr*

[4] *Program volumes and $ are aligned with the revenue payment year*

A cursory Westlaw search identified more than 2,000 cases in which Anthem was a party or was cited in other relevant cases. At present, the most significant is a pending US federal civil fraud action in the US District Court for the Southern District of New York. In this case, Anthem is accused of submitting false diagnosis code claims to Medicare to generate tens of millions of dollars in fraudulent revenue. Here is link to the US Attorney's statement: https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-files-civil-fraud-suit-against-anthem-inc-falsely-certifying

In addition, regarding the civil fraud case, I am attaching the original complaint and a summary from Westlaw of the more than 194 docket proceedings that have transpired in this matter since original filing in 2020. The parties were disputing matters as recently as this week.

Here are a few highlights of cases, settlements, fines, and penalties that I came across in Westlaw, press briefings, and news articles:

- $16 million owed to HHS Office of Civil Rights for a record HIPAA data breach violation
- $23.6 million settlement for a breach of fiduciary duty on 401(K) management
- $594 million class action antitrust settlement (regarding BCBS anti-trust)
- Settled for an undisclosed amount in a lawsuit brought by Valley Health over $11.4 million in past due claims
- $39.5 million in penalties and fines regarding security breach
- $115 million to settle action regarding a security breach
- Settled for an undisclosed amount in a lawsuit brought by Bon Secours over $93 million in unpaid claims
- $690,000 in fines in California for delay in reimbursement
- $300,000 in fines in Virginia for failure to pay claims

This list is intended for summary purposes and is in no way exhaustive.

Good afternoon. I'm Maria Bowen, Vice President of Governmental Affairs with the Louisiana State Medical Society. I'm here today speaking on behalf of the State Medical Society and the following statewide specialty organizations, as well as a number of local societies which include:

- Louisiana Academy of Family Physicians
- Louisiana Chapter of the American Academy of Pediatrics
- Louisiana Society of Anesthesiologists
- Louisiana Chapter of the American College of Physicians
- Louisiana Academy of Eye Physicians and Surgeons
- Louisiana Chapter of the American College of Emergency Physicians
- Louisiana Chapter of the American Congress of Obstetricians and Gynecologists
- Louisiana Orthopaedic Association
- Louisiana Psychiatric Medical Association
- Louisiana Society of Interventional Pain Physicians
- Louisiana Society of Plastic Surgeons
- Calcasieu Parish Medical Society
- Capital Area Medical Society
- Jefferson Parish Medical Society
- Lafayette Parish Medical Society
- Northwest Louisiana Medical Society

Our physician members and the members of the organizations standing with us have specifically asked that LSMS speak on their behalf. They are rightfully concerned and want to convey those concerns about what could happen to their patients with any disruption to patient care. They are rightfully concerned about the impacts on their current and future contracts and their ability to maintain a working relationship with the insurers. They are very cognizant that regardless of the outcome of the upcoming proceedings, they will need to continue to have a working relationship with these insurers in order to maintain viable medical practices.

This is a very large business transaction. Anytime corporations are involved in transactions of this magnitude, you have to anticipate changes. Neither of these corporations, however, will be personally impacted by these changes – Louisiana's patients, their physicians and other health care providers will be, though. And in this particular instance, Louisiana physicians aren't just physicians. They're business owners worried about their ability to maintain appropriate, affordable coverage for their employees. They're policy holders worried about adequate benefits. And they're patients worried about their own health needs. They are concerned about increased premiums for the sake of corporate profit, narrowing networks that exclude specialists and local quality practices in order to increase the financial bottom line. They are worried about significant reimbursement reductions, unpaid and underpaid claims, improper authorization denials and all of the other occurrences that our counterparts around the country have shared with us. They are further worried about changing business practices being dictated from remote corporate headquarters. Insurance is difficult enough to navigate when there aren't artificial administrative hurdles and people aren't pawns in a game. You are all very aware of the struggles involved when huge corporate entities put profits over people or you wouldn't have supported the physician community last year when we sought such significant prior authorization reforms. AND I would be remiss if I didn't emphatically say thank you for supporting us and Louisiana's patients in that reform effort.

Last week, LSMS crafted an open letter to patients because of the many physician members who have patients looking for answers. Patients have serious reservations about their continuity of healthcare based on news reports from other states where patients have been reassigned to physicians they don't know. Please understand that our physicians don't just care for the 90,000+ PPO policy owners who get to vote. Our physicians also care for the remainder of the 1.9 million non-voting Blue Cross customers in HMO plans and in Healthy Blue Medicaid plans and in employee group plans to include some offered through your very own Office of Group Benefits. Our physicians care about and treat their patients regardless of their insurance plan. Physicians have expressed serious concerns about their practices if this sale is finalized. If they aren't treated fairly; if they aren't able to negotiate fair contracts and if they aren't adequately and timely paid for their services, they may have no other choice but to terminate contracts, change business models or practice their profession elsewhere. They also have concerns about being arbitrarily terminated from networks they've been part of for years.

What we're hearing from around the country has only increased the concerns people have.

- We have physicians in Wisconsin sharing information from the Wisconsin Hospital Association discussing millions in payment delays that have left physicians and other providers holding the bag.

- In addition, the American Hospital Association calls Elevance out for being particularly notorious for slow or no payment to hospitals and pre-authorization delays that put patient's health at risk and contribute to clinician burnout.

- We have organizations in New Hampshire, Maine, Indiana and elsewhere reporting tens of millions of dollars in underpayment and inappropriate denials from Anthem/Elevance potentially resulting in contract terminations and patient access concerns.

- We have the State of Georgia fining Anthem Blue Cross $5 Million after determining the company violated policyholders' rights for years, including improper claims settlement practices and violations of state law.

- While promising that the same people in Louisiana will still have jobs and physicians and other providers will have access to familiar employees, Becker's is reporting what Elevance confirms and terms as "changes" to its workforce.

- We have healthcare lobbyists in Missouri sharing videos of grassroots advocates protesting at the doors of Elevance Health's headquarters in Indiana because they can't get anyone to answer their questions.

- California physicians have shared that they have patients worried about being reassigned to physicians they don't know thanks to a contract dispute between UC's Health System and Elevance/Anthem. This contract impacts over 600,000 Anthem members.

- The California Medical Association has further filed a complaint on Elevance/Anthem's refusal to reimburse for emergency services that have already been provided.

There is no doubt where the Louisiana State Medical Society stands right now. We stand with our physicians and their patients who have watched this partnership occur in other states and are very worried about what they are seeing and hearing. We've always been told to learn from history so that we don't repeat history. The articles and information shared from our counterparts and our physicians' peers is plentiful and it is concerning.

I very much appreciate your time and interest this morning. We welcome the additional sunshine you are focusing on this transaction. And we look forward to continuing to work with you on this and other endeavors.

STAFF FILE PHOTO BY MICHAEL JOHNSON

A stand-up metal detector sits at the entrance of the Istrouma High School gym on Dec. 18 in Baton Rouge.

VIOLENCE

Continued from page 1A

"All of those things are going to have to be pivotal in whatever administration that we are coming up with next, because you have to get the school culture things under control as well as safety before you can talk about academics," Johnson said.

Board Vice President Patrick Martin urged Smith to take the survey findings and devise a "comprehensive set of recommendations for policy changes" for the board to consider to improve safety.

The survey was conducted by Boston-based District Management Group, hired at a cost not to exceed $30,000. The firm, also known as the DM Group, already has been doing extensive work with the system to improve literacy. In September, the school system hired the firm again for $49,375 to do follow-up work with a handful of schools to reduce "incidents of disruption and violence" partly through "consistent performance monitoring" of their schools.

According to school officials, that work began in early January in support of five high schools: Broadmoor, Glen Oaks, Istrouma, Scotlandville and Woodlawn. It is to conclude at the end of March.

That initiative coincides with another recent school safety initiative: the purchase of 25 walk-through metal detectors, enough for every middle and high school in the parish. They are supposed to go live later this month.

The results from the DM Group survey mirror the results of a survey that the Louisiana Federation of Teachers, or LFT, conducted last year, which was completed by almost 1,700 of its members across the state. About 55% of those respondents from the teachers union agreed or strongly agreed with the statement, "I feel safe at this school." Thirty percent disagreed or strongly disagreed, and 15% said they felt neither safe nor unsafe.

Meanwhile, 75% of LFT members consider student behavior a problem, 52% see student-on-student violence as a problem, and 46% say that they themselves are victims of student violence.

Representatives from the DM Group presented the results from its employee survey at the Jan. 24 meeting of the parish School Board. The firm was supposed to give its presentation five months earlier in August, but the board put the matter off in deference to the school transportation crisis that dominated the start of the current school year.

The negative effects of cellphones and social media came up frequently during the survey, as well as in a series of focus groups the firm conducted to figure out what questions to ask. Cellphones and social media often fan the flames of disputes between students or serve as tools for cyberbullying.

Simone Carpenter, a director with the DM Group, told board members that many employees feel "some of the (district) policies around cellphones might not have been the right policies or strict enough policies."

The school system allows students to have cellphones at school. Students are prohibited from using them during the school day, unless otherwise authorized, but students routinely use them anyway.

A few Louisiana school districts are more strict on cellphone use. For instance, City of Baker schools this year instituted a districtwide ban, requiring that students drop off their phones at the front office and then retrieve them only when the school day is over.

"A lot of the issues we have with cellphones stem from the social media issues that are taking place outside of school time, so those things kind of work hand in hand," said School Board President Carla Powell-Lewis, who works as a teacher in Zachary.

She joked that if cellphone reception is made as bad at the schools as it is at Central Office on South Foster Drive "that would solve a whole lot of problems."

Johnson said the elementary school she works at recently instituted a cellphone ban similar to Baker, but students try to sneak them in anyway. One favorite game, she said, involves students going to the bathroom, where security cameras aren't used, and breaking out their cellphones.

"They get to the bathroom and record themselves fighting, just to be social media famous," she said.

When school lets out, the students retrieve their phones from the office and start causing new problems on the walk or bus ride home, Johnson said.

Board member Dadrius Lanus said he wants to see the options for restricting cellphones given potential legal concerns if such policies go too far.

"I just want to know how we go about doing that," Lanus said.

The biggest safety concerns came from middle school staff, who report feeling a bit less safe and that they see more violent and disruptive incidents than their peers. Board member Cliff Lewis asked why.

"Sometimes it has to do with what students are going through at that stage in life," said Michele Sumter with the DM Group. "While there are many things we can put in place, you will see very similar data to this across the country."

The employee survey concluded with questions about the culture of the school system. Respondents were given 11 statements and asked whether they agree or disagree with them.

The statement they found most agreeable, 63%, was, "My peers embrace effective collegiality and collaboration in support of learners." The statements to which they were most hostile involved district leaders. The lowest, with just 30% agreeing, was "District leaders actively engage stakeholders to support the institution's priorities."

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30 January 2024

An open letter to Louisiana's patients regarding the acquisition of Blue Cross by Elevance Health

As a patient in Louisiana, you have a right to be very concerned about the current efforts of Blue Cross Blue Shield of Louisiana (BCBSLA) to convert itself from a not-for-profit entity to a for profit Stock Insurance Company to be acquired by Elevance Health. Many physicians have reached out to us and requested that we provide them with information that can be shared with their patients.

We will begin with the same statement we will end with: **As a policy holder who is deemed a voting member on the proposed plan of reorganization of BCBSLA, the Louisiana State Medical Society (LSMS) has voted NO.**

If you have been deemed a voting member, you will have received a packet from BCBSLA. **We encourage you to also vote NO! If you've already voted, you can go online and change your vote until February 19th.**

We don't urge caution lightly. And in today's world, we don't operate in a vacuum. LSMS has been in contact with our counterparts in other states, and physicians have been communicating with their peers around the country – to include the other 14 states where this acquisition has occurred. Physicians are not telling good stories in those states. Most reports indicate that there is a sweet start to the union, but by year two everything starts to change, as your renewal will be at the purview of Elevance – not BCBSLA. In fact, the BCBSLA mailings allude to this with the following statements:

> *"The plan of reorganization does not change your plan benefits or increase the cost of your insurance* ***for the current plan year."***
>
> and
>
> *"The plan of reorganization will not change the doctors and hospitals in our Blue Cross networks* ***for the current plan year."***

The cash offer of $3,000 to every eligible policyholder is an inducement to many people to vote with BCBSLA on these efforts. As we generally hear from patients that they are "paying more to get less" when they renew their health insurance, you may quickly see that $3,000 return to your new health insurer.

Sometimes "too big" really is "too big." It is detrimental to put your health at risk simply to achieve greater profits for a corporation. Thanks to current overreaching administrative burdens placed on policy holders by corporate entities, you and your physicians are already fighting to get medical care for which you have paid. When you start adding even more layers of administration between you and your benefits, the potential to increase the corporate practice of medicine is very concerning. Do you want your insurance company or your physician determining what's appropriate for you?

Sharing our concerns are the: Louisiana Academy of Eye Physicians and Surgeons, Louisiana Academy of Family Physicians, Louisiana Chapter of the American College of Emergency Physicians, Louisiana Chapter of the American Congress of Obstetricians and Gynecologists, Louisiana Chapter of the American Academy of Pediatrics, Louisiana Orthopaedic Association, Louisiana Psychiatric Medical Association, Louisiana Society of Interventional Pain Physicians, Louisiana Society of Plastic Surgeons, Calcasieu Parish Medical Society, Capital Area Medical Society, Jefferson Parish Medical Society, Lafayette Parish Medical Society, and Northwest Louisiana Medical Society.

We end with the same statement we began with: **As a policy holder who is deemed a voting member on the proposed plan of reorganization of BCBSLA, the Louisiana State Medical Society (LSMS) has voted NO.**

Learn more at https://lsms.org/page/BCBSElevanceAcquisition.

www.lsms.org

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BCBSLA Information Statement

You may at this time select how you wish your proxy to be voted. The Board of Directors recommendations are in blue. To make your selections, click on the radio buttons. The last selection on how you wish your proxy to be voted will be counted. Please note that the total number of votes granted by this proxy will be based on the total number of policies held by you on December 31, 2023, the Effective Date of the adoption of the Plan of Reorganization by the Board of Directors of the Company. You must select For or Against or your vote will not be tabulated.

Make Your Selection	
The Adoption of the Plan of Reorganization by the Board of Directors of the Company.	○ **For** ○ Against
Enter your E-mail address for confirmation of your selection. Your Email	
Click SUBMIT PROXY after making your selection.	SUBMIT PROXY

Your instruction on how your proxy is to be voted has been recorded

Your selection is indicated below:

Description	Your Selection
The Adoption of the Plan of Reorganization by the Board of Directors of the Company.	Against

A confirmation was sent to your email address. Only your latest selection will be counted. If want to you change your selection on how your proxy is to be voted please re-select how your proxy is to be voted on behalf of your policy or policies

[Go Back and Adjust Your Votes]

Louisiana

Grant your Proxy **FOR** our Plan of Reorganization

Change Blue Cross and Blue Shield of Louisiana from a Mutual Insurance Company to a Stock Insurance Company

- Cash payment to Eligible Members of approximately $3,000 per Eligible Policy.
- Creation of a new, billion dollar foundation funded by proceeds from the transaction with Elevance Health focused only on improving Louisiana.
- Blue Cross and Blue Shield of Louisiana will remain a local Blue Cross and Blue Shield company with local customer service, the same network of healthcare providers, and the same offices and employee base in the state.
- The plan of reorganization does not change your plan benefits or increase the cost of your insurance for the current plan year. Upon renewal of any health insurance policy, the law and/or policy terms, unrelated to the plan of reorganization, allow for changes in plan benefits and premiums.
- The plan of reorganization will not change the doctors and hospitals in our Blue Cross networks for the current plan year. At any time, unrelated to the plan of reorganization and in the ordinary course of business, providers may join or leave the network.
- Blue Cross will be a part of Elevance Health, which already owns 14 Blue Cross companies across the United States.
- Blue Cross will have access to greater financial resources to introduce and maintain market-leading customer services and programs.

Explanatory Note: *The following information is only a summary of certain results anticipated to be achieved by the proposed Plan of Reorganization. Please refer to the enclosed Member Information Statement for more information on the proposed transaction.*

26GN1157 R12/23

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross Blue Shield Association.

30 January 2024

An open letter to Louisiana's patients regarding the acquisition of Blue Cross by Elevance Health

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We don't urge caution lightly. And in today's world, we don't operate in a vacuum. LSMS has been in contact with our counterparts in other states, and physicians have been communicating with their peers around the country – to include the other 14 states where this acquisition has occurred. Physicians are not telling good stories in those states. Most reports indicate that there is a sweet start to the union, but by year two everything starts to change, as your renewal will be at the purview of Elevance – not BCBSLA. In fact, the BCBSLA mailings allude to this with the following statements:

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And

> *"The plan of reorganization will not change the doctors and hospitals in our Blue Cross networks* ***for the current plan year****."*

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Sometimes "too big" really is "too big." It is detrimental to put your health at risk simply to achieve greater profits for a corporation. Thanks to current overreaching administrative burdens placed on policy holders by corporate entities, you and your physicians are already fighting to get medical care for which you have paid. When you start adding even more layers of administration between you and your benefits, the potential to increase the corporate practice of medicine is very concerning. Do you want your insurance company or your physician determining what's appropriate for you?

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Learn more at https://lsms.org/page/BCBSElevanceAcquisition.

January 8, 2024

Tim Temple, Commissioner
Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804

Re: Elevance Health Acquisition of Blue Cross Blue Shield of Louisiana

Dear Commissioner Temple:

On behalf of Louisiana physicians and the patients we care for, I would like to express our continued apprehension regarding the proposed acquisition of Blue Cross Blue Shield of Louisiana (BCBSLA) by Elevance Health. Since our public comments dated September 18 (attached), we've continued to talk to physician colleagues in other states; our Board met with Elevance leadership, and we have reviewed the updated filing (which contains very limited changes).

Our Board respectfully requests that all interested parties be provided a comprehensive outline of the deficiencies identified by BCBSLA, which prompted the interest in the proposed acquisition by Elevance Health, inclusive of financial considerations, information technology support as well as overall business processes and strategy.

In turn, we strongly believe Elevance Health should publicly delineate in specific detail how their organization is prepared to respond to all such deficiencies in a manner that would benefit the current policy holders, the provider community, and the citizens of Louisiana as a whole.

At present, the Louisiana State Medical Society, identified as one of the approximately ninety thousand policy holders considered a "voting member" relative to the proposed plan of reorganization continues to urge caution with the intent to vote "no".

Sincerely,

Richard Paddock, M.D.
President

cc: Governor, Jeff Landry
Attorney General, Liz Murrill

September 18, 2023

James J. Donelon, Commissioner
Louisiana Department of Insurance
P.O. Box 94214
Baton Rouge, LA 70804

Re: Elevance Health Acquisition of Blue Cross Blue Shield of Louisiana

Dear Commissioner Donelon:

On behalf of Louisiana physicians and the patients we care for, I would like to express our collective apprehension related to the pending acquisition of Blue Cross Blue Shield of Louisiana (BCBSLA) by Elevance Health. For several months, we have all been told that "nothing will change" or "its business as usual" after the sale is completed. However, we believe that anything that occurs on a scale of this magnitude rarely happens without considerable change and lots of questions and concerns. As such, we have multiple concerns related to increased premiums, reduced benefits, and limited access to care for our patients. Additionally, we are acutely aware of what has transpired in other states where multiple lawsuits have been filed with specific allegations of underpayment and inappropriate denials. These concerns are even more critical when you consider BCBSLA will transfer over 60% of the private health insurance market in our state from a home grown not for profit company to a publicly traded one, where profits and shareholder value are cherished above all else. As the state that ranks last in every significant health care metric, it would be detrimental to put our patients' health at risk to achieve exorbitant profits for a corporation.

While we applaud your decision to delay any possible decision on the final approval of the proposed acquisition, we still believe this is happening too fast and should be delayed even further. We welcome the involvement and scrutiny of Attorney General Jeff Landry's office, as well as, the United States Department of Justice, as the final decision of this sale will impact every single resident of Louisiana and the maximum amount of due diligence, and caution, should be exercised.

At this time, the Louisiana State Medical Society, as one of the approximately ninety thousand policy holders, who owned an in force BCBSLA policy issued on January 23, 2023, and is considered a "voting member" on the proposed plan of reorganization regarding the conversion from a mutual insurance company to a stock insurance company, will be voting "no".

Sincerely,

Richard J. Paddock, M.D.
President

WISCONSIN HOSPITAL ASSOCIATION
ADVOCATE. ADVANCE. LEAD.
The Valued Voice
Physician Edition

Vol. 11, Issue 9 Tuesday, May 2, 2023

Anthem Payment Delays Reaching Sizable Levels

As much as $300 million in unpaid claims in New Hampshire, millions more in Wisconsin and across the U.S.

For the past two years, mega health insurance company Anthem has experienced significant payment delays, resulting in millions of dollars owed to hospitals across the country, including right here in Wisconsin.

"We are hearing from more and more of our members that have concerns about Anthem payment delays," said WHA President and CEO Eric Borgerding. "Whether it is due to technical system issues, lack of sufficient staffing, or other challenges doesn't really matter—health care providers are too often left holding the bag when insurers systems fail."

According to a recent report from Becker's, hospitals in New Hampshire have experienced claims processing delays since 2021, now totaling about $300 million. According to a New Hampshire Hospital Association report, about 1/3 of the accounts receivable were outstanding for greater than 90 days. And in March 2022, the state of Georgia fined Anthem $5 million for failure to pay insurance claims timely.

Hospitals here in Wisconsin are experiencing similar issues, with at least one—Aurora—having filed a lawsuit in September 2022 alleging that despite repeated attempts to resolve the issue with Anthem, it failed to pay 25,000 claims that were pending for more than 180 days, amounting to payments owed on more than $125 million in billed charges.

Aspirus Health in Wisconsin has also experienced significant claims delays. According to CEO Matt Heywood, "We have in good faith provided exceptional care to patients with Anthem insurance. It is becoming more difficult for us to do so, though, given the financial burden we are carrying because of outstanding Anthem claims dating back to last year for which we have received no payment. Anthem has made certain to collect its premiums but has not passed along full compensation to the dedicated caregivers who provide care."

Other Articles in this Issue

- Anthem Payment Delays Reaching Sizable Levels
- WHA Advocacy Day Brings in Nearly 1,000 Participants
- DHS Secretary-Designee Kirsten Johnson Discusses Health Care Priorities with WHA Board
- WHA and Members Back in D.C. Pushing for Continued Regulatory Flexibility and Support of Vital Hospital Priorities
- Wisconsin's Super Compact Continues Past the End of the Public Health Emergency

AHA Statement on Report from Elevance Health

Rick Pollack
President and CEO
American Hospital Association

August 4, 2023

A new "report" from Elevance Health — the large, for-profit commercial insurer formerly known as Anthem — draws absurd conclusions about the impact of health care systems on access to care, cost and quality. Of greatest irony is that while the national health plan behemoth, which dominates many insurer markets, is pointing fingers at the actual health care providers serving patients, it is pocketing record profits. Indeed, if Elevance is so concerned about health care costs, perhaps it should consider its own pricing strategies that have resulted in the company earning nearly $2 billion in profit in the second quarter of this year alone.

With all the recent news coverage on the bad behavior of commercial insurers, let's take this latest "report" for what it is — just another attempt to distract people from the reality of how some insurers, like Elevance, delay and deny patients' access to care. Elevance is particularly notorious for slow or no payment to hospitals and pre-authorization delays that put patient's health at risk and contribute to clinician burnout.

This biased piece fails to recognize the immense benefits of hospital and health system mergers for patients. Perhaps the most egregious omission is the recognition that mergers often prevent struggling hospitals — especially in rural and other medically underserved areas — from closing and that it is inadequate payment by payers, like Elevance, that destabilize these providers to begin with.

BECKER'S
ASC REVIEW

Insurer under fire for millions in unpaid claims

Anthem has captured the attention of multiple hospitals and health systems across the U.S. as allegations of underpayment and inappropriate denials accumulate.

The insurer has been forced to pay millions already and continues to face off with providers.

Anthem is facing allegations of $70 million in unpaid claims from Portland-based MaineHealth. The health system said earlier this year that its flagship hospital, Maine Medical Center, would no longer contract with the insurer after its contract expires next year. Jeffrey Barkin, MD, president of the Maine Medical Association, said other providers in the state are leaving Anthem for the same reason.

In Georgia, the state insurance commissioner fined Anthem Blue Cross Blue Shield $5 million in March for failing to pay in a timely manner, delays in loading provider contracts and inaccurate provider directories.

VCU Health in Richmond, Va., said last year that 40 percent of its claims with Anthem were more than 90 days old and the insurer owed $385 million, according to the *Richmond Times-Dispatch*. The Virginia Hospital and Healthcare Association said Anthem has hundreds of millions of dollars in late and unpaid claims to hospitals across the state.

Eleven Indiana hospitals have also had trouble with Anthem. The hospitals alleged Anthem's reimbursement system added a $50 triage fee and asked for additional patient records to avoid denial for 60 to 70 percent of thousands of emergency room claims from 2017-20. The hospitals alleged the strategy breached their contract with Anthem because hospitals are required to stabilize all patients requesting emergency services. A federal arbiter recently ordered Anthem to pay $4.5 million to the hospitals and said the insurer cannot use its list of diagnostic codes to downgrade or deny claims.

The Indiana hospitals are still counting the denied claims and said they are owed $12 million from Anthem due to downgraded claims.

The American Hospital Association accused Anthem of asking for prior authorizations for routine surgeries as roadblocks to patient care in a letter sent to the insurer last year. In 2021, 53 percent of Anthem's medical bills for the second quarter were unpaid, amounting to $2.5 billion, according to the Times-Dispatch report.

Laura Dyrda - Tuesday, April 19, 2022

https://www.beckersasc.com/asc-coding-billing-and-collections/insurer-under-fire-for-millions-in-unpaid-claims.html

Georgia fines Anthem Blue Cross Blue Shield $5M fine for claims settlement practices

The Commissioner's office said Anthem must develop a plan to address the alleged violations

The State of Georgia on Tuesday slapped Anthem Blue Cross Blue Shield with a $5 million fine after determining the health insurance had engaged in a years-long practice of violating policyholder's rights.

Insurance and Safety Fire Commissioner John F. King announced the fine during a Tuesday morning press conference at the state Capitol, calling it the largest in the agency's history.

"[A]fter numerous complaints made to our office regarding the operations of Blue Cross Blue Shield from individuals, physicians, hospitals, and others from around the state, I instructed my staff to conduct an extensive examination into the carrier's practices," King said.

The examination, which spanned several months, uncovered "serious" issues, King said. These included improper claims settlement practices, violations of state law, failure to reply to consumer complaints in a timely manner, inaccurate provider directories and "significant delays in loading provider contacts."

BIDEN ADMINISTRATION TO STOP REIMBURSING HOSPITALS FOR COVID-19 CARE FOR UNINSURED

Anthem Blue Cross Blue Shield told FOX Business in a statement the examination focused on a provider database that was implemented in 2015 but is no longer in use.

"We have since migrated to a new platform with the goal of improving accuracy and transparent," the company said. "We are dedicated to those we serve and partner with, and we believe the recent enhancements we have made will create an improved overall care provider."

CLICK HERE TO READ FOX BUSINESS ON THE GO

The commissioner's office said Blue Cross Blue Shield must develop a new plan to address the violations and that it may be hit could be hit with additional fines if it misses certain benchmarks.

Bradfor Betz - March 29, 2022

BECKER'S

PAYER ISSUES

Elevance Health cuts jobs as company confirms 'changes'

Former employees with Elevance Health, previously known as Anthem, and its subsidiaries have taken to social media regarding an unknown number of job cuts they say are occurring across the company. Elevance confirmed "recent changes" with *Becker's*.

"We know the healthcare landscape is competitive, dynamic and ever-changing, and it challenges us to drive solutions that will deliver transformational impact and value to those we are privileged to serve," a company spokesperson said in late September. "As a result, we have made some adjustments to our resources to better position our company. However, these recent changes are limited in scope and will not impact our customers' benefits, services or interrupt any continuity in their access to care."

Elevance, based in Indianapolis, did not specify the number of employees affected. The company employs about 100,000 people and has not filed any WARN documents with the state of Indiana.

Across LinkedIn, former Elevance employees detailed jobs cuts they say took place in September and October:

- A former program manager for data quality wrote in October that "Elevance Health is releasing over 10,000 employees in a large reduction in force, including me."
- A former pharmacy benefit specialist said in late September that "a group of us, including myself, experienced a workforce transition as we were unfortunately laid off from our positions at Elevance Health."
- A former instructional designer wrote in October that she had been let go after 10 months with Elevance.
- A former project manager at ZipDrug, part of Elevance's pharmacy benefits division, said in October his position "was eliminated in a round of layoffs."
- A former communications manager at Elevance said in October she was "part of a reduction in force."
- A health services director at Elevance shared professional resources for employees "impacted by the reduction in force."
- A former software engineer at Elevance wrote in October that he was laid off "as a result of restructuring."
- A former release train manager at Elevance said she was let go from the company "due to a reduction in force."

The cuts at Elevance come as other large healthcare companies with insurance units have laid off employees this year, including Centene, CVS Health and UnitedHealth Group.

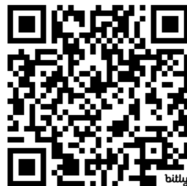
In its most recent financial earnings report published in July, Elevance said total revenues in the second quarter were $43.7 billion. The company's net income was $1.9 billion in the second quarter, up 13% from the same period last year.

Total medical membership at Elevance is 48 million as of June 30, an increase of 2% year over year. There are 11.8 million Medicaid members and 2.1 million Medicare Advantage members.

Jakob Emerson - Thursday, October 12, 2023

Subscribe to the following topics: elevanceanthembcbscarelonpharmacy

Grassroots organization holds impromptu protest in lobby of Elevance headquarters



Meredith Hackler - Nov. 14, 2022

INDIANAPOLIS — Protesters from the progressive Grass Roots organization People's Action entered the headquarters of Elevance insurance company, formerly known as BlueCross BlueShield, Monday morning.

They did so after sending a list of demands and questions to the CEO and got no reply. Emotions were high, and one security guard got physical and punched one of the protesters in the face. One big issue People's Action was protesting is insurance claim denials.

Recent Stories from wrtv.com

In the letter the organization sent to the CEO they were requesting actions like overturning any existing denials for treatment recommended by medical professionals and laying out the demographics of denied claims. To read the letter click here. Organizers say that they just want answers.

"We want to know the truth about where these claim denials are happening," Jaime Izaguirre, one of the organizers of the protest said. "We want to know whether they are disproportionately impacting urban or rural folks or black people, right? It's as simple as that it needs to be known."

The organization says that private insurance companies deny over 240 million insurance claims from policyholders every year. One person who says he has experienced this firsthand is Lane Fulton from Bloomington.

"With Anthem here, I got a latent denial on claims after I had already paid off my bills from one of my six surgeries that I had in a three-year period and that was infuriating," Lane Fulton said. "I played by the rules, and I was still being held accountable for debt they denied after the fact, after my surgeries."

The protesters were asked to leave the property but continued their remarks outside. While no one from Elevance addressed their concerns, they feel making their voices heard is one step toward getting insurance companies to put care over costs.

"We want this private insurance company that sits in an office in Indianapolis to know that we are not ashamed to need care and we are not ashamed to demand it," Izaguirre said.

People from as far as Texas and Iowa took part in the protest. We reached out to Elevance for a comment on the issues these protesters were wanting answers to. They replied with this statement.

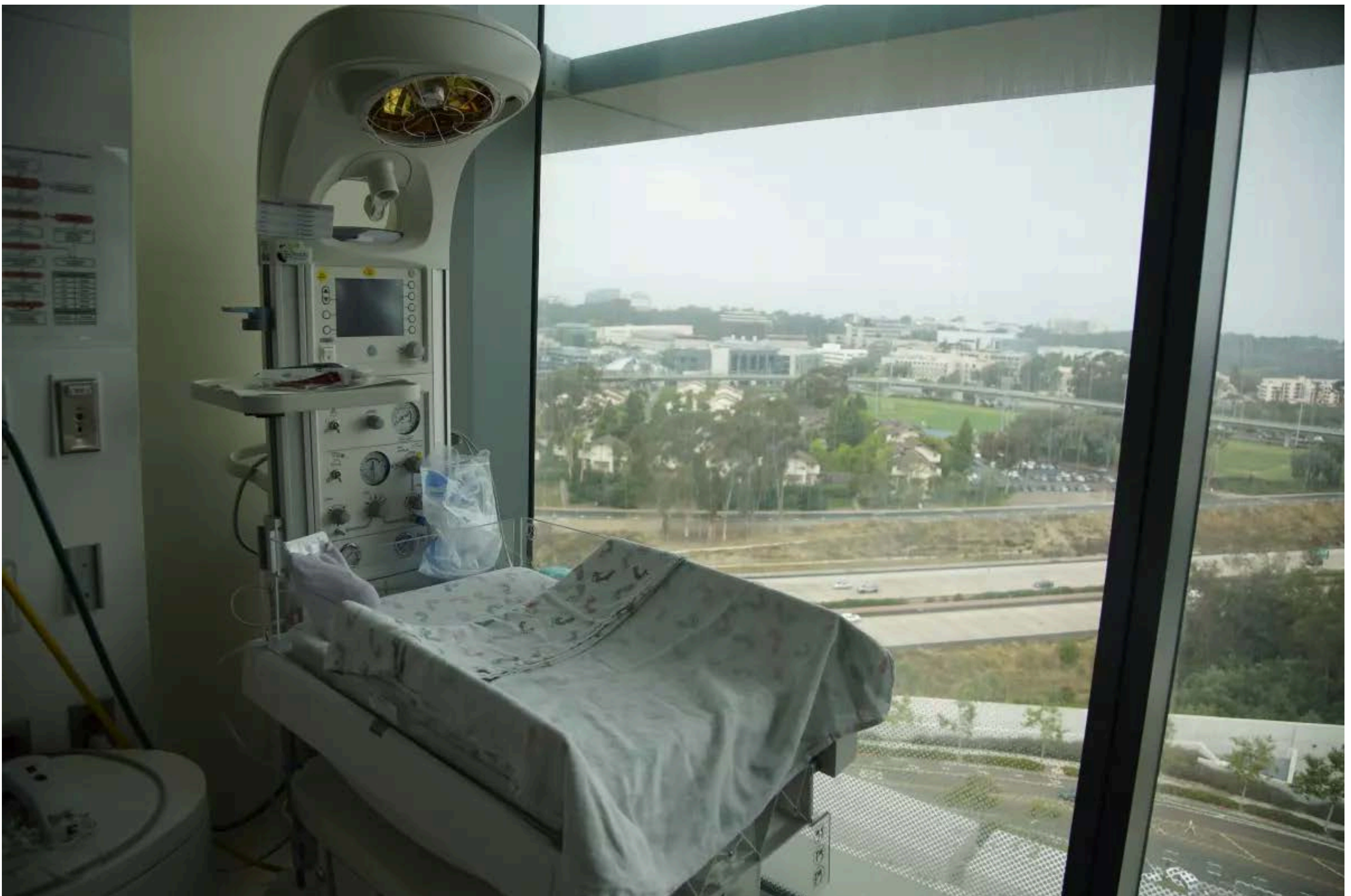
"As a company that provides high-quality health benefits for 47 million people, we work every day to ensure that our consumers have access to proven medical services supported by the latest medical evidence."

During the protests, a person can be seen being struck by a security guard within the facility.
Elevance Health Insurance Protest

For more information about People's Action clickhere.

HEALTH

UCSD Health access for 60,000 Anthem Blue Cross members in San Diego hangs in balance



Inside a maternity room at the Rady Women and Infants Pavilion at UCSD Jacobs Medical Center in La Jolla. (Alejandro Tamayo / The San Diego Union-Tribune)

Provider and carrier have served termination notices for the end of the year, but say they have now extended coverage through February

BY PAUL SISSON

OCT. 13, 2023 5:34 PM PT

Anthem Blue Cross recently delayed plans to notify thousands of its beneficiaries statewide that they will be assigned different doctors in 2024 because it has been unable to come to a new contract agreement with the University of California's five health systems.

Both sides said Friday that they have agreed to extend the contract, set to expire on Dec. 31, through Mar. 1, 2024. The extra two months provides a bit more runway for negotiations that, if unsuccessful, could affect about 600,000 Anthem members with UC doctors — roughly 60,000 living in San Diego County.

The situation comes at the same time that Scripps Health has announced that its two most popular medical groups will no longer participate in Medicare Advantage plans in 2024, an announcement that will have many shopping for different coverage this fall.

The extension also pushes out notification requirements for those in Anthem health maintenance organization (HMO) plans. State law requires carriers to notify beneficiaries at least 60 days before a contract expires, meaning that letters would have had to go out by the end of October

notifying thousands of Anthem HMO members that they would be reassigned to primary care doctors outside the UC system after the contract expired on Dec. 31.

About 9,000 of those HMO patients, officials confirmed, are currently assigned to doctors with UC San Diego Health. The remainder are in preferred provider organization (PPO) plans offered by Anthem. Prior notice is not required for PPO plans, a government official said, because these plans do not generally assign enrollees to specific doctors.

Both sides declined to specify exactly what the sticking points have been that have kept Anthem and UC from signing a new contract, though the carrier said in a written statement that contract discussions began more than a year ago, indicating that they "are a standard, normal and routine part of the health care industry and something we take very seriously."

Anthem and UC said Friday that they are optimistic that a new deal will be reached before the end of the year.

Patricia Maysent, chief executive officer of UC San Diego Health, added that failure to find common ground would be most disruptive for those currently undergoing less common treatment which, in some cases, is only offered in the San Diego market by UCSD.

"We don't want our patients to feel like they have to be worried that they're (not) going to have access to their cancer doctors or their transplant doctors because they get transferred away from us," Maysent said.

Typically, when medical providers and health insurance companies fail to pull together a new services agreement, reimbursement for services rendered and the process for authorization of services are the sticking points.

Anthem's statement indicates that discussions "are broad and include both financial and nonfinancial elements," which Maysent agreed is the case. In addition to trying to make sure that inflation-driven cost increases are covered, the executive said providers are also looking for a more streamlined process of care approvals.

A top-three concern in a recent survey of UCSD doctors, Maysent said, is "dealing with insurance companies to get things approved that they know have to happen."

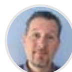
The contract situation, which UCSD recently noted on its website at health.ucsd.edu/anthem, arrives at a time when Medicare Advantage plans, and many commercial health insurance plans that companies offer for their employees, are entering the annual open enrollment period. This is an enrollee's brief annual chance to switch carriers, or from one plan to another offered by their existing carrier, if they wish.

The question on the minds of many who currently want to continue seeing UCSD doctors, then, is whether they should find a non-Anthem plan that has contracts with university doctors or hold fast and trust that the recent two-month extension means that an agreement will be reached.

Thousands of beneficiaries with the California Public Employees' Retirement System faced just such a situation in recent months as their open enrollment period started on Sept. 18 and ended Friday. An official with CalPERS said in an email Friday that information on how many left Anthem plans over uncertainty with UC contracting will not be available until Nov. 6.

Health insurance broker Craig Gussin, who has served the San Diego region for many years, said he is not too concerned. He said he has seen negotiations devolve to the point where warning letters are sent to members many times in the past, only to quickly resolve.

"Give it a few weeks, or maybe until mid-January 2024, and they will come to an agreement. They have every time in the past," Gussin said.



Paul Sisson

CALIFORNIA
MEDICAL
ASSOCIATION

CMA files complaint about Anthem's unlawful denial of claims for emergency services

The California Medical Association (CMA) has submitted a formal complaint with the California Department of Managed Health Care (DMHC) regarding Anthem Blue Cross' ongoing pattern of denying payment for emergency department services in violation of California law.

Although California law states payment for emergency services may only be denied if a plan determines the services were not performed, Anthem has adopted a policy under which it routinely denies claims that include high level emergency department evaluation and management (E/M) services. As a result, Anthem is not only refusing payment for the emergency E/M service, but also failing to reimburse the remaining uncontested portion of these claims. Anthem is also failing to provide an accurate and clear explanation of the reasons for denial, and subjecting physicians to unnecessary and unreasonable requests for patient medical records beyond what is needed to determine payor liability.

Given the dollar value of denied claims and the impact of the denials on physicians' ability to provide emergency care, Anthem's practice may also represent an unjust payment practice by unnecessarily delaying payment for complete and accurate claims.

"Anthem's denials have placed significant undue financial hardship on emergency physicians throughout California who, for the last two years, have served on the front lines caring for COVID-19 patients," wrote CMA CEO Dustin Corcoran in a letter to DMHC. "Anthem cannot be allowed to profit from unpaid emergency services provided to its enrollees. DMHC must take swift action to ensure that Anthem complies with California laws designed to protect health care consumers and providers."

CMA is urging DMHC to formally investigate and take appropriate enforcement action to require Anthem to promptly reimburse physicians for denied emergency room services with interest.

For more information, see CMA's letter.

CALIFORNIA MEDICAL ASSOCIATION

February 27, 2023

Mary Watanabe, Director
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Submitted electronically via email (Mary.Watanabe@dmhc.ca.gov)

Re: Anthem Blue Cross Denial of Emergency Services

Dear Director Watanabe,

On behalf of our nearly 50,000 physician and medical student members, the California Medical Association (CMA) submits this formal complaint regarding Anthem Blue Cross' ("Anthem's") ongoing pattern of denying payment for emergency department services. Specifically, Anthem has adopted a policy under which it routinely denies claims that include high level emergency department evaluation and management (E/M) services. As a result, Anthem is not only refusing payment for the emergency E/M service, but also failing to reimburse the remaining uncontested portion of these claims, failing to provide an accurate and clear explanation of the reasons for denial, and subjecting physicians to likely unnecessary and unreasonable requests for patient medical records beyond what is needed to determine payor liability.

Anthem's failure to pay for emergency services provided to its enrollees appears to represent a clear violation of California law, which states payment for emergency services may only be denied if the plan determines the services were not performed. Further, given the dollar value of denied claims and the impact of the denials on the physicians' ability to provide emergency care, Anthem's practice may also represent an unjust pattern by unnecessarily delaying payment for complete and accurate claims.

Anthem's denials have placed significant undo financial hardship on emergency physicians throughout California who, for the last two years, have served on the front lines caring for COVID-19 patients. CMA urges the Department of Managed Health Care (DMHC) to promptly investigate Anthem's practices regarding emergency department claims. Anthem cannot be allowed to profit from unpaid emergency services provided to its enrollees. The DMHC must take swift action to ensure that

Anthem complies with California laws designed to protect health care consumers and providers.

Failure to Reimburse for Emergency Services

California law is clear - health plans and insurers may only deny emergency services if they reasonably determine that the services were never performed (Health & Safety Code § 1371.4(c)). However, in 2020 Anthem began routinely denying claims that include high level emergency E/M services, specifically CPT 99285 (referred to as level 5 E/M services). Anthem asserted a variety of reasons for the denials, but none of those cited indicate that Anthem reasonably believes the services were never performed. Rather, the denial reasons include, "Missing patient record," "Separately billed services/tests have been bundled," "Other adjustments; the disposition of this claim/service is pending further review," and "Contractual obligations; charges exceed provider's contracted/legislated fee arrangement."

Anthem does not dispute that the services billed were, in fact, performed. Rather, Anthem asserts that it is disputing the level of service billed and refuses to reimburse for the services provided. This is contrary to generally accepted standards of care and physicians' duty of care to patients, and results in physicians bearing Anthem's share of the cost providing medically necessary care in the process.

Not only does Anthem's conduct appear to violate the law,[1] it creates extreme financial hardship for the emergency physicians providing services to Anthem enrollees. Additionally, Anthem's pattern of denying emergency services ultimately results in significantly delayed statements to patients as the Explanation of Benefits (EOBs) do not reflect any patient cost sharing due, which is not accurate.

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[1] Anthem has faced legal scrutiny for its payment policy for emergency department claims in Indiana, in the context of Medicaid contracts. A federal arbitrator reportedly found Anthem's practice to constitute a breach of contract and to violate federal Medicaid regulations on coverage of emergency services (42 CFR § 438.114), and ordered Anthem to pay $4.5 million to 11 hospitals. *Medscape*, "Indiana Hospitals Awarded $4.5 Million over ED Billing Dispute with Anthem," Apr. 20, 2022, https://www.medscape.com/viewarticle/972423?src=#vp_2; *Indianapolis Business Journal*, "Anthem pays $4.5M to Indiana hospitals in ER billing dispute," Apr. 15, 2022, https://www.ibj.com/articles/anthem-pays-4-5m-in-er-bill-dispute. While the claims at issue in the present dispute do not, to our knowledge, involve Medicaid/Medi-Cal enrollees, some involve Medicare Advantage contracts, which are subject to similar federal standards (42 CFR §422.113).

Failure to Pay Uncontested Portion of Claim

California Health & Safety Code §1371.35 requires health plans to reimburse, contest, or deny a complete claim (or portion of a complete claim) within 45 working days of receipt of the complete claim for HMO claims or within 30 working days for PPO claims. Uncontested portions of the claim must be reimbursed within the respective 30 or 45 working days after receipt by the plan. Plans that fail to pay the uncontested portion of the claims within the required timeframe are subject to a penalty of the greater of $15 per each 12-month period or interest at the rate of 15% per annum for the period of time the payment is late. If the plan fails to automatically include interest due on the late claim payment, the plan must pay the provider $10/late claim in addition to any amounts due.

A review of the EOBs provided to CMA by various emergency physician practices throughout the state demonstrates that Anthem is not reimbursing the uncontested portion of services of the affected claims. Rather, Anthem continues to wrongly deny payment of those services. Physicians report that routine radiology, diagnostic, and minor surgical services that are not being contested go unpaid without a valid explanation for the denial. This practice of not reimbursing the uncontested portions of the claim is inconsistent with 28 C.C.R. § 1300.71(h)(i) &(j).

Requests for Records That Are Not Reasonably Relevant

For claims involving emergency services, California regulations allow health plans to request "reasonably relevant information," which is defined as the minimum amount of information that enables an appropriately qualified claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability (28 C.C.R. § 1300.71(a)(10)&(11)). However, Anthem's practice of requiring the submission of medical records for all claims billed with level 5 emergency room E/M service appears to be completely unrelated to its determination of whether it is liable for the claims. Rather, Anthem has advised affected physicians it is disputing the coding of services on the claim, not whether the payor is liable for the payment of the emergency services claims incurred.

In contrast, Anthem is not routinely requesting medical records for claims that include level 3 or 4 E/M codes or denying these claims for lack of records. The plan is, however, denying or disputing level 5 emergency visit E/M claims without proper basis to question the validity of those claims. As a result, Anthem is unjustly withholding payment on a significant number of claims and forcing emergency physicians to undertake onerous and unreasonable record requests to receive appropriate reimbursement. Anthem's policy appears intended to create

administrative barriers to disincentivize physicians from billing for level 5 E/M services provided in the emergency department.

Lack of Consistency in Denial Reason Codes

Anthem's denial reason codes are also not consistent with the rationale for the denial and as such, are potentially in violation of 28 C.C.R § 1300.71(d)(1) which requires plans to provide an "…accurate and clear written explanation of the specific reasons for the action taken…." As stated above, Anthem is utilizing many different denial reason codes, none of which appear to reflect the actual reason for denial.

CMA is aware that the DMHC has engaged with Anthem on this issue during the past year. However, those discussions have not resulted in any change in Anthem's practices. Absent DMHC action to hold Anthem accountable for failing to pay for emergency services it is legally required to pay, emergency physicians continue to face serious financial hardship. Meanwhile, Anthem profited $1.7B in Q2 of 2022.

Incomplete Disclosure of Payment Policies

Anthem has reportedly refused to disclose the criteria it is using to adjudicate level 5 E/M claims. Anthem may be using an algorithm to process these claims, but it has not disclosed this or any other methodology to contracting providers, in violation of 28 C.C.R § 1300.71(o)(2) which requires plans to provide "…detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims…."

CMA urges the DMHC to formally investigate and take appropriate enforcement action to require Anthem to promptly reimburse physicians for denied emergency room service with interest.

If you have any questions or wish to discuss this matter in more detail, please do not hesitate to contact Jodi Black at (916) 551-2863 or by email at jblack@cmadocs.org or Mark Lane at (916) 551-2865 or mlane@cmadocs.org.

Respectfully,

Dustin Corcoran
Chief Executive Officer
California Medical Association

cc: **Jamie Ostroff, Esq**., Chief Legal Officer and General Counsel, California Medical Association (via email at jostroff@cmadocs.org)

Sarah Ream, General Counsel, Department of Managed Health Care (via email at sarah.ream@dmhc.ca.gov)

Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations, Department of Managed Health Care (via email at amanda.levy@dmhc.ca.gov)

Enclosures

Elevance confirms ‘adjustments’ to resources as employees report job cuts

An article from

Elevance, formerly known as Anthem, employs nearly 100,000 people and serves more than 117 million customers, according to the company.

Elevance headquarters in Indianapolis, Indiana Permission granted by Elevance Health

Emily Olsen - Oct. 12, 2023

Elevance Health confirmed it had made “adjustments” to its resources after some employees reported job cuts at the company and its subsidiaries on social media.

The job cuts affected workers with various titles, including software engineer, project manager, and pharmacy benefit specialist, at Elevance or its pharmacy services division, ZipDrug, according to posts on LinkedIn.

Elevance did not address questions from Healthcare Dive on whether there were official layoffs, or the number of employees affected.

Instead, a company spokesperson said:

“We know the healthcare landscape is competitive, dynamic, and ever-changing, and it challenges us to drive solutions that will deliver transformational impact and value to those we are privileged to serve.”

“As a result, we have made some adjustments to our resources to better position our company,” the spokesperson added. “However, these recent changes are limited in scope and will not impact our customers’ benefits, services or interrupt any continuity in their access to care.”

Elevance, formerly known as Anthem, employs nearly 100,000 associates and serves more than 117 million customers, according to the company. It operates plans under the Anthem Blue Cross, Anthem Blue Cross and Blue Shield and Wellpoint brands, and runs its Carelon health services subsidiary.

The insurer, one of the largest in the U.S., beat Wall Street expectations in the second quarter with revenue of $43.7 billion, up 13% year over year, and profit of $1.9 billion.

Elevance raised its full-year earnings guidance on the results, and reported a lower medical loss ratio even as some health insurers raised red flags over fears of higher-than-anticipated outpatient utilization earlier in the summer.

But the insurer also reported its Medicaid membership fell by 135,000 in the second quarter as states resumed eligibility checks after a period of continuous enrollment during the COVID-19 pandemic.

The company reports third quarter financial results next week.

Fellow health insurer Centene recently said it was laying off about 3% of its workforce totaling 2,000 employees. CVS Health, which owns insurer Aetna, confirmed earlier this summer it would lay off 5,000 workers.

MORNINGSTAR

Provided by Dow Jones
Oct 18, 2023 5:41 AM CDT

Elevance Health 3Q Revenue Rises on Higher Premiums

By Dean Seal

Elevance Health's revenue rose in the third quarter on higher premiums and contributions from its pharmacy benefit manager CarelonRx.

The health insurer and healthcare-services provider, formerly known as Anthem, posted a profit of $1.29 billion, or $5.45 a share, compared with $1.6 billion, or $6.62 a share, in the same quarter a year ago.

Stripping out one-time items, adjusted earnings were $8.99 a share. Analysts surveyed by FactSet had been expecting $8.45 a share.

Quarterly revenue rose 7.2% to $42.85 billion, topping analyst forecasts for $42.69 billion, according to FactSet.

Elevance's top line was pushed higher by growth in premium revenue from the health benefits business and higher pharmacy product revenue from CarelonRx, due in part to its acquisition of BioPlus in the first quarter of 2023. Premiums were up 4.6% to $35.26 billion.

Membership rose to 47.3 million, driven by growth in BlueCard, Affordable Care Act health plans and Medicare Advantage membership, largely offset by attrition in Medicaid as eligibility redeterminations resumed, a new competitor entered one of its state Medicaid programs and its employer group risk-based business declined.

The benefit expense ratio, a measure of the proportion of premiums paid out in healthcare costs, improved by 40 basis points to 86.8% due to by premium rate adjustments.

Write to Dean Seal at dean.seal@wsj.com

(END) Dow Jones Newswires

October 18, 2023 06:41 ET (10:41 GMT)

Elevance controls medical costs to $6B profit in 2023

An article from

Rebecca Pifer - Jan. 24, 2024

The payer curbed the worst of medical cost growth last year, and expects to do the same in 2024 — an assumption one analyst called “aggressive” given persistent higher utilization among seniors.

Elevance headquarters in Indianapolis, Indiana Permission granted by Elevance Health

This audio is auto-generated. Please let us know if you have feedback.

Dive Brief:

- Elevance Health raked in $6 billion in profit last year on revenue of more than $171 billion — a better performance than Wall Street expected, given that high medical costs have been dogging payers.
- The payer beat analysts’ consensus expectations for earnings and revenue in the fourth quarter of 2023, with a topline of $42.7 billion, up 7% year over year. Elevance’s fourth-quarter profit of $831 million was down, however, by 5% year over year.
- Elevance chalked its revenue growth up to higher premiums and growth in its pharmacy benefit manager CarelonRx. Analysts said the Indianapolis, Indiana-based payer also benefited from better-than-expected medical costs and higher investment income in the quarter.

Dive Insight:

Stocks of managed care companies fell in the first few weeks of 2024, as UnitedHealth and Humana warned that elevated medical costs that dampened earnings had persisted into the new year. Medicare seniors receiving more healthcare than payers expected led Humana to slash its 2023 profit outlook and UnitedHealth to report its highest medical costs since the start of the COVID-19 pandemic.

Elevance’s shares were also pressured by investors’ utilization concerns coming into its fourth-quarter and full-year earnings release

However, the payer’s stock rallied Wednesday after it released its financials before market open.

Despite cost concerns, Elevance’s medical loss ratio — a marker of how much insurers are spending on patient care — improved in both the fourth quarter and 2023 overall compared to the prior-year period, to 89.2% and 87% respectively.

And Elevance’s projection for medical costs in 2024 is relatively stable. The payer expects an MLR of about 87% this year.

“Overall 4Q results look solid against a backdrop of low expectations and high concerns around trend,” Leerink analyst Whit Mayo wrote in a Wednesday note on Elevance’s results.

Yet, Elevance’s guide to a flat MLR this year is an “aggressive assumption” given higher utilization, Mayo said.

Elevance did see higher utilization in the fourth quarter, especially among seniors receiving outpatient care like orthopedic procedures, along with the normal seasonal uptick in respiratory illnesses and vaccines, CFO Mark Kaye said on a Wednesday morning call with investors. However, the payer said its premium adjustments covered the worst of rising medical costs.

Elevance offers Blues-affiliated plans in 14 states, along with Medicare and Medicaid plans through a subsidiary called Wellpoint.

The health insurer's membership fell in 2023 because of Medicaid redeterminations, as states continued rechecking individuals' eligibility for the safety-net insurance program.

Nearly two-thirds of Elevance's Medicaid members have been redetermined to date. Close to 30% of those unenrolled before September have rejoined an Elevance product, CEO Gail Boudreaux said on the investor call.

Yet, Elevance's total medical membership dropped by 570,000 people to 47 million by the end of 2023.

The company projects its enrollment will continue falling in 2024, to between 45.8 million and 46.6 million people by the end of the year.

Elevance still heralds Medicare Advantage, where the government contracts with private payers to administer the care of Medicare seniors, as a key growth area. However, the insurer doesn't think its MA membership will grow at all in 2024.

That's after Elevance saw more competition for members in key markets than it had expected. And after Elevance revised its MA bids in response to upcoming (and unfavorable) rate changes in the program, more members dropped out of its plans than it had planned.

Elevance also exited certain markets that had been underperforming for years, resulting in a decline of roughly 174,000 members in the mainland U.S. and Puerto Rico, according to Felicia Norwood, who runs Elevance's Medicare and Medicaid businesses.

As a result, though MA membership should remain flat this year, earnings per member in the program should improve, Norwood said on the call.

Elevance is not the first payer to have its 2024 outlook hampered by regulatory changes to MA around rate revisions and quality ratings.

The insurer sued the federal government in December over changes to how regulators calculate MA quality ratings, called stars. The changes could cost Elevance hundreds of millions of dollars in quality bonus revenue next year.

Boudreaux said Elevance is taking steps to curb the worst of the losses. Along with changes to its bids, Elevance started cutting costs late last year and is working to weave artificial intelligence into its operations.

Elevance also kicked off layoffs in the fall that have impacted employees in multiple states.

"We anticipate that our health benefits business is going to continue to grow in [2025] after a reset year in [2024]," Boudreaux told investors.

Bon Secours sues Anthem in latest battle in war between two groups

HENRICO COUNTY, Va. (WRIC) — The fate of some Medicaid patients in the Richmond region remains up in the air as tension continues to escalate between two prominent healthcare entities.

A week after Anthem Blue Cross Blue Shield hit Bon Secours with a cease-and-desist amid ongoing contract issues, the healthcare system responded with its own lawsuit.

On Monday, Aug. 28. 2023, Bon Secours filed a complaint in Henrico County Circuit Court against the large medical insurance provider. They alleged that — just in Virginia — Anthem owes the healthcare system around $93 million in unpaid and underpaid claims.

At the beginning of August, 11,000 Anthem Medicare Advantage patients lost coverage at Bon Secours facilities. In a one-on-one interview with 8News, Anthem President Monica Schmude expressed concern regarding the now-unclear future of 35,000 Medicaid patients. The new lawsuit added fuel to the fire.

"I found out about the legal action at the same time the public find out about the legal action," Schmude said.

The legal action was built upon Bon Secours' claims that Anthem practiced "no-pay" and "slow-pay" tactics for nearly four years, resulting in that aforementioned multi-million dollar sum.

According to Bon Secours, the payment timeframe outlined in prior agreements rests between 30 and 60 days. The lawsuit suggests that Anthem violated this rule by delaying payments, neglecting to comply within mandated time periods. The healthcare system also alleged that the insurance provider downgraded emergency room (ER) claims.

Schmude disputed these claims, telling 8News these allegations were untrue. She fired back that Anthem believes Bon Secours up-charges ER claims.

"It escalated over a short period of time from this organization to more than 200% of what it had been before," Schmude said.

In a statement, Bon Secours said they've tried to remedy this issue privately for years. They added they're not alone and referenced an incident from July in which the Virginia Bureau of Insurance ordered Anthem pay a settlement after not processing claims in a timely manner.

Schmude believes this particular lawsuit exists solely to distract from ongoing negotiations that have impacted thousands of Virginia patients as Bon Secours seeks to increase prices mid-contract.

"Let's get to the table to talk about solutions," Schmude said. "Because we have great ideas we'd love to share with them. That will not be on the backs of the employers paying more."
PREVIOUS: Contract dispute between Anthem and Bon Secours escalates, insurance company files cease and desist

This conflict between the two healthcare groups isn't new. The two parties have been battling for months as they struggle to reach contract agreements. However, according to Bon Secours, this feud actually goes back to 2019.

Patients should keep in mind that if issues are not resolved by Oct. 1, Anthem *Medicaid* patients will join *Medicare Advantage* patients in losing coverage at Bon Secours facilities. Plans can vary, so patients are urged to check with Anthem to hear specific options.

Henrico County News
Sierra Krug
Aug 30, 2023

IBJ
INDIANAPOLIS
BUSINESS JOURNAL

Elevance Health must face federal suit alleging Medicare Advantage fraud

IBJ Staff - Oct. 5, 2022

ndianapolis-based Elevance Health Inc. must face a federal lawsuit alleging that the company defrauded the U.S. government of millions of dollars by falsely certifying incorrect diagnosis data from doctors and other health providers.

In a ruling announced this week, Judge Andrew Carter of the U.S. District Court for the Southern District of New York said Elevance—which was known as Anthem Inc. until a corporate rebranding in late June—failed to show the lawsuit should be dismissed for lack of materiality.

Carter said the total amount allegedly overpaid by the Centers for Medicare and Medicaid Services to Elevance could total well more than $100 million, making the government's costs "substantial and not merely administrative."

The U.S. Justice Department filed the civil fraud action against Elevance in March 2020

The complaint accuses Elevance, one of the nation's largest providers of Medicare Advantage plans for seniors, of causing the Centers for Medicare and Medicaid Services to overpay the company based on inaccurate and inflated information between early 2014 and early 2018.

Medicare Advantage plans are health insurance policies for senior citizens, administered by private insurance companies under contract with Medicare. Under the program, the government pays private insurers a monthly amount to provide health care benefits for seniors.

The Medicare Advantage plans are hugely popular for their wide raft of benefits, with monthly premiums that are often lower than those of traditional Medicare.

Under the plans, Elevance provides health coverage for Medicare beneficiaries. In return, it received payments from the government based on the patients' medical conditions and demographic factors.

The Justice Department sued Elevance under the federal False Claims Act and is seeking civil fines and triple damages.

The case is one of several Justice Department civil lawsuits against companies that participate in Medicare Advantage.

1A. STATUTORY REQUIREMENTS OF LOUISIANA REVISED STATUTES 22:236.3

RS 22:236.3

§236.3. Consideration and dividend protections

A. In effecting a conversion of a reorganizing mutual, each eligible member shall be entitled to consideration in an amount equal to his or its equitable share of the value of the reorganizing mutual as provided for in the plan of reorganization, as follows:

(1) The consideration to be distributed to eligible members may consist of cash, stock of the reorganized company or its parent corporation, or if appropriate for tax or other reasons, additional life insurance and annuity benefits, any combination of these forms of consideration, or other forms of consideration acceptable to the commissioner. The form or forms of consideration to be distributed to an eligible member may differ according to the class or category of policy owned by the eligible member. The choice of the form or forms of consideration to be distributed to eligible members in accordance with the class or category of policy owned by such members may take into account such factors as the type of policy with respect to which the consideration is being distributed and the amount being distributed with respect to such policies, the country of residence, or tax status of the member or other appropriate factors; however, if the consideration to be distributed to an eligible member will be in a form other than common stock of a publicly traded company, the plan of reorganization shall include provisions for determining, in a reasonable manner, the value of the consideration by means of reference to the per share public market value of the registered common stock of the reorganized company or its parent corporation or another method acceptable to the commissioner.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from a qualified investment banker that the provision of consideration upon the extinguishment of the membership interests pursuant to the plan of reorganization is fair to the eligible members, as a group, from a financial point of view.

B. The method of allocating consideration among eligible members shall be fair and equitable, as follows:

(1) The method shall provide for each eligible member to receive: (a) a fixed component of consideration or a variable component of consideration, or both; or (b) any other component of consideration acceptable to the commissioner. Components may reflect, based upon fair and equitable formulas, methods, and assumptions, factors such as estimated proportionate historical and prospective contributions to surplus of classes or groupings of policies and contracts to the aggregate component of consideration being distributed to eligible members, with each eligible member receiving a distribution in accordance with the type of policy owned by the eligible member, or other factors the commissioner may approve.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from an actuary who is a member of the American Academy of Actuaries that the methodology and underlying assumptions for allocation of consideration among eligible members are reasonable and appropriate and the resulting allocation is fair and equitable.

C. At the option of the reorganizing mutual, any shares of the reorganized insurer or its parent corporation included in the eligible members' consideration may be placed on the effective date of the reorganization in a trust or other entity existing for the exclusive benefit of eligible members and established for the purpose of effecting the reorganization, such consideration or the proceeds of the sale of such consideration to be distributed to such eligible members by means of a process specified in the plan of reorganization and not to last more than twenty-one years after the effective date of the reorganization or until notification of the death of the eligible member or the death of the insured, whichever occurs first.

D.(1) The plan of reorganization shall provide for the reasonable dividend expectations of policyholders of any reorganized insurer through the establishment, or in the case of a reorganizing mutual insurance holding company the continuation, of dividend protections, which may consist of a closed block or any other method acceptable to the commissioner. The sole purpose of any dividend protections shall be to provide for reasonable policyholder dividend expectations.

(2) Any dividend protections provision may be limited to participating individual life insurance policies and participating individual annuity contracts in force or deemed to be in force by the plan of reorganization on the effective date of the reorganization, or, in the case of a reorganized insurer in a mutual insurance holding company system, on the effective date of its reorganization as such, for which the insurer has or had an experience-based dividend scale due, paid or accrued by action of the board of directors of the insurer in the year in which the plan of reorganization is or was adopted; however, other categories of policies and benefits not described in this Paragraph may be included or excluded, subject to the approval of the commissioner.

(3) In the event that dividend protections have been provided to policyholders of a reorganized insurer as part of a previous plan of reorganization, such dividend protections may be continued in effect without change in satisfaction of the requirements of this Section.

R.S. 22:236.3 A. (1) The consideration to be distributed to eligible members may consist of cash, stock of the reorganized company or its parent corporation…

1A. STATUTORY REQUIREMENTS OF LOUISIANA REVISED STATUTES 22:236.3

RS 22:236.3

§236.3. Consideration and dividend protections

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(1) The consideration to be distributed to eligible members may consist of cash, stock of the reorganized company or its parent corporation, or if appropriate for tax or other reasons, additional life insurance and annuity benefits, any combination of these forms of consideration, or other forms of consideration acceptable to the commissioner. The form or forms of consideration to be distributed to an eligible member may differ according to the class or category of policy owned by the eligible member. The choice of the form or forms of consideration to be distributed to eligible members in accordance with the class or category of policy owned by such members may take into account such factors as the type of policy with respect to which the consideration is being distributed and the amount being distributed with respect to such policies, the country of residence, or tax status of the member or other appropriate factors; however, if the consideration to be distributed to an eligible member will be in a form other than common stock of a publicly traded company, the plan of reorganization shall include provisions for determining, in a reasonable manner, the value of the consideration by means of reference to the per share public market value of the registered common stock of the reorganized company or its parent corporation or another method acceptable to the commissioner.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from a qualified investment banker that the provision of consideration upon the extinguishment of the membership interests pursuant to the plan of reorganization is fair to the eligible members, as a group, from a financial point of view.

B. The method of allocating consideration among eligible members shall be fair and equitable, as follows:

(1) The method shall provide for each eligible member to receive: (a) a fixed component of consideration or a variable component of consideration, or both; or (b) any other component of consideration acceptable to the commissioner. Components may reflect, based upon fair and equitable formulas, methods, and assumptions, factors such as estimated proportionate historical and prospective contributions to surplus of classes or groupings of policies and contracts to the aggregate component of consideration being distributed to eligible members, with each eligible member receiving a distribution in accordance with the type of policy owned by the eligible member, or other factors the commissioner may approve.

(2) The reorganizing mutual shall obtain an opinion addressed to the board of directors of the reorganizing mutual from an actuary who is a member of the American Academy of Actuaries that the methodology and underlying assumptions for allocation of consideration among eligible members are reasonable and appropriate and the resulting allocation is fair and equitable.

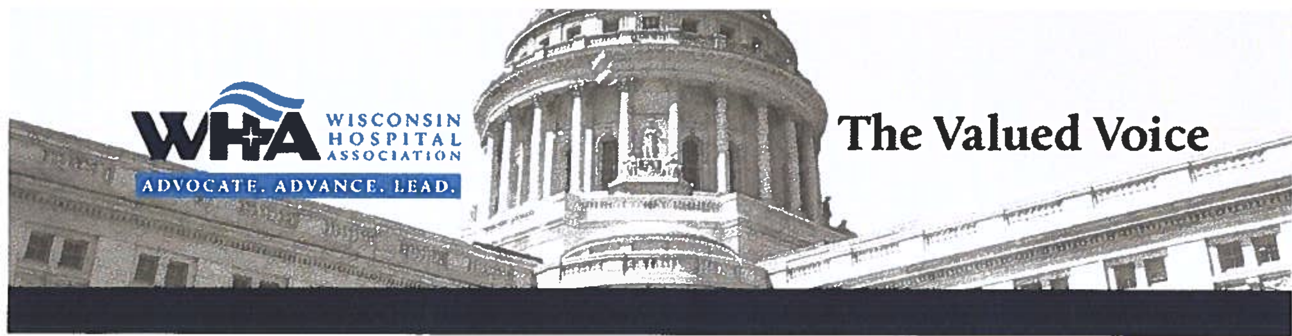
C. At the option of the reorganizing mutual, any shares of the reorganized insurer or its parent corporation included in the eligible members' consideration may be placed on the effective date of the reorganization in a trust or other entity existing for the exclusive benefit of eligible members and established for the purpose of effecting the reorganization, such consideration or the proceeds of the sale of such consideration to be distributed to such eligible members by means of a process specified in the plan of reorganization and not to last more than twenty-one years after the effective date of the reorganization or until notification of the death of the eligible member or the death of the insured, whichever occurs first.

D.(1) The plan of reorganization shall provide for the reasonable dividend expectations of policyholders of any reorganized insurer through the establishment, or in the case of a reorganizing mutual insurance holding company the continuation, of dividend protections, which may consist of a closed block or any other method acceptable to the commissioner. The sole purpose of any dividend protections shall be to provide for reasonable policyholder dividend expectations.

(2) Any dividend protections provision may be limited to participating individual life insurance policies and participating individual annuity contracts in force or deemed to be in force by the plan of reorganization on the effective date of the reorganization, or, in the case of a reorganized insurer in a mutual insurance holding company system, on the effective date of its reorganization as such, for which the insurer has or had an experience-based dividend scale due, paid or accrued by action of the board of directors of the insurer in the year in which the plan of reorganization is or was adopted; however, other categories of policies and benefits not described in this Paragraph may be included or excluded, subject to the approval of the commissioner.

(3) In the event that dividend protections have been provided to policyholders of a reorganized insurer as part of a previous plan of reorganization, such dividend protections may be continued in effect without change in satisfaction of the requirements of this Section.

R.S. 22:236.3 C. At the option of the reorganizing mutual, any shares of the reorganized insurer or its parent corporation included in the eligible members' consideration may be placed on the effective date of the reorganization in a trust or other entity existing for the exclusive benefit of eligible members…



Vol. 67, Issue 17 Thursday, April 27, 2023

Anthem Payment Delays Reaching Sizable Levels

As much as $300 million in unpaid claims in New Hampshire, millions more in Wisconsin and across the U.S.

For the past two years, mega health insurance company Anthem has experienced significant payment delays, resulting in millions of dollars owed to hospitals across the country, including right here in Wisconsin.

"We are hearing from more and more of our members that have concerns about Anthem payment delays," said WHA President and CEO Eric Borgerding. "Whether it is due to technical system issues, lack of sufficient staffing, or other challenges doesn't really matter—health care providers are too often left holding the bag when insurers systems fail."

According to a recent report from Becker's, hospitals in New Hampshire have experienced claims processing delays since 2021, now totaling about $300 million. According to a New Hampshire Hospital Association report, about 1/3 of the accounts receivable were outstanding for greater than 90 days. And in March 2022, the state of Georgia fined Anthem $5 million for failure to pay insurance claims timely.

Hospitals here in Wisconsin are experiencing similar issues, with at least one—Aurora—having filed a lawsuit in September 2022 alleging that despite repeated attempts to resolve the issue with Anthem, it failed to pay 25,000 claims that were pending for more than 180 days, amounting to payments owed on more than $125 million in billed charges.

Aspirus Health in Wisconsin has also experienced significant claims delays. According to CEO Matt Heywood, "We have in good faith provided exceptional care to patients with Anthem insurance. It is becoming more difficult for us to do so, though, given the financial burden we are carrying because of outstanding Anthem claims dating back to last year for which we have received no payment. Anthem has made certain to collect its premiums but has not passed along full compensation to the dedicated caregivers who provide care."

Other Articles in this Issue

- Former Governors Doyle and Thompson encourage Advocacy Day Attendees to Rise Above Partisanship, Tell Their Story
- Gov. Tony Evers Discusses Proposed State Budget Investments for Hospitals in Remarks to WHA Advocacy Day Attendees
- Stoughton Health Receives WHA's 2023 Advocacy All-Star Award
- Rep. Mark Born Receives WHA's 2023 Advocate of the Year Award
- Lawmakers Discuss State Budget Priorities, Debate Solutions to Workforce Licensure Delays during WHA Advocacy Day Legislative Panel
- Inaugural Quality Improvement Poster Showcase
- Anthem Payment Delays Reaching Sizable Levels
- WHA and Members Back in D.C. Pushing for Continued Regulatory Flexibility and Support of Vital Hospital Priorities
- PRESIDENT'S COLUMN: Hospitals Show Impressive Gains Complying with Federal Price Transparency Law

Big Insurance Met Its Match When It Turned Down a Top Trial Lawyer's Request for Cancer Treatment

Blue Cross and Blue Shield denied payment for the proton therapy Robert "Skeeter" Salim's doctor ordered to fight his throat cancer. But he was no ordinary patient. He was a celebrated litigator. And he was ready to fight.

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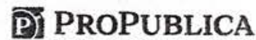


Donate

Robert "Skeeter" Salim in his office in Natchitoches, Louisiana. After Salim was diagnosed with stage four throat cancer, his health insurance, Blue Cross and Blue Shield of Louisiana, refused to pay for proton therapy, recommended by Salim's doctor. Salim, named one of the country's top litigators, fought back. Danielle Villasana for ProPublica

by T. Christian Miller

Nov. 7, 2023, 5 a.m. EST

ProPublica is a nonprofit newsroom that investigates abuses of power. Sign up to receive our biggest stories as soon as they're published.

In August 2018, Robert Salim and eight of his friends and relatives flew to the steamy heat of New York City to watch the U.S. Open.

The group — most of them lawyers who were old tennis buddies from college — gathered every few years to attend the championship. They raced from court to court to catch as many matches as possible. They hung out at bars, splurged on high-priced meals and caught up on each others' lives.

But that year, Salim had trouble walking the half-mile from the subway station to the Billie Jean King National Tennis Center in Flushing Meadows without stopping two or three times to rest. Back in his hotel room, he was coughing badly, his phlegm speckled with spots of blood. Although he had kept fit for a 67-year-old, he felt ragged.

Salim, whose friends call him Skeeter, flew home to Houston, where he saw his family doctor. After dozens of tests and visits to specialists, he received his diagnosis: stage 4 throat cancer. A tumor almost an inch long was growing under the back of his tongue, lodged like a rock. It had spread to his lymph nodes. Dr. Clifton Fuller, his oncologist at the MD Anderson Cancer Center, called it "massive oral disease."

Still, Fuller told Salim that his type of throat cancer would respond well to a treatment known as proton therapy, which focuses a tight beam of radiation on a tumor. So Fuller's staff quickly sought approval from Salim's health insurer, marking its fax "URGENT REQUEST": "Please treat this request as expedited based on the patient's diagnosis which is considered life threatening."

The answer arrived two days later. Blue Cross and Blue Shield of Louisiana would not pay for proton therapy; the costly procedure was appropriate only after doctors had previously tried other methods for irradiating the head and neck. "This treatment is not medically necessary for you," the rejection letter read.

Fuller told Salim that he might have to use a cheaper form of radiation that is less precise. Normally outgoing and optimistic, Salim felt his chest tighten as Fuller described the possible side effects of that other type of treatment. Because there were many critical organs near Salim's tumor, the damage could be severe, causing loss of hearing, diminished sense of taste and smell, and brain impairment, like memory loss.

At that point, Salim seemed in danger of joining millions of other Americans denied payment for medical treatment. These patients often settle for outdated, riskier procedures or simply forgo care.

But Salim was no ordinary patient. He was, in fact, an aggressive litigator who had been named one of the 100 best trial lawyers in America. In a long career working from Natchitoches, Louisiana, a tiny city in the Creole heartland, he had helped extract settlements worth hundreds of millions of dollars from massive corporations that had harmed consumers with unsafe products, including pelvic mesh and the pain reliever Vioxx.

Salim decided to do what few people can afford to do. He paid MD Anderson $95,862.95 for his proton therapy and readied for a battle with Blue Cross, the biggest insurance company in Louisiana. As always, Skeeter Salim was determined to win.

It would be Goliath vs. Goliath.

First image: Salim in the private jet he uses to commute between his home in Houston, Texas, and his office in Natchitoches. Second image: Awards on display in Salim's office. Danielle Villasana for ProPublica

"It's not about the money for me. I've been blessed and we have an extremely lucrative practice," said Salim, a broad-set man quick with jokes. "But I would like to see other people that are not in the same situation not get run over by these people. There's no telling how many billions the insurers made by denying claims on a bogus basis."

Blue Cross and Blue Shield of Louisiana declined to comment, citing ongoing litigation.

In his decades as a plaintiff's lawyer, Salim had relied upon consumer protection laws and billion-dollar judgments to make companies fix their bad practices. But now he stood on different terrain, facing a 1970s-era federal law that deprived patients of tools to fight, let alone change, abuses by the insurance industry.

And interviews, court documents and previously confidential emails and records from Blue Cross, its contractors and MD Anderson would expose the inner workings of a large insurer and an unnerving truth: To overcome a system tilted heavily in favor of the insurance industry, you need money, a dogged doctor and a friend with unusual skills.

"Arbitrary and Capricious"

Salim was angry. For years, he had paid Blue Cross more than $100,000 in annual premiums to cover himself, the employees of his law firm and their family members.

In mid-October 2018, he scrawled a note on a legal pad: "Blue Cross' denial is arbitrary and capricious and will lead to irreversible harm to my physical being."

for approval of the proton
therapy. Blue Cross denial
is arbitrary & capricious and
will lead to irreversible harm
to my physical being.
Of course BCBS will be
responsible for all payments,
penalties and att. fees in

A note Salim wrote complaining about Blue Cross' denial of payment for his medical care Courtesy of Robert Salim

And so Salim began his unusual journey to appeal an insurance company rejection. Few patients ever do so. One study of Obamacare health plans purchased on healthcare.gov found that less than 1% of people tried to overturn claim denials.

When a patient files an appeal, insurance company doctors are supposed to take a fresh look to reconsider the denial, relying on medical guidelines, their own clinical experience, scientific studies and the recommendations of professional societies.

But the insurance industry doctors who shot down Salim's appeal did little to consult outside sources, a ProPublica review found. They cut and pasted guidelines created by a company called AIM Specialty Health: "The requested proton beam therapy is not medically necessary for this patient," one rejection letter read.

Many insurers won't pay for certain specialized or expensive treatments unless a patient gets approval in advance. Blue Cross and other health plans often farm out those reviews to companies like AIM. The insurance industry maintains such companies keep health care costs down and help patients by rejecting unnecessary and unproven treatments. Critics say the companies unfairly deny claims, noting that they market themselves to insurers by promising to slash costs.

In Salim's case, AIM made decisions using its own guidelines, which it said at the time were based on medical studies and the recommendations of professional medical associations. AIM's parent company, Anthem, renamed itself Elevance Health in 2022, and subsequently changed AIM's name to Carelon Medical Benefits Management. In a statement, Elevance said that Carelon "uses evidence-based clinical guidelines to assess requests."

At Blue Cross, Salim's appeal started with a review by one of its own doctors, an ear, nose and throat specialist. He affirmed the denial using language taken directly from AIM's guidelines.

The insurer then routed Salim's request to an outside company called AllMed that it had hired to render expert opinions. A day later, AllMed's doctor, a radiation oncologist, affirmed the decision to deny payment for Salim's care. He, too, copied AIM's guidelines in explaining his reasons. AllMed did not return requests for comment.

Not willing to give up, Fuller, Salim's doctor, took a step physicians rarely do: He asked Blue Cross to have an independent medical review board unaffiliated with the insurer or AIM examine Salim's claim. Louisiana's Department of Insurance randomly selected the review company, Medical Review Institute of America.

Fuller didn't skimp on evidence. He sent the company a 225-page request containing Salim's medical records, MD Anderson's evaluation and outside studies supporting the use of proton therapy.

The next day, the Medical Review Institute denied the claim. Its doctor, a radiation oncologist, not only quoted AIM's guidelines, but also cited four studies that raised questions about the evidence for proton therapy. The Medical Review Institute did not return requests for comment.

In 19 days, five different people at four different companies had reviewed Salim's case. Each had denied his request for treatment. Each had cited AIM's guidelines. The appeal process was over.

Before the review was complete, Salim had decided to pay out of pocket for the proton beam therapy. "If there's a tumor in there, and it's growing, why are we waiting so long to do something?" he asked Fuller.

Over more than two and half months that fall and winter, Salim visited MD Anderson multiple times a week. At each radiation session, he strapped on a custom mask that covered his entire face. Nurses locked him into arm and leg restraints. Then he had to hold still for 45 minutes while the proton therapy machine thrummed around him.

In the background, he sometimes heard the nurses playing the 1977 Kansas song, "Dust in the Wind."

"What a terrible song to play," he thought.

On Dec. 24, he endured two sessions in a day to finish up. He had completed his treatments — a Christmas present to himself. But he wasn't done fighting.

A Useful Friendship

A few months after recovering, Salim decided to sue Blue Cross to force them to pay.

There was one problem. Salim held a type of insurance governed by a relatively obscure federal statute: the Employee Retirement Income Security Act. The Department of Labor is charged with enforcing the law, known as ERISA.

The 1974 law is vague and lacks teeth. Court rulings interpreting this law have often tilted in favor of insurers. For instance, insurance companies

have broad authority to decide what to cover and what to deny. And the law does not allow for punitive damages, which are designed to punish a company for abuse or fraud by eating into its profits.

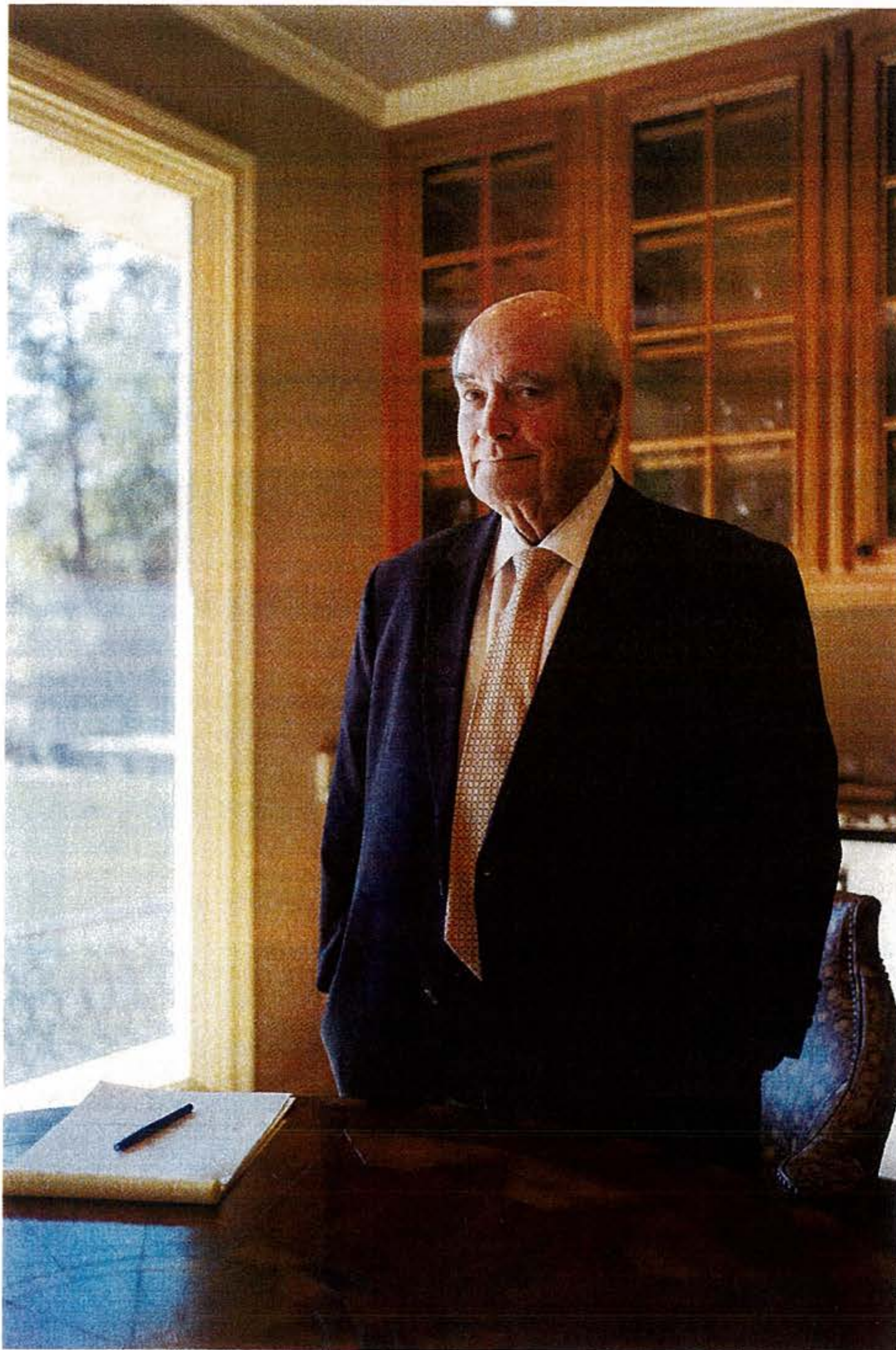
Instead, patients who win ERISA cases get money to cover their treatment and the expense of hiring a lawyer. Nothing more.

Such cases do not, in other words, bring in the big dollars like those Salim had won in large personal injury lawsuits. Few attorneys in the country handle ERISA complaints. Salim said he talked with some of them. All told him his case was unwinnable.

But Salim had a secret weapon: his childhood buddy Ronald Corkern.

Salim grew up a few blocks away from Corkern in Natchitoches (pronounced "nack-a-tish"), a northwestern Louisiana town founded in 1714 and set high on the banks of Cane River Lake. Shops with wrought-iron balconies and columned galleries line the city's red brick main road. Well-preserved slave plantations ring the outskirts.

The city is known for two things: "Steel Magnolias," a 1989 movie about female friendships, was filmed there. And singer-songwriter Jim Croce and his entourage were killed when their plane struck a pecan tree near the end of the runway at the local airport.



Ronald Corkern at Salim's office Danielle Villasana for ProPublica

Salim and Corkern left for different law schools, but both returned to practice in their hometown. They often found themselves on opposite sides of the courtroom, facing off in more than 100 trials, sometimes pulling pranks on one another.

Affable and deeply engaged in the civic issues of his hometown, Corkern had spent much of his life as a lawyer defending auto insurers. He had never before argued an ERISA case. But for his friend, he was willing to try.

"I got trapped into handling this case," Corkern joked. At the end of February 2019, he sued Blue Cross. He started in state court, but Blue Cross quickly got it bumped to federal court in Alexandria, Louisiana, where ERISA law would apply.

Over the next several years, lawyers for Blue Cross argued that under the law, insurers had the ultimate authority to determine what to cover, and Blue Cross had decided that proton therapy wasn't medically necessary in this case. Salim's lawsuit, they contended, should be dismissed.

But prior court rulings had carved out an exception: If Corkern could prove that Blue Cross had committed an "abuse of discretion" — for instance, if it had blatantly ignored or twisted evidence supporting the therapy — the judge could force the insurer to pay Salim for his treatment.

A nine-page letter written by Fuller, Salim's doctor, argued that very thing, criticizing the guidelines that AIM and Blue Cross had relied upon to deny payment.

AIM had cited 48 research studies to support its rejection of proton therapy. Fuller found only a few that pertained to head and neck cancer. One of those was out of date: It cited guidelines by a professional society of radiation oncologists that had subsequently been updated to support proton therapy for head and neck cancers.

And Fuller noted that AIM had "glaringly omitted" information from the National Comprehensive Cancer Network, an alliance of cancer treatment centers that included MD Anderson. In May 2017, the network issued guidelines that said the therapy was under investigation and noted that studies had indicated its potential in reducing radiation doses to critical nearby organs for some cancers. While proton therapy may have similar efficacy as other kinds of radiation treatment at eliminating cancer, studies have shown it generally has fewer side effects in treating sensitive regions of the body — a surgeon's scalpel versus a steak knife.

Fuller's touché: 17 academic studies (including some he co-authored) that supported the use of proton beam therapy. Several found significant decreases in radiation exposure and fewer side effects.

The therapy "minimizes toxicity for Mr. Salim, resulting in a more rapid recovery from the treatment of his cancer and less cost to him and you (as his insurer)," wrote Fuller, who declined to comment for this story.

Fuller's letter played a big role in the case. A federal magistrate, Judge Joseph H.L. Perez-Montes, cited it 16 times in his 19-page opinion. Fuller showed that most of the evidence used by Blue Cross was "either outdated or did not pertain to the treatment of head and neck cancer," Perez-Montes wrote. Blue Cross, he said, had "abused its discretion."

A federal judge reviewed Perez-Montes decision and ordered Blue Cross to pay Salim for his proton therapy treatment.

Blue Cross appealed that ruling to the Fifth Circuit Court of Appeals in New Orleans. The company argued that the lower court had erred in accepting Fuller's analysis over the insurer's own experts. On May 3, 2023 — more than four years after Corkern filed the suit — a panel of judges ruled for Salim.

It is unclear why Blue Cross fought so hard to avoid paying Salim. In its appeal, the insurer told the court that the case involved an "important issue" regarding the interpretation of benefits under the ERISA law. It is

unknown how much Blue Cross spent on the case. Corkern charged his friend the bargain price of $36,185.

Corkern, left, and Salim. The two friends are still fighting Blue Cross over payments for health care and attorney's fees. Danielle Villasana for ProPublica

An Unsettled Bill

The treatment worked. Salim has been cancer-free for almost five years, and he suffered few long-term side effects. His Creole accent now has a slight rasp to it. If his next checkup turns up no signs of a tumor, his doctors will consider him cured.

This year, he joined his friends for the U.S. Open again. And he's found a new Goliath, joining other attorneys in a suit against the country's largest pharmacy benefit managers — intermediaries in the buying and selling of medicines who have been accused of artificially inflating prices.

The Blue Cross lawsuit was the last one that Corkern ever filed. He spends most of his time these days conducting mediations between aggrieved parties.

The case itself remains open. The judges ruled that Blue Cross must pay for Salim's treatment. But they did not say how much.

Salim is expecting the full $95,862.95 he paid. However, court records show that Blue Cross has said it only needs to pay Salim the discounted rate it had negotiated with MD Anderson at the time of his radiation treatment: $35,170.47. That's what Blue Cross would have paid if its doctors had said yes in the first place.

While not setting a precedent, the case may help persuade insurers and other courts that proton therapy is medically necessary in certain cases, legal experts said.

"They were wrong. Proton radiation is not experimental. It's a wonderful tool," Salim said. "If I played even a small part, it was a very successful lawsuit."

Update, Nov. 20, 2023: *On Nov. 13, a federal judge ordered Blue Cross and Blue Shield of Louisiana to pay Robert "Skeeter" Salim the full amount of his bill, plus interest, along with Ronald Corkern's legal expenses.*

T. Christian Miller

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STATES *of* HEALTH

Community Catalyst *Volume 11, No. 4, Summer 2002*

Getting to No: How Kansas Advocates Derailed the Anthem Steamroller

A battle royale has taken shape in Kansas about the future of its Blue Cross and Blue Shield plan. This past February, Kansas Insurance Commissioner Kathleen Sebelius rocked the corporate health care establishment by refusing to allow Anthem Insurance Company to buy the state's independent Blue Cross and Blue Shield plan. Then, in June, a state judge overturned her decision. Now the case is headed to appeals court, where Sebelius will seek to have her decision reinstated. At the heart of the legal wrangling is the unprecedented manner in which advocates have asserted consumer interests, raising issues that will persist long after the courts hand down a final ruling. States of Health *looks at how consumer advocates have responded to the proposed Blues transaction, a process that has strengthened the health consumer voice in Kansas—and offers important lessons for advocates in other states as well.*

At the end of May 2001, the news broke that the Indiana-based corporate giant Anthem Insurance intended to take over Blue Cross and Blue Shield of Kansas. Local health care advocates mobilized almost immediately.

"We had to get involved," says Terri Roberts, executive director of the Kansas State Nurses Association (KSNA) which, together with the Kansas Association for the Medically Underserved (KAMU), formed the core of the emerging opposition effort. "We couldn't just stand by and let that happen, because we knew what it could mean," Roberts adds.

What the takeover could mean was a dramatic change in the state's health care system, especially given that the Blues plan covers 70 percent of Kansans.

Blue Cross and Blue Shield of Kansas (BCBSKS) is a "mutually owned" company. That is, its policyholders own it, and the company's main objective is to serve them. Anthem is a stock corporation, owned by its shareholders. Turning a profit is vital: it has a fiduciary responsibility to maximize shareholder investment. As a part of Anthem, BCBSKS would have to shift its allegiance from its policyholders to its shareholders, and the Kansas advocates were concerned that such a change would be detrimental to the public interest. They sought to convince their state's insurance commissioner that an insurance company is more likely to provide access to good health care if the top priority of its owners is good health care.

"We wanted to make sure our government did the right thing," says Roberts. The key question was what impact the conversion would have on policyholders and, indeed, on health care coverage for all Kansans. Also, advocates were looking "beyond the transaction's immediate impact, to what it might mean for Kansans 20 years from now," Roberts adds. "Because once a health plan is part of a big for-profit organization, that's it. There's no going back."

Community Catalyst staff had worked on and off with advocates in Kansas for years, always with an eye toward a possible transaction involving the state's Blue Cross and Blue Shield plan. That involvement intensified with the announcement of the proposed sale.

Dawn Touzin of Community Catalyst, a veteran of such battles, was enlisted to provide the Kansas advocates with technical support. But she flew to the Midwest in January 2002 for public hearings on the proposed takeover with a heavy heart. "It's like David and Goliath," she remembers thinking glumly—except that she seriously doubted David would prevail.

Touzin was just being realistic. "Anthem had already acquired independent Blues plans in eight states, including the one in its home state of Indiana," she explains. "They had this incredibly effective juggernaut; anyone going up against them had lost."

Indeed, "conversions"—in which nonprofit or mutually owned health plans become for-profit enterprises, often by allowing themselves to be gobbled up by a large insurer such as Anthem—have been a prominent feature of the national health care landscape for a decade. Advocates have

STATES of HEALTH

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often had little recourse but to pursue smaller victories, devoting most of their energy to securing the best possible deal—and whatever consumer protections they could extract—from the would-be new owner.

Since 1996, the Community Health Assets Project, a joint project of Community Catalyst and the West Coast Regional Office of Consumers Union, has helped local and state health advocates to intervene and shape such deals. CHAP's focus has been on developing basic standards to ensure adequate public input and regulatory oversight, preserve charitable assets, and prevent self-dealing or other improper profiteering from the transaction.

As director of Community Catalyst's CHAP team, Touzin was prepared to suffer through the usual: Anthem representatives would point to rising health care costs, suggest that only a big business like their own could remain solvent, and collect *pro forma* approval from the state's insurance commissioner.

But she was in for a surprise. On the very first afternoon of the hearings, she found herself "emailing the folks back at Community Catalyst and saying, 'There's something really different going on here.'"

Scrutinizing the "Bigger is Better" Mantra

Touzin got her first clue that Kansas would be different the minute she set foot in the hearing room. It was packed. Both the public and the press were well represented. More than that, they were informed on the issues, ready to ask questions, and willing to devote a lot of energy to the three days of hearings planned.

Then came rounds of testimony and cross-examination. Both KSNA and KAMU, along with the Kansas Medical Society and the Kansas Hospital Association, had been granted intervenor status: that is, they could play an active role in the proceedings conducted by Insurance Commissioner Kathleen Sebelius. They would not only have access to the same information as the general public would, but they could request more. In addition, Sebelius had appointed a team of her staff and some outside counsel to review key particulars of the proposed acquisition. She herself was acting as an impartial adjudicator.

"Anthem was saying the same thing in Kansas that they had said in every other state," says Touzin. "They got out the 'bigger is better' mantra and went through their usual litany of benefits. But this time people weren't just nodding and saying OK. The intervenors and the Insurance Department and the independent experts Sebelius had brought in had all done their homework and found reasons to be concerned. They were ready to demand more than just vague assertions that everything was going to be great if Anthem took over BCBSKS. They wanted evidence."

Corporate Embarrassment

They got almost none. Within hours, it was clear that BCBSKS could not even document how it had decided to agree to the acquisition. In a buyout, normal business protocol dictates that the company to be purchased give its board an executive summary detailing the pros and cons of the sale, a review that is done to ensure "due diligence." Generally, a corporate board requires at least that much in order to fulfill its fiduciary responsibilities.

When asked to supply such a report to the court, however, a BCBSKS vice president "admitted under oath that there was never an executive summary in written form—that arguments were just presented orally to the board," says Roberts. "He said that while various department managers had put together various pieces of paper, no one had ever compiled them. And he added that those documents had been destroyed."

Roberts believes that this moment was critical. She says, "Anyone who knows about these kinds of transactions had to be thinking, 'What?! You never prepared an executive summary?! What?! You destroyed documents?!' It made everything very suspect. Businesses simply do not make decisions of this magnitude without something in writing to show their board."

At the very least, Roberts adds, this testimony made clear that BCBSKS never seriously believed it owed the public any explanation of its decision to become part of Anthem.

Analyzing Anthem's Numbers

As the hearings moved on, investigators turned their attention to

Kansas Insurance Commissioner Kathleen Sebelius meeting with Community Catalyst's CHAP team, including Senior Legal Advisor Stephen Rosenfeld.

Anthem's specific claims about the effects of the buyout. Here again, the outcome was embarrassing to the companies.

For example, Anthem claimed that the buyout would generate additional revenue to pay shareholders by improving efficiency. But inquiry into the matter revealed that, in fact, the BCBSKS operation is much leaner than Anthem's, with an overall administrative expense ratio of 9 percent, compared with Anthem's 11.5 percent.

Anthem had also made a point of saying that it wanted only a small profit from BCBSKS—2 to 2.5 percent—but PricewaterhouseCoopers had conducted an independent analysis showing that, to achieve even this modest goal, Anthem would have to increase premiums 7 percent above increases BCBSKS would be expected to make. That meant 7 percent on top of the normal health cost increases that experts across the board are projecting over the next few years, increases that are expected to average 15 to 20 percent across the United States in 2003.

Significantly, Sebelius was not required to conduct such a financial analysis—nor did she have to show that the proposed transaction was good for Kansans. By law, she was required to approve the deal if she found there was no harm. Yet she hired PricewaterhouseCoopers to make as outside, independent assessment which could have come back in favor of the deal. But the analysis PwC delivered was, in fact, negative and very specific about the costly impact on BCBSKS policyholders.

It was clear the brunt of Anthem's 7 percent increases would largely fall on Blue Cross and Blue Shield subscribers covered by small group and non-group policies. As the new plan operator, Anthem would need to strengthen its ties to its largest accounts, for fear of losing them to competitor health plans. That would mean minimizing, to the extent possible, major rate increases on those groups.

Small-group and non-group beneficiaries have few options besides Blue Cross, however. In Kansas, as in other states, the number of companies offering them coverage has dwindled, in part because of the high administrative costs of managing these accounts—especially relative to the revenue they generate. So small group and non-group subscribers can't go elsewhere to buy coverage.

These subscribers have no market clout and almost no shelter from sizeable rate increases, notes Joyce Volmut, executive director of Kansas Association for the Medically Underserved. "If you have fewer than 50 employees and want to buy small-group coverage for your workers... Blue Cross is the only game in town. Some employers already find they can't afford it," she says.

It became clear during the Blue Cross and Blue Shield proceedings that Anthem's proposal could spell big trouble for people who buy their health coverage on the small group or non-group market. Furthermore, that problem translated into an enormous impact statewide, because Kansas has few large employers; most Kansans work for small businesses. With BCBSKS covering 70 percent of all Kansans, it was not a pretty picture.

According to Touzin, these findings about premium increases "weighed heavily. It became obvious that the deal was not in the public interest."

On February 11, two weeks before the deadline, Sebelius announced that she was rejecting the Anthem deal. She had concluded that its proposed acquisition of the independent Blue Cross and Blue Shield plan in Kansas "would be hazardous and prejudicial to the insurance-buying public," a decision clearly indicating that as a regulator, Sebelius' had strong public interest instincts.

A Courageous Decision

"The final order from Sebelius is just fascinating to read," Touzin says. "You can see how she looked at all the supposed benefits of the Anthem deal and said, essentially, 'It doesn't fly.'"

Sebelius more or less dismisses Anthem's claim that the buyout would provide greater "access to capital" and

"financial flexibility." The order flatly states that the deal would "largely inure to the benefit of Anthem and its investors, not the policyholders and the insurance-buying public."

In response to the claim that Anthem would introduce cost-saving economies of scale, Sebelius writes that the corporation "presented little evidence of any efficiencies that could be achieved." She also notes that the evidence it did present was based on "its past performance following other acquisitions." Such evidence is faulty, she says, because "Anthem's other acquisitions involved troubled companies. BCBSKS is not a troubled company."

Finally, Sebelius addresses the matter of premium increases. She is frank about why she lends credence to the 7 percent figure: that projection, she points out, comes from "the only systematic, analytic review of the Kansas insurance market." She also points out that this review focuses, appropriately, on the small group and individual insurance markets, which would be most vulnerable were Anthem to impose major rate increases.

The final order takes all this into account. KAMU's Volmut notes that Sebelius "always said it was her responsibility to make a decision on behalf of all those Kansans who didn't have a voice in the matter, and in the end, that's exactly what she did. It was very courageous."

An Alignment of the Universe

In retrospect, Touzin sees the Kansas experience as one where "there's a sort of alignment of the universe—the various factors all arrange themselves in such a way that you get a picture you've never seen before." What happened can be attributed partly to conditions in the state itself. Kansans turn out to be much more critical and tough-minded than Anthem had anticipated.

Sebelius' regulatory style was also a factor. When consumer interests were at stake, she was willing to ask the

Kathleen Sebelius at Community Catalyst

What brought her to Massachusetts was her Democratic candidacy for the governor's seat in Kansas. But when Kathleen Sebelius visited with Community Catalyst staff in early June, she arrived as the Kansas state Insurance Commissioner and as something of a hero.

Just a few months earlier, Sebelius had rejected the Anthem Insurance proposal to take over the state's Blue Cross and Blue Shield plan. Community Catalyst staff members Dawn Touzin and Phillip Gonzalez had been working hand-in-hand with Kansas advocates Terri Roberts of the Kansas State Nurses Association and Joyce Volmut of the Kansas Association for the Medically Underserved for months to ensure that the interests of Kansas health care consumers, especially the medically underserved in Kansas, would be well represented in the proceeding.

In the process, consumer advocates had come to respect Sebelius' regulatory style. She was absolutely thorough, devoting substantial resources and time to carefully considering the deal's probable impact on Kansans. With her decision not to approve the Anthem buy-out, the commissioner confirmed what advocates had suspected: that the regulator viewed the public interest as a critical component of her responsibilities.

Having testified before Sebelius in the Kansas proceedings, Touzin, who directs Community Catalyst's Community Health Assets Project team, welcomed the chance to exchange views with the Kansas regulator. Like Touzin, Gonzalez, and their Kansas colleagues, Sebelius said she was astonished by the sheer number of people who came to meetings wanting to know more about the Blue Cross and Blue Shield proposal.

"You have to remember," she noted, "that this was December, which is a busy time for everyone, not to mention it being a bad weather month. But still, all these people came."

Touzin says it was fascinating to look back at the Department of Insurance proceedings from the regulator's vantage point.

"It was clear the Commissioner carefully considered the arguments that consumer advocates put before her during the process," Touzin says. "What was equally gratifying to hear, this many weeks later, was how she regarded the arguments put forward by Anthem and Blue Cross and Blue Shield. Basically, she shared our view that the deal, while very beneficial to Anthem's acquisition goals, would be 'hazardous and prejudicial to the people of Kansas.' She thought their presentation was very weak, and that not being able to produce any 'due diligence' documentation really hurt their case."

Sebelius lauded Community Catalyst for the added perspective it brought to the oversight process. And, she said, the deliberations convinced her that Kansas needs to create a consumer health advocacy group.

"I've tried to represent the consumer perspective myself," she said, "but the dynamic is odd. There really needs to be a consumer group. There needs to be that balance in the dialogue. . . . Otherwise, you can end up having hearings with 25 insurance company representatives and then someone from the medical society. And you get a very skewed dialogue."

Just three days after Sebelius's Boston visit, Kansas District Court Judge Terry L. Bullock overturned her decision. Sebelius said the judge's decision disappointed her, but said she would not retreat from her commitment to protecting Kansans from a deal that she felt was "simply wrong for the health care and economic security of the people of Kansas and our business community."

Commissioner Sebelius has filed a petition to appeal Judge Bullock's decision. The move was immediately applauded by consumer advocates, who remain unswerving in their belief that Sebelius will prevail.

hard questions: What impact will this have on consumers in this state? What will it mean for insurance premiums in this state? Should this transaction be approved? And she had a strong political incentive to ask those questions in this case, because she is running for governor. She could not have failed to notice the groundswell of public sentiment against the buyout.

Another factor that worked in the advocacy community's favor was the new financial stability of many independent Blues plans, including the Kansas plan. When the first conversions were on the table in the 1990s, a number of independent Blues were fiscally shaky. To be sure, ups and downs are inherent to the insurance industry, but in the early 1990s, the industry encountered a truly exceptional "down" portion of this up-and-down cycle.

Health care costs had risen exceptionally steeply, and many independent insurers found themselves with a deficit that was considerably bigger than they were comfortable with. Also, because of market pressures, these companies couldn't respond with an immediate major increase in premiums. Their only choice was to ride the cycle out as usual—to sit tight and raise premiums gradually over several years. In this context, joining forces with a larger insurer seemed a wise move.

Changed Blues Environment

By 2001, however, when Anthem was poised to buy out BCBSKS, premium revenues and claims expenses were, overall, much more in sync. There was no pressing need to convert. Or, as Touzin puts it, "Anthem had a history of being able to say, 'It would be beneficial to the people if we took over this plan because otherwise the sky is falling.' And in Kansas they had to reframe that. They had to say, 'Well, the sky isn't falling right now, but you know what? It might fall someday, and if it ever does, you'd be a lot better off if a big company like us owned you.'" Clearly, that didn't have the same ring.

Meanwhile, consumer advocates were reaping the benefits of their own steadfast "capacity-building" work. Technical expertise on how to approach conversions had gained critical mass. Years ago, large insurers were the only players who went into conversion battles with a real game plan; advocates invariably had to scramble to catch up.

That started changing several years ago, when Community Catalyst began working with local and state health advocacy groups to develop a public interest and consumer protection approach to these transactions, an approach that was strengthened when it joined forces with Consumers Union to form the Community Health Assets Project (CHAP). The fact that New England consumer advocates had gone up against Anthem in its quick pursuit of several Blues plans in their region in the years before the Kansas sale was proposed intensified the learning curve.

"Capacity-Building" Was Key

While Anthem's conversion machinery was as well-oiled as ever, Community Catalyst and its partner groups had accumulated the background they needed for shrewd analysis and strategic thinking.

They knew, for example, how important it was to educate the press. They were also familiar with both the formal details of conversions and the informal maneuvers large corporations tend to rely on. They knew not only what documents each of the parties involved had to file but what the key elements were of each document. If a corporate opponent tried to set up parameters that would work in its favor—say, a particularly long or short timeline—consumer advocates could figure out what was up right away and respond.

Furthermore, the network of relationships connecting Community Catalyst with like-minded local groups had grown. This aspect of capacity-building turned out to be pivotal: it meant that opponents of the Anthem deal could organize with dispatch, they could share know-how readily, and they could use that know-how effectively.

Forging a Solid Partnership

The relationships that became so important in Kansas did not materialize overnight. KSNA's executive director Terri Roberts recalls that her organization and KAMU had first worked with Community Catalyst about four years earlier, when BCBSKS was fighting Kansas Attorney General Carla Stovall over the issue of charitable obligations.

That issue had been one of the enduring features of an earlier attempt by BCBSKS to merge with BCBS of Kansas City. That deal had fallen apart after the Attorneys General of both Kansas and Missouri had expressed doubts about its legality, in large part because the question of charitable obligations had not been settled for either company. However, BKBSKS did not allow the charitable obligations issue to drop. A series of suits and counter-suits between Stovall and BCBSKS had followed. Basically, BCBSKS's position had been that it had no charitable obligations. Stovall's position was that it did.

What mostly caught the eye of Roberts and other advocates was the simple fact that BCBSKS had chosen to pursue the matter so doggedly. "BCBSKS seemed to be clearing the way so that it could do something, probably a conversion," Roberts says.

Charitable obligations, Roberts knew, are among the most hotly con-

tested issues in any conversion. Consumer advocates usually insist on preserving assets for the public, pointing out that a company or hospital with any history of nonprofit status does not actually own those assets. By law, the assets, built up from years of tax exemptions and other forms of community support, belong to the community and must be returned to the community when the company converts to for-profit status. Although BCBSKS was a mutually owned company at the time, it had been nonprofit until 1992, so this legal principle would certainly apply.

In most conversions, a company returns the charitable assets to the community by endowing a new health foundation. The foundation, in turn, must continue serving those same purposes for which the nonprofit institution was originally created: thus, it is charged with improving community health and supporting efforts that respond to community health needs. But if a company could enter into a conversion having already resolved that it had no charitable obligations, it would simplify the conversion review process by avoiding the key question of how much of its value is owned by the community.

When Blue Cross and Blue Shield of Kansas claimed it had no such legal obligation, it was taking a risk. If it lost this fight, its debt to the community would be acknowledged legally, and in no uncertain terms. KSNA, KAMU, and Community Catalyst labored to make sure that was the outcome.

They succeeded. In August 2000, the Sunflower Foundation was created to receive the charitable obligations of BCBSKS. Just as significant was that the effort helped Community Catalyst and Kansas consumer groups forge a solid partnership and develop an enduring appreciation for each other's strengths.

Frank McLoughlin, staff attorney at Community Catalyst throughout this period, says that he was "always impressed with the positive, optimistic attitude of the main players in Kansas. Right from the beginning, I sensed a lot of confidence and energy." He also stresses that "the Kansans were very focused on practical solutions to problems," and that such solutions "are a lot of what Community Catalyst is all about."

Immediately in Touch

After that first battle, Phillip Gonzalez, director of Community Catalyst's Community Philanthropy Initiative, picked up where McLoughlin left off, providing the Kansas Attorney General's office and the fledgling Sunflower Foundation with ideas and information on best practices. In the late spring of 2001, when Anthem announced its plans to acquire BCBSKS, he immediately called Roberts and Volmut. "We all put our heads together and decided we wanted to do something about this," Gonzalez says.

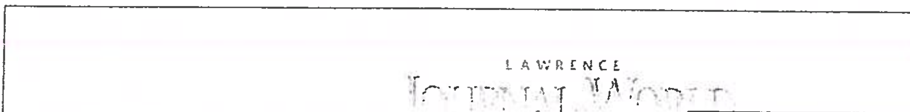
Next on board was Kim Moore, who runs the state's United Methodist Health Ministries Fund. While Moore did not take a position against the Anthem buyout, he wanted to ensure that its potential implications would be thoroughly investigated. The fund made a grant to KAMU to raise questions in the public interest. The money also paid for legal counsel. For that job, KAMU hired Karen Eager, an up-and-coming attorney with an interest in public health.

At this point, the Kansas Medical Society and the Kansas Hospital Association joined KSNA and KAMU in petitioning for intervenor status. As Roberts explains, this meant that "every one of the major health provider groups—hospitals, doctors, nurses, and clinics—were on the record as saying they wanted to take a serious look at the Anthem deal." The message to Kansans was unmistakable: the buyout was no trivial matter.

Going Public

With the team in place, events moved quickly. Community Catalyst collaborated with Karen Eager on legal tactics, preparing her for possible pitfalls and briefing her about conversion battles in other states.

Other team members were warned about different sorts of traps, including how Anthem might try to soften their positions on certain issues. For instance, says Roberts, "we were advised that Anthem would probably bring their medical director and their legislative person around to try to cultivate a relationship with us, and they did do that. It had worked for them in other states, so they tried it in our state."


LAWRENCE Journal-World

The Front Page

Sebelius kills insurance deal

Anthem denial is first in U.S.

By Scott Rothschild, Journal-World Staff Writer
TUESDAY, FEBRUARY 12, 2002

TOPEKA — Saying it would have cost the state too much, Insurance Commissioner ... company's bid to gobble up the biggest health insurer in Kansas.

Sebelius breaks ground with Anthem ruling

Last Modified: 8:32 a.m. 2/13/2002

By Michael Hooper
The Capital-Journal

Community Catalyst deputy director Susan Sherry notes there's nothing inherently wrong with a health insurer trying to meet with consumer advocates. "If the company's sincerely interested in understanding community health needs, it may very well be a good thing," she says. "But it could just be a public relations move, which makes it all the more important to stay focused on the public's real health care needs and concerns. You've got to be on guard."

By the time Anthem came calling, Roberts notes, the Kansas advocates were prepared. "Because we already knew that this was their basic *modus operandi*, we were ready," she notes. "We stayed focused on our mission and weren't taken in by that kind of solicitation."

Focusing on the Press

Community Catalyst advocates also helped the Kansas groups develop a sound relationship with the media. Timely, well-crafted press releases kept journalists informed about newsworthy events and core concerns. Thoroughly briefed team members were made available for interviews so they could articulate plainly, with compelling quotes, just what was at stake in the Anthem buyout.

And the press responded. Every step of the way, newspapers were full of stories about Anthem and BCBSKS, and the coverage was aggressive.

Then came five public comment meetings, which Sebelius set up so people could air their concerns to Anthem and BCBSKS representatives. Kansans arrived in droves. In all, some 1,200 attended the meetings, with a minimum of 150 at each. Community Catalyst's Gonzalez remarks that "everyone involved was overwhelmed by the numbers of people who turned out, especially because in Kansas many drove long distances to get to the nearest urban center. One meeting was held in western Kansas, in Garden City, and for some folks it likely meant having to drive a couple of hours on country roads just to get there."

Community Catalyst President Kate Villers listens as Sebelius reflects on her BCBSKS decision.

The Public Demands Answers

Moreover, he says, these people "all had burning questions to ask." And they were dogged about demanding answers. When they didn't have a public comment meeting to go to—or when, as often happened, Anthem and BCBSKS representatives did not answer a question to their satisfaction —they sought out other sources.

"We started getting all these calls at Community Catalyst," Gonzalez remembers. "I had one guy at a tractor dealership call me. There was a city councilor. And some other small business people. They called because they'd seen a piece in the local paper or a meeting notice somewhere in town. Some had found our website. Some were policyholders, and they called because they had nobody else to talk to about what was going on. They were people who really took the deal seriously."

In fact, even the journalists, who make their living from asking questions, were showing an unusual degree of interest. Gonzalez reflects that he knew they had hit a nerve when, in the middle of routine interviews, reporters started asking him about what might happen to their own families' health care in the wake of a conversion.

Momentum All Its Own

"We began to feel like the Kansas work was developing a momentum all its own," he says. "There was the sense that the public was getting on board, and events were moving fast, faster than we'd ever anticipated. I don't think any of us had envisioned the intensity of public concern that was coalescing around the deal—not in our wildest dreams."

What was going on turned out to be burgeoning skepticism that would eventually derail the BKBSKS conversion. And the after-effects of the debate in Kansas, no matter how the state's courts ultimately rule, will surely extend beyond the deal's outcome.

KSNA, KAMU, and Community Catalyst hope that advocates can use the energy generated by Kansans' interest in this issue to jump start a statewide consumer group specifically dedicated to health care issues. So far, provider groups have driven health care advocacy in Kansas, but providers and funders alike believe their efforts could be vastly strengthened if people concerned about health and representing a cross-section of communities in Kansas were drawn into the mix.

In addition, Anthem's defeat in Kansas—at the very least, in the proceedings before Sebelius and her regulatory staff—could set a precedent for other states.

To be sure, this is not the first time a large insurer has lost out on a bid to acquire an independent Blues plan. In the late 1990s, consumer health advocates working with Community Cata-

lyst and the Universal Health Care Action Network of Ohio helped defeat HCA/Columbia's attempt to buy out a BCBS plan there.

In that case, though, explains Gonzalez, the buzz had been largely about the scandalous amounts of money that executives stood to make. In Kansas, Anthem avoided that sort of controversy and did not offer any major financial incentives to BCBSKS officials.

Thus, the pivotal question of what impact the conversion might have on consumers never got lost in Kansas. It remained at the center of the debate and was the focal point in the Insurance Commission proceedings.

"That question is the one that people need to keep in mind," Gonzalez emphasizes. "Doing so elevates the standards for reviewing such deals."

Setting a Precedent

As events in Kansas have unfolded, people in other states considering conversions have been watching closely. For example, consumers in Maryland, Delaware, the District of Columbia, and parts of northern Virginia are following the Kansas transaction closely.

These consumers are concerned about the large California insurer Wellpoint, which is trying to take over CareFirst, a nonprofit Blues plan. Many seem to be concluding that a CareFirst buyout might not be good for them or the public as a whole.

And they refuse to be distracted. Their careful, clear-headed questioning about the possible impact of the deal on access to health care has continued even as new public outrage has flared over the perks and bonuses company executives might earn if the Wellpoint purchase goes through. In particular, there seems to a growing realization that the largest premium increases and benefit cuts could fall on CareFirst's small group and non-group subscribers.

In other ways, as well, the Kansas decision has been taking place at a particularly important time, given less

Judges Overturns Sebelius Ruling

The state officials presiding over the proposed sale of Blue Cross and Blue Shield of Kansas to Anthem Insurance have been full of surprises.

Two weeks before February's decision deadline, Insurance Commissioner Kathleen Sebelius caught many off guard when she rejected Anthem's purchase plans and called the proposal "hazardous and prejudicial to the insurance buying public." Sebelius based her decision on a detailed, independent analysis of the deal's likely impact on insurance premiums in Kansas, finding that the sale would raise premiums $248 million over five years, significantly more than would be necessary without the acquisition.

In June, District Judge Terry L. Bullock of the Kansas District Court overturned the Sebelius decision, ruling that she had exceeded her authority. "Although the commissioner is granted power to supervise insurers and to enforce the Kansas insurance code, she is not authorized to add or change established legal requirements or take regulatory action based upon anticipated premium rates or levels of surplus that would be either required by or consistent with the law," Bullock wrote.

"Bullock was asserting a very narrow reading of Kansas state law," explains Community Catalyst CHAP team director Dawn Touzin. "Essentially his ruling says that Sebelius may have been correct in her math, and her cost analysis, but she has no authority to draw conclusions based on that assessment. His view appears to be that the Insurance Commissioner has no discretion to consider what impact those cost figures may have on people's access to health care coverage."

While Sebelius warned in her order against small- and non-group rate increases that Anthem would impose if the deal were approved, Bullock said she had no business trying to protect the public from such premium hikes. He argued that such increases were needed; otherwise, the other Blues insurance lines would be subsidizing small- and non-group plans, which he said the law forbids.

"But this wasn't about cross-subsidies. Sebelius was talking about premium increases that would be required within the line of business, required because of Anthem's stated profit goals," says Community Catalyst deputy director Susan Sherry.

Within days, Sebelius announced she would file an appeal with the Kansas Court of Appeals and would seek to have the case transferred to the state Supreme Court. In fact, the Appeals Court has overturned many Bullock decisions, including some of his administrative rulings.

In her statement on the ruling, Sebelius declared the Bullock ruling "incorrect" and said, "I denied the out-of-state takeover of Kansas Blue Cross and Blue Shield because it would have cost Kansas families and businesses millions of dollars in increased premiums and threatened the local health care decision-making Kansans depend on from Blue Cross. Anthem of Indiana is an aggressive, for-profit holding company whose primary objective is to beat its national competitors. That may be fine for Anthem, but it's simply wrong for the health care and economic security of the people of Kansas and our business community."

Sebelius has also made clear that the fight is not yet over.

"When all is said and done" she said, "the people of Kansas will be protected and Kansas Blue Cross and Blue Shield will remain in the hands of its local policyholders."

If the case goes to the state's highest court, a ruling is not expected before December 2002.

welcome developments in the world of conversions. Also on the radar screen is New York, where Empire BCBS has announced it is converting from non-profit to for-profit status—and most of the estimated $1 billion that would otherwise go into a conversion foundation will be used to pay for short-term increases in the hospital worker salaries. The take-home message for legislators in many financially strapped states seems to be that, number one, conversions free up enormous sums of money and, number two, those funds may be usurped to plug budget shortfalls.

Empire: Non-Profit Mission Abandoned

Community Catalyst health issues director Michael Miller speaks for many advocates when he bemoans the decision of New York Governor George Pataki to use up much of the Empire asset set-aside to fund health care worker pay raises. "There is certainly a high degree of opportunism in the Empire deal," says Miller. "The governor has no idea how the salary increase for health workers will be sustained once the Empire money has been spent, but in the short run it allows him to secure union support in the upcoming election without having to address the issue of whether taxes are needed to adequately pay the workers. While we support fair wages for health care workers, this deal diverts funds from the primary purpose for which Blue Cross plans were granted tax-exempt status in the first place: to make health insurance widely available and affordable."

Advocates around the country are understandably concerned about the Empire precedent. Cash-strapped states are resorting to all kinds of one-time schemes to balance their budgets. In this environment, the charitable

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assets built up over years in Blue Cross and Blue Shield plans could be dissipated all too quickly in the rush to close budget gaps.

The Need to Remain Vigilant

Still, Gonzalez cautions that establishing a conversion foundation does not necessarily guarantee that assets will be safeguarded. The challenge for advocates is to keep their eye on health care access, and to watch carefully both "the spirit and the letter" of any move regarding a conversion foundation said to be focused on "improving community health." One telltale sign to watch for: will the resulting foundation function openly or will its operations be a closed political process?

Legislators can, and do, alter the laws governing conversion foundations whenever they feel the need. Even more sobering, officials have been known to gain control of foundations without passing new laws. For example, in Colorado, the governor "convinced the foundation board to change their bylaws. At his urging they took the final authority for appointing board members away from the foundation's community advisory committee and gave it to the governor," Gonzalez notes.

To avert a repetition of the New York scenario, the public and consumer advocates need to be alert for these threats and prepare to fight them. In the meantime, though, what happened in Kansas is a reminder that saying no to conversions is a real option.

Community Catalyst's Touzin maintains that this alone will raise the level of debate on conversion issues.

Asking the Key Question

"Historically, we as advocates have always said the first thing that needs to be looked at in any conversion is whether it should actually take place, but we've never been able to spend much time on that question," she says. "There's always been a rush to jump to the next set of questions. Typically, the conversation would end up with people saying 'Yeah, yeah, but let's get on with business. What are we going to do with the money?'"

The way Kansas consumers, their advocates, and the state's top insurance regulator have examined Anthem's proposal ups the ante, making clear that it's no longer enough to simply focus on health plan finances and the shape of a potential new conversion foundation.

"Kansas demonstrates that there need not be a rush to talk about the money," Touzin says. "The key question, the question that really warrants careful scrutiny, is the question we have always pushed to raise: 'What will the health impact of this transaction be?' And that question is not just a theoretical matter. Kansas demonstrates the kind of analysis that can take place, indeed, should take place, when regulators, advocates, and the public attempt to fully come to grips with the health impact of a proposed health plan transaction."

Regardless of how the Kansas court ultimately rules, the decision that Kathleen Sebelius reached, the process that she presided over, and the questions that emerged through thorough public involvement and detailed press coverage—all of that will still have transpired, providing a road map for true public engagement on one of today's most difficult health care resource issues. That victory stands and affirms the ongoing efforts of consumer advocates around the country who are fighting to preserve and expand health care access.

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- **SALIM PAID FOR THE $95,862 PROTON TREATMENT THEN SUED BCBSLA**
- **SALIM WON HIS ERISA CLAIM IN FEDERAL COURT INCLUDIING APPEAL TO THE 5TH CIRCUIT**
- **THE JUDGEMENT FOUND THAT BCBSLA COMMITTED "ABUSE OF DISCRETION" AND FOUND THAT THE AIM / CARELON GUIDELINES WERE OUTDATED OR DID NOT PERTAIN TO HEAD & NECK CANCER**

BUYOUT = HEALTHCARE CRISIS IN LA

- **INCREASE IN DENIED CLAIMS TO PAY FOR PROFITS**
- **INCREASED PREMIUMS**
  - **BCBS CURRENTLY HAS NO REASON TO RAISE PREMIUMS WITH A $1.8B SURPLUS**
  - **WHY DEPLETE A $1.8 B RESERVE THAT TOOK DECADES TO BUILDUP THEN ADD $500 MM PROFIT FOR ELEVANCE TO THE BOTTOM LINE THAT WILL CAUSE PREMIUMS TO INCREASE DRAMATICALLY**
- **LOWER & SLOWER PAYOUTS TO PROVIDERS**
  - **WHY REPLACE A NON-PROFIT WITH A FOR PROFIT THAT IS FAMOUS FOR NOT PAYING OR SLOW PAYING HOSPITALS, PROVIDERS AND DENYING PATIENT CLAIMS**
- **HIGHER COSTS**
  - **ELEVANCE HAS A LOWER CMS MEDICARE RATING OF 3.5 STARS COMPARED TO 4.5 STARS FOR BCBSLA**
- **CLAIMED BENEFITS OF BUYOUT SIMPLY DO NOT EXIST**
  - **BCBSLA CURRENTLY HAS A CHARITABLE FOUNDATION, DIGITAL SOLUTIONS, & WHOLE HEALTH SOLUTIONS THAT SIMILAR OR BETTER**

LA HEALTH INSURANCE CRISIS?

AGAINST THE BCBSLA REORGANIZATION AND BUYOUT BY ELEVANCE

Honorable Senators and Chairmen,

Thank you for the opportunity to address the Senate Insurance & Health and Welfare Committee today. My name is Bridgette Gilbert, I am a licensed Insurance Agent but today I am here on behalf of Health Agents for America (HAFA), a non-profit trade association dedicated to representing independent health agents across all 50 states.

Over the past year, our members have convened to discuss concerns related to Elevance, prompting our appearance before this distinguished committee today. Our primary focus has been on issues such as unpaid or delayed claims, challenges in contracting with healthcare providers, and the unfortunate loss of jobs within Elevance plans throughout the United States.

HAFA holds a unique perspective in that our members include insurance agents representing Elevance in various states. This positions us to provide insights into the expectations and potential outcomes should the sale proceed. Additionally, we stand here today in support of our current partner, Blue Cross and Blue Shield of Louisiana, with whom we have established relationships, ensuring a level of confidence that a sale could jeopardize.

Unlike other large insurance companies operating in Louisiana, we have a direct line of communication with Blue Cross and Blue Shield of Louisiana. This familiarity allows us to navigate issues efficiently and advocate for the best interests of our clients.

It's crucial to clarify that our testimony is not driven by concerns over potential loss of commissions. Instead, we are here to represent over a million consumers across the United States who rely on us for education and assistance with changes and challenges related to healthcare networks and claims. Our commitment to full transparency underscores our desire to ensure that all relevant issues are thoroughly discussed before any changes that could impact more than 60% of Louisianans currently covered by Blue Cross Blue Shield.

We are ready and willing to engage in a constructive dialogue, providing any necessary information to address your inquiries. Thank you for your time and consideration.

Bridgette Gilbert
Health Agents for America (HAFA)