

# HEALTH PLAN WEEK

Timely Business, Financial and Regulatory News of the Health Insurance Industry

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## Earnings Preview: First Quarter Was Worst For Plans in 11 Years, Equities Analysts Say

For publicly traded health plans, the first quarter of 2008 will go down as the worst single quarter for stock performance in more than a decade, equities analysts say. While the Standard & Poor's (S&P) 500 stock index is down 10% for the quarter, the managed care sector is off 35%.

Centene Corp. and UnitedHealth Group — which will kick off the earnings season on April 22 (see box, p. 5) — are each expected to lower their full-year earnings projections. Other health plans will likely follow suit with negative earnings revisions for the remainder of 2008. The anticipated revisions, analysts say, reflect expectations of a higher commercial medical loss ratio and reduction in investment income (due to recent interest-rate cuts).

Aaron Vaughn, a securities analyst in the St. Louis office of Edward Jones, says health plan stocks are trading at "historic lows" relative to their price-to-earnings (P/E) ratios.

The next worst quarter was the fourth quarter of 1997, "when the sector underperformed the S&P 500 by 22.6%," adds Stifel Nicolaus equities analyst Tom Carroll. Back then, he tells *HPW*, there was an abundance of managed care companies, and they competed largely on price to improve market share. While investors rewarded firms that successfully grew membership, some health plans reduced prices at their own peril, and ultimately failed in that strategy because premium revenue wasn't enough to cover medical costs, he says.

*continued on p. 5*

## Incentives, New CPT Codes Nudge Docs To Make 'Virtual House Calls,' Insurers Say

Health plans report slow but steady progress in getting physicians to add e-visits to their practices. They attribute this progress to the increasing sophistication of the technology and the fact that fears about abuses and "e-mail nightmares" have failed to materialize. Insurers tell *HPW* that, as they and member physicians gain more experience with e-visits, the result will be significant cost and productivity benefits for physicians, health plans, employers and patients.

These plans also are quick to correct a common misconception about e-communications: It has nothing to do with regular e-mail. Rather, communications take place on secure Web-based applications that are HIPAA compliant and address the quality-of-care concerns that have been raised by physicians, medical societies and privacy advocates.

Bolstering the move to e-communications is the American Medical Association's new permanent CPT-4 code enabling reimbursement for online consultations and the *eRisk Guidelines for Physician-Patient Online Communications* developed by the eRisk Working Group for Healthcare. Proponents also say that the current push by health plans, employers and the federal government to get physicians to e-prescribe (*HPW*

3/24/08, p. 1), a feature integrated into most e-communications Web applications, will bring more physicians into the e-visit fold and serve as a stepping stone to the adoption of electronic health records.

### CIGNA to Roll Out National Program

CIGNA Corp. launched its four-state e-visit pilot program in 2007 and expects a national rollout in 2009. The plan reimburses participating physicians for e-visits by eligible members covering 150 different kinds of non-urgent health treatments through its "virtual house call" program. Reimbursement for e-visits is the same or lower than for office visits. Wendy Sherry, healthcare product vice president, tells *HPW* that self-funded employers can save \$40 on office-visit replacements, noting that a \$65 average office visit reimbursement versus the \$25 that CIGNA pays for an e-visit "equates to a significant cost savings."

Among the productivity benefits, Sherry says, is improved physician office workflow. "Online messaging relieves much of the stress felt by practices that rely on telephones as their main communications tools with

patients." For example, a practice typically will make two to three phone calls just to report a lab result. Online messaging eliminates the phone tag. It also saves time previously wasted by office staff (and patients) scheduling time-consuming office visits for non-urgent care needs. Secure online messaging also empowers physicians to collaboratively share a patient's most current information with their colleagues in the network, Sherry adds.

CIGNA says 9,000 of its network physicians are signed up with RelayHealth, the health plan's e-visit vendor. Sherry says that CIGNA is aggressively working to "build a critical mass of physicians using online Web services so that more members will use these types of visits for their non-urgent medical needs." CIGNA's marketing effort includes waiving Relay's monthly fee (approximately \$100 per practice) for a three-month trial period. She says the number of providers registering for RelayHealth is increasing by roughly one-third every six months.

The initial obstacle to physician adoption has been on the technology side, mainly concerns about the clinical quality security of online visits. *Among those concerns:* the asymmetrical nature of an online visit, where patients might not provide sufficient clinical information about a condition, leading to back-and-forth communications between physician and patient. Another concern was that patients would use e-visits for urgent conditions. Sherry says that both concerns are addressed in the Web application.

To ensure that the physician receives adequate clinical information, the application uses an interactive set of algorithms that prompts the patient through a series of questions about the medical condition. Should the situation be urgent and an office visit required, the system tells the member to schedule a visit.

### Three Questions About E-Visits

Sherry advises health plans considering investing in an e-visit program to ask three critical questions about the application:

- ◆ **Clinical efficacy:** Does the Web-based application provide clinicians and patients with access to Web-enabled knowledge resources and powerful decision-making tools that will ensure that physicians receive adequate clinical information from patients and alert patients when they need to schedule in-office visits for urgent care?
- ◆ **Security:** Does the application incorporate such features as audit trails, encryption and other measures to ensure security and privacy?
- ◆ **Scalability:** Can the application handle future growth in registered providers, members and inquiry traffic?

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Aetna Inc., which also uses the RelayHealth platform, is reimbursing participating physicians for e-visits at the same level as an in-person visit, depending on Aetna's contract with the physician and the member's benefit schedule. Chere Parton, head of provider e-solutions, says that the average national reimbursement rate is \$30 per e-visit. Primary care physicians as well as physicians in 30 medical specialty categories are covered.

Aetna began reimbursing for e-visits in 2006 when it launched a pilot project in California and Florida. The project was expanded to Washington state in 2007 and rolled out nationally this year. About 5,300 Aetna participating physicians are registered for e-visits, and Parton says that in 2007 RelayHealth had registered about 60,000 "convenience services" by patients (requests for lab results, appointments, referrals, prescription refills and the like) and 455 Web visits.

### **'Technology Hump' Is Challenging**

Parton also stresses the importance of the application's use of clinical algorithms to conduct "structured" virtual visits as a selling point, since it reassures physicians that they will receive adequate clinical information about the patient's condition. "It's a rigorous interview with the algorithms driving the online questionnaire," Parton says.

Aetna markets e-visits to participating physicians as a more efficient way to interact with patients, improve patient safety (the application fully documents all e-visits), and achieve practice efficiencies by cutting down on phone calls and unnecessary office visits.

"Our biggest concern when we first started this was that if we began paying for Web visits, it would open the flood gates," Parton says. "People think of it as e-mail, and we were afraid of possible abuse and high utilization. But we haven't seen any of this. The Web visits are being used (by patients) only when they're appropriate."

Blue Shield of California now has more than a dozen medical groups, representing approximately 3,200 HMO providers connected to 80,000 registered California Blue Shield members, engaging in e-visits through RelayHealth. Elise Anderson, a spokesperson for the insurer, says that a study of the RelayHealth program found that the e-visits were reducing office-visit claim costs by \$1.92 per member per month. Physician satisfaction ratings exceed 90% among users, and more than half of the physicians surveyed said they preferred e-visits to office visits for non-urgent medical issues, according to Anderson.

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## **Limited Underwriting Gains May Affect Plans Into '09, Study Says**

Rising health care costs have made it increasingly difficult for health plans to boost revenues as fast as expenses. And that trend is likely to continue until at least the end of 2009, according to a study released April 11 by Kennebunkport, Maine-based Mark Farrah Associates (MFA), an aggregator of health insurance data. The study is based on the quarterly and annual financial data health plans are required to file with state insurance regulators. The analysis included data from 431 health plans that filed data between 2002 and 2006.

Whether there is an underwriting cycle for managed care has been debated for years, but this analysis shows that there is "a true cycle," says Product Manager Debra Donahue. "What we saw during that five-year period was three years of underwriting or operating gains, and now we are trending down." But that's not to say that health plans haven't been or can't continue to be profitable, she says, as long as they are careful.

Health plans might opt to use investment income to offset some of the difference between operating costs and revenue to maintain the same level of profitability, she explains. But if health plans allow the gap between expenses and premiums to grow too great, they might need large premium increases in the future to improve profitability should investment income shift. "Large premium increases are unacceptable to most customers," she says.

Even though health plans in the study realized an aggregate gain of \$10.18 billion for 2006, it was less than the \$10.22 billion netted for 2005, according to the re-

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port. That translates to a 1.3% per-member per-month (PMPM) "underwriting growth" decline, the company reports. From 2004 to 2005, the collective PMPM growth rate for revenues was 7.4%, according to MFA. Medical expenses PMPM grew 7.0% and administrative expenses (including claims adjustment expenses) rose 8.6%. During that same period, growth in underwriting profits PMPM was 12.0%. From 2005 to 2006, the study finds, the collective growth rate for revenues PMPM declined to 6.2%. At the same time, growth rates for medical and administrative expenses PMPM dropped to 6.7% and 7.0%, respectively. In line with tempered growth for rev-

enue and expenses, the growth rate for aggregate underwriting profits dipped to negative 1.3%, MFA says.

Only plans that filed the 2006 Health Annual Statement and consistently reported revenues for all five years were included in the analysis. The research sample included health plans domiciled in every state except Alaska and Mississippi. Washington, D.C. was also included. Excluded from the data were California HMOs that are not required to file annual statements with the National Association of Insurance Commissioners.

To see a copy of the report, visit [www.markfarrah.com/healthcarebs.asp](http://www.markfarrah.com/healthcarebs.asp). Contact Donahue at [ddonahue@markfarrah.com](mailto:ddonahue@markfarrah.com). ♦

### *Rescinded Calif. Individuals Get Chance for Reinstatement*

The California Department of Managed Health Care (DMHC) could force health plans in the state to reinstate coverage for thousands of individuals. The department has ordered re-reviews of each rescission over the past four years by a DMHC-selected independent arbiter. The move comes as part of an ongoing investigation into the rescission practices and policies of California-based health plans (*HPW 3/10/08, p. 4*).

On April 17, the department said it ordered three health plans to immediately reinstate policies for 26 consumers who it determined had their coverage wrongfully rescinded. The department said it ordered the reinstatement as part of an investigation of the rescission practices of five largest health plans offering individual coverage in California, among them Anthem Blue Cross, a WellPoint, Inc. unit (formerly Blue Cross of California), Blue Shield of California and Kaiser Permanente.

The arbiter, according to DMHC, will determine remedies, such as payment of medical care and premiums, for those who are found to have been wrongfully rescinded.

DMHC said that "each plan must immediately institute uniform business practices for rescission" to ensure a fair process for future enrollees. The agency said it already has taken a number of steps to protect patients from wrongful rescission, which include assisting patients who contacted its HMO Help Center to regain their coverage.

According to the department, full details of the investigations and potential penalties will be released within the next few weeks.

Call DMHC spokesperson Lynne Randolph at (916) 445-7442.

### **Not-for-Profits Are Less Exposed, But Not Immune to Volatile Markets**

Not-for-profit health plans are not affected by economic downturns in the same way as their for-profit counterparts (see story, p. 1) but that's not to say they are completely immune to volatile financial markets. While the investments of not-for-profit insurers tend to be less prone to market fluctuations, if the economy's woes extend through 2008, lowered interest rates on investments could impact premiums in 2009.

Not-for-profit health plans will likely see some negative effect from lower interest rates, says Oppenheimer & Co. equities analyst Carl McDonald. Those insurers, he explains, tend to rely more on investment income for pretax profits. The vast majority of investments "are fine," which means the lower rates won't have much of an impact this year, he says. "But the decline in investment income "will be a factor in their pricing decisions next year...in terms of raising premiums to compensate for lost returns."

The investment portfolios of not-for-profit Blues plans, for example, are made up largely of fixed-income securities, adds Aaron Vaughn, a securities analyst in the St. Louis office of Edward Jones. And because fixed-income yields are low, it is affecting them."

#### **Diversified Investments Limit Losses**

BlueCross BlueShield of Tennessee (BCBST), CareFirst BlueCross BlueShield, Highmark Inc. and The Regence Group tell *HPW* that their diversified investment portfolios have helped temper the impact of a struggling stock market. The insurers also say that because they are not heavily invested in the subprime mortgage market, the effect of its implosion has been limited on their investment results.

The Tennessee Blues plan is "focused on holding liquid, high-quality securities, with an emphasis on shorter-duration assets," says Alaine Zachary, director of

investments and assistant treasurer. In the current investment environment, BCBST “was also fortunate to have a material allocation to TIPS [i.e., Treasury Inflation-Protected Securities available from the U.S. Treasury], which has helped to protect the portfolio during the recent downturn,” she says.

Likewise, CareFirst continues “to invest in extremely high-quality securities and maintain a well-diversified portfolio,” said spokesperson Michael Sullivan, who asserts that the insurer has not been “materially impacted” by recent market events. Regence will stick with its current investment policy “despite the recent short-term volatility within the markets,” says Andreas Ellis, director and assistant treasurer at the company. He says the company believes “that a long-term perspective needs to be applied to our asset allocation.” He adds that the allocation needs to emphasize diversification, liquidity and high quality.

Highmark rebalanced its investment portfolio in 2007, “as we do periodically,” says plan spokesperson Michael Weinstein. The rebalancing brought higher net realized gains in 2007 compared with those in 2006, “resulting in better than anticipated investment income in 2007.” But he adds that the plan anticipates that investment income in 2008 will be lower than in 2007.

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## More Plans May Cut Forecasts

*continued from p. 1*

Much of the first-quarter deterioration, however, didn’t occur until March 10, when WellPoint, Inc. shocked investors by lowering its full-year 2008 earnings per share expectations (*HPW 3/17/08, p. 1*). Humana Inc. followed the next day with its own revision, citing different reasons. While Aetna Inc. and CIGNA Corp. responded to those revisions by reaffirming earnings forecasts, UnitedHealth Group, Health Net, Inc. and Coventry Health Care, Inc. have since released statements that fell short of reaffirming earlier forecasts. Health Net, for example, said in a recent Form 8-K filing with the Securities and Exchange Commission that its earlier guidance was not to be relied upon.

Carroll explains that the market responded “violently” to WellPoint’s announcement because the insurer has traditionally been considered the safest stock in the sector. “A Blue Cross and Blue Shield company was just

not supposed to experience the types of mistakes that it reported,” he asserts. While the “challenging operational environment” WellPoint officials outlined in their guidance revision was nothing new to the industry, the announcement amplified the sense of operational challenges the managed care sector has been feeling the past few years, he adds.

## United, Centene Expected to Revise Forecasts

Carroll predicts that United and Centene will lower their earnings forecasts on April 22. Perhaps Health Net and Coventry will reduce their numbers, too, he says. “It’s somewhat expected,” he says. “If your stock is down and the market is already pricing your business as if the numbers have already come down, why not give yourself a little more wiggle room in earnings?”

In her April 16 note to investors, Morgan Stanley analyst Christine Arnold said her firm has lowered its earnings projections for United based on “environmental as well as execution-related challenges.” Along with an anticipated rise in the Medicare Advantage (MA) medical loss ratio, she said stand-alone Medicare Prescription Drug Plans are likely to be less profitable due to United’s “generous formulary.” The richer formulary, she suggested, could lead to adverse selection by attracting seniors who are high utilizers of prescription drugs.

*continued*

### Scheduled First-Quarter 2008 Earnings Conference Calls

The first-quarter earnings season officially kicks off April 22 when UnitedHealth Group and Centene Corp. release their results. Below is a look at the dates and times of conference calls that selected managed care organizations have scheduled to discuss their first-quarter earnings. Times listed are Eastern Daylight Time.

- ◆ Centene Corp. — April 22 (8 a.m.)
- ◆ UnitedHealth Group — April, 22 (8:30 a.m.)
- ◆ WellPoint, Inc. — April 23 (8 a.m.)
- ◆ Aetna Inc. — April 24 (8:30 a.m.)
- ◆ Coventry Health Care, Inc. — April 25 (8:30 a.m.)
- ◆ Humana Inc. — April 28 (9 a.m.)
- ◆ Health Net, Inc. — April 30 (8:30 a.m.)
- ◆ CIGNA Corp. — May 1 (8:30 a.m.)
- ◆ HealthSpring, Inc. — April 30 (10 a.m.)

SOURCE: Compiled by *HPW* from company statements.

Vaughn says that United will likely lower its full-year guidance slightly. "If they bring it down by only a couple of pennies [per share], the market is likely to react favorably," he says.

Arnold suggests that United could improve its medical cost trend by as much as 200 basis points (2%) by improving claims accuracy. This is not "an opportunity shared by [United's] peers," she wrote.

Medical loss ratios have been flat for the last three or four years for the industry as a whole, which means that margins are not expanding. Premiums paid by employers and individuals "have just barely covered medical cost trends," Carroll says. "And that has been the environment the past couple of years. Analysts agree that enrollment on the commercial side, for most health plans, is flat or declining and premium yields are suffering. Aetna appears to be one of the few carriers that has been successful in growing its commercial membership.

### P/E Ratios Plummet to Single Digits

As of the end of March, the mean estimated P/E ratio for 2008 was 8.6 times, according to data supplied to HPW by Banc of America Securities (see table below). That number is down dramatically from the 13.9 reported on the same date a year ago, and is less than half the 18.4 reported at the end of March 2006. Carroll says that while the P/E ratio will likely creep up a bit over the next 10 months, health plans probably won't see a P/E much above 9 or 10 this year.

Analysts say the lower P/E, however, isn't likely to help or hinder acquisitions in the sector. While Aetna now has a higher P/E multiple than does United, which historically has not been the case, a higher P/E alone isn't likely to encourage or deter acquisitions, they say.

"While [P/E] multiples are lower, everyone's multiple is lower, so it doesn't impact the relative differences in multiples all that much," says Oppenheimer & Co. equities analyst Carl McDonald. One exception, he adds, is WellPoint, which he says is among the health plans least likely to pursue a merger or acquisition this year. WellPoint "will likely focus internally on fixing its issues rather than on a deal of any significance," he tells HPW.

### Health Plans Turn to Government Payers

With growth in the commercial segment stagnating, equities analysts predict health plans will turn more to government payers. "It is our opinion that [health plans] are going to be much bigger government contractors," Carroll says. "Medicare, Medicaid and state health initiatives is what is going to drive incremental enrollment growth and earnings over the next several years. Medicare will be a cornerstone of that growth." But, he adds, "the jury is still out" about what such a trend will mean for earnings.

While stock prices for Medicaid HMOs, such as AMERIGROUP Corp., Centene and Molina Healthcare, Inc. have come down along with those for health plans with large commercial memberships, Carroll says their prices could be artificially low. "The Medicaid HMO

## Year-to-Date Stock Price Loss or Gain and Price-to-Earnings Ratios as of Last Trading Day of March 2006 to 2008

Managed Care Organization	2006 YTD gain (loss)	P/E Ratio March 30, 2006	2007 YTD gain (loss)	P/E Ratio March 30, 2007	2008 YTD gain (loss)	P/E Ratio March 31, 2008
Aetna Inc.	4.2%	17.8x	1.4%	11.9x	(27.1%)	9.3x
CIGNA Corp.	16.9%	16.3x	8.4%	11.9x	(24.5%)	8.4x
Coventry Health Care, Inc.	(5.2%)	15.5x	12.0%	12.6x	(31.9%)	8.1x
Health Net Inc.	(1.4%)	17.0x	10.6%	13.0x	(36.2%)	6.7x
Humana Inc.	(3.1%)	19.2x	4.9%	12.3x	(40.4%)	7.9x
UnitedHealth Group	(10.1%)	19.2x	(1.4%)	15.5x	(41.0%)	8.2x
WellPoint, Inc.	(3.0%)	16.9x	3.1%	14.6x	(49.7%)	7.8x
AMERIGROUP Corp.	8.1%	26.1x	(15.3%)	13.4x	(25.0%)	9.5x
Centene Corp.	11.0%	17.4x	(14.6%)	11.1x	(49.2%)	7.1x
Molina Healthcare, Inc.	25.6%	23.5x	(5.9%)	14.2x	(36.9%)	9.4x
WellCare Health Plans, Inc.	11.2%	18.9x	23.7%	17.6x	(8.2%)	7.9x
Magellan Health Services, Inc.	28.7%	23.3x	(2.8%)	20.7x	(14.9%)	16.9x
Assurant, Inc.	13.2%	12.8x	(2.9%)	10.0x	(9.0%)	8.8x
Universal American Financial Corp.	2.1%	11.9x	4.0%	11.9x	(58.6%)	6.3x
<b>Industry Mean</b>	<b>6.7%</b>	<b>18.4x</b>	<b>2.6%</b>	<b>13.9x</b>	<b>(30.0%)</b>	<b>8.6x</b>

SOURCE: Compiled by HPW based on data supplied by Banc of America Securities, LLC.

model is completely different from WellPoint's commercial business," he says. Although Medicaid HMOs are not immune to problems, and even have a population more at risk for influenza-influenced utilization increases, they don't face the same challenges. "The Medicaid HMOs could be the best stocks in the sector for the rest of the year.

Equities analysts agree that the volatile sector could be good news for long-term investors who are willing to hang onto the stock for three to five years. Vaughn says "this is an attractive point to get into the industry."

Vaughn, who covers WellPoint, United and Aetna, says he has buy ratings on all of them.

Wall Street's already low expectations for the sector, he predicts, could have a favorable effect on stock prices if those revisions aren't as bad as investors anticipate. "We will need a couple of quarters to build back the confidence among investors," he adds.

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## SPECIALTY PRODUCT BRIEFS

◆ **WellPoint, Inc. said it acquired Resolution Health, Inc., a health care information technology company.** According to WellPoint, under the acquisition Resolution will continue to expand the services it provides to WellPoint as well as to its growing number of other customers nationwide. Resolution's tools analyze medical and pharmacy claims data, lab results, health benefit plan information and personal health information of individual plan members. WellPoint says it will work with Resolution to identify opportunities to help close gaps between recommended care and the care that members actually receive. Terms of the agreement were not disclosed. The transaction will not have an impact on WellPoint's current earnings per share guidance for 2008, the company says. Call WellPoint spokesperson Kristin Binns at (212) 697-7802.

◆ **The Health & Wellness Institute (HWI) said it signed a three-year contract to provide health management tools for Wellmark Blue Cross and Blue Shield of Iowa and its subsidiaries.** As part of the contract, which runs through 2010, the institute said, it will design and deliver on-site and community-based work-site wellness programs and services. HWI said it will also provide account management to Wellmark employer groups and members as part of the insurer's Whole Health Dimensions. That is Wellmark's suite of member health and wellness programs and services designed to help people lead healthier lives. Visit [www.hwainstitute.com](http://www.hwainstitute.com) or [www.wellmark.com](http://www.wellmark.com).

◆ **HealthCore, Inc., a subsidiary of WellPoint, said it's developing a Safety Sentinel System in response to the increasing demand to be more effective and rapid in monitoring the safety of**

**pharmaceuticals after U.S. Food and Drug Administration approval.** WellPoint said its Safety Sentinel System is aimed at advancing national efforts to identify safety risks associated with drugs and other clinical care decisions. This will allow physicians and other health care professionals to make more informed decisions about how to treat their patients, the company said. Ultimately, the system is expected to be capable of continually monitoring WellPoint's 35-million-member database and identifying increases in health problems among members taking a given drug, indicating a potential Serious Adverse Event, according to the company. WellPoint said it anticipates that the Safety Sentinel System will make it possible to examine whether particular combinations of treatments could cause serious medical problems, especially in patients with certain diseases or health conditions. Visit [www.wellpoint.com](http://www.wellpoint.com).

◆ **ValueOptions New Mexico said it will award more than \$7.3 million to 82 behavioral health care providers for the expansion of community-based services across the state.** In addition to the \$3.1 million already announced by the company to be distributed for community reinvestment funds for 2008, ValueOptions added another \$4.2 million in order to create the Community-Based Services Expansion Fund, for a total of \$7.3 million. ValueOptions explained that it received proposals for \$20 million in projects, and had only \$3.1 million to award. As a result, ValueOptions decided to create the new Community-Based Services Expansion Program, and to fund it with \$4.2 million, which it will now donate to some of the organizations around the state that had hoped to receive grants from the Community Reinvestment Program, according to the company. Visit [www.valueoptions.com/newmexico](http://www.valueoptions.com/newmexico).

## HEALTH PLAN BRIEFS

◆ **A panel of Blue Cross and Blue Shield executives said the current fee-for-service system of medical care is untenable and called for reforms in an April 15 briefing attended by congressional staffers and journalists on Capitol Hill.** Solutions must include strategies that reorient incentives toward improved quality and controlled costs, said Alissa Fox, vice president of legislative and regulatory policy for the Blue Cross and Blue Shield Association (BCBSA). Expanding a system that is inefficient or ineffective will make health care unaffordable, she added, asserting that 30% of today's health care spending is for care that is inappropriate. The briefing was held as part of BCBSA's "The Pathway to Covering America" proposal, unveiled early this year. Physicians from three Blues plans described their programs, which address changing payment incentives. Blue Cross Blue Shield of Massachusetts elaborated on its program, called the Alternative Quality Contract (*HPW 1/28/08, p. 1*), that links payments to improved clinical performance. And Blue Cross Blue Shield of North Dakota discussed its partnership with a provider group to create a medical-home model that focuses on members with chronic conditions, including diabetes. Call Fox at (202) 626-4780.

◆ **Massachusetts' Commonwealth Health Insurance Connector said it approved a 5% increase to the monthly premium for "affordable" insurance plans that renew in July 2008.** The agency announced the new levels for the next 12 months on April 17. Also, the penalty for not having coverage increased to \$912 if a person is uninsured for the entire year and if the state deems insurance affordable for that person. Powers said individuals with annual income of more than \$52,500 would be considered able to afford coverage — regardless of the premium. And an individual earning between \$37,501 and \$42,500 annually would be required to purchase coverage if the premium was \$220 per month or less. The Connector said 340,000 residents are newly insured since coverage became mandatory, "more than half of its uninsured." Call spokesperson Dick Powers at (617) 933-3141.

◆ **Minnesota's eight nonprofit health insurers posted combined losses of \$71 million, making 2007 the third straight year of operating losses for the firms, according to information released April 17 by the Minnesota Council of Health Plans (MCHP).**

The insurers collectively spent \$14.3 billion in 2007 to cover health services — up 7% from a year ago — and used interest income primarily generated from investing its reserves to cover the shortfall, MCHP reports. The health plans also paid more than \$218 million in taxes and assessments — 26% more than they paid four years ago, according to the report. About 90 cents of every premium dollar was dedicated to patient care, and 10 cents was spent on taxes, assessments and other administrative costs, MCHP says. Contact Eileen Smith at [smith@mnhealthplans.org](mailto:smith@mnhealthplans.org).

◆ **CMS on April 14 proposed adding eight more "never-events" to its list of conditions that it will not pay for if a patient acquires them during a hospital stay.** The agency said the eight additional "never events" include hospital-acquired surgical site infections following certain elective procedures, Legionnaires' disease, extreme blood-sugar derangement, Iatrogenic pneumothorax (collapse of the lung), delirium ventilator-associated pneumonia, deep vein thrombosis/pulmonary embolism (formation/movement of a blood clot), *staphylococcus aureus* septicemia (bloodstream infection) or *clostridium difficile* associated disease. Call the CMS Office of Public Affairs at (202) 690-6145. Separately, CIGNA Corp. said that as of Oct. 1, it will no longer reimburse hospitals for patient expenses related to CMS's initial set of "never events." *Editor's note: HPW will sponsor an audioconference on health plans' "Never Events" strategies on Tuesday, May 13 at 1 p.m. Eastern time. Registration will begin soon at [www.AISHealth.com](http://www.AISHealth.com).*

◆ **Triple-S Management Corp., a Puerto Rico-based Blues plan that became publicly owned late last year, is expected to meet its earnings projections for the year.** The firm is benefiting from its investments — and from no local influenza epidemics like those that negatively impacted some mainland health plans. Equities analysts say the health plan's geographic isolation helped it avoid the costly mainland U.S. influenza season that resulted in higher-than-expected medical costs for some major health plans. Triple-S also is not heavily invested in markets subject to the wave of lower interest rates that are dragging down investment earnings at other for-profit plans (see story, p. 1). According to one analyst, a fair amount of Triple-S's investment portfolio has a fixed interest rate, and therefore is not as exposed to market fluctuations. Visit [www.ssspr.com](http://www.ssspr.com).

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