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HEALTH PLAN WEEK

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

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Managing Editor
Steve Davis
sdavis@aishealth.com

Contributing Editors
Eve Collins
Renée Frojo
Angela Maas

Associate Editor
BJ Taylor

Executive Editor
Jill Brown

For Small Employers, Low Rate Hikes Trump Grandfather Status; Big Employers Stay Put

With the fall open-enrollment season fast approaching, health insurers and benefits consultants tell *HPW* that their largest employer clients are likely to stick with their existing benefits plans to avoid certain provisions of the reform law that are required for "new" health plans. But small employers appear ready to dump "grandfather" status if switching carriers — or revamping a plan design — would help offset rate hikes for 2011.

Case in point: During a recent conference call to discuss second-quarter earnings, Aetna Inc. President Mark Bertolini said his company was seeing far fewer RFPs in the market this year. Aetna's national accounts team tells *HPW* that the process of putting a large employer's benefits program out for bid is time-consuming and expensive. "In today's economy, plan sponsors may make the decision to hold off on the process for another year or so and simply maintain their current benefit programs," Aetna said in an e-mail response to *HPW*.

Health plans that existed on or before March 23 — the day the health reform law was enacted — are exempt from some requirements of the new law. Health plans that retain grandfather status won't have to abide by provisions such as coverage of adult children up to age 26 and first-dollar benefits for certain preventive services. Employers will lose grandfather status if they drop coverage for a particular medical condition, if overall benefits are reduced "significantly" or if out-of-pocket costs for enrollees are increased too much. Fully insured employers will lose grandfather status by switching carriers. Although self-funded employers are allowed to switch administrators as long as the plan design isn't altered, a new provider network could be considered too much of a change and could result in lost grandfathered status.

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Bad Economy Lifts Enrollment in Student Plans, but Reform Rules Are Unclear

As colleges and universities open their doors this month and next, health insurers and brokers that sell health insurance to students expect strong enrollment despite a provision of the health reform law that extends dependent coverage up to age 26. But they agree that guidance is needed to clarify how student coverage will be viewed under the reform law.

Student health insurance is filed in each state as a limited-duration policy and rated on a group basis. It's unclear if student plans will continue to be regulated like group plans under the reform law or subject to individual health insurance reforms.

On Aug. 12, the American College Health Association, along with 11 other higher education organizations, sent a letter to HHS Sec. Kathleen Sebelius and Nancy-Ann DeParle, director of the White House Office of Health Reform, seeking clarification on provisions of the reform law that could affect student health plans. Specifically, the letter, accompanied by an issue paper, seeks regulatory clarification with regard to the

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application of the legislation's insurance market reforms and the individual mandate to college student health plans.

"To what degree does the federal law really apply to student insurance products?" asks Teresa Koster, division president of Gallagher Koster, an insurance brokerage and account management firm that specializes in student health coverage. If student health plans are required to comply with rules such as immediate coverage for pre-existing conditions, first-dollar preventive coverage, medical loss ratio (MLR) floors and the removal of lifetime and annual maximums, "significant pricing and coverage changes will need to be made," she tells *HPW*. Student policies now are filed and approved as blanket limited-duration policies that are subject to state regulations. "If student health plans have to change so much that they are price prohibitive,…that will place stress on student health centers," she adds.

Koster's firm, a division of Arthur J. Gallagher Risk Management Services, Inc., works with most major sellers of student health coverage. Overall, Koster says enrollment in student health coverage has been growing over the past five years and has experienced a bump of 7% to 10% during the past two years due to high unemployment and a struggling job market, she tells *HPW*.

Aetna Inc., the nation's largest seller of student policies, says its Aetna Student Health (ASH) plans cover 521,000 lives out of an estimated 3 million to 3.5 million university and college enrollees who have student health coverage. UnitedHealth Group has about 390,000 student enrollees.

Despite the expansion of dependent coverage, Brian St. Hilaire, senior director of market relations for ASH, says enrollment in student plans is likely to increase. He points to a recent American College Health Plan Association study that found that an increased number of schools have mandated coverage.

Unlike more traditional health insurance products, student plans are designed to supplement wellness and preventive health services provided on campus. The costs of those services typically are folded into tuition costs. While increased demand and utilization have caused rates to increase, the cost of student health insurance has been ticking up only in the low to mid-single digits. Annual premiums typically are $1,200 to $1,300, although premiums and plan designs vary.

Although a few states require colleges and universities to offer student coverage, the rules typically are left to the discretion of the school. While health insurance at public schools tends to be voluntary, many private schools automatically enroll students in plans unless a waiver is completed to confirm adequate coverage elsewhere, such as through a parent. Auto-enrollment is a key feature for student health plans and has helped keep costs in check by ensuring "a healthy level" of enrollment, says Koster.

Many Students Won't Qualify as Dependents

Koster says that while the increase in the dependent age is likely to have some impact on enrollment in student health plans — particularly among undergraduates — she points out that the average student age at many community colleges is 27 or older. Many graduate students also might be too old to qualify as dependents.

Aetna says the average age of its student enrollees is 25, and 30% of its student members are age 26 or older. Foreign nationals make up 10% to 15%. Moreover, because the dependent rule doesn't go into effect until Jan. 1 for employers that follow a calendar year, student health plans aren't likely to experience an enrollment decline when the school year begins.

Koster doesn't expect many students to drop student insurance once they become eligible for coverage through a parent in early 2011. And a parent's coverage might not be the appropriate choice if its network doesn't include providers near the school.

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She says under the reform law, it's unclear if student health plans would be able to refund a part of the coverage cost if a student moves to a parent's plan midyear.

Mass. Blues Adds 11,000 Students

Massachusetts has mandated insurance coverage for all college students since 1989. This month, 11,000 state and community college students will receive coverage through a state contract awarded to Blue Cross Blue Shield of Massachusetts. The Blues plan won a contract early this year to offer "enhanced coverage" to the students. The coverage, which includes a broad provider network, as well as wellness and medical management benefits, went into effect this month.

The improvements were prompted by a report that indicated students in Massachusetts were not receiving "appropriate coverage or value" through existing plans, according to an April statement from Gov. Deval Patrick's (D) office. About 53,000 students, including those covered through the state contract, are enrolled in the Blues plan's Blue Care Elect Preferred (PPO) across 37 campuses in the state. Outside of the state contract, enrollment in student health plans doesn't fluctuate much. "Schools are unlike companies in that organic growth and enrollment reductions don't generally occur due to the finite nature of class size and dorm room availability," says Massachusetts Blues plan spokesperson Jenna McPhee.

McPhee says competition for student contracts is increasing as more local not-for-profits enter the market.

The benefit level for the Blues plan's core student product doesn't include caps for outpatient or pharmacy benefits and doesn't have an annual benefit maximum, which is common among student policies, according to McPhee.

Although it typically sells its student plans through brokers and agents, McPhee says her company is doing more "direct student communications" because students — and their parents — can influence decisions made by their school. The company also uses e-mail, text messaging and smart-phone applications to reach the student population, she says.

St. Hilaire says the competitive landscape for student health coverage is changing. "Over the past few years we have seen a number of nonhealth carriers enter the student health business, as well as local carriers and other national health plans. We expect this trend to continue," he says.

To see a copy to ACHA's letter and issue paper, visit www.acha.org/Topics/Health_Care_Reform/PPACA_Regulatory_Clarification_Request.pdf.

Contact Matthew Wiggin for St. Hilaire at wigginm@aetna.com, Koster at Teresa_koster@ajg.com and McPhee at jenna.mcphee@bcbsma.com. ✧

For Health Insurers, Data Mining Is Key to Countering Medical Errors

Medical errors cost American health plans and their members an astounding $19.5 billion in 2008, according to a report released Aug. 9 by the Society of Actuaries (SOA).

The vast majority of the costs — about $17 billion — are directly attributable to inpatient, outpatient and prescription drug services. The report was commissioned by SOA and completed by consultants with Milliman, Inc., who used medical claims data for a large population of insured consumers. The report estimates that 6.3 million medical injuries occurred in 2008. Of those, 1.5 million were attributable to errors.

"It's clear that health insurers and their members are paying for the cost of errors and injuries, which impacts the cost of care and rates," says Jim Toole, a member of SOA's board of directors and an author of the report. Mining of data is the key to managing error, Toole tells

Medical Errors With the Largest Annual Measurable Cost

Error Type	Count of Injuries (2008)	% of Injuries That Are Errors	Medical Cost per Error	Total Cost per Error*	Total Annual Cost of Errors
Pressure ulcer (Medicare never event)	394,699	>90%	$8,730	$10,288	$3.85 billion
Post-operative infection	265,995	>90%	$13,312	$14,548	$3.67 billion
Mechanical complication of device, implant or graft	268,353	10% to 35%	$17,709	$18,771	$1.13 billion
Postlaminectomy	505,881	10% to 35%	$8,739	$9,863	$1.12 billion
Hemorrhage complicating a procedure	156,433	35% to 65%	$8,665	$12,272	$960 million

*Total cost per error includes indirect costs related to lost productivity due to short-term disability and increased mortality rates among individuals who experience medical errors.
SOURCE: *The Economic Measurement of Medical Errors.* Based on claims data. Commissioned by the Society of Actuaries and completed by Milliman, Inc. August 2010.

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AIS's Health Business Daily *and* Government News of the Week.

HPW. If insurers were to start mining claims, they could give members their choice of providers. "We talk about transparency of cost, but what about transparency of quality? Right now there is no *Good Housekeeping* seal of approval for a hospital," he points out.

There are no specific billing codes for medical errors (although there are for injuries), so the researchers had to comb through medical claims to find incidents. "A medical error is defined as an injury that results from inappropriate medical care," according to the report. They used a list of ICD-9 codes for hospital-acquired conditions (i.e., never events).

The report lists the 10 most expensive errors. For four of them, more than 90% of the injuries occur because of medical errors: pressure ulcers; postoperative infection; infection following infusion, injection, transfusion or vaccination; and infection due to central venous catheter.

Safety Benchmarks Are Needed

Patient safety is a nebulous issue because the health care industry doesn't have benchmarks for it, Toole says. In comparison, the country reduced the highway mortality rate by 35% more than 20 years through changes in the auto industry and public policy, combined with driver education, he points out. "Imagine if in one part of the country, stoplights were red, yellow and green, and on the other side they were green, purple and blue. We have to agree on standards to know where we're starting from," he says. And in health care, "every cardiac surgeon has a different approach [when] something as simple as a checklist can significantly reduce errors."

Toole points out that the data used for this report were from claims already submitted by hospitals, so the findings are unbiased. "We're taking hundreds of millions of records and, instead of pointing the finger, we're trying to understand the incidents in order to improve outcomes," he says. "We can't manage what isn't measured."

Read the report at www.soa.org/files/pdf/research-econ-measurement.pdf. ✧

Pennsylvania Insurance Commissioner 'Exchanges' Job Titles

Beginning Aug. 30, Pennsylvania Insurance Commissioner Joel Ario will head the newly created Office of Insurance Exchanges. The OIE will be part of HHS's Office of Consumer Information and Insurance Oversight, which was established by the health care reform law. Pennsylvania Gov. Edward Rendell (D) named Robert Pratter acting insurance commissioner, according to an Aug. 9 statement issued by the governor.

Ario's new office will oversee the health insurance exchanges that each state is required to have up and running by 2014. Ario, Pennsylvania's insurance commissioner since July 2007 and insurance commissioner in Oregon from 2000 to 2007, is vice chairman of the National Association of Insurance Commissioners' (NAIC) Health Insurance Committee. Last month in Washington, D.C., he moderated a hearing on exchanges for NAIC's subcommittee on insurance exchanges *(HPW 7/26/10, p. 2)*. Ario could not be reached for comment about his new role.

Join AIS on Aug. 31 for an exclusive panel discussion: **Insurance Exchanges: How to Prepare for Their Impact on Small-group and Individual Markets.** *Panelists include* ***Rob Mercado****, vice president, technology products and services at eHealth Inc.;* ***Vince Ashton,*** *executive director of the New York Health Purchasing Alliance;* ***Bruce Caswell,*** *president and general manager of the health services segment at MAXIMUS; and* ***Timothy Stoltzfus Jost, J.D.****, health law professor at the Washington and Lee University School of Law. For additional information or to sign up, please call (800) 521-4323, or visit the MarketPlace at www.AISHealth.com.*

Federal Funding Prompts Maryland Group to Consider Launching Co-op

The Maryland Nonprofit Health Insurance Co-op is about three months into a year-long feasibility study that will determine the viability of a non-profit health insurance cooperative that would offer low-cost coverage to "working class" families and individuals in Maryland. The coverage would be available to residents in about 80% of the state who have annual incomes between 133% and 400% of the Federal Poverty Guidelines. The steering committee expects to make a "go or no-go" decision no later than July 1, 2011, says Peter Beilenson, M.D., health officer for Howard County, Md., and chairman of the co-op's steering group.

A provision in the health reform law sets aside $6 billion in start-up grants for new health insurance cooperatives. Beilenson estimates that the Maryland entity would need at least $100 million in reserves to get off the ground. But beyond that, it would need to have enough members — at least 50,000 — to be self-sustaining, he estimates. "We are not counting on federal grants to sustain it."

"I think there is a unique chance to design a very consumer-friendly and administrative-efficient system," Beilenson tells *HPW*. In January 2009, Beilenson helped

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launch HealthyHoward, a countywide "access program" that serves low-income people in Howard County. That program, which has about 1,000 members, will be terminated in 2014 once the insurance mandate, and state health insurance exchanges, becomes effective. The services offered through HealthyHoward won't qualify as required health insurance.

During last year's debate on health reform, co-ops were offered up as a more palatable alternative to a government-run public insurance option, which was strongly opposed by Republican lawmakers and health insurers. Sen. Kent Conrad (D-N.D.) proposed a network of 50 nonprofit health insurance cooperatives to compete against private plans. The reform law includes the formation of the Consumer Operated and Oriented Program (called the CO-OP program) to help establish "nonprofit member-run health insurance issuers" that will offer plans for the individual and small-group markets. Co-ops must be private, nonprofit, state-licensed entities, independent of commercial insurance carriers and primarily engaged in providing health care coverage. They also must be new market entrants, and government entities and commercial health insurers are excluded from forming them. HealthPartners in Minnesota and Group Health Cooperative in Washington state are among only a few large-scale co-ops.

Beilenson says that if his group decides to move forward with the co-op, it will need to be operational by 2013, when federal funding is dispersed. But co-ops that offer health insurance through an exchange must meet the same standards (i.e., minimum coverage levels, state requirements, etc.) as other insurers working via exchanges have to meet. Beilenson admits that compliance with those rules could make it difficult to offer lower-cost coverage. Moreover, co-ops will need to establish high-quality, efficient, low-cost provider networks. Beilenson says his group is considering a range of options to attract providers.

Limited Interest in Co-ops, So Far

A report released last month by the research arm of Computer Sciences Corp.'s Global Healthcare Group determined that a few co-ops are likely to emerge as a result of the reform law, but they aren't likely to represent much of a trend. Federal funding is the main reason co-ops might form, Jordan Battani, a principal researcher in CSC's Emerging Practices Group and the report's author, told *HPW*'s sister publication *AIS's Health Reform Week.* "But I don't think there's anything competitively different in a co-op as a new option" under reform. Moreover, she couldn't find anything to differentiate co-ops from what individuals and small businesses could get via exchanges starting in 2014. Co-ops must meet the same standards (i.e., minimum coverage levels, state requirements, etc.) as other insurers working via exchanges. "People might think co-ops could offer a more cost-effective alternative, but the question is how can co-ops get big enough to [gain] these cost efficiencies?" she says.

Battani said she expects that new co-ops will be regionally focused and tied to regional provider networks. Ownership in the product as a co-op member could be enticing to some individuals, she said. "But I don't think many will pay a premium for that. To the contrary, I think they'd expect it to be less costly" than competing health insurance plans. And even if co-ops are appealing, it will be difficult for them to compete in a low-cost, low-priced, standardized market, according to Battani.

Contact Beilenson at (410) 313-6363 or Battani at jbattani@csc.com. ✧

Big Employers Turn to 'Grandfather'

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"Our experience mirrors [Bertolini's] observation.… RFPs are down," says Chris Hulla, a principal in the Denver office of Buck Consultants. He suggests that with tight human resources budgets, employers don't want to waste time and money on an RFP — and negotiating a new contract — only to find out that emerging health reform regulations "leave them second guessing" their decision.

Ed Kaplan, senior vice president and national health practice leader in The Segal Company's New York office, says he's seen "a noticeable reduction" in fully insured medical plan bids this year. Still-emerging regulations around the reform rules, as well as confusion over the grandfather rule, likely caused some employers to delay or put off bids, he says. And like Hulla, Kaplan says some employers simply might not have the time and money needed to switch insurance plans, communicate changes with employees and update systems.

Employers offering coverage that already includes some of the new-plan requirements (e.g., first-dollar coverage for preventive services) will get the most value from revamping their plan design or switching carriers than sticking within the parameters that allow them to maintain grandfather status, Hulla says. However, "if the cost increase from grandfathered to nongrandfathered is significant, clients are jumping through the necessary hoops to maintain grandfathering, for the near term at least."

Small Employers Most Likely to Switch

Health insurers that work with smaller employers say they have seen an increase in RFPs and sales so far this year. Some fully insured employers have determined that it will be cheaper to switch carriers and forgo grand-

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father status than to remain with the same coverage options for another year, says Chantel Sheaks, a principal of government affairs in the National Technical Resources Group of Buck Consultants. "One employer told me about a 35% increase for a renewal. By going to a different carrier, the increase would only be 10% to 15%. That's a no-brainer," she says. Sheaks recently gave a presentation entitled *Grandfather Status, be Prepared to Lose it.*

Kaplan agrees and says some plan sponsors are beginning to realize that keeping grandfathered status might not be worth the lost ability to switch insurers or have greater control over future benefit design and contribution strategy.

Tre Bittner, director of sales at Geisinger Health Plan, says his company's business for fiscal year 2010, which ended June 30, is up about 5% over the previous period. Geisinger targets employers with between two and 150 employees. Given the provisions of the grandfather status, an employer can lose that status just by tweaking an annual deductible by a couple hundred dollars. Bittner says he doesn't think many small employers are very concerned about losing grandfather status. "They're worried more about keeping [premium] costs low," he says.

More Business Newsletters From AIS

✔ ***AIS's Health Reform Week,*** designed to help savvy business leaders in health care understand what the enormous changes *mean* to them ... and what they can *do* about it.

✔ ***Medicare Advantage News***, a biweekly newsletter with updates and business analysis on the Medicare and Medicaid managed care programs.

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Health Alliance Plan is on track to see about the same, or slightly higher, number of RFPs this year compared to 2009. However, more employers delayed RFP submission this year, likely as they waited to see whether health reform legislation would be enacted, says spokesperson Susan Schwandt. The company targets employers with between 25 and 250 employees, and most of its RFPs come from employers with 1,000 or more employees.

Neil Waldron, chief marketing officer at Rocky Mountain Health Plans, says sales are up. RMHP's typical client has 10 employees. "The biggest problem in the small case market is the employer's inability to maintain insurance coverage due to affordability," says Waldron. Some employers are dropping dependent coverage or boosting cost sharing to reduce premium rate hikes. He suggests that even as the economy improves, small employers are likely to drop insurance coverage completely.

Grandfather Status May Be Pricey

Aetna spokesperson Mohit Ghose says some small employers simply can't afford to maintain grandfathered status for their health plans. "Affordability is the No. 1 concern for these customers, and they historically make changes every year to preserve access and maintain affordability," he tells *HPW*. Larger customers, he adds, might try to maintain grandfathered status over the short term, but the lack of flexibility in the health reform law and associated costs "will ultimately lead them to give up grandfathering in order to stick to their longer-term plans to best provide affordable benefits to their employees," he says.

The federal government's own estimates show that a majority of businesses will not maintain grandfathered status by 2013, and Ghose says Aetna expects similar outcomes among its client base.

Sheaks argues that although the law cites "grandfather status," it's not an accurate use of the term. "It's actually a delayed effective date," she asserts. "To be 'grandfathered' in legal terms means the rules won't ever apply to you. But the preamble of the interim final regulations relating to grandfathered plans says that grandfathered status is designed to give plan sponsors time to transition to the new rules,…[and this] sounds like a delayed effective date to me."

Contact Hulla at christopher.hulla@buckconsultants.com, Kaplan at ekaplan@segalco.com, Waldron at neil.waldron@rmhp.org, Ghose at ghosem@aetna.com, Sheaks at chantel.sheaks@buckconsultants.com, Schwandt at sschwan1@hap.org and Amy Bowen for Bittner at albowen@thehealthplan.com. ✧

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FINANCIAL NEWS

◆ **Despite a decrease in second-quarter earnings due to its discontinued legacy reinsurance business, CIGNA Corp. beat Wall Street's expectations.** The health plan operator on Aug. 5 reported net income of $294 million ($1.06 per share) — a 32% decrease from $435 million ($1.58 per share) in the second quarter a year ago. The consensus expectation was $1.01 per share. CIGNA's medical membership as of June 30 was 11.4 million — up by 176,000 from the same date a year ago, and up 12,000 members from the first quarter of the year. Premiums and fees in the second quarter grew by about 15% from the year-ago period due to net membership growth and a change in membership mix, the company said. CIGNA's revenue increased 19% to $5.35 billion. Like virtually every other publicly traded health plan this quarter, CIGNA boosted its full-year 2010 earnings forecast to a range of $4.10 to $4.40 — from $3.75 to $4.15. The company said it repurchased about 3.7 million shares of its stock ($123 million) during the second quarter and approximately 2.5 million shares ($77 million) between July 1 and Aug. 4. Visit www.cigna.com.

◆ **Led by its Medicare Advantage (MA) business and lower administrative costs, Humana Inc. on Aug. 2 reported a 21% increase in second-quarter earnings.** The company reported net income of $340.1 million ($2 per share), up from $281.8 million ($1.67 per share) in the year-ago period. As of June 30, Humana said, its MA plans covered 1.76 million lives — up 17% from the same date a year ago. The company also reported significant gains on the commercial side of its business, which had quarterly pretax earnings of $115.2 million — up substantially from $35.3 million in the year-ago period. Second-quarter revenues increased 10% to $865 billion from $790 billion in the previous quarter. The solid earnings prompted the company to edge up its full-year earnings forecast to a range of $5.65 to $5.75 a share, compared with $5.55 to $5.65 previously. Visit www.humana.com.

◆ **On Aug. 9, WellCare Health Plans, Inc., a seller of MA plans, posted a net loss for the second quarter of $128.9 million ($3.05 per share) — due primarily to charges related to legal settlements — compared with net income of $37.0 million (88 cents per share) in the year-ago period.** The company agreed on the "material terms" of a $200 million settlement to resolve claims in a class-action lawsuit related to state and federal fraud investigations under its former management *(HPW 7/12/10, p. 7)*. Premium revenues plunged to $1.34 billion from $1.79 billion as a result of its pullout from MA private-fee-for-service products at the end of last year coupled with the impact of CMS marketing and enrollment sanctions on its Medicare plans, WellCare said. Enrollment in the company's Medicaid products as of June 30 was 800,698, down from 813,759 on the same date a year ago. During a conference call with investors, CEO Alec Cunningham attributed that largely to its decision to pull out of certain Florida counties. Cunningham said he doesn't anticipate any rate reductions the remainder of this year and that the Georgia rate hike appears to be in the 1.5% to 2% range. WellCare slightly raised its earnings guidance for full-year 2010 to a range of $2.05 to $2.20 per share from $2 to $2.20. Visit www.wellcare.com.

◆ **Managed Medicaid operator AMERIGROUP Corp. on July 30 beat analyst expectations by reporting second-quarter net income of $67.2 million ($1.31 per share), up from $49.6 million (94 cents per share) in the year-ago period.** Total revenues jumped 11.3% to $1.4 billion. Membership as of June 30 was 1,904,000, up from 1,723,000 one year earlier, according to AMERIGROUP. The company's full-year guidance, which does not include earnings-per-share projections, calls for revenues to increase in the "low-double-digit range." Visit www.amerigroup.com.

◆ **Although shares of Molina Healthcare, Inc.'s stock price increased about 30% during the first half of the year, its second-quarter earnings declined from the year-ago period.** The managed Medicaid company on Aug. 4 posted second-quarter net income of $10.58 million (41 cents per share), down from $14.57 million (56 cents per share) in the year-ago period. Premium revenues advanced to $976.7 million from $925.5 million, as membership grew to 1,498,000 on June 30 from 1,368,000 one year earlier, the company said. CEO Mario Molina, M.D., said he expects rate increases the rest of this year to be in the "low single digits." Visit www.molinahealthcare.com.

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HEALTH PLAN BRIEFS

◆ **A coalition made up of federal and state law enforcement agencies have filed a total of 54 lawsuits and regulatory actions against companies that are marketing "medical discount plans" as health insurance,** according to the FTC. The coalition consists of the FTC, insurance commissioners and attorneys general from 24 states. The FTC said telemarketers have allegedly pitched various false claims to individuals, including that the companies work with major medical insurers, the discount plan was widely accepted by physicians and the plan would save consumers up to 85% on medical expenses. The FTC also charged many of these companies with misrepresenting their refund policies. Visit ftc.gov/medicaldiscountscams.

◆ **CMS on Aug. 10 issued a final rule that implemented changes to the Payment Error Rate Measurement (PERM) program for Medicaid and the Children's Health Insurance Program (CHIP).** CMS said it uses PERM to measure the number of improper payments to Medicaid and CHIP, and to establish national-level rates for each program. After receiving stakeholder input, the agency said it changed the process for reviewing cases in which states have simplified enrollment efforts, eliminated duplication of eligibility reviews conducted during the same fiscal year, extended the time a medical provider has before having to submit documentation and granted additional time for states to submit corrective action plans. To view the regulation, visit www.cms.gov/PERM.

◆ **Stock prices of health plans plummeted about 5% — much more than the overall market — Aug. 11 after release of a letter from Democratic congressional leaders stating that their "legislative intent" in the health reform law was not to allow exclusion of federal income taxes from revenues used in calculation of plans' medical loss ratios.** Some securities analysts earlier had concluded based on other sources that federal income taxes could be excluded from the denominator, thereby making it easier for plans to meet the minimum MLR requirements in the reform law, and one analyst had estimated the value of such exclusion at 0.25 percentage points in the MLR calculation. The interpretation in the Aug. 10 congressional letter addressed to HHS Sec. Kathleen Sebelius is likely to be challenged by the health plan industry, said analyst Christine Arnold of Cowen and Co. in an Aug. 11 research note. Contact Arnold at christine.arnold@cowen.com.

◆ **On Aug. 10, Centene Corp.'s Florida subsidiary, Sunshine State Health Plan, said it inked a definitive agreement to acquire Citrus Health Care's Medicaid and long-term care (LTC) diversion assets.** Financial details of the acquisition were not disclosed. Citrus, a subsidiary of PHC Holdings of Florida, Inc., serves 52,000 nonreform Medicaid members and 2,000 LTC members in the Tampa and Orlando metropolitan areas. Centene said the transaction is consistent with Sunshine State's goal of growing its nonreform Medicaid market share through acquisitions in the state. According to the insurer, the acquisition of the LTC diversion unit also opens a new growth opportunity for it in Florida. Citrus' Medicaid and LTC diversion business are expected to add revenues of between $120 million to $130 million on an annual basis, said Centene. The insurer expects the acquisition to be neutral to 2010 earnings and accretive to earnings by about 8 to 10 cents per share. Visit www.centene.com.

◆ **Blue Cross Blue Shield of Massachusetts and the Massachusetts Division of Insurance (DOI) have reached an agreement over the insurer's small-business and individual premium rates.** On April 1, DOI disapproved 235 of 274 base-rate changes filed by insurers, finding them to be "excessive and unreasonable" *(HPW 6/14/10, p. 8)*. Following a five-month disagreement, the Blues plan said Aug. 7 that both parties agreed on rate increases, which range from 0.4% and 12.9% compared with 2009 levels. The new rates are effective Sept. 1 for both small businesses and individuals renewing on or after April 1, according to the insurer. DOI has reached similar agreements with Harvard Pilgrim Health Care, Tufts Health Plan and Neighborhood Health Plan. Visit www.mass.gov or www.bluecrossma.com.

◆ **PEOPLE ON THE MOVE:** AMERIGROUP elected retired Admiral **Joseph W. Prueher** and former Treasury Secretary **John W. Snow** to its board. Prueher is now the James R. Schlesinger Distinguished Professor at the University of Virginia's Miller Center of Public Affairs, and Snow is president of the consulting firm JWS Associates LLC…. Aetna Inc. says **Wayne Rawlins, M.D.,** will take on a new position focused on addressing racial and ethnic disparities in health care. He will serve as the lead clinician focused on identifying areas where disparities exist among minority members and spearheading programs that lead to more equitable health care, the company said.

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