

# HEALTH PLAN WEEK

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

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**PUBLISHER'S NOTE:**  
*HPW will not be published next week. The next issue will be dated Mar. 7.*

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## CMS's Latest MA Enrollment Data Indicate 'Demise Has Been Greatly Exaggerated'

Despite a shortened selling season, flat reimbursement, fewer carriers and dire predictions from the Congressional Budget Office (CBO), enrollment in Medicare Advantage (MA) plans for the 2011 plan year exceeded even the most optimistic expectations. As of Jan. 14, 12.2 million lives were enrolled in an MA plan — now about 25% of all Medicare beneficiaries — CMS reported Feb. 14 (see table, p. 7).

Last fall, CBO predicted that reimbursement cuts called for by the reform law would cause MA enrollment to shrink from 10.6 million — as of the end of 2009 — to 8.9 million by 2019. Without the reform law, enrollment might have increased to nearly 14 million by 2019.

"The rumors of the death of Medicare Advantage were greatly exaggerated," quips John Gorman, CEO of Washington, D.C.-based Gorman Health Group, LLC. "Everything we are seeing now indicates that MA is still a great value for the money...and [beneficiaries] are choosing it in large numbers."

*continued on p. 7*

## Insurers Team With Advocacy Groups to Educate Women About Elective Inductions

Four major health insurers are working with quality improvement organizations and experts across the country on a number of infant safety programs to encourage women, doctors and hospitals to limit electively scheduled deliveries until at least 39 weeks of pregnancy.

Babies born before 39 weeks of gestation have a higher likelihood of developing respiratory distress syndrome, being admitted to the neonatal intensive care unit and being put on a ventilator.

To educate women about the risks of scheduled early deliveries without sound medical reason, Aetna Inc., CIGNA Corp., UnitedHealth Group and WellPoint, Inc. have responded to a "Call to Action" partnership with the March of Dimes, The Leap-

### **Publisher's Note: Accessing Electronic Issues of HPW**

Several subscribers have provided feedback about the inconvenience of needing a password to access HPW electronically on AIS's new website at AISHealth.com, so we thought an explanation was in order.

PDFs attached to bulk e-mails are no longer a viable way to deliver information, since bulk e-mails with PDFs are rejected by many spam filters. Prior to the launch of AIS's new website, because of an epidemic of PDF/spam problems, AIS was posting the latest issue of HPW on an unprotected page in cyberspace, where anyone (subscriber or not) could access it. This short-term fix has now been replaced with your password-protected subscriber page at AISHealth.com, which has many subscriber benefits in addition to back issues of HPW and a searchable database of all articles. If you haven't yet signed up for Web access, simply click the blue "Login" button at [www.AISHealth.com](http://www.AISHealth.com), then follow the "Forgot your password?" link to receive further instructions.

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frog Group and others to collaborate on an awareness campaign that includes three key messages: (1) The last weeks of pregnancy are important, (2) there are risks for mothers and babies if births are scheduled before 39 weeks for nonmedical reasons, and (3) expectant mothers should investigate the rates of elective deliveries for hospitals in their community. Health plans contacted by *HPW* declined to compare costs between electively scheduled deliveries and non-induced births.

### United Has Two-Pronged Approach

UnitedHealth has a two-pronged approach directed toward both physicians and members that it developed after a review of 2005 data. The plan looked at selected markets in the Southwest and found that 48% of babies admitted to the neonatal intensive care unit (NICU) were born to mothers who had scheduled deliveries, many of which were before 39 weeks gestation. After the plan shared its data with the hospitals and physicians in those areas, there was a 46% decrease in NICU admissions

within the first three months, a statistic that has remained consistent. The plan now does data sharing not just with physicians but also with hospitals that perform a lot of deliveries among its members. "We're taking some of the best practices and sharing them with hospitals." United is also reaching out to members to let them know that "the last few weeks of pregnancy are important to the baby," says Tina Groat, M.D., national medical director of women's health at UnitedHealth.

"This is both a quality of care and a cost issue," Groat says. "A baby should not be born electively before 39 weeks unless there is a clinical indication" to do so.

The Call to Action was issued by Leapfrog in response to data it announced Jan. 26, which showed that 773 hospitals reported 57,000 early elective deliveries by cesarean section or induction. Leapfrog identified the rates as part of its 2010 hospital survey.

"Children born too early face many health and developmental risks, so we should do everything we can to reduce the number of unnecessary early deliveries," says Jeff Kang, M.D., CIGNA's chief medical officer. It's "a very serious problem that can be solved through information and education."

### Early Deliveries Are Common

Leapfrog said its report also discovered the first real evidence that the practice of scheduling newborn deliveries before 39 weeks without a medical reason is common and varies widely, even among hospitals in the same community or state.

For example, in Los Angeles, hospitals reported rates as low as 4% and as high as 29%. In Boston, Leapfrog saw similar variations, with some hospitals reporting near 0% and others as high as 27%.

"Hospitals, health plans, providers and communities need to do more to protect women and babies from this harmful practice," says Leapfrog CEO Leah Binder. "And women need to protect themselves by refusing to schedule their deliveries before 39 weeks without a sound medical reason, and by knowing the facts about the hospitals they plan to deliver in."

Aetna said it is reaching out to pregnant members to let them know how important it is to give their babies the benefit of full gestation, helping and encouraging hospitals to prevent earlier deliveries when they are not medically necessary for the mother or baby, and letting members know which hospitals have programs in place to avoid early electively scheduled deliveries.

"For every week prior to 39 weeks of pregnancy that a baby is delivered, the chance of having health and development problems that require care in a neonatal intensive care unit nearly doubles," says Marjorie Schulman, M.D., a senior medical director at Aetna with 25

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years of experience as a NICU doctor. “We want to help our members and doctors avoid that unnecessary risk. It’s really a protective effort.”

Aetna is also doing its own outreach to targeted hospitals, encouraging them to use the March of Dimes toolkit to establish education programs. The insurer will also survey hospitals annually and update the directory designations accordingly as more hospitals take steps to reduce early elective deliveries.

In a scheduled delivery, labor does not begin on its own. Instead, the doctor and the patient schedule a date to induce labor or perform a cesarean section. “Practice patterns become ingrained, and it’s difficult sometimes for health systems to incorporate new best practices,” Binder tells *HPW*. “For whatever reason, it’s become a cultural standard.”

According to the CDC, between 1990 and 2005, there was a 20% increase in babies born before the 37th week of gestation and a 29% increase in births occurring at 37 to 39 weeks of gestation. Data from the American Congress of Obstetricians and Gynecologists (ACOG) show that there were more than 1.3 million C-sections in 2006 in the U.S., up from less than 800,000 in 1996.

The American Hospital Association agrees that action must be taken. “Hospitals must look to the recommendations of the ACOG and work with their physicians to end elective deliveries before 39 weeks,” says Jack Ludmir, M.D., chair of AHA’s section for maternal and child health and chair of obstetrics and gynecology at Pennsylvania Hospital. “Elective delivery prior to 39 weeks, that is deliveries without medical indication, is not an acceptable obstetrical practice.”

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## Insurance Agents Rally Against Reform Law, Commission Cuts

With some health insurers trimming commissions to the bone this year, the 700+ insurance agents who attended the National Association of Health Underwriters’ (NAHU) annual Capitol Conference in Washington, D.C., were eager for some good news. Prior to the start of the general session Feb. 15, songs such as Kenny Loggins’ “Danger Zone” and John Mellencamp’s “Small Town” helped to set the meeting’s tone.

Since Jan. 1, the reform law has required health insurers to spend at least 80 cents of every health care dollar on patient care for their individual and small-group

products. The medical loss ratio (MLR) provision has prompted many health plans to reduce administrative costs by targeting broker commission arrangements.

A taskforce within the National Association of Insurance Commissioners continues to encourage HHS to keep agents from being included as an administrative expense in the final rule, NAIC President and Iowa Insurance Commissioner Susan Voss said during a Feb. 15 presentation. She explained that the association was unsuccessful in convincing HHS to exclude broker commissions from the MLR rule — or to create a waiver for agents — because NAIC’s members were unable to agree on a solution. However, Voss told attendees that she advocating a strategy that would allow for a “phase-in” of the MLR rules, which, she said, small carriers will have a difficult time meeting. “I’m very disappointed in what HHS has done with the MLR,” she said.

Rep. Mike Rogers (R-Mich.) offered fierce criticism of the reform law and encouraged attendees to meet with lawmakers and their staffs to “make their voices heard.”

In a show of hands, a majority of attendees indicated their agencies had either laid off employees or knew of agencies that had since last March when the reform law was enacted. “So much for helping the economy,” he quipped.

Democratic lawmakers, said Rogers, argue “that by taking [agents] out of the equation, that’s how they’re going to put pressure on premiums. And I argue you’re going to have a lot of small businesses that aren’t going to have the same choices as they had before, and aren’t going to understand the best deal they can get,” he told attendees.

Rogers also condemned the Obama administration for granting more than 700 waivers that make corporations and unions exempt from the reform law for at least a year. According to HHS, more than 2 million people — many of whom have limited-benefit policies — will be exempt from the law (*HPW 10/18/10, p. 1*).

### Exchanges: Is There a Role for Brokers?

Once state insurance exchanges are operational in 2014, there will be a role for brokers and agents, particularly in the small-group market, said former Pennsylvania Insurance Commissioner Joel Ario, who has headed HHS’s Office of Insurance Exchanges since September. A provision in the law requires states to create Small Business Health Options Programs (SHOP) exchanges to help small employers find coverage and enroll workers. Agents, he explained, often do more for small employers than just help them choose health plans. NAHU has long argued that navigators need to be licensed, as agents are, to ensure that they understand the complexities of health coverage. Ario said the law envisions “baseline similar-

ties" between navigators and insurance agents. However, he said agents sometimes don't possess necessary "linguistic capacities" and "don't necessarily serve all of the different populations as well as they could be served." Those comments were met with boos.

Ario said he agreed with NAHU's recommendation that products sold inside the exchanges need to be bound by the same regulations as those sold outside of them. "If the exchanges are going to have a different set of rules,... I think you are introducing much more potential for adverse selection."

Visit NAHU at [www.nahu.org](http://www.nahu.org). ✧

## Low Medical Costs in 2010 Could Pressure Rates This Year

Increased financial responsibility — combined with plan designs that steer enrollees away from expensive and less effective medical treatments — could help keep utilization rates low in 2011 and beyond, according to a pair of studies released this month. And that trend could pressure health insurers to hold premium rates flat for the 2012 plan year. But a third report predicts that underwriting income and margins for health insurers will trend down in 2011 as utilization levels bounce back to more normal levels.

The struggling economy, high unemployment and expiration of federal funding for COBRA continuation coverage helped keep utilization levels low in 2010. But improved benefit design and stricter medical management efforts from insurers could help keep those levels

low, according to a report released Feb. 16 by Moody's Investors Service.

While encouraging members to be more cost conscious isn't a new idea for health insurers, prior to the economic downturn, employers were reluctant to implement benefit designs that placed greater financial responsibility on employees. But the recession — combined with health reform and high unemployment — created a perfect storm where insurers, employers and members had a vested interest in controlling costs, explains Steve Zaharuk, senior vice president at Moody's. And once the economy rebounds, employers aren't likely to slash deductibles and copayments back to their prior levels. "Once a lesson is learned and something productive is in place, employers aren't going to revert back," he says.

According to Moody's, this "cultural shift" could keep downward pressure on utilization. Moreover, the report says health insurers are doing more to limit coverage or to provide "reimbursement disincentives" for treatments where there is no evidence of improved medical outcomes (*HPW 2/14/11, p. 3*).

### Utilization Could Bounce Back

But A.M. Best Co. isn't as optimistic that utilization rates will remain low and expects underwriting income and margins to trend down in 2011 as utilization returns to more normal levels, according to a report issued Feb. 14. Moreover, the study suggests margins and earnings could deteriorate this year due to minimum medical loss ratios and increased pressure from HHS and state regulators to keep rate hikes to a minimum.

## People on the Move

Assurant, Inc. has named **Alan Colberg** to the newly created position of executive vice president of marketing and business development. Colberg most recently was with the consulting firm Bain & Company, Inc....HealthPlan Holdings has appointed **Richard Leopold** chief information officer and **Richard Campagna** chief operating officer (COO) at American Benefit Plan Administrators, Inc. ABPA is HealthPlan Holding's third-party administrator. Prior to joining ABPA, Leopold was executive director of e-business at USAA in San Antonio and an executive advisor in enterprise architecture at WellPoint, Inc. Previous positions include executive director of e-business at Kaiser Permanente. And Campagna most recently was vice president of operations at WellCare Health Plans, where he also served as vice president of en-

terprise claims and vice president of configurations. Previous positions include senior vice president of operations at Definity Health and senior vice president of operations at Group Health Incorporated.... Former Fidelity Investments CEO **Rodger Lawson** joined UnitedHealth Group's board of directors. He will stand for re-election by shareholders at the 2011 annual meeting along with the other members of the board, who are elected annually....**Tim Huckle** has been named COO at Blue Cross Blue Shield of North Dakota. He previously was executive vice president of health operations. Huckle joined BCBSND in 1986 as a work management specialist....Blue Cross Blue Shield of Arizona named **Matthew Wandoloski** vice president, strategy and informatics. Most recently he was a partner at Mercer Consulting.

“Even if we just have a normal flu season in 2011, there will be an impact on utilization,” says A.M. Best analyst Sally Rosen. While she agrees that consumers cut back on health care services in 2010, she warns that utilization could spike in the future if members avoid needed care or skimp on prescriptions.

Zaharuk disagrees and says health plan enrollees appear to be more frugal in their health care purchases than in the past. “And even doctors are now more aware of how they’re being reimbursed by insurers and by the government. I don’t think that people are limiting necessary health care; it just seems that they might be using it more wisely.”

Gavin Magor, senior insurance analyst at Weiss Ratings, agrees and says higher copays and deductibles have encouraged “consumers to be a bit more selective about the treatments they’re seeking, and insurers are seeing some benefit from that.” Based on the sector’s 2011 earnings projections, however, most insurers seem to agree with A.M. Best’s prediction for higher utilization in 2011.

### **Costs Drop for First Time in Decade**

For the first time in a decade, the health insurance industry, as a whole, did not see an increase in medical expenses, according to a study released Feb. 14 by Weiss. Medical costs for that period were 1.6% lower than during the same nine months of 2009, according to the report. By contrast, medical expenses grew by an average of 10.3% each year between 2005 and 2009. The study is based on nine months’ worth of claims data provided

to the National Association of Insurance Commissioners by 852 health insurers. Based on the latest numbers, Weiss estimates that medical expenses for full-year 2010 could be as much as 3% lower than in 2009. That trend, if it continues, could place even greater pressure on health insurers to keep rate hikes to a minimum or potentially hold rates flat for the 2012 plan year, says Magor, the report’s author.

And while medical use was down, patients who were admitted to hospitals spent slightly less time there compared with 2009 levels. According to the study, the average number of days spent in hospitals fell by an average of 2% from 2009’s levels, which were 3.2% lower than the prior year, Magor tells *HPW*, adding that there is no evidence to suggest that insurers have increased claim-denial rates or coverage exclusions.

Although medical costs are down overall, 470 (55%) of health plans experienced higher medical costs during the three quarters of 2010 compared with the same period in 2009. For example, while Aetna Inc.’s medical costs fell 14.1% versus the same period a year earlier, New York-based Group Health Inc. said costs jumped 16%. Magor says there is no clear explanation for the differences among plans.

Matthew Coffina, an equities analyst at Morningstar, Inc., agrees with the report’s conclusion that continued below-normal utilization could result in a short-term margin boost for health insurers. But while lower costs should eventually be reflected in premiums, “sooner or

## **Beyond Buy and Bill: Managing Specialty Therapies Under the Medical Benefit**

- What are the financial, operational and clinical challenges in health plan efforts to manage specialty drugs that fall on the medical side?
- What are the advantages of applying pharmacy benefit principles to specialty drugs adjudicated under the medical benefit?
- What kind of specialty drug cost savings could health plans generate from shifting physicians from a buy-and-bill model to a single specialty pharmacy provider?
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later costs will likely accelerate in an unexpected way, which could result in margin contraction that offsets any near-term improvements," he tells *HPW*. "The 2010 experience is basically the opposite of 2008." He also notes that lower-than-expected costs in the commercial market will result in higher rebates for health insurers that operate at or below the required medical loss ratio (MLR) floors.

But that's not necessarily a bad thing, says Zaharuk. While he agrees that lower-than-expected medical costs will translate to bigger rebates under the MLR rule, he suggests most health insurers would prefer to offer a rebate than exceed the MLR minimum. "If the lowest MLR I can have is 80% [for small-group and individual products], if I come in at 78%, I'll give out the other 2% as a rebate. But if I come in at 85%, no one is going to give me an extra 5% to bring me down to 80%," he explains.

Magor says some health plans might have to tap investment income to remain profitable given the pressure to meet MLR minimums. While large companies will continue to generate enough income in premiums to grow investment income, smaller ones won't and could be acquired or forced to exit unprofitable markets.

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## Managed Medicare, Medicaid Firms Post Strong Fourth-Quarter Earnings

Several publicly traded health insurers that rely on government payers posted better-than-expected fourth-quarter 2010 earnings during the week of Feb. 14. Here's a look at some of the highlights:

◆ **HealthSpring, Inc.:** On Feb. 18, the Tennessee-based health plan operator reported fourth-quarter 2010 net income of \$50.9 million (88 cents per share), up from \$38.8 million (68 cents per share) in the year-ago period. The results beat analysts' consensus earnings expectations by 10 cents per share. The most recent earnings results include one month's contribution (about 6 cents per share) from the operations of Bravo Health, Inc., which HealthSpring acquired on Nov. 30. The company said its full-year earnings were \$3.39 — up 40.7% from \$2.41 in 2009. HealthSpring's Medicare Advantage (MA) products as of Dec. 31, 2010, covered 304,604 lives, an increase of 61% from the same date a year ago. Premium revenue for the year was \$3.1 billion — up 17.8% from 2009. In a prepared statement, the company said it had experienced "substantial" MA membership growth during the 2011 enrollment season, despite the reduced sales and marketing period (see story, p. 1). The company's 2011 guid-

ance predicts "a return to a more normalized health care trend in most of our products." The company reported a fourth-quarter medical loss ratio (MLR) of 80.0%, an improvement from 81.1% in the year-ago period. Changes in benefit design and decreases in inpatient utilization contributed to the decrease, according to the company.

◆ **WellCare Health Plans, Inc.:** The managed Medicare and Medicaid operator on Feb. 16 reported \$26.1 million (61 cents per share) in net income for the fourth quarter of 2010 — up from \$11.1 million (26 cents per share) in the fourth quarter of 2009. The company said its overall enrollment fell from 2.3 million members on Dec. 31, 2009, to 2.2 million on Dec. 31, 2010. Enrollment in its Medicaid plans dropped by 9,000 year-over-year to 1.3 million as of Dec. 31, 2010. Enrollment in WellCare's MA plans decreased year-over-year by 109,000 members. The withdrawal from private fee-for-service (PFFS) plans reduced membership by 95,000 year-over-year. Premium revenue for the fourth quarter 2010 decreased 17% year-over-year to \$1.3 billion. The company said the drop in enrollment was the result of its withdrawal of PFFS plans and the impact of the 2009 CMS marketing sanction on MA revenue. Last year, 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). For 2011, WellCare predicts net income will be between \$2.45 and \$2.70 per share.

◆ **AMERIGROUP Corp.:** The company on Feb. 18 easily beat analysts' expectations by posting fourth-quarter 2010 net income of \$79.6 million (\$1.59 a share), up from \$40.2 million (79 cents a share) in the year-ago period. Wall Street analysts had collectively predicted earnings of \$1.12 per share. For all of 2010, the company's net income was \$273.4 million (\$5.40 per share), versus net income of \$149.3 million (\$2.85 per share) for full-year 2009. Total revenue for the fourth quarter was \$1.5 billion, a 10.2% increase over the fourth quarter of 2009 and a 5% increase over the third quarter of 2010. AMERIGROUP said it ended 2010 with 1.9 million members — an increase of 143,000 from the end of 2009 but unchanged from the third quarter of 2010.

◆ **Molina Healthcare, Inc.:** Molina on Feb. 17 beat Wall Street's earnings expectations by reporting fourth-quarter 2010 net income of \$17.6 million (58 cents per share), up from \$4.5 million (18 cents per share) in the year-ago period. The earnings consensus among analysts was 52 cents per share. Net income for all of 2010 was \$55.0 million (\$1.98 per share), up from \$30.9 million (\$1.19 per share) for 2009. Molina said its MLR in the fourth quarter of 2010 was 82.7%, an improvement over an MLR of 84.2% in the third quarter and 87.5% in the fourth quarter of 2009. ✧

## MA Enrollment Beats Expectations

*continued from p. 1*

Craig Ritter, owner of Harrisburg, Pa.-based Ritter Insurance Marketing, says the latest enrollment results exceeded his expectations, but he notes that comparing 2010's enrollment period to the most recent period can be misleading due to 2010's compressed selling season. In past years, the Annual Election Period (AEP) was followed by an open-enrollment period that ran from Jan. 1 to March 31.

The AEP for the 2011 plan year indicates much higher growth compared with 2010. About 194,000 members were added through February of this year, versus just 79,000 added for the same period last year. However, 2009's open enrollment period, which extended into 2010, allowed for further growth. By April of 2010, MA membership had increased from 79,000 to 238,000. "Without [the extended enrollment period] this year, it is hard to imagine that level of growth this March and April. Therefore, when we compare the membership growth in April, the 2011 and 2010 numbers may be relatively close," he explains. Ritter's firm provides marketing services for health insurers and recruits agents to sell their products.

Despite reform law provisions that require additional benefits, monthly rates for 2011 averaged \$35.69 — down 45 cents from the 2010 average. Rates will get squeezed further for 2012 and 2013 as reimbursement is brought to parity with traditional Medicare.

Gorman says MA carriers appear to have adapted well to the new rate requirements. And "they were actually helped by how aggressive CMS was in terms of holding the line on premiums and making sure they stayed right about where they were last year" during the most recent bid cycle.

Moreover, he says, a majority of people who are aging into Medicare are familiar with commercial health coverage and comfortable with the MA model. Over the last couple of years, about 40% of newly eligible people choose an MA plan over traditional Medicare fee for service.

### For Seniors, Money Talks

The main reasons people choose an MA plan over traditional Medicare continue to be price and convenience, Gorman explains. Some MA plans offer premiums between zero and \$25 a month, while the average premium for a Medicare Prescription Drug Plan (PDP) might be \$40 an month. "When you stack [MA] up against the [PDP] plans — combined with a Medigap policy — in almost every comparison, MA comes out ahead as far as price and out-of-pocket costs," he says.

Health plans that succeed in the reforming MA market will need to offer greater efficiency, improved care coordination and exceptional customer service, says Andrew Shea, director of corporate and MA marketing at Essence Healthcare, a Missouri-based MA HMO that has members in Illinois, Missouri, New York and Washington state.

"In our view, those plans that cannot achieve gains in these areas will either become acquisition targets or will simply leave the marketplace, but we don't anticipate this happening until at least 2013," Shea says.

Gorman says carriers also will need to be more creative in marketing their MA plans. He points to the recent collaboration between Wal-Mart Stores Inc. and Humana Inc. to sell a cobranded Part D plan as an example. The Humana Walmart-Preferred Rx Plan was announced last November. Health insurers also are placing greater dependence on Web-based sales, which helps them avoid broker commissions. Group sales at seminars are also becoming a more common sales tactic, he says. But for health insurers that have the financial means, growth through acquisition is preferred, he adds.

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### Medicare Advantage Enrollment Among Selected Carriers

Health Plan	Medicare Advantage (MA) Members as of Jan. 14, 2011	Members Added/(Lost) Since Nov. 14, 2010	Prescription Drug Plan (PDP) Members
UnitedHealth Group	2.09 million	109,162	4.73 million
Humana Inc.	1.76 million	137,950	2.33 million
Not-for-Profit Blues plans*	1.27 million	119,173	1.09 million
Kaiser Permanente	998,487	16,568	N/A
WellPoint, Inc.	488,579	54,970	757,548
Aetna Inc.	436,127	(39,766)	453,148
HealthSpring, Inc.	304,360	24,297	831,609
Universal American Corp.	288,729	(111,229)	N/A
Health Net, Inc.	279,511	(66,929)	407,635
Coventry Health Care, Inc.	224,371	(5,461)	1.16 million
Aveta Inc.	184,439	4,318	1,630
EmblemHealth, Inc.	169,517	(1,052)	87,306
WellCare Health Plans, Inc.	116,084	1,859	932,472
<b>Total Enrollment</b>	<b>12.16 million</b>	<b>290,232</b>	<b>18.52 million</b>

\*Collective enrollment among all participating not-for-profit Blue Cross and Blue Shield plans.

N/A = Not applicable

SOURCE: CMS, Stifel, Nicolaus & Company, Inc., February 2011.

## HEALTH PLAN BRIEFS

◆ **President Obama's 2012 budget proposal would delay a 25% reduction in Medicare reimbursement for physicians from Jan. 1, 2012, to Jan. 1, 2014.** The \$62.2 billion "doc fix" would be funded by cutting the Medicaid tax threshold and Medicaid outlays for durable medical equipment and increasing the number of lower-cost generics on the market. These measures would offset the \$54.4 billion cost of the physician reimbursement cut and would yield an additional \$7.8 billion in savings. The budget can be found at [www.hhs.gov/about/FY2012budget/fy2012bib.pdf](http://www.hhs.gov/about/FY2012budget/fy2012bib.pdf). To view testimony from CMS, visit <http://budget.house.gov/UploadedFiles/fostertestimony1262011.pdf>, or to view the White House blog, visit [www.whitehouse.gov/blog/2011/01/26/health-care-costs](http://www.whitehouse.gov/blog/2011/01/26/health-care-costs).

◆ **The Obama administration granted waivers to four states allowing health insurers to continue offering limited benefit, or "mini-med," plans,** a senior CMS official told a House committee on Feb. 15. The waivers from the health reform law were granted to Florida, New Jersey, Ohio and Tennessee, according to Steven Larson, director of CMS's Center for Consumer Information and Insurance Oversight. Under the reform law, health plans must provide at least \$750,000 in coverage for essential benefits beginning this year, more than what many mini-med plans offer. Larson argued that the waivers are needed because mini-med plans are often the only insurance offered to some workers, and that the administration had promised that consumers would be able to keep their current coverage under the reform law. To view the hearing, visit [www.youtube.com/watch?v=LExWPjdA2L4](http://www.youtube.com/watch?v=LExWPjdA2L4).

◆ **Three physicians were among 20 people indicted on health care fraud, kickback and money laundering charges for their parts in a scheme to defraud Medicare of \$200 million,** the Department of Justice said Feb. 15. The defendants worked with and for American Therapeutic Corp. (ATC) and Medlink Professional Management Group Inc. The individuals submitted false claims for mental health services administered at ATC facilities that were medically unnecessary or that were never provided, according to the indictment. The feds allege that the three physicians regularly altered and instructed others to alter patient charts and notes from therapy sessions to make it appear that patients being treated

qualified for partial hospitalization program treatments. Visit [www.justice.gov](http://www.justice.gov).

◆ **HHS said Arizona can let a federal waiver expire, allowing the state to drop individuals from its Medicaid rolls without violating the reform law's "maintenance of effort" provision.** Last month, Arizona Gov. Jan Brewer (R) sent a letter to HHS Sec. Kathleen Sebelius seeking permission to drop 250,000 childless adults from its Medicaid program in an effort to save \$541.5 million. In a Feb. 15 letter to Brewer, HHS said that any reduction in eligibility caused by its federal waiver expiring on Sept. 20 would not violate the reform law. The state has a waiver from HHS that allows it to cover childless adults. Charles Boorady, an equalities analyst with Credit Suisse, said he believes HHS's decision will be viewed negatively by investors. To view the Feb. 15 letter, visit [www.azgovernor.gov/dms/upload/PR\\_021511\\_SebeliusLetter.pdf](http://www.azgovernor.gov/dms/upload/PR_021511_SebeliusLetter.pdf).

◆ **On Feb. 16, HHS awarded \$241 million in "early innovator" grants to several states to develop and implement the framework needed to operate their health insurance exchanges.** The agency said these states will build exchange IT models that other states can adopt before exchanges go into effect in 2014. The states are Kansas, Maryland, Oklahoma, Oregon, Wisconsin and a consortium of New England states. Information on how much each state or consortium will receive, and how each will use the grant funds, is available at [www.HealthCare.gov](http://www.HealthCare.gov).

◆ **Assurant Health Access members who have spent more than \$500 in out-of-pocket costs will be offered a payment advocacy service to help in reducing costs,** according to the insurer. The service, which is free to those members who qualify, is offered by Health Payment Advocates (HPA), a health care financial advocacy firm. HPA's staff will work on behalf of Assurant's members to find solutions with medical providers, including obtaining discounts on the amount owed or enrolling in a payment plan or charity care program, according to Assurant. Visit [www.assuranthealth.com](http://www.assuranthealth.com).

◆ **CORRECTION:** An article in the Feb. 14 issue cited a product from HealthPartners that offers premiums 5% to 20% lower than similar plans that include the Mayo Clinic as an in-network provider. The article incorrectly said the rates were higher.

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