

# HEALTH PLAN WEEK

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

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## With Daschle at Both White House and HHS, Reform Moves One Step Closer to Reality

Momentum for health reform — and for pushing health plans to prove their value — picked up significant steam Nov. 19 after President-elect Barack Obama tapped former Sen. Tom Daschle (D-S.D.) to serve as HHS Secretary and, reportedly, become the White House “health czar.” Daschle, a former Senate majority leader, must first be confirmed by the Senate for the HHS position.

Washington insiders contacted by *HPW* say the pick shows Obama’s strong commitment to health reform. Speculation about the new CMS head ranges from Jeanne Lambrew, who co-authored Daschle’s 2008 book *Critical: What We Can Do About the Health-Care Crisis*, to Elizabeth Fowler, a former WellPoint, Inc. executive and Capitol Hill veteran who now serves on the Senate Finance Committee staff.

“The odds of health reform will go up significantly with him at HHS,” says Tom Scully, who headed CMS between 2001 and 2003. Both Scully and Daschle now work for the law firm Alston & Bird.

Selecting Daschle to work directly with the White House on health policy is an acknowledgment of the role the new administration expects him to play in spearheading reform efforts and in working with Congress on Obama’s vision of reform, says Nancy-Ann DeParle, a managing director of New York City-based CCMP Capital. DeParle was administrator of the Health Care Financing Administration (now CMS) from 1997 to October 2000.

*continued on p. 6*

## Employers Switch Plans, Boost Deductibles, Focus on Wellness to Keep Costs in Check

Although many small employers will pay more for health coverage in 2009 than they did this year, premiums did not increase significantly, according to an informal telephone survey of health insurance brokers and benefits consultants conducted by *HPW*. But employers, they contend, have been able to keep rate hikes in check only through the introduction of substantially higher deductibles and larger copayments.

*Case in point:* A study released Nov. 19 by Mercer LLC determined that while health plan costs rose just 6.3% between 2007 and 2008, the median deductible amount doubled from \$500 to \$1,000 for single PPO coverage. About 80% of surveyed employers said they require a deductible (see chart, p. 3). In 2000, by contrast, only about half of employers imposed a deductible, and the median amount was just \$250. The study is based on nearly 3,000 employers that each have at least 10 employees.

Bill Sharon, an employee benefits consultant in the Tampa Bay, Fla., office of Aon Consulting, says health plan premium increases this year have been the highest he’s seen in several years. That, combined with a sinking economy, has encouraged employers to make “more aggressive changes” to the coverage options being offered during this fall’s open-enrollment period. Strategies include boosting deductibles, copays, coinsurance and/or out-of-pocket maximums as well as offering first-dollar coverage

for preventive services and strengthening wellness and chronic condition management programs.

"Most employers are introducing some form of consumerism into their health care program," he says. "For some employers, that might mean encouraging members to get preventive health screenings and participate in weight-management or smoking-cessation programs. For others, it might include better preventive benefits and an [account-based] consumer-driven health plan."

Vinnie Daboul, an insurance agent in Springfield, Mass., says he's never seen rates increase by less than 8% each year. What's different this year, he says, is that rates are increasing even as employers switch to plans that require significantly higher deductibles. "When you have an 18% increase even after moving to a \$2,000 [annual] deductible...that is amazing," he tells *HPW*. "Ten years ago, you would never have seen a deductible, just copays. And employees would have gone crazy if you even suggested moving from a \$5 to a \$10 copay. It's a much different world now."

Russ Childers, an independent agent based in Americus, Ga., reports a similar scenario. Average rate increases for the 2009 plan year, he says, are about the same as they were a year ago. But some employers are moving to plans that require deductibles of as much as \$5,000. Employers, he explains, understand that their workers have watched their 401(k) retirement plan investments plummet due to the slumping stock market. "They don't want to give them a double whammy by increasing their [coverage] rates on top of that," he says.

Chuck Baxter, an agent in Fredericksburg, Va., agrees that the economy has made more employers reluctant to pass on more premium costs to their employees. And one of his clients this fall opted to absorb a 21% rate hike rather than introduce a deductible, he tells *HPW*.

"Increasing contributions and copayments at this time is a further burden on employees that I think most companies want to avoid if their renewal costs are not increasing dramatically," adds Robert Burnett, a principal with Buck Consultants in New York City.

### Employers Switch Carriers, Plan Designs

Scott Leavitt, a Boise, Idaho-based insurance broker and president of the National Health Underwriters Association, says employers in his area are moving to less expensive coverage options, such as high-deductible plans that can be paired with either a health savings account (HSA) or a health reimbursement arrangement (HRA). Some are offering HSA contributions, for example, in an effort to steer employees to the lower-cost plans.

Health insurers, he adds, are meeting demand for low-cost options by offering a wider range of high-deductible products that include first-dollar benefits for some services such as preventive care, lab work and X-rays.

Leavitt adds that as employers cut staff levels, many of the laid-off employees are forgoing COBRA coverage in favor of less pricey high-deductible individual policies. "With the employee base shrinking and a shift to the individual market, brokers have to work that much harder to find solutions for our clients," he says.

Becky McLaughlan, a principal with Troy, Mich.-based brokerage firm McGraw Wentworth, says most of her employer clients saw rate increases of 10% or less, which is similar to what they've had in past years. Like many employers, she says her clients are trying to keep rate increases under control by boosting deductibles and copays and asking employees to contribute more for their coverage. Some also are adding "surcharges" to cover spouses, and others are offering lower premiums to employees who don't smoke.

Health plans, she says, have grown noticeably more aggressive in her part of the state. Grand Rapids-based

**Health Plan Week** (ISSN: 1937-6650) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, [www.AISHealth.com](http://www.AISHealth.com).

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Call Steve Davis at 1-800-521-4323 with story ideas for future issues.

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Priority Health, for example, has recently moved into the Detroit area and has been targeting the small-group market. HealthPlus of Michigan, another relatively new arrival to the Detroit area, has been offering attractive rates to attract new clients, she says. "We have a lot of companies that are tied to the auto industry, and they've gotten pretty aggressive in terms of plan-design changes" for the 2009 plan year, she says.

Elaine Hicks, a broker in Green Bay, Wis., says "employers are definitely shopping for new carriers. We have done an astronomical number of quotes this fall," she says. Wisconsin Physicians Service Insurance Corp., she notes, offers affordable rates, but has more limited provider networks than other health plans.

"In the small-group market, employers struggle with health coverage costs. But the only things they can do are drop coverage, move to another carrier or alter their benefit design," Baxter says. While switching carriers can be an effective short-term solution, he says typically health plans that offer much lower rates "either don't know what they're doing or they're buying business and will increase rates in the future."

Sam Bennett, an agent based in Columbia, Mo., says he tries to work with the health plan when rates increase by 15% or more. Typically, he says, health plans are willing to help reduce the increase. "I get the feeling that health plans are trying hard to keep their business on the

books and don't want to lose any business." Bennett says he works primarily with The Principal Group and Assurant, Inc.

Elaine Fodor, an agent in Raton, N.M., says in some cases neither the employer nor the employee can afford the rate increase. She has suggested to some clients that moving a spouse to an individual policy might be less expensive than insuring them through the employer's group policy. But, she adds, employers that cancel group coverage could make it impossible for chronically ill employees to find coverage in the individual market.

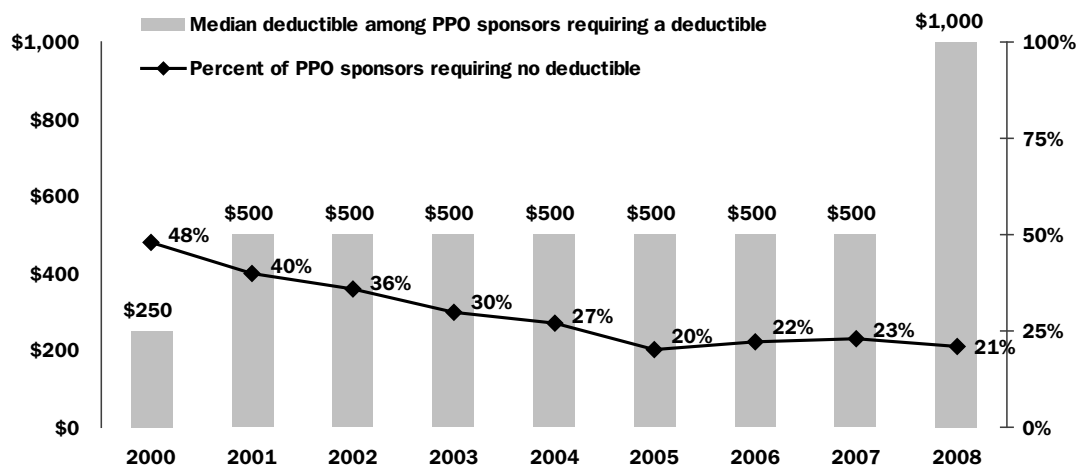
### Can Wellness Programs Stabilize Rate Hikes?

Employers, Daboul says, will eventually need to turn to chronic disease management programs to control rate hikes. Aggressive efforts to promote wellness and health management helped some employers to keep 2009 renewal rates from being excessive, according to Burnett. "Employers understand that over the long term, improvement in their employees' health, and preventive care engagement, is a solution they are sticking with, and they will not adjust that strategy due to a banking crisis and slumping housing and stock markets."

Childers says his employer clients are becoming more interested in controlling coverage costs by improving the health of employees. Some are charging lower

## Median PPO Deductible Doubles in 2008

According to a recent study from Mercer, LLC, the median deductible required by employers for single PPO coverage doubled between 2007 and 2008. According to Mercer, more than half of employers now require an annual deductible of \$1,000 or more.



SOURCE AND METHODOLOGY: Mercer, LLC. Based on a survey of 2,900 employers with 10 or more employees, released November 2008.

rates for people who don't smoke or who complete a health risk assessment.

Sara Taylor, annual enrollment leader at Hewitt Associates, says, "We see a lot of companies that dabbled in offering health risk assessments are now offering some financial incentive to employees who take them," she says. "It's being communicated as being part of the open-enrollment process."

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## Pa. Senate Committee Votes to Bar Highmark-Independence Merger

The ballyhooed proposed merger of Highmark Inc. and Independence Blue Cross (IBC), both of Pennsylvania, is now facing opposition from the commonwealth's Senate Banking and Insurance Committee. The committee issued recommendations against the merger to Pennsylvania Insurance Commissioner Joel Ario on Nov. 20. Meanwhile the commissioner has remained mum on the merger, which he will either approve or disapprove in January.

The merger, proposed in March 2007, would create the largest insurer in Pennsylvania and one of the largest Blue Cross and Blue Shield plans in the country. The two Blues plans have consistently touted consumer benefits that would be created through the new entity's financial efficiencies. But critics, including members of the state legislature and the Pennsylvania Medical Society, contend that the merger would give the combined entity a near monopoly status in the state.

Senate Banking Committee Chairman Don White (R) said that committee made "a recommendation that the Insurance Department deny the proposed merger." Ac-

ording to White, the committee found that the merger "violates three of the seven standards prescribed in the Insurance Holding Company Act," which the commissioner must abide by in making his decision.

He added, "The prevailing themes throughout the Banking and Insurance Committee's review were that the proposed merger would further restrict, if not completely eliminate, any remaining competition in Pennsylvania's health care insurance marketplace, while providing minimal — if any — tangible benefits for policyholders and/or providers."

In the event that Ario approves the merger, the committee recommended 11 conditions.

One such recommendation would prevent the new entity from using 'most-favored nation' (requiring that the contracting health plan get the provider's lowest rates) or exclusive provider (preventing providers from contracting with other health plans) clauses in its provider contracts.

The committee also recommended that the new plan be required to establish premium rates without regard to applicants' health status. It asked the commissioner to require a provider-initiated dispute resolution process and report executive salaries to the insurance department. Another condition would restrict the new insurer from converting to for-profit status without legislation.

### Highmark Touts Merger Benefits

In a prepared statement in response to the committee's recommendations, Highmark said it continues to believe that "the merits of the proposed combination, combined with the tens of thousands of pages filed with the Department detailing its positive impact, strongly support the Insurance Department's approval of the combination of IBC and Highmark."

The company added, "We are pleased that several members of the Senate Committee continue to publicly support the consolidation. The insurer also noted that "the independent consultants hired by the Insurance Department have confirmed that the \$1 billion in economic benefits that the transaction is expected to yield are real and meaningful and will directly benefit our subscribers, customers and the uninsured."

The insurance department has 60 days from the final recommendation to make its decision on the merger, Ario spokesperson Rosanne Placey tells *HPW*. "If we disapprove this transaction, they cannot move forward with consolidating their operations," she explains. She adds that the likelihood of the firms resubmitting an amended application if the merger was disapproved "is very small."

## Health Reform Under President Obama: Likely Priorities and Time Frames for 8 Possible Initiatives

Join Bruce Merlin Fried and Henry J. Aaron for a December 9 audioconference.

Visit [www.AISHealth.com](http://www.AISHealth.com), call 800-521-4323 or see enclosed insert

Independence did not respond to requests for comment by press time.

Call White spokesperson Joe Pittman at (724) 357-0151, Highmark spokesperson Michael Weinstein at (412) 544-7903 or Placey at (717) 787-3289. ✧

## **With Payment Cuts Nearly Certain, MA Plans Must Demonstrate Value**

With little money to address health reform measures, such as the expansion of the State Children's Health Insurance Program (SCHIP), the incoming Obama administration and 111th Congress are almost certain to target payments made to insurers that operate Medicare Advantage (MA) plans. But there still are opportunities for health plans, despite potentially drastic reimbursement cuts, according to consultant John Gorman, CEO of Washington, D.C.-based Gorman Health Group, LLC. In a Nov. 13 audioconference sponsored by AIS, Gorman made his predictions for MA under the new administration and Congress and offered strategies for health plans to succeed.

The president-elect, on several occasions, mentioned his intention to cut MA rates to 100% of Medicare fee-for-service (FFS) levels. MA insurers now receive an average of about 113% of FFS.

For health plans, a reduction to 100% would translate to about \$144 less per member per month in 2014 based on 2008 dollars. Such a move, if phased in over the next five years, would save the government about \$17 billion by 2014, Gorman estimated. During that period, MA plans would get annual rate increases of between 1.8% and 2.7% while medical costs would increase between 8% and 10% during the same period. If rates are reduced over a three-year period, as Rep. Pete Stark (D-Calif.) has proposed, "the effect of this will be much more dramatic," Gorman told listeners.

### **Congress Won't Kill MA**

But this doesn't mean Congress intends to kill MA, Gorman asserted. As of Nov. 1, CMS reports 10.2 million lives are enrolled in MA. Given the success of Medicare Part D and the growth of MA since the enactment of the Medicare reform law in 2003, health plans will continue to have a role in Medicare, he added.

"I cannot imagine any scenario where a member of Congress would support legislation that would eliminate Medicare Advantage or the prescription drug plan program and then be able to go home and face the voters," he contended.

It will be difficult for the Congress to cut MA for 2010 if it doesn't pass legislation before June 2009, when plans

are required to submit their bids for the 2010 plan year. Legislation passed after June is likely to mean rate cuts won't go into effect until after 2011, Gorman said.

But even if reimbursement reductions are enacted as early as 2010, he said, health plans still have time to insulate themselves through "retrospective risk adjustment management." Gorman explained that combing through claims and other data associated with the members can help plans identify diagnostic codes that have not yet been submitted into CMS. This can help health plans ensure that they're paid appropriately for their more costly members.

Health plans also need to determine how to demonstrate value and show that MA is a better alternative than Medicare FFS, Gorman asserted. One way to do that is through better management of chronically ill members. Two out of every four dollars spent on Medicare go toward treating diabetes and cardiovascular disease. In addition, one in four Medicare dollars is spent during the last six months of life.

And if health plans don't have something to say about what they can do to contribute to a better outlook for the fiscal solvency of Medicare, then we might as well all just hang it up and go home because managed care really should be about taking care of sick, elderly people," Gorman told attendees.

### **Boomers to Have Major Effect on Enrollment**

The likely reimbursement cuts are likely to prompt some health plans to leave markets, and is likely to mean more consolidation. Medicare itself will see a tremendous increase in new members beginning in 2011 as the baby boomers enter the program. Over the next decade, Medicare expenditures are expected to double. But the baby boomers, unlike the World War II generation, will have more disposable income than their parents and will understand managed care. They're also far more interested in self-management of their own health, according to Gorman. And 75% of them use the Internet for health information, as opposed to about 25% of the World War II generation.

"This has really got to [be part of] our strategies for our product portfolios, our benefit designs and even little day-to-day functions like how we do customer service and make information accessible over the Web for members that we hope to enroll in the coming years," Gorman said. ✧

*To purchase a recording or a transcript of the Nov. 13 AIS audioconference, What an Obama Presidency Will Mean for Medicare Advantage and Part D, please call (800) 521-4323 or e-mail [customerserv@aispub.com](mailto:customerserv@aispub.com).*

## Daschle May Lift Reform Chances

continued from p. 1

Daschle and Obama agree on the need to improve access to and increase the value of health care. In his new role, Daschle is likely to push health plans to demonstrate that they add value to the health system and are helping to improve outcomes. "Everyone in health care will have their feet held to the fire on that," DeParle tells *HPW*.

Along with overseeing HHS, Daschle is expected to report directly to the president and help draft the reform proposal that the White House submits to Congress.

Consultant John Gorman, president of Washington, D.C.-based Gorman Health Group, LLC, called Daschle an excellent pick because "he understands the ins and outs of Medicare and Medicaid" from his days on the Senate Finance Committee.

The health czar position would ensure that Daschle is "at the table of every aspect of discussions around health reform," Gorman says, who adds that the former senator will be taking on the equivalent of three or four full-time jobs by overseeing HHS, FDA and the National Institutes of Health, among other agencies.

### Daschle Expected to Bring 'New Energy'

Bruce Merlin Fried, a partner at law firm Sonnenschein Nath & Rosenthal LLP in Washington, D.C., said the appointment extends beyond the immediate focus of health reform. "This is a man who can bring new energy and focus to people who work down in the trenches of various HHS entities," such as the FDA and CMS.

DeParle, who had dealings with Daschle while he was a member of the Senate Finance Committee, describes him to *HPW* as a deliberate, fair and moderate lawmaker who listened to all sides of an issue.

Scully, who played a key role in 2003's Medicare reform legislation, agrees that Daschle is a wise choice to head HHS and says he has "a very workable" approach to health reform. "I agree with maybe 95% of what he says in his book," Scully tells *HPW*, adding that his most significant disagreement is Daschle's idea to make Medicare available to people under the age of 65. Such a move, Scully explains, would likely not be popular with some stakeholders. "Medicare and Medicaid already accounts for 55% to 60% of all hospital payments as well as a huge percentage of physician payments. If you expand [Medicare] to people younger than 65, you will screw up whatever market forces we have left."

But not everyone agrees health reform is possible, with or without Daschle on board. "This [appointment] does nothing for the momentum of health reform," as-

serts Tom Miller, a resident fellow at the right-leaning American Enterprise Institute for Public Policy Research.

Miller points to an idea proposed in Daschle's book of establishing a Federal Health Board that would function similarly to the Federal Reserve by enforcing health policy. "There was a steep learning curve, during which time we had a little thing called the Great Depression," he quips about the Federal Reserve. "And health care is much more complicated than controlling inflation."

### CMS Director Will Play Key Role

Gorman notes that Daschle has never been known as an ardent supporter of Medicare Advantage (MA) plans. But he adds that as someone who represented a rural state, Daschle could be influential in blunting reimbursement reductions for insurers that operate MA plans in rural and secondary markets. "Those would be among the hardest hit by a phase-down in rates," he tells *HPW*. The Senate Finance Committee, which has jurisdiction over Medicare, includes a chairman and several key members from rural states including Montana and Iowa.

As for the head of CMS, Gorman suggests the administration will choose either someone with a strong background in health policy who understands Medicare and Medicaid or someone with a clinical background and experience in health management. "It's really the cost of managing chronic illnesses that is wreaking havoc on Medicare," he asserts. One possibility is former Well-Point public policy vice president Fowler. Last February, Senate Finance Committee Chairman Max Baucus (D-Mont.) hired Fowler as his senior counsel. She also had worked for Baucus on the finance committee between 2001 and 2005.

"I think she would be a brilliant choice," Gorman says. "She's a veteran of the Hill and would be good for health plans because she understands Medicare and Medicaid programs from the business side as well as from the policy side."

Lambrew, who co-authored Daschle's book on health reform, is another possible choice to head CMS, according to Scully. Now senior fellow at the Center for American Progress and an associate professor of public affairs at the University of Texas, Lambrew served as program associate director for health at the Office of Management and Budget (OMB) and as the senior health analyst at the National Economic Council (NEC). "She's smart and talented and would be a good choice," Scully says. Other possibilities include Avalere Health founder Dan Mendelson, who served as associate director for health at OMB between 1998 and 2000, and Harvard economics professor David Cutler, who served on the Council of Economic Advisors and NEC under President Clinton.

Whether health reform is accomplished through a comprehensive bill or piecemeal, CMS will play a critical role, Fried asserts. "I would hope the next CMS administrator will bring a depth of expertise about the programs and how they are implemented in the real world," he tells *HPW*. "All the regulations are based on good intentions, but how they will be implemented by health plans, hospitals, labs and other entities must also be considered."

Miller suggests that Daschle could run into problems in working with some lawmakers because he doesn't have a reputation of "playing nice" with Republican senators. "At the end of the day, if you have bad ideas and bad health policy you're trying to ram down the throat of the country, I don't care who you are; nothing is going to get done," Miller says.

Gorman, however, calls Daschle a "skilled negotiator." While Daschle might have issues with some Republican senators, he is respected by Charles Grassley (R-Iowa), ranking minority member on the Senate Finance Committee, and others who have key roles in health policy.

"When we go through the early part of a new administration, people start to think anything is possible, but it's not. It might take six months to a year before that reality sets in," Miller says.

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## STATE HEALTH REFORM BRIEFS

♦ **Illinois is likely to become the next state to require that health plans cover the diagnosis and treatment of autism.** The passed legislation, which Gov. Rod Blagojevich (D) indicated he would sign, would require coverage up to \$36,000 a year, the *Chicago Tribune* reported Nov. 21. About 4,500 families across the state will qualify for coverage. Last spring, Florida Gov. Charlie Crist (R) signed a bill that requires large-group policies to cover most costs associated with the diagnosis and treatment of autism. Coverage for autism is one of the fastest-growing state mandates and can be tricky for health plans to price because the severity of the condition and treatment options can vary widely, according to the Council for Affordable Health Benefits. Visit Blagojevich's Web site at [www.illinois.gov](http://www.illinois.gov).

♦ **A 65-page proposal released this month by Louisiana Gov. Bobby Jindal (R) seeks to revamp the state's \$7 billion Medicaid program and control costs by shifting enrollees from the current fee-for-service model to managed care networks.** Under the proposal, Medicaid recipients could enroll in a care network that would manage their care, including preventive care. The proposal includes initiatives to focus on preventive primary care so people don't rely on emergency rooms for basic services. The governor's proposal also would upgrade medical records systems, promote cost transparency and provide incentives for employers to offer insurance to employees. A recent study by the UnitedHealth Foundation shows that Louisiana ranks dead last, 50th, in terms of overall health. However, the state ranks 11th in terms of Medicaid spending per capita.

And about 24% of the state's adults are uninsured. Visit [www.gov.state.la.us](http://www.gov.state.la.us).

♦ **Kentucky Gov. Steve Beshear (D) this month announced plans to enroll in KCHIP the more than 67,000 children in the state who don't have health coverage** but who qualify for Kentucky's free or low-cost children's health insurance program. KCHIP, according to the governor's office, has partnered with United Way and other community groups to find the eligible children and enroll them. The governor's goal is to get 35,000 Kentucky children enrolled in KCHIP by 2010. KCHIP also has eliminated the need to participate in a face-to-face enrollment interview and will allow people to apply online. Visit [www.kidshealth.ky.gov](http://www.kidshealth.ky.gov).

♦ **Connecticut Gov. Jodi Rell (R) this month said providers that want to participate in the state's HUSKY program for children do not have to also participate in the state's Charter Oak program for uninsured adults**, which began accepting enrollees this fall. Aetna, Inc., UnitedHealth Group's AmeriChoice unit and Community Health Network have contracts with the state for both programs, but have reported difficulty in building provider networks for both plans. Providers have complained that Charter Oak's reimbursement rates are too low. In a letter to Connecticut Attorney General Richard Blumenthal (D), state Insurance Commissioner Michael Starkowski said the ability to enroll providers separately "should help accelerate the growth of the HUSKY provider networks." Visit [www.charter oakhealth-plan.com/coh/site/default.asp](http://www.charter oakhealth-plan.com/coh/site/default.asp).

## HEALTH PLAN BRIEFS

◆ **On Nov. 18, Michigan Attorney General Mike Cox (R), Chuck Bell of Consumers Union and Eric Schneidewind of the Michigan chapter of AARP urged the Michigan legislature to stop a bill being pushed by Blue Cross Blue Shield of Michigan (BCBSM).** According to the attorney general's office, "the proposal would guarantee rate hikes on seniors and the seriously ill, eliminate financial oversight by the governor and attorney general, and allow BCBSM to purchase for-profit companies." Cox asserted that following the elections, the Michigan Blues plan began pushing legislation that would allow it to reduce its capacity as the insurer of last resort, a move Cox called "the worst case scenario for our state." The legislation would allow BCBSM to raise rates even if there's opposition from the governor or state attorney general, double pre-existing condition waiting periods to 12 months and increase premium rates for sick customers. The insurer wants the legislative changes to stop its losses in the individual market, Cox said. But he countered that the plan has grown its surplus to \$3 billion and increased executive pay by 53% between 2006 and 2007. Call John Sellek for Cox at (517) 373-8060.

◆ **AARP said that it has hired an outside investigator after a Senate inquiry found evidence of deceptive marketing for some of its health insurance products** (*HPW 11/17/08, p. 1*). The investigation, commissioned by the senior advocacy group and UnitedHealth Group, will be conducted by Elizabeth Rowe Costle, former insurance commissioner of Vermont. At issue are AARP-branded health plans being sold by UnitedHealth. The plans, sold under names like Essential Plus or Hospital Indemnity Plan, have been purchased by more than a million people, according to *The New York Times*. Sen. Charles Grassley (R-Iowa) had asked the organization to look into the marketing of the products. Call AARP spokesperson Steve Hahn at (202) 434-2592.

◆ **Georgetown University was subpoenaed by New York Attorney General Andrew Cuomo (D) as part of an investigation of how colleges and health plans interact** *The Washington Post* reports. Families have expressed concern that institutions are requiring students to buy coverage even if they are covered under their parents' policies. Georgetown spokesperson Andy Pino confirmed that the school has received the subpoena and said it will respond

appropriately. The investigation also includes several public and private campuses in New York state. Call Pino at (202) 687-4328.

◆ **Local Medicare Advantage (MA) PPOs are growing in rural areas.** That's according to a new Medicare marketplace analysis by Avalere Health. The firm asserted that the difficulty of setting up adequate provider networks in rural areas has traditionally kept them underserved. However, of all new 2008 MA PPOs, 62%, or 4,502 plans, were set up in rural areas, Avalere analysts found. And MA enrollment in rural areas often shifted into local PPOs in 2008, rather than into private-fee-for-service plans or HMOs, the firm said. Call Avalere spokesperson Lindsey Spindle at (202) 207-1337.

◆ **Nearly half (49%) or more than 150,000 providers told the Physicians' Foundations that they plan to reduce the number of patients they see or to stop practicing entirely over the next three years.** And 78% of physicians contend that there is an existing shortage of primary care providers in the U.S. already. Those figures are from a survey of 12,000 responding providers that the organization released on Nov. 18. "At a time when the new Administration and new Congress are talking about ways to expand access to healthcare, the harsh reality is that there might not be enough doctors to handle the increased number of people who might want to see them if they get health insurance," said Walker Ray, M.D., vice president of the group. Visit [www.physiciansfoundations.org/news](http://www.physiciansfoundations.org/news).

◆ **Sen. Edward Kennedy (D-Mass.) established three working groups dealing with health reform under the Senate Committee on Health, Education, Labor and Pensions, which he chairs.** The groups, according to Kennedy's office, will concentrate on prevention and public health, improvements in the quality of care and insurance coverage. Kennedy, who recently returned to the Senate after brain surgery, asserted that "we've been making real progress in our discussions about a consensus approach, and I'm optimistic we'll succeed." Sen. Tom Harkin (D-Iowa) will lead the public health group, Sen. Barbara Mikulski (D-Md.) will lead the quality care group and Sen. Hillary Clinton (D-N.Y.) will lead the coverage group. Call Kennedy spokesperson Melissa Wagoner at (202) 224-2633.

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