

HEALTH PLAN WEEK

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

Contents

- 3** MA Enrollment Gains Are Slowing Among Publicly Traded Plans
- 3** *Table: 10 Largest Publicly Traded Managed Care Companies*
- 4** CEOs Answer Reform Queries From *HPW*
- 5** MA Cuts Are Imminent, Senate Committee Aide Warns
- 6** *New Studies in the Field*
- 8** *Health Plan Briefs*

Managing Editor

Steve Davis

Contributing Editor

Jill Brown

Associate Editor

Chris Meehan

Executive Editor

James Gutman

Health Reform, Obama and New Congress: Four Questions for Top Health Plan Execs

CEOs from the nation's largest health plans unanimously support the idea of health reform and agree that incremental changes (such as the expansion of the State Children's Health Insurance Program) are likely to take place during the early part of 2009, with broader measures enacted over the next four years. Several of them tell *HPW* that while they support the idea of a guaranteed-issue rule, such a requirement must be paired with an enforceable law that would require all Americans to have health coverage.

"The current health care system has many important strengths that can be built upon, but we also recognize that there are severe deficiencies too," Aetna Inc. CEO Ron Williams tells *HPW*. "It's in no one's interest to maintain the status quo."

With President-elect Barack Obama set to take the oath of office Jan. 20, *HPW* contacted top executives from Aetna, UnitedHealth Group, CIGNA Corp., Humana Inc. and WellPoint, Inc. and asked them to weigh in on the future of health reform under the new administration and the 111th Congress (see their responses, p. 4).

For any health reform efforts to succeed, they agree that the next administration and Congress must first address the soaring cost of medical care and prescription drugs.

"We have to be serious about addressing the cost of health care as we work to expand coverage," says Humana CEO Mike McCallister. "And under the surface of nearly all the issues that reformers want to address, you will find the problem of ever-increasing costs." Such costs, he explains, include the cost of care and drugs as well as the cost of ineffective and inappropriate care, the cost of failure to provide preventive and effective care and the cost of the continual introduction of new medical technologies.

Patient Outreach Could Help Inoculate Plans Against Flu-Related Utilization Rate Hikes

While it's still, too early to tell if the upcoming influenza season will be mild, moderate or severe, health plans tell *HPW* that they're extending their outreach efforts to get as many of their members vaccinated as possible. And a researcher associated with the strain-selection process used in developing each year's vaccine tells *HPW* that this year's version should be right on target.

And that's good news for health plans. Last year's unexpectedly severe flu season, which was worsened by a partially ineffective vaccine, led to higher medical costs, especially among plans that have large Medicaid and Medicare populations. Case in point: In its first-quarter 2008 earnings results, CIGNA Corp. said the unexpectedly severe flu season cost it \$4 million in the quarter (*HPW* 5/5/08, p. 1).

One change from last year: The CDC's Advisory Committee on Immunization Practices (ACIP) includes several new immunization targets for the 2008-2009 season, including recommendations that all healthy children ages six months through 18 years receive the vaccine. Vaccinating nursing home residents also is a high priority for this season. Overall, the CDC is recommending that a record number of healthy as well as at-risk people be vaccinated.

continued

As for the vaccine's effectiveness, Doris Bucher, Ph.D., associate professor of microbiology and immunology at New York Medical College, Valhalla, N.Y., tells *HPW* that "the strains that are in [this year's] vaccine match what is out there to the best of our knowledge." Bucher is a member of the team that grew part of the flu virus used in making this season's vaccine. She also says that it's too early to tell how severe the season will be. Early CDC surveillance data suggest an "average" season.

Mild, Muted Strain Expected

Morgan Stanley research analysts also say that the first month of the flu season has been "muted compared to last year and consistent with relatively past mild seasons." But they caution that the severity of the season can't be determined until January 2009, and that "heavy flu outbreaks abroad make it possible that higher incidence may yet lie ahead."

Case in point: A year ago, when HealthSpring, Inc. missed its first-quarter earnings guidance, the company acknowledged that a greater-than-expected incidence of flu was at least partially to blame. In his March 3 note to

investors, Oppenheimer & Co. analyst Carl McDonald wrote that although last year's flu season was somewhat mild, "it was strong in the Southeast where HealthSpring has virtually all of its membership."

In its Feb. 14 call with investors, HealthSpring President and CEO Herbert Fritch acknowledged that this season's flu-related activity had little impact in the fourth quarter of 2007, but added that hospital admission rates began to pick in mid-January in several markets.

The CDC also says that an "all-time high" supply of vaccine is available, with 14 million more doses available this year than were available for the 2007-2008 season. The CDC also says it is stockpiling a reserve supply of vaccine. The agency also hopes to speed up its surveillance alert capabilities by using Google's new Flu Trends tool to track the spread of flu. The tool, announced Nov. 11, uses data from Google's search engine to estimate flu activity in local areas.

Health plans, meanwhile, are taking no chances and have expanded outreach strategies to remind members to get vaccinated. Many health plans say they are steering members to local retail clinics and pharmacies for their shots. And most target their high-risk members for added outreach.

James Howatt, chief medical officer for Molina Healthcare, which serves Medicare and Medicaid members, tells *HPW* that the plan focuses first on vaccinating its high-risk members, including the elderly and those with comorbid and chronic conditions. It then turns its attention to its general member populations using mailings and outreach to its network providers. The plan also promotes immunization through its network of community pharmacies. Howatt says that it uses its owned and operated clinics in California to target children, the elderly and high-risk group members.

More Plans Use IVR Technology

While most health plans use mailings and messages in member print materials to promote awareness and encourage immunization, a growing number of plans now use interactive voice recognition (IVR) technology and other automated phone messaging technologies. Both WellPoint, Inc. and Harvard Pilgrim Health Plan use this technology to remind members of the importance of receiving flu shots.

In its automated voice messaging outreach to First Seniority Freedom members, Harvard Pilgrim steers members with cardiac disease, asthma, diabetes and other chronic conditions to neighborhood flu clinics where they can receive free immunizations. UnitedHealth Group says it incorporates immunization reminders into its call-center messages.

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.

Copyright © 2008 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

Health Plan Week is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Steve Davis; Contributing Editor, Jill Brown; Associate Editor, Chris Meehan; Executive Editor, James Gutman; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Director, Andrea Gudeon

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

Subscriptions to *HPW* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist aisalert@aispub.com to ensure delivery.

To order **Health Plan Week**:

- (1) Call 1-800-521-4323 (major credit cards accepted),
- (2) Order online at www.AISHealth.com, or
- (3) Staple your business card to this form and mail it to:
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Payment Enclosed* \$647

Bill Me \$677

*Make checks payable to Atlantic Information Services, Inc.
D.C. residents add 5.75% sales tax.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order **Health Plan Week on CD**, a searchable CD with all issues of the newsletter published from January 2005 to June 2008. (\$89 for subscribers; \$389 for non-subscribers.)

Health plans also are steering their members to near-by retail clinics and pharmacy chains. United has contracted with several pharmacy chains as well as VaxAmerica to provide flu shots for its Medicare health plan members. CIGNA began contracting with MinuteClinics for immunizations and other services in 2006. Some WellPoint plans steer members to local Wal-Mart stores that offer flu shots. Members are reimbursed up to \$20 for the immunization. Blue Cross Blue Shield of North Carolina also contracts with retail pharmacies, including CVS MinuteClinics, and pays for member immunizations at these sites.

Contact Kathleen O’Guin for Howatt at kathleen.oguin@molinahealthcare.com, Joseph Mondy for CIGNA at joseph.mondy@cigna.com, Daryl Richard for United at daryl_p_richard@uhc.com, Jill Becher for WellPoint at jill.becher@bcbswi.com and Lydia Bernstein for Harvard Pilgrim at (617) 509-7702. ✧

MA Enrollment Gains Are Slowing Among Publicly Traded Plans

Enrollment increases in Medicare Advantage (MA) plans slowed for the Nov. 1 payment cycle, according to data reported this month by CMS. MA enrollment grew by about 34,000 lives over the previous month, while it increased by 53,000 members the previous month.

The payment cycle reflects enrollment as of Oct. 10. Overall, more than 10.2 million lives are now covered by an MA plan — an increase of nearly 1.4 million lives from

the same date a year ago. UnitedHealth Group, the largest seller of MA plans with 1.5 million members, saw its enrollment grow by slightly more than 6,000 lives — about half of the enrollment growth reported last month. Humana Inc. had the largest enrollment gain with 18,000 new members, much of which was due to last month’s acquisition of PHP Companies Inc., which does business as Cariten Healthcare. At the time of the acquisition, Cariten had 46,900 MA enrollees, according to an Oct. 31 statement from Humana.

CMS Posts New Rules for MA Sales

Along with posting its monthly MA enrollment numbers, CMS this month also issued what are likely to be final rules for the 2009 plan year regarding how health plans can compensate agents and brokers who sell MA and stand-alone Medicare Prescription Drug Plan (PDP) options. The compensation rule was issued Nov. 10, just five days before the start of the 2009 open-enrollment season. Although CMS is accepting public comments until Dec. 15, the revised regulations took effect immediately.

Under the revised rules, health plans can base their 2009 broker compensation structure on 2006 compensation, or they can conduct a market analysis of the compensation paid by sponsors in their service area in 2006 and 2007 for sales of the same types of Medicare plans and trend it forward to arrive at a 2009 compensation level. CMS said plans failing to meet the Nov. 17 deadline would be deemed to be out of compliance and face possible penalties. ✧

10 Largest Publicly Traded Managed Care Companies Ranked by Third-Quarter 2008 Premium Revenue

Company	3Q08 Health Premium and Fee Revenue	Enrollment as of Sept. 30, 2008				
		Total Enrollment*	Self-Funded		Fully Insured	
			Enrollment	% of Total Enrollment	Enrollment	% of Total Enrollment
UnitedHealth Group	\$20.2 billion	30.3 million	16.0 million	53.3%	14.3 million	47.2%
WellPoint, Inc.	\$15.3 billion	35.3 million	18.7 million	53.0%	16.7 million	47.3%
Aetna Inc.	\$7.8 billion	17.7 million	11.5 million	65.0%	6.1 million	34.5%
Humana Inc.	\$7.1 billion	8.4 million	3.0 million	35.7%	5.4 million	64.3%
CIGNA Corp.	\$4.1 billion	11.9 million	8.2 million	68.9%	3.7 million	31.1%
Health Net, Inc.	\$3.8 billion	6.7 million	45,000	0.7%	6.6 million	98.5%
Coventry Health Care, Inc.	\$3.0 billion	3.7 million	1.4 million	36.6%	2.4 million	63.4%
AMERIGROUP Corp.	\$1.1 billion	1.7 million	165,000	9.6%	1.5 million	90.4%
Centene Corp.	\$897.1 million	1.2 million	0	0	1.2 million	100%
Molina Healthcare, Inc.	\$791.6 million	1.2 million	0	0	1.2 million	100%

* Enrollment sums may not total exactly due to rounding.

SOURCE: Compiled by Atlantic Information Services, Inc. from company financial statements, November 2008.

CEOs Answer Reform Queries From HPW Reform Must Address Cost of Care, Health Plan Leaders Assert

In an *HPW* exclusive, CEOs from the nation's largest health plans say they are encouraged that health reform remains a top priority for the incoming presidential administration and Congress but worry about whether reform efforts will successfully address rising health care costs. Here's a look at how they separately responded to *HPW*'s questions about health reform:

(1) Do you expect the Obama administration and Congress will be able to enact major health reform in 2009? Over the next four years?

Hanway: It appears that the 111th Congress will begin the process of reform, both in incremental steps and broader reforms, next year. It is always hard to judge congressional action, but we believe that a strong effort will be made to complete reforms in the next Congress.

McCallister: The prospects for incremental reform are strong. For instance, we expect to see action early in 2009 on reauthorization and expansion of SCHIP [i.e., the State Children's Health Insurance Program]. And many key congressional leaders have put health reform high on their list of priorities, increasing the opportunity that we can move past incremental reforms to not only cover everyone, but also address the concerns many Americans have about health care affordability.

Williams: I'm encouraged by the growing recognition that there are significant costs associated with doing nothing in the health care arena. When I talk to the people we serve at Aetna, they consistently point out — correctly — that there's a direct link between their health care coverage and their financial well-being. We can expect some

HPW contacted the nation's largest health plans and asked their top executives to weigh in on health reform and the likely steps the Obama administration and 111th Congress would take to achieve it. The participants are:

Ron Williams, Aetna Inc. chairman and CEO

H. Edward Hanway, CIGNA Corp. chairman and CEO

Mike McCallister, Humana Inc. president and CEO

Stephen Hemsley, United-Health Group president and CEO

Brad Fluegel, WellPoint, Inc. executive vice president

sort of "down payment" in 2009 (e.g., SCHIP, Medicaid issues, health information technology) while other larger issues are worked out for later in the term. Over the longer haul, there's no doubt that our system needs some fundamental fixes, not the least of which is to control the rapidly growing costs of health care in America. But there are also some

sensible and straightforward policy interventions I believe can put the system on the road to recovery. These include: institute an individual coverage requirement; enroll people already eligible for public programs; develop a truly integrated health information system; improve health care quality and value by creating a new institution dedicated to comparing the efficacy and cost-effectiveness of technologies, practices and treatments; use the tax system to the advantage of all who purchase coverage; find new ways to pool individuals.

Hemsley: We have a significant opportunity to improve the health care system, and we should approach it in its broadest context. We should be striving for comprehensive and continuous reform, which we hope begins in 2009, and continues over the next four years and beyond. Given the sensitive, complex, social and commercial nature of our health system — and its central role in the ability of American business to be competitive — any reform should be taken in thoughtful stages.

Fluegel: A sustainable reduction in the number of the uninsured...can only be achieved by the public and private sector working together to address cost and quality while expanding access to coverage. Initially we anticipate there will be incremental reform efforts focused on increasing access for children. During the next four years, we expect to see more comprehensive reform efforts and encourage those efforts to focus on improving quality while reducing costs in our system. Without targeting the underlying cost and quality issues, reform efforts to increase access to affordable health care coverage will not be sustainable.

(2) What actions do you expect regarding the availability of health coverage?

Hemsley: It is not really possible to assess the impact of expanded coverage options until greater specifics are provided. Steps that increase coverage options and make these options simpler to pursue may be popular for many because they offer the ability to respond to immediate health care and financial needs. However, this approach represents a good example of a response that addresses a symptom and not the root cause. The opportunity for broader and durable reform lies in improved, systemwide dynamics around basic health care system costs. To address those core cost issues requires focus on the central cost drivers across the entire system viewed as a whole and then taking actions that will better contain those costs without compromising appropriate care, access or quality.

Hanway: We expect Congress to attempt to adopt the concept of a national pooling system, which was defined

during the campaign as a National Health Insurance Exchange. Private carriers would then offer their plans on the Exchange. The impact on the industry is currently unclear, as we really need to wait for many details to be specified.

McCallister: We support an individual mandate and guaranteed issue within the framework of comprehensive reform. Requiring everyone to purchase coverage would bring younger and healthier individuals into the health insurance system, where they could offset some of the costs of others who need more care. Humana and other private insurers would continue to play a central role. Many congressional leaders understand that people want coverage and are worried about not being able to purchase [it]. To make guaranteed issue work, though, you must combine it with an individual mandate.

Williams: The problem with guaranteed issue is that it creates incentives for people to delay signing up for coverage until they know they are going to need health care. That's not insurance. Insurance is about protecting against unknown risk. But I, along with my industry peers, think there's a way to guarantee coverage without creating the wrong incentives — and that is to require everyone to have insurance. If everyone is compelled to possess health insurance, the problem of people trying to game the system by avoiding coverage until they know they need it essentially goes away. In other words, there's a compromise. We can guarantee coverage if there's a guarantee that everyone is participating.

(3) What actions do you expect in 2009 regarding the affordability of health insurance?

Williams: Too often, I've seen the debate about affordability focused on the prices of health insurance. This may be inappropriate, but it's not entirely surprising.

When people are paying more and more in premiums, it is tempting to point the finger at the insurance companies. But focusing on the profits and administrative costs of private health insurers is fundamentally misdirected. It's like using a thermometer to take the temperature of a sick patient, not liking the level of reading showing a high fever, and then breaking the thermometer to address the situation rather than treating the underlying disease causing the temperature in the first place. In other words, premiums are but a symptom of the larger underlying health care costs. In the short term, getting kids covered [i.e., through SCHIP] would be a great start, and it has to be done by April. And as this debate unfolds, I hope policymakers — and the public at large — will address the eligible-but-not-enrolled problem associated with both the SCHIP and Medicaid programs. There are 11 million children and adults who are currently eligible for these programs, yet remain uninsured. Getting them into the system should be a priority.

McCallister: The most significant hurdle to expanding coverage and reforming health care is the rising cost of care. Increasing health insurance premiums are a symptom of these costs. [Along with SCHIP expansion], we also could see subsidies and tax credits to help people obtain coverage. We see opportunities in these changes to both help our existing members and to provide coverage to others. Government partnerships with the private sector in the delivery of complex public programs have become the norm over the last 30 years. Private-sector organizations offer a number of distinct features that add value for the government: expanded reach, flexibility in the face of changing priorities, adaptability to diverse conditions, and the innovation that stems from competitive market forces.

MA Cuts Are Imminent, Senate Finance Committee Aide Warns

Health insurers that operate Medicare Advantage (MA) plans can expect "further cuts" in reimbursement, a Democratic aide to the Senate Finance Committee said at a Nov. 24 health policy briefing in Washington, D.C. The aide, who asked not to be identified, said she isn't sure that reducing MA plan payments to 100% of fee-for-service (FFS) Medicare levels makes sense, and that the committee also is considering "some form of blended payment and looking for direction" from the Medicare Payment Advisory Commission (MedPAC).

Simon Stevens, CEO of UnitedHealth Group's Ovation division, the industry's lone representative, told attendees that MA, by virtue of its funding structure, is providing more benefits at reduced cost compared to traditional Medicare FFS.

Stevens also contended that managed Medicare has the potential to improve quality of care and reduce health disparities. He urged lawmakers to consider that low-income minorities, who tend to enroll in MA plans in disproportionately high numbers, could be hardest hit from declining MA payment rates.

The briefing, sponsored by *Health Affairs*, coincided with the release of three studies about MA. One, by MedPAC analysts, found that the current structure of MA benefits has not been beneficial for the overall population and hasn't produced "any overall savings for the Medicare program."

The studies are available at <http://content.healthaffairs.org/index.dtl>. ♦

Hanway: We expect the administration will take immediate action in its first 100 days on reauthorization of SCHIP to expand coverage to low-income children. To the extent that that expansion of coverage captures those without health insurance, you could argue that such coverage would reduce the cost shift from uninsured to insured and help reduce premium costs for those insured.

Hemsley: Providing health coverage for children should be a priority. By passing SCHIP legislation, we will be able to better serve the needs of millions of children who are currently eligible but not enrolled in the program. That would be a good first-stage step as part of a broader reform effort.

Fluegel: The Obama administration and Congress will need to make SCHIP reauthorization a priority in the early part of next year. We support the reauthorization of SCHIP at a funding level that will, at a minimum, sustain coverage for all children and parents currently enrolled as well as support coverage for all children who are eligible but not enrolled. We also support increasing funding for SCHIP outreach. Too many children who are eligible for SCHIP remain uninsured, possibly because their parents are not aware they are eligible or they do not know how to enroll.

(4) What is your biggest concern about the prospect of health reform during the next administration?

McCallister: Much of the cost problem has to do with a lack of “system-ness” in our system — the absence of coordination, continuity and integration — too much unwanted variation in what is delivered and how it’s delivered. Making coverage affordable will require deci-

sive action. We must make cost and quality transparent so consumers can make educated decisions; we must connect the system and create efficiency using health information technology; and we must adopt comparative effectiveness measures to ensure medical devices and therapies deliver value.

Hanway: We’re concerned that reforms may not address the fundamental problem of rising costs of health care, similar to the issues that have confronted the Massachusetts model. Expanding access without controlling costs is only half of the problem.

Fluegel: We must do a better job — in coordination with government — to make sure our health care dollars are allocated fairly and efficiently. We need to make sure high-quality care is within the reach of all Americans. And we need to not only increase and expand public-financing programs for individuals and families with low incomes; we need to make sure those who are eligible actually take advantage of them. Then we can capitalize on the savings in the health care system that may be achieved when more Americans have coverage.

Hemsley: The prospect of health reform actually provides a sense of optimism. The central concern for us and others is how to best achieve it. It needs to be approached broadly and thoughtfully with a whole-system perspective and a standard of fairness. Even the best change is disruptive and needs to be planned and managed. So how reform is considered, planned, executed and adjusted is key. It will require consistent, vigilant assessment and readjustment to achieve the goals we all believe should be possible. ✧

NEW STUDIES IN THE FIELD

◆ **Raymond McCaskey, former CEO of Health Care Service Corp. (HCSC), earned \$10.3 million in total compensation in 2007 and was the highest-paid CEO among more than 30 Blue Cross and Blue Shield plan operators,** according to a study of 2007 compensation information compiled this month by *The AIS Report on Blue Cross and Blue Shield Plans*, a sister publication of *HPW*. WellPoint, Inc. CEO Angela Braly last year received \$9.1 million in salary, bonus, stock and option awards, according to the report. Braly, however, did not become CEO until June 1, 2007. HCSC, which operates Blues plans in four states, has about 12 million enrollees and is about one-third the size of WellPoint in terms of enrollment. Robert Lufitano, M.D., CEO of Blue Cross and Blue Shield of Florida, was the highest-paid CEO among single-state Blues plans with \$7.2 million in

2007 compensation. To see compensation details, visit www.aishealth.com/pdf/blu1108.pdf.

◆ **Although low fees discourage physicians from treating Medicaid patients, payment delays also play an important role in physician decisions to avoid Medicaid patients,** according to a study released Nov. 18 by the Center for Studying Health System Change (HSC) and published in the journal *Health Affairs*. The study found that average reimbursement times for Medicaid varied considerably across states, from a low of 36.9 adjusted days in Kansas to a high of 114.6 days in Pennsylvania. Reimbursement times for Medicaid were longer on average than reimbursement times for commercial insurers in every state. Previous research has shown that about half of U.S. physicians accept all new

NEW STUDIES IN THE FIELD

Medicaid patients, compared with more than 70% of physicians who accept all new privately insured and Medicare patients. The study included about 4,900 physicians in 21 states. Visit www.hschange.org/content/1025, or contact Alwyn Cassil at acassil@hschange.org.

◆ **About 75% of recently surveyed Americans, and nearly 80% of health industry leaders, say they expect major health care reform legislation to be passed during the first term of Barack Obama's presidency,** according to results of a survey released Nov. 20 by the National Association of Children's Hospitals and Related Institutions (NACHRI) and PricewaterhouseCoopers LLP. More than half of those surveyed said they were concerned that they would not be able to afford health insurance in the future. The study is based on responses from 1,000 American adults and more than 800 health industry leaders, including policymakers and executives from hospitals, health plans, pharmaceutical companies, associations and other major employers. The survey results also found a high demand for both cost reduction and expansion of coverage for the uninsured. Health industry leaders were nearly unanimous (98%) in their support of investing in prevention programs for chronic illnesses. For more information, visit www.childrenshospitals.net, or contact Gillian Ray at gray@nachri.org.

◆ **Personal health records (PHRs) could reduce the nation's health care bill by \$19 billion a year,** according to a study released in November by the Center for Information Technology Leadership (CITL) at Partners HealthCare System in Boston. The savings estimate assumes a 10-year rollout and an 80% usage rate. To make "interoperable" PHRs available to 80% of the population, the cost would be about \$3.7 billion, and it would be another \$1.9 billion a year to maintain them. The study identified eight functions in which PHRs could lead to savings. Those functions include electronic appointment scheduling and the ability to share test results and medication lists. Most of the savings would go to health plans, but health care providers also would benefit. CITL's PHR advisory board estimated that the average American would save 7.6 hours per year through e-visits, which would translate to a savings of about \$20 billion a year in recovered wages. Along with cost savings, increased use of PHRs also would

help improve the quality of care by enabling providers to make more informed decisions by using "pre-encounter questionnaires," according to the report. To see a copy of the study, visit www.citl.org/research/pdf/citl_phr_press_release.pdf.

◆ **The cost of health coverage for a typical family increases about \$100 per month when state governments limit price adjustments based on factors including as age, health or unhealthy behaviors such as smoking,** according to the results of a study from Brigham Young University economist Mark Showalter. Seven states prevent insurers from adjusting prices based on one or more factors such as age, health status or "risky behavior." Showalter and other researchers found that community-rating rules increased family premiums by between 21% and 33%. The researchers also found that health insurance premiums rise 10% or more when a state government makes insurers accept all doctors, hospitals or pharmacies instead of steering customers to an exclusive network of providers. Showalter began the research during an appointment as a senior economist for the U.S. Council of Economic Advisers. He co-authored the study with Amanda Kowalski of the National Bureau of Economic Research and William Congdon of The Brookings Institution. Their report will appear in the academic journal *Forum for Health Economics & Policy*. To see the complete study, visit www.bepress.com/fhpep/11/2/8.

◆ **The up-front cost of a major health reform effort will be less than doing nothing at all,** according to a study released this month by the New America Foundation. In 2006, according to the report, the U.S. economy lost as much as \$200 billion due to the poor health and shorter life span of the uninsured. The cost of the average employer-sponsored health insurance plan for a family will reach \$24,000 in 2016 — an 84% increase over 2008 premium levels, the study finds. New Mexico, Maine and South Carolina will see the greatest percentage increases in the cost of family policies over the next eight years. The study also predicts that the average annual deductible nationwide will increase 73% to almost \$2,700 by 2016. Average copayments will climb to \$30. To see the complete report, visit www.newamerica.net/files/NAF_CostofDoingNothing.pdf.

HEALTH PLAN BRIEFS

◆ **The trade groups America's Health Insurance Plans (AHIP) and Blue Cross and Blue Shield Association (BCBSA) on Nov. 20 said they supported a national mandate that would require health plans to guarantee health coverage for all individuals regardless of an applicant's health status.** A guaranteed-issue requirement, however, would need to be paired with an enforceable individual coverage mandate, the groups said. "With everyone covered through an effective individual mandate, insurance can function as intended and spread the risk over a broad and representative population, and thereby avoid the risk of only those who need insurance purchasing coverage," BCBSA President and CEO Scott Serota said in a prepared statement. The Council for Affordable Health Insurance (CAHI), however, contends that coupling a guaranteed-issue rule with an individual mandate invites the government to "micromanage" health insurance policies, reduce consumer choices and dramatically drive up the cost of coverage. Instead, CAHI advocates ensuring that consumers have access to a wide range of affordable policies, along with subsidies for those who can't afford coverage, and a well-functioning safety net such as high-risk pools. Visit CAHI at www.cahi.org. Contact AHIP's Robert Zirkelbach at (202) 778-8493 and BCBSA's Kelly Miller at kelly.miller@bcbsa.com.

◆ **Horizon Blue Cross Blue Shield of New Jersey offered a preliminary settlement Nov. 24 to pay up to \$3.6 million — largely to plaintiffs' lawyers — to end a class-action suit alleging it wrongfully denied claims submitted by patients who had an eating disorder,** according to the *New Jersey Law Journal*. The offer, which is subject to approval by a federal judge, would provide about \$1.18 million to some enrollees who contend they couldn't get coverage for extended bulimia and anorexia treatments under their Horizon plans. The terms are similar to those in a settlement approved in October between Aetna Inc. and a class of eating-disorder patients, according to the *Journal*. In both cases, the suit's stated goal was to get the insurers to treat eating disorders as biologically based mental illnesses such as schizophrenia. Visit www.law.com.

◆ **The number of uninsured children in the U.S. now stands at 8.6 million (about one in nine),** according to a report issued Nov. 25 by Families USA, a Washington, D.C.-based consumer advocacy group. The report, based on recent Census Bureau data, reflects the three-year period 2005-2007 and therefore does not reflect the

worsening economic climate in 2008. According to the report, 60% of the nation's uninsured children come from low-income families (families with annual incomes of less than \$35,200 for a family of three) who are likely eligible for Medicaid or State Children's Health Insurance Programs (SCHIP). To see the full report, visit www.familiesusa.org/assets/pdfs/uninsured-kids-2008/national-report.pdf.

◆ **Nationwide Specialty Health says its new line of Ca\$hBack Plans helps employers protect their employees against unexpected medical costs such as hospital stays.** The products are aimed at individuals who have high-deductible health insurance policies. Employers are able to choose a level of coverage to offer within the accident, hospital or combination product lines based on what works best with their existing health plan and the needs of their employees, according to Nationwide. All Ca\$hback Plans pay the insured directly regardless of any other insurance. Contact Terri Erlenbach at erlenbach@nwbetterhealth.com.

◆ **Humana Inc. has launched an educational tool to help small employers understand how health plan enrollees use various benefits.** The Humana Health Plan Guide will be published twice a year and is aimed at employers with between five and 99 employees. It offers information about the percentage of deductibles met, prescription-drug usage, preventive-care office visits and in-network vs. out-of-network services usage. Visit www.humana.com/employers/tools/.

PEOPLE ON THE MOVE: Fallon Community Health Plan named **Kristen Veitch** director of technical and business services. She previously held positions in network management and information technology at Private Healthcare Systems, Inc. ... **Carol Sato** was named director of Medicare operations for Humana Inc.'s Hawaii operations. She previously was director of benefits administration at Kaiser Foundation Health Plan in Hawaii. ... **Anurag Chandra** has joined HealthMarkets, Inc. as executive vice president and chief administrative officer. He previously led insurance, consumer finance and asset-management functions at Aquiline Capital Partners. Blue Cross and Blue Shield of Vermont CEO **William Milnes, Jr.** said he will retire on Nov. 30. **Don George**, vice president of managed health systems and senior vice president and chief operating officer of the company's HMO affiliate, will act as interim CEO.

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,
HERE ARE THREE EASY WAYS TO SIGN UP:**



(1) Call us at **800-521-4323**



(2) Fax the order form on page 2 to **202-331-9542**



(3) Visit the MarketPlace at **www.AISHealth.com**

**IF YOU ARE A SUBSCRIBER
AND WANT TO ROUTINELY FORWARD THIS
E-MAIL EDITION TO OTHERS IN YOUR ORGANIZATION:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these e-mail editions without prior authorization from AIS, since strict copyright restrictions apply.)