

MEDICARE ADVANTAGE NEWS

Biweekly News and Analysis on the Medicare and Medicaid Managed Care Programs

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MA Plans Face Pay Phase-down to 100% of FFS, Intense Scrutiny Under New Congress

The Nov. 4 election of Sen. Barack Obama (D-Ill.) as president and more Democrats in Congress almost certainly will result in a phase-down of Medicare Advantage (MA) plan payment rates to 100% of fee-for-service (FFS) rates over the next few years, according to Washington, D.C.-based policy experts. In early 2009, they expect to see reauthorization and expansion of the State Children's Health Insurance Program (SCHIP), discussion of U.S. health reform and continued scrutiny of the MA program on Capitol Hill.

"I think there's a near certainty that Medicare Advantage payments rates will be equalized with fee-for-service. The only question is how quickly," former HCFA Administrator Gail Wilensky, now a senior fellow at Project HOPE, an international health education foundation, told *MAN* Nov. 14. "Whether it will phase down to 100% or take a dramatic change quickly is the only question. My hope and expectation is it would phase in over several years so it doesn't tax the system too much."

With expanded Democratic margins, "the past could be prologue," John Gorman, CEO of consulting firm Gorman Health Group, LLC, told an AIS-sponsored audioconference Nov. 13.

His firm estimates that MA plans in the aggregate are looking at \$144.34 less per member per month (PMPM) in all markets from a benchmark phase-down to 100% of FFS by 2014 (see chart, p. 7). But he said the impact of MA cuts could vary dramatically from county to county.

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CMS Modifies Rule on Agent Compensation, Asks Plans to Send Historical Broker Data

Responding to congressional concerns, CMS issued revised compensation requirements Nov. 10 on how plan sponsors pay agents and brokers selling Medicare Advantage (MA) and Medicare Part D prescription drug plan options. Industry experts say the new interim final rule — issued five days before the 2009 open-enrollment period began — left plans scrambling to find accurate historical data on commissions to certify and submit to CMS within days, even as they try to make up lost ground from a late start in selling 2009 products. CMS is accepting public comments until Dec. 15, but the revised regulations took effect immediately.

Under the agency's interim rules, by Nov. 17 each plan sponsor had to certify and submit to CMS the agent compensation structures paid in years 2006 through 2008, along with the compensation that they will use for 2009. CMS said similar information had to be provided to agents, brokers and other third parties under contract to sell their plans. Plans basing their 2009 compensation structure on 2006 compensation had until Nov. 13 to submit certification of 2006 broker data to CMS.

continued

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CMS said plans failing to meet the Nov. 17 deadline would be deemed to be out of compliance and face possible penalties. Plans are locked into the compensation structures submitted to CMS unless the agency gives prior approval for modifications.

According to CMS, the new interim rule modifies regulations that CMS issued Sept. 18 requiring that plans pay agents on a six-year cycle by:

◆ *Specifying that agent compensation must reflect fair-market value based on the commissions paid by the plan in the past, adjusted for inflation for similar products in the same geographic area.*

◆ *Requiring that renewal compensation be no more, or no less, than half of the compensation paid for that beneficiary in the initial year of the six-year compensation cycle established in the rule released Sept. 15 (MAN 9/25/08, p. 1).*

◆ *Imposing similar limits on payments to entities such as Field Marketing Organizations (FMOs).*

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CMS, in issuing the interim rule on commissions, noted that other marketing provisions found in its Sept. 18 regulations still apply.

To prevent “churning” of beneficiaries into new plans based on agents’ financial incentives, CMS said it still is requiring that plans pay renewal-rate compensation amounts in 2009 rather than paying first-year compensation for any plan changes. If CMS determines that an initial commission was warranted, plans retrospectively must pay agents an additional amount for a total payment of the initial compensation rate as filed with CMS, agency officials said.

The agency allowed plan sponsors to take one of two approaches: They could base their 2009 broker compensation structure on 2006 compensation, or they could 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 it will take 2006 and 2007 compensation data reported by plans in order to determine whether a plan’s 2009 compensation structure is “commensurate with fair market value,” the law firm of Neal, Gerber & Eisenberg LLP explained in a Nov. 11 memo to clients. CMS said it will investigate plan “outliers” — an undefined term — and take enforcement action as appropriate, including possibly requiring plan “outliers” to adjust their 2009 compensation levels downward.

Plans Were Left ‘Scrambling’ to Find Data

Chicago-based attorney Tom Bixby, a partner in Neal, Gerber & Eisenberg’s health law group, said the interim rules on compensation — which don’t apply to plans’ employed sales agents, though CMS continues to review the matter — left plans “scrambling” to find historical data within a very short period of time. “It was aggressive by CMS to say the least,” he said of the timeline, noting that one filing deadline arrived prior to CMS’s formal publication of the rule.

“Plans were challenged to come up with accurate data in such a short period of time,” agreed Jane Galvin, Washington, D.C.-based director of regulatory affairs for the Blue Cross and Blue Shield Association.

Bixby told *MAN* Nov. 17 that CMS’s revised interim rule likely will accomplish what CMS wants to accomplish: ensuring that commissions don’t increase dramatically and promote “churning.” But at the same time, he asserted that the rule “really stifles the ability of plans to modify what they’re doing and react to the market. It’s kind of a ‘meat cleaver’ approach.”

“CMS is really trying to get this to a level playing field, and they’re trying real hard,” Jeff Fox, president of Gorman Health Group, LLC, told *MAN* Nov. 14.

"...We're going through a tough exercise this way. At the end of the day, they could've said these are the [commission] caps in various markets. I think plans would've been OK with that." Indeed, Fox said he wouldn't be surprised if CMS decides to set maximum commissions by market as a next step for 2010, assuming the agency finds that it has the legal authority to do so.

Fox asserted that the "lateness of response" from CMS on agent compensation requirements has put plans behind schedule in trying to sell 2009 products. "I think enrollment numbers from the annual election period [AEP, running from Nov. 15 through Dec. 31] will be impacted tremendously," he said. "I think the plans are very disappointed in how long it took to come out, and

MA Plans Set Up Costly Call Centers, Work to Keep Pace With Marketing Regs

Aside from agent commissions, industry consultant Jeff Fox tells *MAN* that scope of appointments with beneficiaries — and properly documenting that the beneficiary knows in advance what 2009 Medicare Advantage (MA) and Part D products the agent is coming out to discuss — is the biggest execution risk for Medicare plans.

"Plans are pushing and struggling to get call centers in place to do most of these appointments over the phone," says Fox, who is president of Gorman Health Group, LLC. He says the risk of getting beneficiary approvals for appointments on paper is that it could remain unclear whether the agent got the OK before going out or afterward. Moreover, he says, it could take five to six business days for the agent to get the beneficiary's response in the mail — and the agent cannot go out to see the beneficiary until the mailed reply is received. Thus, he says, his firm recommends that plans set up call centers so conversations are recorded in case of a CMS audit.

A significant number of plans are setting up call centers, and that is adding to their member-acquisition costs, Fox says. If a plan sets up a call center internally, he says, it probably will cost \$500,000 just for the technology, or the plan can spend \$50,000 for setup charges and pay additional per-minute charges through a vendor. "Plans didn't budget for this in their bids in June," he says. "You usually don't make money in the first year for a beneficiary; now it will take longer for return on investment."

New regulations on scope of appointments and other marketing provisions were issued Sept. 15 by CMS, along with an interim final rule on commissions that was updated Nov. 10 (see story, p. 1). The deadline for public comments on the marketing rules — published Sept. 18 in the *Federal Register* — was Nov. 17. The Blue Cross and Blue Shield Association (BCBSA) weighed in with concerns, including the need to strike a balance between protecting beneficiaries from inap-

propriate marketing while preserving plans' ability to continue "their trusted relationship" with members.

Specifically, the association cited plans' ability to communicate with current members, including beneficiaries now enrolled in Medicare products as well as those members, enrolled in other plan products, aging into Medicare and exploring their options as newly eligible Medicare beneficiaries. "We support CMS's ban on door-to-door solicitation... We recommend, however, that CMS clarify the difference between marketing to prospective enrollees and plan communications with current members, so as to preserve and protect a plan's ability to call, contact, write to, and otherwise interact with current members about the benefits and services available to them," states the Nov. 17 letter from BCBSA's Alissa Fox, vice president of legislative and regulatory affairs, to CMS Acting Administrator Kerry Weems.

The association adds that CMS should not impose compensation requirements on plans' internal sales staff: "We believe this is the appropriate approach given that employed sales staff may or may not have other lines of business for which they have responsibilities, do not receive compensation in six year cycles, have other performance and compensation issues that are separate and apart from those for independent agents and brokers, and have not been the focus of the Congress... or other interested parties or advocacy groups."

Ideally, a plan wants to train agents prior to the start of the selling season Oct. 1, says Chicago-based attorney Tom Bixby, a partner in law firm Neal, Gerber & Eisenberg's health law group. But CMS has "put out new marketing guidance virtually every week since mid-September," he says, "and with so much put out, it's getting pretty hard to keep people up to speed."

Contact Fox at (602) 956-4175 and Bixby at (312) 269-8050.

wonder why CMS didn't just give a number" to cap commissions.

At this point, Fox said, "Health plans are nervous about their numbers for the annual election period. They're nervous about their late start. But hopefully they can recover and get the attention of these agents."

Fox said the current situation happened so fast that plans couldn't build a strategy with internal sales staff. "For 2010, I think plans will look at the costs for using employed sales and smaller broker networks for some outlying areas," he said. "In '09, plans [simply] had to get through." He said his firm is advising its clients to say that FMOs must accept any new rates from CMS in their contracts in case the plans are deemed "outliers" and their rates are subject to negotiation.

Under CMS's Nov. 10 revisions, Fox explained that an organization selling products in 2006 and using brokers had to go back and certify 2006 broker payments by Nov. 13, after which CMS will use 5% to 6% trend factors to figure out the plan's 2009 compensation rates. "You certify that's what you paid in '06, and that'll be fine," Fox said. "But a lot [of MA organizations] didn't have brokers in '06 or didn't have plans."

Thus, CMS offered the second approach that allows an organization to take the fair-market value for what was being paid by other plans in its market in 2006 and 2007 and trend it forward to calculate 2009 commissions — for

submission by Nov. 17. He said he thinks most plans took the average of fair-market value. "They're hoping to get clean data," he added.

"CMS sent out models, and they're pretty complex. Health plans are working around the clock; they'll be working this weekend," Fox said Nov. 14. Plans must go to CMS to request any modifications to their initial submissions, so any small gaffe on commissions is "like missing a benefit by \$50 to \$100. You could lose the interest of agents to sell your product. ... There's a lot at stake. The AEP starts [Nov. 15], and a lot of [agents] don't know what they're getting paid yet."

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Medicaid Plans Report Challenges, Savings Potential in Care for Duals

A Medicaid-focused plan in Arizona entered the Medicare Advantage (MA) program in January 2008 with a Special Needs Plan (SNP) for people dually eligible for Medicare and Medicaid. Nearly a year later, as the SNP tries to coordinate care for its approximately 100 enrollees, it is finding a high level of confusion among beneficiaries — many of whom are non-English-speaking low-income elderly Hispanics — about the benefits to which they are entitled.

"Many are trying to pay a prescription copay even though it's covered," Kathy Oestreich, CEO of University Physicians Health Care in Tucson, Ariz., said at a Nov. 12 policy briefing sponsored by the Association for Community Affiliated Plans (ACAP) and Medicaid Health Plans of America (MHPA). "I think the biggest thing we've learned about this population... is that many are trying to pay for services that are covered benefits for them."

The event was held to release a report, "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities," written by The Lewin Group and sponsored by both Medicaid plan groups.

The report concludes that large-scale savings could be achieved by shifting the dually eligible population into fully capitated managed care organizations responsible for coordinating member services.

Estimated spending for 2008 on the nation's nearly 8 million dual eligibles will reach \$239 billion nationwide, comprising about 40% of the Medicaid program's total spending and 25% of Medicare expenditures, said Mary Kennedy, ACAP's director of Medicare.

Total spending for duals "is effectively hidden in the budgets of two programs with no clear accountability for spending, access or quality of care," Kennedy asserted,

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adding that each program has “incentives for ‘containing costs’ by shifting costs to the other program.”

The report estimates potential cost savings from putting duals into a capitated setting on a national basis and on a state-by-state basis, “to show states what they can achieve,” said Joel Menges, vice president of Lewin. He said researchers looked at data over a 15-year period [2010 through 2024] because the dynamics of managed care evolve over time. “We feel pretty confident these are reasonable numbers,” he said, noting that Lewin estimated reductions of 20% in inpatient costs and 15% in pharmacy costs compared with fee-for-service costs over the prior year from using managed care plans for duals.

Among the Lewin report’s findings:

◆ **Under existing policies, care costs will continue to escalate due to an increase in the number of dual eligibles and in per-capita costs.** Annual spending is projected to reach \$777 billion in 2024, which is more than three times the current level. Annual per-capita costs are expected to climb from about \$25,000 in 2005 to nearly \$80,000 in 2024.

◆ **Nationwide, there would be an immediate savings of 2.7% for populations put into an integrated (i.e., both Medicare and Medicaid) capitation model.** The savings would accrue entirely on the Medicare side for the first five years, necessitating policy changes so that states could avoid Medicaid losses over this time period, according to Lewin. That translates into a \$300-billion-plus savings over the 15-year period, including savings of \$50 billion from 2010 through 2014.

Contact Kennedy at (202) 701-4749 and Menges at (703) 269-5598. ✦

MA Plans Must Prepare for 100% of FFS Pay, Deliver ‘Sellable’ Products

Given the near certainty that a strengthened Democratic presence in Washington will result in equalized payment rates between Medicare Advantage plans and fee-for-service (FFS) Medicare, MA plans must prepare for it. Many plans will have to make decisions over the next several months on why they got into the MA market and whether to remain, a longtime consultant says.

“Looking at the demographics [of a rapidly increasing elderly population in the U.S.], you almost have to be in Medicare,” John Gorman, CEO of consulting firm Gorman Health Group, LLC, told an AIS-sponsored audioconference Nov. 13. But MA organizations must evaluate their ability to offer a “value proposition” to beneficiaries and look at current enrollment and future potential in specific markets and counties — all with an eye toward deciding whether they have the financial capacity to deliver “affordable, sellable” MA plans by

2011. If not, he advised that MA organizations consider product “pruning” strategies.

“If potential revenue won’t cover costs in two to three years, you’ll start seeing service areas contracting, consolidation as big plans gobble up smaller plans, private-equity firms coming into this space — and pruning,” Gorman said. He suggested that MA plans seeking to remain competitive in this new era that began with the July enactment of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 ought to focus on the following areas:

◆ **Aggressive revenue management.** Proper enrollment determines payment rates, he says, so even keying errors during the enrollment process can have a major impact on MA plan revenues. “We recommend to a lot of plans, if you have other books of business like Medicaid and commercial, consider separate revenue management for MA because it’s so complex,” he said.

◆ **Products and sales.** “Now is the time to determine whether a PPO is a good fit for your organization,” Gorman said. Employers facing the departure of those MA private-fee-for-service (PFFS) plans deciding that network creation by 2011 is infeasible will be looking for Medicare PPOs, he said. He added that some Medicare supplemental insurance buyers may see the PPO as more cost-effective than their current coverage. In addition to PPOs, MA organizations ought to focus on group retirees, he asserted, given that significant policy changes by CMS in the past year opened up the group opportunity to smaller and regional plans. In April, CMS said it would ease network adequacy requirements for plans, allowing them to serve national accounts as long as they cover most of a group’s retirees in network (*MAN 4/24/08, p. 1*).

With CMS issuing new regulations on commissions (see story, p. 1) and marketing, Gorman said plans ought to revamp their sales strategies, pulling away from huge media buys to focus on more targeted ad campaigns. Plans have detailed data on where they are gaining and losing members, he said, so instead of engaging in “street fights” with “an 800-pound gorilla stealing your members,” it might make sense to go after weaklings in the market and try to gain their members. He noted that the new regulation on agent compensation “just increased your acquisition costs by two to three times” because plans now must provide compensation over several years.

◆ **Compliance.** Focus on high-risk areas and become proactive, Gorman advised. “On compliance we know there will be more regulations coming... Compliance doesn’t get the resources it needs. You need to throw technology at it,” he said, for example by allowing plan

executives to dial up sites and see how the plan is doing on specific measures in real time.

◆ **Medical management.** “Get back to basics and focus on chronic care management,” Gorman said, citing the oft-quoted national data indicating that the 20% of Medicare beneficiaries who are chronically ill account for 80% of the program’s costs.

In the MIPPA era, MA plans’ revenue will be in line with FFS, accountability will be much greater, and competition will continue to be intense as the market consolidates, Gorman concluded. “At the end of the day, MA has to show value...and stay in the game that way.”

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Pay Cuts for MA Seen as Likely

continued from p. 1

Rep. Pete Stark (D-Calif.), chairman of the House Ways and Means health subcommittee, “is dusting off CHAMP legislation as we speak,” Gorman said. Under the Children’s Health and Medicare Protection Act (H.R. 3162), which passed the House in August 2007 but went no farther, the federal government would have slashed payments to MA plans by more than \$50 billion over five years and combined that savings with higher federal taxes on tobacco to expand SCHIP. The bill would have cut MA payments to 100% of FFS over a three-year period. Ultimately, President Bush vetoed a compromise House-Senate bill separate from CHAMP that settled on smaller MA cuts.

Jane Galvin, Washington, D.C.-based director of regulatory affairs for the Blue Cross and Blue Shield Association, told *MAN* Nov. 17 it is possible that Congress will reintroduce provisions in the CHAMP bill designed to ensure that beneficiaries in MA plans don’t pay more for cost sharing than do beneficiaries with traditional FFS coverage. This may prove challenging for MA plans facing revenue cuts that could affect cost-sharing amounts, she noted.

Obama’s Medicare reform plan specifically calls for eliminating “excessive subsidies” to MA plans, and would pay plans at the same rate as FFS, Gorman explained. He said the Obama administration’s first priority will be to extend and expand SCHIP, which is the linchpin of its health reform proposal, and then the new administration must figure out what to do about a Medicare physician pay cut scheduled to take effect in January 2010. Bids on 2010 MA products must be submitted to CMS by June 2009, so if the legislation isn’t completed by then, such cuts are unlikely until 2011, he noted. He said Obama also is expected to seek to repeal the ban against direct Part D prescription drug price negotiation

by the federal government, aggressively fight Medicare fraud and abuse, and put significant focus on chronic disease management, coordinated care and quality improvement initiatives within the Medicare program.

Under the new political landscape, Wilensky said that to expect equalization of MA and FFS payment rates within two to three years “is not unreasonable.” She said that “three to five years would be the gentlest glide that MA could hope for — and I’d be surprised if it’s that long.” By contrast, Wilensky, who headed HCFA from 1990 to 1992 during the senior Bush’s presidency, told *MAN* four years ago that George W. Bush’s second term and GOP control of the 109th Congress would be, for Medicare managed care companies, “the best thing they could have possibly hoped for” (*MAN* 11/18/04, p. 1).

Tom Scully, who was CMS administrator from 2001 through 2003 (the current MA program was created under Medicare reform law at the tail end of his tenure), told *MAN* Nov. 14 there is “a good chance” that Congress will equalize MA and FFS payment rates in three years instead of five years — or even sooner. He asserted that “policy-wise, you can justify it,” given MA plans’ current level of profitability, but telling seniors who are satisfied with their plans that they will pay more for coverage won’t be as easy for federal lawmakers, “who generally don’t care about health plans but care about beneficiaries.”

Scully ‘Never Intended Rates to Be This High’

“I certainly never intended [MA] rates to be this high, but it is what it is,” said Scully, who is now senior counsel at the Alston & Bird law firm. Scully noted that when he served on the board of Oxford Health Plans in the late 1990s — at a time when Medicare managed care plans were paid at 95% of FFS — Oxford “did extremely well.” He described MA as “generally a better value” than FFS Medicare, and said an unattained goal during his tenure at CMS “was to get rid of Medigap” (i.e., Medicare supplemental insurance).

“I don’t think the sky is falling,” Scully said of the current MA landscape. “...Is the growth going to slow? Yes...It was probably artificially high to begin with.... Going forward, growth will slow, but I think it’s still a good business...” Given the likely impending changes, MA might comprise 20% to 22% of Medicare enrollment five years down the road, similar to the current figure, instead of 35% to 40%, he said.

Wilensky, Scully and Gorman predict that given the U.S. economy’s woes, incremental health reform is a likelier path than comprehensive reform — with reauthorization and expansion of SCHIP as an early priority. Authorization for SCHIP now runs through March 2009. Scully said that ailing Sen. Ted Kennedy (D-Mass.) has

many friendly colleagues likely to promote his health reform agenda as his legacy, but the federal budget deficit makes comprehensive reform difficult in the near term.

Another significant issue is how quickly Congress will move on the next Medicare physician pay fix. Physicians face a 20% pay cut from Medicare going into effect Jan. 1, 2010, “and obviously Medicare Advantage will become one of the big offsets for this pay fix,” Gorman told the Nov. 13 audioconference. He described MA plans as now being “on a collision course” with physicians, who are facing Medicare pay cuts even as their practice costs escalate dramatically.

Gorman noted that physicians are lobbying Congress, saying they won’t be able to take Medicare patients just as the Medicare population is starting to double — spurred on by the impending entry of the first baby boomers.

Yet Gorman stressed that despite political and budgetary challenges, he does not think the MA program is in jeopardy. He said he can’t see Congress eliminating either the MA or Medicare Part D prescription drug benefit program when nearly 28 million beneficiaries now are enrolled in some form of managed care plan through these programs and most enrollees cite satisfaction with their plans. But while Congress won’t eliminate the programs, federal lawmakers will look closely at reimbursement and regulation, he said.

Gorman cited “staggering costs” of \$177 billion that are needed even to freeze physician pay rates at 2007 levels for the next decade — and shifting MA pay to 100% of

FFS would pull in only \$17 billion over that time period. Thus, he said, Congress’s ability to fund a long-term physician pay fix will depend on whether it still requires “pay-as-you-go” laws.

The PPO space in Medicare will get “very crowded very quickly” as MA private-fee-for-service (PFFS) plan sponsors try to hold onto their membership, now totaling 2.3 million nationwide, Gorman said. (PFFS plans operating in areas with two or more MA plans must create networks by 2011, and that could spur plan sponsors’ shift to PPOs.) Entry of the first baby boomers into Medicare also is likely to cause PPO enrollment to “soar” in 2011 and 2012, he predicted.

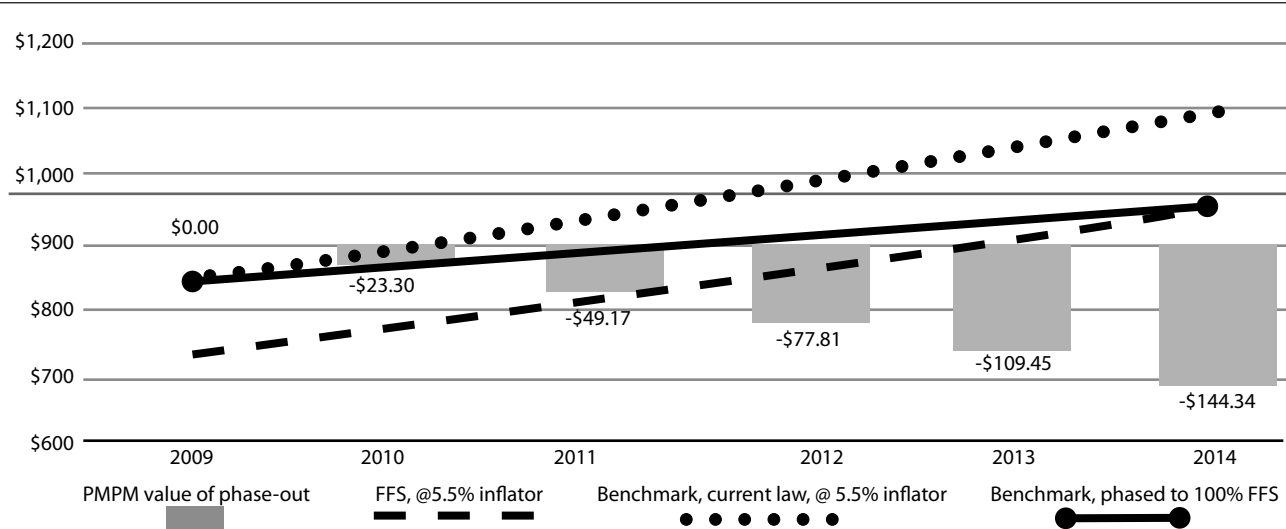
About 1.1 million beneficiaries now are enrolled in employer-group MA plans, Gorman said. But he said a growing number of public- and private-sector employers are moving from self-insured products to MA products with a Part D prescription drug benefit, and this movement will intensify as employers review every line item in their budgets. Thus, he forecast that MA plans will see 5 million to 6 million new enrollees from the employer sector over the next few years, and he described this as “the new land grab” for those plans positioning for it.

Contact Wilensky at (301) 347-3903, Scully at (202) 756-3459, Gorman at (202) 364-8283 and Galvin at (202) 626-8651 ✦

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What a ‘Level Playing Field’ for Medicare Advantage Means

Aggregate Per-Member, Per-Month (PMPM) Impact, All Markets, of a Benchmark Phase Down to 100% of Fee-for-Service (FFS), Weighted by September 2008 Enrollment



SOURCE: Copyright ©2008, Gorman Health Group, LLC, November 2008

NEWS BRIEFS

◆ **WellCare Health Plans, Inc.'s stock price plunged 54%, or \$10.77 per share, on Nov. 13 after the company reported that its medical loss ratio (MLR) was two to four percentage points higher for the first nine months of 2008 than for the same period in 2007.** The key issue appears to be WellCare's stand-alone Prescription Drug Plan (PDP) product, which is generating much lower than expected profit margins this year, Oppenheimer & Co. analyst Carl McDonald said in a recent note. For the first six months, WellCare cited a widening in the risk corridors governing payments from CMS in 2008 from 2.5% to 5.0% as the rationale for its higher year-to-year PDP MLR. But it said this factor should have reversed in the second half of the year, which doesn't appear to be the case, the analyst added. McDonald noted that WellCare should get some relief from this issue in 2009, as it should lose about 450,000 PDP Medicare-Medicaid dual-eligible and low-income senior beneficiaries on Jan. 1, 2009 because the company bid above the benchmark for getting subsidized beneficiaries. Based on WellCare's MLR being worse than he expected, McDonald said he is cutting the health plan's stock-price target to \$26 per share from \$53. WellCare's shares closed at \$9.43 on Nov. 17. Contact McDonald at (212) 667-6558 or carl.mcdonald@opco.com.

◆ **Connecticut Gov. M. Jodi Rell (R) on Nov. 14 said that the state will no longer require health plans that want to participate also in its HUSKY plan for low-income children to participate also in its new Charter Oak plan for the uninsured.** The governor said the "de-linking" of HUSKY and Charter Oak will make it easier for health plans to negotiate and reach agreements with physicians and hospitals to serve patients in either plan. For several months, Democratic lawmakers — who control both the state House and the Senate — have been critical of Rell's plan to link both programs, arguing that HUSKY patients and particularly the 200,000-plus children it serves are too vulnerable to risk by linking their provider network to the new Charter Oak program, reports the *Hartford Courant*. Rell also said that her administration would negotiate with Anthem Health Plans Inc. to allow about 154,000 HUSKY patients to continue to use its 7,500-physician network through Jan. 31, the *Journal Inquirer* reports. That move would give Aetna Better Health and Am-

eriChoice of Connecticut, hired to operate HUSKY in place of Anthem, time to try to boost the plans' slowly developing provider networks for Charter Oak (*MAN* 7/3/08, p. 8), according to the newspaper. On Nov. 17, state attorney General Richard Blumenthal (D) recommended that the state rebid the contracts for both programs, arguing that the two are really not officially "de-linked." However, Rell said that she sees no need for that, the *New Haven Register* reports. Contact Rell's office at (860) 566-4840.

◆ **Health Net, Inc. posted third-quarter net income of \$18.5 million, or 17 cents per share, compared with a year-ago loss of \$103.9 million, or 93 cents per share.** But analysts polled by Thomson Reuters expected much higher net earnings of 88 cents per share. Health Net attributed the lower than expected profit to costs from its Medicare and commercial health plans that were significantly higher than expected. The company said it has addressed the Medicare Advantage (MA) cost issue in bids for 2009. Health Net's "health plan services" MLR for the quarter rose to 87.5% from 82.9% a year ago. The firm also said its membership of more than 3.7 million at the end of the third quarter was down 4,000 from a year earlier. But the plan's MA membership grew by 54,000 members, or 22.6%, to 293,000 members on Sept. 30 from the level a year ago. Visit www.healthnet.com.

◆ **BlueCross BlueShield of Tennessee has expanded its MA PPO network from four to 22 counties across the state.** The Blues plan's MA PPO product, BlueAdvantage, now includes approximately 9,000 new physicians and several major hospitals throughout Tennessee. In addition to Knox, Anderson, Loudon and Sevier counties, BlueAdvantage is now available in Bradley, Campbell, Carroll, Davidson, Dyer, Greene, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Marion, Polk, Roane, Shelby, Sullivan, Warren and Weakley counties. Visit www.bcbst-medicare.com.

◆ **Miami-based Preferred Care Partners is expanding its MA health plans Healthy America and Healthy America Plus into Lake, Sumter and Marion counties in Florida in 2009** Preferred Care now has a provider network of 23 hospitals and more than 1,500 physicians throughout Miami-Dade and Broward counties. Visit www.psohealth.com.

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