

HEALTH PLAN WEEK

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

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More Employers Turn to Eligibility Audits To Counter Coverage Costs, Reform Rules

Benefits consultants queried by *HPW* say spouse surcharges and dependent eligibility audits are on the rise due to increased coverage costs and concern that expanding eligibility for adult dependent children — as called for by the health reform law — will require them to cover more lives.

Michael Smith, president of ConSova Corp., a Colorado-based company that conducts dependent eligibility audits, says his firm experienced a drop in audit requests shortly after the reform law was enacted in March (*HPW* 3/29/10, p. 1), but reports that interest picked up sharply a few months later as employers concluded that the law would lead to higher coverage costs. There also is concern that a provision that allows dependent children to remain on a parent's plan to age 26 will lead to higher "dependent ratios," especially for adult children, he adds (*HPW* 3/29/10, p. 4). According to some estimates, that provision will boost coverage costs by between 0.25% and 2%.

Requests for dependent audits at Mercer LLC are up between 30% and 40% compared with a year ago. Such audits typically determine that between 3% and 8% of an employer's covered dependents are ineligible, says Dan Priga, a partner at Mercer who heads the company's Performance Audit Group. The cost of covering a dependent typically runs between \$2,000 and \$3,000 a year. "So the return on investment (ROI) could be on a magnitude of 8 to 1 or more depending on the size of the organization," he tells *HPW*. The recent increased interest in audits, he adds, is more likely due to rising coverage costs than fear of the reform law's dependent provision.

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Beaten Up By Congress and the Public, Insurers Must Reshape Image, Impact Regs

Industry observers queried by *HPW* say health insurers have no one but themselves to blame for a poor public image, vilification by the media and the Obama administration, and a health reform law that could have a profoundly negative impact on their profits. But they agree it's still possible for the industry to repair its tattered image and influence regulations that will affect key provisions of the health reform law. The nation's five largest health plans allegedly are strategizing to do just that, by launching a new nonprofit entity funded with \$20 million.

"If you were to do sort of a roster of the winners and losers from the health reform debate, clearly the health insurance industry would be on the losing side," says Michael Franc, vice president of government relations at the Heritage Foundation, a conservative think tank based in Washington, D.C.

"Heretofore, health insurers haven't done the best job of communicating the value proposition they bring to the marketplace," says Henry Loubet, senior vice president and chief strategy officer at Keenan, a California-based health care consulting brokerage firm. "At the same time, that's a very challenging thing to do when the White House and administration decides [the health insurance industry] is the entity that is

responsible for most of the problems" in health care. Loubet is a former UnitedHealth Group executive.

Despite the managed care sector's battered public perception, approval ratings for Congress and the federal government are even worse, Franc notes. "That's an inherent advantage for any campaign that [health insurers] decide to mount. Trying to influence the decisions by one of the least popular institutions in our society right now means [insurers] have an advantage on the playing field." But there are a lot of players (e.g., public interest groups) on the field, and health insurers don't have a lot of running room. To succeed, they must figure out a way to get their voice heard above all others, he tells *HPW*.

Five Biggest Insurers Form Alliance

The nation's five largest health plans are "in serious discussions" about creating a new nonprofit group and funding it with a \$20 million war chest that would be used to "influence tight congressional races" and improve the industry's battered image, according to the Center for Public Integrity. Representatives from UnitedHealth, CIGNA Corp. and Aetna Inc. declined a request from *HPW* to comment on the alleged coalition. Spokes-

people from WellPoint, Inc. and Humana Inc. did not respond to the requests.

A campaign to influence the reform law's implementation could be effective if health insurers have a strong commitment and the financial resources to back it up, says Helen Darling, president of the National Business Group on Health. "But because the individual market has had a number of problems, and insurance companies have been so demonized, the industry will struggle to get the public to understand what is true and what is inaccurate and out of context," she tells *HPW*. "The industry will want to be as careful as possible and explain with trustworthy and reliable data what can be done to ensure an effective and efficient market."

Fred Karutz, general manager of health plan solutions at Silverlink Communications and a former executive with Blues plan operator Health Care Service Corp., says it's important that health insurers work to influence the regulations because they understand what works and what doesn't. The reform law, he adds, could undermine the existing system of employer-based coverage and could devastate the small-group market over the next five years. "I believe there is nothing wrong with insurance companies informing the debate," he tells *HPW*. Karutz suggests that insurers will work on strategies that will help them avoid adverse selection and encourage the vast majority of the population to purchase coverage through exchanges or directly from the carriers.

To change public perception and influence regulations, Franc says the industry must explain why their vision of regulation's implementation will be more advantageous to the public than the government's strategy. Health plans need to ask questions like, "who should be advising your doctor on best practices? Your health plan, which has access to millions of pieces of real data, or some bureaucrat?" he asks. Moreover, health insurers must explain why they have a financial stake in improving the quality of care that their members receive, he adds.

MLR, Exchanges Are Key Issues

Henry Aaron, Ph.D., a health policy expert at the Brookings Institute, says a well-funded war chest, if it exists, would be most effective if used to impact regulations related to health insurance exchanges, which are slated to be operational by 2014. "If I were planning how to spend a war chest, that is where I would put my chips," he tells *HPW*.

Carl Doty, vice president of enterprise strategy at customer relationship marketing agency Merkle, Inc., says he wouldn't be surprised if the largest health insurers have joined forces. He also agrees with Aaron that influencing the insurance exchanges would likely be a

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top priority for such a group. Rather than repealing elements of the law, he says the goal of the group is more likely to be ensuring that the implementation of the law is executed in a way in which all of the facts are on the table with regard to how the business of health insurance is done. Health insurers, he says, “need to provide complete transparency in what’s driving profits, medical cost trends, premium increases, etc.,” he tells *HPW*. Health plans also are concerned about the methodology that will be used to calculate medical loss ratio (MLR) floors, the structure and enforcement of the individual mandate and the definition of “minimum acceptable coverage.”

Loubet suggests that the industry focus on ways to improve the affordability of health coverage, which he says is missing from the health reform law. “It is incumbent upon [the insurance industry] to come up with solutions that are focused on affordability. To not come out with ideas and recommendations around affordability is not acceptable.”

AHIP Was ‘Hamstrung’ By Members

According to an Aug. 3 *Bloomberg* article, the alleged coalition of health insurers is debating whether to call for the ouster of Karen Ignagni, president and CEO of the America’s Health Insurance Plans (AHIP) trade group. The article cites unnamed sources.

But industry consultant Joe Paduda, a principal at Health Strategy Associates, LLC, says AHIP was “hamstrung by the colossal missteps” of its members during the health reform debate. He points to widely publicized rescissions, soaring profits among publicly traded companies and Anthem Blue Cross of California’s ill-timed rate hike for individual policies, which led to a congressional hearing just as the reform law was teetering toward failure (*HPW* 2/15/10, p. 1). “The industry is completely tone deaf, making Ignagni’s job damn near impossible,” he asserts.

Aaron agrees and says he doesn’t think health plans have anything to gain by replacing Ignagni. “She strikes me as an articulate and effective advocate.”

continued

MCO Stocks Rebound in July; Medicare, Medicaid Stocks Lead the Way

After a rocky June, most health plan stock prices bounced back in July, although prices for the sector are down an average of 0.6% since Jan. 1. Health plans with large percentages of Medicare and Medicaid business fared the best last month. While stock prices for commercial carriers were up an average of 4% in July, managed Medicaid company stock prices ticked up an average of 5.8%. On the Medicare side, HealthSpring, Inc.’s stock closed at \$18.80 on July 30 — up 21.2% from the last day of June. On July 29, the company credited membership gains and retention, as well as lower-than-expected utilization, for helping to boost its second-quarter earnings by 75% from the year-ago period. HealthSpring sells Medicare Advantage plans in seven states and has a national stand-alone Medicare Part D product.

	Closing Stock Price on 7/30/2010	July Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2010 EPS*	Consensus 2010 P/E Ratio*
COMMERCIAL					
Aetna Inc.	\$27.85	5.6%	(12.1%)	\$3.15	8.8 x
CIGNA Corp.	\$30.76	(1.0%)	(12.8%)	\$4.10	7.5 x
Coventry Health Care, Inc.	\$19.83	12.2%	(18.4%)	\$2.60	7.6 x
Health Net, Inc.	\$23.55	(3.4%)	1.1%	\$2.45	9.6 x
UnitedHealth Group	\$30.45	7.2%	(0.1%)	\$3.54	8.6 x
WellPoint, Inc.	\$50.72	3.7%	(13.0%)	\$6.29	8.1 x
Commercial Mean		4.0%	(9.2%)		8.4 x
MEDICARE					
HealthSpring, Inc.	\$18.80	21.2%	6.8%	\$2.95	6.4 x
Humana Inc.	\$47.02	3.0%	7.1%	\$5.71	8.2 x
Medicare Mean		12.1%	6.9%		7.3 x
MEDICAID					
AMERIGROUP Corp.	\$35.76	10.1%	32.6%	\$3.09	11.6 x
Centene Corp.	\$21.31	(0.9%)	0.7%	\$1.82	11.7 x
Molina Healthcare, Inc.	\$29.81	3.5%	30.3%	\$1.63	18.3 x
WellCare Health Plans, Inc.	\$25.79	8.6%	-29.8%	\$2.23	11.6 x
Medicaid Mean		5.3%	8.5%		13.3 x
Industry Mean		5.8%	(0.6%)		9.8x

* Estimates are based on analysts' consensus estimates for full-year 2010.

SOURCE: Bank of America Merrill Lynch. Compiled by Atlantic Information Services, Inc., August 2010.

AHIP spokesperson Robert Zirkelbach declined to comment on the *Bloomberg* article's reference to Ignagni. "I'm not going to waste my time responding to anonymous so-called 'sources.' We are focused on doing our part to control soaring medical costs and implementing the new reforms in a way that will minimize disruption for the 200 million people our members serve."

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Edward Jones Downgrades Three 'Unattractive' Health Plan Stocks

Investment firm Edward Jones on July 30 downgraded the stocks of three health insurers from "hold" to "sell," calling the companies "unattractive long-term investments" due in part to how health care reform will affect the market structure. But another equities analyst disagrees and tells *HPW* that such calls overestimate the negative impact that the reform law will have on health plan stocks.

Edward Jones separately downgraded Aetna Inc., UnitedHealth Group and WellPoint, Inc. and intends to drop coverage of all three firms as of Aug. 27. The investment firm concludes that changes in the market structure "brought on by [the reform law] will likely pressure profitability over the long term" and "will negatively impact future profit growth and more than offset the anticipated influx of newly insured members." The firm cites insurers as "the most exposed to the negative consequences of health care reform." While the health plans have varying business mixes, they likely will trade as a group, according to Edward Jones.

"We are probably early in this call," says Aaron Vaughn, an analyst in the St. Louis office of Edward Jones who drafted the reports. "But we're looking ahead to 2013, 2014." Vaughn tells *HPW*, "In the short term these stocks probably will do OK — but as long-term investments it just isn't attractive."

However, not all analysts agree with Vaughn's take on health reform's impact on insurers.

"I was a little surprised to see the downgrade at this point," says Matthew Coffina, an analyst in the Chicago office of Morningstar, Inc. Coffina tells *HPW*, "I didn't think [Edward Jones] had any insight we haven't had for a year."

Coffina considers companies such as UnitedHealth and WellPoint still to be strong investments, adding that the health care industry "is the most undervalued" sector at this point. He tells *HPW* that some investors and analysts are "overestimating the impact of health reform," as "the negatives have already been accounted for" in the companies' current stock prices. However, he adds, "Only time will tell."

Regardless, Vaughn maintains that investors should shy away from health insurers. He adds that there is little these insurers can do to improve their status. "They're in a difficult spot," Vaughn says, adding, "They don't control their own destinies in many ways."

Vaughn in the note cited several major factors for the downgrade. One is that health insurance exchanges — mandated in the health reform law — will result in lower profit margins. Another reason is that the risk for insurers increases if the individual mandate included in the reform law is not fully implemented. Additionally, "gaming the system," or only purchasing coverage when there is a medical need, raises health care costs, as seen in Massachusetts following the 2006 enactment of that state's health reform law. Finally, the high level of political and regulatory scrutiny does not show signs of abating.

Rather than investing in managed care companies, Edward Jones recommends other health industries, such as pharmaceutical companies, specifically Johnson & Johnson Services, Inc. and Abbott Laboratories, and pharmacy benefit management companies, namely Express Scripts, Inc. and Medco Health Solutions, Inc.

Contact Vaughn at (314) 515-5718 and Coffina at (312) 696-6864. ✧

Off-Label Cancer Drug Coverage Can Pose Challenge for Plans

When an FDA advisory committee recently voted to revoke the approval for a common use of a popular cancer therapy, projections were rampant that health plans could very likely stop reimbursing for the drug. However, even when it comes to high-cost cancer drugs, most payers do not make coverage decisions based solely on FDA approval. Nevertheless, having some kind of utilization management on these therapies can ensure that the drugs are used for medically necessary indications and therefore are more likely to produce better financial outcomes for plans and health outcomes for plan members.

At issue is the possible revocation of Genentech Inc.'s Avastin (bevacizumab) indication as a first-line therapy for a specific type of advanced breast cancer. The FDA also has approved the drug for colorectal, lung, brain and kidney cancer. But plans that spoke with *HPW* say they

reimburse for additional off-label uses of Avastin that are supported in medical literature and by professional oncology associations such as the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN).

CIGNA Corp., for instance, covers the drug in four additional uses, including for a form of age-related macular degeneration. In determining the plan's coverage policy, "we use an evidence-based process that looks at multiple sources of evidence," John Poniatowski, director of specialty pharmacy clinical programs, tells *HPW*. "Oncology in general is very dynamic, with many ongoing studies. We track studies and publications" as they come out, as well as monitor the FDA's actions, to make sure drug coverage is appropriate.

And appropriate coverage is particularly important not just in terms of patient outcomes but also health plan costs. Rashmi Wadehra, health care analyst at Datamonitor, tells *HPW* that the per-patient cost for Avastin as a first-line treatment for breast cancer is \$99,951.

Sean Karbowicz, Pharm.D., manager of clinical pharmacy for RegenceRx, the not-for-profit pharmacy benefit management program of The Regence Group, says that until earlier this year, the plan did not have any utilization management strategy on Avastin. However, when Regence saw Avastin use in "certain cancers despite having poor-quality evidence for effectiveness for those cancers" — in addition to some use "when better-value

treatments may have been options" — it placed prior authorization on the therapy, he says.

"Independently and ahead of the recent FDA advisory committee's recommendations on Avastin, we have been working to implement a coverage policy for Avastin that would only cover Avastin when it is a good treatment value for our members," Karbowicz tells *HPW*. He adds that "it is a challenge to implement these types of policies, however, because compendia and national guidelines (such as NCCN) do list Avastin as one of many options for several cancers, such as breast cancer."

Even if the FDA accepts the panel's recommendation and revokes Avastin's breast cancer approval, "I'm not sure we'd do anything from a claims denial" standpoint, Donna Paine, Pharm.D., clinical pharmacy specialist at Blue Cross & Blue Shield of Rhode Island, tells *HPW*. The plan is "more open" when it comes to coverage of cancer drugs, she says. "Oncologists can use most oncology drugs as they see appropriate."

According to Alan Rosenberg, M.D., WellPoint Inc.'s vice president of medical policy, if the FDA retracts the approval, WellPoint's medical policy and technology assessment committee will consider numerous sources of data, including "the rationale for the FDA's determination and the clinical information submitted to the FDA," as well as recommendations by "major professional groups such as ASCO and NCCN." He notes that "certain states have laws and/or regulations regarding

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benefit plan determinations for drugs based on inclusion in specific compendia, and any applicable state laws or regulations would also be followed.”

One point that sources agree on is if the FDA retracts the approval — which many industry insiders tell *HPW* is highly likely — health plans most certainly will face a coverage quandary.

“The question out there is if the FDA revokes the use of Avastin in breast cancer, and patients currently on it are receiving benefit from it, does a health plan require the physician to stop that therapy?” asks Joe Kasid, director of specialty trade operations for D2 Pharma Consulting, LLC. “This is an ethical as well as a critical question.”

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Audits Called ‘Established Practice’

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Jay Savan, an employee benefits consultant in the St. Louis office of Towers Watson, says eligibility audits are now less of a trend and more of a “newly established practice” for large employers. David Delahanty, a benefits consultant in Towers Watson’s Minneapolis office, agrees and says a typical audit of a large employer will determine that 6% to 10% of dependents are ineligible for coverage. However, he says children generally don’t incur high medical expenses, so dropping their coverage might only reduce medical spending by 1% to 3%. Smith places potential cost reduction a bit higher at 3% to 5%, and he says his firm typically identifies 8% to 14% of dependents as ineligible.

Given typical coverage costs for dependents and spouses, an employer can offset the cost of a dependent audit if just 1.5% to 2% of its dependents are determined to be ineligible, says Judy Felhaber, principal and national audit and reporting practice leader at Buck Consultants.

But dependent audits are labor intensive and might be worthwhile only for large employers that cover a significant number of dependents. Audits also can lead to public relations problems if employees consider it intrusive, Delahanty warns.

Strategies for identifying ineligible dependents range from occasional spot checks to companywide policies that require documentation for each dependent and spouse covered by a company’s health plan. Delahanty says about 20% of large employers now require some documentation for dependents.

Felhaber says employers are moving away from eligibility spot checks and instead are reviewing their entire dependent population. They also are increasingly adding verification requirements for newly enrolled dependents, and annual population samplings to “re-verify” dependents whose status might have changed. She says a majority of her clients now request documentation before dependents can be covered.

Asking employees to document eligibility of their dependents is critical, Smith says, adding that employers that opt not to go that route could be leaving 20% to 25% of the savings on the table.

To promote new verification rules, some employers are incorporating educational materials and “amnesty provisions” in most initial dependent verification reviews, Felhaber says. “This process encourages employee compliance by removing the fear of the discovery of an ineligible dependent [e.g., unintentional noncompliance] and promotes a sense of future shared responsibility between employee and employer.”

Rescission Provision May Affect Audits

Once a dependent is determined to be ineligible, some employers require workers to reimburse them for costs associated with the coverage. In some cases, an employer has made the cancellation retroactive, leaving the ineligible enrollee responsible for medical expenses already incurred. But a rescission provision of the reform law allows insurers to rescind coverage “only in the case of fraud or an intentional misrepresentation of a material fact.” For employers that follow a calendar year, the provision goes into effect on Jan. 1.

“The rescission rule makes it a lot harder to cut people off who might have improperly added someone to a plan,” says Angela Bohmann, an attorney who heads the compensation and employee benefits practice at the law firm Leonard, Street and Deinard in Minneapolis. “Unless you can show fraud, you are not allowed to drop someone retroactively who is making premium payments. And it can be hard to prove fraud. You have to show that someone intentionally misrepresented themselves...and that is difficult.”

And retroactive terminations can be an administrative nightmare for health insurers and third party administrators if it involves trying to recoup claim costs. “It’s like trying to unscramble an egg,” says David Ermer, an employee benefits attorney at the law firm Gordon & Ermer in Washington, D.C. But Smith says it’s rare for employers to request funds back from their workers. “Most employers want to remove ineligibles and continue eligibility verification activities to realize future savings by avoiding costly claims,” he says. Felhaber agrees and says the best cost-containment strategy “is

to prevent the payment in the first place." The ROI for dependent audits, she adds, typically comes from future cost-avoidance versus the collection of a financial penalty or retroactive claim expenditures from the employee.

Some Spouses See Surcharge

Delahanty says surcharges for spouses who have access to coverage through another employer typically range from \$50 to \$100 a month, and are becoming common among employers. And with good reason: Medical expenses for a spouse can be 10% to 30% higher than for an employee, he says. A medical condition, for example, might prevent a spouse from being employed. Smith says between 15% and 28% of employees' spouses — who are not charged an additional fee for coverage — have access to insurance through their own employer.

Bohmann says she has a few clients who either don't allow coverage for a spouse who has access to coverage through another employer or have required the spouse also to be covered under the spouse's employer's plan, making the client's coverage secondary for the spouse. "Employers don't want to pick up another employer's responsibility for providing coverage."

Savan says one client has a similar strategy. A spouse who has access to coverage through an employer must enroll in their employer's plan in order to be eligible for coverage as a spouse. "Given the way such coverage is coordinated, the spouse's employer's plan would pay first, followed by my client's plan, so the spouse is paying the same premium they would for primary coverage, but receiving what amounts to supplemental, or secondary, coverage."

To help ensure that only eligible spouses and dependents have coverage, Bohmann says employers are likely to "beef up" their enrollment forms with specific questions about a dependent's eligibility. Some will require documentation, such as birth certificates and marriage licenses.

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Economy, Reform Fears May Lead to Double-Digit Hikes

After several years of rate hikes in the high single digits, group health insurance renewal rates for the 2011 plan year are expected to increase an average of 11% for PPOs and 9% for HMOs, according to preliminary results from actuarial and consulting firm Milliman. The rate hikes exclude member demographics, plan-design changes and shifts in premium sharing between employer and employee. The complete version of Milliman's *2010 Group Health Insurance Survey*, based on a nationwide survey of health insurers, is expected in late October. Preliminary results were released Aug. 2.

While it's too early to determine the reason behind the expected rate increases, Doug Proebsting, a principal and consulting actuary at Milliman and coauthor of the report, says contributing factors likely include high unemployment and the unknown impact of the health reform law.

As the economy began to flounder in 2008, health insurers lost members on the group side. And some members — worried that they might lose their jobs and coverage — increased utilization.

"This could explain the trend increase," he tells *HPW*. Proebsting notes that for the past six years, the

rate-hike trend has been headed downward, although there have been "a few blips up."

"It's not a dramatic increase [for 2011], but the trend isn't headed down anymore," he says.

And premium increases are likely to continue if health care providers turn to commercial carriers to help offset growing Medicaid and Medicare populations. "Medicaid reimburses [providers] significantly below average, Medicare pays below average and commercial carriers pay above average, which brings everything back to about average," he says. To make up for the lower reimbursement rates from government payers, providers can either "become more efficient, or they could decide to just increase rates on the commercial side," he says. "Insurers are just the middleman, and their premiums reflect what they are being charged by providers and the fees that are negotiated."

Hospitals in some cities are profitable because they offset low Medicare reimbursements by charging significantly higher rates to commercial insurers, according to results of a Milliman study released in March (*HPW* 3/29/10, p. 8)

For more information about the preliminary results, visit www.milliman.com.

HEALTH PLAN BRIEFS

◆ **Medicare will remain solvent until 2029 — 12 years longer than earlier projections, the program's trustees predicted.** At an Aug. 5 press conference to discuss the report, HHS Sec. Kathleen Sebelius pointed to the health reform law for helping to "strengthen the solvency of the Medicare Trust fund." In 2009, Medicare provided coverage to 46.3 million people with total expenditures of \$509 billion (3.5% of the gross domestic product), and the average benefit per enrollee was \$11,743. Income for the program in 2009 was \$508 billion. The expenses in 2009 were slightly lower than estimated in last year's Trustee's Report. That report concluded that costs would account for 11% of the GDP within 75 years. In the new report, based on the cost-containment efforts of the health reform law, Medicare is projected to represent 6.4% percent of GDP in 2084, according to a prepared statement by CMS's newly appointed administrator Don Berwick, M.D. Berwick's comments are available on Medicare's home page, www.medicare.gov, under "What's New." CMS also posted a fact sheet on the Medicare Trustees Report that can be found at www.cms.gov/apps/media/press/factsheet.asp?Counter=3823.

◆ **Tufts Health Plan and the Massachusetts Division of Insurance have reached an agreement over Tufts' small business and individual premium rates.** On April 1, DOI disapproved 235 of 274 base rate changes filed by insurers, finding them to be "excessive and unreasonable" (HPW 6/14/10, p. 8). Following a five-month disagreement, Tufts said Aug. 2 that both parties agreed on rate increases, which range from 5.8% to 12.8% when compared with 2009 levels. The new rates are effective Sept. 1 for both small businesses and individuals renewing on or after April 1, according to the insurer. In June and July, DOI reached similar agreements with Harvard Pilgrim Health Care and Neighborhood Health Plan. Visit www.mass.gov or www.tuftshealthplan.com.

◆ **Missouri residents on Aug. 3 overwhelmingly voted in favor of a state measure that bars the federal government from requiring individuals to purchase health coverage and levying a fine against those who don't.** The referendum measure passed 71% to 29%. Voters in the state were the first in the country to vote directly on the individual mandate provision under the health reform law,

reported the *Washington Post*. More than 20 states, including Virginia and Florida, are suing HHS and the departments of Labor and Treasury challenging the constitutionality of the individual mandate provision (HPW 3/29/10, p. 5). Last week, a federal judge rejected the Obama administration's request to dismiss Virginia's case, allowing it to proceed. Arizona and Oklahoma have similar measures on the ballot in November. Visit www.mo.gov.

◆ **It's official: Ingenix, a subsidiary of United-Health Group that supplies clinical and cost management data and tools, has acquired Executive Health Resources Inc., a medical services firm.**

The transaction, which was valued by *Bloomberg Businessweek* at about \$1.5 billion (HPW 8/2/10, p. 8), is expected to close before the end of 2010. Terms of the deal were not disclosed. The companies said the deal will help them better manage medical necessity compliance requirements as hospitals and health systems serve a growing number of patients with Medicaid and Medicare. EHR has more than 1,100 hospital and health system clients. Visit www.ingenix.com.

◆ **Aetna Inc. said Aug. 1 that its Aetna Global Benefits (AGB) unit will offer two regional health plans (RHPs) for employers in the Middle East.** The two plans, RHP Lifestyle Plus and RHP Lifestyle, will offer different levels of coverage and benefits for expatriates living in that region, according to Aetna. In addition to covering hospital stays and outpatient treatment, the insurer said the two plans will offer access to AGB's international network of more than 750 medical providers, coverage of evacuation benefits and out-of-area coverage of accident and emergency treatment. The plans also offer optional benefits such as routine dental treatment, maternity services, chronic conditions and wellness programs. Visit www.aetnaglobalbenefits.com.

◆ **On Aug. 2, HSA Bank launched a "streamlined" website for individuals and small groups looking to enroll in a health savings account.** HSA Bank said it condensed the time it takes individuals to enroll in an HSA by cutting the online enrollment process to just four steps. The company added that the new website was designed to more closely resemble HSA Bank's informational website at www.hsabank.com. Visit www.hsabank.com/enrollonline.

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