

HEALTH PLAN WEEK

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

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Blood in the Water May Trigger Republican Frenzy to Shred Reform Law Provisions

The shift in leadership in the House — combined with Republican gubernatorial wins in at least six key states — could make it easier for health insurers to voice concerns about unappealing provisions of the health reform law, industry observers tell *HPW*. And although an outright repeal of the law will be virtually impossible for at least two years, House committee hearings, aggressive oversight of the law and conservative interpretations of guidance could hinder forward momentum.

Key House committees, such as Ways and Means, Commerce and possibly Appropriations, are expected to hold hearings on provisions of the law, and are likely to voice concern about the impact it will have on small employers and their ability to offer health coverage. Republican committee leaders are also more likely to listen to the concerns voiced by health insurers and their trade groups than were their Democratic colleagues.

And the change in leadership could give health insurers a new forum to highlight regulations that they consider to be harmful to their business model, their clients or enrollees. "Right now, there is a perception that HHS can come out with any regulation they want and not face any pushback," says former CMS Administrator Tom Scully, who is now with the law firm Alston & Bird. But some industry observers predict that the Democratic-led Senate might hold hearings of its own to highlight beneficial elements of the law.

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Some Insurers Are Already Paring Down Broker Commissions Due to MLR Reg

Insurance agents and brokers queried by *HPW* say some health insurers have already reduced commission rates for some product lines in anticipation of the medical loss ratio (MLR) regulation that goes into effect Jan. 1.

In a letter sent to brokers and agents in late October, Blues plan operator CareFirst BlueCross BlueShield said it would reduce commissions for small groups (two to 50 employees) by 15% beginning in 2011. CareFirst operates Blues plans in Maryland, Washington, D.C., and northern Virginia. The company alluded to the MLR rule as a reason for the reduction.

Coventry Health Plans of Delaware recently canceled all general-agent contracts effective Jan. 1, 2010, and reduced GA compensation on "in-force lives" for those GAs, according to a Maryland-based brokerage firm that asked not to be named. GA organizations work as wholesale distributors that recruit and train independent agents to sell products for insurance carriers.

Joel Wood, senior vice president of The Council of Insurance Agents & Brokers, says commissions — particularly for the small-group and individual markets — are going to be squeezed as a result of the reform law rule that requires insurers to maintain a medical loss ratio (MLR) of 80% for those products. He tells *HPW* that he has heard

anecdotal reports that confirm some health insurers have already reduced broker commissions.

"I know that there is more need for broker guidance than ever before," says Wood. "There is tremendous anxiety about the implementation of [the reform law], and brokers are playing more, not less, of a role in helping corporations secure coverage that best suits the needs of their employees."

Rick Bailey, an insurance agent based in Woodstock, Ga., says commissions for small-group policies in Georgia probably won't change much in 2011. But the individual market will be a different story because of the MLR requirement. Along with reducing commission rates, some insurers might look to cut operating costs by reducing the number of agents approved to sell their products. Or health insurers might opt to base commission rates on volume, which could prompt some agents to diversify or leave the market. "Low-volume producers will need to look at the possibilities of charging fees or packaging value-added services such as payroll...for a fee," he tells *HPW*. Bailey says his strategy for the next year is to build "an exceptional customer experience," which he hopes will help set his agency apart from competitors "if health insurance moves to being more of a commodity."

Over the summer, Russ Childers, an agent based in Americus, Ga., says carriers he works with mailed letters warning of potential commission cuts. Childers says about 40% of his agency's revenue comes from health insurance.

And although he hasn't received any formal notice, Wayne Sakamoto, president of Florida-based Health Insurance Interactive, Inc., says Blue Cross Blue Shield of Florida appears to have altered its small-group commission rates. He tells *HPW* that rates quoted for small-group plans with a December 2010 start date were higher than those that would go into effect Jan. 1, 2011.

George Pantos, executive director at the Healthcare Performance Management Institute, a health care research and education organization, says the reform law will force brokers and agents to diversify their products. "Brokers can replace commissions with revenue from essential health care performance management tools, like wellness programs, case management, disease management and proactive member engagement through social and other media," he says. "Services like these are all included in the definition of medical care according to the new medical loss ratio requirements."

NAIC Urges HHS to Consider Broker Role

Late last month, the National Association of Insurance Commissioners (NAIC) submitted its final MLR regulation recommendations to HHS. A cover letter, however, warned that the MLR rule — and its negative impact on commissions — could inadvertently diminish the role of brokers and agents.

A proposed amendment to the NAIC's MLR formula calls for agent commissions to be excluded from the MLR calculation, which means those costs wouldn't be categorized as either administrative expenses or medical care. Although the commission "pass-through" amendment had strong support from several state insurance commissioners, NAIC didn't vote for fear it might have prompted HHS to reject the association's entire recommendation, according to John Prible, vice president of federal government affairs at the Independent Insurance Agents and Brokers of America, Inc. HHS officials and NAIC staff had raised concerns about the legality of the measure, Prible explained during an Oct. 26 webinar sponsored by AIS. "We weren't surprised by the end result, but we were very disappointed," he told attendees. As an alternative, NAIC created an executive-level subgroup to work with HHS on the issue of agent commissions.

There is some indication that small health insurers that cater primarily to the individual market will be exempt from the minimum MLR requirement, according to C. Steven Tucker, president of Palatine, Ill.-based

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broker Small Business Insurance Services Inc. Tucker says that's the word from several small carriers that have had recent discussions with NAIC and HHS representatives. However, commissions on individual policies sold by large carriers that also cater to the small- and large-group markets are expected to be whittled down dramatically beginning Jan. 1. Tucker expects the rule will be made official before the end of the year. Once that happens, "broker/agents like myself, who have had their advance commissions cut in half since August, should be restored," he tells *HPW*. But the commission cuts have already prompted some brokers to leave the industry, he adds.

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AHIP Goes Through Post-Reform Restructuring: Adds, Cuts Staff

Seven months after President Obama enacted the health reform law, America's Health Insurance Plans (AHIP) is restructuring. Some former health plan executives and former AHIP staffers tell *HPW* that some large members have been disappointed with the result of the reform law. Moreover, they say the trade association is having a difficult time meeting the needs of its diverse membership.

The Hill reported Oct. 31 that the trade association had trimmed its staff of about 160 by 10%. AHIP acknowledges it has reduced staff, but says the cuts were strategic. In a memo sent to member executives Oct. 26, AHIP president and CEO Karen Ignagni noted that the organization was restructuring "to meet the advocacy and policy needs of a new era in health care."

While AHIP says some positions were eliminated, others were combined. Its federal and state advocacy departments are moving under one umbrella. The association says it is adding new positions and isn't scaling back its lobbying efforts.

AHIP has approximately 1,300 members that run the gamut from publicly traded *FORTUNE 500* behemoths such as UnitedHealth Group and WellPoint, Inc. (and their subsidiaries) to small regional insurers to long-term care and specialty insurers such as Aflac, Inc. Membership has increased since the reform law was enacted, AHIP says.

"When a trade association gets to be that all-encompassing, it becomes difficult to represent all of the members," one former AHIP employee, who asked not to be named, tells *HPW*. "There is always going to be tension

between what the large managed care companies want and what the niche insurers are looking for."

Members Were Disappointed

As lawmakers pushed health reform legislation forward in 2009 and early 2010, health insurers demonstrated unwavering support for AHIP's mission. But behind the scenes, cracks were forming, according to former AHIP and health plan executives who spoke to *HPW* on the condition of anonymity. Although the association helped to derail the public insurance option and ensured that an individual mandate was included in the law — two critical issues for the industry — there was a feeling among some health plan executives that AHIP didn't go far enough in addressing other key provisions.

"The for-profits didn't want to settle for any compromise. They had poured enough money into AHIP and its allies to get exactly what they wanted out of the legislation. ... In particular, they were not happy with the [small] penalty for the individual mandate," says Wendell Potter, who headed CIGNA Corp.'s communication department until turning against the industry during the reform debate.

He says he wonders about AHIP's long-term viability. Potter is now the senior fellow on health care at the Center for Media and Democracy and is one of 20 consumer representatives working with the National Association of Insurance Commissioners (NAIC).

In an April *Forbes* magazine article, CIGNA CEO David Cordani criticized AHIP on the outcome of the reform law and the vilification of the industry. One former executive with a publicly traded health insurer confirms to *HPW* that the five largest health insurers had discussions this summer about spinning off a separate lobbying group because AHIP wasn't seen as aggressive enough (*HPW 8/9/10, p. 1*).

But publicly, media staffers from those health plans were instructed to say only that their company supported AHIP's mission, according to one former media relations employee.

The medical loss ratio (MLR) regulation, which HHS is expected to issue any day, is now the single biggest issue for most health plans, says industry consultant Joseph Paduda, principal at Health Strategy Associates, LLC. Paduda says members have been disappointed in AHIP's influence on NAIC as it developed the formula. Potter adds that the industry "has been lobbying NAIC as heavily as it lobbied Congress."

AHIP Adds Two Key Execs

AHIP's lobbying muscle will be critical for the industry, especially as states begin to establish insurance exchanges and determine which health plans will be able

to participate. Paduda suggests the association is likely to shift from legislative lobbying to interactions with HHS and CMS to help influence the shape of reform-related regulations.

AHIP Adds Implementation Experts

While Ignagni's Oct. 26 memo didn't cite AHIP's staff reduction, it did highlight the addition of two new members. Joe Miller, an antitrust attorney who most recently served as assistant chief of the Dept. of Justice's litigation section, has served as AHIP's general counsel since August.

Ties to the DOJ could be helpful as the department continues to scrutinize provider-payer contracts and potential antitrust issues (*HPW 10/25/10, p. 1*). Daniel Durham, who will join AHIP Nov. 15 as executive vice president for policy and regulatory affairs, is vice president for policy at PhRMA. Durham's background also includes "high-level" experience within HHS — a background that could be beneficial to AHIP as HHS hammers out reform guidance.

"AHIP appears to be positioning itself as experts in the implementation of health care reform to show value to members," says a former communications head for a Blue Cross and Blue Shield plan, who adds that Durham's expertise is in implementation. That's "the next frontier, and one for which the states in particular have been clamoring for help."

Election Offers Some New Opportunities

Former UnitedHealth Group executive Henry Loubet says the implementation of the reform law could provide AHIP with "a new opportunity to forge some new alliances and new approaches to deal with the current turmoil around reform. Frankly, there is some silver lining in that regard," he tells *HPW*. Loubet is now senior vice president and chief strategy officer at Keenan, a California-based health care consulting and brokerage firm.

Fred Karutz, a former executive with Blues plan operator Health Care Service Corp., agrees that the future could be bright for AHIP. Karutz is now general manager of health plan solutions at Silverlink Communications. "The [Nov. 2] election has created a renewed opportunity to address the unintended consequences of reform and frame out solutions that will leverage what works today," he tells *HPW*.

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Repeal Talk Could Influence Dems

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While election results were still rolling in Nov. 2, presumptive House Speaker John Boehner (R-Ohio) reiterated his pledge to repeal the health reform law. Although the strong Republican majority in the House — combined with about a dozen fiscally conservative Democratic lawmakers — will be able to pass such legislation by an overwhelming majority, it will either die in the Senate or be vetoed by President Obama.

"But that will lob a grenade into the tent, so it's worth their effort from that perspective," says Scully. "They are going to beat that drum for two years....It's going to be very uncomfortable for Democrats."

Despite their majority in the Senate, Democratic members from conservative states who are up for re-election in 2012 — such as Nebraska's Ben Nelson — could be swayed to support substantial changes to the law, or repeal, if it continues to be unpopular with voters, he adds.

And repeals aren't unheard of in Washington. In 1988, Scully helped push through catastrophic health coverage legislation. Although that law had bipartisan support, and was far less ambitious than the Patient Protection and Affordable Care Act, it was repealed "in a tidal wave of emotion" in 1989, he recalls. "I don't see that happening yet, but Republicans are going to smell blood, and I think they are going to beat this up every day for the next two years. It will probably be the single biggest issue in President Obama's re-election campaign in 2012."

If efforts to repeal the law fail, the Republican-controlled House might try to pass amendments. That presents a much more interesting prospect because amendments — especially if they appear aimed at the cost and quality problems (i.e., provider, rather than insurer, issues) — may have a chance in both the Senate and in the administration, suggests Jack Rovner, an attorney and founding principal at the Chicago-based Health Law Consultancy. "But there has been little concrete from Republicans so far to suggest what they may propose as fixes for the cost, quality and access problems," he notes.

New Interpretations May Help Plans

Lawmakers probably can't alter the law's statutory requirements, but much of the language in the law is vague and open to interpretation, says Kim Monk, managing director at Capital Alpha Partners, LLC, a Washington, D.C.-based equities research firm. Regulations have been issued on several provisions such as grandfathering and dependent coverage to age 26. And HHS is expected to issue final regulations on medical loss ratios

(MLRs) any day. “All of that is subject to interpretation,” she tells *HPW*. House lawmakers, for example, might interpret the law as requiring HHS to certify NAIC’s MLR recommendations with no alterations, says Monk.

“And if the House feels that a reg is reaching too far, they could push back on that,” she says.

The health insurance industry could find itself in an awkward position, says Danielle Doane, director of government affairs at Heritage Action for America, the advocacy arm at The Heritage Foundation, a conservative think tank based in Washington, D.C. Although the industry was demonized by the administration and HHS, it was involved in the crafting of the reform law and agreed to some concessions opposed by Republicans. And some Democratic lawmakers agreed to provisions they didn’t like because they wanted support from health insurers. “They don’t have any real allies anymore.

The Republicans aren’t going to go to the mat for them, and Democrats sure won’t,” she says. Health insurers “should be thinking very creatively about how to reach out to this new majority in the House. They need to find some friends pretty quickly.” Doane says The Heritage Foundation’s top priority is to push for a full repeal of the reform law.

Reform Law Could See Tweaks

Here’s a look at several key health reform issues and how they might be influenced by a Republican-led House:

◆ *Spending and funding:* A more fiscally conservative House is likely to be most concerned with the cost of federal entitlement programs. That could mean that some reform law provisions — such as the expansion of Medicaid and federal subsidies for individual coverage

Medicare Rate Cuts Didn’t Spook Humana, HealthSpring Investors in October

With the exception of two health insurers that have significant stakes in Medicare Advantage (MA), some investors seemed frightened to invest in the sector, despite lower-than-expected medical costs. HealthSpring, Inc.’s stock price, which jumped 13% in October, is up a staggering 65.8% since the beginning of the year. As of Sept. 30, 2010, the company had 198,055 MA enrollees — up 6.1% from the same date a year ago. Enrollment in its standalone Medicare Part D products was 409,239 on Sept. 30, 2010 — up 30.7% from the end of 2009’s third quarter. As of Sept. 30, 2010, Humana Inc.’s MA plans covered more than 1.7 million people — up 250,000 (17%) from the same date last year, according to the company’s third-quarter earnings (see *Financial News*, p. 7). On the commercial side, Humana had 3.1 million enrollees as of Sept. 30 — down 296,000 (9%) from the same date a year ago.

	Closing Stock Price on 10/29/2010	October Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2010 EPS*	Consensus 2010 P/E Ratio*
COMMERCIAL					
Aetna Inc.	\$29.86	(5.5%)	(5.8%)	\$3.21	9.3x
CIGNA Corp.	\$35.16	(1.7%)	(0.3%)	\$4.42	8.0x
Coventry Health Care, Inc.	\$23.42	8.8%	(3.6%)	\$2.84	8.2x
Health Net, Inc.	\$26.89	(1.1%)	15.5%	\$2.55	10.5x
UnitedHealth Group	\$36.05	2.7%	18.3%	\$3.96	9.1x
WellPoint, Inc.	\$54.34	(4.1%)	(6.8%)	\$6.39	8.5x
Commercial Mean		(0.2%)	2.9%		8.9x
MEDICARE					
HealthSpring, Inc.	\$29.19	13.0%	65.8%	\$3.17	9.2x
Humana Inc.	\$58.29	16.0%	32.8%	\$6.42	9.1x
Medicare Mean		14.5%	49.3%		9.1x
MEDICAID					
AMERIGROUP Corp.	\$41.73	(1.7%)	54.8%	\$3.64	11.5x
Centene Corp.	\$22.32	(5.4%)	5.4%	\$1.81	12.3x
Molina Healthcare, Inc.	\$25.92	(4.0%)	13.3%	\$1.85	14.0x
WellCare Health Plans, Inc.	\$27.78	(4.1%)	(24.4%)	\$2.32	12.0x
Medicaid Mean		(3.8%)	12.3%		12.4x
Industry Mean		1.1%	13.7%		10.1x

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

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

— will be under scrutiny. “Those are the [provisions] that are most at risk,” according to John Hickman, an employee benefits attorney at Alston & Bird. And much of the funding for those programs will come from the excise tax on the insurance industry and a tax on so-called Cadillac health plans. But those provisions don’t kick in until 2018. “So there is a period of years where the outlays exceed the balancing revenue.” Hickman offered his perspective on the election during a Nov. 3 AIS webinar on health reform compliance challenges.

Discretionary spending could also be targeted. The reform law allocates at least \$115 billion in discretionary spending, which could be targeted by Republican lawmakers, adds Monk. The Congressional Budget Office, for example, has estimated that regulatory agencies will need upwards of \$20 billion to implement the law over the next decade. HHS intends to hire 600 new employees for a division that will help regulate private insurers, help build state insurance exchanges and set rates. IRS will need at least \$5 billion over the next 10 years to enforce the individual mandate once it goes into effect in 2014. Moreover, HHS now has authority to issue virtually unlimited grants to states to help them build their insurance exchanges. The House could block such funding through the appropriations process. “Not only can they hamstring HHS and Treasury, but they also can hamper federal dollars intended for the states,” she adds. But if that’s the approach they take, it means more uncertainty for the health care industry over the next two years. “And that’s devastating to this industry,” adds Winifred Hayes, Ph.D., CEO and founder of health technology evaluation firm Hayes, Inc., based in Lansdale, Pa.

◆ **Influence from the states:** Former HCA CEO Rick Scott, who will be sworn in as Florida’s governor in January, has been “an outspoken proponent of free markets and for-profit health care...and will likely support policy that allows for private-sector partnerships with government programs,” Credit Suisse equities analyst Charles Boorady wrote in a Nov. 3 note to investors. In state attorney general races, several Republican candidates ran on the platform that they would contest the constitutionality of some reform law provisions, says Hickman. State lawsuits might be filed to challenge the individual mandate and the expansion of the Medicaid program, Monk predicts. “And if the individual mandate is determined to be unconstitutional, other parts of the law could crumble.” Such a suit, she notes, could mean years of litigation and appeals that could go all the way to the Supreme Court. Carlton Doty, vice president of enterprise strategy at Merkle, Inc., predicts there will be more “realistic oversight and less anti-insurance rhetoric” at the state level. “The real story, however, doesn’t lie in the premium controls, it lies in how specific reform provisions will be implemented in state markets,” he explains. State regulators, AGs and governors will be able to influence the direction of insurance exchanges, high-risk pools, multistate health care choice compacts and the potential merger of the individual and small group markets, he adds.

◆ **Accountable care organizations:** At a recent meeting on ACOs, Hayes says there was an enormous amount of angst among providers who were in attendance. Providers expressed concern that assuming too much risk will be detrimental, and agreed that the shared savings

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wouldn't be effective at driving down costs or improving quality because the fee-for-service model offers too powerful of a financial incentive to maintain the status quo, Hayes says. "And most physician practices aren't prepared to assume risk...and state regulators aren't set up to oversee risk-bearing ACOs," she adds.

◆ **Medicare Advantage:** House leaders likely will push back on the cuts to MA plans slated for 2012, particularly if they prompt some health plans to leave certain markets, drop benefits or boost copayments, Monk predicts.

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FINANCIAL NEWS

◆ **WellPoint, Inc. on Nov. 3 reported net income of \$739.1 million (\$1.84 per share), up from \$730.2 million (\$1.53 per share) in the third quarter of 2009.** Revenue dropped 5.7% from the year-ago period to \$14.33 billion. The earnings results beat analyst earnings consensus of \$1.57. WellPoint said its medical enrollment as of Sept. 30 was 33.5 million, down 1.1% (382,000 members) from the same date a year ago. The decline occurred in the company's non-Blues business, which fell by nearly 600,000 members, primarily due to its decision to transfer its UniCare individual and group business in Texas and Illinois to another carrier. The decline in non-Blues enrollment was partially offset by growth of 76,000 members in Blue-branded commercial products, an increase of 66,000 members in the Federal Employee Program and growth of 35,000 and 31,000 members, respectively, in state-sponsored and senior businesses. WellPoint raised full-year net income per share guidance to at least \$6.45.

◆ **On Nov. 3, Aetna Inc. reported third-quarter net income of \$497.6 million (\$1.19 per share), up 53% from \$326.2 million (73 cents per share) in the same quarter of 2009.** The company cited lower utilization costs as part of the reason for the improvement. Analysts had anticipated earnings of 68 cents per share. Medical membership totaled 18.5 million members on Sept. 30, 2010, down 74,000 members from the previous quarter. Declining membership was partially offset by premium rate increases. The company boosted its projected full-year 2010 earnings to \$3.60 a share. In a note to investors, Citi Investment Research & Analysis equities analyst Carl McDonald predicted that Aetna's earnings will drop in 2011 to \$3.05 per share. He suggested that Medicaid seems like a logical area of expansion for the company, but said it would likely need to grow that segment through an acquisition "to make Med-

icaid anything more than an afterthought to the company's overall earnings."

◆ **Managed Medicare and Medicaid plan operator WellCare, Inc. on Nov. 4 reported third-quarter net income of \$37.9 million (89 cents per share), up from \$34.7 million (82 cents per share) for the third quarter of 2009.** The earnings exceeded analysts' expectations by 24 cents per share. WellCare reported that total medical expenses were down nearly 20% from the year-ago period. The company also increased its full-year 2010 guidance to a range of \$2.30 to \$2.35 from a previous range of between \$2.05 and \$2.20. Total enrollment as of Sept. 30, 2010, was 2.2 million — down 5.6% from 2.3 million on the same date a year ago. Enrollment in the Medicaid segment grew by 6,000 to 1.3 million as of September 30, 2010, largely due to growth in the Georgia Medicaid program, the company said. Medicare Advantage (MA) enrollment decreased by 124,000 members primarily due to the company's withdrawal from the Medicare Private Fee-for-Service business.

◆ **Lower-than-expected medical claims costs — combined with increased enrollment in its Medicare Advantage (MA) business — helped Humana Inc. post a 30% jump in third-quarter earnings.**

For the period that ended Sept. 30, Humana reported net income of \$393.2 million (\$2.32 per share) — up from \$301.5 million (\$1.78 per share) in the year-ago period. The company had previously projected earnings of between \$1.65 and \$1.75 per share, and the consensus among Wall Street analysts was \$1.66 per share. Revenue increased 9% to \$8.42 billion. The results, posted Nov. 1, also prompted the company to raise its full-year earnings guidance to a range of between \$6.40 and \$6.50, from its earlier projection of \$5.65 to \$5.75.

HEALTH PLAN BRIEFS

◆ **Thomas Sullivan on Nov. 1 resigned from his post as Connecticut insurance commissioner, effective Nov. 12.** The commissioner was criticized by both HHS and Connecticut Attorney General Richard Blumenthal (D) for approving rate hikes by Anthem Blue Cross and Blue Shield of up to 47% for individual products (*HPW 10/25/10, p. 8*). Before resigning, Sullivan followed through on his Oct. 22 pledge to hold a public hearing on Anthem's 2011 rate filing. The hearing, scheduled for Nov. 17, will consider whether the proposed premium increases for Anthem's grandfathered individual products are "excessive, inadequate or unfairly discriminatory." The rate hikes would take effect Jan. 1, 2011. Visit www.ct.gov/cid.

◆ **CareFirst BlueCross BlueShield said Nov. 4 that, beginning immediately, it will let nurse practitioners (NPs) participate in its provider networks as independent primary care providers.** Previously CareFirst permitted NPs to participate in its networks independently of physicians only in certain areas with limited access to primary care physicians. Under CareFirst's revised policy, NPs may enroll in its provider networks to serve as independent primary care providers throughout the company's Maryland, northern Virginia and District of Columbia service area. NPs must attest that they have a written collaborative agreement with a physician of the same specialty who is a member in good standing of the same provider networks as the NP. Contact Kevin Kane at kevin.kane@carefirst.com.

◆ **Ninety percent of employees who receive health benefits from their employers say those benefits are as important as their salary,** according to the recent *Mercer Workplace Survey*. Of the 1,502 survey participants, 83% said their out-of-pocket expenses are probably or definitely worth it, compared with 73% in 2008, said Mercer. But the health care reform law was greeted with deep skepticism. According to the survey, 17% said they expect to be better off as a result of health reform, while 60% expect to be worse off in terms of the taxes they will have to pay, and 42% expect to be worse off overall. To view the survey, visit www.mercer.com/articles/workplace-survey2010.

◆ **Blue Cross and Blue Shield of North Carolina launched Blue Advantage Saver, a low-cost health plan for coverage effective Jan. 1.** Blue Advantage

Saver, which has three plan designs, covers preventive care at 100% with no cost sharing, according to the Blues plan. BCBSNC added that cost sharing varies by plan. For example, in one benefit design, a member would have a \$25 copayment for unlimited nonpreventive visits to a medical provider. Another design has no limit on visits, but each visit is subject to a deductible and coinsurance. ER and urgent care services and visits to a specialist are also subject to a deductible and coinsurance. Visit www.bcbsnc.com.

◆ **About one-third of chief financial officers and senior comptrollers said they plan to reduce health care benefits in 2011,** a new survey by Grant Thornton International found. When asked what their greatest pricing pressure is, 84% cited employee benefits such as health care and pensions, compared with 68% earlier in the year, according to the survey. Grant Thornton also found that 30% of respondents said they would decrease average health benefits costs per employee, 49% replied they would remain the same, and 21% predicted an increase. Visit www.grantthornton.com.

◆ **The National Committee for Quality Assurance on Nov. 2 released its 2010 list of "best health plans" for Medicare and Medicaid beneficiaries.** The rankings are based on clinical quality, member satisfaction and NCQA accreditation scores. Out of 183 Medicare health plans, NCQA's top five are Capital Health Plan, Kaiser Foundation Health Plan of Colorado, Fallon Community Health Plan, Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Health Plan of Southern California. Of the 104 Medicaid plans that NCQA scored, its top five picks are Fallon Community Health Plan, Kaiser Foundation Health Plan of Hawaii, Neighborhood Health Plan, Boston Medical Center HealthNet Plan and Network Health. For a complete list of NCQA's rankings, visit www.ncqa.org/tabid/1268/Default.aspx.

◆ **UnitedHealth Group said its board of directors on Nov. 2 authorized a quarterly dividend of 12.5 cents per common share.** The dividend, United said, will be paid on Dec. 21, 2010, to all shareholders of record on Dec. 7, 2010. United's shares closed at \$36.66 on Nov. 3. Visit www.unitedhealthgroup.com.

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