

HEALTH PLAN WEEK

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

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Managing Editor

Steve Davis
sdavis@aishealth.com

Contributing Editors

Angela Maas
Chris Silva

Associate Editor

BJ Taylor

Executive Editor

Jill Brown

Uncertainty, Compliance Keep Plans From Influencing, Preparing for Reforming World

On March 23, one year will have passed since the enactment of the health reform law (*HPW* 3/29/10, p. 1). While employers and insurers are already complying with several parts of the law, the most significant, industry-altering provisions don't go into effect until 2014 and 2018. But some industry observers contend the insurance industry isn't devoting nearly enough energy to shaping the forthcoming rules, or in preparing for the rapidly changing market.

The insurance lobby has had "modest" success so far in influencing the rules that will govern their members, says Henry Loubet, vice president and chief strategy officer at Keenan, a California-based consulting and insurance brokerage firm. He points to the medical loss ratio (MLR) guidance as an example, which he says "went through with little change." Loubet is a former CEO of UnitedHealth Group's western region.

Yet-to-be-written rules that will establish state insurance exchanges and minimum essential benefits packages, for example, "will dramatically alter the insurance market forever," says Shawn Nowicki, director of health policy at the Northeast Business Group on Health.

But the industry appears to be sitting on its hands. Rather than waiting for regulations to be finalized, health insurers need to be proactive in working with state and federal regulators.

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Help Lines, Case Managers Can Reduce Utilization and Supplement Office Visits

Not long after her husband was diagnosed with brain cancer, "Shelly" received a phone call from a case manager who specialized in oncology. Along with offering detailed information about treatment options, potential drug interactions, likely side effects and applicable studies, the regular telephone calls offered emotional support. Frank, a case manager at OptumHealth, spoke with Shelly at least every other week, but was always available to research questions she didn't think to ask the doctor. Shelly, a flight attendant who left nursing 15 years ago, says she was amazed at the level of information she received from her husband's case manager, such as how certain foods might alter the effects of a drug...something the oncologist never mentioned.

For health insurers, telephone-based case managers and 24-hour nurse help lines can direct members to appropriate providers, reduce unnecessary trips to the emergency room and supplement doctor visits. Health plans rely on claims data and other triggers to identify members who might benefit from case management. Some calls to nurse help lines lead to longer-term case management.

In this issue of *HPW*, we profile telephone-based care programs offered by UnitedHealth Group's OptumHealth subsidiary, Aetna Inc., CIGNA Corp. and Humana Inc. (see sidebar, p. 3).

Nurses who staff help lines don't diagnose the patient, but rather help determine a course of action based on their symptoms and clinical guidelines, says Christine Crowe,

director of specialty case management at CIGNA. "It's not meant to be a deterrent. Sometimes our nurses are the ones who call the ambulance or talk someone into going to the hospital who would otherwise stay home."

Along with helping members understand a diagnosis or treatment regimen, telephone-based case managers might also explain a member's coverage, identify network providers or offer directions to the nearest urgent care facility for a member on vacation. Some case managers help patients come up with a list of questions to bring to a doctor visit.

"Sometimes members need help in processing all of the information that they get from their physician," explains Susan Kosman, Aetna's chief nursing officer. Case managers are trained to help chronically ill patients understand how to manage their disease and become more engaged, she adds. Aetna employs more than 3,000 nurses who either work out of one of Aetna's offices or out of their home.

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Physicians and other caregivers in a hospital or medical office often don't have time to do anything more than diagnose a patient and prescribe a treatment. Telephone-based case managers, by contrast, do have the luxury of time to, for example, to explain how a medication works and the importance of compliance, adds Crowe.

OptumHealth Touts 2-to-1 ROI

OptumHealth, which makes its programs available to other carriers, says its customers typically see a 2-to-1 return on investment (ROI). The company uses a "monetized-engagement" model to measure savings from its inbound call program. The methodology measures medical cost savings from avoided utilization of hospitals, emergency rooms, urgent care and doctors.

"The cost savings might come from talking with someone about their treatment options before they engage the health care system, and in 'closing gaps' based on evidence-based medicine," explains Matt McDonough, senior director of health care decision support. "The other piece of this is the savings associated with workplace productivity. People who get the right care at the right time, for example, aren't sitting in an ER late at night and skipping work the next day." OptumHealth has about 300 nurses nationwide split between nine regions.

OptumHealth's NurseLine nurses typically conclude their calls by asking the member about their intended path of treatment prior to the call, and whether the call changed that. To determine the value of the call, OptumHealth compares the member's pre-intent to claims data. A monetary value is assigned if a member, for example, went to an urgent care facility rather than to an ER, McDonough explains, adding that sometimes the savings are longer term. A member who intended to stay home might head to the ER on the nurse's recommendation, for example.

Consider this example based on 840 members who called into OptumHealth's NurseLine:

- ◆ **About 420 calls** were triage-related (e.g., in need of guidance, referral and clinical expertise).
- ◆ **113 members** were appropriately guided to a form of care available for their condition that was less expensive than their initial course of action.
- ◆ **53 members** avoided an unnecessary ER visit, and 37 of them chose a lower level of care, such as an urgent care facility.

But sometimes the savings aren't as tangible. Early this month, a diabetic member contacted Aetna's 24-hour nurse help line with questions about mixing different types of insulin. After the nurse explained that mixing the drugs could be fatal, the member admitted suicide was the intent. While continuing the conversation, the

fast-thinking nurse had a colleague call 911. As she continued the conversation, she convinced the member to accept the help that was about to arrive, and connected the member to needed services, explains Kosman.

Specialization Is Critical in Case Management

About 200 of CIGNA's nearly 600 medical case managers fall into one of four specialty areas: oncology, maternity, neonatal and transplant, which became the insurer's first specialty case-management program 10 years ago.

Advancements in medical technology made it possible for case managers to help reduce hospital stays among transplant patients, Crowe says. "In the past, there were types of infusion you wouldn't have considered doing outside of a hospital, but specialized pumps and ease of administration allow patients to take care of themselves at home," she explains. "As medical technology has evolved, case management has kept pace or stayed ahead of it."

McDonough agrees that nurses who specialize in complex medical conditions are a key component of case management. OptumHealth has about 300 nurses na-

tionwide split between nine operational sites. The nurses must complete a "rigorous and continuous" training program to ensure they are up to speed on the latest clinical guidelines. McDonough says he and his team regularly monitor calls to ensure quality standards.

Employers Help Promote Programs

As employers have become more focused on improving the health of their workers, health plans are expanding the number of case managers and health coaches devoted to wellness. They might, for example, help a member set and achieve weight-loss goals. A health risk assessment conducted at the worksite might prompt a call from a case manager or coach, Kosman says. "A high [body mass index], for example, could trigger a call, or the risk assessment might identify a person as a smoker who wants to quit," she explains. "Any employer that has a wellness program likely would want an employee with a [body mass index] over 30 to have a case manager reach out to them."

But there is little ROI if members don't know about case managers or 24-hour nurse lines. Open-enrollment times, for example, can be a good opportunity to high-

Humana Partners With Intel on Video-Based Pilot for Heart Patients

A telehealth pilot program launched last month by Humana Cares will take telephone-based case management to the next level by adding a video-monitoring feature that allows nurses to see and interact with 2,000 congestive heart failure patients. The 16-to-18-month pilot, which uses Intel's Health Guide technology, also lets nurses remotely monitor patients' heart rate, blood pressure and other key vital signs. Humana Cares is a division launched by Humana Inc. two years ago. The concept is to use a holistic approach to care that combines telephonic with on-site management to support the patient, spouse, family and caregiver.

Patients who participate in the pilot will take part in a three-minute daily session with a case manager who will ask a few questions about their care compliance, explains Kate Marcus, a process manager for Humana Cares who is overseeing the project. Patients also will be asked to weigh themselves and check various vitals, which the care manager will monitor in real time. Marcus says the technology offers quick responses to potential problems. *Case in point:* Recently, a nurse asked a patient about a sudden weight increase since fluid retention can exacerbate congestive heart failure. The patient explained he had run

out of a medication and the pharmacy refused to refill it early. The nurse was able to have the prescription filled immediately. "The next day, the weight began to come down," Marcus tells *HPW*. The majority of participants are enrolled in a Medicare Advantage plan, although some participants have commercial coverage.

The touch-screen videoconferencing unit — about the size of a toaster — gives nurses the ability to spot subtle changes in a patient's condition based on facial expressions, skin color or breathing. It also provides the member with a deeper connection to the nurse. And the unit includes modules that patients can play to learn more about a condition.

The customizable technology can be used to monitor patients with a variety of conditions. A glucometer, for example, could be added to remotely monitor diabetic patients.

Marcus says the technology will be especially helpful to rural patients who might be several hours away from the nearest hospital. She expects the pilot will help keep participants out of the hospital and give them more control over their health.

Contact Mitch Lubitz for Marcus at mlubitz@humana.com.

light those features. CIGNA says some of its employer clients include information about the services in their employees' paychecks. But the communication needs to be ongoing. A female employee, for example, probably won't pay attention to information about maternity case management until she becomes pregnant, says Crowe.

Beyond working with a case manager, pregnant CIGNA members who enroll in the text4baby service receive regular text messages about care based on the expected due date. text4baby is a program of the National Healthy Mothers, Healthy Babies Coalition. CIGNA promotes the program through its Healthy Pregnancies, Healthy Babies programs as well as through its nurse line. After the baby arrives, mothers can receive ongoing messages related to immunizations and well-baby checkups.

Going beyond its nurse help lines, Aetna last month made TelaDoc, Inc. available to members in most of its fully insured plans in Texas and Florida. Dallas-based TelaDoc connects patients to a nationwide network of licensed, board-certified primary care physicians for non-urgent care telephone consultations. The company boasts more than 3 million members. Members typically pay \$38 or less for each consultation depending on the health plan. Copayments, deductibles and coinsurance apply. A summary of each consultation is captured in an electronic health record (EHR), which the member can share with a primary care physician, according to Aetna.

Contact Molly McMillen for McDonough at molly.mcmillen@optumhealth.com, Mark Slitt for Crowe at mark.slitt@cigna.com and Ethan Slavin for Kosman at slavine@aetna.com. ✧

Blue Shield of California Backs Down From 'Reasonable' Rate Hike

In a surprising move, Blue Shield of California backed away from proposed rate increases for its individual products, despite an independent actuary's recent assessment that the increases were justified. The announcement is more evidence that state regulators, combined with bad publicity, are putting pressure health insurers to keep rate hikes to a minimum.

In a March 17 note to investors, Credit-Suisse equities analyst Charles Boorady said the decision isn't likely to have much of an impact on other large insurers, such as Health Net, Inc., WellPoint, Inc. and UnitedHealth Group that have a stake in California. Those companies, he notes, have phased in rate increases "more gradually." Pointing to California's elected Democratic insurance commissioner, Boorady also suggested that the decision could have been the result of political pressure to "cover up" the impact the reform law is having on premiums in the individual market.

The Blue Shield of California (BSC) rate hikes, which were slated to go into effect May 1, would have been the third increase since October. For some policy holders, the latest rate hike would have collectively pushed premiums up as much as 87%, and on average, the third increase would have increased rates by another 6.5%.

In a prepared statement March 16, BSC chairman and CEO Bruce Bodaken said the company would not increase rates for the remainder of the year. That announcement came on the heels of a March 12 statement in which the company apologized to members for the upcoming rate increases but explained that they were necessary due to medical expenses that far exceeded premiums collected for some policies. The company said it lost \$27 million on individual policies in 2010 and, despite rate hikes, expected to lose money again this year.

"By agreeing not to raise rates this year, we are helping to make coverage more affordable for our members during tough economic times. It's a financial risk for us, but a risk that's worth taking," Bodaken said March 16.

California Insurance Commissioner Dave Jones (D) said he was pleased by the company's decision.

As of Dec. 31, 2010, the insurer's individual policies covered 338,241 lives, nearly 12% of its total membership, according to the recently published *AIS's Directory of Health Plans: 2011*.

Rate Hike Is Called 'Reasonable'

On Jan. 6 — just three days after being sworn into office — Jones asked Blue Shield of California to delay its proposed rate hikes for the individual market by 60 days beyond the March 1 effective date. Under California law, the insurance commissioner does not have the authority to reject hike proposals.

The company initially refused Jones' delay request, but later agreed to it and hired an outside actuary to determine if the proposed rate increases were justified. On March 1, the company said the review confirmed that the proposed rates were "reasonable" and met the medical loss ratio requirements of state and federal law.

Jones also asked WellPoint's California unit, Anthem Blue Cross, to delay its rate increase by 60 days, with which the company complied. In December, the insurer filed for a 9.8% increase on individual policies, effective April 1.

Insurers in other states are seeing similar pressure. Last month, the Michigan insurance commissioner allowed Blue Cross Blue Shield of Michigan to boost its rates by 7% for group-conversion products and 9% for individual plans. The new rates go into effect April 1. The insurer says it filed for rates that were far below what it needed and that it continues to lose "tens of millions" of dollars on its individual products.

Read Jones' statement at www.insurance.ca.gov/0400-news/0100-press-releases/2011/release-040-11.cfm. Read Bodaken's statement at www.blueshieldca.com/bsc/newsroom/pr/ratewithdrawal_031611.jhtml. Contact BSC's Johnny Wong at johnny.wong@blueshieldca.com. ✧

Under Fire from Massachusetts' AG, Insurers Re-think Board Payouts

The number of Massachusetts insurers stating they will re-examine how their board members are compensated is growing after Attorney General Martha Coakley (D) publicly lambasted Blue Cross Blue Shield of Massachusetts (BCBSMA) for its practices in the area.

Harvard Pilgrim Health Care and Tufts Health Plan have confirmed to *HPW* that they are evaluating their respective policies on compensation for board members. This follows a March 8 statement from the Massachusetts Blues plan that it has "voluntarily agreed to immediately and indefinitely suspend the fees" paid to the company's board members.

Despite contentions from some insurers that they need to be able to attract top talent, some analysts say the board members should feel distinguished enough by simply overseeing health care plans for consumers.

"Will BCBSMA have difficulty recruiting for new board members if compensation is not available or if honorariums are modest? The honor and privilege of being a board member at BCBSMA should be sufficient, given the present day and its many challenges," says Bill TenHoor, president of TenHoor and Associates, a strategic planning and market analysis firm based in Duxbury, Mass.

BCBSMA issued the statement after Coakley excoriated the company for payments to directors that ranged from \$10,000 to \$84,463, according to documents filed with the state Division of Insurance. Coakley also took issue with an \$11 million payout to former CEO Cleve Killingsworth.

"The compensation of board members at public charities is extraordinarily rare in Massachusetts, and for good reason," Coakley said in a March 8 statement. "As part of our ongoing investigation into director compensation, we had asked the boards of the non-profit health insurers to justify the basis by which they are compensated, and have not been satisfied by those responses. In addition, we are continuing our review into the compensation and separation agreement of the former Blue Cross CEO."

The Massachusetts Blues plan said it accepts full responsibility for the payout to Killingsworth, and noted

that compensation to current CEO Andrew Dreyfus is significantly reduced to \$800,000.

But BCBSMA also took the opportunity to hint at a possible change in operating status if it continues to receive scrutiny in its role as a not-for-profit.

"Our classification as a public charity creates expectations that we will operate like museums, universities and human service organizations," the insurer said in a prepared statement. "Unlike those groups, we do not solicit or receive donations or government grants, and we pay significant local, state and federal taxes. We believe it would be much healthier to have an environment where our expectations are clear to everyone — to government officials, to the community, and to us."

Policies Are Being Reviewed

Harvard Pilgrim sang a similar tune in a statement provided to *HPW*. "Unlike other nonprofit organizations operating in Massachusetts only, Harvard Pilgrim must address a significantly greater number of complex federal and state laws in its various states of operation," the insurer said, noting that it also serves members in New Hampshire and Maine. "Our directors actively participate in the operation of a \$3 billion business and we rely on them to apply their specialized experience and skills in the areas of law, accounting, finance and medicine, to support our company and its mission."

Payments made to Harvard Pilgrim board members ranged from \$21,900 to \$68,100. The company said its current practice is to pay directors an annual stipend of \$12,500. Additional payments are made if a member participates in other duties beyond the board's scope, such as working on various committees or attending meetings.

"In 12 years, Harvard Pilgrim went from the brink of insolvency to the standard by which every health plan in the country is measured. Every step of the way our board of directors reviewed every major action we have taken," the company told *HPW*.

Nonetheless, the insurer said it, too, is evaluating its policy for compensating its board of directors.

Tufts Health Plan confirmed that it is also reviewing its compensation policies. While the insurer declined to comment further on the matter, it did confirm a report in *The Boston Globe* that board member Thomas P. O'Neill III asked Tufts CEO James Roosevelt Jr. to give fees he hasn't received yet this year to Boston Health Care for the Homeless.

Payments to Tufts board members ranged from \$19,500 to \$82,500. O'Neill, who is chief executive of Boston public affairs firm O'Neill & Associates, earned \$26,000 in board fees from Tufts last year, according to newspaper.

continued

Board members for Fallon Community Health Plan earned between \$13,900 and \$24,350. On March 18, the company said it had voluntarily suspended compensation for its board members, effective immediately.

Providing affordable, efficient health care is a colossal challenge facing the industry today, TenHoor tells *HPW*. However, "Given the current circumstances, the

image of board members attending only periodic meetings and receiving compensation often exceeding the annual salaries of many of its insured middle-class population who often struggle to pay premiums is a study in contrasts no non-profit organization should wish to surface," he says.

Contact TenHoor at (781) 934-9676, Harvard Pilgrim at mary_ellen_conlon@harvardpilgrim.org, and Tufts at Patti_Embry-Tautenhahn@tufts-health.com. ✧

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✓ *ACO Business News*, a hard-hitting monthly newsletter with timely news and business strategies on accountable care organizations — to help hospitals, physicians, health plans and their advisers learn how to transform exciting ACO opportunities into winning business strategies.

✓ *A Guide to Health Insurance Reform*, a user-friendly print/electronic service to help track, understand and comply with dozens of reform-driven federal rules that are revolutionizing health insurance benefit design.

✓ *A Practical Guide to Federal Medical Loss Ratio Requirements* offers guidance on big-dollar questions stemming from provisions in the reform law that set minimum medical loss ratios. Six leading authorities on different angles of MLR implementation provide insights into possible ramifications on benefit design, broker commissions, technology investments, medical utilization review and more.

✓ *AIS's Health Reform Week*, a weekly newsletter designed to help savvy business leaders in health care understand what the enormous changes *mean* to them ... and what they can *do* about it.

✓ *Complying With the Mental Health Parity and Addiction Equity Act* provides hands-on guidance for making complicated benefit design decisions that comply with the parity requirements. The book is written by experienced health benefits attorneys John R. Hickman, Esq., and Laurie Kirkwood, Esq., of the law firm of Alston & Bird, LLP.

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Insurers Can Still Influence Reform

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"The system needs to drive quality up and [coverage] costs down if the private market expects to have a future," says Terry Stone, a partner in the Boston office of law firm Oliver Wyman. If the industry just sits back and waits for regulations to come out, "they can rest assured that the rules are going to be fairly draconian and will allow for little innovation or ability to make a profit," she tells *HPW*. Despite uncertainty about how the law will be implemented, insurers need to take the lead. Health plans should be arming themselves with insights about what consumers want, and then collaborating with regulators and providers, "to focus the dialog on how to work together to create a sustainable health care ecosystem that better meets consumer needs, and is affordable for the long run," she says. Too often, regulators are skeptical of health plan intentions, she adds.

Here's a look at how industry observers say provisions of the law are impacting health insurers, employers and brokers and how it is likely to shape the future of health coverage:

◆ **Insurers will shift more resources to market development:** Since the reform law was enacted, health insurers have had to devote too much time, money and resources to "inward-facing activities related to compliance and operational-alignment activities," crowding out resources for developing innovative strategies that address coverage costs and health care quality, says Stone. Issues related to the reform law have, for example, eclipsed compliance issues tied to ICD-10. Insurers, doctors and hospitals need to adopt an updated version of the International Classification of Diseases code sets by Oct. 1, 2013, and be compliant with updated 5010 electronic transaction standards by Jan. 1, 2012 (*HPW* 2/7/11, p. 1). Moreover, Stone says, the burden of the regulation and compliance has kept many insurers from devoting time and resources to the enormous transformation required to compete in the retail-like environment that health exchanges will create. "Most insurers are waiting for regulations [related to exchanges] rather than influencing the rules of the game," she says. Loubet adds that

court challenges and Republican efforts to repeal the law have created uncertainties in the industry.

◆ **More flexibility is possible at the state level:** The result of last November's congressional election, along with continued vigilance of health plans in telling their story, has "helped create the right environment to promote more HHS flexibility at a state level for the implementation of reform law provisions," says Fred Karutz, general manager of health plan solutions at Silverlink Communications. While that could create more challenges for health plans to accommodate unique approaches in each state, he says it also will form the basis of experimentation that can allow for broader state adoption of best practices. "And it is clear from the [favorable] experience with Medicaid managed care, that states will be properly motivated to find ways to encourage health plan participation in the exchanges." Prior to joining Silverlink, Karutz spent 10 years as a corporate vice president at Health Care Service Corp., which operates Blues plans in four states.

◆ **Storm clouds caused by MLR floors might have a silver lining for brokers:** The MLR floors that went into effect Jan. 1 have had both positive and negative impact on agents and brokers, Nowicki says. Most health plans have restructured broker commissions — or are planning to do so — by reducing percent-of-premium payment levels or by moving to a per-member per-month payment system. But at the same time, "the law is galvanizing broker/agent supporters and raising awareness regarding the important role brokers play in the marketplace and will need to serve come 2014 when health insurance exchanges are implemented," he says. "There is now relatively broad consensus that brokers and agents will certainly have a major role to play in states' exchanges, especially in marketplaces where they're already active and have been for years."

◆ **Big employers will abandon grandfathered status for 2012:** For the 2011 plan year, some large employers determined it would be easier to seek grandfathered status for existing plans than to comply with provisions of the law (e.g., coverage of dependents up to age 26, removal of lifetime maximums, first-dollar coverage of preventive services) that went into effect on Sept. 23, 2010. In some cases, employers eliminated local HMO offerings that could not be grandfathered due to increases in coverage costs, says Mark Stember, an attorney in the Washington, D.C., law firm Kilpatrick Townsend & Stockton LLP. Some employers that previously bundled medical, dental and vision coverage spun dental and vision into separate options, which are exempt from the law. "I think we will see a lot of plans switching for 2012, due to the restrictions on being grandfathered plans." He adds that some employers are considering adding coverage tiers for dependent coverage (*HPW 3/14/11, p. 1*). While they are boosting coverage costs for dependents, they are only modestly increasing the share for employee coverage, Stember says.

◆ **Few employers will drop coverage:** A 40% excise tax on high-cost health plans that will take effect four years later will prompt some employers to whittle down benefits now to help avoid the tax later. For now, though, Nowicki says, "all signs point to employers — large ones in particular — continuing to offer benefits to full-time active employees despite the major changes coming down the pike."

Contact Jennifer Sheridan for Stone at Jenn.Sheridan@oliverwyman.com, Marit Davies for Karutz at mdavies@silverlink.com, Jennifer Davis for Loubet at jdavis@keenan.com, Nowicki at snowicki@nebgh.org and Stember at mstember@kilpatricktownsend.com. ✧

HEALTH PLAN BRIEFS

◆ **Reps. Mike Rogers (R-Mich.) and John Borrow (D-Ga.) are sponsoring a bill to remove health insurance broker commissions from the minimum medical loss ratio (MLR) calculation.** Under the health reform law, broker commissions are categorized as a nonmedical cost, which has motivated some insurers to lower broker fees as a way to reduce their administrative spending. The National Association of Insurance Commissioners (NAIC) worked with Rogers and Borrow, among others, on the bill, which has a good chance of passing in the House but will face hurdles in the Democrat-controlled Senate.

Last week, Sen. Jay Rockefeller (D-W.Va.) sent a letter to the NAIC president expressing his concerns about the proposed legislation. In the letter, Rockefeller said that although he "recognizes the valuable role agents and brokers play in helping...consumers and businesses purchase health insurance," he couldn't "support a proposal that would allow agents, brokers and health insurance companies to retain the estimated \$1 billion in benefits that American consumers will receive next year thanks to the health care reform law." For more information, visit www.house.gov or www.naic.org.

HEALTH PLAN BRIEFS (continued)

◆ **Both the California Department of Managed Health Care (DMHC) and the California Department of Insurance (DOI) are launching investigations into Health Net, Inc.'s security practices, after the insurer reported that 1.9 million members' data are missing.** Health Net said March 14 that it was notified by its IT vendor, IBM, that nine server drives went missing from its Rancho Cordova, Calif., data center. The insurer said the missing drives contained names, addresses, health information and Social Security numbers for current and past enrollees. California Insurance Commissioner Dave Jones said his follow-up investigation will look into whether the company did everything it could to "avoid and appropriately remedy" the data breach, which occurred in February. Health Net said it will offer affected individuals two years of free credit monitoring services, the restoration of credit files and insurance for identity theft. Visit www.healthnet.com.

◆ **Although no legislation has been drafted to combine California's DMHC and DOI, the debate is beginning to heat up,** the *Sacramento Business Journal* reported March 14. According to the *Journal*, California is the only state with two agencies that regulate health insurers, with DMHC overseeing plans that cover 21.6 million state residents and about 2.4 million residents under DOI's oversight. Policymakers and health advocates argue that combining these two agencies could reduce state spending and create a less confusing structure for consumers, the publication reported. A spokesperson with DOI told the *Journal* that the "dual structure is confusing to consumers, inefficient and duplicative and can definitely lead to regulatory inconstancy." Cindy Ehnes, who stepped down recently as director of DMHC, expressed concern about the idea of allowing DOI to regulate insurers, stating that her former department has more authority and oversees more health plans than DOI, the *Journal* reported. Visit www.insurance.ca.gov or www.dmhc.ca.gov.

◆ **As much as 50% of all private health insurance claim rejection appeals are successful,** according to a March 16 Government Accountability Office (GAO) report. The review, which was requested by Congress, collected insurance rejection data from California, Connecticut, Florida, Maryland, New York and Ohio. According to GAO, 50% of appeals

to insurers in Maryland for all of 2009 led to decision reversals, and 48% in Ohio for the first quarter of 2010 did so. The report found that third-party appeals are also frequently reversed. For example, a study conducted by America's Health Insurance Plans on 37 states' external appeal programs showed that for 2003 and 2004, about 40% of external appeals resulted in denials being reversed, according to GAO. View the report by checking the March 17 *From the Editor* entry at <http://aishealth.com/health-plan-week>.

◆ **On March 14, Maine insurance regulators began public sessions on Anthem Blue Cross Blue Shield of Maine's proposed rate increases of nearly 10% for several of its individual health insurance products, which cover about 11,000 customers.** The rate hikes are slated to take effect July 1, if approved by the Maine Bureau of Insurance (MBI). On March 8, HHS granted the state a waiver in response to a request from MBI, which warned that the MLR provision of the reform law was likely to cause MEGA Life & Health Insurance Co. to pull out of the market. Anthem has nearly 50% of the state's individual market, while MEGA controls 33% (*HPW 3/14/11, p. 1*). Individuals in Anthem's high deductible plan, HealthChoice HDHP, could see rates hikes as high as 19% if approved, according to MBI. As of Jan. 28, 2011, HealthChoice HDHP had 427 members. Visit www.anthem.com.

◆ **Member satisfaction with health plans that share characteristics of integrated delivery systems is much higher than with non-IDS plans,** according to the J.D. Power and Associates 2011 *U.S. Member Health Insurance Plan Study*. Satisfaction among members in an IDS plan averages 741 on a 1,000-point scale, compared with 691 among members of non-IDS plans, the report found. J.D. Power added that members of IDS plans have a better understanding of their coverage and the processes necessary to receive services. For example, among IDS plan members, 63% said they "completely understand" the benefits covered, compared with 52% among non-IDS plan members. Similarly, 44% of IDS plan members said they completely understand how to receive preventive services, while just 24% of non-IDS plan members reported the same. In 2011, overall member satisfaction is at the lowest point since the study's inception in 2007. Visit www.jdpower.com.

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