

HEALTH PLAN WEEK

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

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Anthem Seeks HMO Treasure With Brand-New Calif. Model Targeting Kaiser's Market

California's HMO market received a jolt on Sept. 17 when WellPoint, Inc.'s Anthem Blue Cross unveiled a new integrated health system called Anthem Blue Cross Vivity to do battle in two massive Southern California counties against market leader Kaiser Permanente. The organization brings Anthem together with seven providers in what the insurer calls a first-of-its-kind approach that features an insurer and competing health systems aligning financial risk and gain tied to the quality of care delivered to members.

Vivity is not an accountable care organization (ACO) but does contain elements of that business model. It promises to undercut current Kaiser premiums for standard HMO coverage by around 10% and has a major first client for 2015: the California Public Employees' Retirement System (CalPERS), which has agreed to make Vivity an option on its health benefits offerings.

"At first, I thought it was a huge ACO," Susan Ridgely, a senior policy analyst at RAND Corp, tells *HPW*. But this ACO is built on the base of an HMO contract. "Medicare is using ACOs on the fee-for-service side to address costs there. But for some reason, here in California, the commercial health plans seem to be building on the HMO side. And employers may say, 'they already sold me an HMO. Why would they sell me an ACO on top of an HMO?' But the connection is between hospital and ambulatory care," she continues. Since hospitals and medical groups are often under separate financial arrangements, they have no relationship to one another and no incentive in common. Vivity ties the two together.

The collaborating health systems are: Cedars-Sinai Medical Center, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center and UCLA Health System. Vivity has targeted the

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Massachusetts Takes Stock of 'Reform 2.0,' Sees Mixed Results in Cost Containment Bid

Massachusetts's first measurement of spending across the entire state health care system found market-share heavyweight Blue Cross Blue Shield of Massachusetts the sole commercial carrier with spending in 2013 above the 3.6% benchmark set by the 2012 "health reform 2.0 law." Peering deep into the state's health insurance sector, the report released on Sept. 2 by the state's Center for Health Information and Analysis (CHIA) also revealed fading consumer participation in alternative payment models and the growing popularity of PPOs vs. HMOs.

The wider implications of the Massachusetts market analysis are uncertain, but the results do provide a unique snapshot of how insurance market trends influence and are influenced by policy initiatives, market watchers say.

"It did seem like it did succeed last year. Even though growth was above inflation, it was below the target number for the year," Matthew Fisher, associate for the law firm Mirick, O'Connell, DeMallie & Lougee, LLP in Worcester, Mass., tells *HPW*. CHIA said

overall spending in the entire Massachusetts health system grew by 2.3% in 2013 from 2012, which was positive compared to the benchmark but negative considering the inflation rate was only 1.5% last year. "I think it can be viewed at least as a partial victory, although there are concerning signs pointing to costs rising for this year. A lot of people are trying to temper expectations that it's not going to the goal for two years in a row. But the bottom line is it may be a little too early to tell. The changes that were being put into place will take time to be fully effective," he says.

The law sets health care cost growth goals for the commonwealth at an amount no greater than the growth in the state's overall economy, or gross state product (GSP), for the years 2013 to 2017. For 2018 to 2022, the target growth rate in health care costs is 0.5% below the GSP. If any health care entity fails to meet those targets, they would have to submit a Performance Improvement Plan to the state's Health Policy Commission for review (*HPW 11/11/13, p. 1*). Stakeholders that do not implement the corrective plan could face fines of up to \$500,000.

The person in charge of collecting the spending data says it is important to focus on where the state has come from in the way of costs. "Based on federal statistics, Massachusetts for a long time has been one of the most

expensive states in the country for health care, and of course the United States spends more on health care than the rest of the world. So that makes Massachusetts one of the most expensive health care environments in the world," Aron Boros, CHIA's executive director, tells *HPW*. "We measured total spending growth between 2012 and 2013 and found that spending was still growing somewhat faster than inflation, but overall had slowed significantly from what we were seeing in previous years. In previous years we had 5% to 7% growth," he adds.

There are still some pieces of the 2.0 reform law to be phased in, Fisher says. "In terms of the target growth number, the most important part is that there is no enforcement mechanism in place yet. That is still another year or two down the road before that can happen," he explains. "I would guess that once the state government actually has punitive tools to be able to use to force compliance, then that may have an impact as well in terms of meeting the growth containment goals."

Alternative Payment Models, ACOs Are in Play

In addition to cost containment, Fisher says one of the underlying goals of reform 2.0 is to increase care coordination whether it be through accountable care organization (ACO)-like structures or via the push for alternative payment methodologies (APMs), like the Blues plan's Alternative Quality Contract (*HPW 8/6/12, p. 4*). "If it is clear there is a capitated type payment, then the providers have an inherent, monetary incentive to try and coordinate their care. That is a work in progress. It is a fairly philosophical shift from the fee-for-service model that had been operated for so many years," he adds.

There was, however, some sobering news on the alternative payment front in the report. "Adoption rates of global payment contracts in Massachusetts have been above national adoption rates. However, proportionally fewer commercial members were enrolled with primary care providers paid under all Alternative Payment Methodologies in 2013 (34%) than in 2012 (35%)," the report said.

In addition, CHIA said APMs are mainly used today for patient care within HMO-type insurance plans. "However, the proportion of commercial members (MA residents only) enrolled in HMO-type products decreased by 10.8 percentage points between 2010 and 2013. This trend was concurrent with a slow but continuing shift toward enrollment in self-insured coverage, in which HMO plan designs are used much less regularly than fully insured coverage," the CHIA report added.

On the spending growth issue, the CHIA report said the Blues plan's 3.65% spending uptick surpassed all other insurers in 2013. "Both the biggest insurer, Blue Cross Blue Shield of MA, and the biggest physician group,

Health Plan Week (ISSN: 1937-6650) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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Partners Community HealthCare Inc., reported spending increases that were among the largest," the report said.

Other insurers operating in the state saw much different results, but since the Blues plan possesses a 40% market share, some of the more positive numbers were muted.

For instance, UnitedHealth Group's UnitedHealthcare unit experienced a 19% decline in what CHIA calls the Health Status Adjusted Total Medical Expense (HSA TME). This is a metric that accounts for variations in health status of a payer's full-claim members. Differences in HSA TME levels (dollar amounts) reflect variation in provider prices, utilization patterns (e.g., provider network) and covered services. UnitedHealth has only 9% of the Massachusetts market.

Although the Massachusetts Blues plan did not respond to *HPW's* questions on its 2013 spending, in the *Boston Globe* on Sept. 2, the carrier refuted CHIA's figures. The insurer said its own numbers put 2013 spending growth at only 2.1%.

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Research on E-Cigs Is Needed To Determine Policy Specifics

With research on electronic cigarettes scant and federal regulation nonexistent, health insurers are tight-lipped regarding how new data and guidance might affect established smoking policies.

Electronic cigarettes, or e-cigarettes, are battery-operated mechanisms that convert liquid nicotine into vapor, eliminating many of the harmful agents found in tobacco smoke. Little research has been done to determine their potential health hazards, however, and insurers are hesitant to speculate on how or if e-cigarettes could be incorporated into health benefit plans in the future once more is known and forthcoming FDA regulations are in place, market sources say.

Many insurers' smoking policies incentivize against the use of tobacco by offering their smoke-free beneficiaries lower monthly premiums or rewarding them through wellness programs. Because e-cigarettes have no tobacco, their inclusion in a wellness program could be tricky since members who use them will test positive on the blood cotinine test used to determine smoking habits. But the debate over e-cigarettes' health risks and their use

Translate 2015 Star Ratings Into Your Plan's New MA/Part D Strategies

- Which types of plans scored best and worst in 2015 star ratings? Which showed the greatest change?
- To what extent have regional disparities lessened? What might CMS do to deal with those stars disparities in the future?
- How did MA SNPs fare? What new measures are in store for them in 2016 and beyond?
- Which of CMS's star-rating domains are MA and Part D plans finding the hardest to manage? Which present the greatest opportunities for future bottom-line impact?
- Which measures dragged down plan performance the most? To what extent were drug-related measures a factor?
- How did plans fare with the newest star-ratings measures?
- To what extent should marketing strategies be affected by the actual 2015 star ratings of your competitors?
- How is the star-rating program likely to change for 2016 and beyond?

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as a smoking cessation tool could eventually make them attractive to insurers interested in luring their customers away from the destructive elements of conventional tobacco.

Alere WellBeing, which provides wellness programs to more than 750 employers and 28 states, recommends that its clients that test for cotinine levels treat e-cigarettes as a nicotine replacement therapy, similar to employees who test positive because they are using nicotine gum or patches. "Individuals who fall into this category and are randomly selected for nicotine testing should be considered a non-tobacco user and tested at a later date. Clients should develop their own policy for those rare instances where individuals are using e-cigarettes recreationally on a long-term basis (i.e. not as part of a tobacco cessation regime)," Alere advises.

What Are Current Insurer Attitudes?

Some insurance companies, like Cigna Corp., are treating e-cigarettes the same way they treat regular cigarettes, due to their reliance on nicotine. While not considered a carcinogen, nicotine is still considered a potential "tumor promoter" since it alters certain essential biological processes, like regulation of cell proliferation. The vapor also contains traces of other carcinogens, although at levels much lower than traditional cigarettes.

Joe Mondy, a Cigna spokesperson, tells *HPW* that the company does not offer incentives for use of e-cigarettes over traditional cigarettes, citing the need for more research to determine if any benefit actually exists. He declines to provide any insight into how policy might change if future research determined e-cigarettes are significantly safer than conventional smoking.

Similarly, University of Pittsburgh Medical Center (UPMC) Health Plan Vice President of Medical Affairs Stephen Perkins, M.D., said in a statement that the carrier

is holding off on policy revisions due to lack of research, but stressed that a recent employee smoking ban during working hours includes e-cigarettes.

While e-cigarette advocates say the devices have potential as a smoking-cessation technique, no research exists to confirm the claim and the FDA has banned manufacturers from marketing their product as such. Many companies, like Aetna Inc., regard e-cigarettes as a smoking substitute instead of a quitting method. Aetna's website lists e-cigarettes as an ineligible health expense, saying that an e-cigarette "is not an approved smoking cessation product but rather a replacement."

FDA Weighs New Regulations

While the FDA now regulates e-cigarettes only as therapeutic devices, in April the agency proposed a rule to extend its control of tobacco and nicotine products to include e-cigarettes for general usage (79 FR 23141, April 25, 2014). The public comment period closed on Aug. 8. FDA spokesperson Jenny Haliski says the agency does not have an estimate on when it will issue a final rule.

Once regulated, the FDA will have the ability to conduct research on ingredient lists and health effects, as well as monitor marketing and advertising. While research is still limited, enough has been done to prompt the World Health Organization (WHO) to issue a report to its member nations in July, summarizing findings.

The report found e-cigarettes still contain toxic elements like formaldehyde and acrolein. But substance levels varied due to the wide range of products available: Some e-cigarettes had a fraction of the toxicants found in many conventional cigarettes, while others had levels as high as certain regular cigarettes.

One major concern of health care advocates is the growing role the tobacco industry has in the e-cigarette market, which was initially created by small, independent companies. If e-cigarette manufacturers hope to market their product as a smoking-cessation tool, the tie to big tobacco, which has a vested interest in maintaining a customer base, could hurt their credibility. WHO reported that all major international tobacco companies now have an e-cigarette product of their own, and one is currently filing suit against its competitors over patents, indicating a more aggressive business strategy.

Another obstacle in the way of a smoking cessation label is the appeal the new products could have to nonsmokers and adolescents. E-cigarettes are currently available in flavors ranging from cola to chocolate, which many say could lure adolescents into the nicotine trap. WHO reported that e-cigarette usage is increasing rapidly among adolescents, although all but a few respondents were also traditional smokers.

Additional News of the Week

Coverage of these health plan developments was included in this week's issue of *Spotlight on Health Insurers*:

- Humana, Iora Health Partner on ACO
- IBC Launches Private Exchange for Employers
- UCLA Physicians on LiveHealth Online
- Cigna Releases Corporate Responsibility Report
- Capital BlueCross to Open Harrisburg Store
- Highmark Leads on Procedure, Others Wait

Links to these additional news stories can be accessed at www.AISHealth.com/enews/spotlightonhealthinsurers.

The WHO report concluded with a recommendation to ban e-cigarettes in public places and sales to minors, require transparency with regard to the tobacco industry's involvement in manufacturing and lobbying, place necessary health warnings on marketed products and standardize nicotine levels.

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Anthem Breaks New Ground

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large employer markets in Los Angeles and Orange counties to start and will market the HMO for coverage beginning on Jan. 1, 2015. The eight partners of the joint venture will each provide capital and will each share equally in the company's profits or losses.

Anthem says the collaboration is good for consumers who will be able to enjoy more coordinated care across a large and diverse provider network. "In the creation of Vivity, accessing health care has been greatly simplified and costs have been made vastly more predictable. When Vivity members go to the doctor, have a medical procedure or pick up a prescription, all they pay is their copay. They won't have to worry about meeting deductibles or deciphering complicated medical bills," Pam Kehaly, president, West Region, Anthem Blue Cross, said during a press conference on Sept. 17.

A veteran California-based consultant calls Vivity a positive for Anthem and the providers, but questions the hype about aggressiveness of the competition among the health systems. Henry Loubet, chief strategy officer for Keenan, and former CEO of UnitedHealthcare's Western operations, tells *HPW* such talk may be "overblown" since the acreage covered by Vivity is so large. "Still, I think it's a significant step forward, a good move toward much more integrated and simplified care," he adds.

Anthem's foray is both an offensive and defensive move, Steve Valentine, president of the Camden Group, a health care consulting firm in El Segundo, Calif., tells *HPW*. "It is not only Anthem, but the seven health systems they hooked up with, that all want to eat into Kaiser as well. The seven systems' per capita utilization is down...and every time Kaiser grows it creates heartburn for Anthem. Anthem wants premiums. The seven want to get utilization," he says.

The members Vivity draws may come not only from Kaiser, however, but also from existing PPOs, Ridgely says. "The movement here might be on the PPO side. I don't know if you measure the effect of this by measuring either changes in Kaiser's premium, or whether people left Kaiser and went to Anthem, as much as what hap-

pens in the PPO market," she says. This is because of the attractive network Anthem has assembled, and promise of better care management at lower prices.

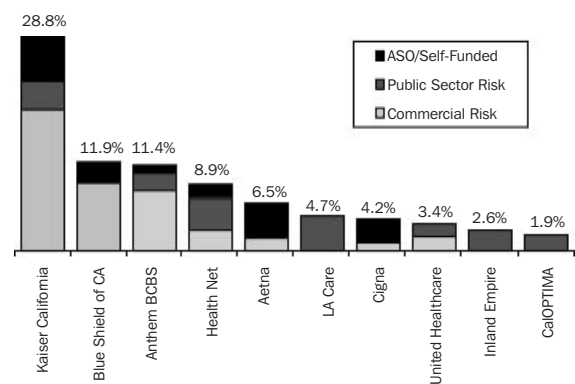
"I think the advantage of building it on an HMO contract is that you can keep the patients in-network. If you did it in a PPO, you still might be able to encourage your beneficiaries, change their design to try to push beneficiaries to certain providers," Ridgely says. "But in the end, [with] the PPO, as long as your provider is in the network you can still go to them, versus an HMO where you still have to usually see a primary care doctor and get a referral and you have a network you have to choose from. And I think what Anthem did here is create like the uber network."

This super network includes well-known academic medical centers that people want access to, she says, helping Anthem deflate complaints about the narrowing of provider choices for consumers. "That is why a lot of people don't like Kaiser. It is because what people want is choice of doctors. Over and over again people will say, 'I want to be able to see the doctor that I want to see. [And with Vivity] I might even think about getting out of my PPO and signing up for this HMO because look at the breadth of the network here.'"

continued

Market Share, by Enrollment, of Top 10 Calif. Plans, With Sector Divisions

Kaiser Permanente is the leading health plan in California with 7 million members at the end of 2013 and a 29% market share. Blue Shield of California is a distant second with almost 3 million members. Three of the top 10 plans — LA Care Health Plan, Inland Empire Health Plan and CalOPTIMA — operate in the public sector exclusively. 92 health plans covered a total of 24.6 million members in California at the end of 2013.



SOURCE: AIS's *Directory of Health Plans: 2014*. Visit <http://aishealth.com/marketplace/ais-directory-health-plans> for ordering information or call (800) 521-4323. Enrollment data as available during fourth quarter 2013. Market share as percentage of total insured lives attributed to state.

Another Southern California market consultant agrees that the Anthem model is unique. "It is novel that more than one hospital system is willing to enter into an arrangement like that, together, more so than it's novel that a carrier and a hospital system would do that," Robert Burnell, principal in the Los Angeles office of Buck Consultants at Xerox, tells *HPW*.

He predicts that Kaiser will take a wait-and-see approach, considering there is no way to know if Vivity will work and given the strong brand that the HMO holds in California.

Loubet says it will be noteworthy to track how the Vivity provider network holds up to logistical pressures as well. "They are targeting large employers, but when you're a large employer you have a wide geographical area where people drive in from. And some of those areas aren't covered, it appears. So the question becomes in regards to coverage in outlying areas, how will that be provided?" he says.

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Respiratory Illness Has Attention Of Plans, but Few Claims So Far

A severe respiratory ailment afflicting hundreds of children across Midwestern states like Illinois and Missouri and into other areas of the country has the attention of the health insurance industry. But one major carrier says there has been no uptick yet in claims tied to the enterovirus D68 (EV-D68). The Centers for Disease Control and Prevention (CDC) says it is watching the situation closely, as are financial market analysts concerned about how any illness impacts the bottom line of insurers through increased medical utilization.

EV-D68 can cause mild to severe illness, with the worst instances requiring life support for breathing problems. Children with asthma are most vulnerable. No deaths have been reported.

The CDC said the virus has caused higher pediatric emergency room visits, hospitalizations and intensive care stays in large cities like Chicago and Kansas City with clusters identified in 12 states. Carl McDonald, securities analyst for Citigroup Global Markets, in a Sept. 15 research note said "publicly traded plans don't have a tremendous amount of exposure to Illinois and Missouri. In the commercial risk business, Humana has the biggest relative presence in those two states (15% of commercial risk premiums), followed by Aetna and United (both at 6% of commercial risk premiums)."

Humana Inc. and UnitedHealth Group did not respond to questions about the virus, but Aetna said as with other illnesses, it is tracking this latest one. "We are always monitoring reports of infectious diseases. While the front line of addressing any scale of a virus outbreak are health authorities and treating physicians, we partner with organizations to promote awareness, prevention and treatment measures, including the CDC and other federal agencies, state and

local health departments, health care providers, our employer customers and others," Cynthia Michener, a spokesperson for Aetna, tells *HPW*. "As far as utilization, claims have a long tail and it's far too early to tell about utilization."

McDonald said because EV-D68 is mainly affecting children, it is Medicaid plans that will most likely take the brunt of the hit from higher utilization. "In Illinois, the Medicaid managed care plans are Family Health Network, Meridian Health Plan and WellCare [Health Plans, Inc.]. And in Missouri, the Medicaid plans are Aetna, Centene [Corp.] and WellCare," he added.

The CDC said there are no vaccines to prevent EV-D68 infections and no specific treatment. The illness can be diagnosed only by doing lab tests on specimens from a person's nose and throat. "Many hospitals and some doctors' offices can test ill patients to see if they have enterovirus infection. However, most cannot do specific testing to determine the type of enterovirus, like EV-D68. Some state health departments and CDC can do this sort of testing. CDC recommends that clinicians only consider EV-D68 testing for patients with severe respiratory illness and when the cause is unclear," the agency said.

Vishnu Lekraj, senior analyst – health care for Morningstar Inc., says it will be a "couple of months" before insurers see any claims-related bump from the virus. Typically, he adds, the industry charts October as the time of year to gauge estimates on how severe the annual flu season will be. But this outbreak is not related to the regular flu.

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HEALTH PLAN BRIEFS

◆ **Schenectady, N.Y.-based MVP Healthcare, Inc. on Sept. 16 said federal reimbursement cuts for Medicare Advantage (MA) plans prompted it to discontinue two of its five MA offerings in the Rochester area of New York for 2015.** The three remaining plans will demand higher co-pays and have sharply higher premiums, depending on the selection. Denise Gonick, MVP CEO, said “back-to-back cuts totaling up to 11.9% of federal reimbursement of Medicare Advantage plans, despite the ever-rising cost of caring for an aging population” were too much for the insurer to handle. About 19,000 MA members will see their current plans end, she said. The premium increases for the remaining MA offerings in the affected areas will range from \$29 to \$64.50 a month, or 44.8% on average. Gonick said MVP and other carriers in New York and elsewhere face several more years of disruption as the Affordable Care Act (ACA) continues to roll out. “MVP supports the goal of the ACA, which is to make sure everyone has access to health care,” she said. “Unfortunately, health care costs continue to soar. You can’t spend money that you don’t have.” Visit tinyurl.com/ofot4qw.

◆ **A Sept. 15 report by the Government Accountability Office (GAO) said the vast majority of health insurers it sampled sold plans on public exchanges without segregating funds that paid for abortion services.** The ACA prohibits using federal subsidies to pay for abortions. Private insurers, the law states, must collect separate payments from customers for abortion coverage, except in cases of rape, incest or risk of the mother’s life. GAO’s report (GAO-14-742R), which was commissioned by House Republicans, found that 15 out of 18 insurers sold exchange plans without separating the payments. The politics of this issue run deep, since anti-abortion Democrats made the abortion payment segregation language a condition for supporting the ACA. Visit tinyurl.com/l6fm3e9.

◆ **CMS Administrator Marilyn Tavenner told a House Oversight and Government Reform Committee hearing on Sept. 18 that the number of people enrolled in public exchange coverage is now 7.3 million, down 700,000 from earlier in the year.** The lower tally is a result of enrollees not paying their first month’s premium and dropping out of coverage. Tavenner said she expects total enrollment to be

stable until the next open enrollment season starts on Nov. 15. Visit tinyurl.com/opnpzsb.

◆ **Senate Democrats turned back an effort by Sen. David Vitter (R-La.) to pass a House bill that would have allowed consumers to keep health plans not in compliance with the Affordable Care Act through 2018,** *The Hill* newspaper said on Sept. 17. The week prior, Rep. Bill Cassidy’s (R-La.) legislation (H.R. 3522) gained approval in the House (*HPW 9/15/14, p. 7*). Visit tinyurl.com/l2l3mlx.

◆ **Saying the business was not sustainable, PreferredOne, the top selling insurer on the Minnesota public exchange MNSure, is exiting the marketplace for 2015.** Four Minnesota-based insurers will participate on the exchange next year: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and UCare Health Plan, Inc. Visit tinyurl.com/kyfa9t6.

◆ **Aluminum manufacturer Alcoa Inc. is moving some of its white-collar retirees to a private insurance exchange operated by employee benefits firm Towers Watson,** the *Pittsburgh Post-Tribune* said on Sept. 9. The decision does not impact union retirees. A shift to a private exchange might help employers avoid the so-called Cadillac tax — a 40% excise tax on high-value health plans that will take effect in 2018. Other large corporations have made similar moves recently, notably IBM Corp. and Time Warner Inc. (*HPW 9/16/13, p. 1*). Visit tinyurl.com/oxsnxye.

◆ **CMS on Sept. 16 issued quality and financial performance results for its Medicare Accountable Care Organization (ACOs) programs.** The agency said ACOs in the Pioneer ACO Model and Medicare Shared Savings Program generated more than \$372 million in total savings. “The encouraging news comes from preliminary quality and financial results from the second year of performance for 23 Pioneer ACOs, and final results from the first year of performance for 220 Shared Savings Program ACOs,” CMS said. Visit tinyurl.com/o477hfg.

◆ **Double-digit increases in premiums in the small group insurance market are common,** according to a September study by the Urban Institute. Researchers examined premiums for each state since 2000, and found that premiums had increased by 5.5% overall. The report said while double-digit increases are com-

HEALTH PLAN BRIEFS (continued)

mon, they are frequently offset by smaller increases or decreases the following year. Visit tinyurl.com/nn3gocl.

◆ **Humana Inc. CEO Bruce Broussard told Reuters on Sept. 17 that the entrance of UnitedHealth Group in some two dozen public exchanges for 2015 from just a smattering this year will spur competition.** He also said that many large insurers are pricing their premiums within a tighter range of about 10% for next year in many markets. This differs from the 2014 strategy when pricing had much greater variation, Broussard said. Visit tinyurl.com/kojo2dk.

◆ **Hepatitis C patients who take Sovaldi discontinue therapy four times as often as in clinical trials,** according to a CVS Health study released on Sept. 17. CVS followed nearly 2,000 patients from December 2013 to August 2014 and found discontinuation rates for Sovaldi patients were 8.1% over the course of the recommended 12-week program. The study also found that patients new to the disease were more likely to discontinue treatment than those in more advanced stages. Visit tinyurl.com/obgfl7s.

◆ **Individual health insurance rates, coverage and costs are significantly lower in states that were more active in implementing the Affordable Care Act,** a Sept. 15 report released by the Brookings Institution finds. The five states that ceded ACA enforcement to the federal government, used the federal exchange and did not expand Medicaid were worse off by \$245 per participant in the individual insured market on an annualized basis, compared with states that took some role in implementing reform. The functionality of the state's insurance exchange paralleled costs as well: the five states that had severe issues with their exchanges were worse off by \$750 per person on an annualized basis than the states whose exchanges were functioning properly. Maine enrollees fared the best with health care reform, gaining around \$1,500 per participant annually, while Oregon enrollees fared the worst, losing around \$850 per person. Visit tinyurl.com/pfdzhw2.

◆ **A Sept. 16 report from the Government Accountability Office (GAO) determined security issues continue to plague HealthCare.gov.** The paper outlines more than 20 security issues that federal investigators say need to be fixed before the next

open-enrollment period begins on Nov. 15. The paper notes that CMS has taken measures to protect the security and privacy of the data it holds, but "weaknesses remain." Visit tinyurl.com/mqetox7.

◆ **Massachusetts officials are requesting another extension of its existing Commonwealth Care programs and temporary Medicaid services through the first two months of next year,** the *Boston Business Journal* reported on Sept. 11. According to the newspaper, officials estimate around 450,000 people will be re-enrolling through the state's new public exchange website, and with current coverage slated to end Dec. 31, they've asked that the extensions be staggered to help space out the number of enrollees. Under the proposal, current plans will end on varying dates throughout January and February. Visit tinyurl.com/lsl7c2v.

◆ **Wisconsin Sen. Ron Johnson (R) is continuing to challenge the Office of Personnel Management's (OPM) adoption of a rule that allows some members of Congress to continue their pre-existing federal benefits, while other members and staffers are given a subsidy to be used for buying coverage through the public exchange.** Johnson filed suit in January but lost after the Wisconsin district court ruled he lacked legal standing to challenge OPM. He is now appealing to the 7th Circuit Court of Appeals. Visit tinyurl.com/qfyxmfb.

◆ **PEOPLE ON THE MOVE:** Puerto Rico's Blues plan operator Triple-S Management Corp. said **Carlos Carrero**, the head of its Medicare Advantage business, is retiring....Kaiser Foundation Hospitals and Health Plan, Inc. named **Richard Daniels** interim chief information officer. He is now senior vice president of enterprise shared services for Kaiser Permanente, which includes oversight of end user services, national facilities services and national pharmacy operations. Daniels replaces **Philip Fasano**, who said he is leaving the organization....**Gary Drews** is the interim CEO for Colorado's state-run insurance exchange. Drews was appointed by Connect for Health Colorado's board of directors. He replaces former CEO **Patty Fontneau**, who left to become president of Cigna Corp.'s private exchange business. Drews previously was CEO of TheWorldWeWant, LLC and former seven-year chief financial officer of the Colorado Health Foundation. The board expects to name a permanent CEO later this year.

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