Volume 23, Number 19 May 27, 2013

Health Plan Week

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

Contents

Looking for a back issue of **HPW**? *PDF issues, plus a searchable article database, are archived on your subscriber-only Web page — all the way back to 2008! Log in at* ***www.AISHealth.com*** *and click on the newsletter title in the gray "My Subscriptions" box on the right.*

Calif. Exchange Selects 13 Insurers, Says Premium Rise Will Not Create 'Price Shock'

A baker's dozen of health insurance carriers are tentatively slated to sell plans on the Covered California marketplace when open enrollment begins Oct. 1. The expected 5.3 million state residents eligible to buy insurance on the exchange will see premium prices lower than originally forecast by outside actuaries and industry stakeholders, according to Covered California officials who unveiled the plans and rates on May 23. But industry consultants say it's too soon to make an accurate assessment of how much prices will rise next year in the individual market.

Insurers already holding sizable market shares in the state's individual market, and selected for the California exchange, are expected to add hundreds of thousands of new lives to their portfolios. Meanwhile, the major national carriers that did not participate, like UnitedHealth Group's UnitedHealthcare unit, will not see much of an impact since they are focused on mostly large-group customers, consultants say.

The 13 carriers in the individual market are Alameda Alliance for Health, WellPoint, Inc.'s Anthem Blue Cross of California, Blue Shield of California, Chinese Community Health Plan, Contra Costa Health Services, Health Net, Inc., Kaiser Permanente, L.A. Care Health Plan, Molina Healthcare, Inc., Sharp HealthCare, Valley Health Plan, Ventura County Health Care Plan and Western Health Advantage.

Covered California provided a detailed look at the 19 rating regions. Some of the more rural areas of the state will see only three insurers competing and more populated areas twice as many or more plans competing. For example, rating region 1, in the northern tier of the state, will have in its silver metal tier an Anthem PPO, a Blue Shield exclusive provider organization (EPO) and a Kaiser HMO vying for customers. A single 40 year old would pay $112 per month for the Anthem PPO if earning 200% of the fed-

continued on p. 3

Clarifications, Guidance and Final Regs Don't Answer All Insurers' ACA Questions

Trying to keep pace with the flow of information from federal agencies charged with implementing the Affordable Care Act (ACA) is like "drinking water from a fire hose," Ray Ramthun, president of Maryland-based HSA Consulting Services and a former senior health policy advisor to President George W. Bush, tells *HPW*. But even as this unceasing amount of guidance and regulation accumulates, health plans still may not have every piece of the puzzle filled in before new marketplaces and industry reforms launch in 2014.

Although HHS and other agencies have released rules and guidance recently on Medicare medical loss ratio (MLR) requirements and technical issues tied to Medicaid eligibility, there are several other regulations sitting at the Office of Management and Budget waiting to come out any day now, industry sources say.

For instance, Tim Jost, a Washington and Lee University law professor and consumer representative for the National Association of Insurance Commissioners, tells *HPW* there are some significant final rules nearing release that insurers still are waiting to see,

notably one covering wellness and preventive care. "The wellness reg is very important to employers and I guess it is very important to insurers too. In fact, that might be the most important because for a lot of the administrative services plans and larger and small-group insurers, they have really been pushing wellness plans and see that as a major new revenue source," he says.

Even though wellness programs have been around for some time, the changes made by the ACA, like increasing the maximum reward from 20% to 30% and even as high as 50% of the cost of health coverage for enrollees who participate in certain types of wellness programs, are expected to make them even more of a focus for health plans and their employer clients. The draft rule, which came out on Nov. 20, 2012, seeks to offer flexibility by not specifying the types of wellness programs employers can offer. It does, however, specify that rewards under the program must be available to "all similarly situated individuals," according to the Department of Labor, and bars underwriting practices that could reduce benefits based on health status *(HPW 12/3/12, p. 1)*.

"The ACA makes some changes and the proposed regulation really tightens [wellness rules] up quite a bit" from the original regulations offered by former President George W. Bush's administration in 2006. "If my recollection is correct, aromatherapy would count as a treatment," Jost adds, referring to the initial, pre-ACA rules.

"I think the most controversial issue is under what circumstances a person can be excused from meeting some of the requirements of a wellness plan. If you have a medical condition that makes it difficult or impossible to meet a requirement, they have to come up with another way of meeting the requirements of the plan. And that has been a huge issue with consumers because consumer groups that I talk to a lot are very concerned that wellness programs are simply becoming another means of health status underwriting, that you impose a health status-related goal, like requiring BMI [Body Mass Index] at a certain level or a blood glucose level at a certain level," he says.

Other final rules that are expected to be made public soon are regulations on Medicaid eligibility under the ACA's expansion opportunity for the states, as well as premium tax credit eligibility and cost sharing premiums in Medicaid. Jost says this is a large and complicated matter, with all of the provisions of the proposed regulation running some 300 to 400 pages. Insurers are also waiting for a final regulation on how the federal SHOP (Small Business Health Options Program) exchange is going to work and pieces to come on employer mandate and individual mandate rules.

Ramthun says overall, the health insurance industry should have expected this constant flow of new information from the federal government considering the complexity of health reform. "I think health insurers have the key pieces, but not everything they want. It is frustrating but what can you do? With something this massive, you just hope there is no penalty as a result of missing something," he says.

PCIP, Medicare MLR Rules Come Out

The latest activity on the regulation front came late on May 17 when HHS released an interim final rule with comment period on the Pre-existing Condition Insurance Plan (PCIP) in an effort to stretch the program's funding by limiting payments to providers. The rule says that starting with services offered on or after June 15, payments to providers for services provided in the program will be limited to 100% of the Medicare payment rate. This does not include payments for prescription drugs, organ and tissue transplants, dialysis and durable medical equipment.

The rule follows an announcement by HHS on Feb. 15 that the high-risk pools were no longer accepting new enrollees to ensure the PCIP program's $5 billion in funding would not be exhausted. The program is intended to bridge high-cost uninsured individuals to 2014 when major provisions of the health reform law take effect, in-

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.

Editor, Patrick Connole; Managing Editor, Steve Davis; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Editor, Carrie Epps

Subscriptions to *HPW* include free electronic delivery in addition to the print copy, quarterly Key Financial Indicators for major health plans (in print and posted on the subscriber Web page), e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *HPW* content and archives of past issues.

To order an annual subscription to **Health Plan Week** ($637 bill me; $607 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

cluding subsidized coverage under insurance exchanges and a ban on health insurers' practices of declining coverage because of pre-existing conditions and charging higher premiums on the basis of health status. HHS said then that the program had spent roughly $2.4 billion on medical claims and nearly $180 million on administrative costs as of Dec. 31 *(HPW 2/25/13, p. 1)*.

CMS also released on May 17 a letter to state health officials and Medicaid directors offering enrollment strategies to facilitate the enrollment of new beneficiaries under the program's expansion next year. Jost says even those states not expanding Medicaid will have to switch to new modified adjusted gross income standards and new household composition rules on Jan. 1, 2014, to determine Medicaid and CHIP eligibility for children, parents, caretaker relatives and pregnant women. If a state is expanding Medicaid, it also must use the new system for enrollment of non-elderly, non-disabled adults.

Finally, HHS also issued a final rule late on May 17 concerning MLR requirements for Medicare Advantage (MA) plans and Part D Prescription Drug Plans (PDPs). The rule, which sources said is very similar to the draft proposal, implements an 85% MLR cap on MA plans and PDPs, HHS said. Any plan not meeting the requirements for three years in a row would face enrollment sanctions. If an MA plan missed the target five straight years it would be subject to contract termination, HHS said.

Contact Jost at jostt@wlu.edu and Ramthun at roy@hsaconsultingservices.com. ✧

Calif. Exchange Attracts Insurers

continued from p. 1

eral poverty level (FPL), $121 for the Blue Shield EPO or $149 for the Kaiser HMO. A similar customer in the northern section of Los Angeles County, or rating region 15, will choose from seven carriers offering monthly rates that range from $90 for a Health Net HMO to $162 for the Kaiser HMO. Los Angeles County is so large it has two rating regions, the northern and southern.

Covered California will not announce small-group market plan participants until next month. State insurance regulators still must approve the rates listed by Covered California for the 13 carriers. After that step, the exchange and insurers will finalize their contracts in June.

One of the insurers present at the unveiling, Blue Shield of California, said its existing individual market customers will see a premium rate rise of between 8% and 13% in 2014 compared with products the insurer is offering this year. Blue Shield CEO Paul Markovich cautioned that it was very difficult to make direct comparisons and account for individual circumstances like age. But "on average, absent fees in the Affordable Care Act and the change of benefits, there will be an 8% increase. Including fees and new benefits, it will be 13%," Markovich said, adding the numbers applied only to Blue Shield customers.

Doing his own investigation, Robert Laszewski, president of Health Policy and Strategy Associates, LLC in Alexandria, Va., tells *HPW* that he found higher prices than what Covered California is stating in its public pronouncements. "I looked on esurance for a 91011 ZIP code in Southern California. I put in a 38 year old for single coverage. Anthem for a $1,500 deductible, 75% coverage, is currently priced at $233. A $2,000 deductible with 70/30 coverage is currently priced at $168. The exchange is showing average premiums for the silver [plan, $2,000 deductible] ranging from $304 to $335 for the three-lowest plans. It is hard to compare geography and plan design, but these rates are about 50% more than what people are buying common coverage for today with about the same deductible in the Los Angeles area," he says.

Praise for Depth of Plan Coverage, Design

Despite the uncertainty on how prices will shake out, market watchers say the die is cast in the nation's largest state for a robust assortment of standardized coverage options on all "metal tiers" across the 19 separate geographical regions of California. The fact that California has progressed to this point in its market development is impressive, Henry Loubet, chief strategy officer for Keenan, a California-based health care consulting and brokerage firm, tells *HPW*.

"I would say this should be an attractive option for individuals, especially with subsidies," Loubet says. The number of plans selected seems about right, considering more than 30 applied to bid. "It is a reasonable number and is a good cross-section. You have large plans like Anthem and Kaiser and smaller regional plans like Sharp and Western Health Advantage," he says. On first blush, Loubet says the premium prices appear to offer "pretty attractive" rates at the lower or younger end of the market and less so on the higher, older side when compared with what is being offered today.

Peter Harbage, president of Harbage Consulting, based in Sacramento, Calif., and former assistant secretary of health for the state of California, tells *HPW* "the rates seem favorable. People have choice. Today is a big step in the right direction."

Even though big national firms in the health insurance industry were missing from the 13 carriers named as participants, among them UnitedHealthcare, Aetna Inc. and Cigna Corp., it did not surprise insiders. This is because in terms of California's individual market, the

trio do not hold sizable market share like Anthem Blue Cross, Blue Shield and Kaiser, which combined have more than 85% of the pie. In addition, executives from the big three have said repeatedly they plan to be selective in deciding which exchanges to take part in. "I think they looked at this and the one-year contracts and the fair amount of uncertainty with what will take place, and did not want to get involved right in the beginning. And they are not large players in the individual and small-group markets in California," Loubet says.

For health plans, the reaction by employers to what they see priced in the individual market will come later, likely even in the 2015 open-enrollment cycle as the wait-and-see approach will likely continue for some time when it comes to exchanges, Loubet says. And insurers not doing business inside the exchange probably won't see an immediate impact due to their lack of activity in the individual space currently.

State Offers Details Where Others Do Not

California's exchange delivered the most comprehensive look yet at how a state-run exchange will appear to both consumers and the health insurance sector. This differs from Colorado, which recently informed the public that 11 plans had filed rates for its exchange, but did not disclose details on the carriers or pricing. And considering that HHS has said it will not make public the plans or rates to be offered on federally facilitated or partnership exchanges until the fall, the California report is a big step forward in information-sharing, consultants say.

Peter Lee, executive director of Covered California, said the best frame of reference for how good rates will be in 2014 is by looking at premiums currently available in the small employer market in California. "Comparing rates Covered California has achieved to comparable products in the small employer markets, our rates ranged from 2% above the 2013 average premium to 29% below the rates in California's most populous markets. This is impressive since the 2014 products include doctor visits, prescriptions, hospital stays and more essential benefits. Additionally, there is financial protection like a maximum out-of-pocket-cost of $6,350, which will dramatically reduce the chances of someone filing bankruptcy because of medical bills," the exchange said.

Lee said a March report by Milliman that was sponsored by the exchange estimated that rates would increase roughly 25% on average, but such numbers were not realized when health carriers submitted their bids, he said. "What happened to the rate shock? Health plans to be consumer focused had to think first about affordability," Lee said. To achieve this goal, the carriers needed to consider the risk mix, get providers in their networks

to accept lower medical payments, and trust the health reform law's risk protections and lower administrative costs.

The next steps call for health plans to submit their bids to either the Department of Managed Health Care or the Department of Insurance, which will assess the rates for reasonableness. When that process is complete, Covered California will enter into final contracts with health plans. The exchange said insurers cannot raise or lower their rates unless the regulator finds them to be unreasonable, in which case the exchange would reconsider their rates.

Christine Arnold, a securities analyst for Cowen and Company, said in a May 20 note to investors before the Covered California announcement that current individual market leaders Health Net and WellPoint had the most to gain in terms of enrollment if selected for the California exchange. "WellPoint enrolled roughly 46% of the individual health insurance market in California as of year-end 2011 and we believe the company could enroll an additional 276,000 to 552,000 individuals eligible for subsidies through the exchange in 2014," Arnold said. Health Net is in line for an additional 18,000 to 36,000 individuals if it holds a 3% share of the individual market in 2014, she said.

Securities analyst Brian Wright of Monness Crespi Hardt in a May 21 memo agreed that WellPoint had the broadest geographical presence in the individual and small-group markets among publicly traded carriers, with Health Net focused more on Southern California. In addition to the market shares current market players have, Wright said rate levels would also be weighed "as Oregon and Washington have announced rate levels lower than many had expected [$210 to $239 per month for 21 year olds in Washington before subsidies and $169 to $422 for a 40 year old in Oregon]." He expected pricing in the California exchange to be slightly above small-group rates in the state, "though narrow network, value-based benefit designs could trim price levels somewhat."

Descriptions of the health plans on the Covered California exchange are at http://tinyurl.com/ozsjv35.

Contact Arnold at christine.arnold@cowen.com, Harbage at peter@harbageconsulting.com, Laszewski at robert.laszewski@healthpol.com, Loubet at hloubet@keenan.com and Wright at bwright@mchny.com. ✧

Upheaval Hits WellPoint Board; Cigna CFO Nicoletti Departs

In a May 14 filing to the U.S. Securities and Exchange Commission, WellPoint, Inc. told federal authorities that three of its 11 board directors had resigned for personal reasons, just six weeks after the insurer installed Joseph Swedish as its new CEO. A day earlier, rival insurer Cigna Corp. issued a statement saying that current vice president of finance, Thomas McCarthy, would replace Ralph Nicoletti as chief financial officer (CFO) this summer. Again, the rationale cited for Nicoletti's departure was personal reasons.

Brian Wright, securities analyst for Monness Crespi Hardt, in a May 14 note to investors said the WellPoint board resignations were "fortuitous for CEO Swedish as it allows him the opportunity to upgrade the talent of his board and we believe investors will view this favorably, as well." WellPoint on April 24 reported much better-than-predicted results for its first quarter of 2013 on favorable medical loss ratio numbers driven by lower utilization. It was the initial earnings period with Swedish in charge, but he didn't actually start work until March 25 *(HPW 4/29/13, p. 5)*. Swedish on May 20 also consolidated WellPoint's operating units (see brief, p. 8).

Wright added that the now-departed director Lenox Baker, Jr., M.D., a retired cardiac surgeon, had "historical ties" to Swedish's predecessor Angela Braly. The two other directors to step down were Susan Bayh, a lawyer and wife of former Sen. Evan Bayh (D-Ind.), and Sheila Burke, a faculty member at both the JFK School of Government at Harvard University and Georgetown University. Braly resigned last Aug. 28 under pressure from shareholders disturbed by the insurer's weak stock market performance and overall direction *(HPW 9/3/12, p. 1)*.

A third insurer, EmblemHealth, Inc., on May 15 said CEO Anthony Watson would retire effective on May 31. He has 28 years of experience with EmblemHealth and HIP Health Plan of New York (HIP). Watson in 2006 agreed with Frank Branchini, CEO of Group Health Incorporated (GHI), to merge HIP and GHI forming EmblemHealth. Watson has been chairman and CEO of EmblemHealth and Branchini its president and chief operating officer (COO). Branchini will now take the roles formerly held by Watson, while Dan Finke will become president and COO when confirmed at the EmblemHealth annual board meeting on May 22.

Contact Wright at bwright@mchny.com.

Key Financial Data for Leading Health Plans — First Quarter 2013 (Year-to-Date)

See more health plan financial data — including year-over-year comparisons of leading health plans' net income, premium revenue, medical loss ratios and net margins — at *Health Plan Week's* subscriber-only Web page at http://AISHealth.com. Click on "Key Financial Indicators" to access the data. *HPW* subscribers received a link to a complimentary Excel spreadsheet with this data, along with links to prior quarters, in the email that transmitted the PDF version of the newsletter. Non-subscribers can access this information for $141 per quarter at http://aishealth.com/marketplace/key-financial-indicators-leading-health-plans. If you are an *HPW* subscriber and do not receive subscriber emails, please contact custserv@aishealth.com or call 800-521-4323.

Company	Premium Revenue	Hospital/ Medical Costs	Pharmacy Costs	Total Medical Costs	Medical Loss Ratio	Administrative Costs	Admin. Expense Ratio	Net Income (Loss)	Net Margin
Aetna, Inc.	$7,785,800,000	NA	NA	$6,379,500,000	81.94%	$1,442,000,000	18.52%	$490,100,000	6.29%
Arkansas BCBS	$337,956,263	$179,054,699	$52,485,735	$278,148,834	82.30%	$21,236,320	6.28%	$14,938,148	4.42%
BCBS of Alabama	$1,011,703,384	$517,954,899	$191,152,678	$906,937,498	89.64%	$53,509,073	5.29%	$19,033,684	1.88%
BCBS of Arizona	$372,739,675	$182,602,892	$49,228,324	$277,831,851	74.54%	$25,253,590	6.78%	$32,969,866	8.85%
BCBS of Florida	$1,727,328,752	$955,961,483	$252,062,186	$1,430,840,171	82.84%	$183,413,875	10.62%	$6,282,351	0.36%
BCBS of Kansas City	$315,376,117	$212,137,387	$29,905,296	$246,211,988	78.07%	$22,122,617	7.01%	$1,907,224	0.60%
BCBS of Louisiana	$545,220,646	$319,297,257	$87,049,245	$407,042,502	74.66%	$55,592,257	10.20%	$54,969,608	10.08%
BCBS of Massachusetts	$1,582,330,757	$1,035,054,503	$216,348,906	$1,416,198,738	89.50%	$90,233,969	5.70%	$27,989,381	1.77%
BCBS of Michigan	$1,651,428,923	$1,180,524,011	$217,675,049	$1,437,099,017	87.02%	$173,919,682	10.53%	$42,750,058	2.59%
BCBS of Minnesota	$1,006,699,951	$650,000,166	$109,545,653	$841,666,531	83.61%	$82,408,404	8.19%	$51,013,351	5.07%
BCBS of Nebraska	$386,394,546	$256,330,526	$48,721,841	$310,947,253	80.47%	$36,038,850	9.33%	$20,915,150	5.41%
BCBS of North Carolina	$1,401,402,772	$885,787,240	$228,439,478	$1,243,546,439	88.74%	$94,331,161	6.73%	$33,088,063	2.36%
BCBS of Rhode Island	$388,388,000	$224,559,678	$42,395,113	$323,364,140	83.26%	$35,351,302	9.10%	$23,289,533	6.00%
BCBS of South Carolina	$524,922,455	$228,802,468	$75,093,639	$403,022,406	76.78%	$46,939,964	8.94%	$19,057,716	3.63%
BCBS of Tennessee	$904,622,759	$521,001,617	NA	$695,351,176	76.87%	$72,050,774	7.96%	$74,845,545	8.27%
Blue Cross of NE Pennsylvania	$59,232,873	$49,405,729	$3,558,618	$53,588,726	90.47%	$2,054,521	3.47%	$4,028,394	6.80%
Blue Shield of California	$1,996,944,000	NA	NA	$1,733,120,000	86.79%	$261,351,000	13.09%	$114,975,000	5.76%
Capital Blue Cross	$362,762,030	$362,762,030	$38,763,006	$328,903,130	90.67%	$38,903,130	10.72%	($3,120,706)	-0.86%
CareFirst BCBS	$1,755,069,797	$1,125,379,540	$334,766,273	$1,547,849,781	88.19%	$175,611,775	10.01%	$37,999,913	2.17%
CareSource	$946,112,796	$570,808,102	$161,292,331	$791,413,690	83.65%	$108,222,180	11.44%	$38,556,598	4.08%
Centene Corp.	$2,509,049,000	NA	NA	$2,267,400,000	90.37%	$210,348,000	8.38%	$23,002,000	0.92%
Cigna HealthCare	$5,000,000,000	NA	NA	$4,047,000,000	80.94%	$1,319,000,000	26.38%	$427,000,000	8.54%
EmblemHealth, Inc.	$2,528,784,363	$1,429,726,952	$301,729,698	$2,176,322,000	86.06%	$209,545,218	8.29%	$33,270,323	1.32%
Group Health Cooperative	$825,991,099	$545,898,612	$93,896,676	$682,011,339	82.57%	$67,055,990	8.12%	$60,412,490	7.31%
Harvard Pilgrim Health Care	$502,701,875	$342,204,689	$57,916,931	$435,683,831	86.67%	$48,383,560	9.62%	$4,608,658	0.92%

Web addresses cited in this issue are live links in the PDF version, which is accessible at HPW's subscriber-only page at http://aishealth.com/newsletters/healthplanweek.

Company	Premium Revenue	Hospital/ Medical Costs	Pharmacy Costs	Total Medical Costs	Medical Loss Ratio	Administrative Costs	Admin. Expense Ratio	Net Income (Loss)	Net Margin
Hawaii Medical Service Assn.	$635,924,080	$500,302,092	$75,253,890	$595,708,011	93.68%	$38,925,328	6.12%	($3,567,265)	-0.56%
Health Alliance Plan of Michigan	$470,194,791	$310,790,000	$56,268,904	$423,808,353	90.13%	$35,197,767	7.49%	$5,598,857	1.19%
Health Care Service Corp.	$5,515,056,325	$3,677,345,642	$645,909,991	$4,398,493,441	79.75%	$465,981,258	8.45%	$338,704,482	6.14%
Health Net, Inc.	$2,632,069,000	NA	NA	$2,268,736,000	86.20%	$245,235,000	9.32%	$50,050,000	1.90%
HealthNow New York, Inc.	$618,142,397	$410,081,648	$87,703,451	$571,369,213	92.43%	$49,317,588	7.98%	($4,388,605)	-0.71%
HealthPartners, Inc.	$229,983,000	$165,745,000	$17,297,000	$183,042,000	79.59%	$30,431,000	13.23%	$9,015,000	3.92%
Highmark, Inc.	$2,554,095,086	$1,912,096,117	$357,970,150	$2,290,906,674	89.70%	$127,948,523	5.01%	($45,548,353)	-1.78%
Humana, Inc.	$9,868,000,000	NA	NA	$8,195,000,000	83.05%	$1,446,000,000	14.65%	$473,000,000	4.79%
Kaiser Permanente	$2,757,895,264	$1,157,739,140	$257,305,181	$2,588,048,391	93.84%	$141,402,243	5.13%	$36,525,462	1.32%
Lifetime Healthcare Companies/ Excellus	$1,570,804,971	$974,468,799	$267,637,003	$1,380,876,211	87.91%	$116,782,623	7.43%	$74,689,085	4.75%
Managed Health, Inc.	$411,539,594	$206,384,807	$57,784,330	$356,651,175	86.66%	$51,416,956	12.49%	($2,874,492)	-0.70%
Medica Health Plans	$787,187,904	$574,966,144	$83,512,111	$699,102,855	88.81%	$73,516,532	9.34%	$8,604,287	1.09%
Medical Mutual of Ohio	$616,491,825	$296,634,295	$67,318,697	$446,020,833	72.35%	$80,437,226	13.05%	$49,324,032	8.00%
Molina Healthcare	$1,534,608,000	NA	NA	$1,288,754,000	83.98%	$141,407,000	9.21%	$29,915,000	1.95%
MVP Health Care	$569,816,256	$415,636,818	$76,257,365	$530,604,716	93.12%	$50,323,347	8.83%	($17,383,870)	-3.05%
Premera Blue Cross	$629,345,521	$425,837,089	$62,975,096	$544,848,932	86.57%	$36,564,869	5.81%	$24,866,163	3.95%
Priority Health	$570,205,559	$395,048,816	$69,471,606	$504,117,934	88.41%	$33,614,548	5.90%	$16,470,565	2.89%
Regence Group, The	$1,494,128,412	$759,458,111	$188,027,792	$1,240,626,627	83.03%	$116,525,531	7.80%	$83,506,415	5.59%
SelectHealth	$359,963,282	$230,410,641	$33,025,130	$299,322,717	83.15%	$20,646,989	5.74%	$28,584,766	7.94%
Tufts Associated Health Plans	$684,055,782	$506,058,691	$72,926,726	$607,790,934	88.85%	$47,159,968	6.89%	$15,889,179	2.32%
UnitedHealth Group	$27,274,000,000	NA	NA	$22,569,000,000	82.75%	$4,614,000,000	16.92%	$1,240,000,000	4.55%
UPMC Health Plan	$918,284,548	$526,037,131	$151,742,219	$835,607,996	91.00%	$76,518,053	8.33%	$153,239	0.02%
WellCare Health Plans	$2,252,325,000	NA	NA	$1,987,283,000	88.23%	$213,376,000	9.47%	$21,518,000	0.96%
Wellmark, Inc.	$848,055,822	$502,645,872	$104,168,473	$665,576,184	78.48%	$69,994,162	8.25%	$82,517,757	9.73%
WellPoint, Inc.	$16,435,600,000	NA	NA	$13,748,700,000	83.65%	$1,979,100,000	12.04%	$885,200,000	5.39%

NA= not available. Medical Loss Ratio=Medical Costs/Premium Revenue. Net Margin=Net Income/Premium Revenue. Administrative Cost Ratio=Admin Costs/Premium Revenue
SOURCE/METHODOLOGY: Prepared by AIS researchers based on selected data points from annual and quarterly financial statements filed with the U.S. Securities and Exchange Commission and relevant state insurance departments. Health plans have been selected based on medical risk enrollment as of end of year 2012, per *AIS's Directory of Health Plans: 2013*. The data set represents companies identified as Health Insurance, HMO and Hospital, Medical and Dental Service or Indemnity (HDMI) companies. Data are not available for companies identified as life and health, disability, annuity or other insurance companies. Data may represent dental, vision and other lines of business in addition to medical benefits, where applicable. Some companies are consolidated, representing two or more subsidiaries with premium revenue. Some cost breakdowns may be unavailable. Costs may be defined differently by different sources; administrative costs may or may not include cost of sales. Medical costs include hospital/medical and pharmacy costs, prior to reinsurance recoveries. Cigna data represents medical operations of the company's Global Health Care segment only; other companies' data includes total operations. The publisher does not warrant that the information contained herein is complete or accurate.

HEALTH PLAN BRIEFS

◆ **Minnesota's legislature has approved a new insurance mandate that will require some health plans in the state to cover intensive autism treatment that can cost as much as $100,000 per year,** according to a May 21 article in the *Minneapolis Star Tribune.* Minnesota Gov. Mark Dayton (D) was set to sign the legislation into law as *HPW* went to press. The bill calls for state-regulated health plans to pay for any autism treatment that's considered medically necessary for children up to age 18. The mandate will apply only to insurers covering 50 or more employees in fully insured plans, and excludes most large employers, which are self-insured. The newspaper said it will affect around 750,000 state residents or 14% of the population. Visit http://tinyurl.com/pmzv4j9.

◆ **WellPoint, Inc. on May 20 told investors in a Securities and Exchange Commission (SEC) filing that it would reorganize the company's business units to two from the current four.** In a memo included in the SEC filing, WellPoint CEO Joe Swedish said he is making the move following the completion of his first 60 days in office in order to "increase accountability and enable our businesses to more quickly respond to market changes." The Commercial and Specialty Business Division (CSBD) comprises local group and national accounts, exchange and individual businesses, specialty businesses and 1-800-CONTACTS. The Government Business Division (GBD) consists of Medicaid, Medicare, national government services and the federal employee program. Ken Goulet will lead CSBD operations and Dick Zoretic will head the GBD. Swedish also said in the memo that Lori Beer, executive vice president, specialty businesses and information technology, will be departing WellPoint due to the reorganization. Visit http://tinyurl.com/pjka6tj.

◆ **Aetna Inc. on May 20 launched its Patient-Centered Medical Home (PCMH) program in New York to recognize primary care physicians who better manage and coordinate their patients' care.** Participating doctors in Aetna's networks who qualify will receive a quarterly payment for each commercial Aetna member in their care. Aetna serves 880,000 commercial members in New York and more than 200 physician practices are part of the PCMH, the company said. Visit http://tinyurl.com/nhwqt4t.

◆ **UnitedHealth Group's UnitedHealthcare Community Plan is adding 13 additional counties to its New York state government-sponsored health insurance program in the Hudson Valley, capital and central regions of New York,** the insurer said May 20. The program was previously available in New York City, Long Island and portions of central New York. The community plan offers products for individuals and families who may qualify for Medicaid, Family Health Plus, Child Health Plus, New York Medicaid Advantage or dual-eligible plans. UnitedHealthcare serves 3.8 million-plus members in New York. Visit http://tinyurl.com/nozgbs8.

◆ **WellCare Health Plans, Inc. on May 20 said its Medicare Advantage (MA) members now will have access to 370-plus Take Care Clinics in select Walgreen Co. pharmacies in 19 states and Washington, D.C.** Take Care Clinics, operated by Walgreens' Take Care Health Systems unit, are in Arizona, Colorado, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nevada, New Jersey, Ohio, Pennsylvania, Tennessee, Texas and Wisconsin and Washington, D.C. Visit http://tinyurl.com/pvdnf4h.

◆ **Wellmark Blue Cross and Blue Shield of Iowa said May 21 it's collaborating with Mercy Medical Center in Cedar Rapids and the University of Iowa Hospitals and Clinics in Iowa City to create an accountable care organization (ACO).** The new ACO will focus on coordinating patient care to improve quality, provide greater value and slow increases in health care costs, according to Wellmark. A spokesperson for Wellmark told *HPW* that there will be no more ACOs announced in 2013, but that they are currently working with potential ACOs for a January 2014 start date. Visit www.wellmark.com.

◆ **Humana Inc. said May 22 that it plans to open a RightSource mail-order pharmacy call center and support operation in Irving, Texas, in August.** Humana Pharmacy Solutions' RightSource unit provides mail-order delivery to members' homes. The insurer said it expects to bring more than 620 new jobs to the area over the next three years. Visit http://tinyurl.com/o6nfdrk.

◆ **PEOPLE ON THE MOVE:** CalOptima named **Patti McFarland** chief financial officer (CFO). McFarland previously was CFO at Central Coast Alliance for Health....WellCare Health Plans, Inc.'s board of directors elected **David Gallitano** chairman.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)