Volume 23, Number 42 November 25, 2013

HEALTH PLAN WEEK

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

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*PUBLISHER'S NOTE: **HPW** will not be published next week. The next issue will be dated Dec. 9. Happy Thanksgiving!*

Editor
Patrick Connole
pconnole@aishealth.com

Contributing Editor
Judy Packer-Tursman

Managing Editor
Steve Davis

Executive Editor
Jill Brown

Fate of Key ACA Provisions May Hinge on Nov. 30 Deadline to Fix HealthCare.gov

The wheels will go whirling off the Obamacare bus if HHS's hobbled HealthCare.gov website isn't humming by the agency's self-imposed Nov. 30 deadline, a panel of securities analysts and industry observers warned at the Center for Studying Health System Change's annual Wall Street Comes to Washington conference on Nov. 19.

"It all comes down to Nov. 30. If the website is not functioning,…then I think you see a stampede of Democratic legislators in risky elections this year [drafting] legislation as fast as they can to delay the individual mandate or extend the open-enrollment period," predicted Carl McDonald, a securities analyst at Citigroup Global Markets Inc. Lawmakers are worried that a constituent — whose insurance policy was cancelled because it's not compliant with the Affordable Care Act (ACA) — will wind up uninsured due to an inability to access exchange-based coverage. If that person were to have a catastrophic event that results in a $50,000 hospital bill in January, "it's game over if it happens in your district.…At least that's the feeling that a lot of [Democratic lawmakers] have right now," he told attendees.

Much of the success or failure of the website is now in the hands of Quality Software Services, Inc. (QSSI), a contractor that in October accepted partial blame for the troubled rollout of the website. QSSI, which UnitedHealth Group's Optum unit acquired in 2012, had a contract for developing the federal Data Services Hub and the front-end enrollment system *(HPW 12/17/12, p. 3)*. The company is now charged with

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Insurers Wade Through Their Options as States, Exchanges Ponder Enrollment Fixes

State insurance regulators are continuing to issue decisions on whether to follow President Obama's lead and allow previously cancelled health plans to see new life even though coverage does not meet Affordable Care Act (ACA) standards *(HPW 11/18/13, p. 1)*, putting health insurers in the middle of a shifting market landscape, industry consultants say. The next steps for carriers will be to determine how regulatory decisions will affect their product lineup for 2014 and whether it makes economic sense to seek renewals for cancelled plans or to instead focus on exchange-related or off-exchange opportunities separate from those policies.

In that light, the board of the California exchange, Covered California, voted 5-0 on Nov. 21 to reject extensions for these cancelled plans for one year, saying doing so would distort their efforts in implementing the ACA and confuse consumers trying to figure out their options for 2014. This puts California with other states like Massachusetts, Minnesota and New York that are operating their own exchanges and also said no to letting cancelled plans back into the market.

Covered California did, however, make moves to ensure the more than 1.1 million customers whose plans have been cancelled can get more direction on how to find exchange-based coverage. These changes include extending the deadline from Dec. 15

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
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to Dec. 23 for enrollment in coverage taking effect on Jan. 1, 2014, and stretching the deadline for payments due from Dec. 26 to Jan. 5, 2014. The board also is establishing a telephone hotline for consumers to resolve enrollment questions, sending information directly to affected individuals that provides clear options for coverage, and engaging consumers in their communities through thousands of insurance agents, enrollment counselors and certified educators.

Still, other insurance departments and public exchanges, like in Florida and North Carolina where powerful Blues plans are supportive of extending cancelled plans, have said yes to reviving these once-dead plans even though doing so will take an enormous effort to finalize before year's end. In all states, regulators and health plans are weighing a series of factors in their decision-making. Among them is the question of whether granting extensions will inflate premiums by sending older and sicker people to exchanges while healthier people get to keep their 2013 plans through 2014, negatively affecting the risk pool. Another question is whether carriers can resubmit rates to account for higher medical costs. For instance, Blue Cross and Blue Shield of North Carolina has asked regulators for premiums as much as 24% higher for these formerly cancelled individual plans.

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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Editor, Patrick Connole; Contributing Editor, Judy Packer-Tursman; Managing Editor, Steve Davis; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Assistant, Ivory Smith

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"The big challenge is on the exchange side, because you are carving off a big chunk of the existing individual market that otherwise was priced to go on the exchange," Brian Weible, vice president and actuary at Wakely Consulting Group, tells *HPW*.

Policy Shift Is Each State's Call

In Kansas, Linda Sheppard, special counsel and health care policy and analysis director for the Kansas Insurance Department, tells *HPW* that it will be a "scramble" to get once-cancelled policies renewed in time for 2014. The state's largest insurer, Blue Cross and Blue Shield of Kansas, said it would send out notices to around 10,000 policyholders that their previously cancelled plans can now be extended through next year. "Blue Cross did not have approved rates going into 2014 because they had not planned on selling these plans in 2014. So, part of what we're working is on rate filings for those plans," she says. "Certainly they will be adjusted higher for medical costs and age adjustments."

For health insurers in Minnesota, a state that rejected the option to extend cancelled plans, it was "crucial" to not let such coverage back into the marketplace, Julie Brunner, executive director of the Minnesota Council of Health Plans, tells *HPW*. "We were clear in our letter to the governor it was not possible for us to make these changes and reinstate policies that no longer exist, provide notice and meet a Jan. 1 deadline. So, it was critical. Most importantly, we knew it would lead to huge confusion and potentially prevent people from finding coverage on the [MNSure] exchange," she says.

With California's rejection of Obama's proposed plan extensions, 10 of the 51 insurance commissioners across the country, including Washington, D.C., said they would not comply with the president's Nov. 14 policy change, according to a map compiled by America's Health Insurance Plans. Twelve states have said they will give insurers the option of continuing to offer plans that were cancelled because they did not meet the ACA's new minimum requirements. Most of the remaining states said they are still examining the policy change and conferring with insurers.

Where Do Insurers Go From Here?

What does this latest market confusion mean to insurers and their 2014 strategies? Dan Mendelson, president of Avalere Health LLC, says Obama's proposal may not mean much. "I think at the end of the day, this is going to have a relatively small effect on the market," he tells *HPW*. "I think about half of the insurance commissioners will decide not to allow this insurance in their states. And many of the policies will not be offered because they are unprofitable, and why would the insurance companies offer them? Frankly, most of these people

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who had these policies will be better off buying their policies on the exchange. A lot of them will be subsidized and the product is just a lot more stable."

Henry Loubet, the chief strategy officer for Keenan, a California-based health care consulting and brokerage firm, and former CEO of UnitedHealthcare's Western operations, tells *HPW* that the proposal "creates a lot of uncertainty in the marketplace…which I think is so unfortunate because there are so many good aspects of what is out there [in the ACA]. Insurers have taken a significant amount of risk with guaranteed issue, no medical underwriting and everything else, in addition to all the challenges of administering this."

"There are definitely more challenges now because you are sort of fracturing the risk pools," Dan Schuyler, head of the health insurance exchange practice at Utah-based consulting firm Leavitt Partners and the former director of technology at the Utah Health Exchange, tells *HPW*.

"And the carriers were planning on a certain group of people being in a certain risk pool if you will to be able to assess the risk adjustment and the reinsurance," he says. "So now you could have this fragmentation where people will be in for the next 13 months....[That] makes it very difficult to assess how that risk is going to be shared throughout the marketplace. It sort of destabilizes those risk pools."

If insurers see the cancelled policy renewals putting a dent in their exchange business because of the actuarial shifts, that "is definitely going to have an impact on costs.

continued

State-Run Public Exchanges Gather Enrollees, Skirt Most FFE Mayhem

A health insurance executive whose carrier is active on the Connecticut public exchange tells *HPW* that the state's early start in forming Access Health CT and across-the-board stakeholder support are reasons why the marketplace has experienced a successful first six weeks. In general, the 14 states and District of Columbia that chose to run their own exchanges have seen fewer operational hazards than the federal facilitated exchanges (FFEs), and some have stood out for their performance, including Access Health CT, Kentucky's kynect and Minnesota's MNSure.

"So far it is going pretty well," Michael Wise, president of ConnectiCare, a subsidiary of New York-based EmblemHealth, tells *HPW*. "This is new to everybody but our general expectation was that things would start off generally slow. It is brand new and takes people a little bit of time to understand what the options are, and so I would say the start has been about on our expectation. The real question is, will enrollment accelerate over time or will it not? That is yet to be seen."

The fact that the state sought broad participation to make the exchange work is one key to the good start, he says. "I think this was in part due to the leadership that was on board. They realized the exchange was not a regulatory body, but it was a distribution vehicle. So because of that they really worked with the health plans to try to ensure that the transactions between us would really work, [and] it would fulfill the mission that they were charged with," Wise says.

As in other state-run exchanges, Access Health CT has made demographic information on enrollees much more readily available than has HHS. The Connecticut exchange reports that WellPoint, Inc. unit Anthem Blue Cross and Blue Shield of Connecticut has garnered the most business thus far with 62% of the market and ConnectiCare at 35%, and as of Nov. 14, 54% of the 12,648 individuals enrolled in private insurance plans and government-funded Medicaid are between 45 and 64. Excluding Medicaid, of the 7,092 who enrolled in private insurance, 61% are between 45 and 64.

For Wise, the numbers show the exchange skewing slightly older than first expected, and customers have tended to buy more gold plans than projected. "Not surprisingly, half of the people are in various silver plan options and about a quarter in gold options. It may be a little bit more on the gold side than originally anticipated [as opposed to silver]," Wise says.

The federal website issues have not affected Access Health CT, but the interactions with the Federal Data Hub to verify enrollee identification and subsidy status are a concern.

Kevin Counihan, CEO of Access Health CT, tells *HPW* the exchange is as "self-sufficient" as possible and thus far has a 96.5% satisfaction rate from its users. He says the woes at the federal level have created a gap in perception that may prevent as many people enrolling on exchanges because of the attention to early defects, but the Connecticut marketplace has been fortunate in its ability to enroll people.

Contact Counihan via Amy Tibor at amy.tibor@ct.gov and Wise via Amanda Mueller at amandam@cashman-katz.com.

So it will be interesting to see how that affects what carrier are going to have to do to make up those costs come third quarter of 2014 when they start doing the projections for the renewals for 2015," Schuyler says.

HHS Seeks More Carrier Website Traffic

Against the backdrop of these state-by-state assessments, the larger issue is if and when HHS can fix its faltering HealthCare.gov website for enrolling people on federally facilitated exchanges (FFEs).

The ACA already allows carriers to sell exchange-based coverage through their own websites, as well as via web-based entities. But HHS is working to make "it easier for insurance companies to enroll the full gamut of people directly," Mendelson says. "It only makes sense, because while these websites are down you can call the insurers in your area and get coverage. There is nothing preventing them; these websites are just intermediaries," he adds. "What they [HHS officials] are doing is facilitating the subsidy calculations by the insurers" in a go-around to take pressure off the still troubled HealthCare.gov site.

Agents and brokers can also be called on to play a larger role in the effort to boost enrollment in exchange-related products, according to Kathryn Gaglione, spokesperson for the National Association of Health Underwriters. "Agents can in essence stand in line for their clients. They can also fill out paper applications and look for plans outside of the exchanges. Even if someone qualifies for a subsidy, that doesn't necessarily make it the best option. Many subsidies aren't substantial, and there are other health and financial issues that might make the plans on the exchange impractical for some people," she says.

Insurers and regulators did get some clarification on how to approach members who were previously told that their plans were cancelled. On Nov. 21, CMS issued a letter to state insurance commissioners outlining a transitional policy for non-grandfathered coverage in the small-group and individual health insurance markets. The document can be viewed at http://tinyurl.com/n3hqd7b.

Contact Schuyler at dan.schuyler@leavittpartners.com, Mendelson at dmendelson@avalerehealth.net, Sheppard via Bob Hanson at bhanson@ksinsurance.org, Loubet via Jennifer Davis at jdavis@keenan.com, Brunner via Eileene Smith at smith@mnhealthplans.org, Gaglione at kgaglione@nahu.org and Weible at brianw@wakely.com. ✧

Managed Long-Term Care: Evolving Strategies for Health Plans

- What kinds of procurement approaches are being used for managed LTC nationwide?
- How do state approaches differ in areas such as network contracting and care management?
- What are the levels and methods of determining payment rates for managed LTC?
- What compliance standards will managed LTC plans have to meet?
- How did Florida develop its new Medicaid managed long-term care procurement? What steps is the plan that won the most regions in this procurement taking to get ready for that giant program?
- What are the staffing and facility levels associated with Florida's initiative?
- How is Massachusetts approaching LTC for duals in its just-launched, CMS-approved demonstration program?
- How is one of the Massachusetts plans offering LTC in the duals initiative handling the challenges in implementation and financing?
- Where do the greatest opportunities exist for a health plan seeking to enter — or improve upon its current — managed LTC business?

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Website Enters Crucial Time

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managing the process of fixing the website, noted Sheryl Skolnick, Ph.D., managing director at CRT Capital Group.

"I find it very interesting that this all comes down to the capability of a general contractor owned by a managed care company that has elected to participate in" a limited number of individual exchanges, she said. "From a technology perspective, we are very much reliant on the ability of UnitedHealth to get things done in order to know if we are going to have a turnover in the Democratic Party….This is setting up to be quite an eventful [Thanksgiving] holiday," she quipped.

Analysts Cut Enrollment Projections

Prior to the launch of the exchange open-enrollment period, the Congressional Budget Office (CBO) had projected exchange enrollment of 7 million (composed of 4 million previously uninsured, 2 million currently insured and 1 million whose employers had dropped health coverage).

McDonald said he initially thought CBO's estimate of already insured enrollees was too low given that half of the 10 million people who now have individual coverage will qualify for federal premium assistance. Ultimately, a majority of them might switch, which would push enrollment higher than CBO's projections, he said. But given the challenges the exchanges have faced to date, he said it was doubtful "we will get anywhere near that number." Matthew Borsch, an analyst at Goldman, Sachs & Co., said that his firm cut its enrollment projections four weeks ago — from 7 million to 5 million. He noted there was no real science to the forecast other than factoring in the problems the websites have encountered.

During a Nov. 6 conference call to discuss third-quarter 2013 earnings, Humana Inc. Chief Operating Officer James Murray said company would likely need to slash its initial 2014 enrollment projection of 500,000 to 250,000 or less. Aetna Inc. has urged the administration to temporarily "pause" HealthCare.gov until all fixes are made. And based on preliminary demographic information from state-run insurance exchanges, the marketplaces could wind up with an older and sicker population.

"But I don't think that should surprise anyone given the website issues," McDonald told attendees. "If you're sick, you're willing to [sit in front of a computer] all day and every day.…If you're healthy, you're just not going to." Moreover, some exchanges have indicated that many enrollees don't qualify for premium subsidies, which could indicate poor health status.

While the risk corridors called for by the ACA were designed to protect health plans from adverse selection, Robert Berenson, M.D., a fellow at the Urban Institute who also spoke at the conference, noted that the provision was becoming a political issue because it is seen as "bailing out insurance companies" by some Republican lawmakers.

Medicaid Attracts Much Carrier Interest

Many of the products being sold on the exchanges by Medicaid managed care companies appear to be aimed at low-income populations so that they can retain enrollees who cycle between Medicaid and commercial coverage, said Borsch.

But those plans often are among the lowest-priced options on the exchanges, which could attract some higher-income enrollees, he added. "The tradeoff typically is more restrictive networks or providers that have historically been oriented toward serving a Medicaid population," he said.

McDonald added that an enrollee might be surprised if the only in-network hospital is an inner-city facility. And Medicaid managed care companies haven't previously had to worry about out-of-network services.

While about half of the states have opted not to expand Medicaid eligibility, analysts predicted more states would change that position over the next couple of years. Much of the opposition to the expansion has been more politically than financially driven, McDonald said. But the political climate in a state such as Texas would need to change substantially before that would happen, Skolnick added. States that have expanded Medicaid appear to be relying more on managed care.

Contact McDonald at carl.mcdonald@citi.com and Borsch at matthew.borsch@gs.com. Visit http://tinyurl.com/knmhgld for a webcast of the conference. ✧

Additional News of the Week

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

- Are Insurers Luring Customers From Exchanges?
- Wellmark to Run Ads Mocking ACA Website
- Ala. Blues Won't Reinstate Canceled Policies
- Blue Cross: Pay Higher Rates to Keep Policies
- Cigna to Hire in Pittsburgh
- United Cuts Thousands of Physicians From Network

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

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Key Financial Data for Leading Health Plans — Third 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 e-mails, 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.	$28,512,300,000	NA	NA	$23,548,300,000	82.59%	$5,154,800,000	18.08%	$1,544,700,000	5.42%
Arkansas BCBS	$1,040,596,630	$550,265,224	$153,681,524	$826,593,409	79.43%	$70,890,221	6.81%	$37,062,360	3.56%
BCBS of Alabama	$3,096,903,640	$1,529,083,672	$559,346,976	$2,722,791,834	87.92%	$176,866,530	5.71%	$75,936,512	2.45%
BCBS of Arizona	$1,130,485,088	$594,095,275	$158,202,736	$908,584,369	80.37%	$74,730,343	6.61%	$83,323,501	7.37%
BCBS of Florida	$5,188,517,143	$2,867,663,738	$778,612,506	$4,337,842,708	83.60%	$554,692,324	10.69%	$148,112,188	2.85%
BCBS of Kansas City	$934,976,667	$672,992,231	$93,217,184	$783,687,475	83.82%	$96,875,896	10.36%	$6,266,959	0.67%
BCBS of Louisiana	$1,624,965,590	$1,059,541,205	$273,812,259	$1,334,273,067	82.11%	$170,470,048	10.49%	$77,060,117	4.74%
BCBS of Massachusetts	$4,685,552,230	$3,147,347,197	$651,478,872	$4,290,638,338	91.57%	$257,241,040	5.49%	$65,004,855	1.39%
BCBS of Michigan	$4,942,016,448	$3,486,677,491	$673,046,968	$4,267,026,372	86.34%	$606,083,599	12.26%	$15,480,037	0.31%
BCBS of Minnesota	$3,051,740,351	$1,995,218,969	$346,814,342	$2,595,533,294	85.05%	$255,880,814	8.38%	$109,980,960	3.60%
BCBS of Nebraska	$1,170,362,831	$810,746,750	$150,308,966	$979,749,121	83.71%	$111,057,119	9.49%	$42,255,923	3.61%
BCBS of North Carolina	$4,314,184,601	$2,702,812,452	$654,493,260	$3,757,146,744	87.09%	$331,771,120	7.69%	$119,886,304	2.78%
BCBS of Rhode Island	$1,154,535,792	$688,200,314	$126,936,519	$984,959,255	85.31%	$106,341,472	9.21%	$28,865,073	2.50%
BCBS of South Carolina	$1,590,767,002	$702,173,927	$229,704,753	$1,227,265,882	77.15%	$131,485,479	8.27%	$76,025,682	4.78%
BCBS of Tennessee	$2,735,835,807	$1,641,384,047	$818,441,000	$2,199,863,717	80.41%	$218,263,769	7.98%	$155,808,415	5.70%
Blue Cross of NE Pennsylvania	$217,273,389	$188,422,517	$11,213,685	$200,702,090	92.37%	$7,571,030	3.48%	$15,302,211	7.04%
Blue Shield of California	$6,193,025,000	NA	$818,441,000	$5,396,650,000	87.14%	$775,173,000	12.52%	$235,136,000	3.80%
Capital Blue Cross	$944,966,898	$944,966,898	$86,807,525	$837,191,854	88.59%	$99,529,550	10.53%	($2,640,107)	-0.28%
CareFirst BCBS	$5,534,044,271	$3,316,560,784	$1,001,230,229	$4,681,735,016	84.60%	$556,907,395	10.06%	$81,789,419	1.48%
CareSource	$2,931,785,020	$1,771,526,439	$505,565,021	$2,461,368,149	83.95%	$338,167,661	11.53%	$107,867,101	3.68%
Centene Corp.	$7,659,418,000	NA	NA	$6,810,892,000	88.92%	$694,204,000	9.06%	$111,859,000	1.46%
Cigna HealthCare	$14,751,000,000	NA	NA	$11,864,000,000	80.43%	$4,054,000,000	27.48%	$1,230,000,000	8.34%
EmblemHealth, Inc.	$7,382,504,383	$4,261,413,392	$876,354,579	$6,467,016,095	87.60%	$622,395,902	8.43%	$137,874,179	1.87%
Group Health Cooperative	$2,464,848,669	$1,711,590,028	$269,072,048	$2,112,967,913	85.72%	$195,465,619	7.93%	$107,136,779	4.35%
Harvard Pilgrim Health Care	$1,513,338,586	$1,018,590,736	$176,497,227	$1,318,646,021	87.13%	$153,432,775	10.14%	$9,142,869	0.60%

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.	$1,988,209,648	$1,594,979,468	$221,343,652	$1,876,676,192	94.39%	$117,122,727	5.89%	($5,461,657)	-0.27%
Health Alliance Plan of Michigan	$1,408,136,914	$912,399,742	$174,891,481	$1,256,015,737	89.20%	$118,854,280	8.44%	$18,843,290	1.34%
Health Care Service Corp.	$16,791,169,465	$11,771,663,061	$2,069,744,922	$14,015,051,770	83.47%	$1,240,137,010	7.39%	$890,107,302	5.30%
Health Net, Inc.	$7,817,697,000	NA	NA	$6,657,215,000	85.16%	$804,355,000	10.29%	$150,373,000	1.92%
HealthNow New York, Inc.	$1,844,545,204	$1,190,165,161	$268,656,454	$1,682,807,196	91.23%	$144,743,172	7.85%	$6,754,249	0.37%
HealthPartners, Inc.	$674,846,000	$493,366,000	$58,426,000	$551,792,000	81.77%	$82,320,000	12.20%	$18,680,000	2.77%
Highmark, Inc.	$7,598,044,042	$5,682,411,100	$1,036,188,862	$6,779,360,656	89.23%	$386,595,260	5.09%	$134,761,385	1.77%
Humana, Inc.	$29,267,000,000	NA	NA	$24,361,000,000	83.24%	$4,447,000,000	15.19%	$1,261,000,000	4.31%
Kaiser Permanente	$8,283,115,449	$3,516,261,848	$798,196,799	$7,875,677,594	95.08%	$441,096,788	5.33%	($127,276,159)	-1.54%
Lifetime Healthcare Companies/Excellus	$4,714,270,757	$3,064,782,979	$678,971,417	$4,234,805,282	89.83%	$359,199,515	7.62%	$50,721,427	1.08%
Managed Health, Inc.	$1,193,149,328	$633,999,376	$127,332,061	$1,037,926,788	86.99%	$139,151,435	11.66%	($5,357,424)	-0.45%
Medica Health Plans	$2,411,957,874	$1,765,417,038	$266,038,383	$2,157,992,851	89.47%	$220,644,564	9.15%	$17,727,066	0.73%
Medical Mutual of Ohio	$1,862,543,484	$957,597,445	$211,714,592	$1,453,536,473	78.04%	$194,827,697	10.46%	$102,688,334	5.51%
Molina Healthcare	$4,583,818,000	NA	NA	$3,965,834,000	86.52%	$478,990,000	10.45%	$62,055,000	1.35%
MVP Health Care	$1,686,340,338	$1,201,811,701	$205,270,525	$1,522,497,581	90.28%	$140,965,841	8.36%	$4,771,860	0.28%
Premera Blue Cross	$1,935,411,401	$1,301,333,478	$203,241,389	$1,672,175,905	86.40%	$113,642,009	5.87%	$68,626,374	3.55%
Priority Health	$1,716,797,659	$1,168,635,675	$213,551,460	$1,504,851,964	87.65%	$105,595,222	6.15%	$52,367,431	3.05%
Regence Group, The	$4,437,756,128	$2,237,727,496	$583,719,000	$3,701,750,618	83.41%	$359,884,408	8.11%	$111,368,024	2.51%
SelectHealth	$1,090,646,864	$701,561,848	$102,938,368	$935,546,237	85.78%	$61,078,777	5.60%	$65,424,954	6.00%
Tufts Associated Health Plans	$2,070,168,390	$1,509,573,752	$210,952,077	$1,808,793,607	87.37%	$151,302,807	7.31%	$77,749,161	3.76%
UnitedHealth Group	$81,850,000,000	NA	NA	$66,786,000,000	81.60%	$14,308,000,000	17.48%	$4,198,000,000	5.13%
UPMC Health Plan	$2,839,578,496	$1,615,112,711	$453,015,375	$2,552,725,048	89.90%	$242,302,723	8.53%	$18,948,537	0.67%
WellCare Health Plans	$7,075,254,000	NA	NA	$6,147,863,000	86.89%	$637,590,000	9.01%	$132,412,000	1.87%
Wellmark, Inc.	$2,524,095,903	$1,545,990,889	$321,848,605	$2,051,175,242	81.26%	$214,457,791	8.50%	$161,995,355	6.42%
WellPoint, Inc.	$49,509,500,000	NA	NA	$41,656,300,000	84.14%	$6,275,600,000	12.68%	$2,341,500,000	4.73%

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.

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HEALTH PLAN BRIEFS

◆ **HHS is planning to delay the start of the second year of public exchange enrollment by a month in order to give health insurers some extra time to set rates based on their 2014 experiences,** according to a Nov. 22 report in *Politico* quoting an HHS official. The delay would mean that enrollment for the 2015 plan year would start on Nov. 15, 2014, and end on Jan. 15, 2015, instead of the original window from Oct. 15 to Dec. 7. Visit http://tinyurl.com/nlq8hmf.

◆ **A top CMS technology official said that up to 40% of the HealthCare.gov website is still being built, particularly the "back-office systems,"** ***The New York Times*** **reported Nov. 19.** "We still have to build the financial management aspects of the system, which includes our accounting system and payment system and reconciliation system," Henry Chao, CMS's deputy chief information officer and deputy director in the Office of Information Services, told the House Energy and Commerce Committee at a hearing. In written testimony, Chao noted that some fixes have already been completed, including the ability to successfully create an account. "This issue is something that we identified on October 1, and we have made significant progress since then to deliver a much smoother process for consumers. Users can now successfully create an account and continue through the full application and enrollment process. We are now able to process nearly 17,000 registrants per hour, or 5 per second, with almost no errors," he said. Read the Times article at http://tinyurl.com/k4wrbw6. Read Chao's testimony at http://tinyurl.com/k45se4p.

◆ **Health Net, Inc., Blue Shield of California and WellPoint, Inc. unit Anthem Blue Cross were ordered to "cease and desist" by the California Department of Managed Health Care.** The agency had received complaints that the carriers had denied members coverage for speech and occupational therapy before determining whether the treatments were medically necessary, according to a Nov. 18 article in the *Sacramento Business Journal*. Brad Kieffer, Health Net spokesperson, told the newspaper that the carrier is reviewing the order and will consider all options before moving forward. Blue Shield and Anthem said they are also in the review process, and intend to work with regulators to resolve the matter. Visit http://tinyurl.com/k4kepc5.

◆ **Alaska Sen. Mark Begich (D) on Nov. 19 introduced legislation calling for the creation of "copper plans" within the Affordable Care Act as a way to attract younger consumers** who are willing to pay more in out-of-pocket medical costs in exchange for lower premiums. The plans would cover the 10 essential health benefits as required in the reform law. Begich's bill would require insurers to pay for at least half of covered medical services. Visit http://tinyurl.com/kesvmrm.

◆ **Cigna Corp. and University Hospital's Accountable Care Organization (UHACO) on Nov. 18 announced the launch of a collaborative care initiative in Cleveland, Ohio.** Approximately 10,000 Cigna members now receive care from the 1,500 primary care physicians and specialists of Cleveland's University Hospitals. Through the initiative, Cigna will provide patient-specific data to help UHACO care coordinators identify, among other things, patients at risk for readmission and those overdue for important health screenings as well as those who may have skipped a prescription refill. Cigna has 75 collaborative accountable care initiatives in 26 states and intends to reach 100 in 2014. Visit http://tinyurl.com/kxanr9b.

◆ **MNSure, the Minnesota state-run public health insurance exchange, on Nov. 19 said consumers in the Rochester area may buy any of seven plans offered by Medica,** expanding the choice of coverage from just one Blue Cross Blue Shield of Minnesota plan with a $3,000 deductible, according to a report in the *Post-Bulletin*. Under the Medica plans, a 40-year-old nonsmoker in Rochester can get a bronze plan with a $6,350 individual deductible for $257.17 per month, the newspaper said. That is more than double the cost for similar plans that start at $115.32 in the Minneapolis/St. Paul region. Visit http://tinyurl.com/kj99jox.

◆ **PEOPLE ON THE MOVE:** Health Care Service Corp. unit Blue Cross and Blue Shield of Texas named **Jack Towsley** divisional senior vice president for the company's Texas Health Care Delivery segment. He most recently served as senior vice president, payor relations for Health Management Associates, Inc.… CVS Caremark Corp. appointed **Tracy Bahl** executive vice president, health plans. Bahl spent 10 years at UnitedHealth Group, where he served as CEO of the Uniprise division that covered national accounts business, consumer health business, financial services business and service and technology operations.

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