

HEALTH PLAN WEEK

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

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Federal Enrollees to See Rates Jump 7.2%; UnitedHealth Pulls CDH Options From FEHBP

For the 2011 plan year, premiums for health plans offered through the Federal Employees Health Benefits Program will increase an average of 7.2% — down from last year's 8.8% hike. While the National Treasury Employees Union expressed disappointment in the increase, David Ermer, an attorney at the law firm Gordon & Ermer in Washington, D.C., called the rate hike "a pleasant surprise" given the average age of a federal employee (late 40s) and health reform requirements that participating insurers had to incorporate. Ermer is general counsel for the Association of Federal Health Organizations.

According to the Office of Personnel Management, 207 health plan choices will be offered through FEHBP. While two health insurers will participate for the first time this year, six will pull out. Three years after they were made available through FEHBP, UnitedHealth Group will discontinue its two account-based offerings for the 2011 plan year (see table, p. 7). The company, however, will continue to offer its HMO option, which has more than 200,000 federal enrollees. About 8 million federal employees, retirees and dependents have coverage through FEHBP.

UnitedHealth's High Deductible Health Plan option, which includes a health reimbursement arrangement (HRA), and its health savings account (HSA)-based option, collectively covered 7,424 enrollees, according to the Office of Personnel Management. The company made the plans available in mid-Atlantic markets in 2007 and expanded to 24 additional states in 2008. In the private sector, UnitedHealth remains the largest seller of account-based plans with more than 3.4 million enrollees and 25,000 employer clients, according to spokesperson Daryl Richard.

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Insurers Are Leaving Money on the Table if Subrogation Audit Ends With Questionnaire

Health insurers that don't take advantage of technology and outside databases to conduct subrogation audits — or who limit their investigations to accident questionnaires — are leaving money on the table.

Subrogation is the recovery from a third party of medical costs that were originally paid under a medical plan benefit. These claims typically are the result of an accident in which payment might have been made under automobile, workers' compensation, homeowners or commercial property insurance.

While most employees can name their health insurance carrier, very few can name their employer's workers' compensation carrier. As a result, employees who are injured on the job tend to pull out a health insurance card at the hospital.

The concept of subrogation has its roots in ancient Roman law, according to Gary Wickert, an attorney at the Wisconsin-based law firm Matthiesen, Wickert & Lehrer. Wickert is the author of *ERISA and Health Insurance Subrogation in All 50 States*, which is in its fourth edition. But some health insurers view subrogation as drudgery and an investment they are not willing to make, he tells HPW.

continued

Wickert calls subrogation "a significant piece of the insurance underwriting puzzle." Most health plan policies include the contractual right to be subrogated and to be reimbursed for claims paid if the injured beneficiary makes a recovery from a third-party responsible for the loss. "This prevents a double recovery from the insured, and that gives [health plans] a way to hold down premiums," Wickert explains. "Subrogation can represent a rather substantial source of income, even though it's technically reimbursement and not income." More than \$1 billion is recovered annually through subrogation on health plans, he adds. Many states require that subrogation recoveries be included in the formula used by insurance companies when underwriting risks and calculating premiums.

Paul Gitnik, an attorney with the Pittsburgh law firm Keevican Weiss Bauerle & Hirsch LLC, agrees that subrogation is underused and says health insurers tend to view subrogation as "a necessary evil." But, he adds, it's one of the few areas in health insurance where money is coming in rather than being paid out. "It should be a core function for health insurers," he tells *HPW*. Gitnik founded SOCRETES, Inc., a health payer claims recovery

firm that was acquired in 2008 by Connecticut-based SCIOinspire Corp.

Audits Could Yield 2% of Claims

While subrogation audits conducted by a well-run health insurer might generate an average 0.5% of paid claims, one subrogation expert says the use of technology and outside databases could quadruple that percentage.

That figure should be as high as 2%, says Tom Riordan, CEO of Connecticut-based HealthCare Subrogation Group LLC. He says his firm has developed software that allows it to sift through claims and identify patterns that could indicate a third party is responsible for payment. Automobile accidents, for example, can result in head, neck and back injuries. The software runs through all of the ICD-9, DRG and CPT codes and flags related claims for those body parts into a "grouped pattern," he explains. In the case of a factory worker treated for lung cancer asbestosis, Riordan says "there is a high probability" that patient has filed a workers' compensation claim if the doctor determined a relationship between the member's illness and occupation.

"Our business is a needle-in-a-haystack business," he says. "There are millions and millions of claims paid by a large health insurer, and we have to figure out if some of those paid claims might have a pattern that fits a recovery profile." Members whose claims data fit certain patterns are checked against state workers' compensation databases and national data.

Questionnaires Are Only Part of Solution

Health plans, as well as some third-party vendors, tend to begin and end their subrogation efforts with an accident questionnaire. Riordan calls such questionnaires a "worn-out idea." Ninety-nine out of 100 health insurers won't follow up on a survey if the member indicates that he or she was not involved in an accident, he quips. In some cases, a claim might be filed long after the questionnaire was sent.

Wickert agrees and says such surveys are "notoriously ineffective" because they often don't reveal cases where there might be a third-party liability. Members typically answer "no" when asked if a third party was involved because they believe that answering "yes" could lead to an investigation or further involvement on their part. But under most health insurance contracts, the policyholder has an obligation to cooperate and respond honestly, including letting the health plan know if a third party might be liable, he says.

Gitnik says that questionnaires are, and should remain, the core to subrogation recovery efforts, but says technology (e.g., automated calling programs and software that can identify claim patterns) must be incor-

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porated. "By making your [claims] data think, you can drastically reduce the amount of false positive questionnaires. You would think that health plans and subrogation firms would be embracing this technology, but they're behind the curve," he says.

"Ten years ago, you couldn't integrate your data like you can today, and you couldn't get an automated call out to a member like you can today."

Along with technology, Riordan's firm taps third-party data sources that contain claim and/or lawsuit data. That information, he says, is much more effective than an accident questionnaire, "which relies on the injured party telling you what happened to them." Such data sources include state workers' compensation board matching databases, ISO Claimsearch, LexisNexis and Recovery Data Connect. In 1971, a group of large property and casualty insurer created Insurance Services Office (ISO), a joint database to help protect them against fraud. ISO is now a public company that operates national property and casualty claim databases.

"It's the combination of how we systemically analyze the claims and group them into accident and occupational disease patterns plus the use of third-party data sources that produces the superior results," he says.

Audits Help Employers Spot Problems

CIGNA Corp., which has used an outside subrogation vendor since 1997, says recoveries average between 0.5% and 1% of paid claims. Approximately 10% of investigations result in active subrogation cases, says Wendy Sherry, vice president of product development. Of those, 74% are from questionnaires and 26% from additional information gathered by the vendor's investigative team.

"Once a recovery is received, CIGNA refunds the full amount back to the [employer] client. The fee for this service is based on the amount of the recovery," Sherry explains. The client is charged and the vendor is paid after the refund is processed.

Although the ability to recover through subrogation depends on language in each client's benefit plan design, CIGNA's standard is to include the appropriate subroga-

Most Health Plans Post Double-Digit Stock Gains in September

After a bumpy summer, health plan stocks surged in September. Collectively, stock prices for the 12 health plans tracked by HPW increased 13.6% in September, and are up 12.2% from the beginning of the year. Stock prices for 10 health plans had double-digit increases last month. HealthSpring, Inc.'s stock price ended the month at \$25.84 — up 24.5% from the end of August, and up nearly 50% from Jan. 1. Humana Inc.'s stock price had the lowest gain at just 5.1%. WellCare Health Plans' stock price, which jumped nearly 17% in September, is still down 21.2% from the beginning of the year.

	Closing Stock Price on 9/30/2010	September Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2010 EPS*	Consensus 2010 P/E Ratio*
COMMERCIAL					
Aetna Inc.	\$31.61	18.3%	(0.3%)	\$3.20	9.9 x
CIGNA Corp.	\$35.78	11.0%	1.4%	\$4.40	8.1 x
Coventry Health Care, Inc.	\$21.53	11.3%	(11.4%)	\$2.83	7.6 x
Health Net, Inc.	\$27.19	13.9%	16.7%	\$2.54	10.7 x
UnitedHealth Group	\$35.11	10.7%	15.2%	\$3.60	9.8 x
WellPoint, Inc.	\$56.64	14.1%	(2.8%)	\$6.36	8.9 x
Commercial Mean		13.2%	3.2%		9.2 x
MEDICARE					
HealthSpring, Inc.	\$25.84	24.5%	46.7%	\$3.17	8.2 x
Humana Inc.	\$50.24	5.1%	14.5%	\$6.33	7.9 x
Medicare Mean		14.8%	30.6%		8.0 x
MEDICAID					
AMERIGROUP Corp.	\$42.47	15.1%	57.5%	\$3.63	11.7 x
Centene Corp.	\$23.59	16.7%	11.4%	\$1.82	13.0 x
Molina Healthcare, Inc.	\$26.99	6.4%	18.0%	\$1.71	15.8 x
WellCare Health Plans, Inc.	\$28.96	16.7%	(21.2%)	\$2.32	12.5 x
Medicaid Mean		13.7%	16.4%		13.2 x
Industry Mean		13.6%	12.2%		10.3x

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

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

tion language in its policies to ensure that its self-insured clients can benefit from subrogation recoveries.

When a potential claim is identified, the vendor sends a letter and questionnaire to the customer or member. If they confirm the claims were accident-related and the customer's plan language supports recovery, CIGNA will notify all parties of the plan's right to recover, Sherry explains.

Bruce Caputo, national audit practice leader at the consulting firm Towers Watson, says the demand for claims audits has been steadily increasing over the past few years. Caputo's clients typically are self-insured employers. A typical audit will look at a year's worth of claims and ensure the health plan is administering the benefits correctly.

"We are looking to make sure that the claim is from someone who is eligible for benefits. We make sure the claim is being paid accurately, that the data are entered correctly and was paid according to the enrollee's annual deductible and copayment. Audits also look to make sure that out-of-network providers were paid using accurate usual, customary and reasonable (UCR) rates," Caputo says.

"When a client is either changing vendors or changing its plan design, they might engage us to go in and make sure the vendor is setting up the plan correctly before it goes live. We make sure the deductibles, copayments and coinsurances are programmed correctly."

The National Association of Subrogation Professionals is working on a study of health care subrogation

trends, which is slated to be released late this year. Riordan says it will be the first study of its kind.

Contact Wickert at gwickert@mw-law.com, Riordan at triordan@hcsnet.net, Caputo at bruce.caputo@tower-swatson.com, Joe Mondy for Sherry at joseph.mondy@cigna.com and Gitnik at pgitnik@gitnik.com. ♦

Enhanced EOBs May Offer More Detail, But Could Cause Problems

State and federal regulators could get tougher on health plans that don't make their explanation of benefit (EOB) forms easier to read and ensure that they describe how to appeal a denied claim.

Case in point: The New York Insurance Dept. (NYID) on Oct. 4 announced that Aetna Inc. had paid an \$850,000 fine to settle charges related to its EOBs and state prompt-pay requirements. Aetna tells *HPW* that the violations were discovered during examinations that took place between 2001 and 2005. Nearly all of them have been corrected, some several years ago.

NYID spokesperson Andy Mais says New York has some of the nation's most stringent consumer protection laws when it comes to health insurance. The EOB, he tells *HPW*, "really has to be clear so consumers fully understand their claim [and] how their claim has been handled."

In a prepared statement Oct. 4, Insurance Superintendent James Wrynn said EOBs need to provide consumers with easy-to-understand details about how much they have to pay and why. The forms also should explain

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how members can appeal if they believe the amount charged is incorrect or if coverage was denied.

Last June, HHS, along with the departments of Labor (DOL) and Treasury, issued an interim final rule that, among other things, requires EOBs to include diagnosis and procedure codes, a date of service, the provider name and the claim amount. Denied claims must include a description of the standard used by the health plan to deny a claim and contact information for consumer assistance, according to the Groom Law Group in Washington, D.C. Moreover, the rule shortens DOL's existing 72-hour notification period for urgent claims to no more than 24 hours after the receipt of a claim. The rule applies to nongrandfathered plans that have a plan year beginning after Sept. 23.

But Susan Pisano, a spokesperson for the trade group America's Health Insurance Plans (AHIP), says there are concerns among health insurers about how useful diagnosis and procedure codes will be to consumers. More than 7,500 CPT codes and 17,000 ICD-9 codes are in use. Adding those diagnosis and procedure codes in the notice "presents administrative and operational challenges for processing benefit determinations requiring modifications to information technology systems, benefits administration and notice formats and processing," AHIP Senior Vice President Jeffrey Gabardi explained in a Sept. 21 letter to HHS. "Adding diagnosis and procedure codes and descriptions will increase the length and complexity of the EOB information beyond the one-page disclosure form provided in most cases today."

There also could be some privacy issues because EOBs typically are mailed to the subscriber. Pisano says there are likely better ways — such as a hotline — to provide members with such detailed information.

Aetna Improves EOB Consistency

According to NYID, Aetna's EOB violations include:

- ◆ *Failure to issue EOBs* in certain required instances;
- ◆ *Failure to identify the service* for which the claim was made;
- ◆ *Failure to contain a specific explanation* for not providing full reimbursement for the amount claimed, and
- ◆ *Failure to include information about the claimant's right to appeal* a denial of benefits.

"The process errors related to EOBs have been corrected and EOBs issued by our claim systems now have a more consistent look and feel," says spokesperson Ethan Slavin. Aetna, he adds, is in the process of adding "enhanced service code descriptions" to its EOBs. These descriptions were taken from the American Medical Association and are the written versions of the CPT codes. The company also is adding the actual numeric CPT

codes to the EOB as well. Any written descriptions that fall into a privacy designation (e.g., mental health) will be grouped into a more generic description, Slavin adds.

Contact Pisano at spisano@ahip.org, Mais at amais@ins.state.ny.us and Slavin at slavine@aetna.com. ♦

Reference-Based Pricing Could Help Employers Trim Rx Costs

As employers finalize 2011 benefit designs, it's clear that most are becoming "more active" in managing their employees' prescription drug benefits. But the strategies they choose to control pharmacy spending are diverging into two different camps, according to several pharmacy benefit consultants. Some employers are sticking with the tried and true value-based insurance design, while the more "innovative" employers are promoting consumerism by implementing reference-based pricing models.

The basic premise of value-based insurance design is to remove barriers (i.e., cost) to essential, high-value drugs to promote better overall health outcomes. Employers that continue to use value-based benefit designs are "aiming to promote therapy adherence," and are focused on selected medications to treat conditions such as cardiovascular disease and high blood pressure, says Nadina Rosier, Towers Watson's North America pharmacy practice leader.

Meanwhile, a few employers are experimenting with an approach "that is aggressively moving the marketplace towards consumerism in an innovative way," Rosier told *HPW's* sister publication *Drug Benefit News*. These employers are implementing "reference-based pricing models for therapy categories that have viable generic equivalents or alternatives," such as proton-pump inhibitors or drugs to treat multiple sclerosis, she explains. "These models cap the company benefit on a therapeutic category basis, which primarily impacts the expensive, brand-name drugs in the class."

The method's downside is that it could increase cost sharing with employees. This is because most of the tactics used in pharmacy management — such as mandatory generics and step therapy — "can only result in limited or one-time savings," Chris Nee, president of health care consulting company PharMedQuest, says. However, because drug costs keep rising, "the remaining option to provide cost savings is to increase cost sharing with patients."

Such strategies employed through this model include removing prescription drugs that have over-the-counter equivalents from the formulary, increasing the use of step-therapy and prior-authorization requirements, and implementing four-tier formularies.

continued

According to Michael Jacobs, national clinical practice leader at Buck Consultants, these innovative employers are betting that consumers are becoming more engaged in managing their health. "People are going to ask the question about what alternatives are," he argues. "And this idea that anyone would ask those questions and start doing some research gets into a philosophy that many employers are including in their benefit about consumer engagement."

Value-based insurance design, on the other hand, "aims to make everything as carefree as possible for the employee," Jacobs contends. "If you make things too easy, people will take certain medications just for the sake of it because it doesn't cost them anything." This, in turn, can increase costs for employers by unnecessarily paying more for expensive therapies, he adds.

Cost can be used as an incentive to move people to better-value drugs, Jacobs agrees. The only problem is that "some employers have removed the barriers, but they haven't taught people how to use the resources," he adds. "If you're the employer, give your employee resources and access to a professional."

Contact Rosier through Jessica Nelson at jnelson@kwitco.com, Nee at chris@pharmedquest.com and Jacobs at (770) 916-6018. ♦

This article was excerpted from the Sept. 24 issue of Drug Benefit News. For more information about this publication, or to order, visit the MarketPlace at www.AISHealth.com.

FEHBP Rates Grow by 7.2%

continued from p. 1

Jennifer Simon, member education manager at American Postal Workers Union Health Plan (APWU), says she's not sure why UnitedHealth's account-based plans didn't attract more participants. UnitedHealth's consumer-directed health (CDH) option is virtually identical to the one it administers for APWU. "We took a different approach to marketing, and it has worked," she tells *HPW*.

Nearly 30,000 lives are enrolled in APWU's seven-year-old CDH option. Almost one-third of Aetna Inc.'s 312,000 federal enrollees are covered by an account-based health plan, and the Government Employees Health Association, Inc., which provides coverage to about 480,000, says about 7,900 are enrolled in its CDH option.

FEHBP members will see their rates increase 7.2% for 2011. By contrast, consulting firm Hewitt Associates recently projected that large, self-insured employers would see coverage costs increase an average of 8.8% in 2011 (*HPW* 10/4/10, p. 3). PricewaterhouseCoopers projects an average rate hike of 9% for 2011, while Aon Consulting estimates a 10.5% jump.

Last fall, FEHBP's largest participant, the Blue Cross and Blue Shield Association's (BCBSA) Federal Employee Program (FEP), announced rate hikes of 15% for its Standard Option and 9% for its Basic Option. For 2011, premiums for the Standard Option will increase 6.9% for self-only coverage (7.6% for family plans). FEP provides coverage to about 61% of FEHBP's participants.

26 Is the New 22 for FEHBP

Health insurers that participate in the federal program must offer coverage to dependent children to age 26 (up from age 22 previously), and offer first-dollar coverage for in-network preventive benefits, as required by the health reform law.

Tom Bernatavitz, Aetna's vice president of federal plans, estimates that the expanded dependent coverage and first-dollar preventive care mandates increased Aetna's premiums by about 1.5%. An OPM requirement that plans offer tobacco cessation benefits (including coverage for seven FDA-approved medications and counseling sessions) likely increased costs by an additional 1%. Aetna, which has about 312,000 federal enrollees, says between 15,000 and 20,000 dependents have "aged out" and become ineligible for coverage over the past four

SelectHealth Hopes to Boost Experience With Feds

Utah-based SelectHealth is one of two new participants in the Federal Employees Health Benefits Program (FEHBP). Its HMO will be one of about a dozen national and local options available to the state's 60,000 federal employees, dependents and retirees. SelectHealth also administers Utah's federal high-risk pool and the Children's Health Insurance Program. Wisconsin-based MercyCare HMO is the other new participant for the 2011 plan year (see story, p. 1).

Kaleb Holt, product development manager at SelectHealth, says getting up to speed on FEHBP's rules was challenging, but tells *HPW* that "any experience we can get with government programs is going to help us going forward." Holt declines to offer enrollment expectations, but says experience in the federal program might be more valuable than strong enrollment in the first year of the program. "As the government becomes more involved in health coverage, it will be easier for us to enter new markets if we are already participating."

More than 200 health plan choices will be offered through FEHBP in 2011.

years. He adds that enrollment among previously ineligible dependents could tick up a bit "but it won't be a knock-your-socks-off kind of a number."

Aetna's HRA and HSA-based options have included first-dollar coverage for preventive care since being introduced in 2004 and 2005, respectively, Bernatavitz adds. Aetna's HMO options previously required a copayment for preventive care.

Premiums for APWU's CDH option will remain unchanged for 2011, partially because the plan already included first-dollar preventive coverage. Rates for its more traditional High-Option plan will increase 7%.

FEHBP Plans Target Wellness

In 2010, BCBSA's FEP program offered to waive copays on annual physicals for enrollees who completed an online health risk assessment. For 2011, Standard Option enrollees who use the Blue Health Assessment tool will reduce their annual deductible by \$50, while Basic Option members will receive a \$35 debit card that can be used for qualified medical expenses. Through the assessment, FEP can identify members who are at risk for health problems related to weight or depression, for example and encourage them to enroll in programs to help manage those conditions.

"Some of the most [expensive] chronic diseases are preventable," says Jena Estes, vice president of BCBSA's FEP program. "We're working closely with those members, and are giving them information and tools. And when possible we're offering incentives to stave off [those] diseases."

Beginning in 2011, FEP Standard Option members who switch from certain brand-name drugs to an equivalent generic drug, will have their cost share waived for the first four fills of that generic medication dispensed by a preferred retail pharmacy or a mail-order pharmacy. FEP members also will be eligible for free nutritional counseling, well child care from birth to the age of 22, and cancer screenings and immunizations when preferred providers are used. And members who face pregnancy-related depression can receive up to four free visits with a preferred provider. FEP also is offering free individual coaching when a preferred provider is used.

APWU says it will enhance existing wellness programs aimed at members who have, or are at risk of developing, diabetes or hypertension. The one-year-old programs are available to people enrolled in the CDH option. Office visits and lab work are free when a network provider is used, and generic drugs are free when dispensed via mail-order. Of the more than 2,000 people enrolled in APWU's hypertension program, 252 have improved their numbers from "hypertension to pre-hypertension or from pre-hypertension to normal," says

Simon. While improvements were also seen in the diabetes program, results are not yet available.

"We have been amazed at the success of the programs," says Simon. "Some people have enrolled [in APWU's option] just for that." But is there a risk of adverse selection if a program encourages expensive diabetic members to enroll? "We hope they do enroll," she asserts.

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FEHBP Plan Terminations for 2011

More than 16,000 people who have coverage through the Federal Employees Health Benefits Program (FEHBP) will need to choose a new plan during the upcoming open-enrollment period, which begins Nov. 8. Six health plan operators will terminate their offerings, while several others will eliminate options or reduce service areas. Most notable is UnitedHealthcare Group, which will terminate its health reimbursement arrangement (HRA)-based consumer-directed health (CDH) plans and its high-deductible options in 25 states and the District of Columbia (see story, p. 1). Collectively, 7,424 members were enrolled in those plans, according to the Office of Personnel Management. Moreover, FEHBP enrollees in 12 states will not have an HMO option. Just two new health plans will join FEHBP beginning Jan. 1: MercyCare HMO in Wisconsin and SelectHealth HMO in Utah. Below is a look at health plans exiting FEHBP for 2011:

Health Plan Name	State or Region	Number of Enrollees
Aetna Open Access*	Ohio	2,913
AmeriHealth HMO	N.J.	1,185
BlueCHIP Coordinated Health Plan	R.I.	1,067
Community Blue	N.Y.	142
Coventry Health Care of Louisiana**	La.	2
HealthAmerica Pennsylvania*	Pa.	109
Humana CoverageFirst*	Ariz., Fla., La., Tenn., Texas, Utah	1,427
Fallon Community Health Plan (standard option)*	Mass.	619
PacificCare of Nevada	Nev.	1,228
UnitedHealthcare (CDH and high-deductible plan options)	Ariz., Ark., Calif., Colo., D.C., Fla., Ga., Ill., Iowa, Kan., La., Md., Miss., Mo., Nev., N.M., N.C., Ohio, Okla., Ore., R.I., Tenn., Texas, Va., Wash., Wis.	7,424
Vantage Health Plans	La.	152
Total Affected Enrollees		16,262
*Will remain in FEHBP, but will withdraw from some markets in the listed states		
**Will remain in FEHBP, but will terminate its high-deductible health plan		
SOURCE: Office of Personnel Management, October 2010		

HEALTH PLAN BRIEFS

◆ **Connecticut Attorney General Richard Blumenthal (D) blasted the state Insurance Department's approval of rate hikes requested by Aetna Inc. and Anthem Blue Cross and Blue Shield, and asked that CDI reconsider its decisions.**

In a letter to Insurance Commissioner Thomas Sullivan, Blumenthal said the department failed to "consider medical trends since the last rate increase; insurer expenses and profits; administrative costs; and the impact on potential policyholders" in determining whether the insurers' rate requests were excessive. Insurance Department spokesperson Dawn McDaniel tells *HPW* that Aetna had requested a 24.7% increase for its small-group plan and was approved for an 18% increase. She added that the insurer asked for and received a 14.2% increase for large-group coverage. Anthem, McDaniel says, was approved to increase rates for new individual customers by up to 22.9%. The insurance department stressed that the increases are for new customers only, and not existing policies, which are priced at June 2009 rates. In response to Blumenthal's letter, Sullivan said that he would not reopen the filing "since the department based its approval on sound actuarial analysis, not on political grandstanding." Visit www.ct.gov/cid/site/default.asp or www.ct.gov/ag/site/default.asp.

◆ **3M Corp. told retirees that it will end the company's retiree health insurance plan, citing health reform as a major contributor to its decision,** reported *The Wall Street Journal*. The company began notifying retirees on Oct. 1 that in 2013 they will receive an unspecified health reimbursement to purchase insurance policies, according to the newspaper. 3M said it began notifying retirees early to allow them time to change benefits during the current benefit-enrollment period, the *Journal* reported. A 3M memo that was reviewed by the newspaper told retirees that the Medicare insurance marketplace has improved, with many benefit plans that are better personalized to their needs, "often at lower costs than what they pay for retiree medical coverage through 3M." The company has about 23,000 retirees. Visit www.3m.com.

◆ **Federal Trade Commission Chairman Jon Leibowitz said some antitrust laws could be waived if they hinder the creation of effective Accountable Care Organizations (ACOs)** under terms of the health reform law, *Kaiser Health News* reported on

Oct. 5. During remarks at the workshop on ACOs convened by the HHS Office of Inspector General, CMS and the FTC, Leibowitz said HHS would explore an "expedited review process" for hospitals and doctors looking to determine if new partnerships they form to provide care would violate antitrust laws. CMS Administrator Donald Berwick, M.D., said the government agencies that oversee physicians and hospitals will work together to give unified guidance on how to form ACOs. "We will need a regulatory framework that nurtures cooperation, while it guards against the lingering threat of inappropriate practices," he said. HHS Inspector General Daniel Levinson said, "We want to make sure ACOs are not unduly inhibited by existing fraud and abuse laws.... Our rules should not stand in the way of improving quality and reducing costs through ACOs." Visit www.ftc.gov/opp/workshops/aco/index.shtml.

◆ **Cinergy Health Inc., a Florida-based insurance agent, was fined \$500,000 by the New York Insurance Department for allegedly "misleading consumers into believing they were buying comprehensive health insurance."** The department said that buyers instead received limited-benefit health insurance or "mini-meds." Cinergy and its sublicensee, Steven Trattner, agreed to the fine and to comply with a code of conduct for any future sales of mini-meds in the state, according to the department. In September 2009, Cinergy Health stopped selling insurance, which was underwritten by American Medical and Life Insurance, after that plan was fined \$700,000 for allegedly defrauding consumers with ads indicating that its limited-benefit health insurance plan offered comprehensive medical coverage (*HPW* 9/07/09, p. 8). At that time, Cinergy said it was unaware that its ads for American Medical's plans were not compliant with state laws until the insurer was fined. Visit www.cinergyhealth.com.

◆ **Blue Cross Blue Shield of Michigan said it will offer some new health plans for small businesses beginning Jan. 1, 2011.** The insurer said its new Simply Blue PPO has several deductible and copayment options and can be combined with a health reimbursement arrangement or health savings account. In addition to Simply Blue, the Blues plan said its product portfolio will also include other PPO and HMO wellness-based and consumer-directed health plans. Visit www.bcbsm.com.

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