

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HPW will not be published next week.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 March 2.

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Stimulus Bill Would Dedicate Billions to Comparative Effectiveness Research, EHRs

The Senate and House on Feb. 11 reached a compromise on a massive economic stimulus package that allocates billions of dollars to fund medical comparative effectiveness research (CER) and speed the adoption of electronic health records (EHRs). The full text of the 1,071-page bill (H.R. 1) was made available to the public Feb. 13. It is expected to be passed by both houses and signed by President Obama by Feb. 16.

While the CER funding — called for in the \$789 billion American Recovery and Reinvestment Bill of 2009 — could help reduce inappropriate and unnecessary care, and justify lower compensation rates for some treatments and drugs, some industry observers tell *HPW* that it isn't likely to have a dramatic impact on health care costs.

There is a "profound" lack of comparative effectiveness research for new medical technologies and drugs, says Winifred Hayes, Ph.D., CEO and founder of health technology evaluation firm Hayes, Inc., based in Lansdale, Pa. Research funded by the pharmaceutical industry or manufacturers can be seen as biased, she says, adding that federal CER funding could create more reliable and unbiased information. The Senate bill called for the creation of a 15-member Coordinating Council for Comparative Effectiveness Research made up of members appointed by the White House. That provision is included in the House-Senate compromise version of the bill. Hayes says she worries that such a group could create a new level of bureaucracy and innovation "bottlenecks."

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Plans Use Variety of Strategies to Identify, Ensure Compliance Among Diabetics

With diabetes affecting 24 million Americans and costing the economy close to \$180 billion last year in medical and other costs, health plans say they are taking a fresh look at their intervention strategies and implementing new approaches to identifying and then helping people with diabetes manage their conditions more effectively.

But health plans interviewed by *HPW* say that the problem goes beyond helping diabetics manage their disease. "One-quarter of those with diabetes don't even know they have the disease," says Deneen Vojta, M.D., UnitedHealth Group's vice president for clinical innovations. "We also know that about 57 million people are pre-diabetics and that the majority of them are unaware of their risk." Compounding the problem, she says, is the fact that about 60% of people with diabetes don't follow their self-management regimens, often because of the personal costs involved. "We have no choice but to get control of this situation on the front end."

On Jan. 15, United announced the launch of its Diabetes Health Plan with built-in preventive care incentives (*HPW* 2/9/09, p. 1). As a value-based design, the plan eliminates copayments for many of the out-of-pocket expenses that discourage many diabetics from effectively managing their condition.

"We know that only 40% of people with diabetes follow the American Diabetes Association (ADA) prevention and treatment guidelines," Vojta says. "So we took a step

back and asked what kind of an approach would encourage people with diabetes to better manage their condition." United also is targeting the substantial number of people who are at risk for developing diabetes but who are unaware of their risk.

The insurer says it conducted extensive consumer research on the plan last year, focusing heavily on the "intent-to-purchase" factor. More than 300 people with diabetes were involved in the focus groups. "If somewhere in the range of 25% of those participating say they would buy a product, you know you're doing well," Vojta says. "We achieved a 73% intent-to-purchase response rate when we explained the details."

The plan starts at the front end with a broad screening initiative to catch pre-diabetics and diabetics alike. Screening is provided in physician offices, work sites and retail clinics that United works with.

The plan then focuses on one of the major barriers to compliance: the substantial out-of-pocket expenses associated with diabetes-related drugs, supplies and physi-

cian office visits. United's plan eliminates these copays so members don't pay for certain diabetes-related supplies and prescription drugs — including insulin, statins, oral anti-glycemics and anti-depressants — and some clinician visits. Members also have free access to online monitoring and education tools as well as self-monitoring training. And they receive a customized roadmap to help them adhere to the ADA guidelines. Vojta says member savings amount to about \$500 per year.

Members who follow the guidelines during their first year in the plan are eligible for continued membership in year two. Members who, for whatever reasons, do not comply revert back to their traditional health plan.

Vojta points out that the plan is participation- rather than outcomes-based, meaning that it focuses on screening, education and adherence, leaving outcomes up to the clinician. "We're not measuring how many members get their hemoglobin levels down. We're focusing on getting people screened, educated and connected with their physicians. Their individual physicians will drive the clinical outcomes."

Three employer clients are testing the plan this year. "We want to see how the plan resonates with employers, how compliance rates change after year one, and what factors come into play for those who find it difficult to adhere to the ADA guidelines," Vojta says. She adds that United will implement a broader market rollout of the plan in 2010.

Aetna Takes Integrated DM Approach

Aetna Inc. brought its disease management (DM) program in-house in 2006, and substantially redesigned it to focus on managing individual members across all of their health conditions rather than focusing on disease silos. "This is a useful approach for members with diabetes," says Sherry Brodeur, Aetna's head of program design and sales support for national care management, "because people with diabetes typically have other health conditions." She notes that Aetna's program manages more than 30 different conditions, "and when one member has several of them, as diabetics typically do, we manage them all for that individual."

Once members with diabetes (or at risk of diabetes) are identified, Aetna begins by assessing their readiness to change and identifying their personal concerns and needs. "Every person looks at his or her own health status in a very personalized way," Brodeur says. "So we use a motivational interviewing approach based on Prochaska's Transtheoretical Model of Behavior Change to determine where the person is in terms of their readiness to undertake a change in their behavior." The next step: addressing the member's self-identified concerns and

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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goals. "If an obese person identifies weight as the most important concern, then we address weight management, exercise, perhaps nutrition. And we use this as a gateway to diabetes intervention," she explains.

Brodeur says that Aetna's outreach and intervention strategies are highly tailored to each individual. "We found out that what doesn't work [with these programs] is for us to go in with a prescribed set of questions and approaches. As a result, Aetna approaches individual members "where they are in their lives and how (and when) they want to be approached rather than doing this from Aetna's standpoint." The program also is closely linked with Aetna's quality management-tied initiative to ensure that member and provider concerns are addressed.

HCSC Targets Obesity as 'Gateway' to Diabetes

Health Care Service Corp. (HCSC) says it is using obesity as a gateway for its diabetes intervention and management initiative. The company, which operates Blues plans in New Mexico, Oklahoma, Texas and Illinois, began pilot testing a special early chronic disease intervention program targeting Metabolic Syndrome (Met-S), a precursor to obesity, in January 2008 (*HPW* 10/27/08, p. 1). Its new Blue Care Connections Lifestyle Management Program, which HCSC pilot tested in 2006, refined in 2007 and launched last year, also focuses on obesity as a condition that substantially raises the risk of morbidity from diabetes and other chronic conditions.

"We reach out to anyone who has been identified through a health risk assessment or other means as obese or at risk of obesity for intervention," Joe Smith, senior supervisor for HCSC's enterprise lifestyle management program, tells *HPW*. Anyone with a body mass index (BMI) over 25 is flagged for outreach. "If it turns out that the member has diabetes, that member is considered to be a high-priority case," he adds. The program also reaches out to those identified as being at risk for diabetes. Members are then assessed by a clinical coach and a determination made as to whether the member should work with a coach or a nurse. Members are also evaluated using the Prochaska readiness-to-change scale.

Once in the program, members work with their coaches to create care plans and start using the tools they will need to understand their condition and comply with their care plans. Smith says that the coaches typically work with members for an average of nine months, although they can extend this for another two or three months before a case is "closed." HCSC tracks members on an ongoing basis and flags anyone who relapses. "We will reach out to those members and re-enroll them in the program," Smith says. "But the goal is to give members

the tools they need to take an active role in their health and successfully manage their diseases."

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New from AIS, The Next Generation of Disease Management: 2009 and Beyond is a thought-provoking book that provides expert insight into where the DM industry is headed. Ten leaders in the DM industry weigh in on pressing issues such as: the build-versus-buy debate; using predictive modeling; measuring results; integrating care coordination; leveraging technology; and more. Visit www.AISHealth.com/Products/bdm.html for more information and to order.

CIGNA, Aetna Are Latest Plans To Be Sued Over Ingenix Data

Another week, and there's another round of lawsuits against health plans that relied on data from Ingenix, Inc. to calculate their usual, customary and reasonable (UCR) rates for out-of-network services.

On Feb. 10, the American Medical Association (AMA) joined with state medical associations in Connecticut, New Jersey, New York, North Carolina and Texas to sue Aetna Inc. and CIGNA Corp. over their use of the data. The suits, filed in U.S. District Court in New Jersey, contend that for more than a decade the two health plans "used a corrupt system to underpay physicians for out-of-network medical services and forced patients to pay an excessive portion of the costs." Along with recovering reimbursements for physicians who might have been underpaid, AMA says that the litigation is intended to end the insurers' dependence on Ingenix data. However, as part of an agreement between Ingenix's parent company, UnitedHealth Group, and New York Attorney General Andrew Cuomo (D), two Ingenix databases will be shut down this year once a new, not-for-profit and independent entity is up and running. Several health plans, including United and Aetna, have agreed to help fund the new entity, which will, among other things, supply health plans with claims-based data.

Leslie Moran, a spokesperson for the New York Health Plan Association, says the AMA and participating medical associations are simply "piling on" existing lawsuits rather than looking for ways to bring health care costs under control. "The AMA, in filing this suit, basically is saying it wants a blank check to charge whatever the market will bear." Moran contends that too much attention is being paid to reimbursement rates and too little to fees charged by out-of-network providers.

continued

"We're disappointed the medical community has chosen to litigate on top of already pending consumer litigation on the same topic. If everyone believes they are entitled to additional payments, the health care system as a whole will bear the burden and increase costs for everyone," says Aetna spokesperson Cynthia Michener. In a prepared statement, CIGNA spokesperson Chris Curran argued that the insurer's payments to out-of-network doctors are "robust and fair, and greater transparency in regards to physician pricing will prove that point."

This AMA suit comes on the heels of an investigation into Aetna's student health insurance subsidiary, which had underpaid more than \$5.1 million for out-of-network services over the past decade. In an agreement with Cuomo's office announced Feb. 2, the insurer said it would reimburse affected members (*HPW 2/9/09, p. 4*). In a well publicized press conference a month earlier, Cuomo contended that Ingenix manipulated its data to help its health plan clients keep UCR rates low (*HPW 1/19/09, p. 1*). Ingenix says its databases are used by about 1,500 health plans and other firms. The data are compiled from more than 1.3 billion claims each year.

On the same day the AMA suit was filed, Cuomo's office said that two more health plans had agreed to stop using Ingenix data and would contribute funds to the new not-for-profit entity. Independent Health and HealthNow New York, Inc., both based in Buffalo, N.Y., also agreed to provide members with more information about their methods of determining reimbursement rates, according to Cuomo's office. Early this month, Cuomo's office announced its intent to sue Albany-based Capital District Physicians' Health Plan, Inc. for consumer fraud, "as the company has failed to embrace reform and discontinue use of Ingenix," according to a prepared statement from Cuomo's office. Over the next five years, Independent Health says, it will contribute \$475,000 to help fund the new independent entity. HealthNow will contribute \$212,500 over the same period. HealthNow's contribution is lower because it also will contribute its valuable data to the new database.

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Bill's CER Provision Gets Scrutiny

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Of the \$1.1 billion that would be dedicated to CER, about \$300 million would be used by the Agency for Healthcare Research and Quality (AHRQ), \$400 million would go to the National Institutes of Health and \$400 million would be given to HHS to allocate.

Unlike the Senate bill, the compromise bill does not retain the word "clinical" in its language. However, conferees intend the funding and research will be used to evaluate and compare clinical outcomes, effectiveness, risk and benefits of two or more medical treatments and services that address a medical condition, according to information provided to *HPW* by Capitol Hill observers. The conferees do not intend the funding to be used to mandate coverage, reimbursement or other policies for any public or private payer, according to congressional summaries. The Pharmaceutical Research and Manufacturers of America (PhRMA) trade group had pushed for the Senate version of the CER, which emphasizes research on "clinical" effectiveness rather than cost effectiveness.

The Blue Cross and Blue Shield Association's (BCBSA) 2008 Pathway to Covering America proposal calls for the creation of a public-private, independent institute to support research that compares the effectiveness of new and existing medical procedures, drugs, devices and biologics. According to that report, 30% of care is ineffective, redundant or inappropriate. "When we can look head-to-head at comparison of procedures, drugs and devices to determine what is most effective, the right care can be delivered at the right time, the right place and

Monthly MCO Stock Performance			
	Closing Stock Price on 1/30/2009	Closing stock Price on 12/31/2008	January Gain (Loss)
Commercial			
Aetna Inc.	\$31.00	\$28.50	8.7%
CIGNA Corp.	\$17.36	\$16.85	3.0%
Coventry Health Care, Inc.	\$15.13	\$14.88	1.7%
Health Net, Inc.	\$14.63	\$10.89	34.3%
Triple-S Management Corp.	\$14.39	\$11.50	25.1%
UnitedHealth Group	\$28.33	\$26.60	6.5%
WellPoint, Inc.	\$41.45	\$42.13	(1.6%)
Medicare			
Humana Inc.	\$37.93	\$37.28	1.7%
HealthSpring, Inc.	\$17.42	\$19.97	(10.0%)
Medicaid			
AMERIGROUP Corp.	\$27.97	\$29.52	(5.3%)
Centene Corp.	\$17.73	\$19.71	(10.0%)
Molina Healthcare, Inc.	\$17.54	\$17.61	(0.4%)
WellCare Health Plans, Inc.	\$14.78	\$12.86	14.9%
Specialty			
Magellan Health Services, Inc.	\$36.22	\$39.16	(7.5%)
Other			
Assurant, Inc.	\$26.40	\$30.00	(12.0%)
Universal American Corp.	\$9.86	\$8.82	11.8%
SOURCE: Compiled by Atlantic Information Services, Inc., February 2009			

the first time," says Justine Handelman, BCBSA's executive director of legislative and regulatory policy. "When you improve quality, you often can lower overall health care spending." The funding called for in the bill could be "the downpayment" on a permanent public institute on comparative effectiveness, along the lines of earlier proposals from Sens. Max Baucus (D-Mont.) and Kent Conrad (D-N.D.), she tells *HPW*.

The CER funding, Hayes says, could give health plans better-quality evidence by which to make coverage determinations and reimbursement decisions. And that could help plans justify higher compensation for some treatments, while limiting payments for others that are considered less effective. Funding for CER also could reduce some of the administrative burden on health plans, thereby helping them manage networks more efficiently in terms of quality, adds Jon Glaudemans, senior vice president at Avalere Health, a Washington, D.C., consulting firm.

Bob Moffit, Ph.D., director of the Center for Health Policy Studies at the right-leaning Heritage Foundation in Washington, D.C., warns that CER could give the government a way to ration care. "It's alarming to think that comparative effectiveness could be used to determine that if a procedure or drug is too expensive, it won't be prescribed. [Lawmakers] have said it won't be used to dictate to patients or their doctors the treatments they can have, but this could be the first step toward that."

David Abernethy, senior vice president of government relations at Emblem Health, Inc., disagrees that CER will be used to ration care. Emblem is the parent company of Group Health Incorporated and HIP Health Plan of New York. While he says CER could help reduce instances of unnecessary or inappropriate care, he argues that it isn't likely to have a dramatic impact on health care costs. "The health care industry is made up of very smart people. If [an agency] suggests one treatment isn't as useful as another, they might come up with a new treatment." Until about a year ago, Abernethy was a member of the Coalition for Health Services Research, a multi-stakeholder advisory committee that investigated potential applications of comparative effectiveness research. The coalition was established by AHRQ.

Bill Calls for \$19 Billion for Health IT

The stimulus package allocates \$19 billion for health information technology (IT), with \$17 billion dedicated to financial incentives for Medicare and Medicaid providers, and \$2 billion for grants. Medicare financial incentives are slated to begin in 2011, with physicians receiving temporary bonus payments of between \$44,000 and \$64,000, and hospitals receiving as much as \$11 million each if they are deemed "meaningfully" using

electronic health records. Lawmakers set 2014 as the implementation deadline. The bonuses will be tied to measurable outcomes. And providers that don't adopt health IT could be penalized under a structure similar to the e-prescribing rule for Medicare that went into effect Jan. 1. The Medicare Improvements for Patients and Providers Act of 2008 calls for a two-year, 2% incentive payment for eligible physicians who use e-prescribing for Medicare patients. Physicians who do not use e-prescribing technology could see their payments cut by 1% starting in 2012 and by more in 2013 and 2014.

The EHR provisions could translate to higher costs for health insurers in the near term as they deal with conversion and interoperability issues, says Alan Cohen, professor of health policy and management, and executive director at Boston University Health Policy Institute. However, he adds, health plans could see some potential cost savings in the long run if network providers adopt electronic systems envisioned by lawmakers.

If the bill is enacted, HHS would be given flexibility in determining how to ensure privacy for EHRs and whether new regulations are needed for consent. The security provisions will be implemented through guidance from HHS, "so there will be a lot of work ahead in how the finer details of the rules are shaped, and health

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plans should have a voice in that," says Kathy Roe, partner in the health law group at Neal, Gerber & Eisenberg LLP in Chicago. Handelman says the Blues association intends to work closely with HHS to ensure that privacy and security are protected "but that we aren't hindering the adoption of health IT or critical health care functions that can improve quality and rein in costs."

However, new rules aimed at protecting the privacy of electronic data could add an unnecessary and cumbersome layer to HIPAA, warns Abernethy. "We already have elaborate systems in place for the protection of paper records. I understand the worry that digital records can be easily transferable, but there is no evidence to suggest that there is wide-ranging abuse going on," he contends. "And there is ample statutory authority under HIPAA to prosecute anyone who does something wrong. A lot of good habits have been developed under HIPAA, so why do we now need additional protections just because we are moving toward EHRs. That really doesn't make any sense."

The increased adoption of EHRs probably isn't going to have a profound impact on health plans, although it could improve efficiencies and reduce redundant tests if, for example, a hospital in Wisconsin is able to access a patient's X-ray from a hospital in New York, he adds. Privacy issues tied to EHRs could create new hurdles for health plans. "Plans will find it easier through the EHR incentives to manage the quality of care in their networks," Glaudemans adds. "On the other hand, the privacy provisions could make it more difficult for them to execute intervention programs on a real-time basis," he says.

Changes Expected for COBRA, Medicaid

Other provisions in the stimulus bill will affect Medicaid and COBRA:

On Medicaid, the bill calls for an \$87 billion across-the-board increase to the Federal Matching Assistance Percentage (FMAP) of 6.2% for all states, equating to 65% of the funding, with the remaining 35% reserved for additional FMAP increases for states with the highest unemployment, according to BCBSA. States cannot curtail eligibility if they accept the enhanced FMAP.

On COBRA, the bill creates a subsidy of 60% of premium for nine months for people terminated from jobs. But even a 60% government subsidy won't make COBRA coverage affordable for people who have lost their jobs and were accustomed to having an employer subsidize 80% or more of the cost, says Abernethy. And the balance of COBRA coverage must be paid by the enrollee with post-tax dollars. A controversial provision in the House's version of the bill would allow former employees who are 55 or older, and those who have been with the employer at least 10 years, to continue their coverage through COBRA until they find coverage somewhere else or become eligible for Medicare (*HPW 2/2/09, p. 3*). As of *HPW's* press time, the provision does not appear to be included in the final bill.

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HEALTH PLAN BRIEFS

◆ **Two California health insurers recently reached agreements with state and city officials to end lawsuits from former members whose coverage was rescinded after filing expensive medical claims.** On Feb. 11, Anthem Blue Cross, a WellPoint, Inc. unit in California, agreed to pay up to \$15 million and to offer new coverage to 2,330 people whose coverage it previously had rescinded. The agreement included a \$1 million fine to the California Department of Insurance and reimbursement to those people for out-of-pocket medical expenses that they had to pay following their policy rescissions. Those reimbursements could be as much as \$14 million. In exchange, the department will stop prosecuting the plan for wrongful rescissions to individual PPO enrollees. On Feb. 12, Health Net agreed to pay as

much as \$14 million to settle litigation over the canceling of health policies for 800 former members, the *Los Angeles Times* reported. Under the deal, each individual whose health policy was rescinded is eligible to get up to \$218,000, according to the Times. However, the average payment is expected to be \$7,836, the newspaper added. In addition to the payments to customers, the deal requires Health Net to pay a fine of \$2 million to the Los Angeles City Attorney and to contribute \$500,000 to charities. The insurer also is liable for the plaintiffs' attorneys' fees. Visit www.healthnet.com or www.anthem.com/ca.

◆ **Anthem Blue Cross said it will raise premiums 30% for approximately 640,000 of its individual policyholders effective March 1.** Anthem, which covers about 800,000 individual policyholders in

HEALTH PLAN BRIEFS

California, blamed the increase in health costs for the higher premiums. Specifically, Anthem attributed the rate increase to “the increasing need for medical services, the use of new, expensive prescription drugs and advanced technologies.” The new rates reflect current medical cost trends based on current individual medical expenses and projections, plan spokesperson Ben Singer told *HPW*. Members also may see increases due to their age, he said. Call Singer at (818) 234-0749.

◆ **On Feb. 6, Kaiser Permanente notified approximately 6,000 of its northern California employees that a computer had been recovered that contained employee personal data.** The insurer said the data included employee names, addresses, phone numbers, Social Security numbers and date of birth. “To our knowledge, only a handful of employees have reported identity theft,” Kaiser said in a written statement. The company said that because sensitive employee information was included on the stolen computer, it will provide one year of free credit monitoring to employees whose information was included. Kaiser reported that no member information or personal health information was on the stolen computer. In March 2005, the California Department of Managed Health Care fined Kaiser \$200,000 after a former employee posted links to members’ protected health information on her Web log (*HPW* 3/21/05, p. 8). Visit www.kaiserpermanente.org.

◆ **Mississippi Insurance Commissioner Mike Chaney (R) awarded two hospitals more than \$550,000 in settlements from the liquidation of Family Health Care Plus Inc., a defunct Mississippi-based health plan.** Gulfport Memorial Hospital in Gulfport received \$482,569, and Singing River Hospital in Pascagoula received \$72,825. Both hospitals were among the out-of-network providers owed substantial funds, according to the Mississippi Insurance Dept. State insurance examiners seized Family Health Care in October 2004, after the Chancery Court of the First Judicial District of Hinds County approved their findings that the insurer was insolvent. The court also named the insurance commissioner the insurer’s court-appointed liquidator. Visit www.mid.state.ms.us.

◆ **Medica said it created a program to help recently laid-off Minnesotans understand the health insurance options available to them.** Most laid-off

workers who have had coverage through their former employers are now being offered COBRA, which allows them to continue that group coverage at their own expense. Medica said its information campaign uses an advertising component to draw attention to the high cost of COBRA with online tools, seminars and phone counselors to help people understand the less expensive alternatives available. The insurer said that information will be placed in local newspapers, Internet job search sites and social networking sites; out-of-home locations such as billboards and coffee-cup sleeves at some metro area coffee shops; and radio spots. Visit www.medica.com.

◆ **ValueOptions New Mexico, Inc. said it has filed a formal protest and requested a stay of procurement for New Mexico’s managed behavioral health care request for proposal (RFP). The contract was recently awarded to OptumHealth New Mexico.**

ValueOptions asserted that the contract award to OptumHealth was not based on criteria published in the RFP, that evaluation criteria were improperly applied, that evidence regarding the winning bidder’s integrity and business ethics were ignored, that a serious conflict of interest was overlooked, and that proposal evaluators failed to consider the absence of necessary software licenses by the winning bidder. The filing also asked that the contract be terminated and either re-bid or awarded to ValueOptions New Mexico. ValueOptions was the previous mental health provider for the state. Visit www.ValueOptions.com.

◆ **Anthem Blue Cross and Blue Shield in Missouri said its members can now search for local, in-network doctors and hospitals with any Web-enabled cell phone or hand-held device.** Members can visit www.anthem.com/mobile from any Web-enabled device to identify and browse in-network providers by address, city, state, ZIP code or name. The tool also includes physicians’ phone numbers and addresses, including step-by-step driving directions specifically designed for small screens. Visit www.anthem.com.

◆ **CORRECTION:** An article in the Feb. 9 issue incorrectly identified David A. Jones, Jr. as a co-founder of Humana Inc. His father, David A. Jones, co-founded the firm. David A. Jones, Jr. is non-executive chairman of the board at Humana. He also is chairman and managing director of Chrysalis Ventures, a Louisville, Ky.-based venture capital firm.

FINANCIAL NEWS

◆ **Despite a 57% drop in net earnings versus the 2007 period, Aetna Inc.'s fourth-quarter financial results met the expectations of most analysts and slightly exceeded expectations of others.** Fourth-quarter net income fell to \$194.7 million (42 cents per share) from \$448.4 million (87 cents per share) in the year-earlier period. Full-year 2008 net income was \$2.83 per share, 18% lower than in 2007, primarily due to investment losses, the company said. Revenue for the year grew 9% to \$7.76 billion from \$7.14 billion. The company's fourth-quarter EPS includes a 42-cent investment loss, an 8-cent severance charge for the cost of reducing its staff by 1,000 and a 4-cent charge related to a recent agreement with the New York attorney general's office (see story, p. 3). Medical membership was 17.7 million members on Dec. 31, 2008, up 848,000 lives from the same date a year ago and up 33,000 from the end of the third quarter of 2008. Aetna maintained its 2009 EPS forecast of \$3.85 to \$3.95 for 2009 and said it expects 7% enrollment growth (about 1.2 million members) during the year, much of which is expected to be on the commercial side. The company has signed contracts recently with marquee-name employers including Bank of America and Home Depot, Inc.

◆ **Citing higher medical costs, Molina Healthcare Inc., a managed Medicaid firm, reported fourth-quarter 2008 net income of \$15.5 million (58 cents per share), down from \$17.9 million (63 cents per share) in the year-ago period.** Despite the decline, the company's results, released Feb. 11, were in line with analyst expectations. Net income for the full year increased to \$62.4 million (\$2.25 per diluted share) from \$58.3 million (\$2.05 per share) in 2007, Molina said. The company reiterated its 2009 outlook, which it established three weeks ago at its Investor Day meeting. Revenue for the quarter increased to \$812.5 million from \$678.6 million on increased membership and higher premium payments. Gains were offset by higher expenses, which rose to \$785 million from \$648 million, driven by rising medical costs, according to Molina. In his note to investors, Goldman Sachs analyst Matthew Borsch said enrollment gains in several states where Molina operates were higher than expected. However, he added that California's Medicaid program is a concern because the state could have Medicaid funding issues due to "severe budget shortfalls" that won't

likely be repaired by more federal matching called for in the economic stimulus bill (see story, p. 1).

◆ **Centene Corp., another managed Medicaid operator, on Feb. 10 reported fourth-quarter net income of \$21.4 million (49 cents per share), up from \$1.5 million (3 cents per share) in the year-ago period.** Revenue for the quarter increased 22% to \$902.8 million from \$739.8 million. The company also reaffirmed its 2009 EPS outlook range of between \$1.82 and \$1.94 on revenue between \$3.65 billion and \$3.78 billion. While the recently approved expansion of State Children's Health Insurance Program (SCHIP) presents a good growth opportunity for Centene, Oppenheimer & Co. equities analyst Carl McDonald said in a note to investors that it's not likely to have much of an effect on the company's 2009 earnings because Centene has already incorporated the effect the renewal and expansion will have in its 2009 earnings guidance. McDonald also noted that the company could lose half of its Texas rural Children's Health Insurance Program contract because the state intends to add another vendor to the pact. "As a result, even with additional SCHIP earnings, we think it will be difficult for Centene to meet even the low end of its long-term earnings [growth] target of 15-20%, and 2010 will be the second consecutive year the company has fallen short of its earnings goal," he wrote.

◆ **Coventry Health Care, Inc. on Feb. 10 reported fourth-quarter 2008 earnings of \$88.2 million (60 cents per share), down from \$184.3 million (\$1.18 per share) in the year-ago period,** but in line with most analysts' expectations and the company's previously announced expectations. For the full year, total revenues were \$11.9 billion with net earnings of \$381.9 million (\$2.54 per share), down from \$626.1 million (\$3.98 per share) in 2007. In a prepared statement, Coventry CEO Allen Wise said the company "is completely focused on achieving 2009 guidance and expanding margins in 2010 and beyond." Wise, who led the company for eight years before retiring, took over for Dale Wolf when Wolf abruptly resigned that post last month (*HPW* 2/2/09, p. 1). The company said it added 97,000 Medicare Advantage members in 2008 — up 34% from the previous year. It also added 227,000 lives to its Medicare Part D business — up 32% from the previous year.

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