

HEALTH PLAN WEEK

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

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HPW will not be published next week. The next issue will be dated Sept. 21.

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Health Reform Update

Obama Is Expected to Back Away From Public Option, Tout Areas of Agreement

On Sept. 9, one day after Congress returns from its month-long recess, President Obama will attempt to regain political steam and public support for health reform by addressing a joint session of Congress. To do that, the president is likely to distance himself from the public insurance option, a strategy that would be seen as a victory for health plans, industry observers tell *HPW*. Some observers also suggest that the president may call for a scaled-down, less costly bill.

Bruce Merlin Fried, a partner at law firm Sonnenschein Nath & Rosenthal LLP in Washington, D.C., says Obama needs to remind the American people, the vast majority of whom have health coverage, that health reform is about much more than expanding coverage to the uninsured. "Fundamentally [health reform] is about bending the [cost] curve so that five to 10 years from now we can all afford health insurance. At the end of the day, it is really a patriotic call to attend to the country's needs. If we do this right, no one is going to be completely happy, but everyone will be better off," he says. Fried was a health policy advisor to Obama during his bid for the White House.

The president needs to outline a concrete plan that is more limited than proposals now in Congress, but still comprehensive enough to expand coverage substantially and reform the individual insurance market, says Paul Ginsburg, president of the insurer-backed Center for Studying Health System Change. "It is time to abandon the public plan idea, which neither moderate Democrats nor moderate Republicans can vote for."

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Proposed 35% Excise Tax on Benefits Would Likely Hit Middle-Income Employees Hardest

One component under consideration in the Senate Finance Committee's (SFC) long-delayed health reform bill is a 35% excise tax on certain employer-sponsored health benefits. While such a tax would be aimed at health plans that sell so-called "gold-plated plans" — and indirectly at the employers that buy them — the proposal would likely hit middle-income employees in general (especially those with chronic conditions) and union members in particular the hardest. It also could encourage some employers to scale back coverage.

A July 27 *New York Times* article reports that Goldman Sachs Group, Inc. spends more than \$40,000 a year on medical and dental coverage for each of its 400 or so executives who enroll in the company's benefits package.

Such rich benefit packages tend to be offered by self-insured employers and generally are not sold on an insured basis by commercial carriers, notes Edmund Haislmaier, a senior research fellow in health policy studies at the Heritage Foundation, a right-leaning think tank based in Washington, D.C. But the proposed cap on benefits before a tax is applied would likely be far lower.

continued

The excise tax, as initially conceived, would have placed a cap on the income-tax exclusion for employer-provided health insurance. Under that proposal, benefits above the cap would have been considered taxable income to the individual. A more politically palatable version, proposed by SFC member John Kerry (D-Mass.), would impose an excise tax on health insurers and self-funded employer plans for family benefits that exceed \$21,000 a year (or \$8,000 for single coverage). The proposal, which could generate \$180 billion over 10 years, calls for the tax to go into effect by 2013.

While the excise tax itself wouldn't generate much new tax revenue, it could incentivize employers to move compensation out of non-taxable health benefits and into taxable wages, explains William Sweetnam, a principal with Groom Law Group in Washington, D.C. That, in turn, would mean more tax revenue with which to fund health reform. Haislmaier disagrees that scaled-back benefits would prompt wage increases. Rather, he says, pretax money previously spent on health benefits likely would be shifted into other pretax benefits.

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Some lawmakers expect that a cap on health benefits will "bend the cost curve" if it means people previously enrolled in high-cost plans would have lower utilization costs since they would be responsible for paying more costs themselves. There would be no impact on benefits funded by employees on an after-tax payroll-deduction basis.

Robert Zirkelbach, a spokesperson for the America's Health Insurance Plans trade group, says a new tax on health insurance costs "takes our health care system in the wrong direction by making coverage less affordable for families and small businesses across the country."

But Uwe Reinhardt, Ph.D., a renowned professor of health economics at Princeton University, suggests that taxing health benefits in some form makes sense. "One can do so either by income level, in which case it becomes another tax targeted on only the rich, or on the size of hitherto non-taxed compensation, which is what capping will do," he tells *HPW*. "I believe that before long, more middle-class families will have to pay higher taxes than they do now," Reinhardt says. "Financing the government solely on the backs of the rich, although perhaps just, runs into economic problems because of the disincentives it creates."

Health Accounts Could Count Against Cap

While details are sketchy, the value of other benefits, such as dental and vision coverage, as well as flexible spending accounts (FSAs) and health savings accounts (HSAs), would likely be added to the items subject to the tax, says John Hickman, an employee benefits attorney with the law firm Alston & Bird.

Here's an example of how the tax might affect an employee: The employee's total annual health benefit package has a price tag of \$23,000. The amount above \$21,000 is subject to the 35% tax (\$700). The annual per-member cost for family medical coverage is \$17,250 (paid by the employer). The remaining \$5,750 is for other coverage such as dental and vision. The cost of medical coverage is 75%, which means 75% of the tax (\$525) is charged to the primary insurance carrier. The insurance company would then build that amount back into the premium paid by the employer, Hickman explains. If the plan is self-funded, the \$525 excise-tax penalty for the medical coverage likely would be assessed against the employer that sponsors the plan. About 55% of employees who have health coverage through work are enrolled in a self-insured plan, according to the Employee Benefit Research Group.

"If you do that with each type of coverage, the employer is ultimately the entity that has to collect the excise taxes, determine how much it is, and reallocate it to either the insurance carrier or to the self-funded plan," Hickman explains. "It's complicated, especially for dual-

income working families, and would mean a lot of new administrative work for employers.”

The average cost of employer-sponsored coverage in 2008 was \$12,680 for family coverage (\$4,704 for single), according to a study released by the Kaiser Family Foundation. While Congress estimates that the proposed excise tax will impact less than 7% of Americans, Hickman suggests that the percentage would be higher when the value of all health benefits (e.g., dental, vision, wellness, HSA, FSA contributions) are factored in. Some employees, for example, have chronic conditions and make benefit elections with that in mind under their FSA or HSA arrangement. Others are enrolled in high-cost plans negotiated by their unions. And if double-digit rate hikes continue, the average cost of coverage will be closer to the cap by the time it's slated to go into effect.

The proposal is likely to be met with opposition from employer and union groups, which could prompt lawmakers to raise the cap and/or delay enactment until 2014 or 2015. They also could limit the tax to only medical plans.

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H1N1 Threat Could Trigger Some Unnecessary Expenses for Plans

While the financial implications of the H1N1 virus pandemic for health plans in the upcoming flu season remain unknown, the mere threat of the virus could actually lead to an increase in unnecessary doctor visits and precautionary measures, some analysts say.

Since the end of the seasonal flu season early this year (which occurred about the same time that H1N1 hit), health plans have been weighed down by a rise in medical costs and concerns related to the new flu strain. However, such increases in cost have not been linked to higher incidence of patients needing treatment for H1N1. Instead, “most of the higher costs managed care has faced have been for higher doctor office visits from people who thought they had H1N1, but didn't,” Edward Jones equities analyst Steve Shubitz tells *HPW*.

Adding to fears about an H1N1 outbreak this fall is an Aug. 24 report from the President's Council of Advisors on Science and Technology. The report estimates the H1N1 virus could kill as many as 90,000 Americans and land up to 1.8 million in the hospital (*HPW* 8/31/09, p. 8).

Before these estimates were released, most large health plan operators — including Aetna Inc., United-Health Group and WellPoint, Inc. — expressed concern for upcoming elevated costs during their second-quarter

earnings conference calls with investors and said they've incorporated higher flu costs into their medical loss forecasts, according to Matthew Coffina, an equities analyst at Morningstar, Inc. United, for example, reported that costs associated with H1N1 contributed a little more than 20 basis points (0.2%) to their medical cost ratio — a cost that is “barely worth noting,” he says.

Shubitz says few health plans are pricing in expectations for a pandemic and seem to be expecting only a moderately worse than average flu season. But “the potential exists that if the H1N1 virus spreads rapidly, it could cause a downward pressure on earnings results,” he adds.

Coffina contends that H1N1 flu is unlikely to have a meaningful impact on the long-run value of health plan stocks, “unless we got into some kind of really devastating pandemic,” he says. “But from what I've heard, it seems like H1N1 is likely to be no more severe than a normal flu season.”

Another major medical cost for health plans will come from offering members the H1N1 vaccine as soon as it becomes available, which is likely by October. Last month, several large health plans told *HPW* that they would offer the H1N1 vaccine to members whose benefits cover vaccinations (*HPW* 8/24/09, p. 1). While this could have a substantial financial impact on plans, the exact cost implications are “unclear at this point,” CIGNA Corp. spokesperson Gloria Rosanio tells *HPW*. “While we anticipate higher demand for the vaccine, this is offset by the fact that public health officials are also planning on providing vaccines for free through public health clinics,” she says.

Although health plans have myriad strategies in place to prepare for a widespread pandemic, new higher

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estimates on the potential severity or spread of the H1N1 virus haven't prompted them to upgrade their plans. "We'll deal with this as we have all along through educating our members and facilitating access to cost-effective preventive methods and treatments," says William Fried, M.D., Aetna's medical director for the mid-Atlantic region and the head of the insurer's pandemic flu planning team.

The most effective thing plans can do now is offer vaccinations and implement methods to encourage their members to get vaccinated, Fried says. Aetna has a large public education plan under way, in which it will be utilizing radio, social media and public service announcements to educate people on the importance of vaccinations. CIGNA says it will have a 24-hour information line and a team of health advisors on hand to educate its members on all aspects of the H1N1 flu.

In the end, Coffina contends, this could all be waste. "I have no idea whether it makes more sense to vaccinate or not from a total cost perspective," he says, adding that it all depends on the number of people who will get vaccinated that would have otherwise ended up in the hospital or ER. "From the cases reported so far, it sounds like a mass vaccination program is likely to be more expensive (in a purely financial sense, ignoring the costs of pain/suffering, etc.) than would have been the costs of just treating those people who got sick."

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House Committee Investigates Health Plan 'Purging' Strategy

A little more than a week after it requested executive compensation data from more than 50 health plans (*HPW 8/24/09, p. 8*), the House Energy and Commerce Committee is investigating whether health plans intentionally "purge" their small-employer clients when claims costs increase significantly.

The top executives at six companies — UnitedHealth Group, WellPoint, Inc., Aetna Inc., Humana Inc., Medica and Wellmark Blue Cross Blue Shield — were asked to provide detailed information about policies sold to groups of 100 or fewer employees since January 2007. The letters, sent Aug. 31, were signed by Committee Chairman Henry Waxman (D-Calif.) and Rep. Bart Stupak (D-Mich.) who chairs the Subcommittee on Oversight and Investigations. The committee, according to the letter, has information that suggests "health insurance companies terminate the coverage of small businesses that have become expensive to insure by cancelling their policies or by raising their premiums to unaffordable rates."

Industry trade association America's Health Insurance Plans (AHIP) criticized the letters as being part of a politically timed and politically motivated "fishing expedition" being used to justify the creation of a government-run insurance option. "Health plans are already highly regulated at both the federal and the state level," says AHIP spokesperson Robert Zirkelbach.

The investigation appears to have been prompted by the testimony of a former CIGNA Corp. executive. At a June 24 hearing before the Senate Committee on Com-

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merce, Science and Transportation, Wendell Potter, who retired last year as CIGNA's vice president for corporate communications, testified that large health insurers routinely and intentionally boost premium rates for small employers that have high claim costs in an effort to get them to switch carriers (*HPW 6/29/09, p. 3*).

While CIGNA is not among the six companies to have received a letter, that company is working to comply with a separate request from Sen. John D. "Jay" Rockefeller IV (D-W.Va.). In an Aug. 5 letter to CIGNA Chairman and CEO Edward Hanway, Rockefeller asked for an explanation of the term "purging," which was used by CIGNA President and Chief Operating Officer David Cordani during a February conference call to discuss fourth-quarter 2008 earnings results. CIGNA spokesperson Chris Curran says the company submitted its response on Sept. 2.

Most of the health plans contacted by *HPW* declined to comment on the latest round of letters beyond saying that the request was being reviewed. Medica spokesperson Larry Bussey, however, expressed surprise that a regional not-for-profit company was being investigated alongside publicly traded behemoths such as United and WellPoint. One possible explanation, he says, is an Aug. 7 *Business Week* article that profiled a Medica client that saw a 72% rate increase after one of its employees was treated for pancreatic cancer. "What that article didn't say was that we reduced the [rate] increase by half, and that group did renew with us," Bussey says. He adds that as a not-for-profit health plan, Medica competes for members and doesn't have the same financial motive to eliminate high-cost employer clients. Moreover, he says, state regulators must approve Medica's benchmark renewal rate for clients with 50 or fewer enrollees. "And we apply standard underwriting procedures based on [claims] experience with protections to mitigate against high-claims experience," he tells *HPW*.

To see a copy of the letters sent to health plan executives, visit <http://tinyurl.com/kke3u4>. ↵

Obama May Not Push Public Option

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Matt Perry, an equities analyst with Wells Fargo Securities, agrees that the White House is likely to back away from requiring that a public option be included in a final reform bill. Americans, he says, are most concerned about the cost of health reform and the threat of government control, which many people equate with the proposed public insurance option. Perry suggests, however, that Obama probably won't "officially" compromise on cost or on the public option in his speech. More likely, he will either outline a set of key principles that must be included in a final bill (and not mention the public option

Protest of TRICARE Pact Loss Helps Health Net Stock Post Big Gain

With the exception of the Medicaid segment, most health plan stock prices increased modestly in August. In the commercial segment, Health Net, Inc.'s stock ended the month at \$15.32 — up 13.2% from the end of July. In a Sept. 1 note to investors, Stifel Nicolaus upgraded shares of Health Net to "buy" with a target price of \$20 per share, and increased its 2010 earnings-per-share estimate to \$2 from \$1.70. Health Net, which filed a formal protest after losing its TRICARE contract (*HPW 7/20/09, p. 1*), could get several months of additional revenue as a result of the protest, equities analyst Thomas Carroll explained in the note. The Government Accountability Office (GAO) has 100 days to render a decision regarding the protest, and the company has indicated that it will file an amended protest. The new contract is expected to begin 10 months after the GAO finalizes its decision, which would mean Health Net's contract termination would be delayed until sometime between August and October 2010, rather than April, as originally scheduled.

The loss of the TRICARE business, combined with the pending sale of its Northeast business to UnitedHealth Group (*HPW 7/27/09, p. 1*), also creates a "less complicated business," according to Carroll. The leaner company, he added, could mean it is "better packaged" for a possible sale.

	Closing Stock Price on 8/31/09	Closing Stock Price on 7/31/09	August Gain (Loss)
Commercial			
Aetna Inc.	\$28.50	\$26.97	5.7%
CIGNA Corp.	\$29.43	\$28.40	3.6%
Coventry Health Care, Inc.	\$21.83	\$23.00	(5.1%)
Health Net, Inc.	\$15.32	\$13.53	13.2%
Triple-S Management Corp.	\$18.54	\$17.09	8.5%
UnitedHealth Group	\$28.00	\$28.05	(0.2%)
WellPoint, Inc.	\$52.85	\$52.64	0.4%
Medicare			
Humana Inc.	\$35.70	\$32.85	8.7%
HealthSpring, Inc.	\$13.23	\$12.63	4.7%
Medicaid			
AMERIGROUP Corp.	\$23.65	\$24.62	(3.9%)
Centene Corp.	\$17.31	\$19.32	(10.4%)
Molina Healthcare, Inc.	\$20.25	\$22.59	(10.3%)
WellCare Health Plans, Inc.	\$24.27	\$22.26	9.0%
Specialty			
Magellan Health Services, Inc.	\$32.09	\$32.36	(0.8%)
Other			
Assurant, Inc.	\$29.95	\$25.52	17.3%
Universal American Corp.	\$9.18	\$9.10	0.9%
SOURCE: Compiled by Atlantic Information Services, Inc., September 2009			

or cost), or he will state that the public plan is important, but not essential to his conception of reform, Perry tells *HPW*. The “public plan is more likely to be officially dropped in either the House or in conference committee between the House and Senate,” he suggests.

Fried says that addressing the proposed public option could be tricky for the White House. “On one hand you’ve got the most progressive wing of the Democratic party that feels passionately about [including a public option], and you’ve also got the moderate [Democrats] who are certainly less passionate if not opposed to it,” he tells *HPW*. “Let’s face it, the White House and Democratic party absolutely understand the political implications of failure. Failure is not an option, so at the end of the day, the Democrats will craft a bill that will be passed. And I believe it will be substantial and closer to what is being debated.”

No Public Option Would Boost Plan Stocks

Dropping the public option from a final reform bill would be a tremendous victory for health plans. In a research note to investors, Perry suggested the chance of a public option being implemented “is now approaching 0%.” Without the threat of a public plan, the valuation of publicly traded stocks could collectively increase to between 10 times and 11 times 2009 earnings per share (EPS), Perry said. The sector now trades at about 9.5 times estimated 2009 EPS.

“The best thing the president could do is to say that reform is off track...too complicated and controversial,” says Neil Trautwein, vice president and employee benefits policy counsel at the National Retail Federation. And Congress, he adds, should recognize that reform doesn’t need to be done all at once. Rather, it could address insurance market reform first along with subsidies for low-income coverage, he says.

Henry Miller, Ph.D., managing director of health care at LECG, LLC, however, says he believes a public option will remain in the bill. That version, however, likely will be weaker than existing proposals and could resemble Medicare Advantage (MA) plans with fewer restrictions and more generous provider reimbursement. LECG is an international consulting firm that specializes in economic analysis and dispute resolution.

Consultant William DeMarco, president of DeMarco and Associates, agrees that a public option could be managed by private contractors like MA plans. “This means there [would be] oversight and control at the federal level, but local insurance commissioners [would] govern consumer complaints and local insurance companies [would] bid to get the chance to sell and administer the program.”

In order to make progress, policymakers need to go beyond hot-button issues such as the public insurance option and end-of-life counseling and stress the elements of reform that have broad agreement, says Bonnie Washington, vice president at Avalere Health LLC, a Washington, D.C.-based consulting firm. “From what I’ve heard, [Obama] will put a stake in the ground and offer some specifics.”

Henry Loubet, senior vice president and chief strategy officer at Keenan, a California-based health care consulting and brokerage firm, agrees that the president should stress proposals that have bipartisan support, such as prevention, improved health information technology and expanded health coverage for the uninsured. “I believe the president is best served by reverting back to his original strategy of bipartisanship if he hopes to regain momentum and support for the health reform plan,” he says, adding that “the private sector has a lot to offer as part of a total solution.” Loubet is a former UnitedHealth Group executive. Fried agrees and says the president should emphasize proposed changes, such as guaranteed-issue coverage, that have bipartisan support.

‘Gang of Six’ Is Now a Quartet

The last hope for a bipartisan health reform bill is in the hands of six members of the Senate Finance Committee (SFC) who were negotiating on the bill during the congressional recess. Two Republican members of the so-called Gang of Six, however, have recently begun to distance themselves from Democratic proposals. In the GOP’s weekly radio Aug. 29, Sen. Mike Enzi (R-Wyo.) said the “Democrats are trying to rush a bill through the process that will actually make our nation’s finances sicker without saving you money.” He also said the bills “raid Medicare.” And during a Sept. 3 news conference, Sen. Charles Grassley (R-Iowa), the SFC’s ranking minority member, suggested that the only way to get bipartisan agreement on health reform is to defeat the Democrats’ reform proposals. “Then the Democrats will come to the Republican leadership. And at that point, the only way they will get health care reform is bipartisan,” he said, adding that it would be a mistake for Democratic lawmakers to push a partisan bill through Congress. “You need to have something that has broad bipartisan support when you’re restructuring one-sixth of the economy.”

Olympia Snow (R-Maine), the third Republican in the Gang of Six, has suggested that a public insurance option should be created only if the private health insurance sector is unable to meet certain expanded access and affordability standards within a specified time frame. Fried says such a strategy could be seen as a compromise to the public option.

Despite shrinking hopes for some Republican support for a Democratic-led reform bill, Senate Democrats are unlikely to try to pass a bill on their own. Through a process called reconciliation, Senate Democrats could pass a reform bill on their own with 50 votes, rather than the filibuster-proof 60. Reconciliation is a procedure under the Congressional Budget Act of 1974 by which Congress implements budget resolution policies that primarily affect permanent spending and revenue programs. The procedure was intended only to adjust revenue and spending levels to help reduce deficits.

In an April 2 letter to fellow lawmakers, Sen. Robert Byrd (D-W.Va), the lawmaker for whom the reconciliation process was named, stressed his opposition to using the strategy to pass a health reform bill. "I can tell you that the ironclad parliamentary procedures it authorizes were never intended for this purpose."

Although the reconciliation approach might allow some elements of health care reform to be passed, it would be difficult to expand coverage to the uninsured within the required budget-neutral structure, Miller says. "Since expanded coverage is the key element of reform, I do not think it will be tried," he says. "If the reconciliation process is used, however, it likely would focus on

efforts to support innovative approaches to cost containment and incentives to states to develop approaches to cover the uninsured," Miller adds.

The Byrd rule requirements make passing a health reform bill through reconciliation very complicated. "The rules basically require that each provision in the bill has a savings or spending consequence, which means anything extraneous could be removed from the bill," Washington explains. "Insurance reforms, a public insurance option and health insurance cooperatives are all questionable. Any bill passed using this process would likely need to be an altered version of current reform proposals."

Moreover, the Byrd rule prohibits an increase in the deficit beyond the budget window, as specified in the most recent budget resolution. This year, that's a five year window. "That would cause complications, especially if [new health reform laws] don't go into effect until 2013," she adds.

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HEALTH PLAN BRIEFS

♦ **A California-based consumer group alleged that UnitedHealth Group and WellPoint, Inc. coerced employees into writing letters to members of Congress and attending "town-hall" meetings, during business hours, in an effort to "weaken health reform."** Both health plan operators deny the allegations. In a Sept. 2 letter to California Attorney General (AG) Jerry Brown (D), Consumer Watchdog called for an investigation into tactics used by the insurers, which the group contends violate the state's Labor Code. In addition, Consumer Watchdog said both companies urged employees to attend and participate in town-hall meetings to demand that health reform "not contain any Medicare-like public non-profit alternative to private insurance," according to Consumer Watchdog. In a prepared statement provided to *HPW*, United called the allegations "completely false and particularly disappointing, as we have been one of the biggest proponents for modernizing our health care system." The company says it made information available to its employees who wanted to voluntarily participate in town-hall meetings or write to their elected officials. "We have told our employees to participate as individuals, not on

behalf of the company, with their unique messages and personal perspective," United said. A WellPoint spokesperson says the company has not yet seen the complaint, but asserted, "we believe it is important and permissible to provide up-to-date information about health reform to our associates." To see a copy of the group's letter, visit www.consumerwatchdog.org/pr. Contact United spokesperson John Parker at john_e_parker@uhc.com... In an unrelated matter, AG Brown on Sept. 3 announced that his office has launched an inquiry into how HMOs review and pay insurance claims submitted by doctors, hospitals and other medical providers. The investigation, according to Brown's office, was prompted by reports that California's five largest health insurers deny insurance claims at rates of up to 39.6%.

♦ **HealthMarkets, Inc. and two subsidiaries have been ordered to leave the Massachusetts market and pay \$17 million in "consumer relief, penalties and costs"** for what AG Martha Coakley (D) said were unfair and deceptive marketing practices used to convince self-employed people and small businesses to purchase limited-benefit plans. Coakley's

HEALTH PLAN BRIEFS (continued)

office said the insurer also failed to provide benefits mandated by state law and denied health plan membership based on pre-existing conditions. Coakley's office on Aug. 31 said it had resolved a lawsuit against HealthMarkets and its subsidiaries MEGA Life and Health Insurance Co. and Mid-West National Life Insurance. In a prepared statement released that same day, HealthMarkets said its subsidiary insurance companies will focus solely on marketing its ancillary vision, dental and related specialty plans in Massachusetts and will discontinue marketing health insurance products in the state after Sept. 30. The insurer and its subsidiaries also were banned for at least five years from selling their health plans in Massachusetts and are required to exit the Massachusetts health plan business completely. They are allowed to renew existing health plans with individuals and small businesses through 2012, giving current policyholders ample time to obtain other coverage, according to Coakley's office. The settlement, the result of a multi-year investigation, is believed to be the largest consumer-protection settlement against a health plan in Massachusetts history. Visit Coakley's office at <http://tinyurl.com/lhdfh8> or HealthMarkets at www.healthmarkets.com.

◆ **Cinergy Health's heavily advertised, low-cost medical insurance is providing far less coverage than the company's ads promised, said New York and Florida state insurance regulators**, according to *The Miami Herald*. Although Cinergy's Web site and ads portrayed it as an insurer providing medical policies, Cinergy is an insurance agent that sells policies but does not underwrite them, the newspaper reported. After an investigation, New York state insurance regulators determined that the company actually writing the policies, American Medical and Life Insurance, defrauded consumers with ads indicating that its limited-benefit health insurance plan offers comprehensive medical coverage. American Medical was fined \$700,000 by the New York Insurance Department for the allegedly misleading ads. It also was banned from selling any more of the limited-benefit medical plans in that state. Last month, Cinergy severed its ties with American Medical and also stopped selling health care plans for another insurer — Guaranteed Trust Life Insurance — that was backed by American Medical, a Cinergy spokesperson told the Herald. Florida's

Office of Insurance Regulation ruled that Cinergy's ads on American Medical's behalf were misleading, but it has not yet determined what action it will take against American Medical, according to the publication. A spokesperson for Cinergy told the newspaper that it wasn't aware that the ads it was running didn't meet New York state insurance regulations until American Medical was fined last month. Visit www.ins.state.ny.us.

◆ **The Detroit Public Schools overpaid approximately \$3.4 million in late fees and medical bills to Blue Cross Blue Shield of Michigan (BCBSM), which agreed to pay DPS back immediately**, reported *The Detroit News*. The error was discovered in a contract review conducted by Aon Consulting for DPS, according to the newspaper. The *Detroit News* reported on Aug. 28 that the review found the insurer had overcharged DPS \$404,490 in late fees, assessing a 2% charge instead of the correct 1% charge. The review also found the school system overpaid \$3 million for medical claims and administrative costs, added the publication. Helen Stojic, spokesperson for the Michigan Blues plan, tells *HPW* that it discovered the overpayment while reconciling financial payments. "These were not services billed to DPS but rather paid in error to BCBSM. Those funds will be returned to DPS with interest," she tells *HPW*.

◆ **On Sept. 3, Maine Gov. John Baldacci (D) announced that the state will receive \$8.5 million this year from HHS to provide affordable health insurance for uninsured part-time, seasonal and direct-care workers at companies with more than 50 employees.** The grant was announced as HHS Sec. Kathleen Sebelius visited Maine. The state also is eligible for up to \$8.5 million each year for the next four years, for a total of \$42.5 million over the five-year project period. Along with helping to insure more people, the cash infusion will help Dirigo Health, the state's ailing universal coverage initiative, to become an insurance exchange, according to Baldacci's office....On Aug. 24, Maine enacted the Health Care Bill of Rights, which gives the state's insurance superintendent greater authority to oversee health plan rate increases. The new law will also require health plans to provide clear, understandable explanations of the benefits when a claim is filed so that enrollees have a better understanding of what is covered under their policy.

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