

HEALTH PLAN WEEK

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

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Innovations Needed to Reform System Could Disappear Due to Limited VC Funding

While reforming the health care system is a top goal of the Obama administration, many of the innovative ideas needed to improve efficiencies for health plans and providers could shrivel up and blow away due to a dramatic lack of funding from venture capital (VC) firms, industry observers warn.

And limited funding for firms that can help improve efficiencies and eliminate waste in the bloated \$2 trillion health care industry could make the U.S. less competitive in the global economy and "wind up bankrupting us," warns Albert Waxman, Ph.D., a former behavioral health plan CEO who is now senior managing member at New York City-based Psilos Group, a health care-focused VC firm.

In the fourth quarter of 2008, venture capitalists invested a scant \$42 million in just 15 health care services deals, according to results of a MoneyTree study released late last month by the National Venture Capital Association (NVCA) and PricewaterhouseCoopers (PWC). Of all VC dollars invested in 2008, less than 1% went to health care services firms (see table, p. 6). In 1998, by contrast, VC firms poured nearly \$1 billion into about 150 deals with health services firms, according to the study. But that field is now seen as too risky, both financially and politically, explains Emily Mendell, vice president of strategic affairs at NVCA, which represents 450 U.S.-based VC firms.

"The reality is that venture capitalists have not made much money in health services and there are no real buyers for those companies," says Tracy Leteroff, global managing partner in PWC's Life Sciences Industry Services division. "A decade ago, there were a lot of casualties among venture capitalists who invested in health services companies. There's not a great track record of successful [mergers and acquisitions], and public markets aren't very interested" in these firms, he tells *HPW*.

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Health Insurers Weigh Trade-offs Between Centralized Services, Personalized Service

In lean economic times, health insurers are under particular pressure to operate as efficiently as possible while still maintaining customer service levels. HealthNow New York, Inc. recently decentralized many of its administrative functions to strategic business units (SBUs) by customer size, in a bid to make its services more personalized. Other insurers, including Medica, Aetna Inc. and WellPoint, Inc., are keeping more functions centralized while still trying to achieve some of the benefits of specialization.

HealthNow, parent of Blue Cross and Blue Shield plans in upstate New York, reorganized into four SBUs for government programs, self-insured employers, employer groups of 151 or more, and small groups and individuals. Each SBU is responsible for profit and loss, customer satisfaction, medical utilization and market share. The insurer created co-located teams for each SBU to house administrative functions such as sales, account and broker management, product design, underwriting, enrollment, billing, customer service, claims processing, medical management and disease management.

Decentralizing insurance functions became common in the 1990s, says Peter Kongstvedt, M.D., principal of consulting firm P.R. Kongstvedt Co., LLC. And it's still typical

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for health insurers to have dedicated units that cater to self-insured clients' needs, because these customers are large and tend to have wide variability in benefit designs and administrative requirements.

But as health insurers have consolidated, many have centralized core functions such as claims processing and customer service. "It was just an efficiencies issue," he says. However, he adds, "the SBU approach tends to be a more market-facing approach." And back in the 1990s, health insurance "was still a growth market, and so your No. 1 concern wasn't necessarily growth then — it was premium cost compression." Now, however, "the market is shrinking. Everybody is redoubling their customer-facing functions."

HealthNow completed the reorganization in December 2007, says Michael Giaquinto, senior vice president of the insurer's general business market, which comprises individuals and accounts of up to 150 enrollees. "We needed a way to differentiate ourselves and to really improve our client experience," he says. The model also can't be easily duplicated by competitors.

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Giaquinto says the reorganization is paying off for HealthNow, with higher enrollment and satisfaction survey results since late 2007. His unit grew from 125,000 customers in July 2007 to almost 140,000 at the end of 2008. "The company's numbers are up as well," he adds.

It took about two years to complete the whole reorganization — a period during which the insurer also was moving into new headquarters. "The way the building is designed...all billing, account management, account support, underwriters, case and disease management — we all sit on the same floor, so they can really work with each other to impact that client experience," Giaquinto explains. "In the past, it was very, very centralized. Customer service could have been on another floor, and billing and enrollment could have been on another floor. Today you can just walk over and see somebody."

Giaquinto asserts that the new structure isn't more expensive. "Net-net, we're about even with the FTEs [i.e., full-time equivalent staff members] in the old structure." The insurer was able to automate some internal processes such as setting up new groups. "And where we added staff was in the account management areas."

HealthNow is now much more responsive, he contends, and can dedicate more resources to smaller clients. "We were able to create dedicated teams to focus on our chamber [of commerce] and association business...[and] create more account managers and account-support folks to deal with the small groups," Giaquinto says.

Other Insurers Take a Middle Road

That ability to focus on smaller business units is an advantage of a decentralized model, agrees Jana Johnson, senior vice president of operations at Medica. "You have the David and Goliath [problem], where you're always going to focus your resources [on larger customers and segments] if you centralize," she says.

"I've seen it in my career go round robin, I guess, between centralized and decentralized," Johnson says, adding that Medica is not planning a reorganization. "I see the pros and cons of both...My ultimate approach would be a centralized approach with dedicated staff to make sure we meet those specific customer needs," she says. To do so, "it makes some sense to specialize, even if it is inefficient." But with a decentralized approach, "you risk creating silos,...so one business unit might get overwhelmed with volume and the other sits idle with capacity."

Medica segments its customer service, with the commercial customer call team segmented into units for large-group, jumbo accounts and "high-need customers" and a separate unit for middle-market and small-group customers. There are two sales teams: one for seniors and individuals, and another for commercial group customers.

Underwriting, however, is centralized, both to achieve “economies of scale and also [because of] subject-matter expertise,” Johnson says. Medical management and disease management also are centralized, “and they support all of our products and segments.” The health plan outsources all claims, enrollment and billing functions to UnitedHealth Group.

WellPoint Has ‘Virtual’ Teams

It’s possible to go too far in either centralizing or decentralizing functions, says David Finkel, senior vice president of service operations at WellPoint. If everything is centralized, “it’s absolutely the most efficient model, but you tend to dehumanize some of what you’re doing.... And if you go too far to the decentralized side, what you start to have is a much more human touch and many more close relationships, but then things start to get lost in the shuffle,” he says. “It becomes a lot more expensive, and there’s a lot more redundancy built in.”

WellPoint has “decentralized our teams in still-centralized environments,” Finkel says. The insurer has many large service centers, rather than three or four “mega centers,” he explains. Within each center, the insurer has specialized commercial teams segmented by geography. Depending on the market, teams are either located together, or are “virtually” co-located.

For smaller health plans, such as Blue Cross and Blue Shield of Maine, “we have one team for customer service, claims, all enrollment and billing, and it also has the medical management people all working together,” Finkel says. In larger divisions such as Blue Cross of California, there are a couple of large service centers dedicated to the state, but the employees still are divided into teams.

By contrast, specialized departments such as underwriting are driven by an enterprise-wide management approach, with one set of disciplines that all underwriters employ, he says. But different underwriters focus on different types of customers.

Aetna takes a hybrid approach, providing some customer-facing functions on a local market basis, further segmented by customer size, says James Reid, vice president for regional business customer operations at the insurer. For example, in the Jacksonville, Fla., customer service center, there are several teams dedicated to different segments — such as Aetna’s small, middle-market and national-account members — within that local market. A similar model applies to Aetna’s claims processing, enrollment and billing functions.

“We also do apply some shared resources across our business model,” he says. They include the medical management and disease management departments.

In some areas, Aetna has physically located functional areas that support one segment, such as the small-

group unit, Reid says. But because of Aetna’s size, “in some instances we may not have the same skill sets in one geographical location.” In addition, about 30% of the insurer’s workers telecommute.

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Daschle’s HHS Exit Expected to Delay, Not Derail, Reform Efforts

Former Sen. Tom Daschle’s decision to withdraw his nomination as HHS secretary won’t derail the Obama administration’s efforts to reform the health care system. But it will mean a significant setback and will delay the impact on health plans, industry observers tell *HPW*. Daschle, who pulled out of the running Feb. 2 after admitting errors on his income taxes, also was expected to head the new White House Office of Health Care Reform. It’s unlikely the Obama administration will be able to fill both slots with just one person.

“There is no question this slides the idea of health reform to 2010. There is no way we will see any major reform this year,” says John Gorman, CEO of Gorman Health Group, LLC, a Washington, D.C.-based consulting firm. “But the Obama administration isn’t going to let the issue slide just because a nominee took a fall. The White House will still push [reform], but they need to have a captain at the helm of the ship first.”

One of the significant strengths Daschle would have brought to the office is the “incredible relationship and regard that he enjoys with House and Senate leaders from both parties,” adds Bruce Merlin Fried, a partner at law firm Sonnenschein Nath & Rosenthal LLP in Washington, D.C. “In no small way, he would have been the lobbyist-in-chief for the president’s health reform plans. He would have been an awesome proponent for the president’s initiatives.” Fried was chief coordinator of the Clinton administration’s Health Care Advisory Group in 1992.

Howard Dean, M.D., a six-term governor of Vermont and former chairman of the Democratic National Committee, may be next in line for the HHS secretary post, according to one well-placed source. But neither Dean nor any other candidate being considered will likely also be tapped to serve as the health policy czar at the White House. Other possible HHS secretary candidates include Kansas Gov. and former state insurance commissioner Kathleen Sebelius (D), U.S. Rep. Rosa DeLauro (D) of Connecticut and former CMS administrator and FDA head Mark McClellan, M.D., who also served as a senior policy director for health care and related economic

issues during the first two years of George W. Bush's administration.

Gorman suggests that the Obama administration might seek a congressman or senator to fill the HHS post, but doubts that the nominee also will be asked to head the White House health reform office. While Dean might be picked to head HHS, Gorman says it's very unlikely he also would be asked to head the health reform office at the White House. And it's unlikely a CMS administrator will be appointed before a new person is nominated to head HHS, he adds.

Fried says the team Daschle assembled is likely to remain in place, including Jeanne Lambrew, who was named deputy director of the health reform office at the White House. Lambrew co-authored Daschle's 2008 book on health reform.

"With the exception of Daschle, the White House has its A-team together and they won't want to lose that," Fried says. However, he adds that whoever is selected to head HHS and the White House reform office could push to change some of the players.

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Aetna Agrees to Reimburse Students \$5.1 Million for Underpayments

An investigation of Aetna Inc.'s student health insurance subsidiary determined that it underpaid more than \$5.1 million in out-of-network claims between 1998 and April 1, 2008, New York Attorney General (AG) Andrew Cuomo (D) announced Feb. 2. One attorney tells *HPW* that other health plans could face similar problems if they relied on outdated information to calculate their usual, customary and reasonable (UCR) rates for out-of-network services.

That's what happened in this case. The claim platform used by Aetna's student health insurance subsidiary, The Chickering Group (acquired in 2003), is separate from Aetna's primary claim platform, which is updated twice a year with data from Ingenix, Inc. Aetna last month said it would stop using the Ingenix databases to determine UCR charges after Cuomo said a high-profile investigation into Ingenix, a subsidiary of UnitedHealth Group, determined its databases were flawed.

"We learned that Chickering was not following this practice on its claim platform — hence the underpayments on some of its out-of-network claims," Aetna spokesperson Cynthia Michener tells *HPW*. She adds that the issue with Chickering came to light last year when Cuomo's office launched an investigation into Ingenix. Aetna brought the claims system up to date so that future payments would be correct, and then it began

analyzing past claims data to identify claims that might have been under paid. "We then developed a mechanism for reprocessing those claims."

Aetna said this month that it would reimburse more than 73,000 former and current students who had health coverage through the firm, and in some cases, their doctors. The company also will pay interest and penalties. The affected claims, according to Aetna, represent about 3% of the student health subsidiary's claims volume. The underpayments average about \$25 each, the insurer adds.

Several other health insurers, including United and Harvard Pilgrim Health Care, sell health insurance products designed specifically for students. Calls to Cuomo's office seeking comment on possible investigations into these firms were not returned. Aetna says its Chickering subsidiary has the largest share of the market with 512,000 students from 189 colleges and universities.

Problems Surfaced Last Summer

Last June, after identifying the problem with its student health subsidiary, Aetna says it notified several state AGs. Connecticut AG Richard Blumenthal (D) asked Aetna to reimburse approximately 1,300 college students in Connecticut — and more nationwide — for charges that enrollees were improperly asked to pay out of pocket. As part of that investigation, Aetna said it determined that thousands of college students — in Connecticut, New Jersey and New York — were under-reimbursed for out-of-network health services.

Health plans that rely on outdated claims data could find themselves in hot water, warns Barbara Quackenbos, a partner in New Jersey law firm Wilentz, Goldman & Spitzer, PA. "Part of what got Health Net into such trouble with the New Jersey Dept. of Banking and Insurance was its persistent use of 1998 Ingenix data between 2001 and 2003." Her firm represented the plaintiffs in a UCR case against Health Net, Inc. that resulted in a \$215 million settlement last July (*HPW* 1/19/09, p. 1).

Several health plans contacted by *HPW* say they intend to use continue to use the Ingenix database to set UCR rates until the new database is up and running, as was called for in the Ingenix settlement. On Feb. 4, MVP Healthcare, Inc. became the latest health insurer to agree to end its reliance on Ingenix's data. Cuomo's office announced that the company would contribute \$535,000 over five years to help establish a not-for-profit database that would take the place of two Ingenix databases that will be shut down when the new one is up and running. Aetna and United also have agreed to contribute to the creation of the new entity (*HPW* 1/19/09, p. 1)

Robert Laszewski, president of Health Policy and Strategy Associates, LLC, a policy and marketplace consulting firm based in Alexandria, Va., suggests that most health plans will have no choice but to use the Ingenix

database until the new one is up. He contends that the new database is unlikely to be much different.

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VC Funds Gap Hurts Health Services

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Mendell, however, suggests that some venture capitalists have been encouraged by the Obama administration, which she says seems to understand the value of applying technology to solve complex problems.

“At a time when we need it most, we are killing off a lot of the innovative companies that are working out new ways to organize, finance or deliver health care,” says David Brailer, M.D., Ph.D., a former National Health Information Technology Coordinator who is now chairman of Health Evolution Partners, a San Francisco-based VC firm. Over the past decade, he tells *HPW*, many investors turned away from health services in favor of biotechnology, which seemed less risky. If the U.S. economy wasn’t in tatters, he argues, some investors would now be turning back to health care services firms. “This is a perilous time for early-stage companies,” he tells *HPW*. Some firms that have potential might not be able to find funding because many investors are funneling their capital into their safest bets “and letting the other ones just die.” Another problem is that early customers of venture-backed firms have cut back on spending and are averse to becoming early adopters for unproven products and services.

“The fact that the health system is broken in so many ways is an important reason to invest in it,” adds David Jones, chairman and managing director of Chrysalis Ventures, a Louisville, Ky.-based VC firm that invests in health services. Jones also is the co-founder and non-executive chairman of the board at Humana Inc.

There is a market for new innovations in any system as dysfunctional as the health care system, Waxman argues. Waste, inefficiency and errors cause 30% to 40% of the spending on health care, he asserts, adding that technology, such as high-speed communication systems, high-quality personalized medical content, electronic medical records (EMRs) and personal health records could “expand the capabilities of providers and improve efficiencies for health plans.

But adoption is just as critical as innovation. Lefteroff says that creating an EMR that doctors would adopt has long been the Holy Grail for health services companies. While physicians and hospitals are quick to assimilate new medical technologies into their practices, they generally are reluctant to embrace costly back-office technologies. He suggests that VC investments could continue

to dry up for health services firms unless health reform creates some new, unexpected opportunities. “The miniscule amount being invested now in [health services firms] isn’t going to scratch the surface of having any sort of impact on improving the health care system.”

But VCs say some of their investments are already beginning to have an impact. Here’s a look at a few VC-backed health services firms and their strategies to improve health care delivery.

◆ **E-prescribing system piloted in Florida:** Prematics, Inc., an e-prescribing firm based in Vienna, Va., was formed by Kevin Hutchinson, who founded SureScripts, and Jim Bradley, who founded RxHub. After their firms merged, the two entrepreneurs launched Prematics. “We backed the company because of its high-quality management team and their ability to work with managed care organizations to accomplish strategic goals beyond just prescribing pills,” Brailer says. Last fall, Prematics and Availity LLC (an electronic data interchange clearinghouse and information exchange firm) launched a three-month e-prescribing pilot with physician practices in Miami and Tampa, Fla. Through the program, physicians can order the most clinically appropriate, cost-effective medications with real-time access to patient medication history, eligibility and formulary information, according to a prepared statement from Prematics. The pilot was launched with support from Humana and Blue Cross and Blue Shield of Florida. The Medicare Improvements for Patients and Providers Act of 2008, which went into effect this year, calls for a two-year, 2% incentive payment for eligible physicians who use e-prescribing for Medicare patients. Physicians who do not use the technology could see their payments cut by 1% starting in 2012 and by more in 2013 and 2014.

◆ **Remote monitoring slashes hospital stays:** Another area ripe for innovation is chronic disease. “We know

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that chronic illnesses require close monitoring because patients have a tendency to get worse in a relatively short amount of time if they fail to comply with treatment," Waxman explains. "We think technology (i.e., remote monitoring, personalized messages) can be used to improve compliance. He points to Health Hero Network, a Palo Alto, Calif.-based firm acquired by The Bosch Group in 2007. Psilos was once the principal shareholder in the firm. The company developed a user-friendly monitoring device to serve as an interface between patients at home and care providers. Through increased communication with caregivers, behavior modification and prevention, Health Hero says it can dramatically reduce hospitalizations. CMS last month extended and expanded a three-year project with the firm designed to illustrate how telehealth technology can improve care and reduce hospitalizations associated with conditions such as heart and lung disease and diabetes. The project, launched in 2006 with medical groups in Wenatchee, Wash., and Bend, Ore., was extended to January 31, 2012, and could be expanded to include an additional location.

◆ **Personalized e-mails improve compliance:** In 2003, Chrysalis invested in HealthMedia, an Ann Arbor, Mich.-based firm that had developed an automated disease management system for chronically ill patients. The system uses highly personalized e-mail messaging to create a Web-based health coach. In 2007, the company was selected by Kaiser Permanente to be its program-wide health risk assessment system. And last fall HealthMedia was acquired by Johnson & Johnson, which intends to use the company as a platform on which to build a multi-billion-dollar consumer health coaching business.

◆ **Software boosts benefits for chronically ill:** A year ago, Psilos invested \$13 million in HealthEdge, a Burlington, Mass.-based firm that offers "next-generation claims and benefit administration" for health insurers. The compa-

ny's software allows health plans to drill through claims data to identify members who either are chronically ill or might be in danger of developing a condition. Once such members are identified, their coverage benefits can be modified to reduce or eliminate copayments for disease-specific medications. "If you are a diabetic, we don't want to charge you a copay for your medicine; we want you to take your medicine. And we don't want to charge a copay to see a doctor, because we want you to see the doctor," Waxman explains. "If you are compliant with your care and your medicine, we know you will spend less time in the hospital."

Psilos also invested \$15.5 million in Triveris, Inc., an Eatontown, N.J.-based firm, that provides the infrastructure for "value-based" health plans (for large corporate accounts) and also sells the plans directly to small employers. The software from the two firms "forms the backbone of UnitedHealth Group's new value-based diabetes health plan," says Lisa Suennen, a co-founder and managing member of Psilos. The goal of United's new program is to reduce out-of-pocket costs for diabetic members as well as those who are at risk for developing the disease, Suennen explains. Members who enroll in the program can get free diabetes drugs and supplies, and reduced copayments on doctor visits for regular screenings and exams. They also receive health coaching to help them learn about and manage their disease.

"I think the administration is intent on bringing about reform, and they are looking for ideas. I think the opportunities for entrepreneurs in this space are huge," Brailer says.

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Venture Capital Investments in Health Services Firms, 1998 to 2008

Year	Total Venture Capital Spending	Amount Spent on Health Services	Percentage of Total Spent on Health Services	Health Services Venture Capital Deals	Total Venture Capital Deals
1998	\$21.1 billion	\$935.4 million	4.4%	149	3,647
1999	\$54.0 billion	\$1.5 billion	2.7%	159	5,502
2000	\$104.8 billion	\$1.4 billion	1.3%	163	7,900
2001	\$40.6 billion	\$503.5 million	1.2%	101	4,484
2002	\$22.0 billion	\$373.3 million	1.7%	67	3,102
2003	\$19.8 billion	\$225.8 million	1.1%	67	2,944
2004	\$22.5 billion	\$362.8 million	1.6%	59	3,093
2005	\$23.2 billion	\$399.1 million	1.7%	66	3,155
2006	\$26.7 billion	\$398.9 million	1.5%	54	3,675
2007	\$30.9 billion	\$268.4 million	0.9%	52	3,952
2008	\$28.3 billion	\$194.9 million	0.7%	50	3,808

SOURCE: PricewaterhouseCoopers/National Venture Capital Association MoneyTree Report, January 2009

FINANCIAL NEWS

◆ **Despite a substantial drop in earnings versus the 2007 period, a revised 2009 earnings outlook and a prediction that it would lose more enrollees this year than previously stated, investors interpreted CIGNA Corp.'s fourth-quarter financial results as positive news.**

The company reported its results Feb. 5 before the stock market opened. After falling nearly 70% in 2008, the stock price soared 19% from \$18.44 to \$21.39. Just six weeks after reaffirming its 2009 outlook at its Investor Day meeting, CIGNA lowered its earnings per share (EPS) estimate to a range of \$3.95 to \$4.25 per share from a range of \$4.00 to \$4.30 per share. The company also predicted its enrollment would decline by 3% in 2009, more than the 2% previously cited. CIGNA's fourth-quarter adjusted EPS of 49 cents, after extraordinary charges, met or exceeded most analyst expectations. The consensus was 41 cents. Revenues for the fourth quarter climbed 6.6% to \$4.8 billion. In his note to investors, Wachovia Capital Markets analyst Matt Perry said his firm boosted its 2009 EPS estimate to \$3.70 from \$3.54. "The concerns that had plagued [CIGNA] recently, including the investment portfolio, reinsurance losses and the underfunded pension plan, have faded as the company's capital position and outlook stabilized," Perry said in his note. CIGNA reported a net loss of \$209 million (77 cents per share) for the fourth quarter, compared with net income of \$263 million (93 cents per share) for the year-ago period. The company blamed the results on investment losses and losses from its run-off Guaranteed Minimum Income Benefits business and Guaranteed Minimum Death Benefits business. Excluding those losses, EPS for the quarter would have been \$1.20 per share, according to Oppenheimer & Co. equities analyst Carl McDonald. The company also reported better-than-expected health care earnings due largely to its Great-West Healthcare subsidiary, which added \$35 million (13 cents per share) in earnings versus the year-ago period. Visit www.cigna.com.

◆ **On Feb. 2, Humana posted fourth-quarter 2008 net earnings of \$173.4 million (\$1.03 per share), down from \$243.2 million (\$1.43 per share) in the year-ago period.** The company blamed much of the decrease on higher prescription drug plan claim expenses and a drop in investment income. The results, however, were in line with analyst expectations. Most importantly, the company also reaffirmed its estimated 2009 EPS guidance range of between

\$5.90 and \$6.10 per share. In his note to investors, Oppenheimer & Co. equities analyst Carl McDonald estimated that Humana's 2009 earnings would come in at \$6.10 per share — on the high end of the company's projected range. Humana's EPS for full-year 2008 was \$3.83. Fourth-quarter revenue increased 18% to \$7.49 billion from \$6.34 billion in the year-ago period. The company said total premium and administrative services fees rose 19% from the same period a year ago, primarily driven by a 24% increase in Medicare Advantage (MA) enrollment. MA enrollment as of Dec. 31 was up by 293,000 lives from the same date a year ago. While Humana's 2009 outlook appears stable, it could run into some problems in 2010 and 2011 if MA reimbursement levels are reduced by the government. Visit www.humana.com.

◆ **While Health Net, Inc. reported a sharp decline in net income Feb. 3, due largely to \$48.8 million in restructuring charges, its fourth-quarter 2008 earnings results were in line with analyst expectations.**

Excluding extraordinary charges, the company reported net income of \$63.1 million (61 cents per share), down nearly 50% from \$123.4 million (\$1.10 per share) in the year-ago period. For full-year 2008, the company reported net income of \$95 million (88 cents per share), down from \$193.7 million (\$1.70 per share) in 2007. The company's total medical enrollment on Dec. 31 was 3.7 million, down 1% (about 34,000) from the same date a year ago. The decrease wasn't as bad as some analysts had predicted. Its commercial risk enrollment fell 9% (201,000 members) during 2008, and MA membership jumped 25% to 295,000. "Given that 67% of the company's commercial risk enrollment comes from California, a state especially hard-hit by the economic crisis, steep enrollment declines seem likely to persist in 2009," Morgan Stanley equities analyst David Veal said in his note to investors. Total revenues increased 8% in the fourth quarter to \$3.9 billion from \$3.6 billion in the year-ago period. The company reaffirmed its full-year 2009 earnings guidance of between \$2.25 and \$2.40 per share, excluding the impact of \$60 million to \$70 million in expected pretax operations strategy-related charges. Veal said the fourth-quarter results "met rather low expectations and the reaffirmation of 2009 guidance helped alleviate some of the bearish sentiment that has kept shares trading at a discount to peers." Visit www.healthnet.com.

HEALTH PLAN BRIEFS

◆ **On Feb. 4, President Obama signed legislation that reauthorizes and expands the State Children's Health Insurance Program (SCHIP).** Earlier in the day, the House — on a 290-135 vote — passed the Senate version of the SCHIP legislation that expands insurance to an additional 4 million children. The new law also gives SCHIP an additional \$35 billion over the next five years. The extra \$35 billion in costs would be funded by a 62-cent-per-pack increase in the federal tax on cigarettes and other tobacco products. The new law removes a restriction that prevented states from enrolling middle-class children without first proving that nearly all poor children had been enrolled. Some states found it difficult to meet that criterion. Former President Bush twice vetoed similar legislation (*HPW 10/8/07, p. 8*). Visit www.whitehouse.gov.

◆ **Citing a loss of up to \$1 billion on health plans for individuals, Blue Cross Blue Shield of Michigan (BCBSM) filed a request with the Michigan Office of Financial and Insurance Regulation to raise rates for 400,000 people who purchase individual health coverage.** On Jan. 16, the Blues plan said it would cut up to 1,000 jobs, reduce spending and seek rate increases on products for individuals (*HPW 1/26/09, p. 8*). The requested average rate increases are 56% for individual plans, 42% for group conversion plans and 31% for Medicare supplemental plans. The insurer reported that the request does not affect its group health members. In addition to the workforce reduction, the company's cost-saving measures for 2009 include a salary reduction for senior executives, a freeze on executive pay for the second time in the past three years, a reduction in the number of executives employed at the company and a freeze on salaries for non-unionized workers, according to the insurer. Visit www.bcbsm.com.

◆ **AMERIGROUP Corp. said Feb. 2 that its wholly owned Nevada health plan began offering services to individuals enrolled in Medicaid and SCHIP programs.** AMERIGROUP Community Care of Nevada will be one of two health plans to serve approximately 100,000 Medicaid and SCHIP enrollees in Clark (including Las Vegas) and Washoe (including Reno) counties. Through its subsidiaries, AMERIGROUP now serves approximately 1.6 million people in Florida, Georgia, Maryland, Nevada, New Jersey, New Mexico, New York, Ohio, South Carolina, Tennessee, Texas and Virginia. Visit www.amerigroupcorp.com.

◆ **On Jan. 30, the U.S. Court of Appeals for the D.C. Circuit ruled against a consumer group seeking access to Medicare claims filed by physicians in an effort to monitor quality and to control waste.** In August 2007, the Consumers' CHECKBOOK group won a lower-court ruling that ordered HHS to release certain data from the records of every physician claim paid by Medicare. However, HHS and the American Medical Assn. appealed the 2007 decision. In the most recent ruling, the court said freedom-of-information laws are mainly intended to shed light on government operations, not the workings of private businesses. "The crux of the court's determination today that physicians' privacy interests outweigh the public interest in disclosure is its conclusion that the requested data cannot assist the public in assessing either the quality of Medicare services or HHS's efforts to combat fraud and waste," Consumers' CHECKBOOK said in a prepared statement. Visit www.checkbook.org.

◆ **Most people who are purchasing health insurance online have recently lost group health insurance benefits or have seen their employer push the full cost of the group plan onto the employees,** according to NationalHealthInsuranceBrokers.com. Mike Ramos, a spokesperson for the health insurance broker, said the firm's primary clients three-years ago were self-employed health insurance purchasers. Ramos said, the biggest challenge his company now faces is how to educate these first-time buyers on what benefits they need and how the health insurance plan will work. Visit www.nationalinsurancebrokers.com.

◆ **Blue Cross Blue Shield of Massachusetts (BCBSMA) gave \$250,000 in grants through a new program aimed at training trustees at five Massachusetts hospitals to improve the quality of care the hospitals provide to patients.** Trustee Advantage is a one-year program that includes a coaching experience, an in-depth practicum and participation in a peer learning environment with other grant awardees. The insurer said it awarded five \$50,000 grants, with the hospitals each matching \$25,000 — for a total of \$375,000 invested in the program. The five hospitals are Beth Israel Deaconess Hospital — Needham, Emerson Hospital, Harrington Hospital, Lowell General Hospital and Winchester Hospital. Visit www.bluecrossma.com.

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