

HEALTH PLAN WEEK

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

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Go to www.AISHealth.com for a 10-page summary of the health reform bill passed by the U.S. House on November 7.

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Small Employers Face Rate Hikes of 15%+; Committee Asks Insurers to Explain Why

Prompted by news reports that many small employers are facing annual rate hikes of 15% or more, a Senate committee this month launched an investigation into how health plans determine premiums for their smallest clients. Insurance agents and brokers queried by *HPW* say many of their small-group clients will actually see rates jump more than 20% for the 2010 plan year. And that, coupled with the still-struggling economy, has forced some of them to consider dropping health benefits altogether. While health plans agree that annual rate hikes in the small-group market can be steep, they argue that rising medical costs are to blame.

When it comes to health coverage, “the key issue for small employers has always been affordability. But without addressing the underlying health care cost drivers, we might not be able to do all we can to improve affordability,” says Aetna Inc. spokesperson Mohit Ghose.

Four of the nation’s largest health plans — Aetna, Humana Inc., WellPoint, Inc. and UnitedHealth Group — have until Nov. 17 to comply with a request from the Senate Health, Education, Labor and Pensions (HELP) Committee to explain how initial and renewal premium rates are determined for the small-group (50 or fewer employees) market. In letters from HELP Committee Chairman Tom Harkin (D-Iowa), the health plans also are asked to offer include average premium rate increases for 2010 before any plan-design changes were made, regardless of whether the rates were accepted by the clients. Harkin also asked the plans to include a list of the 10 highest rate hikes (by percentage) offered to small employers for 2010 and the factors used to justify those increases. Spokespersons for Aetna and WellPoint declined to comment on the investigation beyond saying they will work with Harkin’s office to respond appropriately to the request. United and Humana had not responded by *HPW*’s press time.

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Plans That Use Member Enrollment Data To Push Political Agenda Might Violate Law

Health plans could face stiff penalties under HIPAA if they use enrollment information to contact members without their permission and urge them to join grassroots advocacy campaigns or take a stance on a political issue.

Case in point: In September, Humana Inc. pulled 900,000 names and addresses from its Medicare Advantage database and sent those beneficiaries letters recommending that they fight against proposed “significant cuts” to the MA program (*HPW* 9/28/09, p. 3). CMS ordered Humana to cease all such mailings, which it says violated the health insurer’s Medicare contract. CMS also says the letters might have violated HIPAA, and asked the HHS Office for Civil Rights (OCR) to investigate.

In an Oct. 16 “notice of non-compliance,” CMS told Humana that it should have obtained prior authorizations from its members or from the government before mailing the letters. Simultaneous with the non-compliance letter, CMS issued “guidance” clarifying permitted and prohibited mailings to enrollees of all Medicare plans. Under

that guidance, before health plans can engage their MA, Medicare Part D and cost-plan members, they must first contact them and obtain authorization to communicate further on an issue, CMS says. Specifically, communications that require member authorization include "volunteer or community activities, pending state or federal legislation and joining grassroots advocacy organizations and information about such advocacy," the agency says.

"It is a privacy-rule violation to use patient demographic information in this way without consent," says Deven McGraw, director of the Health Privacy Project at the Center for Democracy and Technology.

Humana spokesperson Thomas Noland tells *HPW* he has no information to indicate whether OCR is investigating the plan for possible HIPAA violations. He declined further comment except to say that Humana was "pleased" CMS had resolved its issues with the plan.

So far, Humana is the only health plan known to have been admonished for using member information in this way. Blue Cross Blue Shield of North Carolina

sent letters asking members to contact a U.S. senator to oppose a public option in national health reform, but a plan spokesperson says it used voter records, not patient records, to select those who received the mailings.

Prior Authorization Likely Is Needed

Marketing materials and communications about fundraising are two examples of communications already regulated under HIPAA. Both require prior approval by members or are strictly limited without an authorization. But "advocacy" communications might need a new category under HIPAA, given CMS's stance on the Humana letters.

CMS warned Humana that the agency "may take additional compliance or enforcement action, including the possible imposition of intermediate sanctions or civil monetary penalties" if future communications violate "federal requirements or CMS guidelines."

In spelling out the procedure for obtaining and archiving authorizations, CMS notes that it is "adopting the same requirements for these authorizations as required by the HIPAA privacy rule."

If OCR determines that Humana violated the privacy rule, it could impose fines up to \$1.5 million per year under a general HIPAA penalty scheme now in effect. HIPAA fines are now doubled as a result of the American Recovery and Reinvestment Act of 2009. The stimulus law contains beefed-up and new HIPAA enforcement options, including fines, under provisions called the HITECH Act.

Attorney Calls CMS 'Hypocritical'

Jeff Drummond, a partner with the law firm of Jackson Walker LLP, based in Dallas, says Humana could defend the use of its enrollment data as falling into the HIPAA exemption for operations, contending this was an effort to communicate benefits information to its members, much like describing changes in a drug formulary, he tells *HPW*. Using names and addresses, he says, surely qualifies as "minimal use" as called for under HIPAA, and he points out that while Humana used protected health information for this purpose, it did not "disclose" any PHI.

Drummond says he was angered by CMS's attention to the issue, which he saw as hypocritical and "thuggish," especially given that HHS itself has a link on its Web site that links to www.HealthReform.gov, and invites visitors to "state your support for health reform this year."

"If HHS or Congress changed the Medicare Advantage program to allow coverage for a new procedure or product, would the MA plan be prohibited from letting the beneficiaries know? No," Drummond says. "If the Democrats' health reform plan was going to add benefits to MA and the MA plans notified their beneficiaries

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about these possible new benefits, do you think in any way HHS would have started a HIPAA investigation? The answer to that question is pretty obvious.”

Fines Turn on ‘Willful’ Determination

Under the HITECH Act, the size of the fine is based on whether a health plan or other HIPAA covered entity (CE) “willfully” violated the law, defined as a “conscious, intentional failure or reckless indifference to the obligation to comply with the [relevant] provision violated.” Fines can be imposed as follows:

- ◆ If the violator did not know that he or she violated the law, and would not have known by exercising due diligence, the penalty for an identical violation is at least \$100 and up to \$50,000 for each violation.
- ◆ If the violation was due to reasonable cause, not willful neglect, the penalty is at least \$1,000 and up to \$50,000 for each violation.
- ◆ If the violation was due to willful neglect and was corrected within 30 days of when the CE knew or should have known about it, the penalty is at least \$10,000 and up to \$50,000 for each violation.
- ◆ If the violation was due to willful neglect and was not corrected, the penalty is at least \$50,000 for each violation. For all tiers, the maximum penalty amount for violations of an identical provision is \$1.5 million per calendar year.

HIPAA expert Kirk Nahra, a partner with Washington, D.C.-based law firm Wiley Rein, LLP, tells *HPW* it is “not obvious” to him that Humana’s letters qualify as activities allowed without patient authorization under HIPAA.

“It’s a close call,” says Nahra. If the letters did fall into a gray area, OCR couldn’t logically conclude that Humana consciously violated an unclear provision, he says.

“OCR has an enforcement rule with a lot of detail, but they ultimately have discretion and flexibility, too,” he says. “This does not jump out to me as a privacy abuse.”

The rule limits fines for the same infraction. In this case, should a violation have occurred, OCR would be unlikely to impose a fine for each of the 900,000 letters, but would perhaps levy just one fine for the single act of accessing the data and sending a letter.

Nahra adds that, in considering this case, OCR might also conclude there was little harm that members could have suffered as a result of Humana’s actions, although the law does not figure harm into its penalty calculations.

Like CMS, OCR may also wish to issue guidance clarifying communications that require an authorization under HIPAA, Nahra says. He adds that it would be unlikely that OCR would impose fines, saying instead issuing guidance “is the most likely outcome” of this case.

In the interim, health plans that do want to enter the reform fray might be best served by placing paid advertisements, lobbying on their own or putting up billboards, Nahra suggests.

“There is nothing that would prohibit health plans from being involved and expressing their opinions about health reform,” agrees Reece Hirsch, a partner at Morgan, Lewis and Bockius LLP in San Francisco. “It is not clear-cut as to whether it is permissible to contact their enrollees. I think as a general matter they need to proceed with caution if they are contacting their members about something that isn’t part and parcel of providing health care benefits.”

Contact Noland at tnoland@humana.com, McGraw at deven@cdt.org, Drummond at jdrummond@jw.com, Nahra at knahra@wileyrein.com and Hirsch at rhirsch@morganlewis.com. ✧

Health Reform Update

Removing Lifetime Benefit Caps Would Boost Coverage Costs, Risk

A provision included in the House’s recently passed health reform bill — as well as in both Senate bills — would ban health plans from including lifetime benefit maximums in their policies. While such a rule would protect enrollees from financial ruin if they or dependents are hit by a high-cost medical condition, it likely will push coverage costs a bit higher for everyone. And while premium increases are likely to be small as a result, the overall risk for health plans, reinsurers and stop-loss carriers could be enormous.

Eliminating lifetime medical maximums will inevitably increase coverage costs over time, says Randy Abbott, an employee benefits consultant with Watson Wyatt. Removing the cap, he predicts, could lead to annual premium increases of between 3% and 5% depending on the value of claims in excess of the employer’s “historical

Lifetime Insurance Maximums (In-Network) Among Large Employers

Unlimited	45.3%
More than \$2 million	13.8%
Less than \$1 million	0.1%
\$2 million	28.4%
\$1.5 million to \$2 million	3.5%
\$1 million to \$1.5 million	0.3%
\$1 million	8.5%

SOURCE AND METHODOLOGY: Towers Perrin, November 2009. Based on data from 723 large employers.

maximum" over time. "The cost of care is intensifying each year as technology, treatment protocols and available drugs become more advanced," Abbott explains. "Eliminating the maximum opens the floodgate and will create higher costs. Depending on the employer's claim experience, it could be a trickle or a flood."

Ed Kaplan, senior vice president and national health practice leader at consulting firm Segal Co., says more than half of his firm's large, self-insured

employer clients have eliminated lifetime maximums. Among those that still have lifetime limits, the most common amount is \$1 million. Eliminating a \$1 million benefit maximum typically will cause their premiums to increase only by about 1%, he says. "But there have cases where an insurance carrier has said it would raise rates by 2%," he asserts, adding that health plans tend to be conservative in protecting themselves against risk.

NEW STUDIES IN THE FIELD

◆ **One in six individuals living with diabetes say they avoid or delay needed medical care because of cost**, according to a new HHS report. The report, *Preventing and Treating Diabetes: Health Insurance Reform and Diabetes in America*, found that the annual health care expense for a diabetic in 2007 totaled \$11,477. HHS said that 80% of people with diabetes went uninsured after having lost coverage due to health insurance transitions triggered by job change or layoff, a move, divorce, graduation from college, or a change in income or health status. According to the report, health insurance reform would lower health care costs for people with diabetes by capping annual out-of-pocket expenses, eliminating discrimination for pre-existing conditions and health status, creating a health insurance exchange, providing coverage for preventive screenings and reducing health disparities. "Health insurance reform will help ensure these Americans can get the prescription drugs and supplies they need and bring down premiums so all Americans can have high-quality, affordable health insurance," said HHS Sec. Kathleen Sebelius in a prepared statement. Visit www.HealthReform.gov.

◆ **Health plans are pursuing new strategies to tap the growth potential of the individual market**, according to a study released Nov. 5 by the Center for Studying Health System Change (CSHSC). While non-group health plans traditionally have attracted older and sicker individuals who don't have access to employer-based coverage, the percentage of people with employer-based coverage is declining, and more young and healthy people are forgoing coverage. Plus, any major reform bill that winds up on the president's desk is likely to call for subsidies for individual coverage. Between August and December 2008, CSHSC conducted interviews with health plan executives, insurance brokers, health plan associations, consumer advocacy groups and state insurance

commissioner offices in 12 communities. While the individual market in those communities typically was dominated by large insurers that have a significant group-insurance business, specialized insurers that focus on non-group sales were among the top three competitors in half of the communities studied. New entrants to the individual market, among the 12 communities studied, have been most prevalent in Cleveland, Little Rock, Ark., Phoenix and Greenville, N.C., due to the "less restrictive regulatory environments there compared to the other communities. To see the complete report, visit www.hschange.org/content/1093/.

◆ **Employers that offer account-based health coverage to their employees are altering their contribution strategies**, according to a study released Nov. 2 by the Employee Benefit Research Institute (EBRI). The percentage of employers that contribute to their employees' health reimbursement arrangement (HRA) or health savings account (HSA) plans fell from 67% in 2008 to 63% in 2009, according to the study. The percentage of employers that make contributions to those accounts, however, has not changed in a statistically significant manner since 2006, according to EBRI. Among employees who receive an employer contribution, those with employee-only coverage saw annual employer contributions increase between 2006 and 2008, but decline in 2009. By contrast, employees with family coverage saw employer contribution levels increase in 2009, according to the study. In 2009, 4% of the adult population with private health insurance was enrolled in a plan that included an HRA or an HSA, up one percentage point from the previous year, according to EBRI. Overall, 8.9% of adults with private insurance either were in an account-based health plan or were enrolled in an HSA-qualified plan but had not opened an account. To see the full report, visit www.ebri.org. ✧

Among Towers Perrin's large-employer clients, only about half of them still include lifetime benefit maximums. Jay Savan, an employee benefits consultant in Towers' St. Louis office, says the impact on premiums for employers that have removed the cap has been negligible. "It used to be that a \$1 million [lifetime maximum] is what every health plan had, and no one ever went above that. But \$1 million caps are in the minority now (see table, p. 3).

While many self-insured employers have removed the beneficiaries' lifetime maximums from their health plans, their own stop-loss policies certainly include a cap. Self-funded employers typically buy specific, per-claim stop-loss protection, which usually is limited to a value at or near the plan's lifetime maximum. "Employers can expect a double hit as the plan cost increases and the premiums for stop-loss coverage rise to reflect the new law," Abbott contends.

Although actuaries have access to mountains of data about claims in excess of \$1 million, there are virtually no data available for claims in excess of \$5 million that could be used for health plans that have unlimited risk. And actuaries need data to price the risk, explains an actuary with a medical reinsurer who asked not to be identified. "There is no reinsurer that has an unlimited cap, and I would venture to guess that most don't accept risk in excess of \$5 million," he says. For a small stop-loss carrier that has \$30 million worth of premiums, a claim of \$10 million would put it out of business, he adds.

Contact Abbott at randall.abbott@watsonwyatt.com, Savan at jay.savan@towersperrin.com and Kaplan at ekaplan@segalco.com. ✧

Health Reform Update

10 House Reform Bill Provisions That Could Impact Health Plans

The U.S. House of Representatives on Nov. 7 passed the Affordable Health Care for America Act (H.R. 3962). Minutes after the bill passed, industry trade groups America's Health Insurance Plans and the Blue Cross and Blue Shield Association issued statements opposing the legislation. Here's a look at 10 provisions that could impact health plans if enacted:

(1) **Insurance exchange:** Creates a national insurance exchange by 2013 with an option for states to operate their own entities. Individuals not enrolled in employer-sponsored insurance, Medicare or Medicaid can purchase coverage. The exchange also is open to businesses, starting with small firms and growing over time.

(2) **Public option:** Creates a public insurance option available within the exchange by 2013. Calls for HHS to negotiate rates with providers. The option would receive

"startup administrative funding," but would have to amortize those costs as part of determining future premiums.

(3) **Cooperatives:** Provides states with loans to help develop insurance cooperatives as an additional option. Also allows the sale of health insurance across state lines when state legislatures agree to allow it.

(4) **Medicare:** Beginning in 2014, requires Medicare Advantage (MA) plans to maintain medical loss ratios of at least 85%. Reduces MA payments over three years to achieve parity with traditional fee-for-service rates. Eliminates the Part D "doughnut hole" coverage gap over time.

(5) **Medicaid:** Expands coverage to those with annual incomes of 150% of the federal poverty level (\$33,100 per year for a family of four) or less. Requires states that now cover those above 150% of the FPL to maintain eligibility. States receive full federal funding for costs of expansion populations in 2013 and 2014.

(6) **Commercial coverage:** Beginning in 2010, bans health status and pre-existing conditions from being used to rate or deny coverage. Also prohibits annual or lifetime limits on medical spending (see story, p. 3). Employers have a five-year grace period to comply with the caps. Also limits annual out-of-pocket expenses to \$5,000 for an individual and \$10,000 for a family, with lower levels for lower- and middle-income families.

(7) **Employers:** Requires most employers to contribute at least 72.5% toward employee premiums (65% for family coverage). Employers that don't offer qualified coverage must contribute 8% of their payroll to help cover expenses of employees who seek coverage through the exchange. Exempts small employers (annual payrolls of \$500,000 or less).

(8) **Individuals:** Requires individuals to obtain coverage or pay a fee equal to 2.5% of their adjusted income above the filing threshold (\$9,350 for single coverage, \$18,700 for couples) or the average premium on the exchange. Individuals and families below the income tax filing are exempt.

(9) **Income-base surcharge:** Imposes a 5.4% surcharge on taxpayers with adjusted gross income in excess of \$1 million (married and filing a joint return) and \$500,000 (single).

(10) **Health account caps:** Eliminates nontaxable reimbursements of over-the-counter medications from health flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs). Limits annual FSA contributions to \$2,500 (*HPW 11/9/09, p. 6*), and increases the penalty for non-health related distributions from HSAs from 10% to 20%.

Access a link to a summary of the bill at www.AISHealth.com. ✧

Small Employers Try to Offset Hikes

continued from p. 1

Small employers have virtually no purchasing power when it comes to purchasing small-group health insurance and could be devastated by future rate hikes if just one employee is injured in an accident or winds up with an expensive medical condition, says C. Steven Tucker, an insurance broker based in suburban Chicago.

"Small-group health insurance can be a business killer," he tells *HPW*. "Even if your work force is completely healthy, if just one employee has an accident or an expensive illness, your rates can be increased by as much as 67% at the time of underwriting, or upon renewal, in most states."

He adds that small group underwriting loads in Indiana can be as high as 108%, and up to 300% in Michigan. Such rate increases typically force employers to seek coverage from another carrier or to forgo the purchase of, or renewal of, group health insurance altogether.

In Colorado, the range for rate increases for small employers runs from the mid-teens up to more than 50%, says Tina Neuendorf, senior vice president at Business Services Group in Colorado Springs. Some employers now have such high deductibles that "they consider themselves to be uninsured despite having health insurance," she says.

To counter the increases, brokers and agents say their clients are boosting employee-paid premiums, raising

out-of-pocket maximums and increasing copayments and annual deductibles. And some employers now require enrollees to pay the full cost of prescription drugs, up to the annual deductible, rather than make a small copayment.

Vinnie Daboul, senior vice president at TD Insurance in West Springfield, Mass., says many of his smallest clients are moving to deductibles of between \$1,000 and \$2,000 for single coverage.

Some employers also are reducing the percentage they contribute toward coverage. An employer that paid 80% of individual coverage costs this year might switch to 70% or 75% for 2010, he says. "So far, we haven't seen any employers drop coverage, but it's something they're now talking about," he says.

House Bill Includes Employer Mandate

And some employers are doing more than just talking about it, says Scott Leavitt, a Boise, Idaho-based insurance broker and former president of the National Association of Health Underwriters (NAHU). About 10% of Leavitt's clients have opted to drop coverage for 2010. "Small employers have been hit hard by the economy. Many of the smallest ones are just gone. The ones that are surviving are doing whatever they can to offer benefits." In Idaho, Leavitt says, renewals for 2010 are coming in with premium hikes between 15% and 25%, compared with a 10% to 12% increase in medical trend.

How to Amend HIPAA Business Associate Agreements to Comply With the HITECH Act: Strategies for Meeting the February Deadline

- What contract language should CEs consider using related to their BAs' compliance with breach notification and the security rule?
- What strategies should CEs consider to effectively manage the onerous task of amending scores (if not hundreds) of BA agreements in the next three months?
- How much time should CEs give BAs to notify them of a security breach, since the CE itself must go public with certain breaches in 60 days?
- What definition of "breach" should CEs give to their BAs? Should it include the "harm" standard or should CEs reserve this determination for themselves?
- To what extent have the HIPAA liabilities of covered entities been lessened with these new obligations for business associates?

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But some employers that drop coverage could face financial penalties under provisions included in the recently passed House reform bill (H.R. 3962). Provisions of the bill would require employers with payrolls above \$500,000 to contribute (for each full-time employee) 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage.

The penalty for failing to do so would be a 2%-to-6% tax on employers with payrolls between \$500,000 and \$750,000, and an 8% tax for employers with payrolls above \$750,000. An employer with a payroll of \$500,000 typically represents a business with about 17 employees.

While an employer mandate could help expand the risk pool and ensure the future of group-based health coverage, the House proposal is too punitive, says John Prible, vice president of federal government affairs at the Independent Insurance Agents and Brokers of America.

CDH, Self-Funding Could Lower Rates

Several agents say they have urged their clients to consider a consumer-directed health (CDH) plan, which typically offers lower premiums in exchange for higher deductibles. Tucker says one client saw rates drop by 30% after swapping a more traditional, \$1,000-deductible plan for a CDH product with a \$2,600 deductible. The business owner also has agreed to cover any claim in its entirety that is between \$1,500 and \$2,600 for his 25 employees. All claims larger than \$2,600 will be paid by the insurance carrier at 100%.

Daboul says that some of his larger clients (50 to 75 lives) are considering moving to a partially or fully self-insured plan. But switching to a self-funded health plan can be a gamble, warns Leavitt. "If everyone in the company is healthy, the employer can save money, but if you have a couple big [claims], it might not work out as well."

Neuendorf says she has seen an increase in "alternative funding" arrangements between employers and insurers. Under this scenario, the employer pays a "fully insured equivalent rate" to its insurance carrier. Internally, the insurer tracks information such as monthly paid claims, enrollment and large claimants, and reports the information back to the employer on a monthly or quarterly basis, she explains.

One key advantage with the arrangement is the ability to share in savings when claims run less than expected. Depending on the contract, savings can be substantial, and can be returned to the employer or jointly shared with the insurance company, which helps lower administrative costs, Neuendorf explains.

"If the plan exceeds the insurance carrier's projected claims figures, the insurance carrier is 100% responsible for the loss and can't come back to the employer after the plan year is over to try and recoup those dollars."

To see the letters Harkin sent to health plans, visit http://help.senate.gov/Maj_press/2009_11_03.pdf. Contact Tucker at smallbusinssvcs@aol.com, Neuendorf at tina.neuendorf@bsg-co.com, Daboul at vinnie.daboul@tdinsure.com and Leavitt at saladl@aol.com. ♦

HEALTH PLAN BRIEFS

♦ **At least two large health insurance companies have urged their employees to contact U.S. senators and urge them to oppose certain health reform provisions**, according to copies of letters released Nov. 12 by Consumer Watchdog, a California-based consumer-advocacy group. (Debate on the Senate's version of a health reform bill could begin the week of Nov. 16). Form letters distributed via e-mail to UnitedHealth Group employees on Nov. 10 urge lawmakers to resist any publicly financed health care option, prevent financial changes to Medicare Advantage and enact tougher penalties on Americans who fail to buy private insurance. Employees also were encouraged to write letters to local newspapers but instructed them not to identify themselves as United employees. CIGNA Corp. launched a similar campaign to enlist its employees to contact lawmakers, on behalf of the company, to "educate them" about certain reform measures,

according to Consumer Watchdog. CIGNA spokesperson Chris Curran says his company routinely updates its employees on the status of health care reform and has several intranet pages devoted to the issues. "Much like other industries, our suggestions include contacting their legislators and educating them to the role that they — the employees — play in bringing high-quality health services to millions of Americans." A United spokesperson did not respond to a request for comment by *HPW's* press time. To see copies of the letters, visit www.consumerwatchdog.org/pr/.

♦ **Independence Blue Cross (IBC) has offered early retirement packages to 840 employees, with 530 accepting**, the *Philadelphia Business Journal* reported Nov. 6. IBC, which in June eliminated about 125 jobs because of the economic downturn, has not ruled out future job reductions, according to the *Journal*. The

HEALTH PLAN BRIEFS (continued)

company has about 5,700 employees. IBC said employees who accepted the buyout had on average 21 years of experience with the company, the business publication reported. The insurer posted a loss of \$78.7 million in 2008, after recording a profit of \$170.9 million the previous year. Visit www.ibx.com.

◆ **Connecticut Attorney General Richard Blumenthal (D) said Nov. 9 that he's investigating the Blue Cross and Blue Shield Association's (BCBSA) loss of confidential information for its 18,817 network physicians in Connecticut and 850,000 nationwide.** The information, which included tax identification and some Social Security numbers, was on an employee's laptop computer that was stolen in Chicago (*HPW 10/19/09, p. 3*). Blumenthal said in a prepared statement that BCBSA and its affiliates may have violated state law by losing the information and failing to notify providers in a timely manner. Although the computer was stolen in late August, BCBSA and its licensee failed to inform the affected health care providers until late October, Blumenthal added. Jeff Smokler, a spokesperson for BCBSA, told *HPW* that "within days of discovering the security breach, the Blue Cross and Blue Shield Association began the in-depth process of notifying our 39 independent licensees and identifying which of their providers were impacted and how." He added, "We take very seriously the attorney general's comments and continue to work to rectify the situation." Visit www.ct.gov/ag or www.bcbs.com.

◆ **UnitedHealth Group said Nov. 10 that its health information subsidiary Ingenix would acquire CareMedic Services Inc., a revenue-cycle-management (RCM) company.** UnitedHealth didn't disclose how much it is paying for St. Petersburg, Fla.-based CareMedic, but did describe the acquisition as a cash transaction. With the acquisition of CareMedic, United said, Ingenix will offer hospitals a combined suite of services addressing each major component of a hospital's RCM, including patient registration, eligibility verification, financial clearance, coding and compliance, bill submission, denials management and remittance processing. CareMedic has contracts with more than 2,500 provider facilities across the U.S. and Puerto Rico. Visit www.ingenix.com or www.caremedic.com.

◆ **Insurers made much higher profits on health coverage sold to the approximately 95,000 college**

students in Massachusetts than on plans available to the general public, according to a recent report by the state's Division of Health Care Finance and Policy (DHCFF). *The Student Health Program Baseline Report* also found that college-student plans in the state have higher administrative costs. The result is that less of the premiums paid by students goes toward medical care, according to DHCFF. On average, 30 cents of every premium dollar goes toward profits and administrative costs, compared with 12 cents for plans sold to the general public, the report found. DHCFF said students at state schools faced the greatest disparity, with 45 cents of every insurance dollar they pay going to profit and administrative costs instead of medical care. The study was initiated after students at several campuses complained that the lower-cost insurance products marketed to them offer limited coverage, leaving many vulnerable to enormous medical debts after accidents or serious injuries, according to DHCFF. To view the report, visit <http://tinyurl.com/DHCFF-Report>.

◆ **CLARIFICATION:** An article in the Oct. 26 issue of *HPW* explained that without a permanent fix to the formula used to set Medicare provider fees, Medicare Advantage (MA) plans will become increasingly less profitable. The article didn't clearly explain why this would occur. Under current law, providers face a scheduled 21.5% reduction in Medicare fees for 2010. While next year's scheduled fee cut will likely be eliminated by Congress (as it has been in past years), for every five percentage points of the scheduled rate cut that Congress eliminates, it increases the fees that MA plans must pay providers by one percentage point (if they link their physician payments to Medicare fee-for-service levels). "This means that as the SGR (i.e. the Sustainable Growth Rate measure used in determining Medicare's provider payments) continues to increase, plans will lose by roughly the incremental amount each year in the sense that the payments the plan receives from CMS will not keep pace with the provider fee expense," explains Brian Weible, an actuary and principal at Wakely Consulting. However, when health plans bid, most anticipate that Congress will address the issue and physician fee schedules will not decline. The "real" reduction in the benchmarks is the net difference between the catch-up and the trend. But each year's projected reduction due to the SGR will almost certainly be bigger than the prior year's catch-up. Therefore, the overpayment will be less each year.

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