

HEALTH PLAN WEEK

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

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In a Reforming System, Cigna Acquisition Illustrates Importance of Scale, Diversity

Cigna Corp. on Oct. 24 said it intends to acquire Nashville-based HealthSpring, Inc. for \$3.8 billion. That deal — along with at least two more announced the same week by other carriers — illustrates how health insurers view the importance of scale and diversity under the health reform law.

"Diversification is definitely the No. 1 target for health insurers in this current market, with scale coming in a close second, because the only thing we can be sure of from Washington is that we are in for a significant amount of more change," says Mark Reiboldt, vice president at Atlanta-based Coker Capital Advisors.

Cigna tells *HPW* that acquiring a large seller of Medicare Advantage (MA) plans will allow it to serve commercial members even as they age into Medicare. The pending purchase, which is expected to close in the first half of 2012, would be Cigna's largest acquisition since 2008 when it spent \$1.5 billion buying Great-West Healthcare, Inc. (see table, p. 6).

"For someone who is a commercial customer today, when they reach a certain age, they can remain a customer of Cigna's as they move into the Medicare stage of their life," says Matt Manders, president of Cigna's U.S. Service, Clinical and Specialty division. "This also creates a good path for us under reform as [we respond to] changes around the delivery model."

Also on Oct. 24, Amerigroup Corp. signed an agreement to purchase a majority of the operating assets and contract rights of Health Plus, one of the largest Medicaid managed care companies in New York (about 320,000 lives) for \$85 million in cash. Two

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WellPoint, Aetna Boost Full-Year Estimates, Though Utilization Could Creep Up in 2012

Earnings for large health insurers this third-quarter earnings season are picking up right where they left off in the second quarter. Strong earnings driven by continued low utilization trends helped WellPoint, Inc. and Aetna Inc. beat Wall Street estimates. And even though WellPoint, Aetna and Cigna Corp. saw their profit fall in the quarter compared with the prior-year period, they raised full-year earnings projections, signaling a bullish sentiment through the end of the year.

However, some analysts are warning that sooner or later, utilization will return to normal levels.

"The factors that seem to be driving slower-than-normal utilization — increased cost sharing combined with the weak economy, which is causing people to avoid the health-care system whenever possible — do not seem to be abating," Morningstar analyst Matt Coffina tells *HPW*. "Of course, the counterargument is that you can't delay healthcare forever, so at some point that pent-up demand will result in accelerating costs. Your guess is as good as mine as to when that might be."

Here's a look at the highlights from health plan operators that reported earnings during the week of Oct. 24.

continued

◆ **WellPoint:** The Blues plan operator's strong earnings were driven by robust membership gains, particularly in the national business and senior segments, as well as improving medical cost trends, which the insurer now projects will be around 7%, plus or minus 0.5 percentage points.

Most analysts lauded WellPoint's results. "WellPoint produced a strong quarter featuring impressive revenue growth while managing medical cost efficiently," Openheimer analyst Michael Wiederhorn wrote in an Oct. 26 note.

Overall medical enrollment grew 2.6% year over year to 34.4 million as of Sept. 30, 2011, compared with 33.5 million on the same date a year earlier. Commercial membership grew by 2.4%, from 27.1 million to 27.7 million, while senior enrollment rose by 14.8%, from 1.3 million to 1.4 million, buoyed by the addition of 57,000 members through its acquisition of CareMore Health Group (*HPW 6/13/11, p. 3*). However, individual enrollment dropped 5.7% to 1.9 million. At the end of the quarter, 60% of WellPoint's medical enrollment was self-funded, while 40% was fully insured.

WellPoint expects to end the year with 34 million members, a slight decrease from where enrollment presently stands. During an Oct. 26 earnings call to

discuss results, CEO Angela Braly said there was modest in-group attrition during the third quarter, which is expected to continue into the fourth quarter. Moreover, she warned that in-group membership attrition will continue to be an issue in 2012 as the number of workers with health benefits "may decline modestly," adding she expects individual membership would be negatively impacted by the economy.

The Blues plan operator saw its medical loss ratio (MLR) increase 1.3 percentage points to 85.1% from the year-ago quarter, partly resulting from changes WellPoint had to make to reserves to reflect higher-than-expected medical costs incurred in prior quarters. In addition, growth in senior membership and adverse selection in some Medicare Advantage (MA) products helped drive up the MLR. WellPoint expects to end the year with an MLR of between 85.0% and 85.2%, which is lower than prior guidance, Chief Financial Officer Wayne Deveydt noted. And although utilization has remained stable or is going down in all categories except pharmacy, he said he anticipates that inpatient utilization will rebound in 2012.

For the year, WellPoint now expects net income to be in the range of \$7.18 to \$7.28 per share, up from \$6.90 to \$7.10. Deveydt added that the insurer sees growth from this base next year.

WellPoint's strong earnings were a relief to investors after its second-quarter earnings were marred by an adverse-selection issue in its MA program in Northern California that resulted in a decline in operating margins in that business (*HPW 8/1/11, p. 1*). Braly said the insurer has restructured its MA portfolio in California, and the insurer plans to expand its MA footprint in Georgia, Missouri, Virginia and Texas. Deveydt added that he believes the senior business operating gain will improve by \$150 million in 2012.

◆ **Aetna:** The health plan operator easily trounced analysts' expectations with third-quarter earnings per share of \$1.45, well above the consensus estimate of \$1.15 per share. The insurer was helped by continued low medical utilization, a trend seen throughout the year by other managed care companies.

And despite a 1% decrease in profit in the quarter to \$490.4 million, Aetna upped its 2011 full-year earnings projection to \$5 per share, compared with an earlier estimate of between \$4.60 and \$4.70 per share. Aetna also offered an initial 2012 earnings estimate of "at least" \$4.80 per share. During an Oct. 27 conference call, Chief Financial Officer Joseph Zubretsky said that while the 2012 projection represented a base, he conceded a return to more normal utilization was likely inevitable. "We just don't think utilization can stay this low for very much longer." The insurer also said it expects the 2012 medical cost trend to be higher than that projected for 2011.

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Coffina says managed care companies will face margin pressures over the next few years, including increased scrutiny over rate increases and a difficult reimbursement environment for Medicare and Medicaid. And “the last time we saw the effects of accelerating health care cost trends was early 2008, and managed care stocks still haven’t recovered.”

Unlike rivals WellPoint and UnitedHealth Group, which reported results on Oct. 18 (*HPW 10/24/11, p. 1*), Aetna saw its overall medical enrollment drop in the quarter to 18.2 million, a decline of 1.6% over the prior-year period. Commercial enrollment declined nearly 2.1% to 16.7 million.

Aetna performed particularly well in its overall MLR, which stood at 78.9% for the third quarter, a decline of 2.9 percentage points compared with the third quarter of 2010. The commercial MLR declined 2.7 percentage points to 77.8%.

Cowen & Co. analyst Christine Arnold, who rates Aetna a buy, said in an Oct. 27 research note that many third-quarter metrics came in better than expected and shares “are compelling at current prices.”

◆ **Cigna:** Just a matter of days after deciding it wanted to expand its Medicare Advantage business by purchasing HealthSpring for \$3.8 billion (see story, p. 1), Cigna

disappointed investors Oct. 28 as its third-quarter profit fell 35% year over year. And unlike other large managed care providers that have already reported, Cigna’s earnings missed analyst expectations. Adjusted net income was \$1.20 per share, though analysts were expecting it to come in at \$1.23 per share. Cigna was hampered by losses of \$179 million from its guaranteed minimum income benefits and variable annuity death benefits businesses, both of which were discontinued in 2000, but are still operating in run-off mode. Its medical enrollment rose 1.8% to 12.7 million from a year earlier, increasing just 47,000 during the quarter.

Despite the lackluster results, Cigna on Oct. 25 said it would again raise its full-year earnings projection to between \$5.05 and \$5.30 per share, up from a previous range of \$4.10 to \$4.40.

◆ **Centene Corp.:** Centene’s third-quarter profit came in above Street expectations, driven by higher membership and a lower MLR. For the quarter, Centene’s profit jumped nearly 28% to almost \$29 million, on earnings per share of 55 cents, beating analyst projections by a penny. The company Oct. 25 also raised its full-year guidance to \$2.09 to \$2.13 a share, up from \$2.03 to \$2.13 a share. Centene’s MLR was at 83% in the quarter, down

Final ACO Regulations: Will Medicare ACOs Now ‘Work’ and Attract Greater Industry Interest?

- What steps did CMS take to make this program more attractive to potential participants, in terms of reducing financial risk, decreasing the number of quality measures, changing from retrospective to prospective assignment, and providing assistance to rural providers?
- Do these changes go far enough to overcome strong industry concerns with the program? How much interest is there now likely to be?
- How will the new proposals influence the sort of governance structures that will prevail? Are most ACOs likely to be physician-led, or will hospitals dominate?
- If patients can “opt out” of data sharing in Medicare ACOs, what incentive will they have to stay in these delivery models?
- To what extent will the Medicare Shared Savings Program’s reliance on fee-for-service be its downfall? How can this be overcome?
- What impact are these regs likely to have on the continued development of private-sector ACOs?

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from 84.2% in the year-ago period. Overall medical enrollment grew 116,600, or 7.7%, to 1.63 million.

◆ **Molina Healthcare, Inc.:** The MA and Medicaid managed care operator on Oct. 25 posted third-quarter net income of nearly \$19 million (41 cents per share), up from \$16.2 million (38 cents per share) in the year-ago period, aided by an enrollment increase of 8%. The company reported premium revenues increased 13.2% to \$1.1 billion. The insurer's MLR rose slightly to 84.3% from 84.2% in the year-ago quarter. Molina also has authorized a share repurchase of up to \$75 million.

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More Employers Using Incentives To Encourage Healthy Behavior

In an effort to reduce health insurance costs and encourage better productivity, an increasing number of employers are using financial incentives to promote healthy behavior, according to the results of a study released Oct. 25 by benefits consulting firm Towers Watson.

The incentives can include a low premium contributions for employees who identify themselves as non-smokers — and bigger paycheck deductions for those who are — as well as smaller deductions for employees who agree to complete health risk appraisals or biometric screenings.

Towers Watson found that 54% of employers now use financial rewards for employees who participate in health management programs or activities. Next year, 80% of employers expect to do so. Also, while 19% of employers use penalties such as higher premiums or deductibles for employees who do not complete the programs, that figure will double to 38% next year.

"The results verify...our experience that there are more and more companies who have been passive or not very aggressive [in improving worker health] who are now coming on," says Michael Wood, a senior consultant in health and productivity at Towers Watson who worked closely on the study.

He tells *HPW* that many employers also are trying to cut employee health plan expenditures in advance of the excise tax on high-cost plans they could be subject to in 2018 (*HPW* 9/6/10, p. 1).

And the health care savings that can be achieved through wellness programs are sizeable. The Towers survey found that companies with "effective" programs can have annual health care costs that are more than \$1,000 less per employee compared with firms without them. In addition, companies with the "effective" programs tended to have health care costs trends that were more

than one percentage point lower than those seen with other employers.

The results do not come as a surprise to Paul Fronstin, Ph. D., a senior research associate with the Employee Benefit Research Institute, who tells *HPW* that the greater use of financial incentives and wellness programs is just starting. He adds that he has been hearing about more employers that are encouraging their employees to go through biometric screenings, which can help identify current and potential health problems and provide proactive ways to address them.

"Employers are desperate to do something about health care costs since they realize 20% of the population drives 80% of health spending," he says, noting that this 20% tends to have chronic conditions. "Employers are also concerned about the other 80% because they don't want them to join that 20%."

Towers Confirms Earlier Studies

Tower's results mirror those found by other consulting firms. In Aon Hewitt's 2011 Health Care Survey, released earlier this year, 47% of employers said that they offer incentives for employees to participate in health care programs while another 28% said they might add them in the next three to five years. And while only 13% of companies said they use penalties or disincentive tactics to encourage employee adoption of health management programs, 36% say they intend to introduce them in the next three to five years.

Mercer's National Survey of Employer-Sponsored Health Plans, released last November, found that in 2010, 27% of large employers with health management programs provided incentives for employees to take advantage of them. Those often took the form of cash (average \$75) or a reduction in premium contribution (average \$180).

The Towers survey includes responses from 335 human resources or health benefit managers in the U.S. and Canada with 1,000 or more employees. However, Fronstin says that because only large employers, which typically are self-insured, were surveyed, it's not clear whether small employers, which tend to be fully insured, would see any direct savings.

Wellness programs can benefit both employees and employers in other ways, such as improved productivity, Towers found. Companies with effective health programs had average revenues per employee that were 40% higher than companies that didn't.

The Towers Watson survey, "2011/2012 Staying@ Work Report," is available at www.towerswatson.com/united-states/press/5708.

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Blues Plans Dominate Market In Nearly Every State, AMA Says

Four out of five metro areas lack a competitive commercial health insurance market, according to an analysis released Oct. 25 by the American Medical Association. And markets could become even more concentrated as large insurers gobble up smaller ones to gain scale in order to offset increased costs tied to the reform law (see story, p. 1). Although some critics blame insurer market concentration for premium hikes, others point to provider consolidation as a key driver in coverage costs. The trade group America's Health Insurance Plans (AHIP) contends that the AMA data are flawed.

According to AMA's analysis, nonprofit and for-profit Blue Cross and Blue Shield plans dominate the managed care market in all but seven states — Arizona, California, Colorado, Nevada, New Jersey, Utah and Wyoming. And in all but one of those states, a Blues plan is the second largest carrier. Wyoming's insurance landscape is controlled by Cigna Corp. (45%) and UnitedHealthcare (21%).

The report, which measures market concentration in 47 states and the District of Columbia, determined there is a "significant absence" of competition among health insurers in 83% of those markets. And in about half of those markets, at least one health insurer had a commercial market share of 50%. Montana, North Dakota and Wisconsin were not included in the data.

In Alabama, the state's second largest carrier, UnitedHealthcare, has just 5% of the market. The state's Blues plan has 90%. Alabama was cited as the nation's least competitive state for health insurance. The report concludes that there "have been no observed benefits" of market consolidation and warns that too much market power by an insurer "is detrimental to society."

Exchanges, CO-OPs May Spark Competition

Some industry observers contend tax credits for low-income individuals and small businesses called for by the reform law will translate to millions of new members, which could lure new competitors to some markets. Moreover, the reform law calls for the development of retail-focused state insurance exchanges as well as Consumer Operated and Oriented Plans (CO-OPs).

In Mississippi, the state Blues plan controls 55% of the overall managed care market, while UnitedHealth has 23%, according to AMA's data. The state's insurance department, however, is optimistic that its insurance exchange will help it add a few more players to the mix.

"We hope [the exchange] will be a competitive marketplace and will attract competitors.... We can't be certain of that, but that is the goal," says Aaron Sisk,

the department's senior staff attorney. "We have such a skewed competitive marketplace right now. We have so little competition... that we can only benefit from more competitors."

Health insurers argue that they need scale to keep coverage costs from spiking as health systems consolidate and dominate markets (*HPW 9/10/11, p. 1*). "Consumers in every market have numerous choices among plan types and insurers," says AHIP spokesperson Robert Zirkelbach. "Moreover, research examining competition in health care markets increasingly points to provider consolidation as a significant factor driving up health care costs for families and employers."

He tells *HPW* that AHIP this year submitted a report on health plan mergers to the Dept. of Justice and the Federal Trade Commission that called into question data previously released by the AMA. The paper, "Federal Health Plan Merger Enforcement Is Consistent and Robust," was written by Cory Capps, Ph.D., of Bates White, LLC, a former staff economist at the antitrust division of the Department of Justice. Bates, according to Zirkelbach, determined that data used by the AMA on health plan concentration was "plagued by a number of significant limitations" and "fail basic checks of accuracy and reliability."

AHIP also released a study on the consolidation of hospitals in June.

For more information about AMA's report: *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, visit www.ama-assn.org. To see AHIP's report, *Market Concentration of Hospitals*, visit <http://tinyurl.com/3egwra9>. ✧

Deal Would Give Cigna Instant Scale

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days later, Coventry Health Care, Inc. said it had signed an agreement to acquire Children's Mercy Family Health Partners (FHP), a Medicaid managed care firm operated by Children's Mercy Hospital, Kansas City, Mo.

"Medicare and dual-Medicare-Medicaid lives will remain a key theme for organic and acquisition-driven growth" among large health plan operators, Credit-Suisse analyst Charles Boorady wrote in an Oct. 25 note to investors.

While the proposed acquisition of HealthSpring could prompt further consolidation among MA companies, there are a finite number of potential targets. "There simply are not enough public managed care companies to support a repeat of the 2002-2007 [merger and acquisition] wave,... a period which saw the acquisition of ten publicly-traded managed care companies," Matthew Borsch, an analyst at Goldman, Sachs & Co., wrote in

a research note. But desire for larger public-sector footprints among the four largest health insurers appears to have been accelerated by the reform law, and will likely to drive further consolidation, “particularly acquisitions of smaller, non-public health plans, which have continued at a steady pace,” he added.

Cigna’s MA experience is limited to Cigna Health-Care of Arizona, Inc., an HMO that covers 46,000 lives. HealthSpring would give Cigna instant Medicare scale with 340,000 additional MA lives in 11 states and Washington, D.C., and more than 700,000 Medicare Part D drug plan members nationwide — more than doubling Cigna’s enrollment in that program. Along with helping diversify Cigna’s product line, the acquisition also would allow it to “spread fixed costs over a much larger base, while making them a real player in a growing business that has decent near-term reimbursement visibility, particularly if Republicans gain more power in the upcoming elections,” Carl McDonald, an equities analyst at Citigroup Global Markets, wrote in an Oct. 25 research note.

Industry observers agree that Cigna’s acquisition of HealthSpring is a good strategic move as long as it can hang on to the company’s leadership. Bringing in HealthSpring’s management team appears to be “one of the major draws” of the acquisition, says Matthew Coffina, a health care analyst at Morningstar, Inc. But the company’s ability to retain that team will depend largely on how much flexibility Cigna allows it, he tells *HPW*.

And retaining HealthSpring’s leadership is particularly critical given Cigna’s limited experience with MA. And too many management departures could negatively impact the relationships HealthSpring has forged with provider groups, “which would force Cigna to run a nearly \$6 billion business that they don’t have much experience with,” McDonald warned.

Manders agrees that retaining the company’s leadership will be important, and draws parallels between the pending HealthSpring acquisition and Cigna’s purchase of Great-West. In both instances “we wanted the intellectual capital....We wanted to leverage [Great-West’s] infrastructure.” Manders adds that HealthSpring brings a unique physician-engagement model to the table, which Cigna would use to grow its MA business as well as incorporating the model into its commercial products. “Strategically, we will have critical mass [in MA], and it’s with a unique partner that is very much aligned strategically with us.” Both companies, he explains, are philosophically aligned when it comes to the importance of clinical excellence, consumer engagement and customer experience.

During a conference call announcing the deal, HealthSpring CEO and President Herb Fritch “sounded excited” about the opportunity to leverage his company’s differentiated approach to physician engagement across Cigna’s broader book of business, Coffina notes.

Reiboldt suggests that rather than assimilate HealthSpring, it would be easier for Cigna to move its small MA operation over to HealthSpring and allow the company to operate as a separate subsidiary until the long-term outlook of MA becomes clearer. “That would appear to be the way that shareholders could reap the most benefit from this deal in the shortest amount of time, which Cigna needs,” he tells *HPW*. “Trying to tackle a full integration right away would require significant investment, and in a relatively short timeframe, they may have to completely change much of that work, based on market and policy changes.” But, he notes, at some point, Cigna will need to figure out how to integrate the two companies and their products.

Neither Cigna nor HealthSpring have indicated how the acquisition might impact SXC Health Solutions

Cigna Corp.’s Major Acquisitions Over Past Five Years

Company	Core Business	Date	Purchase Price
HealthSpring, Inc.,* Nashville, Tenn.	Medicare Advantage	Pending (expected to close first half of 2012)	\$3.8 billion
FirstAssist Insurance Services, Sussex, England	Travel insurance	September 2011	\$110 million
Vanbreda International, Antwerp, Belgium	International health plans	August 2010	Not disclosed
Kronos Optimal Health Co., Phoenix	Wellness	February 2010	\$5 million
Great-West Healthcare, Inc., Denver	Small-group health insurance	April 2008	\$1.5 billion
Sagamore Health Network, Inc., Carmel, Ind.	Leased health care provider network	August 2007	Not disclosed
vieLife Ltd, London	Wellness	December 2006	Not disclosed
Star HRG, Phoenix	Limited benefit, low-cost health plans	July 2006	\$175 million

*HealthSpring acquired Bravo Health, Inc. in November 2010 for \$545 million.
SOURCE: Cigna Corp. and *HPW* archives. October 2011.

Corp., a pharmacy benefits manager (PBM) that counts HealthSpring as its largest customer. Cigna operates its own PBM. News of the acquisition Oct. 24 spooked investors, who sent SXC's stock price plummeting 23% to close that day at \$43.37 per share. The company is less than one year into a three-year contract with HealthSpring to manage its \$1 billion in annual health spend.

In an unrelated development, Cigna's business strategy also negatively impacted earnings for Healthways, Inc., a wellness plan operator that has had a longstanding disease-management contract with Cigna. During a conference call with investors to discuss third-quarter earnings, Healthways noted that Cigna would bring its wellness business in-house and did not intend to renew the contract, which is worth about \$110 million a year or about 16% of Healthways' 2011 revenues. In a note to investors, Thomas Carroll, an equities analyst at Stifel, Nicolaus & Company, Inc., suggested that the loss of the contract "will drag revenue and earnings for at least two years despite many potential growth opportunities."

There are just six independent MA carriers with more than 100,000 lives — most notably WellCare Health Plans, Inc. and Universal American Corp. Among the nation's five largest publicly traded health plan operators, Aetna Inc. is the only one that hasn't done much "to im-

prove its retail Medicare franchise this year," according to McDonald. Aetna has fewer than 400,000 MA lives.

But there also are a number of regional MA companies that could be good targets for large carriers that are looking to create multiple lines of business and/or are seeking broader geographies and larger populations, says Jim Smith, a senior vice president at the Camden Group. And Medicaid managed care companies might be another good acquisition target for large health insurers looking to diversify their product mix and boost market share, he adds. For health insurers, "the key is the ability to grow membership, revenue and net income in the face of more of the U.S. population being covered by governmental programs," he tells *HPW*.

Case in point: Coventry's proposed acquisition of FHP, for example, would translate to about 210,000 new Medicaid members, most of whom are in Missouri. The operation has annual revenues of more than \$450 million. The deal would expand Coventry's Medicaid managed care business to nearly 900,000 members across 10 states, and would bring its total membership to about 1.5 million.

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HEALTH PLAN BRIEFS

◆ **UnitedHealth Group dropped its objection to a request from the New York State Department of Financial Services (DFS) to make public details of its proposed rate increase**, the department said Oct. 25. UnitedHealth, the state's largest health insurer, along with nine other carriers and the New York Health Plan Association, had contended that details of the requests should remain secret. Department Superintendent Benjamin Lawsky disagreed, saying the public should have an opportunity to comment on the proposed rates. In an Oct. 19 decision, the department rejected the insurers' argument in the name of transparency. Seven other carriers also have dropped their objections, *The New York Times* reported Oct. 28, though Independent Health and MVP Health Care have not. Under a 2010 state law, insurers need prior approval from DFS for certain rate increases. Visit www.dfs.ny.gov.

◆ **New York state regulators have approved premium increases for 2012 from two large health insurers, though the hikes are less than what was requested**, the *Rochester Democrat and Chronicle*

reported Oct. 26. Excellus BlueCross BlueShield had requested an average 8.8% increase across its community-related plans, which primarily impact small businesses and individuals. DFS granted an average increase of 8.32%. MVP Health Plans sought an average increase of 12.32% across its community-related plans. It received an average 9.06% increase. Experience-rated, self-funded and Medicare Advantage (MA) plans are not impacted by DFS's decisions. Visit www.dfs.ny.gov.

◆ **Industry trade group America's Health Insurance Plans (AHIP) Oct. 25 filed an amicus brief with the U.S. Supreme Court, asking it to review an 11th Circuit Court of Appeals decision that declared the health reform law's individual mandate unconstitutional.** The case did not determine whether other provisions of the law, such as insurance market reforms, also should be struck down, AHIP spokesman Robert Zirkelbach says. AHIP is asking the high court to have both parties argue whether other provisions of the law should be invalidated if the individ-

HEALTH PLAN BRIEFS (continued)

ual mandate is declared unconstitutional. The brief is available at <http://tinyurl.com/ahipbrief>.

◆ **Capital BlueCross has begun offering pet insurance as an additional benefit to members**, the *Philadelphia Inquirer* reported Oct. 25. Harrisburg, Pa.-based Capital is offering the insurance, which is managed by Philadelphia-based PetPlan, as a voluntary benefit to employers and individuals. Capital is believed to be the first Blues plan to offer pet insurance, Stacy Balaban, Capital's senior director for strategic development, told the newspaper. PetPlan's policies are underwritten by the Allianz Group. An Aetna subsidiary, Aetna Insurance Company of Connecticut, has been underwriting pet insurance policies for Boise, Idaho-based Pets Best Insurance LLC since 2008 (*HPW* 5/30/11, p. 1). Visit www.cap-bluecross.com.

◆ **Jackson Health System's board of directors voted 3-1 on Oct. 19 to sell its troubled 12,000-member Medicaid managed care plan to Simply Healthcare Plans**, reported *The Miami Herald*. Under the proposed deal, Simply Healthcare, a less than two-year-old MA and Medicaid insurer started by Florida managed care entrepreneur Miguel "Mike" Fernandez, will pay the health system up to \$2.5 million and absolve Jackson of potentially \$3 million more in losses, according to the newspaper. State

regulators still need to accept the offer before the sale can become final. Separately, Jackson Health was notified Oct. 25 that its JMH Health Plan belatedly is being allowed to market its MA plan to seniors, the newspaper reported. Under a consent order with state regulators, JMH Health Plan must become profitable by Dec. 31, 2012, or it will have to "wind down its operations and voluntarily surrender its certificate of authority," according to the *Herald*. Visit www.jhsmiami.org or www.simplyhealthcareplans.com.

◆ **PEOPLE ON THE MOVE:** BlueCross BlueShield of Tennessee promoted **Ginger Pettway** to director of brand strategy and new media. She previously was its advertising manager....**Angela Hult** was named director of business and community relations for Regence BlueCross BlueShield of Oregon. She previously oversaw all of The Regence Group's media relations efforts....The Washington, D.C.-based Patient-Centered Outcomes Research Institute (PCORI) appointed **Anne Beal, M.D.**, as its first chief operating officer. She had been serving as president of the Aetna Foundation. PCORI was established by Congress through the health reform law, but acts as an independent non-profit to conduct research about making best medical evidence available to help patients and their health care providers make more informed decisions.

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