

# HEALTH PLAN WEEK

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

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## Other Plans Are Likely to Feel Effects From WellPoint, Humana Revision Bombshells

March madness began a little early for health plan investors after WellPoint, Inc. on March 10 dramatically lowered its first-quarter and full-year 2008 earnings expectations. Humana Inc. followed suit two days later but cited company-specific reasons for its revision.

Equities analysts, caught off guard by WellPoint's announcement, were quick to downgrade expectations for several other carriers. WellPoint's revised outlook, combined with the presidential election in November, could lead to "continued share stagnation" for health plan operators in 2008, Stifel Nicolaus Capital Markets analyst Thomas Carroll wrote in his March 11 note to investors. Carroll added that he was shocked by WellPoint's revision, "considering the level of confidence with which management spoke as recently as February 13, 2008."

Aetna, Inc. CIGNA Corp. and Health Net, Inc. have reaffirmed earnings guidance in response to WellPoint's announcement. And while UnitedHealth Group didn't confirm its 2008 guidance, it did issue a statement on March 13 that suggested the first two months of 2008 were in line with its expectations. The exception, United noted, was a higher-than-expected impact from influenza (*HPW 3/10/08, p. 1*). In its March 10 statement, WellPoint asserted that medical costs for Medicare Advantage (MA) plans exceeded its expectations as more elderly beneficiaries caught the flu.

*continued on p. 6*

## Tumultuous Provider-Payer Relationships Getting More Contentious, Studies Find

The historically rocky marriage between health plans and their network providers is crumbling, according to two recent surveys of hospital executives and physicians. And, as has happened in the past, failing relationships can ultimately have a negative effect on earnings for health plans.

The 113 hospital executives who responded to one of those surveys early this year (see chart, p. 3) gave three of the nation's five largest health plans more negative scores than positive ones. By far the most disliked and least trusted health plan operator was UnitedHealth Group, which received an unfavorable rating from 91% of respondents. The average unfavorable rating among the other plans was 41%. United, however, was not the largest insurer in terms of revenue for the average responding hospital, and its reimbursement rates were not significantly lower than those of the other plans.

Among the chief complaints against United were ones tied to claims denials, low reimbursement rates and an unwillingness to "fix claims." When asked which health plan was most difficult to negotiate with, 64% of hospital executives cited United, while 2% pointed to Aetna, Inc. United also was ranked as the slowest to process and pay claims. Overall, Aetna fared the best, with only 37% of respondents citing an unfavorable opinion of the company. Results of the survey were released this month by Santa Barbara, Calif.-based Davies Public Affairs. All participants were responsible for nego-

tiating contracts with health plans and represent more than 10% of the nation's hospitals, according to Davies.

United was quick to dismiss the study as "narrow" and "non-scientific." The study failed to reflect the favorable relationships that United has with most of its 4,800 network hospitals, says United spokesperson Daryl Richard. "We work directly and collaboratively with hospitals to decrease administrative cost and complexity so that hospitals receive fair compensation for services, at the same time balancing overall health care costs in line with the Consumer Price Index on behalf of our customers," he says.

Joseph Paduda, president of Health Strategies Associates, says hospital executives most likely to respond to this type of survey are those who have complaints or who have had a negative experience with a health plan.

Health plan consultant John Gorman, CEO of Washington, D.C.-based Gorman Health Group, LLC., says he's not surprised that hospital executives rated United so poorly. "They wield the biggest club in the market and are not afraid to use it" during negotiations, he says. "But

doctors and hospital execs don't like feeling bullied." Gorman says that health plans could do a lot to improve relationships with providers by paying claims in a timely and accurate manner and by "manning the phones" with people who can answer questions and solve problems. "You don't have to pay astronomically high rates," he adds. "This is fundamentally a cash-flow matter for providers."

Paduda says providers often are caught between the patient and the health plan because they know the patient is liable for any charges the health plan denies. Another problem from the perspective of providers has been the rapid consolidation among health plans over the past several years, says one industry observer and hospital board member who asked not to be identified. When a health plan contracts with a hospital, there is an expectation about what that health plan will be like to work with, he says. This can create problems when that insurer is acquired by another company with a completely different philosophy, he explains.

Henry Loubet, a senior vice president in the Oakland, Calif., office of Keenan & Associates, says the relationship between providers and insurers is critically important to the managed care industry. But, he adds, those relationships have worsened in the past few years "which is troubling." According to Loubet, health plans and providers need to be aligned in order to provide the best care for the members they both serve. Low ratings in areas such as honesty and candor could be in part a reflection of how tough United is when it comes to negotiating rates, he asserts. While health plans need to be more transparent by sharing information on how they make their decisions, hospitals and other providers also need to be more transparent about their rates as well, he says. Between 1996 and 1999, Loubet was the CEO of United's West Coast operations.

"I think a lot of health insurers understand fundamentally that they need to do a better job in dealing with providers," Paduda adds.

### Aetna Leadership Change Improved Relations

Aetna admits it had dismal relationships with many of its providers in the mid-to-late 1990s after the company (then Aetna Life Insurance Co.) acquired US Healthcare, Inc. for \$8.9 billion (*HPW* 4/15/96, p. 1). The acquisition made Aetna the nation's largest health insurer and a target for much of the building backlash against managed care.

Aetna came into new markets with a swagger and antagonized providers, Paduda says. "They would say, 'here is what we will pay and if we deny a procedure, that's just the way it is,'" he recalls. But that model led to

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tremendous backlash against managed care and prompted providers to drop out of Aetna's networks.

"Back then, we had a lot of focus on how to collaborate with [providers] to achieve *our* goals rather than sitting across the table from them and hammering out the best deal," explains Allen Karp, vice president of health care delivery at Aetna.

On Sept. 15, 2000, Aetna named John Rowe, M.D. — the former CEO of Mount Sinai N.Y.U. Medical Center and Health System — as its president and CEO. One of his key missions was to improve Aetna's relationships with providers. In the month before Rowe was hired, Aetna reported a 17% drop in second-quarter net profit while its competitors posted strong earnings (*HPW* 8/7/00, p. 1).

Rowe "helped lead a cultural change in the way we approached providers...and made a number of fundamental changes in the way we interacted," according to Karp. One of those changes, he says, was the development of a provider service center staffed by people who were "subject-matter experts" on provider issues. Previously, providers that called with problems were routed to the insurer's customer service department, where multiple transfers were common. Aetna's profits have shown strong growth in recent years.

Karp says it's important for health insurers to meet regularly with health system and hospital executives to discuss ways to improve efficiencies. "Then, when you get to the [contract] negotiating phase, you've already got a relationship," he explains. "But it's not always a panacea...We might have [a change] we know providers won't like. When that happens, we have a dialogue and reach out to them in advance."

Paduda agrees that Aetna has made big strides in improved provider relationships over the past decade. "When there's a dispute, Aetna's [*modus operandi*] is not to immediately deny the claim, but to look for more information and reach an accommodation. Providers need to feel like they are being dealt with professionally," he says.

"You are always going to have somewhat of a contentious relationship with providers when you talk about fees," Karp says. But if you have an ongoing dialogue, you can get things done that you otherwise couldn't." In the days after the US Healthcare acquisition, he says, Aetna might get providers to agree to a rate, but the backlash was ultimately damaging to the company.

**Insurers Are Equally Bad, Texas Docs Say**

The relationship between physicians and health plans has long been more adversarial than collegial, says Lewis Foxhall, M.D., vice president for health policy at the University of Texas M.D. Anderson Cancer Center

and president-elect of the Houston-based Harris County Medical Society (HCMS).

Results of an HCMS member survey last December prompted the six largest health plans in the Houston area to meet with HCMS members to determine how to resolve some of the issues that were uncovered. Nearly 500 physicians from Harris and surrounding counties responded to the survey, which asked them to rate Aetna, Blue Cross and Blue Shield of Texas, CIGNA Corp., Humana Inc., UniCare and United.

"The six health plans were uniformly bad. And that makes it even more challenging because we can't point to any [insurer] that is doing a great job," Foxhall tells *HPW*.

According to the study:

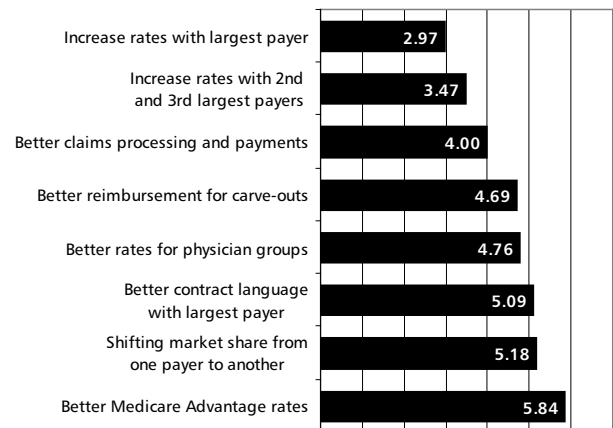
- ◆ More than 65% doctors said they have experienced difficulty getting their patients' medical services approved,
- ◆ 70% of physicians said insurers had denied payment of medically necessary care,
- ◆ Nearly 70% of doctors reported problems with getting paid on time, and 64% said they were paid less than their contracted rates.

*continued*

**Health Plan Contract Priorities Cited by Hospitals**

The ability to increase reimbursement rates from their largest payer was cited as the top priority, in a survey of hospital executives conducted by Santa Barbara, Calif.-based Davies Public Affairs.

Here's a look at the top issues ranked on a scale of 1 (most important) to 8 (least important):



SOURCE AND METHODOLOGY: Davies Public Affairs, March 2008. Based on results of an online survey of hospital executives. Data from 118 respondents were collected between Jan. 22 and Feb. 18.

This isn't an area where a big public relations campaign isn't going to do it, says Gorman. Doctors just want to get paid for services rendered, and they want insurance companies to add value for their patients instead of getting in the way of their care, he explains. Gorman suggests that the vast amounts of claims and clinical data held by health plans could be used to give providers actionable data about their patients. Foxhall agrees and says there is great potential in wellness, prevention and screening programs (see story below) where health plans could play a role in improving the overall health of their members. "But we haven't seen much effort on their part," he says.

To see a copy of the Davies report, visit [www.daviespublicaffairs.com](http://www.daviespublicaffairs.com). To see a copy of the HCMS report, visit [www.hcms.org/Template.aspx?id=468](http://www.hcms.org/Template.aspx?id=468). Contact Foxhall at [lfoxhall@mdanderson.org](mailto:lfoxhall@mdanderson.org), Richard at [daryl\\_richard@uhc.com](mailto:daryl_richard@uhc.com), Paduda at [jpaduda@healthstrategyassoc.com](mailto:jpaduda@healthstrategyassoc.com), Loubet at [hloubet@keen.com](mailto:hloubet@keen.com) and Gorman at [jgorman@gormanhealthgroup.com](mailto:jgorman@gormanhealthgroup.com). ✧

## For Wellness Programs, Cash Is King; Management Passion Is Key

After experiencing a dip in popularity during the 1990s, employee health and wellness programs are becoming a routine part of doing business for health plans.

Almost two-thirds of all employers now offer some kind of wellness program. Most say it isn't just about saving on health care expenses. Rather, healthy employees are more satisfied, more productive and have lower absentee rates. In addition, the work force is aging, and older employees will experience more chronic events as they age. "Because 75% of chronic events are preventable through lifestyle changes and interventions, keeping a work force as healthy as possible is a win-win situation for everyone," Anna Silberman, vice president of preventive health services at Highmark, Inc., tells *HPW*.

Health plans are part of this trend, and often use their internal employee programs to test interventions and motivators and take what they've learned to their commercial accounts. As one health plan executive tells *HPW*, "We use our employees as a test population for our interventions. We know that health promotion works. But we want to get the bugs out of the process before we take it to our commercial accounts."

While several factors contribute to the success of a health and wellness program, health plans say that two stand out as critical: "Best practices tell us that it's a combination of top management passion driving a corporate culture of wellness, and financial incentives," says Stewart Price, marketing director for Unity Health Plan of Wisconsin. "Without incentives, you'll get a 20% par-

ticipation rate right off the bat. But these tend to be the healthy individuals. That rate will start to drop by year two and three." Price says that it's the high- and medium-risk employees that you need to identify and target for participation. "They will join once they see that financial incentives are involved." Something as small as a \$25 incentive can help drive a two-thirds participation rate for completing health risk assessments (HRA), according to the Wellness Councils of America (WELCOA).

### Commitment From Top Is Essential

But commitment from top management, especially from the CEO, is critical. Price points to Highsmith, Inc., a Unity commercial account, where the company's CEO is "almost a fanatic" about building a base of healthy employees. The company's wellness program incentivizes its employees by linking participation to the amount the company pays for an employee's health coverage premium. Employees who participate in the wellness program have 75% of their insurance premium paid by the company. Refuse to participate, and the company pays only 60% of the premium.

*The result:* In addition to a measurably healthier and highly motivated work force, with a low turnover rate (8.7%), increases in the company's health insurance premiums have held remarkably steady over the past several years, averaging just under 4%, says Price. Workers' compensation costs also have dropped.

Blue Cross and Blue Shield of Nebraska's Blue Health Advantage program also won an award from WELCOA in 2007, and much of the program's success can be attributed to Steve Martin, the company's CEO.

"Martin is passionate about wellness. He believes deeply in the importance of helping people understand their health status and make healthy choices," says Lee Handke, Pharm.D., vice president of health network and wellness services. Martin "believes that if people are aware of their health status and how it compares to the norm, healthy behaviors will follow." Martin had wellness written into the policy manual and mission statement. He even put treadmills in the executive conference room so managers can exercise while they meet.

Integrated into the company's annual HRA is a corporate health culture audit. "We include questions in the HRA to find out whether employees value health and wellness, if they feel that the workplace supports a healthy lifestyle or is stressful, and if the company's culture and policies support and encourage healthy behaviors," Handke says. "We conducted our first health culture audit in 2005, and we now have solid baseline numbers to use in evaluating the data we generate from these assessments."

The Nebraska Blues plan makes the audit tool available to its commercial accounts for use in their programs. Companies also are walked through the 7-C Steps recommended by WELCOA for building a "Well Workplace."

The insurer uses cash awards to incent its employees and achieve a 91% participation rate. "There's no doubt that cash is king when it comes to incentives," says Handke. "But the first incentives were movie tickets, and we got a 72% participation rate. That demonstrates that smaller incentives in some cases may work as well as larger ones, so an incentive program doesn't have to break the bank." The company now budgets about \$90 per employee for its incentive programs. This year, the company linked 10% of employee bonus checks to participation in wellness activities.

### Highmark Touts 90% Participation

Highmark Inc. reports that it combines a strong culture of wellness with incentives to achieve a 90% participation rate in its employee health and wellness program. "Top leaders must walk the talk," says Anna Silberman, Highmark vice president of preventive health services. "Our CEO has let everyone in the organization know that he's completed our Lifestyle Returns program. We also have 100% participation in the program by top management."

The company's Lifestyle Returns Program motivates employees to participate by offering \$350 in cash to employees who participate in all aspects of the five-step program, including taking the HRA and completing screenings and exams based on age and gender. In 2006, 90% of employees participated in at least one wellness program. The number of employees participating in all five steps increased from 46% in 2006 to 56% this year. Complete the program early, and an employee is entered in a raffle for an all-expense-paid "healthy" vacation at a Utah spa (no free vacation time, however).

The company also achieved higher compliance rates for physical exams and screenings when it brought the tests in house and incented employees to take them. "Before we began using incentives, and when employees had to visit a physician's office for the tests, we were seeing only a 9.7% compliance rate," Silberman notes. "In 2006, when we brought them in house and made them part of the Lifestyle Returns program, compliance jumped to 51%. Last year, it went up to 59%."

Highmark's employee wellness initiative has had a positive impact on its health costs. The increase in those costs among employees participating in the program was about 34% between 2001 and 2005, while costs for those not participating increased 40%, the company says.

Highmark recently published a study showing that its wellness program has produced \$1.65 in savings per

employee for every dollar it spent on the program. The data showed that per-person per-year costs for those participating in the wellness program were \$176 lower than for non-participants, although that doesn't take into account the previous health of the employees. Inpatient expenses came in \$182 lower. "Inpatient care expenses are a real marker when it comes to managing health care costs, so we knew the program was working when we saw that figure," Silberman tells *HPW*.

Contact Stewart Price at (608) 643-1512, Bev Carlson for Lee Handke at (402) 548-4328 or Kaitlin O'Brien for Anna Silberman at (412) 544-6006. ✧

### More Than 90,000 Oregonians Sign Up to Apply for Health Coverage

A staggering 91,675 Oregonians signed up to receive one of the 3,000 available applications for the Oregon Health Plan's Standard benefit package (*HPW* 2/11/08, p. 8). The Standard benefit, which now covers 17,700 enrollees, is for low-income residents who otherwise aren't eligible for Medicaid. The applications were assigned by lottery and sent to winners on March 10. About one in six Oregon residents, or about 600,000 people, lack health coverage.

On March 12 a Families USA report estimated that one working-age Oregonian dies each day because he or she did not have health insurance. It found that, based on figures reported by the Institute of Medicine and the Urban Institute, nearly 1,900 people between the ages of 25 and 64 died between 2000 and 2006 because they lacked health coverage.

Bruce Goldberg, M.D., director of the Oregon Department of Human Services (DHS) said the report emphasized the need for comprehensive health care reform. "It's important to understand and document the consequences of lack of health coverage. It's more important

### Innovative Provider Payment Strategy or Capitation All Over Again?

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that we do something to assure people get the health care they need," he says.

Oregon Health Plan, the state's Medicaid program, is offered through DHS. The Medicaid program covers a total of more than 300,000 residents, says department spokesperson Jim Sellers. The Standard benefit can support a monthly average of 24,000 enrollees, and enrollment has been closed since July 2004. The coverage has no premium for those with incomes less than 10% of the Federal Poverty Level, but about 63% of enrollees are responsible for a monthly premium of between \$9 and \$20, for which beneficiaries are billed every six months.

In its heyday, the program covered nearly 132,000 people, Sellers says. That was in July 1995. Since then, he tells *HPW*, enrollment has fallen by attrition that the department allowed to occur. The state, which originally

funded the program through the general state fund, changed its funding structure some years ago, Sellers explains. He says the benefit package is now funded through a tax that Medicaid managed care plans and hospitals in the state agreed to pay. But "the money derived from those two industry groups is significantly less than what the state fund formerly [funded] it at," he says.

Those who receive applications will have to return them to the department within 30 days, according to Sellers. The department will then review them and enroll the eligible persons. After that, the department will hold another lottery drawing for 3,000 more applications, based on the original list of those who are interested in coverage. The process will continue until the plan adds up to 10,000 new enrollees during the remainder of the program's two-year budget, which is about eight months old, he explains.

Sellers says the 2009 legislature, which will convene next January, is likely to consider new legislation to address the issue of health care reform in Oregon.

Call Sellers at (503) 945-5738 or Families USA spokesperson Robert Meissner (202) 628-3030. ↵

### Blues Plans See 60% Enrollment Jump In Account-Based Products

The nation's Blue Cross and Blue Shield (BCBS) plans say their account-based health plans collectively cover more than 4 million lives, according to data collected by *HPW's* sister publication, *Inside Consumer-Directed Care*. That's up from 2.5 million lives on the same date a year ago. At least 1.65 million lives were enrolled in a plan that included a health reimbursement arrangement, and more than 2.35 million were covered by a plan that is qualified to work with a health savings account (HSA). Nationally, BCBS plans provide health coverage for about 100 million people.

<b>WellPoint, Inc.</b> (Includes Blues plans in Calif., Colo., Conn., Ga., Ind., Ky., Maine, Mo., Nev., N.H., N.Y., Ohio, Va. and Wis.)	Combined enrollment in HRA-based and HSA-qualified plans: 1.35 million as of Dec. 31, 2007
<b>Health Care Service Corporation</b> (Includes Blues plans in Ill., N.M., Okla. and Texas)	HSA-qualified plans: 344,000 HRA-based plans: 212,000 Plans that include 'incentive-funded' HRA: 114,000
<b>CareFirst BlueCross BlueShield</b> (Includes Blues plans in Md., Va. and Washington, D.C.)	Combined HRA and high-deductible health plan (HDHP)/HSA enrollment: 184,013
<b>The Regence Group</b> (Includes Blues plans in Idaho, Ore., Utah and Washington state)	Lives enrolled in an HSA-qualified plan or similar account-based product: 187,000
<b>Blue Cross and Blue Shield of Minnesota</b>	HSA-qualified plans: 155,070 HRA-based plans: 129,700
<b>Blue Cross and Blue Shield of Florida</b>	HSA-qualified plans: 158,455 HRA-based plans: 7,710
<b>Blue Cross Blue Shield of Michigan</b>	HSA-qualified plans: 122,317 HRA-based plans: 26,407, as of Dec. 31, 2007
<b>Blue Cross Blue Shield of Massachusetts</b>	HSA-qualified plans: 9,500 HRA-based plans: 91,000
<b>Blue Cross Blue Shield of Tennessee</b>	HSA-qualified plans: 64,654 HRA-based plans: 6,195

Editor's note: Unless otherwise noted, all data are as of Jan. 1, 2008. SOURCE AND METHODOLOGY: Based on enrollment data provided by Blues plan officials and compiled by AIS.

### Rising Costs Could Eat Plan Profits

*continued from p. 1*

Shortly after the market closed March 10, WellPoint said its full-year 2008 net income would be in the range of \$5.76 to \$6.01 per share (assuming net realized investment gains of approximately 6 cents per share), a revision from the previous forecast of \$6.41 per share. The company said the revised growth outlook represents an increase of approximately 4% to 8% from net income of \$5.56 per share reported for last year. The company cited higher-than-expected medical costs, combined with lower-than-expected fully insured enrollment. The higher medical costs, analysts say, could translate to lower profits for other health plans as well.

Jittery investors responded harshly to WellPoint's revision, sending shares plummeting 28% (\$18.66 per share) to close March 11 at \$47.26 — the lowest price in more than three years for WellPoint stock. Since going public in the 1990s, WellPoint has been the only publicly traded health plan operator that never missed an earnings projection, Oppenheimer & Co. analyst Carl McDonald said in a note to investors. WellPoint's announcement "will turn out to be one of those seminal events in managed care history...." "There's not a lot that WellPoint can do to save this year," he wrote.

WellPoint's competitors also took a beating on Wall Street the day after it announced its revised earnings estimates. Chief among them was Humana, which is highly dependent on the Medicare market. Humana's

stock closed at \$62.70 on March 10 and traded as low as \$42.85 the next day before closing at \$47.38. On March 12, Humana issued an even larger negative revision than WellPoint's, which caused Humana stock to tumble an additional 14% that day.

The revised guidance, Humana said in a prepared statement, is the result of updated financial projections for the company's stand-alone Medicare Prescription Drug Plans (PDPs). The company said its MA, commercial and military services businesses are not affected by this revision in earnings guidance.

Humana lowered its first-quarter earnings guidance to between 44 cents and 46 cents. That's down significantly from its earlier guidance of 80 cents to 85 cents. Humana now projects its full-year per-share earnings will be in the range of \$4.00 to 4.25, down from \$5.35 to \$5.55 forecast earlier. During the first two months of the year, Humana said it experienced higher-than-expected claims volume in its PDPs.

"Humana's issue is primarily related to an actuarial mistake in pricing a richer benefit version of its [PDPs]," McDonald wrote, adding that Humana will be able

## NEW PRODUCTS & SERVICES

◆ **Aetna, Inc. on March 12 launched a new personalized medical search engine.** The insurer says its Aetna SmartSource mines information from its "vast databases" to provide members with customized health information. The program scours various databases to find information about health issues, local network providers, commonly used medication and treatment options and estimated costs for services. Search results are based on a member's insurance plan, gender, ZIP code and overall health, according to Aetna. To ensure the search results are relevant, Aetna partnered with Healthline Networks, a San Francisco-based health information firm, to build a search engine that incorporates specific data about each user, as well as information stored in the member's personal health record. Contact Aetna's Betsy Sell at [selle@aetna.com](mailto:selle@aetna.com). Visit [www.healthline.com](http://www.healthline.com) or [www.aetna.com](http://www.aetna.com).

◆ **CareFirst BlueCross BlueShield has teamed up with P4 Healthcare to launch an "oncology treatment pathway program"** to promote the delivery of high-quality, cost-efficient patient care, according to P4 Healthcare, a Maryland-based firm that specializes in oncology practices. CareFirst is the parent company of Blues plans in Maryland, northern Virginia and Washington, D.C. Physicians who participate in the program will receive increased reimbursements for delivering the right patient care at the right time while helping to manage drug costs associated with quality oncology care, P4 Healthcare says. "Rewarding doctors for quality care certainly helps the patient, but the [program] will also allow payers to better understand and manage the costs associated with cancer care, including the adoption of innovative therapies," says Jeffrey Scott, M.D.,

the company's president and medical director. Visit [www.P4Healthcare.com](http://www.P4Healthcare.com).

◆ **Valley Preferred, a PPO owned by the Lehigh Valley (Pa.) Physician Hospital Organization (PHO), says it has signed a partnership agreement with UnitedHealthCare** that will allow the PHO to offer a new suite of products to employer clients. Through the agreement, employers can choose from 11 plan designs that include account-based consumer-directed products. The agreement also expands Valley Preferred's provider network by 46 hospitals and 12,000 physicians through United's eastern Pennsylvania network. The Valley Preferred network includes 33 hospitals and more than 3,000 physicians. Employers also will have access to the PHO's corporate health-enhancement program — Care Beyond the Coverage — which includes on-site health and wellness education, corporate health fairs, health seminars, employee assistance programs, health screenings and health awareness profiles. Visit [www.valleypreferred.com/docs/news.htm](http://www.valleypreferred.com/docs/news.htm).

◆ **Health Alliance Plan (HAP) last month launched an interactive tool designed to help consumers play a more active role in their health care decisions.** HAP also distributed a CD version of the course to more than 800 metro Detroit employers. The interactive course contains the following nine modules and includes audio narration and learning tools. The modules include choosing and using a health plan, choosing a personal care physician and prescription drug management. The free Wise Health Care Consumer course, developed by HAP and O/E Learning, Inc. of Troy, Mich. is available to the public at [www.hap.org/whcc](http://www.hap.org/whcc). Contact Susan Schwandt at [sschwan1@hap.org](mailto:sschwan1@hap.org).

to rectify those problems well ahead of the early June submission of bids for 2009 to CMS. "Of course, higher pricing will result in lower PDP membership next year, particularly since Humana is likely to bid above the benchmark [i.e., for qualifying for assignment of low-income subsidy beneficiaries] in a number of regions,

and its [Medicare-Medicaid] dual eligibles will be re-assigned to other lower cost plans," he wrote.

To see a copy of WellPoint's statement, visit [http://media.corporate-ir.net/media\\_files/irol/13/130104/news/2008guidance.pdf](http://media.corporate-ir.net/media_files/irol/13/130104/news/2008guidance.pdf). To see Humana's statement, visit [www.businesswire.com/portal/site/humana](http://www.businesswire.com/portal/site/humana). ✧

## HEALTH PLAN BRIEFS

◆ **Iowa's House of Representatives approved by a vote of 97-0 HF 2539, which would reform the state's health care system in an attempt to cover all residents.** According to state Rep. Lisa Heddens (D), the bill sets a goal that every Iowa child will have health insurance by the end of 2010. It establishes that "every Iowan will have a patient-centered medical home," under which a medical provider will focus on prevention and chronic care management for each of its patients in an attempt to reduce costs. The bill would allow young adults to stay on their parent's insurance policy until they reach age 25 or they graduate from college, whichever is later. State residents with pre-existing conditions also would continue to receive insurance coverage if they leave group insurance and enter the individual insurance market. The bill now goes to the Senate, which had passed its own version of health care reform. Funding has not yet been identified for the bill. Call Heddens' office at (515) 281-3221.

◆ **First Tennessee Bank National Association subsidiary First Horizon Insurance Services, Inc. was selected by the National Association of Independent Truckers (NAIT) as its exclusive provider of high-deductible health plans and health savings accounts.** Under the partnership, NAIT members will have dedicated access to information, service and support for their health coverage needs. First Horizon says it offers a variety of plans to clients nationwide. Call First Horizon National spokesperson Martin Trussell at (913) 317-2085.

◆ **UnitedHealth Group unit OptumHealth Behavioral Solutions says it has entered into a strategic agreement with Tucson, Ariz.-based Providence Service Corp.** OptumHealth's public-sector market provides benefits and services to approximately 1.2 million people across 30 states. Providence owns and manages entities that provide home- and community-based social services to government-sponsored clients under programs such as welfare, juvenile

justice, Medicaid and corrections in 35 states and Washington, D.C. Under the agreement, Providence will become a preferred provider to OptumHealth Behavioral Solutions and its affiliates for specific behavioral health services. Contracts for designated markets will be negotiated at the state level. In addition, terms, conditions and fees will be based on the specific services provided in each location, the companies say. Call OptumHealth spokesperson Brad Lotterman at (714) 445-0453.

◆ **The Georgia Senate on March 6 passed SB 404, a bill that would create a Web site to allow consumers and business owners to compare and purchase health plans.** The bill, known as the "Georgia Health Marketplace Act," would establish a Web portal where people are able to compare deductibles, copayments, benefits and premiums. They also would be able to purchase a plan using pretax dollars via the site, according to the *Atlanta Journal-Constitution*. The site would offer a traditional health plan, a plan for businesses with fewer than 50 employees, PeachCare for children — Georgia's State Children's Health Insurance Program, catastrophic care for 18- to 25-year-olds and a plan under which consumers buy coverage directly from medical providers. The bill also would allow consumers to set up health savings accounts, the newspaper reported. The bill was in the House for a second reading on March 12. Visit [www.legis.state.ga.us/legis/2007\\_08/sum/sb404.htm](http://www.legis.state.ga.us/legis/2007_08/sum/sb404.htm).

◆ **PEOPLE ON THE MOVE: Jamie Miller**, WellPoint, Inc.'s chief accounting officer since August, resigned March 11, just one day after the insurer dramatically altered its earnings expectations for 2008 (see story, p. 1)...**Charlie Young**, senior vice president of corporate communications at WellPoint, resigned from his post the same week....**WellCare Health Plans, Inc.** says **Thomas F. O'Neil III**, formerly a partner at DLA Piper US LLP, will join the company as senior vice president, general counsel and secretary next month.

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