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Health Plan Week

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

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Did Wall St. Kill Health Reform? Bailouts, Economy May Trump Plans to Fix System

Just six months ago, the idea of health care reform was arguably the nation's top domestic policy issue. Not anymore. An economy gasping for air, a six-year war with an estimated price tag of $12 billion a month, record meltdowns on Wall Street *(HPW 9/22/08, p. 1)* and a planned $700 billion bailout for the nation's financial system will make it difficult, if not impossible, for the next administration and Congress to overhaul the ailing health care system, industry observers tell *HPW*. Given that health reform measures proposed by both presidential nominees call for radical changes to the existing system of health coverage, lowering the reform threat level from orange to yellow is generally good news for health plans. However, the escalating financial crisis actually could move health reform to the political forefront in 2009, some observers say. And a major Medicare reform bill that may target Medicare Advantage (MA) plans is almost certain.

Democratic presidential nominee Sen. Barack Obama (D-Ill.) on Sept. 23 acknowledged that the proposed bailout would likely delay some of his campaign proposals including health care reform. That same day, the House Ways and Means Health Subcommittee and the Senate Finance Committee held separate hearings to discuss the cost of health reform in the wake of an expected congressional bailout.

"I don't think health reform is dead, but it is certainly on life support at the moment, and Obama's comment this week is about as good a barometer as you can get," says consultant John Gorman, CEO of Gorman Health Group, LLC.

continued on p. 4

Payers Weigh Coverage Costs, Problems In Deciding on Bariatric Surgery Benefits

As payers digest results of a new study showing a much quicker return on investment for obesity surgery costs than was previously thought, there still is wide variability in coverage for bariatric surgery among insurers and employers. Some contend that payers might be more inclined to cover the procedures if it takes just two to four years to recover their costs. But other companies — both ones that cover the surgery and those that refuse to — assert that the study findings won't have much impact on their coverage decisions. And some observers question whether return-on-investment calculations are an appropriate tool for assessing bariatric surgery coverage.

The study, published Sept. 8 in *The American Journal of Managed Care,* found that insurers fully recovered the $17,000 average cost of laparoscopic surgery in about two years and the $26,000 average cost of traditional, open bariatric surgery in about four years, through reductions in costs for drugs, physician visits and hospital services. By comparing post-operative claims costs incurred by morbidly obese patients who had the surgery with costs incurred by those who did not, the authors found that costs rose faster for the patients who did not get surgery.

"Originally, the estimate was a 10-year [return on] investment," says Dean Hatfield, senior vice president and health practice leader at Sibson Consulting, a subsidiary of

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The Segal Co. that provides human resources consulting to employers with 3,000 to 30,000 workers. "If it's going to two to four years, they [i.e., employers] certainly will take a hard look at it and determine whether they should include [coverage for bariatric surgery]."

Hatfield tells *HPW* that few employers among Sibson's clients now cover bariatric surgery. "Based on, one, the newness of the surgery and second, the lack of real data as to the return on the investment, most have leaned against it," he explains. "Now, if you really believe the two- to four-year period, that may open up the discussion," causing employers to consider changing benefits.

Hatfield says he advises employers to review their own data. "If they do have a high obesity population, then it may make sense" to cover the surgeries. "And secondly, look at the turnover," particularly for key employees who are long-term, loyal, high-value workers. "If they have enough of those who need the surgery," coverage may make sense.

Coverage is much more widespread among *FORTUNE* 500 employers, contends LuAnn Heinen, director of the Institute on the Costs and Health Effects of Obesity at the National Business Group on Health (NBGH). "We have a high percentage that covers some [type] of bariatric surgery," most commonly gastric bypass and LAP-BAND Adjustable Gastric Banding surgeries. She estimates that 86% to 88% of NBGH's member employers already cover the procedures. "This is just one study," she adds, "and by itself wouldn't drive much change."

Several insurers, such as Medical Mutual of Ohio and Blue Cross Blue Shield of Arizona, cover bariatric surgery for all fully insured members, and say most self-funded employer clients cover the procedures as well.

"Some of our employer groups will put a dollar limit on it," such as a maximum of $10,000 in coverage, says Sharlene Kahn, director of case and disease management at Medical Mutual of Ohio. "That usually will cover the surgery," she says, "but a lot of times, if they run into any kind of major complications, it will not cover it."

She says the study results confirm Medical Mutual's experience. "What we find is that for the obese member who has bariatric surgery, where their costs tend to go down is usually when they have diabetes that's out of control and they have high blood pressure and they'll have high cholesterol — all due to weight," Kahn says. "So usually from bariatric surgery we do see costs go down because there are all those other conditions that get under control." But, she adds, "I don't know about the two- to four-year" time frame estimated by the study authors.

Insurers Tweak Coverage Rules

Kahn adds that Medical Mutual has reduced the amount of time patients are required to participate in a weight-control program before having the surgery from 12 to six months. And the insurer is investigating a center-of-excellence program for bariatric surgery centers.

The Arizona Blues plan also includes bariatric surgery coverage "as part of our standard benefits package in our individual and group plans," says spokesperson Carlos DellaMaddalena. "Large groups can customize their benefit, but for the most part most groups do include that surgery in their package." In both cases, the benefit is subject to copayment, deductible and coinsurance requirements, he adds.

Other insurers, such as Blue Cross and Blue Shield of Florida, refuse to cover the surgery. The Florida Blues plan ceased coverage in 2004, "based not on cost but on problems with quality issues," says Barry Schwartz, M.D., the insurer's vice president of network management. "That policy is still in place," he says. "We cover it for self-funded accounts if they wish to, but for fully insured [enrollees] we do not."

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Schwartz asks if bariatric surgery "is something…we want to spend money on, considering all the uninsured in this country and all the problems with the health care system?" And he adds that in his view, "we're dealing with something that's inescapably a lifestyle issue.…If they cut down on what they're eating and exercise, they will lose weight. So we have people that for one reason or another are not doing that."

Aetna Inc. does not cover bariatric surgery in its fully insured products unless the plan sponsor has purchased a rider, says spokesperson Walt Cherniak. But "many of Aetna's national accounts and middle-market non-HMO customers include coverage for bariatric surgery as a rider," he adds. "We sort of put it into their court, where if they want to cover it, it's available to them." Cherniak declines to speculate on whether Aetna expects to revise its coverage policy as a result of the study findings.

Study Design Is Called Weak

Schwartz questions the study's findings, noting that the study was funded by Ethicon Endo-Surgery, Inc., a Johnson & Johnson subsidiary that develops and markets medical devices for minimally invasive and open surgical procedures. He also cites what he calls weaknesses in the study design. For example, Schwartz says, the study doesn't follow patients' actual experience, but rather simply compares claims experience.

In addition, the study authors say they selected control groups by choosing patients with an age within 10 years of the surgery patient, the same sex and state of residence, the same 10 comorbidities and similar costs. But, Schwartz says, the control-group members were not matched for body mass index or weight, so they could have been substantially less healthy than the patients who underwent surgery.

"The biggest issue with these kinds of studies is that, from my knowledge, we don't have any good long-term studies," Schwartz says. "One of the problems with these surgeries is the lack of follow-up," which can lead to complications. And when studies start coming out that compare costs over a long period of time, the findings might be different, he contends.

In an editorial published in the same issue of *The American Journal of Managed Care* as the study, Eric Finkelstein, Ph.D. and Derek Brown, Ph.D. argue that return-on-investment calculations should not be used to assess bariatric surgery coverage any more than they would be used for treatment of cancer, heart disease or diabetes.

"Bariatric procedures should not be held to a different standard than other medical or surgical interventions, regardless of what the return on investment might actually be," they argue. "The coverage decision should be based on whether or not the intervention can improve the condition in a cost-effective manner compared with other potential treatments."

Call Segal spokesperson Mary Feldman at (212) 251-5029, Heinen at (202) 669-6356, Medical Mutual spokesperson Ed Byers at (216) 687-2685, Cherniak at (410) 691-1405, DellaMaddalena at (602) 864-4067 or Hammond at (803) 264-4626. ✧

2009 Will Be 'Big Ugly Year' for Medicare, Former CMS Head Warns

Former CMS Administrator Tom Scully predicts that 2009 will be "a big ugly year" for Medicare in general and Medicare Advantage (MA) plans in particular. He made that prediction during a "CMS Administrator Roundtable" discussion at the America's Health Insurance Plans (AHIP) annual Medicare and Medicaid conference in Washington, D.C., Sept. 23. The panel, which included two other former CMS chiefs, offered their perspectives on the future of Medicare.

"There hasn't been a major Medicare [reform] law in several years, and some people think it can't happen,"

Part D Premiums to Jump 24%

Premiums for all stand-alone Medicare Part D drug plans will jump an average 24% (from $30 to $37 a month), and the average cost for the most popular plans will increase more than 30%, according to data released Sept. 25 by CMS and analyzed by Avalere Health LLC, a Washington, D.C.-based firm. The 10 largest drug plans raised premiums from 8% to 64%. Monthly premiums for Humana Inc.'s products, according to Avalere, will increase from $25.52 this year to $40.83 in 2009.

On Sept. 19, CMS said monthly premiums for Medicare Part B would be $96.40 for 2009, the same as it was for 2008. The agency noted that this is the first year since 2000 that the standard Part B premium did not increase over the prior year. The monthly Medicare Part B premium covers a portion of the cost of physician services, outpatient hospital services, certain home health services, durable medical equipment and other items.

The list of national stand-alone Prescription Drug Plans (PDPs) and state-specific fact sheets can be found at: www.cms.hhs.gov/center/openenrollment.asp.

Call CMS spokesperson Steve Hahn at (202) 690-6149.

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Scully told attendees (apparently not regarding the July 2008 law as major). "But it can happen, and it likely will happen next year almost for sure." Such a bill, he added, will almost certainly target rates paid to MA insurers.

Nancy-Ann DeParle, who left the agency — then known as the Health Care Financing Administration (HCFA) — in 2000, agreed that a major Medicare bill is inevitable next year given the turmoil on Wall Street and the growing national deficit. "And if I'm correct, health plans need to get ready," she warned. Insurers that sell MA plans, she added, need to provide CMS with a rationale for the price differential between MA and traditional Medicare fee-for-service (FFS). "I could actually argue in favor of paying [MA insurers] more under Medicare if they are really doing something to manage care and are showing results," she said.

With the Medicare system expected to be insolvent by 2019, Congress has some time to revamp the way it reimburses physicians, former HCFA Administrator Gail Wilensky, Ph.D. said. A key problem under the existing Medicare FFS model, she told attendees, is that the quality of care that physicians provide has no effect on their level of reimbursement. "Nothing they do, good or bad, impacts their fees," she said. "It's a broken part of Medicare that urgently needs to get fixed."

One of the problems with FFS Medicare is that when you pay a physician a fixed dollar amount for an office visit, you are not paying him or her to do chronic care management, she explained. And MA insurers haven't yet demonstrated that they can improve the health of enrollees, according to Wilensky. "Medicare Advantage insurers have the ability to lead the way and demonstrate to policymakers, beneficiaries and taxpayers that they are providing real value. That is the challenge for plans in the year ahead." However, she cautioned against trying to make too many changes to the system at once. "I would advocate a more moderate approach over the next 10 years," Wilensky said.

Scully agreed and said the traditional Medicare FFS system rewards providers and health plans for the quantity of services provided rather than efforts to improve health. CMS contracts with Blue Cross and Blue Shield plans to administer the Medicare FFS program. "They write the checks, and [CMS] pays them a 0.5% administration fee," he explained. "When you do that, you become incredibly fast at writing checks and don't care how many services or CT scans you pay for." Instead, Scully says, the contracted Blues plans should receive a flat, annual per-member fee for managing care. "You get a better performance when you put the third party at [financial] risk."

"The fundamental problem with Medicare is price fixing….Hospitals and doctors get paid the same whether they do a good job or bad job," Scully contended.

Wilensky agreed and said Medicare has traditionally focused on controlling the price of health care services rather than controlling spending.

Contact Scully at thomas.scully@alston.com, Wilensky at Project Hope at www.projecthope.org and DeParle at CCMP Capital at www.ccmpcapital.com. ✧

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Major Reform Efforts Called Unlikely

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But even if the proposed $700 billion bailout and the $200 billion needed to save Freddie Mac and Fannie Mae are taken off the table, the nation's budget deficit is expected to climb from $407 billion this year to $480 billion in 2009, adds Ray Scheppach, executive director of the National Governors Association. "And that doesn't include any supplemental spending for the war, hurricanes or other disasters," he tells *HPW*.

Any successful reform efforts are more likely to come from Congress than from the next presidential

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administration (see story, p. 7), says Paul Fronstin, senior research associate at the Employee Benefit Research Institute. Scheppach agrees and says that while strategies to expand health coverage aren't likely to succeed anytime soon, the next Congress could score some relatively easy victories by addressing health care quality and information technology (IT). Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance, adds that despite the differences in reform proposals touted by Obama and Republican presidential nominee Sen. John McCain (R-Ariz.), they "do agree pretty readily" on the need to emphasize preventive care, information technology and improved quality, he says.

Turmoil Could Hasten Need for Change

Without funds to address health care, lawmakers would likely need to increase taxes, which could "tip the already fragile economy into full-blown recession," says Jeffrey Munn, design and development leader in the health management division of Hewitt Associates.

But that could place even greater pressure on lawmakers to address health care. While pressures created on Wall Street are likely to take the emphasis off reform for the next year or two, "difficulties this severe have a way of rippling out to other sectors in ways we cannot always predict," says managed care consultant Peter Kongstvedt, M.D., principal of P. R. Kongstvedt Co..

A weakened economy and tighter credit will result in fewer jobs and leaner health coverage benefits, or the elimination of benefits altogether, he tells *HPW*. That could translate to a larger uninsured population and an increase in medical-related bankruptcies. And tighter credit could push health care providers and manufacturers to raise prices, which ultimately will lead to higher premium costs. As those issues become more apparent, Kongstvedt says, Congress will realize that, next to the meltdown of the financial markets, health-related costs are the biggest drag on the economy. Then health reform "is seen in the light of economic reform more than social reform, therefore enabling renewed debate," he explains. "If a bipartisan Congress goes in for the massive bailout of financial institutions, then they've been bloodied and are more likely to do it again for the other massive economic sector — health care."

Sara Rosenbaum, chair of the Department of Health Policy at George Washington University School of Public Health and Health Services, agrees and says that the financial crisis could embolden broader action. "The economics of health care are so serious, and it is impossible to introduce systemwide accountability without across-the-board reform," she tells *HPW.*

Gorman agrees but says that while more economic strife could move health care reform up on the list of national priorities, improvements to the system are likely to be incremental. One issue that Congress is certain to take up in 2009 is Medicare, which could be part of a broader reform effort. Without a congressional fix before 2010, physicians will face at least a 20% Medicare payment cut. "It'll probably happen next fall. And that's when the knives will come out" for MA plans, Gorman asserts. "MA will be firmly in the crosshairs as a funding source" for any reform effort, he says. "We keep telling the in-

Medical Cost Trend Among Commercial Health Plans

Company	Segment	Medical Cost Trend Second Quarter 2008	Anticipated Medical Cost Trend for 2009*
Aetna, Inc.	Commercial	7.5%	8.0%
	Inpatient	Mid-to-high single digits	
	Outpatient	Low double digits	
	Physician	Low-to-mid single digits	
	Pharmacy	High single digits	
CIGNA Corp.	Overall	7.0%	7.5%
	Inpatient	High single digits	
	Outpatient	High single digits	
	Physician	Mid-single digits	
	Pharmacy	Mid-single digits	
Coventry	Commercial	9.0%	Not available
	Inpatient	10% to 11%	
	Outpatient	11% to 14%	
	Physician	6% to 7%	
	Pharmacy	6% to 8%	
Health Net, Inc.	Commercial	8.4%	
	Inpatient	10%-to-low double-digits	Not available
	Outpatient	Not available	
	Physician	Mid-single digits	
	Pharmacy	Mid-to-high-single digits	
UnitedHealth Group	Commercial	7.5%	8.0%
	Inpatient	11.5% to 12%	
	Outpatient	6% to 7%	
	Physician	4% to 5% per physician	
	Pharmacy	6% to 7%	
WellPoint, Inc.	Commercial	8.0%	8.5%
	Inpatient	Low double-digits	
	Outpatient	Mid-to-upper single digits	
	Physician	Mid-single digits	
	Pharmacy	Mid-single digits	

*Based on comments from health plan executives.
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dustry to prepare for rates to be in line with [traditional] fee-for-service Medicare over the next five years."

Medicare cuts also could be seen as a way to address the growing deficit, former CMS Administrator Tom Scully said during a Sept. 23 panel discussion at the annual Medicare and Medicaid conference sponsored by the America's Health Insurance Plans trade group (see story, p. 3). Regardless of who wins the White House in November, "next year is going to be a complete wasteland," he told attendees. "The next administration isn't going to cut defense spending or Social Security, so what you have left is Medicare, Medicaid or new taxes to help address the deficit," he told attendees.

Contact Gorman at jgorman@gormanhealthgroup.com, Fronstin at fronstin@ebri.org, Munn at jeff.munn@hewitt.com, Kongstvedt at peter@kongstvedt.com and Rosenbaum at sarar@gwu.edu. ✧

SPECIALTY PRODUCT BRIEFS

◆ **As part of its commitment to "total employee health and wellness," Aetna Inc. said Sept. 24 that it will expand its Global Health Connections program to provide international members with additional resources to help manage their health.** The new offerings include enhancements to the insurer's maternity management program, as well as new weight-management programs. Aetna Global Health Connections program, which was launched in April, already features international disease management, maternity education and wellness education. Contact Stephanie Ancillai at AncillaiS@aetna.com.

◆ **Senior Care Action Network (SCAN), a not-for-profit health plan that serves Arizona Medicare enrollees, said Sept. 22 that it will expand its offerings in Maricopa County in 2009 with the addition of a new Medicare Advantage (MA) plan.** Medicare-eligible individuals in that county will be able to choose SCAN as their health plan during the upcoming Medicare open-enrollment season. The MA plan will be the third product offered by SCAN in Arizona. The company also offers a Special Needs Plan for Medicare beneficiaries enrolled in the Arizona Long Term Care System (ALTCS). Another product, SCAN Long Term Care, offers services to nearly 2,000 beneficiaries who are enrolled in the ALTCS program in Maricopa County. Benefit details on the new MA product will be announced on Oct. 1. Visit www.scanhealthplan.com.

◆ **Delta Dental Insurance Co. said this month that it has made its "value plans" available to small-to-midsized employers in Florida.** Employers with fewer than 300 employees can offer either a PPO program or a prepaid program. Either plan can be offered as an employer-sponsored program with varying levels of employee contribution, or on a voluntary basis, which means the employee pays the entire monthly premium. Other programs are available for larger employers. Delta Dental has offered benefits to small employers in Florida for several years, but the company says the new programs feature more affordable premiums. Florida is the first state in which Delta is offering the new plans, but new states will be added in the near future, the company says. Contact Elizabeth Risberg at erisberg@delta.org.

◆ **The new SureBlue health plan for small businesses announced this month by Blue Cross Blue Shield of Minnesota is designed to transition employees over a three-year period from traditional health plans to an account-based health plan.** The new plan will be available to small employers starting Jan. 1, 2009. The plan has a built-in three-year premium rate guarantee to protect employers from jumps in coverage costs. But to qualify, members must agree to participate in health risk assessments and make use of various wellness tools, including telephonic coaching. The tools are provided through Whole Person Health Support, the company's wellness program. Contact Jean Miller for Shawn Patterson at jean_m_miller@bluecrossmn.com.

◆ **Prime Therapeutics, a pharmacy benefit manager owned by Blue Cross and Blue Shield plans, said last month that it had completed a certification process with SureScripts-RxHub** that will allow prescribers using SureScripts-RxHub technology to send prescriptions electronically to PrimeMail, Prime Therapeutics' mail-order pharmacy. In 2007, PrimeMail processed nearly 3.6 million prescriptions, the PBM said. Meanwhile, WellPoint NextRx, the PBM unit of WellPoint, Inc., said that SureScripts-RxHub connectivity for e-prescribing is now available to physicians in Rhode Island through Blue Cross & Blue Shield of Rhode Island. Contact Chris Medici at chris.medici@bcbsri.org, Rob Cronin at rob.cronin@SureScriptsRxHub.com and Sheila Thelemann at SThelemann@primetherapeutics.com.

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Wyden-Bennett Bill Could Move in '09, Observers Say

A bill proposed by Sens. Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) has strong bipartisan support and wouldn't require additional federal funding, according to estimates released in May by the Congressional Budget Office (CBO) and the Joint Committee on Taxation. The proposal would not require additional federal spending and would generate savings after the first two years of implementation, according to CBO.

John Gorman, CEO of Gorman Health Group, LLC., says there already are enough votes in the Senate to push the bill forward, but it hasn't moved out of committee because the Democratic majority doesn't want to "hand Bush a victory during his last year in office," he contends. Paul Fronstin, senior research associate at the Employee Benefit Research Institute, agrees that the bill has broad bipartisan appeal and says "even though both [presidential] candidates have completely different [reform] plans, I can't imagine it would be vetoed by the next president, whoever it is."

Bill Would Alter Tax Benefits

The Healthy Americans Act (S.334) would require employers to convert the money they now spend on employee health coverage into salary increases. Employees would then have to purchase health coverage on their own through a state-run agency, which would operate as an insurance broker in each state. Those who don't enroll could face financial penalties. Under the bill, which is co-sponsored by a bipartisan coalition of 14 senators, anyone not covered by Medicare or the military would be required to purchase coverage through a private health insurer.

While health plans would not be allowed to deny coverage, "risk-adjustment systems" would compensate those that take on more financial risk than their competitors. People now covered through Medicaid or other state-sponsored programs would enroll in private health plans under the proposal.

A study released Sept. 17 by The Lewin Group determined that the bill, if implemented, also would reduce health coverage costs for enrollees. Lewin is a subsidiary of Ingenix, which is owned by UnitedHealth Group.

If an employee decides to purchase a lower-cost plan such as an HMO or a high-deductible plan that includes a health savings account (HSA), the individual retains the full amount of the [tax] savings," explains John Sheils, senior vice president at Lewin, who helped craft the bill. Employees, he adds, would no longer be limited to the coverage options offered by an employer, although employers would still be able to offer health coverage. Employers that have an aggressive wellness programs or a low-risk population, for example, might be able to save money by continuing to offer coverage to employees.

Under the proposal, low-income people could receive federal subsidies to purchase coverage, and some won't pay anything. Most enrollees would pay a "community-rated" premium, but premiums paid to the health plans would be risk adjusted.

"It's not like this will be easy, but I think this bill will stand where others fall because it is fully funded," Sheils says.

Legislation Is Called Too Radical

However, the Wyden bill, in its current form, would be more of a drastic change to the existing health care system than the strategies proposed by either Sen. Barack Obama (D-Ill.) or Sen. John McCain (R-Ariz.), says Kaye Pestaina, vice president of health compliance at The Segal Co. consulting firm.

And Ron Bachman, a senior fellow of the Center for Health Transformation and president of Healthcare Visions, Inc., says that the idea of changing the existing system of employer-based coverage is a bad idea. "I am very opposed to the Wyden bill and the removal of the employer tax benefit," he asserts. "The distribution through employers is an effective way to provide health coverage. I would rather see a system where individuals get the same tax benefits as employers."

While the Wyden bill is likely to generate some interest among lawmakers, it represents too radical of a change, says Henry Loubet, a senior vice president in the Oakland, Calif., office of Keenan & Associates. Loubet was CEO of UnitedHealth Group's West Coast operations between 1996 and 1999. "I just don't see it happening, he tells *HPW*. "The reality is that there are so many vested interests in health care that would need to agree to this. There also would be legal challenges. I see it as being a very daunting task."

Contact Mary Vander Leest for Shiels at mary.vanderleest@ingenix.com, Loubet at hloubet@keenan.com or Bachman at ronbachman@healthcarevisions.net.

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HEALTH PLAN BRIEFS

◆ **The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 passed the House of Representatives on Sept. 23 on a vote of 376 to 47.** The bill, H.R. 6983, sponsored by Patrick Kennedy (D-R.I.) and Jim Ramstad (R-Minn.), would stop health insurers from "placing discriminatory restrictions on mental health and addition treatments," according to a statement from Kennedy's office. The bill would end the disparities between mental health and medical benefits and allow covered individuals to receive the treatment they need, the office said. However, because the Senate passed a different version of the bills, lawmakers in the House and Senate will need to agree on a final bill to send to the president. Call Kennedy's office at (202) 225-4911.

◆ **The Maryland Health Care Commission (MHCC) on Sept. 22 released a report comparing the quality of PPO plans.** The MHCC said it compiled the performance report to show side-by-side results of HMOs and PPOs in the state. According to the commission, Aetna Inc., CareFirst BlueCross BlueShield, CIGNA Corp. and UnitedHealth Group voluntarily collected and reported PPO comparative data in 2008. In the report, Kaiser Permanente received the most above-average scores for its HMOs, and MAMSI Life had that distinction most often for PPOs. The report evaluates plans on clinical and member satisfaction measures. The free report, is available at www.mhcc.maryland.gov. Call Allie Gebhardt for MHCC at (301) 581-7293.

◆ **A new survey by The Regence Group concluded that consumers have difficulties understanding the "common concepts that describe their coverage."** The company, which operates Blues plans in Idaho, Oregon, Utah and Washington state asked 961 people with coverage to define terms and calculate their bill. Of the respondents, 60% answered correctly half the time, and only four in 100 answered correctly 80% of the time. Research following the survey also found that people were both too afraid and embarrassed to ask what words used in the survey meant. Robert Harris, who oversees Regence's market research, said in a prepared statement, "One thing we learned is that glossaries don't cut it.…Our industry must simplify our language to help people get full value from their health plan." The survey also found that people believe their health plan is the most trustworthy source of information on their insurance coverage and that 90% of insured persons thought they were adequately protected by their health plan. Call Regence spokesperson Angela Hult at (503) 412-7902.

◆ **Aetna Inc. said it added an independent external review feature on individual health plan coverage rescissions.** According to the insurer, the review allows individual enrollees facing rescission of their coverage to obtain an independent third-party review of Aetna's decision. The verdict, Aetna added, will be binding on the company. The panel will be conducted by "medical professionals from Boston-based MCMC LLC," which the insurer says has provided more than 1 million such reviews. Among all of the individual policies it has sold, Aetna says its rescission rate is less than 0.03%. The majority of its limited policy rescissions are due to insurance fraud — situations in which an individual "obtains a policy under false pretense" and lets the policy lapse after receiving medical treatment, the company said. Call Aetna spokesperson Mohit Ghose at (202) 297-6396.

◆ **America's Health Insurance Plans (AHIP) released a report finding that Medicare Advantage (MA) is an important coverage option for minority and low-income seniors.** That's according to the latest data from the Medicare Current Beneficiary Survey (MCBS), AHIP said. "These data underscore the value Medicare Advantage plans provide to low-income and minority beneficiaries," Karen Ignagni, president and CEO of AHIP, said in a prepared statement. Of all MA beneficiaries, 48% had incomes less than $20,000, according to AHIP. And 71% of the minority MA beneficiaries had incomes below $20,000. To view the Medicare Advantage data analysis, visit www.ahipresearch.org.

◆ **Kaiser Permanente on Sept. 23 showcased electronic health record (EHR) interoperability with the Department of Veterans Affairs (VA) and private-sector providers.** The plan, the VA and providers can share information through Kaiser's interoperable health information exchange, the health plan said. Kaiser said it demonstrated the tool with a virtual wounded soldier to show how providers "could safely and securely share sample medical history across multiple EHR systems." Call Kaiser spokesperson Alexandra Matisoff-Li at (510) 271-5624.

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