

Business News and Strategies for Health Plans, Pharma, Hospitals and Providers

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Initial Benefit-Design Changes May Lift Medical Costs Slightly; Wild Cards Remain

It seems likely that near-term changes to benefit designs required by the health reform law will push medical costs up by just a percentage point or two, say insurance executives, actuaries and consultants. But if HHS interprets the law's language more aggressively than expected, insurers and employers could find themselves on the hook for much higher medical costs this year and next.

Once HHS promulgates rules, small fully insured plans and self-funded employers likely will need to renegotiate reinsurance contracts. But for now, the best thing payers and plan sponsors can do is to remain conservative about what they promise to enrollees in terms of expanded benefits.

This year's changes include an end to pre-existing condition exclusions for children, an extension of dependent coverage to age 26 and the elimination of lifetime benefit limits. All take effect for plan years that start after Sept. 23, 2010, six months after enactment.

Taken together, the benefit-design changes are likely to drive costs up by a low-single-digit range, estimates Dave Tuomala, a director of actuarial consulting at Ingenix Consulting. And "most carriers probably would not try to do some kind of midyear [premium] change for this."

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MLR Provisions in Law Will Trigger Cost Reclassifications, Cuts; Regs Will Be Key

Of all the health reform law provisions affecting insurers, the ones with the least clarity and among the greatest potential impact are those setting minimum medical loss ratios (MLRs). And while the impact and timetable will be different for Medicare Advantage (MA) versus commercial plans, one thing is very much the same: Insurers will cut their administrative costs, whether by actual expenditure chopping or reclassification — which already has started — or both.

Several analysts contend that many insurers will cut sales commission rates to reduce the administrative percentage of costs to comply with MLR requirements, but others disagree or say it will vary dramatically by market. One observer says carriers' advertising expenses could be a casualty. Many say that others will do what WellPoint, Inc. did recently and reclassify expenses for nurse hotlines and disease management programs as medical instead of administrative.

But all consultants and securities analysts queried by *HRW* agreed on a couple of things. The first is that it is impossible to fully assess and plan for the impact of the MLR rules until HHS clarifies how MLRs will be defined under the law in terms of what qualifies as medical costs and how MLRs will be measured (e.g., on a state-by-state basis versus planwide or companywide). An MLR essentially is medical expense divided by premiums, but what goes into that numerator is at issue. The second point of agreement is that the potential impact of MLR provisions on earnings is likely to be significant, especially for commercial plans. A report released by the Senate Commerce

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Committee April 15 underscored that, since it found most big publicly held insurers now have substantially lower MLRs than the benchmarks in the law.

The basic MLR provisions in the law are separate for commercial versus MA plans. Beginning in January 2011, commercial plans will have to report and maintain a minimum 85% MLR for large-group business and 80% for small-group and individual business. For MA plans, the minimum MLR is 85%, but it doesn't start until 2014. All plans exceeding the benchmarks must rebate the difference. However, the additional MA penalties are particularly onerous: a one-year suspension for enrolling new members if the MLR is less than 85% for three successive years and loss of the MA contract if the MLR falls short of that threshold for five consecutive years.

HHS Sec. Kathleen Sebelius (a former Kansas insurance commissioner) has said the department intends to issue implementation regulations for MLR "as soon as possible," and has sought input from the National Association of Insurance Commissioners, insurers and other stakeholders (see brief, p. 8).

In MLRs as in many other parts of the reform law, "the real game is with the regulations," says consultant

Robert Laszewski, a former health insurance executive who is president of Health Policy and Strategy Associates.

Those officials preparing the MLR regulations, he tells *HRW*, need to be careful that they don't spur insurers to do away with disease and medical management programs that can lower future medical costs by lumping them in with administrative expenses.

On the other hand, the recent step taken by WellPoint to reclassify such expenses, including wellness programs, as medical and thereby raise its MLR outlook for 2010 by more than 1% also raises questions, according to Laszewski. Insurers themselves shouldn't be allowed to define what's in an MLR, he asserts.

Some insurers themselves, though, already have faced MLR definition issues because of state regulations. New Jersey, for example, requires small-employer and individual-coverage MLRs of at least 80%, up from 75% in 2009, notes Robert Meehan, vice president, consumer and senior markets at Horizon Blue Cross Blue Shield of New Jersey. Moreover, "New Jersey has had a history of changing the definition of what's allowable and what's not" in MLR calculations, he tells *HRW*. It's "very controversial because when you have a staff-model HMO, all administrative expenses get included as claim expenses," giving those plan models a distinct advantage over traditional insurers such as Horizon.

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MLR Rule May Lower Brokers' Commissions in Individual Market

If insurers' medical loss ratios (MLRs) fall below the required floor levels, they may seek to add items like quality management and taxes to medical costs or cut commissions to increase the ratio.

Individual Market	
Initial Medical Loss Ratio (MLR)	63-68%
Include Quality/Disease Management	65-70%
Include Taxes/Fees	68-73%
MLR Floor	80%
Margin MLR Shortfall	7-12%
Original Broker Commissions	13-18%
Assumed Post-Floor Commissions	1-11%
Small-Group Market	
Initial MLR	76%
Include Quality/Disease Management	78%
Include Taxes/Fees	80-81%
MLR Floor	80%
Margin MLR Shortfall	0-1%
Original Broker Commissions	7%
Assumed Post-Floor Commissions	6-7%
SOURCE: Christine Arnold, Cowen and Co., March 26, 2010.	

He adds that other critical elements in the federal regulations will include time periods (the shorter the period, the more the fluctuation in MLRs from period to period) and the level (e.g., local plan versus parent company) for which allowable MLRs are calculated.

State MLRs Could Cut Profits

It is the latter issue that particularly concerns securities analyst Carl McDonald of Oppenheimer & Co. "The problem for the industry is that each plan seems to have at least one market where they are extraordinarily profitable," he wrote in an April 8 report to investors. "If the minimum MLR is applied on a state by state basis, which we think is likely, all of that excess profitability disappears."

He contends that multistate plans will have a tough time meeting minimum MLR requirements in all markets, noting the big variations now (see table, this page). Assuming statewide MLR standards application and even assuming insurers have the ability to increase the MLR five percentage points by reclassifications, "we estimate the average company will see earnings negatively impacted by 5% or more in 2011," McDonald predicts. He says that the law effectively caps profit margins of health insurers and penalizes them for pricing above their medical-cost trend by requiring annual rebates to members if the carriers exceed the allowable MLRs.

What then should insurers do about it? Along with care-management expenses, insurers could reclassify portions of health care IT spending as medical and could exclude premium taxes from revenues, McDonald says.

Insurers also are likely to slash broker sales commissions in the individual market and make minor cuts to them in the small-group market, maintains Christine Arnold, a securities analyst at Cowen & Co. Her rationale (see table, p. 2) is that the MLRs are relatively low (even after adjustments for care

management costs and taxes) and commissions high in the difficult individual market. But she cautions that this will be "no easy feat."

Laszewski has a slightly different view. Commission cuts, he says, will depend on what is in the forthcoming MLR regulations. If insurers wind up with a half- or one-point gap to meet the minimum required MLR, "broker commissions are likely to be at the top of the list" of administrative expenses to reduce, he maintains. This may also occur in the MA market, particularly since plans in that sector will incur big payment cuts, he adds, even though MA plan MLRs now typically are close to the 85% level mandated for 2014 and beyond.

Commission-cut decisions are likely to vary among MA insurers on a plan-by-plan basis, says Pat Dunks, a principal and consulting actuary at Milliman. He points out that some MA plans don't even use brokers and contends that while some cuts in MA commissions (which already are capped by CMS) could occur, non-MA sectors stand to get hit harder on commissions.

For most MA organizations, Dunks tells *HRW*, the 85% MLR requirement "isn't going to be a huge deal." He complains, though, of the one-sidedness of the requirement. If an MA plan has a poor year, "nobody gives you anything back.... They've taken away the upside" since if plans perform better than targeted, they have to give the excess back.

He cites a specific problem for the MA plans. Since their bids for the next year are due to CMS in June, they must assess "political things" beyond their control, such as this year what Congress will do about scheduled Medicare physician payment cuts. If plans are conservative in their forecasts and they wind up doing better than expected, Dunks says, they could trip over the MLR provision once it takes effect.

At what level and on what period of time an MLR requirement is applied makes a big difference to national

WellPoint's MLR Varies Substantially by Market

Plan	Lives	Member Months	PMPM	Premiums	Medical Expense	MLR	Refund per Statutory Entity	Refund per Statutory Entity Assuming 200 Basis-Point SG&A to MLR Shift
Individual	2,217,069	26,926,420	\$181.24	\$4,880,023,522	\$3,574,289,574	73.2%	\$357,927,683	\$283,056,468
Small Group	2,080,688	25,487,615	\$289.10	\$7,368,383,914	\$5,829,360,933	79.1%	\$205,310,989	\$118,660,485
Large Group	7,284,798	88,348,097	\$213.87	\$18,895,159,820	\$16,041,635,980	84.9%	\$328,832,909	\$168,323,409
Total	11,582,555	140,762,132	\$221.25	\$31,143,567,256	\$25,445,286,487	81.7%	\$892,071,581	\$570,040,362

PMPM = per member per month. MLR = medical loss ratio. SG&A = sales, general and administrative costs.

Note: Figures reflect WellPoint's 2008 financial results for the commercial market excluding California.

SOURCE: Company reports and Oppenheimer & Co. analysis, April 2010.

MA carriers, according to Dunks. The more variation they have from location to location or year to year, he explains, the more likely they are going to have to rebate. Thus, a rolling average would be better than a one-year basis to smooth out variations, he says, adding, however, that Congress' intent in this regard is "unclear."

Actuary Brian Weible, a principal in Wakely Consulting Group, says he assumes the intent is a rolling average, but even that leaves questions about whether claims should be summed up and averaged over the entire period. MLRs for MA plans will be calculated at the plan level, he theorizes, since that's how they operate on contracts.

He sees several kinds of questions and inequities resulting from the MLR requirements. For instance, he tells *HRW*, medical management is considered a medical cost if a salaried employee of a provider performs it, but it may be an administrative cost if an MA plan does it. Moreover, medical costs vary a lot from location to location while administrative costs don't vary nearly as much, Weible says.

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Private, Public-Sector Programs Show What to Expect on ACO Rules

Provider groups gearing up to participate in the Medicare Accountable Care Organization (ACO) pilot programs created in the new health reform law face a daunting task of preparing. That's because even though the programs start in January 2012, CMS is nowhere close to issuing the regulations defining how performance will be measured or savings computed and shared with providers, and says it can't even discuss those topics yet. But there are some recent public- and private-sector programs that give a good idea of what to expect, experts say.

One clear implication is that the law's ACO provisions "massively" favor multispecialty physician practices not associated with hospitals, Francois de Brantes, CEO of Bridges to Excellence, tells *HRW*. His private-sector organization now operates in 13 states and has paid \$12.4 million to providers through programs with financial incentives to deliver safer, more effective and efficient care.

At least initially, ACOs probably will use claims-based measures and will measure savings based on a three-year trend, with the precise terms perhaps negotiated individually between CMS and each ACO to account for geographical and other differences, Larry Kocot tells

HRW. A former top CMS official, Kocot now is deputy director of the Engelberg Center for Health Reform at the Brookings Institution, which has been co-sponsoring a private-sector ACO initiative that influenced the ACO provisions in the reform law.

The statute, which authorizes ACOs in fee-for-service Medicare, defines them as provider-based organizations comprised of multiple levels of providers and responsible for the full continuum of care. They are held accountable for overall costs and quality of care and share in the savings from it. The statute lists certain provider entities as eligible to participate (e.g., group practices, networks of individual practices, physician-hospital organizations and integrated delivery networks), but also allows for other groups that the HHS secretary deems appropriate.

The statute does not spell out performance measures, expenditure benchmarks, how savings would be measured, savings thresholds to qualify for payments, or even the portion of savings ACOs would get. And CMS spokesperson Peter Ashkenaz tells *HRW* "it's too early for us to discuss any of this."

With little concrete detail, the first step for provider entities wanting to participate in the new ACOs is to measure current and historical Medicare spending, and recognize that the reform law provides no new money to pay for the ACO program, says Douglas Hastings. A frequent speaker at ACO conferences, Hastings chairs the board at health care law firm Epstein Becker & Green. Then, he says, the government needs to set target savings levels and a formula for splitting savings if those targets are achieved.

While he cautions there is no basis for saying the CMS rules will come out this way, Hastings notes that an ACO project involving the Brookings Institution, the Dartmouth Institute for Health Policy and Clinical Analysis and hospitals gives 80% of the savings to providers.

ACOs under the new law, he points out, will need to have enough primary care physicians to deliver care to at least 5,000 Medicare beneficiaries. The law doesn't specify payment methodology for the program but does allow use of partial capitation arrangements.

He says ACOs should expect to be measured on the basis of patient outcomes and satisfaction as well as cost efficiency.

Expect Use of Claims Data to Measure Quality

Specifically, says Kocot, providers should expect claims data to be used in such quality measures as cancer screening, depression follow-up and management, testing for hemoglobin A_{1c} and lipid levels, testing for appropriate use of high-risk medications, and timely outpatient follow-up for congestive heart failure (CHF) patients. It is not yet known, he says, whether just process measures as opposed to actual results will be used as quality measures.

Kocot contends although "some ACOs will fail," successful ones could share in significant savings, based on factors such as the results of the recent Medicare Physician Group Practice (PGP) demonstration program. After three years, he notes, all 10 participating sites in the PGP met quality goals and, in the third year, five of the 10 met savings goals and reaped a total of \$25 million in rewards.

For physician groups, the steps needed under an ACO-type structure are clear and measurable, suggests de Brantes. They include avoiding hospitalizations, emergency department visits, and unnecessary use of specialists and diagnostic services, plus improving outcomes on patients with chronic illnesses, he says. With CHF patients, he adds, the bulk of expenditures may be on avoidable hospitalizations, so that groups preventing these can save "real money."

The ACO language "seems to be implying some sort of gain-sharing," de Brantes asserts, adding "whether it's 50-50 or 60-40, I don't know." He notes that in the PGP, which involves very large groups, it has been 50-50.

For hospitals, measuring and compensating for performance in an ACO is "tremendously challenging," he contends. The scope of services is far greater, he explains, and you're dealing with inpatient, acute medical and even outpatient services if the hospital has a clinic. Computing savings becomes "very tricky" since you have to assess such things as what should be the prevalence of

knee replacements and strokes. There might be 500 or more measures, says de Brantes.

There are issues even for multispecialty group practices, de Brantes adds. If the group is already doing well, according to de Brantes, it may be hard to achieve additional savings. And practices tied in with hospitals may have another issue since the revenue gain of a small reward stemming from cutting hospital utilization may be dwarfed by the loss of hospital revenue.

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Ounce of Prevention Will Boost Rates Now, May Cut Future Costs

A provision of the reform law that requires first-dollar coverage for preventive services will mean additional benefits for some people — particularly those enrolled in bare-bones individual and small-group plans — but will cause premiums to tick up slightly.

Premiums for products that don't now include preventive services could increase by 3% to 4%, while premiums for plans that now require a copayment for preventive services will likely go up by 1% to 2%, predicts Jeffrey Kang, M.D., chief medical officer at CIGNA Corp. While premiums will rise in the short term, the long-term effect of the provision could be a decrease in preventable

For Some Hospitals, New Charity-Care Policies Already Took Effect

Some nonprofit hospitals are scrambling to comply with new requirements for patient financial assistance, collections and charges mandated by the health reform law. In fact, since the provisions apply to fiscal years beginning after March 23, hospitals whose tax years started April 1, 2010, must already be in compliance.

Among the requirements of Section 9007, nonprofit hospitals must have a written financial policy, including eligibility criteria for financial assistance and the methodology used to calculate amounts charged. Patients who qualify for assistance must not be charged more than the "amounts generally billed" to insured patients. And hospitals must first determine whether patients are eligible for assistance before using "extraordinary collection actions."

The most time-consuming requirement for hospitals is adjusting the amounts to be charged to patients eligible for assistance, says Don Stuart, a Nashville, Tenn.-based partner at law firm Waller Lansden Dortch & Davis LLP. That's "because of the systems that they

have in place for billing," he tells *HRW*. Some hospital financial systems that now charge uninsured patients gross charges must be adjusted to charge the amount "generally billed" to insured patients. "You need quite a bit of a time frame in order to incorporate that into a hospital system," he says.

Many hospitals already have written financial-assistance policies, he says. Others "may need to revise some policies or change some requirements and standards."

The IRS is charged with verifying that requirements are met, Stuart says, since noncompliant hospitals could lose their tax exemption. He says the IRS probably will revise the 2010 version of Form 990, particularly Schedule H, which gathers data about hospitals' charity care and community benefit. The IRS also will issue further guidance on areas such as what qualifies as "extraordinary collection actions."

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chronic diseases, which would help to bend the cost curve, says Frederic Goldstein, president of U.S. Preventive Medicine, Inc., a vendor of primary, secondary and tertiary prevention and care advocacy programs. What's more, a health insurer that can boast high preventive-services compliance among its members might gain a competitive edge as employers continue to focus on ways to improve the health of their employees, he tells *HRW*.

Along with mandating coverage for all immunizations recommended by the CDC, the law requires preventive services outlined by HHS's U.S. Preventive Services Task Force (USPSTF) with an A or B rating to be covered. For plan years that begin on or after Sept. 23, 2010, new policies must provide coverage — without cost sharing — for those preventive services and screenings for adults, infants and children. Health insurance plans in operation as of March 23, 2010, don't have to comply with the provision until Jan. 1, 2014, although final rules could alter those schedules.

Although Blue Cross and Blue Shield of Florida already includes first-dollar coverage for many preventive services, the new provision will expand that. And it's unclear what impact compliance will have on premiums or utilization, says Randy Kammer, vice president of regulatory affairs and public policy. "Initially, you need to make some guesses [about utilization] for different populations, and then you have to do some pricing," she explains. "Our biggest challenge is to understand the scope of it and the impact it will have on premiums."

While numerous health insurers already provide coverage for many preventive services, the key difference is the elimination of cost sharing. And that change could cause some administrative headaches for health insurers, notes Justine Handelman, executive director for legislative and regulatory policy at the Blue Cross and Blue Shield Association.

Plans, Providers Must Boost Utilization

Despite the inclusion of preventive benefits, there is no guarantee that members will suddenly seek recommended tests and services. To change that, health plans, employers and physicians will need to educate the population about the advantages of preventive care, says Robert Gould, Ph.D., CEO of advocacy group Partnership for Prevention.

About 75% of CIGNA's employer clients now offer first-dollar coverage for preventive benefits, and 100% of CIGNA's account-based health plans cover preventive care outside of the deductible. Despite that, utilization of preventive services hovers at about 60%.

For employers, the return on investment (ROI) could be substantial. In-house wellness programs, for example, average more than \$3.25 for every \$1 spent, according to

a January article in the journal *Health Affairs*. The savings come from reduced medical expenses, fewer disability claims and increased productivity. But "sometimes the ROI can be two or three years out...so there is some risk that someone could leave [the health plan] before that ROI is realized," says Kang.

Industry observers say HHS needs to clarify several issues. It's unclear if all of the recommended screenings will need to be covered across the board or just for certain populations. Sickle cell anemia screening, for example, makes sense only for African American enrollees. Michael Parkinson, M.D., former president of the American College of Preventive Medicine, says it's likely that health plans will need to offer age- and gender-specific packages of evidence-based services that mirror the USPSTF guidelines.

Here are three key questions HHS needs to answer:

(1) **Immunizations:** Can health plans require a copay for an office visit while covering the vaccine itself at 100%?

(2) **When is a plan "new"?** It's unclear whether a renewed plan will be considered "new" under this provision, or grandfathered as an existing plan.

(3) **Are preventive drugs included?** HHS will need to clarify whether health plans must also cover so-called "preventive drugs" (e.g., statins for hyperlipidemia, antihypertensives, diabetic drugs), says Parkinson. Some observers tell *HRW* that drugs likely won't be included. And few drugs are preventive 100% of the time.

"Health insurers will have to redouble their efforts to insure that consumers, [physicians] and their staffs and employers understand what's in the [new] benefit and what's not and why," Parkinson tells *HRW*. "Appropriate coding will need to be emphasized and communicated to all stakeholders....Old practices die hard."

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Impact of First Changes Is Small

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But that's if the regs are written as expected. For example, some uncertainty still surrounds the ban on pre-existing condition exclusions in children's coverage.

Of the benefit-design provisions taking effect this year, "I think that's the one we've been seeing the most concerns about," Tuomala says. "The concern is that that will be interpreted very broadly and require insurers to take all children," he explains — say, a 25-year-old with

massive health issues, even though the parent does not hold a policy. Payers are worried that “the rules that come out are far more expansive — and then we’ll need to quantify...[whether they] require increases in the rates that we weren’t anticipating.”

HHS Sec. Kathleen Sebelius clarified the law’s intent in a March 29 letter to America’s Health Insurance Plans, explaining that “children with pre-existing conditions may not be denied access to their parents’ health insurance plan,” and “insurance companies will no longer be allowed to insure a child, but exclude treatments for that child’s pre-existing condition.” She promised to issue rules “in the weeks ahead” outlining requirements.

Sebelius’s letter was reassuring in that it suggests health insurers will have “probably limited exposure,” Tuomala says. It appears that the reg will apply only to dependents added to existing policies, Tuomala says — for example, a policyholder with family coverage who has a dependent under the age of 26 who was not covered, because he or she either had aged off previous insurance or had a pre-existing condition. “For someone who aged off because the prior limit was age 22, to now put them back on is not really a big deal.”

Insurers in many states also will have to follow both federal and state rules. For example, New Jersey’s dependent-coverage law goes up to age 31, but unlike under the new federal law, dependents must pay a separate premium, says Robert Meehan, vice president, consumer and senior markets at Horizon Blue Cross Blue Shield of New Jersey. “If you’re 28 or 29, the New Jersey legislation will still be of value to you. If you’re under 26, the federal law will be better for you because there’s no separate premium,” he explains.

Firms Wait on Dependent Contribution Regs

Self-funded employers also are anxiously awaiting guidance on dependents, and are fielding a high volume of inquiries on that provision from employees. The problem is that until guidance comes out, it’s unclear “what sort of contribution structure you can establish,” says Dean Hatfield, national health practice leader at Sibson Consulting, a division of The Segal Group, Inc., such as creating a separate rate tier or charging 100% of premiums for adult children.

For now, Sibson is advising self-funded employers to be conservative in their budget assumptions and in communications with employees. Most self-funded employers will not have to comply until Jan. 1, 2011 — and some may delay open-enrollment periods if it takes too long to finalize benefit designs and publish communication documents.

The elimination of lifetime maximums likely will have only a “modest effect,” adding more risk “some-

where on the order of 1% to 2%” of medical costs, Tuomala says.

The reform law requires health insurers to eliminate the use of lifetime limits for plan years that start after Sept. 23 (employers that follow a calendar plan year have until Jan. 1, 2011). The law allows a “restricted annual limit” until 2014, but the HHS secretary “shall ensure that access to needed services is made available with a minimal impact on premiums.”

Almost 60% of health plans have a lifetime limit, and about 43% of them have a \$2 million limit or greater, Hatfield says. With lifetime limits of \$2 million to \$5 million, “it’s relatively uncommon that people exceed that,” Tuomala says.

Lack of Data on Lifetime Costs Is Problem

One complicating factor is that despite the wealth of claims data, plans have little information on true lifetime costs for some very costly conditions for which new treatments are available, warns Peter Kongstvedt, M.D., a consultant and principal of P.R. Kongstvedt Co., LLC. For example, the newer, safer recombinant clotting factors for hemophilia are very expensive, but have been on the market only for a few years. “The dilemma that plans face is, are they going to have enough credible data to be able to go back and change rates?” he asks.

Small health plans and self-funded employers, however, will see higher costs immediately because of the need to purchase additional reinsurance to cover any costs employees or dependents may incur above the previous \$2 million to \$5 million limit.

Suppose an employer with a \$1 million lifetime limit assumes full risk for per-employee lifetime medical costs up to \$200,000, but purchases reinsurance for costs between \$200,000 and \$1 million, Hatfield says. Once the lifetime limit is eliminated, “then it comes down to [the reinsurer’s] actuaries determining how many people do you think...are going to exceed the million-dollar threshold?” It probably is not many, he says, “but it still could happen, so they will adjust their rates based on what they think is the added risk that they’re taking on.”

Hatfield estimates that reinsurance premiums will rise “about 1% — maybe less. It might be a little bit more.” The actual rise depends on the demographics of the employer’s covered population. “For example, if you have a population that has a lot of young females that is in a location where maybe there are a lot of premature babies,” that would drive up reinsurance premiums.

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HEALTH REFORM BRIEFS

◆ **Two proposed rules published in the April 14 Federal Register call for comments on the medical loss ratio (MLR) and premium review provisions of the health reform law.** HHS, IRS, the Treasury and Labor departments and the Employee Benefits Security Administration requested comments on the MLR rule (see story, p. 1), adding that they are "especially interested in the perspectives of health insurance issuers and states." Among other areas, the departments are seeking comments on factors that contribute to fluctuations in MLRs, how MLR methodologies used by states and insurers compare, how MLRs are calculated for newer and smaller plans; how states treat activities that improve health care quality, how MLR data should be aggregated; and methods used by states to enforce MLR requirements. HHS also is seeking comments on the premium review rule, including methodologies used by states that now review rate increases, data used by insurers to justify increases, and how justifications should be made public. Comments are due by May 14 and may be submitted at www.regulations.gov. View the MLR notice at tinyurl.com/y2p9ska and the premium review notice at tinyurl.com/y2vxxgd.

◆ **In their first-quarter 2010 earnings reports, some drug makers attached billion-dollar price tags to the higher government rebates required by the reform law.** The law boosts the mandatory Medicaid rebate from 15.1% to 23.1% of the average manufacturer price, retroactive to Jan. 1, 2010, and extends rebates to health insurers that manage Medicaid programs, effective March 23, 2010. Johnson & Johnson estimated April 20 that 2010 revenue would fall \$400 million to \$500 million as a result of reform, "approximately 3% of our 2009 [U.S.] pharmaceutical sales," according to J&J CFO Dominic Caruso. J&J had \$61.9 billion in 2009 revenues. Caruso estimated that the pharmaceutical industry as a whole would see revenue fall by \$4 billion in 2010, or 2% of the U.S. branded pharmaceutical market, as a result of the higher rebates. Eli Lilly & Co. on April 19 estimated that higher rebates would lower 2010 revenue by \$350 million to \$400 million. That company posted \$21.8 billion in 2009 revenue.

◆ **UnitedHealth Group raised eyebrows when it reported April 20 that its UnitedHealthcare commercial unit had a first-quarter 2010 MLR of 79.1%, down from 81.5% for the same period in 2009.**

Starting this year, insurers will have to report MLRs, and in 2011 will have to pay rebates to consumers if the percentage falls below 80% for individual and small-group segments and 85% for large groups. CFO G. Mike Mikan defended the MLR during a conference call to discuss first-quarter 2010 financial results. "We expected a slight decrease in that loss ratio in 2010 with no expected H1N1 flu," Mikan said. "Our business is seasonal. Our loss ratio within the commercial business increases over the year, especially into the fourth quarter where we expect that as deductibles wear off that utilization will increase," he explained. The insurer estimated a full-year 2010 MLR of 83.5%. Visit www.unitedhealthgroup.com.

◆ **HHS on April 19 said it created a new Office of Consumer Information and Insurance Oversight** to provide "leadership for implementing the provisions of the health reform bill that address private health insurance." Divisions include Oversight, which will perform premium rate reviews and enforce compliance with insurance market and MLR rules; Insurance Programs, which will administer the temporary high-risk pool and early-retiree reinsurance programs; Consumer Support, which will compile and maintain comparative premium price data and provide assistance to consumers; and Health Insurance Exchanges. View the notice at tinyurl.com/y76ffg3.

◆ **UnitedHealth Group, Kaiser Permanente, Humana Inc., WellPoint, Inc. and other Blue Cross Blue Shield plans are among those health insurers that have agreed to expand dependent eligibility ahead of the September deadline.** Under the health reform law, most children under the age of 26 may remain on their parents' policies — but that provision doesn't take effect until the renewal date for plan years starting Sept. 23, 2010. Beginning June 1, WellPoint said, it will allow students who would age off their parents' fully insured individual and group policies to remain on them. Self-funded employers may choose not to offer the extended coverage, WellPoint added. UnitedHealth said it would adjust eligibility ages for fully insured health plans offered through its UnitedHealthcare subsidiary to extend coverage for graduating college students. HHS Sec. Kathleen Sebelius said she expects other insurers to make similar changes to eligibility structures. View the WellPoint statement at tinyurl.com/y7wrnzj and the United statement at tinyurl.com/y6vyo8o.

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