said, also make it impossible for smaller competitors to enter the market.

"I would recommend that Congress take a look at those types of clauses and outlaw them…plain and simply outlaw them," he asserted.

Rendell also said that the state insurance commissioner should be allowed to regulate health coverage rates, and he called for an end to rating systems used by some health plans to determine coverage rates based on possible risk. "Small businesses in many states get killed by the rating system," he asserted. "If you have 10 employees, and two 28-year-old men leave and you replace them with two 25-year-old women, your [health coverage] rates, unless they are controlled, will spike through the roof because those women are of child-bearing age and are potential risks. Many states, including Pennsylvania, still allow health plans to use such demographic ratings." Rendell said he would like to require that criteria for ratings be limited to age and geography.

Rendell used the hearing as an opportunity to tout his proposed Cover All Pennsylvanians (CAP) program, which he told committee members would dramatically reduce the number of uninsured in the state by offering subsidized coverage to small employers and individuals. Between 2000 and 2007, Rendell said, nearly 500,000 state residents had lost health coverage that previously had been offered through an employer. Between 1996 and 2005, the cost of employer-sponsored family health coverage grew from $4,800 a year to $11,400, he added.

The "stripped-down" coverage, he said, would include preventive care, hospitalization, generic drugs and mental health care services, and would be subsidized by a combination of federal and state dollars. Employers would be required to pay $130 per month per employee, and most workers would pay monthly premiums of between $40 and $60 based on household income. Families earning less than 150% of the federal poverty level would not pay, he explained.

"We believe that this will cover everyone who works for a small business and low-wage businesses," Rendell told the committee. "All insurers in the state would be required to offer the product without the subsidy." CAP, so far, has received a lukewarm reception from health plans in the state *(HPW 10/1/07, p. 1).*

For more information, visit www.house.gov/smbiz/democrats/PressReleases/2008/pr-02-26-08-healthcare-govs.htm. To see highlights from the hearing, visit www.youtube.com/watch?v=QgiLiiJLQec&feature=PlayList&p=D408F73549A33FAF&index=0. ✧

Health Plans Urged to Use RFPs To Extract Better PBM Rx Pricing

Health plans and other pharmaceutical payers could reduce their pharmacy benefit spending by 10% to 30% if they used the request-for-proposal (RFP) bidding process to extract airtight contracts from competing pharmacy benefit managers (PBMs), asserts one consultant. Because of the flawed RFP process today, a winning PBM's promises and pricing projections almost never materialize in the final contract, says Linda Cahn, president of Pharmacy Benefit Consultants.

In a series of free informational videos posted recently on the Internet, Cahn contends that consulting firms — which are hired by Rx payers to evaluate competing PBM bids — fail to use the leverage of the RFP to draft, negotiate and execute airtight PBM contracts. Consultants contacted by *HPW* agree that the RFP process could be improved upon, but some take issue with Cahn's assertions. Among other things, she says that many consulting firms:

◆ ***Have "terrible undisclosed conflicts of interest" with PBMs.*** "Unbeknownst to the health plans, many consulting firms are collecting large amounts of money from certain PBMs," Cahn says in a video;

◆ ***Fail to seek information from PBMs that can be verified.*** "For example, most questioners ask, 'What is your PBM accuracy rate?' Not surprisingly every PBM contestant in virtually every RFP, knowing the answer can't possibly be verified, answers 99.9999%," she says.

◆ ***Never require any PBM to bind itself to provide the projected drug prices in the final contract.***

◆ ***Select the finalist before the actual PBM contract has been negotiated.*** "In fact, most consulting firms don't

even discuss a single contract term with any PBM contestant during the RFP," she contends.

"Everything about your prescription coverage flows from your prescription contract," says Cahn, an attorney who in the late 1990s sued some of the largest PBMs over their business practices. First, plans should require consultants to disclose any conflicts of interest, she says. The plan can then require its consultant to distribute a draft contract — which eliminates all loopholes — to the PBM contestants. Each PBM fills in the blanks with binding contract prices and guarantees, she says. The process is repeated, with each round of negotiations extracting better contract terms and prices.

Alliance Coal, LLC, a self-insured mining company with roughly 7,500 members, used Cahn's RFP approach last spring. The process resulted in the company switching from Express Scripts, Inc. to much smaller PBM Envision Pharmaceutical Services, Inc. That contract started Nov. 1, 2007. Alliance already is seeing significant savings, says Paul Mackey, the company's general manager of human resources benefits. "We're well on track to get some of our projections," he says. "It's safe to say it is going to be more than 10%, and that's very conservative."

Some other consultants say they take a similar approach to the RFP process. Sean Brandle, national pharmacy leader at The Segal Co., says that his consulting firm not only sends out a bid document to contestants, but also requests that each PBM send in a signature-ready copy of a contract that the client could sign. After an analysis of the bids and the contracts, Segal will say to its client, "The best contract really came from XYZ. It gives you the most benefits," he explains.

Brandle also stresses that there are certain things a client must do to have a successful relationship with

Fourth-Quarter 2007 Financial Results of Publicly Traded Managed Care Companies (for the period that ended Dec. 31, 2007)

	Net Income (Loss) for Fourth-Quarter		Fourth-Quarter Income (Loss) per Diluted Share for		Medical Enrollment on Dec. 31,		Fourth-Quarter Medical-Cost Ratio for		Fourth-Quarter Administrative-Cost Ratio for	
	2007	2006	2007	2006	2007	2006	2007	2006	2007	2006
Aetna, Inc.	$448.4 million	$434.1 million	$0.87	$0.80	16.8 million	15.4 million	79.2%[1]	79.8%[1]	19.0%	19.4%
AMERIGROUP Corp.	$31.1 million	$29.9 million	$0.57	$0.56	1.7 million	1.3 million	82.9%	80.4%	13.1%	14.2%
Assurant, Inc.	$120.8 million[2]	$252.5 million[2]	$1.01	$2.01	871,000	935,000	62.0%[3]	63.3%[3]	29.5%[3]	30.3%[3]
Centene Corp.	$14.7 million	$13.8 million	$0.03	$0.31	1.4 million	1.3 million	84.0%	82.1%	14.3%	12.8%
CIGNA Corp.	$263 million	$232 million	$0.93	$0.76	10.1 million	9.4 million	84.6%[4]	83.9%[4]	27.3%[5]	26.3%[5]
Coventry Health Care, Inc.	$184.3 million	$156.1 million	$1.18	$0.97	4.0 million	2.5 million	78.1%[6]	78.3%[6]	18.1%	13.0%
HealthSpring, Inc.	$26.2 million	$20.1 million	$0.46	$0.35	153,197[7]	143,000	78.1%[8]	79.6%[8]	11.7%	14.5%
Health Net, Inc.	$123.4 million	$84.8 million[8]	$1.10	$0.76	6.6 million	6.3 million	82.6%[9]	82.9%[9]	10.5%	13.3%
Humana Inc.	$243.3 million	$155.0 million	$1.43	$0.92	7.9 million	7.7 million	80.3%	83.2%	16.0%	14.7%
Molina Healthcare, Inc.	$17.9 million	$10.7 million	$0.63	$0.38	1.1 million	1.1 million	83.6%	85.1%	11.8%	11.1%
UnitedHealth Group	$1.2 billion	$1.1 billion	$0.92	$0.84	27.9 million	28.6 million	79.9%[10]	80.0%[10]	14.4%	15.0%
WellPoint, Inc.	$859.1 million	$801.1 million	$1.51	$1.28	34.8 million	34.1 million	82.9%	81.0%	13.8%	15.7%

1 Ratio is for all medical and dental risk products.
2 Includes $27 million of after-tax realized losses from other than temporary impairments in the investment portfolio. Includes a $63.9 million after-tax gain from the sale of Private Healthcare Systems, Inc. and $40.5 million of after-tax income from a legal settlement.
3 Ratios are for Assurant Health only.
4 Ratios are for commercial risk products, excluding voluntary/limited benefit business.
5 Ratios are for CIGNA HealthCare business unit.
6 Ratios are for health plan business only.
7 HealthSpring acquired Leon Medical Centers Health Plans on Oct. 1, 2007. As of the acquisition date, the health plan had approximately 25,800 members.
8 Ratio is for Medicare products only
9 Ratios exclude TRICARE enrollment
10 Ratio is for all risk-based business and products

NOTE: WellCare Health Plans, Inc. was omitted from this table because it has delayed reporting full financial and operating data for the fourth quarter of 2007 in light of an ongoing investigation by federal and state agencies. Sierra Health Services, Inc.'s fourth-quarter 2007 financial data had not been released as of *HPW*'s press time. Sierra's acquisition by UnitedHealth Group was approved on Feb. 25.

SOURCE: Compiled by Atlantic Information Services, Inc. from company financial reports.

a PBM. "And I don't think that you can really achieve that in the long run by just mandating," he says. Brandle contends that plans have to work with them in such areas as clinical capabilities, formulary management and customer service. These are "a lot of hard-core things that can cause real problems for clients," he asserts.

On the issue of conflicts of interest, Brandle says that Segal does not receive payments from PBMs. "We know that some of our competitors do have arrangements," he adds. For example, some consulting firms charge a bidders' fee that the winning PBM pays to the consultant. "It's important that those types of payment arrangements be disclosed," Brandle says.

To view the video, visit www.youtube.com/watch?v=H-4LJeyjR6E. Contact Cahn at (973) 975-0900 or Brandle at sbrandle@segalco.com. ✧

Humana to Boost MA Rolls in Nevada

continued from p. 1

Humana introduced its MA product to the Nevada market in January 2006. The insurer says its MA product now covers 1,750 lives. Another 13,750 seniors are covered by Humana's stand-alone Medicare Prescription Drug Plan (PDP), and about 400 members are enrolled in a recently introduced Medicare supplement plan. Nationally, Humana has 1.4 million MA members and 4.2 million lives covered by its PDP.

"Nevada is a smaller and newer market for us. As a result of the [United] acquisition, we will substantially increase our market share in Las Vegas," says Debbie Smith, regional president of senior products for Humana's Western Region. Upon completion of the Sierra acquisition, Humana also will begin a multi-year contract with Healthcare Partners of Nevada, a provider network that includes six group-provider locations and a network of providers in Clark and eight other counties.

Anthem Blue Cross and Blue Shield of Nevada, a WellPoint subsidiary, launched an MA product in Nevada on Jan. 1, 2008. "I think there is an opportunity for some growth in that market. There certainly are a lot of seniors retiring here, as well as a lot of early retirees who aren't yet eligible for Medicare, says Mike Murphy, president of the Las Vegas-based WellPoint subsidiary.

Deal Will Alter Insurance Landscape

In an e-mail comment to *HPW*, M. Donald Kowitz, president and CEO of Reno-based Saint Mary's Health Plans, says his company "is concerned about consolidation in the health plan market and the potential reduction in choice for consumers that the merger could cause."

Murphy is more optimistic. "I think the [health insurance] landscape in Las Vegas and Nevada will definitely change, but I also see this as a heck of an opportunity for us," he says. "Any time there is change, people look to re-evaluate options and decisions they've made in the past. We have a great business plan and are optimistic." Anthem has about 324,000 members throughout the state, most of which are in the Reno market. Anthem says its enrollment in the Las Vegas market, where Sierra is the dominant insurer, grew 9% in 2007. After adding Catholic Healthcare West hospitals to its network last November, Murphy says, every hospital in the Las Vegas area is in Anthem's network.

Although the name of the second suitor for Sierra last year was not made public, Oppenheimer & Co. analyst Carl McDonald tells *HPW* that it was WellPoint. While WellPoint offered the same price as United, it wasn't willing to reimburse Sierra the $25 million fee United agreed to if regulatory issues kept the deal from being finalized before the Feb. 29 deadline, according to McDonald. "WellPoint was also seeking a greater number of representations and warranties from Sierra management," he adds.

Contact Ross McLerran for Smith at rmclerran@humana.com, McDonald at Carl.McDonald@us.cibc.com, Murphy at Mike.nevada.murphy@anthem.com, DeRosa at (702) 252-0888. ✧

NEW STUDIES IN THE FIELD

◆ **Employers can save $1.65 in health care expenses for every dollar spent on a comprehensive employee wellness program,** finds a recent study by Highmark, Inc. that was published in the February 2008 issue of the *Journal of Occupational and Environmental Medicine (JOEM).* The study was based on Highmark's own corporate wellness program, which reported saving $1.3 million during a four-year period. Researchers examined the health care costs reflected in the medical claims of employees who participated in wellness programs, as well as nonparticipants with comparable health risks. According to the researchers, reduced inpatient costs yielded the highest return on investment, partially due to increased use of screenings and medications among employees. "There is a common misconception that these studies represent people who are already healthy and motivated. It's simply not the case," says Brian Day, Ed.D., director of advanced analytics at Highmark. "One of the most significant findings showed that those involved in wellness activities were not healthier at the start of the program," Day adds. The study's results can be found at www.joem.org.

◆ **California hospitals collected a higher percentage of their listed charges from uninsured patients than from Medicare,** according to a study published in the Feb. 5, 2008, issue of *Health Affairs.* The study, "Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices?" found that from 2001 to 2002, hospitals collected on average 18% more of their charges from uninsured patients than from Medicare, and from 2004 to 2005 hospitals collected on average 20% more of the charges from uninsured patients. The study concludes that the net prices paid by uninsured patients to hospitals increased from 2001 to 2005 because the uninsured paid the same or more than Medicare and, during that period, Medicare increased payments to hospitals by 13%. The study was funded by the USC Center for Health Financing, Policy and Management and the Robert Wood Johnson Foundation. Visit www.healthaffairs.org.

◆ **People are satisfied in an HMO only as long as participation is voluntary and they are not forced to participate in them instead of in a less-managed care plan like a PPO,** according to a new study by the University of Michigan (U-M). The study, "Insurer Competitive Strategy and Enrollment in Newly Offered Preferred Provider Organizations," looked at turnover and enrollment among insurance plans in 2005, the year that the two insurers serving U-M employees decided to begin offering PPOs. The results showed that most of the new PPO customers switched from less-managed care plans and not from other HMOs, according to the researchers. The results suggest that the perceived dislike for HMOs could stem from the context in which they are offered, rather than from actual or perceived deficiencies in the HMO system, says Richard Hirth, professor of health management and policy at U-M. In addition to advocating giving employees a choice of insurance plans, the study suggests that employees might be more accepting of HMOs if they reside in a geographic region where HMOs have a good reputation. The complete study will be in the Spring 2008 issue of the journal *Inquiry*. Visit www.inquiryjournal.org.

◆ **Faced with double-digit annual increases in the use of advanced imaging services, such as computed tomography (CT) scans and positron emission tomography (PET) scans, health plans are stepping up efforts to slow the proliferation of advanced imaging services,** according to a study by the Center for Studying Health System Change (HSC). Along with escalating cost pressures resulting from the rapid growth in imaging utilization, there also are growing concerns about patient safety and quality of care related to rapid increases in magnetic resonance imaging (MRI), CT scans, PET scans and nuclear cardiology imaging, HSC adds. According to researchers, plan strategies range from informing physicians about evidence-based imaging guidelines to requiring prior authorization of services to credentialing physicians and imaging equipment. Mindful of the physician backlash against managed care in the 1990s, HSC says, plans are instituting requirements they perceive to be less intrusive and burdensome for physicians. Some physicians, however, view the requirements as administratively onerous and obstacles to patient care, according to the study. "Despite physician objections, health plans generally have stood firm because they believe the cost savings and patient safety gains outweigh the negatives," says HSC Health Researcher Ann Tynan, co-author of the study. Visit www.hschange.com/CONTENT/968 to view the study's findings.

HEALTH PLAN BRIEFS

◆ **By 2017, health care spending is projected to reach more than $4.3 trillion and comprise 19.5% U.S.'s gross domestic product, CMS reported Feb. 25.** The department predicted that health care spending in the U.S. will grow by 6.7% in 2007 and will continue to increase annually at a rate near that through 2017. CMS's Office of the Actuary, which prepared the report, added that annual growth in health spending is anticipated to be higher than the annual growth predicted for both the overall economy (4.9%) and for general inflation (2.4%). Among the cost drivers cited were — in the early years — an increase in hospital spending, which is expected to accelerate from "7.0% in 2006 to 7.5% in 2007, partly attributable to higher Medicaid payment rates." Medicare spending growth also is expected to accelerate, reaching 8.0% annually by 2017, as the baby boom generation begins to enroll. Call CMS spokesperson Steve Hahn at (202) 690-6149.

◆ **California's health plans paid $65 million in HMO-based pay-for-performance rewards to physician groups for their 2006 performance** — $10 million more than the previous year, according to the Integrated Healthcare Association (IHA). The rewards, the organization added, were distributed during the third and fourth quarters of 2007. Health plans in California that presented such rewards include Aetna, Inc., Blue Cross of California (a WellPoint, Inc. unit), Blue Shield of California, CIGNA Corp., Health Net, Inc., PacifiCare (a UnitedHealth Group unit) and Western Health Advantage. Call IHA spokesperson Cindy Ernst at (510) 208-1740.

◆ **New York City Mayor Michael Bloomberg (I) and Health Commissioner Thomas Frieden, M.D., unveiled the city's "next-generation" electronic health records (EHRs), being used by more than 200 primary-care providers.** Bloomberg's office said the city is "on track to meet its goal of equipping more than 1,000 local health care providers — many of them practicing in the city's poorest and sickest neighborhoods — with secure EHR systems by the end of the year," which should benefit more than a million people. Under the project, providers with more than 30% Medicaid and uninsured patients are offered a subsidized package of EHR software and services — including licenses, on-site training, data interfaces, and two years of maintenance and support. The initiative is being supported by a $3.2 million grant from New York state and evaluated through $5 million in funding from the Centers of Disease Control and Prevention and the Agency for Healthcare Research and Quality. Call Bloomberg spokesperson Stu Loeser at (212) 788-2958.

◆ **During the National Governors Association's Winter Meeting in Washington, D.C., Feb. 23 to Feb. 25, governors from both the Republican and Democratic parties called on Congress to place a moratorium on proposed Medicaid regulations that would reduce federal spending on the program by an estimated $18.5 billion** over the next five years and would make the states responsible for funding $13 billion of the shortfall. Arizona Gov. Janet Napolitano (D) asserted that the move is particularly difficult at a time when state revenues are declining from an economic downturn. Under the Bush administration's proposals, CMS would ban the use of federal Medicaid money to pay for doctor training, eliminate some funds for disability programs, and limit Medicaid payments to hospitals and nursing homes run by state governments.… **During the conference, governors also talked with Congress about reauthorizing the State Children's Health Insurance Program (SCHIP) program,** which now is slated to expire in March 2009. Massachusetts Gov. Deval Patrick (D) and Washington Gov. Chris Gregoire (D) asked members of the House Energy and Commerce Committee to rescind an Aug. 17, 2007, CMS directive that Patrick said "imposed new enrollment, administrative and procedural requirements that impair the Commonwealth's Medicaid and SCHIP programs." The governors said the regulations, which require that 95% of children in a state's poorest families must be covered before enrolling higher-income children, are too stringent. Call National Governors Association spokesperson Christopher Cashman at (202) 624-7787.

◆ **PEOPLE ON THE MOVE:** Health Net Federal Services, a division of Health Net, Inc. appointed **Joyce Grissom, M.D.** medical director. She was medical director, director of quality for TRICARE Management Activity. **Carrie Harris-Muller** was promoted to chief administrative officer for Kaiser Permanente of the Mid-Atlantic States.…Magellan Health Services Inc., named **René Lerer** president and CEO. Lerer succeeds **Steven Shulman,** who will become non-executive chairman of the board.

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