

MANAGED CARE WEEK

Timely Business and Financial News of the Managed Care Industry

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MCOs, Analysts Predict 2006 Medical Costs Will Moderate; Rx, Outpatient Drive Trend

Overall medical cost trends likely will continue to moderate in 2006, health insurers and financial analysts predict, with slowdowns driven by increased availability and utilization of generic drugs and slowing utilization. Still, MCOs will face challenges in certain cost areas this year, including specialty drugs and outpatient services.

So far, the two largest health insurers have reported 2005 financial results: WellPoint, Inc., with 34 million enrollees, unveiled earnings on Jan. 25 (see story, p. 3), and 27-million-member UnitedHealth Group posted results on Jan. 19. The 11 remaining publicly traded insurers report 2005 earnings over the next few weeks.

Moderating medical cost trends are a key component of several analysts' financial predictions for publicly traded health insurers' financial results in 2006.

JPMorgan analyst Scott Fidel told investors that "medical cost trends should continue to show a downward bias in 2006," falling to the 8.0% range. "Product and benefit designs continue to tighten as employers remain focused on controlling their overall health care spend," he said. "We see the opportunity for the companies to report some modest deceleration in both the pharmacy and outpatient components."

CIBC World Markets analyst Carl McDonald predicted that "slowing medical costs, particularly lower drug costs, will drive earnings upside this year" for managed care companies. He highlighted several factors bringing down the rate of increase in medical costs. Higher generic drug utilization could drive down the pharmacy cost trend by a few percentage points, McDonald said. And inpatient pricing could improve in 2006, and some insurers are working to slow down outpatient costs in areas like radiology services. Overall utilization also is likely to continue at the lower level seen in 2005. McDonald pointed out that United reported declining utilization during the most recent quarter, while hospital chain Health Management Associates, Inc. reported that inpatient admissions fell 1.6% during the fourth quarter of 2005.

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Insurers Invest in Predictive Modeling to Set Rates, Predict Enrollment for Accounts

Predicting modeling gained popularity among health insurers because of the software's ability to identify members with chronic conditions. Now, however, more and more MCOs are using these sophisticated applications to help set premiums for new or renewing groups, and to model underwriting and enrollment assumptions as employer contributions and benefit designs change.

The software programs analyze a few years of past medical claims data, as well as lab, pharmacy and other records where available, to predict how expensive an enrollee is likely to be in the future. Often, the most expensive patients in terms of past claims history aren't those most likely to cost a lot in the future.

Actuaries typically look at previous claims costs in order to estimate future expenses, explains Reid Smiley, manager of medical underwriting, data support and

reporting at BlueCross BlueShield of Tennessee. But a \$500 claim for a broken arm is not a good indicator of future claims, while \$500 for an initial cancer workup could indicate that the diagnosis "is going to produce significant claims in the following year," he says.

"Everybody recognizes that it's probably the wave of the future," says Courtney White, a principal and consulting actuary at Milliman, Inc. The consulting firm assists health insurers in evaluating and implementing vendors' predictive modeling programs. The trend is driven in part by the explosion in the amount of data available to health plans for use in underwriting, he explains. Predictive modeling helps plans to "tap into that data and use every available piece of information."

White estimates that less than one-third of health plans now use predictive modeling for underwriting, but he predicts this percentage will increase over the next five years.

Marilyn Kramer, president of Boston-based predictive modeling software company DxCG, Inc., says she thinks usage is much more widespread, with "a little more than half" of plans now using these applications in

the underwriting process. "We just really have seen a sea change in the past two to three years in terms of acceptance," she contends. "If one [MCO] does it, everyone does it because they're very concerned about competitors being able to select against them," she explains.

Kramer says half of DxCG's customers started with predictive modeling for physician profiling, and moved from there to care management, and finally to underwriting. DxCG offer a predictive modeling platform with modules for underwriting, high-cost case identification, disease management and other functions.

White adds that a predictive modeling system is "definitely a substantial investment." He estimates that packages cost \$200,000 to \$500,000, depending on what capabilities are offered and how the product is structured. Both Kramer and Lee declined to provide specific pricing information for their systems.

Humana Uses Tool to Predict Enrollment

Humana Inc. created its own predictive modeling tool rather than using an off-the-shelf product from an external vendor. The application, called SmartStart, initially was developed to assist the insurer in rating consumer-directed products, says Penny Hahn, the insurer's actuarial director.

The insurer's underwriters use it to set premiums for groups, while the internal sales team and some external brokers use it to help employers forecast the results of different benefit choices. They "use it to model different benefit plans, combinations of plans and different employer contribution strategies," she explains.

"We plug in some basic claims cost information, the employer's current contribution strategy, all the current plan designs, all the future plan designs and all the enrollment," she says. For example, an employer might consider offering a high-deductible health plan alongside traditional PPO and HMO offerings. "You're going to expect healthier people to move to the new plan designs," Hahn says. "The tool anticipates positive and adverse selection between plans and adjusts the rates accordingly."

Generally, predictive modeling doesn't serve as a total replacement for actuaries' more traditional tools. Instead, "it's a part of their underwriting practice," Kramer says, along with "other models that actuaries traditionally use."

The Tennessee Blues plan is preparing to implement a predictive modeling program from MEDai to replace an existing tool that's several years old, Smiley says. The application will be used as "just a portion of the underwriting ratings formula," he explains, along with age, gender and industry classification. In the future, "we're probably going to take a look at how an improved tool

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might allow us to, down the road, adjust our rating formula if it warrants more credibility or a heavier weight.”

Humana doesn't expect to use SmartStart for other products. “We don't see as much variance when quoting HMO or PPO [plans],” Hahn says.

Insurers are more likely to rely on predictive modeling for underwriting when writing small cases, White says. “In a small group of under 50 employees, it's one of the primary tools,” he explains. That's because an insurer might process 500 small groups per month, so “you really want to take an approach that's efficient.” A predictive modeling system ensures a more “effective and accurate” underwriting process than would be achieved by simply using regular claims data, he asserts.

As the group size gets larger, individual quirks are smoothed out, allowing for more accurate predictions.

With large groups of 500 or more employees, predictive modeling is simply one tool among many, White says. An actuary might use predictive modeling “as a supplement to normal underwriting techniques,” he explains, in which the actuary reviews the group's previous claims experience. If the data are considered “100% credible,” then the actuary applies the expected medical cost trend for the upcoming year and makes benefit adjustments to reflect changes in plan design. And if the data are not 100% credible, the actuary might blend the group's experience with the community rate.

Experts Downplay Legal Issues

Although some observers raise concerns about regulatory or legal issues associated with using predictive modeling for underwriting, experts downplay these concerns.

White says that legal concerns are not an issue as long as the health insurer is operating within the confines of state insurance law. He says one state, Georgia, bars insurers from using diagnosis-based measures for setting premiums for renewing groups. He hasn't encountered other states that bar underwriting techniques such as those used by predictive modeling programs.

White adds that he doesn't expect health insurers to start incorporating genetic data into underwriting models for another 10 years. “I think we're a long way from that,” White says. The life insurance industry already uses genetic data, he notes. But life insurers are trying to predict only one piece of data: the date on which they will pay out already agreed-upon benefits. Health insurers, by contrast, are much more dynamic, White says, trying to predict a wide range of medical events and associated costs in a much shorter time frame.

For more information, call White at (404) 237-7060, Kramer at (617) 303-3790 or Humana spokesperson Mary Sellers at (502) 580-3689. ♦

WellPoint Posts Big Earnings Gain

Solid enrollment growth and lower-than-expected medical costs helped drive WellPoint, Inc.'s fourth-quarter 2005 financial results.

WellPoint reported fourth-quarter 2005 net income of \$652.0 million, or \$1.04 per share, compared with \$184.5 million, or 46 cents per share, for the year-ago quarter. The large jump in net income was partly the result of Anthem, Inc.'s November 2004 acquisition of WellPoint Health Networks, Inc. (*MCW 12/6/04, p. 4*). The 2004 period reflects a full quarter of results for Anthem, Inc., but only one month of WellPoint earnings.

On a combined basis, the two insurers would have reported a health care segment operating gain of \$784.5 million for the fourth quarter of 2004. In the most recent quarter, that figure rose 14.2% to \$896.2 million.

WellPoint Has Almost 34 Million Members

Including the acquisition of WellChoice, Inc., that closed in late December (*MCW 1/2/06, p. 8*), WellPoint had 33.9 million members. Excluding that purchase, WellPoint would have reported 29.1 million members, a 4.8% increase from 27.7 million members on Dec. 31, 2004. The insurer said organic enrollment growth was driven by the national-accounts and Medicaid segments.

For full-year 2006, WellPoint is projecting net income of \$4.54 per share. Some analysts say the per-share earnings figure may be low. CIBC World Markets analyst Carl McDonald called the estimate “conservative, since it assumes only modest core earnings growth, and no benefit from slowing medical expenses, which should drive upside, particularly in the second half of the year.”

The 2006 estimate includes \$25 million in savings and revenue enhancements resulting from the WellChoice purchase. WellPoint projects another \$25 million in synergies each year through 2010. Anthem's WellPoint buy produced \$150 million in 2005 synergies.

Despite that, WellPoint's administrative cost ratio rose to 16.5% for the fourth quarter of 2005 vs. 16.3% for the same period in 2004, driven by Medicare Part D implementation costs and higher executive compensation payments that are tied to financial results.

Another analyst expressed disappointment at the lower-than-expected administrative savings. “We hope to see more benefit from the Anthem and WellChoice mergers in 2006 membership gains and/or SG&A [i.e., selling, general and administrative] cost reductions,” said Morgan Stanley analyst Christine Arnold.

WellPoint's stock fell 0.5% from \$73.19 on Jan. 24 to close at \$72.86 on the following day. The company reported results before the market opened on Jan. 25.

Call WellPoint spokesperson Jim Kappel at (317) 488-6400. ♦

CDH Enrollment Surged in Past Year

Two surveys found large gains in high-deductible health plan membership, with health savings account (HSA)-linked plans topping 3 million this year and health reimbursement arrangement (HRA)-based products reaching 2.9 million.

The two studies — by America's Health Insurance Plans (AHIP) and AIS newsletter *Inside Consumer-Directed Care* (ICDC) — were unveiled a week before President Bush's Jan. 31 State of the Union message, which is expected to call for less restrictive HSA rules and expanded tax benefits.

AHIP unveiled preliminary figures from a survey of trade association members. The group found a sharp increase in enrollment in HSA-based consumer-directed health (CDH) plans, compared with the 1,031,000-member level reported in March 2005. The association did not survey membership in HDHPs that are linked to HRAs.

ICDC conducted a smaller-scale survey, turning up almost 2 million HSA-based members (vs. 600,000 in

January 2005) and 2.9 million HRA-linked enrollees (up from 2.5 million last year). UnitedHealth Group is the largest CDH plan sponsor, ICDC found, with 846,000 enrollees in HRA-based plans and 655,000 in HSA-linked products.

Although 6 million members is a sizable figure for an innovative product that only became available in 2004, it still represents just 4% of all enrollees in employer-sponsored health plans.

During his State of the Union speech, Bush is expected to urge Congress to make HSAs more attractive to Americans. During a Jan. 19 speech in Sterling, Va., he touted the tax benefits associated with HSAs and urged small business to "take a look at them." Bush told attendees that he would "call on Congress...to make these health savings accounts more attractive, more portable, more individualized." Two days later, in his weekly radio address, the president offered a similar message.

During a conference call to discuss the survey results, AHIP President Karen Ignagni told reporters that "we expect that in Congress this year, there'll be considerable discussion" about ways to make CDH plans more attractive, such as by increasing savings limits, allowing account holders to roll over balances in flexible spending accounts and easing restrictions on drug coverage.

In addition, Ignagni said, Bush has called for tax reforms that would make it easier for individuals to purchase health insurance. "White House staff have been saying that they are seeking to have a level playing field" between the tax treatment of employers and individuals who purchase health insurance. She noted that "individuals who are not offered insurance on the job...don't have the same ability to take advantage of tax subsidies."

For more information, call AHIP spokesperson Mohit Ghose at (202) 778-8494. ♦

MCOs See Lower Medical Cost Trend

continued from p. 1

United told investors that it expects "continued stability" in medical cost trends, with increases of 8% — plus or minus a half-percentage point — in 2006. CEO William McGuire, M.D., said specialty drugs will be one of the drivers of rising medical costs this year, helping to boost pharmacy expenses 7% to 7.5% in 2006.

McGuire said specialty pharmacy costs represented 17% of total per-member per-month pharmacy costs in 2005. In 2003, spending on specialty drugs rose 30%, but the growth rate fell to 17% in 2004 and 13.5% in 2005. "We recognize there's going to be a continued flow of these kinds of drugs into the market," he said. Along with purchasing and distribution strategies aimed at

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reducing unit costs of the medications, one of United's major goals is "trying to focus the use of these pharmaceuticals in the hands of the most competent and able physicians for the particular specialized problems that the drugs are attempting to get after."

Among the top drivers of specialty pharmaceutical costs are medications for growth hormone deficiency, rheumatoid arthritis, hepatitis C and multiple sclerosis, McGuire added.

WellPoint, which is projecting a medical cost trend in the 8% range for 2006, said inpatient and pharmacy expenses are slowing down. "Outpatient is the number-

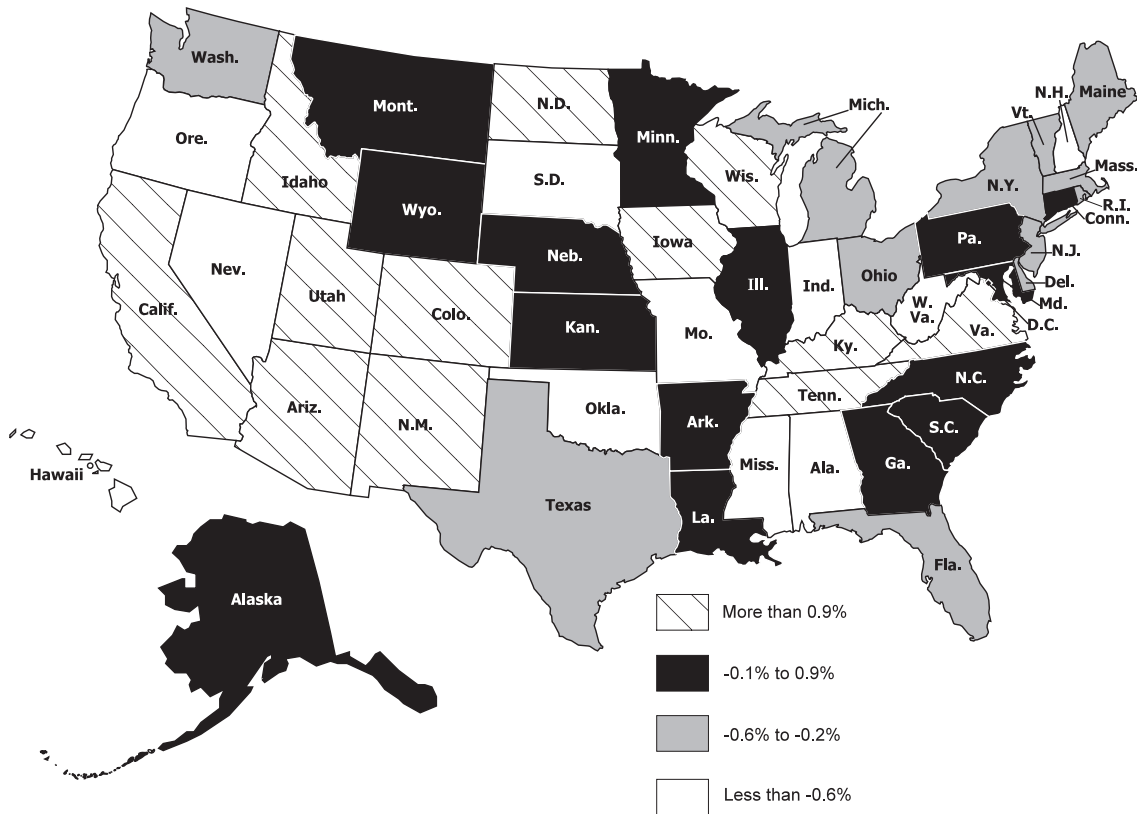
one driver, the one that we're very focused on," CFO David Colby told investors

Contracting and medical management strategies are helping to slow the rate of increase of outpatient costs, which is 85% cost-driven and 15% utilization-driven. Colby pointed to the insurer's radiology management initiative, which is being expanded to California. That program, introduced in WellPoint's Central region, has helped to reduce the advanced imaging services trend.

Call WellPoint spokesperson James Kappel at (317) 488-6400 or United spokesperson Mark Lindsay at (952) 992-4297. ♦

Percentage Change in Individual Insurance Coverage, 2000-2004

Between 2000 and 2004, 1.2 million U.S. citizens moved to individual health insurance policies from employer-sponsored coverage or Medicaid, Medicare and uninsured rolls. That represents a 0.3-percentage-point increase, on average. Colorado, Idaho, Kentucky, Utah and Wisconsin showed the biggest increases of 2.0 percentage points or more. Meanwhile, Hawaii had the greatest percentage decrease, at 3.5 percentage points, in individual insurance coverage. Indiana, Mississippi, Nevada, New Hampshire, Oklahoma and West Virginia also saw decreases of 1 point or more.



NOTES: For California, Hawaii, Idaho, Kentucky, Mississippi, New Hampshire, New Mexico, Oklahoma, Tennessee, Utah, Washington state, West Virginia and Wisconsin, the change in the number of people by coverage type between 2000 and 2004 is statistically significant at the .10 level.

SOURCE: The Kaiser Family Foundation, statehealthfacts.org. Data sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

NEW STUDIES IN THE FIELD

◆ **In their first year, the Medicare Coordinated Care Demonstrations haven't led to statistically significant increases in patients' compliance with treatment regimens,** according to a study by Mathematica Policy Research, Inc. The demonstrations seek to improve outcomes and reduce costs for beneficiaries with heart disease, diabetes and other chronic conditions. The projects are working to encourage patient compliance with medication, diet and exercise recommendations and to improve communication among physicians and between physicians and patients. The Mathematica evaluation also found that most programs had trouble enrolling patients, with the most successful ones leveraging strong physician relationships and access to patient databases. CMS selected 15 programs for the demonstration, which began enrolling patients in April 2002. The demonstrations were slated to last four years, but CMS extended the end dates for 11 programs to 2008. Call Mathematica spokesperson Randall Brown at (609) 275-2393.

◆ **State efforts to expand health coverage to parents of Medicaid-eligible children were successful,** though some initiatives resulted in a corresponding decrease in private insurance coverage, according to a study published Jan. 17 on the *Health Affairs* Web site. The study reviews states' efforts to expand insurance coverage to parents in four states: California, Massachusetts, New Jersey and Wisconsin, and the impact of those efforts on adults. Decreases in parents' uninsurance rates ranged from a 4.1-percentage-point decline in New Jersey to an 8.8-percentage-point drop in Wisconsin. During the same period, however, the private coverage rate also fell. New Jersey had the largest decline, at 14.7%, while Massachusetts had the smallest, at 0.4%. Visit www.healthaffairs.org.

◆ **Many states are experimenting with new strategies for covering the uninsured,** according to the 2006 *State of the States* report. The evaluation was produced by the State Coverage Initiatives program, part of The Robert Wood Johnson Foundation. Efforts vary from sweeping new initiatives such as Illinois' Covering All Kids Health Insurance Act, which extends health insurance to every child in the state, to Maryland's Fair Share Health Care Fund, which requires an employer with more than 10,000 workers to spend at least 8% of its payroll on health insurance or pay into a public fund. Kansas

created a new health care purchasing authority to manage Medicaid, SCHIP, pharmacy programs, the state employees' health plan and other programs. And Montana allowed small businesses to band together to purchase health insurance, and also began providing tax credits and premium assistance to some groups. Visit www.statecoverage.net.

◆ **Fewer than 20% of employers offer prevention programs aimed at lifestyle modification,** according to a study published in the Jan. 12 *American Journal of Health Promotion*. The study, by Partnership for Prevention, finds that just 4% of companies offer optimal tobacco cessation programs. Instead, many employers rely on their health insurance carrier. Almost half of employers require their health plans to cover some clinical preventive services. Call Christine Countryman for Partnership for Prevention at (202) 326-1741.

◆ **Rising out-of-pocket health care costs and slow wage growth are challenging workers' ability to save for retirement,** according to The Commonwealth Fund Survey of Older Adults. The study highlights challenges faced by older adults, including high rates of chronic health conditions and unstable insurance coverage. In addition, the survey found, more than half of older adults with individual coverage spent \$3,600 or more per year on health insurance premiums, vs. just 16% of older adults with employer-sponsored coverage. And 38% of uninsured older adults and 37% of those with individual coverage spend \$1,000 or more per year on out-of-pocket costs. Visit www.cmfw.org.

◆ **Premiums for consumer-directed health plans rose at a slower rate in 2005 than did premiums for other types of health insurance,** according to a study by the Deloitte Center for Health Solutions and The ERISA Industry Committee. On average, consumer-directed health (CDH) plan premiums rose 2.8% from 2004 to 2005, vs. 8% for HMOs, 8.5% for POS plans, 7.2% for PPOs and 6.4% for indemnity plans. The average premium increase for all plan types was 7.3%. Employers said they expect similar rate hikes this year: 2.6% for CDH plans, 7.4% for HMOs, 7.3% for POS plans, 7.5% for PPOs and 6.6% for indemnity plans. The survey of 152 major U.S. employers was conducted in late December and early January. Call Deloitte spokesperson Tony Jewell at (202) 220-2772.

ICORE Manages SP Injectables With Payer-Focused Approach

When ICORE Healthcare, Inc. was formed in April 2003, health insurers weren't as involved as they could be in managing specialty pharmacy (SP) injectables. "We realized that there were opportunities on the payer side to manage the injectable process," says Kjel Johnson, Pharm.D., vice president of strategic operations for the company.

"Group purchasing organizations and various oncology and medical groups were providing information to providers. There was a whole educational process in place for providers," he explains. There were also a number of companies, he says, aligned more closely with pharmaceutical companies and physicians. "But payers seemed to know the least of the whole process...Ninety-five percent of payers weren't even measuring costs. How can you manage costs if you don't even measure them?" he asks.

ICORE founder Raju Mantena, who also serves as CEO and president, points out that the company doesn't just look at SP costs on the pharmacy side, as the majority of SPs and pharmacy benefit managers do. It considers costs on the medical side as well, he says. "We felt there was a huge opportunity for health plans to manage these trends."

Mantena contends that changes in the SP industry, such as the change to Average Sales Price for determining allowable prices under Medicare, have shifted the focus from physicians to payers. "The influence of the payers has increased substantially the last few years," he says. "Overall, payers are really at the center of the whole thing."

Variety of Approaches Offered

Orlando, Fla.-based ICORE's strategic distribution division is used to support health plans' initiatives in managing costs, says Johnson. The company employs six savings drivers to achieve this: (1) preferred product positioning and rebate optimization; (2) SP distribution through its Florida and New York sites; (3) reimbursement optimization, which ensures that the provider is paid fairly, not too low or too high; (4) claims processing improvement, which helps reduce errors; (5) benefit design optimization, which incentivizes the patient to use high-quality, low-cost medications; and (6) utilization management.

ICORE gets medical, pharmacy and home health care data, and looks at the current run rate of spending, says Johnson, in order to determine potential savings. The savings will apply to 80% of a health plan's injectable spend. According to ICORE, with the various initiatives that payers can take, total savings potential is 29% for rebates, 16% for product steerage, 10% for claims

processing, 30% for benefit design, 20% for fee-schedule and SP use, and 5% for utilization management. The timing varies from rapid to long for these.

The company, which has about 50 employees, works to achieve "complete transparency" for commercial payers, says Johnson. "In the current injectable space, there is some room to go" toward realizing this, he asserts. "It's all relative" when it comes to full transparency, he says, but "you can get really close" to achieving it.

It is important for payers to realize, says Johnson, that "specialty pharmacies will only ever have access to 50% of injectables." Physicians have access to the other half, and "you will never get these out of the physician's office," he says. But, he contends, taking cost, reimbursement and adjudication into account, this may not be such a bad thing, as payers may not want the large amount of work with little payback that may occur.

ICORE Achieves Savings in 30 Days

Johnson says that the company can "start saving money for clients in 30 days" with such approaches as reducing errors in claims processing. This represents a marked difference from other companies in the market, contends Johnson, who says that others may take one and a half years of effort that will produce a 0.3% savings through distribution.

With the average trend of injectables at 23% to 25% annually, and oncology at about 23%, "when you save 0.3% on a 23% trend line, you're not chewing much off the cost," he says.

ICORE covers about 40 million lives, says Mantena, through its work with national health plans with as much as 10 million-plus lives and some regional plans, including some Blues plans. Johnson declines to disclose the company's SP revenues.

Getting managed care to shift its approach is usually not a quick process, Mantena says. "But the fact that we have 40 million lives validates our strength of offering. All the health plans that have been quick to respond and sign on speak for themselves. We are two-and-a-half years old, but the response has been just incredible."

Contact Johnson at kjohnson@icorehealthcare.com or George Petrovas at george@icorehealthcare.com. ✧

This article was excerpted from AIS's monthly newsletter, Specialty Pharmacy News, designed to help health plans, PBMs, providers and employers manage costs more aggressively and deliver biotech and injectables more effectively. Visit www.AISHealth.com/Products/NewsSPN.html for more information about the newsletter, or call Atlantic Information Services, Inc. at (800) 521-4323 to request a free copy.

MANAGED CARE BRIEFS

◆ **Humana Inc. has agreed to acquire CHA HMO, Inc.** CHA HMO, which does business as CHA Health, has 96,000 Kentucky members and is majority-owned by the University of Kentucky. Humana traditionally has been a strong competitor in Louisville, Lexington and northern Kentucky, the company said, and the CHA purchase — along with Humana's contract to provide health benefits to state employees (*MCW 10/31/05, p. 8*) — will help it compete for commercial business throughout the state. The University of Kentucky said it wanted to focus on its clinical mission. Humana did not disclose terms of the deal. Call Humana spokesperson Jim Turner at (502) 580-3644.

◆ **American Independence Corp. said its Independence American Insurance Co. subsidiary is filing to sell consumer-directed health (CDH) plans to small employers and individuals in 20 states.**

American Independence also said it agreed to acquire Insurers Administrative Corp. (IAC), a Phoenix-based distributor of CDH and other health plans. Call American Independence spokesperson David Kettig at (212) 355-4141, ext. 3047.

◆ **CMS said it will make up the difference to states** between amounts the states incurred in drug costs during the transition to the Medicare Part D drug benefit and amounts reimbursed to the states by Prescription Drug Plans (PDPs). Some states have made unexpected outlays to provide emergency drug assistance to beneficiaries who could not verify eligibility for drug benefits and/or federal subsidies (*MCW 1/23/06, p. 1*). CMS devised a system for PDPs to reimburse the states, but conceded that many states may not be made whole in that process, since many PDPs have negotiated better discounts than have state Medicaid programs. Visit www.cms.hhs.gov.

◆ **Nashville, Tenn.-based health plan operator HealthSpring, Inc., priced its initial public offering (IPO) of stock at between \$16 and \$18 a share.** In a Form S-1 filed with the Securities and Exchange Commission, HealthSpring did not specify a date for the initial offering, but news reports indicate the IPO could come this week. HealthSpring will offer 12 million shares, and majority owner GTCR Golder Rauner, LLC, will offer another 5 million shares. Call HealthSpring CFO Kevin McNamara at (615) 291-7000.

◆ **CareFirst BlueCross BlueShield said it was successful in the first year of the CareFirst Commitment initiative,** which was aimed at improving quality of and access to care, lowering costs and addressing health care disparities (*MCW 1/24/05, p. 1*). The insurer said 2005 operating earnings were reduced by \$60 million in order to moderate premium increases. Call CareFirst spokesperson Heather Wasserman at (800) 914-6397.

◆ **MVP Health Care is launching a pay-for-performance program to reward physicians** who adopt health information technology to help improve health care. The health plan teamed with Bridges to Excellence and the National Committee for Quality Assurance to offer primary care physician practices the Physician Office Link Program. Call MVP spokesperson Gary Hughes at (518) 388-2319.

◆ **The Office of Personnel Management (OPM) said that the Postmasters Benefit Plan would no longer be a part of the Federal Employees Health Benefits Program.** OPM said the financial risk to the 8,100 enrollees in the Postmasters plan exceeds standards set for federal employees and retirees (*MCW 12/12/05, p. 6*). National League of Postmasters President Steve LeNoir said he would meet with OPM to discuss the termination. Call OPM spokesperson Michael Orenstein at (202) 606-2402.

◆ **Acting New Jersey Gov. Richard Codey (D) signed a bill that allows parents to provide insurance for their children up to the age of 30.** A.B. 3759 requires health plans to offer continued coverage for dependents who are unmarried, have no dependents of their own, are a resident of the state or enrolled in higher education, and have no other form of coverage. Previously, parents could provide coverage only for dependents up to age 23 who live at home. Visit www.state.nj.us.

◆ **New York Superintendent of Insurance Howard Mills said CIGNA Healthcare of New York, Inc. paid the insurance department a \$150,000 fine for neglecting consumer complaints.** Mills added that CIGNA said it will take action to prevent the recurrence of the violations. The insurance department said CIGNA repeatedly failed to meet a 15-business-day deadline for responding to consumer complaints. CIGNA did not respond to a request for comment. Visit www.ins.state.ny.us.

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