Volume 18, Number 25 July 28, 2008

Health Plan Week

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

Contents

3 Double-Digit Rate Hike Will Prompt Much Tougher Client Negotiations

3 *Table:* Preliminary National HMO Rate Increases

4 Medicare E-Prescribing Incentive Could Spread to Commercial Side

5 AHIP CEO Launches Health Care Reform Campaign, Faces Critics

6 Judge Approves $255 Million Settlement Against Health Net

8 *Health Plan Briefs*

Managing Editor
Steve Davis

Contributing Editor
Jill Brown

Associate Editor
Chris Meehan

Executive Editor
James Gutman

WellPoint, United Results: Few Surprises Help Restore Some Investor Confidence

Investors and analysts breathed a collective sigh of relief July 23 when WellPoint, Inc. reported its second-quarter earnings. While quarterly earnings were down 10% from the same period a year ago, the news was better than many analysts anticipated. It also came two days after UnitedHealth Group reported earnings that slightly beat Wall Street expectations. By the end of the day, despite back-to-back declines in quarterly profit, WellPoint's share price had jumped 9.1% to $53.17. The stock closed at $52.33 on July 24, a day when the overall stock market plummeted.

On July 2, United cut its 2008 earnings outlook for the second time in just six months. Some industry observers worried that other health plans, such as WellPoint, would follow suit *(HPW 7/14/08, p. 1)*, or that United would report more bad news. On July 21, United eased concerns that its problems might be worsening when it released slightly better-than-expected quarterly results.

"There definitely was a concern that the other shoe might drop this week when WellPoint released its earnings. There was fear that things could get worse," says Aaron Vaughn, a securities analyst in the St. Louis office of Edward Jones. "The fact that both WellPoint and United beat Wall Street's expectations was secondary to the fact that they both maintained guidance for the year. They are both saying that they don't expect things to get any worse."

continued on p. 6

Communication, Retention Become Critical For Plans as Commercial Enrollment Erodes

For health plans, retaining premium revenue is taking on increasing importance at a time when membership growth is sluggish and acquiring a new member can be six times more expensive than retaining an existing one.

Conventional wisdom holds that satisfied members translate into retained members. But experience shows that this isn't necessarily the case. The key, according to George Van Antwerp, a vice president of health care marketing firm Silverlink Communications Inc., is moving as many existing members as possible into the "top box," where members are not just satisfied but also loyal. According to J.D. Power and Associates — a consumer satisfaction measurement firm — 81% of these members are most likely to renew given their experiences with a health plan.

But it's not just any experience, says Van Antwerp. Creating satisfied and loyal customers in an over-communicated, diverse and competitive marketplace requires a new approach to customer communications: personalized messaging and touch-point experiences that exceed a member's expectations.

Health plans historically have fallen short when it comes to member communications. Deloitte LLP's 2008 Survey of Health Care Consumers found that only 8% of those polled understood their health insurance completely. This is a critical finding because, according to Van Antwerp, members switch health plans in many cases without

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
An independent publication not affiliated with insurers, vendors, consultants or associations

realizing that their current plan offers identical products and services to those that lured them to a new plan.

"Poor communication is symptomatic of the health [insurance] industry, which is ironic because it's a service industry," Ross Goldberg, president of Kevin/Ross Public Relations, tells *HPW*. "My relationship with my health plan is far more personal than my relationship with an airline," he says. But while his health insurer knows about his health status, it sends only periodic generic messages. The airline he flies, by contrast, regularly uses data about his preferences to personalize each of its interactions with him.

Generic Messaging Said to Have Little Effect

Other industries learned years ago that generic, one-size-fits-all messaging is no longer effective at reaching and influencing a diverse customer base. And health plans can learn from these industries. "Every communication with a health plan member should be a personalized one-on-one encounter rather than an average experience," says Van Antwerp, adding that to be effective, a message must be highly targeted and personalized. "You have to deliver the right message to the right person at the right time." There are no typical consumers, typical families or typical demographics, he says. Customers must be micro-segmented into subgroups.

Several plans are now following the lead of merchandisers and political campaigns by micro-segmenting their members according to demographics, geographics, attitudes and behaviors (health status also plays a role). It's the "soccer moms" micro-trending strategy that helped Bill Clinton win a second presidential term. To micro-segment members, health plans crunch internal plan data and external data from call centers and other sources to determine what matters most to members in each identified micro-segment. Messages and interactions are then personalized — not just by content but also by when and how the message is delivered, including Web, e-mail, regular mail, phone and even text messaging.

Micro-segmenting also is used to market products to specific subgroups and, once captured, retain members. WellPoint, Inc.'s suite of Tonik health plans *(HPW 5/6/06, p. 7),* for example, was designed to reduce attrition among individual and small-group members. The plan's Web site (www.tonikplans.com) and collateral materials are designed to create an experience that appeals to recent graduates and young adults micro-segmented into "thrill seekers," "part-time daredevils" and "calculated risk takers." WellPoint says that the Tonik experience has improved retention rates by 20%.

Micro-Segmenting Requires Meeting Challenges

But micro-segmenting isn't easy. "You have to 'boil the ocean' to try to figure out what people need and will respond to according to where they fit within a particular segment," says Van Antwerp. *One challenge:* The large numbers of variables that can be used to create micro-segments. Health care is highly localized and demographically influenced, and if these and other considerations unique to health care are not factored in, resulting micro-segments can be misleading. Some, for example, question Deloitte's use of six broad segments to categorize the health care consumer market, noting that the segments are not based on demographics.

Another challenge: Consumers' lives and situations change, often quickly, as they move through expected and unexpected transitions, including health status, making it an evolutionary rather than a static process.

Silverlink's quarterly HealthComm Behavior Index surveys commercially insured adults to collect demographic and health status data and measure their responses to personalized health care communications. Van Antwerp notes that insurers can use these kinds of data to test what they consider to be successful communications strategies. He advises plans to continually run

Health Plan Week (ISSN: 1937-6650) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

Copyright © 2008 by Atlantic Information Services, Inc. All rights reserved. No part of this publication may be reproduced or transmitted by any means, electronic or mechanical, including photocopy, FAX or electronic delivery without the prior written permission of the publisher.

Health Plan Week is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Steve Davis; Contributing Editor, Jill Brown; Associate Editor, Chris Meehan; Executive Editor, James Gutman; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Gwen Arnold; Production Director, Andrea Gudeon

Call Steve Davis at 1-800-521-4323 with story ideas for future issues.

Subscriptions to *HPW* include free e-mail delivery in addition to the print copy. To sign up, call AIS at 800-521-4323. E-mail recipients should whitelist **aisalert@aispub.com** to ensure delivery.

To order **Health Plan Week:**

(1) Call 1-800-521-4323 (major credit cards accepted),

(2) Order online at www.AISHealth.com, or

(3) Staple your business card to this form and mail it to:
AIS, 1100 17th St., NW, Suite 300, Wash., DC 20036.

Payment Enclosed* ❑ $647

Bill Me ❑ $677

*Make checks payable to Atlantic Information Services, Inc.
D.C. residents add 5.75% sales tax.

Call 800-521-4323 (or visit the Marketplace at www.AISHealth.com) to order ***Health Plan Week on CD***, a searchable CD with all issues of the newsletter published from January 2005 to June 2008. ($89 for subscribers; $389 for non-subscribers.)

Visit www.AISHealth.com/conflist.html to review a free, regularly updated six-month calendar with dozens of *Upcoming Health Business Meetings.*

new "challengers" against their "champions" to achieve better outcomes. Challengers could evaluate what factors work best at achieving behavior change, such as the wording of a message, call patterns, an individual's income indicators, geography and health status. "You try different messages to see what people respond to and how they react."

Finally, the goal is an outcome, not a process. "It's not how many messages you send out or whether people open the letter," says Van Antwerp. "Rather, it's how many people took the desired action you were trying to achieve based on the message."

Moving people into the top box also means identifying key customer "touch points," those moments that matter most to a plan member. These touch points, or what one health plan executive calls golden moments, can be leveraged to create exceptional experiences that exceed what the customer already expects from the plan. Providing this "above and beyond" experience, Van Antwerp says, will help turn satisfied customers into loyal customers that will stay with the plan.

Van Antwerp himself had an "above and beyond" experience when Sprint, his cellular carrier, called and told him that based on his monthly usage, they were recommending that he switch to a lower-cost but equally effective package. "That clearly exceeded my expectations and made a lasting impression."

Call Centers: Touch Points and Data Sources

Lance Shipp, chief operating officer of The Beryl Companies, an operator of call-center outsourcing services for health plans and hospitals, tells *HPW* that a call center is both a critical touch point and a source of data for creating personalized customer experiences. "You have the opportunity to build a strong positive relationship that will make the caller want to continue to do business with you."

For Shipp, the call-center process begins with empathy and compassion for the person on the phone. "Unlike computers and appliances, heath care is a very personal and intimate issue. People want to be treated as individuals and with empathy," Shipp says. "If you do this, the experience will make the caller want to come back again."

Van Antwerp agrees, noting that many plans have their call centers focus on average seconds to answer (ASA) metrics, although research suggests that many callers don't pay attention to this. Rather, the call center should give the impression that the plan is there to help the member and that the plan views the member as a valued partner and not a cost center, he says.

Shipp says that advances in customer relationship management (CRM) technology make it possible for a call center to collect information about preferences, experiences and other information from each inbound caller that can be used by the health plan to micro-segment and personalize its outbound communications.

Contact Susan Frankle for Van Antwerp at sfrankle@silverlink.com, and Carol Stevenson at carols@kevinross.net for Shipp and Goldberg. ✧

Double-Digit Rate Hike Will Prompt Much Tougher Client Negotiations

A rocky economy, combined with an anticipated double-digit rate hike for HMOs in 2009, will prompt employers to use tougher negotiating tactics with health plans as they finalize benefit packages for the fall open enrollment season.

Preliminary analysis indicates that premium rates for fully insured HMOs will jump by 11.8% in 2009, according to a study released July 15 by Hewitt Associates. The human resources consulting firm says employers are likely to use "more aggressive" negotiating strategies with their vendors this summer to keep rate hikes in check. And as plans struggle to retain existing clients in their commercial HMO business, employers could be successful at winning a lower renewal rate for 2009, says Maureen Fay, a principal and co-author of the study.

"When [health plans] are pressed by a client they want to retain, we expect the rate increase will come down by an average of two to three percentage points," she tells *HPW*. "There is some conservatism built into the rates" by plans. *Case in point:* While Hewitt's initially forecast HMO rate increase for 2008 was 13.2%, final rates increased by only 9.4% because of a combination of employer actions, including negotiations and plan changes.

Other cost-cutting tactics cited in the study include:

◆ ***Consolidation of health plans:*** An increasing number of employers are expected to eliminate underperforming HMOs and move their covered lives into options offered by their most efficient carriers.

◆ ***Self- insuring:*** Employers also are moving away from local and regional fully insured HMOs and are consolidating enrollees under self-insured arrangements.

◆ ***Multi-year partnerships:*** Employers are increasingly negotiating multi-year partnerships with their health

Preliminary National HMO Rate Increases

Year	Increase
2009	11.8%
2008	13.2%
2007	11.7%
2006	12.4%

SOURCE AND METHODOLOGY: Hewitt Associates, based on HMO rate information from 160 large employers. July 2008

Go to www.AISHealth.com to sign up for FREE e-mail newsletters —
AIS's Health Business Daily *and* Government News of the Week.

plans to improve employee health. They also are holding their health plans accountable for improved clinical outcomes, reductions in claim costs, and high member satisfaction levels, according to Hewitt. Wellness programs, Fay says, have gained popularity among self-insured employers that want to improve the productivity and well-being of employees by helping them to stay healthy. That trend is now growing to include employers covered under fully insured plans.

◆ ***Dependent audits:*** Over the past five years, more than 40% of Hewitt's clients have conducted an audit to find and remove dependents who don't qualify for coverage from their plans. Another 10% of employers intend to conduct an audit this year. ✧

Medicare E-Prescribing Incentive Could Spread to Commercial Side

New financial incentives for the electronic submission of Medicare prescriptions could prompt physicians to replace paper pads with PDAs. It also could encourage commercial carriers to launch similar efforts to promote the use of e-prescribing among network providers.

On July 21, as part of the Medicare reform law enacted this month *(HPW 7/21/08, p. 1),* HHS outlined its strategy to boost Medicare payments for doctors who e-prescribe. For two years, beginning in 2009, Medicare will offer a 2% incentive payment to eligible physicians. The financial incentive will drop to 1% in 2011 and 2012, and to 0.5% in 2013. HHS has not yet identified how many or what percentage of prescriptions a physician will need to submit electronically to qualify for the incentives. Physicians who do not use the technology will see Medicare reimbursements reduced by 1% in 2012, 1.5% in 2013 and 2% in 2014. Some providers will be exempt from the requirements, however.

"Anything the government can do to support e-prescribing is helpful," says Matt Walsh, associate vice president, purchaser initiatives at Health Alliance Plan (HAP), a part of the Henry Ford Health System and a member of the Southeastern Michigan e-Prescribing Initiative. Walsh adds that details of the initiative, such as how the government will assess compliance, need to be worked out. He suggests that fields used to transmit a prescription to a pharmacy could be set up to automatically identify electronically submitted prescriptions. Those data could then be used by CMS. Such a model, he adds, would require some "teamwork" between pharmacies, e-prescribing vendors and the government. A model that requires self-reported data, he warns, will mean additional work for physicians and would be prone to error. Based on what is written in the bill, he explains, it seems that a physician whose business consists of 50% Medicare patients will have much more of a financial incentive to switch to e-prescribing than will a doctor whose business is just 5% Medicare.

The new law could prompt commercial insurers to consider similar financial incentives to their most valued physicians, says Anthony Schueth, CEO and managing partner of Point-of-Care Partners, a Coral Springs, Fla.-based consulting firm. "Many commercial payers have been waiting to see what incentives CMS would offer. What they've proposed is a different type of model that could be used as a benchmark for private health plans." Commercial payers, he explains, will need to determine if they are willing to contribute additional incentives or if some sort of financial penalty might make sense. Financial incentives could go a long way in encouraging e-prescribing.

But convincing physicians to embrace the technology, Walsh says, could take more than money. Some physicians, particularly those who have been practicing a long time, are either afraid of e-prescribing or simply don't like it.

"They feel they will have a more difficult time shifting [to e-prescribing] than will a recent medical school graduate who has always used computers," he says. And a doctor in a small practice might not have the time, skills or staff needed to make the transition to e-prescribing as quick and painless as it can be. Getting over the learning curve and completing the "full workflow transition" typically is a two-week process, Walsh says, adding that he has never seen a practice revert back to paper prescriptions after successfully making it through the transition period. Walsh also notes that a recent study of 500 Michigan physician practices that were e-prescribing found that 90% indicated that e-prescribing met or exceeded their expectations.

Medicare expects to save as much as $156 million over the five-year course of the program in avoided adverse drug events. CMS estimates that Medicare beneficiaries collectively experience as many as 530,000 adverse drug events every year, contributed to in part by negative interactions with other drugs, or by a prescriber's lack of information about a patient's medication history, according to HHS. The Institute of Medicine estimates that more than 1.5 million Americans are injured each year by drug errors.

N.C. Blues Plan Expands E-Prescribing Effort

On July 22, Blue Cross and Blue Shield of North Carolina (BCBSNC) said it had launched an e-prescribing Web site through which providers will have access to free Web-based software, vendor sources for discounted hardware and connectivity, and other e-prescribing technology options. Since launching its pilot program in

Call 800-521-4323 (or go to the MarketPlace on AISHealth.com) to order Health Plan Week on CD*, a searchable CD with all issues of the newsletter published from January 2005 to June 2008. ($89 for subscribers; $389 non-subscribers.)*

2006, the Blues plan says, more than 4 million electronic prescriptions have been written. The insurer is partnering with Community Care of North Carolina and its 14 regional health care networks.

BCBSNC is offering a one-time $1,000 incentive to network providers who want to participate in the program. To qualify for the incentive, providers must be registered with a certified e-prescribing vendor and must access medication history for a minimum of 20 patients in the fourth quarter of 2008. Incentives will be paid in first quarter 2009. Any pharmacies not able to accept electronic prescriptions also will qualify for a $1,000 incentive if they become electronically enabled by the end of 2008.

It is estimated that electronic prescribing can generate cost savings of approximately $250 per doctor per month because of increased use of generics, avoidance of unnecessary or inappropriate prescriptions and other efficiencies.

Contact Walsh at mwalsh@hap.org or Schueth at tonys@pocp.com. ✧

AHIP CEO Launches Health Care Reform Campaign, Faces Critics

The America's Health Insurance Plans (AHIP) trade group launched a campaign intended to support its health care reform goals that already is encountering critics. The organization says the campaign focuses on six principles: coverage, affordability, quality, value, choice and portability. AHIP joins other efforts to keep health care reform in the public mindset in this election year. But one other recently formed group with its own health care reform agenda — Health Care for America Now! (HCAN) — isn't a fan of AHIP's campaign.

AHIP launched its Campaign for an American Solution July 22 in Columbus, Ohio, where CEO Karen Ignagni held a roundtable discussion with uninsured residents of the city and "community leaders," according to the trade group. The AHIP campaign includes print advertisements and a separate Web site, www.americanhealthsolution.org.

The Ohio discussion was the first of a planned series that will be held in a number of cities, including Boston, Detroit, Minneapolis and New York City, AHIP spokesperson Robert Zirkelbach tells *HPW*. He says the Ohio event was the first because "Ohio is representative of the rest of the country; it's an important state in the upcoming election," He asserts that AHIP wants to make sure people get involved in the health care discussion, and that it should be a top issue in upcoming presidential and congressional elections.

The campaign is based on health care reform proposals that AHIP has developed over the past few years. The proposals seek to cover every American; create a safer, higher-quality health care system; and offer guaranteed-access for individuals *(HPW 6/9/08, p. 4)*, according to AHIP.

UnitedHealth Group is aware of AHIP's campaign and supports it, spokesperson John Parker tells *HPW*. "I think it's a new approach," he says. He adds, "I think AHIP's well suited to organize an effort like this, and it's a good opportunity" to go into the market and "see what the uninsured face."

HCAN — a campaign launched by more than 100 labor groups, community organizations, providers, small businesses and think tanks — has pledged to show up at all of AHIP's scheduled stops. Prior to the Columbus event, Richard Kirsch, HCAN's national campaign director, argued against AHIP's campaign. "Grassroots? Please. The new AHIP campaign will try sewing its own brand of Astroturf with the goal…of recruiting 100,000 activists who like their private health insurance," he said in a prepared statement.

During the Columbus discussion, Kim Betton, a member of HCAN, contended that when health plans talk about profitability, "you guys have all these different rules and regulations on how not to pay out money! And you make profits off of that."

Ignagni responded that "if you talk to a hospital, you talk to a doctor, you talk to any insurance company — in the for-profit industry or the not-for-profit industry — no margins, no mission." She also said, "We don't have the idea that we have all the answers. We don't have the idea that we're the only folks who can be listened to in this dialogue."

Call Zirkelbach at (202) 778-8493, Parker at (202) 654-9931 or visit healthcareforamericanow.org. ✧

Winning Strategies for MA Plans and PDPs Under the Mid-July Medicare Law

Join **John Gorman** and **Jean LeMasurier** of Gorman Health Group for an **August 7 audioconference.**

Visit www.AISHealth.com

United Results Offer No Surprises

continued from p. 1

Sally Rosen, a financial analyst with A.M. Best Co., agrees and says that while both companies have revised their full-year earnings projections, the issues that drove those revisions do not appear to be getting worse than the companies initially thought, she tells *HPW*.

With United's guidance revision early this month, many people were expecting another round of bad news, says Brad Ellis, a director in the insurance group at Fitch Ratings. "Maybe the silence [from WellPoint] gave people the jitters," he tells *HPW*. "But I think people are tapping their fingers now waiting for Aetna [Inc.] because that is the only major plan that hasn't stubbed its toe yet this year. "

While earnings results from the nation's two largest health plans were generally good news for the sector, Ellis cautions that there are no guarantees that the industry won't suffer more problems this year. "Nothing is written in stone, and there are a lot of [contract] renewals that will go on for the remainder of the year," he tells *HPW*. "We remain a little apprehensive" about publicly traded health plans. On July 9, Fitch changed its outlook for the health insurance sector from "stable" to "negative," citing lower anticipated profits into 2009 and limited financial flexibility.

Among health plans that have not yet posted their second-quarter earnings, Aetna and Humana Inc. previously reaffirmed their guidance. "We expect earnings [of those companies] to be in line with projections," Rosen tells *HPW*.

President and CEO Angela Braly kicked off WellPoint's July 23 conference call with investors by noting that in the second quarter of the year, the company "began to see a number of improvements as compared to the first quarter." The company had revised its earnings expectations just four months earlier. Net income for the second quarter was $750.5 million ($1.44 per share), down from $835.2 million ($1.35 per share) in the same period a year ago, WellPoint said. Full-year net income is now expected to be in the range of $5.42 to $5.57 per share, according to the company. The high end of

Judge Approves $255 Million Settlement Against Health Net

A U.S. District Court in New Jersey has approved a $255 million settlement in three class-action suits against Health Net, Inc, according to a July 24 statement issued by Wilentz, Goldman & Spitzer, P.A. the law firm that represented the plaintiffs. The suits — related to amounts paid for out-of-network services — could "be an important precedent" for health plans that have substantial out-of-network claim utilization, says Ed Kaplan, national health practice leader in Segal Company's New York City office.

Health Net offered details of the suit, and its likely financial implications, in its third-quarter 2007 earnings report. "The only thing new here is that the judge just finalized the agreement," says Health Net spokesperson Margita Thompson.

The suits charge Health Net and several regional subsidiaries with using a flawed database produced by Ingenix, a subsidiary of UnitedHealth Group, to "improperly reimburse" its members for insurance claims for out-of-network medical treatment. The class period extends back to 1997 and involves more than 2 million people in several states.

The first of the three suits was filed in December 2001 in New Jersey federal court. The class-action lawsuits relate to certain Health Net out-of-network commercial claims payment practices for the period between 1995 and July 2007, according to Health Net's third-quarter statement.

According to the suit, Health Net violated the federal Employee Retirement Income Security Act (ERISA), New Jersey's employer health plan law, and the U.S. Racketeer Influenced and Corrupt Organizations Act "by systemically underpaying members," according to the law firm. As part of the settlement, Health Net does not admit liability.

Under the terms of the settlement, Health Net will pay $215 million to more than 2 million participants in its health insurance plans. The company also will spend $40 million on business-practice changes.

Last February, Ingenix, which operates a database used by more than 1,500 health plans and insurers, was at the heart of an investigation into rate-setting practices launched by New York Attorney General Andrew Cuomo (D) *(HPW 2/18/08, p. 1)*.

To read details of the suits, see Health Net's third-quarter 2007 earnings report at http://health-net.tekgroup.com/article_display.cfm?article_id=5174§ion_id=1, or see the July 24 statement issued by Wilentz, Goldman & Spitzer at www.wilentz.com/Personal_News_AnnouncementDetails.aspx?ID=62.

Copyright © 2008 by Atlantic Information Services, Inc. All rights reserved. Reproduction by any means — including photocopy, FAX or electronic delivery — is a violation of federal copyright law punishable by fines of up to $150,000 per violation.

WellPoint's full-year projection is lower than the $5.67 figure the company announced last month. The revision, according to WellPoint, was due to lower-than-expected fully insured enrollment and costs associated with WellPoint's recent settlement of allegations of inappropriate individual policy rescissions in California.

Medical enrollment as of June 30 was 35.3 million — up 507,000 (1.5%) from the same date a year ago. WellPoint credited its national business for much of the growth. Enrollment, however, was down 99,000 from the end of the previous quarter. Much of the membership drop was due to WellPoint's decision to leave Ohio's Medicaid program, through which the company had 142,000 members. Braly said payment rates in Ohio "were not actuarially sound." The company also expects to lose about 150,000 members in Connecticut and another 50,000 members in Nevada when it leaves those state-sponsored programs this year. Braly called the loss of membership "disappointing."

As in the case of WellPoint, investors responded favorably to United's lackluster but expected second-quarter earnings by pushing the company's stock price up 10% by the end of the day to $26.21 a share. The company reported net income of $337 million (27 cents a share), down from $1.23 billion (89 cents a share) in the year-ago period. The earnings per share were 1 cent higher than the company projected July 2. United also reiterated that its full-year 2008 net earnings should be in the range of $2.95 to $3.05 per share on revenues of about $81 billion.

On July 2, United cut its 2008 earnings outlook for the second time in just six months. The company previously projected earnings of $3.55 to $3.60 per share. Some industry observers say other health plans could follow suit when they release their second-quarter results later this month.

United reported total enrollment of 32.7 million lives as of June 30, up from 31.1 million at the end of 2007, and from 32.4 million at the end of the first quarter. Much of the increase in the second quarter was the result of United's acquisition of Unison Health Plans, which added 320,000 lives in the Medicaid segment. Enrollment on the commercial-risk side declined by 95,000 lives from the end of the first quarter, and is down 520,000 from the end of June 2007.

More Health Plans Report Lower Earnings

Among other companies' newly reported results:

◆ ***Coventry Health Care, Inc.*** — In its second-quarter earnings report, released July 25, Coventry cited high medical costs as a key reason for sharply lower profit levels. The insurer reported net income of $83.2 million (55 cents per share), down from $151.3 million (96 cents per share) during the year-ago period. Last month, Coventry warned investors that its second-quarter earnings would be between 55 cents and 57 cents per share. The company also said it ended the second quarter with 4.7 million lives — up from 4.6 million at the end of the previous quarter and from 4.1 million on the same date a year ago. The company reaffirmed its full-year earnings expectations.

◆ ***AMERIGROUP Corp.*** — On July 24, the company posted a net loss of $162.5 million ($3.07 per share) for the second quarter of 2008. Included in the loss was a one-time charge of $234.2 million for its previously announced civil litigation settlement (see brief, p. 8). The second-quarter loss compares with a profit of $32.8 million (61 cents a share) in the second quarter of 2007. Excluding the impact of that charge, the company says, its second-quarter 2008 net income would have been $36.7 million (68 cents per share). AMERIGROUP said it expects the full-year 2008 net loss to be in the range of $1.35 to $1.45 per diluted share, which includes the impact of charges related to the settlement. As of June 30, the company had 1.7 million members — up 12.6% from the same date a year ago and up 1.9% from the end of the first quarter of 2008.

◆ ***Centene Corp.*** — The Medicaid insurer on July 22 reported net earnings of $18.0 million (41 cents per share) for the second quarter of 2008, up from $10.2 million (23 cents per share) for the same period a year ago. The increase in earnings was primarily driven by premium rate increases in Georgia and membership growth in Texas and Ohio. Also, Centene's contract with the Texas Foster Care program began April 1. As of June 30, the company's Medicaid managed care enrollment was 1.2 million, up from 1.1 million on the same date a year ago.

◆ ***WellCare Health Plans, Inc.*** — WellCare reported July 21 that it would restate its consolidated full-year financial statements for 2004, 2005, 2006 and the first half of 2007. The restatements, according to the company, are the result of accounting errors related to contracts with the Florida Agency for Health Care Administration, the Florida Healthy Kids Corp. and the Illinois Department of Health and Family Services. In his July 22 note to investors, Oppenheimer & Co. equities analyst Carl McDonald noted that since being raided by state and federal investigators last October *(HPW 10/29/07, p. 1)*, WellCare's stock has slid about 75%. "The restatement is further evidence to suggest WellCare's issues are nowhere near as severe as the market previously believed," he said in his note. He added that although the company didn't offer a timeline for filing its delayed Form 10-K and putting the investigation behind it, the restatement suggests "we're closer to the end than the beginning."

Contact Ellis at bradley.ellis@fitchratings.com, Jackie Knolhoff for Vaughn at jackie.knolhoff@edwardjones.com and Rosen at Sally.Rosen@ambest.com. ✧

Go to www.AISHealth.com to sign up for *AIS's Health Business Daily*, a quick-and-easy daily news feed that is informative, provocative...and free.

HEALTH PLAN BRIEFS

◆ **California Gov. Arnold Schwarzenegger (R) signed into law AB 1150, which bans health plans from rewarding their employees for canceling or limiting a patient's health insurance.** The governor's office said he signed the bill to protect consumers from unfair health care coverage rescissions. "To increase consumer protections, the Governor's legislative proposal on rescission includes stronger upfront requirements for health plans before they issue coverage to individuals, protects patients from being rescinded if their doctor never told them about a medical condition that affects their ability to obtain coverage and provides for an independent third-party review when a health plan seeks to rescind or cancel an enrollee's coverage," according to a prepared statement. The governor's office also reasserted that the governor is interested in enacting more comprehensive health reform legislation. Visit gov.ca.gov/press-release/10271.

◆ **AMERIGROUP Corp. said it will pay $225 million to the United States and the state of Illinois, plus about $9 million in legal fees related to civil litigation it is settling.** The settlement stems from allegations that the company intentionally did not enroll pregnant women or other high-risk Illinois residents in its Medicaid managed care plan there. The firm admits to no wrongdoing under the settlement. The company in the second quarter took a one-time charge of $199 million, net of an estimated tax benefit of about $35 million (see story, p. 1), related to the settlement. AMERIGROUP added that it will pay the settlement from funds it previously had established in response to the $334 million in judgments against the firm in the case. The company added that it is entering into a corporate integrity agreement with the Office of Inspector General of HHS in relation to the settlement. Call AMERIGROUP spokesperson Kent Jenkins at (757) 518-3671.

◆ **AvMed Health Plans and Delta Dental Insurance Co. said they have partnered to provide dental coverage for AvMed's group clients in Florida.** Under the agreement, AvMed group clients can choose to offer their employees one of two dental plans, DeltaCare USA (a prepaid program) or Delta Dental PPO (a preferred provider program). The plans can be offered on a voluntary basis or as an employer-sponsored benefit, AvMed said. Both Delta options cover preventive services such as cleanings and X-rays, as well as restorative, major and orthodontic coverage, the company said. The products are available only to those AvMed clients with at least five primary enrollees for the PPO and three for the prepaid plan, and who do not now have a Delta Dental plan, according to AvMed. Call AvMed spokesperson Conchita Ruiz-Topinka at (305) 671-7306.

◆ **House Small Business Committee Chairwoman Nydia M. Velázquez (D-N.Y.) and Rep. Joe Pitts (R-Pa.) introduced the "Small Business Cooperative for Healthcare Options to Improve Coverage for Employees" (Small Business CHOICE) Act of 2008.** According to the committee, the bill takes elements from the leading presidential candidates' health reform proposals and would "help curb the rising costs of health insurance plans for entrepreneurs." The committee added that the legislation would lessen the volatility of premiums and add "important incentives helping small firms expand coverage for working families." The bill would offer a refundable tax credit of 65% to small businesses, those with less than 100 employees, that offer health insurance to employees. The legislation also would reduce risks for health plans by allowing small firms to form voluntary health cooperatives through which they can pool employees. The committee said "self-employed individuals would save $5,000 per year on health coverage costs," and other small firms would save more than 34%. Visit www.house.gov/smbiz.

◆ **The Connecticut Health Reinsurance Association, the state's high-risk pool, will receive a $1.18 million grant from HHS.** The department awarded more than $49 million to 30 states to help them run their high-risk insurance pools, the *Hartford Courant* reports. Connecticut's pool has 2,554 policies in force, the newspaper said. Visit www.hract.org.

◆ **Quotebroker Insurance Services said it is making health insurance brokerage services available in Texas.** According to Quotebroker, it offers free health insurance quotes and high-risk plans "for those who have difficulty obtaining affordable health insurance." The company provides services to individuals, families, groups and associations. The brokerage now offers services in Texas, Arizona, California and Nevada. Quotebroker said its free insurance quotes are available online. Call Quotebroker spokesperson Vince Pappadato at (661) 702-1755.

Call Bailey Sterrett at 202-775-9008, ext. 3034 for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data…daily, weekly or whenever you need it.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

(1) Call us at **800-521-4323**

(2) Fax the order form on page 2 to **202-331-9542**

(3) Visit the MarketPlace at **www.AISHealth.com**

If You Are a Subscriber And Want to Routinely Forward this E-mail Edition to Others in Your Organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these e-mail editions without prior authorization from AIS, since strict copyright restrictions apply.)