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Health Plan Week

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

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Will Employers Drop Coverage After 2014? Probably…Not, Industry Observers Tell *HPW*

Nearly one-third of employers will "definitely" or "probably" drop insurance coverage and send employees to state insurance exchanges in the years after 2014 — the year the exchanges are slated to be operational — according to a new report that has attracted a lot of attention in the mainstream media. But industry observers contacted by *HPW* are dubious that employer-based coverage — particularly among large employers — will change much once exchanges are up and running.

The report, published in the June issue of the *McKinsey Quarterly*, is based on a survey of 1,300 employers conducted early this year across various industries, geographies and employer sizes. The study also concludes that at least 30% of employers "would gain economically from dropping coverage" even if they countered the loss of health coverage with higher salaries or other benefits. But coverage offered through state exchanges probably won't be as rich and most likely will be more expensive than employer-based coverage, sources tell *HPW*. And employers that drop coverage could find it difficult to attract and retain employees.

The study's conclusion "is not credible," says David Godofsky, the leader of the Employee Benefits & Executive Compensation Group at the law firm Alston & Bird. Reduced FICA taxes for employers, reduced income and FICA taxes for employees, and group rates — which are less expensive than individual rates — for insurance are among "the powerful incentives" that compel employers to offer coverage now, he tells *HPW*. And those incentives won't change after 2014. "Employees want insurance not only for the risk reduction but also for the negotiated discounts that insurers get — which are substantial — and the tax benefits."

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New Risk-Pool Rates May Boost Enrollment, But Barriers Could Go Beyond Just Price

On May 31, HHS said premiums for federally operated Pre-Existing Condition Insurance Plans (PCIPs) would be reduced by as much as 40% in some states. Health insurers and third-party administrators (TPAs) that operate state PCIPs say they're optimistic about HHS's decision but concede they're not yet certain if they'll be able to cut rates in states where they administer the programs. Moreover, a requirement that applicants be without health coverage for at least six months might be a bigger barrier to enrollment than high premiums.

The Congressional Budget Office estimated that as many as 4 million uninsured Americans would qualify for the program — which was created by the health reform law — and predicted that 200,000 would be enrolled by 2013. The government set aside $5 billion to fund the plans.

As of March 31, just 18,313 people were enrolled nationally in PCIPs, which were designed to serve as a bridge for people who can't otherwise find health coverage. Once the state insurance exchanges are operational in 2014, high-risk members will be able to purchase coverage without being charged higher rates due to a pre-existing condition.

continued

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Government Employees Health Association, Inc. (GEHA) administers PCIPs for the federal government in 23 states plus the District of Columbia. Rates will be reduced in 17 of those states beginning July 1, and six states will see premiums shrink by 40%. "We expect that lower PCIP premiums in many of these states will lead to increased enrollment," says Cindy Butler, GEHA's research and development manager.

Nevada Insurance Commissioner Brett Barratt tells *HPW* he's optimistic that the lower premiums will encourage some of the thousands of qualified applicants in the state to enroll. Indeed, Caesars Palace in Las Vegas might have more people lounging around its swimming pools on any given day than the 182 people now enrolled in Nevada's high-risk pool. Coverage offered through that PCIP, which is administered by GEHA, will be slashed by 37.5%. That will put coverage costs on par with individual coverage sold by commercial carriers. Nevada received $61 million in federal dollars to run the program for the next three years. Only a fraction of that funding has been tapped so far.

Last year, Blue Cross and Blue Shield plans and a handful for regional carriers were awarded contracts to administer PCIPs *(HPW 8/30/10, p. 1)*. Group Health, Inc. (GHI), which administers New York's PCIP, says its program has 1,500 enrollees, and an additional 200 have been approved for coverage. The enrollment is higher than that in most states due to an outreach campaign aimed at potential members. GHI, an EmblemHealth company, has an employee dedicated solely to boosting the program's visibility and enrollment. Along with past TV and Internet advertisements, GHI is working with hospitals and disease-based special interest groups to promote the program, says spokesperson Ilene Margolin. She says it's too soon to tell if PCIP rates in the state will be reduced. "We are in discussions with the State Department of Insurance about whether New York will reduce premiums."

New Formula Leads to Lower Rates

CMS initially based PCIP premiums on the average commercial rates charged among all of the 23 states and the District of Columbia, and adjusted that average for local medical cost factors. Since then, CMS has obtained additional premium data on the individual market from carrier filings. The enhanced data, according to HHS, are both state-specific and specific to the most popular and affordable health plans. The new data indicated that premiums were too high in many states.

In a May 31 letter to PCIP administrators, HHS outlined a number of strategies that could be used to reduce rates such as incorporating new individual market data or revising the methodology for determining the standard risk rate. Several PCIP administrators tell *HPW* that they're not yet sure if such methodologies will translate to lower rates.

Going Without Coverage Is Biggest Barrier

Only applicants who have been without health insurance for at least six months can qualify for coverage through a PCIP. That rule, more than high premiums, has been the biggest barrier in attracting enrollees, says Russ Childers, an agent based in Americus, Ga. "People with significant health problems do not feel no coverage is an option," he says. "Most of these folks don't even look at the cost of the PCIP, although it would be significantly less than their current premium" under COBRA, for example.

James Drennan, a principal and consulting actuary at Ingenix Consulting, a subsidiary of UnitedHealth Group, agrees that rule, along with limited communication about PCIPs, are the main reasons for low enrollment. "Cutting premiums will be unlikely to increase enrollment significantly….It appears that the publicity caused by the premium reduction has brought the attention of some uninsured people to the plan, which may result in additional enrollment for those uninsured who meet the six-months-with-no-coverage requirement."

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While that rule remains, beginning July 1, individuals applying for coverage in federally administered PCIPs will no longer be required to provide a denial letter from an insurance company.

Instead, HHS says applicants can provide a letter from a doctor, physician assistant or nurse practitioner — dated within the last 12 months — that indicates the applicant has, or had, a medical condition, disability or illness. But it's unclear what will qualify as an allowable medical condition.

Brokers Can Earn $100 per Enrollee

Beginning sometime this fall, insurance agents and brokers will be eligible for an incentive of $100 for each member they successfully enrollee in a federally operated PCIP. This is on par with what some state high-risk pools now pay agents. Some state PCIP administrators tell *HPW* that they are looking into similar compensation models.

Barratt says he's encouraged by the move. "We have some good agents and brokers who are enrolling people now, and $100 [per enrollee] will help offset some of their costs," he says.

Along with a financial incentive, the decision seems to indicate that HHS understands the value that brokers and agents bring to the table, which might be a positive sign that HHS might be warming to the idea of eliminating commissions from the medical loss ratio rule, suggests Roy Ramthun, president of HAS Consulting Services. Ramthun served as a special assistant on economic policy at the White House during the George W. Bush administration.

Childers says brokers and agents often encounter and try to help individuals with pre-existing conditions who are having trouble obtaining traditional private coverage. "While many of them offer this service free of charge, the additional money "will help compensate them in the future for their professional help."

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WellPoint Agrees to Buy Senior Specialty Firm for $800 Million

WellPoint, Inc. has agreed to acquire CareMore Health Group — a privately-held, California-based operator of Medicare Advantage (MA) plans, clinics and disease-management programs for seniors — WellPoint said in a prepared statement June 8.

CareMore's reported price tag of about $800 million works out to almost $15,000 per member. By contrast, HealthSpring, Inc. paid $545 million to acquire Bravo Health, Inc., which had nearly double the number of MA members and 400,000 Medicare Part D prescription drug plan lives, Citi Investment Research analyst Carl McDonald wrote in a June 9 note. But, he added, CareMore's clinical operations presumably generate revenue, too.

The reported acquisition price, according to McDonald, suggests that publicly traded Medicare assets are undervalued. "Universal American and WellCare [Health Plans, Inc. are] valued at less than a third of what WellPoint believes CareMore is worth," he wrote, adding that the CareMore deal probably won't be the last significant MA acquisition of the year.

The acquisition would add to WellPoint's "already dominant position in California, Arizona and Nevada," Credit-Suisse equities analyst Charles Boorady wrote in

This Month in *Health Plan Week* History

In May 1991, Atlantic Information Services launched *Managed Care Week* (now *HPW*). Over the past two decades, we've produced nearly 1,000 issues along with myriad special reports. Here's a look at the issues we were tracking in June 20 years, 10 years and five years ago:

June 3, 1991: Health Net Converts to For-Profit — Health Net, the second largest HMO in California, is converting from a nonprofit corporation to a for-profit, employee-owned business corporation….

June 4, 2001: Anthem Swallows Kansas Blues on Its March to For-Profit Conversion — Blue Cross and Blue Shield of Kansas will become a wholly owned subsidiary of Anthem, Inc., which now operates eight Blue Cross and Blue Shield plans….

June 12, 2006: Calif. DOI's Push to Boost MLRs Could Change Pricing — John Garamendi (D), commissioner of the California Dept. of Insurance, said June 1 that he intends to issue regulations requiring health insurers to have a medical loss ratio of at least 70%, up from the current 50% level….

SOURCE: *Health Plan Week* archives

a note to investors. CareMore's MA plans cover about 54,000 lives, and it operates 26 clinics staffed by physicians, nurse practitioners, nutritionists and other care providers. The company has about 1,200 employees. Alan Hoops, CareMore's chairman and CEO, previously served as president and CEO of PacifiCare, a publicly traded California-based health insurer that was acquired by UnitedHealth Group in 2005 *(HPW 7/11/05, p. 1)*.

As of March 31, WellPoint reported 1.33 million members in its senior business — mostly in MA plans. As of March 31, WellPoint said its total medical enrollment was 34.2 million.

The transaction, which is expected to close by the end of 2011 pending state regulatory approvals, is expected to be neutral to earnings in 2012 and accretive in 2013 and beyond, according to WellPoint's Chief Financial Officer Wayne DeVeydt.

To see WellPoint's statement on the pending deal, visit http://tinyurl.com/3taghx3. ✧

Molina Loses Louisiana Medicaid Contract; Stock Prices Fall 4%

Molina Healthcare, Inc., a Medicaid managed care company, says it received word June 9 that the Louisiana Office of State Purchasing had issued an intent to award its Medicaid Management Information System (MMIS) project to CNSI. The contract is worth about $50 million a year to Molina, or 1% of their revenues, Credit-Suisse equities analyst Charles Boorady wrote in a note to investors. The company will continue to maintain the existing MMIS contract for a couple of years until a new system is implemented by the new vendor and approved by CMS, according to Molina Executive Account Manager Karl Schnur. The news pushed Molina's stock price to $25.34 by 10 a.m. Friday — down nearly 4% from the previous day's close. Schnur tells *HPW* that Molina, and entities that later became a part of Molina, have serviced the contract since 1984.

Earlier in the week, Wedbush Securities lowered its price target for Molina from $45 to $30 due to the company's 3-for-2 stock split that was announced in April. Visit www.molinahealthcare.com. ✧

Reform May Push Benefit Changes

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Bill Sharon, a benefits consultant at Towers Watson, says he's surprised by McKinsey's findings. A mere 3% of employers surveyed by his company last year indicated that they would likely drop health coverage once insurance exchanges become an option. Those survey respondents were predominantly large employers (i.e., more than 1,000 employees). "Although the McKinsey study is more recent,…I don't think we've had more clarity in the past year. In fact, some would argue we have less clarity now than we did a year ago," he tells *HPW*.

But Paul Fronstin, Ph.D., a senior research associate with the Employee Benefit Research Institute, says the exchanges will be a "game changer" by creating a viable alternative to employer-based coverage. Once some employers opt to make the move, others will follow. "It doesn't matter if the percentage in a survey is 30% or 3% — the first one to [drop coverage] is going to trigger others to do it," he contends.

Small Employers Have More Incentive to Drop

The threat of fines could give employers another reason to maintain existing benefits, says Carol Taylor, director of compliance at Orlando, Fla.-based Beacon Benefit Consulting. Beginning in 2014, employers that have at least 51 employees and don't offer coverage are subject to an annual per-employee penalty of $2,000 for each full-time employee (FTE) after the first 30. And employers that do offer coverage could be penalized $3,000 for each employee who qualifies for a subsidy (i.e., 133% to 400% of the Federal Poverty Level (FPL)) and opts for coverage through an exchange. Rules about exactly how these penalties will work still need to be clarified through guidance, Taylor notes.

But employers with fewer than 51 workers won't be penalized for not providing health coverage. As a result, low-wage firms that provide coverage will be at a competitive disadvantage if similar-sized firms drop coverage and boost wages, says Devon Herrick, Ph.D., senior fellow at the right-leaning National Center for Policy Analysis. "For moderate-income workers, the exchange subsidy is about five times greater than the tax subsidy for employer plans," he explains. "In many instances, workers will qualify for subsidies worth $15,000 or more depending on their income and where they live. This is especially true in high-cost areas," he says. "Any time the exchange subsidy far exceeds the penalty for much of a firm's work force, it makes sense from an employer standpoint to drop coverage, pay the fine, raise cash wages and send workers to the exchange."

Penalties based on the number of FTEs also could provide employers with a financial reason to use more

part-time workers, adds Taylor. But HHS could minimize that issue, for example, by implementing a "look-back" rule that bases penalties on the number of FTEs a company had a year earlier, Taylor suggests.

Health care consultant Robert Laszewski, president of Health Policy and Strategy Associates, LLC, agrees that the lack of penalties, combined with guarantee-issue coverage in the exchange, could create a compelling financial case for small employers to drop coverage.

"Uncle Sam is the new payer subsidizing premiums, and the leading health plans will all be on the exchange with benefit plans that will look a lot like the plans employees will be leaving behind," he tells *HPW*. "It gets a lot harder for the employer to make such a decision when the fine is taken into consideration. Also, when the work force has higher incomes, the decision is more problematic since the federal subsidies are most generous for families making less than about $55,000 per year." Employees who are below 140% of the FPL aren't subject to rating bands, which could make the coverage even more affordable, Fronstin adds.

Adverse Selection = Bigger Premiums

Individual options offered through an exchange are usually going to be high-deductible, expensive plans that will be financially unattractive to the typical employee, according to several industry observers. And that will put more pressure on employers to keep coverage intact, particularly for large employers.

The exchanges are likely to attract people who qualify for a subsidy and those who were previously uninsured due to a pre-existing condition. That sort of risk pool will make adverse selection within the exchanges a significant threat.

Godofsky predicts that adverse selection will ensure that premiums for exchange-based coverage will be more expensive than those for employer-sponsored plans. "In order to keep employees, an employer who drops coverage will have to increase salaries by more than the cost savings. All of this comes before you apply the penalty of $2,000 per employee if you drop coverage. Paying a penalty for not offering coverage provides an incentive to offer coverage. Having to provide insurance for currently uninsured groups is not an incentive to drop coverage; it is an incentive to raise the employee premium."

Insurers Must Create 'Seamless Transition'

If the exchanges do prompt a mass exodus from employer-based coverage, McKinsey suggests that health insurers might be able to counter losses on the group side by boosting enrollment on the individual side if they can offer "a seamless transition for workers" who transition from employer-sponsored coverage to an exchange-based option. More than 70% of employees would stay with their insurer, according to McKinsey's research.

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Assuming nothing changes legislatively, Carl Doty, vice president and practice leader of consumer product strategy at Forrester Research, agrees that consumers are likely to stick with their existing carrier if the transition is easy and the coverage is similar. McKinsey's statement "indicates consumers' desire to not be disrupted,… but I think that disruption is inevitable," he tells *HPW*. "Most consumers can't afford to pay what their [employer-based] policies actually cost, so they will have to downgrade their coverage significantly. This will trigger a 'shopping effect,' and insurers will suffer large hits to retention rates." To fend off member attrition, insurers will need to disrupt their own business models and create plans that emphasize "simplification, personalization and digitization," he says.

The transition from coverage offered by a self-insured company to full-risk, exchange-based coverage "will be a net positive for managed care," Credit-Suisse analyst Charles Boorady wrote in a June 6 note to investors. "However we will likely see winners and losers within managed care," he added.

The McKinsey study looks to "the years after 2014," which is still a long time away, and details about coverage, premiums and how the exchanges will operate are still unknown. While Fronstin says employers are likely to move employees onto exchanges at some point, the transition will probably occur over many years rather than overnight. The move to exchanges "is likely to play out no differently than other changes in employee benefits," he says. The move toward managed care, for example, occurred over decades. "The difference today might be desperation.…Employers are desperate to do something."

Ken Sperling, global leader of the Health & Benefits Practice with Aon Hewitt, agrees that big changes will take time. "We may, in fact, see a shift from traditional group models to individual products, just as we are currently seeing in the post-65 retiree marketplace," he says. "But it will happen slowly, and only when the alternative offers a superior value proposition to the employer and employee. That's what health insurers will need to offer in order to grow as the market shift occurs."

And many employers want to wait to see how the reform law — and the development of exchanges — plays out before making any bold moves. "Both proposed and final regulations for key provisions [of the law] have yet to be promulgated. Additionally just over half the states are currently pushing for reform's repeal through the

Health Plan Stocks Stalled in May, but Remain up 44% Since Jan. 1

Stock prices for four of the 12 publicly traded stocks tracked by *HPW* declined slightly in May. For the year, however, stock prices are collectively up nearly 44% since Jan. 1, with Medicaid and Medicare stocks seeing the biggest gains.

	Closing Stock Price on 5/31/2011	May Gain (Loss)	Full-Year Gain (Loss)	Consensus 2011 EPS*	Consensus 2011 P/E Ratio*
COMMERCIAL					
Aetna Inc.	$43.68	5.6%	43.2%	$4.36	10.0 x
CIGNA Corp.	$49.89	6.5%	36.1%	$5.02	9.9 x
Coventry Health Care, Inc.	$35.18	9.0%	33.3%	$2.97	11.8 x
Health Net, Inc.	$32.09	(3.6%)	17.6%	$2.99	10.7 x
UnitedHealth Group	$48.95	(0.6%)	35.6%	$4.19	11.7 x
WellPoint, Inc.	$78.17	1.8%	37.5%	$7.02	11.1 x
Commercial Mean		**3.1%**	**33.9%**		**10.9 x**
MEDICARE					
HealthSpring, Inc.	$43.85	5.7%	65.3%	$3.71	11.8 x
Humana Inc.	$80.53	5.8%	47.1%	$7.02	11.5 x
Medicare Mean		**5.7%**	**56.2%**		**11.6 x**
MEDICAID					
AMERIGROUP Corp.	$70.91	3.8%	61.5%	$4.45	15.9 x
Centene Corp.	$34.80	(3.9%)	37.3%	$2.11	16.5 x
Molina Healthcare, Inc.	$27.18	(5.2%)	46.4%	$1.54	17.6 x
WellCare Health Plans, Inc.	$49.25	12.4%	63.0%	$3.72	13.2 x
Medicaid Mean		**1.8%**	**52.0%**		**15.8 x**
Industry Mean		**3.1%**	**43.6%**		**12.7 x**

* Estimates are based on analysts' consensus estimates for full-year 2011.
SOURCE: Bank of America Merrill Lynch. Compiled by Atlantic Information Services, Inc., June 2011.

court system, an indication of the significant resistance to the law and just the first big challenge of many that are probable," notes Bill TenHoor, president of TenHoor and Associates, a strategic planning and market analysis firm based in Duxbury, Mass. Even if the reform law stays intact, it will take several years for attitudes among employers to change. But if the reform law does help to stabilize coverage costs, employers will have even less incentive to drop coverage, he adds.

For employers, determining whether to drop coverage will be a matter of crunching the numbers. While some small employers will determine it makes more financial sense to eliminate health benefits, tax incentives and a need to attract and retain employees will give larger employers a reason to maintain benefits, says Shawn Nowicki, director of health policy at Northeast Business Group on Health. Many employers, he says, are tweaking existing plans to avoid the 40% excise tax on high-cost plans, "a clear sign that they intend to stay in the game for a number of years."

"I think all employers will be doing the math to see what their situation will be in 2014," says Helen Darling, president and CEO of the National Business Group on Health. "If you do the math, the penalty [for not offering coverage] is relatively low compared to cost of coverage. But that might not continue to be the case."

Presumably, in the end, most companies will make the financial decision that is best for them. And that will rarely, if ever, be to drop coverage entirely. More likely, employee premiums will rise, Godofsky says.

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People on the Move

CIGNA Corp. named **Ralph Nicoletti** executive vice president and chief financial officer (CFO). He will join the company on June 20. Most recently, Nicoletti served as executive vice president and CFO at Chicago-based Alberto-Culver, Inc., a manufacturer and marketer of personal care and household brands recently acquired by Unilever Group….**Scott Kipper,** who has headed Louisiana's Office of Group Benefits (OGB) since April, has resigned. He will leave his post on June 24, the day after the state's regular legislative session ends. OGB provides health and life insurance to more than 148,000 state workers and retirees and more than 107,000 of their dependents….UnitedHealth Group hired **Rich Baer** as its top legal officer. He previously was general counsel and chief administrative officer at Denver-based Qwest Communications International Inc. **Mitchell Zamoff** will take over as chief legal officer for UnitedHealthcare, and **Christopher Walsh** was named to the same post at United's Optum subsidiary. Walsh and Zamoff will retain their current roles as executive vice president and general counsel for UnitedHealth Group. The appointments were effective May 31….Michigan-based Health Alliance Plan (HAP) has appointed **Todd Hutchison, DeAndre Lipscomb** and **Bob Smythe** to its leadership team. Hutchison, vice president of underwriting and actuarial services, previously served as vice president of sales and account management at Health Alliance Medical Plans. Lipscomb was named vice president of community outreach. He previously was director of market communications at Blue Cross Blue Shield of Michigan, where he was a member of the Diversity and Inclusion Leadership council. Smythe, HAP's new vice president of provider network operations, most recently was interim chief operating officer at St. Joseph Mercy Hospital in Ann Arbor, Mich.

Tennessee Blues Terminates Two Executives: Nearly two years after joining BlueCross BlueShield of Tennessee as director of pharmacy programs for its government business and emerging markets unit, **Matthew Palmgren, Pharm.D.,** has been terminated after previously being on administrative leave, *The Chattanoogan* reported June 7. Palmgren's wife has been missing since April 30, according to the newspaper, which notes that no charges have been filed and police have not released details about the situation. **Tammy Helton,** manager of government product development, also was let go by the insurer, which cited misuse of company equipment and inappropriate email use for letting both employees go, the newspaper reported June 8. A spokesperson for the Tennessee Blues plan declined *HPW*'s request for comment. In court records, Palmgren indicated that his wife was suffering from severe mental illness and claimed their children's passports are missing, according to the newspaper. Prior to joining the Tennessee Blues plan, Palmgren was director of clinical pharmacy programs at Humana, Inc., where he helped develop the company's Medicare Part D formularies. From 2002 to 2004, he was clinical services manager at BlueCross BlueShield of Alabama, according to a July 2009 announcement from BlueCross BlueShield of Tennessee.

HEALTH PLAN BRIEFS

◆ **Group Health Options' 53,000 individual plan members on July 1 will see a rate hike of 18%, as well as other changes to their plans.** Group Health and its subsidiary Group Health Cooperative will also charge copayments for newborns and higher fees for larger families in its individual products. Traditionally the insurers have waived the newborn copay and charged only a flat two-child rate, regardless of the number of children. Group Health spokesman Mike Foley told *HPW* that newborn copays and higher premiums for larger families have become standard practices for the industry. Foley said the changes were necessary because of the explosion of growth of new enrollees that "occurred during a time of economic turmoil, which added to the inherent challenge of accurately predicting utilization trends for such an influx of new individual members." Visit www.ghc.org.

◆ **Health Alliance Medical Plans asked a judge June 6 to block the new Illinois health insurance contracts for state employees, retirees and dependents from going into effect July 1 and to continue to use its plan as an option.** On April 6, the Illinois Department of Healthcare and Family Services announced that it was dropping Humana, Inc. and Health Alliance from the state's insurance program and was selecting Blue Cross and Blue Shield of Illinois and BCBS Blue Advantage instead *(HPW 4/25/11, p. 8)*. Health Alliance asked a circuit court judge for a temporary restraining order to block the new contracts until the insurer's case can receive a full review in court. On May 31, the American Federation of State, County and Municipal Employees (AFSCME) filed a grievance against the state, arguing the decision to drop Health Alliance and Humana violates the State Employees Group Insurance Act. A bill that would extend all existing state insurance contracts for two years, restructure the bidding process and give the Commission on Government Accountability and Forecasting greater authority to approve or reject state insurance contracts was sent to Gov. Pat Quinn's (D) desk June 2. It is unknown if Quinn plans to sign the bill. For more information, visit https://healthalliance.org.

◆ **Blue Shield of California on June 7 authorized a new rule that limits its annual income to 2% of revenue and requires any profit in excess of that to be returned to customers and the community.** The Blues plan said since the new rule is being implemented retroactively to 2010, the insurer will pay back $180 million in excess profit. Individual policyholders will receive a 30% premium credit, or about $80 for individuals and $250 for a family of four, on their October 2011 bill, according to the Blues plan. For small-group plans with fewer than 50 employees, the credit will be $125 for one person and about $340 for a family of four. The insurer noted that employers that pay part of the premium will decide how the credit is distributed to employees. Blue Shield added that it will provide $10 million in funding to California hospitals and physician groups to participate more efficiently in accountable care organizations. Visit www.blueshieldca.com.

◆ **Medco Health Solutions, Inc. said May 27 that the Blue Cross Blue Shield Association will not renew its $3 billion contract with Medco to handle mail-order and specialty drug benefits for the Federal Employee Program (FEP).** The contract, which Medco had handled since 2008, will go to CVS Caremark Corp., which already administers the FEP's clinical programs and retail pharmacy benefit management services. CVS Caremark will take over the additional services Jan. 1, 2012. Medco said the loss won't affect its 2011 earnings. Visit http://info.cvscaremark.com.

◆ **Coventry Health Care Inc. said May 31 that a court approved its $150.5 million settlement of a class-action lawsuit that accused it of violating Louisiana's Any Willing Provider Act.** The suit alleged that Coventry's subsidiary First Health Group Corp. violated notice provisions of the state's Any Willing Provider Act related to the treatment of injured workers with worker's compensation claims. In July, a state appeals court upheld a $262 million judgment against First Health. The insurer added that it will record a gain of $159.3 million, or 68 cents per share, in the second quarter because it set aside more money than it needed to cover the settlement *(HPW 8/2/10, p. 8)*. For more information, visit www.coventryhealthcare.com.

◆ **CORRECTION:** An article in the May 30 issue of *HPW* incorrectly indicated that people enrolled in Health Alliance Plan's Health Engagement product can see reduced premiums by completing a health risk assessment. Members enrolled in that product save on out-of-pocket costs (e.g., deductibles, copayments, coinsurance) rather than premiums.

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2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

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