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VC Firms See Potential in Health Services, But Investments Under Reform Are Risky

The health reform law — and the year leading up to its enactment — put a big chill on venture capital (VC) investments in the health services sector. But there appears to be at least some thawing, VC firms tell *HPW*. And that could be good news for health insurers if new technologies can help them reduce administrative costs, boost efficiencies and improve patient outcomes.

In the third quarter of 2010, venture capitalists plugged $128 million into the health services sector — triple the amount invested in the previous quarter and 12 times the amount seen in the year-ago period, according to a quarterly survey of VC investment trends conducted by the National Venture Capital Association (NVCA) and PricewaterhouseCoopers. Just three of the 17 sectors cited by the study experienced investment increases between the second and third quarters. A NVCA spokesperson tells *HPW* that it's too early to know what caused the spike or whether it is sustainable. The percentage of VC dollars dedicated to businesses in the health services sector has been declining for the past several years, and made up less than 1% of total VC investments in 2009 (see chart, p. 5).

VC firms "are starting to look for new opportunities and maybe the time has finally come where they can make some money in this space," says Tracy Lefteroff, global managing partner in PWC's Life Sciences Industry Services division. But, he warns, health services is one sector where VC firms have historically found it difficult to turn a profit. And while the reform law has created an enormous need for innovation, it's nearly impossible to determine which types of companies will thrive.

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Staggering Growth in Diabetes Pushes Insurers to Identify and Treat Those at Risk

As many as 1 in 3 U.S. adults could have diabetes by 2050 if current trends continue, according to data released in late October by the Centers for Disease Control and Prevention (CDC). About 1 in 10 adults have diabetes now. The cost, combined with soaring growth of the illness, is prompting some health plans and employers to take a more aggressive approach in identifying and treating diabetic members and those who are at risk.

Health insurers queried by *HPW* say commercially insured diabetic members consume between $8,000 and $12,000 a year in care, excluding prescription drugs. Charlie Smith, M.D., chief medical officer for national accounts at CIGNA Corp., estimates a typical diabetic member consumes between $8,000 and $10,000 a year in care. But other chronic conditions, such as diabetes, back pain and depression, which often accompany diabetes, can increase costs tenfold, he adds.

"The private sector is starting to recognize that in this new world of cost containment, you can't continue to reduce premiums by selective underwriting," says Ken

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Thorpe, Ph.D., a public health policy researcher at Emory University. Just 20 years ago, cancer and heart disease drove most of the nation's medical spending. Over the past decade, diabetes, however, has become the most expensive condition for health insurers. But unlike cancer, diabetes — along with high blood pressure, high cholesterol and back problems — can be traced to obesity.

Financial incentives offered to employees who maintain healthy weights are likely to become more prevalent among health insurers and employers. Value-based benefit designs that offer discounted or free medications to diabetic employees in exchange for compliance are also becoming more common. "I think you're going to see a lot more interest by health plans to really build this capacity out because we are seeing both short-term and long-term reductions in spending," Thorpe tells *HPW*.

Finding Prediabetics Is Key

While the CDC estimates 24 million Americans have diabetes, a staggering 57 million people are at risk of developing it. According to 2007 data from the American Diabetes Association, nearly 6 million diabetics don't know they have the disease.

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Moreover, some studies suggest that about 11% of prediabetics become diabetic each year, and 80% of diabetes is due to obesity, says Sami Bég, M.D., associate medical director for U.S. Preventive Medicine, Inc., a provider of wellness, chronic condition management and care advocacy programs.

Health insurers contacted by *HPW* agree that identifying and engaging prediabetic patients early is critical. Aetna Inc. is piloting a metabolic syndrome screening program on its own employees. Metabolic syndrome refers to a group of five risk factors that increase the risk of cardiovascular disease and diabetes.

Members who have healthy levels in at least three of the five risk factors will receive a $300 reduction in their 2011 insurance premiums. The program began this summer, which gave Aetna employees time to get conditions under control — typically through diet and exercise — before the company's open-enrollment period gets underway in November. "We are talking to plan sponsors about how they can implement a similar program," says Laura Clapper, M.D., senior medical director of national accounts.

United Works to Grow Alliance

In 2002, a national trial dubbed the Diabetes Prevention Program (DPP) concluded that weight loss of just 8% — through exercise and diet — reduced the risk of developing diabetes by 58% among obese and overweight participants considered prediabetic. Participants age 60 and older reduced their risk by 71%. The program received funding from CDC and the National Institutes of Health. Over the past several years, the protocols used by DPP have been implemented by the YMCA, which has received some funding from the CDC.

While DPP was successful, the program wasn't scalable because it relied on one-on-one counseling with clinical personnel and nutritionists. Costs averaged about $2,700 per participant over three years. The YMCA-based program, which uses group counseling, costs just $400 a year per participant, but the results have been virtually the same.

Although the results of the DPP are impressive, Christine Ferguson, associate research professor at George Washington University's Dept. of Health Policy, says coverage for conditions that often lead to diabetes sometimes aren't covered by health plans. "There is a stigma related to obesity, and there isn't a clear consensus that this is a condition that needs to be treated as opposed to it being more of a personal-responsibility issue."

Last spring, UnitedHealth Group — through a partnership with YMCA of the USA and Walgreen Co. — launched the Diabetes Prevention and Control Alliance,

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which it says is "a scaling" of the DPP and another program that worked directly with pharmacists. Through the program, a trained lifestyle coach encourages participants to eat healthier diets, increase physical activity and learn about other behavior modifications. After the initial 16 core sessions, participants meet monthly.

"As insurers, we have the information on clinical performance, we have population data, a robust technology platform and the ability to structure consumer and provider incentives," says Deneen Vojta, M.D., UnitedHealth's vice president for clinical innovations.

In UnitedHealth's commercial book of business, prediabetic members consume an average of $3,600 a year in care, excluding prescription drugs. Once the member becomes diabetic, that number balloons to $12,000 a year. "So the algebra is pretty easy. We have to prevent that conversion or it will bankrupt [the nation's health care] system."

Vojta says diabetes is too big of a problem even for a very large health company like United to tackle alone. The company is encouraging other health insurers to participate in its alliance. So far Minnesota-based Medica has joined, and Vojta says another "major Minnesota" insurer will be announced soon.

The Alliance builds on a value-based benefit design UnitedHealth launched a year earlier *(HPW 2/9/09, p. 1)*. That program offers financial incentives to diabetic and prediabetic members who routinely follow recommended steps to manage their condition (e.g., regular blood-sugar checks, wellness coaching, routine exams and preventive screenings).

Participants also received diabetes supplies and diabetes-related prescription drugs at no charge, as well as lower copayments for related doctor visits. About 60% of people with diabetes don't follow their self-management regimens, often because of the personal costs involved. Vojta says diabetic members have since increased compliance by about 20%. Member savings amount to about $500 per year.

CIGNA says it is seeing more interest in value-based benefit design among its employer clients, particularly when it comes to diabetic employees. "I just spoke with an employer this week that is implementing first-dollar coverage for generics to treat diabetes," says CIGNA's Smith. "A pretty high percentage of that company's work force has diabetes…and many of them are not very compliant with their treatment. Cost can be a barrier for a lot of employees, so the idea is to reward their compliance with free generics."

Risk Assessment Can Find Prediabetics

Health insurers agree that identifying prediabetics can be challenging because there typically aren't enough claims data. But even a paper risk evaluation can flag some at-risk members. Vojta says 90% of prediabetics are unaware of their condition. And 65% of prediabetics will have diabetes in three to six years if they don't improve their lifestyles.

A major challenge in identifying diabetic and prediabetic members is getting them to the doctor, says Natalie Benner, R.N., regional manager at Geisinger Health Plan (GHP). The company recently partnered with ProSight

N.C. Blues Foundation Aims to Improve Health of Toddlers

North Carolina has the fifth-highest rate of childhood obesity in the country. More than 31% of North Carolina's children ages 2 to 4 are considered at risk for becoming overweight or are overweight.

On Oct. 26, the Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation made a three-year, $3 million commitment to tackle that issue. The program, dubbed *Shape NC:* Healthy Starts for Young Children, is being launched with the N.C. Partnership for Children Inc. (NCPC). The program focuses on children from birth through age five who attend daycare centers throughout the state.

"We have children now who are showing signs of adult diseases," says Kathy Higgins, BCBSNC Foundation president. "And we know that [children] who are overweight or at risk could face lifelong health problems. Their risk of high blood pressure, joint pain and diabetes are just magnified. It also places unnecessary stress and pressure on a young person's heart and joints. It's sad."

Shape NC builds upon existing NCPC networks across the state to target children in child care facilities, their families and child care professionals to increase knowledge of nutrition and the importance of physical activity, according to the North Carolina Blues plan. The program is expected to reach 60,000 children, 3,000 families and 2,500 child care teachers/directors.

BCBSNC Foundation is a separate, independent nonprofit foundation.

For more information, visit the newsroom at www.bcbsnc.com.

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to sponsor an onsite "Diabetes Day." Members came to a local clinic for preventive eye exams, foot exams, and blood pressure monitoring at no cost and no copay.

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Low Utilization Continues to Push MCO Earnings Beyond Expectations

Citing low utilization in the third quarter, several health insurers have followed UnitedHealth Group's lead *(HPW 10/25/10, p. 1)* by posting better-than-expected earnings and raising full-year earnings projections. Here's a look at highlights from health plans that posted third-quarter 2010 earnings during the last week of October:

◆ ***CIGNA Corp.:*** CIGNA on Oct. 29 posted a 6.7% drop in third-quarter net revenue, due in part to discontinued business lines. The earnings results, however, easily beat analyst projections. For third-quarter 2010, CIGNA's net income was $307 million ($1.13 per share), a slight decline from $329 million ($1.19 per share) in the year-ago period. The earnings consensus among analysts was $1.06. The company boosted its full-year earnings forecast to a range of $4.35 to $4.50 per share (from an earlier estimate of $4.10 to $4.40). Revenue increased 17% to $5.27 billion. The company repurchased about 2.5 million shares of its stock for $77 million during the quarter and about 6.2 million shares for $200 million year to date. Medical membership as of Sept. 30 was 11.4 million — up 339,000 from the same date a year ago and up 78,000 from the previous quarter. In a note to investors, Cowen & Co. equities analyst Christine Arnold said the company's enrollment trends were better than expected both in the administrative services only and commercial risk segments.

◆ ***HealthSpring, Inc.:*** The Medicare Advantage (MA) operator reported net income of $53.8 million (95 cents per share), up 27.1% from the $42.3 million (77 cents per share) that the company reported in the third quarter of 2009. MA membership grew to 198,055 — up 6.1% from the year-ago period and up 4.7% from the end of 2009. The company's stand-alone PDP membership jumped 34.6% from the year-ago period to 409,239. Herb Fritch, CEO and chairman, attributed the strong earnings results to better-than-expected Part D membership growth and pharmacy rebates. But Carl McDonald, an equities analyst at Citigroup Global Markets, suggests that the company's earnings "would be down in 2011" without its pending acquisition of Bravo Health, Inc., which the company announced in August.

◆ ***Centene Corp.:*** On Oct. 26, Medicaid managed care operator Centene cited a substantial rise in its medical

Preparing for Medical Loss Ratio Regulations: The Clock Starts Ticking on Jan. 1

- What will be the impact on insurers of the inclusions and exclusions for quality-improvement expenses? The exclusion of certain taxes in the MLR calculation?
- What are the implications for health plans of the levels of aggregation at which MLRs will be determined and rebates applied?
- How will insurers be affected by upcoming decisions on "credibility adjustments" for random statistical variations and three-year averaging for rebate calculations?
- What is likely to happen if there is not a phase-in period for the MLR requirements in the individual market?
- What are the next steps in the MLR regulations and enforcement process?
- What can and should health plans do now to prepare for MLR rule implementation?

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loss ratio (MLR) as a primary reason for its decision to pull out of two Medicaid "reform" counties in Florida at the end of this year. In its conference call with investors to discuss third-quarter earnings, Chairman and CEO Michael Neidorff said "states will be under even more pressure next year." Third-quarter premium revenues climbed 9.5% from the year-ago level to $1.06 billion in the third quarter, the company said, attributing those gains to rate hikes as well as a 6.1% membership boost. Medicaid enrollment as of Sept. 30 was 1.12 million — up from 1.04 million on the same date a year ago. Much of the enrollment growth was seen in Florida, Ohio and South Carolina. But the company's overall third-quarter earnings from continuing operations dropped to 44 cents a share from 51 cents a share in the year-ago period, partly due to an investment loss but also because of a rise in the MLR to 84.2% from 83.7%, the firm said. ✧

Medicare Cuts May Halt Investments

continued from p. 1

David Brailer, M.D., Ph.D., who served as HHS's first National Health Information Technology Coordinator, says VC firms are more reluctant to invest in companies that offer provider-based services — such as inventory management or disease management — due to a fear that reimbursement cuts in Medicare will mean hospitals and physician groups have less money to invest in technology. And tools that health insurers might use to manage populations or run disease management programs could be negatively affected by the reform law provision that requires health plans to maintain certain medical loss ratio (MLR) floors. Such programs, he cautions, could wind up counting toward overhead rather than patient care. Moreover, while many innovations used by Medicare Advantage carriers (e.g., population management software or programs to improve the use of home health services) came from VC-backed companies, there is concern that MA companies will have less money to spend on technology due to reimbursement reductions called for by the reform law.

"If the Obama administration and Congress intentionally wanted to make it harder for investors to support innovative companies in the health care industry, they couldn't be more effective than they are right now," quips Brailer, now chairman of Health Evolution Partners, a San Francisco-based VC firm.

While VC firms that tend to "dabble" in health services are likely to tighten their purse strings, companies that know the nuances of the industry could see new opportunities due to the reform law, Brailer adds.

"I see a ton of opportunity," says David Jones, chairman and managing director of Chrysalis Ventures, a Louisville, Ky.-based VC firm that invests in health care services and media firms.

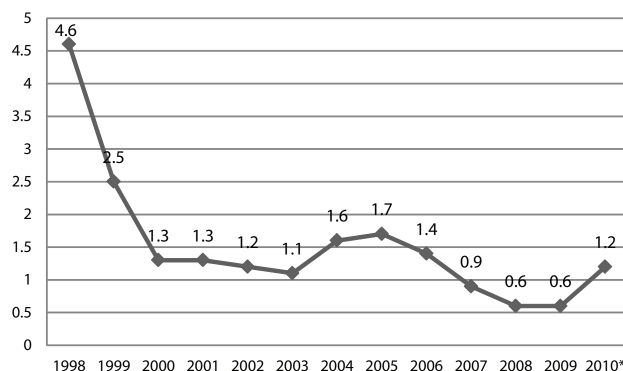
'Tremendous Interest' in IT Companies

With calls for improved technology woven throughout the reform law, the most obvious area for growth within the health services sector is IT. "Venture funds right now are trying to figure out how to build a business around that…and determine whether funding might be available," Lefteroff tells *HPW*.

Lisa Suennen, a cofounder and managing member of Psilos Group, agrees that there is "tremendous interest" in IT among VC firms. She also agrees that it's unclear how a company would be reimbursed for technologies such as patient telemonitoring, condition tracking or automated systems aimed at improving patient health. Psilos, a New York City-based health care-focused VC firm, invests in health care services, health care IT and medical technology.

Anecdotally, Suennen tells *HPW* that she's seeing more business plans than she did a year ago. She's also had numerous inquiries from VC firms that typically invest in biotechnology and medical devices that have newfound interest in the health care IT sector. The medical technology sector has recently become less attractive to VC firms, partially because the reform law has imposed a 2.9% excise tax on the sale of medical devices beginning in 2013. Moreover, manufacturers will need to abide by new safety and comparative effectiveness research requirements. Those factors could drastically curtail investment in medical devices. Brailer agrees that investors seem to be fleeing the medical device sector,

Percentage of Venture Capital Dollars Spent on Health Services, 1998 to 2010



*Does not include fourth-quarter data

SOURCE: PricewaterhouseCoopers/National Venture Capital Association MoneyTree Report, October 2010.

which he says is also the result of stricter regulatory actions by the FDA.

"Now that money is looking for new places to go and the place to go looks like health IT and services," Suennen says.

But Brailer cautions that it can take years for a health IT company to become profitable. "They're not going to become billion-dollar companies overnight. There's still a very long slog to build up a real innovative health IT company."

VC Investments Could Cut Insurer Costs

Here's a look at several areas where VC companies see some investment potential:

◆ ***Automated sales:*** A reform law provision that requires health insurers to maintain an 80% MLR for individual and small-group products could translate to opportunity for firms that can automate sales. Health insurers "are going to have to look much more aggressively at outsourcing, and there is real opportunity in that," Jones says. "If you look at the individual and small-group plans, as much as 8% to 12% of the cost of the premium is going to agent commissions. With a 70% MLR, health plans can bear that cost, but when you move it to 80%, that just won't work." A company in Chrysalis' portfolio, Connecture, Inc., automates sales for health insurers through the carrier's website "or whatever the health insurer's front end is," says Jones, who adds that the company's pipeline of sales opportunities is "exploding."

Venture Capital Investments in Health Services Firms, 1998 to 2010

Year	Amount Spent on Health Services	Total Venture Capital Spending	Health Services Venture Capital Deals	Total Deals
1998	$916.9 million	$19.6 billion	154	3,694
1999	$1.3 billion	$51.4 billion	158	5,555
2000	$1.3 billion	$100.0 billion	165	7,979
2001	$520.2 million	$38.2 billion	107	4,546
2002	$348.6 million	$20.8 billion	71	3,158
2003	$211.4 million	$18.9 billion	70	2,991
2004	$365.3 million	$21.8 billion	59	3,146
2005	$401.6 million	$22.6 billion	67	3,194
2006	$362.8 million	$26.1 billion	50	3,748
2007	$278.7 million	$30.0 billion	55	4,029
2008	$181.3 million	$28.0 billion	52	4,014
2009	$108.4 million	$18.2 billion	37	2,916
2010*	$196.0 million	$16.7 billion	31	2,497

* Does not include fourth-quarter 2010 data.

SOURCE: PricewaterhouseCoopers/National Venture Capital Association MoneyTree Report, October 2010.

Connecture has contracts with 11 of the top 20 health insurance companies and more than 40% of the nation's Blues plans, he says. Moreover, Jones says the state insurance exchanges, which are slated to be operational by 2014, could offer even more opportunity for firms that automate sales.

◆ ***Patient safety:*** Another area with some potential is patient safety, particularly around innovations that can reduce medical errors, says Suennen. Such technology could become very important to hospitals as public and private payers reduce or prohibit reimbursement for hospital-acquired conditions (i.e., never events). CMS implemented its hospital-acquired condition reimbursement reduction methodology in 2008, and many health insurers made similar reimbursement adjustments to their hospital contracts. Early this year, the Blue Cross and Blue Shield Association said it implemented a systemwide policy that prohibits its licensees from reimbursing contracted hospitals for preventable errors.

◆ ***The newly insured:*** Many of the estimated 30 million people who are now uninsured don't have a primary care physician, which prompts some of them to seek care at the emergency room. While an expanded Medicaid program and subsidized private insurance is expected to shrink that number dramatically beginning in 2014, the newly insured might not know how to find a provider. MyHealthDirect, Inc., a company in Chrysalis' portfolio, gathers information about available appointments — at physician offices and other clinical settings — and makes it available to patients and providers. A triage nurse at a hospital, for example, might determine that a patient would be better served in a doctor's office. The software helps the caregiver identify openings and book appointments. If, for example, the patient speaks only Spanish and doesn't have a car, the software would identify Spanish-speaking providers near the hospital or close to a bus line, Jones explains. The application, he says, is similar to OpenTable.com, an online restaurant reservation system.

◆ ***Retirees:*** Rather than investing in new firms, Psilos is spending most of its time right now on growing businesses already in its portfolio. One of them, California-based Extend Health, Inc., operates what Suennen describes as a private insurance exchange for retirees. The company, which works primarily with large employers and unions, helps employers transfer their retirees from group coverage to private Medicare plans. It generates about $40 million in annual revenues.

◆ ***Medicaid enrollees:*** Some VC firms are eyeing Medicaid as an area with some opportunity. But despite the expected increase in Medicaid enrollment of as much as 20 million beginning in 2014, there is concern that state budgets will place pressure on Medicaid companies to spend on services needed immediately, rather than

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investing in products or services that are going to improve member health, Brailer says.

◆ ***Accountable care organizations:*** Although there is a lot of interest in ACOs among VC firms, particularly with regulations due out soon from CMS outlining ACO requirements in Medicare, not much money is flowing because there isn't yet a clear model to invest in, says Brailer. "No one knows what an ACO is going to look like."

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HEALTH PLAN BRIEFS

◆ **In an Oct. 22 Form 8K filing with the Securities and Exchange Commission, WellPoint Inc. said it will pay Dijuana Lewis $3.2 million in severance pay.** According to the filing, WellPoint terminated Lewis, president and CEO of the Comprehensive Health Solutions Business Unit and executive vice president, "without cause" Oct. 19 *(HPW 10/25/10, p. 6)*. Sources with knowledge of the situation told the *Indianapolis Business Journal* that Lewis was unhappy with CEO Angela Braly's decision to shift some duties to Lori Beer, who was named executive vice president of the newly formed enterprise business services organization. Visit www.wellpoint.com or www.sec.gov.

◆ **Munich Reinsurance Co., through its subsidiary Munich Health North America, Inc., agreed on Oct. 26 to acquire Windsor Health Group, Inc. for $125 million in cash,** in a deal expected to be completed by the end of 2010. Munich said the deal would strengthen its position in the Medicare market. Windsor operates Medicare Advantage HMO and Special Needs Plans for more than 75,000 members in Alabama, Arkansas, Mississippi, South Carolina and Tennessee. In 2008, Munich Re purchased Sterling Life Insurance Co., which has MA plans in all 50 states. Visit www.munichre.com and www.windsorhealthgroup.com.

◆ **Employers may be permitted to change health insurers without losing "grandfathered" status, as long as the benefit design remains the same,** a White House official who asked not to be identified told Bloomberg. Under the health reform law, employers that switch insurance carriers or make substantial benefit-design changes after March 23, 2010, lose their grandfathered status and must comply with new insurance regulations such as ones requiring 100% coverage of preventive care. Visit www.whitehouse.gov or www.hhs.gov.

◆ **Delaware Insurance Commissioner Karen Weldin Stewart (D) said she soon expects to receive the results of an investigation into whether three insurers inappropriately denied coverage for tests designed to diagnose heart problems,** the *News Journal* reported Oct. 28. In March, Stewart launched market conduct examinations after several articles suggested that Blue Cross Blue Shield of Delaware, Aetna Inc. and Coventry Health Care, Inc. were refusing to pay for advanced imaging tests, according to the Journal. Stewart said the report will not be made public until at least January in order to give the insurers time to contest any findings, the Journal said. An Aetna spokesperson told the newspaper that it reimplemented pre-authorization requirements in September. The newspaper added that BCBSD and Coventry did not respond to its calls. Visit www.delawareinsurance.gov.

◆ **Bloomington, Minn.-based health insurer HealthPartners on Oct. 25 launched virtuwell.com, an online diagnosis and treatment service.** For $40 or less, depending on insurance coverage, customers will have 24/7 online access to nurse practitioners who can offer treatment recommendations and prescriptions for conditions such as colds, coughs, allergies, ear pain and yeast and urinary tract infections, according to HealthPartners. Visit www.virtuwell.com.

◆ **CIGNA Corp. said its members can use Web-enabled mobile phones to compare drug prices, locate an urgent care center or find an in-network physician or specialist.** When their phone's GPS function is enabled, members can use CIGNA Mobile to locate more than 1 million network physicians, specialists, dentists, hospitals, medical facilities and pharmacies, according to CIGNA. The insurer said its mobile application can also be used to cost-compare medications covered by CIGNA, search real-time prices at 60,000 pharmacies nationwide, find the closest retail pharmacy locations and speed-dial CIGNA Home Delivery Pharmacy to place medication orders or get answers to pharmacy plan questions. Visit www.cigna.com.

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NEW STUDIES IN THE FIELD

◆ **Federal dollars allocated to help laid-off workers afford COBRA continuation health coverage helped fewer individuals than initially expected,** according to a recent report from the Employee Benefit Research Institute (EBRI). To help involuntarily terminated employees continue their employer-sponsored group health coverage, Congress included a 65% federal subsidy for COBRA continuation coverage — for up to nine months — in the American Recovery and Reinvestment Act of 2009 (ARRA), which was signed into law Feb. 17, 2009 *(HPW 2/16/09, p. 1)*. to cover administrative costs. But even with the subsidy, many unemployed people were unable to afford the cost of coverage, according to the report. EBRI notes that there are widely conflicting estimates of how many people benefited from the COBRA subsidy, but says generally far fewer people took advantage of it than the federal government estimated when the subsidy was announced. Visit www.ebri.org.

◆ **The cost of employer-based health coverage can vary widely among states,** according to data released Oct. 20 by United Benefit Advisors. While Alaska has the highest average annual cost ($10,881 per employee), the only other states where coverage costs exceed $10,000 are in the northeast: Connecticut, Massachusetts, New Jersey and New York. States with the lowest average annual coverage costs are Kentucky ($6,342), Arkansas ($6,422) and Idaho ($6,529). The full survey will be available to the public on Nov. 1. Contact William Stafford at bstafford@UBAbenefits.com.

◆ **Between now and 2015, the shortage of physicians across all specialties will quadruple,** according to a recent estimate from the Association of American Medical Colleges (AAMC) based on projections by the Center for Workforce Studies. Previous projections showed a baseline shortage of 39,600 doctors by 2015. The revised estimate is closer to 63,000, according to AAMC. Moreover, in 2015, the U.S. will face a shortage of 33,100 physicians in specialties such as cardiology, oncology, and emergency medicine. The U.S. Census Bureau is projecting a 36% increase in the number of Americans over age 65 over the next decade. During the same period, one-third of all physicians is expected to retire. Contact Retha Sherrod at rsherrod@aamc.org.

◆ **Premiums for the most popular types of employer-based health coverage will increase an average of 10% for the 2011 plan year,** according to a report released in October by Buck Consulting. On Oct. 27, Milliman's 2010 Group Health Insurance Survey estimated premium rate increases for January 2011 renewals will average 10.2% for HMOs and 11.7% for PPOs. Economic uncertainty likely played a big part in the increase because layoffs have left many employers with an older, sicker work force, according to Buck. That study is based on a survey of more than 120 health insurers and plan administrators. Premiums for PPOs are expected to increase by an average of 11.6% — a slight uptick from the 11.1% increase projected in last year's report. HMO rates are expected to grow an average of 10.6% while rates for account-based health plans will increase by an average of 11.3%. For more information about Buck's National Health Care Trend Survey, visit www.buck-surveys.com. Information about Milliman's findings can be found at www.milliman.com.

◆ **Possibly prompted by fears of a link to autism, vaccination rates among children with private health coverage have declined,** according to a new report from the National Committee for Quality Assurance (NCQA). The study also noted that vaccination rates continue to rise for children covered by Medicaid. Childhood vaccination rates in 2009 declined by almost four percentage points in commercial plans, according to NCQA. Unproven theories that increasing autism rates among children are tied to vaccinations might be encouraging some parents to refuse them, according to NCQA. *The State of Health Care Quality Report* examined quality data from over 1,000 health plans that collectively cover 118 million people. Visit www.ncqa.org.

◆ **Federal and state governments could save taxpayers about $3.5 trillion over the next 25 years by expanding the use of coordinated care programs in Medicare and Medicaid,** according to an analysis by UnitedHealth Group. The "fragmented care and rising costs" in the government programs, according to the study, is due largely to the existing fee-for-service model and the limited communication and coordination that go with it. UnitedHealth is the nation's largest seller of Medicare Advantage (MA) and Medicaid managed care programs. Visit www.unitedhealthgroup.com/reform.

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