

HEALTH PLAN WEEK

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

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Aetna Makes \$500M Wager on HIE, but Will Providers Trust Insurers With Clinical Data?

Aetna Inc. on Dec. 6 said that it had entered into an agreement to acquire Medicity — a Utah-based health information exchange (HIE) vendor — for about \$500 million. The proposed deal illustrates the growing realization that diversification will be critical to survive in the rapidly reforming health insurance space. But such acquisitions could be a gamble, particularly if providers are leery about handing over clinical data to an entity owned by a health insurer, industry observers tell *HPW*.

Health insurers for years have tried to figure out how to access important clinical data and distribute that information to network providers in an effort to improve patient outcomes, says former National Health Information Technology Coordinator David Brailer, M.D., Ph.D., now chairman of Health Evolution Partners, a San Francisco-based venture capital firm. Rather than build proprietary connections to their own network providers, acquiring HIE vendors will give health insurers access to more open networks, he says. “The whole point of an HIE is that everyone participates in an area... so you have complete and detailed patient information,” he explains. Brailer was appointed by President George W. Bush as the nation’s first “health information czar.”

Health plans like the idea of participating in an HIE where they can augment their claims data with clinical outcomes indicators to better track disease management and patient progress. Moreover, outcomes data allow the health plan to measure quality performance to administer pay-for-performance programs and transparency, explains Bruce Taffel, M.D., chief medical officer at SharedHealth, an HIE and health IT subsidiary launched by BlueCross BlueShield of Tennessee in 2005.

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Federal Scrutiny May Prompt States to Clamp Down on Rate-Hike Requests

Recent rate-increase rejections from state regulators — combined with impending regulations from HHS — could mean health insurers will find it increasingly difficult to boost premiums. And industry observers warn that health insurers could abandon markets if increased rate scrutiny begins to eat into their profits.

Industry observers, including several former state insurance commissioners, tell *HPW* that pressure from HHS and the White House could encourage state regulators to demonstrate their ability to clamp down on rate hikes that might be seen as excessive. But denied rates could prompt some health plans to pull out of unprofitable markets, leaving fewer competitors. And the loss of carriers could drive rates even higher, they warn.

With some exceptions, state insurance commissioners “are notoriously weak on rate regulation, even when they have the authority,” says former Texas Insurance Commissioner J. Robert Hunter, who is now with the Consumer Federation of America. But fear of “losing turf” to HHS, he says, will push them to defend state control over premiums by getting tougher on rate increases.

continued

"I think there is going to be increased pressure on state regulators" to hold down premium hikes, adds former Maryland Insurance Commissioner Al Redmer, now president of Landmark Insurance and Financial Group. State regulators "will have the federal government whispering in their ears. And this is the same government that has the ability to dole out billions of dollars in grants to the states as a result of the [health reform] law." After leaving office, Redmer served as CEO of Coventry Health Care of Delaware, Inc.

"It is clear that the federal law contemplates greater scrutiny by the states of rate increases," adds Florida Deputy Insurance Commissioner Mary Beth Senkewicz. Florida has authority over small-group and individual insurance rates.

Senkewicz says her office has already approved rate increases averaging 2.1% for contract changes due to health reform law provisions that became effective on Sept. 23, and adds that it will be impossible to predict how the new medical loss ratio (MLR) regulations will impact future rates.

"However, we do know that one way to increase the dollar amount allotted to administrative expenses is to raise the premium," she says. "The MLR requirements

will have a bigger effect on the small-group market, and, in particular, the individual market." The Florida Office of Insurance Regulation, she says, intends to request an adjustment to the 80% MLR requirement from HHS for the individual market.

Rates Rejected in Fla., Wash.

The Washington state Dept. of Insurance (DOI) on Dec. 7 rejected proposed rate increases of between 3.7% and 4.9% for individual products sold by subsidiaries of Blues plan operator The Regence Group. The latest rate requests came just two months after double-digit increases became effective for other individual insurance products sold by Regence subsidiaries Regence BlueShield (18.4%) and Asuris Northwest Health (23.7%).

Shortly after those rate hikes were approved, Regence indicated it would discontinue those plans, making way for 149,000 enrollees to migrate to its new Evolve suite of individual products, for which the most recent rate requests were made. Evolve was introduced in early 2010. Health insurers that operate in Washington state are only allowed to file a rate change for their individual health plans once a year. Additional rate changes are allowed if the plan is required to cover new benefits. "Regence chose to replace its health plans with its new Evolve plans at the same time it filed a rate change for the new health reform benefits," according to a prepared statement from the Washington state DOI.

The quashed rate hike requests in Washington state come on the heels of the Connecticut Dept. of Insurance's Dec. 3 decision to reject a 20% rate increase request for Anthem Blue Cross and Blue Shield's individual products. That decision was praised by the White House in a Dec. 6 blog entry.

The rate denial in Connecticut happened two months after HHS questioned former Connecticut Insurance Commissioner Thomas Sullivan's decision to grant Anthem rate hikes of up to 47% for its individual products. After defending that decision, Sullivan ordered a public hearing on the rate-hike requests, and submitted his resignation, effective Nov. 12, five days before the hearing date. The decision to deny the request was made by Acting Insurance Commissioner Barbara Spear. Sarah Yeager, a spokesperson for Anthem's parent company, WellPoint, Inc., said only that it is reviewing the ruling.

In a note to investors, Christine Arnold, an equities analyst at Cowen & Co., called the decision by the Connecticut Insurance Department a "dangerous precedent particularly in light of the [Obama] administration's encouragement of a stricter review process." Some industry observers, however, say the rate rejections were at least partially related to state-specific issues.

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A spokesperson for outgoing Oklahoma Insurance Commissioner Kim Holland (D) says it's important for regulators to consider the long-term solvency of health insurers along with protecting consumers from unjustified rate hikes. "You can't just look at one number," spokesperson Karina Henderson tells *HPW*, adding that Holland's office has the authority to regulate HMOs and small-group plans. Holland was defeated by Republican John Doak in last month's elections.

North Carolina Insurance Commissioner Wayne Goodwin says his office only approves rate adjustments "that are demonstrated as actuarially sound and warranted. All insurance rates that we approve must meet our statutory definitions of not being unfairly discriminatory or excessive." He tells *HPW* that pressure from HHS or the White House isn't likely to make those guidelines any stricter.

But there is a downside to getting tough on rate hikes, says former Mississippi Insurance Commissioner

George Dale, now a senior public policy advisor at the law firm of Baker, Donelson, Bearman, Caldwell & Berkowitz. "There are so many factors that need to be taken into consideration when setting rates that I'm fearful [that stricter rate scrutiny] might affect the big picture of having a voluntary insurance market," he tells *HPW*. "And if the market dries up, will a federally subsidized program need to step in? This could be a backdoor way to get government control of the insurance industry."

During his reign as insurance commissioner in the early part of the decade, Redmer says he made weekly calls to health plan executives whose companies didn't have a presence in Maryland. The idea was to encourage more competitors in the state. He says he was surprised that those executives not only understood the competitive landscape in Maryland, but also were familiar with the political environment.

"These people are very astute, focused and they think long-term," he says. "So if they are in a market

Monthly Stock Prices: What a Difference a Couple of Years Make

Two years ago, health plan stock prices were in a free-fall. For the first 11 months of that year, the sector's earnings per share (EPS) average was down a staggering 56%. Health Net, Inc.'s stock price, for example, had plunged 81% to just \$9 per share. Stock prices, however, came back strong in 2010. Health Net's stock closed at \$27 on Nov. 30 — up almost 16% since January and triple its November 2008 price. Health plans that work primarily in Medicare and Medicaid fared better than commercial plans in 2010. Although HealthSpring, Inc.'s EPS fell 8.1% in November, it is up more than 50% since the beginning of the year. And AMERIGROUP Inc.'s stock price on Nov. 30 was \$43.03 — up nearly 60% since the beginning of the year, and nearly double what it was two years ago.

	Closing Stock Price on 11/30/2010	November Gain (Loss)	Year-to-Date Gain (Loss)	Consensus 2010 EPS*	Consensus 2010 P/E Ratio*
COMMERCIAL					
Aetna Inc.	\$29.62	(0.8%)	(6.6%)	\$3.61	8.2 x
CIGNA Corp.	\$36.81	4.7%	4.4%	\$4.48	8.2 x
Coventry Health Care, Inc.	\$25.32	8.1%	4.2%	\$3.63	7.0 x
Health Net, Inc.	\$27.00	0.4%	15.9%	\$2.58	10.5 x
UnitedHealth Group	\$36.52	1.3%	19.8%	\$3.97	9.2 x
WellPoint, Inc.	\$55.74	2.6%	(4.4%)	\$6.54	8.5 x
Commercial Mean		2.7%	5.6%		8.6 x
MEDICARE					
HealthSpring, Inc.	\$26.83	(8.1%)	52.4%	\$3.27	8.2 x
Humana Inc.	\$56.04	(3.9%)	27.7%	\$6.95	8.1 x
Medicare Mean		(6.0%)	40.0%		8.1 x
MEDICAID					
AMERIGROUP Corp.	\$43.03	3.1%	59.6%	\$4.90	8.8 x
Centene Corp.	\$23.25	4.2%	9.8%	\$1.82	12.8 x
Molina Healthcare, Inc.	\$25.39	(2.0%)	11.0%	\$1.91	13.3 x
WellCare Health Plans, Inc.	\$28.15	1.3%	(23.4%)	\$2.44	11.5 x
Medicaid Mean		1.6%	14.3%		11.6 x
Industry Mean		0.9%	14.2%		9.5x

* Estimates are based on analysts' consensus estimates for full-year 2010.

SOURCE: Bank of America Merrill Lynch. Compiled by Atlantic Information Services, Inc., November 2010.

where they don't see any long-term potential for profitability, they will begin the process of unwinding that business and moving."

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Aetna's Change to Broker Fees Could Prompt Others to Follow

Aetna Inc. is the latest health plan operator to revamp the way it pays broker commissions.

In a letter sent to insurance brokers last month, Aetna explained that, beginning Feb. 1, brokers in certain states will be reimbursed based on a "service fee model" for employers with 51 or more employees. Under this structure, employers will compensate the broker directly. The company now calculates commissions based on a percentage of premiums. Aetna's new fee structure is more typical among large self-insured employers.

In a Dec. 6 note to investors, Charles Boorady, an equities analyst at Credit Suisse, said that other health insurers are likely to move to a direct service fee model over the next year if it proves to be successful for Aetna. The model also could be adopted for small-group and individual products.

The letter, which Aetna shared with *HPW* on Dec. 8, blames the change on the medical loss ratio (MLR) provision of the health reform law. Under that provision, which goes into effect on Jan. 1, health plans must meet an 80% MLR for individual and small-group products, and an 85% MLR on the large-group side.

Many health insurers have already announced plans to alter commission structures for their individual and small-group plans (*HPW* 11/8/10, p. 1). Some carriers have reduced commission rates for those products by as much as 50%. But Aetna is changing the commission model for its larger group clients, too.

In the mid-to-large group market, a commission of 3% or 4% typically is buried in the premium, explains Scott Leavitt, owner of Scott Leavitt Insurance & Financial Services in Boise, Idaho, and former president of the National Association of Health Underwriters. Even though employers now pay commissions as part of the premium, when they see the fee broken out, they might not want to pay it, or they might try to negotiate a lower rate with the broker, Leavitt tells *HPW*.

If other health insurers follow Aetna's lead, premiums will be more transparent and brokers will need to transform themselves into business consultants to justify their commission to clients, he adds.

Brokers and agents "really are going to have to sell their services and the value that they bring more than ever before," Leavitt says. And some brokers might try to compete on commission rates as they struggle to keep their businesses afloat.

"It's going to be very competitive out there because some agents are going to be fighting for their livelihood. They will be willing to negotiate in ways they maybe haven't before," he adds.

And in an effort to save on the commission, there is a danger that some employers will bypass the broker and contact health plans directly.

Contact Leavitt at saladl@aol.com and Aetna's Cynthia Michener at michenerc@aetna.com. ♦

As a Marketing Tool, @Blues Plans Are Slow to Embrace Social Media

In an effort to boost their marketing presence, Blue Cross and Blue Shield plans are popping up more frequently on social media sites such as Twitter and Facebook. But Blues plans, like the rest of the health insurance industry, are late to the social media game.

Indeed, "the big picture is the whole insurance industry is very conservative," says Thomas Harpointner, CEO at AIS Media, an Atlanta-based interactive marketing company (that is not affiliated with Atlantic Information Services, Inc.). "And if you compare Blue plans to other insurance companies, they're way behind. To say they're coming along kicking and screaming might be an overstatement — but not much of one."

Some Blues plans already have invested heavily in social media. Blue Cross Blue Shield of Massachusetts, for example, has gotten on the text4baby bandwagon, offering the free mobile information service designed to promote maternal and child health to its members. An educational program of the National Healthy Mothers, Healthy Babies Coalition, text4baby provides educational and preventive health information to pregnant women and new moms, the Massachusetts Blues plan says. Women who sign up for the service receive free text messages each week, timed to their due date or the baby's date of birth, on topics ranging from health care access and immunizations to oral health and car seat safety.

Jenna McPhee, spokesperson at the plan, notes that almost 90% of Americans over the age of 13 own a cell phone and that "the text4baby program was [thus] a perfect fit for us to begin exploring texting as an emerging communication channel. It's the way people communicate today — and it's a great way to provide information in a timely manner."

Among other efforts, the Massachusetts Blues plan has “utilized social sharing and bookmarking functions on our web properties,” McPhee tells *HPW*’s sister publication *The AIS Report on Blue Cross and Blue Shield Plans*, “and we’ve advertised on social networking and mobile websites and utilized mobile text messaging.” Just this summer, the plan launched its first mobile app, called “Goal Getter,” a plan-branded pedometer for the iPhone that “helps members engage in healthy behaviors and increases brand awareness,” she adds. “We will be adding new applications to continue to promote member health engagement and build our relationship with our members. Additionally, we have grown our social media listening capabilities and view listening as as much a part of our strategy as executing.”

Still, McPhee says the insurer is proceeding cautiously. “Social media environments are relatively new for our members and our organization. We are being very cognizant of member needs, privacy issues and protecting our brand identity, but we do have a working model in place to continue to evolve and enhance our presence.”

Regence Uses Twitter, Facebook

The Regence Group is leveraging its marketing outreach across several social media platforms, including a separate Twitter feed for each individual plan, a page for its corporate foundation, one dedicated to conversations about health care costs and one for job seekers. “We all collaborate on ideas for tweets,” reports Joanna Fief, the plans’ strategic communications specialist.

The plans also are in the process of developing a Regence Facebook page, but, Fief says, “as part of our effort to create a dialogue about health care costs, we already have a page called ‘What’s The Real Cost,’ which has nearly 1,000 fans and is connected to our @TheRealCost Twitter page and our ‘What’s The Real Cost’ blog.”

In addition, myRegence.com, Regence’s member website, is designed to be an online community for members that offers an online forum where they can discuss health care topics ranging from weight loss to broken bones. Members also can instant message with a customer service representative through the site.

“We started using social media because conversations about our company and our products were happening without us,” Fief explains. “As a company, we recognized that the way society communicates was changing, and the way we communicate with our members and employees needed to reflect that change. We’ve also been able to answer questions from members who might not have called customer service directly.”

If Blues plans balk at embracing the future, Harpointner warns, smaller plans may outmaneuver them. “A battleship is less nimble than a speedboat,” he says.

“Bigger plans make a bigger impact over the long term, but a smaller plan can implement a social networking strategy more quickly. It doesn’t take much time to set up a Facebook page.” And while it’s never too late to get with the social media program, the longer Blues plans go without a robust social networking presence, the more they risk getting left behind — because “consumer sentiment against a lack of social media presence is going to be high.”

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This article was excerpted from the December issue of HPW’s sister publication The AIS Report on Blue Cross and Blue Shield Plans. For more information or to order, visit the MarketPlace at www.AISHealth.com.

HIE Seen as a ‘Good Fit’ for Aetna

continued from p. 1

Medicity’s technology allows 760 hospitals and 125,000 physicians in the U.S. to exchange medical data, according to the statement from Aetna. Medicity will operate as a separate entity within Aetna and will maintain its existing leadership structure.

In 2005, Aetna paid \$400 million to acquire ActiveHealth Management, a technology-driven clinical-decision support and data analytics firm. While ActiveHealth provides Aetna with important content and tools that help decipher complex data, “what it lacks is a population-management hook,” Brailer says.

Medicity “is a great fit for Aetna and a great fit with ActiveHealth,” adds Peter Kongstvedt, M.D., a consultant and principal of P.R. Kongstvedt Co., LLC. The combination of Medicity and ActiveHealth, he adds, “could provide substantial value to the new types of provider organizations that are coming together.” Medicity’s platform allows information to be sent to physicians via desktop computers as well as through mobile devices.

Diversification Is Critical for Plans

The acquisition agreement — which Aetna expects to finalize in early 2011 — is the second major deal in four months between a publicly traded health plan operator and an HIE vendor. In August, UnitedHealth Group’s IT subsidiary Ingenix acquired Axolotl, a California-based HIE firm (see table, p. 7). While Aetna’s decision to purchase an HIE firm might have been accelerated by Ingenix’s deal, it’s more likely that the two companies have come to similar conclusions about the future of their business.

With federally mandated medical loss ratio (MLR) minimums limiting administration costs and profit

margins, large health insurers will need to diversify their business portfolios. And acquisitions “that provide greater leverage of resources” will make sense, Kongstvedt says.

Moreover, the “essential benefits” — required for individual and small-group products offered through health insurance exchanges — will make it difficult for insurers to use product design to differentiate themselves from competitors. As a result, some insurers will search for value-added services to offer existing and potential members.

Health insurers are positioning themselves to be data brokers, says Jordan Battani, a principal researcher in Computer Sciences Corporation’s Global Health Care Group. “It’s a niche that’s growing, and it’s a niche where the scale and capacity of large insurers will add value, particularly if they decouple that service from their insurance-carrier services — and support data and analytics for populations they don’t necessarily provide health coverage for.” As a result, he explains, health plans would be able to aggregate data across multiple organizations, locations and regions.

While risk management is a core competency for health insurers, hospitals and providers aren’t set up to manage risk. By acquiring HIE firms, health insurers could become essential sources of intelligence and guidance that health care organizations need to manage the risk of the populations they serve, adds John Moore, managing partner of Chilmark Research, a Massachusetts-based firm that conducts market research and analysis on the adoption and use of health care information technology (HIT).

“There is also the overarching trend toward the comingling of administrative and clinical data to meet pay-for-performance and quality metrics as a result of health

reform,” he says. Chilmark is finalizing a report on the HIE market that will include profiles of 21 HIE vendors.

David Lenihan, founder and former CEO of CareGain, Inc., says there are parallels between the recent round of HIE acquisitions and purchases of consumer-driven health (CDH) vendors several years ago. CareGain, a CDH software vendor, was acquired by Fiserv and later sold to Canopy Financial.

“A few years ago, we saw most of the early [CDH] companies being acquired (e.g., Definity Health, Luminos and CareGain) by health insurers to enable needed plan design and technology capability,” he says. “Health care continues to be an attractive area for investment, particularly in the areas of patient engagement, payments and in the emerging space of social media. Plans will continue to invest to take advantage of these new technologies and services to adapt quickly and protect market share.”

Lack of Trust Could Derail HIEs

Providers are generally uncomfortable with the idea of a health insurer having access to clinical data. The growth of managed care three decades ago gave health insurers a strong financial incentive to keep rates low by controlling utilization. Those efforts, while largely effective, eroded consumer confidence and led to a level of distrust among providers.

Industry observers predict that both Aetna and UnitedHealth will face challenges in convincing provider communities that they won’t somehow tap clinical data to boost earnings for their shareholders.

“The level of suspicion that providers have toward health insurers has always been very high, whether deservedly so or not,” says Kongstvedt. “And while there is no real-world reason to believe that Aetna could or

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would use access to an HIE's data to somehow do some vague but bad thing to providers, I'll be surprised if we don't hear that fear raised. An unfounded fear is still a fear."

Moore agrees and says most providers will be reluctant to engage in an HIE whose technology is owned by a health insurer. Laying those fears to rest, he says, will require a significant amount of education and messaging. Health insurers, he contends, will need to convince providers that the HIEs are managed as separate entities and that they have built thick firewalls between those entities and their core insurance business.

"Having pioneered the HIE space, I can tell you no one wanted health plans at the table...and I don't think it's much different now," he says. UnitedHealth and Aetna "are making a very bold bet that they will be able to reposition themselves as trusted intermediaries."

"It is a bit of a risky bet. I think health plans will need to demonstrate that they can wall off the clinical data, and convince providers that they are not going to use it for negotiating or rate setting or coverage denials."

Brailer suggests that health insurers allay such fears by explaining that the reform law restricts them from using data for anything other than improving member health. "They will need to convince providers and the public that they won't revert back to animal behavior and use this data the way health plans have traditionally used data, which is to get a leg up in the competitive insurance market," he says.

Firewalls Might Not Be Enough

Taffel maintains that he can speak from experience that the level of trust is low when an HIE is affiliated with a health insurer. "There is this feeling [among providers] that if they contribute more data to a health plan, the health plan then could gain more power and influence over them," he explains. "But if they own the data, they can maintain a certain edge over insurers. The [Tennessee] Blues plan is completely fire-walled from Shared Health, and they don't have access to anything that we do. But, in the minds of many providers, a perception of a conflict of interest might persist."

The distrust of the insurance industry could give an advantage to other large-scale aggregators of data and analytics, Battani says. And health insurers might be late to the HIE game. Other technology firms, such as those that offer electronic health records, are far ahead of insurers. And those firms already are trusted information intermediaries, Bailer adds. But opportunities for stand-alone health IT vendors will shrink if insurers are able to demonstrate the value of large-scale data aggregation.

While Taffel suggests that other health insurers will pay close attention to how Aetna and UnitedHealth grow

their HIE entities, other health plans are more likely to contract with HIE vendors rather than acquire them.

But Brailer predicts more acquisitions ahead. "Some health plans are positioning themselves as health care delivery organizations, and others will remain more as insurance companies," Brailer says. "This is a very acquisition rich period and we are only in the first round of a lot of these transformations."

And size might not matter for potential HIE acquisitions. As long as the HIE has a solid infrastructure in place, and the ability to map various data sources (e.g., electronic health records, lab results, prescription drugs, claims data), "they can reach scale pretty quickly," Brailer says. Health insurers that are considering an acquisition are likely to do it with the understanding that they are buying the HIE infrastructure that they eventually will be able to roll out across their coverage areas, he adds.

"If I were running a health plan, I would invest in things that would allow me to be seen as the entity that will help achieve some of the goals that consumers and hospitals and doctors have," says Brailer. "I don't think Medicity or Axolotl were anywhere close to what I would call a national HIE player. They were both regional players, and there are other regional players out there."

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Top 10 Health Information Exchange Vendors		
Here's a look at the 10 largest health information exchange vendors based on data from Chilmark Research.		
Vendor	Home Office	Website
Axolotl	San Jose, Calif.	www.axolotl.com
Carefx, Corp.	Scottsdale, Ariz.	www.carefx.com
CareEvolution, Inc.	Ann Arbor, Mich.	careevolution.com
Informatics Corporation of America, Inc.	Nashville, Tenn.	www.icainformatics.com
InterSystems Corp.	Cambridge, Mass.	www.intersystems.com
Medicity	Salt Lake City	www.medicity.com
MedPlus, Inc.	Mason, Ohio	www.medplus.com
Microsoft Amalga	Redmond, Wash	www.microsoft.com/amalga
Orion Health	Santa Monica, Calif.	www.orionhealth.com
RelayHealth	Atlanta	www.relayhealth.com
SOURCE: Chilmark Research, December 2010.		

HEALTH PLAN BRIEFS

◆ **Some of the nation's largest health insurers are closer to creating their own "inside-the-beltway coalition" aimed at influencing changes to and implementation of the health reform law,** *Kaiser Health News* reported. The five insurers — Aetna Inc., CIGNA Corp., Humana Inc., UnitedHealthGroup and WellPoint, Inc. — are rumored to be window-shopping public relation firms in Washington, D.C., according to KHN. A source familiar with the search told the news service that the insurers saw how much influence they had in Washington after spending millions of dollars in 2009 and 2010 on lobbying and the election. In August, *HPW* reported that the health plans had been in discussions about forming a lobbying group separate from America's Health Insurance Plans (*HPW* 8/9/10, p. 1). Despite reports the five insurers may leave AHIP, a spokesperson for Humana told KHN that it doesn't plan to leave the trade group. AHIP had no comment on the rumored coalition. Visit www.aetna.com, www.cigna.com, www.humana.com, www.uhc.com and www.wellpoint.com.

◆ **On Dec. 3, Aetna's board of directors approved a repurchase of up to an additional \$750 million in common stock.** The insurer already has the authority to purchase \$257 million under its current buyback plans. Aetna reported having about 400 million shares outstanding on Sept. 30, 2010, down from 430.1 million shares at the beginning of 2010, according to a Securities and Exchange Commission filing. At the close of trading on Dec. 9, Aetna's stock was \$29.99 a share. Visit www.aetna.com.

◆ **Georgia Insurance Commissioner John Oxendine (R) has repeated his stance that so-called "most-favored nation" (MFN) clauses, in which medical providers typically agree to give one payer the lowest rate on services, are illegal,** reported the *Atlanta Journal-Constitution*. In July, Oxendine warned the state's largest insurer, WellPoint subsidiary Blue Cross and Blue Shield of Georgia, to remove such clauses from contracts. In retaliation, the Blues plan filed a lawsuit against Oxendine arguing that the clauses were not only legal, but beneficial for customers, according to the Journal. The case is still pending in court. On Oct. 18, the U.S. Dept. of Justice, along with the Michigan Attorney General's office, filed a civil antitrust lawsuit against Blue Cross

Blue Shield of Michigan (BCBSM) for its use of MFN clauses in its contracts with hospitals and health systems (*HPW* 10/25/10, p. 1). At least 16 states limit or ban these clauses, according to the newspaper. Visit www.gainsurance.org.

◆ **Wisconsin Gov.-elect Scott Walker (R) said that while he opposes the individual mandate in the health reform law, he does support state health exchanges,** according to Wisconsin Public Radio. Walker stated that his administration is open to creating a health exchange that would be based on Utah's health exchange, and not the Massachusetts model, the station reported. Walker said that he likes Utah's exchange where individuals and employers use their combined purchasing power to shop for insurance and where the government "gets out of the way," Wisconsin Public Radio reported. Visit www.wpr.org.

◆ **Bloomington, Minn.-based health insurer HealthPartners has expanded virtuwel.com, an online diagnosis and treatment service, to Wisconsin.** On Oct. 25, the insurer launched virtuwel.com for its Minnesota members (*HPW* 11/1/10, p. 7). For \$40 or less per visit, depending on insurance coverage, customers 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.virtuwel.com.

◆ **Michigan's Court of Appeals ruled on Dec. 7 that The Accident Fund, a subsidiary of Blue Cross Blue Shield of Michigan, was allowed by state law to purchase four out-of-state insurance companies,** according to the *Detroit Free Press*. But the appeals court referred the decision of whether the Blues plan broke state law when it gave its subsidiary \$125 million for the purchase of the four firms back to a lower court, according to the newspaper. A spokesperson for Michigan Attorney General Mike Cox told the *Free Press* that his office may appeal the ruling in hopes of convincing the court that BCBSM was actually orchestrating these purchases, and not its subsidiary. The Blues plan told the newspaper that The Accident Fund, not its parent company, made the investment decisions. Visit www.bcbsm.com.

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