Cigna Cements Deal for Medical Home Firm, Deepening HealthSpring’s Business

Cigna Corp.’s Sept. 3 purchase of medical home care firm Alegis Care, a portfolio company of Triton Pacific Capital Partners, will help grow the insurer’s HealthSpring unit in the Medicare Advantage (MA) space, consultants say, and also extend a trend that has seen major carriers push their business lines away from a dependence on commercial premiums. Regardless of whether the recent buying spree by Cigna, UnitedHealth Group and other national insurers pays off, the acquisitions will continue as long as Wall Street favors them and carriers remain wary of traditional health plan opportunities, these sources say.

In announcing the deal under the Cigna-HealthSpring name and not just Cigna, the insurer is making it known that this is a strategic purchase to expand the HealthSpring Medicare plan business, which Cigna acquired in late 2011 (HPW 10/31/11, p. 1), Peter Kongstvedt, M.D., senior faculty member at George Mason University and principal of Virginia-based consulting firm P.R. Kongstvedt Co., tells HPW. “It’s a good strategic match. They are acquiring a company that specializes in one of the things that HealthSpring does. So it’s not just an acquisition for the sake of revenue and market,” he says. “It is very strategic that they bought HealthSpring, and that’s a considerable business, and now they [Cigna] get a company with specialized skills for what HealthSpring needs.”

Alegis, based in Chicago and founded in 1995, provides home care for homebound Medicare and Medicaid patients, and specializes in serving the chronically ill and elderly. Cigna spokesperson Graham Harrison tells HPW the deal plays directly continued on p. 7

Plans Work to Improve Asthma Care, Prepare for Wave of New Cases in 2014

Across the U.S., health plans cite progress in improving health outcomes and reducing costs for asthmatic members. But researchers examining the issue more globally worry that asthma’s incidence, hospitalization rates and related costs continue to increase. Against this challenging backdrop, managed care plans, especially in Medicaid, are preparing for an impending influx — on and off health insurance exchanges — of new members with asthma, a chronic lung disease that disproportionately affects minorities and people living in poverty.

Many echo the view of Kylanne Green, president and CEO of URAC, a health care accreditation organization that will recognize what it describes as various plans’ cutting-edge approaches to disease management (DM), including asthma care, at a quality summit in late September. In an overhauled market about to launch exchanges, plans “have a great opportunity to innovate new ways to deliver care that is better for patients and improves quality and value,” she asserts.

“That’s certainly the hope,” agrees Caroline Pearson, vice president of Avalere Health LLC, a Washington, D.C.-based consulting firm. But Avalere’s analysis indicates
there will be a high incidence of chronic obstructive pulmonary disease (COPD) and asthma among people newly eligible for Medicaid starting in January 2014, she tells HPW. “We estimate about 19% [of new Medicaid eligibles] will have a diagnosis of COPD or asthma,” Pearson says, as will about 19% of uninsured Americans who will qualify for subsidized exchange coverage. (Avalere did not single out asthma in its analysis.)

Facing the prospect of one in five new members with COPD or asthma, Pearson says, “speaks to the ongoing need that commercial and Medicaid plans will have to focus on disease management” and care coordination efforts. Moreover, she notes that health plans will have to focus on outreach to previously uninsured members unaccustomed to seeking medical treatment.

**Disease Care Commands Huge Resources**

In general, the costs of asthma are staggering. When several agencies joined HHS in launching a Coordinated Federal Action Plan to Reduce Racial and Ethnic Asthma Disparities in May 2012, federal officials put asthma’s annual economic cost at about $56 billion, including direct medical costs from hospital stays and indirect costs such as lost school and work days.

The American Lung Association (ALA) says asthma, which inflames and narrows the airways, results in nearly 11 million ambulatory physician encounters and 440,000 hospitalizations annually. The Centers for Disease Control and Prevention (CDC) said in 2011 that annual medical expenses on average run about $3,300 per person with asthma.

All told, nearly 26 million Americans, including 7 million children, have asthma, and the numbers are increasing annually, according to the most recent federal estimates. And studies indicate that uninsured Americans with asthma, about four in 10 of whom are unable to afford medications, are less likely to take daily prescription drugs to keep their condition under control.

With medication compliance at the heart of asthma DM efforts, ALA said on Aug. 13 that its research centers are recruiting for a study into whether using a Continuous Positive Airway Pressure (CPAP) device — now used for sleep apnea — also can improve asthma control. If CPAP is found to be effective, ALA says this would introduce “an entirely new way to treat asthma without medication.”

**Exchanges May Insure Many More Asthmatics**

At issue is whether the situation will improve as millions of now-uninsured Americans, many with chronic illnesses such as asthma, begin enrolling Oct. 1 into plans for coverage in the overhauled health insurance market starting Jan. 1. CEO Howard Kahn of L.A. Care Health Plan, the nation’s largest public health plan, says his nonprofit HMO serving 1 million-plus members in five programs including Medi-Cal (California’s Medicaid program) and Healthy Families doesn’t expect a large influx of children from Medicaid expansion under reform. But L.A. Care is bracing for a large number of new adult members, including those with chronic illnesses, “and asthma and particularly COPD have substantial costs,” he tells HPW. “That’s where we’ll see a lot of new costs.”

On the flip side, Kahn says, currently uninsured people are seeking emergency care because they lack access to programs such as L.A. Care’s asthma DM program. The advent of changes starting in 2014 under reform “means [such people] will be able to be identified by our health plan…and will get medical treatment,” along with help in reducing asthma triggers in their homes, he says.

The HMO’s L.A. Cares About Asthma program, which focuses on medical and environmental interventions, includes educational mailings, an asthma action plan, nurse case managers and home visits from community-based organizations.

Citing the need for “consistent access to health care and appropriate controller drugs,” Kahn says the asthma program set up several years ago is working: Of 1.2 mil-


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lion L.A. Care members, 52,829 had asthma as of August 2013. Of these, just shy of 30,000 participants are children aged 18 or younger. Among members completing at least two home visits during 2012, there was a 52% average reduction in asthma-related emergency room visits from 2011 to 2012, along with significant improvement on an asthma control test.

L.A. Care cites a systematic review of existing research by a national task force in 2011, which found a return on investment (ROI) ranging from $5.30 to $14 for every dollar invested in “home-based multi-trigger, multi-component environmental interventions” for asthmatic children and adolescents. Other studies have shown even higher returns when community interventions are combined with other improvements to clinical care, the plan says.

Actual ROI figures for L.A. Care’s asthma program were unavailable.

Ernie Moy, M.D., a medical officer at the Agency for Healthcare Research and Quality, notes that AHRQ has an asthma ROI calculator. He says the calculator remains relevant several years after its introduction because plans and states still can use it to determine what ROI they can generate with asthma DM interventions — allowing states to see the potential for greater cost savings even as the Medicaid population grows.

According to the National Committee for Quality Assurance’s (NCQA) measure on the appropriate use of medications for people with asthma, the compliance rate for commercial HMO members was 91.9% in 2011, up from 57.7% in 1999. “So, in general, I would say asthma care in the main has been getting better,” NCQA spokesperson Andy Reynolds tells HPW. But he concedes that Medicaid plans’ overall medication compliance rate for asthmatic members fell to 85% in 2011, down from 88.4% in 2010. He says NCQA on Oct. 23 will release a report on plans’ 2012 performance on measures.

Some Say Care Is Improving; Others Disagree

Moy counters that he views asthma as “an important topic generally, because asthma care has not gotten better. If anything, it has gotten worse.” He says NCQA represents plans voluntarily participating in its program, whereas AHRQ looks at asthma “from a population perspective.” Thus, NCQA is using HEDIS measures to determine whether physicians are giving prescriptions to asthmatic patients, he says, “but we’re looking at what patients actually use.”

For asthmatic patients, including those in fee-for-service (FFS) plans and the uninsured, as well as those in managed care plans, the medication compliance “rates are low, in the 30% range, for people taking a controller medication daily or almost daily,” Moy says. Under re-
form, he says, “We certainly hope the rates of people getting recommended asthma care go up. But for the plans, they’ll be taking this new population and factoring it in, and their [asthma medication compliance] rates may go down,” at least initially.

Moy cites more U.S. hospital stays related to asthma. AHRQ reported in 2012 that adult hospitalization rates for asthma from 2000 to 2009 rose from 112 per 100,000 adults to 131 per 100,000. He describes this as “a very significant and dramatic rise” that plans cannot deny, “unless plans think this increase is just from people outside MCOs, but I wouldn’t think so.” He also worries that federal guidelines for asthma care were promoted heavily to providers about a decade ago, but now the national effort “seems to have lost its traction.”

Amid such divergent views on the general progress of asthma care in the U.S., some plans’ individual efforts are getting attention. URAC, for example, will highlight an individualized, home-based asthma management program for children and adults run by Family Health Network, among other plan efforts, at its upcoming meeting in Washington, D.C.

**Nearly Half of All States Will Expand Medicaid Eligibility in 2014**

As of Sept. 4, a total of 24 states and the District of Columbia will expand Medicaid eligibility for their state residents as permitted under the Affordable Care Act (ACA). Another 22 states will not expand their programs, and the remaining four are leaning against doing so, but no final decision has been made, according to consultants at Avalere Health LLC. The choice states have on Medicaid expansion stems from the June 2012 Supreme Court decision on the ACA’s constitutionality, which struck down the law’s provision granting HHS authority to withhold all Medicaid funding from states that don’t expand eligibility by 2014 to persons with annual incomes up to 133% of the federal poverty level. Instead, HHS may withhold only the funding for the expansion population, the Supreme Court ruled, leaving states free to choose whether to expand without jeopardizing existing Medicaid funding (HPW 7/2/12, p. 1).

*Arkansas and Iowa have submitted waivers to use premium assistance models with exchange plans for parts of their expansion populations; Tennessee is considering a similar model for expansion beneficiaries.

**Michigan’s expansion likely will take effect in March or April 2014 and will require waiver approval from CMS for a number of provisions, including the use of health savings accounts.
In addition to nurse case managers’ phone calls, Chicago-based Family Health Network’s Asthma CarePartners program, which began in August 2011, uses community health workers to educate high-risk members with asthma about disease triggers by visiting their homes. Members are referred to the program by case managers and, once enrolled, get six home visits and monthly phone contact over one-and-a-half years. The program, run in partnership with the Sinai Urban Health Institute, initially was for one year, but it recently added six more months to continue tracking members’ asthma management efforts.

Barbara Hay, Family Health Network’s chief operating officer, tells HPW the plan won’t participate in the state exchange’s first year in 2014. But an Illinois statewide mandate for Medicaid managed care begins in 2014, she says, and the plan expects “a significant increase” of new members. This will include people with asthma who previously had coverage and routine care but likely ended up in emergency rooms instead of getting help in managing symptoms, she says.

Contact Pearson at cpearson@avalere.net, Kahn via Amy Gurango at agurango@lacare.org, Moy at ernest.moy@ahrq.hhs.gov and Hay via Sarah Mahisekar at smahisekar@fhnchicago.com.

**ACO-to-MA Transition Involves Array of Rules and Requirements**

Medicare Shared Savings Program (MSSP) and Pioneer accountable care organizations (ACOs) that want to open Medicare Advantage (MA) plans will need to consider how to address a myriad number of requirements ranging from insurance reserves to compliance issues.

However, ACOs that do make the move could see financial rewards that well exceed the possible shared savings from the two Medicare ACO programs, said William MacBain, senior vice president, finance, for consulting firm Gorman Health Group, LLC.

It’s not a strategy that will suit every organization, MacBain told attendees at a recent webinar sponsored by AIS and Gorman Health Group LLC. “This is for Medicare ACOs looking for an exit strategy: provider organizations who have tasted risk and like it, but are looking for something that does not have the sort of issues that Medicare ACO programs have.”

In a previous webinar, MacBain detailed the reasons MSSP and Pioneer ACOs should consider shifting to the MA program. Specifically, he said, the programs as they are currently designed will result in ever-tightening benchmarks, under which it will be very difficult to earn shared savings.

In the most recent webinar session, MacBain and two colleagues explained the details of how an MSSP or Pioneer plan could move toward becoming an MA plan or a provider network contracting with an MA plan in either a shared-risk arrangement or on a capitated basis.

Choosing to become an MA plan involves a move upstream to the payer side and involves more complex issues, while staying on the provider side and sharing risk as a network contracted with MA plans might “look something like what you’re doing now as an ACO, or moving further into full capitation,” MacBain said. Either option, he added, could represent a successful strategy for a current Medicare ACO.

**New Insurers Face Several Hurdles**

There’s no getting around it: Medicare ACOs that opt to open their own MA plans will need to become an insurance company, MacBain said. That means deciding whether to be for-profit or not-for-profit — there are advantages and disadvantages to both types of entities — and it also means coping with state licensure, ownership and control, and raising capital, he said.

MA plans must meet hefty financial reserve requirements, and an ACO that decides to run one must learn the insurance business, which “is counter-intuitive for many health care providers,” he said.

In addition, new MA plans need to start with an emphasis on CMS’s five-star quality rating and bonus system. “If your competitors are earning four to five stars, you’ve got to at least match them,” MacBain said. New MA plans also need to learn how to interact with CMS, he said, adding, “negotiating with CMS is a bit tougher because there are regulatory issues.”

It’s absolutely critical for ACOs moving into the MA space to have a business plan, MacBain said, and to craft one, the organization needs to “know why you’re doing this and what you expect to accomplish.” The business plan also should cover sales and marketing, health care delivery, operations and finance, he said.

Applying to become an MA plan actually is a very technical process with hard-and-fast deadlines and rules for electronic — not paper — application submissions. And Regan Pennypacker, senior director of compliance solutions for Gorman Health Group, urged organizations to start as soon as possible once they know they’re going to go that route.

Leadership support “from the top down, indicating this is a priority” is critical, as is having the “right subject matter experts” — those who know provider networking, Part D drug plans and CMS compliance — at the table, Pennypacker told attendees at the webinar.

“Avoid throwing spaghetti at the wall,” she said. “You want to make sure you minimize the deficiencies
[in your application] they will identify.” Also, she urged prospective MA plans to ask CMS for help if it’s needed.

The application process itself consists of the notice of intent to apply, which for 2015 is due on Nov. 9, 2013, and the annual application, which for 2015 will be due in late February 2014. Organizations will need to understand the items required for MA and Medicare Part D applicants, Pennypacker said. MA Special Needs Plans (SNPs) have additional specific requirements, she added.

To meet the requirements and the deadlines, Pennypacker recommended establishing a work plan using the CMS documents as a base, and assigning each area to specific work groups. “This also establishes accountability in your organization,” she said. Potential MA plans will have a chance to correct their submissions, but the goal should be an initial application that’s as complete and correct as possible, she said.

MA Plans Have Options

The most common problems identified by CMS in MA applications include deficiencies in networks, compliance and Part D areas, she said.

ACOs that don’t feel up to meeting the MA requirements can opt to contract with an existing MA plan as a participating provider organization, said Aaron Eaton, chief development officer for Gorman Health Group. That most likely will involve some sort of risk-based contract with the MA plan, he said.

Organizations can consider a capitated contract or a modified fee-for-service arrangement with savings bonuses, Eaton told attendees at the webinar. “The main thing is, you want to be sure it covers a reasonable cost of care, it provides incentives, and it is risk-adjusted,” he said. Contracts also should include some recognition for a positive impact on the MA plan’s quality score, he said.

Even though contracting with an MA plan represents a simpler option than opening your own MA plan, current Medicare ACOs shouldn’t “just wing it,” Eaton warned. “Know what services you are accountable for, know the reasonable expectations for frequency, know the average cost per unit of service in your market area and know what you will need to manage or change in order to show a profit.”

State Snapshot: Calif. Prep for Market Changes as Oct. 1 Looms

An insurance broker trained to instruct others on the intricacies of the Covered California state-run exchange says the race to beat the Oct. 1 start date deadline is going full bore, offering a snapshot of the activity taking place across the country to prepare for the new marketplaces.

But as more details come out on how the individual market will work next year in the nation’s most populous state, Neil Crosby, director of sales, Warner Pacific Insurance Services, Westlake Village, Calif., wonders how slimmed-down provider networks will be able to meet consumer demand and if customers know what to expect from exchange-based plans as a result.

With so much talk about how the exchange’s individual premiums in 2014 are not going to be markedly more expensive than policies sold this year, people don’t realize only “30% of the providers will be in the exchange market versus” the outside market, he tells HPW. To keep premiums low, according to Crosby, carriers have demanded sharp reimbursement cuts, offering to pay just 80% of Medicare rates in some cases. “That is 35% to 38% of what providers may be getting for fully insured patients or cash-only patients now,” he adds.

The narrower networks, especially in rural areas of the states, may mean some consumers won’t be able to continue their patient-provider relationships since many providers are not going along with the exchange-related reimbursement structure, Crosby says. “People may be thinking they will get the same health plan as before, but their doctors might not be in it,” he adds.

Three Insurers Stand to Win Market

Separately, in a Sept. 5 investor note exploring the California exchange, Ralph Giacobbe, a securities analyst with Credit Suisse, said the state should see greater-than-expected uptake in the market. “Based on our analysis of the California rates, and considering government subsidies, we believe uptake in the California exchange will be higher than national average, and higher than our initial expectation for 2014. Of the 2.6 million subsidy-eligible, we estimate a 32% uptake versus 23% for the national average, and total exchange enrollment of over 1 million versus expectation of less than 800,000,” he wrote.

Giacobbe said WellPoint, Inc. unit Anthem Blue Cross of California, Blue Shield of California and HealthNet, Inc. appear positioned to capture the most exchange enrollment next year, as they offer the lowest-cost Silver and Bronze plans in the individual market.

For more information, contact Crosby at NCrosby@WarnerPacific.com and Giacobbe at ralph.giacobbe@credit-suisse.com.
Insurer Deal Boosts Medicare Play
continued from p. 1

into the insurer’s physician engagement model since Alegis has a strong clinician mindset and makes it easy for senior citizens to work with their own doctor. In 2013, Alegis will provide services to nearly 31,000 seniors across 10 states, including Cigna-HealthSpring customers in Delaware, Illinois, Maryland, Pennsylvania and Washington, D.C. Terms of the deal were not disclosed.

Medicare Gains Drive Purchases

The Cigna move is another sign that the industry sees government-paid reimbursement as the wave of the future. “The commercial market as we know it today is permanently changing, and in fact we are seeing that percentage shift for the first time in history where a majority of people in America are now tied to Medicare and Medicaid….Certainly when we get the exchanges up, it will be even more so,” William DeMarco, president and CEO of Pendulum HealthCare Development Corp., a management services firm, tells HPW. “So what a lot of these groups are doing is saying, ‘How can I reinvest my money correctly as a big insurance company in the healthcare space?’” This notion is being driven home by Wall Street investors, who are pushing carriers to reduce their expenses in managing physicians, resulting in acquisitions like the one for Alegis. “You can be buying up a lot of these other types of delivery system organizations, so now you have taken what is a variable cost and turned it into a fixed cost,” he adds.

DeMarco says “the other side of the ledger” for health insurers involves acquiring companies able to help control administrative costs, such as technology developers. He cites the path that UnitedHealth Group is following with its Optum subsidiary to seek out better efficiencies in coordinating care. “Again, it’s Wall Street saying a return on investment for a mere premium company — where that premium revenue is their sole source of income — is not going to be as attractive as will be a company that has a three-legged stool. These companies have acquired providers, have acquired systems companies and have the premiums that continue to scale and have less administrative costs, less unpredictability in terms of provider reimbursement,” he says.

The question for DeMarco isn’t why Cigna would buy a company like Alegis, but whether the two can integrate management and operations. That process has not been smooth at all for insurers, he says. “You can guess what some of the issues are. You’ve got a large, stable company who thinks they know all the answers, and they buy a very young, entrepreneurial company, and they do have the answers. They know how to manage chronic care because they’ve been in Medicare for 20 years; they do know how to manage medical homes because they’ve been in medical homes for 20 years. So moving all that together is really difficult because of the large corporation that is perhaps past its prime, and a lot of these smaller companies aren’t even to their prime yet,” DeMarco says.

Cigna’s Harrison says integration should not be an issue, noting the success the insurer has had in making HealthSpring an integral part of its business. She also says “there will not be a lot of management change” within Alegis since Cigna really is interested in the firm’s capabilities. Harrison adds that Alegis also will be serving other payers in its third-party administration business.

Kongstvedt says whether Cigna can successfully integrate Alegis is an open question. “Some of them [i.e., insurer purchases in general] have been integrated very well and others not as well, and the value did not get realized. But Cigna is a pretty experienced company. They have learned a lot of lessons along the way — at least prior individuals have — and there is a lot of institutionalized knowledge dating back to the 1990s when they made acquisitions that were much tougher to deal with,” he says, referring in part to its integration of Prudential’s HMOs and health care business.

Major Carriers Seek Brain Power

Some of the trouble that comes with buying niche companies is that the goal of the major carrier is not a traditional one when it comes to acquisitions. “The idea here isn’t so much to build up and buy up these companies to create a huge asset. Instead, the idea is to suck the information from the knowledge base of these companies and try and apply it to the larger-scale insured populations,” DeMarco says. “And that is where they are having trouble because a lot of these groups, they work in different markets, but they don’t work in every market, so you can’t just take it and stamp it out; you really have to have some custom design to it.”

He points to the success of some Blue Cross and Blue Shield plans in hiring away talent. “I think some of the smaller insurance companies that have invested in hiring people with provider relations backgrounds, physician backgrounds, those companies — and I’m going to say Blue Cross being one of them — have probably done better than going out and buying a lot of new companies that they are going to try and integrate with their systems,” DeMarco says.

The “hidden capital” then is gained by hiring people to create a group with the brain power to create new centers of excellence within an insurance company.

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**HEALTH PLAN BRIEFS**

- **WellCare Health Plans, Inc.** on Sept. 5 said it will buy Windsor Health Group, Inc. of Atlanta, a unit of Munich Re. Terms were not disclosed. Windsor caters to Medicare beneficiaries with Medicare Advantage (MA), prescription drug plan and Medicare supplement products. Windsor offers MA plans in 297 counties, mostly in Arkansas, Mississippi, South Carolina and Tennessee. Visit http://tinyurl.com/kuxoqqq.

- **The Washington Health Benefit Exchange** on Sept. 4 said its board-certified qualified health plans will be offered through Washington planfinder, the online marketplace for the state’s public exchange. The following carriers won approval to sell health and pediatric dental plans through the exchange, which begins open enrollment on Oct. 1: BridgeSpan Health Company, a unit of Cambia Health Solutions; Community Health Plan of Washington; Group Health Cooperative; LifeWise, a unit of Premera Blue Cross; Molina Healthcare of Washington, Inc., a unit of Molina Healthcare, Inc.; Premera Blue Cross; and Kaiser Permanente’s Kaiser Foundation Health Plan of the Northwest (which also will be the sole small business carrier). Delta Dental of Washington, Kaiser, LifeWise and Premera also will offer pediatric dental plans. Visit http://tinyurl.com/m5fzhkn.

- **HealthNet, Inc.** on Sept. 4 said its subsidiary Health Net Federal Services, LLC won a Veterans Affairs contract under the VA’s Patient Centered Community Care program, which will give veterans the ability to access care via a non-VA provider network when a local VA medical center is unavailable. TriWest Healthcare Alliance signed a similar deal with the VA, and the combined contracts are worth a maximum of $9.4 billion over five years, with HealthNet receiving as much as $5 billion and TriWest up to $4.4 billion. Visit http://tinyurl.com/kwhbymh.

- **Nevada’s Division of Insurance has released premiums for plans in the individual market that will be sold on the public exchange launching next year and starting open enrollment on Oct. 1, according to the Las Vegas Review-Journal on Sept. 4. The rates apply to products sold on and off the Silver State Health Insurance Exchange. Some specific rates differed from the preliminary schedule released in July, and more details on what consumers can buy will not be released until the exchange opens. Four carriers are selling plans on the exchange: WellPoint, Inc. unit Anthem Blue Cross; UnitedHealth Group subsidiary Health Plan of Nevada, Inc.; Nevada Health CO-OP; and Saint Mary’s Health Plans, a unit of Dignity Health. Visit http://tinyurl.com/lcf2kzx.

- **UnitedHealth Group subsidiary UnitedHealthcare** on Aug. 20 formally introduced an online electronic bill-payment service that since its launch in late July has processed 16,000 payments from members of the nation’s largest health plan. The online service is called myClaims Manager and marks the first such online payment system offered by a national carrier, according to UnitedHealthcare. The bill-pay feature is also an enhancement to the insurer’s plan participant portal at www.myuhc.com, Victoria Bogatyrenko, a vice president of product development and innovation at UnitedHealthcare, tells HPW. The next addition to the insurer’s portal will extend the online billing system to mobile devices. Visit http://tinyurl.com/l87w8o4.

- If uninsured young adults (ages 19-29) spurn health insurance that is offered to them under the Affordable Care Act, it will be because of cost and not because they feel “invincible” and do not need medical care, according to a new study by the Commonwealth Fund. Data from the Commonwealth Fund Health Insurance Tracking Surveys of Young Adults “suggest that as young adults...gain awareness of the new coverage options available in January 2014, they will eventually enroll in large numbers.... Of the estimated 15.7 million young adults who spent some time uninsured between March 2012 and March 2013, more than 80% will be eligible next year for subsidized insurance or Medicaid” under the reform law. But as of March 2013, only 27% of young adults were aware of the new state marketplaces. Visit http://tinyurl.com/m2sqrfg.

- **PEOPLE ON THE MOVE: WellCare Health Plans, Inc.** named Michael Polen to the newly created position of senior vice president, operations. Polen’s previous positions at the company included roles in corporate initiatives and strategy, health plan operations and finance. The insurer said in conjunction with Polen’s new role, Walter Cooper’s position as chief administrative officer has been eliminated, and he is no longer with WellCare. Also, Dan Paquin, who held the position of president, national health plans, is no longer with WellCare.
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