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HEALTH PLAN WEEK

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

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Eight Months Into Obama Administration, CMS's Unfilled Top Position Causes Concern

In October, it will be three years since Mark McClellan, M.D. — the last Senate-confirmed CMS administrator — left the agency. In interviews with *HPW*, some former CMS/HCFA leaders say they're surprised the Obama administration has allowed such a key post to remain vacant. And while HHS Sec. Kathleen Sebelius is rumored to be close to announcing a candidate, calls and e-mails to the department and agency, as well as to the White House Office of Health Reform, seeking confirmation were not returned by *HPW*'s press time.

Gail Wilensky, Ph.D., a senior fellow at Project HOPE who ran the agency (then known as HCFA) for two years during the George H.W. Bush administration, says she doesn't understand why the administration hasn't yet filled the position. "It is really baffling to me," she tells *HPW*. "All of the [health reform] bills under consideration include substantial changes for Medicare and/or Medicaid, which by definition involves CMS. You'd think [the Obama administration] would like to have the person leading the agency to be involved in some of the policy discussions."

Since McClellan left the agency in October 2006, there have been four acting administrators, including Kerry Weems, who was appointed by President Bush but was never confirmed by the Democratic-majority Senate (see table, p. 7). Weems left the job in January. He declined to comment for this article.

continued on p. 6

Calif. Rescission Bill Could Reduce Plans' Underwriting Burden, Level Playing Field

Although California health plans opposed the anti-rescission bill passed by state lawmakers this month, some analysts put a positive spin on the measure. They argue that the bill will reduce the administrative burden for all health plans and level the playing field for insurers with less aggressive post-claims underwriting policies. Meanwhile, health plans outside California also may find themselves operating under new rescission rules, since language barring the practice appears in federal health reform bills such as H.R. 3200 and the Senate Finance Committee bill marked up by Chairman Max Baucus (D-Mont.) (see brief, p. 8).

A.B. 2 would require an automatic external review before health plans can rescind individual health insurance policies. Cancellations would occur only if the policyholder was found to have intentionally withheld information about pertinent medical conditions. The bill also would create a standardized health insurance application for individual enrollees, and would require insurers to complete all medical underwriting before the policy takes effect.

The bill, proposed by Assemblymember Hector De La Torre (D), was passed by the California Senate on Sept. 8 and by the Assembly on Sept. 10. It and hundreds of other bills now await the signature of Gov. Arnold Schwarzenegger (R), who has said he won't ink any legislation until lawmakers act on water rights issues. The governor

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vetoed an anti-rescission measure last year. He has not taken a position on A.B. 2, although he has been critical of insurers' rescission practices. If signed, the bill would take effect in January 2011.

A primary objection to A.B. 2 is the legal standard requiring the insurer to prove that the policyholder "intentionally" withheld information, says Kathleen McKenna, executive director of public policy advocacy at Kaiser Permanente. "That standard is virtually impossible to meet and would result in litigation in almost any rescission case that is contested."

McKenna tells *HPW* that Kaiser Permanente supports rescission reform, including "clear statutory guidelines" for cancellations, the "requirement that all health plans and insurers use standard information and health history questions," the independent review board to approve rescissions and the prohibition of rescissions except in cases where "an applicant misstates or omits relevant information regarding health history when asked on the application."

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"In reality, you would find that insurers would almost never appeal [negative decisions by the rescission review board],…unless the decision was really egregious," predicts J.P. Wieske, director of state affairs for the Council for Affordable Health Insurance.

Bill May Ease Administrative Burden

In practice, using a standardized application for individual applicants may be easier than constantly tinkering with homegrown enrollment forms, says Joseph Paduda, a principal at Madison, Conn.-based consulting firm Health Strategy Associates.

"Health plans are constantly looking at their data to try to identify what demographic, lifestyle and other factors [drive up costs], and what data points they can legally collect and ask about," he says. Insurers then do "statistical analysis to determine what the correlation of data points is with actual claims experience." For example, Paduda says, an insurer might note increased costs for orthopedic injuries in the Lake Tahoe area concentrated in young males between ages 18 and 30. In response, the insurer might decide that "we're going to change our rating factor there, we're going to increase premiums and risk, and ask questions about what kind of lifestyle activities you participate in."

So although complying with A.B. 2 may "require some changes from an actuarial perspective;…health plans are constantly refining and updating policies and metrics and algorithms," Paduda contends.

He also speculates that some health plans have invested a lot of resources in post-claims underwriting at the expense of pre-enrollment medical underwriting operations. Such insurers "figured that they would sign up more folks on the front end, knowing they could probably get rid of some on the back end.…So they wouldn't invest as much in medical underwriting on the front end."

And even if Schwarzenegger vetoes the bill, there are strategies more health insurers could adopt to avoid the need for some rescissions. Wieske says some insurers are far more aggressive about pre-enrollment underwriting, thereby limiting the number of post-claims rescissions.

He points to one insurer, which he declines to identify, that conducts telephone interviews with all potential enrollees. During the interview, staff members "re-ask questions on the application and add general information [such as] 'What prescriptions are you on, when was your spouse's last doctor visit and your last doctor's visit?'" The result was that "a huge number of substandard ratings or declines come from [information gleaned from] the telephone interview."

In the end, Paduda says, a consistent policy on cancellations "would probably be a lot less work for a health

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plan than digging through the minutia of individual policyholders' histories to determine whether they ever made a mistake on the application."

The bill also will level the playing field between aggressive and less aggressive plans, he contends. "Some health plans went extremely far and were extremely liberal in interpreting what they could do under their rescission policy," he says. "Clearly, there's an advantage for a health plan that will use any pretext to cancel someone's policy if they dare to ever have a claim."

"I'd be very surprised if there is not an anti-rescission clause in a federal health care reform initiative. There's been so much publicity about what's happened in California," Paduda says. But, he adds, "in a federal bill, it's going to be in the context of prevention of medical underwriting." Both House and Senate versions of health care reform bills would require guaranteed issue and bar medical underwriting, he says. However, the issue of rescissions "still has to be addressed in a federal universal underwriting bill…because even if there's no underwriting, there's still a way for health plans to cancel coverage."

No other state legislature is likely to enact a rescission bill this year, Wieske says. Most state legislatures

CMS Orders Plans to Suspend 'Misleading' MA Reform Mailings

At the urging of federal lawmakers including Senate Finance Committee Chairman Max Baucus (D-Mont.), CMS Sept. 18 sent a letter to Humana Inc. telling the Kentucky-based company "immediately" to stop sending letters to Medicare Advantage (MA) members that warn about the threat of health reform. The warning prompted outrage from the Senate's Republican leadership. In a letter to HHS Sec. Kathleen Sebelius, Sen. Mitch McConnell (R-Ky.) referred to CMS's warning as a "gag order" and threatened to block any political appointments to positions within HHS, including the long-vacant CMS administrator post (see story, p. 1).

According to the Humana letter that CMS halted, "millions of seniors and disabled individuals could lose many of the important benefits and services that make Medicare Advantage health plans so valuable." CMS also demanded that Humana remove any related materials from its Web site. Citing its concerns with Humana's action, CMS broadened the warning to cover the entire MA industry Sept. 21 and warned carriers to "suspend potentially misleading mailings to beneficiaries about health care and insurance reform."

Sen. Max Baucus (D-Mont.), who chairs the powerful Senate Finance Committee (SFC), for example, has proposed trimming $113 billion from the MA program. Such cuts could prompt some health plans to trim benefits, boost premiums or leave less profitable rural markets. America's Health Insurance Plans (AHIP) spokesman Robert Zirkelbach responded in a Sept. 22 statement that seniors "have a right to know how the current reform proposals will affect the coverage they currently like and rely on." Sen. Orrin Hatch (R-Utah) introduced an amendment to SFC's reform bill that would require HHS to certify that no more than 1 million seniors would lose current coverage as a result of reform. The amendment was voted down.

Humana spokesperson Tom Noland says the insurer has stopped the beneficiary mailings and taken related materials off its Web site. As of June 30, Humana had 1.5 million MA enrollees and nearly 2 million stand-alone Prescription Drug Plan (PDP) members.

Baucus accused the industry of employing "scare tactics. In the Sept. 18 letter, Teresa DeCaro, acting director of CMS's Medicare Drug and Health Plan Contract Administration, noted that the insurer's mailing was placed in an envelope stating that it contained "important information about your Medicare Advantage plan — open today!"

Specifically, Humana's undated letter states: "Leading health reform proposals being considered in Washington, D.C., this summer include billions in Medicare Advantage funding cuts, as well as spending reductions to original Medicare and Medicaid. While these programs need to be made more efficient, if the proposed funding cut levels become law, **millions of seniors and disabled individuals could lose many of the important benefits and services** [bolded typeface in Humana's letter] that make Medicare Advantage health plans so valuable."

Separately, CMS on Sept. 9 lifted the marketing and enrollment suspension against WellPoint, Inc. In January, the agency had imposed intermediate sanctions, suspending WellPoint's marketing and enrollment for MA and Part D contracts and citing serious operational deficiencies. CMS has not lifted similar sanctions against operators of two Florida-based MA plans: WellCare Health Plans, Inc. and Citrus Health Care.

Contact Noland at tnoland@humana.com, and DeCaro through the CMS press office at (202) 690-6145.

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now are out of session for the year, but also many states have been holding off on state health laws in order to see what happens with federal health care reform proposals.

Wisconsin already has a law requiring external review for rescission decisions, Wieske adds. But the California bill "is much more detailed than the Wisconsin bill is, so some of that is actually positive because it's important to flesh these things out."

Contact McKenna at Kathleen.Mckenna@kp.org, Ezra at (415) 229-5447, Paduda at (203) 314-2632 or Wieske at (920) 499-8803. ✧

Health Reform Update

Insurance Exchanges Could Help Small Plans Boost Enrollment

State-run health insurance exchanges, as proposed in the Senate Finance Committee's health reform markup *(HPW 9/21/09, p. 1)* as well as in other bills, could give small health plans an opportunity to compete against much larger players.

In an interview with *HPW*, Jon Kingsdale, executive director of the Commonwealth Health Insurance Connector Authority, says insurance exchanges in Massachusetts have led to disproportionate enrollment increases for some smaller carriers.

Since the state enacted its health reform law in 2006, Network Health says it has seen its enrollment balloon from about 80,000 members to just over 150,000. From the time it was founded in 1997, Network Health has served the state's Medicaid population. But the state's 2006 health reform law opened the door for a new group of enrollees — individuals and families with annual incomes below 300% of the federal poverty level (FPL). The enrollment "surpassed everyone's expectations," says Debbie Gordon, the insurer's senior director of marketing. Network Health is one of five managed Medicaid operators that participate in Commonwealth Care, an insurance exchange that offers subsidized health insurance coverage. The other insurance exchange, Commonwealth Choice, offers unsubsidized individual health coverage.

More than 45,000 Network Health enrollees have coverage through Commonwealth Care, and the other 107,000 have Medicaid coverage, which also increased after the state's reform law expanded eligibility for children. "The reform [law] here has certainly expanded our business and ability to live out our mission: to improve the health and well-being of our members and their communities," Gordon tells *HPW*.

Neighborhood Health Plan (NHP) also has experienced a significant enrollment increase as a result of the state's reform law. While the insurer is predominantly a managed Medicaid operator, it also sells commercial coverage. About 70% of the company's 200,000 enrollees have coverage through MassHealth, the state's Medicaid program. The remaining 30% have coverage through Commonwealth Care, Commonwealth Choice or traditional commercial insurance.

"Low-income people…that was a whole new market for us that didn't exist prior to reform," says Mike Nickey, director of product strategy and manager of Connector programs. About 4,500 of the company's 30,000 commercial enrollees have coverage through Commonwealth Choice. Most of NHP's commercial enrollees have coverage through an employer. Nickey tells *HPW* that the exchange allowed his company to compete against larger health plans based on price. "We have a focused network and low overhead, so our premiums tend to be lower than our competitors," he explains. "Consequently, NHP appears at or near the top of the list through the Connector, which ranks health plans by price on its Web site. This can be a more attractive advantage to potential enrollees than we might otherwise have outside of the exchange."

Exchange Increases Visibility

Between Dec. 31, 2006, and March 31, 2009, Fallon Community Health Plan grew by 17,245 members. A portion of that growth can be attributed directly to its participation in the two insurance exchanges, says Sonja Brehm, director of business and product development. "Having the Connector has definitely increased our visibility within the Massachusetts marketplace," she tells *HPW*. "But a larger part of our growth has come from employer groups and is a direct result of our continued service-area and provider-network expansions." Similarly, Tufts Health Plan added more than 40,000 members since reform was enacted. Much of its enrollment growth can be traced to the individual mandate, which prompted many previously uninsured people to enroll in coverage offered by an employer.

If a similar model of state-run insurance exchanges were rolled out nationally, it could help smaller health plans compete against larger players, says Carla Bettano, vice president of business development at NHP. "It's a way to even the playing field with larger plans. In the case of the Connector, health plans are all on a level playing field, and price has become a driving force." *Case in point:* The health insurer is now the fourth largest carrier in the state in terms of membership. Prior to reform, it ranked sixth, she says, adding that the reform law helped it grow different lines of business.

Contact Bettano at Carla_Bettano@nhp.org, Gordon at debbie.gordon@network-health.org and Lauren Petit for Brehm at lauren.dibenedetto@fchp.org. ✧

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Michigan Officials Question Blues Plan's Acquisition Target

Marking its second acquisition within Michigan in the past three years, Blue Care Network (BCN) this month struck a deal to buy assets of an HMO arm of Lansing-based Sparrow Health Systems for an undisclosed price. BCN is a subsidiary of the state's largest insurer, Blue Cross and Blue Shield of Michigan (BCBSM).

While BCN touts the deal as a way to strengthen Sparrow's ability to care for patients, one regulator and the state's health plan industry association are concerned about what the merger could mean for Michigan's competitive landscape and insurance premiums.

In the deal announced Sept. 15, Southfield-based BCN agreed to take on the membership and purchase nearly every asset belonging to Sparrow's HMO, Physicians Health Plan of Mid-Michigan (PHP). If finalized, BCN will acquire PHP's nearly 80,000 members as well as its 18,000-member Medicaid HMO. Neither company will disclose the terms of agreement until they get final approval on the deal from the Michigan Office of Financial and Insurance Regulation and the Michigan Community Health Department. PHP posted net income of $3.2 million on revenue of $175.3 million for 2008.

BCN has the state's largest HMO network of physicians and hospitals in the state, including 4,300 primary care physicians and 116 hospitals — compared with PHP's more narrowly centered mid-Michigan network of 11 hospitals and 1,300 physicians.

Jeanne Carlson, BCN's president and CEO, says the deal enables Sparrow to "focus on its core services of

NEW STUDIES IN THE FIELD

◆ **Not allowing age adjustments in insurance rates that are more restrictive than 5 to 1 would cause "dramatic premium spikes" for the young and healthy in the individual insurance market,"** according to a the results of a study released Sept. 23 by the Blue Cross and Blue Shield Association. An amendment added to the Senate Finance Committee's health reform bill would allow health plans to vary their premiums by the age of the insured by a ratio of 4 to 1, rather than the 5-to-1 ratio called for in the earlier version of the bill *(HPW 9/21/09, p. 1)*. The amendment was introduced Sept. 22 by Sen. Ron Wyden (D-Wash.). Wyden's original amendment would have limited age rating to a 2-to-1 ratio. The data were prepared by Oliver Wyman's Actuarial and Health and Life Sciences practice. A 2-to-1 age-rating ratio, according to the study, would increase premiums for the youngest and healthiest Americans in the individual market in many states by nearly 50%, compared with a 5-to-1 age rating ratio. Currently, 42 states permit health plans to vary premiums based on age by 5 to 1 or more. To see the complete study, visit http://tinyurl.com/mfbrc8.

◆ **The U.S. Census Bureau announced this month that the number of people without health insurance grew to 46.3 million in 2008 from 45.7 million in 2007.** During the same period, the number of people covered by private health insurance decreased from 202 million to 201 million, while the number covered by government health insurance climbed from 83.0 million to 87.4 million. The number of people covered by employment-based health insurance declined from 177.4 million to 176.3 million. One bright spot was the number of uninsured children, which is at the lowest level since 1987, according to the recently released Census report. In 2008, there were 7.3 million uninsured children, a decline of 800,000 from 8.1 million the previous year. Jocelyn Guyer, co-director of the Center for Children and Families at Georgetown University's Health Policy Institute, called the reduction "a testament to the effectiveness of public programs in covering children as a majority of states maintained or strengthened their Medicaid and/or Children's Health Insurance Programs despite tough economic times." For more details, visit http://tinyurl.com/p96zja.

◆ **A large majority of surveyed employers anticipates that, if enacted, health care reform will lead to higher health care costs and weaken employers' role in providing coverage to workers,** according to a new poll by consulting firm Watson Wyatt. The poll of 160 employers found that 73% said they believe employees' health care costs will increase if health reform legislation is enacted. Watson Wyatt found that 86% of those surveyed said that health care proposals being considered would also weaken the role employer-sponsored plans play in heath care coverage. The poll found that only 29% would support a tax on high-income employees with high-cost plans and that 19% said they would support a tax on insurers of high-cost plans. An even smaller percentage — 11% — would support taxing employer contributions to health care as income, according to Watson Wyatt. Visit www.watsonwyatt.com.

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providing quality, compassionate health care to the mid-Michigan community." She adds the acquisition should aid PHP and BCN customers by spreading administrative costs across the expanded membership, helping keep health care costs low and offering long-term value to members and providers.

Michigan AG Is 'Skeptical'

Michigan Attorney General Mike Cox (R), however, doesn't seem convinced. "Blue Cross and its subsidiaries must explain how they can afford to buy another company even as they fight to raise rates on seniors," he says. "Could these funds have been used instead to help avoid rate increases on struggling Michigan residents? Until that question is answered, I will remain skeptical."

Cox, a persistent critic of BCBSM, notes that the company and its subsidiaries have spent more than $350 million acquiring other companies since 2005. But during the same time, the Blues plan has reported millions of dollars in losses and asked for rate increases on multiple lines of health insurance. Cox adds that the company has a history of making loans and transfers to its subsidiaries to acquire other companies and wants to know if such transactions are part of BCN's deal with PHP.

Hot New Products From AIS

✔ ***The AIS Guide to Blue Cross and Blue Shield Plans: 2009,*** with info on Blues plans' products, market strategies, acquisitions and alliances — including financial projections and data on revenues, earnings, enrollment and medical loss ratios. Not affiliated with BlueCross BlueShield Association or its member companies.

✔ ***Health Plan Facts, Trends & Data: 2009-2010***, with health plan news, trends, data, directories and other practical resources to help you make sense of the state of the industry. This new edition covers today's hottest issues, including health reform and the turbulent economy's impact on health plans.

✔ ***Complying With the Mental Health Parity and Addiction Equity Act*** provides hands-on guidance for making complicated benefit design decisions that comply with the parity requirements. The book is written by experienced health benefits attorneys John R. Hickman, Esq., and Laurie Kirkwood, Esq., of the law firm of Alston & Bird, LLP.

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To this, BCBSM spokesperson Helen Stojic just emphasizes that the acquisition is by BCN, "which is a separate company from BCBSM."

Others are wary of what the deal could mean for Michigan's competitive landscape. Dave Waymire, a spokesperson for the Michigan Association of Health Plans, fears the deal "will create an even more dominant monopoly in the Lansing region." Pointing to a report from advocacy group Health Care for America Now, he notes that BCBSM already controlled 65% of the overall Michigan market in 2007. "Presumably, this would have taken that up at least a tick or two," Waymire says. While he hesitates to elaborate on what this means, he adds, "I think you can see the handwriting on the wall."

Contact Waymire at dwaymire@mwadvocacy.com and Stojic at (313) 549-9884. Contact John Selleck for Cox at (517) 373-8060. ✧

A CMS Administrator by Christmas?

continued from p. 1

Leslie Norwalk, who served as acting administrator between 2006 and 2007, says it's unlikely that the administration will nominate someone during the middle of a heated health reform debate in the Senate. "I don't care how good a nominee is, that person would be grilled by the Senate during the middle of a health reform debate," she tells *HPW*. The reform debate would make the confirmation process "a lot more awkward given the rancor and debate around health reform. But on the flip side, [the reform debate] makes that job more important." Norwalk, who spent six years at CMS, is now with the law firm Epstein Becker & Green.

Tom Scully, who headed the agency during President George W. Bush's first term, says it is possible that a nominee could be announced as Congress debates health reform. However, confirmation by the Senate "would be a long slog," he tells *HPW*. And if a nominee were announced today, confirmation likely wouldn't occur before Congress adjourns for the year, he says.

And Republicans could make the process even more difficult. In a Sept. 23 letter to Sebelius, Sen. Mitch McConnell (R-Ky.) warned that he and the Republican leadership would work to block any appointments unless CMS lifts "a gag order" that bars health plans from warning seniors about proposed changes to Medicare Advantage (see story, p. 3.)

Scully says that the ability to successfully work with Congress was a critical skill to have during his time as CMS administrator. But because the current White House has assembled such a strong team of experts, the next CMS administrator might not need to spend as much time on the Hill, he contends.

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As for the likely nominees, it's anybody's guess. Liz Fowler, Senate Finance Committee Chairman Max Baucus' (D-Mont.) senior counsel since February 2008, has been mentioned by some industry observers as a likely candidate. Dennis Smith, acting administrator in early 2004, says that David Goetz, commissioner of Tennessee's Dept. of Finance and Administration, is a possible candidate who possesses the skill set needed to deal with the bureaucracy inside CMS. (Smith is now the senior fellow in health care reform at The Heritage Foundation's Center for Health Policy Studies.) Scully suggests that Virginia Sec. of Health and Human Resources Marilyn Tavenner would be another strong candidate. Scully, however, cautions against speculation, noting that he wasn't even considered to be among the top 100 candidates when he was appointed to the post "out of the blue."

Headless CMS May Be More Conservative

Wilensky contends that not having a Senate-confirmed administrator places the agency at a disadvantage whenever there are internal discussions or disagreements among agencies and/or the White House. "If there are confirmed appointees from NIH or other agencies, and [CMS] is being run by a career person, there is not much of a contest if there is a disagreement about policy and decision making." She adds that the lack of a confirmed administrator also makes the agency much more conservative.

"Careerists are not going to take aggressive new actions because they might not be allowed to and because they don't feel they have the designated authority to do so," she explains.

Smith agrees that the agency is more conservative without a confirmed administrator. The acting administrator is "just maintaining the status quo until the political leadership is in place," he explains. "It's unfortunate because CMS has so much work to do and will fall further and further behind on important initiatives where political leadership is needed." Charlene Frizzera, the current acting administrator, was Smith's deputy. He says that while she is "very skilled" and well liked throughout the agency, "to play the role that needs to be played, you need a political appointee who can deal with peers [e.g., within HHS, OMB and the White House] on an equal basis." One political appointee at CMS, Jonathan Blum, is acting director of the Center for Drug and Health Plan Choice. Blum, a former staffer for Baucus, had previously been a vice president at consulting firm Avalere Health. Cindy Mann, director of the Center for Medicaid and State Operations (CMSO), was appointed to the position by Sebelius in May. Mann, a research professor at Georgetown University's Health Policy Institute, was director of CMSO's Family and Children's Health Programs between 1999 and 2001.

Although Norwalk was an acting administrator, she says she wouldn't have operated any differently had she been confirmed by the Senate. "I can assure you that as an acting administrator, I acted," she quips. "There is nothing I would have done differently had I been confirmed by the Senate…absolutely nothing. I suspect [Weems] was much the same way." But unlike Weems and Norwalk, Frizzera is not a political appointee. In that role, Norwalk explains, she's not as involved in policy issues. And the layer of levels needed as a result could make it more difficult for staff to get decisions on policy issues.

Scully says that working with Congress and the White House might not be as critical for the next CMS administrator as it has been during previous administrations. "When I was administrator, the White House didn't have many people who dealt with Medicare and Medicaid. Now you have an army of people in the White House with a lot of experience, including [former CMS administrator] Nancy-Ann DeParle, who knows CMS as well as anyone." DeParle heads the newly created White House Office of Health Reform.

Contact Marguerite Higgins for Smith at marguerite.higgins@heritage.org, Josh Karlen for Norwalk at jkarlen@ebglaw.com and Gloria Burrell for Wilensky at gburrell@projecthope.org. ✧

HCFA/CMS Administrators Over the Past 23 Years

Administrator	Term
William L. Roper, M.D.	5/86 to 2/89
Terry Coleman, Acting	2/89 to 3/89
Louis Hays, Acting	3/89 to 2/90
Gail R. Wilensky, Ph.D.	2/90 to 3/92
J. Michael Hudson, Acting	3/92 to 4/92
William Toby, Acting	4/92 to 5/93
Bruce C. Vladeck	5/93 to 9/97
Nancy-Ann DeParle, Acting	9/97 to 11/97
Nancy-Ann DeParle	11/97 to 9//00
Michael M. Hash, Acting	9/00 to 12/00
Robert A. Berenson, M.D., Acting Deputy	12/00 to 1/01
Michael McMullan, Acting Deputy	1/01 to 5/01
Thomas A. Scully	5/01 to 12/03
Dennis G. Smith, Acting	12/03 to 3/04
Mark B. McClellan, M.D., Ph.D.	3/04 to 10/06
Leslie V. Norwalk, Acting	10/06 to 7/07
Herb B. Kuhn, Acting Deputy	7/07 to 9/07
Kerry Weems, Acting	9/5/07 to 1/09
Charlene Frizzera, Acting	1/09 to present

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HEALTH PLAN BRIEFS

◆ **In a memo to WellPoint, Inc managers, the insurer said it is weighing more job cuts as it wrestles with enrollment declines stemming from a weak economy,** reported *Reuters* on Sept. 23. In response to a query from *HPW*, WellPoint spokesperson Kristin Binns said the economic downturn has caused many of its employer clients to reduce the size of their labor force. "This in turn has affected the membership of WellPoint's affiliated health plans. As a result, we are examining ways we can operate more efficiently in 2010," she said. The memo to managers noted that while discretionary spending would be scrutinized to reduce costs, it also indicate that staffing levels would need to be reduced. The memo did not specify how many job cuts WellPoint was considering. In January, WellPoint eliminated about 1,500 positions after "steeper-than-expected investment losses" *(HPW 1/26/09, p. 8)*. WellPoint employs about 42,000 workers. Visit www.wellpoint.com.

◆ **Congressional Budget Office (CBO) Director Douglas Elmendorf told members of the Senate Finance Committee that seniors in Medicare's managed care plans could see reduced benefits under Chairman Max Baucus' (D-Mont.) health reform plan,** according to *The Associated Press.* Speaking before a Sept. 22 Senate Finance Committee markup session, Elmendorf seemed to contradict President Obama's frequent claim that seniors wouldn't see their Medicare benefits cut under a health care overhaul, the AP reported. Baucus' bill would cut payments to Medicare Advantage (MA) plans by more than $100 billion over 10 years. Elmendorf told the committee that the changes "would reduce the extra benefits that would be made available to beneficiaries through Medicare Advantage plans," according to the wire service. But Senate Finance Committee aides stressed that core Medicare benefits wouldn't be cut because the plans are required to offer the benefits available under traditional Medicare fee-for-service coverage, added the AP. In response to Elmendorf's comments, White House spokesman Reid Cherlin said in a prepared statement that "even under the competitive bidding proposal in the legislation, Medicare Advantage plans will still be paid more than traditional Medicare plans. Yes, they'll need to compete, and they'll need to be more efficient, but they'll still have more money to work with than traditional Medicare." Elmendorf told the committee that he expected MA plans to lose 2.7 million enrollees over the next decade, the AP reported. Visit http://finance.senate.gov or www.cbo.gov.

◆ **The Senate Finance Committee (SFC) on Sept. 22 began its markup of the America's Healthy Future Act that is expected to continue through the end of the month.** On Sept. 24, SFC Chairman Max Baucus (D-Mont.) accused Sen. Jon Kyl (R-Ariz.) of stalling the markup process when he suggested that elements of the bill would lead to a government takeover of the health care system. That same day, Baucus scolded Republicans for supporting the status quo by not supporting his bill. The committee also rejected an amendment to require pharmaceutical firms to give bigger discounts to Medicare on drugs for low-income seniors. An amendment introduced by Sen. Jay Rockefeller (D-W.Va.) and added to the bill would require HHS to develop standardized definitions for medical terms as well as definitions for common insurance terms such as premium, deductible, coinsurance, copayment, out-of-pocket limit and usual, customary and reasonable (UCR) fees. Another adopted Rockefeller amendment would eliminate annual and lifetime limits for all plans participating in state exchanges and preclude group health plans from imposing unreasonable annual or lifetime limits on coverage.

◆ **Vice President Joe Biden told a standing-room-only audience at the National Association of Insurance Commissioners meeting Sept. 22 that basic "ground rules" are needed for insurance companies.** At a minimum, Biden said, insurers should be prohibited from: discriminating for pre-existing conditions; charging exorbitant out-of-pocket expenses, deductibles or copays; charging copays for preventive care; dropping coverage of the seriously ill; discriminating by gender; or capping lifetime coverage. "If every company has to have some guarantees, no company is at a competitive disadvantage," he added. Biden said the individual-mandate and guaranteed-issue proposal, which would prevent health insurers from dropping unhealthy customers, would add a pool of 30 million to 40 million new, healthy, young customers, who are inexpensive to cover. In stressing the need for reform, Biden presented new White House findings that health insurance premiums have gone up between 90% to 150% over the last decade, far more than wages and inflation. Visit www.naic.org or www.whitehouse.gov.

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