Insurers Are Preparing for More Medicaid, Fierce Competition

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WellPoint Bets $4.9 Billion on Medicaid Expansion, but Will Other Carriers Ante Up?

WellPoint, Inc.’s July 9 statement that it would pay $4.9 billion to acquire Medicaid managed care provider Amerigroup Corp. likely will spur other large carriers to consider acquisitions, as the expansion of Medicaid in 2014 represents the most significant growth opportunity in years, industry observers and analysts tell HPW.

“There’s no question Medicaid is going to be a much larger payer after 2014, and insurers see this as a growth opportunity…albeit one fraught with peril if they don’t get the details right,” says Joseph Paduda, a principal at Health Strategy Associates LLC.

“WellPoint needed more expertise, a bigger footprint and a lot more experience with this market and demographic — not only for the Medicaid expansion, but for the rest of the uninsured that will be covered…post 2014.”

With the acquisition of Amerigroup, which has 2.3 million members in 13 states, WellPoint will become one of the largest players in the Medicaid space. WellPoint now has just under 1.9 million Medicaid members spread out over 10 states, with the only overlap in New York and Virginia. WellPoint also has partnerships with Blue Cross and Blue Shield plans in South Carolina and Texas to help administer Medicaid benefits in those states.

The deal is expected to close in the first quarter of 2013. As a result of the U.S. Supreme Court’s decision upholding the health reform law (HPW 7/2/12, p. 1), up to 17 million new beneficiaries will be eligible for Medicaid in 2014 (see story, p. 3), a point continued on p. 7

Candidates Taking On State Insurance Commissioners Vow to Attract New Carriers

Although most of the nation is focused on the presidential election in November, insurance commissioners in five states also are campaigning to keep their jobs. In interviews with HPW, their challengers promise to increase competition among health insurers by making their states more business friendly, and to protect consumers by cracking down on onerous regulations.

An analysis by HPW shows that insurance commissioners in Delaware, Montana, North Carolina, North Dakota and Washington state are up for re-election (see table, p. 3). In those states, plus another six and the U.S. Virgin Islands, insurance commissioners are elected.

Of the five insurance commissioners up for re-election, all but one have just one term under their belt. Washington Insurance Commissioner Mike Kreidler (D) will be trying for his fourth term, though, in a race against three challengers: Republican John Adams, who ran against Kreidler in 2008; Scott Riley, also a Republican; and Independent Brian Berend.

According to his website, Adams, who runs his own insurance brokerage, Seattle General Agency Inc., will work to reduce overregulation. Berend says he will use his office to make sure that health insurers do not engage in “medical rescission.”

continued
Riley, who runs an insurance and stockbroker training business, tells HPW that he will eliminate barriers insurance companies face when trying to compete in the state by streamlining the approval process companies face. This will include reforming prior approval statutes that Riley says are a disincentive for new carriers to come into the Washington market.

He adds that he would also make the office itself run more efficiently, as well as push for cross state competition, noting a significant population is based in the southern cities on the border with Oregon.

Kreidler tells HPW that he has encouraged more competition in the state and says that provisions in the health care reform law, including exchanges, will help to do this. However, he admits that some insurers may find it difficult to break into the Washington market which is dominated by three health plans: Premera Blue Cross, Regence BlueShield and Group Health Cooperative.

“I’m very concerned to make sure as we go forward, we maintain the stability of our health insurance market from a financial solvency standpoint, but also make sure we keep it on a level playing field,” he says, adding that he has been working closely with the state’s major insurers regarding their concerns with implementing health care reform.

In Delaware, Karen Weldon Stewart (D) will not only face a Republican challenger, Benjamin Mobley, but three challengers from her own party: Mitch Crane, Paul Gallagher and Dennis Spivak. David Eisenhour is also running as a Libertarian candidate.

Crane, a former judge in Pennsylvania who served as regulatory counsel under Stewart’s predecessor, Matt Denn (D), tells HPW that Stewart’s approval of Blue Cross Blue Shield of Delaware’s affiliation with Highmark Inc. was a mistake that will lead to the loss of 800 jobs in the state and create a near monopoly in Delaware.

“Unlike her predecessors of both parties, Commissioner Stewart has failed to even attempt to bring competition into this state,” he says. “Most of the major health insurance companies in the [country] do not market in Delaware. Those few who do are contracting in what is not a level playing field.”

Montana Commissioner of Insurance and Securities Monica Lindeen (D) is facing a challenge from Derek Skees (R), who now serves in the Montana House of Representatives.

“I want to increase the ability for the major and independent insurance companies to compete in an environment that protects consumers, by allowing them to operate as a private sector company. The key to reducing costs is eliminating onerous regulation that has nothing to do with fraud prevention and consumer protection,” Skees states on his campaign website.

**Industry Execs Run in N.C.**

In North Carolina, Commissioner of Insurance Wayne Goodwin (D) will face one of two Republican challengers, Mike Causey or Richard Morgan. A July 17 runoff election will determine Goodwin’s opponent.

Causey, a retired insurance executive with 30 years in the field, says he will push to increase insurance competition in the state, as well as establish a consumer advocate in the department. Morgan, a former speaker of the North Carolina House who runs The Morgan Group, a consulting firm and insurance brokerage, says increased competition is key to keeping insurance costs down and adds that he will work to eliminate “needless” insurance mandates, according to a campaign flyer.

In North Dakota, Insurance Commissioner Adam Hamm (R) is facing a challenge from Tom Potter (D), a pastor and former University of North Dakota professor. No information on his platform was available as of press time.

Incumbent regulators who are appointed by their state’s governor also could lose their jobs after gubernatorial races are decided. Governors in Missouri, Utah, Vermont and West Virginia are seeking re-election and if they lose, their insurance commissioner might be gone.
with them. Indiana and New Hampshire also will likely see new commissioners in November since Indiana Gov. Mitch Daniels (R) is not running for re-election due to term limits, and New Hampshire Gov. John Lynch (D) is retiring.

Contact Kreidler at publicaffairs@oic.wa.gov, Stewart at karen.stewart@state.de.us, Lindeen via Lucas Hamilton at lhamilton@mt.gov, Goodwin at commissioner@ncdoi.gov, Hamm via Andrea Fonkert at afonkert@nd.gov, Crane at judgemitch@aol.com, Mobley at mobleybenjamin2012@gmail.com, Morgan at richard@richardmorgan.com, Adams at adams-seagen@att.net, and Riley at mulsgroup@gmail.com.

### Insurers Are Preparing for More Medicaid, Fierce Competition

While a growing number of states are turning to private insurers to manage their Medicaid populations, competition among Medicaid managed care companies is growing more aggressive as states place greater emphasis on quality measures, provider access and member satisfaction. And competition could heat up even more given the potential payoff from an expanded Medicaid program that could add more than 16 million uninsured people to the system in 2014.

*Case in point:* An Ohio judge this month allowed five more health plans to join a lawsuit challenging Ohio’s preliminary Medicaid contract awards (see briefs, p. 8). Competition is fierce even for relatively small markets such as New Hampshire, which recently decided to move the majority of its 150,000 Medicaid lives into managed care, notes Robert Damler, principal and consulting actuary in Milliman’s Indianapolis office. New Hampshire’s request for proposals (RFP) attracted bids from several out-of-state companies. The $2.23 billion contract, which is slated to go into effect in December, was awarded to three out-of-state carriers: An HMO affiliated with the Boston Medical Center; a plan operated by Centene Corp.; and an HMO run by Meridian Health Plan, a physician-owned company with plans in Illinois, Iowa and Michigan. New Hampshire anticipates the move to managed care will save it $16 million in the first year.

### Medicaid Competition Heats Up

“This is the type of interest you’re seeing from Medicaid health plans, whether you’re in a big state like Ohio, or the smallest of states,” Damler says, adding that mounting competition in the Medicaid space will push carriers to make their bids as compelling as possible by ensuring they have “a strong provider network, strong quality measures, experienced staff, good contracting.” But more aggressive bidding from larger, well-capitalized carriers could make it difficult for smaller carriers to compete, he adds.

However, a growing interest in quality measures could give some small, local carriers an advantage over much larger entities. In their RFPs, some states are increasing the amount they will withhold from carriers that don’t hit quality measures, says Damler. While states historically might have withheld one-quarter to one-half percent of their capitation rate, more recent contracts have boosted that percentage to between 1% and 3%, he says.

States also are paying closer attention to patient satisfaction and provider-to-patient ratios. Sometimes a small Medicaid company that’s affiliated with a hospital system might be able to impact quality measures more eas-

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**States Where Insurance Commissioners Are Elected or Appointed**

<table>
<thead>
<tr>
<th>State</th>
<th>Commissioner</th>
<th>Party Affiliation</th>
<th>Elected to Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Dave Jones</td>
<td>Democrat</td>
<td>2010</td>
</tr>
<tr>
<td>Delaware</td>
<td>Karen Weldin</td>
<td>Democrat</td>
<td>2008</td>
</tr>
<tr>
<td>Georgia</td>
<td>Ralph Hudgens</td>
<td>Republican</td>
<td>2010</td>
</tr>
<tr>
<td>Kansas</td>
<td>Sandy Praeger</td>
<td>Republican</td>
<td>2002</td>
</tr>
<tr>
<td>Louisiana</td>
<td>James Donelon</td>
<td>Republican</td>
<td>2006</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Mike Chaney</td>
<td>Republican</td>
<td>2007</td>
</tr>
<tr>
<td>Montana</td>
<td>Monica Lindeen</td>
<td>Democrat</td>
<td>2008</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Wayne Goodwin</td>
<td>Democrat</td>
<td>2008</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Adam Hamm</td>
<td>Democrat</td>
<td>2008</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>John Doak</td>
<td>Republican</td>
<td>2010</td>
</tr>
<tr>
<td>Washington</td>
<td>Mike Kreidler</td>
<td>Democrat</td>
<td>2000</td>
</tr>
</tbody>
</table>

Names of commissioners who are up for re-election appear in bold.

**States With a 2012 Gubernatorial Election Where Commissioner Is Appointed**

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Commissioner</th>
<th>Governor</th>
<th>Party Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana</td>
<td>Stephen Robertson</td>
<td>Mitch Daniels</td>
<td>R</td>
</tr>
<tr>
<td>Missouri</td>
<td>John Huff</td>
<td>Jay Nixon</td>
<td>D</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Roger Sevigry</td>
<td>John Lynch</td>
<td>D</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>Ramon Cruz Colon</td>
<td>Luis Fortuno</td>
<td>R</td>
</tr>
<tr>
<td>Utah</td>
<td>Neal Gooch</td>
<td>Gary Herbert</td>
<td>R</td>
</tr>
<tr>
<td>Vermont</td>
<td>Stephen Kimbell</td>
<td>Peter Shumlin</td>
<td>D</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Michael Riley</td>
<td>Earl Ray Tomblin</td>
<td>D</td>
</tr>
</tbody>
</table>

ily than could an out-of-state carrier that contracts with a large number of medical groups, he adds.

New Members May Have New Needs

Insurers might need to prepare for a new type of Medicaid enrollee. Based on its research, Neighborhood Health Plan of Rhode Island says a portion of the new population will have issues similar to aged, blind and disabled adults. However, the new enrollees also will include young and healthy members as well as those who are older and more chronically ill than the current Medicaid population. The people with more chronic care needs also appear to have more behavioral health and substance abuse issues, says Beth Marootian, director of business development. Moreover, the new Medicaid members “will include individuals with significant social issues including homelessness and a criminal justice background,” she tells HPW. To prepare, she says Neighborhood Health Plan is strengthening its connections to community organizations serving this new population including homeless shelters, correctional facilities, food banks and job training sites. The Medicaid-only health plan was started by Rhode Island’s community health centers.

“Carriers need to be ready with strong medical management programs that can meet both the chronic care and social needs of the population and provider capacity

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### Stock Prices Fizzled in June, but Could Rocket Back in July

Stock prices for 11 publicly traded managed care companies collectively fell nearly 3% in June. That comes on the heels of a dismal May when prices dropped 5.6%.

However, the Supreme Court’s decision to uphold most of the health reform law, combined with WellPoint, Inc.’s proposal to acquire Amerigroup Corp., could cause stock prices to sizzle in July. News that WellPoint was looking to invest nearly $5 billion to acquire the Medicaid managed care company sent Amerigroup’s stock price rocketing 37.7% when the market opened July 9. Stock prices for Centene Corp., WellCare Health Plans, Inc., and Molina Health Care, Inc. were pulled along for the ride. While the high court said states could choose whether to abide by the Medicaid expansion called for by the health reform law, WellPoint’s announcement is a clear signal that the industry sees Medicaid as a significant growth industry. The all-cash deal is expected to close by the end of the first quarter of 2013.

<table>
<thead>
<tr>
<th>Monthly Managed Care Stock Prices</th>
<th>Closing Stock Price on 6/29/2012</th>
<th>June Gain (Loss)</th>
<th>Full-Year Gain (Loss)</th>
<th>Consensus 2012 EPS*</th>
<th>Consensus 2012 P/E Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMERCIAL</strong></td>
<td>Aetna Inc. $38.77 (5.2%) (8.1%)</td>
<td>$5.06 7.7 x</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Cigna Corp. $44.00 0.2% 4.8%</td>
<td>$5.49 8.0 x</td>
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<tr>
<td></td>
<td>Coventry Health Care, Inc. $31.79 4.6% 4.7%</td>
<td>$2.77 11.5 x</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Health Net, Inc. $24.27 (5.3%) (20.2%)</td>
<td>$2.28 10.7 x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UnitedHealth Group $58.50 4.9% 15.4%</td>
<td>$5.01 11.7 x</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>WellPoint, Inc. $63.79 (5.3%) (3.7%)</td>
<td>$7.77 8.2 x</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Commercial Mean (1.0%) (1.2%)</td>
<td>9.6 x</td>
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<tr>
<td><strong>MEDIARE</strong></td>
<td>Humana Inc. $77.44 1.4% (11.6%)</td>
<td>$7.92 8.9 x</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Mean 1.4% (11.6%)</td>
<td>$7.92 8.9 x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td>Amerigroup Corp. $65.91 5.6% 11.6%</td>
<td>$3.78 16.4 x</td>
<td></td>
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<tr>
<td></td>
<td>Centene Corp. $30.16 (16.5%) (23.8%)</td>
<td>$2.18 20.3 x</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Molina Healthcare, Inc. $23.46 (8.0%) 5.1%</td>
<td>$1.55 24.2 x</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>WellCare Health Plans, Inc. $53.00 (6.1%) 1.0%</td>
<td>$5.77 9.8 x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid Mean (6.3%) (1.6%)</td>
<td>17.7 x</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Industry Mean (2.7%) (2.3%)</td>
<td>12.6 x</td>
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</tr>
</tbody>
</table>

* Estimates are based on analysts’ consensus estimates for full-year 2012.

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for increased demand in behavioral health and substance abuse treatment,” she says.

Will Red States Leave Money on the Table?

While Republican governors in at least six states say they will opt out of the health reform law’s requirement to extend Medicaid eligibility to 133% of the federal poverty level (FPL), industry observers predict state leaders will have a change of heart if a Republican fails to win the White House in November. And Medicaid managed care firms are preparing for the expansion even in states where governors oppose the provision.

Health plans will need to prepare for increased capacity and adjust their eligibility systems for the expanded Medicaid program, suggests John Gorman, CEO of Washington, D.C.-based Gorman Health Group, LLC. And that’s particularly true in states where governors oppose the expansion. If governors change their minds, Medicaid managed care companies “can’t get caught flat-footed—or they’ll miss solicitation.”

“We will proceed forward as if expansion will happen in all of the states we’re in,” says Steve O’Dell, senior vice president at Molina Healthcare, Inc., a California-based Medicaid managed care company that operates in nine states.

The Supreme Court’s decision to let states bow out of the Medicaid expansion (HPW 7/2/12, p. 1) “makes it harder for us because now there is a new level of uncertainty stacked on the continuing uncertainty that the election brings,” says O’Dell, who adds that the expansion will ultimately be good news for Molina and other Medicaid managed care companies. If all nine states moved ahead with the expansion, Molina’s Medicaid enrollment could as much as double.

But O’Dell notes that preparing for the growth will require a significant investment in infrastructure, with no guarantees that all states will abide by the expansion provision.

‘Red Meat for Red States’

Gorman doesn’t think any states will be willing to leave billions in federal money on the table. “They’re bluffing. This is purely for political gain, and most of these [governors] will fold before the elections and will take the ACA money in the face of what will be an onslaught of local lobbying that these guys have never even imagined,” he asserts. “This is red meat for red-state governors in their incessant campaign to cut government.”

The protests will likely be led by hospitals that would rather face low reimbursement from Medicaid than deal with ballooning bad debt, Gorman says. Moreover, failing to follow other states in expanding Medicaid could have “a dilutive effect” on health insurers, forcing them to boost premiums to cover higher costs from hospitals facing bad debt. “I think they will realize that this is a hell of a deal being offered to cash-strapped red states.”

Texas Gov. and former presidential candidate Rick Perry (R) is one of the reform law’s fiercest critics and quickly vowed not to expand the state’s Medicaid program shortly after the Supreme Court’s decision. About 1.7 million of the state’s 6.2 million uninsured would qualify for Medicaid coverage if it were expanded. Those residents typically seek care through hospital emergency rooms, charity clinics and federally qualified health centers, says Ken Janda, president and CEO of Houston-based Community Health Choice, a nonprofit HMO that serves low-income members including those covered by Medicaid and the Children’s Health Insurance Program.

Will Governors Change Their Minds?

Beginning in 2014, the federal government will reimburse states at 100% for their expanded Medicaid program. After three years, they will cover 90%. “The feds will kick in $1 trillion and the states will only be asked to pony up about 7% of it,” Gorman explains. “You have to conclude that [rejecting that money] is just opportunistic, fiscally irresponsible, cynical politics at work.” He predicts governors that now oppose the Medicaid expansion will change their minds either immediately before or immediately after the November elections. Rejecting federal money promised for the expanded Medicaid program “would defy all financial and budgetary logic,” Gorman asserts. “The states that need this the most are the states that are putting up the biggest fight against it. It defies logic.”

Janda agrees and says the expansion will reduce the cost-shifting “that costs each of us at least $1,000 year in premiums to indirectly pay for uncompensated care.” But without it, the percentage of insurance premiums devoted to countering uncompensated care will rise, along with local property taxes in counties that have public hospital systems,” he adds.

“The governor will be under great pressure from many Texans to change his stance. Many in the legislature will try to override his current decision in the budget process, and all the managed care plans will be working with them,” Janda says. “Failure to enact the Medicaid expansion would be a moral and economic loss for Texas,” he says.

Contact Damler at rob.damler@milliman.com, Gorman at igorman@gormanhealthgroup.com, Kathleen O’Guin for O’Dell at kathleen.o’guin@molinahealthcare.com and Tom Boucher for Marootian at tboucher@nhpri.org.
Capital BlueCross is joining with longtime partner PinnacleHealth System in a five-year partnership — dubbed an accountable care arrangement (ACA) — that the companies hope will identify patients at high risk for hospitalization and other adverse events and improve their care coordination and treatment.

The project, which doesn’t involve any risk on the part of either party and doesn’t currently have cost savings targets, follows a successful patient-centered medical home (PCMH) pilot that the two organizations implemented in 2010, says Christopher Rumpf, M.D., Capital BlueCross senior vice president and chief medical officer.

The new ACA collaboration between Capital and PinnacleHealth builds on a similar partnership that Capital BlueCross launched with Heritage Medical Group in 2011. PinnacleHealth and Heritage merged earlier this year, forming a group with 65 physicians and 29 nurse practitioners/physician assistants who provide care for more than 25,000 Capital BlueCross patients in a mix of PPO and HMO products.

The new ACA does not involve a new corporate entity, adds Bill Pugh, PinnacleHealth senior vice president, chief financial officer and treasurer. It will be managed by a steering committee, which includes five Pinnacle representatives, two or three of whom will be physicians, plus three representatives from Capital BlueCross.

The program will work to identify high-risk patients, especially those who are non-compliant and who have gaps in their care, says Rumpf. It also will work to make sure physicians or other care managers are intervening at care transition points, such as when people are discharged from the hospital, he says.

Initially, the ACA will focus on setting up data gathering, reporting and monitoring systems to enable care coordination, eliminate unnecessary admissions and manage referrals to specialists, Pugh says. All in all, the two organizations will implement 22 measures dealing with quality of care, three measures with multiple metrics that deal with chronic conditions, two measures covering transition of care and two additional performance measures, he says.

Capital BlueCross and Pinnacle have not set savings targets for the first year. Rumpf says the two organizations want to implement the program fully and see how it goes before determining what potential savings might result from it. Target savings might be based on peer group comparisons, he says.

This story was excerpted from the July issue of HPW sister publication ACO Business News. For more information or to order, visit the MarketPlace at www.AISHealth.com, or call (800) 521-4323.
**WellPoint Boosts Medicaid Stake**

*continued from p. 1*

not lost on WellPoint CEO Angela Braly. In a July 9 conference call, she commented that the court’s ruling influenced the company’s decision.

“We have an expectation and a belief that the opportunities in Medicaid are going to continue no matter what,” Braly said during the call, a reference to statements made by some governors that they will not participate in the Medicaid expansion. “We’re creating value for the states and beneficiaries, and that is a compelling story no matter what happens.”

The Amerigroup deal is WellPoint’s second large acquisition agreement in barely a month. In early June, the insurer said it would buy 1-800 CONTACTS, the nation’s largest direct-to-consumer retailer of contact lenses, for a reported $900 million (HPW 6/11/12, p. 1).

**States Turn to Medicaid Managed Care**

Dan Mendelson, president of Washington, D.C.-based health consulting firm Avalere Health, LLC, says the Amerigroup deal makes sense as more states turn to managed care plans to handle their Medicaid beneficiaries. And while he tells *HPW* that WellPoint agreed to a large price tag for Amerigroup, other pure-play Medicaid companies — such as Centene Corp. and Molina Healthcare, Inc. — have similarly high valuations. Moreover, most of the large carriers want a bigger piece of the Medicaid pie.

“It makes sense to have regional mass...so that if you have a very strong commercial health care presence in a market, and you already have relationships with providers and networks, it makes sense for you to be in other lines of business,” Mendelson says. “And with insurance exchanges coming down the pike, regional mass is a winning strategy.”

Bob Burnell, a principal in the health and productivity practice in Buck Consultants’ Los Angeles office, agrees that the deal makes sense, but tells *HPW* he is surprised that other big insurers have shown reluctance to make acquisitions in the Medicaid space.

“States have been experiencing budget squeezes for a number of years....As that gets worse, they are going to be turning to” Medicaid managed care providers, Burnell says of the opportunity for large insurers.

Wall Street analysts tended to react favorably to the deal, adding that WellPoint’s move could spur further deals in the Medicaid space. “We believe other diversified names might look at the other pure-play Medicaid companies,” Oppenheimer & Co. analyst Michael Wiederhorn said in a July 9 note to investors. Aetna Inc., Humana Inc. and Cigna Corp. could all benefit from increased scale, he added.

At the stock market close on July 9, WellPoint shares gained 3.4%, while Amerigroup shares were up a whopping 38%. Other Medicaid-focused managed care companies were also up on the news, with Centene rising 20%, while Molina and WellCare Health Plans, Inc. both closed up 18%.

Medicaid likely will be the largest beneficiary of the Affordable Care Act and represents a better value proposition for insurers than do private Medicare plans, according to Damien Conover, a health care analyst at Morningstar, Inc.

“Unlike Medicare, which is a single federal program, Medicaid is a collaboration between states and the federal government, with each state running its own program,” Conover tells *HPW*. “This leads to relatively high administrative costs, which a private operator can spread out across members in multiple states. We believe states have passed a tipping point in their approach to managed Medicaid, with many states now looking to outsource a greater portion of their Medicaid populations, including elderly and disabled members, to private MCOs.”

**For States, Expertise Is Key**

As to why other large insurers have not gone after Medicaid MCOs in the past, Conover says some thought they could expand organically into Medicaid. But as recent requests for proposals in states such as Kentucky, Louisiana and Washington indicate, states appear to prefer companies with expertise in the Medicaid space.

The Amerigroup deal also allows WellPoint to spread its exposure beyond the individual and group markets, which historically have been the insurer’s key segments, Monness, Crespi, Hardt & Co. health care services analyst Brian Wright wrote in a July 10 note.

In the last significant insurer acquisition in the Medicaid space, Blue Cross Blue Shield of Michigan and Philadelphia-based Independence Blue Cross (IBC) in August 2011 agreed to pay $170 million, plus another $50 million investment, to Mercy Health Plan for its 50% ownership interest in AmeriHealth Mercy Family of Companies, a large Medicaid managed care company (*HPW* 8/15/11, p. 1). IBC already owned the other 50%.

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The Government Accountability Office (GAO) on July 2 upheld the award of a $20.5 billion TRICARE contract to UnitedHealth Group’s military subsidiary. The contract was protested by TriWest Healthcare Alliance Corp., a consortium of Western nonprofit Blues plans that has been almost solely devoted to TRICARE for 16 years. The TRICARE West region contract, which calls for UnitedHealth to provide health coverage to 2.9 million active-duty military personnel, retirees and dependents in 21 states, includes a 10-month base period, five one-year option periods and a transition-out period (HPW 3/26/12, p. 1). A transition-in period will begin this summer with the contract officially going into effect in April 2013. Following the GAO’s decision, TriWest President and CEO David McIntyre, Jr. said the company will consider what, if any, action it will now take. In its protest, TriWest argued that its proposal was less expensive and said UnitedHealth has no experience in military health care management. Visit www.unitedhealthgroup.com.

A majority of employers waited for the U.S. Supreme Court’s ruling on the health reform law before developing a strategy to address its provisions, according to a survey released July 9 by Mercer. While 40% of employers said they will now take action, another 16% said they will wait until after the November elections to do so. Nearly 30% of respondents said that providing health coverage to any employee who works 30 or more hours a week — as called for by the reform law — presents a “significant challenge.” However, the provision that had nearly half of respondents worried was the excise tax on high-cost plans, which is set to go into effect in 2018. According to survey results, 54% of employers intend to be more aggressive in managing health care costs in light of the high court’s decision, and 41% said they have already taken action. Visit www.mercer.com.

An Ohio county judge has allowed five health plans to intervene in an Aetna, Inc. subsidiary’s lawsuit over its rejection from state Medicaid contracts, The Columbus Dispatch reported July 10. Paramount Advantage, UnitedHealthcare Community Plan of Ohio, Molina Healthcare, Inc., CareSource and Buckeye Community Health Plan, a subsidiary of Centene Corp., are allowed to present arguments. The five Medicaid managed care companies were selected for contracts worth $18 billion, which were slated to begin in January before Judge Richard Sheward (R) granted a restraining order from Aetna Better Health Inc. (HPW 7/2/12, p. 8). Two other plans that were rejected from contracts, Amerigroup Corp. and WellCare Health Plans, Inc., were also allowed to present arguments in the case. Visit www.aetnabetterhealth.com.

Two medical associations and a coalition of providers filed a lawsuit July 3 against Aetna Health of California, Inc., alleging that the insurer threatened to deny patients out-of-network coverage. But Aetna contends the suit is in response to legal action it had taken against providers. The lawsuit against Aetna, spearheaded by the California Medical Association and the county medical associations, also claims Aetna threatened providers with termination of their contracts if they referred patients to out-of-network providers. The suit, which alleges false advertising, breach of contract and unfair business practices, calls for an end to the practices, an immediate injunction, compensation for patients and providers, and punitive damages. But Aetna says it sued some of those same doctors and surgery centers named in this suit “for their egregious billing practices in February of this year,” Aetna spokesperson Anjanette Coplin tells HPW. She adds that some providers have patients’ procedures performed at out-of-network facilities that they own without the patient’s knowledge, thus “putting profits over their patients.” View the medical associations’ lawsuit at www.lacma.md. View Aetna’s February lawsuit at http://tinyurl.com/7q838dx.

PEOPLE ON THE MOVE: Socorro Rivas-Rodriguez will retire as president and CEO of Triple-S Salud on Sept. 30. She will be replaced by Pablo Almodovar-Scalley, who is executive vice president of Triple-S Salud, the managed care subsidiary of Triple-S Management Corp., a Blue Cross and Blue Shield licensee. Can Aydinova joined Blue Cross Blue Shield of North Dakota as director of architecture and chief architect in the IT division. He previously was chief architect for Knowledge Universe.

CORRECTION: In a chart published in the June 25 issue of HPW, the dates detailing enrollment growth in HSA-qualified plans were inadvertently reversed. Enrollment in the plans increased from 1.0 million in March 2005 to 13.4 million in January 2012.
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