

INSURANCE UPDATE

California Adds Physician Groups to Report Cards

California regulators have added a detailed performance rating of leading physician groups to its HMO report card. The state's second annual report card, released October 1, rated the top 10 HMOs by using a scale ranging from poor to excellent in 5 categories: overall customer service, doctor service, and how well the plans help members stay healthy, get better, and live with illness. The plans listed cover 95% of the state's HMO enrollees. The report also rates 80 medical groups that provide care to about 72% of the state's HMO members. The groups are rated in 4 categories: overall score, getting treatment and specialty care, communicating with patients, and timely care and service.

This addition, thought to be the nation's first state-created ranking of physician groups, comes at a time when the usefulness of such reports are under scrutiny. The state's Office of Patient Advocates, which compiled the report, said the medical-group section should be helpful because half of the state's 18 million HMO members cannot switch health plans based on their employers' options. At least these members can compare medical groups within their network. California's report card has greater status because state regulators, rather than consumer groups, compile it.

The HMO ratings are based on a state survey of 35,000 consumers and statistical data that the HMOs gather and report to the National Committee for Quality Assurance. The physician-group ratings derive from data the HMOs collect from medical groups.

The only company to receive an excellent rating in the newest report card was Kaiser Permanente's southern California unit for its preventive care.

Business Insurance,
Oct. 21, 2002

Aetna Plans to Create Mail-Order Drug Unit

Aetna announced its intention to terminate its contract with prescription benefit manager (PBM) Express Scripts and create its own in-house mail-order drug unit. The company aims to make the transition by May 2003.

Already in possession of its own PBM, Aetna would like to develop its mail-order unit around an existing mail-order drug outfit. The insurer is believed to be in talks with such a company but has not disclosed the details. The overall goal is to control its medication costs better. Aetna has 8 million members in its prescription plan, accounting for about \$4 billion annually, a company spokesman said. About 10% of that total involves mail-order medicine currently managed by Express Scripts.

Obstacles to this plan include the challenge of matching the price discounts the former PBM obtained because of its negotiating leverage. However, Aetna should be able to keep rebates that pharmaceutical manufacturers often give PBMs for promoting their products.

Business Insurance, Oct. 28, 2002

Residual Market Exploding

The residual workers' compensation arena is exploding as a result of the hardened workers' compensation market and more selective underwriting by insurers. From January to July 2002, the National Council on Compensation Insurance processed approximately 43,000 applications representing almost \$284 million in premiums, a 41% increase in applications and 73% increase in premiums over the previous year.

Since 2000, the market has hardened by soaring medical costs and increasing claims costs, and 9/11 exacerbated the situation. Today, the residual market is about \$800 to \$900 million, about 8% of the total market.

Business Insurance,
Oct. 21, 2002

Mississippi Considers State-Run Insurer

Governor Ronnie Musgrove is calling for the creation of a state-run medical malpractice insurer as part of a plan to provide relief to health care providers in the state. The governor's proposed Mississippi Care Access and Reliability Enhancement Act would create an insurer that would provide coverage to doctors, hospitals, and nursing homes. Policies would be sold through insurance agents. Initial capital for the insurance company would come from a \$10 million revenue bond.

Insured Workers Paying More of Health Bills

A nationwide survey published last fall confirmed what many workers already knew: they are being asked to pay more of their health care bills out of their pockets. People who got family health insurance through their employers had to contribute \$2084 on average in 2002 toward the cost of the insurance, up 16% from 2001. Employees who got coverage just for themselves were contributing \$454, up 27%. The figures came from a survey released by two nonprofit research organizations—the Kaiser Family Foundation and the Health Research and Educational Trust.

Employees also are paying more out-of-pocket for doctor visits and drugs. Employees who ask for an expensive brand-name drug when a cheaper generic is available now pay an average of \$26 out of their pockets, up from \$21 a year ago. The average deductible also rose 37% to \$276 in the common "preferred provider" plans that encourage employees to use certain doctors and hospitals.

Companies were hit harder themselves, paying an average of \$5870 for each employee with family coverage, up 12% from last year, and \$2606 for single coverage, up 14%. Companies have found they have little control over health care inflation because it is driven largely by new treatments. □

The Wall Street Journal, Sept 6, 2002