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Health Plan Week

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

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Public Exchanges, Wellness Programs Make Mark on Health Insurers' Offerings

Health insurers preparing for this fall's open-enrollment season had to meet new essential health benefit requirements and other provisions of the reform law if they wanted to take part in public exchanges, marking a big change from traditional strategizing, carriers say. With insurers mostly tight-lipped about the details of their new on- or off-exchange product offerings for the fall, waiting for exchange authorities to release plan designs and pricing, those who did discuss their products said high-deductible health plans (HDHPs) and wellness programs are getting a lot of attention for 2014.

Sean Barry, spokesperson for ***Blue Shield of California,*** tells *HPW* that in effect, all products sold on the exchange are "new" to fully comply with the Affordable Care Act (ACA). "While not much will change for individuals who currently receive health insurance through their employer, those who buy individual coverage will have many more options in 2014."

The insurer has prepared provider networks for the state exchange, Covered California, in all 19 rating regions and 54 of the 58 California counties. "The networks include more than 75% of the hospitals and more than 50% of the physicians in our full PPO network," Barry says, adding that Blue Shield's full PPO network consists of 370-plus hospitals and 56,000-plus physicians.

Andrea Gioia, executive director, product innovation at University of Pittsburgh Medical Center's ***UPMC Health Plan,*** tells *HPW* that the number of HDHPs it will offer is growing due to increased employer and consumer demand as well as ACA rules and regulations "that mandate that we offer metallic level plans that comply with actuarial values. Our region [western Pennsylvania] has been behind the national trend in HDHP

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S.C. Blues Plan Makes Major Initial Move Into Telemedicine, Covers Three Specialties

Health insurers armed with data to show that telemedicine can increase access to quality medical care and reduce costs by preventing unnecessary emergency room visits are gradually shifting coverage policies to allow reimbursement in selected specialties. A case in point is in South Carolina, where the state's leading insurer by market share, BlueCross BlueShield of South Carolina, in mid-August said it would start to cover telemedicine for use in high-risk pregnancies, strokes and mental health.

Other insurers already have taken steps to cover telehealth or telemedicine services. For example, Aetna Inc. in 2011 began offering its Florida and Texas members in most of its fully insured plans a telemedicine option in the form of the 24/7 Teledoc service for phone consultations with a physician. WellPoint, Inc., three years ago affiliated with American Well, which has set up similar networks for Blues plans in Hawaii, Minnesota and New York, as well as for UnitedHealth Group's OptumHealth subsidiary, to offer telemedicine services for virtual office visits by Web or telephone. Highmark Inc. in 2012 launched a program offering a telehealth service to its members giving them 24-

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hour access to physicians. Under the program run by Teladoc, the country's largest telehealth provider, members complete a medical history disclosure form and request a consultation. The service costs $38 per consultation and is designed for minor illnesses *(HPW 4/2/12, p. 8)*.

Still, the change in policy by the South Carolina Blues plan is a major breakthrough that should lead to even more inroads for telemedicine in the state, says Jim Ritchie, executive director of the South Carolina Alliance of Health Plans. "I think it is an important development for telemedicine in South Carolina. The carriers that I have represented have all been advocates for telemedicine when it is used appropriately, for ways to reduce costs and increase access and allow the market to develop," he tells *HPW*. "When a Blue Cross steps into the market to reimburse for telemedicine it is an indication that the data is in and this is going to be an effective method, an effective technology, to meet those goals."

Ritchie says UnitedHealthcare, a unit of UnitedHealth Group, already covers some procedures, as does Medical Mutual of Ohio subsidiary Carolina Care Plan and the state's Medicaid program. Emails to UnitedHealthcare and Carolina Care Plan requesting comment on the programs were not returned by press time.

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The alliance, which fought against legislation this year in South Carolina that would have mandated coverage for telemedicine, wants to divide the line between appropriate and inappropriate use of the various forms of telemedicine — including remote monitoring, telephonic consults and video examinations. "Let me give you an appropriate one. South Carolina like many states is a combination of urban and rural communities, so when a rural physician needs a consult in a distant place, telemedicine can fill that gap. That's a good thing. When physicians use telemedicine between floors in the same hospital, that's a bad thing," Ritchie says. "The bill that was introduced to mandate reimbursement to physicians at the same rate whether the physician was an in-person experience or a telemedicine experience; that mandate we opposed strongly. We worked to change that bill so it became a framework for developing telemedicine collaboratively without the need for a mandate. It passed the Senate and is now in a House committee, which will be taken up in January."

Mandates, Reform Law Spur Take Up

Growth in the utilization of telemedicine is being driven by a mix of market drivers and state mandates, American Telemedicine Association CEO Jonathan Linkous tells *HPW*. "Certainly coverage is growing and utilization is growing. There are about 19 states that mandate for private coverage and Medicaid in 44 states covers some part of telemedicine," he says. Radiology and imaging have been a mainstay in the telemedicine coverage area for some time, but that has evolved into live video conferencing led by employers and private payers, including HMOs and other types of capitated plans, Linkous says.

The Affordable Care Act (ACA) also is helping to fuel more acceptance of telemedicine, he says. "In the ACA you see a move away from fee-based structures to managed care and capitated care," he says. There are also dollars being directed to research and development in telemedicine through grants awarded by the Center for Medicare & Medicaid Innovation. "A large number of grants are going to telemedicine," Linkous says.

Data Prove Telemedicine Is Useful

Laura Long, M.D., chief medical officer and vice president for the South Carolina Blues plan, tells *HPW* that the move to cover more telemedicine was a natural, given the progress in collecting data in the specialty areas. "We have well-developed programs in these three areas that have shown improved outcomes for patients," she says. Long estimates that more than half of the nation's 37 Blues plan licensees cover some aspect of telemedicine, as do other carriers in her state. There will be no difference in payment for telemedicine. "It will be the exact same

way as in-person visits for all plans. A high-deductible health plan member will still pay like any other visit, and if you have a copay then they just pay for the copay," Long says.

The Blues plan's definition of telemedicine is the provision of health care across a distance, with the delivery typically involving two-way, real-time videoconferencing by a referring facility — usually a local physician or emergency room staff at a small hospital — and including the patient for a "face-to-face" consultation with a specialist in a referral center. Telemedicine requires secure network connections with active firewalls and encryption modes that meet federal health care privacy laws, Long says.

The South Carolina Blues plan selected the three specialties to cover for telemedicine care — and more specialties are in the offing — after reviewing the data proving the usefulness of doing so and the medical need. "For instance, in teleneurology the South Carolina REACH [Remote Evaluation of Acute ischemic Stroke] program provides state-of-the-art stroke consultation for facilities that don't have access to real-time stroke care. In that golden hour, a member can show up in the emergency room, where they can be evaluated on whether they should be given a clot-busting drug or not. That decision has to be made within the first hour and it really needs that level of expertise," she says. Prior to the REACH program, 40% of the state was within 60 miles or an hour of such a consult, but with REACH that number is up to 80%, Long adds.

Mental health is another area where there has been success in using telemedicine in trials and pilot programs. Long says a lot of patients stay in the emergency room or are inappropriately admitted to a hospital for a more thorough evaluation, but through video conferencing the numbers have been reduced, cutting by 50% the length of stay in an emergency room.

Long says the cost savings are apparent, pointing to the South Carolina Department of Mental Health's (SCDMH) reported savings of $1,800 per member per year when treated with telemedicine consultations. "Most of this is from a 50% reduction in length of stay in the emergency room as well as avoided admissions. Total savings year-to-date from telepsych is $22.8 million [according to SCDMH data]," she says. For telestroke, the REACH program published a recent modeling study that estimated a cost savings of $3,454 and an increase in quality of life by 5.1 adjusted months per patient treated with a throbolytic agent. Overall, the model predicted a $16 million savings in South Carolina over five years if stroke care was increased by 20%.

Meera Narsimhan, M.D., vice dean of Innovative Healthcare Technologies at the University of South Carolina School of Medicine, tells *HPW* that the statewide telepsychiatry initiative has proved to be a promising strategy because of the increased access to emergency psychiatric consultation, facilitated appropriate treatment and increased discharge activities, providing quality care

on the one hand and reduced length of stay on the other hand.

The telepsychiatry service provides consults at 18 emergency departments in rural and urban parts of South Carolina and has served more than 16,000 patients since March 2009. "This program provides emergency psychiatric care access 24 hours a day, seven days a week. The psychiatrist provides assessment and recommendations for initial treatment and works closely with the emergency department doctor in identifying resources in the community to help the patient with follow-up care, a necessity for many patients that reduces the need for re-hospitalization and improves quality of life for the patient," she says. The program shows lower rates of inpatient admission from the emergency department for telepsychiatry versus the control group (11.5% vs. 23.0%) and reduction in length of stay from 3.6 days for the control group compared with 2.9 days for the telehealth group.

Narsimhan adds that BlueCross BlueShield of South Carolina has seen some of the robust results from this project and has been a champion in leading the way to reimburse telehealth, thus increasing access to specialty care for its members in underserved areas. "We are very hopeful that other payers in the state will follow suit."

Contact Narsimhan through Patti Embry-Tautenhan at (803) 264-5452, Carmen Park at cpark@american-telemed.org for Linkous, Ritchie at jritchie@ritchieconvergent.com and Elizabeth Hammond for Long at elizabeth.hammond@bcbssc.com. ✧

Additional News of the Week

Coverage of these health plan developments was included in this week's issue of *Spotlight on Health Insurers:*

- St. Francis, Cigna Start Accountable Care Program
- Humana CEO Sounds Off on Reform, Exchanges
- Humana, YMCA Partner to Educate on Exchanges
- Premera Expected to Get Bigger With Exchange
- IBC Launches Guardian Financial Products
- The Doctor Will Skype You Now
- N.M. Blues Leasing Space for Medicaid Expansion
- Calif. Blue Shield Curbs Costly Cancer Coverage
- UPMC Enlists Employees in Latest Highmark Fight
- Mass. Blues Changes Alternative Quality Contract
- HMA-Miss. Blues Impasse Must End

Links to these additional news stories can be accessed at www.AISHealth.com/enews/spotlightonhealthinsurers.

In Their Own Words

Costs Weigh on Employers, Making 2014 a Year of Change in Benefits

The following interview is part of an occasional series by Health Plan Week *that focuses on particular segments of the health insurance marketplace and vendor community through the words of the industry's leading executives and thought leaders. To suggest a topic and commentator, contact* HPW *Editor Patrick Connole at pconnole@aishealth.com.*

Helen Darling, president of the National Business Group on Health (NBGH), tells *HPW* what she expects to see in the way of health benefit offerings from large employers this fall, including consumer-directed health plans (CDHPs), high-deductible health plans (HDHPs) and wellness program add-ons meant to manage care and tame costs. The shift is on, she says, from PPO-type products to a more aggressive employer-based strategy to lower expenses by incenting better health and adherence.

Separately, NBGH on Aug. 28 released a survey projecting that employee health care benefit expenses at the nation's largest employers would rise 7% in 2014. This marks the third consecutive year employers have projected this cost-increase amount, the group said. In addition, the survey found that some employers see public exchanges as a "viable" option for certain of their employees. The survey, based on responses from 108 of the nation's largest corporations, was conducted in June, before the Obama administration said it would delay to 2015 the implementation of the employer mandate. Find out more about the survey at http://tinyurl.com/pext57o.

HPW: ***What is the theme for this fall's open-enrollment season for large employers' health benefits?***

Darling: I think that most people when they wake up on open-enrollment day will find out that either they have a consumer-directed health plan or a high-deductible health plan, which may have several versions like different levels for the deductible. But the vast majority will have at least one of those, and our data show that about 22% of large employers will have as a single option a high-deductible health plan. So, people won't have a PPO or an HMO; they will just have a high-deductible health plan, though they might have two versions of it. So in a sense we really have made the switch, very much like we did years ago moving from HMOs to PPOs. This is really kind of a tipping point.

HPW: ***Will there be other programs tied to the CDHP or HDHP?***

Darling: A significant number will also have a wellness program that will range from aggressive to mildly favorable. There will be those companies, and you've

already seen those headlines about it, who are saying if you want to have access to a health plan at all or access to the best plan or you don't want to pay a penalty of, say, $100 a month, then you need to participate in a wellness program of some sort. I think it's a very different attitude. There is just more aggression around trying to improve health and control costs than we've seen in a number of years.

HPW: ***What do you think the reaction will be from the employees of these large companies?***

Darling: Some of them will kind of be grousing about that they don't like to be told what to do, but I think actually most of them, especially if the employers communicate the way I see them communicating it, will realize the employer is not trying to be difficult and is actually trying to save them money. For example, if you do what you are expected to do as far as a wellness program, you won't have a penalty. This may mean your actual cost in 2014 may go down a little bit if you do what you need to do.

HPW: ***How will health plans react to these changes by self-funded employer sponsors?***

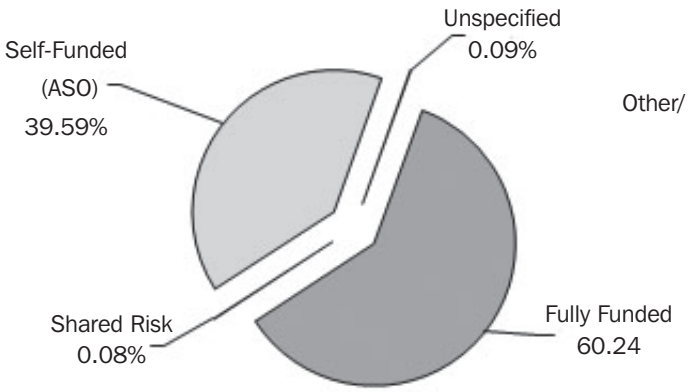
Darling: Basically they [health carriers] just have to administer it, but yes, [employers] pay for a lot of services and for the most part they get them. There is a fair amount of competition out there so if there were a health plan for example that wasn't doing what they were asked to do, they [employers] could change plans.

HPW: ***What types of plan design elements are getting attention within the broader context of CDHPs and HDHPs?***

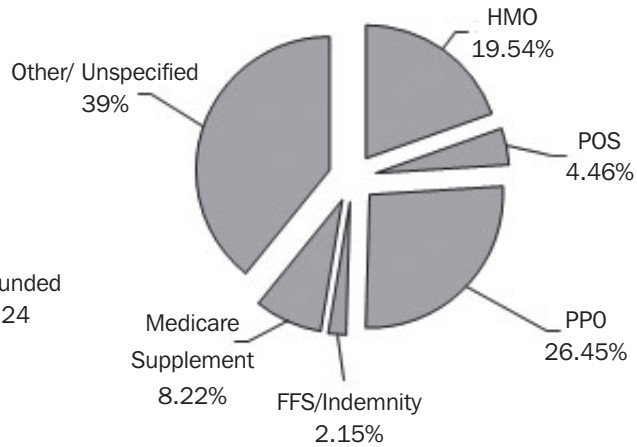
Darling: I think the important thing is it really varies a lot by industry. A lot of people just don't talk about that enough. So, for example, if you compare retail and hospitality and hotels, anything where there are basically low-wage employees, then that group is going to have a very different experience. They may find that workers may be much better off in exchanges because they can get a federal subsidy, which they can't get without being in the exchange. The average large employer is going to continue to provide health benefits in the usual way they've been doing it. Some of the plans that are offered in retail and hospitality tend to have higher cost sharing already and tend not to be as rich. So in a way you don't have to put in more. It's the companies like manufacturing and technology, other places where they have very generous benefits, [where] if they want to control costs then they will have to put in more cost sharing because they didn't have it. It also depends on where you are on the curve or the journey really of from one extreme of letting every flower bloom, we'll cover everything, to how do we control our costs and avoid the Cadillac tax. [The excise or Cadillac tax refers to high-cost insurance products that starting in 2018 will be assessed a tax. The reform law puts the amount of premiums exempt from the excise tax at $10,200 for singles and $27,500 for families in 2018]. Wherever you are on that trajectory will determine what you are doing.

continued

Percentage of Health Plan Enrollment by Risk Type



Percentage of Commercial Risk-Based Enrollment by Plan Model



SOURCE/METHODOLOGY: *AIS's Directory of Health Plans: 2013*. Visit http://aishealth.com/marketplace/aiss-directory-health-plans for ordering information or call (800) 521-4323. Researched by AIS editorial staff. Includes health insurers operating as of Dec. 31, 2012. Enrollment data are as of the fourth quarter of 2012. Totals represent plans that provided figures for the type of enrollment indicated.

HPW: ***What other issues out there will impact health care markets in 2014?***

Darling: Transparency. I think there is a belief, not just among employers, but among the providers themselves that transparency about quality, safety, costs, prices, charges and all those things that when combined with the consumer having at least some reason for caring about it will in fact have a big effect. There is a belief among a lot of people that the U.S. health care system needs comprehensive transparency and it has to be meaningful data and it has to be accessible. There are lots of forces in play, from the people who make mobile apps to health plans who buy those kinds of things. There is a kind of movement afoot to open up to what is going on to the consumer and the purchaser. And we've really never had that before.

Contact Darling via Ed Emerman at eemerman@eaglepr.com. ✧

HHS Delays Sept. Date for Signing Contracts With Insurers on FFEs

Health insurers are rolling with the punches after HHS informed the industry that it would need a few more days past the original estimate of Sept. 5 to Sept. 9 to sign final contracts for qualified health plans selling coverage on the 34 federally facilitated exchanges (FFEs). Health reform watchers, meanwhile, suggested the delay was not a huge impediment to starting open enrollment on time on Oct. 1, but rather another in a series of delays that may or may not be substantial when totaled in whole.

"Health plans are doing everything they can to ensure open enrollment goes as smooth as possible when the exchanges launch on Oct. 1. Given the size and scope of the changes required by the law and all of the work that still needs to be done prior to open enrollment, it is not surprising that some things may be delayed and that there are glitches that need to be worked out," AHIP spokesperson Clare Krusing tells *HPW*.

HHS says the delay is a result of consultations with health carriers and involves technical issues, which have been blamed for other delays in provisions of the reform law, like the one-year postponement of the employer mandate to 2015 *(HPW 7/15/13, p. 1)*. "We remain on track to open the marketplace on time on Oct. 1. We are currently in the plan preview period and in response to issuer feedback, we are providing them with flexibility and time to handle technical requests," CMS spokesperson Brian Cook tells *HPW*.

Henry Aaron, Ph.D., a senior fellow in economic studies at the Brookings Institution, tells *HPW* the enrollment process was not envisioned as some sort of quick event culminating in October or even in 2014. "This is an enrollment process that was originally expected to take about two years to complete, in the sense that enrollment would not reach something near 'steady-state' until 2016," he says. "Sure, everyone wishes that this was a process that worked with clock-work exactitude, and it isn't. The reason is that this is a big law, with lots of moving parts, a law that never had the advantage of going through a conference committee to iron out wrinkles that were seen at the time and, because of the scorched-earth negativism of the House, that cannot have the benefit of a technical corrections bill now."

Most See Exchanges Starting Oct. 1

Tim Jost, a Washington and Lee University law professor and consumer representative for the National Association of Insurance Commissioners, concurs that the delay is nothing more than a speed bump on the road to implementation. "If the federal exchange is up on Oct. 2 or 3 it will not be the end of the world, except with critics of the law. Jan. 1, and really March 31, is what matters," he tells *HPW*. Jost writes a blog for *Health Affairs* at www.healthaffairs.org.

"I'd expect most [exchanges] will be live by Oct. 1, some perhaps delayed a week or two," predicts Joseph Paduda, principal, Health Strategy Associates, LLC. "There are many, many moving parts and it is highly unlikely all will mesh together seamlessly the first time around. If they did, they would be the only part of our health care 'system' that actually works seamlessly, efficiently and correctly," he tells *HPW*. Paduda is the author of a blog at www.ManagedCareMatters.com.

"Everything is getting back-end loaded and the administration keeps saying everything is on schedule. What's next?" Robert Laszewski, president of Health Policy and Strategy Associates, LLC, tells *HPW*. He is the author of a blog at healthpolicyandmarket.blogspot.com.

The HHS contract delay follows the Aug. 23 news from California's state-run marketplace, Covered California, that its Web portal may not be fully operational Oct. 1. Oregon on Aug. 9 said its state-run exchange would not be able to take consumer applications for insurance directly through its Web portal until later in October because of technical issues. The exchange will open on time, Cover Oregon said, with agents or state-approved partners handling applications *(HPW 8/19/13, p. 8)*. Covered California also said open enrollment will start on time.

For more information, contact Krusing at ckrusing@ahip.org, Cook at brian.cook@cms.hhs.gov, Paduda at jpaduda@healthstrategyassoc.com, Laszewski at robert.laszewski@healthpol.com, Jost at jostt@wlu.edu and Aaron at haaron@brookings.edu. ✧

ACA Spurs 2014 Benefit Changes

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adoption but we do see steady and increasing growth in this market," she says. In addition to more new HDHP plans, UPMC will also offer catastrophic plans that are available to consumers under age 30 on the exchange. "The only ancillary product currently offered on the federal exchange is dental, which we plan to offer on the SHOP [Small Business Health Options Program] exchange," Gioia adds.

Putting together plans was a different experience this time around, not only because of reform law requirements, but also because "this is a new market in which the customers are not clearly known, the competition is not known, and the distribution channel is new. We relied heavily on consumer research and direct consumer input to assist in developing products that we feel will be competitive in this untested market," she says.

Insurers Add New Twists for 2014

Other new insurance products are coming from a combination of health and life insurance operators. On Aug. 27, Philadelphia-based ***Independence Blue Cross*** and ***The Guardian Life Insurance Company of America*** said they formed a strategic relationship to provide Guardian's specialty insurance products to the Blues plan's members and employer groups. The new products cover life, short-term disability, long-term disability, accident, critical illness and cancer insurance. The benefits will be available to employers with 51 or more enrolled members this fall for group plan renewals on or after Jan. 1, 2014. By the middle of next year the insurer also will make these offerings available to employers with two to 50 enrolled members.

The attention to wellness programs is clear as carriers across the country are incenting better health. Michigan-based ***Health Alliance Plan*** (HAP), which said it has focused on ensuring that "our 2014 on- and off-exchange products are in compliance with the ACA to meet standards related to benefits, costs, network adequacy and service area," will continue to offer its Health Engagement plans next year, HAP spokesperson Tiffany Baker tells *HPW*. There are two engagement plans that HAP offers to employers, which then offer one or the other to employees. One is Aspire, which rewards those who are simply willing to participate in making small changes that could lead to a healthier lifestyle. The second is called Achieve, which is for people who want to measure their decision to live a healthier lifestyle, via outcomes like lower blood sugar, lower blood pressure and lower BMI.

Lisa Rubino, senior vice president of Medicare, duals and marketplace for ***Molina Healthcare, Inc.,*** tells *HPW* that the focus for Molina is on its core business of Medicaid and low-income populations, resulting in exchange product designs for those with annual incomes of between 138% and 200% of the federal poverty level who churn between Medicaid and the commercial marketplace. What is unique about its strategy is "that in many states [where Molina will be active on exchanges] you will only be responsible for the deductible on the inpatient side. There isn't a deductible or barrier on the outpatient side," she says, adding that cost will be a determining factor for these consumers.

Nation's Largest Retailer Unveils New Products

Large self-funded employers are making new wellness and comparison-shopping tools available to workers. For instance, ***Wal-Mart Stores, Inc.*** says it has informed employees of enhancements to its benefits package. Notably, for 2014 the retailer is offering employees enrolled in a benefit design that is compatible with health reimbursement arrangements (HRAs) or health savings accounts (HSA) free access to transparency vendor Castlight Health's online guide for finding doctors and medical services, Randy Hargrove, Wal-Mart spokesperson, tells *HPW*. The company, which uses Blue Cross Blue Shield plans, Aetna Inc. and UnitedHealth Group unit UnitedHealthcare as its medical administrators, will also offer employees a new vision plan, lower non-tobacco premium rates and an expanded "centers of excellence" program paying 100% of the cost for HRA and HSA plan members requiring hip and knee-joint replacements in addition to certain heart and spine surgeries, he says.

Wal-Mart last October said it would offer enrollees coverage for heart, spine and transplant surgeries at six hospitals and health systems in the U.S., including travel expenses, with no out-of-pocket costs. The announcement and 2014 enhancement to the centers of excellence approach is indicative of a trend where large employers are searching for ways to cut medical costs *(HPW 10/22/12, p. 1)*.

Also, for the first time, the retailer says, starting in 2014 it will permit full-time associates to cover same-sex domestic partners and spouses on company health, life and accident insurance benefits. Wal-Mart's annual enrollment period begins on Oct. 12 and ends Nov. 1.

Contact Barry at sean.barry@blueshieldca.com, Hargrove at randy.hargrove@wal-mart.com, Rubino via Sunny Yu at sunny.yu@molinahealthcare.com, William Modoono for Gioia at modowp@upmc.edu and Baker at tbaker3@hap.org. ✧

HEALTH PLAN BRIEFS

◆ **The IRS on Aug. 27 issued a final rule on the health reform law's individual mandate, explaining how it will determine whether a person has maintained coverage and how the agency will address gaps in coverage.** The IRS clarified the hardship exemption from the individual mandate and said it maintained the "one-day" rule under which individuals are considered to have coverage for a month as long as they have coverage for any day of that month, among many details spelled out in the rule. Read the IRS fact sheet at http://tinyurl.com/k6umonb.

◆ **Aetna Inc. has decided to withdraw from its fifth public exchange, informing New York officials it will not take part in that state's marketplace, according to a Reuters report on Aug. 29**. The insurer said concerns about the financial viability of participating in the individual market in New York led to the decision. Aetna and its Coventry Health unit have applications to market coverage in 10 other states, the article said. To date, Aetna has withdrawn from exchanges in Connecticut, Georgia, Maryland and Ohio *(HPW 8/19/13, p. 8)*. At the same time, Coventry pulled its applications in Georgia and Maryland and earlier in August from Tennessee. Visit http://tinyurl.com/obnjsn8.

◆ **On Aug. 27, the Michigan Senate passed H.B. 4714, which would expand Medicaid eligibility to childless adults with annual incomes up to 133% of the federal poverty level.** If signed by Gov. Rick Snyder (R), which is expected, Michigan would become the 25th state to move forward with the Medicaid expansion under the Affordable Care Act. The bill requires newly eligible beneficiaries to enroll in a contracted health plan. Brian Wright, securities analyst for Monness Crespi Hardt, in an Aug. 28 note said that "While the language is vague at this point, we believe it likely that enrollment in a contracted plan will be a current Medicaid HMO plan." View the legislation at http://tinyurl.com/qyftptb.

◆ **An Aug. 27 investigation by *The Lund Report* found that health insurers have spent more than $550,000 on state and local elections in Oregon since the start of 2011.** Of that amount, more than 40% came from Regence BlueCross BlueShield, which poured in $236,000 for its preferred candidates and causes, the report said. In breaking down the expenditures, the article said the Regence Oregon Political Action Committee (PAC) mostly supported Republican candidates, many of whom lost their races; of the five candidates getting the most money from the insurer, only one won. In response, Regence spokesperson Jared Ishkanian tells *HPW* that a closer examination of the company's contribution history over the last few years "will show that we've donated to both Democrats and Republicans individually and to caucus PACs of both. Our history will also show we mostly support incumbents." Visit http://tinyurl.com/kpz2n79.

◆ **WellPoint, Inc. on Aug. 20 said it has formed a new WellPoint Vision Advisory Board to initiate a dialogue on how the insurer and its provider network can work in a "mutually beneficial manner."** Members come from the vision and eye care fields, and the board is constituted for three years with each member serving a one-year term. WellPoint purchased 1-800 CONTACTS last year for a reported $900 million, putting it squarely into the vision space with the acquisition of the nation's largest direct-to-consumer retailer of contact lenses *(HPW 6/11/12, p. 1)*. Visit http://tinyurl.com/kcjfhqr.

◆ **The Affordable Coverage Project, a coalition of health insurance industry groups, has relaunched www.healthinsurancetaxhurts.org as part of a broader effort to fight against the health reform law's tax on insurers.** The tax is estimated to raise $8 billion in 2014 and $100 billion over the next decade. The Affordable Coverage Project is a campaign initiated by America's Health Insurance Plans, the National Association of Health Underwriters, the National Association of Manufacturers, the National Retail Federation and the U.S. Chamber of Commerce.

◆ **PEOPLE ON THE MOVE:** UCare named **Gregory Hanley** quality management director and **John Rotilie, M.D.**, associate medical director. Hanley was regional director of quality improvement at Coventry Health Care in Kansas City, Mo. Rotilie is an internal medicine physician with Rotilie, Toman, and McRaith, LLC, in St. Paul, Minn….Aflac Inc. hired **Daniel Lebish** as executive vice president and chief operating officer of Aflac Group Insurance. Lebish was executive vice president at Highmark Blue Cross Blue Shield.

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