



Managed Care Company Rankings

The goal of the Verden rankings system is to evaluate how well or how poorly managed care companies (Payers) are performing from the perspective of physician practice management. The data used to rank these Payers comes directly from the companies themselves in the form of policy changes posted on their web sites. For the purpose of this report, data with an effective date from October 1, 2009 to December 31, 2009 (Q4) is eligible for ranking. Please see 'Who We Measured' on page 2 for more information about the Payers selected.

We remind our readers that these are QUARTERLY rankings, and as such, an insurer may do better or worse in any given quarter than the quarter before. Therefore, our reports are not representative of overall performance, but instead provide a snapshot assessment of activity on these insurers' websites over the prior three month period. Ranking accumulation tables at the end of this report provide quarterly comparisons for all of 2009.

What's New

Last quarter we reported that we fully expected the reform debate to be squarely behind us and to have ushered in a new era in U.S. healthcare delivery. At the time of going to press, a decisive vote is looming but we are no closer to the reality of reformed care than last year and may not know the impact for many quarters to come regardless of how the vote goes.

That said, value-based concepts (high efficiency, lower cost, efficacious medicine) is gaining momentum. Last quarter we gave some attention to discussing Value-Based Purchasing and within that context, the advent of 'narrow networks'. That time has arrived. UnitedHealthcare has announced the launch of UnitedHealthcare Core, a PPO alternative to narrow-network HMO products in the Chicago and Northwest Indiana markets which has as one of its features, a narrower network of participants than the traditional benefit plans. To make the grade, providers need to have admitting privileges at a UnitedHealthcare Core participating hospital to be in-network for this plan.

Not content to build programs in collaboration with their physician networks, Payers are going direct to consumers with 'wellness' programs. I attended the Managed Care Business Forum in Washington, DC, a few weeks ago and was left asking myself 'where's (doctor) Waldo?'. Disease management programs, wellness coaching, smoking cessation, nutritional counseling – you name it, and the Payers are working with non-physician third parties to deliver it. Cutting the physician out of the picture? It would certainly appear so.

So what can be done? Some Payers are paying attention and do value the patient-physician relationship and there is an opportunity for physicians to utilize the programs that support good clinical care (you'll find a few in the comments on the following pages). While some programs extend the care that physicians can deliver, we are concerned that several are positioned to substitute for it so discuss with your patients what third-party programs may be available to them through their employer or insurer, and make sure that they understand that these should be in addition to, not instead of, your relationship.

With the advent of spring, here's hoping the reform debate will be squarely behind us by next quarter and that there will be some good news on the horizon for physicians and their patients alike.



Susanne Madden
President and CEO

What we measured

Our analysis is composed of five categories in which each insurance company is given a score. The more points accumulated, the worse companies fare. Points are designated based on multiple criteria, with each metric carrying a different weight.

Data selected for measurement are those policies with an effective date occurring between 10/01/2009 and 12/31/2009 (Q4, 2009). The source data is organized by administrative, reimbursement, pharmacy and medical policy categories and payers are ranked on five (5) measures:

1. Cost to Provider (CP)
2. Volume of Change (VC)
3. Clarity of Communication (CC)
4. Notification Period (NP)
5. Posting Integrity (PI)

A note about the managed care companies listed

HIP and GHI have become more fully integrated under EmblemHealth, however, it has not brought together the GHI and HIP websites. Instead, there is now an Emblem site, and both the GHI and HIP sites remain. Where do you go for information? Looks like you'll need to access all three.

Reminder: AmeriChoice and Oxford Health Plans are both UnitedHealthcare companies, however, each of these three companies have separate policies and procedures and therefore have been ranked separately. Please see endnote for the Anthem plans evaluated under that name in these rankings.*

When we measure

Ranking reports are usually issued within 6 – 8 weeks after the close of the quarter. This allows enough time to capture and post any tardy policy changes that are made effective within the quarter's timeframe but posted by insurers after the quarter closes, as well as the extensive time necessary to appropriately analyze and grade each of the alerts issued by the insurance companies that qualify for ranking.

Who we measured

Of the insurance companies tracked by MPV on a daily basis, these were the insurers ranked this quarter.

Aetna	BlueChoice Health Plan of South Carolina
AmeriChoice	CareFirst BCBS
AmeriGroup	CIGNA Corporation
AmeriHealth	Emblem GHI / HIP
Anthem	Empire BCBS / Wellpoint
Asuris	Excellus BCBS
BCBS of Alabama	Fallon Community Health Plan
BCBS of Florida	Harvard Pilgrim Health Care
BCBS of Georgia	Health Partners, Inc.
BCBS of Illinois	Horizon
BCBS of Louisiana	Humana Inc.
BCBS of Massachusetts	Independence Blue Cross
BCBS of Minnesota	LifeWise Health Plan MVP
BCBS of Mississippi	Oxford Health Plans, LLC
BCBS of Montana	Premera Blue Cross
BCBS of New Mexico	Priority Health
BCBS of North Carolina	Regence
BCBS of Oklahoma	Tufts Health Plans
BCBS of Rhode Island	UniCare
BCBS of South Carolina	United Healthcare
BCBS of Tennessee	Univera Healthcare
BCBS of Texas	Wellcare
BCBS of Vermont	Wellmark, Inc.
BCBS of Western New York	
Blue Cross of Northeastern Pennsylvania	

Metric Weighting (Aggregate Score)

In order to calculate the overall ranking we have assigned weights to each metric:

Metric	Weight
1. Cost to Provider (CP)	50%
2. Volume of Change (VC)	18%
3. Clarity of Communication (CC)	25%
4. Notification Period (NP)	7%
5. Posting Integrity (PI)	Penalty points

How we measured

1. Cost to Provider takes into account policy changes or initiatives affecting reimbursement, and those that added more or less administrative time or complexity to a process in order to adhere to changes. Examples include implementation or withdrawal of pre-authorization, pre-certification, notification, and referral processes; timelines or modified processes that require more or less resources in order to comply with changes; and claims, coding or data errors or improvements resulting in more or less efficiency. These points accounted for 50% of the aggregate score.

We first allocate each individual change a corresponding point before tallying the total points in a given metric for each insurance company. For comparison purposes, we incorporate the ratio of CP/VC in order to account for the variation in number of changes between Payers.

2. Volume of Change takes into account the total amount of policy and procedure change across all categories - medical, administrative, pharmacy and reimbursement – experienced by physicians in a given network. Points are determined by measuring the volume of change by each insurance company compared to overall volume in percentage. Each individual change with an effective date between the beginning and end of the quarter is included in the dataset for each of the insurance companies assessed. These points account for 18% of the aggregate score.

3. Clarity of Communication indicates how well or how poorly insurers make information available on their web sites and how clearly those changes are communicated in updated policies. Of the insurers ranked, their websites are utilized as the primary communication tool for notifying network participants of changes to policies and procedures. The expectation is that providers will monitor these sites for updates in order to keep themselves informed as part of their contractual obligations with an insurer. However, if providers participate with more than an insurer or two, this is a near-

impossible task as it requires constant monitoring and the ability to know exactly what has changed when updates are posted. The MPV Payer subscription service tracks these changes for you by insurer and specialty; please visit their website at mpv.com/sol_payer_alert.php for further information.

This measurement captures whether insurers' clearly identify a new or modified policy, its effective date, and what changes actually occurred. The easier it is to find medical

policies and updates on the site, the fewer points allocated. Additional points are given to insurers that keep their policies and network news behind a log-in barrier. Points are tallied as a whole, rather than for individual alerts, for each insurance company.

These points account for 25% of the aggregate score.

4. Notification Period measures the time elapsing between posting notification of a policy or procedure change and the date upon which the change became effective. We grade insurers on how much notice they give providers of their intent to change a policy or procedure – the less time between posting and effective date, the more points accumulated. We believe that at least thirty days of notification is necessary for providers to respond and adapt to changes. Payers that post 30 days or more ahead of effective date accumulate no points.

These points account for 7% of the aggregate score.

5. Posting Integrity measures policies posted on-line with a retro-active date, or policies altered without an update or revision date being added. Tracking insurers' web sites every day allows us to see when notifications have been back-dated or altered. Because we view this practice as highly deceptive, we allocate a separate ranking for this metric and Payers observed retro-posting or altering information without notification are tagged with a penalty score.

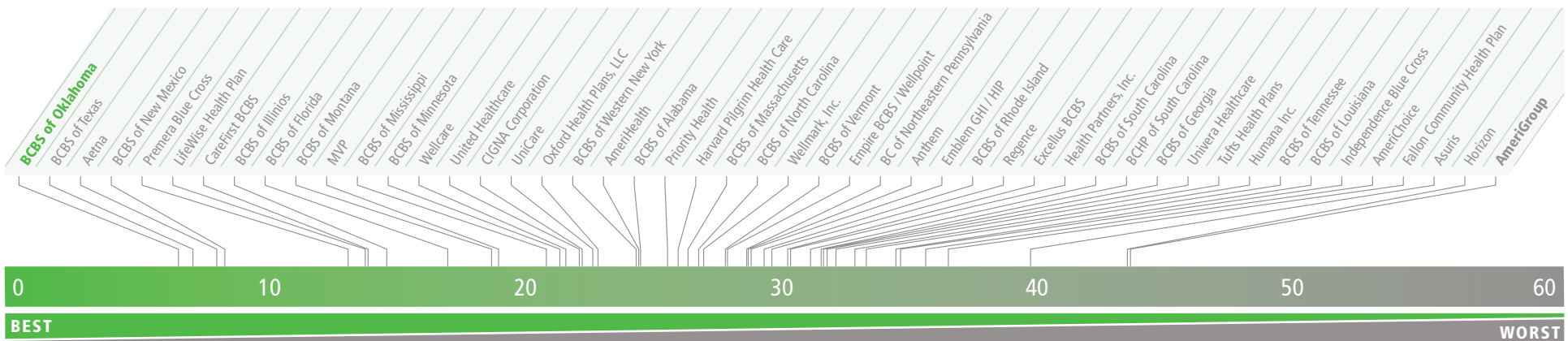
Overall Rankings

Rank	Total Score	Rank	Total Score	Rank	Total Score	Rank	Total Score				
1	BCBS of Oklahoma	6.62	13	BCBS of Minnesota	21.32	25	BCBS of North Carolina	26.67	37	BCHP of South Carolina	31.39
2	BCBS of Texas	7.18	14	Wellcare	21.55	26	Wellmark, Inc.	26.86	38	BCBS of Georgia	31.48
3	Aetna	8.10	15	United Healthcare	22.07	27	BCBS of Vermont	27.70	39	Univera Healthcare	31.62
4	BCBS of New Mexico	8.41	16	CIGNA Corporation	22.18	28	Empire BCBS / Wellpoint	27.78	40	Tufts Health Plans	31.96
5	Premera Blue Cross	13.16	17	UniCare	22.59	29	BC of Northeastern Pennsylvania	28.52	41	Humana Inc.	32.69
6	LifeWise Health Plan	13.82	18	Oxford Health Plans, LLC	22.79	30	Anthem	28.58	42	BCBS of Tennessee	33.13
7	CareFirst BCBS	13.93	19	BCBS of Western New York	24.26	31	Emblem GHI / HIP	28.69	43	BCBS of Louisiana	34.27
8	BCBS of Illinois	14.65	20	AmeriHealth	24.36	32	BCBS of Rhode Island	29.19	44	Independence Blue Cross	34.45
9	BCBS of Florida	17.00	21	BCBS of Alabama	24.43	33	Regence	29.49	45	AmeriChoice	35.42
10	BCBS of Montana	18.69	22	Priority Health	25.47	34	Excellus BCBS	30.10	46	Fallon Community Health Plan	36.29
11	MVP	18.96	23	Harvard Pilgrim Health Care	25.88	35	Health Partners, Inc.	30.21	47	Asuris	39.46
12	BCBS of Mississippi	20.80	24	BCBS of Massachusetts	26.26	36	BCBS of South Carolina	30.98	48	Horizon	43.19
									49	AmeriGroup	43.31

The Health Care Service Corporation (HCSC) group of companies – BCBS of TX, IL, NM, and OK – are the most improved Payers this quarter, with BCBS of Oklahoma taking top billing for overall performance. With a focus on physician engagement, these companies post new policies and policy changes in draft form and make them available to their networks for comment BEFORE implementation. BCBS of TX has an Office of Physician Advocacy which just rolled out the Seasons of Life program, a special pilot program designed to assist physicians’ office staffs and family representatives when the active practice of the physician comes to an end. Upon notification, BCBSTX will assist with claims and notify Texas Medical Association, the Texas Osteopathic Medical Association and the local county medical society when that the physician is no longer practicing. Meanwhile, BCBSIL is busy with supportive outreach programs mailing a letter to members who have not refilled their prescription regularly or have had a lapse in therapy of more than 15 days, with a follow up letter to prescribing physicians with a list of non-adherent members indicating the medications that are overdue for a refill.

AmeriHealth has improved considerably over the previous 2009 quarters, primarily due to investments in supportive clinical technologies. Intended to assist with identifying opportunities for improving clinical quality, the company now issues alerts to primary care physicians, OB/GYNs, endocrinologists, and cardiologists based on administrative data when a member has not received a recommended service, medication, or lab value. They are not the only company to adopt this technology and we expect to see more and more Payers offering the same services in quarters ahead.

Across the board, Payers are offering more robust training programs for physicians and their staff in all aspects of doing business including claims management, real-time adjudication, prior authorization transactions, and navigating web-based services. We can’t help but think that making some of this training a condition of network participation would be a very good thing for practices. The old saying ‘you don’t know what you don’t know’ was never truer when it comes to describing the managed care market. Each company has its own processes, rules, and policies. While we prefer to advocate for consistency in platforms, policies and adjudication, until such uniformity exists Payers requiring practices to learn how to navigate through their business might be a prudent step in lowering costs for everyone. If only we could rely on those cost savings at the Payer level to be invested back into care instead of going toward shareholder profit . . .



1. Cost to Provider (CP)

Rank	Total Score	Rank	Total Score	Rank	Total Score	Rank	Total Score	
1	Premera Blue Cross	0.14	10	CIGNA Corporation	0.52	19	United Healthcare	0.80
2	BCBS of Texas	0.15	11	CareFirst BCBS	0.56	20	BC of Northeastern Pennsylvania	0.84
3	BCBS of New Mexico	0.18	12	BCBS of Illinois	0.60	21	BCBS of Rhode Island	0.86
3	Aetna	0.18	13	Harvard Pilgrim Health Care	0.63	22	BCBS of Minnesota	0.87
4	BCBS of Oklahoma	0.19	14	BCBS of South Carolina	0.71	23	Anthem	0.91
5	LifeWise Health Plan	0.39	15	BCHP of South Carolina	0.73	24	AmeriChoice	0.95
6	BCBS of Western New York	0.45	16	BCBS of Florida	0.75	25	BCBS of Massachusetts	0.98
7	BCBS of Mississippi	0.47	16	Wellmark, Inc.	0.75	26	Independence Blue Cross	1.02
7	Emblem GHI / HIP	0.47	17	BCBS of Louisiana	0.76	27	Empire BCBS / Wellpoint	1.12
8	Wellcare	0.50	18	AmeriHealth	0.77	27	Oxford Health Plans, LLC	1.12
9	Health Partners, Inc.	0.51	19	BCBS of Montana	0.80	28	Priority Health	1.13
10	BCBS of Alabama	0.52	19	MVP	0.80	29	UniCare	1.15
						30	BCBS of Georgia	1.16
						31	Excellus BCBS	1.17
						32	BCBS of Tennessee	1.19
						33	Humana Inc.	1.20
						34	Univera Healthcare	1.21
						35	BCBS of Vermont	1.25
						36	BCBS of North Carolina	1.26
						37	Regence	1.40
						38	Horizon	1.46
						39	Tufts Health Plans	1.49
						40	Asuris	1.69
						41	Fallon Community Health Plan	2.31
						42	AmeriGroup	2.33

The big news this quarter is Priority Health's tumble down the rankings from last quarter with BCBS of TN suffering the same fate. What happened? In the case of BCBS of TN, the volume of alerts soared, double the amount from previous quarters. Prior authorizations for many drugs, changes to reimbursement guidelines and changes to 'medical appropriateness' on many policies really helped rack up the points for them. For Priority Health, numerous coding changes (excluding those that were the result of CPT's issuance of code changes), prior authorizations and changes to coverage within existing policies produced a negative outcome for that Payer.

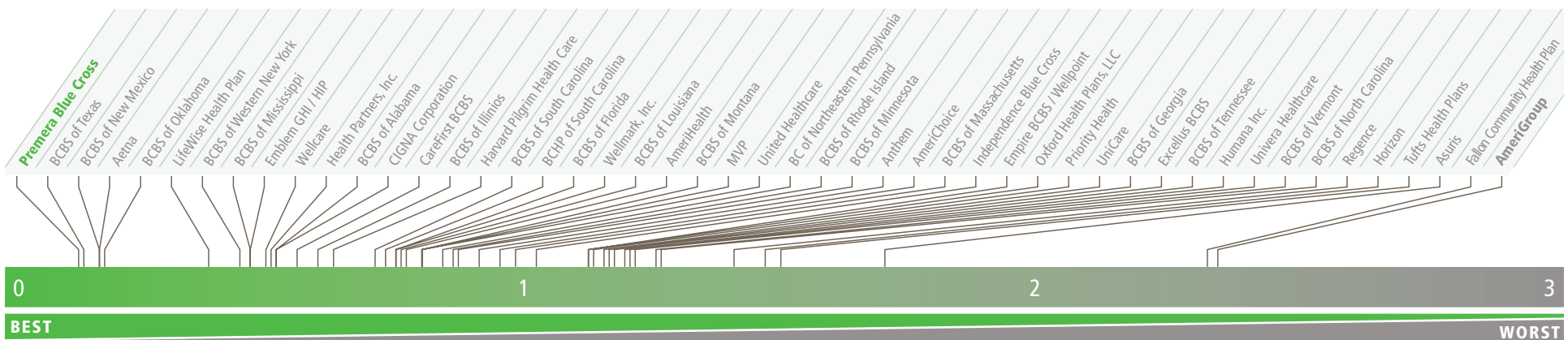
Meanwhile, HCSC's BCBS companies soared thanks in part to BCBS TX reimbursement for Performance Management CPT codes, and modifications to BCBS of NM policies allowing for coverage of more medi-

cally necessary services. We have also seen BCBS of AL relax several policies to allow for coverage of many more procedures, and while we expect to see greater coverage as procedures move from investigational to proven status, it is not often the case that Payers follow closely evidence-based research in this regard.

In an interesting development, UHC is planning a series of changes to its Premium designation program in response to several national specialty and state medical societies and network physicians. This will allow incorporation of nationally endorsed performance measures, new reporting capability to support practice improvement through delivery of actionable information and a simplification of program administration through self-service tools.

Amerigroup plummeted to the bottom of the scale due to some ill-conceived consolidated of each state's policies and a re-branding of the name to 'Real Solution'. With less information available to network participants than AG's previously informative bulletins, we were hard pressed to understand what 'solution' AG thought it was providing to its network here?

CareFirst had far fewer changes to its policies this quarter than last, and after a glitch in our data last quarter, we are pleased to rank MVP once again. It has added an online prior authorization tool to reduce call time and have instituted RelayHealth, a patient and physician online communication service, through a local IPA.



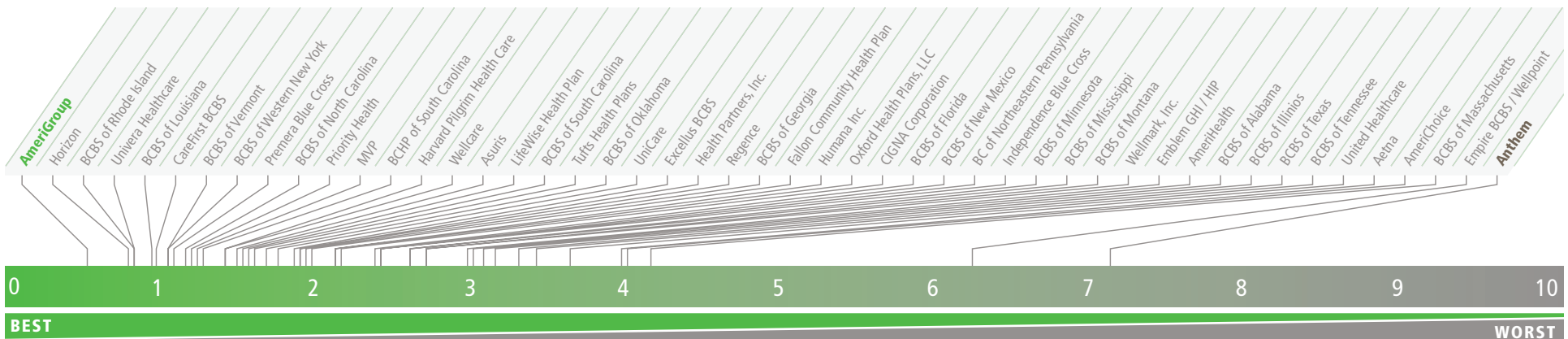
2. Volume of Change (VC)

Rank	Total Score	Rank	Total Score	Rank	Total Score	Rank	Total Score	
1	AmeriGroup	0.23%	13	BCHP of South Carolina	1.02%	25	BCBS of Georgia	1.72%
2	Horizon	0.51%	14	Harvard Pilgrim Health Care	1.17%	26	Fallon Community Health Plan	1.76%
3	BCBS of Rhode Island	0.55%	15	Wellcare	1.17%	27	Humana Inc.	1.92%
4	Univera Healthcare	0.55%	16	Asuris	1.25%	28	Oxford Health Plans, LLC	1.92%
5	BCBS of Louisiana	0.67%	17	LifeWise Health Plan	1.29%	29	CIGNA Corporation	1.96%
6	CareFirst BCBS	0.70%	18	BCBS of South Carolina	1.33%	30	BCBS of Florida	2.19%
7	BCBS of Vermont	0.78%	19	Tufts Health Plans	1.37%	31	BCBS of New Mexico	2.23%
8	BCBS of Western New York	0.78%	20	BCBS of Oklahoma	1.45%	32	BC of Northeastern Pennsylvania	2.23%
9	Premera Blue Cross	0.82%	21	UniCare	1.53%	33	Independence Blue Cross	2.23%
10	BCBS of North Carolina	0.90%	22	Excellus BCBS	1.64%	34	BCBS of Minnesota	2.43%
11	Priority Health	0.94%	23	Health Partners, Inc.	1.68%	35	BCBS of Mississippi	2.43%
12	MVP	0.98%	24	Regence	1.68%	36	BCBS of Montana	2.54%
						37	Wellmark, Inc.	2.54%
						38	Emblem GHI / HIP	2.82%
						39	AmeriHealth	2.86%
						40	BCBS of Alabama	2.93%
						41	BCBS of Illinois	3.01%
						42	BCBS of Texas	3.17%
						43	BCBS of Tennessee	3.29%
						44	United Healthcare	3.52%
						45	Aetna	3.87%
						46	AmeriChoice	3.91%
						47	BCBS of Massachusetts	4.07%
						48	Empire BCBS / Wellpoint	6.26%
						49	Anthem	7.20%

Overall volume has stayed much the same as last quarter, with the exception of Anthem plans, and surprisingly, UHC decreased by several percentage points.

While AmeriGroup tops the charts this quarter, its volume of change is a direct result of less information being available since they switched to Real Solutions. CareFirst, Oxford and Humana's volume all decreased considerably.

Meanwhile, BCBS of MA quadrupled their volume over last quarter with Wellmark close behind. Empire BCBS doubled their activity as did Wellcare.



3. Clarity of Communication (CC)

Rank	Total Score	Rank	Total Score	Rank	Total Score	Rank	Total Score				
1	Aetna	0	6	Premera Blue Cross	4	9	CIGNA Corporation	6.5	12	BC of Northeastern Pennsylvania	9
2	BCBS of Florida	1	6	Priority Health	4	10	AmeriGroup	7	12	Harvard Pilgrim Health Care	9
2	BCBS of Oklahoma	1	7	BCBS of Minnesota	5	10	AmeriHealth	7	13	BCBS of Tennessee	10
2	BCBS of Texas	1	7	BCBS of Montana	5	10	Excellus BCBS	7	14	Asuris	10.5
2	UniCare	1	7	BCBS of North Carolina	5	10	Univera Healthcare	7	15	BCBS of South Carolina	11
3	BCBS of Illinois	2	7	BCBS of Vermont	5	10	Wellcare	7	15	BCHP of South Carolina	11
3	BCBS of New Mexico	2	7	Empire BCBS / Wellpoint	5	11	Anthem	8	16	AmeriChoice	12
3	CareFirst BCBS	2	7	Regence	5	11	BCBS of Georgia	8	16	Emblem GHI / HIP	12
3	LifeWise Health Plan	2	7	Tufts Health Plans	5	11	Humana Inc.	8	16	Independence Blue Cross	12
4	Fallon Community Health Plan	2.5	7	United Healthcare	5	11	Wellmark, Inc.	8	17	BCBS of Western New York	13
5	MVP	3	8	BCBS of Massachusetts	6	12	BCBS of Alabama	9	17	Health Partners, Inc.	13
6	Oxford Health Plans, LLC	4	8	BCBS of Mississippi	6	12	BCBS of Rhode Island	9	18	BCBS of Louisiana	14
									18	Horizon	14

Empire BCBS' score has been returned to normal since it cleaned up confusing dates listed in newsletters and policy change notifications are easier to find.

Several other plans improved how information is presented on their web sites, chief among them the HCSC BCBS companies – BCBS of TX, IL, NM and OK. In addition to providing network providers the opportunity to comment on draft policies prior to implementation (which went into effect several quarters ago) these sites have been streamlined to make popular information easier to find. Descriptions of changes within the policies themselves are also much more comprehensive and detailed.

As stated in previous rankings, those companies that continue to score the worst are those that issue policies without effective dates, and/or updates without details about what has actually changed in those poli-

cies. This not only causes confusion for providers, but allows for certain insurers to routinely breach contract agreements regarding notification periods (e.g. in the case where policy changes have to be posted 30 days prior to implementation, it would be impossible to contest this if no effective and update dates are given). You know who you are.

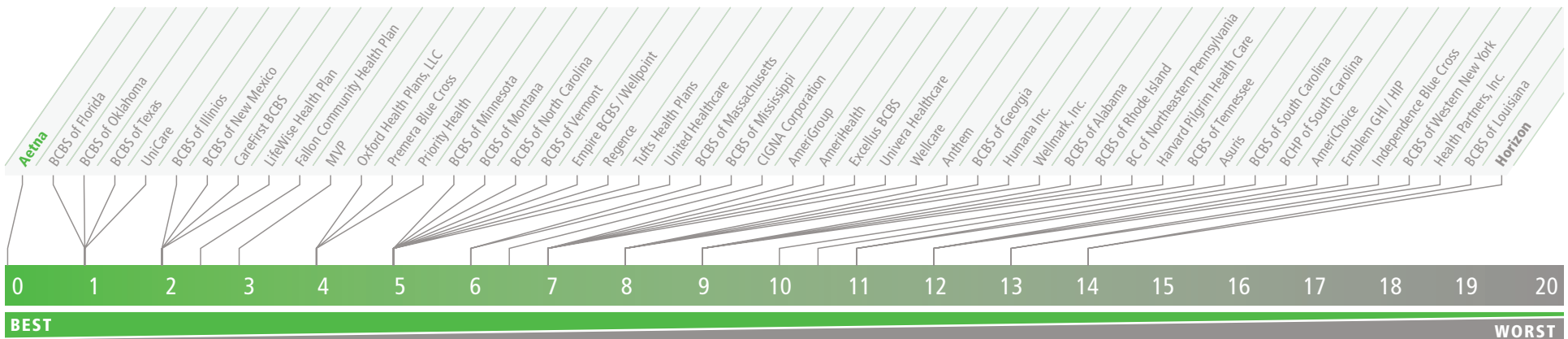
We continue to call for basic standards to be adopted across insurance networks to ensure that a minimum set of criteria is present for each policy. Those standards need to include:

- Original policy effective date and the date policy was posted to site
- Date policy was updated and the date those changes became effective
- Clear statement history within each policy about what precisely changed or was updated

In addition, policies should be easy to find on websites, should not be hidden behind a security layer (log in and password requirement) and providers should be able to search policies by CPT / HCPCS / ICD codes and keywords.

Notification of upcoming changes should be prevalent. For example, both Oxford Health Plans and Aetna publish lists of policy changes by date, listed in an obvious and easy-to-find place.

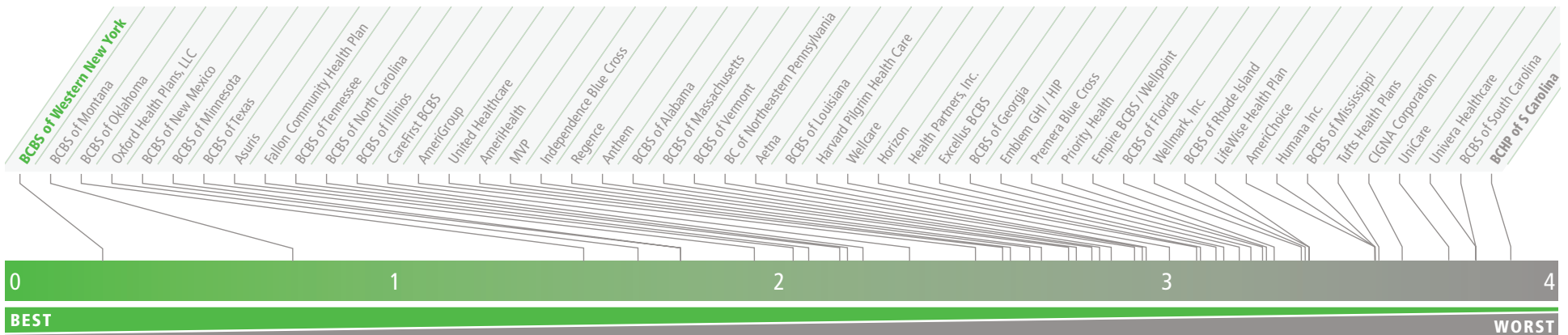
While some insurers have engaged network providers to provide feedback on their sites and accessibility to information, much more needs to be done in terms of improving not just the information itself but how users can reach and use it. Suggestion to Payers: talk to information experts if you really want to crack this issue.



4. Notification Period (NP)

Rank	Total Score	Rank	Total Score	Rank	Total Score	Rank	Total Score	
1	BCBS of Western New York	0.25	12	CareFirst BCBS	2.33	24	Aetna	2.93
2	BCBS of Montana	0.74	13	AmeriGroup	2.50	25	BCBS of Louisiana	2.94
3	BCBS of Oklahoma	1.49	14	United Healthcare	2.57	26	Harvard Pilgrim Health Care	3.00
4	Oxford Health Plans, LLC	1.63	15	AmeriHealth	2.59	27	Wellcare	3.07
5	BCBS of New Mexico	1.74	16	MVP	2.64	28	Horizon	3.08
5	BCBS of Minnesota	1.74	17	Independence Blue Cross	2.67	29	Health Partners, Inc.	3.12
6	BCBS of Texas	1.93	18	Regence	2.74	30	Excellus BCBS	3.14
7	Asuris	2.03	19	Anthem	2.76	31	BCBS of Georgia	3.18
8	Fallon Community Health Plan	2.07	20	BCBS of Alabama	2.80	32	Emblem GHI / HIP	3.21
9	BCBS of Tennessee	2.15	21	BCBS of Massachusetts	2.82	33	Premera Blue Cross	3.24
10	BCBS of North Carolina	2.17	22	BCBS of Vermont	2.85	34	Priority Health	3.25
11	BCBS of Illinois	2.21	23	BC of Northeastern Pennsylvania	2.91	35	Empire BCBS / Wellpoint	3.27
						36	BCBS of Florida	3.34
						37	Wellmark, Inc.	3.35
						38	BCBS of Rhode Island	3.36
						38	LifeWise Health Plan	3.36
						39	AmeriChoice	3.53
						39	Humana Inc.	3.53
						39	BCBS of Mississippi	3.53
						40	Tufts Health Plans	3.54
						41	CIGNA Corporation	3.60
						42	UniCare	3.72
						43	Univera Healthcare	3.79
						43	BCBS of South Carolina	3.79
						44	BCBP of South Carolina	3.88

Notification period improved overall across insurers. We still do not see consistency with at least 30 days notification, even though technology is improving and getting policies updated on sites would seem to be an easy process to maintain. BCBS of Western NY outperformed all Payers in 2009 by clocking a meager .25 points, indicative of a strong focus on getting information to its network in a timely and consistent manner.



5. Posting Integrity (PI)

Posting Integrity infractions occur when an insurer posts a policy with one date, then changes that date to some time prior to the original posting date. We take the position that the primary reason for doing so is to align with claim edits or some other such business decision, which may have an adverse affect on providers.

There were no infractions recorded for the fourth quarter, 2009.

Certificates of Merit

Certificates of Merit have been issued to the following companies for Q4

Lifewise Health Plans

Annual Award for Most Provider Friendly Network
2009

BCBS of Oklahoma (HCSC)

Most Provider-Friendly Insurer
Q4, 2009

Certificates of Merit have been issued to the following companies for Q3

Premera Blue Cross

*Most Improved Clarity
of Communication*
Q3, 2009

Aetna

Most Provider-Friendly Insurer
Q3, 2009

Prior awards for certificates of Merit have been issued to the following companies

Lifewise Health Plans

Most Provider-Friendly Insurer
Q1, 2009 and Q2, 2009

Oxford Health Plans

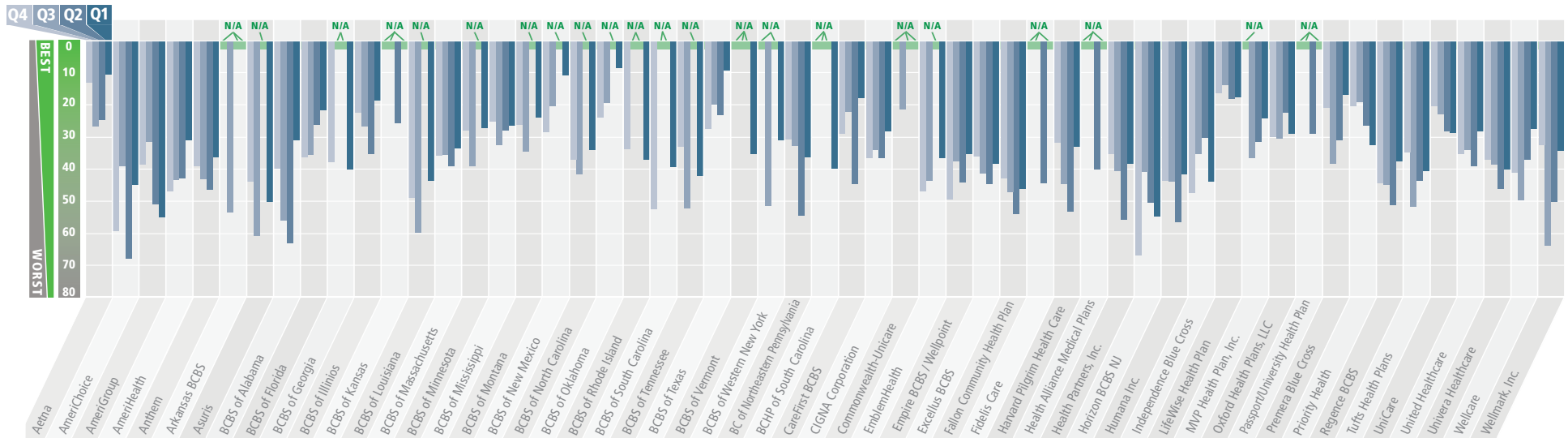
Most Improved Clarity of Communication
Q2, 2008

Aetna Health Plans

*Annual Award for Most Provider Friendly
Network*
2008

Comparison Data

Payer	Q4	Q3	Q2	Q1	Payer	Q4	Q3	Q2	Q1	Payer	Q4	Q3	Q2	Q1
Aetna	8.1	19.4	20.98	10.15	BCBS of Oklahoma	6.62	N/A	15.08	18.8	Health Partners, Inc.	30.21	43.96	31.98	27.68
AmeriChoice	35.42	53.6	30.72	46.82	BCBS of Rhode Island	29.19	N/A	N/A	26.47	Horizon BCBS NJ	43.19	39.78	32.12	52.72
AmeriGroup	43.31	40.08	24.7	30.44	BCBS of South Carolina	30.98	N/A	N/A	41.39	Humana Inc.	32.69	44.63	34.59	34.38
AmeriHealth	24.36	33.76	34.19	36.92	BCBS of Tennessee	33.13	N/A	41.19	26.02	Independence Blue Cross	34.45	23.74	27.65	37.29
Anthem	28.58	36.56	33.99	30.83	BCBS of Texas	7.18	18.07	15.59	21.64	LifeWise Health Plan	13.82	14.16	10.77	12.72
Arkansas BCBS	N/A	N/A	42.14	N/A	BCBS of Vermont	27.7	N/A	N/A	N/A	MVP Health Plan, Inc.	18.96	24.85	28.81	N/A
Asuris	39.46	N/A	47.99	34.51	BCBS of Western New York	24.26	N/A	40.52	N/A	Oxford Health Plans, LLC	22.79	17.59	23.94	23.5
BCBS of Alabama	24.43	49.64	44.08	31.44	BC of Northeastern Pennsylvania	28.52	42.86	25.81	24.24	Passport/University Health Plan	N/A	22.68	N/A	N/A
BCBS of Florida	17	20.6	27.99	28.64	BCHP of South Carolina	31.39	N/A	N/A	N/A	Premiera Blue Cross	13.16	24.4	30.1	16.34
BCBS of Georgia	31.48	N/A	N/A	29.73	CareFirst BCBS	13.93	35.19	17.26	22.7	Priority Health	25.47	20.8	14.87	16
BCBS of Illinois	14.65	27.83	20.88	17.62	CIGNA Corporation	22.18	28.66	26.71	28.73	Regence BCBS	29.49	40.31	35.43	35.03
BCBS of Kansas	N/A	20.13	N/A	N/A	Commonwealth-Unicare	N/A	N/A	16.84	N/A	Tufts Health Plans	31.96	34.33	40.72	27.31
BCBS of Louisiana	34.27	N/A	47.22	38.57	EmblemHealth	28.69	N/A	34.34	36.86	UniCare	22.59	22.08	17.98	16.05
BCBS of Massachusetts	26.26	30.65	28.01	28.22	Empire BCBS / Wellpoint	27.78	34.67	29.45	39	United Healthcare	22.07	30.69	26.68	27.78
BCBS of Minnesota	21.32	N/A	30.76	21.96	Excellus BCBS	30.1	35.18	32.47	28.39	Univera Healthcare	31.62	36.27	30.26	29.12
BCBS of Mississippi	20.8	21.91	25.55	19.7	Fallon Community Health Plan	36.29	42.61	37.15	33.72	Wellcare	21.55	29.15	39.07	32.3
BCBS of Montana	18.69	N/A	27.11	20.62	Fidelis Care	N/A	34.87	N/A	N/A	Wellmark, Inc.	26.86	39.59	50.34	25.54
BCBS of New Mexico	8.41	N/A	15.93	22.32	Harvard Pilgrim Health Care	25.88	41.93	35.09	24.99					
BCBS of North Carolina	26.67	N/A	32.65	29.13	Health Alliance Medical Plans	N/A	31.63	N/A	N/A					



Literature Review: Research, Cost Studies and Notable Information

As healthcare reform comes closer to being a reality, there is a wealth of literature being produced that is identifying and investigating the business of healthcare. Further supporting the policy work we do here at the Verden Group, some recent excellent studies / articles include:

HEALTH CARE REFORM

The Potential Impact of House Health Reform Legislation — January 8, 2010

Health reform as set forth in legislation passed by the U.S. House of Representatives in November would cut the number of uninsured Americans to 24 million by 2019 (a 56 percent decrease) and increase personal spending on health care by about 3.3 percent cumulatively between 2013 and 2019, according to an independent assessment released by the RAND Corporation. In addition, the study finds that under the Affordable Health Care for America Act (H.R. 3962) cumulative federal spending to help low-income people buy private insurance would total \$445 billion by 2019 and federal spending on Medicaid would increase by \$559 billion (a 21 percent hike) over the same period.

The findings are based on the results of analyses using a micro-simulation model created as a part of RAND COMPARE, an ongoing, independent effort to provide decision-makers and the public with objective information about health care reform. The analysis is available at www.randcompare.org, and examines the impact the House bill would have across a variety of alternative design scenarios.

EFFECTIVENESS OF MANAGED CARE

Managed Health Care Survey:

A Survey to Characterize Critical Elements of Public Sector Arrangements

This survey is designed to capture key differences between managed and “un-managed” care as well as differences among managed care arrangements. The survey was developed by a multi-institutional group of collaborators with participation of an expert panel & includes six domains predicted to have an impact on access, service utilization, costs and quality. The domains are: characteristics of the managed care plan, enrolled population, benefit design, payment and risk arrangements, composition of provider networks, and accountability. The survey can usefully differentiate between and among Medicaid FFS programs and Medicaid managed care plans along key domains of interest. Beyond documenting basic features of the plans and providing contextual information, these data can help refine & test hypotheses about how public sector managed care affects access, quality, costs & outcomes of care. RAND report.

www.rand.org/cgi-bin/health/showab.cgi?year=2009&key=2009_427

VALUE-BASED PAYMENT MODELS

Increase the Use of “Bundled” Payment Approaches

This document explores how increased use of bundled payment approaches would affect health system performance along nine dimensions. Bundled payment approaches have the potential to reduce spending, consumer financial risk, and waste. Evidence is mixed regarding how these approaches would affect health. There is no good evidence about the effects of bundled payments on reliability of care or patient experience. Bundled payment approaches are not applicable to coverage or health system capacity. Implementing bundled pay-

ment approaches would require fundamental changes in the way that health care providers bill & are paid for services. The dimensions studied are: Spending; Waste; Patient Experience; Coverage; Operational Feasibility; Consumer Financial Risk; Reliability; Health and Capacity. RAND report.

http://www.rand.org/pubs/technical_reports/TR562.20/

TRENDS IN CONSUMER-DIRECTED HEALTH

Retail Medical Clinics: Update and Implications - 2009 Report

Two years ago, retail clinics’ value proposition seemed solid: convenient locations, low-cost services, and high-quality clinical care for the subset of non-urgent conditions which can be safely treated in a retail setting. However, as is true for many new business models, the path to sustainability is not without risk. Some have characterized the initial wave of retail clinic growth as a bubble likely to burst. Indeed, store closings in 2008 caught the attention of industry observers, while investors challenged operators for stronger returns and business model refinements. What is the status of retail medicine today? What is ahead? This report addresses these important questions. Released November 12, 2009, Deloitte Center for Health Solutions.

http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_RetailClinics_111209.pdf

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