

Mid-Atlantic Health Plan Analysis

Summer 2006 Vol. 6 No. 3
Maryland | District of Columbia | Virginia

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Virginia Passes Small-Business Insurance Bill

By Jan Shuxteau

The ink was barely dry on the signing of **House Bill 761** before brokers and the health plan industry cast doubts on its potential for holding down healthcare costs long-term for small businesses.

The legislation, signed into law by Gov. Timothy Kaine on June 20 and effective July 1, authorizes businesses with fewer than 50 employees to collectively purchase health insurance. If they have a coverage plan already, it allows them to increase health insurance options for their employees.

Under the new law, one or more entity may organize or maintain a small employer health cooperative, banding together to form insurance purchasing pools. This cooperative has flexibility as a single entity to negotiate terms and policies, including premium rates, with insurers. For example, one person or one group may be responsible for collecting and paying premiums, or each company may take responsibility for its own policy.

The health status of an employee or employees is not supposed to prohibit membership in a cooperative or restrict coverage. Insurance for the cooperative must come from licensed insurers who then bear the risk—coverage is fully insured. All state mandated benefits must be included in the plans.

The savings for the pool relies on its size, its composition of sick to well people, its administration and the state mandated benefits.

And therein lies the rub, industry members say. The law does little to bring down the cost of health insurance for small business owners and their employees.

“It’s all based on risk,” explained Anna Healy, policy director for the Virginia Association of Health Plans. “For example, if healthy members find out they can buy a plan on their own that costs less than the cooperative plan, they may decide to drop out. That would leave other members of the cooperative—the sicker members—paying more. That’s the main reason association health plans end up not working. Small businesses will contract to stay in the cooperative for a certain length of time, say three years, but after that those that can pay less without being in the cooperative will get out. The health of the pool, the risk and the underwriting factor in to determine the cost.”

The Landscape On Cooperatives. Small group Cooperative health plans have had mixed success in other states. Maryland has had a small-business reform law in place since 1993, but it allows little flexibility and costs crept up over the allowable levels, making it necessary for a new reform called PharmFlex (which may or may not work), which began this summer. In Oregon, association health plans have been in business for more than a decade and were dealt a blow in August 2006 when the state’s department of insurance

HIGHLIGHTS OF HOUSE BILL 761

- » Allows businesses with fewer than 50 employees to band together to obtain health insurance
- » Any person or persons may organize or maintain cooperative
- » The cooperative can serve as the policyholder of a single policy for all cooperative members or a sponsoring entity facilitating acquisition of separate policies for members
- » An employer’s membership in cooperative cannot be restricted due to health status of an individual
- » Cooperatives must offer coverage to all eligibles of an employer regardless of their health
- » Anyone selling insurance benefits for the cooperative must be a licensed insurer
- » Coverage must be fully insured—carrier retains all risk
- » All state mandated benefits must be included in plans

Source: Virginia Coalition for Health Care

cracked down on insurers for setting up experienced-based ratings, an illegal practice that has crept back into the system as insurers tried to boost profits.

At the same time association health plan legislation was being debated in Virginia, it was also under consideration in Congress. The Health Insurance Marketplace Modernization and Affordability Act of 2006, **S. 1955**, came up for a key vote in the U.S. Senate on May 11 and garnered a 55-vote majority but not the 60 votes necessary to proceed under Senate rules. Introduced by Sen. Mike Enzi (R-Wyoming), the bill would have allowed small business employers to join together to buy health coverage through associations, which would act similarly to a human resource department in a large company. The plan would be exempt from state regulation.

A 2001 study by *Health Affairs* concluded that alliances are unlikely to expand coverage in the small-group market but they have produced demonstrable benefits to employers that participate. Their employers have greater choice in the number and types of plans available to them to take advantage of choice, according to *Health Affairs*. In addition, alliance participants also moved to managed care more rapidly than did other small groups.

Will Smalls Save Money? Large cooperatives can provide the cost savings available to large companies that self insure, according to Kenn Penn, board and executive committee member of the Virginia Small Business Coalition on Health and executive vice president and chief operating officer of ChamberSolutions. Instead of paying monthly premiums, their money goes to pay claims and for reinsurance to protect against future catastrophic claims or total claims that top a certain amount.

PERCENTAGE OF U.S. WORKERS WITH ACCESS TO THESE BENEFITS

Medical care plan	69%
Dental care plan	45%
Vision care plan	28%
Prescription drug plan	63%

Source: Employee Benefit Research Institute, U.S. Department of Labor, 2004

“When a group is self-insured, it is not required to pay the state premium tax [approximately 4 percent savings], and it is not required to offer state mandated benefits [valued at approximately 15 percent savings if all mandated benefits are eliminated],” added Penn. “It has flexibility in determining the covered illnesses. It has the freedom to design the benefits—copayments, deductibles, out-of-pocket limits, etc.—and it also enjoys the cash-flow advantage of having control of the premium money. Lastly, the insurable risk—the potential for claims—of the entire group is spread across more people. In theory, these reasons are why large employers have lower rates than smaller enterprises.”

Gordon Dixon, state director of the National Federation of Independent Business, is also concerned about the cost of state mandates. “It’s yet to be determined whether or not this Virginia law will save money for small businesses. It’s still a big issue. I can tell you this: Virginia is the third or fourth most mandated state in nation for healthcare. There are about 45 healthcare mandates that run the gamut from various screenings to hemophilia coverage.

“Business owners have only a finite amount they can spend,” explained Dixon. “When they go above that amount, costs get shifted to employees who have to decide if they can put more money aside for insurance.”

Penn also pointed out that small businesses are not likely to see a savings on administration. “Due to the fact that each small business must be billed separately, premiums must be collected separately and other reporting must be completed for each small business, administrative savings would be negligible,” he said.

“He’s probably right,” said Dixon about administrative costs. “What we’re hoping to find are people who understand the system well enough to come up with ways to reduce those costs. This could be a health insurance company or an association, for example.”

Will Anyone Want To Play? Another obstacle to the new law is that it puts the onus on the cooperative in finding a carrier. “At present, there is no incentive for a carrier to do so,” Penn said. “The carrier can insure the same employers today on a fully insured basis, including state mandates, without having to deal with a cooperative.”

Paul Bottom, former president of the Virginia Association

of Health Underwriters, shares that opinion. “Look at this law from a broker’s standpoint. Members of the cooperative don’t have to be in the same industry or have common ground. What if a broker went to all of the time and trouble to package their information and give it to Anthem, for example? What is the likelihood that the carrier is going to want to insure that miscellaneous group as an association? Especially, if they think members of the group would back out?”

VAHP’s Healy noted that there was nothing in the law to say that insurance companies had to accept the cooperatives. He also said whether or not they stayed together as a group would depend on whatever contract group members made among themselves.

Penn said he is concerned about the component of the new law that allows any person or persons to organize or maintain a cooperative, regardless of their experience. If things go wrong, this person or entity might jump ship and close down the cooperative, leaving small businesses without coverage, he said.

Now The Good News. Despite potential flaws, there is some good news about the new law. “We think this may be a tool to alleviate the cost of insurance premiums in the future. A lot will be determined by how this plays out,” said NFIB’s Dixon. “To make the economics work, the pools will have to include several thousand members.”

NFIB, which has 9,000 members in Virginia, is not planning to establish a cooperative. “Our business is not health insurance, but to support legislation to help small business survive,” said Dixon.

“Although the bill does not go as far as we hoped in reducing small business health insurance costs, there is some really good news to be gleaned from this new law,” Penn said. “It is important to note that there was a bipartisan effort ‘to get something done.’

“This bill now provides a good foundation from which to build. More specifically, for the first time, Virginia law now allows groups to band together for the sole purpose of obtaining health insurance,” he said. “Before, business could not coalesce unless they had other primary business purposes. Further, the establishment of cooperatives provides a mechanism to unify multiple employers for contracting purposes. Lastly, it provides some opportunity for a new and/or aggressive insurance carrier to enter the Virginia market.”

OUTLOOK: *Work on House Bill 761 brought people to the table who had very different ideas on how to help small business owners provide health insurance to their employees. It gave them a chance to learn from each other and hammer out a compromise. That was a good first step. Its big flaw is that it requires plans to continue to offer all state mandated benefits, which help drive up costs. No matter how well meaning the lawmakers were, they merely dangled a possibility in front of small businesses, then jerked it away.* ■

Only Medicaid Plans Post Membership Growth

By Jan Shuxteau

Enrollment in Mid-Atlantic health plans made barely a ripple in the market from January 2005 to 2006, with membership remaining static for both commercial HMOs and PPOs. Medicaid plans made the only waves by continuing to scoop up members.

“There is a flatness of enrollment for new members,” said Paul Bottom, past president of the Virginia Association of Health Underwriters and owner of Bottom & Associates in Virginia. “What I keep hearing is that small businesses have been leaving the group health insurance market because of rising rates over this last year. It seems to be a phenomenon that’s nationwide as well as one we’ve seen in Virginia.”

Maryland is seeing the same trend. Mark Haraway, vice president of the Maryland Association of Health Underwriters and vice president of sales for DentaQuest Mid-Atlantic, noted that Maryland’s small-group plans have shrinking membership. “About 90 percent of the businesses in Maryland—202,000 of them—have fewer than 50 employees,” he said. “Small-group reform legislation has been in place since 1993, but it has become increasingly expensive with medical costs and the inability of insurance companies to underwrite risk properly.”

PharmFlex Starts. Maryland is a highly regulated state, where the only health insurance package that carriers can sell to Maryland’s small-business owners is a Comprehensive Standard Health Benefit Plan, regulated by the Maryland Health Care Commission. According to state law, the cost of the base CSHBPs must not be greater than 10 percent of the average wage in Maryland. But, as Haraway indicated, costs rose above that amount and employers dropped coverage. The commission stepped in to help out, coming up with PharmFlex, which only went into effect in July. By allowing health plans to change the pharmacy benefit, PharmFlex is supposed to give carriers more flexibility in benefit design, pricing and employer-employee choice—while retaining the tenets of CSHBP. Though there is room for optimism, it’s too early to determine whether it will take hold.

MARYLAND ENROLLMENT LEADERS*

Company	Fully Insured	HMO Lives	PPO Lives	Medicaid
CareFirst	661,186	306,348	354,838	0
United	447,550	405,965	41,585	94,920
CIGNA	240,708	208,265	32,443	0
Kaiser	199,874	199,874	0	0

*As of January 2006.

Source: HealthLeaders-InterStudy Managed Market Surveyor

VIRGINIA ENROLLMENT LEADERS*

Company	Fully Insured	HMO Lives	PPO Lives	Medicaid
WellPoint	969,203	409,760	559,443	137,679
United	327,816	297,452	30,364	19,589
Kaiser	284,293	284,293	0	0
Optima	255,122	237,243	17,879	120,306

*As of January 2006.

Source: HealthLeaders-InterStudy Managed Market Surveyor

“Some plans are still in the development and filing stages,” said Bruce Kozlowski, director of the Center for Health Care Financing and Policy. “Anecdotally, however, we understand that Aetna, Kaiser and Coventry are or will be proposing a new suite of offerings. United is purported to be offering an expanded pharmacy benefit that previously was available in several other states, but not Maryland. CareFirst has been less definitive in its intentions but is a major player in the small-group market.”

He noted that the new flexibility for insurers in benefit design and pricing will allow new choices for employers. “This should prove attractive to employers who may be on the border of discontinuing coverage, employers who have not previously participated in the CSHBP and to young and/or healthy employees who have not participated even when employers offered a plan,” said Kozlowski.

But some insurers remain reluctant to pump up small business coverage. Haraway noted that average age and geographic location have been the only two risk factors allowable to insurers writing plans for small business. These plans must also provide a guaranteed issue and guaranteed renewal, so no company can be denied. “From the consumers’ standpoint these are attractive features, but they allow health plans little ability to place risk properly. This means that rates have gone up consistently and sharply for the last five years, and that has driven membership down in HMOs and PPOs,” said Haraway.

Virginia passed a law this summer that allows small businesses to form cooperatives and apply the economies of scale to buy health insurance. It’s too soon for cooperatives to have formed.

Virginia Numbers Are Static. In Virginia, the rolls of the fully insured dropped from 2.61 million to 2.57 million from January 2005 to January 2006, according to HealthLeaders-InterStudy research. This was a loss of about 36,465 members, or about 1.4 percent.

Commercial HMO enrollment dropped by 105,962

WASHINGTON, D.C. ENROLLMENT LEADERS*

Company	Fully Insured	HMO Lives	PPO Lives	Medicaid
CareFirst	182,353	65,023	117,330	0
AMERIGROUP	40,870	0	0	40,870
D.C. Chartered HP	38,242	38,242	0	38,242
United	34,035	23,642	10,393	1,450

*As of January 2006.

Source: HealthLeaders-InterStudy Managed Market Surveyor

members, or 8.3 percent, from 1.28 million to 1.18 million members during that time.

The number of PPO enrollees went up—barely—from 951,115 in January 2005 to 958,336 in January 2006. That’s an increase of 7,221, less than 1 percent. PPO plans claimed 12.7 percent of the fully insured market both years.

The biggest upswing in enrollment was in the Virginia managed Medicaid segment (not including dual eligibles), where enrollment went up by 53,160 beneficiaries, or 14.6 percent, from 364,259 in January 2005 to 417,419 in January 2006. At the same time, fee-for-service plans were losing numbers as some beneficiaries transitioned into managed care.

Maryland Changes. Health plans added about 71,436 fully insured members in Maryland from January 2005 to January 2006, but they didn’t add them to commercial plans.

Commercial HMO enrollment dropped, though only by about 3.2 percent. Enrollment went from 1.25 million in January 2005 to 1.21 million in January 2006. This was a loss of about 40,000 members, not an especially significant amount given the fact that that number is spread among seven plans (CareFirst, UnitedHealth Group, CIGNA HealthCare, Kaiser Foundation Health Plans, Aetna, Coventry Health Care and AmeriHealth) with commercial HMOs.

In the same time frame, fully insured PPO membership also dropped. Enrollment went down about 13.3 percent, from 636,079 to 551,306, a loss of 84,773 members.

Washington, D.C. In the nation’s capital, the dynamic was not the same. Fully insured PPO plans took a leap up. Between January 2005 and 2006, enrollment went from 99,182 to 146,104, an increase of 46,922 members, or 47.3 percent.

In that time frame, enrollment in commercial HMOs took a step down, moving from 174,050 to 137,397, a loss of 36,653 members, or 21 percent.

Medicaid HMOs, on the other hand, went from a membership of 54,633 in January 2005 to 97,607 in January 2006, an increase of 42,974, or 79 percent.

Health Plans. The Blues plans, CareFirst and Anthem Blue Cross and Blue Shield topped other Mid-Atlantic plans in fully insured enrollment with neck-and-neck numbers from January 2005-January 2006, according to HealthLeaders-InterStudy data.

The largest health plan in the Mid-Atlantic is CareFirst Blue Cross Blue Shield, which had a total of 988,415 fully insured members in January 2006, according to HealthLeaders-InterStudy data. This included about 661,186 fully insured members (29.2 percent of the market) in Maryland, 144,876 members in Virginia (5.6 percent of the market) and 182,353 members (47.6 percent of the market) in Washington, D.C.

In Maryland, CareFirst created the biggest splash in the market with increases in both its PPO and HMO enrollment. The company’s PPO membership went from 136,423 members in January 2005 to 354,838 members in January 2006. Its HMO membership (all commercial) went from 218,474 in January 2005 to 306,348 in January 2006, a 40 percent jump.

In Washington, D.C., CareFirst had another big PPO enrollment boost from January 2005 to January 2006, going from 80,357 members to 117,330—an increase of 46 percent in the relatively small market. The plan lost HMO members, going from 76,723 members in January 2005 to 65,023 in January 2006—a reduction of 15 percent.

As of January 2006, Anthem Blue Cross and Blue Shield of Virginia, owned by WellPoint, Inc., had the largest membership in Virginia. With roughly 969,203 members—it had 37.7 percent of the Virginia market, according to HealthLeaders-InterStudy data. However, the company’s fully insured enrollment dropped about 9 percent from January 2005 when it had an estimated 1,068,587 fully insured HMO and PPO members and a slightly larger percentage of the Virginia market.

Anthem’s fully insured members included about 559,443 in PPOs, which was a drop of 11.6 percent from January 2005 when it had 632,580 PPO members. The fully insured membership also included about 409,760 members in HMOs, or 6 percent less enrollment, in January 2006 than in January 2005. HMO members included about 272,081 in commercial HMOs and 137,679 in a managed Medicaid plan.

Anthem does not count members by plan design and cannot confirm or deny a trend. According to Anthem spokesman Scott Golden, the company’s overall membership increased at the end of the second quarter of 2006 by more than 600,000 members or 2 percent on a comparable basis compared to the end of the second quarter of 2005. Every region of WellPoint contributed to this growth, with increases ranging from 1 percent in the eastern region to 4 percent in the west.

“We have seen particularly strong growth of 8 percent on a comparable basis over the last year in our national account business, and we expect our success to continue,” said Golden. “Our 2007 selling season for national accounts remains competitive, similar to prior years.”

In January 2006, UnitedHealth Group had the second highest membership in Virginia and Maryland. The company had 809,401 fully insured members in the Mid-Atlantic, including about 447,550 in Maryland, 327,816 in Virginia and 34,035 in Washington, D.C. United’s HMO enrollment remained high in both Maryland and Virginia though Mary-

land's numbers were down from January 2005.

The company showed a membership of 94,920 in managed Medicaid in Maryland and 19,589 in Virginia, where it had nothing the year before.

OUTLOOK: *Though health insurance membership remained fairly flat from January 2005 to January 2006 in the Mid-Atlantic*

region, there were frissons among the various health plans—CareFirst's increases in Maryland, for example. The expense of health insurance for small businesses is playing a big role, reducing enrollment in these small-business states. Maryland's PharmFlex, which went into effect July 1, could help, though it does not give insurers much latitude to reduce prices. ■

360° Health: Anthem Brings Care Full Circle

By Jan Shuxteau

WellPoint Inc., the parent company of Anthem Blue Cross and Blue Shield, is launching a \$100 million program called 360° Health in Virginia. 360° Health combines preventive care, health improvement and care coordination programs.

"This program will be a core component of all the WellPoint plans," said Joan Kennedy, senior vice president of WellPoint and president of Health Management Corp., WellPoint's Richmond-based integrated care management company.

The plan began in Georgia in July of 2006, then moved into Virginia. It will roll out in Nevada, Colorado and California in October, followed by Connecticut, Maine and New Hampshire in January and other states in 2007.

Kennedy noted that 360° Health integrates all care management programs and tools into one central resource so that WellPoint's 34 million members can retrieve health information through a single point of contact. "This will simplify members' navigation of the healthcare system," she said. WellPoint members will also be able to get 360° Health benefits by phone, e-mail or a personalized Web site.

"The central program includes many online services. There will be information on hundreds of topics and things such as health risk assessments, weight management plans, smoking cessation and other programs," said Kennedy. Clinical information comes from medical experts at Harvard Medical School and other academic institutions.

"360° Health also includes access to a nurse 24/7 by telephone, maternity management services and care management programs for asthma, diabetes and heart disease," added Kennedy. "There are services for very complex, very intense care management of chronic diseases—those illnesses that account for most of the dollars spent on healthcare. For the chronically ill, it's not just about having one condition. They may have five things wrong, and they need coordination of care."

John Boyle, owner of Boyle Financial Services in Marietta, Ga., is selling the plan, and he agrees. "It seems to me that this program is going in the right direction, trying to manage care better, especially those who need care for chronic conditions," said Boyle. "Getting a better grip on this is a way to better control healthcare costs. Of course, whether or not people will actually use the services provided for them is anyone's guess. You've got to think it will click in sooner or later."

Custom Fit. 360° Health has been set up to be flexible enough to meet the needs of a variety of employers and to be priced accordingly. "We wanted to design a plan with multiple options. We recognized that every employer is different. For large employer groups that self fund, we may recommend a comprehensive package, but we have the ability to custom make," said Kennedy. "Suppose an employer's workforce

lifted heavy boxes all day long, that employer might want a plan that offers more for back injuries."

Personal Health Records. A key component of 360° Health is personal health records, the substance of which is owned and managed by WellPoint members. The PHRs are automatically populated by member-provided information plus claims data received by WellPoint. They can be accessed from any computer with an Internet connection, empowering members to track and share their medical histories with their doctors.

"Our PHRs are the first of their kind to automatically populate personal information, including claims, pharmacy, labs with Web-based information," Kennedy said. She noted that automated patient records have been around for a year, but they have not always been up-to-date or easy for patients to understand. In the case of 360° Health, medical jargon is "translated" into member-friendly language.

"There are many advantages for a PHR," said Kennedy. "For example, members may consent for doctors to have access to their online information. Their PCP can then coordinate the patient's care, reducing multiple testing and watching for prescriptions that would be interactive."

Marketing The Plan. WellPoint is marketing 360° Health through brokers, agents and consulting firms and conducting sales training. "We're marketing this plan in various ways, depending on the region. We launched in Georgia in July and created an entire sales program, training sales associates and holding multiple meetings with brokers. Each region will have materials and literature that have a standard look that is our brand," said Kennedy.

Russell Head, a partner with Group and Benefits Consultants in Augusta, Ga., noted that the program should gain an advantage through WellPoint's branding, which will give it an identity and make its features immediately recognizable as belonging under the same umbrella of products. "It will relate the suite of programs that are offered," said Head. "Everything from the hospital incentive programs, condition management programs, worksite wellness seminars, predic-

360° HEALTH BENEFITS INCLUDE:

- » One central contact point for services
- » Personal health records
- » Information on hundreds of health topics
- » 24-hour-a-day nurse access
- » Maternity management services
- » Care management for asthma, heart disease, diabetes

Source: WellPoint Inc.

360° HEALTH BENEFIT PROGRAM GIVES ACCESS TO:

- » Preventive Care
- » Health Improvement Plans
- » Care Coordination Programs

Source: WellPoint Inc.

tive modeling, the baby connection to disease management for asthma, diabetes and heart disease and the patients' personal health records would wear the brand."

He pointed out that the plan embraces wellness, disease management and quality control—not concepts that carriers have embraced in the past. "These are things that carriers are starting to talk about to lower healthcare costs and help control employee wellness," he said.

William Veal, owner of Veal Employee Benefit Services in Dallas, who has many clients in Georgia, said that he was impressed with WellPoint's Web seminar about 360° Health. He sees the potential of online information, but he wonders whether members will choose to use it. "This program has some really good points, but it faces some big challenges too," he said. "From what I've seen, people are just not all that interested in being educated about healthcare. They won't necessarily read something just because it's there for them."

In addition to healthcare information, 360° Health offers members online wellness and lifestyle programs, discounts

on health-related products and alternative medicine therapies and 24-hour access to WellPoint associates who can provide health information.

It Doesn't Come Cheap. WellPoint has invested nearly \$100 million to date on the development of 360° Health, according to the company.

Kennedy said that the company invested heavily in infrastructure, technology and nurses—spending the most for infrastructure and technology. "But we made a strong commitment to the products as well with state-of-the-art disease management techniques, and the nursing staff for care coordination."

Pilot programs in New York have shown that group customers achieved a 2:1 return on investment on all employees enrolled in the program. Xerox Corp., which has more than 29,700 employees in the United States, piloted several components of 360° Health.

"Xerox's participation is part of our comprehensive approach to give people support and tools to reduce health risks before these risks turn into more serious conditions," said Lawrence Becher, director of benefits for Xerox, in a release.

OUTLOOK: It's being built, so the next question is, will they come? Will consumers take the trouble to use WellPoint's innovative 360° Health or will they approach it as one more task to fit into their days? Clearly, the market is ready for this tool, but consumers may not yet be. ■

Optima Positions CDHP Products For Future

By Jan Shuxteau

Sentara Healthcare's Optima Health Plan began offering consumer-driven health plans in 2005, dabbling its feet in new waters with the help of partnerships in 2006 with HealthEquity Inc., and most recently, with Subimo LLC.

For the next few months, Optima—a nonprofit provider of health benefits for 340,000 members in southeastern and central Virginia—will also be looking at new and related products and a simpler approach for customers.

"We felt that we needed to be in the CDHP market at this point in time," said Sharon Poulos, Optima's director of market research and product development. "We expect to see interest build as time goes by. We haven't seen a lot of demand to date, but providing the CDHP option now positions us for the future."

What the company has seen over the last few months is that employers are interested in consumer-directed plans and have smart questions about their online tools and about health savings accounts and cost advantages.

How They Started. Earlier this year, Optima partnered with HealthEquity to provide HSA client services for Optima's

high-deductible health plans. Members of the new CDHP plan have access to HealthEquity's client advisory services, self-diagnostic tools, a nurse line, pharmaceutical price comparisons, 24-hour customer service and out-of-network bill review and negotiation. They also have access to Optima's network, including Sentara Healthcare Hospitals.

Poulos said that Optima chose to offer HSA-compatible high-deductible health plans rather than health reimbursement arrangements. HSAs, which are by law paired with high-deductible benefit designs, have been on the market nationwide for more than two years and include some features that HRAs do not have. HSAs, for example, allow health accounts to be portable, and unused portions can be rolled over into the following year. Both accounts can be funded by employers, but only HSAs can be funded by individuals.

Poulos noted that in the next six to nine months, Optima may change the way it offers its CDHP. "Right now an employer buys the plan from us and the HSA management function from HealthEquity or from HSA Administrators [another preferred vendor]. What we'd like to do is offer a

more integrated product so customers would not have to deal with two entities. They now pay a fee for the HSA and premium to us. We believe we would have a better adoption rate if we simplify things for employers.”

She said that Optima was investigating the resources necessary to accomplish this change and would then make a decision about how best to accomplish this goal.

Working On Web Developments. Optima Health Plan partnered with Subimo LLC in July to give Optima members access to Subimo’s treatment cost advisor and Spanish Hospital Advisor tools via Optima’s Web site.

Through Subimo’s treatment cost advisor, Optima members are able to see cost estimates for a variety of health conditions and research and compare hospitals in their area. The tool helps consumers estimate the costs of specific healthcare services or episodes of care, providing in-network and out-of-network costs and prices of the most common medical procedures. It connects members to healthcare facilities based on individual preferences, quality indicators, outcome measures and costs. In addition, it provides price estimates for common tests, procedures and doctor visits, allowing users to budget and plan for their treatment.

“Since customers with high deductibles have a large out-of-pocket obligation before coverage kicks in, they are very interested in the cost,” said Poulos. “Before CDHPs came on the market, there was really no incentive for them to find out the cost of an office visit or an X-ray or some procedure. Now they want to know, and we can give them a cost range. We don’t give them an exact dollar amount, but we can give a range. At least, they’ll know approximately how much to expect to pay.”

Subimo’s Spanish Hospital Advisor allows Spanish-speaking members to compare facilities based on demographic

OPTIMA HEALTH PLAN*

Territory: central, southeastern Va.

Ownership: Sentara Healthcare

Commercial HMO lives: 116,539

Managed Medicare: 976

PPO fully insured: 17,879

PPO self-insured: 18,355

*As of January 2006.

Source: HealthLeaders-InterStudy Managed Market Surveyor

clinical outcome measures and other key quality indicators, such as their patient safety information.

A New Tool For The Future. Optima is also looking at adding a physician quality tool to its suite of Web-based decision tools. “Currently, customers can look at hospital quality and can compare pharmacies side by side, but nothing is out there about physicians,” said Poulos. “One reason for that is because it is hard to find criteria that everyone accepts. Subimo and Ingenix, another of our vendors, have developed a physician quality tool that might be usable. It shows if doctors have won awards or have sanctions against them—all publicly available information that no one can take issue with.”

OUTLOOK: *Optima’s careful approach illustrates that while the industry buzz is all about consumer-driven health plans, they are still new to the market and deserve to be approached with a little caution. Optima has probably hit on a way to boost enrollment by tying its health plan and HSA together in a way that simplifies customer bookkeeping.* ■

Elder Health Expanding Market, Products

By Jan Shuxteau



J. Folick

Without much fanfare, Baltimore-based Elder Health is making interesting changes in the Mid-Atlantic and beyond, expanding the company’s reach and offerings in the marketplace, and bringing in new managers to do it.

Elder Health, a for-profit health plan, operates Medicare Advantage plans, including special needs plans, and a stand-alone prescription drug plan for Medicare Part D.

In March, the company hired CEO Jeff Folick. In July, it filled the position of chief financial officer, which has been open for a year, by hiring Scott Tabakin. Jacob Furgatch was named chief administrative officer, and David Yalowitz,

M.D., was named vice president and senior medical director this summer. Five other vice presidents (Scott Ptacek, Mary Ann Eull, Patrick Feyen, Don Fox and Jason Feureman) were named about the same time.

“We brought in Scott Tabakin who has experience with restructuring. Jacob came in to upgrade our operations; his position did not exist before,” explained Folick. “I’m new, and I think it’s only natural for a new CEO to change the leadership a bit. We’ve also reorganized some, moving from a regional structure to a more integrated management structure.”

Folick, who has a strong background in Medicare, was formerly with Health Net and before that with PacifiCare Health Systems, both in California. He expects to broaden Elder Health’s markets, add more members who are not dual eligibles and market more aggressively.

EXPANSION STATES FOR ELDER HEALTH'S PART D STAND-ALONE PLAN*

» California	» Michigan	» New Jersey
» Florida	» Ohio	» Pennsylvania
» Illinois	» New York	» West Virginia

*Effective 2007.

Source: Elder Health

“Elder Health was traditionally a strong competitor with a strong products orientation to the inner-city market, both financially and in terms of growth. About 50 percent of our membership is dual eligible for Medicare and Medicaid. We will continue our focus on that population—we’re good at it, and also there is a need in those inner-city communities,” said Folick.

The company has a special needs plan for dual eligibles, or those eligible for both Medicare and Medicaid, in all of its markets and two non SNPs for non-duals. “We’ll continue to offer both special needs plans and plans not for special needs,” Folick said.

Moving Forward. In late 2004, Elder Health received an equity investment of \$52.5 million led by Frazier Health Care Ventures, Wasatch Advisors, New Enterprise Associates, Conning Capital Partners and Salix Ventures, among others. “Elder Health’s proven track record shows that appropriate preventive care and chronic disease case management can lead to healthier members and solid financial results,” said Nader Naini, general partner of Frazier Healthcare Ventures, when the investment was announced. “Elder Health’s targeting the large market of urban elderly is both strategic and compassionate, and we like to be involved with such intelligent companies.”

Elder Health spokesmen said that the company is using the proceeds to fund the company’s expansion into new markets. Last year, Elder Health went into the District of Columbia, Texas (Houston, San Antonio, Corpus Christi, El Paso) and Pittsburgh (it was formerly only in Philadelphia), offering Medicare Advantage and SNPs.

The company also offered a stand-alone prescription drug plan for Medicare Part D, Elder Health Mid-Atlantic PDP in Maryland, Delaware and the District of Columbia this year.

In the Mid-Atlantic, Elder Health had net income of \$968,000 on total revenues of \$79.1 million in 2005, with a

medical loss ratio of 79 percent, according to HealthLeaders-InterStudy data. Its profit margin in the region was 1.22 percent at year-end.

The company reported more than 7,400 Medicare members in Maryland at year’s end and more than 8,000 by August of 2006, according to the Centers for Medicare & Medicaid Services.

Coming Next Year. Elder Health will cast its nets further in 2007, according to Folick. “We’re expanding our stand-alone PDP products into eight new regions in 2007—California, Florida, Illinois, Michigan, Ohio, New York, New Jersey and Pennsylvania/West Virginia,” he said. The company will not add MA PDPs next year.

But it is beefing up its physician provider network. “Right now in the Mid-Atlantic, we have about 500 primary care physicians, 1,725 specialists and 15 hospitals,” said Folick. “We are adding about 100 PCPs and 250 specialists. We already have the largest hospital network in the Mid-Atlantic, so we’re not targeting additional hospitals. Our goal is to have the physicians contracted in our network by October, ready for the start of open enrollment Nov. 15.”

He explained that the company would broaden its physician network in non-urban counties in Maryland. “We’re strong in Baltimore, but we want to have more of a presence in some of the surrounding counties,” he said.

The company will also offer a new private fee-for-service product in several Maryland and Delaware counties and in Washington, D.C. in 2007.

Reflection. Folick predicted that the government would continue to look to private industry and companies like Elder Health to find the answers for Medicare. “We know we have to provide a high level of service and quality healthcare. We have to be aware of consumers and bring it to them in ways that meet their needs.”

He noted that the No. 1 differentiation among insurers in the Medicare market is who manages healthcare best and in a manner that attracts Medicare members. He pointed out, “You can be good at providing healthcare and saving money. But you still have to put your product out there where people can see the value of it and want it.”

OUTLOOK: *With special needs plans in their infancy, Elder Health is well positioned to provide care for this challenging market as well as other senior markets. The company’s assortment of mostly new (but experienced) company leaders is likely to work hard to make new initiatives happen.* ■

Survey Says Consumers Don't Research Health

By Jan Shuxteau

A new survey commissioned by Destiny Health gives the industry a glimpse of just how much it needs to work in convincing consumers that consumer-driven healthcare is right for them.

It says Americans spend twice as much time researching car and furniture choices than they do selecting a doctor. Six in 10 say they probably wouldn't change their ways even if price and quality information on healthcare providers were readily available.

Opinion Research Corp surveyed 1,000 adults in June. The Guardian Life Insurance Company of America markets Destiny Health Plan in Virginia, Washington, D.C., Maryland, Illinois and Texas. It is also available in Wisconsin through independent brokers.

"People were surprised when they first saw this study, but once they thought about it they realized it made sense. They said to themselves, 'That's true. I probably did spend more time choosing a refrigerator,'" said Patty Peterson, vice president of marketing for Destiny Health.

Barry Swartzberg, executive director of Destiny Health's sister company Discovery Health, said Americans feel disconnected with their healthcare because 97 percent of those in private plans are in a copay/coinsurance system.

"Consumerism is making an impact in every corner of the economy but the doctor's office," Swartzberg said. "And that needs to change if we are to gain control of rising healthcare costs. The issue is 'value'—the merging of cost and quality. Americans are unmatched in seeking value in their consumer-goods purchases, and it is critical that the healthcare system be adjusted to reward a similar degree of diligence."

Peterson pointed out that consumers go to extremes to avoid high gas prices. "We're doing all sorts of things to avoid paying \$3 a gallon at the pump. Isn't it amazing that we're not doing more to bring down the amount we pay for healthcare?" she said.

Transparency: An Issue. Swartzberg said that Medicare recently made available the costs it pays hospitals for a number of procedures and that the agency's Web site—www.hos-

THOSE LIKELY TO SHOP FOR MEDICAL SERVICES

18-34 years old	44%
35-44 years old	38%
45-54 years old	47%
55-64 years old	38%
65+	24%

Source: Opinion Research Corp.

CONSIDERATIONS WHEN LOOKING FOR MEDICAL CARE

% Rating as Extremely Important

Insurance coverage	76%
Referrals from doctors	68%
Convenience	67%
Recommendations from family, friends	67%
Medical fees	56%

Source: Opinion Research Corp.

pitalcompare.hhs.gov—will eventually be refined so patients can input the treatment they are looking for and compare providers by location, cost, quality, complication rate, patient satisfaction and a number of other factors.

"This is great," he said, "but as long as the vast majority of Americans see nothing personal to gain from accessing this kind of data, it is unlikely that very many will go to the trouble."

Some people don't know that so much healthcare information is available or where to find it, conceded Peterson. "However," she added, "even when you ask if having the information right in front of them would make a difference in their choices, they say no. There's got to be something in it for them."

To that point, only 10 percent of survey respondents said they would be "extremely likely" to "shop around" for medical services if they could obtain information on the prices and quality of doctors and hospitals. Combined with the "very likely" responses (29 percent), the total percentage of respondents likely to shop around for healthcare remains below 40 percent.

This attitude also was reflected in the amount of time respondents said they spent researching their last major household purchase versus selecting a doctor. Responses averaged 20 days of research on the household purchase and only 9.7 days on the doctor.

"There is a real gap here, but the onus is not entirely on the American consumer," Swartzberg said. "With traditional insurance paying the bill, there is no compelling reason for Americans to care about getting the best deal from their medical providers, and therein lies the problem. Americans are not healthcare consumers. Americans are passive users of a system that clearly doesn't work. Truly effective consumerism creates knowledgeable and motivated consumers, which in turn lowers cost and improves quality and convenience."

Up For A Change. Studies show that consumer-directed healthcare, a concept that puts consumers in charge of

their healthcare dollars and, under the best models, educates and motivates people to make the best healthcare choices, has tremendous potential to cut costs and encourage healthier lifestyles.

Destiny Health Plan includes an incentive-based wellness program at its core. Members of the Destiny Health Plan are encouraged to make smart choices with rewards for activities that improve their health and wellness. The Destiny Health Vitality Program allows members to earn “vitality bucks” through preventive medical care and public fitness events, among other things. As members accumulate more bucks, they move up in status level, thereby earning additional perks and benefits—and getting healthier along the way.

“The underlying benefit is to get people to stop and think of things such as, ‘If I use generic instead of a brand name, I’ll get the bucks, and realize that they’ll also save themselves and their companies money,’” Peterson said.

OUTLOOK: It’s true that most consumers spend more time picking out furniture than selecting a doctor, so the consumer-driven movement has a big push ahead to get users in the groove. As to whether the promise of an iPod or frequent-flyer miles can provide the incentive to make consumers healthcare savvy, why not? If the user is predisposed to pursue a program anyway, this will be just the thing to push them on. ■

People In The News

Please send announcements to Jan Shuxteau at jshuxteau@healthleaders-interstudy.com.
Announcements may also be faxed to 615-385-4979.



S. Ptacek

Kevin Ruth has been appointed CEO for **UnitedHealthcare's Mid Atlantic** region, replacing **Tom Barbera**, who is retiring. Ruth was chief operating officer of United's Mid-Atlantic plan, which serves members in Washington, D.C., Maryland, Virginia, Delaware, West Virginia, North Carolina and South Carolina.

Aetna has appointed **Steven C. Meholic** as the new head of Aetna Pharmacy Management. Meholic was most recently the vice president for specialty products at Magellan Health Services, and prior to that was a consultant in the Health & Welfare Practice of Towers Perrin and vice president of delivery systems management for United Healthcare.

Mike Burke has joined **Coventry Health Care** as vice president and national sales manager of Medicare distribution. Previously, Burke led the brokerage distribution division for one of the largest national markets of senior insurance products. At Coventry, he will be responsible for further developing Coventry's brokerage and retail network to support Coventry's Medicare initiatives. Coventry is based in Bethesda, Md.

Elder Health, which offers Medicare Advantage health plans in the Mid-Atlantic states, has appointed **Scott Tabakin**, **Jacob Furgatch** and **Scott Ptacek** to its senior leadership team. In addition, **Mary Ann Eull** was named vice president and executive director of Elder Health Mid-Atlantic.

Tabakin was named chief financial officer. He has a 25-year history working in finance in the healthcare industry. Most recently, he was the executive vice president and chief financial officer of AMERIGROUP. Prior to that he was executive vice president and chief financial officer for Beverly Enterprises, the leading provider of healthcare services to the elderly in the United States.

Furgatch was named chief administrative officer, and Ptacek was named executive vice president of sales and marketing. Furgatch, a 20-year veteran of healthcare management, will have companywide responsibility for claims and appeals, customer service, membership accounting, information technology and corporate operations. Furgatch has worked in a variety of healthcare settings including health plans, hospitals, medical groups, IPAs and large self-funded employer groups. He comes to Elder Health from PhysicianWebLink/Monarch Healthcare of California where he was CEO.

Ptacek was formerly the marketing officer of Health Net's senior products division and vice president of Medicare sales and marketing for Health Net of Arizona. Eull has 30 years of experience in managed healthcare, contracting and operations with major insurance companies and healthcare providers. She was the executive director of Medical Imagin Network Inc. In her new role, she will be responsible for Elder Health's Mid-Atlantic provider networks, including network management and provider contracting.

Gwen Skillern, senior vice president and general auditor for Maryland-based **CareFirst BlueCross BlueShield**, has been elected president of the National Association of Black Accountants. Skillern will serve as NABA's president for fiscal year 2007. The association represents more than 100,000 minority professionals in accounting, consulting, finance and information technology. ■

Wal-Mart Law Is On Again, Off Again

By Jan Shuxteau

Maryland's Fair Share Health Care Fund Act—popularly known as the Wal-Mart law—absorbed a serious blow when a federal judge in Baltimore overturned it in July, but within a week, Maryland's Attorney General J. Joseph Curran filed an appeal of the ruling.

Passed by Maryland General Assembly earlier this year, the first-of-its-kind Fair Share law requires companies with 10,000 or more employees to spend at least 8 percent of their payroll on employee healthcare or pay the state the difference. It was nicknamed the "Wal-Mart Law" because Wal-Mart is the only company in Maryland that the law affects. The law was supposed to go into effect in January 2007. Strongly supported nationwide by the AFL-CIO, which has been unable to unionize the retail giant, the Wal-Mart Law was supposed to build momentum to pass similar legislation throughout the country.

But that didn't happen. Similar legislation was proposed in 32 states and rejected in 28. "Fair Share' has not passed any chamber in any state legislature besides Maryland," reported Kelly Hobbs, Wal-Mart spokeswoman. "The Maryland law not only violated federal statute, it did nothing to control the cost of healthcare or improve access to healthcare. It's no wonder that no other legislature has passed a similar proposal."

CAHI Report. In June, the Council for Affordable Health Insurance, a trade association representing insurers and their members, as well as small businesses, physicians and insurance brokers, said the law did nothing to help solve the problem of the uninsured in the state. "Of course, the vast majority of Maryland's uninsured population—99 percent—does not work at Wal-Mart," according to CAHI.

The Wal-Mart bill opened the door to copycat proposals, noted the CAHI. A similar bill, H.B. 1510, mandating that small businesses pay a portion of their employees' health insurance, was introduced after the Wal-Mart Law passed. "While this 'Son of Wal-Mart' did not pass either legislative chamber before the Legislature adjourned its 2006 session, expect it to return in 2007. The precedent has been set," the report said.

Fair Share Saga. In 2005, Maryland's Democrat-controlled General Assembly seized on the idea of reducing the state's healthcare expenses by forcing Wal-Mart to provide more insurance coverage for its employees, many of whom use government-subsidized healthcare. They passed the bill over the objections of Republican Gov. Robert Ehrlich, who saw it as an anti-business measure that would not make health insurance more accessible to most uninsured. When legislators went home at the end of the session, Ehrlich vetoed the bill. They struck back, overriding the veto when they gathered again in January.

At that point, the Retail Industry Leaders Association entered the fray, filing a suit in federal court against Maryland's Labor Secretary Jim Fielder as head of the agency that would administer the law. The association, which includes 400 large retailers, argued that the new Maryland law would encroach on the domain of the federal Employee Retirement Income Security Act of 1974 by forcing businesses to contend with different laws for health coverage in different states. The attorney general's office argued for the law. U.S. District Judge J. Frederick Motz agreed with the association and granted its request for summary judgment.

VARIATIONS OF FAIR SHARE LEGISLATION

State	Bill	Action	Outcome
Maryland	HB 1284/S790	Employers of 10,000 must spend 8% of payroll on health insurance costs	Legislature overrode veto; judge ruled against law
Virginia	HB 2517/SB 6356	Disclosure of spending on healthcare	Died
West Va.	HB 4024/SB 147	Employers of 10,000 must spend 8% of payroll on health insurance costs	Died
Kentucky	HB 98	Employers of 10,000 must spend 8% of payroll on health insurance costs	Died in committee
Colorado	HB 1316	Employers of 3,500 must spend 11% of payroll on healthcare	Failed
Connecticut	SB 462	Retailers who don't provide health insurance and employ at least 5,000 must pay the state \$2.50 per hour per employee	Failed in committee

Source: National Conference of State Legislatures

Motz noted that the law did not try to generate revenue for the state but forced employers to provide a specific level of healthcare coverage for their workforce. In his 32-page opinion, he wrote: “The act violates ERISA’s fundamental purpose of permitting multi-state employers to maintain nationwide health and welfare plans, providing uniform nationwide benefits and permitting uniform national administration.”

More About The Appeal. Meanwhile, Maryland’s attorney general filed an appeal against the ruling despite the fact neither Fielder nor the governor favored this action. If the appeal fails, some legislators say they will craft a new bill for next session.

Kevin Enright, a spokesman for the attorney general’s office, noted that they “respectfully disagree with the court’s determination on several counts.”

In a statement, the attorney general said, “As to the substantive ground, we think the court erred in finding that the law is preempted by ERISA. Instead, as we argued to the court, Supreme Court precedent makes it clear that this law does not impermissibly impact health benefit plans. Employers may choose to pay the tax or avoid paying the tax in several ways.”

Stephen Cannon of the firm of Constantine Cannon in Washington, D.C., outside general council for RILA, said that the state would appeal by presenting its brief to the 4th U.S. Circuit Court of Appeals in Richmond on Sept. 22. He said that RILA would follow with its brief in October, and oral arguments are not likely to occur before December. He noted that a three-judge panel would decide the case.

Wal-Mart Takes Steps. During the last year, Wal-Mart took steps to stop criticism about its health benefits for employees. It expanded access to health benefits and provided low-cost premium plans. Effective in May, all part-time workers and their children were able to enroll in the company plans after workers had 12 months of work (half the former wait period) Additional changes begin in January. They will include:

- Copays on generic drugs for chronic conditions such as diabetes, hypertension, high cholesterol and infections will decrease from \$10 to \$3;
- The formulary of drugs will be increased;
- Average discounts of 20 percent on prescription drugs not covered on the health plan will be offered;
- Lowest premium (\$11 per month) Value Plans will be available to nearly half of Wal-Mart associates;
- The company contribution to employee health savings accounts will be upped to a maximum of \$2,400 per year.

OUTLOOK: *Maryland’s Wal-Mart Law has been a political football with the AFL-CIO and other groups coaching legislators behind the scenes. As predicted, variations of the bill were taken up by other legislatures, but most discovered that this law will not solve the problem of the uninsured, nor will it stop Medicaid from taking a chunk out of state budgets. With less than 1 percent of Maryland’s Medicaid population connected to Wal-Mart, it seems that the General Assembly’s passion may be misplaced.* ■

Healthcare Front, Center In Governor's Race

By Jan Shuxteau

Healthcare is center stage in the Maryland gubernatorial race with Gov. Robert L. Ehrlich announcing a new federal-state program to expand healthcare access for the working poor and Baltimore Mayor Martin O'Malley focusing on the nursing shortage and helping seniors navigate confusing Medicare Part D plans.

"Healthcare is a major issue in the state," said Steve Raabe, president of Opinion Works, a market and opinion research company in Annapolis, which often works in the healthcare industry. "I've seen two polls lately that show that healthcare and the lack of access to affordable healthcare coverage rank second in the state as a leading issue."

Raabe noted an Opinion Works survey of likely voters showed most would support a \$1 tobacco tax increase to pay for healthcare. "The survey shows that 55 percent of likely voters strongly support the tax because it would be dedicated to expand Medicaid and for a stop-smoking program for teens," he said. "If there wasn't an underlying concern about healthcare, taxpayers would not have been receptive to this idea."

The Election Trail. Ehrlich, the first GOP governor in Maryland in 40 years, is seeking re-election, running against Democrat O'Malley for the state's top office. Maryland is typically a blue state, where voters are nearly 2-to-1 Democratic. Some pundits claim that Ehrlich's victory in the last election was a rare event, but he's been relatively popular and is going into the primaries with an approval rating of around 56 percent.

However, Ehrlich is not popular with the Democrat-led General Assembly, which has been vitriolic in its dislike and overridden his vetoes more than 30 times. In the minds of

MAYOR MARTIN O'MALLEY'S HEALTHCARE PLANK

- » Make health insurance more widely available to their employees of small business by using tax credits and allowing a statewide insurance purchasing pool
- » Expand access to healthcare for children through the State Children's Health Insurance Program
- » Address Maryland's nursing shortage
- » Make prescription drugs more affordable
- » Reform medical reporting through information technology
- » Reduce disparities in minority healthcare, by increasing funding for community health centers and conditions that affect more minorities
- » Increase access to care in rural communities by dedicating more state resources to rural communities

Source: Martin O'Malley campaign

GOV. ROBERT EHRLICH'S HEALTHCARE PLANK

- » Increased access to affordable healthcare
- » Improving outcomes for people with disabilities
- » Allowing seniors to remain aging healthy in their home
- » Crafting relief to the medical liability system
- » Investing in and demanding improved outcomes for public mental health and substance abuse programs
- » Addressing health workforce shortages
- » Improving emergency preparedness programs
- » Investing in science and technology research

Source: Robert Ehrlich campaign

some voters, the fact that Ehrlich has taken on the General Assembly by vetoing bills such as the Wal-Mart law (later struck down in federal court), a 2 percent tax on HMOs (resulting in premium increases) and most recently a collection of early voting laws (later struck down in court) has made him a David to their Goliath.

What About O'Malley? O'Malley is no pushover, but he clearly has his work cut out for him on some issues. Both men have good ideas on healthcare, though their approaches are different.

"The governor's overall vision is to build on his record," said Shareese DeLeaver, Ehrlich's campaign spokeswoman. "That record includes a \$1.25 billion increase in Medicaid funding to serve 770,000 low-income Marylanders, children and people with disabilities. It includes expanding access to nine community health centers across the state, serving 37,800 additional Marylanders, and extending primary healthcare, including prescription medicines and mental healthcare."

Ehrlich also started the Department of Disabilities to improve the health of disabled Marylanders and implemented a Medicaid buy-in program to allow people to continue to work without losing their healthcare coverage. Under his watch, a new wraparound senior prescription drug program began, adding to federal benefits with state services for 30,000 low-income seniors.

In campaign releases, O'Malley said that he believes that healthcare "should be a right—not a privilege" for everyone, and he described what he called his "Paths to Progress" in healthcare. He said he would help to make insurance affordable for small business, reduce disparities in minority healthcare and address Maryland's nursing shortage, among other initiatives.

Irony Or Something. In his campaign literature, O'Malley notes that he fought for passage of the Wal-Mart bill, "even in the face of Gov. Ehrlich's veto." And this leads to a twist

in the election campaign. Attorney General Joseph Curran is O'Malley's father-in-law. After legislators overrode Ehrlich's veto and approved the law, the Retail Industry Leaders Association filed suit in federal court to stop it. Curran's shop fought the suit and lost.

Then Curran filed an appeal without the governor's approval. The state constitution forbids the governor from hiring his own counsel, which means Ehrlich has legal defense that favors his opponent.

"I look forward to continuing my administration's aggressive steps to improve healthcare quality, access and affordability in my second term of office," said Ehrlich in a report for constituents. "I recognize that there is more to do, and I will not waver in opposing meaningless health reform such as the Wal-Mart bill, pushing for real medical liability reform to reduce frivolous litigation and addressing the many complicated issues surrounding quality and cost of care for Marylanders in need." ■

Supplement Insurance: Will It Survive Part D?

By Paula DeWitt

Medigap insurance, long a health insurance staple, faces an uncertain future as it competes with the new Part D product and a revival in Medicare managed care products.

For many years, Medicare supplement—also known as Medigap insurance—has been a health insurance staple, supplying consistent and steady margins to the companies that have offered it to Medicare beneficiaries. Covering the out-of-pocket expenses that traditional Medicare doesn't pay, the product found a warm reception with the nation's seniors, particularly those living outside of urban areas. But it's a whole new ball game under the Medicare Modernization Act, which offered seniors a drug benefit as well as the opportunity to enroll in Medicare Advantage HMOs, PPOs and private fee-for-service plans.

Medigap By The Numbers. There were almost 10.4 million lives covered by Medicare supplement policies in 2004, the most recent year for which national membership data is available, according to the National Association of Insurance Commissioners, or NAIC. That's about a fourth of all Medicare beneficiaries.

The largest Med supp carrier is UnitedHealthcare. It accounted for roughly 21 percent of covered lives in 2004. The next-largest player is Health Care Service Corp. (which operates Blues plans in Illinois, Texas, New Mexico and Oklahoma), with just 4.2 percent of the market. As a whole, Blue Cross Blue Shield plans are heavily represented among Med supp carriers, with Blues plans in Massachusetts, Pennsylvania (Highmark), Minnesota, Florida and North Carolina among the top writers.

Medigap policies are largely standardized according to federal law, but the number of carriers and their particular offerings differ markedly by state. Prior to 2006, there were 10 standard plans (12 including the high-deductible versions of Plans F and J), which ran the gamut in terms of benefits offered. Some cover only a portion of the beneficiary's out-of-pocket medical costs, while others pay virtually all deductibles, other co-share payments, and even some prescription drug costs.

Only a minority of Medigap policies ever offered drug benefits, with just 8 percent of Medigap subscribers having the benefit, according to NAIC data. These plans were fairly expensive, offered only limited benefits and contained no catastrophic coverage (as Part D does). As a result, they never really gained great popularity.

By federal law, new Medicare supplement policies written as of Jan. 1, 2006, can no longer offer a drug benefit. That doesn't mean, however, that Med supp customers no longer have ready access to drug coverage. Virtually all of the large Medicare supplement companies—largely health insurance and life insurance companies—are either offering their own

Medicare Part D plan in conjunction with their Medigap plans or have formed a partnership with a Part D provider to offer the coverage. Companies desperately want to hang onto their Med Supp customers—the product is a lucrative one.

"A number of companies make pretty good money in the Med supp marketplace," says Joseph Marinucci, a director with New York-based Standard & Poor's. "I've seen margins range from 5 percent to 10 percent." (In contrast, Medicare PDP margins are expected to be in the 2 percent to 4 percent range).

"The product is underwritten," explains Brad Ellis, a director with Chicago-based Fitch Ratings. "The claims and run-outs are very well known. The spread of risk is pretty good. So, while it's not government-subsidized or your loss isn't limited unless you have reinsurance, there's still enough information to price it well for a good margin."

Making The Sale. UnitedHealthcare has 2.7 million Medigap members and offers its Medicare supplement product in conjunction with AARP, a partnership that began in 1998. (United also has the largest membership among the national stand-alone Part D prescription drug plans). The company sells Medigap through three channels—direct mail, telemarketing and television advertising, according to Jim Pogue, president of Ovations Insurance Solutions, a unit of United.

"We just had a record year of Medicare supplement sales," Pogue says. "We saw very little uptick above our normal [customer] lapse rate, which is only about 7 or 8 percent," with most due to the death of subscribers.

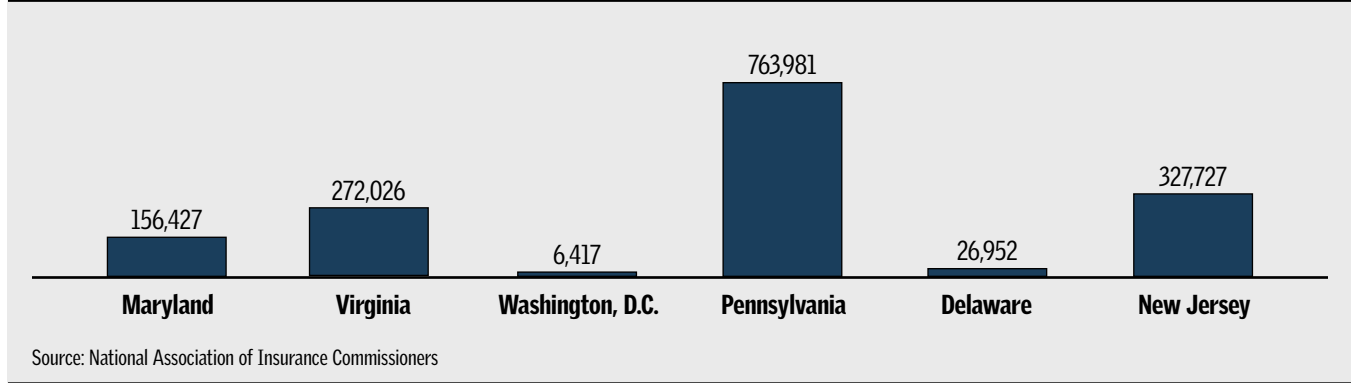
MARKET SHARE OF TOP MEDICARE SUPPLEMENT COMPANIES (2004)*

UnitedHealthcare	21%
Health Care Service Corp.	4.2%
Bankers Life and Casualty Co.	3.3%
Mutual of Omaha	3.3%
Health Alliance Plan of Michigan	3.1%
United American Insurance Co.	3.0%
BC/BS of Massachusetts	2.4%
UnitedHealthcare of NY	2.4%
Highmark (Pennsylvania)	2.2%
BC/BS of Minnesota	1.9%
BC/BS of Florida	1.8%
State Farm	1.6%
BC/BS North Carolina	1.6%

*By total number of policies.

Source: National Association of Insurance Commissioners

MEDICARE SUPPLEMENT, NUMBER OF COVERED LIVES BY STATE (2004)



United had 50 percent market share of all the people who had drug coverage within Medicare supplement, or about 500,000 people, before the beginning of Part D. About three-quarters have decided to keep their Medigap coverage, but drop the non-Part D drug coverage and add Part D. About one-quarter have opted to keep their Medigap policy with non-Part D drug coverage, as allowed for those who were already in a Med Supp plan with drug coverage.

Bankers Life and Casualty Co., a subsidiary of Consec, has formed a partnership with Coventry Health Care to offer its prescription drug plan. Bankers Life covers 315,000 lives nationwide (and its parent company covers another 110,000). “We have about 4,100 career agents across the United States,” says Bankers Life vice president Pat Fleming. “Most of our sales are in the household, where our agents sit down with a prospective client, provide product information and make a sale that best suits the client’s needs.” The agents sell primarily Bankers Life and Casualty products, including Medicare supplement, as well as certain products through partnerships, including the Coventry prescription drug plan. Through May 15, Bankers Life and Consec had over 150,000 PDP sales, significantly more than the company expected.

Fleming says that Med supp sales themselves have increased 20 percent over 2005. “I think a lot of that has to do with having this PDP option.”

Effective Aug. 1, new and existing members of CareFirst BlueCross BlueShield’s MediGap plan in Maryland, Washington, D.C., and northern Virginia became eligible for a 15 percent discount from the standard premium rate. The discount, which is for early enrollment in a MediGap-65 product in Maryland or a Supplement-65 product in the District and northern Virginia, is targeted to new and existing members who are age 65 or older and are within three years of first becoming eligible for Medicare coverage. A 69-year-old individual who became eligible for Medicare more than three years ago would not get the discount.

“The senior population is growing 2.3 percent annually, and we are constantly looking for ways to ensure that as many people are insured as possible,” said Gregory Devou, CareFirst executive vice president and chief marketing officer.

Blue Cross and Blue Shield of North Carolina has been marketing its Med supp products in conjunction with its stand-alone Part D products, and the company has been pleased with the results. “We definitely see that people are interested in both products,” says Drew Narayan, director of individual segment marketing for the North Carolina Blues, which currently has about 120,000 Med supp customers.

For its part, Blue Cross and Blue Shield of Florida, with around 200,000 Med supp members, according to NAIC data, has seen stable Medigap sales. “We don’t really see a lot changing with our [Medicare supplement] business due to Part D,” says Bruce Middlebrooks, spokesman for the Florida Blues.

But some don’t view the long-term Med supp trends very favorably. “We think that Part D will impact Medicare supp sales negatively,” says Fitch Ratings’ Ellis. “How much is hard to say. We just don’t think there’ll be as many new sales of these policies as a result of not having the drug benefit attached to it. People when they want a drug benefit will just go get a Part D plan.”

Still, others believe that Medicare supplement will continue to be a growing product because many people remain interested in the medical gap coverage. “It seems like the purchaser can still make the distinction between the general health coverage that they’re looking for and also make a separate choice about how to obtain Part D,” notes S&P’s Marinucci.

The Competition: Medicare Advantage. The major threat to Medicare supplement is not so much stand-alone Part D, which is being marketed in concert with Med supp, but Medicare Advantage plans, which directly compete with Medigap policies.

“Starting in 2008, Medicare supplement will see erosion in enrollment because the beneficiaries that are buying supps and pairing them with a PDP are going to find that the alternative product, Medicare Advantage, or an MSA [medical savings account], are much better values,” says John Gorman, president and CEO of the Washington, D.C.-based Gorman Health Group. “The HMO was always the product for the lower-income beneficiary and until the MMA [Medicare Modernization Act] was basically the only product that was offered. Now we’ve got

PPOs and private fee-for-service plans, which are going to be attractive to middle- and upper-income seniors.”

Even so, there will always be a large number of people that want the completely open access to providers that Medicare supplement offers, says S&P’s Marinucci. “For them, their preference is to spend relatively a bit more to keep with the broader access.”

Med supp premiums averaged \$1,755 a year for a 65-year-old female in 2005, according to the Jupiter, Fla.-based Weiss Ratings. But even with such hefty premiums, there will continue to be a large market for Med supp, says Donna O’Rourke, senior health analyst at Weiss. “There’s plenty of hesitancy about signing up with a Medicare Advantage plan,” she notes. “Many people are not comfortable with using a provider network and are also concerned that a plan may decide to discontinue services in the future if the product isn’t profitable enough.”

In addition, says O’Rourke, there are two Medicare supplement plans authorized by the Medicare Modernization Act (the so-called K and L plans) that may have appeal for seniors. These plans require greater beneficiary cost-sharing but are available for a lower cost. “Where the other Medigap plans will cover 20 percent of the approved amount that Part B [physician and outpatient costs] doesn’t cover, K will cover 50 percent of that 20 percent, and L covers 75 percent of it,” O’Rourke explains.

Still, even Med supp companies admit that Advantage products, particularly the new private fee-for-service plans (a Medicare replacement plan without a network or contracts, in which terms and conditions are presented to providers, who choose to participate or not) offer formidable competition to Medigap products. “Going into 2006,

there’s been better government funding for Med Advantage plans,” says Bankers Life’s Fleming. “As a result, they’ve really been able to enhance benefits or keep their premiums down to a certain extent.”

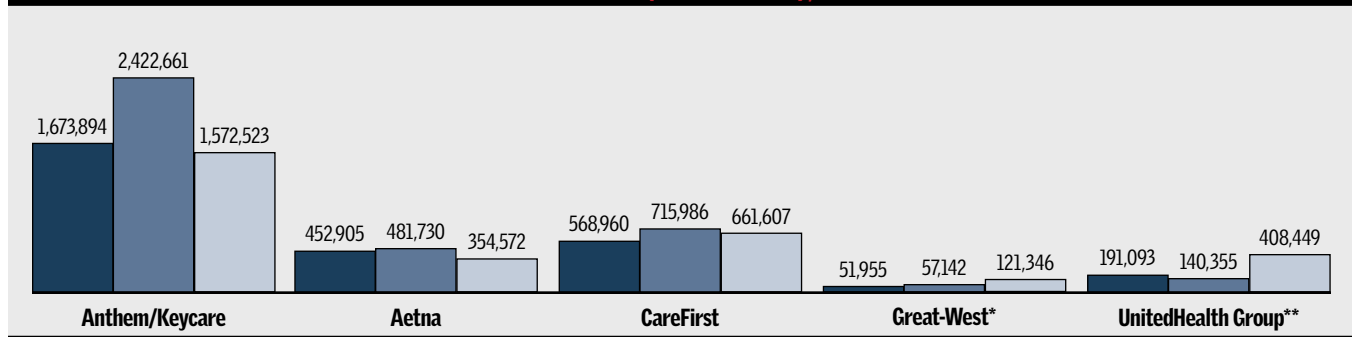
Fleming says that the private fee-for-service plans are really giving Med supp a run for its money. “We directly compete against those plans [PFFS]. Because they don’t typically have provider restrictions (as HMOs and PPOs do), in that respect, they’re similar to Med supp plans. Because of the advantageous funding from CMS, they’re able to come up with a package of benefits and premiums that can be pretty appealing compared to a Med supp.”

United’s Pogue agrees that PFFS offers competition to Med supp. “From a United perspective, we do offer all of the options to the individual—Medicare Advantage [HMO, PPO], private fee-for-service and Med supp. Really all three of them do compete against each other. It’s up to the consumer as to what’s best for their particular needs.”

Fleming notes, however, that funding for Advantage plans in 2007 does not appear to be as favorable as in 2006 and “as a result, I think the MA plans will be challenged to keep pace in terms of benefits and premiums.”

OUTLOOK: Look for the growth of Medicare supplement plans to flatten or decline as they compete with all of the new options available under the Medicare Modernization Act. The biggest threat is private fee-for-service plans, which, like Med supp plans, have few limitations on which providers members can see. Med supp plans still have some strong factors in their favor, especially the longtime loyalty of clients. But as new seniors become eligible for Medicare, Med supps will have a much harder time differentiating themselves in the market. ■

MID-ATLANTIC SINGLE-INSURER PPO ENROLLMENT (PURE + POS), LARGEST 5 PLANS



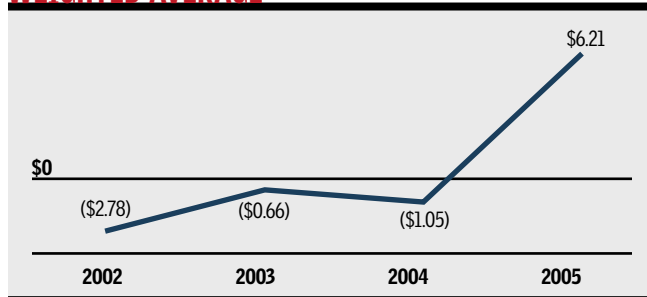
■ January 2004 ■ January 2005 ■ January 2006***

*January 2004 data for Great West was obtained through HealthLeaders-InterStudy's Managed Market Surveyor.

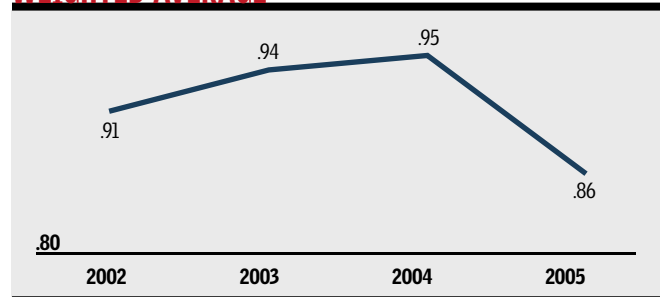
**January 2004 data for UnitedHealth Group was obtained through HealthLeaders-InterStudy's Managed Market Surveyor. In addition, beginning in 2006, United HealthCare Select Plus and Choice Plus products are reported as Fully-Insured and Self-Insured Point-of-Service. Only portions of the Select Plus and Choice Plus enrollment were previously reported, which causes the enrollment figures to vary.

***Data for January 2006 was obtained through HealthLeaders-InterStudy's Managed Market Surveyor.

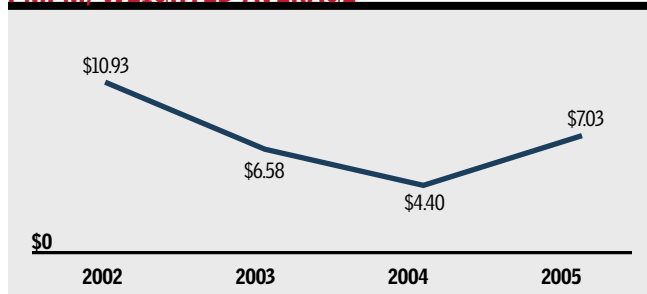
MARYLAND HMOs' NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE



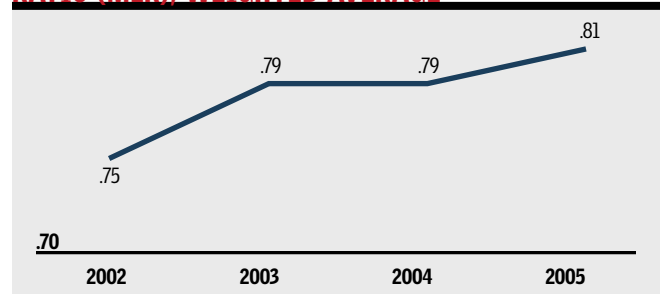
MARYLAND HMOs' MEDICAL LOSS RATIO (MLR), WEIGHTED AVERAGE



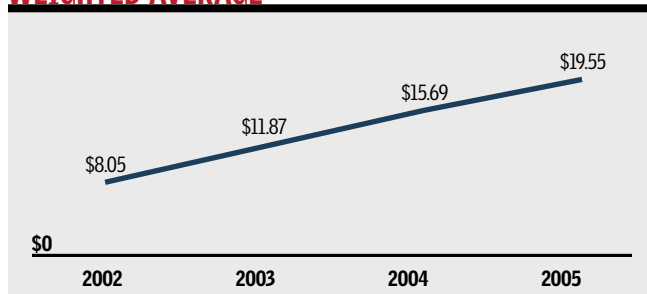
DISTRICT OF COLUMBIA HMOs' NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE



DISTRICT OF COLUMBIA HMOs' MEDICAL LOSS RATIO (MLR), WEIGHTED AVERAGE



VIRGINIA HMOs' NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE



VIRGINIA HMOs' MEDICAL LOSS RATIO (MLR), WEIGHTED AVERAGE

