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Texas

Health Plan Analysis

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In This Issue

3 Medicaid
- 3 Texas Hopes STAR Program Shines In Rollout
- 5 Expansion Puts New STARs On The Horizon

7 Medicare
- 7 XLHealth Expands Its Chronic Care SNP

9 Healthcare IT
- 9 Texas Blues To Mine Blue Health Intelligence

11 Health Plans
- 11 Midland Provider Group Quits UHC Network
- 12 CIGNA Subsidiary Gains Texas Certification
- 12 Texas Blues Adds Online Options, Rewards

14 Financials
- 14 Lone Star State HMOs Continue To Prosper

15 People

16 Elections
- 16 Texas' Kinky Election: Does Healthcare Count?

18 Consumer-Driven Healthcare
- 18 Survey Says Consumers Don't Research Health
- 19 Smart Debit Cards: The Holy Grail Of CDHP

23 Metrics

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Texas Hopes STAR Program Shines In Rollout

By Ric Gross

Texas' attempts to expand managed care into the Medicaid aged, blind and disabled (also known as ABD) population, a program known as STAR+PLUS, has often more closely resembled "Star Wars."

And while it's too early to say the credits have rolled on a happy ending, the saga has at least moved into chapter two. Effective Jan. 1, 2007, the STAR+PLUS program will expand from Harris County, where it has been in operation since 1998, to the Bexar, Nueces and Travis County service areas.

The expansion was supposed to happen in 2005, but was delayed by a contentious legislative debate over its effect on funding for Texas' public hospitals. Hospital supporters argued that public hospitals needed to retain favorable funding levels known as the upper payment limit.

The Texas Hospital Association and others fought to preserve those federal matching dollars, noting that they will amount to $150 million for the two-year period.

In order to preserve the UPL funds, the state crafted a plan that carves inpatient hospital services out of the HMO payment. This allows hospitals to charge based on fee-for-service rates and get reimbursed directly by the state, according to Ted Hughes, press officer for the Texas Health and Human Services Commission.

As part of that compromise, it was agreed that an integrated care management model proposed by the Texas Medical Association would be piloted in the Dallas area. ICM is an enhanced primary care case management program, blending the best features of primary care case management and an HMO.

"We support care management done in a way that doesn't jeopardize the federal funds for public hospitals," said John Hawkins, vice president of government relations for the THA. "We ultimately recognized the state needed to achieve some savings, and I think the compromise goes a long way toward doing that."

This sets the stage for the expansion, with enrollment mandatory in the 29 counties being served beginning January 2007. State officials say the expansion brings the ABD client base to around 140,000, and there are at least two HMOs in each service area, offering recipients some choice.

The Benefits Of ABD Managed Care. The Aged, Blind and Disabled category comprises those with complex and chronic health conditions who are the highest utilizers of care in the Medicaid population. This group is very poor and either aged or permanently disabled, and many states have been hesitant to move this costly and fragile population to a managed care system.

However, Medicaid HMO operators feel the coordination of care they can offer this population can reduce state healthcare costs. Many Medicaid ABD clients have disabilities ranging from cognitive impairments like mental retardation and mental illness to chronic illnesses like cancer, AIDS and congestive heart failure. Many also have physical disabilities that have left them wheelchair-bound or blind.

A care coordination program can address those functional limitations by providing transportation, in-home monitoring and other help. Such programs reduce hospitalization and emergency room use, and also may allow individuals to avoid being institutionalized. Long-term care constituted a third of all Medicaid spending, or $84 billion, in 2003, according to the Kaiser Commission on Medicaid and the Uninsured. The lion's share of this amount (about $56 billion) went to nursing homes.

"The single biggest benefit we bring to this population is the opportunity for them to get the support services they need in order to maintain their independence," said Aileen McCormick, CEO of AMERIGROUP Community Care of Texas. "We ensure that any and all medical services are provided at the right time and in the right setting.

"The beauty of this program is that our intervention and home assessments allow us to identify unmet needs, and correct that, thereby improving their health status, contributing to the reduction in inpatient stays," McCormick continued. "This is a great benefit for the members we serve—as has been evidenced by exceptionally high ratings on member surveys—as well as the state of Texas, evidenced by the decision to expand the program to other urban markets."

Potential For Savings. It's a program analysts agree could make an impact. Joel Menges, vice president with The Lewin Group, a Virginia-based healthcare consulting firm,

STAR+PLUS EXPANSION: AT A GLANCE

Service Area	STAR+PLUS HMOs
Bexar (San Antonio)	Molina Healthcare of Texas, Superior Health Plan, AMERIGROUP (Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson Counties)
Harris (Houston)	Evercare, Superior Health Plan (Brazoria, Fort Bend, Galveston, Harris, Montgomery, Waller Counties)
Nueces (Corpus Christi)	Evercare, Superior Health Plan (Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patrico and Victoria Counties)
Travis (Austin)	Amerigroup, Evercare (Bastrop, Burnet, Caldwell, Hays, Lee, Travis and Williamson Counties)

Source: Texas HHSC

HARRIS COUNTY PILOT: HMOs PRODUCED ONGOING ABD SAVINGS

- » Initial phase (Feb. 1998–Jan. 2000) savings = $4 PMPM
- » Second phase (Sept. 1999 to Aug. 2002) savings = $92 PMPM
- » Inpatient Hospital Stays down 28 percent
- » Community Based Service use up 38 percent
- » Personal Care Service use up 32 percent

Source: The Lewin Group

said the capitated Medicaid model has much to offer the ABD subgroup.

"High claims cost in the ER and pharmacy area are ones the HMO model can impact," Menges said. "Putting this population into a coordinated care model can save money in a constructive way rather than a destructive way.

"It's been really challenging for the state. I think what they have is the best Texas could get politically," Menges added. "If they don't take this in-between step, they are not going to get where they are trying to get in the long-term, which is full risk."

David Rousseau, principal analyst at the Kaiser Commission on Medicaid and the Uninsured, said more states are moving to Medicaid managed care because it gives them some predictability around cost. "Nationally we've seen the percentage of managed care enrollment for Medicaid moving upward since the mid-1990s. About 63 percent nationally are in Medicaid managed care," Rousseau said. "There's a good body of research showing Medicaid enrollees in managed care have relatively similar access to care patterns as fee-for-service enrollees. They are still getting the preventive check-ups and most of the care they need."

Harris Results. Texas is relying on the results of its successful Harris County pilot, which showed PMPM savings of up to $92.

"It's been a successful model there. If you compare the results of the Harris County pilot versus the same population in other parts of the state, you can't argue the program has not been successful," said Jared Wolfe, executive director of the Texas Association of Health Plans. "It has helped reduce ER admissions and provided coordinated care, and made sure beneficiaries had access to community care services."

New ABD Players. With the expansion, Molina Healthcare of Texas and Superior Health Plan are broadening their operations to take on the ABD population. Both plans will be competing with AMERIGROUP in the Bexar service area, while Molina joins AMERIGROUP and Evercare in the Harris area, and Superior joins Evercare in the Nueces service area.

California-based Molina serves Medicaid and Children's Health Insurance Program enrollees in a number of states, including California, Indiana, Michigan, New Mexico, Ohio, Utah and Washington, but is making its initial foray into Texas. Molina's Texas headquarters is located in Grand Prairie, with a satellite office in Houston. Molina is also opening a second satellite office in San Antonio.

Ann Koontz, vice president of health plan operations for Molina Healthcare, said Texas was a state primed for expansion.

"As we do in all states, we go through an evaluation process. Is it going to be a mandatory market? Yes in Texas. Does it have substantial market size? Yes it does," said Koontz said. "We felt Texas fit the bill on all the questions we go through when evaluating a market."

Koontz acknowledged the challenge of entering such a massive service area as Harris County with established players AMERIGROUP and Evercare. However, though new to Texas, Molina is anything but new to this line of business. The plan has 40,000 to 50,000 ABD enrollees across its various states.

Meanwhile, Superior Health Plan is no stranger to Texas, having served the Medicaid and CHIP population for some time, and the insurer has experience with the ABD population, operating such plans in Wisconsin and New Jersey.

"I think our strength is to recognize that one person with congestive heart failure is not the same as another person with congestive heart failure. We take the diagnosis of a person's condition and get involved to address the functional issues," said Rick Fredrickson, vice president for Supplemental Security Income and long-term care programs with Centene Corp.

"The key is the mandated functional assessments. This is a low-income disabled population; you can't just send them a postcard and say did you have your blood sugar checked today," he said.

The Veterans. Meanwhile, Evercare and AMERIGROUP already have their Texas models up and running, due to their participation in the initial Harris County pilot project serving about 60,000 beneficiaries. Still, there are challenges even for established players, as AMERIGROUP's McCormick notes.

"The biggest challenge for expansion is building a robust network in a short period of time, in order to comply with the Jan. 1, 2007, go-live date," she said.

"The long-term support services community has been a good vehicle for getting the word out to prospective members," McCormick added. "Additionally, we have reached out, and will continue to through the fall, to offer orientations and training sessions for providers."

McCormick agrees that in-home assessments are vital to the program's success. "Many of our members do not have working phones and live in extreme poverty," she said. "As a result, the at-home assessments provide invaluable information not only on the health status of a member, but also the living conditions that could affect health outcomes."

Evercare serves more than 100,000 members across the country with programs similar to STARS+PLUS in Ari-

zona, Florida, Massachusetts, Minnesota and Washington. In Texas, Evercare's provider network includes longtime members such as the Harris County Hospital District, The Methodist Hospital System and Doctors Hospital, along with new additions such as Christus Spohn Hospital System in the Nueces service area and the Seton Family of Hospitals in the Travis service area.

OUTLOOK: While the expansion of Medicaid HMOs for the Texas ABD population didn't happen as quickly as originally thought, things are now moving toward implementation. Plans are under the gun to get things up and running for the go-live date, while preparing to meet the savings the state envisions. But with the Legislature not meeting again until January, there are no road-blocks to stop the rollout from finally getting off the ground. ■

Expansion Puts New STARs On The Horizon

By Ric Gross

Texas' extreme Medicaid makeover is continuing its effort to move thousands of Medicaid beneficiaries into managed care, expanding its STAR HMO service area to the Corpus Christi area and adding new HMOs.

STAR is the Texas' managed care program for Medicaid recipients who receive cash through Temporary Assistance For Needy Families (TANF), are pregnant and have a limited income, or whose children have a limited income.

Primary-care case-management is being phased out from the urban service areas of El Paso, Dallas, Lubbock, Houston andSan Antonio, with PCCM members having until the end of December to voluntarily select an HMO. As of January 2005, there were 335,000 Medicaid members in the PCCM program statewide compared with around 770,000 in HMOs, according to HealthLeaders-InterStudy.

"It will be a change for providers who have operated under PCCM for a long time," said Jared Wolfe, executive director of the Texas Association of Health Plans. "So far the state is doing a good job with it. Invariably, things will come up when you go through a transition such as this. But the shift to managed care is smart move for the state. The transition will improve the efficiency of the program and increase the coordination of care delivered."

STAR HMO: AT A GLANCE

Service Area	STAR HMO Choices
Bexar	Community First Health Plan, Aetna*, Superior Health Plan
Dallas	AMERIGROUP, Parkland HEALTHfirst, UniCare of Texas*
El Paso	El Paso First, Superior HealthPlan
Harris	AMERIGROUP, UnitedHealthcare of Texas*, Molina Healthcare of Texas*, Community Health Choice, Texas Children's Health Plan
Lubbock	FirstCare, Superior Health Plan*
Nueces	AMERIGROUP*, Driscoll Children's Health Plan*, Superior Health Plan*
Tarrant	AMERIGROUP, Aetna*, Cook Children's Health Plan*

*Denotes New STAR HMO.

Source: Texas HHSC

New Players. The expansion has attracted new players to the Texas Medicaid market, including Aetna, Molina Healthcare and UniCare.

Aetna won Medicaid HMO contracts for the Bexar and Tarrant service areas, marking its re-entry into the Medicaid business after an absence of several years. The insurer has concentrated on its commercial business for the past few years, having sold or closed most of its Medicaid plans around the country. But Aetna officials saw Texas as fertile ground, and the insurer hopes to build off its brand awareness to gain Medicaid market share.

California-based Molina secured Medicaid and CHIP contracts in the sprawling Harris County area, where it faces competition from three established HMOs—AMERIGROUP, Texas Children's Health Plan and Community Health Choice.

Ann Koontz, vice president of health plan operations for Molina, said there's room in the sandbox for all players.

"We feel we are doing a good job in terms of our network looking good, and our relationship with the state is growing and developing," she said. "Our initial market share may be smaller than we'd like to see it in the beginning, but our intent is to expand."

During its second quarter 2006 conference call with investors, Molina officials projected overall Texas enrollment may reach 15,000 by the end of 2006.

Also entering the Texas Medicaid market for the first time is Illinois-based UniCare, a subsidiary of WellPoint Inc., the largest publicly traded commercial health benefits company in terms of membership in the United States.

UniCare secured the contract for the Dallas service area, where it will face established players AMERIGROUP and Parkland HealthFirst.

"We are entering an area where there are two established competitors who have been there awhile. We have to make sure we get the value we provide front and center so people realize what we have to bring," said Chad Westover, UniCare

vice president for state-sponsored business. “For us this represents a growth opportunity, and one we are looking forward to. We have some internal projections we are working off of, and I think we will be competitive.”

Westover said the plan will open a community resource center in the area with local staff as a home base of operations. “You need a local presence,” he said. “A member needs to know you’re accessible and you care. We make sure we use our community resource center to build that bridge, and make sure there is a place people can come to and we can outreach from.”

While UniCare is new to the STAR HMO program, it offers various commercial plans in the Lone Star State. “I think we have some advantages in that our name is known, but this is a new population for us,” Westover said.

OUTLOOK: Expect beneficiaries to, well, be the beneficiaries of the arrival of new players in the Medicaid market. Competition will be good, as more choice will lead to more efficient care, benefiting taxpayers as well. ■

XLHealth Expands Its Chronic Care SNP

By Ric Gross

Industry watchers expect an explosion of Medicare special needs plans targeted toward chronically ill patients in 2007, and recent moves by Baltimore-based disease management firm XLHealth certainly give credence to the theory.

In early August, the company announced plans to expand its SNP for chronically ill patients to five new states in 2007, including Texas, through its Care Improvement Plus plan. Care Improvement Plus has asked for formal CMS approval of similar plans in Arkansas, Georgia, Missouri and South Carolina. The company launched Care Improvement Plus in Maryland this year, and has plans to expand in that state.

In Texas, the plan will be entering a state with around 580,000 Medicare beneficiaries eligible to join, with marketing set to being Oct. 1, and open enrollment beginning Nov. 15 for a Jan. 1, 2007, effective date. The plan will enroll chronically ill Medicare beneficiaries living with diabetes, heart failure, chronic obstructive pulmonary disease, and/or end-stage renal disease.

"CIP was one of the trailblazers in chronic care plans and has a demonstrated track record in the successful management of complex geriatric cases," said John Gorman, president and CEO of Washington, D.C.-based Gorman Health Group.

Lee Spruiell, regional vice president for Care Improvement Plus, said Texas is a good market for a chronic condition SNP. "It's really about the number of people suffering from these diseases, particularly diabetes," Spruiell said. "Texas has a significant number of Hispanics, and they have a higher prevalence of diabetes."

According to information from the Texas Diabetes Council, for 2003, the mortality rates (per 100,000) for blacks and Hispanics were more than double that of caucasians, 55.3 blacks, 52.3 Hispanics, and 23.7 caucasians, respectively.

"There are a number of people with significant illnesses in the state and there are a lot of unfulfilled needs we are trying to address," Spruiell said. "It's what our company does, and this sprang really from our history."

SNPs Come Of Age. Designed primarily for dual Medicare-Medicaid enrollees, SNPs were initiated by the 2003 Medicare Modernization Act. Dual-eligibles constitute around 18 percent of Medicare beneficiaries and their expenses are, on average, double those of other Medicare beneficiaries. This population also accounts for around 40 percent of Medicaid costs, with most of that expense going toward long-term care. Most are over 65, but there are some younger (disabled) individuals in this group as well.

Medicare reimbursement rates for 2007 are 100 percent risk adjusted, meaning rates paid to the health plans are adjusted according to diagnosis and demographic factors.

"Chronic care SNPs got a small start this year but are poised to explode in 2007, driven by Medicare Advantage risk adjustment going to full implementation and advances in complex case management tactics," Gorman said. "We're expecting more than 75 new SNPs in Medicare next year, most of which will be chronic care plans."

The 2007 reimbursement mechanism makes a chronic care SNP attractive to a plan that can effectively apply coordinated care principles to manage cost, as savings created through this care is where plans can find profitability.

"There are a number of challenges involved. The model that seems to be the most feasible is something that would grow out of disease management firms, they at least have some experience in dealing with some of these kind of conditions," said James M. Verdier, a senior fellow at Washington, D.C.-based Mathematica Policy Research Inc.

"A lot of people have not been getting very good coordination of their care, and could be taking multiple conflicting drugs, and making frequent use of the ER," Verdier added. "There is plenty of opportunity to save money by better managing care for these folks, but you have to get them to enroll."

Verdier also noted that Medicare requires evidence that an enrollee in a Medicare Advantage plan has a chronic illness before it will pay those higher risk adjusted payments for that person.

Care Improvement Plus coordinates care through a care team comprised of a local healthcare manager, local field nurse and telephone coach nurse, each working closely with the beneficiaries' physicians.

TOP 10 SNPs BY ENROLLMENT*

Plan	Enrollment
MMM Healthcare, Inc.	88,497 (PR)
UnitedHealthcare	36,331 (Multiple states)
Gateway Health Plan, Inc.	26,016 (PA)
Keystone Health Plan East, Inc.	25,517 (PA)
Preferred Medicare Choice, Inc.	19,807 (PR)
MCS Life Insurance Company	18,591 (PR)
Managed Health, Inc.	17,557 (NY)
Three Rivers Health Plans, Inc.	13,945 (PA)
Southwest Catholic Health Network	13,731 (AZ)
University of Pittsburgh Medical Center	13,365 (PA)
Total	*273,357**

*51.4% of total SNP enrollment nationwide.

Source: Mathematic Policy Research, from CMS data as of July 2006

TOP AREAS FOR SPECIAL NEEDS PLANS

State	Plans	Enrollment
Puerto Rico	16	148,692
Pennsylvania	11	102,003
Arizona	13	47,135
Minnesota	11	33,692
Texas	13	28,736

Source: Mathematica Policy Research, from CMS data as of July 2006

The plan uses in-home monitoring equipment, including digital scales that record weight and notify the care team of potential problems. Spruiell noted that in heart patients, for example, excessive weight gain could be a sign of fluid retention. "We make contact with the patient and follow up if things fall outside the pre-established parameters," Spruiell said. "We suggest intervention to the patient and primary physician to avoid landing in the hospital.

"A lot of it has to do with helping support the members with their own management of their condition," Spruiell added. "The most cost-effective care is the right care provided at the right time at the right place."

Texas Landscape. While Texas has no SNPs focusing on chronic conditions, there are 14 other SNPs in operation, 13 enrolling dual-eligibles and one focusing on the institutionalized. In the Lone Star State, the top three players all operate plans for dual-eligibles—Evercare, PacifiCare and AMERIGROUP. Evercare has the most enrollment with 10,263, operating a plan in Harris County, while PacifiCare has enrollment of 3,162 in the Dallas-Fort Worth area and 3,273 in the San Antonio area, for a total of 6,435. AMERIGROUP showed enrollment of 5,438 in the Houston/Harris County area.

"There's a lot of competition in Texas. There are a lot of regular dual-eligible SNPs that have had a large amount of Medicare beneficiaries passively enrolled, especially in Harris County," Verdier said. "The fact Texas has a lot of duals has not gone unnoticed. Lots of firms have had a presence in Texas for some time, and they are all out trying to get as much enrollment as they can."

Spruiell said Care Improvement Plus is anticipating even more competition in Texas in 2007. "The things that make the market attractive to us we assume make it attractive to others as well," he said. "Historically Medicaid HMO plans are centered around larger urban areas. We are defined as a regional PPO, and will be serving every county in Texas.

"I do think we will have competition," he added. "I think because of our focus and statewide orientation we have a specific niche."

According to plan officials, approximately 8,111 providers in Texas have joined the plan's network. Spruiell said the plan will be marketing through a combination of brokers and agents, in addition to its own grassroots initiative and through its relationship with providers in the state.

OUTLOOK: XLHealth is no stranger to Texas, having just wound down a demonstration project in the state that enrolled 10,000 chronic care fee-for-service recipients. With experience in the state, and a genesis as a disease management company, chances of running an effective and profitable chronic care SNP in the Lone Star State are quite high. With full risk adjustment, however, the plan will have company in Texas, as more plans will be lining up soon. ■

Texas Blues To Mine Blue Health Intelligence

By Ric Gross

Armed with what company officials call an "unmatched level of information," the Blue Cross Blue Shield Association has unveiled what it hopes will be a major step forward in transparency and analysis of health data.

On Aug. 4, the Blues association announced the creation of Blue Health Intelligence, a HIPAA-compliant database of 20 participating Blues plans nationwide, including Blue Cross and Blue Shield of Texas. The database will offer its largest employers the opportunity to share claims information in order to make better, more informed healthcare decisions for their employees.

BCBSA says BHI arose out of a "strategic business need" in 2003, and in May 2004, the participating plans agreed to fund it proportional to their membership size. BCBSA will not contribute to the funding of Blue Health Intelligence.

The database is comprised of anonymous claims information from more than 79 million individuals that can be mined for information on healthcare trends and best practices.

Gail Boudreaux, executive vice president for Health Care Service Corp.—which includes the Blues plans of Oklahoma, Texas, Illinois and New Mexico—and co-chair of the initiative, said the intelligence will provide an unparalleled depth and breadth of information about a range of healthcare trends.

"This information would help all of us to develop and offer even more valuable employee benefits, tailored to their specific employee needs in a much more granular level than is available anywhere today," she said. "The amount and level of information BHI provides will enhance patient care and greatly inform healthcare decision-making."

BHI will be operational in 2007, with the first reports available in the fourth quarter of this year and employer groups benefiting initially. When fully operational, BHI will offer consumers the ability to compare detailed cost and quality information against their own health options on everything from drugs to doctors and hospitals to the treatment of chronic conditions.

How It Works. The aggregated health data will touch every zip code in the United States, allowing employers to compare cost or utilization trends in different areas of the country, for example.

"At the most basic level, employers want to know the total amount of claims paid, what the utilization looks like, how it compares to last year. They want to know how they can forecast," said Martin G. Foster, president of Blue Cross and Blue Shield of Texas. "Now there will be unique information they will be able to compare to similar groups in similar or different geographies, depending on what they want to accomplish. We will have information from other plans to establish benchmarks and see if there are similarities or dissimilarities across similar groups or geographies."

BLUE HEALTH INTELLIGENCE CHECKLIST

Key Questions	Answers
When will it be operational?	2007
Can members be identified?	No
What will be available initially?	Member enrollment data and medical claims data
How many lives are represented?	79 million
How has access to the data?	Participating plans only

Source: BCBSA

Boudreaux used the example of a Dallas-based department store with more than 800 retail outlets around the country that may have discovered its current employee healthcare costs are up 14 percent from the previous year. That company could take what it knows about its employees, such as age, gender and most prevalent health problems, and BHI would help construct a benchmark group of similar types of retailers, similar types of health, similar size of employees, etc.

"We'll provide enhanced capability to drill down and compare group and regional differences and further identify differences within those," she said. Also important will be the ability to identify disease management programs that can help for people who have this similar base, she said.

Local Blues plans will play a key role when it comes to obtaining the data. An employer customer of a Blues plan will work in partnership with them to develop the criteria, scope and context of the desired reports, and the Blues plan will deliver those reports back. Access will be limited to the Blues plans themselves, but reports will be tailored and custom developed for employers and customers.

"We are not saying here are the keys to the information," Foster noted. "I in Texas will not be able to pull out your specific information in Tennessee, for example. You get aggregate information to tell what the collective experience of the population in Tennessee looks like, and you'll be able to slice and dice it."

Instead of utilizing the Web, data in the BHI system travels through a private secure system and will not be a part of BCBSA's electronic health record, which requires member level data. BHI will be producing only aggregated, de-identified data.

The plan has piqued the interest of industry watchers. Bruce Landon, M.D., associate professor of healthcare policy

at Harvard Medical School, has followed transparency initiatives in Massachusetts and spoke favorably of the plan.

"BHI has the potential to be a national resource for healthcare information that could provide an invaluable resource for research," Landon said. "The database contains more patients than the Medicare database, which has heretofore been considered the gold standard. The key will be what are the processes put in place to keep the data up-to-date and readily accessible for research purposes, and the extent to which the database is used to generate useable and generalizable information."

Steve Cyboran, vice president and consulting actuary in the Chicago office of The Segal Co., said if things stay on track, the results could be promising.

"If they are successful at aggregating the data I think it will be successful, if the funding and patience holds out to make it happen," Cyboran said. "When you are talking about aggregating all this data, it's a lot like building a house, sometimes it takes longer than anticipated. But any time you can get this kind of information into people's hands, it is a good thing."

Blues officials stress the BHI will be the largest healthcare database to date, and Foster said trying to aggregate data from multiple insurance companies is a challenge.

"What makes ours different, for example, in Texas we are in 254 counties, with members in all counties and providers in 252 counties," Foster said. "We have membership in both urban and rural areas across the state. A lot of our competitors collecting data will have information on members primarily from central major metropolitan areas. The breadth of our data helps separate us, and a very diverse population will be included in the database. I don't think you will find a more credible large database than the Blues. I don't think anybody can do it on this level."

Susan Strate, M.D., chair of the Texas Medical Association's Council on Socioeconomics, expressed concern over the inherent limitations of claims data.

"Claims data is the most cost-effective way of gathering data, but it is not reliable in terms of quality and effectiveness as it's not evidence-based scientific data. Claims data can be very misleading," Strate said. "There needs to be a partnership to make the data credible and usable. Physicians have to have a part in this to make sure it's scientifically-based data, including information extracted from medical records."

OUTLOOK: The sheer volume of data available in this initiative does set it apart from the field, but as with a movie script, it looks good on paper but what gets put on the screen is the legacy. But the script certainly shows tremendous potential to make good things happen, and with the collective brain trust behind this initiative, odds of success are greater than odds of failure. ■

Midland Provider Group Quits UHC Network

By Ric Gross

UnitedHealthcare, currently in the midst of high-profile provider contracting disputes in Wisconsin and Colorado, can add Texas to the list—albeit on a smaller scale.

Whereas Colorado and Wisconsin feature battles with major hospital systems around metropolitan cities, Denver and Milwaukee, respectively, the dispute in Texas is with a surgical group in Midland, a rather remote location in Texas' sprawling landscape.

Still, it's a dispute with an impact on customers. Citing a general displeasure with the insurer's reimbursement rates, Midland Surgical Associates pulled out of the UnitedHealthcare network in Midland, where the insurer has around 14,000 members. Statewide, the plan has around 2.5 million members.

According to *The Midland Reporter-Telegram*, Midland Surgical Associates takes three-fifths of the emergency calls at Midland Memorial Hospital. The group wanted higher reimbursements, and when United balked, the physician group dropped from the network.

"We feel we provided them with a fair contract that was competitive based on what the market rates are," said UnitedHealthcare spokeswoman Cheryl Randolph. "We have other providers, so capacity isn't an issue. We are open to continuing discussions."

Midland Surgical Associates may want to follow what's happening in Wisconsin and Colorado. United's contact with Froedtert & Community Health in Wisconsin, which includes Froedtert Hospital, Wauwatosa, and Community Memorial Hospital, Menomonee Falls, is set to expire Jan. 1, 2007, with the system becoming a non-participating provider on Nov. 1 unless a new agreement is reached.

United is seeking a contract that includes fixed rates, and its current contract with Froedtert includes no fixed pricing. Froedtert, meanwhile, isn't happy with the reimbursement level United is offering, a familiar refrain in such disputes.

In Colorado, things are rocky there, as well. United's talks with HCA's HealthONE hospitals dissolved recently over reimbursement rates. In Texas, as in Wisconsin and Colorado, there will have to be some meeting in the middle for these marriages to overcome their seemingly irreconcilable differences.

"UnitedHealthcare is getting pressure from employers to slow the renewal increases and competitive pressure from Humana and the Blues, as brokers market those plans," said Andy Serio, president of Milwaukee's Health Care System Consultants Inc., who has been following United's various contracting battles.

Immovable Object. "United's response, nationally, is to negotiate with healthcare systems on the basis of fixed fees rather than discounts. Fixed fee negotiations are generally not acceptable to large healthcare systems, involving teaching and tertiary care," Serio added. "Thus the current situation is 'an immovable object against an irresistible force.'"

Numerous problems will arise as the Jan. 1, 2007, health insurance renewals approach, Serio said.

"Employers will be faced with uncertainty about their employees' healthcare providers being in-network, and apprehensive disgruntled employees will result unless the contracts between United and the healthcare systems are settled by Nov. 1," Serio said. "If not, employers may be forced to market their health insurance programs in a very short time frame. It may not be 'Happy Holidays' this year for those employers."

Jim Watt, president of Houston-based healthcare consulting firm Employee Benefits Solutions Inc., said the situation has a familiar ring to it.

"It's the same kind of issue we've seen before," he said. "A provider organization doesn't like the contract and voices their opinion in a very public way, only to have employer outrage bring the partners back to the table." ■

UNITED'S CONTRACT BATTLES

Provider	Market	Contract Expiration
Midland Surgical Associates	Midland	July 1
Froedert & Community Health	Eastern Wisconsin	Jan. 1, 2007
HealthOne (HCA)	Denver	Sept. 1, 2006
HCA	Tampa Bay, South Florida	Aug. 29
Sumner Regional Medical Center	Gallatin, Tenn.	Sept. 30

Source: News reports

CIGNA Subsidiary Gains Texas Certification

By Ric Gross

Philadelphia-based Intracorp, a subsidiary of CIGNA Corp., has been certified by the Texas Department of Insurance as a Workers' Compensation Healthcare Network, making it one of the first providers to gain certification in the wake of sweeping workers' compensation reforms.

The workers compensation overhaul, approved in 2005, created Workers' Compensation Healthcare Networks with the hope of controlling escalating workers' compensation costs and improving return-to-work results.

Intracorp Disability Management aims to offer Texas employers, TPAs and carriers an additional resource for managing their workers' compensation costs and for returning employees to productive work. Their plan includes aggressive case management, network-defined utilization review, treatment and return-to-work guidelines, a return-to-work focus and fee management.

Intracorp describes its plan as a "best-practice managed care program" which includes a PPO portfolio that enables customers to define the provider network solution that best meets their needs.

Under the law, entities participating in the Workers' Compensation Healthcare Networks must be approved by the commissioner of insurance and "must adopt treatment guidelines, return-to-work guidelines and individual treatment protocols which must be evidence-based, scientifically valid, outcome focused, and designed to reduce inappropriate or unnecessary healthcare while safeguarding access to necessary care."

"The biggest hurdle was to obtain certification, which we did," said Tammy Bradley, director of case management and product management for Intracorp. "It's now a matter of implementation with our customers."

Certified self-insured employers and carriers are not required by law to participate in a WCHCN, but if they do, any employee who is injured on the job and lives within the service area must choose a treating doctor who is in the WCHCN. Exceptions to this rule include emergency care and/or when the employee designates that an HMO primary care provider be his or her treating doctor for a workers' compensation injury. Designated HMO primary care providers who treat an injured worker must adhere to the WCHCN's case management process and utilization guidelines.

TEXAS WORKERS' COMPENSATION REFORM GOALS

- » Addresses specific problems with the Texas workers' compensation system
- » Curbs excessive medical utilization resulting in high medical costs
- » Improves poor return-to-work outcomes
- » Allows for the creation of certified managed care networks (WCHCN)
- » Controls medical spending
- » Reduces disability durations

Source: Texas Department of Insurance

Procedures. Bradley defines the program as a "medical case management gatekeeper model."

"We use built-in early intervention for predictive modeling. We will do an evaluation and review on all lost time cases for the appropriateness of medical cost management, for example. In addition, we have a list of procedures that require utilization review," Bradley said.

Bradley says the company's return-to-work component includes an early intervention with the employer.

"We will work with employers to come up with a transitional work alternative if the employee can't perform the essential functions of their regular job," she said. "If they can't return to their regular job, we will work with employers to modify their job on a temporary basis. If that is not possible, we'll look at a transitional work alternative for the employee, with a goal of eventually returning to work in the same job."

Intracorp managed slightly more than 1.2 million cases in 2005 with a staff of more than 2,200 certified case managers. ■

Texas Blues Adds Online Options, Rewards

By Ric Gross

Blue Cross and Blue Shield of Texas is rolling out new Web-based tools to make online healthcare purchasing almost as easy as online Christmas shopping.

In May 2006, the insurer unveiled a new electronic quotation and enrollment vehicle for its individual health insurance plans, giving consumers the ability to find the benefits and rates they want and submit applications online. This tool pairs nicely with Blue Cross' Personal Health Manager, introduced last January, which allows members to access secure wellness resources, including an "Ask A Trainer" or "Ask A Nurse" feature, for example, as well the option to take part in a health risk assessment.

PERSONAL HEALTH MANAGER FEATURES

- Ability to set up a personal health record to keep track of and manage health information
- Ask registered nurses health-related questions
- Request nutrition, fitness and weight loss advice from team of certified personal trainers
- Access online content such as health and medical information, wellness tracking tools, videos and interactive tutorials
- Receive targeted wellness and condition-specific information

Source: BCBS of Texas

Now the insurer is adding a new twist to the Personal Health Manager, introducing its "Blue Points" rewards plan in January 2007 for those with Personal Health Manager access. With this feature, plan participants will be able to gain points for participating in healthy lifestyles, and in turn will be able to put those points toward things such as exercise equipment, gift cards, etc.

If You Build It, They Will Come. So far, the online quotation and enrollment feature has been a hit, said Randy Starns, director of consumer markets for the Texas Blues

"It has been met with a great deal of market awareness and demand in a short amount of time," Starns said. "We have had more than 174,000 quotations and close to 6,000 have applied online, and we're real pleased with that. We expect that number to increase as awareness grows in the market."

Prior to the rollout, the plan educated its agent community on the new feature, and adjusted its Web site so the new quotation and enrollment option was easily accessible for consumers visiting the site. "We just started to run commercials [on Aug. 28] and we have seen a significant pick-up already," Starns said. "We had more than 800 hits the first day the commercial ran."

When accessing the tool, consumers will be able to compare prices of plans, compare benefits, and then pick the product that best fits their needs. Payment can also be submitted electronically. Starns said the freedom to access the feature at any time is attractive to consumers, as with work and family obligations taking precedent, it could be late evening after the children have been put to bed, for example, before decisions such as healthcare choices are discussed and initiated.

And there are other bonuses to a tool like this, as well, Starns said. "The transaction is paperless, which makes things much quicker, and it eliminates mail time," he said. "Overall, it cuts the basic processing time by three to four weeks on average. Also it makes a difference in cost—there's the cost of paper, printing and the filing system. We hope it will help us hold the line on some of the increases that occur."

The online application also gives plan officials information that can't be gleaned from a paper transaction. "There is such a rich, robust amount of information that is available to us without having to bother members through surveys," Starns said. "If someone stops during the process of filling out the online application, we know where they stopped and on what question. If a lot of people are stopping at that point, we can say what is it about that question that is proving to be problematic for the consumer?"

Healthy Lifestyles. Meanwhile, groups who are a part of the plan's Blue Care Connection program have access to the Personal Health Manager, which has seen usage increase steadily since its launch.

According to Mary Millar, director of product development and administration for the Texas Blues, in April the tool had about 1,300 unique log-ins, while by August that number had swelled to more than 11,000.

"This offers consumers a one-stop shopping arrangement for wellness resources," Millar said. For example, if a consumer is suffering from hypertension, they will be able to look up articles online about the subject, or if they are looking for ways to eat healthier, they can access a meal planning tool.

"We also have targeted messages aimed at keeping people healthy, such as reminding females to get a mammogram, for instance," Millar said. "There is also a security messaging system, which is totally secure and private. You can ask a nurse or trainer a question and get feedback, unique responses to your questions."

As for the Blue Points reward system, Millar said it has been piloted with a few employer groups and feedback has been positive. "We hope it will encourage members to use the Personal Health Manager, and help members maintain healthier lifestyles," Millar said. "Employers are looking to help their employees maintain healthier lifestyles. This is a tool to help them do that." ■

Lone Star State HMOs Continue To Prosper

By Ric Gross

Though not quite on par with numbers from 2004, Texas HMOs kept alive a four-year streak of profitability in 2005, according to year-end numbers from HealthLeaders-InterStudy.

Texas HMOs overall posted net income of $187.7 million in 2005, down from $194.2 million in 2004, but still up considerably from 2003's take of $163.7 million. Average net income per member, per month, however, increased to $7.60, compared to $5.70 in the year prior. Overall profit margins, meanwhile, continued their year-over-year uptick, coming in at 3.08 percent for 2005, compared to 3.02 percent for 2004 and 2.35 percent for 2003. Meanwhile, average medical loss ratio declined slightly to 0.82.

Several plans are solidly in the black, but only CIGNA and Scott & White Health Plan increased total net income from the year prior. CIGNA HealthCare of Texas reported net income of $16.6 million for 2005, up from 2004's $15.6 million. CIGNA saw its profit margin increase to 7.32 percent for 20005, compared to 6.44 percent the year prior.

Meanwhile, the perennially profitable Scott & White Health Plan bounced back a bit, recording net income of $3.9 million for 2005, compared to $2.7 million for the year prior, with a profit of 0.87 percent, up from 0.61% in 2004.

Moving on to other major players, those leading the way in profitability—but down a bit from 2005—include Aetna Health Inc., AMERIGROUP Texas (Medicaid HMO) and Humana.

Leading the way was Aetna, which closed 2005 with net income of $39.7 million, dipping from 2004's year-end tally of $43.6 million. Likewise, its profit margin dipped, from 2004's 4.36 percent to 4.10 percent in 2005. Aetna recently made a move into the Texas Medicaid market, and as of Sept. 1 began service for the Medicaid and Children's Health Insurance Program (CHIP) populations in Bexar and Tarrant service areas. The plan sees good opportunity in Texas and is hoping the renewed push into the Medicaid market will pay dividends financially.

One of the established Medicaid HMOs Aetna will be competing with for members, AMERIGROUP, has seen steady growth in Texas over the years, particularly in the Fort Worth market. Financially, the plan was down a bit from 2004, with 2005 net income of $20.7 million, compared to $25.2 million the year prior, and a profit margin of 2.44 percent, down from 2004's 3.42 percent. Still, that's up from 2003's net income of $8.3 million for the insurer.

Now under the UnitedHealthcare banner, PacifiCare of Texas Inc. closed 2005 with net income of $16 million, compared to 2004's $19.7 million, with a profit margin of 1.70 percent (compared to 2004's 2.70 percent). The plan's profitability can be tied to the success of its Secure Horizons Medicare product, with the insurer recently expanding its Secure Horizons Gold health plan for dual eligibles in the Texas counties of Johnson, Kaufman, Rockwell and Ellis.

And while, overall, most plans saw profits dip, the picture is much rosier than the bleak portrait of the late 1990s and early 2000s. HMOs in Texas lost a combined total of $326.4 million in 1999, worsening to $471.5 million in 2000 and $463.3 million in 2001. Things began to turn in 2002, with plans posting a combined net income of $11.8 million. The return to profitability was due in part to plans shedding money-losing membership, raising premiums and reducing medical costs.

"One of the criticisms has been about the pricing wars going on. It looks as if that may be subsiding, and plans are much more willing to engage in disciplined pricing," said Jared Wolfe, executive director of the Texas Association of Health Plans. "Texas is a really competitive market. It doesn't have two or three plans with 60 percent to 70 percent of the enrollees. But there seems to be a move toward being more disciplined in pricing."

OUTLOOK: Texas HMO financials are still looking good overall, considering the troubles of several years back. Plans will have to continue keeping a tight rein on costs in order to continue the profitability streak into 2006 and beyond, however. ■

2005 FINANCIAL PERFORMANCE FOR TEXAS HMOs

Plan	2004 Net Income, Profit margin	2005 Net Income, Profit Margin
Aetna	$43.6 million, 4.36%	$39.7 million, 4.10%
AMERIGROUP	$25.2 million, 3.42%	$20.7 million, 2.44%
Humana	$29.3 million, 4.41%	$20.8 million, 4.20%
CIGNA	$15.6 million, 6.4%	$16.5 million, 7.32%
PacifiCare	$19.7 million, 2.70%	$16 million, 1.70%

Source: HealthLeaders-InterStudy

People In The News

Please send announcements to Ric Gross at rgross@healthleaders-interstudy.com. Announcements may also be faxed to 615-385-4979.

S. Ptacek

P. Feyen

Elder Health, which offers Medicare Advantage health plans in Texas, has appointed Scott Tabakin, Jacob Furgatch and Scott Ptacek to its senior leadership team. In addition, Patrick Feyen was named vice president and executive director of Elder Health Texas.

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, a 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.

Feyen previously served as president and chief executive officer of PacifiCare of Texas and Oklahoma. Prior to joining Elder Health, he served as president of The Feyen Group, a healthcare consulting firm. Feyen will be responsible for Elder Health's provider networks in Texas, including network management and provider contracting.

Amy Schornick has been named vice president of network operations for **CIGNA's** North Texas and Oklahoma markets, company officials announced. Most recently, Schornick served as the director of contracting for Texas Health Resources, leading managed care contracting and strategy and reengineering operations to improve efficiencies. Her background also includes leadership positions with Theraphysics, Columbia/HCA and tenure with Anthem Health. ■

Texas' Kinky Election: Does Healthcare Count?

By Ric Gross

Texas' gubernatorial race has all the makings of a hit reality TV show. After all, one candidate goes by the nickname "Grandma" and is the mother of a pair of Bush Administration power brokers, while another candidate is, well, Kinky.

And if Independent candidate/author/humorist Kinky Friedman wins, he's bringing singer/songwriter Willie Nelson with him as his top energy czar. Seriously.

Of course, all this makes for grand theater. In a four-way scramble, incumbent Republican Gov. Rick Perry is squaring off against independents Carole Keeton Strayhorn, nicknamed "Grandma" and mother of Mark McClellan, outgoing administrator of the Centers for Medicare & Medicaid Services, and Scott McClellan, former press secretary for President Bush; Friedman; and Democrat Chris Bell.

But what role, if any, will healthcare play in the debate? Arguably, healthcare should be a pressing issue in Texas, which has the highest rate of uninsurance in the nation with 24.6 percent of its population uninsured. The state also has had a chaotic privatization of its Medicaid and Children's Health Insurance Program enrollment system.

But political observers say the healthcare issues haven't exactly caught fire with the electorate, at least not so far.

"This is one of the weirdest elections I've seen for governor in my 33 years here," said Bob Bezdek, political science professor at Texas A&M University-Corpus Christi. "The Republican Party is in charge in the state, and it would be unlikely for someone other than a Republican to win, except with this crazy four-way race something strange could happen. I'm telling people Rick Perry will probably win, but I wouldn't bet a lot of money on it."

A Problem For Perry? Perry's opponents are trying to make an issue of Perry's record regarding state-sponsored health programs. Texas has a five-year, $899 million contract with Accenture to operate a call-center-based enrollment system for Medicaid, food stamps, CHIP, Temporary Assistance for Needy Families and Medicaid long-term care. At the same time, Texas made it more difficult for families to stay in CHIP, instituting an asset and income reverification and a bi-annual re-enrollment fee for families in poverty.

CHIP enrollment, which had been declining since legislated changes first took effect in September 2003, went into a steeper freefall since December 2005, falling to 295,331 the beginning of August, down from 322,898 in December 2005.

To stop some of the bleeding, the state has continued coverage for 28,000 children who were slated for disenrollment, and has given families more time to pay the CHIP enrollment fee and provide needed information. The state also shelved further rollout of the system because of reports of long wait times, high call abandonment rates, a backlog of applications and lost applications.

THE CANDIDATES

- Gov. Rick Perry—Republican, www.rickperry.org
- Chris Bell—Democrat, www.chrisbell.com
- Carole Strayhorn—Independent, www.carolestrayhorn.com
- Kinky Friedman—Independent, www.kinkyfriedman.com

Source: Candidate Web sites

But the privatization issue hasn't become political kryptonite for the governor, despite efforts by Strayhorn and Bell to make it so. "For Bell it's really been a centerpiece of his discussion," said Harvey Kronberg, a Texas political analyst and publisher of *The Quorum Report*, a newsletter on Texas politics and government. "Strayhorn has been all over the map, it's not clear what the theme of her campaign will be other than she's not Rick Perry. And Kinky has no message at all except for wisecracks.

"In a typical Texas election you have half a million voters in an off-year [non presidential]," Kronberg added. "The profile is empty nester, white, with medium income, and that has not been a constituency that is real engaged with things like CHIP and Medicaid."

Kronberg said while Perry has never enjoyed extremely high marks during his governorship, he's kept his traditional Republican base. Kronberg said as things stand, Perry is leading the pack at around 35 percent in the four-way race.

"I think Perry will be able to hold that base, and that base is not one who cares about [Medicaid and CHIP] issues. The evangelical right is more concerned about end of life and prelife healthcare than issues like administering health insurance for children," Kronberg said. "Bell is making a case that if Democrats come home and vote, they can win. The normal Democratic vote is typically about 40 percent. He is saying if he could get that base out then he could beat Perry, and CHIP is more of a concern to the traditional Democratic base. But can Bell raise enough money to own the microphone?"

The CHIPS Are Down. And yet the CHIP controversy has not gone away. Bell has hammered home the fact he feels the Medicaid and CHIP situation has been mishandled, and between jokes, Friedman has been critical as well. Strayhorn, as state comptroller, has leveled her own criticisms, though Bell has asserted Strayhorn supported the privatization in 2003.

So where does this leave Perry? His camp has said the privatization problems are all solvable, and Perry spokesman Eric Bearse told the *Austin American-Statesman* that declining enrollment in public health insurance programs "is a positive thing that reflects a growing economy," noting around 4,000 were dropped from CHIP in July due to income being too

high. This is a normal occurrence, however, as every month some children lose coverage at renewal due to a higher income, and a consistently larger number are moved from CHIP to Medicaid because their income has dropped.

But on a positive note for the program, August CHIP renewals are up, and Perry could point to those renewals and claim his fixes are working.

"That suggests that should it become a real campaign issue, Perry will point to [the renewals] and say, 'we've turned the corner,'" Kronberg said. "The feeling is he's building a defense in case it does become a real issue."

According to Austin's Center for Public Policy Priorities, CHIP renewal rates improved, at more than 70 percent for June-August compared to 50 percent to 57 percent from January through May.

"The renewal rate has improved a bit over the summer, but we are still below where we need to be and aren't out of the woods yet," said Anne Dunkelberg, health policy analyst and assistant director at the Center for Public Policy Priorities. "It's really hard to say how it will play out as a campaign issue, but the bottom line is the [eligibility contract] is still a fiasco."

The Home Stretch. With quips like, "I'm not pro-choice or pro-life, I'm pro football," Friedman garnered guffaws, but has he garnered votes? The answer is probably yes, but not nearly enough to pull a Jesse Ventura.

Lee Almaguer, a government professor at Midland College, said Perry and Bell are going after the partisan establishment vote and are hoping Texans will dismiss the independent candidates, no matter how funny they are.

"Both established parties are hoping to get their supporters to vote a straight ticket, which is what has been happening in Texas," Almaguer said. "And that is also what has made the Republican Party successful and the dominant party in Texas."

Still, the race will be an interesting to watch down the stretch, as candidates begin to hit the airwaves and delve deeper into their agendas. Strayhorn recently made an effort to bring healthcare to the forefront by unveiling her healthcare plan, which calls for full restoration of CHIP. In announcing her plan, Strayhorn said Texas "ought to ashamed" when it comes to the state's burgeoning uninsured rate.

OUTLOOK: Things certainly haven't been dull in Texas as the Lone Star State steamrolls toward this fall's gubernatorial election. Many may hope that Texas gets Kinky this year—if nothing else it would be a hell of an inauguration party. But we interrupt this vision to get back to reality-the Republican base will put Perry back in office, and there will be no voter mandate for sweeping healthcare reforms in the legislature, either. Still, ya never know... ■

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 as 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 was readily available.

Opinion Research Corp surveyed 1,000 adults in June. The Guardian Life Insurance Company of America markets Destiny Health Plan in Texas along with Virginia, Washington, D.C., Maryland, and Illinois. 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 still receive traditional insurance.

"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.hospitalcompare.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. 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 health care, a concept that puts consumers in charge of their

THOSE LIKELY TO SHOP FOR MEDICAL SERVICES

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

Source: Opinion Research Corp.

CONSIDERATIONS WHEN LOOKING FOR MEDICAL CARE

Consideration	% 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.

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

Destiny Health Plan includes an incentive-based wellness program that 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 of it 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. ■

Smart Debit Cards: The Holy Grail Of CDHP

By Chris Lewis

Imagine the day when buying healthcare is as easy as purchasing prescription drugs at Wal-Mart. You go to your doctor for an office visit, knowing the price beforehand because you've looked it up on the Web. You give the front-desk person your healthcare ID/debit card. One swipe reveals your identity, your health record, and your health plan coverage and eligibility information to the intake person.

After seeing the doctor, the office staff keys in the treatment codes for your visit and the information is transmitted to the insurance carrier. Within 20 seconds, you get a final bill correctly reflecting your plan's price and your deductibles or copays, you use your ID/debit card for payment, and the amount is deducted from the appropriate medical savings account.

As futuristic as it may seem, it's not far off. Responding to the demand for consumer-driven healthcare that is both consumer-friendly and provider-friendly, insurers and payment processors are building technology systems to link banks, payors, providers and consumers. At the point of convergence lies the holy grail of the industry – a smart debit card that will carry all the information needed to make a transaction transparent, efficient and seamless.

Although medical debit cards are widely used now to purchase drugs and other qualified medical items, the card won't reach its full potential until it can be widely used to purchase healthcare at the point of delivery.

A few large insurers are making progress. Humana Inc. has launched a successful real-time claims adjudication system in six medical practice sites so that physicians' offices can be paid in a matter of seconds. UnitedHealth Group is preparing to unveil an integrated ID and debit card that will store members' identification, eligibility status, and health records.

But while those are key pieces to the puzzle, the big picture hasn't come together yet to provide a practical path to widespread use.

"The overwhelming majority of [health accounts] do have debit cards. The question is, do the overwhelming majority of doctors accept them? And the answer is: not so much," said Kevin McKechnie, associate director of the American Bankers Insurance Association. "We have the bank and insurance company talking to each other. We still don't have real–time claims adjudication at the point of service when

DEBIT CARD VENDORS FOR HEALTH-RELATED SAVINGS ACCOUNTS

Vendor*	Product	Visa/MasterCard	Major Health Plan Customers	Financial Partner
Metavante Corp.	MBI Benefits Card	Both	CIGNA	HSA Bank
Evolution Benefits	Benny Card	Both	Highmark BCBS of New Jersey, Delaware & Massachusetts	HSA Bank, Mellon Financial Services, Wells Fargo & BB&T
Motivano	SmartFlex	Visa	Blue Cross of California	UMB Bank
UnitedHealth	N/A	MasterCard	UnitedHealth	Exante Bank
Benefit Resources	Beniversal MasterCard	MasterCard	N/A	BankFirst

*All vendors provide auto-substantiation and multiple account access through their cards.

Source: company Web sites

CDHP ENROLLMENT (JUNE 30, 2006)

Company	Enrollment
UnitedHealth Group	1.8 Million
WellPoint	698,000
Aetna	614,000
Humana	416,000
CIGNA	250,000*

*Figure from Jan. 1, 2006.

Sources: Company investor conference calls, press releases

you go to your doctor and want to swipe your card and know right then and there what you're charged."

That's not to say progress hasn't been made. Medical cards began to take off when the IRS clarified two years ago how these cards could be used to tap into tax-advantaged flexible spending accounts, health reimbursement arrangements and, more recently, health savings accounts.

"You've got to have some mechanism for the individuals to use their account and track their spending over time. I think it's almost a necessary complement to employers' creating these savings accounts," said Andrew Webber, president and CEO of the National Business Coalition on Health.

CDHP Acceptance. An estimated 6 million Americans are participating in consumer-directed health plans this year, and the number is expected to double next year, according to Forrester Research Inc. "The new data we have is that 32 percent of employers currently offer a debit card tied to a spending account, and 15 percent plan to offer them," said Forrester senior analyst Katy Henrickson.

For years, debit cards have been tied to FSA and HRAs, which are set up and controlled by employers to pay for employees' qualified medical expenses. The cards are now mostly used to pay for items purchased at stores and pharmacies, such as prescription drugs, eye glasses and over-the-counter medicines.

The industry has made great headway in the automatic substantiation of medical expenses being deducted from the accounts. The major vendors—including Evolution Benefits [the Benny Card], First Data Healthcare Services and Metavante [MBI Benefits Card]—offer debit cards with the capability to do real-time IRS auto-substantiation at the point of purchase. Recently they have added "multi-purse" technology—the ability to deduct funds from more than one account held by a card holder, after determining the account appropriate for the transaction.

In addition, technology used by Visa and MasterCard Worldwide allow for merchants at a variety of retail establishments—not just pharmacy counters—to code and identify items that qualify for medical spending account purchases so the items can be automatically substantiated and debited from medical accounts.

MasterCard in August unveiled a new card technology enhancement that tracks items' individual SKU inventory codes. That data, collected when the card is swiped at the cash register, is routed along the MasterCard network to the customer's account administrator, which can then automatically determine what items are eligible and send back a message to the merchant approving or denying individual items for account deduction.

The card product was released after new guidance from the IRS in July significantly expanded the potential for debit card use, said Matt Lanford, vice president of global products and healthcare for MasterCard Worldwide.

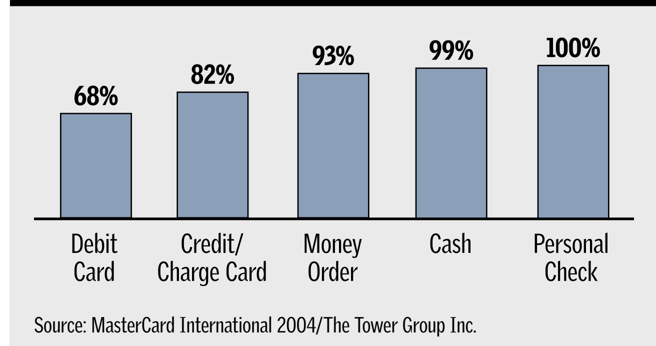
The advisory clarified that the cards can be used not only at the pharmacy counter, but in the general cash register lanes of merchants that have an inventory control system, Lanford said. In addition, records generated in the transaction can be used as proof for substantiation to the IRS. MasterCard's new technology incorporates the record-keeping function, so administrators don't have to collect receipts from employees to verify purchases.

"It's somewhat like an online receipt because now you have exactly what you purchased at the time of the authorization and the administrator can now store that information in their system to produce those reports when the IRS comes in and does an audit," Lanford said.

Debit Card Future. Industry observers say the more recent adoption of health savings accounts, which are tied to high-deductible health insurance plans, will further propel debit card use. Since employees control the funds, the burden of proof to the IRS falls on them, relieving account administrators of the burden of substantiation, but fueling a consumer need for a `smart' card. Also, because HSA funds can be rolled over from year to year and accumulate, banks are looking at them as a new vehicle for asset management.

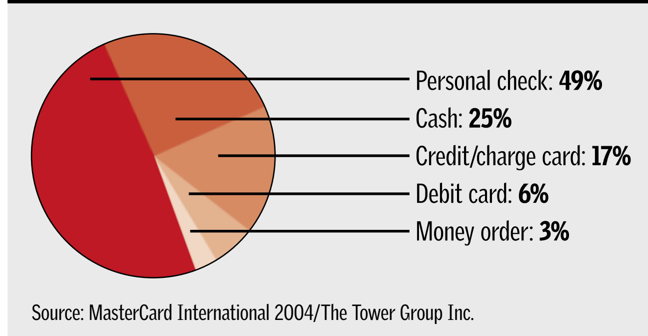
"When you start being able to offer a debit card that people can put in their wallet and take out and swipe, all of a sudden the perceived value of the [high-deductible] plan goes up pretty substantially," said Alexander [Sander] Domaszewicz, senior consultant with Mercer Health & Benefits. He said 83 percent of large HSA sponsors provided a debit card in 2005.

METHODS ACCEPTED AT DOCTOR AND DENTIST OFFICES



Source: MasterCard International 2004/The Tower Group Inc.

PROPORTION OF IN-OFFICE MEDICAL RECEIPTS BY PAYMENT METHOD



Source: MasterCard International 2004/The Tower Group Inc.

The major question facing the industry is not whether, but when and how debit cards will move beyond the pharmacy and store counter and into widespread use at providers' offices. Vendors say the cards can be read by any standard Visa or MasterCard machine. About 83 percent of doctors' offices are now set up to accept major credit cards, while 68 percent of practices accept debit cards, according to TowerGroup.

Standard copays can be automatically deducted. Even if a provider's bill for a service hasn't been adjudicated, debit card account numbers can still be written on bills for deduction after the fact. In addition, debit card technology is well positioned for real-time adjudication because industry insiders estimate 70 percent to 80 percent of claims can be processed on the spot.

Ideally, debit cards will be able to pull up an insurance plan member's medical records and eligibility status to aid in the transaction. There is movement on that front, as well.

First Data's magnetic stripe card technology can be accessed by a physician's practice management software to see the member's identity and eligibility information, said Robyn Bartlett-Andersen, vice president of health care product development. She said the company later this year is testing out a real-time claims adjudication process. So far, she said physician practices have been receptive to the technological changes.

"What is key is that you really need a community or geographic area generally that has all the components in place: a card, members with cards, payors that are going to real-time adjudicate the claims, doctors' offices that have access to the Web interface," Bartlett-Andersen said.

UnitedHealth Group, through its own Exante Bank, is also busy improving the card systems for its 713,000 HSA members and its 1.08 million members with HRAs. The insurer, with more than 25 million enrollees, also manages more than 500,000 flexible spending accounts.

About 20 million UnitedHealth members have a group ID card that displays their eligibility and copay status. In 2007, that card will also contain the member's personal health record and will double as a debit vehicle. Using a card reader connected to the provider's computer via a standard USB port, the provider can then call up the patient's information on the UnitedHealthCareOnline provider portal.

"The office administrator would, using our provider portal, submit the claim right then and there and within 10 seconds get back the allowed charge, how much we the insurer are reimbursing the doctor, and lastly how much the patient owes," said Daryl Richard, vice president of communications for UnitedHealth.

Real-Time Adjudication. Earlier this year, Humana Inc. completed a successful four-month pilot project in real-time adjudication at MacGregor Medical Center in San Antonio, Texas. Working with the clinic's current practice management system, the project enabled the clinic staff to get the claim back from the insurer in 19 seconds so the bill could be presented to the patient on the spot, said Janna Meek, director of Integrated Provider Solutions for Humana.

"Before the pilot started," she said, "they collected about 80 percent of their receivables in 45 to 60 days. With real time claims adjudication, they started collecting about 93 percent at the time of the patient visit. That's huge in terms of cash flow for that provider office," she said. Meek said Humana is marketing real-time claims adjudication to practices that have a high incidence of swipe card activity and a willingness to change workflow processes. The company is also working on technology to have its debit cards carry eligibility and benefit information.

"Currently in most practices you have the front desk person who takes care of getting the patient signed in and that kind of thing. That person would have to be trained in what usually takes place in the back office, which is coding. That's a major change," she said.

The advances may be promising, but there are plenty of skeptics. Nileen Verbeten, vice president at the center for economic services of the California Medical Association, said the swipe card system isn't a "silver bullet" and knows of no practice in California using it.

A number of moving parts in the transaction complicate instant pricing and payment, she said. Practices commonly deal with 15 or more payors with varying product lines. For multi-coded services, prices and payment rules vary widely among insurers, she said. And most payors in California consumer-driven, high-deductible plans instruct the practice to wait until the claim is adjudicated to bill the patient.

"In a normal practice, where you don't have the latest technology and you have a limited number of staff, it is very unlikely that the front desk will tell you what any given payor is going to pay," she said. Both she and McKechnie of the bankers association imagine the administrative headache created by trying to retrofit provider offices for all the varying claims adjudication systems that will be in place.

"There are something like 1,000 different practice management software programs in existence in this country, and that is a major stumbling block towards making a unified data standard that everyone can plug into," McKechnie said.

Humana may have the answer to part of the problem. Meek said all practices that participate in Humana's real-time claims adjudication process enter the claim information into their own practice management software systems, which can be set up to transmit the information using gateway software provided by Availity, eliminating the need for dual entry of the transaction. The beauty of the system, she said, is that it isn't proprietary.

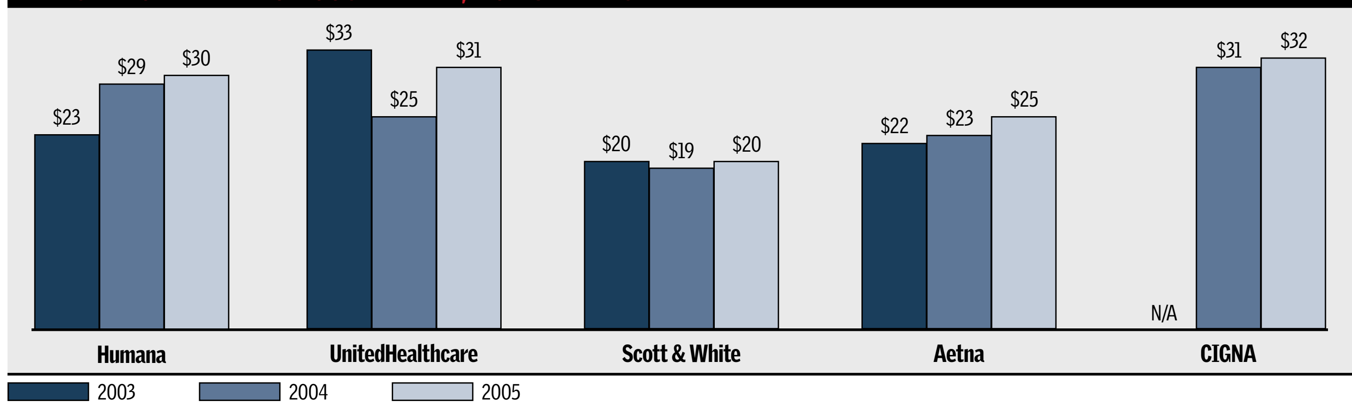
"Any health plan that could real-time adjudicate could join in this multi-payor solution if they would like, and we've offered that to other plans," she said. "If they are part of Availity gateway and they can do real time claims adjudication, then they can be a part of this multi-plan solution."

Verbeten and McKechnie say standardizing payment rules would help. "You need to have a standard price available in a format that a card reader can read before this technology can be utilized," McKechnie said.

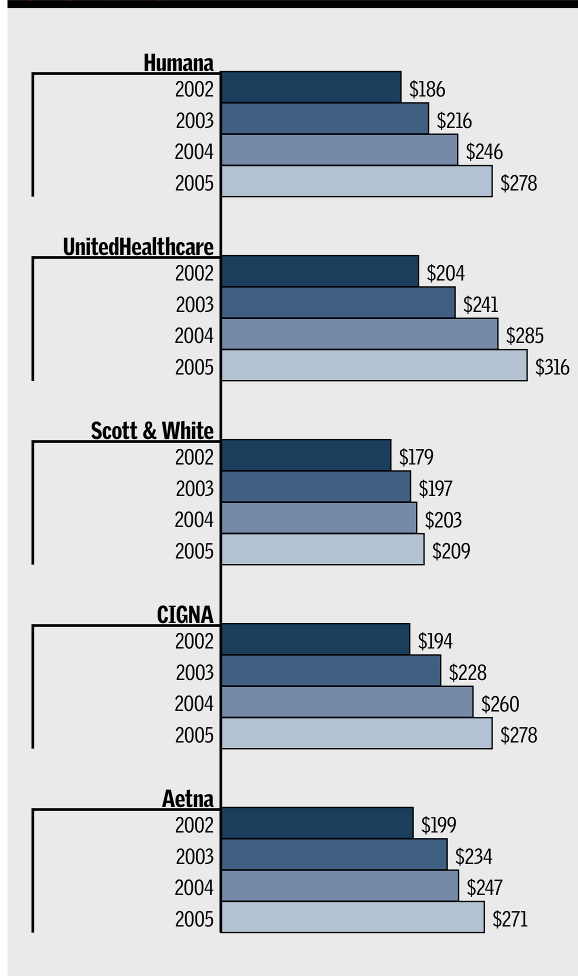
To that end, the HSA Council, formed by his association and the American Bankers Association to encourage the use of health savings accounts, is pushing for legislation that promotes pricing transparency. "I can't imagine going into a doctor's office with a deductible and $1,000 and having no idea what it's going to cost. And so we need that information, we need to know what all this stuff costs. There are bills in Congress to do just that," he said.

OUTLOOK: Medical debit cards are getting smarter every day, moving beyond their role as electronic links to bank accounts to become facilitators of instant member identification, insurance eligibility, and claims adjudication. By 2007, real-time adjudication should be in place with all the major health plans. Expect slower progress, however, in achieving widespread use within providers' offices. They will be more willing to jump on board if they can see how their cash flow issues are resolved with speedier payment of claims and can easily integrate with technology systems to use these cards. ■

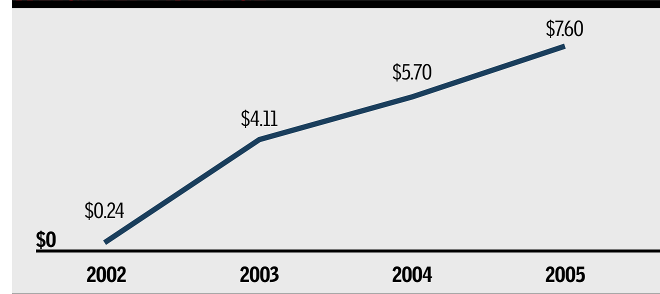
TEXAS HMO PHARMACY COST PMPM, TOP 5 PLANS



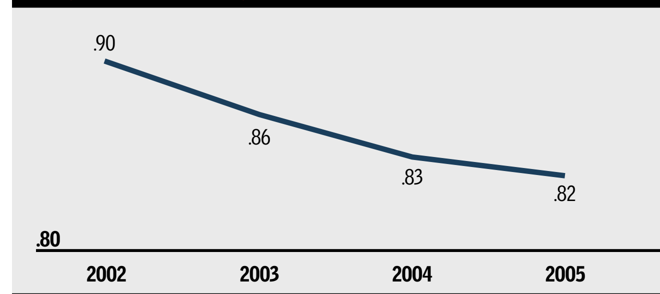
TEXAS HMOs' CHANGE IN PREMIUM PMPM, TOP 5 PLANS



TEXAS HMO NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE



TEXAS HMO MEDICAL LOSS RATIO, WEIGHTED AVERAGE



TEXAS COMMERCIAL HMO PREMIUMS PMPM, WEIGHTED AVERAGE