

# New England Health Plan Analysis

**Winter 2007 Vol. 6 No. 1**

Maine | Massachusetts | New Hampshire | Rhode Island | Vermont

# New England Health Plan Analysis

Winter 2007 Vol. 6 No. 1

*New England Market Analyst*  
**Ric Gross**  
rgross@healthleaders-interstudy.com

*New England Research Analyst*  
**Mimi Pounders**  
mpounders@healthleaders-interstudy.com

## HEALTH PLAN ANALYSIS

---

*Principal Director of Research & Analysis*  
**Sheri Sellmeyer**

*Associate Director of Health Plan Analysis*  
**Jane DuBose**

*Assistant Director of Health Plan Analysis*  
**Paula Wade**

*Health Plan Analysts*  
**Rick Byrne, Ric Gross, Chris Lewis,  
Don Mooradian, Roy Moore,  
Lori Anne Parker, Jan Shuxteau**

## HEALTH PLAN DATA

---

*Director of Research Analysis*  
**Laura K. Black**

*Senior Analysts*  
**Jodi Tonkin, Rebecca Waller**

*Research Analysts*  
**Natasha Al-Qadi, Matthew Amos, Randall Gish,  
Kristi Gumm, Devona Matthews, Mimi Pounders**

## SHARED SERVICES

---

*Senior Software Engineer*  
**Ben Jones**

*Database Analysts*  
**Pam Colangelo, Lance Wolkenbrod**

*Senior Database Administrator*  
**Mike Schellhammer**

*Design & Production*  
**Lisa Hartley**

## SALES & MARKETING

---

*Director of Sales*  
**Eric Matckie**

*Marketing Manager*  
**Kelly Morphy**

*Product Manager*  
**Mark McMahan**

*National Account Managers*  
**Susan Albano, Jacky Lancio**

*National Account Executives*  
**Nina Bellinger, Mary Carol Waters**

*Account Executive*  
**Shea Ivy**

## HEALTHLEADERS-INTERSTUDY

---

*President*  
**Greg George**

*Controller*  
**Tim Meise**

*Operations Manager*  
**Tracy Coats**

*Accounting Assistant*  
**Lisa Williams**

## CORPORATE OFFICE

---

210 12th Avenue South  
Nashville, TN 37203  
Phone: 615.385.4131  
Fax: 615.385.4979  
Toll Free: 888.293.9675

# In This Issue

## 3 Uninsured

- 3 Critical Decisions Looming In Massachusetts
- 5 Phase II Brings New Challenge In Bay State
- 7 California Dream Making Waves In Region
- 9 Maine Eyes New Funding Source For Dirigo

## 12 Wellness

- 12 Wellness Plans Draw Mixed Reactions In R.I.

## 14 Health Plans

- 14 Anthem BC/BS Unveils BlueOptions In Maine
- 15 CIGNA Rolls Out HSA-Qualified Plans In N.H.
- 16 R.I. Blue Cross 'Institutes' Wellness Offering

## 18 People

## 19 Pharmacy

- 19 New Hampshire Sets E-Prescribing Goal Of 2008

## 21 Metrics

Published February 2007. Copyright © 2007 HealthLeaders-InterStudy (a Decision Resources company). All Rights Reserved. Intended for the sole use of a HealthLeaders-InterStudy registered subscriber. Photocopying, forwarding or reproducing in any form, in whole or in part, is a violation of federal copyright law and is strictly prohibited. Selling or otherwise providing this information to third parties violates the contractual agreement under which this report and data are provided and is a violation of federal copyright statutes. Violation of federal copyright law is punishable by fines up to \$100,000. Questions regarding use of this product should be directed to HealthLeaders-InterStudy, 210 12th Avenue South, Nashville, TN 37203; 615.385.4131.

# Critical Decisions Looming In Massachusetts

By Ric Gross

While states such as California are trumpeting efforts to put major healthcare reform into play, the current standard-bearer for such reform—Massachusetts—continues to forge onward.

Members of the state's Commonwealth Care Health Insurance Connector board are working at a breakneck pace to meet the aggressive timetable set by lawmakers when the landmark legislation to insure virtually all of the state's residents was signed into law in April 2006. According to the state's Division of Health Care Finance and Policy, the number of uninsured in the state stood at 372,000 in 2006, putting the Commonwealth's uninsured rate at 6 percent.

Several key pieces of the reform are now in play, including a crucial question on how much premiums would cost. The first stab at premium pricing was disappointing to the Connector board, which is asking those carriers that bid far higher than their competitors—some asking as high as \$380 a month—to return with lower prices. “Clearly, if the uninsured have to pay \$380 for minimal coverage, that would be unaffordable for many of them targeted in the upcoming phase of Commonwealth Care,” said Jon Kingsdale, executive director of the Commonwealth Connector.

In addition to setting premium prices, the Connector also has major decisions to make on unsubsidized health plan offerings for primarily non-group and small-group purchasers, known as Commonwealth Choice plans; the lowest level of coverage individuals must have to satisfy the requirement that all adults participate in health insurance; and the determination of what allows an individual to waive out of this requirement.

According to state officials, individuals will be able to begin enrolling in Commonwealth Choice on May 1, with an effective date of July 1, when the individual mandate kicks in.

Sound like a lot to take in? Try being in the crow's nest scouring for any potential icebergs. “It's been challenging,” said Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology and a member of the Connector board. “I'd say 2006 went as well as we could have hoped, and we'll see what 2007 brings.”

**Getting The Word Out.** One challenge is putting together an effective marketing campaign. Media reports have indicated a general lack of knowledge among the estimated 160,000 uninsured above 300 percent of the federal poverty level who will be required to purchase private health plans, or face a penalty.

“There is a need to get the word out about the individual mandate, and that needs to happen very soon,” said Kate Nordahl, director of policy and research for the Blue Cross Blue Shield of Massachusetts Foundation. “I think there are quite a few people in Massachusetts that don't yet know that that is on the horizon.”

Kingsdale, a former Tufts Health Plan senior vice president, acknowledged there is some work ahead to educate the public, but remains confident that is on track. Toward that end, a full-scale marketing campaign is set to go into effect this spring.

“I think the level of awareness is slowly growing. Back in spring 2006 when we first passed the law, I know awareness of the requirement that everybody participate was just about zero,” Kingsdale said. “I was with a private health plan in the state [early in the process] and we did eight focus groups with 60 individuals, and only one out of the 60 had heard of the requirement that individuals participate.”

However, Kingsdale said it would have proven folly to launch any sort of spirited educational push last spring upon the bill's signing.

“You can't really build huge awareness before it becomes a reality,” Kingsdale said. “If you tell people that a year from now they have to health insurance, it's not going to stay with them. It is not a good use of resources to educate them that far ahead of time. As we near July 1, we will have a huge awareness campaign and promotion, and I think that will stick much more than it would have last April, May or June.”

The state has funds built into the healthcare reform effort for marketing, including around \$2.7 million in outreach money for area groups to use in their efforts to inform the public about the law and the new options. At its Jan. 22 board meeting, the Connector approved a marketing and advertising contract with Weber Shandwick.

Going forward, all eyes will be on the reaction of the public as the individual mandate is triggered. Penalties will kick in on Dec. 31, 2007, as residents filing tax forms for 2007 will have to answer a question about whether they have health insurance. A “no” answer will result in the loss of that taxpayer's personal tax exemption, which is about \$200 for an individual, according to John McDonough, executive director of Health Care For All, the state's most influential healthcare advocacy group. McDonough noted that in tax years 2008 and beyond, the penalty will get more serious, half the cost of the most affordable plan in one's geographic region.

## PROPOSED GUIDELINES FOR LOWEST COST COMMONWEALTH CHOICE PLANS

**Out-of-pocket maximum:** \$5,000 individual; \$10,000 family

**Maximum deductible:** \$2,000 individual; \$4,000 family

**Drugs:** Coverage for brands, generics

**Pre-deductible doctor visits:** 3 per individual; 6 per family

Source: Health Care For All

“Public response and reaction [to the mandate] is going to depend on how many people have to buy insurance that aren’t insured now, how costly it is, and what the exceptions are,” Kingsdale said. “We are charged with making policy to make it affordable for them. How effective we are at educating people and giving them options will influence the degree of public acceptance.”

**Offering A Choice.** Meanwhile, health plans submitted designs for their Commonwealth Choice products on Jan. 16, though it will be some time before details are made available. Decisions should be made around March 8 as to which health plan bids have earned the Connector seal of approval.

However, details are public regarding the criteria health plans had to work with. For instance, the Connector has outlined four distinct types of products insurers needed to present—the ‘top-of-the-line’ Premier plans with limited out-of-pocket cost sharing by enrollees; Value plans with higher out-of-pocket costs at the point of service, calculated to be 80 percent of the Premier plan; the minimum creditable coverage plans representing the lowest level of coverage individuals must have to satisfy the individual mandate and slated to be around 55–60 percent of the Premier plan; and the young adults plan, to be offered to individual, non-group purchasers ages 19–26, with a proposed benefit limit of \$50,000 per illness or accident.

In its request for responses, the Connector encouraged plans to “develop and offer innovative plan designs that more effectively and efficiently deliver care.”

And while details of the filings aren’t known, the state’s largest insurers—Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan and Fallon Community Health Plan—likely submitted bids, as did Neighborhood Health Plan.

Health plans that gain the Connector seal of approval will be able to offer the products for one year, and renewable annually thereafter.

Neighborhood Health Plan, while not among The Big Three insurers, is well known to Connector officials, having been involved in development of the state’s Commonwealth Care managed care product for those earning up to 300 percent of the federal poverty level.

“Having started this in June 2006, we have already developed and launched two new products [with Commonwealth Care], and are now onto a third set. We are becoming accustomed to this pace,” said Deborah Enos, president and CEO of Neighborhood Health Plan. “I would guess what most health plans did, given the compressed time period, was similar to what we did, which was to look at what you are currently offering in the commercial space and build from there.

“We did that, and looked at the specifications of the Connector, and at things we already offered that matched up, and looked at what we needed to tweak,” Enos said. “We started with an existing plan design base, and came up with some new things. I think as we moved into this realm, in

**KEY COMPONENTS OF THE MASSACHUSETTS HEALTHCARE REFORM**

Plan	Target	Status
Commonwealth Care Phase I	<100 percent FPL	Enrollment under way
Commonwealth Care Phase II	100 percent to 300 percent FPL	Enrollment under way
Commonwealth Choice	>300 percent FPL	Enrollment begins May 1

Source: HealthLeaders-InterStudy

some ways we felt a bit more confident as we had the core elements of these plans in place. This population is similar to a membership we have served for many years, so we are talking about expanding what we’ve been doing rather than offering unfamiliar products to a population we have never served before.”

And while potential monthly premiums are not yet known, prices will be cheaper in the Value and minimum creditable coverage plans, for example, at 80 percent and 55 to 60 percent of that price.

Enos said affordability will hopefully not be a problem for NHP. “Healthcare is just expensive, period, and affordable is a relative term,” she said. “In the commercial space, we are somewhat of a niche player, we are primarily a Medicaid plan with a small but steady commercial base. In the commercial space, we tend to be one of the more affordable plans, and I hope that position carries over. We are starting at a good place in terms of affordability.”

**Minimum Coverage, Major Headache.** Meanwhile, all involved are facing difficulties in designing the lowest-priced plans, with a decision on such plans postponed until March 8.

Problems arose Jan. 19 when a subcommittee working on the proposals submitted by health plans announced that premiums would cost around \$380 a month. That produced a firestorm of responses denouncing the packages as too expensive for many who will be required to have coverage.

A major component of the plan is the idea that as individuals stop accessing the free care pool, that money will therefore be redirected. However, if the lowest priced plans are deemed not affordable for many, that poses its own set of problems.

Sen. Richard T. Moore, co-chairman of the Legislature’s Committee on Health Care Financing, told *The Boston Globe* that premiums should be around \$250, because if they are set too high, the state would be forced to grant too many individual mandate waivers.

Even the state’s new governor, Deval Patrick, chimed in, saying at a press conference he was concerned that an

amount around \$400 for someone at 300 percent of the federal poverty level may prove to be unaffordable. The Connector board on Jan. 22 told health plans to head back to the drawing board and re-submit lower-cost bids.

Health plans were instructed to produce plans with certain requirements, such as an out-of-pocket maximum of \$5,000 for an individual, and \$10,000 for a family, and a maximum deductible of \$2,000 for an individual, and \$4,000 for a family. In addition, Connector officials said the plans should cover brand and generic drugs and provide some services pre-deductible (generic medications and three primary care office visits).

Plans call for a vote on the new bids at the March 8 meeting, which would keep things on the pre-arranged timetable.

Needless to say, tough decisions are ahead as the glare of the national spotlight only intensifies.

**OUTLOOK: Not everyone is going to be happy with all decisions going forward; however, give credit to Massachusetts and all those involved for meeting deadlines and getting products into the marketplace. Still, the next few months will help write a pivotal chapter in this saga. Will it be the conclusion? Certainly not. The real success of the plan won't be known for years, but those saying the plan is already teetering are far off base. ■**

## Phase II Brings New Challenge In Bay State

By Ric Gross

Some could say Massachusetts' healthcare reform shares similarities with a perilous house of cards, with each new addition proving more challenging than the one before. And that is certainly true with the second phase of the state's Commonwealth Care initiative, which is allowing thousands of uninsured residents to purchase private health benefit products at affordable rates.

Enrollment began Nov. 1, 2006, for those with incomes less than 100 percent of the federal poverty level, which is \$9,800 for an individual. The second piece of that puzzle, enrollment for those earning up to 300 percent of the federal poverty level (\$29,400), began Jan. 1, 2007.

The new products are being offered by Boston Medical Center HealthNet, Fallon Community Health Plan, Neighborhood Health Plan and Network Health. They allow enrollees to receive inpatient hospital services, outpatient services and preventive care, prescription drugs, mental health and substance abuse services, and vision. There are 38 defined service areas, with 28 featuring three or more participating plans, while only seven service areas have one plan participating—BMC HealthNet.

A key difference is that those earning below 100 percent of the federal poverty level are not charged a premium and face only nominal copays, being auto-assigned a health plan if they did not choose one. However, for the estimated

100,000 in the 100 percent to 300 percent federal poverty level range, there will be a sliding-scale premium, based on income. Members of the Connector wrestled with the decision, wanting to make premiums affordable, yet not too attractive should Commonwealth Care lure them from existing coverage.

Residents earning on the lower scale will pay costs of \$18–\$58 a month, while those earning near 300 percent of the federal poverty level will pay \$70–\$180 a month. Enrollment is voluntary in these plans for the 100 percent to 300 percent group, with no auto-assignment. However, the universal participation requires that every individual in the state purchase health insurance by July 1, 2007, as long as it is deemed affordable. This group is subject to that requirement, barring a special waiver

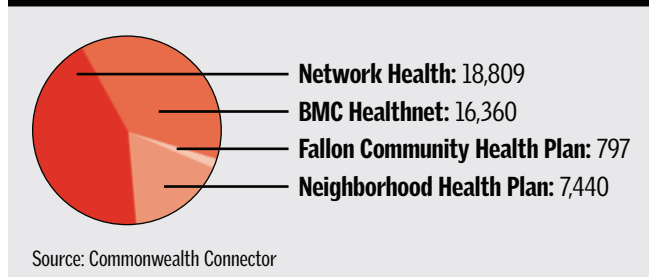
“The second phase of Commonwealth Care is more challenging because enrollees will have to pay premiums and determine whether the premiums are affordable for them,” said John McDonough, executive director of Health Care For All, the state's most influential healthcare advocacy group. “There is a related challenge in finding eligible individuals. The Commonwealth has an aggressive strategy to reach out and identify eligible folks. We have done this before, the key challenge is affordability.”

Deborah Enos, CEO of Neighborhood Health Plan, acknowledged this phase of the reform brings challenges not yet faced by the health plans.

“As we move along we keep moving into the more complex elements, this being one,” Enos said. “There are great benefits available but individuals are required to pay something, and that is a big difference. There are no auto-assignments here. I would suspect the build up in this group might be a bit slower for those reasons. It may take longer to see the penetration levels.”

Awareness could be a problem as well. Plans are implementing a host of outreach efforts, whether it be billboard

### COMMONWEALTH CARE ENROLLMENT



## COMMONWEALTH CARE PLAN TYPES

**Plan Type One:** Less than 100 percent FPL

**Plan Type Two:** 100.1 percent to 200 percent FPL

**Plan Type Three:** 200.1 percent to 300 percent FPL; Low premium option, higher copays

**Plan Type Four:** 200.1 percent to 300 percent FPL; Low copay option, higher premiums

Source: Commonwealth Connector

and radio spots or grassroots marketing through community groups and charities.

“Most people are unaware of the new law and the impact it will have on them,” said Fallon Community Health Plan spokeswoman Christina Andreoli. “We are reaching out to hospitals, providers, social service agencies and other organizations to educate people about the law and who might be eligible.”

An estimated 72,000 of those being targeted for this product have at one point or another accessed the state’s uncompensated care pool, providing state officials a list from which to work. A key component to the plan’s viability is redirecting some state funds now spent on the pool. Massachusetts has available funds it has been paying to hospitals to treat the uninsured, and it has cost the state nearly \$1 billion a year to do so.

Consequently, marketing efforts will likely center around the benefits a managed care plan can bring.

“A large portion of the Commonwealth Care population has been accustomed to accessing care through the uncompensated care pool. For that group they are being asked to pay for health insurance as opposed to accessing free care,” said Kate Nordahl, director of policy and research for the Blue Cross Blue Shield of Massachusetts Foundation. “It is asking people to change behavior, and sign up and pay a monthly fee. However, there is a value as they get a managed care product. It will be a benefit, as they will be getting health insurance, perhaps for the first time in awhile.”

Jon Kingsdale, former Tufts Health Plan senior vice president and current executive director of the Connector, stressed that point as well.

“A major attraction is in connecting an individual with primary care physicians, getting them in to meet that clinician, have a physical, do something like preventive care visits,” Kingsdale said. “They will have to pay something, even though it’s highly subsidized, but it’s a much broader benefit package than they typically can get even if they were using the so-called free care pool. That typically covers emergency and inpatient care; it doesn’t necessarily cover drugs or primary care, those kind of things.”

Each plan has three levels of coverage, with mandated

benefits, and varying copays. For instance, those at the lower income face copayments of \$10 or less for doctor visits, and \$50 for hospital stays. Still, even with packages that provide ambulatory services and rehabilitation services for a variety of disease states, for instance, it may be a tough sell for some who may have gotten by just fine without insurance via such things as walk-in clinics.

“We are stressing that it is a comprehensive way of looking at health, as opposed to looking at it the urgent care way, dealing with something when you are sick,” Enos said. “We are saying look at prevention and the tools available because you have insurance. We are hoping that helps people make a decision to enroll into a plan.”

Plans have sweetened the deal a bit with offers such as gift cards for a first doctor’s visit or for certain screenings, or reimbursement up to a certain level for things such as health club memberships, Weight Watchers and yoga classes.

**Now In Play.** Meanwhile, as of early January around 50,000 residents have qualified, of whom nearly 45,000 are enrolled in Phase 1 of Commonwealth Care, according to the state. Hopes are to have around 70,000 adults enrolled in the entire Commonwealth Care package as of July 1, Kingsdale said.

Those who did not choose a plan were auto-assigned to one. According to Dick Powers, spokesman for the Commonwealth Care, if an enrollee has a history with a plan, they are assigned to it. If not, then 75 percent of the auto-enrollees go to the lowest-priced plan in that region, with the remaining 25 percent going to the next lowest-priced plan in the same service area, Powers said. After auto assignment, they have another 60 days to switch plans if they decide to do so.

“We have been very pleased with how things have gone in phase one,” NHP’s Enos said. “We went in with the assumption we were going to get our members through marketing, outreach and reminding people of our history and our experience in this marketplace. We worked closely with community health centers and did a lot of collaborative outreach. Without auto-assignment, we had to develop a whole marketing strategy around this. And we expect to get more members as the process moves forward.”

In addition to facing no premiums, copays for this group are limited to \$1 for generic drugs, \$3 for all other drugs, and \$3 for a hospital emergency department trip when it is not an emergency. According to state officials, the most that can be charged in copayments in a single calendar year is \$200 for pharmacy services and \$36 for other services.

**OUTLOOK:** *Give the health plans credit for initiating aggressive marketing techniques. While it’s way too early to proclaim this portion of the implementation a success, it is far from a disappointment. In addition to those enrolled in Commonwealth Care, about 53,000 have been enrolled in the state’s MassHealth program, getting the treacherous implementation process off on the right foot.* ■

# California Dream Making Waves In Region

By Ric Gross

While California Gov. Arnold Schwarzenegger’s plan to terminate that state’s uninsured crisis certainly has created contentious debate there, it has caught the attention of healthcare power brokers throughout New England.

In Massachusetts, officials are looking on as proud parents of the plan one pundit dubbed “Massachusetts on steroids.” In Maine, the national spotlight has faded on its Dirigo Health Program, championed in 2003 as a step toward universal coverage, but it offers lessons to the nation on developing consistent funding sources from the start.

Schwarzenegger announced Jan. 9 he would require every Californian to obtain health insurance, a key element of a multi-pronged, \$12 billion approach to expanding health insurance to the one in five people who don’t currently have it.

His universal healthcare plan requires health plans to spend at least 85 cents of every premium dollar on patient care, putting a tighter rein on profits and administrative costs. And insurance companies could no longer deny insurance coverage to people based on health status, age and occupation.

But health plans could gain as many as 4 million to 5 million new customers under the governor’s plan.

Schwarzenegger’s long-awaited plan borrows key concepts from the far-reaching universal healthcare law in Massachusetts, including the individual and employer mandates. But Massachusetts doesn’t have a similar assessment on providers and doesn’t require coverage of undocumented children, as does the California proposal.

The Schwarzenegger proposal also stresses prevention and wellness programs, including the development of a statewide initiative to manage diabetes, encouraging lifestyle changes to reverse the obesity epidemic and boosting resources to

help residents quit smoking. To cut down on medical errors, the governor would require electronic drug prescribing by all providers by 2010 and institute new reporting requirements in medical facilities, among other measures.

However, Massachusetts’s political observers say the Schwarzenegger administration has a long political fight ahead of it in the Democratic-controlled Legislature.

“The Schwarzenegger plan has something to alienate almost everyone,” said John McDonough, executive director of Healthcare For All, a healthcare advocacy group. “Businesses will hate the payroll tax; docs and hospitals will hate the assessments; many insurers will balk at a ban on medical underwriting; many consumers will balk at the individual mandate; progressives will claim it’s a way to stall single payor. Not a promising political recipe.”

Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology and a member of Massachusetts’ Commonwealth Care Health Insurance Connector board, which is overseeing implementation of the law, assisted the Schwarzenegger administration in certain aspects of the plan’s development and spoke favorably of it, despite the challenges ahead.

“I think it’s an excellent plan, and in some sense it is more sweeping [than Massachusetts],” Gruber said. “In California, it will be a tougher row to hoe because it is more ambitious. I think it’s a good plan and I hope in some fashion they get this through, but it will be a much tougher battle, no question.”

**View From The Top.** Under the California plan, adults would have to insure themselves and their children, employers with 10 or more workers would have to make a minimum contribution to health coverage, and providers would be taxed on gross receipts to help subsidize residents’ purchase of health insurance.

But there are also subsidies built into the system for low-income Californians, and a \$4 billion boost in Medi-Cal payments to providers.

Schwarzenegger, the Republican actor-turned-governor who last year vetoed legislation for a single-payor, government-run health system, said each part of the healthcare sector must take responsibility for curbing the “hidden taxes” of healthcare and making it more affordable to all residents.

In Massachusetts, the top gun of the state’s implementation process, former Tufts Health Plan Senior Vice President Jon Kingsdale and current executive director of the Connector, lauded the plan.

“They have put a stake in the ground on several decisions we are still facing. One of them establishes minimum creditable coverage,” Kingsdale said, referencing California’s plan calling for policyholders to maintain a minimum benefit of a

## COMPARING CALIFORNIA'S PROPOSAL TO MASSACHUSETTS' PLAN

Proposal	California	Massachusetts
Universal mandate	Yes	Yes
Medicaid expansion	Yes	Yes
Provider rate increase	Yes	Yes
Requirement on MLR amount	Yes	No
Minimum creditable coverage	Yes	Yes
Employer assessment	Yes	Yes
Coverage of undocumented children	Yes	No

Sources: Gov. Arnold Schwarzenegger’s office, Commonwealth Connector

\$5,000 deductible plan with maximum out-of-pocket limits of \$7,500 per person and \$10,000 per family.

“On the other hand, some of the reforms in their proposal we already have in place,” Kingsdale noted. “For example, requiring health plans to issue and renew policies regardless of the individual’s health is a requirement in Massachusetts has had in place for years, and is almost catch up. It is very much modeled on Massachusetts, though, but the big difference being the uninsured problem in California is literally 12 to 18 times as big a problem for them as us.”

The scale of the proposals is a huge difference among the states. Jay Gellert, CEO of Health Net Inc., quipped at a panel discussion immediately following the governor’s announcement that the plan “makes Massachusetts look like the small state it truly is.”

However, no matter how much muscle Schwarzenegger puts behind the plan, it’s still just a proposal there while in the Bay State, Commonwealth Care Health Insurance is actually happening—the culmination of debate since the late 1980s with a failed plan by then-Gov. Michael Dukakis.

Kingsdale pointed out Massachusetts traveled an often-lonesome highway in what could easily be compared to the proverbial boulevard of broken healthcare dreams.

“I think this is the most distinctive aspect of healthcare reform in Massachusetts—the fact we started to debate this in 2003,” Kingsdale said. “It was three more years until it passed [April 2006], and it will be another two years before fully implemented. It’s a five-year process.”

Kingsdale said it allowed everyone to hash out their differences, giving the current version broad support from key entities such as business and labor leaders, insurers, Republicans, Democrats and more.

“Right now what you can say is that California has a proposal from the governor,” said Kingsdale. “If it is going to be a success, it has to be seen as the beginning of a long process, and not as the first half of a game and now you all you have to do is vote for it—game over.”

Kingsdale noted for the plan to succeed, it has to be seen as more than just getting 51 percent of the legislative vote to make it work. After all, Dukakis’ plan in Massachusetts passed as well, only to crumble before being implemented.

“It’s a long inclusive process, and we’re still in middle of defining our plan and making it work. It’s an experiment,” Kingsdale noted. “We haven’t done it, we have just enacted it and are trying to make it work. We are still in the process of defining what it is as we implement it.”

**The Pressure Is On.** And that puts Massachusetts firmly in the crosshairs as California and others with similar interests will be no doubt be gauging how smoothly implementation does—or doesn’t—go in the Bay State.

“I think we’re on the leading edge of what could be a fundamental healthcare revolution in America, which is both exciting and scary at the same time, because if we fail, it could have the same chilling effect as the Clinton healthcare

**TALE OF TWO STATES—UNINSURED RATES**

	California	Massachusetts
<b>Number</b>	6.5 million	372,000
<b>Rate</b>	20.5%	6%
Sources: U.S. Census Bureau, Division of Health Care Finance		

failure and people will say it can’t be done,” MIT’s Gruber acknowledged. “It puts pressure on us to succeed. Everybody will be watching to see if we can make this work, and we are seeing some positive things. California has come out with a plan, and hopefully there will be a lot more states moving this direction.”

Kingsdale said it is this national attention that quickly brings to mind the words attributed to NASA flight director Gene Kranz during the infamous Apollo 13 saga—failure is not an option.

“The more attention nationally that goes to this subject, and specifically to Massachusetts because we are doing it first, the greater I believe the determination will be here on the part of everybody to do it right,” Kingsdale said.

**Lost In The Shuffle?** Meanwhile, all the attention being heaped on Massachusetts and California has also caught the attention of Maine healthcare aficionados as well.

In 2003, Maine implemented the Dirigo Health Reform Act, using the state’s motto, Dirigo, which translates to “I lead” in Latin—something the state was hoping to do. The sweeping reform initiatives, championed by Democratic Gov. John Baldacci, were meant to help control spiraling healthcare costs in the state and provide coverage for the state’s roughly 130,000 uninsured citizens. It created the DirigoChoice product, a PPO plan administered by Anthem Blue Cross and Blue Shield with sliding-scale discounts provided to members with household incomes below 300 percent of the federal poverty level.

When the plan was announced, officials originally estimated as many as 30,000 would sign up after the first year. Currently around 13,290 are enrolled.

In addition, the plan’s funding mechanism, an assessment levied on insurers, has become a lightning rod for debate. The program is still going forward, though these days the media coverage tends to be more about the problems than the goals.

“Massachusetts and California will struggle as well,” said Steven Michaud, president of the Maine Hospital Association. “These things look great when passed, but there will be struggles come implementation. It is not as simple as issuing mandates. They may have more success than Maine in the long run, but it will be tough for them.”

Katherine Pelletreau, executive director of the Maine Association of Health Plans, noted that to judge any healthcare reform implementation, it takes several years.

“It just takes time,” Pelletreau said. “In Massachusetts, they had a nice series of things that all were in place that motivated a lot of people in positions of power to promote health reform. I think it’s really difficult to judge at this point, it’s still too new, and there is a similar message even around Dirigo.

“We have enrolled a number of people that have coverage now that they might not have had,” she noted. “However, I wouldn’t go so far as to say it’s an unqualified success, as it certainly does have some funding problems.”

**OUTLOOK: Give Schwarzenegger credit. The former “Kindergarten Cop” has come out with both guns a blazing. However, as Kingsdale noted, it took Massachusetts three years to get its plan enacted, so don’t expect Schwarzenegger’s plan to slide right into implementation in its current form, or any form for that matter. However, at least it’s an idea that has opened the debate in that state. And as for Maine, the Dirigo program is doing good things, but that good is being lost in the fog of the battle over its problematic funding mechanism.** ■

## Maine Eyes New Funding Source For Dirigo

By Ric Gross

There could be an end in sight for the Dirigo Health program’s controversial funding mechanism, the much-maligned savings offset payment. However, while many are hoping a RIP sign can be hung over the savings offset payment in 2007, even the most confident of Vegas high rollers would steer clear of placing a bet either way.

Talk of a potential new direction surfaced in late December, when a “Blue Ribbon Commission” formed to study the Dirigo Health program announced it would forward to Gov. John Baldacci proposals that could in effect replace Dirigo’s current funding mechanism.

The centerpiece of the Dirigo Health Reform is the DirigoChoice product, a PPO plan administered by Anthem Blue Cross and Blue Shield with sliding-scale discounts provided to members with household incomes below 300 percent of the federal poverty level. When the plan was announced, officials originally estimated as many as 30,000 would sign up after the first year. At the end of the program’s second year, around 13,290 are enrolled.

The commission recommended an increase in taxes on cigarettes, beer and wine—known collectively as sin taxes—as well as new taxes on sugar drinks and snacks, that could potentially raise around \$64 million. That could replace the savings offset payment, an assessment on insurers and self-insured businesses that, by law, cannot exceed 4 percent of

paid claims and cannot exceed the savings Dirigo Health has achieved in the system.

Lawsuits and contentious debate surrounded the amount of the 2006 assessment, which ended up being \$43.7 million, with the amount set at \$34.3 million in 2007.

That is where the committee’s suggestions could come into play, as the tax increases could cover that amount. Sin-tax increases have been proposed in other states, including Pennsylvania, where Gov. Ed Rendell is proposing a near-universal healthcare plan.

In addition, the Maine commission suggested the state explore the possibility of employer and individual mandates, the latter being reserved for those earning more than 400 percent of the federal poverty level.

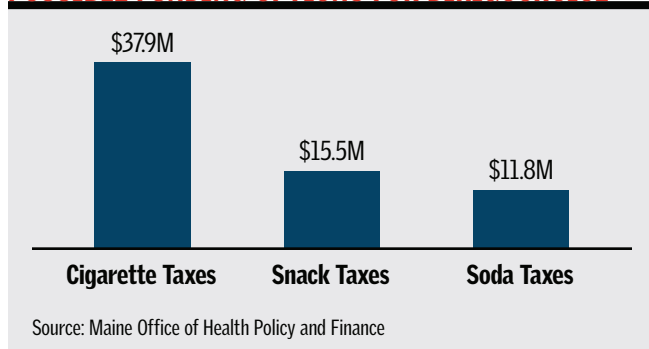
**Uphill Battle?** However, Baldacci must first sign off on the plan, craft a bill and submit it to the Democrat-controlled Legislature “I’m not sure if some of the laws passed in other states will have an impact on what our lawmakers do,” said Elizabeth H. Kilbreth, associate research professor at Maine’s Muskie School of Public Service’s Institute for Health Policy. “Massachusetts passed its law and California has one that has been introduced with funding mechanisms such as assessments on individuals and employers. Whether that would stimulate lawmakers here, I don’t know.

“However, the savings offset payment has proven to be an invitation for litigation. If you are going to identify a source of funding, it would make more sense to identify it and say we are going to go with it,” she added. “If it is an assessment [businesses] can plan around it.”

Sharon Roberts, director of stakeholder relations in Maine for Anthem, said the insurer supports a more broad-based assessment to fund the program.

“Using things like the general fund, or sin taxes, makes more sense,” Roberts said. “We think this is a reasonable approach. The savings offset payment clouds the issue a lot more than it needs to be. If they could put in place some straightforward funding mechanism, money could become available for subsidizing premiums for people who need it.”

### POSSIBLE FUNDING OPTIONS FOR DIRIGOCHOICE



### THREE-YEAR HIGHLIGHTS OF DIRIGO HEALTH

Date	Event
May 2003	Governor unveils Dirigo Health reform plan
June 2003	Legislature passes Dirigo Health Reform package, signed by Gov. Baldacci into law
September 2003	Dirigo Health Reform Act becomes law, governor nominates Dirigo Health Board
May 2004	Dirigo Health Agency releases RFP, seeks carrier to offer DirigoChoice health plan
June 2004	State receives bid from Anthem
October 2004	Small businesses, sole proprietors able to sign up for coverage
February 2005	Individuals able to sign up for coverage
April 2005	State announces membership of 5,263 in DirigoChoice
October 2005	Ruling states Dirigo Health initiatives have resulted in \$43.7 million in savings, amount used to determine amount of savings offset payment on insurers. Amount is unsuccessfully appealed by Maine Association of Health Plans, Maine State Chamber of Commerce, Maine Automobile Dealers Association Insurance Trust and the Maine Bankers Health Trust
January 2006	Savings offset payment to continue Dirigo's funding begins
May 2006	Governor creates Blue Ribbon Commission to study Dirigo's funding mechanism
December 2006	Blue Ribbon Commissions suggests increase in "sin taxes" to help replace savings offset payment

Source: HealthLeaders-InterStudy

Enrique Martinez-Vidal, acting director of State Coverage Initiatives at AcademyHealth, a Washington, D.C.-based health services and policy research organization, said while the attempt may have been good, the funding issue has become the proverbial thorn in the state's side.

"Maine was trying to be upfront about [the savings offset payment], saying we are going to be finding the savings and recapturing them. Maine has tried to create this link and it has become very controversial," he said.

Baldacci hasn't yet tipped his hand, though state officials do realize the storm clouds are multiplying. "The funding of DirigoChoice is controversial and I recognize that we need to get back to a consensus—much like we did when the Dirigo Health Reform was originally created—so we can build on the foundation we have laid," said Trish Riley, director of the governor's office of health policy and finance.

Kristine Ossenfort, senior governmental affairs specialist for the Maine State Chamber of Commerce, said while the chamber has concerns about increasing taxes, it supports the idea of the program being funded through the state's general fund.

"The savings offset payment imposes the costs of funding the program on those employers and individuals who are buying insurance today," Ossenfort said. "A reduction in trend simply does not translate into cash in hand with which to pay the assessment. If expanding access to health insurance through the Dirigo Health program is a priority for the state, as such it should be funded by the state."

**Views From The Board.** Members of the Blue Ribbon Commission contacted by HealthLeaders-InterStudy said the group worked hard to produce solid suggestions for the governor to consider. "I think it is hard to judge what will

happen, but it is a conversation Maine needs to have," said Katherine Pelletreau, executive director of the Maine Association of Health Plans and a member of the commission. "When Dirigo passed in 2003, Maine didn't have this conversation. A lot of the details of the savings offset payment were not clear, and proposing sin taxes to pay for expansion of health insurance will at least force that conversation, which is a good thing."

Steven Michaud, president of the Maine Hospital Association and a member of the commission, said while he strongly favors a new funding mechanism, he remains unsure of the proposal's ultimate fate.

"The [funding mechanism] in my opinion is broken and needs to be fixed," Michaud said. "On the other side, we have a funding mechanism that is in place, and the political reality is there may be some reluctance to increase taxes to fund Dirigo. Replacing the savings offset payment would get rid of the controversy, but that is easier said than done. It depends on what hills the legislature and governor want to climb this session."

Joe Ditre, executive director of Consumers for Affordable Healthcare and another member of the commission, stressed that the tax decision did not mean everyone was giving up on the savings offset payment.

"It is the only way of funding Dirigo's subsidies that is now on the books, and we are not recommending taking that off the books until we have something else," Ditre said. "And even if we get something else in place, we still may find that as a credible way of adding additional revenue dollars into the system. It's very uncertain as to what's going to happen."

Ditre said he is confident a bill that would give the Dirigo Health Board the authority to self-insure the DirigoChoice

health plan product will pass this year, predicting that would ultimately chart a different course for the program. “If we start to reduce administrative overhead and the profits, you can bring the price point down,” he said.

**But Is It Working?** Nearly half of the 13,290 Dirigo-Choice enrollees are individuals, while 27 percent are sole proprietors and their dependents and another 27 percent are enrolled through a small business, according to the Dirigo Health Agency.

“It takes time for a program to get up and running and get the buy-in from the people they are targeting,” said Academy-Health’s Martinez-Vidal. “It is important to give plans time to reach a certain level of maturation.

“There is some criticism because they didn’t get the enrollees they originally talked about. It’s walking a fine line,” he said. “When they originally started out with the reform, they wanted to have a big impact but they created high expectations. It’s a fine line between expectations and reality and Maine is hitting that line. I think it’s actually doing quite well, given the state’s percentage of uninsured and the numbers they have reached out to.”

Besides the funding mechanism, Dirigo has been caught up in politics and perhaps unrealistic expectations. “The problem is, it is a very political issue and always has been,” the hospital association’s Michaud said. “The widespread view of DirigoChoice is that it is underperforming. But in fairness, the number of enrollees is not all that far off from what other states experience when doing something like this. It takes awhile.

“The problem is the rhetoric behind Dirigo was so inflamed in 2003 when they were saying they were going to have universal coverage in five years. They talked of having 31,000, while in three years it’s at 12,000. There were over-hyped expectations surrounding its creation.”

The Maine Chamber of Commerce has expressed concern about the long-term sustainability of the program, noting the number of individuals enrolled in the program is increasing dramatically as a percentage of total enrollment when compared to sole proprietors and small business enrollees,

and that the number of people receiving the highest level of subsidy is continuing to increase.

The state, for its part, vigorously defends the program. The state’s Riley pointed to the \$78 million in savings it was found Dirigo produced over a two-year span, with the growth in hospital charges slowed by an average of 9.4 percent from 2004–2005. Riley also points out the program also funds coverage for more than 5,000 parents through MaineCare, for example, building on Medicaid and making modest expansions in eligibility.

**Mandate On The Way?** Meanwhile, the state is set to potentially explore the possibility of both employer and individual mandates. Ditre says it is something the commission urged the administration to strongly consider.

“The commission didn’t calculate what an employer mandate would bring in because nobody could agree on what the fee would be, and who it would be imposed on. I think people wanted to get to that item but time ran out,” Ditre said. “The report says the commission by majority vote supports an employer mandate to provide coverage and would set up a working group to create the outline of what that mandate would be—a tax on payroll, a fee, an assessment, etc. This could be the most significant form of funding but it all has to be figured out.”

Indications are the state could be open to such a measure. “We started our efforts with a voluntary approach, believing it was unfair to require coverage unless and until costs are brought under control,” Riley said. “Efforts to control costs are under way and need more attention but we, too, are now ready to explore mandates to assure everybody has coverage and that we can work to lower healthcare costs.”

**OUTLOOK:** *Expect debate to be heated this legislative session around the idea of upping taxes and doing away with the savings offset payment. Still, conventional wisdom says something has to be done to lessen the controversy and get on about the business of improving the program. Now is the time to get that done, so the onus is on lawmakers to produce.* ■

# Wellness Plans Draw Mixed Reactions In R.I.

By Ric Gross

Though Rhode Island is just out of the starting block with its new healthcare initiative, concerns are mounting about the cost and design of the program.

In late December, the state's Office of the Health Insurance Commissioner issued product requirements for a wellness benefit plan required to be offered by Blue Cross & Blue Shield of Rhode Island and UnitedHealthcare to businesses with fewer than 50 employees and individuals who purchase healthcare insurance directly from the Rhode Island Blues (known as Direct Pay subscribers).

The product, which insurers are required by law to offer by May 2007, seeks to provide comprehensive benefits and lower premium costs by giving incentives to enrollees who are actively engaged in managing their own healthcare. The WellCare Advisory Committee—a group consisting of small employers, Direct Pay subscribers, employer organizations, health insurance brokers, consumer advocates and labor unions—met throughout late 2006 to develop plan requirements.

The group was required by law to develop a plan with an average premium of less than 10 percent of average wages, or approximately \$314 per month for individual coverage (\$691 for a family), which compares to typical small group premiums exceeding \$400 per month. The committee was charged with balancing the desire for comprehensive coverage and the need for a lower price.

The insurers submitted plan designs to the state in mid-January, with the WellCare committee set to evaluate the offerings Feb. 1.

Matthew Stark, principal policy associate in the Office of the Health Insurance Commissioner, said an estimated

120,000 will be eligible for the plans, though nowhere near that number is expected to sign up.

"We support the effort, however we do have strong concerns about portions of the proposed plan design," said Kim Keough, spokeswoman for Blue Cross & Blue Shield of Rhode Island. "We will certainly continue to work with the committee to develop a plan that meets the objectives. We just don't feel in its current form that it is financially sustainable. We don't think it is actuarially sound under the current criteria. The OHIC is open to suggestions, and we have articulated our concerns to them."

**Plan Requirements.** Committee members put forth requirements for a plan that relies heavily on wellness incentives in an effort to keep costs down. Initiatives call for enrollees to select a primary care physician; complete a health risk appraisal; pledge to either remain at a healthy weight or participate in weight management programs if morbidly obese; pledge to either remain smoke free or participate in smoking cessation programs; and pledge to participate in disease and case management programs if applicable.

Enrollees would have deductibles, copays and coinsurance reduced to amounts normally seen in plans with much higher premiums. For example, in the committee's proposed plan, an enrollee opting for the wellness programs would benefit from a \$500 deductible and \$3,000 maximum out-of-pocket expense versus \$3,000 and \$6,000, respectively, for an enrollee opting out of the wellness program.

In the first year of the program, enrollees will be asked to promise to participate, whereas in the second year, they will be asked to prove participation.

## COMPARING DESIGNS OF WELLCARE WITH OTHER RHODE ISLAND PLANS

Comparable Plans	UnitedHealthcare	WellCare	BC/BS RI
Estimated individual premium	\$315	\$314*	\$341
In-network deductible	\$1,000	\$500†	\$2,000
Hospitalization coinsurance	0% after deductible	0% after deductible	20% after deductible
Other coinsurance	0%	0%‡	20%
Office visit copay (primary/specialist)	\$20/\$20	\$15/\$30‡	\$15/\$25
Urgent care copay	\$50	\$50	\$25
ER copay	\$100	\$100	\$100
Prescription copays	\$10/\$30/\$50	\$5/\$40/\$75	\$7/\$30/\$50

Note: This chart uses estimates and benefit summaries that are for comparison purposes only; actual rates vary based on group demographics.

\*Target premium established by the Legislature.

†For subscribers engaged in the five wellness programs.

‡0% for most benefits; 10% or 20% for select benefits.

§For Tier 1 providers.

Source: Rhode Island Office of the Health Insurance Commissioner

“They are trying to attack the issue of cost through this program. A lot of cost drivers are related to wellness and chronic care. The state is trying to focus on that and affect behavior change,” said Enrique Martinez-Vidal, acting director of State Coverage Initiatives at Academy Health, a Washington, D.C.-based health services and policy research organization.

John C. Gregory, president and CEO of the Northern Rhode Island Chamber of Commerce and a member of the committee, said the group felt its plan requirements were a good place to start the discussion.

“We are not asking carriers to design a program that they are going to lose money on, but we had to get the dialogue going,” he said. “What are some other ways than the traditional plan? The plans have been very cooperative, but I would have been surprised if there wasn’t any type of resistance.”

Another aspect of the plan is the reliance on tiered provider networks. The plan will encourage enrollees to select providers who have demonstrated cost-effective, high-quality practice patterns, with enrollees paying extra for a provider not in a plan’s Tier 1 network, for instance.

**Major Concerns.** Questions concerning the proposals have centered on the length of time for wellness initiatives to pay off, whether premiums will be so low that the plans will be financially unsustainable, and the best method of tiering providers.

Keough said there is no sound way to tier providers in terms of quality, and the Rhode Island Medical Society has put up a red flag as well over the idea of determining quality based on claims data.

Edward M. Mazze, Distinguished University Professor of business administration at the University of Rhode Island and a member of the governor’s insurance council, said there are just too many questions surrounding the plan.

“The notion of figuring out who cost-efficient providers are going to be will take a considerable amount of time,” Mazze said. “We are going to need a definition of what cost-

efficient providers are. There is just insufficient quality data available to support that concept.”

Mazze said the cost level, as it looks now, could still be too expensive for many. “Many jobs that are going to be covered in this program are not high-paying jobs, such as minimum wage workers in the leisure and hospitality industry,” he said. “It’s a great idea to look at this type of program, but from an economic point it will be difficult to support it.”

Mazze said it was understandable the health plans have concerns, ranging from designing a financially stable plan, to ranking providers on down to determining a way to police enrollees’ adherence to the wellness provisions.

“If the plans lose money on this, who else is going to pay? I can’t imagine they’d want to pass the losses on to the premiums of programs doing well for them,” he said. “If they lose money on the way they set their premiums, that money is going to have to be found. So, when they negotiate their contracts with large employers, they will end up raising the rates.”

The Northern Rhode Island Chamber of Commerce’s Gregory said an intense education program would be needed as the plans become available in the marketplace.

“We could put it out there and people could say they aren’t interested because the deductible is too high,” he said. “And having a limited network, we aren’t sure if that will be a plus or minus for folks.”

Stark acknowledged designing competitive benefits is a challenge. “Where are you able to make some cuts? If you want to keep premiums and cost sharing down, what are you willing to trade off? We aren’t talking about a stripped-down plan design.”

**OUTLOOK:** *While benefit designs for the new program in Rhode Island are still up in the air, the state’s efforts to create plans linked to wellness should be lauded. Whether residents are prepared to take the leap into such designs, however, remains a big question.* ■

# Anthem BC/BS Unveils BlueOptions In Maine

By Ric Gross

While Maine is working to enroll more small businesses in its DirigoChoice product, another option has just become available in the marketplace.

Through an alliance between the Maine State Chamber of Commerce and Anthem Blue Cross and Blue Shield, businesses with two to 50 workers, as well as sole proprietors, who are members of a local or regional chamber of commerce now have access to a suite of five health plans called Chamber BlueOptions.

Included in the mix are three PPO plans with varying deductibles and coinsurance levels, as well as an HMO and health savings account options. Coverage became available Jan. 1, and all involved stress the offerings are not in competition with the state's subsidized DirigoChoice product.

Anthem administers the state's DirigoChoice, a PPO plan available in the state with sliding-scale discounts provided to members with household incomes below 300 percent of the federal poverty level. As for businesses, premiums vary depending on the size of the employer, average age of the members, type of business and geographic location.

"We don't see this as being in competition with Dirigo, but rather complementing it," said John Cooper, Anthem regional vice president for sales. "We see this as another choice in the marketplace. We think bringing more options is important, and now you have this and the DirigoChoice product.

"Also, with Dirigo there is an additional segment it is meeting the needs for, the individual market, and there are subsidies with DirigoChoice," Cooper added.

Another piece that differentiates the products is that, with DirigoChoice, for a small business choosing to participate, 75 percent of eligible employees who do not have other creditable coverage must be enrolled in the program,

and businesses must contribute at least 60 percent of the premium for full-time employees.

With Chamber BlueOptions, Anthem was able to gain approval to offer a product whereby only 60 percent of eligible employees are required to sign up for group coverage.

"This gives employers a little more flexibility," Cooper said. "Lowering the threshold from 70 to 65 percent is significant to employers who previously did not offer a health insurance benefit."

**Plan Development.** In putting together the product, Cooper said the insurer wanted to offer something with unique elements tailored to the Maine marketplace.

Being able to offer five choices was a key ingredient to the plan, Cooper said, as was gaining approval for the 60 percent participation threshold. A third aspect is a wellness component, whereby employees can qualify for a 2 percent discount on annual premiums if they undertake certain wellness activities. The discount would become available at employees' annual renewal in 2008 for groups of 25–50 employees.

"A fair amount of healthcare costs are driven by our own behavior, and we think this adds a nice element to the offering," Cooper said.

Joyce LaRoche, vice president of membership and marketing for the chamber, said the product has had favorable reactions. "We've been pleased with the response so far," LaRoche said. "There has been a lot of interest and we've had a number of groups sign up already. The product seems to be a good fit with the needs that are out there."

Cooper said the HSA option should see increased interest in the next few years. "This is really our first comprehensive [consumer-driven health plan] entry into [in Maine], and we expect to see an increase in enrollment in our consumer-driven options in 2007, 2008 and 2009." ■

## ANTHEM BC/BS'S 'MAINE' FOCUS

Product	Audience	Key Features
Chamber BlueOptions	Small businesses who are members of local or regional chamber	Five plan offerings, including HSA
DirigoChoice	Small businesses and individuals	Premiums are subsidized depending on income

Sources: Anthem BC/BS, DirigoChoice

# CIGNA Rolls Out HSA-Qualified Plans In N.H.

By Ric Gross

Six months after launching a health reimbursement arrangement product for midsize groups in New Hampshire, CIGNA HealthCare has added to its consumer-driven product portfolio in the state.

Effective in the first quarter of 2007, New Hampshire employers with 50 or fewer employees will have access to a CIGNA health savings account option through JPMorgan Chase. The offering is part of a product expansion that saw the insurer expand its small-group HSA qualified plan in Arizona, North Carolina, South Carolina, Connecticut, California, New Jersey and New York, with further rollout planned the remainder of the year.

Dave Raccagni, vice president of small-business product marketing for CIGNA HealthCare, said consumer-driven options have been a bit slower to catch on in New Hampshire, but he expects that to change.

"We expect to see consumer driven and HSA adoption pick up in 2007 and into 2008," Raccagni said. "We think it will catch up fairly quickly to some other markets."

Tom Harte, president of New Hampshire's Landmark Benefits, agreed. "The New Hampshire health insurance marketplace has transformed itself from a state where consumers could not locate a HSA-qualified plan to a state where each of the major health insurance companies offers

this product," Harte said. "Determining if this new product to New Hampshire is competitive will take time; however, CIGNA's entrance into this market demonstrates that HSA plans are a long-term viable option for the New Hampshire health insurance consumer."

Raccagni said there are encouraging signs nationally that interest has picked up in such offerings among the small business community.

"Consumer-directed health plans, such as HSAs and HRAs, are a national trend. Some states like New Hampshire may be adopting a bit slower, but we do see a lot of interest and I expect New Hampshire will follow the trend. Certainly, the signs are good. We're providing an option in a market where it's really needed," he said. "I think in the small group market at the moment and for the foreseeable future, HSA plans are the preferred option to HRAs, though it's very possible that could change."

As for when the product will be available in New Hampshire, Raccagni said CIGNA began quoting Feb. 1, with a targeted effective date of around April 1 or shortly thereafter.

"Everything is on track," Raccagni said. "We have been reaching out to brokers and the plans are all in place."

**National Sign Up, Satisfaction.** Nationally, HSAs have yet to have the big "break out" year that many experts began predicting when they were first introduced as part of the Medicare Modernization Act of 2003.

According to a study released in December by the Employee Benefit Research Institute and the Commonwealth Fund, enrollment in CDHPs was virtually unchanged from 2005 to 2006. The study finds that only 1 percent of the privately insured population ages 21 to 64 are enrolled in a CDHP. An additional 7 percent are enrolled in high-deductible, CDHP compatible plans. However, industry estimates put the number at 3 million to 4 million.

CIGNA HealthCare expects its CDHP membership to double in January 2007 and grow to approximately 650,000 by year-end 2007.

The jury is out on just how satisfied consumers who do sign up for a CDHP are with their plan.

According to the EBRI/Commonwealth study, individuals enrolled in CDHPs are more dissatisfied with their health plans than individuals in more comprehensive plans. CIGNA says a year-long analysis of 38,200 claims users of CIGNA Choice Funds show they are becoming more cost conscious but are not sacrificing their care.

Despite differing views on what CDHPs will do, or how effective they will be, carriers are committed to them and more will undoubtedly expand their CDHP options in 2007.

Nationally, CDHPs were given a new boost in December

## CIGNA HEALTHCARE'S ANALYSIS OF CONSUMER-DRIVEN TRENDS

**CIGNA examined 38,200 enrollees in CIGNA Choice Fund from 44 client groups and found in a study released in November of 2006 that:**

- » Total medical (non-pharmacy) costs were 16 percent lower than costs for those enrolled in traditional plans.
- » Pharmacy costs increased slightly over the prior period but were 12 percent lower than traditional plan costs.
- » Choice Fund members increased their use of preventive-care services by 8 percent and were also 12 percent more likely than those enrolled in traditional plans to seek preventive care services.
- » Consumers reported their awareness of the costs and quality of care had increased compared to two years ago (39 percent for cost, 47 percent for quality).
- » Costs associated with chronic care and episodic care declined 2.9 percent and 8.4 percent, respectively.
- » The majority of plan sponsors established individual HRA funds of \$500 or more.
- » 91 percent of plan designs had in-network coinsurance of 20 percent or less.

Source: CIGNA HealthCare

when Congress passed legislation allowing an increase in contribution limits for HSAs for all individuals, the elimination of contribution penalties for mid-year enrollees.

Karen Ignani, president and CEO of America's Health Insurance Plans, has praised the legislation saying it will be positive for consumers and the consumer driven movement. ■

## R.I. Blue Cross 'Institutes' Wellness Offering

By Ric Gross

Wellness programs have certainly gained a significant amount of traction in recent years, as insurers and employers have embraced the idea that a healthier population will help drive down the cost of healthcare.

With this in mind, Blue Cross & Blue Shield of Rhode Island has developed its Health & Wellness Institute, which will offer products such as smoking cessation management programs and classes on exercise and nutrition. The Institute will also sell its programs and services to other Blues plans across the country and other out-of-state organizations interested in offering health and wellness programs to their members.

"Blue Cross & Blue Shield of Rhode Island recognized a fiduciary responsibility to not only treat people who have illness, but also a fiduciary responsibility to help people stay well," said Michael Samuelson, president of the Health and Wellness Institute. "The treatment model is broken. The money is going into treatment and the amount going into this keeps getting bigger and bigger. The system is where treatment comes when you wait and are dealing with an illness, and from an economic standpoint it is broken.

"Early intervention and deterrent are what we are seeing nationally," he added. "At the workplace, another issue is productivity, making sure workers are on the job and productive. Everybody wins."

A recent survey by consulting firm Hewitt Associates found that 42 percent of companies offered some type of health-risk assessment in 2005, up from 29 percent in 2001. Mercer Health & Benefits surveyed smaller employers, those in the 10-499-employee group, and found that 41 percent offered at least one disease management program last year, compared with 31 percent in 2004, and nurse lines were available from 41 percent of those surveyed in 2005, up from 35 percent in 2004.

**The State Of Wellness.** Only 22 percent of adults in the state engage in regular physical activity, 1,500 Rhode Islanders die from smoking every year, and 57 percent of adults statewide are considered overweight or obese, according to the Rhode Island Department of Health.

Samuelson said a well-rounded wellness campaign could certainly help with such numbers and impact the entire affordability issue. "For individuals and employers, we have to get on the left side of the continuum, which is preventive," he said.

In addition, Samuelson noted a number of insurers may be looking to provide this service, but need help on how to get started. He noted the Rhode Island Blues had extensive experience before even launching the Institute.

"What is unique about Blue Cross & Blue Shield of Rhode Island is that for the last 20 years or so they have been developing worksite wellness programs for their members. They have a long history of developing programs such as this," he said. "This is an opportunity to take this product and offer it on a national basis, expanding the mission and helping improve lifestyles. And the money will go back to the state."

Jim Watt, president of Employee Benefits Solutions Inc., a Houston-based healthcare-consulting firm, who follows such initiatives, said well-run wellness programs could make a significant difference

"Targeted wellness initiatives, if well planned and executed upon, can provide enormous dividends for employers both in terms employee sentiment toward the organization that they are employed by, and in the form of true financial savings and/or cost avoidance," Watt said. "Some of the better wellness programs encompass health interventions related to pregnancy, cancer (breast and prostate), and diabetes, among others. Even flu shot programs, if managed properly, can provide a substantial return on investment in employee productivity and managed absenteeism."

Samuelson said the program allows for a personal health audit, and programs can be designed and administered around an individual's health needs. In addition, Samuelson said the program offers a corporate health audit, which incorporates the personal health audit. It can pinpoint what areas to focus on, for example

"An organization may feel the biggest problem is stress, but it may be weight, for example. This tool will help with that," he said. "Once we get a picture of where you are, we can provide the programs for them. We can go onsite and do all the clinical work and get the whole process started."

Samuelson said plans call for setting up Centers of Excellence in different parts of the country, hiring local staff to provide services.

"The concern is not growth, but controlled growth. There is much more demand than what can currently be provided services for, and we want to expand in a quality way," he said. ■

## People In The News

Please send announcements to Ric Gross at [rgross@healthleaders-interstudy.com](mailto:rgross@healthleaders-interstudy.com).  
Announcements may also be faxed to 615-385-4979.



S. Srivastava

**CIGNA HealthCare Inc.** has hired **Sam Srivastava** as the president of its senior segment where he will be responsible for the segments products and services. Srivastava has 15 years' experience in leadership roles at UnitedHealthcare, Ovations, Health Net and Americhoice.

Also at CIGNA, **Eric Elliott** is the new president of CIGNA Pharmacy Management. Elliott once ran product, sales and e-business for CIGNA Pharmacy Management—and led CIGNA's Tel-Drug business—before leaving for Aetna to lead their pharmacy and benefit/voluntary business units. He previously held leadership roles at PCS HealthSystems and Rite Aid Corp. ■

# New Hampshire Sets 2008 E-Prescribing Goal

By Ric Gross

A major electronic health initiative is under way in New Hampshire that state officials say will result in 100 percent e-prescribing capability in the state by October 2008.

While it's an aggressive goal, an estimated 70 percent of pharmacies in the state are already able to receive electronic prescriptions from physicians, according to SureScripts, which operates the Pharmacy Health Information Exchange.

New Hampshire Gov. John Lynch is a strong proponent of such systems, and has led the way by creating the Citizens Health Initiative in early 2006 to bring together providers, insurers, business leaders, consumers and state officials to improve access to care and quality and reduce healthcare costs.

Lynch said New Hampshire would be the first state in the nation where all healthcare providers are able to prescribe medication electronically, if the goal is met. The plan calls for all primary care providers to have the ability to prescribe prescriptions electronically by October 2007 and for all clinicians to do so by October 2008.

The idea certainly has its merits. In July 2006, the Institute of Medicine released a study estimating that problems with the prescription drug system—such as uncertainty about what the doctor prescribed, an inappropriate medication for the patient, wrong dosages or just the wrong drug—cost the healthcare system \$77 billion a year nationally.

State officials noted those costs total \$300 million a year in New Hampshire, for new prescriptions, repeat doctor visits, lost time at doctors' offices and pharmacies, and in-hospital admissions because of adverse drug reactions.

In addition, state officials pointed to Institute of Medicine estimates that 7,000 patients nationally—or up to 30 per capita in New Hampshire—die each year as a result of adverse drug reactions, and 1.4 percent of hospital admissions every year are the result of adverse drug reactions, equating to up to 1,700 hospital admissions in New Hampshire at an average cost of \$10,000 per patient.

The study suggested healthcare providers move to e-prescriptions, a method with proven results. But can New Hampshire reach its lofty 100 percent participation goal? Probably a long shot, but certainly not out of the question.

Kate Berry, senior vice president of business development and alliances at SureScripts, said the Governor's Citizens Health Initiative did its homework. "They considered a number of different projects and focused in on connecting physicians and pharmacies to enable electronic exchange of prescriptions because the infrastructure is already in place."

Berry said Lynch's 100 percent penetration goal is aggressive, but one the state can achieve.

**Why New Hampshire?** "New Hampshire is unique, and that's why in some ways they may be able to move faster

## PHARMACIES CONNECTED FOR E-PRESCRIBING

- » Brooks Pharmacy
- » CVS
- » Family Pharmacy
- » Hannaford Food & Drug
- » Nashua Medical Group
- » Rices Pharmacy
- » Rite Aid
- » Sam's Club Pharmacy
- » Stop & Shop Pharmacy
- » Target Pharmacy
- » Teamsters Rx
- » The Medicine Shoppe
- » The Pillbox Pharmacy
- » The Prescription Center
- » Walgreens
- » Wal-Mart
- » Wingate's Pharmacy Inc.

Source: SureScripts

than other places," Berry said. "First it's a smaller state, and there is already a collaboration in place between community and key leaders. In addition, there is a high concentration of healthcare professionals already using electronic medical record systems, as opposed to being totally paper based. Often, the biggest challenge is for physicians to move from a paper world to an electronic one, and most of these physicians are already accustomed to electronic systems."

Gary Sobelson, M.D., past president of the New Hampshire Medical Society, concurred, saying the state has roughly 2,800 doctors, with many physicians employed by larger hospitals. "There is a very high level of acceptance among doctors for this type of endeavor, a lot of us are already using it and are familiar with it," said Sobelson, who uses such a system in his office in Concord. "I see it as extending what we are already doing to other pockets of doctors."

Most pharmacists can accept e-prescriptions, Berry said. "They are ready to communicate electronically with the physicians right now," she said. "So there is already a good foundation in place to build upon."

Berry noted that currently in New Hampshire, more than 70 percent of the pharmacies are on the Pharmacy Health Information Exchange, which is operated by SureScripts. Included in this mix are Brooks/Eckerd, CVS Pharmacy, Rite Aid, Stop & Shop, Walgreens and Wal-Mart, in addition to many independent pharmacies, Berry added.

SureScripts certifies more than 60 electronic prescribing and EMR systems, Berry said.

Sobelson added that the goal should be to get everyone on compatible systems that have similar features.

"Some of our rural physicians are among the leaders in using electronic health records already, but systems like this will highlight the importance of high speed Internet for those who do not," Sobelson said. "The issues of economics

and state support are yet to be explained in detail, but the information technology explosion that is already going on in New Hampshire hasn't needed public financing. Doctors and hospitals are making the investment because they see it as the best thing for their patients."

There is no mandate for participation, and there are no indications the state is putting money toward the effort. However, state officials have noted e-prescribing can be done with something as simple as a Blackberry. In addition, officials announced dialogue is ongoing with health plans to develop pay-for-performance standards that will reward healthcare providers for meeting benchmarks for high-quality care, and make it easier for them to obtain technology that enables electronic communication with pharmacies.

**EMR Initiative.** Meanwhile, in May 2006 the Citizen's Health Initiative—in partnership with the University of New Hampshire—was awarded a \$350,000 grant from the Agency for an EMR system.

No timetable has been set for implementation, as the state has chosen to focus on the e-prescribing initiative out of the gate. Meanwhile, other states have put their efforts most recently into developing EMR systems.

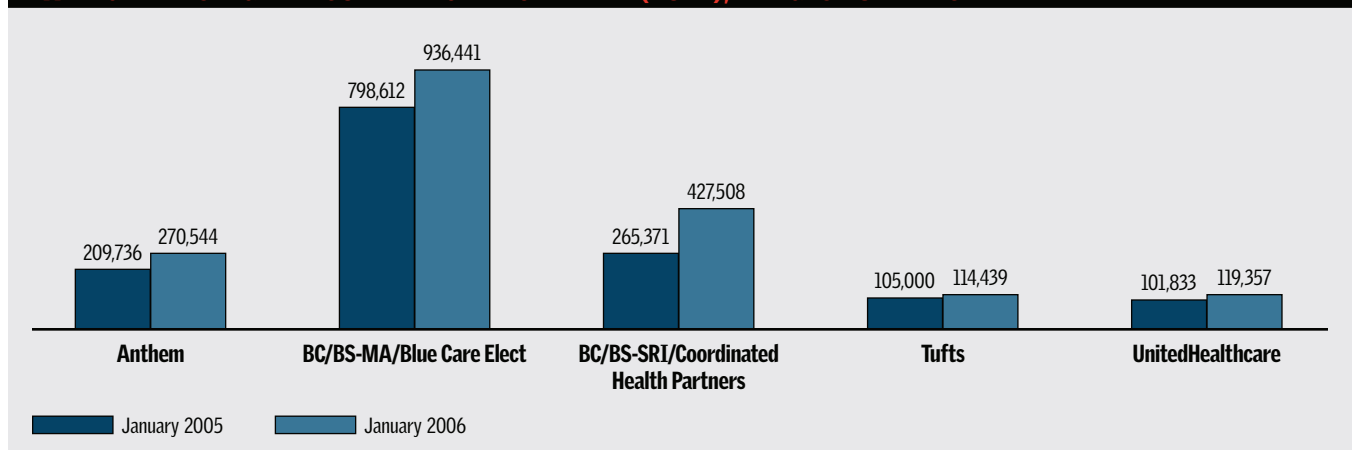
In late 2006 Texas Gov. Rick Perry established the Texas Health Care System Integrity Authority to guide the development of a secure EMR network in the Lone Star State.

In addition, Tennessee Gov. Phil Bredesen issued an executive order in July 2006 establishing a 17-member eHealth Advisory Council, charged with creating a plan to promote the use of EMR, while Wisconsin Gov. Jim Doyle has set up a board charged with developing a plan to automate all healthcare information systems in the Badger State by 2010.

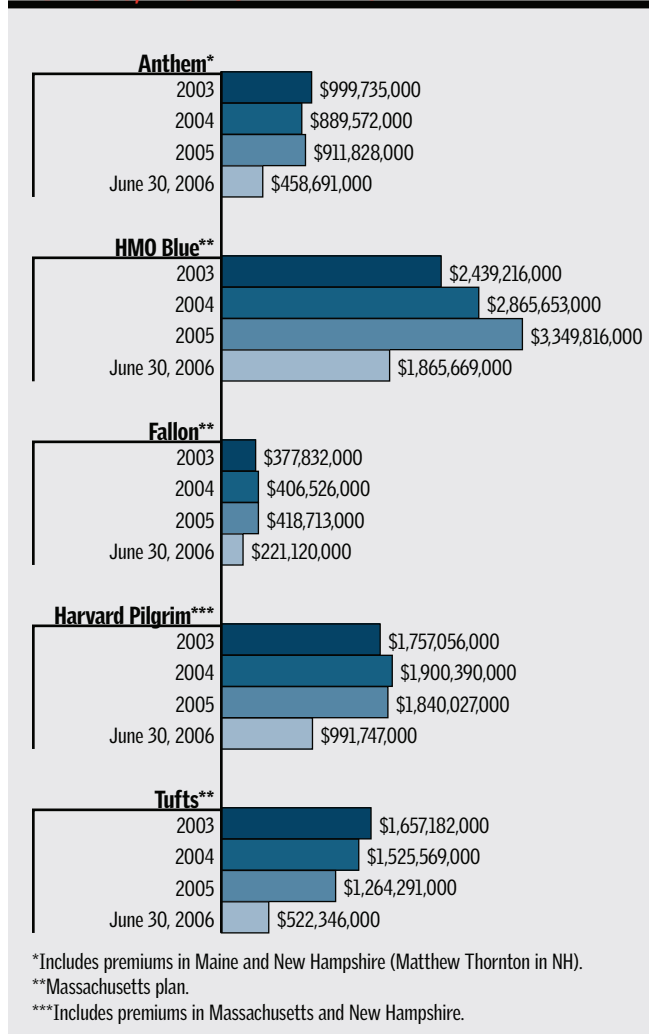
"There is so much now going on across the country [in terms of e-health initiatives]," Berry said. "A few years back we were just trying to educate healthcare stakeholders about e-prescribing, but now the players in the industry are so much more knowledgeable."

**OUTLOOK:** *New Hampshire has come out with seemingly "all-or-nothing" approach in its desire for 100 percent e-prescribing penetration. However, it is not that far-fetched a goal considering the state's geography and the number of physicians. With that in mind, establishing e-prescribing as the initial goal was a shrewd move by state officials, and a more realistic one.* ■

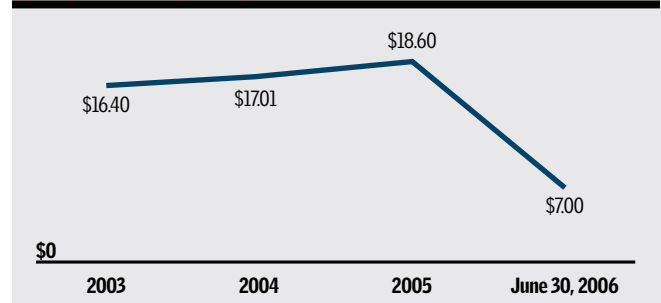
**NEW ENGLAND SINGLE-INSURER PPO ENROLLMENT (PURE), LARGEST 5 PLANS**



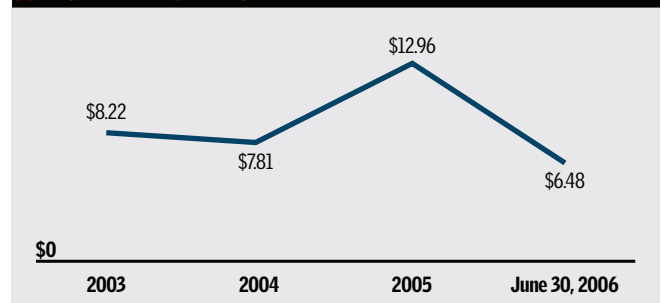
**NEW ENGLAND HMOs' COMMERCIAL PREMIUM REVENUES, REVENUE LEADERS**



**MAINE HMOs' NET INCOME PMPM, WEIGHTED AVERAGE**



**MASSACHUSETTS HMOs' NET INCOME PMPM, WEIGHTED AVERAGE**



**NEW HAMPSHIRE HMOs' NET INCOME PMPM, WEIGHTED AVERAGE**

