

# Texas

## Health Plan Analysis

Summer 2008 Vol. 10 No. 3

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# Coming Soon To Texas Scene: PPO Regulation?

By Bill Melville

A regular review of the Texas Department of Insurance could lead to the agency gaining some regulatory power over PPOs operating in the Lone Star State.

While a commission has not finalized its recommendations on TDI, its initial ideas include mandating that all PPO networks obtain certificates of authority from TDI to operate in Texas. However, the form that regulation should take differs greatly depending on the lobby weighing in.

“It’s a question of what regulation should be imposed,” said Charles Bailey, general counsel for the Texas Hospital Association, which supported the recommendation.

Four key findings emerged from the commission report:

- Texans increasingly receive their health insurance through PPOs.
- TDI’s authority extends to some types of health insurance, but not PPOs.
- The lack of TDI governance over PPOs is behind the times and could harm consumers.
- While the Texas Legislature gave the TDI power to study lack of PPO regulation, it does not have the ability to effectively regulate them.

Under the commission’s initial recommendations, any PPO operating in Texas would need a certificate of authority, and TDI could act against PPOs engaging in illegal practices. The department would also begin to track and analyze PPO complaints. TDI agreed but wanted to modify the recommendations to outline what a PPO must do to hold onto its certificate of authority.

**Critical Commission.** The Texas Sunset Advisory Commission examination of the TDI is a thorough look at whether the department should continue to operate or have its functions merged with another. It has effected health-related agencies before—two decades ago, a sunset review rolled operations of the Texas Health Facilities Commission into other agencies.

Of the state’s 5.5 million fully insured residents, HMOs serve only about 1 million, with PPOs covering the rest.

“Requiring PPOs to obtain a certificate of authority to operate in Texas would ensure that TDI has information about these entities, and could take enforcement action against them if necessary. This minimal certification process would allow the state to look at the problems that can occur among PPOs, providers, insurers, and consumers,” the commission concluded in its June report.

The organization representing the state’s health insurers we braced itself for new regulations, as long as they’re narrowly applied.

“It’s something they’ve experienced in other states, and something we understood would probably come up. We’ve

## RECOMMENDATIONS FOR REGULATING PPOS IN TEXAS

- » PPOs that operate in Texas would be required to hold a certificate of authority.
- » The certificate would be issued once and not subject to renewal.
- » The certificate would grant some regulatory authority to TDI if PPOs engage in unauthorized practices.
- » Applications must include a provider contract template.
- » TDI would track and analyze complaints against PPOs.

Source: Sunset Advisory Commission Hearing Material, Texas Department of Insurance

begun to realize they often confuse the activity of PPO networks with the plans. We felt it would be appropriate for TDI to know how many are out there and have some information on them,” said Jared Wolfe, executive director of the Texas Association of Health Plans.

In its comments to the commission, TAHP supports the recommendation, as long as proprietary PPOs—those run by insurers directly—are not included.

“First, whatever action is taken by legislators, a large portion of the commercial marketplace will continue to be self-funded and exempt from regulation by the state. The commission should be clear in its recommendation that self-funded plans will not be subject to regulation,” Wolfe said in his comments to the commission. He goes on to say that because proprietary PPOs already fall under TDI’s purview as licensed insurers, they should not be subject to the new regulations.

**View From Provider Groups.** However, the Texas Hospital Association takes the position that PPOs should be open to regulation, whether proprietary or servicing a self-funded plan, Bailey said.

“We’re interested in the PPO as an independent entity that’s working with the employers and insurance companies. To the extent that those PPOs are contracting with self-funded ERISA plans, we’d argue they can be regulated. We understand there are limitations to ERISA, but arguably the state could regulate a PPO contracting with a self-funded employer. That will be a very contentious issue,” Bailey said.

In public comments to the commission from John Hawkins, THA’s senior vice president of advocacy and government affairs, the organization said existing state law for preferred provider benefit plans should be applied to PPOs to aid consumers and providers in better navigating the system.

“The establishment of these types of standards on PPOs will ensure transparency and accountability for this sector of the health insurance industry and will provide TDI with an appropriate regulatory framework to monitor compliance,” he said.

**LARGEST PPOS IN TEXAS (JAN. 1, 2008)**

| Health Plan                       | Fully Insured | Self-Insured | Total     |
|-----------------------------------|---------------|--------------|-----------|
| BC/BS of Texas                    | 1,993,981     | 1,768,532    | 3,762,513 |
| Aetna                             | 356,001       | 1,568,157    | 1,942,158 |
| UnitedHealthcare                  | 437,007       | 1,041,976    | 1,478,983 |
| Humana                            | 253,281       | 173,567      | 426,848   |
| UniCare*                          | 96,205        | 207,313      | 300,518   |
| Northwest Texas Healthcare System | 49,249        | 43,249       | 92,498    |
| Brazos Valley Health              | 63,300        | 0            | 63,300    |
| PacifiCare**                      | 43,649        | 7            | 43,656    |

\*WellPoint Subsidiary.

\*\*UnitedHealthcare Subsidiary.

Source: HealthLeaders-InterStudy

Certificate of authority might sound like a simple tweak to state law, but it would greatly expand TDI's abilities. As it stands now, "about 150 plans are on file, however, since the PPOs themselves are not regulated, TDI does not have information on how many PPOs exist," the commission's analysis said.

The Texas Medical Association also came out in favor of regulating PPOs. Much of its testimony focused on restricting so-called "silent PPOs," or insurers taking discounts to which they aren't entitled through rental networks and other means.

"Additional regulatory authority will aid TDI in ensuring that consumer claims are fairly settled. It will also protect consumers/patients from exposure to greater out-of-pocket costs than they otherwise would have been responsible for paying," the TMA's comments stated.

The commission acknowledged this in its review, stating, "even when TDI receives complaints about the behavior of a PPO, it relies on the obligations of the licensed plan to

resolve the consumer's complaint. In fact, although TDI does track some information about consumer complaints involving PPOs, because PPOs are not within the department's jurisdiction, that information is not comprehensive."

Other items it proposed for TDI regulation include prohibiting requirements for physicians to take all of an insurer's products, allowing physicians to opt out of a product an insurer offers, requiring health plans to identify all payors with access to a discounted contract rate and allowing physicians to terminate a contract if additional payors use the discount, among others.

**OUTLOOK:** *With the vast majority of insured Texans enrolled in PPOs, a little regulation seems in order—and long overdue. If PPO regulation makes the final cut of the commission recommendations, the regulations should make an appearance when the Texas Legislature convenes in January.* ■

## Silent PPO Debate Primed To Roar Again In '09

By Bill Melville

As officials consider whether to regulate PPO networks operating in Texas for the first time, a stealthier PPO practice has been placed back in the spotlight. Texas already has a law on the books limiting the practice of so-called silent PPOs, but now foes are calling for stronger enforcement and tighter regulations.

The state's physicians reignited the silent PPO debate as lobbies for consumers, the uninsured, health plans and hospitals debated the overall regulation of PPOs.

"PPOs [that] sell, resell, or lease physician contracts without expressed physician authorizations and the insurance companies that solicit these PPO network services and contract rates should be subject to broadened authority," the

Texas Medical Association testified to a sunset commission that regularly reviews state agencies.

The definition of silent PPO changes depending who is asked. The powerful TMA classifies silent PPOs and rental networks under the same banner. In its comments to the TDI, it acknowledged that some silent PPOs are worse than others, noting that some silent PPOs have no contract with physicians, yet purchase data from a third-party broker and take the lowest price.

However, the Texas Association of Health Plans regards rental networks differently. "It is a legitimate practice," TAHP Executive Director Jared Wolfe said of rental networks. "Silent PPOs take discounts without authorization. TMA is

## STATES DEALING WITH SILENT PPOS

- » Several states are dealing with the complicated silent PPO issue. The Texas Legislature, in 1999, passed Senate Bill 130 which ensured that providers are reimbursed on a discounted basis only if they agree to the discount. The statute specifically prohibits an insurer or third-party administrator (TPA) from reimbursing a physician or provider on a discounted fee basis unless:
  - The insurer or TPA has a contract with the provider or a PPO that has a contract with the provider.
  - The provider agreed to the contract terms.
  - The insurer or TPA agreed to provide coverage for health care services under the insurance policy.
- » North Carolina, Louisiana, Oklahoma, California, Florida and Texas have passed regulation of silent PPOs. Ohio and Connecticut this spring became the most recent states to pass legislation defining and regulating silent PPOs. Several other states have statutes addressing the issue.
- » Nationally, the AMA lobbied to get silent PPOs banned from all Federal Employee Health Benefits Plan contracts.

Sources: Florida Medical Association Quarterly, July 2006; American Medical Association; and Texas Department of Insurance

trying to expand the definition to any discount. Our position has been, ‘We have a law. TDI is fining companies that violate that law. What is the problem here?’ Wolfe said he believes the issue is not a problem “based on complaint volume.”

In its comments about the regulation of PPOs to the Texas Sunset Advisory Commission, the TMA railed against silent PPOs and the need for more regulation of the practice.

Wolfe said that the Texas law already covers the practice of silent PPOs. “Silent PPO activity is illegal when you’re taking a discount you’re not allowed to take. I know of at least three instances in the past year when they’ve levied fines against insurers,” he said.

Houston-based broker James Watt, president of Employee Benefits Solutions, said he has not seen large issues with silent PPOs in Texas.

“The founding idea around the silent PPO was to introduce networks cautiously with employers and benefit from some contracted discounts. But that in large part is no longer the case. Silent PPOs are generally now used in more remote areas where there is a rental network or two. Its impact in metro areas is no longer what it used to be,” he said.

However, the American Medical Association estimated in 2003 that physicians nationwide have lost between \$750 million and \$3 billion annually due to the practice, so the financial impact is significant. Plus, as the TMA noted in its primer on silent PPOs, the use of a lower contracted discount through a silent PPO could leave a health plan member on the hook for the balance of their medical costs.

**Early Adopters.** In the past decade, several states have passed limits on the practice, including California, Kentucky,

Louisiana, North Carolina and Oklahoma. The Connecticut Legislature just clamped down on the practice with a new law restricting it. The AMA has succeeded in having silent PPO arrangements banned from the Federal Employee Health Benefits Plan, the nation’s largest single employer group.

Earlier this year, the TDI levied an \$8,000 fine on Great-West Life and Annuity Insurance Co. for taking provider discounts to which it wasn’t entitled. TDI’s order stated that Great-West, purchased by CIGNA this year, had taken the improper discounts on 11 claims in February 2006. The agency also fined WellPoint subsidiary UniCare, Humana and Metropolitan Life for taking unauthorized discounts.

**Tighter Still.** Stronger regulation of silent PPOs came closer in 2007, but it never reached the floor. Aside from the TMA, its supporters also included the Texas Hospital Association.

“We do support stronger enforcement in this area, but for hospitals, it isn’t as a big a problem,” said Charles Bailey, general counsel for the Texas Hospital Association. The American Hospital Association takes a hard line on silent PPOs.

Texas hospitals do see some silent PPO activity, but big systems look for it in their contracting, while rural and smaller town hospitals see it less because they treat high volumes of Medicare and Medicaid beneficiaries.

Hospitals generally monitor their billings and determine whether the appropriate discount is applied or not. Some can tell who is likely to sell discounts and who isn’t,” Bailey said.

While TAHP testified against the bill, its discussions with supporters almost ended in a compromise, Wolfe said.

“We spent months in negotiations and early signed off on final legislation. We were real close and it didn’t happen because the bill got stalled. It was consistent with our position from the beginning,” he said.

The Sunset Advisory Commission report will serve as an outline for legislation related to the insurance department in the 81st legislative session. Wolfe said he expects silent PPO legislation to return in 2009, but is unsure what direction it might follow.

“Their new definition of silent PPO is very different from what we were talking about in the earlier negotiation. Other states have passed some laws. Based on our last time around, there were some things we can agree upon,” Wolfe said, but noted that if the other parties return to their starting points in negotiations, TAHP will move accordingly.

**OUTLOOK:** *No matter the depth of the problem, the issue of silent PPOs won’t soon go quietly into the Texas night. With the attention garnered by silent PPOs in state legislatures across the country, the practice will undoubtedly get face time in the Texas Legislature’s 2009 session. After nearly crafting a compromise in 2007, the odds improve for passing a bill next year, so long as the parties don’t return to the drawing board. At a time when all corners of the industry clamor for transparency, silent PPOs won’t be allowed to stay in the shadows.* ■

# 3-Shares: Galveston A Go, Others To Follow

By Bill Melville

Five years in the making, Texas' first 3-share plan became active July 1, extending health benefits to small businesses in Galveston County, many of which never before offered coverage to employees.

With enrollment opening a few months ago, the Galveston 3-Share Plan is up and running for the county's small businesses. It began operating on July 1.

The plan opened with 180 members and will increase to 330 within a month, thanks to brisk enrollment. But the plan will soon reach its enrollment ceiling—it will cap membership at 500 members for the two-year pilot.

"We hope to have our 500 by Sept. 1. The average is right around 4.4 enrollees per group," said Jim Rodriguez, executive director of the Galveston 3-Share Plan.

Based on a model created in Muskegon, Mich., employees and employers will each pay \$60 toward a monthly \$180 premium, with the third share coming from an outside source. The Galveston plan's third \$60 share comes from a \$1.6 million Houston endowment grant and institutional funds. Rodriguez said while the bigger immediate priority is getting the plan off the ground, the search for funds to preserve the plan beyond the two-year pilot period is ongoing. "We are working [on] a strategy about sustainability," he said.

It took five years for the Galveston plan to go from drawing board to reality, but the biggest boost came in the last year, when the Texas Legislature gave the plans permission to proceed. As part of the Texas Communities Health Care Coalition, Galveston and four other regions—Dallas, Houston, Central Texas and El Paso—have pooled their resources and development dollars. The Legislature allowed regions to

create these benefit plans, but provided no funding for the actual programs. However, it did provide some grant dollars to design the benefits plans.

In March, the Texas Health and Human Services Commission awarded the coalition a \$700,000 grant for planning and development. The Brazos Valley Council of Governments also received \$300,000 for development of a 5,000-member multi-share plan in its seven-county region. The Texas Department of Insurance also recently awarded the coalition a grant for planning and development.

**Forming A Network.** Unsurprisingly, the Galveston plan's network centers on UTMB. While it only uses part of the medical branch's network, the plan contracts with some outside providers to ensure emergency room and urgent care coverage spans the entire county, Rodriguez said. The biggest concern was ensuring services for members who lived in mainland portions of the county. It contracted with HCA's Mainland Medical Center for emergency room services, but for primary care, members will go to UTMB and affiliated physicians.

"We are using part of their network. It's a smaller network with a select number of clinics. We've supplemented it with some non-UTMB providers," Rodriguez said.

The UTMB connection opens members to all chronic disease management programs the medical branch administers at no cost. Because the plan does not deny membership based on pre-existing conditions and members might not have seen a PCP in some time, the Galveston plan wants members to undergo screenings.

"We are incentivizing them to get a well-check in the first

## GALVESTON 3-SHARE PLAN COVERED BENEFITS

| Benefit                  | Copay                                | Maximum Benefits                      |
|--------------------------|--------------------------------------|---------------------------------------|
| Physician visits         | \$15 for primary; \$30 for specialty | 20 visits per year                    |
| Urgent care clinic       | \$30                                 | Included in 20-visits max             |
| Emergency room           | \$75                                 | No maximums                           |
| Outpatient surgery       | \$75                                 | No maximums                           |
| Hospitalization          | \$200                                | 30 days per year or \$50,000 per year |
| Scans                    | \$75                                 | No outpatient maximum                 |
| Outpatient mental health | \$30                                 | 12 visits per year                    |
| Outpatient pharmacy      | \$25 for generic; \$50 for brand     | \$1,200 per year*                     |

\*\$4 prescription programs do not apply to the maximum benefit.

Source: Galveston 3-Share Plan

**CENTRAL TEXAS REGIONAL HEALTH COVERAGE DRAFT BENEFITS**

| Plan Type                     | Mid Cost  | Low Cost  |
|-------------------------------|-----------|-----------|
| Average premiums*             | \$224     | \$178     |
| Deductible                    | None      | \$500     |
| Coinsurance                   | Variable  | 20%       |
| Out of pocket maximum         | \$5,000   | \$5,500   |
| Yearly maximum benefit**      | \$50,000  | \$50,000  |
| Prescription drug coverage*** | \$15/\$35 | \$15/\$35 |

Note: Covered counties include Travis, Hays, Williamson, Burnet and Caldwell. The benefits listed for Central Texas are not final.

\*Premiums vary based on age and sex but there is no health status underwriting.  
 \*\*Applies to hospital facility.  
 \*\*\*Non-formulary drugs are not covered.

Source: Central Texas Regional Health Coverage Project

30 days. We want to get them established with a PCP and want to ID if there’s anything going on with them that they might not be aware of,” Rodriguez said.

The 330 members come from 76 small businesses across Galveston County. Group sizes vary in the allowed range of two to 50 employees, as do their past experiences with health insurance—or lack thereof.

“The preponderance of responses are from people who’ve never been able to offer it. We’ve gotten a few who had to stop offering it because the cost became too prohibitive,” he said.

For employers who joined, the chance to offer a benefits package for the first time was a major impetus, Rodriguez said. “They want to offer something. This is an opportunity to reward their employees in a way that’s beneficial.”

Businesses cannot simply drop their insurance policies to switch to the Galveston plan because the premiums are cheaper—they must have gone at least one year without insurance prior to applying.

The member experience with health benefits also varies wildly. However, very few have had health insurance in the past. “It’s all the horror stories that people talk about. We’ve heard from folks who haven’t seen a doctor in 20 years,” Rodriguez said.

Officials at UTMB and several other 3-share efforts have

cautioned that the plans are not the comprehensive benefits that come from a health insurer. “This isn’t going to cover every eventuality. It isn’t intended to be a large catastrophic program with deep pockets. It isn’t intended for the person who needs dialysis. But people, especially those with a pre-existing condition who cannot qualify for private insurance, are thankful to have it available to them,” Rodriguez said.

**Late Fall In Central Texas.** While all eyes are on the Galveston plan, the march of 3-share plan development in other regions goes on. The six-county Central Texas group is marching toward a launch, although its plan will be a 2-share as well as a 3-share plan. Employers will have the option of a 2-share plan where they split the costs evenly with the employee; because of the plan’s more limited scope, it will still cost less than traditional health insurance. For lower-wage workers, the 3-share option will be offered, as it is with the Galveston plan.

A physician-led group within the organization developed the draft benefits package. “Now, we’re going back and getting feedback on [the benefits],” said Ann Kitchen, a facilitator of the Central Texas Regional Health Coverage Project and executive director of the Integrated Care Collaborative of Central Texas.

Even if Austin has not secured its third share by its intended launch, the plan can proceed anyway, because of the two-share option. The average monthly costs for either the midlevel or low level cost plans would be well below the cost for comprehensive health insurance.

The apparatus of UTMB’s health plan gave Galveston a leg up; one of the next steps for Central Texas will be hiring a permanent CEO and contracting with a third-party administrator.

**OUTLOOK: While still loaded with long term financial questions, 3-share plans have officially taken root in Texas. With Central Texas and a half-dozen other regions working toward their own plan launches, it could be the path for covering small businesses and nonprofits in a state where few offer health coverage. Their long-term effectiveness will be difficult to determine, but giving small businesses their first taste of health benefits could give 3-share plans some staying power. Five hundred people might be a drop in the uninsured bucket, but this model could be replicated across Texas—provided other counties can find that third share.** ■

# Slowly But Surely, Texas Doctors Take To EMRs

By Bill Melville

You can bring electronic medical records to the healthcare market, but you can't force a physician to implement it.

According to a Texas Medical Association report on its 2007 survey, one third of responding physicians now use an EMR, a jump from 27 percent in 2005. However, that puts it ahead of national average of less than 20 percent using EHRs, according to a June report from *The New England Journal of Medicine*. The report also showed EMR adoption nationwide was most common among large health systems like the Cleveland Clinic or Mayo Clinic and in integrated systems such as Kaiser Permanente, which recently opened up its personal health record option to its full membership.

But technology cannot tie together 43,000-plus physicians across 268,601 square miles in a rapid march. While Texas has clusters of higher adoption rates, it cannot compete with the rates in states one twentieth its size. "I think Texas is average in comparison to most states. Massachusetts and a few other states are way out in front. There are areas in Texas about the size of Rhode Island that are well-organized, but other sections are struggling," said Joseph Schneider, M.D., chairman of the TMA committee on health information technology and chief medical information officer at Baylor Health Care System in Dallas.

Certain factors in the survey are telling—48 percent of physicians under 40 years old use EMRs, up from 37 percent in 2005. Texas also shows a surprising rate of rural adoption; with 47 percent of rural doctors having an EMR, they outpace all other geographic regions.

While EMR adoption is not moving at a rapid pace, the report did show that EMRs are still growing. "There is a steady increase each year in the number of physicians who have EMRs. One of the key measures that will start to come out is how many of those physicians are actually using all the key features of their EMRs," Schneider said.

The survey remained consistent only among those resistant to any type of EMR (25 percent); their demographics

trended older and many fell into facility-based and surgical specialties, according to the TMA report.

On the member and employer group side, there's little argument about EHRs.

"Simplifying the paper morass is highly desirable. The EHR is long overdue. I don't think you'll find anyone opposed to transacting information in a digital way," said James Watt, president of Employee Benefits Solutions, a Houston-based consulting firm. "I think you're getting greater adoption. The insurers are pushing for more of that because of the speed. You'll see widespread adoption," he said.

The trouble for Texas comes in trying to link the entire state. The metropolitan areas of Houston, Dallas-Fort Worth, Austin and San Antonio have greater populations than some states.

"If you're trying to assemble six major metro areas, it's a lot more difficult to come to that sort of consensus in the beginning," Schneider said. Any attempt at large-scale EHR implementation couldn't end at the six big MSAs without leaving out multiple smaller metropolitan areas and scores of rural communities. "You can't just do Dallas or Dallas-Fort Worth. That doesn't move the state forward," he said.

**Health Plan Help?** Schneider said partnerships between interest groups in Massachusetts and other states allowed them to move more quickly toward EHRs. Money from the local health plans in those states didn't hurt the progression of EMRs either.

"In Massachusetts, the Blues put up a large chunk of money to get them organized. I've seen none of that movement here," he said.

Texas Association of Health Plans Executive Director Jared Wolfe agreed, saying there had been little movement beyond some informal discussions. But he did not rule out anything in the future. "We've had some very preliminary conversations, talking to primary-care docs about how we can re-center this medical home concept," he said.

**Implementation Is Everything.** If there's a sword of Damocles hanging over physicians on EMRs, it's the combined costs of implementing the system and the return on investment they receive for switching.

Physicians are concerned with whom the system benefits most. To many, it appears as if the health plans get the biggest benefit, Schneider said.

"If a bank makes its processes electronic and is able to drive down costs and save on business, that benefit goes to that bank. It's a whole lot less clear in terms of the electronic health record. The practice gets about 11 percent of the benefit of every dollar that's saved. They're being asked to pony up the money, but before anything happens, there's an 89 percent tax on any dollar that's saved," Schneider said.

## WHY TEXAS PHYSICIANS DON'T ADOPT EHRs

|   |     |
|---|-----|
| Cost prohibitive .....                    | 63% |
| Benefits do not justify cost .....        | 60% |
| Concerns about EHR reliability .....      | 32% |
| No time for implementation .....          | 32% |
| Waiting for national standards .....      | 31% |
| Security/Privacy/Liability Concerns ..... | 23% |
| Difficulty of data entry .....            | 23% |

Source: Texas Medical Association Special Survey—Electronic Medical Records—2007

**WHAT WOULD CONVINCe NON-ADOPTERS TO TRY EHRs?**

|   |     |
|---|-----|
| Evidence of improved operations .....           | 57% |
| Receipt of grant money .....                    | 52% |
| Evidence of improved patient care .....         | 43% |
| Standards to allow information sharing .....    | 40% |
| Evidence of reduced liability risk .....        | 39% |
| Easier data entry .....                         | 38% |
| Assistance in implementation and training ..... | 35% |
| Awaiting better products .....                  | 30% |
| Help in selecting a system .....                | 30% |
| Help from a local hospital .....                | 28% |
| Nothing .....                                   | 12% |

Source: Texas Medical Association Special Survey—Electronic Medical Records—2007

The digits on the EMR odometer might tick over slowly, but they continue to move upward. In early July, the San Antonio-based Gonzaba Medical Group eliminated its paper charts in favor of EHRs. A 20-physician practice might seem like a drop in the bucket, but Gonzaba will run the new health and wellness clinic for the city’s 11,000 employees, giving it a large employer group to start with.

The Centers for Medicare & Medicaid Services recently announced a five-year pilot program for EHRs in Alabama, Delaware, Georgia, Louisiana, Maine, the Maryland/Washington, D.C., area, Oklahoma and Virginia, plus multi-

county areas in South Dakota, Jacksonville, Fla., Madison, Wis. and Pittsburgh. But doctors elsewhere don’t always have such outlets.

All signs point to most practices seeing their return on investment, albeit not in the short term. “For 75 percent of practices, it pays off economically in the long run. For 25 percent of practices, studies show they’re not getting any return at all. The larger the practice, the more likely they can withstand the time it takes to get this done. The smaller practices, even within the cities, are much less likely to adopt,” Schneider said.

The TMA report showed the same percentage of respondents (25) is not planning to adopt EMRs.

Physicians see the benefits in terms of more efficient patient records and rapid access to information, Schneider said. The challenge comes with the costs they must incur.

“We’ve all seen what has happened to the airline industry and the banking industry. But the tools to do it are hideously expensive. In the end, while we’re taking care of patients, we also have a business to run,” he said.

**OUTLOOK:** *For its size, Texas is slightly ahead of the electronic medical records game, and shouldn’t be compared objectively to smaller states with wider implementation. As the technology becomes more widespread, adoption will likely follow. The higher adoption rate in rural areas is good sign, but is balanced by the high number of physicians opposed to adoption. That represents an obstacle as great as costs and working through different platforms.* ■

## Availity Goes To Next Level With E-Prescribing

By Bill Melville

Availity just began deployment of its CareProfile electronic health record in Texas, and in late 2008, it will join the e-prescribing movement with CarePrescribe, through a partnership with Prematics.

Owned by Blue Cross and Blue Shield of Florida, Humana and Health Care Service Corp., which operates Blue Cross and Blue Shield plans in Illinois, New Mexico, Oklahoma and Texas, CarePrescribe has the potential to open up the floodgates for e-prescribing in Texas, Florida and beyond.

The biggest challenge for Availity is getting physicians comfortable with the change. “Physicians in busy office settings are more and more challenged by today’s economics. Sometimes free is too expensive. If it doesn’t fit in a logical manner, it’s going to be hard to get adoption and utilization.

“We’ve had great success in getting provider offices to adopt the portal as their day-to-day tool for interacting with health plans. We’ve begun to build credibility with our

clinical tools. E-prescribing was a logical next step,” said Russ Thomas, Availity’s chief operating officer.

Availity began looking at adding an e-prescribing function to its physician portal as the demand for clinical functions for similar online platforms has heated up. “Availity and its owners realized the great opportunity to improve health outcomes,” Thomas said.

In Florida, Availity went live a month ago in south Florida and in some locations in the Tampa-St. Petersburg area. He didn’t say which Texas markets would receive CarePrescribe first, but said the rollout will follow Florida’s example. “You’ll see us take a very similar approach in Texas. Our goal is to deploy there later this year, in all likelihood the fourth quarter. We believe in a crawl-walk-run approach with this functionality,” Thomas said.

Availity always intended to contract out for the e-prescribing function. “We understand what we do well. From the out-

## TEXAS E-PRESCRIBING STATISTICS

|  | 2005    | 2006    | 2007      |
|--|---------|---------|-----------|
| New e-prescriptions  | 77,294  | 143,694 | 681,407   |
| E-refill requests  | 155,429 | 243,436 | 579,557   |
| E-refill responses   | 145,551 | 221,796 | 498,058   |
| Total E-prescription transactions                            | 378,274 | 608,926 | 1,759,022 |
| Percentage of total prescriptions transmitted electronically | 0.20%   | 0.33%   | 0.96%     |

Source: SureScripts E-Prescribing Progress Report

set, Availity determined that when it comes to e-prescribing, there are great applications in the market and no need to recreate the wheel.”

Prematics has a history working with large health plans. It launched its ScriptTone e-prescribing system with central Pennsylvania-based Capital Blue Cross. Given Availity’s ownership, it has an opportunity to extend its reach much further through CarePrescribe.

“Availity is a large deal for us. It has different requirements and complexities to it. They represent a broad number of health plans in a broad number of states. This was the beachhead which says, ‘This kind of approach is attractive to other health plans,’” said Kevin Hutchinson, CEO of Prematics.

The move made sense for Availity. “It’s logical for us. Our goal and the goal of our stakeholders is to promote e-prescribing. We see the value clinically and financially. We believe fundamentally that e-prescribing, when appropriately utilized, can improve outcomes and reduce spending in healthcare,” Thomas said.

**Gaining E-Ground.** In regards to e-prescribing, Texas is hard to quantify when compared with other states. In the 2008 SureScripts Safe Rx rankings of statewide e-prescribing penetration, Texas came in 30th nationally, down from 21st in 2006.

However, the state’s size works against it; while total e-prescribing transactions nearly tripled from 2006 to 2007, that only meant an increase from 0.33 percent to 0.96 percent of the state’s total prescriptions.

The strongest growth came from new e-prescriptions, which went from 77,294 to 681,407 from 2005 to 2007, according to the rankings. 2007 appears to be the year in which e-prescribers made their first breakthrough—while still only 4 percent of the state total, their population grew from 692 to 1,569. Growth among the state’s pharmacies

accepting e-prescriptions slowed in 2007. The 2,639 that participated represent 59 percent of the state’s total.

But e-prescribing could be in for a sea change, if recent developments indicate anything.

Two of its national facilitators, RxHub, a patient health information network, and SureScripts, a pharmacy health information exchange, agreed to merge in July, and their combined platform could be the catalyst needed for e-prescribing to take off.

**Easy Act To Follow.** Prematics has begun installing CarePrescribe in physician offices, and because the Availity suite has already been introduced, the groundwork has been laid for the new function.

“In Florida, the physician practices are already Availity clients, and they already have the high speed Internet connectivity, so it’s easier to deploy. It also helps that the footprint is already there. The learning curve is small because they already know how to get into the portal,” Hutchinson said.

Despite the ease of e-prescribing, old habits die hard. Hutchinson said there is still some patient reticence regarding e-prescribing, and consequently, it has made accommodations.

We found that even though we want to make everything electronic, patients still want to have something in hand to take to the pharmacy. We print a patient receipt every time the script is sent to the pharmacy,” he said.

**OUTLOOK:** *With Humana and market-leading Blue plans on board as Availity owners, e-prescribing’s introduction to Availity could give the practice the growth it needs to go into mainstream use. If more health plans join the Availity network or if it gains the blessing of Texas physicians contracting with Humana or the Texas Blue plan, the state could take major e-prescribing leaps in the next three or four years.* ■

# Administrative Costs Decline For Texas HMOs

By Bill Melville

There are few understatements greater than, “Texas isn’t an HMO state.”

Among its 5.5 million fully insured residents, only about 1 million receive coverage from an HMO.

“[Texas] was slow to adopt the HMO delivery system and quick to retreat from it. At the tail end of the HMO growth curve, Texas opted in, but it retreated very quickly once employers determined cost effectiveness wasn’t any better than in the PPO system,” said James Watt, president of Employee Benefits Solutions, a Houston-based benefits consulting firm.

HMOs operating in Texas lend themselves to easy categorization—national operators and local plans covering Medicare, Medicaid and those eligible for benefits under the Children’s Health Insurance Program, or CHIP.

Then there’s Scott & White Health Plan, the long-running commercial HMO, which has endured as other integrated HMOs have shrunk or pulled out of the state altogether, as did Kaiser Permanente.

“HMOs that were created early in the development of the model are strongly focused on quality and outcomes,” said Allan Einboden, CEO of the Scott & White Health Plan. “These companies continue to demonstrate value, while many later entrants abandoned the model. Scott & White Health Plan is focused on superior service with tangible, measurable quality and outcomes,” he said.

Despite the variety of HMO plans in Texas, their average administrative expense ratios (AERs) have been stable at 0.14 in 2006 and 2007, according to HealthLeaders-InterStudy data for HMOs reporting data only for Texas.

Some carriers saw their AERs decline from year to year—Aetna dropped to the state average in 2007 after hitting 0.18 in 2006. Humana, CIGNA HealthCare and UnitedHealthcare of Texas showed more fluctuation during the same period, with UnitedHealth coming in at the high end with 0.18, down from 0.20 in 2006, according to HealthLeaders-InterStudy data (those figures do not include Evercare or PacifiCare, which both tended slightly lower during the same period.)

**Keeping Administration Low.** Breaking the mold, Temple-based Scott & White has kept its rate below 10 percent for the past three years. In 2007, its AER rose 100 basis points to 0.09 after spending the two previous years at 0.08.

Scott & White ranks among the state’s larger commercial HMOs and has remained profitable, earning \$7.66 million on \$507.7 million in total premium dollars in 2007, according to HealthLeaders-InterStudy data. By contrast, HMOs that have government-sponsored enrollment have higher margins—such as Humana, with an 8.2 percent margin—but

Scott & White’s 1.5 percent margin is still in the ballpark of other commercial plans, such as CIGNA HealthCare, with a 1.66-percent margin.

Scott & White is an integrated system of hospitals and physicians, the educational site for the Texas A&M Science Center College of Medicine and the health plan. Einboden said integration drives down costs.

“We believe integration contributes value to maintaining low administrative costs. We don’t have to staff entire departments. We can have one or two people working with the health plan that are part of the larger health system,” Einboden said.

The state’s largest nonprofit plan and largest overall, Blue Cross Blue Shield of Texas, had a companywide AER of 0.12, which covers Blue plans in Oklahoma, New Mexico and Illinois, in addition to Texas. Similar to other national health plans, it saw some mild fluctuations in 2005, but stayed within 2 percentage points of its 2007 rate.

While administrative rates might appear as a small part of the picture, Scott & White’s average 2007 premium rate of \$234 PMPM comes in below the state average (which skews lower from plans participating in public programs.)

Einboden attributed the lower AER to the plan’s ability to combine resources with the hospital and its pursuit of cost-cutting initiatives, such as moving many administrative functions to the Internet.

“We can buy things as a larger entity and get a better price. We think of our administrative costs as being a factor of integration, automation and perspiration. We’re constantly striving to reduce our manual processes. For example, 90 percent of claims are electronic,” Einboden said. “If you’re going to maintain cost structure, you have to be dogmatic about it.” ■

## ADMINISTRATE EXPENSE RATIOS FOR TEXAS HMOs

| Plan                         | 2005  | 2006 | 2007 |
|------------------------------|-------|------|------|
| Aetna                        | 0.17  | 0.18 | 0.14 |
| UnitedHealthcare of Texas    | 0.19  | 0.20 | 0.18 |
| CIGNA HealthCare             | 0.12  | 0.14 | 0.13 |
| Health Care Service Corp.*   | 0.10  | 0.11 | 0.12 |
| Humana                       | 0.15  | 0.12 | 0.14 |
| Scott & White                | 0.08  | 0.08 | 0.09 |
| Texas Children’s Health Plan | -0.15 | 0.14 | 0.11 |

\*Data is for comprehensive filing of all product lines.

Source: HealthLeaders-InterStudy

# ACM Drops Online Enrollment For Individuals

By Bill Melville

After a test drive off the streets of broker-based marketing, Michigan-based American Community Mutual Insurance Co. is back with traditional options for individuals to purchase health insurance.

The company's Precedent offshoot, which sold a slate of four Coverage On Demand plan designs offering low monthly premiums, preventive care and the option to purchase more insurance if needed, has been absorbed back into the parent company.

While Precedent was the company's first foray into Texas, ACM still hopes to find its legs in the individual market after its initial stumble. Now under the American Community Mutual banner again, the company has introduced a wide-ranging suite of individual products.

Coverage On Demand comes to Texas as part of a suite with Medalist II, a PPO plan with a myriad of options, all of which include a unique accident benefit; Next Generation HSA, qualified high-deductible PPO plans with three fund administration options; and Triple Tier, a PPO with a three-level benefit design and a flexible approach to payments.

Although it historically marketed through agents, the online-only approach was an experiment designed to gauge customer interest in new ways of purchasing insurance. In Texas, they didn't bite. "American Community always marketed through the agent community, so this was a test to see if this was a viable model. It turned out it wasn't," said Neil Spero, senior vice president and chief marketing officer for American Community Mutual. "You either advertise or you sell through your agent. The advertising expense became too much of a drain upon the bottom line. We didn't see it work-

ing, so we thought our best opportunity was to continue the product but through the agent community," Spero said.

The 70-year-old health plan operates in 10 states—Arizona, Illinois, Indiana, Iowa, Michigan, Missouri, Nebraska and Ohio, with individual-only plans in Texas and Wisconsin. Coverage On Demand arose from the company's strategic planning efforts several years ago.

The Coverage On Demand product in American Community Mutual's line-up follows the template of Precedent, albeit with some streamlining to improve understanding of the product. "What we decided to do is simplify it. We're using one coinsurance structure and teaming it up with three deductibles. We learned from the past that it was a complicated product," Spero said.

**Targeting Young Adults.** Several insurers have launched individual products aimed at young adults, including WellPoint, marketing Tonik, UnitedHealthcare, marketing Belay, and WellPoint subsidiary UniCare, marketing Sound.

While Texas has a growing individual market, the presidential election has the chance to greatly impact its role in the overall healthcare picture, said James Watt, president of Houston-based Employee Benefits Solutions. Republican John McCain's healthcare platform hinges on tax credits for individuals and a move away from the employer-based model, but Democrat Barack Obama's plan leans on government programs to expand coverage nationally. "McCain's platform focuses on the individual. Obama's doesn't. It will be interesting to see how the politics play out here," Watt said.

Texas has been hit hard by small employers dropping insurance, leading to a large population of working unin-

## AMERICAN COMMUNITY MUTUAL INDIVIDUAL PLAN OFFERINGS

### Triple Tier Plan

- » Plan 1: \$1,000 single network deductible; \$5,000 out of pocket maximum; \$40 copay per network office visit then 100 percent
- » Plan 2: \$3,000 single network deductible; \$76,000 out of pocket maximum; \$50 copay per network office visit, then 100 percent

### Next Generation HSA Plan

- » Deductibles begin at \$1,100 in-network/\$2,200 non-network
- » Choice of 100 percent of 80 percent plans (percentage applies to all covered services after meeting the deductible; out of network rates are 75 percent and 50 percent, respectively)
- » \$300 in preventive care per person
- » \$1,000 annual dental maximum per person
- » Accident benefit, including common family benefit

### Coverage On Demand Plan

- » Low cost base plan, with \$5,000 in coverage
- » Option to purchase coverage after medical expenses incurred
- » Preventive care
- » Accident benefit without deductible
- » Prescription drug coverage
- » Dental care option

### Medalist II PPO

- » Annual eye exam
- » Accident benefit, plus common family accident benefit
- » \$1,000 in annual preventive care
- » \$5 million lifetime policy maximum

Source: American Community Mutual Insurance Co.

sured. “Nationally, the amount of small groups with coverage has decreased four to seven [percentage] points, depending on who you ask. That decrease opens up opportunities for individual products. Many agents are now targeting small groups and offering them individual plans with the promise of lower premiums,” Spero said.

In addition, American Community has included its Next Generation HSA suite to tap the consumer-driven market. “It’s amazing how quickly the market is turning to high-deductibles. Price is definitely a factor now. People are willing to take on a little more of the cost,” Spero said.

American Community picked Texas as the inaugural market for Precedent not only because it has the nation’s highest uninsured rate, but because of the large population of 25 million-plus residents. It stayed for several more factors, Spero said. “It is a good market for Coverage On Demand because of the high uninsured rate and its size, but we also look at other factors, such as the state’s regulatory environment and demographics,” he said.

Spero said bringing the four plans into the market together will be more attractive for its agents and give it a better presence. “To just have the one product would not give our agents enough options,” he said.

In the few months since American Community began its

individual product push through traditional brokers, the response has improved. Spero said the company mobilized immediately upon the switch because its existing agent networks in other states often extended into Texas. Beyond those brokers, it had begun contracting with independent agencies within Texas and has quickly seen improved results. “We’ve sold a couple of hundred contracts. I wouldn’t expect more than that, since there’s a little bit of a learning curve for the agent community,” Spero said.

Coverage On Demand is already on the move, migrating to Michigan, Ohio and Missouri, with more states targeted in early 2009. Spero said it expanded to that trio because of its existing presence there. “Those are our top three states we do business in. We thought we’d launch in those markets and get a good jump,” he said. “We’re opening up three more Jan. 1. We hope to open up three to four more every year after that.”

**OUTLOOK: American Community recognized that healthcare consumers aren’t ready for online-only insurance and reconfigured its individual products. With individual insurance gaining among larger carriers, its entry into the market could be well-timed. With coverage-on-demand part of a larger suite, it stands a better chance of breaking through in the Texas market than under the earlier, online-only system.** ■

## UnitedHealthcare Targets Asian-Americans

By Cody Badaracca

UnitedHealthcare has launched a health plan initiative in Texas catering to Asian Americans in an effort to bridge healthcare disparities among Asian populations in the United States.

“We want to meet the needs in the Asian American market because, based on our research, we know there are some unmet needs and we know what kind of consequences [those needs] are bringing to these populations. These populations are so important because of their size in the market,” explained Amber Jia, national director for Asian American Markets for UnitedHealthcare.

Asian-Americans constitute 4.2 percent of the country’s population, or a little over 12 million people, according to the U.S. Census Bureau. An estimated 15.5 percent of Asian-Americans are uninsured, compared to 10.8 percent of Caucasians.

“Latinos and Asian Americans are going to be the fastest growing immigrant [groups] in the next 30 years,” Jia said. She notes that after California and New York, Texas, Illinois and Washington all have large Asian-American populations and serve as potential markets for the program. The U.S. Census Bureau puts Texas’ Asian population at 915,000 as of July 1, 2007.

UnitedHealthcare’s Asian-American program combines the company’s PPOs and consumer-driven health plans,

or CDHP, with various language and tailored network services. Members enrolled in the program will have access to a national network of 4,800 hospitals and more than 560,000 physicians affiliated with UnitedHealthcare.

“In Houston, none of our competitors has ever had such a dedicated Asian program launched,” Jia said. UnitedHealthcare tries to include in its network doctors who speak Asian languages, and it offers a Web site with capabilities in Chinese, English, Vietnamese and Korean. The program launched in early July 2008.

For those involved with the Asian community in Houston, UnitedHealth’s attraction to the market is understandable.

“Houston has the third largest and the second fastest growing Asian community in the country” said Andrea Caracostis, M.D., CEO of HOPE clinic, a Houston health clinic established in 2002 by the Asian American Health Coalition.

According to Caracostis, approximately 80 percent of the clientele that visit the HOPE clinic are Asian, predominately lower income. But Caracostis warns that targeted programs also need to recognize and respect Asian cultural differences. “Don’t group all Asians in a box,” said Caracostis, “Their religion is different, their language is different, and their beliefs are different.”

**Why An Asian Program?** Asians have linguistic and cultural differences that make accessing healthcare difficult. Those differences, and the high rate of Asian-Americans who are uninsured, were large contributing factors to the formation of the Asian American health program.

Unlike many African Americans, who have been established in the United States for several generations, a large portion of Asian and Latino populations have a language barrier that makes accessing healthcare difficult.

“A lot of patients from Asia cannot have efficient communication with their doctors who don’t speak their languages,” Jia said. “When they go see a doctor, they cannot follow the directions very accurately, including the directions on taking the drugs.”

There are also serious health issues that are more prevalent in Asians that require specific attention. Hepatitis B for example, is 18 times more common among Houston’s Asian Americans than the rest of the population, according to Caracostis. Cancer is another health issue predominant in Asian Americans.

“Mammograms were the lowest here in the Houston Asian community until the Asian American Health Coalition put in place a program called the Phoenix project,” said Caracostis. Through the project, the AAHC and HOPE clinic has screened about 4,000 women within the last 4 years. The low screening rates are in part due to cultural differences, another barrier in healthcare for Asians.

The health disparities even vary between different groups of Asian Americans. “Chinese tend to suffer more diabetes, hypertension, a tendency towards obesity, and Vietnamese have more infectious diseases ...and higher cancer [rates],” said Caracostis.

In addition to language difficulties, there are cultural differences that make certain healthcare procedures awkward. “For example,” Jia said, “Asian women tend to be less willing to see male doctors for some intimate check-ups. If a woman wants to have a check-up for a Pap smear, if she’s from China or Vietnam, she probably would not see a male doctor.”

Many Asian Americans also have spiritual beliefs that might prevent them from accessing healthcare as well. According to a report released by Stanford University, part of the Buddhist system is the belief that through suffering, one can awaken a religious enlightenment. “Buddhism teaches... illness as suffering has value as a catalyst for change and development. Delays in obtaining relief from illness may be a Buddhist stoic response to religious awakening,” the report stated.

“You have to be community oriented, and you have to be sensitive to all the different Asian groups that are very, very different,” Caracostis said. Cultural respect is something very important within Asian American communities, and is something that both the HOPE clinic and UnitedHealth’s Asian program try to be wary of.

**Online Features.** A unique feature of the Asian program is UnitedHealthcare’s Asian American Web site at [www.uchasian.com](http://www.uchasian.com).

## TEN LARGEST CITIES WITH ASIAN POPULATIONS (2000)

| City             | General Population | Asian Population | Percent of Population |
|------------------|--------------------|------------------|-----------------------|
| National         | 281,421,906        | 10,242,998       | 3.6%*                 |
| New York         | 8.0M               | 787,047          | 9.8%                  |
| Los Angeles      | 3.7M               | 369,254          | 9.9%                  |
| San Jose, Calif. | 894,943            | 240,375          | 26.8%                 |
| San Francisco    | 776,733            | 239,565          | 30.8%                 |
| Honolulu         | 371,667            | 207,588          | 55.8%                 |
| San Diego        | 1.2M               | 166,968          | 13.9%                 |
| Chicago          | 2.9M               | 125,974          | 4.3%                  |
| Houston          | 2.0M               | 103,694          | 5.1%                  |
| Fremont, Calif.  | 203,413            | 75,165           | 36.9%                 |
| Seattle          | 563,374            | 73,910           | 13.1%                 |

\*This is estimated to be 4.3 percent as of July 2005.

Source: U.S. Census Bureau

“Based on our study, the Asian American population has the highest access to the Internet compared to all other ethnic groups.” Jia said. The Web site offers links and networking tools for consumers, brokers and employers and is translated into four languages: Korean, Chinese, Vietnamese and English. Another language, Japanese, is being added to the site.

The site is aimed at reducing health disparities in Asian Americans by providing health education, a medical-term dictionary and provider directories that enable the search of doctors who speak a variety of Asian languages. Jia explained that some insurers will consider a physician as having Asian language capabilities, when in reality it might just be a staff member at the physician’s office or hospital who speaks the language. The UnitedHealthcare California provider directory won an “innovation in reducing health disparities” award from the National Committee for Quality Assurance in 2007.

**Language Choices.** UnitedHealthcare translates only four languages on its Web site because there are so many Asian languages.

Jia said a realistic approach was to focus on the bigger populations of Asians with a language need in the United States, the majority of whom are Chinese, Korean and Vietnamese. Even though there are also large populations of Filipino and Asian-Indians in the United States, the official language in those countries is English, “so relatively speaking, they don’t have as much a language barrier that Chinese, Vietnamese, and Koreans do,” Jia said.

However, Japanese is now being added to the Web site, due largely in part to large businesses that are Japanese-owned. Some Japanese automobile companies for instance, while

many of the employees are American, are run by Japanese who may need some in-language support to review health plan options. Jia also said that, because much of the Japanese tradition is relationship-orientated, it would be easier for these Japanese companies to contract with Japanese brokers, and likewise, the brokers would want to see more support in areas with high Japanese populations.

“When we saw this opportunity, we decided that Japanese would be the next one we’re going to move into,” Jia said.

**Next Steps.** Houston is the first Asian market that UnitedHealthcare has ventured into with capabilities acquired from PacifiCare and Oxford, two companies UnitedHealth Group bought in 2005 and 2004, respectively.

Both Oxford and PacifiCare established their Asian programs prior to the merger. Oxford Health began its program

in New York City nearly 13 years ago, and PacifiCare began its west coast program in 2004. UnitedHealth plans to expand the program into other markets with large populations of Asian Americans. Chicago is one of those markets.

“We have been advertising there and partnering with local community organizations,” Jia said.

She also predicts health plans specific to ethnicity will become more and more prevalent, with different companies focusing on specific ethnic populations that are large in the areas in which they operate.

“It really depends on the segment you’re focused on and the geographic area you are focused on, and the type of products you have... I can see a very complex analysis when you decide which will be your next nationality,” she said. ■

## People In The News

Please send announcements to Bill Melville at [wmelville@hl-isy.com](mailto:wmelville@hl-isy.com).  
Announcements also may be faxed to 615-385-4979.



K. Malcomson

**Humana** recently announced that **Celina Burns** has been appointed Dallas-Fort Worth commercial market operations president. She was previously Humana's vice president of network development in North Texas.

Humana also announced that **Ken Malcomson** has been appointed CEO of Humana's West Central Region, covering Texas, Colorado and Utah. He was previously president of Humana's Dallas-Fort Worth commercial operations.

**HealthMarkets Inc.** announced June 5 that **Phillip J. Hildebrand, CLU**, has been named its CEO. Hildebrand previously spent a 33-year career at New York Life Insurance Company, where he reached the position of vice chairman. Hildebrand has served on the boards of New York Life in Hong Kong and Taiwan, as well as MacKay Shields, an institutional investment manager. ■

# CHIP Rebounds, Advocates Eye Future Gains

By Bill Melville

Looking at enrollment for the Texas Children's Health Insurance Program in 2007, it might have been difficult to see how the program would begin to grow again.

With the rebound in effect for more than 10 months, the program's reinstatement of 12-month re-enrollment and several aggressive outreach campaigns have made all the difference.

"You can almost pin [the enrollment jump] to the date the bill went into effect," said Jared Wolfe, executive director of the Texas Association of Health Plans. Sixteen health plans participate in Texas CHIP.

After the state changed the rule that families must re-enroll every six months—except for those at the high end of the income scale—enrollment has quickly returned to levels not seen since the restrictions went into effect in 2003.

Enrollment in the federal state program has blown past the estimated 130,000 children the state expected to add once it loosened the requirements. As of July 2008, the program had 463,939 beneficiaries—up from 444,873 in June and 427,387 in May.

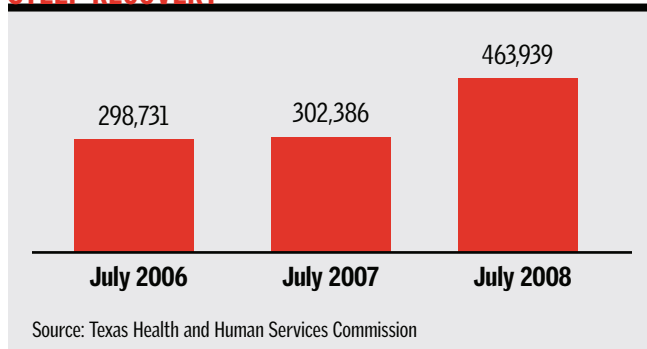
While it hasn't reached the 500,000-plus it covered at the program's peak before the restrictions, it's a far cry from the numbers of the past five years. In July 2006 and 2007, program enrollment has hovered around 300,000.

Since resumption of the 12-month enrollment period in September 2007, the numbers have not crawled back, although it is likely the trend will level out in September, when enrollment finishes a yearly cycle.

CHIP advocates targeted the six-month requirement as the single biggest obstacle to parents seeking CHIP benefits for their children.

"I expected a robust recovery because I knew the twelve- to six-month cut was a big part of the loss in enrollment," said Anne Dunkelberg, associate director for the Austin-based Center for Public Policy Priorities, a nonpartisan think tank and advocacy group.

## TEXAS CHILDREN HEALTH INSURANCE PROGRAM'S STEEP RECOVERY



**Gaining Stability.** Another side of the program's resurrection is the low disenrollment rate—while it ranged as high as 14.1 percent during the years under six-month reenrollment period, it bottomed out at 1.4 percent in March and has not topped 2.5 percent since, so children are staying with the program at a much higher rate.

House Bill 109 passed near the end of the 2007 legislative session, dropped the six-month re-application requirement for all families but those at the top of the CHIP income limits. Other tweaks were designed to ease enrollment and income restrictions.

Having enrollment surpass the expected 130,000 gain will not strain the program or force it to turn anyone away, according to the state.

"We assumed it would increase the rolls by about 130,000. If we exceed that original projection, we don't anticipate any problems. We've never capped enrollment or had waiting lists," said Stephanie Goodman, spokeswoman for the Texas Health and Human Services Commission, which administers CHIP and Medicaid.

HHSC plans an outreach push as the school year draws near. But once September arrives, the monthly enrollment hikes will likely level out. "We would then expect it to stabilize," Goodman said.

**What's Ahead For CHIP?** With the 2009 legislative session coming in January, no one is showing his cards on additional changes to CHIP. A handful of Democratic legislators held a press conference several months ago calling for enrollment to be expanded to 300 percent of the federal poverty level (from the current 200 percent of FPL), but the composition of the House and Senate after the November election will play as much a role as the state's finances.

"Our organizations and others are talking to state leaders to see if the leadership will materialize," Dunkelberg said.

The coalition includes Children's Defense Fund-Texas, Texans Care For Children, the Texas CHIP Coalition and CPPP. One of the coalition's first goals is to have children's Medicaid mirror CHIP and widen the re-enrollment from six to 12 months.

"That is one of the great successful models. It would cut the state's workload in half," Dunkelberg said. Children's Medicaid is the other side of the coin, and covers far more children than CHIP. Initial state estimates show children's Medicaid down to 1.86 million beneficiaries in July, although it covered more than 2 million through the fourth quarter of 2007.

One of the biggest policy issues is covering people just outside the maximum income for enrollment, which the state sets at 200 percent of the federal poverty level, or about \$42,000 for a family of four.

## LARGEST PLANS IN TEXAS CHIP

| Health Plan                                  | July 2006 | July 2007 | July 2008 |
|--|-----------|-----------|-----------|
| Superior Health Plan (all plans and network) | 92,343    | 92,027    | 143,652   |
| Texas Children's Health Plan                 | 45,772    | 45,503    | 69,054    |
| AMERIGROUP                                   | 32,874    | 39,239    | 63,401    |
| Cook Children's Health Plan                  | 27,739    | 19,650    | 28,751    |
| Parkland Community Health Plan               | 19,188    | 18,647    | 27,988    |
| Community First Health Plan                  | 16,043    | 14,458    | 20,749    |
| UnitedHealthcare of Texas                    | N/A       | 15,887    | 20,074    |

Note: HB 109 went into effect after July 2007 enrollment was released.

Source: Texas Health and Human Services Commission

“All of our organizations talk to parents having trouble with the enrollment process and families just above that income limit. Crossing that limit by \$100 a month doesn't put you in any better position to buy insurance. The high-risk pool is not an option because it's too expensive,” Dunkelberg said.

Being responsible for some level of monthly premium is not an issue for most, she said. “People are willing to pay, but they need to be offered the ability to pay something in accordance with their income.”

In the meantime, expect more efforts modeled on the Houston Independent School District's 100 Percent Campaign, an initiative to cover its entire student population with some form of insurance.

While the state's health plans supported HB 109 in 2007, their preference lies with more aggressively enrolling children already eligible before widening the net.

“It is a walk-before-you-can-run situation,” Wolfe said.

**OUTLOOK: Despite all the talk of record surpluses, getting the Texas Legislature to bite on another expansion of children's health insurance benefits so quickly could prove difficult. Backers will have plenty of success stories to illustrate their position, but the short-term focus will probably be greater outreach to enroll the hundreds of thousands of eligible children not in the program. ■**

# Airports, Truck Stops, What's Next For CCCs?

By Cody Badaracca

The retail walk-in clinic business appears to be reaching a new stage in its maturity, finding new niches and encountering new competition from established healthcare systems, hospitals and physician practices.

The Convenient Care Association, the Philadelphia-based industry group that refers to the retail clinic model with the more inclusive term of “convenient care clinics,” estimates there are 950 such clinics currently associated with the CCA, a number that’s gone up from 800 since the end of 2007 and is expected to grow to 1,500 by the end of 2008.

As the clinics take root in cities across the nation, they are starting to stretch their limbs, testing out different venues. Several traditional healthcare systems, such as Wisconsin-based Aurora Health Care, and Geisinger Health Systems in Pennsylvania, have started up their own kinds of CCCs. They continue to refine their convenience and efficiency with the help of electronic medical records and prepaid health visits and are expanding at enormous rates.

According to the latest report by the Census Bureau, in 2006, the number of Americans without health insurance increased from 44.8 million to 47 million, or almost 16 percent of the population. For both the uninsured and insured, CCCs have been incredibly convenient and cost effective.

With prices clearly posted on the door, and the majority of appointments lasting no longer than 30 minutes, consumers can expect to pay an average of \$70 or less for a visit.

CCCs, as opposed to physician-staffed urgent care clinics whose scope of practice is much broader, offer a relatively short range of diagnostics and treatment for conditions such as sore throats, vaccinations and minor injuries.

Utilizing space in retail stores such as CVS, Wal-Mart and Walgreens, CCCs are popping up in most major metropolitan areas across the country and spreading to outlying areas as well. They’re even in airports now.

**Airport Care.** The AeroClinic opened in the summer of 2007. With headquarters in Atlanta, the AeroClinic operates in two major airports: Hartsfield-Jackson Atlanta International Airport and the Philadelphia International Airport. The clinics offer a multitude of services similar to that of other CCCs, but are also equipped to do physical therapy, X-rays and minor suturing. The prices for the AeroClinic vary, but are in line with what other providers are charging, said Rosemary Kelly, chief marketing officer for AeroClinic.

A key factor to the AeroClinic model is the timeliness with which patients are seen.

“It’s very important to get travelers in and out quickly so

## CONVENIENT CARE LANDSCAPE IN TEXAS

### MedBasics

- » **Locations:** Four in Dallas-Fort Worth area Carnival Super Markets, two more planned.
- » **Insurance plans accepted:** None.

### MinuteClinic

- » **Locations:** Eleven in Houston area CVS Pharmacies, 24 in Dallas-Fort Worth area, 10 in Austin area
- » **Insurance plans accepted:** Aetna, Assurant Health, Assurant/Key Benefit Administrators (KBA), Beech Street, Blue Cross Blue Shield of Texas (excluding Blue Choice Solutions and Blue Precision), CBSA, ChoiceCare Network (PPO)—Humana affiliate, CIGNA, Coventry, Definity Health, Federated Mutual Insurance Company, First Health Group Corp., Inc. (Coventry affiliate), Golden Rule—UnitedHealthcare, Great-West Healthcare, Group Health Inc., Humana (excluding HMO), Medicare, PBA (Preferred Benefit Administrators), ppoNEXT, Principal Life Insurance Company, PHCS, UnitedHealthcare.

### RediClinic

- » **Locations:** 14 in Houston area HEB stores, 6 in Central Texas HEB stores (Austin and San Antonio).

- » **Insurance plans accepted:** Aetna, Assurant, Beechstreet, CIGNA, Great-West HealthCare, Humana, Medicare, MultiPlan, PPO Next, United Healthcare; Houston locations only – Blue Cross Blue Shield of Texas and Freedom of Choice.

### MyHealthy Access

- » **Locations:** Six in Houston area Wal-Mart Supercenters
- » **Insurance plans accepted:** None listed.

### Take Care Health Systems

- » **Locations:** 10 in Houston area Walgreens.
- » **Insurance plans accepted:** Aetna, Anthem UniCare PPO, BC/BS of Texas (Traditional/Indemnity) ChoiceCare, CIGNA, Coventry, Great-West Healthcare, Humana, Lower Agency, MultiPlan, PHCS, Planned Administrators, Program Student Assurance Services, UnitedHealthcare.

### Scott & White Express Clinic

- » **Locations:** One in Temple.
- » **Insurance plans accepted:** Scott & White Health Plan.

Sources: Clinic Web sites

they can catch their flight, and frankly, it needs to be that way so that people aren't afraid of coming to use the service, so they know they'll get out expeditiously," Kelly said.

AeroClinic was founded in part by David Satcher, M.D., former surgeon general and former secretary of health. He serves on the board of directors, along with Andrew Young, former ambassador and mayor of Atlanta.

Members of Aetna networks and products can use AeroClinic as an in-network provider, while AeroClinic is in discussions with other payors. "Let's face it, when we're traveling these days, not too many flights are on time, [we] spend a lot of time in an airport. Sometimes, many times, people are sick. This is a convenient way for them to quickly access care while they are waiting for their flight. We wanted to be able to provide that level of service and convenient access for our members when they need it," said Paul Marchetti, who heads Aetna's national network and contracting services. Aetna began contracting with the AeroClinic in May of 2007.

While currently only operating in the two airports, Kelly envisions an AeroClinic to serve stranded and delayed flyers in every major airport across the nation.

**Truck Stop Clinics.** However, airports aren't the only non-traditional venue in which these CCCs are operating. Pilot Travel Center LLC has partnered with Roadside Medical and now offers clinics at Pilot truck stops.

"That's an important venture. Truck drivers have a hard time seeing a primary-care provider because of their travel schedule. When they need immediate care for basic needs, CCCs are ideal," said Tine Hansen-Turton, executive director of the Convenient Care Association.

With test results in 24 hours and routine medications on hand, (although consumers can't get a prescription there) this has been the latest movement in convenient care.

"Think about the lifestyle of truckers, the kind of one-stop needs that they have, that's another way," Marchetti said.

While Aetna doesn't have a contract with these truckstop clinics, Marchetti said he wouldn't discount the idea, provided the arrangement was consistent with the other retail clinic companies with which Aetna contracts.

According to Roadside Medical's Web site, three walk-in clinics are currently open—in Cartersville, Ga., Knoxville, Tenn., and West Memphis, Ark. Another clinic is slated to open soon in eastern St. Louis.

**Scott & White Tests Concept.** While Houston is home to RediClinic, Texas physicians have not given a warm welcome to retail clinics. Legislative attempts to widen the scope of practice to allow more nurse practitioners to see clinic patients met with fierce resistance from the powerful Texas Medical Association. But given the proliferation of clinics, similar legislation could re-emerge in the 2009 legislative session.

Scott & White, the integrated system from Temple, has gotten into the game by opening its first Express Clinic in one of the Scott & White pharmacies. "Express Health

embedded in a Scott & White Health Plan pharmacy will be a pilot site for the model. If it works well, we'll consider expanding the model," said Allan Einboden, CEO of the Scott & White Health Plan.

For now, Scott & White members pay an office-visit copay; claims won't be filed for patients with outside insurance, but they will be responsible for a \$59 visit cost, plus additional test costs as necessary. For members, it's an easy process, Einboden said. "We handle all the insurance [processes] right there," he said. Under current rules, the clinic cannot yet accept Medicare beneficiaries.

Elsewhere in Texas, clinics are on the move. While not truly retail clinics, more companies and governments are opening clinics following the model. Several school districts have considered adding clinics for employees and their families, following the lead of the Mesquite school district, which launched its clinic in early 2008. Other districts in the Rio Grande Valley have gone that route, as did the city of Garland, which reported saving around \$500,000 a year in medical costs as a result.

**Prepaid Health Cards And EMRs.** Because CCCs are driven primarily by their convenience and their locations in retail stores, the next step seems obvious: prepaid health cards. RediClinic now offers a prepaid health card very much like a debit card. Prepaid funds are loaded onto the card, and employees can use the card in exchange for services at RediClinics. It is good for 60 months from the date purchased, and can be modified to meet specific employer's needs. Currently, the card is only available to employers in the Houston region.

CCCs are also using electronic medical records. Patients can come into a CCC and create their own medical record at a kiosk, typing in what ailment they might have. However, because most PCP offices don't have electronic medical records yet, sharing data is difficult.

"Our members have the ability to transfer medical records electronically or via fax. Either way, there is communication between the clinic and the PCP," Hansen-Turton said.

"What we've learned is that that's a major barrier in the country, that we don't all have EMRs and we have no way to share data across the systems," Hansen-Turton said.

**Contracting With Payors.** Most major insurers are now contracting with CCCs as in-network health providers and no longer are viewing them as specialty care providers. Hansen-Turton said that this is because most of the fees for CCCs are as low as or lower than most PCPs they have under contract, costing around \$50 to \$60 on average. Contrast this to \$70 to \$80 for care at a PCP, or several hundred to \$500 for care at an emergency room.

"Insurers were very receptive to it right away because...a lot of people say they would have gone to an urgent care or an emergency room, even though the copays are higher for those two services, the insurance company also pays a lot more for those visits," Hansen-Turton said.

For Aetna, it's all about providing convenient access.

“When you see roughly 30 percent of members going to the emergency room just for minor illnesses that could be treated in an alternative care setting such as retail health, we want to provide that type of option out there for our members,” Marchetti said.

Aetna began contracting with the CCCs about 18 months ago, the first one being MinuteClinic based in Minneapolis. Marchetti said the decision came from Aetna’s consumers. “We were able to bring this concept of retail health into the dialogue with our customers, and get their feedback and interest. And based upon their feedback and interest, we knew that it was something that we needed to pursue.”

**Stopping Point?** But how much can these CCCs grow? Will they eventually flood the market? In March 2008, MinuteClinic, a subsidiary of CVS Caremark Corp., announced it had opened its 500th clinic with the addition of clinic locations in Dallas, Los Angeles and Orlando, Fla. While MinuteClinic seems to be going strong, there have been reports of other clinics shutting down. *The Wall Street Journal* reported that in early 2008, 69 clinics have shut down in over 15 states, likening it to the dot-com bubble of the early 2000s. The report attributed the closures to some clinic

owners thinking they could break even within six months, citing 18 months to two years as being more realistic.

“It’s important to note that while some of the closings have made headlines recently, overall, the industry is still growing,” Ridgway said.

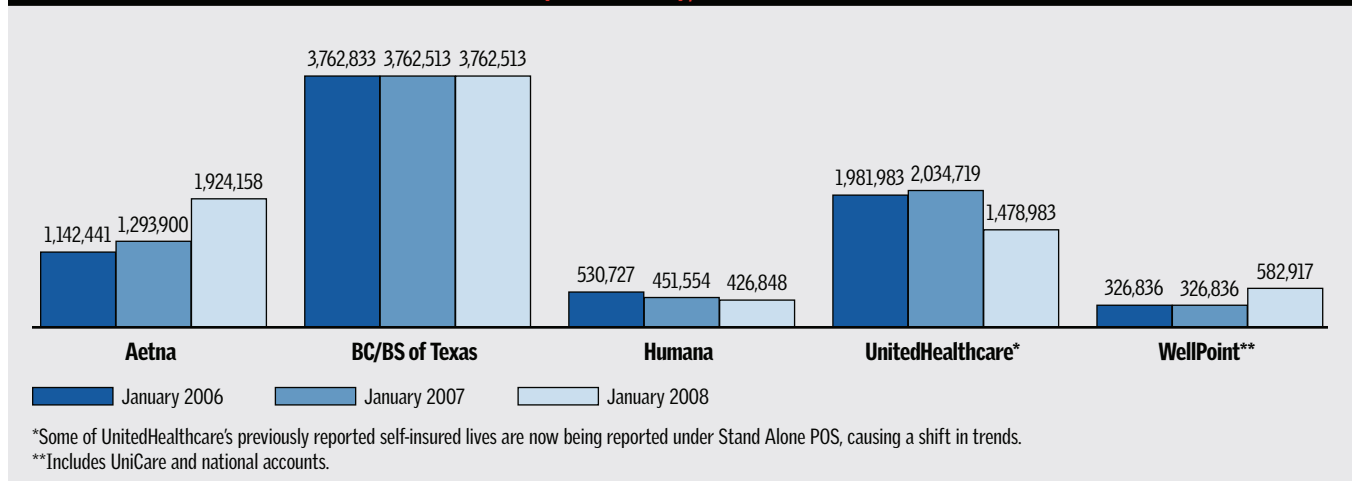
Ridgway said she anticipates the industry growing through 2008 and well into 2009, but realizes that at some point, it will plateau.

Marchetti also believes CCCs are here to stay, but offers some cautionary advice: as there is a behavioral change about these clinics, and more people realize how and where to access them, they need to sustain their growth.

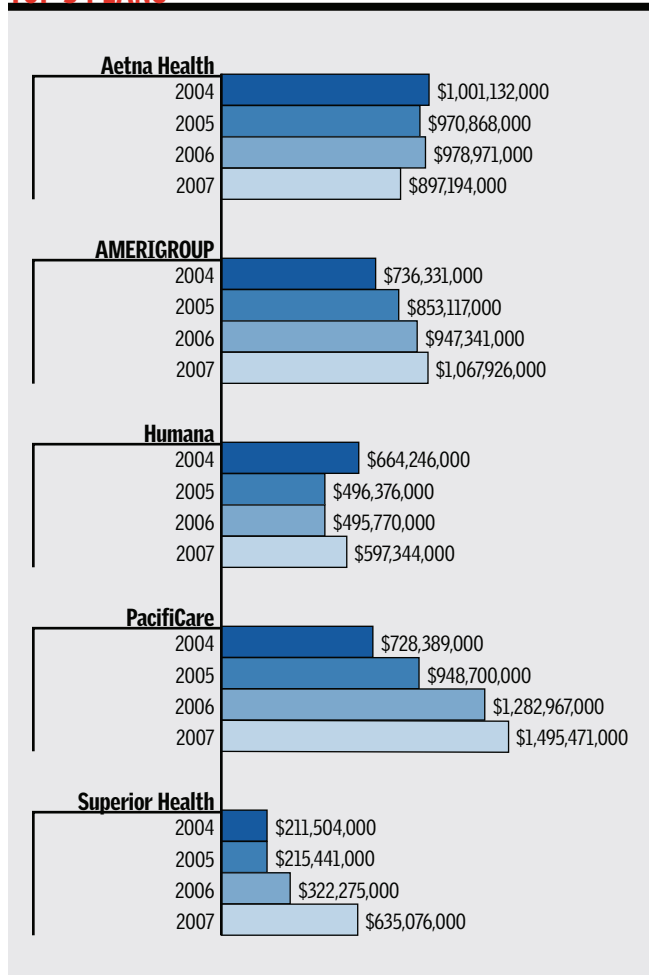
“The retail health organizations, need to slow their growth a little bit based on the behavior changes in the community,” he said.

**OUTLOOK:** *As insurers, consumers and healthcare providers become more accustomed to the idea of CCCs, it appears they’re here to stay. Expanding into new niches will help the industry, as well as the growing movement to digitize medicine, thus connecting the clinics to primary-care doctors and health plans. ■*

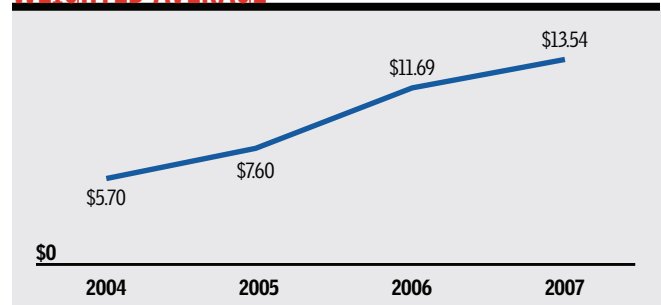
**TEXAS SINGLE-INSURER PPO ENROLLMENT (PURE+POS), TOP 5 PLANS**



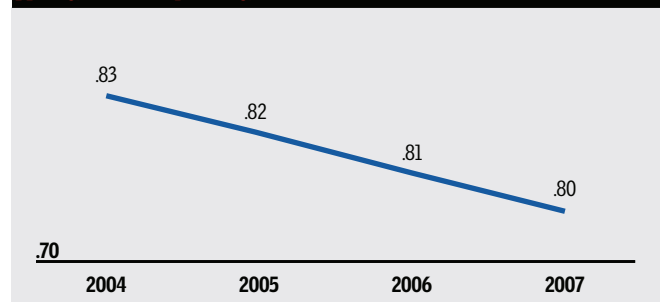
**TEXAS HMOs' PREMIUM REVENUE LEADERS, TOP 5 PLANS**



**TEXAS HMOs' NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE**



**TEXAS HMOs' MEDICAL LOSS RATIO (MLR), WEIGHTED AVERAGE**



**TEXAS HMOs' COMMERCIAL PREMIUM PMPM, WEIGHTED AVERAGE**

