

Texas

Health Plan Analysis

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Blues Of Texas Transparency Tool Under Fire

By Ric Gross

Blue Cross and Blue Shield of Texas has delayed its planned Jan. 1 rollout of a consumer information tool that allows open access to affordability and evidence-based medicine performance information for the largest network of doctors in Texas.

The tool has come under fire from the Texas Medical Association, which launched a vigorous public relations campaign against the tool, objecting to its methodology and its design.

The result? A delay in the implementation of the tool by the Texas Blues, yet a fierce determination on the insurer's part to go forward. Both sides met prior to Christmas in an effort to reach an amicable conclusion.

Still, the flurry of activity in early December between the two sides was played out in a much more public manner than officials with the Texas Blues were expecting. The insurer announced its plans for the BlueCompare tool Dec. 5, generating scant notice from the local media.

But the program made headlines Dec. 13 after the TMA issued a sternly worded, scathing press release calling the tool "faulty" and being more concerned with putting "profit margins ahead of patient care." The two-and-a-half-page release detailed a host of issues the TMA had with the system, starting a very public feud.

Ouch. It also came as a bit of a shock to Blues officials.

"We were very surprised by their release. We think we have a good relationship with the TMA. Our chief medical officer sits on their board, and they are a client of ours," said Darren Rodgers, senior vice president, Health Care Management, for Blue Cross and Blue Shield of Texas. "They only gave us a moment's notice before the release came out. The TMA is a member-driven, physician-advocacy organization, and they have to protect members who may be feeling disadvantaged. I take all those things for what they are.

"But we've gotten the message that they are concerned, and as always, with any issue they point out to us, we want to work with them on it," Rodgers added. "But while it may delay implementation for awhile, we are going forward. We are not going to make any modifications that will undermine the tool's purpose."

Rodgers said he thinks the matter can be cleared up once the parties sit down around a table and air out all grievances. "There are some misunderstandings," Rodgers said. "It's hard for us to communicate a clear message to more than 41,000 physicians across a state as wide as ours. They haven't seen the actual tool yet as it hasn't gone live."

As for the tool's Jan. 1 launch being delayed, the TMA put out a separate release praising that decision, but hinted that it might ask the Texas Legislature to step in if things don't progress in satisfactory fashion.

BLUECOMPARE PROPOSED RANKING SYSTEM

- » **Dark Blue Ribbon**—This physician is recognized for the strongest performance compared to peers, based on the EBM information available.
- » **Light Blue Ribbon**—This physician is recognized for satisfactory performance compared to peers, based on the EBM information available.
- » **Gray Ribbon**—Based on the information available, BC/BS of Texas is not able to recognize this physician or professional provider for one of the following reasons:
 - EBM indicators are not currently applied to the specialty for which this physician or professional provider would be evaluated.
 - The physician does not have enough data in claim files to be recognized.
 - Based on the indicators the insurer is able to calculate from claims and enrollment data, the threshold for recognition was not reached.

Source: BC/BS of Texas

What's Causing All This. The Texas Blues have had an online-physician search tool for some time, and designed the BlueCompare tool to act as a companion to the search function.

The tool, which can be accessed without a password, is designed to provide information on physicians and other providers in the BlueChoice and BlueChoice Solutions networks, giving consumers the ability to access information about doctors' care practices and general affordability prior to receiving treatment.

In an effort to give consumers a view of how their physicians compare to those in their peer group, BlueCompare rates physicians on the delivery of healthcare that meets selected evidence-based medicine guidelines.

In addition, there is an affordability scale feature, which gives consumers an overview of which doctors have historically been more affordable when managing the care of patients with similar medical conditions, within the same geographic area. Texas Blues officials wanted to ensure that Texas' specialist physicians are compared with those who practice in the same area of specialty.

"We see this as a member and physician education opportunity. We can see which physicians across the state were better at hitting their guidelines and which ones weren't, and we can educate physicians in areas of the state who don't perform as well," Rodgers said. "We want all of them to hit their measures. This is not a punitive exercise."

Controversy Ensues. BlueCompare institutes a ranking system, whereby physicians are awarded "ribbons" that have certain indicators—dark blue, light blue, and gray—and this

is one of the tool's components that has caused consternation on the part of the TMA. For instance, a dark blue ribbon indicates the physician is recognized for the strongest performance compared to peers doing the right things for various conditions, based on the evidence-based medicine guidelines available.

The light blue ribbons indicate a satisfactory performance, whereby the gray ribbons have several indications. For instance, the physician may be in a specialty where evidence-based medicine indicators are not applied, or they do not have enough data or patient encounters to be recognized, or they failed to meet the performance threshold.

In its release, the TMA called the gray ribbons a "murky ranking," pointing out that a patient won't know the real reason the physician has been placed in that category.

"Instead of educating patients on where to find quality medical care, BlueCompare will further confuse Texans who are lost in the healthcare maze," Ladon W. Homer, M.D., president of the TMA, said in the release.

For his part, Rodgers acknowledges the ranking system raises some legitimate questions.

Shades Of Gray. "Employers have said if a physician has performed poorly then we should indicate that. Physicians say if I am in a sector that is not measured, or if I have not had enough patient encounters, I am lumped in with the bad guys," Rodgers said. "That is a fair point. My problem is, doing any more would be disclosing which physicians performed poorly. Philosophically we are not in a place where we want to do that yet.

"In a couple of years we may go there if we give them the opportunity to improve their scores and they don't," Rodgers added. "We are telling everyone this is a first-generation tool, and we need to bring the physician community and consumers along with us on this journey."

Rodgers said if there was a way to alleviate concerns without highlighting poor performers, the insurer would be willing to go down that road. "We don't want to call anyone out," he said. "We did it to protect physicians who didn't perform as well."

Another area of concern pinpointed by the TMA was the fact the program uses healthcare bills and insurance claims as opposed to the patients' actual medical records to evaluate the quality of care. "You can tell no more from looking at a claim form that good medical care was provided than you can tell from looking at a restaurant bill that good food was served," Homer said in a release.

Rodgers refutes these arguments, saying the plan has used data sent to them. "We tried to select measures that could be gleaned from administrative data. We use process indicators," Rodgers said. "Did physicians do the tests or procedures according to evidence-based guidelines? When they do procedures they bill us for them. That is why all the indicators are process indicators. We have no measures that factor in outcomes, did the patient get well, etc."

Lost In The Shuffle? Perhaps lost in the mix is the original intent of the tool and whether it would make a difference in selection patterns. Blue Cross and Blue Shield of Texas officials say they hope the tool will help both insured and uninsured consumers make the best and most affordable healthcare choices for their families. That desire is what prompted the insurer to forgo requiring a password for access.

But how effective will it be? So far, national data suggests that public reporting of performance data has had a relatively small impact on consumer choice, said Bruce Landon, M.D., associate professor of healthcare policy at Harvard Medical School, who has followed transparency initiatives in Massachusetts.

"However, public reporting does serve to motivate individuals and institutions to improve," Landon said. "As consumer-directed health plans gain in popularity, public reporting of performance data and prices might become much more influential as consumers will begin to rely, at least to some extent, on this information when making decisions."

However, the TMA has different ideas on the issue of transparency. One need only reference the TMA's BlueCompare release to gauge its stance, saying transparency has been the "standard for centuries" in the medical profession.

"The health plans have the most information to hide—which physicians are and are not in their networks, what their plans actually cover, and where their premium dollars actually go—and they do a very good job of hiding it," the release stated.

With public posturing such as this, one wonders how these private meetings turned out.

OUTLOOK: *It is understandable the TMA has concerns about the Texas Blues' new transparency tool, especially the ribbon ranking system. However, officials with Blue Cross and Blue Shield of Texas feel they are putting out the information in the best system they can. Expect both sides to come to some amicable conclusion, one that possibly could have been reached without the public display of non-affection. But it sure did give the media some good pre-Christmas copy.* ■

CHIP Adds Prenatal Coverage To Help Unborn

By Ric Gross

Having trimmed the state’s Children’s Health Insurance Program in recent years, Texas lawmakers are ready to expand the program to cover prenatal care for women—including non-citizens—whose children will qualify for CHIP coverage at birth.

There are two good reasons for the move: money and money. The federal government gives states a higher matching funds rate for CHIP programs that provide prenatal care to low-income women. Secondly, an investment in providing earlier—and relatively inexpensive—prenatal care to the mothers of CHIP babies, may likely reduce incidence of premature birth and other potentially costly conditions for those babies.

CHIP health plans participating in the expansion include AMERIGROUP, Community First, Community Health, El Paso First, Firstcare, Mercy Health Plan and Parkland HealthFirst.

Under current federal Medicaid regulations, states are required to pay for labor and delivery costs for women, including non-citizens, who meet eligibility criteria. Children born in the United States are citizens, regardless of their parent’s citizenship status, and are eligible for Medicaid if they meet financial eligibility requirements. However, most legal permanent residents (green card holders) and all undocumented immigrants are ineligible for Medicaid under current rules, and thus do not—until this CHIP expansion effort—have access to Medicaid-funded prenatal care.

By covering labor and delivery costs and a majority of the newborns’ subsequent health insurance, the state has been drawing a 60.66 percent federal match in its Medicaid program. Providing expanded prenatal coverage under the CHIP program allows the state to draw the 72.46 percent matching rate.

Under the expanded program, eligibility is for the unborn children of pregnant women who have a household income greater than 185 percent of the federal poverty level and at

or below 200 percent of the federal poverty level, or those who have a household income at or below 200 percent of the federal poverty level but do not qualify for Medicaid due to immigration status.

Linda Hook, nurse program manager for the San Antonio Metropolitan Health District, said the program’s goal is to reduce Texas’ rate of premature births and infant mortality.

“CHIP is about keeping children healthy. This is important to help with our infant mortality and premature births,” Hook said. “There are some people who don’t seek prenatal care because they are scared about access issues. This allows us to see these women who aren’t quite sure about their access.”

The program will replace grants-funded prenatal care programs that Hook said have never been able to meet the need. Most of the time, for example, agencies like the San Antonio Metropolitan Health District were out of grant money by mid-year. Additionally, at the birth of the child, Hook said there often is a delay in the certification of the infant into the Medicaid program. Under current CHIP guidelines, there is a 90-day waiting period for a child enrolled in the program. There’s no such gap in the new program.

“This new program will provide continuous coverage and remove financial barriers the parents may face if the child needs immediate medical care,” Hook added.

In the San Antonio area, the Department of State Health Services estimates that approximately 3,500 women will be eligible for this program. Statewide, according to Ted Hughes, press officer for the Health and Human Services Commission, it is estimated that 40,000 children will be covered through Aug. 31, 2007.

How It Works. CHIP perinate coverage provides up to 12 months of continuous coverage for children from the month of enrollment in the program, including months before the birth. For example, if an unborn child is enrolled during the third month of pregnancy, the child would maintain continuous CHIP coverage until he or she reached the age of six months.

“A child needs health insurance, and this is an opportunity to get at-risk women into the healthcare system prior to delivery,” Hook said. “This starts insurance for the child before it’s born, and it’s the mom’s responsibility to keep that going.”

Benefits include up to 20 prenatal visits; pharmacy, limited laboratory testing, assessments, planning services, education and counseling; prescription drug coverage based on the current CHIP formulary; and hospital facility charges and professional service charges related to labor with delivery only. Program benefits after the child is born include two postpartum visits for the mother, and the traditional CHIP benefit package for the newborn.

TEXAS INFANT DEATHS, BIRTHS AND FETAL DEATHS 2003

	Infant Deaths	Fetal Deaths*	Births
Preterm Births	1,240	1,465	40,645
Unknown	334	449	20,717
Total	2,346	2,258	377,374

*The state requires fetal deaths reported for those 20 weeks or more gestation. This number includes all cases sent into the state (some are less than 20 weeks).

Source: Center for Health Statistics, Texas Department of State Health Services

Non-covered services include inpatient hospital care for the mother of the unborn child that is not related to labor with delivery, such as a broken arm; labor without delivery of the baby (false labor); and most outpatient specialty services for the mother, such as mental health and substance abuse treatment, asthma management and care.

The health plans are charged with recruiting physicians and providers for their networks. Reimbursement rates will be negotiated between the provider and the health plan, with providers submitting claims directly to the plans for payment.

“The provider network for the mother may be limited, mostly due to the limited benefits prenatally,” Hook said. “But for the children, they will have the current provider network that all CHIP-eligible children receive.”

Jared Wolfe, executive director of the Texas Association of Health Plans, said there are still issues to be worked out.

“The state is saying you can take care of the babies but can’t take care of the mom except as it relates to the pregnancy,” Wolfe said. “Are we supposed to do this, pay for it and eat a lot of money covering the mom? There are still some pitfalls we need to work out. We are still talking about how it is going to operate and what the reimbursements are going to look like.”

Concerns. While advocates feel the program has merit, there is concern that undocumented immigrants will not participate for fear that they’ll be caught and deported. Although state officials insist that is not the case, the immigrant community may not be easily convinced.

“There are some signs they may be backing away from this program, due to confusion over the policy and the negative, highly charged immigration debate we’ve been in,” said Anne Dunkelberg, health policy analyst and assistant director at the Austin-based Center for Public Policy Priorities. “I think it will take a good outreach effort. We’re concerned about whether there’ll be some kind of backlash due to the current immigration debate.”

According to Hughes, the state HHSC does not need information about the citizenship or immigration status for anyone but the child, and will not share that information with the Bureau of Citizenship and Immigration Services. Hughes noted the BCIS couldn’t use the application or the enrollment of a child in Medicaid or CHIP to deny a parent admission to the U.S., to harm their permanent resident status or to deport them.

However, that doesn’t mean a cloud of fear or uncertainty won’t keep some expectant mothers away from the program.

“Will there be some who are frightened to use the program? That will be an issue,” Dunkelberg said. “The people who live in the Rio Grande Valley and are used to seeing the border patrol outside of health clinics will have some legitimate fears.”

Abortion Play? In addition, some fear the program is an effort by anti-abortion activists to establish a fetus as a per-

son by extending a federal health entitlement to the unborn. And the nonprofit National Advocates for Pregnant Women has said the policy is a smokescreen for the fact the Bush administration “has done so little to help the uninsured.” In addition, the group decried the fact women would not be covered if they suffer a miscarriage to stillbirth, as it said more than 900,000 women do each year.

Hook said she hopes immigration status and other issues won’t cloud the fact the program offers real advantages for children.

“The main issue is a human being, it’s a child. Women could be in the process of obtaining citizenship or residency status and not be eligible for the Medicaid program, and this provides an avenue of help,” she said. “And it’s not all necessarily undocumented U.S. citizens. There could be many reasons why they are not seeking care.”

The state has made applications for pregnant women available at Health and Human Services Commission benefits offices, participating community-based organizations, and online at www.yourtexasbenefits.com.

Medicaid Expansion Delay. Meanwhile, Texas’ long-frustrated attempts to expand managed care into the Medicaid aged, blind and disabled (also known as ABD) population, a program known as STAR+PLUS, has been delayed until February.

The Health and Human Services Commission is delaying the expansion of the STAR+PLUS program due to a delay in federal approval of the waiver. It was hoped that beginning Jan. 1 the STAR+PLUS program would expand from Harris County, where it has been in operation since 1998, to the Bexar, Nueces and Travis County service areas.

The expansion was originally slated for 2005, but was delayed by a contentious legislative debate over its effect on funding for Texas’ public hospitals.

Plans now call for the program to be operational Feb. 1. According to a state release, clients who have already made their STAR+PLUS health plan selections will continue to receive Medicaid services and will be enrolled in their selected health plan when the program becomes operational. Enrollment will be mandatory in the 29 counties being served, with the expansion bringing the ABD client base to around 140,000, and plans still call for at least two HMOs in each service area, offering recipients some choice.

OUTLOOK: *Whatever the reasons for the CHIP expansion or what agenda is being forwarded, lives will benefit, as will the state of Texas. Any relief on uncompensated care alone for hospitals is a victory in and of itself. However, Texas’ CHIP program has been in a state of disarray over the past few years, due to changes enacted by lawmakers and a new eligibility system. Expect the program itself to be a point of debate in the 2007 legislative session.* ■

More Competition Adds Spice to Part D Market

By Ric Gross

A dizzying number of Medicare Part D stand-alone options didn't deter Texas seniors in 2006, and analysts are expecting big enrollment numbers for 2007 in the Lone Star State as well.

For 2007, Texas seniors were able to choose from 60 stand-alone plan options—up from 47 plans last year. With more than 750,000 seniors self-enrolled in Part D, and another 341,490 automatically enrolled, Texas has the nation's second-largest Part D population, behind California with 2.1 million Medicare beneficiaries.

This year, Lone Star State beneficiaries had 60 stand-alone options to choose from, including 27 plans that offered enhanced benefits or services, representing an increase of eight more choices of enhanced plans than in 2006.

With more new options, more competition and more familiarity with the Part D program, industry-watchers are expecting strong stand-alone PDP enrollment again this year. And as the market matures for Medicare products in Texas, some experts see opportunities for Medicare plans in the private fee-for-service arena.

"The first year of Medicare Part D went pretty well. We had around 40 percent or more of beneficiaries sign up for coverage," said Andrew Crocker, extension program specialist in gerontology and health for the Texas Cooperative Extension. "I think 2007 will be interesting to see the number of people who may change plans."

Larry Jendrusch, senior services program manager for the University of Texas Medical Branch, said from his perspective, the initial confusion over the program seems to have died down.

"It seems people understand the program and don't need the help," he said. "Last year we had around 2,000 come through our program, now it's only a handful. That's not to say they support or agree with it, but we have not seen the anxiety or stress that was a factor last year."

Still, there may be a rude awakening for those seniors whose plan has raised its premium price, or has eliminated certain drugs.

"The biggest confusion is that people are still equating it with Medicare Part A and B. They do not understand it has to be reviewed every year," said Rita Moore, benefit counselor for the Texarkana-based Area Agency on Aging. "Plans, policies and formularies change. Once you sign up you are not finished."

Plans And Players. The average monthly cost for a basic stand-alone prescription drug plan in Texas in 2007 will be \$28.12, while the average cost of an enhanced plan will be \$46.11.

Back are the top two players, UnitedHealthcare and Humana. According to October numbers from the Centers for

TEXAS STAND-ALONE PLANS: LOWEST PREMIUMS

Plan	Benefit Type	Premium	Deductible
WellCare	Basic	\$11	\$265
Humana	Basic	\$12.70	\$265
UnitedHealthcare	Basic	\$18.10	\$265

Source: CMS

Medicare & Medicaid Services, Humana had enrolled 223,738, while UnitedHealthcare showed enrollment of 197,201.

"Everything went really well in 2006. I think the numbers speak for themselves. They really exceeded our expectations," said George Smith, M.D., president for Humana senior products for the region that includes Texas. "Our distribution channels were strong, and we also had the best priced plan in the state [a \$10.31 premium], and all of those added together contributed to us being so successful."

Humana is not the lowest-priced plan in Texas for 2007. That distinction belongs to WellCare, whose Classic plan features a premium of \$11, in addition to a Signature plan, with a \$19.40 premium, and an Enhanced plan with a \$33.60 monthly premium and coverage for generics through the coverage gap.

Too Much Of A Good Thing. For Humana's part, its lowest-cost plan went from \$10.31 to \$12.70, a nominal change, but not the only one for the insurer. In 2006, Humana rolled out prescription drug plans that offered brand coverage during the gap along with a higher premium. These Humana PDP Complete plans proved troublesome because there were few similar competing plans and consumer buying patterns led to higher-than-expected utilization, Humana officials said.

In response, Humana revamped its plans by eliminating brand coverage in the gap and raised prices to match the risk. These new plans offer generic coverage in the gap, and feature a monthly premium of \$76.60 in Texas, but as much as \$88.40 depending on the state.

The company expects the changes to increase profitability and expects to lose a significant part of this group in 2007 as a result. The big unknown is where those consumers will land.

"I'm sure it will cost us some people who are enrolled in that plan—it is a significant change for those that are in it. Those that use generics I think will stay with us," Smith said. "But overall for 2007 we think we will retain the vast majority of our members. We haven't had a huge change in premiums, and we don't think people will want to go through the selection process all over again. If anything, there is more confu-

sion this year because there are more options. I think we will keep the vast majority that we have.”

Moore said the increased competition in Texas will prompt seniors to look at their options and all plans. New players in the market in 2007 include EnvisionRx Plus, First Health, Health Net, NMHC Group Solutions, and Express Script Inc.’s SAMAscript.

“The [seniors] I have been talking to, many are switching. Last year the best priced plan was Humana, but now that is not the case,” Moore said. “There is a lot of competition this year, and many have looked at what Humana did last year. If beneficiaries wanted Humana again, but it wasn’t the best-priced plan for them, we switched them. A lot didn’t realize the plans would alter, that was one of the biggest shocks.”

SierraRx, meanwhile, has picked up where Humana left off and offers an enhanced plan that covers all formulary

drugs, with a \$96.50 monthly premium. By contrast, Humana’s plan in 2006 that covered generics and brands in the gap was priced at \$58.69.

“There is a lot more competition this year in Texas than a year ago, in terms of the number of plans being offered in the state, but we feel good about 2007 and our Medicare opportunities,” Smith said. “We still have the only regional PPO in the state. We are expanding our service area for our HMO, we are adding two counties in the Corpus Christi market and two in the San Antonio area.”

OUTLOOK: Expect enrollment numbers for Part D in Texas to grow in 2007, as seniors are more familiar with the program. And while some will switch plans, Humana and UnitedHealthcare will be in the top spots once again. ■

Generic Drug Price War Heats Up In Texas

By Ric Gross

Consumers looking for low-cost generic drugs in Texas gained two new options in October 2006 when giant retailer Wal-Mart and San Antonio-based H-E-B Pharmacy introduced low-cost generic drug plans.

Wal-Mart's \$4 copay prescription program launched Sept. 22, 2006, in the Tampa Bay, Fla., area, expanded statewide in the Sunshine State on Oct. 6 and quickly found its way into Texas, as Wal-Mart officials ramped up its national rollout plan.

Wal-Mart's foray into the prescription drug business garnered national attention at the time, with analysts suggesting that with the company well known for using its immense buying power to lower prices on everything from toothpaste to tires, the decision to offer cheaper generic drugs could create a ripple effect among pharmacies.

Such is the case in Texas, as H-E-B announced its initiative the day after Wal-Mart made its announcement. Under its plan, customers can sign up for H-E-B Pharmacy Rewards Card, which entitles them to an offering of 500 generic drugs for \$5 at all H-E-B Pharmacies plus savings on all other brand and generic drugs. The drugs being offered at the \$5 price are those that address the most prevalent disease states in Texas, H-E-B officials said, including diabetes, hypertension and heart disease.

Customers who sign up for the H-E-B card will also receive priority scheduling for H-E-B Pharmacy services and access to free health screenings and educational information via mail and e-mail.

In essence, the two are taking different routes—H-E-B being the local chain trying to get members locked in, whereas Wal-Mart is looking to snare the multitude of frequent shoppers.

"Wal-Mart wants to drive more people to their stores—in essence, they want to increase customer volume," said Joseph Paduda, principal of Health Strategy Associates. "It makes sense strategically and tactically for them. They have picked drugs that are pretty inexpensive to start with.

"It's not costing Wal-Mart any money, and they will be able to drive volume and brand themselves as a place where people can go for healthcare needs without really costing themselves a lot of money," Paduda continued. "They are not out there to compete per se with the drug programs like H-E-B. They are competing on drug prices for those who don't have drug cards."

Such low copays will offer the biggest benefit to uninsured customers, as members of many insurance plans already benefit from lower copays through price reductions negotiated between insurers and pharmacies. And with Texas leading the nation in its rate of uninsured, with 24.2 percent

THE DOPE ON GENERIC DRUGS

- » Generic drugs accounted for \$22.3 billion in sales in 2005 versus \$229.5 billion for brand-name.
- » Generic drugs account for 56% of all prescriptions dispensed in the United States.
- » In 2004, the average price of a generic prescription drug was \$28.71, while the same for a brand-name drug was \$95.84.
- » The generic industry is expected to grow by roughly 13% in 2006.
- » Blockbuster products coming off patent are valued at \$22 billion in 2006, \$27 billion in 2007, and \$29 billion in 2008.

Sources: Generic Pharmaceutical Association, IMS Health, Bain & Co.

of its residents lacking health insurance, there are plenty of customers to be had.

"Texas has the highest rate of uninsured, so that factor comes into play. Texas also has a younger population than a lot of areas, so Part D won't come into play as much," said Paduda. "They also have a lot of undocumented workers that do not have health insurance, and will shop at Wal-Mart."

Health Plan Reaction. Aetna spokeswoman Rachele Cunningham said there is some concern members may just pay for their drugs without notifying their insurer.

"Several of Aetna's medical and quality management programs could be affected," Cunningham said. "Since the \$4 [Wal-Mart] copayment is lower than Aetna's average generic copayment of \$10, there is a possibility that Aetna members would not submit their insurance card to the pharmacist and just pay as 'cash' customers. If the pharmacy does not submit these claims because our reimbursement to them would be zero, any of our programs that need claim evidence that a patient received one of the drugs on the list will not operate correctly."

Aetna would prefer members present their ID card and have the claim appropriately processed, since the insurer relies on that claims data to manage members' health. Aetna continuously scans members' claims information in order to detect and alert physicians and members about potentially urgent situations.

Humana has addressed that issue by announcing that members purchasing \$4 prescriptions at Wal-Mart will pay the lower of their copay or the retail price for the drugs.

In other cases, pharmacies may have members' information entered in their computers, and the claim would likely be filed electronically even if the member never presented an ID card for the low-cost medications.

Some See A Downside. In response to the media hype that surrounded the generic price wars, drug store chain

Walgreens announced it would not follow suit, saying it saw little value in the Wal-Mart offer.

Further analysis by Walgreens showed that many of the \$4 generics were already contracted with insurers to be sold for prices between \$3 and \$5. The pharmacies must accept the contracted price, and sell it to the customer at that price regardless of the insured patient's copay. These arrangements exist under average-wholesale-price (AWP) or maximum-allowable-price (MAC) contracts.

Paduda sees a mixed benefit from Wal-Mart's scheme as well. On the one hand, he said, many insured persons may find an advantage in filling a \$4 prescription without even showing their insurer's ID card.

"The much cheaper price will likely lead to higher compliance with drug regimens," said Paduda. "It will probably result in lower future claims for cardiovascular, diabetes and other claims covered by those drugs. So that means good news all around for insurance companies and pharmacy benefit managers that have at-risk programs."

He also believes it will soon have an effect on doctors' prescribing habits as they adapt to patients' requests that save them money.

On the other hand, he noted, many consumers may wind up disappointed with what's available. The list of drugs in the program contains many duplications, and only two of the 20 most commonly prescribed generics, "not exactly the pharmaceutical equivalent of the Talking Elmo doll, at least in terms of popularity," Paduda said.

Paduda believes the recent retail initiatives will drive down generic prices. "We in the U.S. pay more for brand drugs, but in other countries around the world, they pay more for generics," said Paduda. "And when you consider what the intellectual property laws are in places like India, it sets up an opportunity for manufacturing overseas."

OUTLOOK: Examining the details of discount or even free prescription drug offers would make it easy to dismiss them as hype. But the enormous ability of Wal-Mart to move markets makes nothing it does overblown. Indeed, given the high cost of healthcare, some Wal-Mart-ization of the entire sector may be just what the doctor ordered. ■

Humana/Virgin Life Alliance Wins Account

By Ric Gross

Humana Inc., which is teaming with Virgin Life Care on a group and individual offering in the Texas market, welcomed a major new group customer on board Jan. 1 due to the incentive-laced wellness offering.

The San Antonio-based Northside Independent School District, with around 11,000 employees, switched its coverage to Humana Jan. 1, attracted by the HealthMiles rewards program. Humana and Virgin formed a business alliance in early May 2006, which resulted in the development of a Virgin-branded and Humana-administered individual product (known as HealthMiles Plus), and the group offering, HealthMiles.

The key to the pilot is what is known as the Virgin Life Care HealthMiles program, in which participants can earn reward points for participating in an exercise and fitness regime. The more points earned, the more a participant can redeem for merchandise at a variety of participating retail outlets, including Amazon.com, Target, Borders and more. Or, to put it another way, HealthMiles can be looked at as frequent-flier type of miles for people who exercise.

The HealthMiles group product is available to businesses with more than 300 employees in the Dallas-Fort Worth, Austin, Houston, San Antonio and Corpus Christi markets, while the individual product is available statewide.

This facet of Humana's offerings stood out when the Northside Independent School District to put its group health insurance out to bid.

"Wellness is very important to us," said Suzanne Levan, director of employee services for the Northside Independent School District. "Like everybody else, our healthcare costs and insurance rates are going up. When we analyzed the results of our claims data, we found nine of the top 10 diagnoses we were paying claims for were diseases that could be prevented or mitigated by healthier lifestyles."

The district had a wellness component in place with Aetna, its prior carrier, and when putting its contract out for the 2007 bid, asked carriers to present a comprehensive wellness option. Levan said bids came in from four different carriers, but Humana set itself apart from the crowd.

Asking For The Moon And Getting It. "We asked for the moon in hopes we'd get a little bit. We asked for nutrition programs, athletic club memberships and smoking cessation programs, among other things," she said. "Humana was the only one who had a comprehensive program—a health club membership, and a cool way for employees to track their activity through the Virgin LifeCare Health Zone."

Spectrum Athletic Clubs is on board in the initiative, with Virgin Life Care's HealthZone stations set up in 10 Spectrum facilities. The Health Zone features a scale, body fat indicator, blood pressure cuff and touch screen. Participants have sev-

eral ways to use the HealthZone stations in their bid to earn points. The information from the HealthZone is automatically fed to Virgin Life Care's password-protected LifeZone Web site, where members can track their progress and view health and fitness accomplishments on their own personalized Web page.

When employees sign up for Virgin Life Care's Health Miles program, they can choose a HealthPerk to help them reach their health and fitness goals—either a discounted health club membership or a Virgin LifeCare GoZone pedometer.

So, for example, someone who feels they don't have the time to put in at the health club can use the GoZone pedometer to keep track of their activity. The GoZone syncs up to the member's personal LifeZone Web site, enabling them to track their overall activity and progress online.

At the end of each month, the accumulated points are transferred into "Virgin Life Care Cash," which can be put toward gift certificates at the participating retailers.

Prizes And Snapshots. "The whole idea is to get people up and moving around, and give motivation to do so. It can help lower our cost, for things like cardiovascular disease, stress and anxiety," Levan said. "Lots of data suggests as you pay more attention to weight, it lowers the chances of heart disease, for instance. Our whole goal is to change behavior through healthy lifestyles, and hopefully we can mitigate any cost increases going forward."

Levan said the district wanted to encourage enrollees and get a baseline of its population, so it offered employees the opportunity to begin their membership by taking a health snapshot beginning Nov. 1, 2006. Levan said by Nov. 27, 3,300 people that had taken the health snapshot.

"We are currently at 35.7 percent of our employees participating in this wellness program. Of course, we'd love to get

ECONOMIC COSTS OF PHYSICAL INACTIVITY, OBESITY, OVERWEIGHT (2005)

Results from a California study showed the incremental cost to the employer of a physically inactive worker is \$2,400 a year, and \$3,270 for an obese worker.

Risk Factor	Population Incidence	Incremental Cost/Employee/Year*
Inactive	50%	\$2,400
Obese	17.5%	\$3,270
Overweight	35%	\$515

*Cost: Medical, 50%/Productivity, 50%. Results from California Study.

Source: Humana/Virgin Life Care

100 percent to do it, but we'd be thrilled if we got 50 percent to 60 percent of the population to at least be thinking about it," Levan said. "Of the employees who took the health snapshot, more than 50 percent showed as overweight or obese. Our hope is that this program will create an awareness with our employees and provide the environment and incentives for them to make healthy lifestyle changes that will improve their overall health and the District's health costs."

Jim Watt, president of Employee Benefits Solutions Inc., a Houston-based healthcare consulting firm, said Humana's HealthMiles program is a step in the right direction in the area of wellness and well-being.

"It seeks to tie employee health to exercise and other health parameters, which is fully realized through modifications in premium levels," Watt said. "Humana first aligned with HealthMiles on its individual insurance products, and candidly, this is a better alignment than through its group products. Consumerism is best realized without the intervention of employers, and as a result, may provide a better outcome in the individual market. Nevertheless, I applaud Humana for the approach and their investment in this program."

Marianne Fazen, Ph.D., executive director of the Dallas-Fort Worth Business Group on Health, said many employers are taking a look at comprehensive wellness programs as a way to control escalating costs.

"When you are talking about wellness programs, you aren't just talking about smoking cessation or walking during lunch. It is a much more comprehensive approach to benefit design," Fazen said. "It includes such things as disease management, and it's about identifying employees who need the most help and having benefit designs aligned with that."

"I think the Humana program is a good pilot to see if those type of incentives work. It is an innovative approach," she continued. "Participation is key to the whole thing, and sustaining any behavior change that's brought about requires ongoing participation and incentives."

South Africa Success. The program has been an unqualified success in South Africa, where the model began six years ago and has since grown to include 445,000 members. Virgin Life Care officials point to the success of the South African project when talking of their hopes for the U.S. version.

For instance, in 2005, Virgin Life Care members in South Africa logged more than 6 million health measurements, 30,000 fitness assessments and 35,000 health-risk appraisals. Also, after three months, 60 percent of members with high blood pressure had moved to normal, and after nine months this number increased to 66 percent of regular gym users (members who use the gym three times a week).

As for weight, after three months 8 percent of members classified as obese had moved to normal or overweight, while after nine months, this number rose to 14 percent of regular gym users, officials said.

Virgin Life Care plans to offer the program to companies as an added-on benefit, allowing companies to bring it to their employees any time.

OUTLOOK: Employers are searching for ways to get individuals to get off the couch and get active, with some even going as far as letting employees know they could lose their job if they don't undertake efforts to stop smoking, for example. Adopting the Virgin Life Care HealthMiles aspect appears promising, as the school district as done. Let's face it, who wouldn't be interested in shopping with someone else's money? ■

United Aims To Be The Big Insurer On Campus

By Ric Gross

In a move that strengthens its footprint in the student insurance market, UnitedHealth Group has purchased the assets of Student Resources, an operating subsidiary of North Richland, Texas-based HealthMarkets.

Student Resources offers health insurance programs that provide single, school-year coverage to individual students at colleges and universities, as well as providing accident policies for students at public and private schools in pre-kindergarten through grade 12.

The move comes on the heels of UnitedHealthcare partnering with leading African American academic health centers and business leaders to implement healthcare solutions for employees and faculties of historically black colleges and universities. That deal, announced in March 2006, provides access to medical, vision, life, disability and behavioral-health benefits.

Jim Watt, president of Employee Benefits Solutions Inc., a Houston-based healthcare consulting firm, said insurers targeting the "young invincibles" is a savvy business strategy.

"Aetna, UnitedHealthcare and others have made significant commitments and investments expanding membership through colleges and universities," Watt said. "This commitment has included buying specialty companies that have developed a service offering specific to this kind of membership."

"Given the stability in funding for this type of employer, this kind of investment is a sound one, and should serve each of these organizations well, and their shareholders better."

Ken Burdick, CEO, Public Sector, for UnitedHealthcare, said the insurer decided a couple of years ago to begin targeting the student population as a potential growth area.

"It is a specialized segment, and it's fairly diversified. There are a couple of larger players, Student Resources and

A SAMPLING OF STUDENT RESOURCES' CLIENTS

- » American Bar Association/Law Student Division
- » DeVry Institute of Technology
- » Eastern Michigan University
- » Minnesota State Colleges and Universities
- » Pennsylvania State University
- » Pepperdine University
- » Rutgers, The State University of New Jersey
- » University of Colorado System
- » University of Kentucky
- » University of North Texas
- » University of Notre Dame
- » University of Texas System
- » University of Wisconsin System

Source: Student Resources

Chickering [owned by Aetna], and beyond that a large number of players without significant market share,” Burdick said. “Two and a half years ago we launched our product development in this space, and we’ve added about 30,000 students in an 18-month period.

“We have been very pleased with the response in the marketplace,” Burdick continued. “However, one thing we have learned is that this is a very customized offering. The benefit design and the way you negotiate network contracts is significantly different than with a corporate buyer.”

With this in mind, Burdick said the company decided rather than grow organically, it would see if there was an organization operating in the space with the experience and administrative capabilities to support the new line of business.

This led United to Student Resources, a successful outfit operating under the HealthMarkets umbrella, a company that provides health and life insurance to the self-employed, individuals and small businesses. For its part, Student Resources’ rolls showed around 450 clients and 260,000 members at the time of the purchase, which closed Dec. 1, 2006.

“By and large around 85 percent to 90 percent of their business is driven by offering healthcare to college students and graduate students,” Burdick said. “They have been limited due to their network contracts. They had some direct

contracts with some hospital systems, but they don’t have a national footprint, or the network reimbursement arrangements we bring to the table.”

The deal makes sense for both entities. Student Resources brings expertise in a field United is trying to become more familiar with, and United brings its mammoth network of more than 500,000 physicians and other healthcare professionals as well as 4,600 hospitals.

“They have deep expertise in their field, and we can bring that national network,” Burdick said. “There are some geographic areas with a lot of colleges, such as California and New England, where they are especially eager to leverage our network of physicians and hospitals. This is all about growth, and it’s a successful combination of our different capabilities that brought together will be very attractive to customers and prospects.”

For example, in addition to the expanded network, Student Resources members will be able to make use of United’s Web-based tools, including its MyUhc.com portal, which will be especially helpful for the computer-savvy college students.

An advantage for UnitedHealthcare, meanwhile, will be the Plano-based system platform and its claims and service call center Student Resources utilizes, which currently houses around 300 employees—all of which will stay on board.

“Their platform is built around this line of business, and we will be using that as our platform,” Burdick said. “We expect [the Plano call center] will expand as we grow our market share.”

The move also can be seen as a strategic one for United as it goes after the “young invincibles” market in an effort to get them on the insurance rolls at an early age.

“We believe the business is moving to a more consumer-oriented focus. Employers are still very important sponsors, but consumers are increasingly becoming key decision makers,” Burdick said. “We want our members to join us early on [as students] and build relationships with consumers at that early stage, and keep them with us for their entire life.”

OUTLOOK: *With insurers casting an eager eye toward the young invincibles, even going so far as designing snappily named products for this segment, the acquisition of Student Resources is an excellent move by UnitedHealthcare. It brought not only numbers to the healthcare giant, but also expertise in a fast-growing area.* ■

Aetna Reaches Out To Hispanic Colleges

By Ric Gross

Already a factor in the student health insurance market with its Chickering Group products, Aetna has made a move to strengthen its ties to the nation’s Latino collegiate community.

In mid-October 2006, Aetna announced a formal alliance with the Hispanic Association of Colleges and Universities (HACU), whose national headquarters are in San Antonio. A

non-profit organization representing more than 450 colleges and universities in the United States and abroad, HACU's member institutions collectively enroll more than two-thirds of all U.S. Hispanics in higher education.

As a result of the alliance, Aetna is serving as HACU's health partner and will provide online health information to member schools through a link to Aetna's IntelliHealth Web site, executive mentors and guest speakers at HACU events, and financial support for HACU's annual conference.

Company officials say the deal is the latest Aetna initiative focused on gaining knowledge and building relationships within the Latino community. "I have known about HACU and its leadership before I came to Aetna [around two and a half years ago], so I understood the potential and how establishing a mutually beneficial relationship made sense," said Raymond Arroyo, head of diversity for Aetna. "This is a partnership where we want to take steps to bring something to help the community, and it also represents an opportunity for us to expand from the traditional marketplace.

"The student business is a fairly new one for Aetna per se, and there are community colleges that are a member of HACU, and that's not been a traditional focus for Aetna and Chickering," Arroyo added. "Now we are looking to see if it makes sense for us to go into that market, and if so, how could we do it."

Also on the drawing board is a potential case study developed by Aetna and HACU on healthcare disparities and culturally sensitive healthcare delivery that would be offered through HACU's member institutions.

"Research shows Caucasians are healthier than Latinos, and this presents an opportunity to provide outreach and education about how they can take better care of themselves as well as presenting an opportunity to tackle ethnic equality," Arroyo said. "Access is also not something many Hispanics may be particularly comfortable with. They may not understand the system and how it works. We can help with that as well—it's a true win-win."

Antonio Flores, president and CEO of HACU, said in a release that the potential case study is solid indication Aetna is "genuinely interested in meeting the health needs of our community and making a difference in the quality of line of Latinos." In addition, Flores noted Aetna's Web-based tools, mentorship program and financial backing as key ingredients in effecting change in the health status of Latinos.

"We don't want to be just a sponsor at a conference who just shows up, hands them a check and disappears," Arroyo said. "We want this to be a partnership that will make a difference in the community HACU services."

HACU was established in 1986 with a founding membership of 18 institutions. ■

People In The News

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



D. Lakey



S. Srivastava

David L. Lakey has been named as Texas' new commissioner of the **Department of State Health Services**. In his previous role, Lakey served as chief of infectious disease and medical director of the Center for Pulmonary and Infectious Disease Control at the University of Texas Health Center in Tyler. He has been a faculty member there since 1998. In his current role, Lakey also serves as associate director for infectious disease and biosecurity at the UT Center for Biosecurity and Public Health Preparedness. He chairs a bioterrorism preparedness committee for 34 hospitals in East Texas, and he led development of the Public Health Laboratory of East Texas in 2002. He assumed his new role on Jan. 2, succeeding **Eduardo Sanchez**, who left the post in October to become director of the Institute for Health Policy at the University of Texas School of Public Health at Houston.

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. ■

Texas Hopes To Launch Statewide EMR System

By Ric Gross

Texas Gov. Rick Perry has taken the first step toward a statewide electronic medical record system, establishing the Texas Health Care System Integrity Authority to guide the development of a secure electronic medical records network in the Lone Star State.

In early October 2006, Perry issued an executive order creating a public-private partnership that seeks to further efforts to create a secure electronic medical records system, give consumers the ability to comparison shop for healthcare and provide a more robust health insurance market for smaller employers.

Such lofty goals look good on paper, of course, but the public-private initiative is still in its infancy. Perry has appointed 15 diversified industry execs to the Texas Health Care System Integrity Partnership.

This board will serve as an advisory group for the development of the Authority, working through March 1 to develop the financing and governance structures for the Authority.

Perry is not the first governor to come out in support of such an initiative. For instance, in Tennessee, Gov. Phil Bredesen—a former HMO executive and technology enthusiast—is trying to make sure Tennessee's various healthcare stakeholders and regional health information organizations connect in a way that promotes cooperation, respects competition and clears a potential mindfield of sensitive legal, privacy and proprietary issues.

Bredesen issued an executive order in June 2006 establishing a 17-member eHealth Advisory Council, charged with creating a plan to promote the use of electronic medical records and to identify obstacles to the implementation of effective health information infrastructure.

In the Volunteer State, however, funding has already been established with \$6.8 million in grants from the federal Agency for Healthcare Research and Quality, which seeks to promote development of electronic medical records and related health informatics technology during the next five years.

Similarly, in Wisconsin, Gov. Jim Doyle established an eHealth Care Quality and Patient Safety Board which is working to develop a plan to automate all healthcare information systems in the Badger State by 2010. Doyle included funding for a grant and loan program in his last budget, with plans calling for the board to award grants and loans to clinics, HMOs, hospitals, and physicians to help them purchase and implement automated systems.

In the Lone Star State, the funding for the project is unclear, with some speculating funds will likely come from the private sector, though it's anyone's guess at this point.

"I think we all agree this is a step we need to take," said Bill Rasco, president of the Greater San Antonio Hospital Council. "The question is how can Texas become smarter in how

we do this, as we seek to enhance patient care and quality as well as hopefully saving money across the board.

"The issue to me is how do you fund it. You have different health systems buying different programs—can they talk to each other?" Rasco continued. "What can we do in designing them to bring people together? How do you build that? You have to do it a spoke at a time."

David Bradshaw, chief information officer at Memorial Hermann Healthcare System, said a lot of doctor's offices might not be able to absorb the costs involved.

"Moving from pen and paper to computer is an evolving concept. Physicians realize they have to move from pen and paper to computer," Bradshaw said. "It is happening all across the state in large healthcare systems. But there are not a lot of large multiple specialty physician groups.

"How can we help our physicians as they establish these in their office, and how can we connect the offices? We welcome any help the state can bring," Bradshaw added.

Bradshaw highlighted pay-for-performance initiatives as important factors in the equation.

"Ultimately the rate of adoption in doctor's offices will be driven by pay for performance, and that is where the insurers come into play," he said. "Hopefully it will be a situation where they say show us your quality and we will pay you more."

Bruce Landon, M.D., associate professor of healthcare policy at Harvard Medical School, has followed technology initiatives in Massachusetts and said efforts such as Texas' at the state level are crucially important to moving forward on IT interoperability.

"The major challenges to interoperability don't just relate to technology, but also include issues such as privacy, consent, functionality, and expense," Landon said. "Consequently, ensuring the cooperation of government and private entities is needed."

When touting the initiative, Perry noted that the current paper system, which has been estimated to account for 25 percent of healthcare costs, hampers a doctor's ability to know patients' history, what existing conditions they have, or what medicines they are allergic to when they arrive at the emergency room, whereas a shared medical records database could answer such questions.

"Ultimately transparency is the way we all need to go, and it will make a huge difference in our healthcare system," said Steve Cyboran, vice president and consulting actuary in the Chicago office of The Segal Co. "Once people see the differences and providers know consumers are looking at quality and outcomes, they will focus resources on improving those aspects of their practices, and outcomes will improve."

Cyboran hastened to add that Texas is undertaking a huge challenge, one that—metaphorically speaking—may be as big as the state itself. “Issuing an executive order is the first step,” Cyboran said. “Establishing an EMR system and getting it implemented, getting the providers on board and getting the appropriate repository will be a bigger issue, they will realize. But if they can get it done it will move the market and have a huge impact.”

Local Industry Reaction. Perry’s announcement drew favorable comments from the state’s health plan, medical and hospital associations.

“We are looking forward to working with the governor on this,” said the hospital association’s Starr West. “There are a number of private initiatives going on involving healthcare exchange in the state, but it’s working in silos. This creates a public-private partnership that can pull all of these together and make sure the initiatives that are going on are coordinated, so you don’t have one part of the state going in one direction and one in another.”

For its part, the Texas Medical Association supports the plan but has called on the health plans to do their part. “The insurance companies’ computers hold the lion’s share of crit-

ical healthcare transaction information, much of it hidden from view in indecipherable black boxes,” Ladon W. Homer, M.D., president of the association, said in a statement. “Their cooperation is the key to the success of this effort.”

Jared Wolfe, executive director of the Texas Association of Health Plans, said the association would be actively involved in the process.

“EMRs are going to have a big impact on the way healthcare is delivered. It is great the state is getting out front on that and trying to develop a framework to work off of,” Wolfe said. “It’s a few years off until we see any savings. From a quality standpoint alone it is worth the investment.”

Wolfe said the health plan association would be looking at pay-for-performance measures as the process unfolds.

OUTLOOK: *Credit Gov. Perry for getting the ball rolling on this initiative, and Texas would perhaps be well served to cast an eye toward Tennessee’s strides in healthcare technology. Of course, Gov. Bredesen, who still owns a healthcare IT company, perhaps wields more influence there to get the state’s healthcare players to cooperate. However, the major players in the Lone State State appear on board, though the project’s true test lies ahead.* ■

Elephant In The (Legislative) Room: Uninsured

By Ric Gross

As the Texas Legislature gathers for its 80th session this month, healthcare advocates are trying to draw attention to what may be lawmakers' least-favorite issue: Texas' worst-in-the-nation ranking in uninsured citizens.

Both the Texas Hospital Association and the Texas Medical Association have targeted the state's burgeoning uninsured ranks as an area of focus for this session, though it is unclear how much—or little—lawmakers can or will do about the issue.

Almost no one expects a sweeping insurance mandate à la Massachusetts, a state that currently has a plan in the works to insure all of its residents. That exact plan wouldn't work in the Lone Star State for numerous reasons, both economic and political.

Rather, advocates are pinpointing a variety of areas the state can work in to hopefully lower the state's uninsured rate, which stood at 24.2 percent in 2005—the highest in the country. And though some advocates have high hopes, other industry watchers are more skeptical that the Republican-controlled Legislature will do something significant.

"My best estimate is they may nibble around the edges of healthcare, but do little. I don't see any will to do something major to reduce the embarrassing fact we lead the nation in uninsured," said Bob Bezdek, political science professor at Texas A&M University-Corpus Christi. "I'd be willing to bet if they do anything it will be window dressing."

In suggesting lawmakers should take a hard look at the state's uninsured crisis, Bezdek pointed out that exit polls from the 2006 gubernatorial race, which put Republican Gov. Rick Perry back in office, showed that Republicans lost a considerable percentage of Hispanic votes. Bezdek singled out recent projections by Steve H. Murdock, director of the Texas State Data Center, which pointed to a surging Hispanic population in the state.

"Hispanics are very concerned about healthcare. If they become the state's largest demographic group in 10 years and Republicans aren't paying attention to them and their needs, they could be in serious trouble," Bezdek said. "At some point it seems if you want to survive as a political party you would tap into this growing group and tackle issues they are concerned about. Of course they are concerned about education, but healthcare is a major concern."

Code Red. One report that helped shine a spotlight on the uninsured crisis was delivered by the Task Force on Access to Healthcare In Texas this past summer with the eye-catching title of, "Code Red: The Critical Condition of Healthcare in Texas."

The report was released with the intent of stirring up debate prior to the legislative session, stressing that the problem has reached such critical proportion that it is compromising the state's overall health system, economic vitality

CONSEQUENCES OF THE UNINSURED AND UNDERTINSURED IN TEXAS

- » 2,500 uninsured Texans die prematurely
- » 1 million uninsured Texans with chronic illnesses do not receive adequate services
- » 3 million uninsured Texans are less likely to receive preventive and screening services
- » 5.6 million Texans go continuously without insurance throughout the year
- » 8.5 million Texans go without insurance during some point of the year

Source: Code Red: The Critical Condition Of Healthcare In Texas

and health. The report garnered a lot of initial press, and has not gone away, resurfacing in local media reports as lawmakers prepared to return to session.

As for some of the findings, the study found that 79 percent of uninsured adults in Texas are part of the workforce or have one or more family members in the workforce. Contrasting that with cost, the report pointed out that for a family of four at the federal poverty level in 2004 (\$18,100 a year), the average cost of private health insurance (\$9,100) was about half their income.

Also, while most Americans are on health benefit plans through their employers, in Texas the atmosphere is a bit different. Small businesses with fewer than 50 employees make up 73 percent of all businesses in Texas, similar to the national average of 76 percent. However, of these small businesses, only 37 percent offer insurance to employees, compared with the national average of 47 percent. In addition, only 35 percent of employees in small businesses that offered insurance actually enrolled, largely because of cost, the report said.

The task force included representation from Texas' 10 academic health institutions, small and large employers, health providers, insurers and consumers. The task force was created and funded by the academic centers—the Baylor College of Medicine, Texas Tech University Health Science Center, Texas A&M Health Science Center, University of North Texas and the six health institutions of the University of Texas system. Organizers noted the task force's membership was not determined by governmental or political mandate, and while the report was subject to outside peer review, the sponsoring institutions had no control over its content.

The 531-page report (including appendices) includes staggering statistics that are hard to ignore, and lists recommendations including expanded medical education pro-

grams to stem physician and nurse shortages, development of employer premium subsidy programs, and the adoption of a “quality assurance fee” or provider tax to draw down additional federal matching funds.

Industry Reaction. John Hawkins, vice president, government relations, for the Texas Hospital Association, said the association wants to frame all of its issues around getting lawmakers to finally come up with a plan for dealing with the uninsured.

“The issue is really at a crisis point and is putting the state at an economic disadvantage,” Hawkins said. “Taxes are being increased as public hospitals shift costs onto taxpayers, and it’s forcing hospitals to move a lot of costs onto private insurance, making those products less and less affordable.”

Hawkins said any solution would have to be multi-faceted with a host of working parts, such as potential incentives for businesses to provide health insurance. “We need to look at ways to increase the ability for small businesses to purchase affordable insurance,” Hawkins said. “Should the state have mandates? Should the state do a better job of defining what basic catastrophic coverage should be like? There are a lot of regulatory things that can be done on the insurance side.”

Hawkins said there has been more talk and debate on the issue than in recent years, signaling hope something will be put into play. “I do think the prognosis is good as far as the visibility of the issue, but the solution is going to be the tough part,” he said. “The money side of things is definitely tricky, as it will cost the state additional resources.”

Ladon W. Homer, M.D., president of the Texas Medical Association, said the TMA believes there should be ways to provide incentives for businesses to provide health insurance for employees. “Some kind of credit could be extended to these business to promote insurance for their employees,” he said.

Health Plan Agenda. Meanwhile, the Texas Association of Health Plans is prepared to seek a change in funding for the state’s Health Insurance Risk Pool. The state’s pool was created by the Texas Legislature and has been in operation since 1997, providing health insurance to 26,574

eligible Texans who, due to medical conditions, are unable to obtain coverage from commercial insurers.

According to the Texas Conservative Coalition Research Institute, in Texas, risk pool eligibility is extended beyond what federal law mandates. According to a report by the institute, under the 1996 Health Insurance Portability and Accountability Act, federal law requires coverage should be offered to individuals who had at least 18 months of previous health insurance coverage through an employer, church or government plan.

However, the report points out that Texas exceeds this requirement by extending coverage to “medically uninsurable” individuals, regardless of any previous coverage they had.

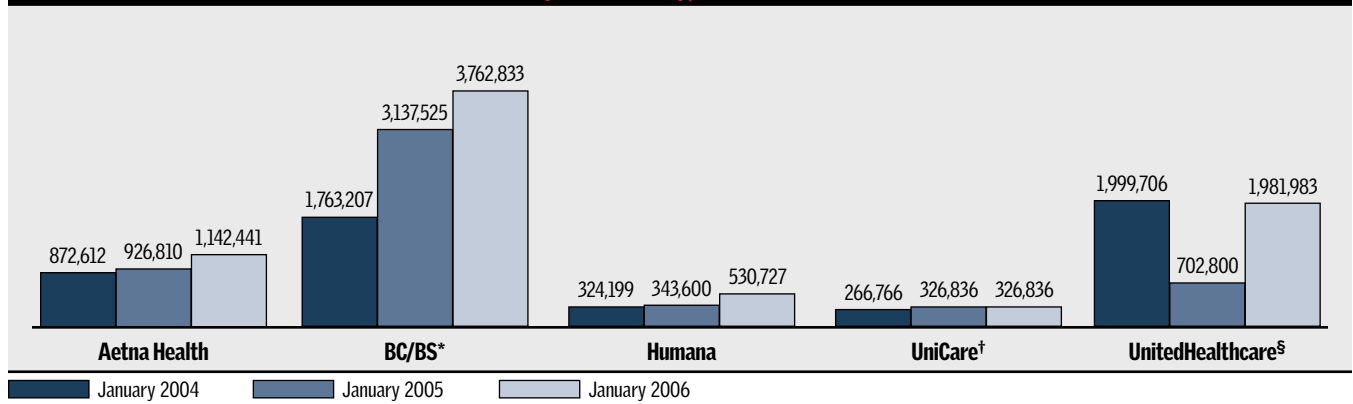
The pool is funded from premiums paid by enrollees and through assessments made against health insurers and HMOs. According to the research institute’s report, in fiscal year 2005, the risk pool earned \$162 million in premiums and \$98 million from assessments against insurers and HMOs, which covered the \$250 million total incurred expenses.

“The risk pool is funded by assessments on health plans; it’s more than \$100 million in assessments on plans and it has been going up,” said Jared Wolfe, executive director of the Texas Association of Health Plans. “There are federal requirements as to who has to be eligible, and the state has added to it. We’d like to find a broad-based funding mechanism, such as maybe the state pay for the ones it has added, rather than us fund the entire thing. That is one of our high priorities.”

Wolfe said risk pool assessments are based on how many covered lives a plan has, which could prove troublesome. “If a plan sells cheap policies like to college students, you are still assessed the same as if you are a comprehensive plan,” Wolfe said. “It is problematic because some plans have a razor-thin profit margin.”

OUTLOOK: *At the OK Corral, the Earps/Doc Holliday came out victorious, but it was a hollow victory indeed based on the bloody aftermath that followed. This upcoming legislative session, healthcare will be tackled in some fashion. But don’t expect a major step toward reducing the state’s uninsured.* ■

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

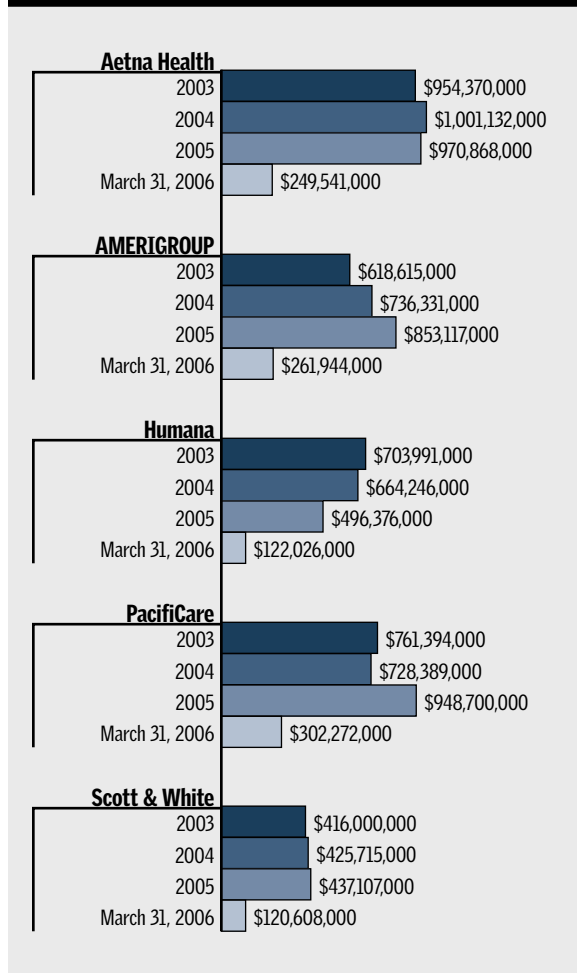


*Data as of July 2005.

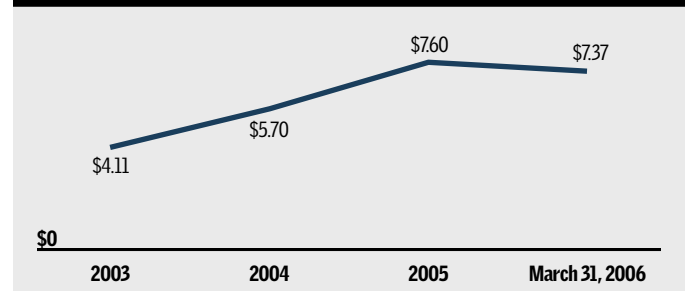
†Data as of January 2005.

§Enrollment for January 2005 did not include PPO POS.

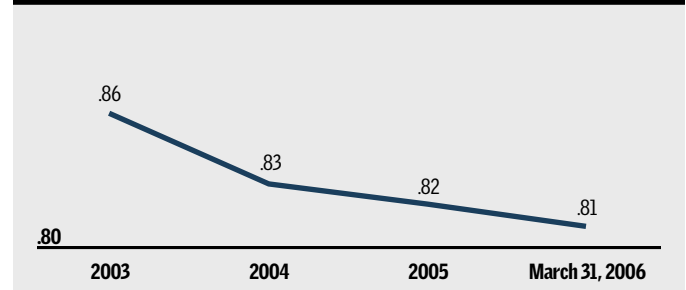
TEXAS HMOs' PREMIUM REVENUE LEADERS, TOP 5 PLANS



TEXAS HMOs' NET INCOME PMPM, WEIGHTED AVERAGE



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



TEXAS HMOs' COMMERCIAL PREMIUMS PMPM, WEIGHTED AVERAGE

