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Texas

Health Plan Analysis

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In This Issue

3 Medicare
- 3 New Medicare Players Enter Texas Market

7 Medicaid
- 7 CHIPs Are Down In Program For Uninsured

9 Employee Wellness Programs
- 9 Getting In The Zone Can Pay Off In Texas
- 10 Texas Blues Join State For Wellness Toolkit

12 Health Plans
- 12 Pay Now Or Pay Later In New UHG Pilot
- 13 Destiny Health Launches New Plan In Texas
- 14 UniCare Launches New Products In Texas

16 Marketing Strategy
- 16 Health Plans Trolling Deep To Find New Members

20 Metrics

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New Medicare Players Enter Texas Market

By Ric Gross

When Medicare reimbursement rates stagnated several years ago, many managed care organizations made the business decision to close up shop, Texas plans being no exception.

However, the Medicare Modernization Act of 2003 brought with it the promise of better funding for the program and, as a result, new opportunities. This scenario has certainly played out in Texas—one look at the horizon reveals a host of new players that have saddled up and ridden into town.

In the past few months, the Lone Star State has seen a number of new plans gain Centers for Medicare & Medicaid Services approval, covering the gamut from Medicare Advantage HMOs to PPOs to special needs plans. In fact, according to the Kaiser Family Foundation's Medicare Health Plan Tracker, nine Medicare Advantage contracts were awarded in Texas in 2005, the most since 22 were awarded in 1999.

Industry watchers say with the environment in play following adoption of the MMA, it's not surprising to see the ranks of Medicare plans in Texas on the rise.

"The retreat that many of the Medicare players made a few years ago largely stemmed from significant cuts in Medicare reimbursements that left little profit opportunity for any of them, resulting in the exodus that we witnessed," said Jim Watt, president of Houston-based healthcare consulting firm Employee Benefits Solutions Inc.

"Reimbursements have since improved, which is driving some of the re-entrance, but I think it's also important to take into account the significant shifts in populations—the baby boomers and sandwich generation—that will comprise a huge market opportunity in the future as the major driving force behind the emergence of Medicare players," Watt added. "What was an afterthought market for many has now become a 'must-play' market for the future."

According to the CMS, 163 new Medicare Advantage plans gained approval to provide services in 2006, with 74 percent of Medicare beneficiaries having access to HMO plans, 52 percent having access to a local PPO plan and 98 percent having access to private fee-for-service plans. In total, the CMS reports there are more than 5 million beneficiaries enrolled in Medicare Advantage plans, with an average of 50,000 per month joining the plans since 2004.

The Medicare Part D drug benefit has played a role as well, with Medicare Advantage enrollment increasing by more than 460,000 since implementation, the CMS reports. In Texas, as of mid-March, the CMS reported that some 243,221 Texans were enrolled in a Medicare Advantage plan featuring the Part D benefit, with a total of almost 1.7 million having some sort of drug coverage. Of that total, 458,538 were in stand-alone plans, 307,765 were dual-eligibles who were automatically enrolled, 403,920 were receiving coverage through a retiree plan and 283,273 were federal retirees.

MEDICARE HMO PREMIUMS IN TEXAS

Plan	Monthly Premium
Valley Advantage Silver (VBHP)	$63.75
Valley Advantage Gold	$106
FIRSTCARE Advantage Silver	$51
FIRSTCARE Advantage Gold	$95
Physicians Health Choice Platinum	$0
Elder Health	$0
Aetna Golden Medicare Premier Plan	$0

Source: Centers for Medicare & Medicaid Services

Andrew Crocker, extension program specialist in gerontology and health for the Texas Cooperative Extension, said the Part D benefit played a big role in the increased number of Medicare Advantage plans now active in the state.

"I think the insurance industry sees Medicare Part D as a cash cow like they've not had before," Crocker said. "Plus, with Medicare putting stipulations in the plan that basically compel beneficiaries to sign up for a plan, how can they go wrong? Then there was also the prospect of garnering some of the dual-eligibles. Knowing rural Texans, though, I think that the 'big' names or the familiar names will be the ones that win out in the end."

According to HealthLeaders-InterStudy data, as of June 30, 2005, there were 2,579,829 residents eligible for Medicare in Texas, an increase of 57,028 from the same period a year ago. And with its mild climate, reasonable cost of living and numerous amenities, such as hundreds of miles of shoreline on the Gulf of Mexico, it is reasonable to expect that number to swell in coming years.

"In east Texas there are quite a few communities around the lakes. It's a nice retirement area," said Larry Jendrusch, senior services program manager for the University of Texas Medical Branch. "Many retire there because they like the weather, much like Florida or Arizona. A lot retire to the Hill Country, around San Antonio, and Marble Falls, west of Austin. Texas is so big, there are also communities where people age in place, on their farms or ranches. In rural Texas, it's much more difficult for them. For an HMO, it's a challenge to get out that far."

With 262,017 square miles of territory, there is certainly a lot of ground to cover in Texas, and a host of plans are working to grab as much market share as possible. "You've seen real aggressive marketing by these insurance companies," Jendrusch said. "It's not real surprising, to see many new players—you follow the money trail. True, there was an exodus, but when the financial incentives are there, it becomes worth their while."

Below is a look at some of the new players that have entered the Texas Medicare market in recent months.

Valley Baptist Health Plans Inc. A locally owned HMO operating near the senior-laden Gulf of Mexico in the Rio Grande Valley, Valley Bapist Health Plans found expanding into the Medicare Advantage arena a logical choice. In fall 2005 the insurer rolled out Medicare Advantage and special needs plans in Cameron, Hidalgo and Willacy counties, along with a few zip codes in Starr County.

The senior population for the plans' service area is about 110,000. "There are two groups we see in the Valley. The first are known as 'winter Texans,' who migrate south around November and return home around March and April," said Mat Robie, executive director of Valley Baptist Health Plans. "The second are those who make the Valley their permanent home." Valley Baptist focused on the latter, playing up its relationships with Valley Baptist Health System and area physicians. "We feel we can offer a cost-effective alternative to traditional Medicare with enriched benefits members would otherwise not have access to," said Robie.

Valley Baptist Health Plans came into the market with seminars, workshops and extensive community outreach to get the word out about its new offerings, and to date, around 1,600 members have signed up. "Our previous presence in the Valley with our commercial insurance products has also played into the positive results," Robie said.

James Springfield, CEO and president of Valley Baptist Health Systems, said with a goal of 3,000 members by the end of June, the plan is definitely on track. "The early returns have been very positive," Springfield said. "We need to get a little more time under our belt before we can start claiming victory, but so far it's been very successful and we are very pleased."

Springfield and Robie also stressed the importance of the SNP product. Designed primarily for dual Medicare-Medicaid enrollees, SNPs were initiated by the MMA and fall under the general category of Medicare Advantage plans. This group is among the most expensive to treat and insure, with their expenses, on average, double those of other Medicare beneficiaries. They also account for 40 percent of Medicaid costs, with most of that expense going toward long-term care. Most are over 65, but there are some younger (disabled) individuals in this group as well.

Valley Baptist's SNP offering is designed as a zero premium plan with low- to no-cost benefits and is offered side-by-side with the Medicare Advantage products, Robie said. "What's also important to us is helping those who may qualify for a special needs plan know the option exists and educate them on the steps they can take to be evaluated for those programs," Robie said. "Our primary focus is education and sales are secondary."

Robie said the dual-eligible SNP population is traditionally one with little familiarity with managed care plans, and many have never been on any traditional insurance. "As a result it takes time to educate these members of our community," he said.

As for competition, on the local HMO front, Tennessee-based HealthSpring (24,547 members statewide) also operates in Cameron and Hidalgo counties. Valley Baptist officials are stressing the plan's local ties. "Members can walk into our office and discuss their coverage with us directly, face-to-face," Robie said.

FIRSTCARE. Operating both an HMO and Medicaid HMO in west and central Texas, FIRSTCARE entered the Medicare Advantage arena in the Lubbock and Abilene markets in fall 2005. In addition, the insurer offered a special needs plan for dual-eligibles in Lubbock.

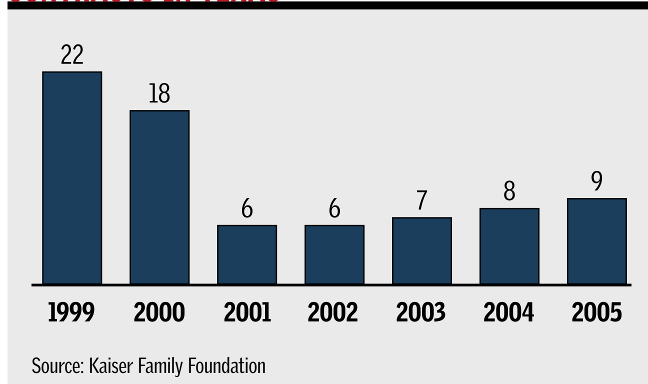
Steve Morgan, regional executive director for FIRSTCARE, said the plan made the move after careful consideration. "We have been hesitant to move into this market. We had watched the changes going on in the market, with more and more Medicare plans having closed down," Morgan said. "We didn't want to be a part of a system that failed or didn't work. We had discussed Medicare for quite awhile, but felt it was not in our interest to participate at the time. After the MMA, we felt it was time to move into the marketplace."

FIRSTCARE, owned by Covenant Health System in Lubbock and Hendrick Medical Center in Abilene, will face competition from Humana, an insurer that has put a lot of time and money into Medicare expansion. Morgan, however, believes FIRSTCARE is well positioned to compete, buoyed by the fact the plan has its roots in Texas.

"We have developed our marketing efforts around the fact we are local. Members have a local place to call or to visit, if they need to come in and speak with one of our customer service representatives or marketing, etc. There is a real convenience there," Morgan said.

Morgan also points to a strong provider network, which includes two of the bigger hospital systems in the region, Covenant and University Medical Center. "We were fortunate to build on the fact we have a good provider network on our commercial side," Morgan said. "We were really talking to the same people about coming on with our Medicare Advantage network.

THROUGH THE YEARS: MEDICARE ADVANTAGE CONTRACTS IN TEXAS



Source: Kaiser Family Foundation

"FIRSTCARE has one of the lowest out-of-service area costs, because so much of the medical care needed by our members can be met right here," he added.

Lubbock, home to Texas Tech University, has a population of more than 200,000, while Abilene has around 117,000 residents, with 30 percent of the population 55 years of age or above, according to the Convention and Visitors Bureau.

"There are a lot of seniors here, not because it's a resort community, per se," Morgan said. "It's an agricultural center and an academic center. The cost of living is very reasonable in west Texas, and once people complete their career they don't feel like they have to move on. I live in Lubbock and am impressed with how many grow up here, go to school here [Texas Tech] and then decide to stay here."

Morgan said the SNP has received moderate interest, and with the MA product being new as well, it takes time for rolls to increase. "We don't have an enormous number of members yet. This is such a word-of-mouth product," Morgan said. "We have done a lot of marketing trying to get the senior community familiar with our product and that we do offer it locally."

Physicians Health Choice. A physician-owned plan new to the Texas Medicare market, Physicians Health Choice launched a Medicare Advantage plan and a SNP in Travis County (Austin) and Nueces County (Corpus Christi) in early fall 2005.

However, according to Nancy Erickson, executive director for the plan, Physicians Health Choice does not come into the Medicare arena bereft of experience. Its parent company, San Antonio-based WellMed, is a physician-owned practice management company established in 1990 that specializes in senior healthcare services. "We bring a lot of experience, and we hired a number of additional people, all with a wealth of Medicare managed care experience," Erickson said.

Much like Morgan at FIRSTCARE, Erickson said the timing was right for a move into Medicare, and she cited the SNP as a vital plan to roll out with. "This is an important program for us," Erickson said. "These beneficiaries need to get consistent care. They are offered all the services under one plan, in a much more coordinated model, and they are able to get a more personal touch. It has been very well received."

According to recent figures, there are around 6,300 dual-eligibles in the Travis County market, with around 50,000-plus Medicare eligibles. Meanwhile, HealthLeaders-InterStudy data shows 52,638 Medicare eligibles in the Corpus Christi metropolitan statistical area as of June 30, 2005.

As the numbers show, there is a market to go after, which was just one of the factors playing into the decision to launch in those specified regions. "We have to choose markets with providers that are aligned with our philosophy and interested in being engaged in the process," Erickson said. "Being a physician-owned plan, we believe physicians have to be engaged in all aspects. We had worked with providers in Corpus Christi in the past and knew them well. In Austin, we knew them professionally and respected them."

Competitors in Nueces County include Medicare HMO operators Humana and PacifiCare (with Secure Horizons).

MEDICARE ADVANTAGE ENROLLMENT AS OF JUNE 30, 2005

Plan	Enrollment
PacifiCare of Texas	91,751
Texas HealthSpring	24,547
Humana	22,377
SelectCare of Texas (PSO)	21,609

Source: HealthLeaders-InterStudy

Elder Health. With plans already active in Maryland, Pennsylvania and Washington, D.C., Elder Health entered four Texas markets last fall—Houston, San Antonio, Corpus Christi and El Paso. In addition to its HMO offering, the plan came in with a special needs plan in those areas as well.

The plan may be new to Texas, but it comes with 10 years of experience in its other markets. "We've taken a proven concept and capability demonstrated in Maryland and Pennsylvania and brought it into Texas to build an organization here," said Dennis Edmonds, president of Elder Health Texas, based in San Antonio.

Elder Health has prior experience in the SNP world as well, operating plans in Maryland and Pennsylvania beginning in 2005. "You have to be willing to staff it and have programs in place to manage that population," Edmonds added. "We built an organization before we came here that had great success managing this complex population from a medical and social needs standpoint. You can't address the dual population without recognizing both."

The plan has solid case management and disease management capabilities, which come into play when initial health assessments are done for all members. "We do that screening ahead of time and if they need disease management, we bring that in right away," Edmonds said. "We want to help them avoid more expensive interventions that occur if you don't get them the help they need right away."

Edmonds said another strength Elder Health brings into play is that it didn't pull out of any of its service areas after reimbursements stagnated in the late 1990s. "When CMS made reimbursements more reasonable, we were well positioned," Edmonds said.

When it came time for Elder Health to expand, its leaders saw Texas as fertile ground. "Texas is both senior heavy and dual-eligible heavy," Edmonds said. "We also look at the competition—is it saturated or is there room for an added competitor?

"Houston has a fair number of plans, what we call moderate competition, as compared to somewhere like Phoenix for

example," Edmonds added. "San Antonio is moderate, with El Paso and Corpus Christi a little bit lighter. We saw room for us to grow amid the competition. The market is not saturated like Phoenix, or some in Florida."

Elder Health plans to expand to one to three sites a year within the next several years, Edmonds said, in the face of competition from such players as Aetna, PacifiCare, Humana and HealthSpring.

Total enrollment in Texas is around 1,200. "I think things are going well," Edmonds said. "You always want to grow as fast as you can, but I'm pleased with the response we've gotten."

Aetna. Aetna once offered a Medicare plan in Texas but exited the Lone Star State—and many other Medicare markets as well—around 2001. Things have since changed, and Aetna returned to Texas with HMO and PPO Medicare offerings in fall 2005 in the Dallas, metro Houston and San Antonio markets.

"We look at where there is a large concentration of retirees, and where we have a strong delivery system," said Gary Culp, general manager, retiree markets, for Aetna's West and Southwest regions. "Texas has a large senior population with a recent influx from Louisiana. Also, in Texas, the lower cost of living and warm climate tends to make it an area attractive to retirees on a fixed income."

Culp said Aetna also looks at some of the buying practices of seniors when determining which markets to enter. "Some are more apt to purchase a Medicare Advantage product. They are looking for more predictability around cost and access to care," he said. "We design the products around three key components—simplicity, predictability and choice. We keep the copays consistent to help seniors predict out-of-pocket costs. That is what seniors are most interested in."

Culp said Texas has been a strong market for Aetna, with reception to its Medicare offerings outpacing company expectations so far. "Historically there have been some strong players in Medicare across the nation, and some of those players exist in this market as well," Culp said. "Texas has been favorable for us."

Aetna is evaluating its Southwest market, which includes Oklahoma, for potential growth opportunities, Culp said.

OUTLOOK: The MMA has certainly made Texas a state to watch with an influx of new Medicare Advantage and special needs plans. Is there room for all? Time will tell, but with the senior population growing, and the sheer size of the state, expect players to expand rapidly in an attempt to capture market share. ■

CHIPs Are Down In Program For Uninsured

By Ric Gross

The year 2006 has certainly gotten off to a bumpy start for Texas and its Children's Health Insurance Program.

With new policy changes officially in effect, enrollment in the program dropped by about 21,000 from December 2005 to March 2006, to 301,911. CHIP numbers dropped by some 15,000 in February alone, sparking concern from healthcare advocates across the state about the ramifications. Texas' CHIP program, which provides low-cost health insurance to uninsured children in families that earn too much to qualify for Medicaid but cannot afford private health insurance, is especially important considering Texas has highest rate of uninsured children in the nation—21.6 percent, or 1.4 million.

Officials with the Texas Health and Human Services Commission are developing a public awareness and outreach campaign to ensure Texas families understand the eligibility requirements and application process, but many feel at this point that is not enough.

"The state has put some ideas on the table, in terms of outreach and communication. We think that is a good and necessary step forward, but we do not believe it is sufficient," said Jared Wolfe, executive director of the Texas Association of Health Plans. "You need to drill down on the data in terms of what's driving the drop. I think a temporary suspension of the policies they are trying to implement would be the right move." There are 12 HMOs participating in the Texas CHIP program.

Ironically, a handful of changes were enacted during the 2005 Legislative session in hopes of stabilizing the CHIP program after years of declining enrollment. In the session, dental, vision and mental health benefits were restored in the CHIP program, two years after being stripped from the program by legislative directive.

As for enrollment criteria, monthly premiums in the program—which were discontinued in 2004—were replaced by a twice-yearly enrollment fee that is income-based. Also, asset verification is required for families whose income exceeds 150 percent of the federal poverty level. Previously, families renewing coverage did not have to provide income or asset verification, instead only providing the information when first applying for CHIP.

Under the new criteria, families receive a renewal form with demographic information and a place to note their income and asset information, according to the HHSC. Families are also asked to provide at least one recent check stub and, if applicable, verification of assets.

The state has pinpointed those two areas—the enrollment fee and income verification—as the determining factors behind the decrease in rolls. According to state officials, the new enrollment fee was announced in renewal packets mailed in December and processed in February, meaning the March enrollment number is the first month to include families paying this fee.

According to the state, out of the February disenrollments, 27 percent were disenrolled due to a renewal packet missing critical information; 22 percent because the client didn't return the renewal packet; 20 percent because children enrolled in Medicaid and so dropped out of CHIP; 18 percent because they failed to pay the new enrollment fee; 10 percent because they had an income now too high for CHIP; and the rest due to an assortment of other reasons, such as immigration status.

Healthcare advocates, however, feel the decline in rolls is putting the program on a slippery slope.

"It was known [since June] the changes were going to be implemented; the question is why didn't the state do outreach to families in the summer and fall that there were going to be premiums again," said Anne Dunkelberg, health policy analyst and assistant director at Austin's Center for Public Policy Priorities. "We have not terminated someone over nonpayment of premiums since January 2004. In the January 2006 packet, it asked for an enrollment fee, with no prior warning to families. The first notice they were getting was in their renewal packet asking for an enrollment fee, when in many cases they haven't had to pay one in two years. It would have been appropriate for the state to start education back in the summer or fall."

Dunkelberg said it is clear the state is working to get to the heart of problem, but concurred with Wolfe in that outreach is not the only avenue that should be explored.

"The solution has to be multi-faceted," she said. "There needs to be a combination of really strong commitment to collaboration with all potential partners and doing outreach and education. It's also going to take considering delaying some of the policy changes as well.

"The state is definitely responding to the concerns—we're just not far enough along to see what the full response is going to be," she added.

Families are required to re-enroll their children every six months, and time is an issue in smoothing out the problems, Wolfe said.

CHIP ENROLLMENT FEES

- No enrollment fee below 133% of the federal poverty level ($2,145/family of four)
- $25 per family, per six-month period, from 133%–150% FPL ($2,145-$2,419/family of four)
- $35 per family, per six-month period, from 151%–185% FPL ($2,420–$2,983/family of four)
- $50 per family, per six-month period, from 186%–200% FPL ($2,984–$3,225/family of four)

Source: Center for Public Policy Priorities

"We are specifically concerned about the next three months. There is a very high volume of renewals coming, because of the way the program is lined up," Wolfe said. "If this trend continues there will be a huge number of children dropped. That's why we think outreach isn't sufficient. It does take time, and if we don't get the situation straightened out I think there will be long-term implications on whether families choose to come back."

Wolfe said while it is reasonable for the state to require income verification, it is also reasonable to assume there is something wrong with the process when a wide number of applications are missing critical pieces of information. "When new enrollments are up, but 70 percent of the families cannot renew, you have to assume there is a problem with the process and not with the families," Wolfe said. "We are not asking the state to ignore the law. We just think they can take some steps that will have an immediate [positive] impact on enrollment."

New Kid In Town. Also added into the mix is the fact the CHIP program has a new contractor for its eligibility system. The state contracted with Accenture to operate a call-center based system. The call centers receive and process applications for beneficiaries applying for Medicaid, food stamps, CHIP, Temporary Assistance for Needy Families and long-term care.

State officials have defended the new system, saying new enrollment in February was almost 24,000, a number higher than the monthly average of new enrollments under the previous contract. A release touted that fact, saying it was a strong indicator the new system is working well and processing cases in a timely manner.

However, there have been clear snafus, as eligibility for 6,000 children was recently restored after it came to light they did not receive proper notice of the new enrollment fee.

According to the Center for Public Policy Priorities, there have been instances of families reporting their applications were lost, and thus having to reapply two or three times to receive coverage.

"The problem consists of a lot of moving parts, it's not one single thing," Dunkelberg said. "It's a mixture of staffing, training and system issues. It can't be easily sorted out."

The state conducted a phone survey of 500 families who didn't return enrollment packets and found the top two reasons were that families forgot or lost the renewal packet or had a change in family situation and no longer qualify for CHIP.

OUTLOOK: CHIP enrollment has been on the decline in Texas since 2003, when a $10 billion budget shortfall promoted the Legislature to implement a number of cuts to the program. Enrollment began to plummet from the some 507,000 that were enrolled in September 2003, and public reaction to those cuts was not favorable. Lawmakers scrambled to try and undo some of the damage, resulting in some benefits being restored in the 2005 session. But putting a finger in one hole of the dike has resulted in a few more opening up. The state will work to get the current enrollment snafus settled, and advocacy groups are willing to do their part. Look for enrollment to stabilize and soon begin creeping back up, perhaps back into the low- to mid-300,000's. ■

Getting In The Zone Can Pay Off In Texas

By Ric Gross

Vince Young and the Texas Longhorns may have finished No. 1 in all major college football polls, but Texas is currently dominating another set of rankings as well. This time, however, it is in much more dubious fashion.

According to *Men's Fitness* magazine's annual rankings of America's Fittest and Fattest Cities, Texas clocked in with five of the top 15 fattest cities—Dallas, No. 4; Houston, No. 5; El Paso, No. 8; San Antonio, No. 12; and Fort Worth, No. 13. Granted, the list certainly is a subjective one; however, it's clear that Texas domination of this kind is best left for the football field.

Toward that end, a new program being rolled out by Virgin Life Care and Humana Inc. in San Antonio could go a long way toward reversing some of those trends.

The project is the first after Humana and Virgin formed a business alliance in early May, and centers around the development of a Virgin-branded and Humana-administered individual health insurance product tied to Virgin Life Care's health and fitness reward program. 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 outlets, including Amazon.com, Target, Borders and more.

A customer call center for HCA Patient Account Services is the first San Antonio business on board, beginning April 4, as Humana is rolling the plan out initially to employers with 300 or more employees.

"HealthMiles are like frequent-flier type of miles for people who exercise. Even if you go dancing, or walk the dog, you are gaining reward points for it," said Joan Kelly, spokeswoman for Virgin Life Care. "People are looking for a change in the healthcare system. This is a very robust program, and I think we've hit on making it a fun way to take something very serious and try to take control of that."

San Antonio joins Tampa as a test site for the program, with Humana offering the program to its associates in its home base of Louisville, Ky., as well. "Virgin is a leading-edge consumer-oriented brand. They have figured out how to have fun and keep the consumer engaged, and I think those things are somewhat missing in the healthcare space," said Jackie Willmot, director of innovation enterprises for Humana. "We have a launch schedule in place, and certainly want to get it out to all of our markets. People are very interested, and now we are really just starting to get them to market."

Willmot noted the nationwide battle with obesity, and pointed to the fact that San Antonio often ranks high on that list. "We think it's unique in this space. It rewards people for just doing something and for trying," she said. "It also doesn't punish those healthy and fit. If all index scores are within range, you get points and rewards just the same as those trying to move to a healthier lifestyle. It's for anybody interested in making healthy decisions."

A variety of wellness initiatives have been launched recently by employers and health plans, featuring numerous partnerships and reward programs. "Recognizing that the insurance industry has largely not been an innovator, many of the traditional players have shifted their focus upon significantly improving the consumer experience," said Jim Watt, president of Employee Benefits Solutions Inc., a Houston-based healthcare consulting firm. "The emergence of these partnerships between insurance company, health club, vitamin store, etc. is just the beginning of this shift in focus to serve all participants in a better way. This is the way of the future, and the future is now."

How It Works. In San Antonio, Spectrum Athletic Clubs is on board as well, 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 several 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.

MAGAZINE WEIGHS IN ON SAN ANTONIO

In its eighth annual roundup of the fittest and fattest cities, *Men's Fitness* magazine ranked San Antonio the 12th fattest city. The article said that:

- According to Nielsen reports, San Antonio residents watched less TV than any of the other cities in the magazine's survey, beating out Milwaukee and Nashville-Davidson (second and third place respectively). That's a positive mark.
- There are fewer ice cream parlors and donut shops per capita than average. Another positive mark.
- However, city parks, clubs, gyms and basketball courts all fall at the low end of the rankings. A not-so-positive mark.
- Obesity is on the rise. San Antonians have the second-highest obesity rate in the survey. Only Detroit has a higher rate. Another not-so-positive mark.

Source: Men's Fitness Magazine

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. "With the GoZone, if you park in the spot furthest away and take extra steps, or take the stairs at work, go dancing or play soccer with the kids, it adds up," Kelly said. "You could dance your way to a new TV. The end result will be that participants feel better, will be more fit and can help reduce healthcare costs, if even a little."

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, Kelly said, adding that individuals are able to earn up to 40,000 points, which is a $400 gift certificate.

South Africa Success. The program has been an unqualified success in South Africa, as the model began there 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, according to company officials, 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 during the year. Humana is the first insurer on board, with more to follow, Kelly said.

OUTLOOK: Employers are searching for ways to get individuals to take better care of themselves, 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—who wouldn't be interested in shopping with someone else's money? That should provide plenty of incentive to get off the couch. ■

Texas Blues Join State For Wellness Toolkit

By Ric Gross

Dr. Paul Handel, vice president and chief medical officer for Blue Cross and Blue Shield of Texas, likes to begin his presentations reciting a simple numerical catch phrase—50, 60, 40, 40, nine.

Or, as Handel later puts it, it has taken 50 years for the nation to move to a point where 60 percent of adults and 40 percent of children are either overweight or obese, issues that can lead to 40 different chronic disease states affecting nine different organ systems. Got your attention yet? Handel certainly hopes so, and that's the message he preaches when discussing health issues, worksite wellness initiatives and the importance of moving toward healthy lifestyles.

It is with this in mind that the Texas Blues collaborated with the Department of State Health Services to produce a toolkit to help Texas employers develop and improve programs for employee wellness. The state has been working to promote employee wellness initiatives, with officials asserting that if an increasing prevalence of overweight and obesity persists, the annual costs associated with excess weight in Texas is projected to reach $15.6 billion by 2010 and could reach $39 billion by 2040.

"When you look at weight and the obesity issue, it can cascade into a host of other diseases, such as type 2 diabetes," Handel said.

In pointing to two potential offshoots of weight and obesity issues, diabetes and heart disease/stroke, Handel referenced statistics from the Centers for Disease and Prevention. For example, total cost for diabetes treatment in 2002 was $132 billion, while total cost related to heart disease and stroke, according to 2003 statistics, was $351.8 billion. As for obesity, stats from 2000 show total cost of care was $117 billion, $61 billion in direct costs and $56 billion in indirect costs.

"Through worksite wellness programs we can reduce the demand for medical service through improved behavior and personal lifestyle choice," Handel said.

A healthy workforce can result in better on-the-job

WORKSITE WELLNESS PROGRAMS—HOW MUCH?

The Wellness Council of America estimates the cost per employee to be between $100 and $150 per year for an effective wellness program that produced a return on investment of $300–$400. Below is a sample expenditure list for various levels of programs:

Program Type	Cost Per Employee
Minimal (largely paper) program	$1–$7
Moderate program	$8–$15
Medium program with several activities	$16–$35
Fairly comprehensive program	$36–$75
Very comprehensive, effective program	$76–$112

Source: Texas Department Of State Health Services, Employee Wellness Toolkit

productivity, fewer sick days and reduced healthcare costs, Handel noted. "Also, if a person leads a healthy lifestyle throughout their working career, one can believe they will be healthier when they retire as well," he said. "Also, we don't want to criminalize the concept of obesity. It's such a complex issue. You can't point the finger at someone who is obese. We want to find out why and then intercede to help them try and overcome that."

Marianne Fazen, Ph.D., executive director of the Dallas-Fort Worth Business Group On Health, said employers are facing the same healthcare challenges today as they did 10 years ago, with overweight and obese workers at the top of the list. But she believes hope is on the horizon with the help of worksite wellness and disease management programs.

"Employees are a captive audience for over half of their waking hours, so engaging them in health improvement initiatives at the worksite makes a lot of sense. Employers understand that pay-off may not come quickly, but they also believe that this is a good place to start," Fazen said.

The Toolkit. For the program with the state, the Texas Blues helped develop the toolkit and worked with the state to develop a program centered on specific interventions.

The worksite wellness toolkit features a host of information for employers, including data, success stories, how to get a program up and running and a communications strategy, among other items. The material can be accessed at the state's Web site, www.dshs.state.tx.us

In the intervention program, Handel said a list was developed with gender- and age-specific screenings. Physicians in Travis County were supplied with a form and asked to check on when an employee came in and had an appropriate screening done.

State employees were given two hours of administrative leave for the screenings, and if they followed through would qualify for eight more hours of administrative leave, basically a day off. Three months into the program, Handel said more than 3,000 have taken advantage of the screenings or set up an appointment.

"We hope this collaboration can be a catalyst to show people how you can begin to do this," Handel said. "Getting a handle on healthcare costs requires a partnership of everybody. We need to provide incentive and education on how these things can make a big difference on longevity and quality of life."

OUTLOOK: As references, the battle of the bulge seems to be a significant problem to face in Texas... need we bring out Men's Fitness again? It also appears the state is working to get procedures in place to turn things around, along with employers, even if it's just baby steps. After all, baby steps are better than no steps when it comes to wellness programs. ■

Pay Now Or Pay Later In New UHG Pilot

By Ric Gross

Bad debt and charity care are ongoing issues for hospitals, both nationwide and in Texas. Indeed, in the Lone Star State, uncompensated care provided by Texas hospitals increased from $3 billion in 1993 to more than $7.7 billion in 2003, according to the Texas Hospital Association.

However, another problem is creeping up on provider groups as well—the number of bills unpaid over an extended period of time by the insured population. Toward that end, UnitedHealth Group has launched a pilot program in Texas it hopes will go a long way toward alleviating that problem, while at the same time providing a convenience value for consumers as well.

Dubbed the OnePay program, the Texas pilot will work like this. After processing an insurance claim, United will pay the amount owed (including the patient's part) directly to the provider, then bill the patient, with payment due after a 20-day grace period. However, if payment cannot be made from an eligible health account, or if the patient does not have a way to pay out of pocket, the insurer will deduct funds from that patient's paycheck (up to $60 per paycheck), with interest as well (set at the prime rate, currently 7.5 percent), until the balance is paid.

It's a pilot that United officials have high hopes for, having launched it April 1 for its own employees in Texas and those of Dallas' Tenet Healthcare Corp. hospital system as the initial test audience. Officials are quick to note that the program is voluntary, and consumers can sign up whenever they want over the course of the year.

UnitedHealthcare picked Texas after analysis showed its hospital systems would provide a good test group, according to Tom Policelli, the insurer's senior vice president-healthcare financial solutions for the insurer's Uniprise business, which is running the pilot.

"Texas has large and well managed hospital systems. We wanted to focus on hospitals first, and Texas has a great market for that," said Policelli. In addition, UnitedHealthcare has established relationships in Texas and can look at its own insurance data and hospitals' data to determine how much consumers do or do not pay. That way it can profile the community that is not paying and draw some conclusions.

Background. Policelli began thinking of the potential of such a program while president of United's consumer-driven healthcare business. "In conversations with hospital systems and providers over the past couple of years, I was hearing a major problem was with consumer receivables—money an insured patient still owed the hospital system after the insurance company payments," he said. "Bad debt and indigent care gets a lot of attention, but I was hearing consumer receivables from the insured population was a growing concern."

Policelli said after looking into the issue, he discovered the problem was indeed an issue, as consumers quite often do not pay what they owe a hospital, and when they do it takes seven months on average. This is where an insurer can come into play.

"Hospitals and providers are at a structural disadvantage when it comes time to collect. They don't have the ability to access information that we could potentially bring to bear," Policelli said. "They don't know if a consumer has an HSA, or FSA or HRA, and how much is or isn't in there. They don't have any connection into the employers, which we do."

Steve Campanini, corporate director of media relations for Tenet Healthcare Corp., confirmed that slow payments from the insured population are a growing concern for hospitals.

The consumer side, meanwhile, can gain as well, Policelli noted. "There is inefficiency for providers and consumers," he said. "On the consumer side, they are getting hit with all sorts of paper and information—from the insurance company, from the provider. Consumers will usually wait until it sorts itself out." And if money is due and the funds are not available, the consumer could put it on a personal credit card and then be hit with a large interest rate, perhaps double digits, as opposed to interest at the prime rate that United would set, Policelli said.

"The consumer has us sorting out the paper blizzard, and we forward the funds on behalf of the consumer," Policelli said. For example, if the consumer owes $250, he or she can write a check or take money from an FSA, HRA or HSA.

If payment isn't made, then it comes out of the consumer's paycheck at the prime interest rate. Patients can dispute bills, of course, and a plan is in place for that.

"In this program, if a consumer has an issue with a particular bill, they can call us and we will reprocess the claim and reprocess what the consumer financing piece was supposed to be," Policelli said. United suspends the payroll deduction while it investigates the dispute.

Policelli stressed that United will be following its adjudication process before remitting payment to hospitals. "Consumers want to make sure we are not going to stop checking things," he said.

Implementation, Deals And Goals. In coming on board, Policelli said hospitals have agreed to take a hit in terms of lower reimbursement rates with the idea that overall cash yield

UNITEDHEALTHCARE IN TEXAS

HMO/POS enrollment: 337,579 (as of July 1, 2005)

Percent of HMO market: 17.4%

Largest concentration of members: Dallas-Fort Worth

Source: HealthLeaders-InterStudy

will improve. "We are trying to make sure the economics make sense for providers and consumers," said Policelli. "It's not going to work unless providers come out financially ahead."

Campanini said Tenet will review what impact the pilot had on reducing bad debt from United patients before deciding whether to extend the program. Locally, AT&T has indicated it may also be interested in such a program.

"We anticipate reaching out and bringing other employers in," Policelli said. "AT&T has been very supportive. They challenged us on how we could help. We are very fortunate to have tough customers like AT&T that really force us to think and come up with something."

As for the process, Policelli said it was important to get a solid mix of participants into the program. "One thing we have to learn is who is signing up and what value are they going to see in it? To be successful, we need to attract a cross-section of people," he said. "If only the rich sign up who always pay their bills, it's of no use to providers. If it's only those with very few resources, it won't pay off for us to offer. It is important that we attract that good cross-section of people. We have to make sure there is added value to consumers and providers. We will have to examine, measure, monitor and change the model as need be."

Policelli said the program would not just be extending credit to those who would normally receive it anyway. "Obviously, though, if you are in bankruptcy we are not going to go petition a judge," he said. "But we do want it to be very broad-based. If we are only giving credit to a CFO at a major corporation, then it's not going to be much help."

Participation in the program will be capped at 100,000 members, Policelli said, adding, "We will know by then if it's successful."

Jim Watt, president of Houston-based healthcare consulting firm Employee Benefits Solutions Inc., said the program has merit, but widespread adoption could be the tricky part. Some industry watchers have pointed to the fact patients may have concerns about paying bills in this fashion from an insurer. "The question is whether adoption will be great by employees. Generally speaking, there is a concern there about carriers' ability to pay and code claims correctly," Watt said. "I see this [pilot] as a good thing, but I would like to see companies be more transparent."

OUTLOOK: UnitedHealthcare's pilot program for capturing the insured population's unpaid bills could be emulated by others if there proves to be clear benefits to both providers and consumers. The program is voluntary, which should make it more palatable to consumers and provide feedback for the next iteration. ■

Destiny Health Launches New Plan In Texas

By Ric Gross

With company CEO Scott Spiker calling Texas an "ideal marketplace" for expansion, Destiny Health Plan has entered the state with its consumer-driven health plans and a large dose of optimism.

Destiny, in a partnership with Guardian Life Insurance Co., is offering plans to businesses with 50–500 employees, though plans can cover as few as three employees and in some cases more than 500, Spiker said. The insurer launched around the beginning of February, rolling out first in Dallas/Forth Worth, Austin/San Antonio and Houston.

Prior to Texas, the Destiny product was offered in the Mid-Atlantic region, along with Illinois, in the partnership with Guardian. It is also available in Massachusetts through a partnership with Tufts Health Plan, and in Wisconsin through affiliated brokers.

In targeting Texas to add to its coverage area, Destiny officials saw a fertile state with tremendous opportunities. "The Texas market is phenomenal," Spiker said. "It's big and sophisticated, and there's a sense of individualism there. The people in Texas get the principle of ownership. Plus we have a partner in Guardian that has an extremely strong footprint in the state of Texas, and that matters a lot to us. Out of all our states, this is probably our biggest mutual investment."

Spiker said since Destiny Health Plan targets small to mid-size businesses, a high-growth state such as Texas is fertile ground for reaching consumers. Spiker added that Texas literally has room to grow, as opposed to the densely populated East Coast market, where the company is well established.

Meanwhile, in launching in the markets it did, Destiny entered urban areas accounting for the state's largest population centers with the greatest concentration of small- to medium-size businesses. Dallas and Fort Worth are major cities only 50 miles apart, while Austin and San Antonio are around 90 miles apart and Houston is the largest population center in Texas. The plan is now rolling out to second-tier centers of commerce all around the state, Spiker said.

"The state represents a ground-floor opportunity for the HSA/wellness format that Destiny offers," Spiker said. "I think the marketplace is ripe for it. I think we'd expect there to be growth at or above what we would expect from our Mid-Atlantic region, probably above given the size and readiness of the Texas market."

The Plan. Included in the Destiny Health Plan, which features an HRA or an HSA, is the Destiny Health Vitality Program, which rewards members for taking steps toward healthier lifestyles. By engaging in activities that support fitness, education, lifestyle and prevention, participants earn "Vitality Bucks," which they can accumulate and spend in a

variety of ways. In addition, participants move up the "Vitality Status" ladder—in essence, the rewards get richer the more members try to get healthy.

All plan members start out at Bronze status, and as they earn Vitality Bucks, move up in status. Bonus points are awarded with each level accrued, and members can use the Vitality Bucks to put toward items in four different categories: travel and leisure; entertainment; shopping; and additional perks. Members can use their Vitality Bucks to buy frequent flier miles for United, American and Delta Airlines; purchase movie tickets; purchase magazine subscriptions; or shop for electronics at the online shopping mall, among other items.

"We believe behavior change starts with wellness incentives. If you put a carrot in front of a person, it gives them extra incentive to do things that make a big difference," Spiker said.

In Texas, there are other factors that give Destiny officials optimism for its product. Spiker noted the Texas Association of Business is building a task force to examine the local healthcare market, and among the agenda items is the support of HSAs for Texas employers. In addition, wellness programs are gaining increased attention nationwide and in the Lone Star State. According to a survey of local employers belonging to the Dallas Fort-Worth Business Group on Health, 77 percent have implemented some kind of wellness program as a means to control healthcare costs.

"Our kind of plan hangs on three principles. One on the principle that people can have control in their lives," Spiker said. "Second, ownership, and I think that resonates well with the Texas marketplace. And third, behavior change. That is where our wellness incentives come into play. The fact of the matter is we have that in our own ability to influence."

SURVEY SAYS...

According to a 2004 survey of Destiny Health Plan members conducted by third-party research firm Analytical Directions:

- 60% of members have done something to reduce the amount they pay for healthcare, such as request generic drugs.
- 85% have started an exercise program in the past year.
- 97% of members believe a person's lifestyle choices have a direct impact on healthcare costs.

Source: Destiny Health Plan

Beyond a specific annual deductible, the plan provides insured benefits for members at different coinsurance levels for in- and out-of-network services. The plan pays 100 percent of eligible medical costs beyond an annual out-of-pocket maximum.

Solid Reception. More than 520 brokers attended three launch events, with Destiny officials training more than 400 agents/brokers on the details and how to quote the plan in the weeks that followed. Additionally, in Austin the insurer has held several broker-sponsored employer seminars where contact has been made with more than 100 employers directly.

"The market is moving better than expectations," Spiker said. "We have had a fantastic volume in terms of quotes. We are starting to write business, and that is ahead of plan. The program is still in its early days, but we are very pleased." ■

UniCare Launches New Products in Texas

By Ric Gross and Lori Anne Parker

UniCare announced recently that it would offer two new lines of individual, family and small-group plans in Illinois and Texas. The Illinois plans were launched in January 2006, and the Texas plans in December 2005. UniCare plans to eventually expand the offerings beyond these two states, which were chosen as test markets for the product, said Mark Gastineau, general manager for individual and small group at UniCare.

"The key right now is that Illinois and Texas are our bigger states with higher populations. So we wanted to test-market the products before launching into other geographies. If they work, we are very good at taking what works and expanding it across the organization," he said. UniCare has an established market presence with about 350,000 enrollees in each of the two states.

Texas was an especially good location in which to launch the product since it is also the state with the highest percentage of uninsured—25 percent in 2004, followed by New Mexico and Oklahoma, according to the Kaiser Family Foundation. Illinois had an uninsured rate of 14 percent.

The new plans reflect both the company's geographic strategy and its overall market segmentation strategy. Ultimately, the company is doing what it can to engage both the employer and the company's employees as customers, Gastineau explained.

Individuals And Families. The FIT portfolio is made up of six different insurance plans with deductibles ranging from $500 to $5,000. Each FIT plan offers doctor, hospital and surgical coverage. The plans also offer first-dollar preventive care and unlimited office visits with a $30 copayment and drug benefits at in-network providers. While the product was designed specifically to respond to what people have been asking for in individual and family plans, the company had to find a way to do this while still maintaining a competitive price point.

"As far as FIT is concerned, for instance, members were asking for more preventive benefits in our plans, but [because]

GETTING FIT IN TEXAS

Plan Features	Texas FIT 500, 1000 Plans	Texas FIT 1500, 2000, 3000, 5000 Plans
Annual deductible (per member, two member maximum)	$500, $1,000	$1,500, $2,000, $3,000, $5,000
Additional out-of-pocket network deductible	$2,000 per member, per year	
Annual out-of-pocket maximum provider	Participating provider: $3,000 per member, $6,000 per family; Non participating: $10,000 per member, $20,000 per family	

Sources: UniCare

we also know that price in the individual market is important… we had to be concerned with that," said Gastineau.

In the end, UniCare was able to do both by using a three-tiered pharmacy benefit design. By doing so "we have been able to reduce costs while giving additional benefits those members valued."

With low price points and fairly rich benefits, the plan has been a success in Texas and is bound to be appealing in Illinois, said Gastineau. Since the December launch, UniCare has seen a "huge increase" in its Texas application volume. "It looks like we have hit it on the mark when it comes to the FIT product," he added.

Small Businesses. In response to the high number of small businesses that do not offer insurance, UniCare decided to launch its Small Group Pathways line. Nearly 50 percent of small businesses do not offer employer-sponsored health benefits. Again, Texas, with its high uninsured rate and large population, was again the perfect place to launch the plan, Gastineau said.

In creating this line, the company's challenge was to price the product such that it would appeal both to employees who might otherwise opt out of coverage altogether, and would re-engage employers who have been unable to offer insurance to their workers.

In the end, UniCare decided to offer employers a line that would allow employees to choose from three products offered side by side. One option is a full medical plan with a higher price, while the other two choices have premiums of $60 to $70 for employees in the 19–29-year-old age bracket.

On the employer side, defined contribution options are as low as $30, and the employer's share of the premium may be tax-deductible.

Another challenge in launching Pathways is marketing to groups that have been uninsured, and the company is working with agents to reach these new markets.

Enrollment. It is still too early to report on enrollment for FIT and Pathways in Illinois since the products are still being introduced to agents across the state, but in Texas, where the FIT plans have been available since Dec.1, 2005, UniCare is "seeing increasing interest," said Gastineau.

Nearly 5,000 members enrolled in one of the FIT plans in February alone. The company is also encouraged by the initial performance of Pathways as agents find new ways of marketing to groups that previously did not have insurance.

Because Pathways is an Employee Retirement Income Security Act plan, employees can enroll in the plan once a year. FIT, on the other hand, is an open-enrollment plan and not regulated by ERISA.

In addition to Small Group Pathways, UniCare hopes to eventually roll out plans that would appeal to small businesses with part-time employees as well. Though only in the initial stages, so far "our conversations with the agent population are very receptive," said Gastineau.

As health costs rise, the company will also continue its efforts to look at the market in segments. What particular segments look like, what they value and the way needs change throughout life stages, as well as how to reach traditionally underserved populations, are all questions the insurer will explore.

UniCare Life & Health Insurance Co. is a national operating subsidiary of WellPoint, Inc., the largest publicly traded commercial health benefits company in terms of membership in the United States.

OUTLOOK: The individual and small-group market is ripe for the picking. Insurers like UniCare will continue to look for new opportunities to grow their plans. Expect commercial insurers across the state to develop more individual and small-group offerings and expect these plans to gather steam. Look for individual and small-group offerings to become more diverse and economical over time, and competitive with the large-group market. ■

Health Plans Trolling Deep For New Members

By Jane DuBose

Researching this report were Micaela Brown, Rick Byrne, Ric Gross, Lori Anne Parker and Don Mooradian

Somewhere in Nevada, a 24-year-old previously uninsured self-employed entrepreneur is signing up for something as staid as health insurance.

In Iowa, farmers are pledging grain harvests for help in funding a health savings account. In California, immigrants from Guatemala are using their consulate identification card as an application tool for healthcare coverage.

And in Kentucky, small businesses are enrolling in a plan that steers them toward "high-efficiency" providers in exchange for lower rates.

State by state, health insurers are combing the depths of the commercial market to find growth in a mature industry. With 43 million uninsured Americans, one would think they'd have no trouble finding eligible candidates.

But the days of the industry going after any individual or group that had a few dollars to spend is over, and the impressive income statements of the publicly (and privately) held insurers reflect the choosiness.

Still, with the growth beast to feed, insurers, consumer-driven companies and banks are segmenting the market to reach people who beforehand may have been unreachable.

HealthLeaders-InterStudy asked companies to discuss their marketing efforts for a few of these segments: Young adults, farmers, immigrants, small business employees or sole proprietors, and the "income tweeners," or those too rich to qualify for public assistance but not so wealthy that paying for health insurance is a non-issue.

Income Tweeners. While there's no doubt that many among the growing number of uninsured are too poor to buy health benefits, there are millions of uninsured who theoretically do have disposable income for such a purchase. With the commercial group insurance market relatively flat, it's no wonder insurers are going after this group.

"As you look at the total uninsured across the country, about a third of those are in households that have incomes of $50,000 or more and, therefore, we think, they can afford some coverage, and we're going after them very aggressively," said Larry Glasscock, chairman and CEO of WellPoint Inc. to investors in a Jan. 25 earnings conference call. Indianapolis-based WellPoint is the nation's largest insurer.

Almost one in three of the uninsured live in households with income of $50,000 or more per year and the fastest-growing income segment of the uninsured is in households earning between $50,000 to $74,999, according to The U.S. Census Bureau data comparing 2004 to 2003.

"We don't segment customers by income, but offer a full range of affordable plans to make healthcare accessible to as many of the uninsured as possible," said Ellen Laden, spokeswoman for Golden Rule Insurance Co., the individual insurance arm of UnitedHealthcare.

Aetna Inc. is another national insurer targeting this group. "This is a very attractive demographic for us to work with," said Laurie Brubaker, head of individual markets at Aetna. The Hartford, Conn.-based insurer currently serves about 100,000 individuals in 13 markets across the country. The company estimates the number of uninsured making $50,000 a year or more is about 14.2 million of the total 44 million uninsured.

The insurer is hoping to lure some of the 17 million who are currently purchasing individual coverage. According to Brubaker, of that group, about 41 percent, or roughly 7 million, have annual incomes in the range of $50,000 and above.

When Aetna began looking at growing its individual market, it did market research on those already purchasing individual plans and then expanded it to those without insurance. The company found there are about seven key life stages related to purchasing health benefits, such as graduating, getting married, starting a business and so on. "As we build our strategy and learn to market to this population, we build it around the life events, which seems to be working very well," said Brubaker.

This strategy allowed the insurer to tease apart and identify the different segments of the market that might buy their products, such as the sole proprietor, early retiree and empty nester. Aetna offers "very robust and comprehensive" benefits to individuals, said Brubaker. The plans cover specialty care, diagnostic services, surgery, emergency care as well as preventive services.

"It's important to note that individuals who have experienced group insurance at any point in their past tend to look for the same comfort and security when buying individual benefits," she said.

While Golden Rule doesn't segment the uninsured market, Laden named who buys the company's health plans. "The

PEOPLE WITHOUT HEALTH INSURANCE IN THE UNITED STATES

	2003	2004
Earning less than $25,000	15.3M (24.2%)	15.1M (24.3%)
Earning $25,000 to $49,999	14.8M (19.9%)	14.8M (20.0%)
Earning $50,000 to $74,999	7.3M (12.5%)	7.8M (13.3%)
Earning $75,000 or more	7.6M (8.2%)	8.1M (8.4%)

Source: U.S. Census Bureau

self-employed, sole proprietors of small businesses, contract workers, part-time workers, and early retirees," she said.

With health plans taking aim at the income tweeners, why are so few signing up?

"That's a great question with no single easy answer," said Brubaker. "One reason is affordability. If you really think about it, an annual household income of $50,000 doesn't necessarily make someone rich, so there are cost concerns."

The United States says a family of five with a household income of $23,400 would qualify as living within 100 percent of the federal poverty level and many states have public assistance programs including Medicaid for that same family if they earned twice that, which is nearly $50,000.

Brubaker surmises another reason is that in the past, not many insurers offered individual plans, so people are unaware it is available. Aetna is working to change that, through ads in radio, TV, print and the Internet. "We are very proud of the fact that 25 percent of new buyers of individual plans are uninsured," she said.

Others say poor financial return is the main reason those who can afford to buy health insurance are staying away. "Let's say you are a young, healthy professional and you only see the doctor once a year. Why would you pay $5,000 to $10,000 a year for a policy? If you are self-employed, the small tax deduction is hardly worth it," observed Devon M. Herrick, senior fellow for Dallas-based National Center for Policy Analysis.

Herrick thinks most healthy people don't need or utilize the level of care covered by most traditional health plans, individual or group. "A typical health plan is like all-you-can-eat buffet, which is not useful if you graze."

Herrick believes that consumer-driven health benefits, especially health savings accounts, are a good choice for those in relatively good health and who can afford the high deductibles. "Why rent when you can own?"

He uses his own situation to illustrate his point. During the past 19 years or so he's been in a group policy. During that time, he's been lucky enough to have medical expenses of about $3,000 and dental expenses of about $5,000. Only about $2,000 of his health and dental bills were covered by insurance, and he had to pay $2,000 out-of-pocket for non-covered medical care and about $4,000 in unreimbursed dental care.

That means Herrick's total health coverage costs over the years were around $31,000 (including dental), but returned only $2,000 in benefits (including dental), and covered only one-quarter of his medical and dental needs. Moreover, he accrued no equity. Today, Herrick has an HSA.

Not Your Father's Health Insurance. When Blue Cross of California, an affiliate of WellPoint Inc., began developing its 2-year-old Tonik product for "young invincibles," it wanted to differentiate its offering. An important concept, says Sherry Jansen of WellPoint's West region, was "it couldn't be their parents' insurance. The product had to be affordable, easy-to-understand and simple to manage," said Jansen, who is business development manager for product and service innovation at WellPoint.

Tonik is targeted to 19–29-year-olds that make up one of the fastest-growing segments of the uninsured. In California alone, there are 1.6 million uninsured adults.

In addition to California, Tonik is being sold in Nevada and Colorado. UniCare Life & Health Insurance Co., another division of WellPoint, recently launched its own version of Tonik. It's called Sound and is being sold initially in Texas and Illinois.

Sound is actually heading in the opposite direction of many health benefits programs. Rather than limiting benefits, its covered benefits include dental services, eyeglasses and even prescription sunglasses. "We actually included things that aren't in a regular plan," said Mark Gastineau, general manager for UniCare individual and small group plans. "This demographic was saying, when I go to the doctor's office, everything should be included in the copay. Our general feeling is that richer, more expensive plans are actually selling at a higher clip than the higher deductible with a lower price point."

WellPoint is able to price the product competitively because it provides only generic-drug coverage in the plan and offers a range of deductibles. Premiums range from $96 to $132 for Tonik and $60 to $114 for Sound.

While all health plans use the Internet heavily these days for marketing, WellPoint and UniCare are taking it to a new level with Tonik and Sound. They're advertising on the popular myspace.com Web site geared to 20-somethings and even younger users as well as on blogs and Yahoo. The Web sites for the products themselves are bright and use trendy graphics. "What we are finding is that everyone is pretty Web savvy these days," Gastineau said. "Clearly, this is a Web-based product. By definition, you have to be on the Web in order to enroll."

In addition, the products are being marketed at events such as rock concerts and the U.S. Surf Open.

The response to Tonik in the West has been strong, Jansen

WELLPOINT'S 'YOUNG INVINCIBLES' PRODUCT DESIGNS

Tonik	Thrill Seeker	Part-Time Daredevil	Calculated Risk Taker
Office visit copay	$20	$30	$40
Deductible	$5,000	$3,000	$1,500
Monthly premium	$96	$109	$132
Sound	**Gravity Bender**	**Curb Jumper**	**The Cruiser**
Office visit copay	$40	$40	$40
Deductible	$5,000	$3,000	$1,500
Monthly premium	$60–$79	$67–$91	$85–$114

Sources: UniCare, Anthem BC/BS, BlueCross of California

said. "The launch of Tonik set a new standard for Blue Cross of California. Less than a year after its launch, it became the second most popular plan in our individual portfolio. Seventy percent of approved Tonik applicants were previously uninsured," she said. Some 70,000 policies have been sold in California.

Corn For Copays. Few segments could be as far apart as surfing-loving 20-somethings in California, and farmers in the heartland. But the Web may be the tie that binds. When Cargill introduced a new health benefits product aimed at farmers, it invited farmers to log into its Webcast introducing it, and some 2,000 did so.

Cargill AgHorizons and Wells Fargo were introducing health savings accounts to farmers in a program called Harvest Health. Participants choose their own health insurance with eHealth Inc. online, or another option, with Wells Fargo providing six mutual fund options. The HSAs, like all others, carry a high-deductible health plan and allow fund owners to avoid taxes on the accounts themselves.

Cargill funds the health accounts based on the amount of grain a farmer commits to deliver. For example, if a family commits 25,000 bushels of corn to Cargill at a maximum price of $2.50 a bushel, Cargill deposits $2,500 into the family's health savings account.

A modern-day take on a company store, the Cargill deal guarantees it a predictable supply of grain and allows cash-strapped farmers to fund medical expenses through their HSAs. "The value to us is to have a predictable flow of grains," said Mark Tracy, assistant vice president at Cargill Risk Management. Our mission is to help farmers prosper. If farmers aren't prospering, then we won't be able to stay in business as well."

Tracy said the reception has been good and that some farmers say it's the first coverage they've ever had. "They are pretty pleased to have any alternative, and it says a lot about how urgent the need is." He said surveys show insurance costs have risen by 60 percent for farmers since 2000.

The Iowa Farm Bureau provides access to a plan from Wellmark Blue Cross and Blue Shield that covers more than 100,000 members. As a result, the uninsured rate among Iowa farmers is relatively low—10 percent to 11 percent—said David J. Lyons, chief business development officer for the Iowa Farm Bureau Federation.

Despite the below-market prices on the PPOs, there's still a struggle, Lyons said, adding that healthcare costs have been rising by double digits while farm incomes are only going up in the single digits. "Even our plans are becoming an economic burden to farmers."

Leroy Watson, legislative affairs director for The National Grange, a rural public-interest organization, said access is a problem for farmers. "Fewer than 10 percent of physicians in the U.S. practice in rural counties," he said. "In the last 25 years, 475 hospitals in rural counties have closed. You can have the best policy in the world, but you need the healthcare delivery system. If you are 60 miles or more away, then the insurance is less valuable."

HOW HARVEST HEALTH WORKS

Step 1: Family chooses health savings account with $2,500 deductible.

Step 2: Family chooses financial trustee for account (Cargill's preferred vendor is Wells Fargo).

Step 3: Cargill deposits $2,500 into the family's HAS account in exchange for a commitment of 25,000 bushels or corn at a maximum price of $2.50 a bushel.

Step 4: Cargill funds the Wells Fargo HSA for every tax year that the family sells its grain to the company.

Source: Cargill AgHorizons

Restaurants, Moms And Pops. The classic under-insured or uninsured American works at a small business or owns his enterprise. Insurers are approaching that market in a number of ways, from offering discounts through business groups to relaxing underwriting standards.

Anthem Blue Cross and Blue Shield in Ohio, Indiana, and Kentucky is pitching its new rules to the market segment with 50 or fewer employees. According to Jimmy Lee, regional vice president of small-group underwriting for Anthem, small businesses with a high percentage of female employees often couldn't get group coverage because a significant portion of their staffs were covered by spouses' and partners' plans. Now, they no longer need to enroll 50 percent of the total eligible employees to qualify for a group plan; they need only sign up 75 percent of the people who don't have coverage from elsewhere, Lee said.

"The idea came from the broker community," Lee said, adding potential customers include retail stores, medical offices and restaurants, among others. "I have a pretty good feel of where they'll come from, but right now, nearly 50 percent of small business employers don't offer coverage."

In Ohio alone, 10 groups signed up in the early stages, and now Anthem, a WellPoint subsidiary, is considering expanding the looser eligibility to include the 50- to 99-employee groups. The change retains existing business, too: shrinking employers that were in danger of slipping below the eligibility threshold can now keep their insurance as well. Another WellPoint subsidiary, Blue Cross and Blue Shield of Missouri, is launching a similar program for small businesses in that state.

Affinity groups provide another way for insurers to reach small-business customers. Though a proposal to enable association health plans has yet to gain any traction in Congress, local chambers of commerce are doing what they can to connect insurers with members.

Humana Inc. entered into a marketing arrangement with the Northern Kentucky Chamber of Commerce that, among other things, gives employers in the two-to-50-employee market who use chamber member-agents to enroll a 3-percent break on premiums. Humana has also re-jiggered its product lineup to make some lower-cost options available to the smaller employers who haven't qualified for them in the past. Kentucky allows

HEALTH INSURANCE COVERAGE IN TEXAS AND THE UNITED STATES*

	Texas	United States
Employer	10,660,910 (48%)	155,778,670 (54%)
Individual	855,110 (4%)	13,968,130 (5%)
Medicaid	2,751,830 (12%)	37,242,750 (13%)
Medicare	2,028,420 (9%)	34,379,930 (12%)
Other public	275,680 (1%)	3,096,400 (1%)
Uninsured	5,478,260 (25%)	45,820,480 (16%)
Total	22,050,200	290,286,350

Source: Kaiser Family Foundation, State Health Facts

mandate-light products that Humana's Director of Commercial Sales Mike Brooks said carry a 6 percent to 8-percent break over standard plan rates. Adding on the company's High Performance network, which directs members to highest-efficiency providers, provides further discounts.

"With these kinds of options, a small business person can pay 10 to 20 percent below standard product rates," said Brooks.

Humana has also tried to differentiate itself from competitors in the small-business market by offering a Benefit Utilization Director, or "Broker BUDdy," a data tool for brokers that tells business owners how their employees are utilizing their benefits, such as how many have hit their deductibles, without revealing individual patient information. Typically, only large businesses could get such information, while small businesses had to settle for reports that only told them their medical loss ratio—near-useless to them, since many small businesses are just one high-cost episode away from a huge spike in MLR anyway. The business owner can use the data better select the appropriate products to offer to their employees, control costs and perhaps avoid large premium increases.

Bridging The Cultural Gap. No health insurer would claim to put non-native Americans in a segment, but they are immensely important to growth. PacifiCare Health Systems, a division of UnitedHealth Group, has approximately half a million Hispanic members, which represent 22 percent of the company's total commercial membership. In California, 27 percent of its members are Hispanic, and the numbers are strong in its legacy states of Arizona, Colorado, Nevada, Oklahoma, Oregon, Texas and Washington.

The Hispanic population is predicted to grow from 14 percent of the U.S. population to 25 percent by 2050, according to U.S. Census figures. Nearly one in three Hispanics is without health insurance, even as their buying power increases.

Cultural differences help explain why Latin American-born consumers aren't too interested in buying health insurance, said Herrick at the National Center for Policy Analysis. "It may well be that they just don't buy into the notion of insurance," Herrick said. "The challenge for insurers will be to find products that immigrants perceive as having value."

Russell Bennett, vice president of Latino Health Solutions for PacifiCare, said the marketing message is often one of education and is less about advertising. "In too many cases, Hispanics can afford it, but don't buy it because they don't understand it."

Health insurance as a foreign concept is not limited to Hispanics. "Health insurance can be an unfamiliar concept for some immigrants and new Americans," said Joe Dangor, communications manager for HealthPartners, a Bloomington, Minn.-based health insurer. "We focus our efforts on working with government agencies, community clinics and employer groups to help explain health insurance and how to obtain it and use it," he said.

HealthPartners markets in minority publications and through community events. For example, it sponsors a booth at the annual Hmong soccer tournament that draws thousands of Hmong immigrants living in the Twin Cities.

PacifiCare and UnitedHealthcare are focusing on limited-benefits plans as one solution to insuring immigrants. The plans offer preventive care services and major-medical insurance but may skimp on services such as brand-name drugs or low copays.

Blue Cross of California has found success by making it easy for Mexicans and other Latinos to sign up for insurance. In October 2004, it partnered with the Mexican Consulate to allow the Matricula Consular card to be used as a means of identification. Last year, it expanded the card to Guatemala-born residents and has a similar arrangement pending with Peru.

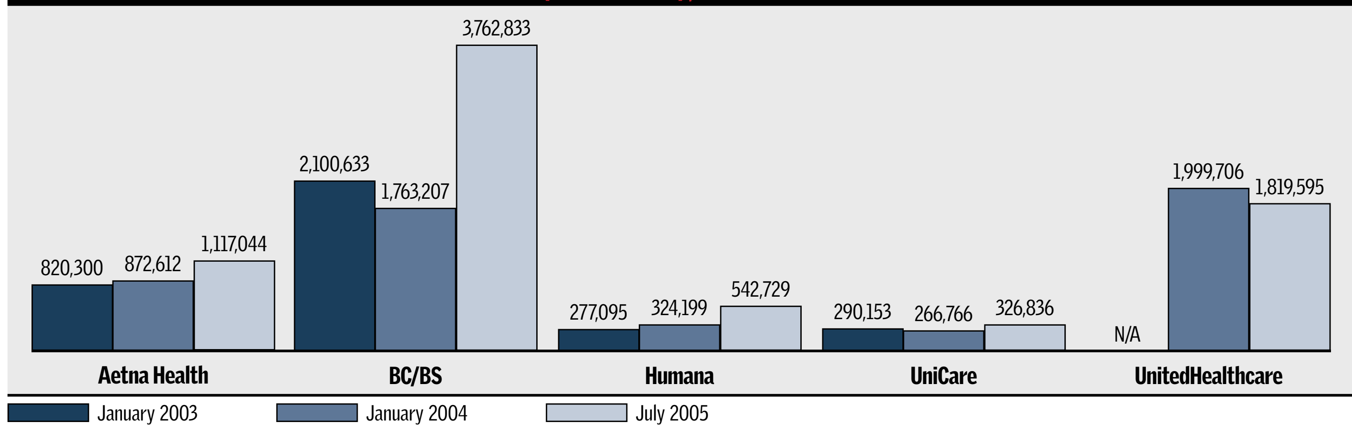
"We want to make sure these people have access to our individual plans," said Robert Alaniz, spokesman for the West region of WellPoint Inc., Blue Cross' parent company. The plans sold to the immigrants typically cost from $79 to $130 a month.

Health Net and Blue Shield of California offer cross-border health options in California that allow members to access lower cost medical care on either side of the U.S-Mexico border. The Salud Con Health Net product offers premiums 30 percent to 50 percent lower than average partly because of the reduced cost of care in Mexico. Blue Shield of California calls its product Access Baja HMO and says its enrollment grew 60 percent since it was launched in 2000 to 3,000 members.

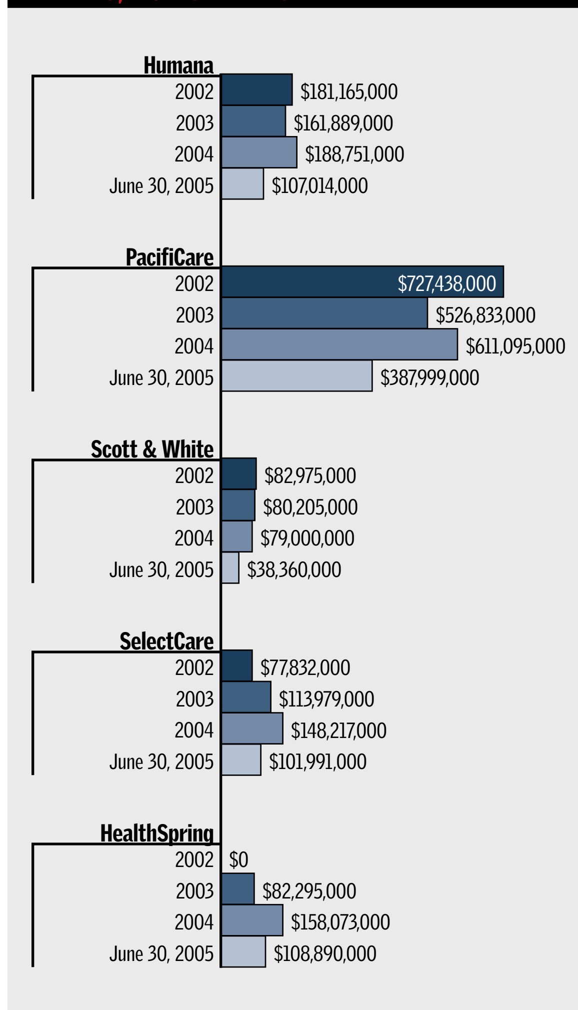
Health Net announced in March that its Mexi-Plan and Health Net Cross-Border plans are the first-ever cross-border healthcare plans available to individual customers who purchase benefits directly from insurers. Nearly half of California's Latinos work for small employers who cannot afford to provide health insurance benefits. As a result, more than 2 million are uninsured in southern California.

OUTLOOK: There are many fields to plow among the ranks of the uninsured as health plans plot growth strategies. The challenge will be finding just the right mix of benefits and affordability, but some insurers are off to a strong start. If the uninsured rate continues to stay high, insurers may be forced to take drastic actions to get more people into the fold, or policymakers at state capitals and in Congress will do it for them. ■

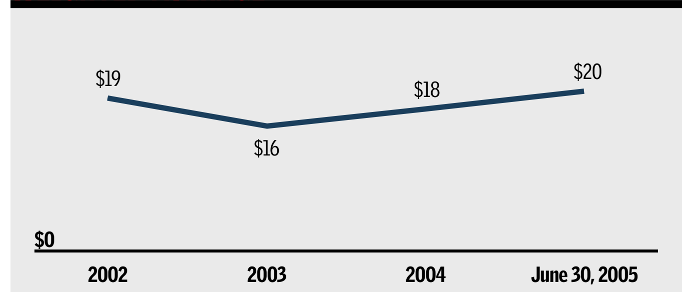
TEXAS SINGLE-INSURER PPO ENROLLMENT (PURE+POS), TOP 5 PLANS



TEXAS MEDICARE HMO PREMIUM REVENUE LEADERS, TOP 5 PLANS



TEXAS HMOs' PHARMACY EXPENSES PMPM, WEIGHTED AVERAGE



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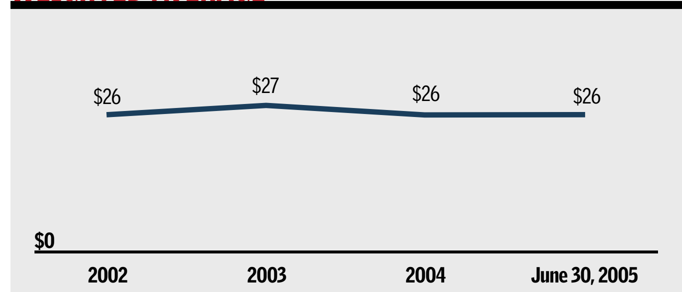

TEXAS HMOs' MEDICAL EXPENSES PMPM, WEIGHTED AVERAGE