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Kansas & Missouri
Health Plan Analysis

Winter 2006 Vol. 3 No. 1

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Report Calls For Managed Care Expansion

By Rick Byrne

The anticipated reform of Missouri Medicaid has arrived in the 2006 session of the General Assembly, not with a bang, but a whimper.

The Missouri Medicaid Reform Commission, which formed last year to gather information to restructure the state-federal health benefit for the poor, published its final report in late December. But rather than prompting swift calls for legislative action, the report has met a subdued initial response.

Gov. Matt Blunt has "taken it under advisement," according to Deborah Scott, spokeswoman for the Missouri Department of Social Services. "He appreciates the hard work that went into the recommendations and is studying the report carefully."

The report called for, among other things, emphasis on personal responsibility, preventive measures and use of technology to control costs. Senate leaders also have created a committee to examine Medicaid fraud. In the area of managed care, which it took the liberty of renaming "coordinated care" in keeping with the notion of many stakeholders coordinating efforts, the commission advocated some expansion to spread more of the state's risk to the private sector.

The report, for example, recommends expanding the HMO model beyond the current 37 counties and considering a pilot program to expand managed care to aged, blind and disabled enrollees. Currently, according to the Kaiser Family Foundation, Missouri ranks 43rd in managed care penetration among the 48 states offering it for Medicaid. Just 44 percent of all Missouri Medicaid beneficiaries enroll in a managed care plan.

Donna Checkett, CEO of Missouri Care, a Medicaid managed care organization that serves the central part of the state, said that she didn't sense any urgency in the Missouri General Assembly to take up a large portion of the report's recommendations. "I think the commission worked very hard, very earnestly," Checkett said. "I'm just not aware that much of that will be put into legislative measures."

Checkett, who has been a leader in Missouri Medicaid since the genesis of its managed care program, said that without a budget crisis, there is not a compelling reason for the state to do a rapid expansion of managed care to the ABD population. With Missouri's enabling legislation for Medicaid due to expire at the end of 2007, she said she expected more reforms in next year's legislative session. The report, she said, will provide a good foundation for changes.

"This seemed like a good first step for a state that has not made any changes to its Medicaid managed care program in about 10 years," she said.

A Tough 2005 For Medicaid. By most accounts, 2005 was a challenging year for Medicaid in Missouri. Blunt, a Republican, teamed with a GOP majority in both houses of the assembly for the first time in decades, called for deep cuts to Medicaid to help balance the state budget, and got them.

PENDING HEALTHCARE LEGISLATION IN KANSAS AND MISSOURI

Kansas

HB 2001 establishes a commission and provides for it powers to create a statewide health insurance plan.

SB 165 makes it a crime of provider fraud for providers to seek reimbursement for copays or other payments already made by insured patients, or waived for cause.

HB 2257 requires insurers to cover inpatient services that a qualified physician declared medically necessary, and that the insurer could not unilaterally cease inpatient coverage where its policy covered such service.

HB 2365 seeks a moratorium on new health insurance mandates.

SB 160 requires insurers to reimburse for covered services where the provider is a specialist clinical social worker or specialist social worker.

Missouri

HB 80 establishes a universal, publicly financed statewide insurance program.

SB 663 removes a statutory barrier to the establishment of association health plans.

SB 622 allows an income tax deduction for farmers and other small businesses that provide health benefits to employees.

SB 567/HB 1089 requires coverage of services to those in Phase 1 or Phase II clinical trials.

SB 813 prohibits insurers from changing health services codes without the permission of the physician.

SB 597 mandates coverage of morbid obesity.

HB 1101 allows employers to negotiate with insurers for reduced deductibles for employees who do not smoke.

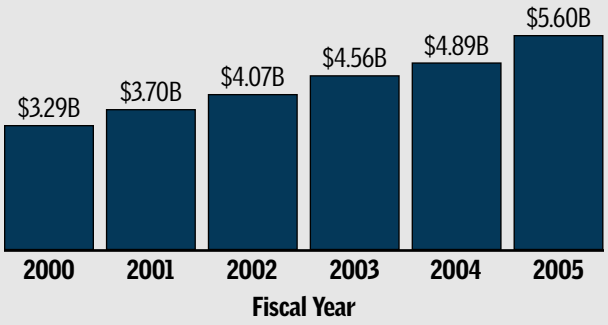
SB 599 allows physicians to collectively negotiate contracts with certain insurers for certain non-fee-related matters, such as formularies, guidelines, definitions of medical necessity and the like.

Source: Kansas Legislature, Missouri General Assembly

Missouri's disenrollment may have been the second largest in the nation last year, behind Tennessee, which cut some 191,000 of 1.2 million beneficiaries. In Missouri, 94,850, or nearly 10 percent of the Medicaid population, lost services and some 300,000 saw services reduced. The state reduced the income eligibility threshold for some groups; in the disabled and elderly category, for example, adults previously qualified with incomes at 100 percent of the federal poverty level, and now it is at 85 percent.

Missouri also introduced copays for some medical services and for prescription drugs in the fee-for-service environment and in managed care.

MEDICAID SPENDING IN MISSOURI



Source: Missouri Department of Social Services

The Medicaid Reform Commission emerged as a light at the end of the tunnel. Established by Senate Bill 539 and Senate Concurrent Resolution 15 during the 2005 legislative session, its goal was to hold hearings from June through November, and use information gathered in the hearings to develop a framework by which Missouri's Medicaid system could be redesigned for better service and cost efficiency. Blue Cross and Blue Shield of Kansas City, Centene Corp. (owner of FirstGuard Health Plan), Community CarePlus, Family Health Partners, Healthcare USA, Mercy Health Plans, Missouri Care, and WellPoint Inc. offered testimony on managed care.

After holding 21 hearings, and entering testimony from hundreds of sources, the 10 panelists—five from the House and five from the Senate, three Republicans and two Democrats from each—produced their 76-page report and made it available before the start of the 2006 session.

With regard to managed Medicaid, the report supported expansion beyond its current 37 counties—all along the Interstate 70 corridor. It advocated expansion to include children and families in the St. Joseph and Springfield areas, as well as contiguous counties to the existing managed care service areas.

The report also recommended specifying a medical loss ratio in any new contract, thus requiring managed care organizations to operate at a predetermined percentage of funding for medical care, and a certain percentage for administration, overhead, and profit.

Despite the broad recommendations of the commission, Missouri lawmakers appear poised to consider other issues. In the first tangible acknowledgement that Missouri's 2005 Medicaid cuts may have gone too far, some legislators have announced that they will seek to restore some of those cuts as the 2006 legislative session gets under way. Restoration of benefits would begin with the working disabled. That segment of the Medicaid population mainly consists of 7,250 mentally disabled Missourians employed in 93 sheltered workshops around the state, receiving below minimum wage to perform menial tasks. Most rely on Medicaid for their health coverage, through the Medical Assistance for Workers with Disabilities program, until it was repealed last year. Legislation to restore the MAWD already has 40 sponsors in the Legislature. The Legislature and governor are working on a new and more equitable program, Scott said.

Tackling The ABD Population. The commission report also proposed a pilot program to begin managed care for the aged, blind and disabled Medicaid eligibles in the current MCO areas. Centene Corp., which has experience managing ABD populations in other states, believes this most expensive of all populations to treat offered perhaps the greatest opportunity to reduce state costs on Medicaid.

"We are concerned about the budget cuts in Missouri, but we're committed to the program," said Robert Schenk, Centene's director of corporate marketing and communications. "There's much more for the state to gain from using managed care for the ABD population."

Though the managed care program is now 10 years old, Missouri has never included the ABD population in it, so inexperience prompted some caution. According to the report, "The fear amongst the advocates for the disabled and mentally ill is that care will be rationed, not managed. There is some basis for that fear."

A key problem in covering ABD patients is a lack of actuarial data specific to Missouri for determining risk. With 20 states already covering their ABD populations with full-risk managed care, some data sharing with other states would be necessary. However, the report also offered the possibility of having the state take on the risk of covering the ABD population, and contracting an administrative-services-only firm to manage their care, with carefully monitored performance standards.

Under any scenario, the state should demand a high level of customer satisfaction and protections for the ABD population, the report advised.

OUTLOOK: It's surprising that a governor and legislature who placed such urgency on reform a year ago were willing to settle for eligibility cuts and a lukewarm response to a comprehensive and compelling list of recommendations. Long-overdue changes for Missouri Medicaid will apparently wait another year, but the expiration of enabling legislation will put a gun to the collective head of the General Assembly to get it done then. ■

Missouri Medicaid HMOs Part Of Profit Trend

By Rick Byrne

One could do worse than operating an HMO in Missouri.

Although the market continues its shift to network-based plans, Missouri HMOs continue to operate profitably. According to HealthLeaders-InterStudy, all but four of the 20 HMOs operating in the state operated in the black through the first six months of 2005. Surprisingly, two Medicaid plans with a history of steady profitability were among the four with operating losses.

Community Care Plus, which was acquired in 2004 by Bush-O'Donnell and Co. and three senior managers, from its former owners, Tenet Health Systems and two Federally Qualified Health Centers, experienced a loss of $1.2 million against revenue of $44.7 million. It's the first loss for CCP, a Medicaid HMO, since the late 1990s. Through the same period a year ago, CCP had pulled a net gain of $4.7 million against receipts of $41 million.

The other surprising loss came from FirstGuard Health Plan, the Kansas City-based Medicaid health plan. It, too, underwent an acquisition in the previous year, getting bought up by St. Louis-based Centene Corp. FirstGuard's second quarter finances showed a $296,000 loss against revenue of $44.9 million. The plan had been profitable for each of the last three years, and through the second quarter of 2004, it showed a gain of $4.9 million on revenues of $50 million. Last year's revenue total includes $6.1 million in management fees, meaning operating revenue was actually $43.9 million for the year before.

Judging from the data, the fact that both plans underwent a buyout in the last year was only a coincidence, as both CCP and FirstGuard experienced spikes in their medical loss ratios in the first six months of 2005. Through calendar year 2004, CCP recorded an MLR of 0.76, and that number had been on a downward trend, at 0.84 in 2003 and 0.88 in 2002, according to HealthLeaders-InterStudy. But through the first two quarters of 2005, it spiked to 0.96, even as administrative expenses dropped to the second lowest in the state, $14 per member, per month.

MISSOURI MEDICAID PREMIUM REVENUES

Plan	Through 2Q 2004	Through 2Q 2005
Blue Advantage	$36.2M	$38.0M
Community Care Plus	$41.0M	$45.1M
Family Health Partners	$48.9M	$55.5M
FirstGuard Health Plan	$44.5M	$44.9M
HealthCare USA	$172.9M	$179.3M
Mercy Health Plans	$41.6M	$50.9M
Missouri Care	$36.3M	$40.4M

Source: HealthLeaders-InterStudy

MISSOURI COMMERCIAL PREMIUM REVENUES

Plan	Through 2Q 2004	Through 2Q 2005
Aetna Inc.	$22.2M	$27.5M
BC/BS of Kansas City (Blue Care)	$61.9M	$70.7M
BC/BS of Missouri (Blue Choice)	$135.4M	$166.0M
Community Health Plan	$31.0M	$30.2M
Coventry Health Care of Kansas	$76.2M	$88.3M
Group Health Plan (Coventry)	$255.2M	$164.4M
Humana Health Plan	$70.0M	$38.9M
Mercy (Premier) Health Plans	$151.1M	$83.3M
UnitedHealthcare	$184.8M	$91.3M

Source: HealthLeaders-InterStudy

At FirstGuard, the MLR also spiked, though not as sharply as CCP's. Through 2004, First Guard showed a medical loss ratio of 0.83, but it climbed to 0.91 in the first six months of 2005.

Officials at the plans, the Missouri Department of Social Services, and the Missouri Association of Health Plans elected not to comment on what factors led to the increased medical costs at the two plans.

Remaining Medicaid Plans. Other Medicaid health plans in Missouri showed positive results through the first two quarters of the year. HealthCare USA, a unit of Coventry Health Care Inc. of Bethesda, Md., yielded the best results, taking in $12.3 million in profit on income of $179.3 million. Family Health Partners and Missouri Care also had a profitable first half in 2005. Mercy Health Plans and Blue Cross and Blue Shield of Kansas City did not separate Medicaid financial results from commercial lines, so they could not be accurately described as profitable. Both did show increased revenues from Medicaid premiums, however, in a year when Missouri excised a tenth of all its beneficiaries.

Less surprising was the unprofitable showing of the Cox Health Systems HMO, a small-market plan that has experienced slight losses for the last two years as more of its business shifts to PPOs. The plan lost $573,000 on revenues of $5 million through June 30, 2005.

The startup Medicare Advantage plan known as Essence also continued to operate in the red, with a negative income of $623,000 on revenues of $4 million in the first six months of 2005. The plan launched on July 1, 2004, and as Essence's fortunes are improving, its leaders see profitability on the horizon.

On a positive note, among all HMOs, three commercial plans recorded profits in the $21 million range through the first two quarters of the year. Blue Cross and Blue Shield of

Kansas City topped the list with a profit of $21.7 million on $433.8 million in revenue. Coventry Health Care of Kansas gained $21.3 million on revenue of $228.7 million, and its Group Health Plan affiliate showed a net gain of $21.1 million on $266.9 million in income. All three plans recorded their results over a two-state area, the Kansas City Blues and Coventry covering Kansas and Missouri, while GHP's business included Missouri and Illinois.

OUTLOOK: Much as one might be inclined to cast a jaundiced eye on two Medicaid plans slipping into red ink for the first time in years, the outcome seems only temporary to us. A handful of expensive patients can be all it takes to cause a six-figure swing when profits operate on a razor's edge as they do with Medicaid health plans. The unpopularity of Missouri's Medicaid cuts, coupled with the reform commission's advice for more managed care, will likely result in improving results for all Medicaid HMOs by this time next year. ■

Kansas Blues Co-Brands To Get In On Part D

By Rick Byrne

With Medicare beneficiaries everywhere scratching their heads and asking "Why so many choices?" as they contemplate signing up for the new prescription drug benefit, there are also new names alongside long-familiar ones in co-marketing arrangements.

Most states have 35 to 45 different plan designs available from 15–20 different companies. Companies that chose to participate in the program that launched Jan. 1 offer two or three plans, with premiums at different price points and differentiated by level of benefit.

A survey of the available plans in Kansas and Missouri reveals that the large, multi-state, national payors are represented, like Aetna, CIGNA HealthCare, Humana, UniCare and UnitedHealthcare. Pharmacy benefit management companies are also well-represented, with Medco, Express Scripts and Caremark all offering plans. Companies not necessarily well-known in the region, but bringing with them a depth of Medicare experience elsewhere, like Sterling, PacifiCare and WellCare, also offer prescription drug plans.

No health plans with home bases in Kansas and Missouri elected to start up their own stand-alone Medicare drug plan. But that doesn't mean members of locally based plans won't have a familiar name to enroll with.

One of these, Blue Cross and Blue Shield of Kansas has entered into a co-branding arrangement with WellPoint Inc., the nation's largest health insurer, which has been approved for a drug plan in all 50 states. In Kansas, it will co-brand with the Blues plan under the Blue Medicare Rx label.

Blue Cross and Blue Shield of Kansas has established itself as a leader in the Medicare supplement market, claiming 50 percent of the over-65 market in the all-but-two counties it serves in the state. The Kansas Blues also serve as the fiscal intermediary for the Medicare Part A program in Kansas and the carrier for Medicare Part B in Kansas, Nebraska and northwestern Missouri. In 2003, the company said it paid $2.6 billion for Medicare claims, serving 871,000 Medicare beneficiaries in these areas.

"WellPoint is partnering with many other Blue plans for them to be able to do something on a more national level," said Mary Beth Chambers, spokeswoman for Blue Cross and Blue Shield of Kansas. "We are responsible for marketing in our service area, and WellPoint will be responsible for customer service, administration and risk. WellPoint also created the formulary."

The Kansas Blues will promote the plan through the media most familiar to Kansans, as well as a direct mail effort that will include a special newsletter to existing members.

"A key theme will be letting people know they don't have to have Medicare Part D coverage through the same company they have Supplemental coverage with," Chambers said. "But they might want to consider sticking with the name and the company they are most familiar with."

A minority of plans with Medicare membership has taken a wait-and-see attitude toward the new benefit. In Missouri, Mercy Health Plans has not announced its Part D plans, despite being the second-largest purveyors of Medicare HMOs, with 20,601 members in a Medicare Advantage plan as of Dec. 31, 2004. Preferred Health Systems of Kansas has also not announced an arrangement, despite a large Medicare Supplemental business.

The low-risk position of staying out of Part D carries with it a downside, beyond the money left on the table by postponing entry. John Gorman, president of the Gorman Health Group benefits consultants, said those with members in Medicare Supplement plans under Parts H, I and J, will probably lose those members if they don't have a Part D offering.

"Participating in Medicare is not for everybody, and there are any number of reasons not to do it, one of which is risk aversion," Gorman said. "Others are lacking necessary investment capital, or other strategic priorities that mean it just didn't make the cut."

Some health plans are also still licking their wounds from their involvement with Medicare+Choice, the federal government's first attempt at Medicare HMOs. Payors dropped out when budget-balancing efforts in Washington resulted in stagnant rates.

OUTLOOK: Certainly we can see some wisdom in smaller, locally operated, provider-owned health plans not trying to reinvent the

MEDICARE PART D: WHO'S GOT THEIR OWN PLAN?

Missouri Medicare Plan	Type	Enrollment	Own Plan?
UnitedHealthcare	HMO, PPO	50,364	Yes
Premier Health Plans	HMO	20,601	No
Group Health Plan	HMO	12,701	Yes
Coventry Health Care	HMO, PPO	12,387	Yes
Humana Health Plan	HMO	11,581	Yes
Essence	HMO	233	No

Kansas Medicare Plan	Type	Enrollment	Own Plan?
Humana Health Plan	HMO	7,713	Yes
Coventry Health Care	HMO	2,619	Yes
Consolidated Association of RR Employees	HCPP	1,892	No

Sources: HealthLeaders-InterStudy, CMS

wheel on Medicare Part D. However, those with the experience and an existing membership base have to offer a plan if they hope to keep their members, and thus have entered relationships with pharmacy benefit managers and others. This is a wise move for these plans, but ultimately will leave some money on the table as it diminishes their margins. ■

State Revamps Medicare Wraparound Drug Plan

By Rick Byrne

When Medicare Part D drug plans rolled out on Jan. 1, so did an updated wraparound drug plan to help senior citizens in Missouri pay for their medications.

Missouri Rx, or MoRx for short, replaces the state's previous drug assistance plan, Senior Rx, which had operated for three years. Senior Rx had been launched with the notion that it could provide a modest drug benefit for those seniors who could not afford a private health plan with drug coverage, but whose finances made them ineligible for Medicaid. By statute, MoRx is limited to seniors with incomes under 200 percent of the federal poverty level.

The beneficiaries of MoRx in the first year of the program will be those who formerly were enrolled in Senior Rx, as well as those seniors who are eligible for Medicare and Medicaid, the dual-eligible population. As with the national Part D plan, dual eligibles were automatically enrolled in MoRx, without any additional costs or paperwork. Former Senior Rx members were also automatically enrolled as well, as long as they were enrolled in a Part D plan.

MoRx administrators had discussed the possibility of expanding the program to other persons who meet the eligibility criteria with an open enrollment session next fall, but Missouri's state fiscal climate may keep that from happening.

"There is no firm position on any expansion at this time," said Deborah Scott, spokeswoman for the Missouri Department of Social Services. "Resource availability is a consideration."

KANSAS & MISSOURI PART D PLANS ACCEPTING AUTO-ENROLLMENT

- Coventry/First Health*
- Humana
- Marquette National Life
- Medco**
- MemberHealth**
- One Nation
- PacifiCare
- Pennsylvania National Life
- SilverScript
- UniCare
- UnitedHealthcare
- WellCare

*Kansas only
**Missouri only

Source: CMS

The plan will coordinate benefits with any Medicare Part D plan, and pays 50 percent of all out of pocket costs—deductibles, the coverage gap and all copays—after Medicare pays its share. The member will pay the full premium for their Part D plan, however.

Missouri Rx is paying one-half of the out-of-pocket expenses for seniors enrolled in Part D, except for the premium payments, said George Oestrich, director of pharmacy for the Division of Medical Services within the Missouri Department of Social Services. There is no subsidy for premium payments, he said.

The formulary under MoRx will match the formulary of the member's selected Part D plan. Certain drugs that Medicare has excluded from coverage, but were traditionally covered for dual eligible members by Missouri Medicaid—such as over-the-counter drugs, vitamins, minerals, limited cough and cold drugs, benzodiazepines and barbiturates—will continue to be covered for these people by the wrap-around plan as well.

Administrators of MoRx say about 14,000 people from the Senior Rx program plus 140,000 people eligible for both Medicare and Medicaid have already been enrolled in the wrap-around plan. When all eligible persons are identified, enrollment for MoRx should reach 160,000.

Kansas. Kansas offers a Senior Pharmacy Assistance Program, which enrolls around 5,000 members. The program, run through the Kansas Department on Aging, offers up to $1,200 a year in assistance to seniors whose incomes are less than 135 percent of federal poverty level, and who meet other qualifying guidelines. The program has not been adapted to work in concert with Part D, however, and is only available to seniors who have no private insurance that covers prescription drugs.

OUTLOOK: Not all states have come through with wraparound prescription drug plans for needy seniors. Kudos to Missouri legislators for thinking ahead. Ironically, the legislation that created MoRx was included without debate in the 2005 budget package that cut 94,850 people off Medicaid. The program won't be able to expand until Missouri legislators can find a way to loosen the purse strings, which likely won't happen in this session of the General Assembly. ■

Blues Plans Targeting Working Uninsured

By Rick Byrne

Two Blue Cross insurers have taken two different approaches toward reaching the same customer, working uninsured people.

Blue Cross and Blue Shield of Kansas City will apply subsidies from a charitable fund and other concessions to bring a high-deductible PPO to an affordable price point. Blue Cross and Blue Shield of Kansas, on the other hand, has sought concessions and other endorsements to offer a low-cost plan.

Blue Cross and Blue Shield of Kansas City, which serves two counties in Kansas and 32 Missouri counties in the metropolitan Kansas City area, announced its low-cost group plan, CommunityBlue, in November. Just a few weeks later, Blue Cross and Blue Shield of Kansas, which serves the remaining 103 counties in Kansas, announced the availability of a similar program called Value Blue.

Families USA, a Washington-based healthcare advocacy group, estimates that 12.2 percent of Missourians, or about 702,000, will be uninsured for all of 2005 while the Kaiser Family Foundation estimates 663,420 uninsured in 2004. Also, Families USA said, people without insurance tend to wind up in emergency rooms for treatment, a costly alternative that can delay care for those with critical health issues, taxes government resources and causes private insurance rates to rise. An estimated 1.4 million Missourians and another 624,000 Kansans went without coverage for all or part of the years 2002 and 2003, according to Blue Cross and Blue Shield of Kansas City. In Kansas City alone, the insurer said 270,000 people live without coverage, and when they seek service, the costs get passed on to the pool of insured people through uncompensated or charity care.

Joining Forces. The Greater Kansas City Chamber of Commerce is joining Blue Cross and Blue Shield of Kansas City in providing subsidies for employees in small groups. The Chamber's board of directors, not coincidentally, is chaired by the Blues' CEO, Tom Bowser. Bowser calls CommunityBlue a "social experiment" because of the unique arrangement that will bring many partners into the funding of CommunityBlue, and call for sacrifices by many of the stakeholders.

Under CommunityBlue's funding program, Bowser has committed Blue Cross to subsidize up to $1 million a year for each 1,000 lives enrolled in the plan, through waived administrative costs and donations to a non-profit foundation known as the Community Health Fund. The Chamber of Commerce has donated $10,000 to the cause, and other corporate donors will be asked to contribute as well, to help a subset of income-eligible plan members to meet the relatively high deductibles.

"We are subsidizing the product in several ways, including waiving half of the company's normal administrative fee for CommunityBlue, pledging that all profits will be returned to the program, and donations to the Community Health Fund," said Sue Johnson, spokeswoman for Blue Cross and Blue Shield of Kansas City.

UNINSURED IN KANSAS & MISSOURI

	Kansas	Missouri	United States
Uninsured Rate	11%	12%	16%
Number of Uninsured	295,460	663,420	45.8M
% Change 2000–2004	–0.2%	3.7%	1.7%
% of Private Employers Offering Health Insurance	54.2%	53.3%	56.2%

Source: Kaiser Family Foundation

Brokers will also take half their usual commission for selling CommunityBlue to employers. The average premium cost per month is approximately $100, half of which will be paid by the employer, with the employee paying the other half. Plans are offered with a $1,500 and $5,000 deductible for individuals, and $3,000 and $10,000 for families. However, with the help of the Health Fund, households served by CommunityBlue with incomes below 200 percent of federal poverty level will have their first $500 of service paid for an individual, and $500 for a family.

The plan's sales targets will be small businesses, primarily in the service sector, that have not offered coverage in the last year. Johnson said the groups would be small businesses such as restaurants, lawn-care companies, dry cleaners, and catering groups. To be eligible, the company must have no more than 99 employees, 60 percent of them making under $30,000 a year, and 90 percent of them living in the Blues' service area. If a firm meets all those criteria, all employees can join.

Since the plan will operate as a high-deductible PPO, services will be at discounted rates when sought from the insurer's Preferred Care network providers. Enrollment targets also are not high, due to the difficulty of marketing to the ultra-small groups.

"If we can have 1,000 people covered by CommunityBlue by the end of the year, we would consider that a success," Johnson said.

"To make the program work better," she added, the plan has already been adjusted to liberalize its availability. Prior to launch, eligibility limits would require 75 percent of employees in a group make less than $30,000, and to qualify for first-dollar help, a household would have had to be under 150 percent of federal poverty level. But the commitment to the program comes from the top of the organization, say supporters at the Kansas City Chamber.

"Tom Bowser made improving healthcare his top priority as chairman of the chamber," said Pam Whiting, vice president of

COMMUNITY BLUE SAMPLE PREMIUM RATES

Sample Member	Plan 1 $5,000 Ded.	Plan 2 $1,500 Ded.
Male, age 28, Kansas	$70.21	$91.82
Male, age 28, Missouri	$66.78	$87.33
Female, age 28, Kansas	$134.64	$172.15
Female, age 28, Missouri	$125.21	$163.74

Source: Blue Cross and Blue Shield of Kansas City

marketing for the Chamber of Commerce. "Not only with CommunityBlue, but Tom worked very hard on a funding proposal put before voters last April, that put more money into safety-net hospitals in the city."

Kansas Blues Follow Suit. At Blue Cross and Blue Shield of Kansas, spokeswoman Mary Beth Chambers has previously told HealthLeaders-InterStudy that the insurer's biggest competition is not another health insurer, but rather, the uninsured. A new program called Value Blue has just launched to help uninsured Kansans purchase affordable coverage.

"For a lot of small businesses, insurance premiums are too high, or the business just doesn't offer coverage," Chambers said. "If there's an employer group, and the employees qualify under the income eligibility for this product, the employees can all have Blue Cross coverage, different plans. We're all excited about it."

The Kansas Blues took a different approach than their Kansas City counterparts to meet the needs of their different demographic. With endorsement from the Kansas Medical Society, Kansas Hospital Association and the Kansas Insurance Department, the Kansas Blues approached providers and asked them to take 50 percent of their usual reimbursement for covered services to Value Blue members. Not all have signed on, but enough have that with its effective date on March 1, Value Blue could be offered in 87 of the 103 counties served by the insurer. The plan will come online in the remaining counties when the local network reaches critical mass.

As with the Kansas City Blues' Community Blue, the Kansas Blues are not loading their administrative costs into the program to keep the premium affordable for the eligible population. The company said it is not yet sure how much it will absorb to develop, promote and administer Value Blue.

The benefits are not as rich as the copay world of HMOs, but the co-insurance built into Value Blue is commonplace among PPO users. It has a maximum out of pocket cost of $2,000 for individuals and $6,000 for three or more people. Chambers admits the customer base will be a hard target to hit, but it is unfortunately one that grows bigger all the time.

"Ninety-five percent of the uninsured in Kansas live in a household where someone is employed," she said. "There's a gap between those that are income eligible for Medicaid and those that have access and income to be able to afford traditional insurance. It's a pretty large gap in middle, but mostly it will target those Kansans in the working class that work for small businesses."

OUTLOOK: We're confident that the actuarial acumen and other hard work that went into CommunityBlue and Value Blue will make them break-even-or-better propositions, since someone going to work every day tends to be healthy. But to reach even their own admittedly modest sales goals, marketing to these ultra-small groups practically has to be door-to-door. Even then, affordability obstacles may remain, but the strength of the Blues brand should help sell to those already inclined to buy. ■

UniCare, HealthLink Combine Operations

By Rick Byrne and Lori Ann Parker

WellPoint Inc. announced in December that its wholly owned subsidiaries HealthLink Inc. and UniCare Life & Health Insurance Co. will combine operations, sharing product lines and offering wider provider networks.

HealthLink, with its headquarters in St. Louis, boasts a large Missouri enrollment, and considerable business in neighboring states as well. According to UniCare spokesman Tony Felts, HealthLink serves 650,000 Missouri members, and another 550,000 in Illinois, Indiana, Kentucky, Virginia, Iowa and Arkansas. Since Blue Cross and Blue Shield of Missouri will remain the dominant WellPoint unit in the state, the Blues will take over some functions of HealthLink.

"Blue Cross and Blue Shield of Missouri will assume the responsibility of management of HealthLink in Missouri, including sales and service of the network," said Felts, spokesman for UniCare. "Outside Missouri, UniCare assumes that responsibility for Healthlink."

Felts said that, though the operations will combine within WellPoint, customers should not notice a difference in the branding of HealthLink and UniCare. The reorganization, expected to be complete by the close of 2006, should improve service for members.

"Members will be able to choose from an enhanced portfolio of affordable products and broader provider networks," Felts said. "In addition, this will increase access to improved technology that will include new e-business options in 2006. For members, premiums will not increase as a result of this reorganization. In fact, the reduction in administrative costs that we anticipate as a result of this reorganization should have a positive effect on the member's health insurance costs."

The new business unit will serve more than 2.5 million medical members. "This reorganization will allow both HealthLink and UniCare to have new distribution channels for its products and services. This also creates operation synergies, lower administrative costs and improvements in quality of care for HealthLink and UniCare members."

Felts said the change focuses mainly on internal reorganization. "There will be a continuity of leadership with David Fields remaining president of the new organization. David Ott, who has spent many years with HealthLink, will steer the transition as the senior vice president of business development," he said.

According to HealthLeaders-InterStudy, Blue Cross and Blue Shield of Missouri enrolled 113,975 HMO and POS members through July 1, 2004, and 476,000 members in its Alliance PPO through September 30, 2004. HealthLink HMO showed 9,658 members, although three quarters of those were self-insured. It reported just 94 members to the state of Missouri at the end of 2004.

"HealthLink has a very good product, and they are long-standing in this market," said Jay Savan, benefits consultant in the St. Louis office of Towers Perrin. "That's why I'm surprised their integration strategy is what it is. I thought they might just brand it as Blue Cross and sell it that way."

He said that UniCare's sweet spot is the PPO small-group space, while HealthLink finds broad acceptance outside metropolitan areas, with trustee union plans and in workers' compensation.

OUTLOOK: The HealthLink and UniCare brands are fighting for survival within WellPoint, and face tough sledding to maintain their relevance against the ubiquitous and bulletproof Blues brands that make up the bulk of the company's business. Combining their operations may indeed improve customer service, as each does different things well. How rapidly they integrate with each other, and whether performance gains emerge will likely determine whether they continue as unique brands, or just get absorbed by the Blues brands. ■

KC Blues Launches IT Pilot With RelayHealth

By Rick Byrne

Anyone who has ever gotten lost in the phone system of a health plan can appreciate a new pilot program for qualified HMO members of Blue Cross and Blue Shield of Kansas City. The insurer has launched a pilot program employing a new technology from RelayHealth, a California-based firm that provides secure online messaging between doctors and patients.

Online messaging makes a lot of sense for both physicians and patients, since it avoids unnecessary office visits, and frees up overburdened providers to move on to other tasks. Qualified members of the insurer's Blue- Care and Blue- Advantage HMOs will be able to contact their primary care physician for what's called a webVisit, to ask questions about any subject—aches and pains, follow-up care or prescription medications, for example.

"Ideally, the physician gets back to you within a day," said Sue Johnson, spokeswoman for Blue Cross and Blue Shield of Kansas City. "Not just webVisits, but lots of other communication services are available through the RelayHealth program. These services include appointment scheduling, health and wellness reminders, delivery of test results, and even e-prescribing."

The member's payoff from secure messaging will come from not actually going to the doctor's office, unless it's truly necessary. To encourage use of the services, patients making a webVisit with a physician online will make only a $10 copay, instead of the usual $20 or $25. The payment takes place online as well via a secure connection, with a credit or debit card, all handled by RelayHealth.

Health plans may have to work a little harder to find the value-added, according to Matthew Holt, a healthcare IT consultant and vice president at Professional Services Solutions Inc. in San Francisco. "The theory is that the e-visit will replace a real one, and therefore be cheaper for the plan overall," Holt said. "The struggle, though, is to get docs to take them up on the offer."

Copays for members will be $10 no matter the diagnosis but physicians will be paid with a fee schedule that is lower than in-person visits. "There's a time savings for both the member and the physician," said Johnson. "But the important thing is the convenience and access these services provide to our members. We're always looking for new and innovative ways to bring extra service and value to members."

The pilot program aims to include over 500 primary care

BLUE CROSS AND BLUE SHIELD OF KANSAS PCP NETWORK

State

Blue Care and Blue Advantage HMO	2,478
Preferred Care and Preferred Care Blue Choice PPO	1,389

Local

PCPs in Kansas City MSA only	655

Source: HealthLeaders-InterStudy

physicians by the end of 2006. The initial rollout targets all PCPs in large practices. In 2007, the Kansas City Blues hope to expand the plans to include all PPO members and specialists in its network.

Looking to the future, RelayHealth promotes its ability to integrate in large-scale e-prescribing and electronic medical record systems as they develop. Providers, the company said, will boost safety through legible, formulary- and interaction-checked prescriptions, transmitted directly to the patient's network pharmacy of choice. Those with electronic medical-record systems will have the ability to streamline charting and workflow using its recently launched Interoperability Toolkit, which promises to connecting RelayHealth to most major EMR systems.

The Kansas City launch is one of RelayHealth's larger efforts. Currently around 3,000 doctors in the Blue Shield of California network now use the system.

OUTLOOK: We applaud any sincere attempts at trying to deliver better service and access to patients, and we believe the Kansas City Blues and RelayHealth are trying to do just that. However, an honest assessment of RelayHealth and similar IT rollouts shows that getting into large group physician offices goes smoothly, but getting into the smaller practices meets with logistical and cultural resistance. If the Blues can offer RelayHealth to all contracted providers by the end of 2007, their effort will be a model for others to follow. ■

People In The News

Please send announcements to Rick Byrne at rbyrne@healthleaders-interstudy.com. Announcements may also be faxed to 615-385-4979.

L. C. Glasscock

Centene Corp. of St. Louis announced a number of appointments to its corporate staff. Glendon Schuster has been appointed vice president and chief information officer. He had been a partner at the consulting firm Accenture. J. Per Brodin has been named vice president and chief accounting officer reporting to Chief Financial Officer Karey Witty. He comes to Centene from May Department Stores. Leon Luttschwager will be the new vice president of operations and business processes for Centene's CenCorp Health Solutions, its specialty services subsidiary. Julia Ciorletti has been appointed as vice president of government relations in the Washington, D.C., office.

Larry C. Glasscock, already serving as president and CEO of **WellPoint Inc.**, was elected chairman of the board of directors for the company. He replaces Leonard D. Schaeffer, who stepped down as a board member and chairman one year after the merger of the former Anthem Inc. and WellPoint Health Networks Inc. The vacancy on the board appears likely to remain open until the completion of WellPoint's pending acquisition of WellChoice, since terms of the merger call for a WellChoice board member to join WellPoint's board.

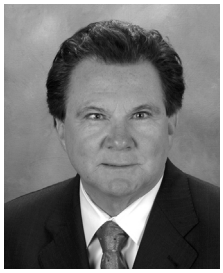
In other changes at WellPoint, Tom Snead, president and CEO of the Southeast region, will leave in the first quarter of 2006; Ron Ponder, executive vice president and chief information officer has left as well, to be replaced by Mark Boxer, who has gained the new title of executive vice president of technology and operations and chief information officer. WellPoint also recently announced the promotions of Susan Rawlings to president of senior services and senior vice president for WellPoint and Lynne Gross to president of senior markets in the company's Central Region and senior vice president for WellPoint. Kathy Zorica has also been named vice president and general manager for the Under 65 Individual Market in the Central Region. She is responsible for the financial performance, underwriting, sales, retention and broker service for individual plans in Indiana, Kentucky, Missouri and Ohio.

CIGNA Corp. has combined two senior leadership positions into one. The company has combined CIGNA Group Insurance and CIGNA Dental & Vision Care units and has named Karen S. Rohan to fill the post. She had already been serving as president of the dental and vision unit. ■

Programs Use Creative 'Carrots' For Wellness

By Rick Byrne

Employers are taking a tougher stance against smoking and obesity among workers in an effort to control healthcare costs, but their efforts use more carrots than sticks. Health plans and benefits consultants in Kansas-Missouri say it's unlikely employers will go as far as the Michigan firm that recently fired four workers who refused to be tested for tobacco use.



R. J. Dutton

For one thing, state laws in the two states, along with 28 others, protect workers who smoke from being fired, according to the National Workrights Institute. Furthermore, Kansas City employee benefits firm R. J. Dutton Inc. says while employers can charge obese employees more than those of normal weight, they must do so under certain conditions. "You can, as long as you do it within a bona fide wellness program, as long as you don't discriminate in cases where, for medical reasons, an individual can't participate in a weight-loss or exercise program," Dutton said.

Dutton also said it's difficult to place surcharges on obesity for employees because there is a lack of consensus on what constitutes obesity. "An example is someone who exercises and lifts weights may actually have a higher body-mass index than someone who does not."

United Benefits Advisors, a national alliance of benefits consultants, reported in the fall of 2005 that 3.1 percent of employers surveyed nationally have adopted premium differentials for tobacco users. An additional 11.2 percent said they would probably adopt a differential in the next year.

Firing employees for tobacco use is extreme, but "we may see more of that happening as evidence builds around personal behavior and how it affects health costs," said David Steurer, director of membership for the Wellness Councils of America. "We wouldn't recommend such measures for everybody, but it might be interesting to watch."

In 2001, the federal government issued new guidelines under the Health Insurance Portability and Accountability Act that specifically defined what measures employers could take to offer what it called a Bona Fide Wellness Plan, or BFWP. Now, employers, health plans and vendors have begun to experiment within those guidelines, finding new incentives for employee wellness, and in some ways, exploring new territory that even HIPAA creators didn't think of.

Punishment And Reward. Scotts Miracle-Gro, an Ohio-based maker of lawn and garden products, has told its 5,300 U.S. workers that those who smoke could be fired this fall unless they make an effort to quit. The company has hired an outside vendor, Whole Health Management, to launch a 24,000-square-foot on-site health clinic, pharmacy, and wellness and fitness center, and also undertake management of attendant programs, including smoking cessation.

Others have taken a more nurturing approach. Last April, Humana Inc., the health insurer based in Louisville, Ky., with members in both Kansas and Missouri, took a poll of its employees to see who smoked in the last year. Those who hadn't smoked received $5 off of their portion of the premium per pay period."

"We did implement that to help encourage healthy behaviors," said Mary Sellers, spokeswoman for Humana. "Seventy percent of our employee population who enrolled on July 1 are nonsmokers, which totaled about 8,000 of Humana's associates. They received the discount."

At its multiple offices in the Topeka area, Blue Cross and Blue Shield of Kansas has reduced the number of places available for employees who smoke. A new headquarters campus is under construction that will bring most staff in satellite offices under one roof, and the plan includes Club Blue, an on-site fitness center.

"We also run Weight Watchers programs on campus, and the corporation sends out information on how to avoid repetitive stress injuries, and the benefits of walking," said Mary Beth Chambers, spokeswoman for the Kansas Blues. "But as far as incentives and bonuses, we haven't gotten that far yet."

For plan members, the Kansas Blues offers wellness options that aren't workplace-driven in a package called Resource Blue. It's typical of what many insurers now offer, with discounts to a network of fitness centers, massage therapy, and complementary medicine, such as acupuncture and chiropractic that would not be covered by insurance.

Humana has also now partnered with Virgin Lifecare, a vendor that coordinates wellness rewards programs, to offer such options for the insurer's employer groups. Employees of participating companies earn reward points for healthy behaviors, which can be applied to everything from paying the copay for health services to purchasing workout or outdoor equipment. Participants are even eligible to win prizes like a car, or a trip to Virgin entrepreneur Richard Branson's personal island.

"You will see more incentives. Maybe not as strong as you see on nonsmoker discounts. But employers will start to set up wellness accounts or funds," said Beth Bierbower, vice president of product innovation for Humana. "Through those accounts and programs like Virgin, they'll expand so they're not just for adults, but also for children. The initial focus will be on the employee, but it will evolve to cover the whole family."

Mercy Health Plans in St. Louis for two years has offered to self-insured employers a product called My Choice that meets HIPAA requirements to be a BFWP. Sixteen employers in St. Louis and another two in southwest Missouri have chosen My Choice, for a total of more than 16,000 members. About 75

CRITERIA FOR HIPAA'S BONA FIDE WELLNESS PROGRAM (BFWP)

- The plan must limit the reward to 10%, 15% or 20% of the cost of coverage. The premium differential may not exceed 20% of the full cost of single coverage under the plan (even if they have family coverage).
- The program must be reasonably designed to promote health or prevent disease.
- The plan must allow participants to re-qualify for the reward/incentive at least once per year.
- The plan must be available to all similarly situated participants and a reasonable alternative must be available for them to gain the reward. Tailored alternatives must be available to anyone unable to achieve the health standard due to a medical condition, or for whom the health standard is medically inadvisable.
- All plan materials describing the program must include adequate disclosure about the BFWP and the fact that individual accommodations are available.

Source: HIPPA

percent of the people who have it as an option sign up and stick with My Choice. Of the remaining employees, most are smokers who wouldn't or couldn't quit, said William Bennett, senior vice president of field operations for Mercy.

It begins with the member's agreement to undergo a health appraisal through a secure Web-based site, with non-employee specific global results shared with the employer. Those indicate the overall health status of the group. The employee must pledge to take part in age-appropriate preventive care, to not smoke or enter a smoking-cessation program, enter into a weight-loss program over a certain body-mass index, and wear seat belts at all times. In addition, the chronically ill must follow nationally recognized best practices for disease management.

In exchange, the employee will see some kind of financial benefit, compared to those who enroll in Mercy's standard plan. Mercy recommends a tiered co-insurance set-up and premium incentives, but each employer decides what the incentives will be in accordance with HIPPA guidelines.

Risk-Rating. Highsmith, a mail-order firm of about 240 employees in Fort Atkinson, Wisc., is one of the first firms to introduce employee risk-rating, which requires employees to pay more toward health premiums if they don't participate in wellness activities. Its activities include health screening and weight loss and smoking cessation, all on company time.

Highsmith's insurance costs went from almost 53 percent increases in 1989 to single-digit healthcare increases. The Wellness Council reports that Highsmith's expenditures within its HMO are consistently 20 to 30 percent lower than the average for all employers in the pool.

"There are a lot of different ways wellness spreads around in different companies," Steurer said. "But if the CEO believes in this, that can make it happen. If it starts in the human resources department, or the middle or lower ranks of a company the program can be strengthened by capturing senior-level and involvement." Duncan Highsmith (CEO of the family-owned company), has made a commitment through strong leadership. He's proven that by doing that, he gets bottom-line return."

Dutton said there's no denying that offering wellness programs and incentives cost employers money. Insurers typically add them.

"The employers have to make an investment in curbing their own costs," he said. "The costs for the first year might go up a bit because employees who haven't been going to the doctor may begin getting routine check-ups. But it may result in avoiding larger expenses in the future."

He said many of R. J. Dutton's clients have come to the conclusion that managed care has not been effective in holding down costs. "Employers are more challenged than ever to control their costs. Consumer plans shift more cost to employees and are intended to encourage accountability. Wellness programs can effectively complement these types of plans by educating employees and encourage modification of behavior to more healthy lifestyles."

"The last frontier is when an employer asks, 'What can I do to help my employees be better consumers?'" he said.

OUTLOOK: The value-add of wellness programs will continue to increase as more employers adopt consumer-driven health plans. There's a vast vendor market ready to assist them, but as our analysis shows, some companies have the appropriate leadership to go it alone. ■

HSAs Making Waves, But No Storm In 2006

By Ric Gross and Rick Byrne

When health savings accounts were created in 2003—a result of the sweeping Medicare Modernization Act—many insiders and analysts began to look ahead for a potential "breakout" year for the accounts.

Some looked to 2006, labeling it as the critical year for the accounts, and the high-deductible health plans they are tied into. But have the plans gained traction as expected? And moreover, with such a new—and somewhat complex—option thrown into the sometimes-dizzying healthcare array of healthcare designs, is a breakout year even possible?

The answer is likely no, but health plan executives and consultants believe adoption of HSAs will significantly expand beyond the estimated 3.5 million enrollees currently in account-based plans.

"I think they [HSAs] will continue to grow and evolve. I think it's unrealistic to be looking to see them explode," said Peter Kongstvedt, senior executive in Accenture's Health & Life Sciences practice. "When you think about the health system in the U.S., it's huge. Overnight change is pretty hard to do."

Those sentiments were echoed by Robin Downey, head of product development for Aetna's consumer-directed plans.

"I think HSA adoption has been very good. It really depends on what you are gauging it against and what expectations were," Downey said. "If you thought the entire world was going to switch to HSAs overnight, that didn't happen. The other side said only small employers would be interested in it, and that is not true either."

Only one national insurer has consumer-driven enrollment of 1 million or more. That's UnitedHealth Group, which purchased CDHP pioneer Definity Health in 2004, and counts 400,000 in HSAs and another 600,000 in health reimbursement arrangements. Blue Cross and Blue Shield of Missouri's parent WellPoint had 434,000 account-based members in late 2005, said John Watts, president and CEO of national accounts for WellPoint. Aetna has around 64,000 members in an HSA-compatible high-deductible plan and more than 400,000 in total account-based enrollment.

Humana had some 350,000 in its SmartSuite offering (which includes more than HSAs), while CIGNA had around 125,000 in CIGNA Choice Fund products, which includes HSAs and HRAs. Its enrollment doubled on Jan. 1.

Local Scene. In Kansas, and especially in Missouri with its well-earned reputation for skepticism as the Show-Me State, consumer-driven plans have been slow to catch on. Blue Cross and Blue Shield of Kansas, the largest insurer based in that state, did not begin offering HSAs until summer of 2005, and has seen little demand or interest in them. Preferred Health Systems only recently announced a partnership with HealthEquity to boost interest in its consumer-driven offerings.

CONSUMER-DRIVEN LANDSCAPE

Plan	CDHP Enrollment	Preferred Bank
Aetna	400,000	JPMorgan Chase
CIGNA HealthCare	250,000	JPMorgan Chase
Humana	355,000	UMB Bank
Kaiser	N/A	Wells Fargo
Lumenos	N/A	Mellon Financial
UnitedHealthcare	1 million	Exante Bank
WellPoint/Anthem	434,000	JPMorgan Chase

Source: Health plans

Mercy Health Plans, one of the largest insurers in Missouri with over 136,000 lives in commercial, Medicare and Medicaid HMOs, numbers itself among the CDHP skeptics, and has pursued wellness through other methods.

"We come at this from a different angle," said William Bennett, senior vice president of field operations for Mercy Health Plans in St. Louis. "We have high deductible health plans, but we feel the opposite: that the consumer-driven model within the industry won't do much to control healthcare costs. It is a good cost-shift; however, a very small percent of the population drives the great majority of costs. We've gone heavily into wellness and disease management to attempt to lower employer costs and increase employee productivity."

Mercy's plan, called My Choice, is a consumer-centered plan and is available to both insured and self-funded employers and meets HIPAA requirements for a bona fide wellness plan. Mercy does not offer health savings accounts to manipulate member behavior. Bennett said Mercy leaders believe high-cost procedures are not that discretionary, it is difficult to discern value, and there's little savings to be found among low-cost members, the most likely users of HSAs.

Jay Savan, benefits consultant in the St. Louis office of Towers Perrin, finds himself in Missouri's minority, however. He's bullish on consumer-driven health plans and expects to see a big uptick in 2006. He doesn't think it's a fad, and he doesn't think it's going anywhere but up.

"I think we're seeing big growth this year," Savan said. "We've predicted the '06 enrollment will total about 10 million participants. When you look at the growth trend, that's enormous, especially when you realize that in 2002, it was 100,000."

Alexander Domaszewicz, principal with Mercer Human Resource Consulting and national leader for the group's consumerism specialty practice, believes account-based enrollment could be 5 million in 2006. But that's only 3 percent of

EMPLOYERS LIKELY TO OFFER CDHPS IN 2006–07

	Currently Offer	Likely In '06*	Likely In '07*
All employers	2%	11%	13%
Small employers (10–499)	2%	11%	13%
Large employers (500+)	5%	13%	17%
Jumbo employers (20,000+)	22%	29%	31%

*Selected 5 on a 5-point scale, where 1 = not at all likely and 5 = very likely. Includes employers that currently offer; 2007 figure includes employers likely to offer in 2006.

Source: Mercer Health & Benefits LLC

the 160 million people enrolled in commercial plans. "The concept is mainstream—adoption as a mainstream concept will take time," he said.

Initial projections that half of employers would offer the plans in 2006 were likely inflated, Domaszewicz said. "I would say those projections were a little bit aggressive. People need time to get their minds around this." That said, Domaszewicz believes one-half of large employers could offer the benefit designs in three to five years.

Among smaller employers, HSAs haven't taken off as predicted because of the complexity of the plans and the education needed, according to a recent survey by the Council of Insurance Agents & Brokers. Interest is growing, but actual sales are increasing at a much more modest rate, the brokers report.

The Plans. HSAs are, by law, coupled with high-deductible health plans, and are typically priced so money saved on premiums can theoretically be deposited into the account. For customers switching from a traditional low-deductible design, the premium savings can be as high as 35 percent to 40 percent.

For 2006, in order to qualify for an HSA, an individual's minimum deductible must be at least $1,050, or $2,100 for a family. The annual out-of-pocket expenses for 2006, including deductibles and copays, cannot exceed $5,250 for self-coverage and $10,500 for family coverage.

A person pays for medical expenses out of the account until he or she has met his or her deductible. Coverage kicks in after the deductible is met. The idea is that if consumers are spending what amounts to their own money, they will become better, more educated healthcare consumers.

"I think we have come to some general agreement that the idea of individual accountability with regards to health and health spending makes sense," said Meredith Baratz, vice president of market solutions for Definity Health, a UnitedHealth Group company. "You can't just anoint people as consumers. There has to be outreach and support and giving people the opportunity to understand the options and opportunities."

As consumer-driven plans mature, health plans have beefed up tools for consumers to use in helping them navigate the medical system. Tom Richards, CIGNA senior vice president of development, said having a "health coach" is critical. "We don't view HSAs as a high-deductible health plan alongside a bank account. We view consumerism much more broadly," he said. "HSAs need to be part of an integrated health plan, and you have to make employees true healthcare consumers."

HSAs have been touted for their portability, unlike HRAs, and supporters have also pointed to the ability for the HSA funds to grow, tax free, through investment earnings, much like an IRA. In many instances, employers contribute directly into the funds as well. Unused funds at the end of the year roll over for use in later years.

However, Bill Sharon, senior vice president for Aon Consulting, said perhaps too much attention is being paid to tax benefits and the possibility of saving for the future in regards to HSAs.

"I would say, for these to really work, and for employers and employees to continue to be enthused, there is still going to have to be a good health plan and a good network," Sharon said. "There will have to be a focus on consumer education so people can make better purchasing decisions. It is fundamentally still a health plan, and 90 percent of the dollars are still going to be paid for healthcare services. There will have to be a good network, good claims adjudication and good consumer tools and education—all of those have to be present for it to be effective."

Numbers Game. According to Mercer's 2005 survey of employers, completed in the summer of 2005, consumer-directed health plans showed the largest growth in implementation among so-called jumbo firms, or businesses with 20,000 or more employees. According to the survey, consumer-directed health plan offerings rose sharply, from 12 percent in 2004 to 22 percent offering the plans in 2005. Meanwhile, the percentage of small employers (10–499 employees) offering HSAs doubled, but it was from only 1 percent to 2 percent, the survey showed.

Small-employer adoption is likely to mushroom in 2006, however, with the survey showing a potential 11 percent of them making HSAs available to their employees.

"HSAs have only been around a brief while now, and I think 2006 will see a significant bump in the number of employers adopting them," according to Mercer's Domaszewicz. "There are really two levels of adoption. At the employer level, you need to overcome the inertia of folks to keep the plans they always have. At the employee level, assuming they may have an HMO and PPO competing, you have to overcome the inertia of the employee to try and get up to speed on what these plans really mean and how they could work for them and their family."

Jack Rowe, M.D., Aetna's CEO, said employees can take as long as two years to accept consumer-driven choices at their workplaces. In a conference call with investors, Rowe said the most important metric would be the number of employers offering the designs, not the numbers of individuals in them.

Meanwhile, a March 2005 report by Forrester Research predicts the number of HSAs will grow to more than 6 million in 2008, with funds in those accounts covering more than $9 bil-

lion in medical expenses and accumulating almost $5 billion in assets.

For Savan of Towers Perrin, the leading indicator for account-driven healthcare is the integration of the financial services business into the health insurance realm.

"The technology to support healthcare accounts is now mainstreaming, and in order to create market share, it's growing," he said. "It's an extremely exciting time, watching change happen. But we definitely are watching the convergence of the insurance world and the financial services world. Blue Cross has been around a long time and never saw a reason to charter a bank. Now they have."

Among health plans' CDHP developments:

■ United's iPlan HSA platform, in conjunction with United-owned Exante Bank, has a series of Web-based tools designed to help consumers with the specifics of their plan and how to understand treatment costs. Beginning in January 2006, consumers gained new HSA investment options through Exante. Baratz said United has more than 8,000 employers with an HSA-based program, a number expected to reach 9,000–10,000 in 2006.

■ The Blue Cross and Blue Shield Association is planning to develop its own bank, Blue Healthcare Bank, to handle administrative and financial support for HSAs, HRAs and flexible spending accounts developed by Blue Cross companies.

■ CIGNA, meanwhile, offers its CIGNA Choice Fund HSA with JPMorgan Chase serving as its financial partner. As of Jan. 1, CIGNA Choice Fund HSA participants gained the option to invest the money in their HSA in up to six mutual funds from firms including JPMorgan Funds, T. Rowe Price and Royce Funds. The available cash balances in a person's HSA determines eligibility, as those with balances greater than $2,000 will have the mutual fund investment options. Features also include a debit card and checkbook from JPMorgan Chase in an integrated benefits plan, without member-level account setup or monthly fees.

CIGNA expanded its consumer-directed portfolio of late, recently broadened its offerings to businesses with 51–200 employees in markets such as Kansas, Missouri, Illinois, Indiana, Georgia, Ohio and the Mid-Atlantic

■ WellPoint is sweetening its consumer-driven package in 2006 with access to the BlueCard PPO, the national Blue Cross network program. Watts believes growth will be gradual. Watts said WellPoint purchased Lumenos in part because its products had already moved beyond a first-generation slate to include preventive benefits and first-dollar drug coverage.

■ Aetna, meanwhile, touts its online tools such as Aetna Navigator, a member self-service Web site that provides a record of personal health information, and DocFind, a directory members can use to search for healthcare professionals and facilities by particular criteria. As for membership, Downey said Aetna currently shows about 64,000 members in a high-deductible health plan compatible with an HSA, with about 21,000 having an HSA account.

Aetna reports higher adoption for HSAs than HRAs for 2006. Thirteen new national employers are adopting HRAs for the first time, while 38 are buying HSAs, she said. "For small group, we have about 1,400 to 1,500 [employers] now in high-deductible health plans compatible with HSAs," Downey added.

No doubt, health plans have high hopes for the consumer-driven movement, and efforts are being made to get the plans to the forefront. As for the future, the window-shopping does seem to certainly be increasing for the plans, but only time—and consumers—will tell whether the buzz around HSAs turns into a roar.

OUTLOOK: The consumer-driven movement should continue to gather momentum, although it will be at a slower pace than many first thought. A big question will be whether HSAs and HRAs gain enough traction to make serious dents in controlling medical-cost inflation. Second-generation designs have come a long way toward giving consumers information they need to make better choices, but employers and consumers remain skeptical. ■

2006 HSA CONTRIBUTIONS

Consumers can make contributions to HSAs each year that they are eligible. They can contribute up to the amount of an HDHP deductible but no more than $2,700* for single coverage and $5,450* for family coverage.

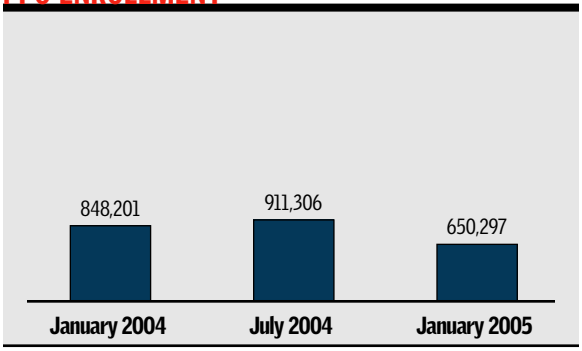
HDHP Deductible Single Coverage	Maximum HSA Deposit
$1,050	$1,050
$1,500	$1,500
$2,000	$2,000
$2,500	$2,500
$3,000	$2,700

HDHP Deductible Family Coverage	Maximum HSA Deposit
$2,100	$2,100
$3,000	$3,000
$4,000	$4,000
$5,000	$5,000
$6,000	$5,450

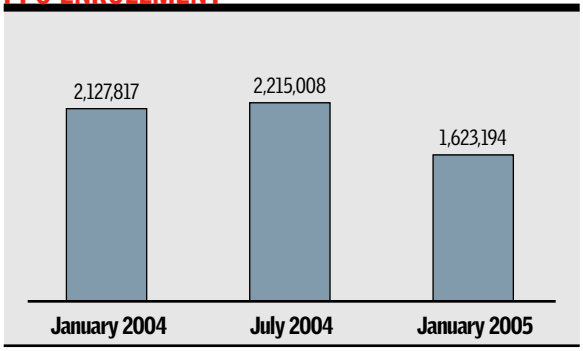
*2006 amounts; adjusted annually for inflation.

Source: U.S. Department of the Treasury

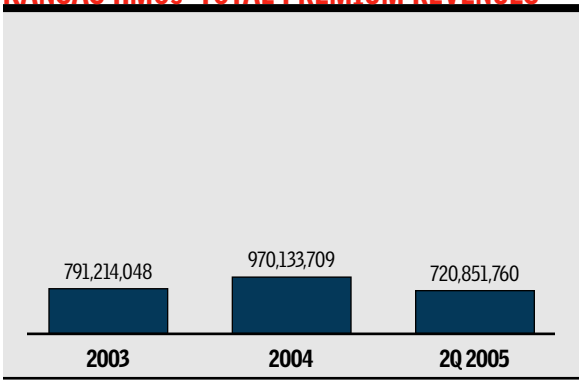
KANSAS COMMERCIAL SINGLE-INSURER PPO ENROLLMENT



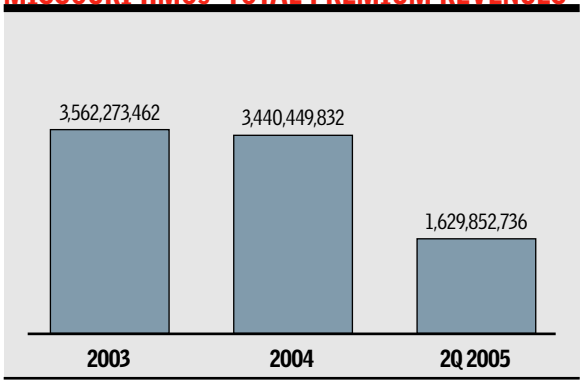
MISSOURI COMMERCIAL SINGLE-INSURER PPO ENROLLMENT



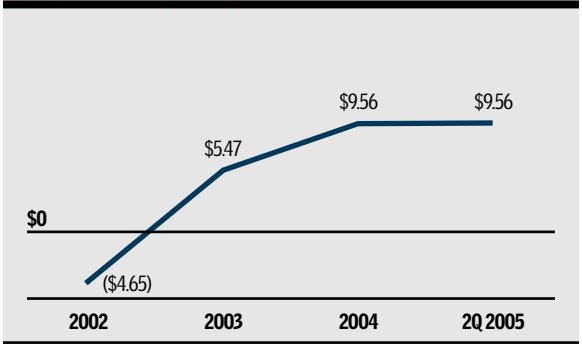
KANSAS HMOs' TOTAL PREMIUM REVENUES



MISSOURI HMOs' TOTAL PREMIUM REVENUES



KANSAS HMOs' NET INCOME (LOSS) PMPM, WEIGHTED AVERAGE



MISSOURI HMOs' NET INCOME PMPM, WEIGHTED AVERAGE