

Georgia, Alabama & Louisiana Health Plan Analysis

Fall 2007 Vol. 15 No. 4

Georgia, Alabama & Louisiana

Health Plan Analysis

Fall 2007 Vol. 15 No. 4

Georgia, Alabama & Louisiana Market Analyst
Jan Shuxteau
jshuxteau@healthleaders-interstudy.com

Georgia, Alabama & Louisiana Research Analyst
Kristi Gumm
kgumm@healthleaders-interstudy.com

HEALTH PLAN ANALYSIS

Principal Director of Research & Analysis
Sheri Sellmeyer

Associate Director of Health Plan Analysis
Jane DuBose

Assistant Director of Health Plan Analysis
Paula Wade

Health Plan Analysts
Rick Byrne, Ric Gross, Chris Lewis,
Don Mooradian, Bill Melville, Roy Moore,
Jan Shuxteau, Heather Wicks

HEALTH PLAN DATA

Director of Data Operations
Russell Workman

Director of Research Analysis
Laura K. Black

Product Manager
Mark McMahan

Project Manager
Rebecca Waller

Database Analyst
Lance Wolkenbrod

Senior Analysts
Randall Gish, Jodi Tonkin

Research Analysts
Natasha Al-Qadi, Kristi Gumm, Geppe Hernandez,
John King, Devona Matthews, Mimi Pounders,
Andrew Wharton

SHARED SERVICES

Senior Software Engineer
Ben Jones

Senior Database Administrator
Mike Schellhammer

Database Administrator
Stephen Ham

Design & Production
Lisa Roman

SALES & MARKETING

Director of Sales
Eric Matckie

Marketing Manager
Kelly Morphy

National Account Managers
Susan Albano, Jacky Lancio, Jolayne Perry

National Account Executives
Nina Bellinger, Bob Fucile, Jed Maley, Chris Mars

Account Executive
Shea Ivy

HEALTHLEADERS-INTERSTUDY

Operations Manager
Tracy Coats

Controller
David Banning

Staff Accountant
Jackie Sawyer

CORPORATE OFFICE

One Vantage Way, B-300
Nashville, TN 37228
Phone: 615.385.4131
Fax: 615.385.4979
Toll Free: 888.293.9675

In This Issue

3 Uninsured

3 Georgia Proposals Zero In On Working Poor

5 New La. Governor Has Big Healthcare Resume

7 Medicaid

7 Managed Care Still Taking Bumpy Ride In Ga.

10 Medicare

10 Higher Premiums, More Uniformity In Part D

13 Disease Management

13 Predictive Medicine: Emory Studies Biomarkers

15 Public Employees

15 Federal Workers Will See Small Premium Hikes

17 Health Plans

17 Humana Launches New Individual Plans In Ga.

18 Aetna's ValuePick Targets Small Businesses

19 Ga., Ala., And La. Health Plan Briefs

20 People

21 Metrics

Published November 2007. Copyright © 2007 HealthLeaders-InterStudy (a Decision Resources company). All Rights Reserved. Intended for the sole use of a HealthLeaders-InterStudy registered subscriber. Photocopying, forwarding or reproducing in any form, in whole or in part, is a violation of federal copyright law and is strictly prohibited. Selling or otherwise providing this information to third parties violates the contractual agreement under which this report and data are provided and is a violation of federal copyright statutes. Violation of federal copyright law is punishable by fines up to \$100,000. Questions regarding use of this product should be directed to HealthLeaders-InterStudy, One Vantage Way, B-300, Nashville, TN 37228; 615.385.4131.

Georgia Proposals Zero In On Working Poor

By Jan Shuxteau

Georgia Gov. Sonny Perdue has proposed a plan to punch up the of small businesses to offer health benefits to their employees, while Lt. Gov. Casey Cagle is promoting a different initiative to get healthcare to the working poor.

Some 380,000 of Georgia's 1.65 million uninsured are part of a small-business household. They work for employers with fewer than 50 employees and earn less than 300 percent of the federal poverty level, approximately \$62,000 for a family of four or \$30,600 for a single adult. As many as 30,000 employees could be insured under Perdue's plan.

Cagle's Healthcare Safety Net would create a system of health clinics to cater to the working poor and a Web site called the Georgia Health Marketplace that would be a clearinghouse of healthcare products available for purchase.

Both proposals will be introduced in the coming legislative session, which begins in January.

Perdue Proposal, Costs. Under Perdue's proposal, the Health Insurance Partnership for Georgia, small businesses would be able to voluntarily join the partnership and offer private health insurance options to employees.

The cost of the insurance plan would be a joint responsibility, shared by the employee, employer and a combination of state general appropriations funds and federal funds acquired through a Section 1115 waiver. Because Georgia's Medicaid initiatives have realized savings in both state and federal funds, the state anticipates that the federal government will approve using saved federal dollars to help cover its share of the cost.

Tennessee has launched a similar three-share program, but it does not use federal funding. Cover Tennessee includes a program geared to small business; it had 11,689 enrollees as of October 2007 after launching in April.

While the exact level of state investment will not be known until details of the program are finalized, Perdue said he is willing to invest up to \$20 million to have the program available by July 1, 2008. A \$20 million state investment, when combined with federal funds and contributions from employee and employer premiums, could result in more than \$182 million in insurance coverage for about one-tenth of those in small business.

While insuring 30,000 people seems like a small number, "you have to start somewhere," said Pat Ketsche, associate professor at Georgia State University's Institute of Health Administration. "It makes sense to start small, partly because there is uncertainty about how the plan would work and how people would respond to it. To me, this seems like a reasonable attempt to stick a toe in the water to shore up the healthcare system."

Kirk McGhee, president of the Georgia Association of Health Plans, agrees. He pointed out that some lawmakers

ELIGIBLE PARTICIPANTS OF GOV. PERDUE'S HEALTHCARE PLAN

- » Sole proprietors
- » Employees of businesses with 50 or fewer workers
- » Those earning less than 300 percent of the FPL
- » Employees who work at least 20 hours per week
- » Those who do not have access to other insurance
- » Employees who have not had insurance in six months
- » Residents of Georgia at least six months
- » Citizens or qualified legal aliens

Source: Governor's Office of Communications

are too eager to rush headlong into programs. "There are a hodgepodge of plans across the country," he said.

He noted that insurers were heartened because the governor showed a willingness to help small business in a way that will not harm the private market. "This plan is not going to damage the market in any way," said McGhee. "It could set the tone for reform, not only in Georgia, but across the nation."

Small Business Hopeful. David Raynor, Georgia State Director of the National Federation of Independent Business, said that the partnership could be an "extraordinary opportunity" for small businesses, which generally favor market-driven proposals. He pointed out that key components of the proposal are well in line with what small business owners want. "First and foremost is affordability. This is what drives small business owners' ability to provide insurance to their employees," said Raynor. "Other components are portability—so that employees can take the plan with them if they leave—and easy access."

Raynor noted that NFIB research shows that the rising cost of health insurance has been the top concern for small business owners for the last 20 years.

Making the program voluntary also carries weight with small employers, Raynor said. "What we saw in the past were attempts to mandate businesses to provide health insurance or contributions to a health benefits program. These were introduced in the Legislature but didn't pass," he said. "The fact that this plan would be voluntary is very enticing. If business owners choose not to participate, they don't have to."

Small business owners are, however, concerned about Perdue's proposed government subsidies, which they say could come with an eventual price tag. "Small business owners are fearful that allowing the government to come in and pay for a portion of healthcare, you will go down the dangerous road toward socialized medicine," Raynor explained.

UNINSURED BY WORK STATUS IN FAMILY (2005-2006)

	Ga. Number	Ga. %	U.S. Number	U.S.%
At least 1 full-time worker	1,163,216	71%	32,779,097	71%
Part-time workers	143,140	9%	5,178,841	11%
Non workers	338,459	21%	8,495,474	18%
Total	1,644,815	100%	46,453,411	100%

Source: Kaiser Family Foundation

Ketsche noted, however, “Overall, my thinking is that the subsidy is necessary for low-income individuals. A family health plan is \$10,000, maybe nearer \$12,000. Families earning \$60,000, about three-times the poverty level, just can’t afford that.”

She pointed out that high-deductible plans may be less expensive, but their value proposition may not work for a moderate income family.

“This is a three-share program, or maybe even a four-share program, with responsibility for care at different levels: federal, state, private business and, in this case, the insurance industry,” said McGhee. “Also, this program says that you, as an insurance consumer, have to have skin in the game. You have to contribute. And it says to the private market, you may not like the rules, but this is a way to make things work.”

Eligibility. Employees eligible for the Perdue plan would include sole proprietors or those who work for small businesses of 50 employees or fewer. Eligible employees must work at least 20 hours per week and earn less than 300 percent of the FPL. Employees that earn more than the income cap are still eligible for coverage, but their premium cost would be split between the employer and employee.

According to the state, the goal is to offer several options for private healthcare coverage, based mostly on the amount of premium an employee chooses to pay. These would include a plan comparable to that of state employees and including its benchmarks; a high-deductible plan with a health savings account; and a plan with basic benefits that still meets the requirements of the Small Business Employee Choice of Benefits Health Insurance Plan Act.

“This is what we refer to as a mandate light plan,” said Raynor of the last plan. “The Legislature looked at authorizing a mandate-free plan back in 2005, but it didn’t pass. Some of the mandates were added back when the bill was amended, making it mandate light rather than mandate-free, and it passed.”

Under Perdue’s plan, employers must offer at least the benchmark plan to employees if they choose to participate. Employees cannot qualify to participate if they already have access to insurance or qualify for Medicaid or TRICARE. The plan would only be open to Georgia residents.

It would be open to individuals with pre-existing conditions. “The governor is adamant about this,” said McGhee. “Pre-existing conditions will not be allowed to exclude coverage.”

Cagle’s Health Initiative. The lieutenant governor would ease the problem of Georgia’s uninsured through two initiatives: the Georgia Health Marketplace and the Healthcare Safety Net.

The Georgia Health Marketplace creates a clearinghouse of healthcare products available for purchase through a state Web site. Multiple insurers, physician groups and state-subsidized healthcare plans would be represented. This streamlined system coupled with newly offered products—along with the portability of the products—could produce savings for consumers.

Cagle’s Healthcare Safety Net would make grants available to pay for five pilot safety net clinics to serve indigent patients. Clinical services would be offered for certain chronic diseases and certain emergency room treatments.

Raynor noted that though Cagle’s plan is not directed toward small businesses, it would impact small business employees without health insurance. “Many of the working uninsured would take advantage of the clinics,” said Raynor. “We’re interested in working with the lieutenant governor as he develops his plan.”

OUTLOOK: *Georgia is taking a cautious plunge into the cold water of healthcare initiatives, seeking to lessen the ranks of the uninsured. Both Perdue’s plan and Cagle’s are tentative steps, but they are steps in the right direction. Expect some concern over the requirement that insurers have guaranteed issue. Georgia is one of the few states that does not have a high-risk pool.* ■

New La. Governor Has Big Healthcare Resume

By Jan Shuxteau



B. Jindal

Louisiana healthcare will be a priority for Republican Congressman Bobby Jindal who was elected governor in the primary Oct. 19.

By capturing more than 50 percent of the vote, Jindal automatically won the governorship and avoids a run off.

Gil Dupré, president of the Louisiana Association of Health Plans, says he expects Jindal will put the spotlight on Louisiana healthcare.

“He talked about it during his campaign and provided his own healthcare plan, not in detail, but conceptually. We’ve looked forward to having someone in office with his depth of knowledge about healthcare.”

The Louisiana Hospital Association endorsed Jindal. “We need health reform in our state, and Bobby Jindal can tackle that,” said John Matessino, president and CEO of the association. “We have this antiquated system of delivering healthcare through the Charity Hospital System, which receives a disproportionate share of government dollars. We do not advocate getting rid of the system, but we need to look at creative ways of covering the working poor so that they are not all trying to go to one particular hospital, going past more convenient facilities and then waiting for hours in line before they get treatment.”

Dupré also said that the state’s approach to the charity system will be a key part of any reform. “The governor-elect has said he recognized that we need that system and we need to build some type of hospital in New Orleans though it might have a different mission.”

Jindal will have “to face what to do about Big Charity,” the Katrina-devastated flagship hospital of the Charity Hospital System, noted Matessino. The building was old, declining and in line for replacement even before it was flooded by Katrina. Nevertheless, its fate is a sore subject with many Louisianans.

“I’m glad we’re not spending money on that building,” said Matessino, “but most people agree that we need a new hospital. What they don’t agree on is how big it needs to be or how much money we need to spend. Discussion about a \$1.3 to a \$1.5 billion building is unsettling to a lot of people.”

The Healthcare Governor. Jindal is something of a healthcare legend. Named as one of the 100 most powerful people in healthcare by *Modern Healthcare*, he launched his political career by reining in Louisiana’s runaway Medicaid budget and exposing corruption after he was named secretary of the state Department of Health and Hospitals at the age of 24. Two years later, he left state government to serve as executive director of the National Bipartisan Commission on

the Future of Medicare. After that, he was named assistant secretary of Health and Human Services. Returning to Louisiana, he ran for governor in 2003 and barely lost to Kathleen Blanco in the last gubernatorial race. He was then elected to Congress for two terms.

“The time is right politically for there to be a lot of change,” Dupré said. “Still, the governor has to work through the Legislature, and that will be a very different body from what it was.”

It will be different because term limits took effect in this election, resulting in almost a 50 percent turnover among lawmakers. The make-up of the Legislature will be determined after the November run-off. Some 49 seats are up for grabs—nine in the Senate and 40 in the House. In addition to that, Jindal has said he will not name legislative leadership posts, a prerogative traditionally used by Louisiana’s governors.

Matessino observed that the new governor “knows the landscape” and understands what’s going on in Louisiana healthcare.

Jindal’s Plan. In October Jindal announced his Health Care Reform Plan, stating that anyone who thinks Louisiana does not need healthcare change “clearly has their head in the sand.” He said he will focus on initiatives for preventive primary care and will give more control to local communities, patients and doctors and less to bureaucrats. He said that he will upgrade the medical records system, promote transparency in healthcare costs and support incentives for employers to encourage them to offer insurance to their employees. He promised improvements to the Charity Hospital System that will make it community-friendly and to help citizens afford prescription drugs.

In a release about Jindal’s healthcare plan, former Speaker of the House and founder of the Center for Health Transformation Newt Gingrich said, “Congressman Jindal’s plan begins with a brutally candid assessment of where Louisiana

KEY ELEMENTS IN JINDAL’S HEALTHCARE PLANS

- » Primary care providers to coordinate care
- » Emphasis on preventive medicine
- » Greater reliance on technology
- » Transparency of cost and quality measures
- » Place more control in the hands of patients and communities
- » Provide incentives to employers to provide insurance
- » Improve the charity hospital system
- » Help citizens afford life-saving prescription drugs

Source: bobbyjindal.com

currently ranks relative to other states—48th in obesity, 49th in infant mortality, 48th in cancer fatalities, 47th in adults with health insurance coverage and 50th in overall health outcomes. These unpleasant facts are absolutely unacceptable. But they create an environment for transformational change.”

Gingrich noted that Jindal’s plan emphasizes preventive and primary care as the best ways to achieve and maintain a healthy population. “He [Jindal] recognizes that a diverse healthcare delivery system is best able to meet the needs of individuals,” said Gingrich. “He therefore favors allowing people to buy the type of insurance coverage that can best meet their own specific needs. Our current system, be it Medicare, Medicaid, or your employer’s plan, largely involves you taking what’s offered regardless of whether it is the ideal plan for you.”

Dupré said that Jindal doesn’t just talk about issues, such as covering the uninsured and providing better quality care, but he also talks about costs. “We don’t hear much about costs from most candidates, but governor-elect Jindal recognizes that money must be used wisely, and that cost is an integral part of every plan.”

Jindal’s plan contains several key elements that most stakeholders support: the use of technology, the recognition that there have to be more effective ways of dealing with fraud and waste and the value of transparency of cost and quality information.

“Also, we like his ideas about relying on the private healthcare system to help the state deliver and finance healthcare in a better way. There’s a lot the private sector can teach government to make healthcare more effective.”

The Playing Field Jindal Has. Some of Jindal’s proposals are similar to those put forth by lawmakers in the last legislative session. They approved SB 1, which requires Medicaid enrollees to have medical homes—private and public clinics or doctors’ offices—where their healthcare needs would be coordinated by primary care providers, then tracked and recorded electronically.

Noting that he can only guess what elements of the bill Jindal might support, Dupré added, “The medical homes concept would be consistent with what we know about Jindal’s belief in healthcare efficiency—more emphasis on outpatient care and coordination of care. That is exactly what the medical home concept is about.”

OUTLOOK: *During this transition period before Jindal’s January swearing in, expect him to meet and seek advice from all major stakeholders in healthcare. He is likely to look at best practices nationwide before he announces any initiatives. He comes to office on a tide of popularity that may enable him to transform the state’s broken healthcare system.* ■

Managed Care Still Taking Bumpy Ride In Ga.

By Jan Shuxteau

No one ever said that bringing managed care to Georgia Medicaid was going to be easy. And it hasn't been.

Nevertheless, Michael Neidorff, Centene Corp. president and CEO, noted that Georgia compares well with other states that have done same thing. "We have seen other states try and bring on a million lives within a quarter or two have really significant problems. So, despite the issues we're facing there and some of these transitional things, I think they've done a pretty good job trying to sort through it," he said during Centene's recent earnings conference call.

Georgia Families, the managed Medicaid program that was launched last summer, has enrolled more than 1 million beneficiaries and taken an estimated \$203 million less from state coffers than traditional fee-for-service Medicaid would have taken.

For that much money, you would expect some pain, and Georgia got some, especially in early days. Stakeholders experienced the typical hassles of a huge transition. The care management organizations—WellCare, Peach State (Centene) and AMERIGROUP—contracted by the state to manage Medicaid had not worked with Georgia providers before. They signed eleventh-hour contracts with hospitals and other providers but some uncomfortable with the contracts. The lateness of the signings made it impossible for the plans to input into computer systems all of the information necessary to process claims files on time. This turned off the taps on cash flow in hospitals and clinics, and bills didn't get paid.

On top of this, patients and providers were unaccustomed to the CMO's pre-authorization requirements. The companies, on the other hand, were unaccustomed to doing without them. Doctors disliked the tedious, time-consuming paperwork. To try to sort this out, the plans waived their typical authorization procedures for 60 days.

Patients got caught up in all sorts of problems (some of which continue) from confusion over where to go for care to treatment delays to problems with authorization.

On the positive side, many administrative problems have

been resolved, and patients are learning the new way of doing things. "Communication is the most important thing," said Kathy Driggers, chief of the managed care division of the Georgia Department of Community Health. "We can't do enough of it with members."

The ER Challenges. But the transition continues to trouble stakeholders. "There are still big challenges. To sum it up, the system is more about managing cost than managing care," said Kevin Bloye, a spokesman for the Georgia Association of Hospitals. "That's what we feared from the beginning."

The association has worked as an intermediary between hospitals and the health plans often during the past year. A major problem between the two groups revolves around the use of and payment for emergency room service.

"Medicaid patients have gone to the ER with varying degrees of illness, but the CMOs will often only pay triage rates—in most cases that's a \$50 check—which is much less than the cost," said Bloye. "There are some incredible examples of cases the CMOs said were not emergencies: a baby with a fever of almost 105, a pregnant woman bleeding profusely in the last trimester."

He explained that ER claims not accepted by the CMOs must go through an appeals process to be reconsidered. On the surface, this seems fair, but in reality it means that hospitals spend hours filing appeals. When the majority of claims are disputed, the hospitals pay increased administrative costs even though the appeals are successful 60 percent of the time.

AMERIGROUP has not been involved in this fight, but has paid ER claims according to the guidelines spelled out in its contract with the state, said Peter Lobred, a spokesman for AMERIGROUP.

"We act proactively managing member care," said Lobred. "We emphasize prevention. Our goal and that of the providers and DCH is to help members live healthier lives."

Mike Cotton, chief operating officer of WellCare, said, "WellCare is not denying claims and is paying 50 percent of claims at triage [rate]."

FINANCIAL PERFORMANCE OF GEORGIA MEDICAID HMOs*

Plan	Revenues	Net Loss	Hospital/Medical Expenses PMPM	Hospital Expenses PMPM	Medical Loss Ratio	Administrative Expense Ratio
AMERIGROUP	\$118.1M	(\$17.2M)	\$108	\$41	0.88	0.20
Peach State Health Care	\$217.0M	(\$7.5M)	\$118	\$36	0.83	0.19
WellCare	\$352.1M	(\$18.3M)	\$134	\$33	0.88	0.20

*Six months ending Dec. 31, 2006.

Source: HealthLeaders-InterStudy

CMOS TARGET ER OVERUSE BY:

- » Calling members after ER visit
- » Network development with urgent care clinics
- » Working with PCPs to expand evening hours
- » Following up with PCPs who routinely send patients to ERs
- » Outreach to high-volume PCPs with unusual practice patterns, such as high pharmacy costs, high ER use

Source: Georgia Department of Community Health

In any event, payment rates continue to be a problem in the eyes of hospitals. “We’re seeing fallout from the ER situation right now,” said Bloye. “More doctors are getting out of Medicaid or limiting how many Medicaid patients they take. Hospitals are stuck. By law, they must treat everyone who comes into an ER even if the health plans don’t pay.”

ER Use Is Still High. State officials know that the hospitals aren’t happy and are seeing a decline in reimbursement, and they want to improve the situation. “After listening and talking with the hospitals, we decided that one improvement performance project the CMOs should undertake is the reduction of inappropriate ER utilization. The project would focus on what can be done to reduce the problem [of overuse] whether it is outreach to members or working with providers.”

The three CMOs are already trying to institute change in ER use among their members. At some high-volume ERs, they station an employee to talk to non emergent patients, making sure members know when to use their PCP rather than the ER. They have arrangements with some hospitals to fax a list of their members who mistakenly show up in the ER. They contact the members and the members’ PCPs to find out why.

The reasons run the gamut. “In some cases, it may be that a PCP closes at 5 p.m. and doesn’t have an answering service,” said Driggers. “It may be a lack of urgent care facilities in a community or simply that patients know there is always a TV, heat and air conditioning in the ER.”

Of course, none of this addresses the disinclination of CMOs to accept many ER claims.

The Plans’ Dilemma. Meanwhile, and not unexpectedly, all three plans reported financial losses in Georgia as of Dec. 31, 2006, when Georgia Families was only six months old. At that time, their losses, according to HealthLeaders-InterStudy, were \$17.3 million for AMERIGROUP, \$7.5 million for Peach State and \$18.3 million for WellCare.

From June 2006 through October 2007, the state paid the CMOs \$2.7 billion, according to Driggers. WellCare covers all six Medicaid regions; AMERIGROUP covers north, east, southeast and Atlanta regions, and Peach State in Atlanta, the central and southwest regions.

In its Oct. 25 earnings report, AMERIGROUP noted that

its Georgia membership is now “relatively stable” at 218,000 members though it is anticipated to drop somewhat in the next quarter because the state’s Medicaid enrollment is also expected to drop. “Variations like this are normal and consistent with what we have seen in other markets in the past,” reported President and CEO Jim Carlson.

In their earnings reports, both AMERIGROUP and Centene noted a possible rate increase in the low single digits in Georgia. They also mentioned improving their medical loss ratio over the 16 months since the launch of the program.

Peach State shook up its leadership team in Georgia after getting fined \$3.7 million this fall by the state for delays in authorizing treatment.

WellCare is apparently in the midst of damage control after the FBI executed a search warrant at its corporate offices in Tampa, Fla., on Oct. 25. The company is continuing its operations and details behind the raid have not been divulged. In a letter to Georgia Health Commissioner Rhonda Medows, Cotton said, “We are cooperating with the authorities. Our number one priority is making sure that our members have access to needed care and services. Our essential services are operational and will remain uninterrupted.”

Keeping Track Of Business. The CMOs have to do what Driggers describes as a “huge amount of reporting” to the state about their operation of Georgia Families. “They submit 58 different regular reports, and the CEO, CFO and COO have to personally attest to the accuracy of the information,” she said. Among other things, the CMOs also do provider site visits and in-company surveys.

The state has completed two audits of Georgia Families and is beginning another. “Early this year, we had a company do an audit on ER payment, reviewing all three CMOs and how they paid ER claims, as well as an audit of prior authorization timeliness, which resulted in the sanction against Peach State,” she said.

The third audit, which is being conducted by a national CPA firm, is about claims payments by each plan. The audit results are not yet available.

In the future, the state will focus more on quality outcomes. “This is important to us and to providers. They’ve told us, ‘You said if we suffered all of this pain, we’d have better health outcomes. Where’s the proof of that?’” said Driggers. “Well, it takes awhile to determine that. We’re refining what the indicators will be to make sure they represent the whole spectrum of members.”

Bloye pointed out that the hospitals hadn’t seen much on the care management side, just the cost side. “From the beginning, the CMOs promised to focus on member outreach and education designed to modify behavior that would ultimately reduce inappropriate use of the emergency room and improve health status. It’s safe to say that more than a year later, that promise remains unfulfilled.”

Who Participates? As of October, Georgia Families had 926,211 members, the majority of whom are children and

mothers. This is about 200,000 less than estimated when the program began.

“There’s been an overall decline in Medicaid enrollment over the last year and a half,” observed Driggers. “The time coincides with the program but has more to do with improvements in the economy—enrollment numbers always decline when financial times are good. We are also doing a better, stricter job of validating income levels and verifying citizenship.”

Georgia Families provides healthcare services to children enrolled in PeachCare for Kids and certain children, men, pregnant women, and women with breast or cervical cancer covered by Medicaid. Children in foster care are not enrolled in Georgia Families. The remainder of Georgia’s Medicaid population includes lower-income and aged, blind and disabled citizens.

Under Georgia Families, patients are allowed to choose a doctor and a health plan. If they fail to choose, they are automatically assigned to a plan by state officials and to a primary care physician by the health plans. When possible, they are assigned to a PCP known to them or a family member. If that doesn’t work, they are assigned a PCP in their geographic proximity.

Each patient’s CMO is responsible for all of his healthcare needs either by direct provision or by referral. The program offers all benefits previously offered to Medicaid members when they were under private fee-for-service plans.

What Are Savings? Georgia Families is expected to reduce high Medicaid costs, while channeling patients into a medical home that will see to their primary and preventive care. DCH estimated last year that Georgia would reduce its Medicaid bill, which was rising by about 14 percent annually, by \$200 million in the fiscal year ending June 30, 2007. The state contracted with all three insurers in mid 2005, awarding them contracts expected to total about \$3 billion annually in a per-member, pre-month fee arrangement.

OUTLOOK: *Expect greater emphasis to be placed on quality of care among Medicaid patients over the next year as data. The state will be better able to judge if patients are receiving the treatment they need. And expect more concern over providers, especially if Grady Hospital—the largest-volume Medicaid hospital in Georgia—cannot pull out of the financial slump that threatens to shut it down.* ■

Higher Premiums, More Uniformity In Part D

By Jan Shuxteau

Though typically brand loyal, Medicare beneficiaries in the Deep South are, nevertheless, likely to switch prescription drug plans in 2008 to avoid rising premiums and to find coverage in the gap period.

Though most premiums for Medicare Part D stand-alone plans will increase by only \$5 to \$8 in Alabama, Georgia and Louisiana, some will show significant increases. For example, Blue Cross and Blue Shield of Georgia's Blue Premium plan will go up by 32 percent from \$53 to \$70, and CIGNA's Signature Rx Plus Complete will go up by 49 percent in Georgia, 53 percent in Alabama and 40 percent in Louisiana.

Only three plans in the three states will show much of a decrease. Alabama's Blues Option 2 will go down \$12 per month, and SilverScript will decrease premiums for two Enhanced plans in Georgia by \$7 to \$8 per month. Two or three other plans in each of the three states showed small decreases—around \$1 each—in their Enhanced plans.

In addition, a list of 2008 Medicare Part D offerings recently made public by the Centers for Medicare & Medicaid Services shows that insurers with gap plans are covering generics only and are limiting the kind of generics they will cover. The industry trend is toward greater uniformity in gap coverage although some plans have bare-bones formularies and others have more robust ones, said Babette Edgar, senior vice president, operations and quality assurance at Gorman Health Group and former director of formulary management at CMS.

The coverage gap is a provision of the Medicare Part D benefit originally devised to keep Medicare drug spending below a target of \$400 billion over a 10-year period. In 2008, the gap will occur when seniors reach \$2,510 in drug costs and will run until they reach \$4,050 in total out-of-pocket expense. At that time, catastrophic coverage will kick in.

In 2008, the third year of Medicare Part D, no plans will offer coverage for all formulary drugs during the gap. Las-Vegas-based Sierra Health, which offered a nationwide all-formulary Enhanced plan in 2007, incurred millions of dollars in losses and announced earlier this year that it will not offer an Enhanced design at all in 2008. Sierra will sell a Basic plan in Alabama, Georgia and Louisiana with premiums of \$45.10, 38.70 and \$42.30, respectively, and no coverage in the gap.

"They [Sierra] got creamed," said Bob Atlas, a senior vice president at Avalere Health. "I think interest has chilled from other plans because of the Sierra experience."

Sierra, which served 44,300 people at the end of the second quarter of this year, was hit by severe adverse selection. Sicker patients who required expensive brand and specialty drugs turned to Sierra to get coverage after Humana Inc. dropped a similar product from the market.

UnitedHealth Group unveiled a new initiative that may up the ante for coverage in gap. The company announced that it will offer mail-order generic drugs free of charge to its Medicare Part D members next year.

Formularies Are A Factor. Susan Segrest, director of the State Health Insurance Assistance Program in Alabama, said that the fact that the carriers aren't covering name-brand medicines during the gap "will be an issue" as seniors try to choose an appropriate PDP for next year.

Nevertheless, seniors will still find a plan that they can change to and save money, said Alan Heumann, Louisiana SHIP director. "We may ask: If you've got to have a drug that's not on the formulary, will you still save money if you move to a plan where that drug is covered?" said Heumann. "The main thing is going to be comparing stand-alone PDPs and Medicare Advantage PDPs."

State Health Insurance Programs exist to help seniors navi-

COMPARISON OF SELECT ENHANCED PDPs IN ALABAMA

Plan	Premium 2007/2008	Annual Deductible 2007/2008	Gap Coverage 2007/2008
UnitedHealthcare	\$45.30/\$24.30	\$0/\$275	No/No
UHC AARP Medicare Rx Enhanced	\$50.60/\$65.80	\$0/\$0	Generics/All preferred generics
BC/BS BlueRx Option II	\$54.50/\$42	\$250/\$0	No/No
BC/BS BlueRx Option III	\$59/\$67.50	\$0/\$0	Generics/All preferred generics
Humana Enhanced	\$26.50/\$30.20	\$0/\$0	No/No
Humana Complete	\$88.40/\$90.20	\$0/\$0	Generics/All preferred generics

Source: Centers for Medicare & Medicaid Services

COMPARISON OF SELECT ENHANCED PDPs IN LOUISIANA

Plan	Premium 2007/2008	Annual Deductible 2007/2008	Gap Coverage 2007/2008
BC/BS RxBlue Basic	\$37.40/\$36.30	\$0/\$200	No/No
Humana Enhanced	\$22.50/\$28.60	\$0/\$0	No/No
Humana Complete	\$80.80/\$84	\$0/\$0	Generics/All generics
SilverScript Complete	\$40/\$48.60	\$0/\$0	Generics/All generics
UnitedHealthcare Extended 2007 Rx Value 2008	\$45.90/\$24.50	\$0/\$275	No/No
UHC AARP Medicare Rx Enhanced	\$51.50/\$66.30	\$0/\$0	Generics/All preferred generics

Source: Centers for Medicare & Medicaid Services

gate the maze of PDPs and select the best plan for their needs. Heumann said that enrollment, which occurs nationwide from Nov. 16-Dec. 31, should be less confusing than in the previous two years because seniors know better what to expect. He added, however, that most Medicare recipients do not know how to use computers. “I’ve heard that the over-65 crowd is supposed to be the fastest growing group of computer users. But I know that way more than half the people we see don’t know how to use them [to compare plans],” he said.

The Bayou State. Comparing plans in Louisiana is going to be particularly important in light of numerous changes. Heumann noted that in 2008 there will be fewer plans with deductibles and less coverage of brand names in the gap. “They are all clumping toward the middle—not a lot of variation in formularies or in benefit designs and not as much coverage in the gap,” explained Heumann. “The insurers are looking for common ground to be able to compete.”

In 2008, there will be 50 stand-alone Part D benefit designs in Louisiana, as compared to 53 in 2007.

AmeriHealth Advantage, NMHC Group Solutions and SAMAScript are leaving the stand-alone market in Louisiana. NMHC and SAMAScript have dropped their Part D plans in every state.

The lowest-cost plan will be SilverScript Basic with a premium of \$14.30 per month. Nine plans will offer premiums for under \$25.

The lowest cost Enhanced plan will be First Health Secure—new this year—which has a monthly premium of \$18.90 and no gap coverage. In 2007, First Health had two other designs: Premier Basic and Select Enhanced—which will continue to be offered.

Seven Enhanced designs, including two from SilverScript, will cover all generics during the gap. More than twice that number offered gap coverage in Louisiana last year. The lowest cost Enhanced plan with gap coverage is SilverScript Plus at \$39.30 per month.

Three insurers lowered premium rates for their Enhanced

plans. Aetna’s Rx Plus and Premier plans will go down by \$1 to \$3, and Coventry’s AdvantraRx Value plan will go down by \$1.50. SilverScript’s Plus and Complete plans will go down by about \$1.

UnitedHealthcare will drop its Extended Enhanced plan next year. In Louisiana, it carried a premium of \$45.90 and no gap coverage in 2007. Next year, UHC will offer United Health Rx Value Enhanced plan in Louisiana with a premium rate of \$25.40 and no gap coverage.

WellCare will drop its Enhanced plan in 2008 nationwide and instead offer two Basic plans. Nationally, WellCare is one of the largest Medicare Part D vendors, with 971,000 members as of June 30, according to the company. CIBC World Markets’ healthcare equities analyst Carl McDonald predicted in October that WellCare will be a national enrollment winner in 2008 because it will be able to continue its dual-eligible plans in California where it stands to gain more than 115,000 enrollees.

In Louisiana, however, WellCare is expected to lose enrollment because it was above the CMS benchmark for dual eligible enrollees in the state and will lose its duals there in 2008.

What’s Going On In Alabama? Segrest said she expects a deluge of seniors in SHIP centers when open enrollment begins. “Seniors will come in with stacks of brochures about stand-alones and about Medicare Advantage plans. They can’t tell the difference between the two since many companies offer both. We’re planning to do a lot of education,” she said.

In 2008, there will be 53 stand-alone Part D benefit designs in Alabama as compared to 57 this year.

The same three insurers that are pulling out of Louisiana—AmeriHealth Advantage, NMHC Group Solutions and SAMAScript—will pull out of Alabama next year.

The lowest cost plan in Alabama will be First Health Secure Enhanced at \$18 a month and no gap coverage.

The lowest cost Enhanced plan with all generic coverage in the gap is MEMBERHEALTH’s Gold plan at \$49.70.

Two other Enhanced plans are \$2 to \$4 less per month,

COMPARISON OF SELECT ENHANCED PDPs IN GEORGIA

Plan	Premium 2007/2008	Annual Deductible 2007/2008	Gap Coverage 2007/2008
Blue MedicareRx Plus	\$41.80/\$43.40	\$0/\$0	No/No
Blue Medicare Rx Premier	\$53/\$68.80	\$0/\$0	Generics/Some generics
Coventry AdvantraRx Premier	\$48.70/\$50.40	\$0/\$0	Generics, preferred brands/ All preferred generics
Humana Enhanced	\$25.40/\$31.60	\$0/\$0	No/No
Humana Complete	\$86.60/\$94.90	\$0/\$0	Generics/All preferred generics
UnitedHealthcare AARP MedicareRx Enhanced	\$48/\$63.10	\$0/\$0	Generics/All preferred generics

Source: Centers for Medicare & Medicaid Services

but they cover only preferred generics. They are the Advantage Allegiance Plan by RxAmerica for \$45 and First Health Select for \$47.60.

Alabama has 10 plans priced less than \$25 per month.

Most carriers raised premium rates for their Enhanced options by less than \$5 a month, but some went considerably higher. In addition to CIGNA Complete, Envision Rx went up 58 percent and Pennsylvania Life Insurance’s Pathway Gold went up 35 percent.

However, a handful of Enhanced plans will cost less: Aetna Medicare Rx Plus reduced its price 20 cents, Blue Cross and Blue Shield of Alabama’s BlueRx Option II went down \$12, Coventry’s AdvantraRx Value plan went down by about \$2.50. Two Enhanced plans stayed the same: Silver Scrip Plus at \$42 and the UnitedHealthcare Enhanced plan at \$45.30.

Georgia Part D. Like those in Alabama and Louisiana, Georgia Medicare recipients will have fewer benefit selections from which to choose in 2008. Fifty-four designs will be offered, as compared to 56 in 2007.

Insurers that will pull out of Georgia are AmeriHealth Advantage, NMHC Group Solutions and SAMAScript.

The lowest cost plan will be First Health Secure Enhanced option, which will have a monthly premium of \$16.60 and no coverage in the gap. The only other plan that will have a monthly premium below \$20 is Aetna’s Rx Essentials for \$18.40.

There will, however, be 11 plans with monthly premiums under \$25 per month.

Six Enhanced plans will cover all generic drugs during the gap, the lowest price of which will be SilverScript Plus with a premium of \$35.30. The next lowest priced will be SilverScript Complete with a premium of \$42.60.

Most carriers raised premium rates for their Enhanced options by \$5 or so though some were higher. Premiums for Blue Cross and Blue Shield of Georgia’s Blue MedicareRx Premium plan will go up by 30 percent from \$53 to almost \$70. Envision Rx Plus Gold will go up 61 percent from about \$61 to about \$98. Pennsylvania Life Insurance’s Prescription Pathway Platinum will go up 32 percent from about \$47 to about \$69.

Three carriers will charge less than last year. For example, SilverScript’s two Enhanced plans will drop \$7 to \$8 in price in 2008. Coventry’s Advantra Rx Value and Aetna’s Rx Plus will go down by a couple of dollars.

Health Net dropped its Orange Option 3 but its Option 2 will be an Enhanced plan in Georgia next year. “We found that it [Option 3] wasn’t particular popular in the marketplace, which actually surprised us,” said Mark El-Tawil, chief senior products officer for Health Net. “We thought that plan would be popular, and it was priced pretty competitively.”

OUTLOOK: Like the rest of the country, the South will see premium prices for Medicare Part D go up slightly on average. Nevertheless, the premiums are still affordable, and beneficiaries can switch to suit themselves. Gap coverage may have some people stumped. They won’t be able to beat the system with a Sierra or a Humana plan that pays it all. ■

Predictive Medicine: Emory Studies Biomarkers

By Jan Shuxteau

Science resembles science fiction at Emory University, where medical researchers are pushing ahead with a project that they think could revolutionize healthcare.

The university began a \$50 million initiative in predictive medicine, studying factors in healthy people that could determine what disease will eventually overtake them. The idea for the project came out of a series of faculty discussions over the last four years that culminated in the recognition that the healthcare system focused more on disease than on health.

Then came the realization that they had the tools to turn that picture around. “Because of the tremendous advances in science and technology, it is possible to measure normal functions in the human body in ways that haven’t been possible before,” said Kenneth Brigham, M.D., who leads the initiative. “And there will be even more opportunities in the future—this is just the beginning.”

What Will Happen? Emory researchers at the Center for Health Discovery and Well Being, a unit of the Predictive Health Initiative, soon will begin screening healthy test subjects (13,000 Emory employees) for genetic and biologic clues to future illness. They will work with healthy individuals in order to learn more about the internal mechanisms that control a disease. The screenings will include the accumulation of each subject’s medical history, family medical history, health data (such as height, weight, bone density, vascular health and percent of body fat) and analytical blood tests.

Most of the blood tests—50 in all—will provide routine information, but some will provide much more. They are the so-called biomarkers that will provide what Brigham describes as “broadly predictive” information. These are measures of inflammation, immune function, oxidative stress and regenerative potential—circulating stem cells in the blood.

“These four things will be very robust in predicting health,” said Brigham. “One purpose [of this initiative] is to discover biomarkers that define health and predict maintenance of health or ‘unhealth,’ which is not disease but very early deviation from health, and provide clues of intervention that can be employed to restore people to their healthy state long before any disease actually develops.”

Steps To Take. Emory researchers say that individuals, knowing that they have or are developing a likelihood of contracting a certain disease, will also know to make lifestyle changes and find medication and treatments to keep themselves healthy. Many of these medications and treatments have yet to be developed and will appear as the technology reveals what the best biomarkers are and what interventions will change the inherent risk revealed by that biomarker.

GOALS OF EMORY’S PREDICTIVE HEALTH INITIATIVE

- » Define health, identifying it in terms of biologic, social and mental components.
- » Discover biomarkers that predict health and provide clues for intervention.
- » Create a demonstration project of a clinical laboratory for evaluating and validating both predictors and interventions to maintain health.

Source: Kenneth Brigham, M.D.

Doctors have long had rudimentary methods for determining disease risk. For example, routine tests can predict a likelihood of heart disease. But strides in biology and genetics are now allowing doctors to calculate what goes on in the human body more precisely than ever before. Screenings can lock on mutated or missing genes. They can detect abnormalities in the body’s chemistry that are forerunners of disease. Diabetics, for example, can begin developing diabetes 10 years before symptoms appear, at which point their kidneys are already affected and require costly treatment.

The researchers believe predictive medicine will cut runaway healthcare expense, enabling patients to be treated years before they reach a painful and costly stage of chronic or catastrophic illness.

Questions To Face. But predictive medicine will present new ethical dilemmas and enormous change. “I think it will have a tremendous impact on all aspects of the system including physicians, hospitals, the pharmaceutical and insurance industries and individuals,” said Brigham. “In the long run, it will be a social and economic positive. A predictive health system will change where resources go and what kinds of metrics are used to develop business models. It will require a big culture change across the board.”

He anticipates new interventions keeping pace with discoveries in predictive medicine. “Identifying a health profile and following it over time will provide data as well as rationale for intervening in new ways that keep people from getting sick,” he explained.

Patricia Ketsche, associate professor at Georgia State University’s Institute of Health Administration, said, “From a personal health standpoint, I think people would want this [predictive health] information as long as there is something they can do about it. If there’s not a thing in the world they can do to make things better, then I’m not so sure.”

She noted that there would be a host of ethical problems about who should have access to an individual’s predictive information and what they could do with that information.

“Privacy is tricky in this context because when you sign up for insurance you consent to allow insurers to look at your records, and you’re waiving your right to privacy,” agreed John Lantos, M.D., who holds the John D. Frances chair in bioethics at the Center for Practical Bioethics. “I think the more relevant issue would be discrimination. It would be illegal to discriminate against people based on genetic information.”

He added that the situation could be awkward from an insurance company’s perspective if widespread testing showed that virtually everybody had bad genes of one kind or another. “If insurance companies tried to exclude people because of a bad gene, they could put themselves out of business,” remarked Lantos.

“I don’t think my industry is ready to make that kind of colossal mistake—to use this as a tool to exclude people,” said Kirk McGhee, president of the Georgia Health Plan Association. “We want to cover people. That’s how we make money.”

He added that most states have a prohibition about using DNA information for underwriting purposes.

“The reality is that the same fire that burns you can also be used to warm you. Information that could be used to exclude people will instead be used to keep people healthier,” said McGhee.

While researchers develop biomarkers and track disease, they will also come up with better medicines and disease management. Pre-existing conditions might even become a thing of the past, McGhee theorized. “We want to cover people—more of them—and do it more effectively,” said McGhee. “We know two things that will save us as an industry: getting 90 percent of people covered and keeping them healthy.”

Responsibility. Brigham noted that the initiative will accumulate an enormous amount of information about people and their health. “It is absolutely essential to maintain

confidentiality,” he said. “We must prevent this information from being used adversely.”

To ensure that this happens, researchers are working with information technology experts to design databases that are airtight. “Everything revolves around confidentiality. What happens to the information? Who has it? Where is it stored? It’s really the information that is at the center of the ethical factor,” said Brigham.

The Cost Of This. While the university is bearing the cost of the initial research screenings, individuals would eventually bear the cost of their own predictive screenings—from \$5,000 to \$7,000 per person, according to Brigham. “We envision that over time we will learn what things have the most predictive value and create a more streamlined screening process—the retail version, which would be more cost effective.”

Meanwhile, he would like to see insurance companies take a role someday, providing coverage for predictive screening. “That’s what we need to happen,” he said.

McGhee considered, “We might be able to pay for this. It would be a lot less expensive for insurers to pay for this than for treatment for a catastrophic disease. Plus, we could continue to insure these customers for a long time and keep them healthy.”

Lantos noted, “It’s a question of whether this ends up being medically necessary or just some sort of weird item. Part of it would depend on if the predictions were right. It will take awhile before we figure out if the tests are useful.”

OUTLOOK: *The ability to think outside the box and come up with a different paradigm for healthcare gives an optimistic view of the future. Why not try to unlock the secrets of disease and conquer those that can be conquered long before they destroy a life? U.S. healthcare needs to move from its traditional focus and keep an open mind on innovative models.* ■

Federal Workers Will See Small Premium Hikes

By Jan Shuxteau

For the second consecutive year, federal employees will see their health insurance premiums increase by an average of only about 2 percent for the upcoming year, reported the U.S. Office of Personnel Management. In contrast, private-sector employees can expect to pay an extra 6 percent in 2008, according to a survey by the Kaiser Family Foundation.

“OPM staff work aggressively with health insurance plans to hold down premium costs for federal employees, retirees and dependents, while at the same time negotiating for a comprehensive set of benefits,” said Mike Orenstein, a spokesman for OPM.

Reserve funds were also tapped to keep costs down. An FEHBP statute requires experience-rated carriers to put a small percentage of their total premiums into a reserve fund that can be used to offset fluctuations in healthcare costs. “OPM routinely uses the reserves to adjust premium increases from year to year,” Orenstein added.

Without using reserves, the OPM estimated federal employees would have paid an average of three percentage points more for their premiums this year—still less than the private sector.

“Because the reserves are replenished yearly, the OPM has the flexibility to use these funds to balance premium growth in the future,” said Orenstein.

By law, the federal government pays on average 72 percent of the premium cost for enrollees.

Federal benefits open-enrollment season is Nov. 12-Dec. 10 government wide.

Changes For 2008. The FEHBP will offer 283 health plan choices in 2008, only one less than this year. Three HMOs were added, as well as 10 plans with low options.

“Fourteen plans are terminating at the end of 2007, which means about 29,000 enrollees will need to select new health plans for 2008,” reported Orenstein. “There will be 32 high-deductible health plan choices next year, an increase from the 29 available today. More than 9,000 people are currently enrolled in high-deductible health plans, and about 25,000 are enrolled in three additional consumer-driven health plans.”

He noted that the Blue Cross Blue Shield Service Benefit Plan Basic Option is offering HDHP pilot plans in four areas: Tennessee, Ohio, Minnesota and several counties in Kansas/Missouri.

In addition, several plans have added or enhanced hearing benefits for dependent children. “Hearing loss is one of the most common congenital birth defects in the United States. OPM’s annual request for on benefits and rates urged our plans to review their current hearing benefits to ensure that enrollees, especially newborns and children, have appropriate coverage,” said Orenstein. “As a result, many more children

DOING BUSINESS WITH THE FEHBP

The Office of Personnel Management has urged FEHB carriers to work toward the following short-term objectives:

1. Enhance educational efforts to make plan members more aware of how HIT can help improve quality and control costs over the long term;
2. Offer personal health records to enrollees based on their claims, medications and medical history information currently available in carrier healthcare systems;
3. Encourage pharmacy benefit managers to provide incentives for ePrescribing;
4. Link disease management programs to HIT; and,
5. Ensure compliance with federal requirements to protect the privacy of individually identifiable health information.

Source: U.S. Office of Personnel Management

will now have access to this benefit, including hearing aids, under the FEHBP in 2008.”

The FEHBP’s largest health plan, the Blue Cross and Blue Shield Service Benefit Plan, has also changed its pharmacy benefit manager to Caremark for retail service and Medco Health Solutions for mail order in 2008.

In The Deep South. All eligible federal employees and retirees have a choice of at least eight fee-for-service plans that offer benefits nationwide. In many areas, the employees also have the option to enroll in HMOs.

Aetna HealthFund is the only FEHBP carrier in Alabama. The insurer also has FEHBP plans in Georgia and Louisiana. In all three states, Aetna offers a CDHP and an HDHP with a monthly premium of \$82.06 for a single CDHP and \$67 for a single HDHP. For a family, the monthly premium for CDHP is \$188.75 and \$146.72 for an HDHP.

In Georgia, Humana CoverageFirst, Kaiser Foundation Health Plan and UnitedHealthcare also provide health plans to the state’s federal employees, retirees and dependents. The average cost of a single plan for an employee is \$85 with a range of premium prices from \$64.55 to \$105.78. The average family plan premium is \$195.70 with a range of costs from \$146.72 to \$260.98.

Humana, Coventry Health Care, Vantage Health Plan and UnitedHealthcare also have FEHBP plans in Louisiana. The average cost of a single plan premium for an employee in the Bayou State is \$120.29 with a range of premium prices from \$67 to \$271.51. The average family plan costs the employee \$263.42. The range of premium prices is from \$146.72 to a high of \$647.04.

Established in 1960 and now almost 8 million members

PREMIUM RATES FOR FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM FOR EMPLOYEE-ONLY COVERAGE

Plan	Total Monthly Premium	Government Pays	Employee Pays	Change In Employee Payment
Aetna CDHP (Alabama)	\$328.25	\$246.19	\$82.06	\$10.95
Aetna CDHP (Georgia)	\$328.25	\$246.19	\$82.06	\$10.95
Humana CDHP (Georgia)	\$258.20	\$193.65	\$64.55	\$5.34
Kaiser Standard (Georgia)	\$293.17	\$219.88	\$73.29	\$2.28
UnitedHealthcare HDHP (Georgia)	\$358.19	\$268.64	\$89.55	\$21.24
Aetna CDHP (Louisiana)	\$328.25	\$246.19	\$82.06	\$10.95
Coventry Standard (Louisiana)	\$401.48	\$301.11	\$100.37	\$14.42
Humana CDHP (Louisiana)	\$288.60	\$216.45	\$72.15	\$5.97
UnitedHealthcare HDHP (Louisiana)	\$358.19	\$268.64	\$89.55	\$21.24
Vantage Standard (Louisiana)	\$360.68	\$270.65	\$90.21	N/A

Source: U.S. Office of Personnel Management

strong, the Federal Employees Health Benefits Program is the largest employer-based health benefits program in the country. It annually provides \$34 billion in healthcare benefits.

It earns high marks from participants; nearly 85 percent of eligible federal employees are enrolled in the program. When federally employed spouses who are covered as family members are also included, that statistic rises to 90 percent. An estimated 75 percent of eligible federal retirees are also enrolled.

What It Does. The OPM does not act as an insurer. Instead, it sponsors and administers the FEHB program. Benefits are provided through contracts with insurance companies, which compete with one another for enrollment.

The OPM also offers federal consumers supplementary insurance benefits: group rate coverage for dental and vision benefits and long-term care coverage. In addition, the OPM

offers what it calls the FSAFEDS program, allowing employees to use pre-tax dollars and defray the cost of qualifying healthcare expenses not covered by insurance.

OUTLOOK: *Great benefits have always been cited as a reason to be employed by the federal government. The benefits program offers a broad selection of health plans from which employees can choose, and it keeps premiums low. What's not to like? Well, there's always something for somebody. In this case, it's the fact that employees and annuitants pay the full cost of the insurance premiums for dental and vision supplements (though at group rates) with no premium contribution from the government—unlike the FEHBP which pays on average 72 percent of the premiums.* ■

Humana Launches New Individual Plans In Ga.

By Rick Byrne and Jan Shuxteau

Humana has introduced a new line of individual health insurance plans in 15 states, including Georgia, that is an expansion of its HumanaOne portfolio now sold in a broader footprint.

The more carefully segmented benefits packages in the three new products do away with the concept of the one-size-fits-all individual health plan, instead tailoring the benefits in ways that meet the needs of the various customers that shop for such plans. Individual plan shoppers may be self-employed entrepreneurs, small business employees, part-time workers, students or pre-Medicare retirees—essentially anyone who doesn't get their coverage from an employer.

Humana leaders felt the time was right to market more heavily to the individual buyer. They saw the potential market for individual products at 17.3 million nationwide. Humana already serves 225,000 individuals in 26 states. The individual market is expected to grow by 5 percent to 8 percent annually over the next five years.

Three Names, Many Permutations. Each of the three products has further options for customization depending on the budget, lifestyle and personal preference of the buyer. Called HumanaOne Portrait, HumanaOne Autograph, and monogram from HumanaOne, these packages offer three in-network coinsurance levels and 17 annual deductible choices, as well as optional benefits such as dental insurance, life insurance, and supplemental accident coverage.

HumanaOne Portrait targets the security-minded buyer who wants benefits like those provided by big employers. They tend to be older and have recently transitioned out of a group plan, having gone into business for themselves or taken an early retirement or buyout.

HumanaOne Autograph aims at the customer seeking more flexibility in benefits to fit their overall financial strategy. Three of the five plans under the Autograph banner are qualified for a health savings account.

Finally, monogram by HumanaOne has been marketed toward the young invincibles. It offers catastrophic coverage with high deductibles and premiums as low as \$30 a month.

Deductibles for the full line of new plans range from \$1,000 to \$7,500 for single coverage and from \$2,000 to \$15,000 for family coverage. Humana guarantees the premium on the HumanaOne line for one full year from the start of coverage, as long as the insured maintains the same benefit level and features, and remains in the same area.

Purchasers will have access to Humana's nationwide network of doctors and hospitals, and if they move, they can take their coverage with them. Those who work or travel away from home can receive in-network benefits by seeing any one of the 400,000 Humana-contracted doctors, hospitals

HUMANA ENROLLMENT TRENDS IN GEORGIA

Date	HMO	PPO
Jan. 1, 2004	17,820	33,375
Jan. 1, 2005	18,391	27,800
Jan. 1, 2006	22,528	30,839
Jan. 1, 2007	27,105	24,600

Source: HealthLeaders-InterStudy

and other healthcare providers across the country. Members also have access to Humana's full suite of online tools and resources, allowing them to check claims status, medical expenses or compare hospital, doctor and prescription costs among other things.

Catching On In Georgia. The pricing of Humana products has caught the interest of Georgia consumers.

"Humana products are really starting to move in Georgia, and it's mostly due to their network. They have a point-of-service network, instead of a PPO, and that helps pricing come out better," said Rick Bailey, president of the Georgia Health Underwriters Association and owner of Rick Bailey & Company in Woodstock, Ga. "Their network acts more like an HMO model. Discounts may be deeper, and that flows over to make premiums lower."

Bailey noted that the individual and small-group markets are very competitive in Georgia, so Humana is working hard to stay in the game. "With the recent changes they've made, they're becoming a player here. They've done a good job of creating a comparison sheet for sellers. This seems to be new ground for them," he explained.

In addition to that, the company uses a tele-application process that Bailey says is a big timesaver. Would-be customers get an information sheet with the agent's name and Humana's phone number. The prospective client calls the underwriting department and can often get an approval in a few hours. "The application process usually takes two weeks—and four is more likely—so to cut it down to two hours is really something," said Bailey.

The company also gains a competitive edge since it is one of very few insurers in the Georgia market that use the tele-application process.

Humana says it is developing a tool called a Plan Pointer that helps agents zero in on the one or two plans that best fit clients' needs.

Small Business Plan With A Hook. Humana's other new product launch this summer may call to mind images of Crocodile Dundee, but the "No Worry" package isn't

aimed at rugged individualists from the Australian Outback. Instead, it's a small-business program aimed at giving employers in the 51-to-99-employee segment certainty about premium renewal rates.

Rolling out in 17 states, including Georgia and Louisiana, the No Worry package will offer at each employer a suite of health plans of varying health plan designs, built off the company's point-of-service provider network, much like the company's SmartSuite. One of the selections will be Humana's CoverageFirst and a high-deductible health plan compatible with a health savings account, as well as the mainstream Humana PPO, with the company's ChoiceCare and Humana Preferred networks available. All other PPO products have been discontinued for the 2008 plan year.

The selling hook in No Worry is predictable, single-digit rate increases for three years. Humana guarantees the annual premium increase will not exceed 6 percent for the first two years, and if the employer gets 90 percent of members to take a health risk assessment, the increase in the second and third years will be held to 4.5 percent. The catch is that the employer and workers will give themselves over to Humana's medical management specialists and be asked to engage more fully in their healthcare decisions. Specifically, 75 percent of the employees must give their e-mail addresses and phone numbers, allowing Humana to identify members who might benefit from intervention offered for conditions such as diabetes and heart disease. ■

Aetna's ValuePick Targets Small Businesses

By Jan Shuxteau

Aetna is offering a set of new products to a niche of Georgia's uninsured markets: entrepreneurs with start-up businesses and previously uninsured small business owners.

The plans, called ValuePick, are priced to allow the businesses to provide coverage for their employees.

"Small businesses face a constant challenge to find health insurance for their workers," said Cynthia Follmer, head of Aetna's Georgia markets. "Probably the three areas that most concern businesses, especially newly formed businesses, are cost, contribution and participation. All insurers require a certain minimum level of participation in any plan for it to be considered for coverage. We know it can be challenging for employers to get employees to choose a certain plan. Also, there is the matter of employer contribution. How much can an employer afford to contribute to employee insurance? With ValuePick we've tried to address these three challenges."

She noted that the plan required "minimum participation," of at least four participants—very small by industry standards—and the lowest possible employer contribution. Reduced participation and employer contributions are available to newly formed and previously uninsured small businesses.

ValuePick offers three affordable plan designs with coverage. The plans are focused on preventive care with affordable

VALUEPICK DESIGN OPTIONS

- » Point-of-service Plan with out-of-network and pharma coverage
- » An HMO with pharma coverage
- » A high-deductible, HSA compatible plan

Source: Aetna

premiums in exchange for higher out of pocket costs for non-preventive care services.

"I commend Aetna for proactively providing healthcare solutions for small businesses and minority communities," Michael T. Hill, president and CEO of the Atlanta Metropolitan Black Chamber of Commerce, said in a release. "We look forward to working with Aetna and building a lasting relationship."

ValuePick's designs include an HMO with out-of-network benefits, a point-of-service plan with no referral required and a qualified high deductible health plan that can be partnered with a health savings account. All of the designs have higher deductibles than typical plans and a lower lifetime maximum benefit. Depending on the size of the employer, all three plans can be offered.

ValuePick covers and encourages preventive care by waiving the deductible for preventive care services. "We want people to go ahead—without hesitating over cost—and get the screenings, vaccinations and other preventive care they need," said Follmer. The plans also include a pharmacy benefit for generic drugs with no deductible.

They will be marketed through insurance agents and brokers in the Georgia market.

"The pricing on the ValuePick plans allows companies to offer health benefits that before had no viable option, due

AETNA COVERAGE IN GEORGIA

- » Covers almost 500,000 in Atlanta area
- » Network includes 151 hospitals
- » 4,229 primary care physicians
- » 8,416 specialists

Source: Aetna

to the high cost of health insurance,” said agent Kevin W. Smith, of Atlanta’s KSA Insurance Agency, in a release. “A company is always going to need a group solution to attract and retain employees. The ValuePick plans help the agent meet the needs of the small-group market. I applaud what Aetna is doing to cover some of the uninsured population.”

More than 1 million Georgia residents lack health insurance. In recent years, Aetna has introduced plans aimed

at expanding access to various segments of the uninsured population. The Chickering Group, acquired by Aetna in 2003, provides affordable coverage for students. Strategic Resource Company, acquired in 2005, provides coverage for hourly and part-time workers who otherwise might not find affordable coverage. And Georgia is one of 24 states in which Aetna has begun offering individual plans. ■

Ga., Ala. And La. Health Plan Briefs

By Jan Shuxteau

Care Improvement Plus Offers SNPs In Ga.

The Centers for Medicare & Medicaid Services has given Care Improvement Plus a contract to offer its chronic condition special needs plan in 2008 to residents of Georgia, as well as Arkansas, Maryland, Missouri, South Carolina, and Texas. Care Improvement Plus focuses exclusively on the healthcare needs of chronically ill Medicare beneficiaries living with diabetes, heart failure, chronic obstructive pulmonary disease and/or end-stage renal disease.

To date, the plan has enrolled more than 73,000 members, making it the largest chronic-care SNP in the country.

Each plan member is assigned a Care Improvement Plus care team made up of a local healthcare manager, local field nurse and telephone coach nurse, all of whom work closely with the beneficiary’s physicians to coordinate services and help provide optimal care.

Louisiana Blue Cross Offers Portable Personal Health Record

Blue Cross and Blue Shield of Louisiana is giving many of its customers free access to its new personal health record service, where they can store and organize important health information in a secure online record that will remain accessible to them even if they leave Blue Cross.

The personal health record is the latest addition to a variety of online health tools offered by the insurer. For example, its AccessBlue is a secure, self-service Web portal through which customers can view a payer-based health record based on Blue Cross claims data. They can also review the status of current claims, order replacement ID cards and handle many other routine requests. ■

People In The News

Please send announcements to Jan Shuxteau at jshuxteau@healthleaders-interstudy.com.
Announcements may also be faxed to 615-385-4979.



K.A. Mahmood

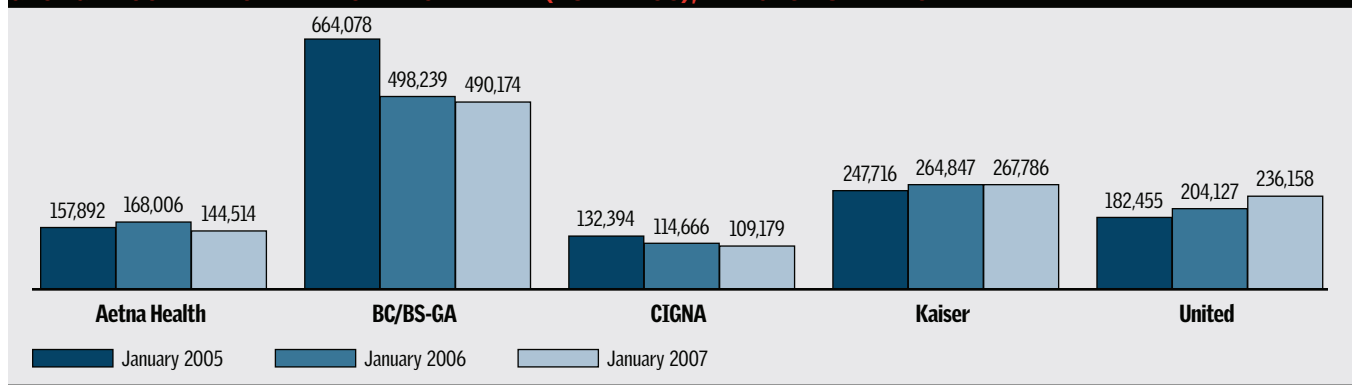
Centene Corp. named **Michael Cadger** as president and CEO of its Georgia subsidiary, Peach State Health Plan. Cadger reports to **Christopher Bowers**, senior vice president, health plan business Unit for Centene, and will be based in the Peach State corporate office in Smyrna, Georgia. Cadger has more than 30 years of relevant experience in the health and managed care industry. He was formerly president of Pinnacle Health Care Management.

Humana promoted **Robert Hitchcock** to vice president of Medicare market operations for the Western division in Chicago. Hitchcock had served as president of Medicare operations for the North region.

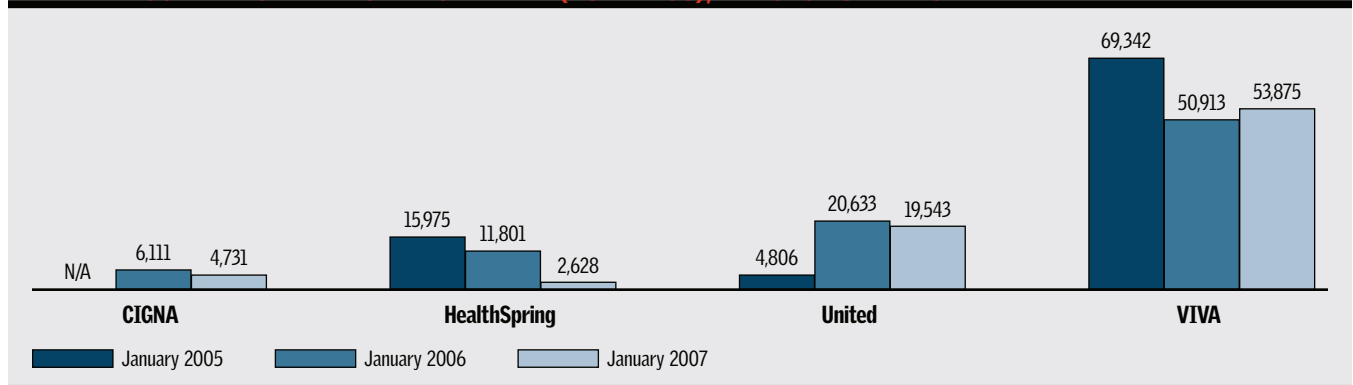
HealthMarkets recently named **K. Alec Mahmood** as its senior vice president of budget, planning and analysis. Previously, Mahmood was chief operating officer and chief financial officer of the Medicaid division and the Medicare special needs plan division of Coventry Health Care Inc.

AMERIGROUP Corp. has named **James B. Carlson** president and CEO and promoted **Richard C. Zoretic** to chief operating officer. Carlson replaces **Jeffrey L. McWaters**, the company founder, who will remain chairman of the board of directors. Carlson had served as COO and will continue to have six executive vice presidents reporting to him, along with Zoretic and Chief Financial Officer **James W. Truess**. Zoretic joined AMERIGROUP four years ago, and served most recently as executive vice president of health plan operations. ■

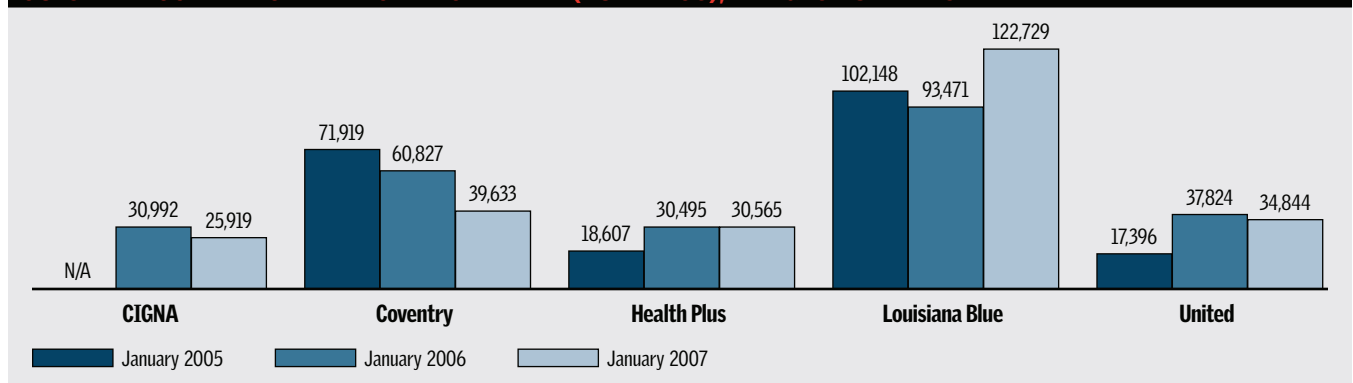
GEORGIA COMMERCIAL HMO ENROLLMENT (PURE+POS), LARGEST 5 PLANS



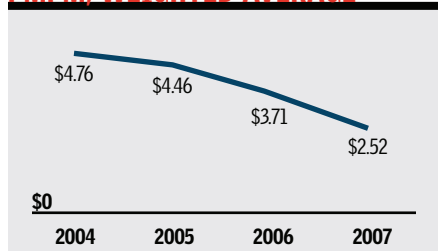
ALABAMA COMMERCIAL HMO ENROLLMENT (PURE+POS), LARGEST 5 PLANS



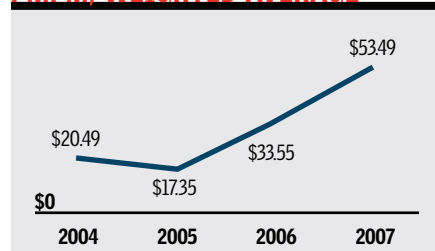
LOUISIANA COMMERCIAL HMO ENROLLMENT (PURE+POS), LARGEST 5 PLANS



GEORGIA HMOs' NET INCOME PMPM, WEIGHTED AVERAGE



ALABAMA HMOs' NET INCOME PMPM, WEIGHTED AVERAGE



LOUISIANA HMOs' NET INCOME PMPM, WEIGHTED AVERAGE

