

HEALTH PLAN WEEK

Timely Business, Financial and Regulatory News of the Health Insurance Industry

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Managing Editor

Steve Davis

Contributing Editor

Jill Brown

Associate Editor

Chris Meehan

Executive Editor

James Gutman

United's Vast New Web Portal Could Prompt Other Plans to Launch Online Tools, Services

UnitedHealth Group on Dec. 1 became the first health plan to fully launch itself into the increasingly crowded field of online health content, personal health records (PHRs) and e-commerce. That same day, Blue Cross Blue Shield of Massachusetts said a new partnership with Google Health would allow its members to import claims-based health information into a PHR. Last month, Aetna Inc. said it would give members access to Microsoft Corp.'s HealthVault PHR (*HPW 10/27/08, p. 8*).

The announcements show a trend among health plans to capitalize on a population that increasingly relies on the Internet for health information, and an expectation that consumers will want to store their health data electronically. A growing number of health plans is investing in "next generation" health portals that offer health management tools, such as health risk assessments (HRAs) and health activity diaries, says Michael Solomon, affiliated consultant at Point-of-Care Partners, a Florida-based firm that specializes in e-prescribing and electronic health records (EHRs). And online health-management features will become increasingly important for insurers as employers look for ways to keep their employees healthy and productive through wellness and chronic-care management programs, he adds.

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Value-Based Strategy Unites Health Plans, Employers to Develop Return on Investment

Taking the concept of value-based benefit design beyond its roots in pharmacy benefits management, health plans and employers are exploring a new initiative to create a replicable model — including data-driven tools and resources — to create strategies that focus on improving the health of employees.

Uniting employers and health plans is a new understanding that value-based benefit design is an integrated strategy rather than an isolated benefits structure. Meredith Baratz, vice president of market solutions at UnitedHealth Group, tells *HPW* that while the term "value-based benefits" has been used differently by different groups, a consensus on the term's definition is beginning to emerge. While large employers are in the vanguard of the movement, Baratz says United is "seeing a level of serious interest among brokers representing smaller employers and even from union groups."

A new Missouri-based group, the Kansas City Collaborative, is working to educate employers and health plans about the value of aligning incentives to achieve certain behavior changes, says William Bruning, president and CEO of the Mid-America Coalition on Health Care (MACHC). The employer group also is working to "remove common barriers that prevent many employees from accessing high-quality, cost-effective care and other services." It will do this, Bruning says, by developing tangible, actionable definitions of 'value,' including a broader understanding of all of the returns an employer can realize across all its health care investments.

The result, according to Bruning, will be a comprehensive return-on-investment strategy that assesses employee health risk, demonstrates the outcomes of evidence-

based interventions, and supports the business case for focused, value-based interventions." The two-year pilot, spearheaded by MACHC in collaboration with Pfizer Inc., includes 17 employers as well as all regional health care stakeholders, including hospitals and health insurers. The median size of participating employers is about 4,000 employees.

Blue Cross and Blue Shield of Kansas City, a member of the collaborative, sees the initiative as a way for employers and health plans to learn from each other, especially when it comes to data integration and information sharing. David Gentile, executive vice president and chief member services and subsidiary officer, tells *HPW* that the insurer will be participating in the pilot with its own employee group. Employees of the Blues plan will be able to participate in the company's wellness program, which includes on-site health screening, health risk assessments and wellness classes, he says.

"As one of Kansas City's largest employers, even our organization can benefit from the learning process of how other employers are tackling benefit management in their companies and the successes they have achieved."

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Baratz defines "value-based" as an integrated benefits strategy that inspires healthy behavior and the achievement of specific health goals. For the Kansas City Blues plan, "it's a holistic approach that targets areas that will have the most value across large segments and within employers based on their risk structure," says Gentile.

Value-Based Strategies Are Data-Driven

Also uniting employers and health plans is recognition that the strategy is driven by data from external vendors, including health plans, as well as by the employer itself. *Among data categories being addressed by the collaborative:* employee demographics, benefit design, health risk assessment results, health biometric screening results, disease management interventions, claims data, information from employee assistance programs (EAPs), and data on employee satisfaction, absences, productivity and workers' compensation. "This is the data employers need to integrate into a common set so they can understand the employees' health risks, stratify their employee population, and see the real costs of employee health," Bruning says.

"When employers look only at their direct claims costs, they're ignoring the real return on their health care dollar investment," says Bruning. "They know how much they've invested in health care, but they see only what they're really exposed to in terms of direct medical costs." Bruning cites depression in the workplace as a prime example of this. According to MACHC data, depression is second on the list of top 10 medical conditions as measured by annual medical, drug and productivity costs per 1,000 full-time equivalents (FTEs) for all companies. "It also trends as the number one, two or three drug spend for many employers," Bruning says. "But across the board it's the least diagnosed workplace health problem. Employers don't address it because they're looking only at their direct health care spending. They don't see the other data."

Employers routinely receive data from six or seven vendors, including health plans, disease management companies, EAPs and other sources. But Bruning says the data from each vendor typically come in a unique format that prevents it from being integrated into a master data set.

So during the first phase of the pilot, the collaborative will work with vendors, including the Kansas City Blues plan, to address the need for common data elements. "We convened our first meeting with vendors on Nov. 19 to discuss the importance of being able to integrate data from multiple vendors and explain how this can be done," Bruning says. "No employers were present, so we could have an open and candid discussion."

According to Bruning, the goal for this first phase is to create a template for employers so they can more directly engage their health plans, disease management companies and other vendors and work with them to integrate their data. "We call this "supply chain integration," he says.

During phase two, the coalition will work with its employer members to integrate the internal data they generate through their human resources, risk management and other departments. Bruning notes that in large companies, these data tend to reside in "silos." The goal, he explains, "is to find out how employers can break down these silos, integrate their own data and then add it to the vendor data." Ironically, employers say this could be more difficult than tackling the vendor-data issue. But once this is done, Bruning says, employers can begin to measure the returns from all their health-related programs and services, not just benefit design.

The initiative also is focusing on getting employers of all sizes, but especially smaller employers, to look at all the time and money they now invest in employee health and wellness, view their investments as value-based strategies, and then evaluate them as they would value any investment, Bruning says.

Contact Bruning at bbruning@machc.org, Sue Johnson for Gentile at sue.johnson@bcbskc.com and Daryl Richard for Baratz at daryl_p_richard@uhc.com. ♦

Government Business Will Offset Commercial Declines, United Says

Several factors, including large employers that didn't renew their contracts for 2009, will lead to an enrollment decline of between 1 million and 1.5 million commercial members in 2009, UnitedHealth Group said Dec. 2 at its annual Investor Day meeting in New York City. The forecast includes an expected drop of between 450,000 and 800,000 in its more lucrative full-risk plans. As of Sept. 30, United had 14.3 million members in its risk-based business and 16 million in its self-funded business.

The anticipated drop in membership on the commercial side, the company told investors, will be partially offset by an estimated increase of between 550,000 and 700,000 new members in United's government business, including Medicare Advantage, where the company expects to add as many as 135,000 members in 2009. United executives also told investors that they expect net income of between \$3.4 billion and \$3.7 billion (\$2.90 to \$3.15 per share) in 2009. For full-year 2008, the company projects net income of \$3.7 billion (\$2.95 to \$2.98 per share).

Equities analysts agreed that the enrollment news was slightly worse than anticipated. In his note to investors, Thomas Carroll, an equities analyst at Stifel

Plan Stock Prices Continue to Slide

While health plan stock prices declined in November, the drop was more modest than in October. Four health plans, Humana Inc., Triple-S Management Corp., Molina Healthcare, Inc. and Universal American Corp. all had slight stock price gains in November versus the previous month. For the year, stock prices among commercial carriers are down 67.1%. Health Net, Inc.'s stock price closed at \$9.01 on Nov. 28 — down more than 80% from the price at the end of 2007. CIGNA Corp.'s stock price dropped 77.5% during the same period.

November Health Plan Stock Performance

	Closing Stock Price on 11/28/08	2008 YTD Gain (Loss)	November Gain (Loss)	2008 P/E Ratio*
Commercial				
Aetna Inc.	\$21.82	(62.2%)	(12.3%)	5.5x
CIGNA Corp.	\$12.11	(77.5%)	(25.7%)	3.5x
Coventry Health Care, Inc.	\$12.47	(79.0%)	(5.5%)	4.1x
Health Net, Inc.	\$9.01	(81.3%)	(30.0%)	4.8x
Triple-S Management Corp.	\$10.90	(46.1%)	6.8%	6.1x
UnitedHealth Group	\$21.01	(63.9%)	(11.5%)	7.1x
WellPoint, Inc.	\$35.60	(59.4%)	(8.4%)	6.5x
Commercial Mean		(67.1%)	(12.4%)	5.4x
Medicare				
Humana Inc.	\$30.23	(59.9%)	2.2%	7.0x
HealthSpring, Inc.	\$14.59	(23.4%)	(11.7%)	6.8x
Medicare Mean		(41.6%)	(4.8%)	6.9x
Medicaid				
AMERIGROUP Corp.	\$24.56	(32.6%)	(1.8%)	9.4x
Centene Corp.	\$18.50	(32.6%)	(1.8%)	9.5x
Molina Healthcare, Inc.	\$23.69	(38.8%)	6.4%	10.4x
WellCare Health Plans, Inc.	\$8.96	(78.9%)	(62.9%)	1.8x
Medicaid Mean		(45.7%)	(15.0%)	7.8x
Specialty				
Magellan Health Services, Inc.	\$32.85	(29.6%)	(11.1%)	16.0x
Other				
Assurant, Inc.	\$21.77	(67.5%)	(14.6%)	4.4x
Universal American Corp.	\$9.94	(61.2%)	12.3%	3.8x
Industry Mean		(55.9%)	(10.6%)	6.8x
Standard & Poor's 500 Index	896.24	(39.0%)	(7.5%)	9.5x
Morgan Stanley Healthcare Payor Index	833.45	(60.8%)	(12.0%)	N/A

N/A = Not applicable

*Earnings estimates are based on analysts' consensus estimates for full-year 2008.

SOURCE: Banc of America Securities, LLC. For more information, contact Brian Wright at brian.wright@bofasescurities.com.

Nicolaus Capital Markets, wrote that 2009 is likely to be another tough year for United "marked by declining enrollment, rising loss ratios driven by mix and medical trend, and health reform initiatives." He added that United might not be facing such large declines if it had priced its products more in line "with a rising cost trend."

In a letter to Investor Day attendees, United CEO Stephen Hemsley contended that United's diversification in myriad lines of business is likely to help it emerge from any reform efforts as a strong player. "Our businesses touch virtually every aspect of health care and, as a result, we believe our capabilities and experience position us well to not only advance workable solutions during the reform debate, but also to turn those ideas into reality as the health care landscape evolves," he said.

Despite the decline in commercial membership, growth in United's Medicare and Medicaid businesses, operational improvements and "marginal pricing considerations" could help the company deliver \$3 in earnings per share in 2009, Banc of America Securities, LLC equities analyst Brian Wright wrote in his note to investors.

A Webcast of the meeting is available at www.unitedhealthgroup.com/Investors/InvestorConferenceAccept.aspx. Contact Wright at brian.wright@bofasecurities.com and Carroll at tacarroll@stifel.com. ♦

New AHIP Health Reform Proposal Draws Mixed Reaction From Groups

In its latest health reform proposal, America's Health Insurance Plans (AHIP) contends that congressional action could slow health care cost growth over the next five years by \$500 billion. The reaction to the proposal from some health care advocacy groups was mixed, however.

At a Dec. 3 press conference in Washington, D.C., to release its updated health reform proposal, AHIP CEO Karen Ignagni said that "universal coverage is within reach and can be achieved by building on the current system." She added that reforms to the health care system could be based on the existing system. AHIP's proposal includes the trade group's previous call for guaranteed-issue coverage for people with pre-existing conditions coupled with an individual-coverage mandate. At the press conference, AHIP urged lawmakers to develop a public-private advisory group to make policy recommendations on wasteful spending, provider payment structures and administrative cost reductions.

The proposal seeks a federally mandated, affordable "essential benefits plan" not subject to state-level benefit mandates, Ignagni said. She explained that the proposal calls for portable health coverage that would include prevention and wellness benefits and acute and chronic care. The proposal, she added, would allow anybody with an

annual income under 100% of the federal poverty level (\$10,800 for one person or \$21,200 for a family of four in 2008) to have access to free health coverage, and would furnish premium assistance on a sliding scale for families with incomes up to 400% of FPL.

Jim Roosevelt, CEO of Watertown, Mass.-based Tufts Health Plan and co-chair of AHIP's Policy Committee, tells *HPW* that programs such as the Massachusetts Health Reform Act won't work on a national level (*HPW* 4/10/06, p. 1). "But I think that there are definitely results to be looked at." Prior to the state's health reform effort, about 7% of Massachusetts's population was uninsured. "We're now down below 3% [uninsured]." He contends that "it is an experiment, but an experiment with some lab results."

In a prepared statement, Sen. Ted Kennedy (D-Mass.) said, "The insurance industry has advanced serious proposals that deserve serious analysis and consideration."

Some groups, however, disagreed strongly with AHIP's proposal. Rose Ann DeMoro, executive director of the California Nurses Association, contended that it amounts to a "massive public bailout of one of the wealthiest private industries in America. Rather than subsidizing these industries through laws mandating Americans purchase their products, we would be better off either letting them fail, or simply taking them over." The group favors a single-payer system.

And Richard Kirsch, national campaign manager of Health Care for America Now, argued that "AHIP's plan still lets insurers charge higher premiums for older and sicker people and for women. Their proposal pushes high-deductible plans and still lets insurance companies decide whether or not to approve the care your doctor says you need."

Call AHIP spokesperson Robert Zirkelbach at (202) 778-8493, Patty Embry-Tautenham for Roosevelt at (617) 972-1090, Mollie Turner for Neilson at (202) 789-7430 and Chuck Idelson for DeMoro at (415) 559-8991, or visit blog.healthcareforamericanow.org. ♦

Will Health Savings Accounts Survive Obama's Reform Efforts?

Since January 2004, health savings accounts (HSAs) have been a key component of the Bush administration's health policy. But some industry observers contacted by *HPW* predict that the incoming Obama administration and 111th Congress could work to dismantle the accounts, or at least erect barriers to make them less attractive. Others contend that the Obama administration and Congress are more likely to simply ignore account-based

coverage, which is not likely to fit into any of their health reform efforts.

Paul Feldstein, a professor of health care management at the University of California in Irvine, suggests that some Democratic lawmakers see HSAs as a threat to their version of health reform, and says they could propose changes to the tax code that would make the accounts more restrictive. Bruce Fried, a partner at law firm Sonnenschein Nath & Rosenthal LLP in Washington, D.C., agrees that some of the tax advantages HSAs have received could be removed by the incoming Congress. Fried was chief coordinator of the Clinton administration's Health Care Advisory Group in 1992. "There will be little appetite to continue HSAs. I think many people have perceived this as emblematic of the ideology of the Bush administration," he says.

While the incoming Obama administration supports the existing employer-based system of health coverage, there are indications that it might not fully support HSAs, says John Hickman, an employee benefits attorney with the law firm Alston & Bird. A rule that would require substantiation for all HSA distributions is one potential roadblock that already has some Democratic support. "The key word for [consumer-directed health] advocates is vigilance," he says.

Roy Ramthun, who co-wrote much of the early HSA guidance in 2004 while working at the Treasury Dept., agrees that a substantiation rule, or other restrictions, could hamper the growth of HSAs. But he adds that Congress is unlikely to try to eliminate HSAs. "Too many people would be affected now," he tells *HPW*.

Enrollment Could Boom in 2009

Some industry observers say there is too much momentum to derail account-based health plans. More than 12 million lives are now covered by a health plan that either includes a health reimbursement arrangement (HRA) or is compatible with an HSA. And with more employers than ever offering such plans to employees during this fall's open-enrollment period, that number is expected to jump on Jan. 1. Plus, banks collectively now hold more than \$4 billion in HSA assets.

With more than half of all large employers now offering an account-based health plan as an option, the offering has become "ingrained and continues to be a powerful tool," says Randy Abbott, an employee benefits consultant in the Boston office of Watson Wyatt.

"Nothing on the table would indicate to me that [such plans] are going to go away."

Paul Fronstin, senior research associate at the Employee Benefit Research Institute in Washington, D.C., agrees and says the incoming Obama administration "certainly won't be friendly toward HSAs, and is highly

unlikely to support anything that expands them. But with millions of Americans enrolled in these plans, it is also highly unlikely that the administration will do anything to prohibit or stunt their growth."

Jay Savan, an employee benefits consultant in the St. Louis office of Towers Perrin, says the potential for account-based health coverage actually remains as bright as ever. The exclusion of employer contributions for health coverage now is uncapped and is the Treasury Dept.'s third-largest tax expenditure. Savan contends that the tax break will need to be capped at some point, "particularly if Obama intends to have any money left to pay for an expanded [State Children's Health Insurance Program] or other federal subsidies that ensure children have health coverage, as he's maintained as part of his platform."

And if a cap is placed on the amount of pretax dollars employees can contribute to their health coverage, employers will be pressed by their employees to offer options that don't exceed the tax cap. Low-premium, account-based plans might be an attractive option, Savan says.

Ramthun says he's encouraged that HSA-based health plans remained available in Massachusetts after the state enacted its landmark health reform efforts. "That is a likely model given the [Sen. Ted Kennedy] connections to Obama. I don't believe Kennedy will go farther than where Massachusetts has gone."

Contact Feldstein at pfeldste@uci.edu, Abbott at randall.abbott@watsonwyatt.com, Savan at jay.savan@towersperrin.com and Ramthun at roy@hsaconsulting-services.com. ✧

What President Obama and the New Congress Will Mean for...

1. **Health Reform and 7 Other Major Health Initiatives** (Henry J. Aaron and Bruce Merlin Fried) – 12/9/08 audioconference
2. **Pharmaceutical Costs, Utilization and Management** (Bonnie Washington and Marc Samuels, J.D.) – 12/17/08 audioconference
3. **CD/MP3 and Transcript Available for Medicare Advantage and Part D** (John Gorman) – Audioconference previously held on 11/13/08

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More Insurers Offer Online Services

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"Employers will increasingly demand that health plans...provide tools to help their employees manage their health," he tells *HPW*. "As more consumers move into consumer-directed and individual health insurance policies, health plans will be faced with an imperative to foster loyalty with their members and help them stay well." He points to Aetna, which he says is "aggressively promoting" a health portal and PHR to its members through its ActiveHealth Management subsidiary.

United's free public Web portal, myOptumHealth.com, is operated by OptumHealth, United's health and wellness subsidiary. Content is produced by a 15-person editorial staff that includes medical doctors,

Ph.D.s, registered dietitians and writers from a variety of health publications and Web sites, the company says.

"It's a really great site, and a hub for health information on all levels," says Helen Darling, president of the National Business Group on Health. "And it's free. That gives it an advantage over WebMD, which requires you to pay for some tools such as the health risk assessment."

Solomon says that while it contains "vast amounts of content," it appears "light" on personal health management tools. That could make it difficult for United to compete with established content providers, such as WebMD, LLC and Mayo Clinic, he contends.

But United says its background as one of the nation's largest health and wellness services providers sets it apart from the other players. "We have thousands of health care professionals offering highly sophisticated,

NEW PRODUCTS & SERVICES

◆ **UnitedHealth Group says a new product available through its Golden Rule subsidiary could be attractive to early retirees and others who now have group health coverage but anticipate a need to enroll in individual coverage in the future.** While people who have a pre-existing medical condition might find it difficult to find individual coverage, UnitedHealth Continuity, the insurer says, allows consumers to apply for and "lock in" health coverage while they are healthy, but not use the coverage until they retire, become self-employed or unemployed, or move to a job without health benefits. The new product is being marketed in 25 states, with plans to expand to all of the states in which Golden Rule underwrites health plans. About 80% of people between the ages of 45 and 49 have group health coverage, but just 30% of those between the ages of 60 and 64 have it. "This often leaves people uninsured when they most need affordable access to health care," says Golden Rule CEO Richard Collins. The monthly fee for the coverage guarantee is equal to 20% of the current premium on an individual policy with the deductible chosen. The need for such a coverage guarantee could disappear if Congress and the Obama administration enact a health reform initiative that includes a guaranteed-issue provision. Contact Golden Rule spokesperson Ellen Laden at eladen@goldenrule.com.

◆ **Highmark, Inc., a Pennsylvania-based Blue Cross and Blue Shield plan operator, says it has given its network providers tools that will help**

them have useful discussions with members about their out-of-pocket costs. Highmark says it is the first insurer in the region to roll out real-time capabilities, which give providers the ability to set payment expectations with members. With real-time capabilities, providers can send an electronic claim to Highmark and receive a response indicating the amount that the Highmark member owes. Providers can use these tools prior to service or at the point of service, and then have the option to collect this payment or make payment arrangements with the member at the time services are received, the company says. About 250 providers across Highmark's service area will begin using the real-time tools during the initial rollout period, which started in November. Contact Kristin Ash at kristin.ash@highmark.com.

◆ **Detroit-based Health Alliance Plan (HAP) says it is adding acupuncture and chiropractic services to its Flexible Health Options benefit for Medicare Advantage (MA) members.** Beginning on Jan. 1, HAP's MA members can elect to use up to \$20 per month for acupuncture or chiropractic services not otherwise covered by Medicare. The benefit also offers members up to \$20 a month toward the cost of fitness classes and weight-loss programs. To receive the reimbursement, members must mail a completed form and a receipt each month, showing they paid a fee for a qualifying membership or service. Unused amounts cannot be rolled over to future months. Visit www.hap.org/medicare.

clinically sound, evidence-based health and wellness management programs to millions of [members]. We are taking that expertise, for the first time, and applying it to a free, publicly accessible consumer health portal," explains Scott Heimes, senior vice president of OptumHealth consumer solutions. "It's a very unique approach for a company like ours to invest this much in a direct-to-consumer venture." Heimes did not offer any projections on how widely used the portal will be.

By making its online tools and content available via a public Web portal, Optum says it will gain information about which types of content are most useful, and what drives consumers to access certain tools. That intelligence will be used to improve the usefulness of its private portals that are used by employer clients.

"Through our public site, we can determine what works in engaging consumers," Heimes explains. "The public site then becomes a very large learning lab where we can develop best practices to apply to our private health portal business." Optum says it manages more than 1,000 private portals for its employer clients. Through such portals, employers can direct their employees to enroll in wellness programs, complete health risk assessments and develop personalized health action plans. They also can use the site to find network physicians. And the portals can be used to send personalized messages (such as reminders to have a mammogram or colonoscopy) to employees.

Drug Advertisers Could Pose Problem

Optum's Web site will be used as a vehicle to promote United's medical insurance as well as dental and vision products. The company also will sell advertising space on the site. "That could be a problem," Darling says. The company, she suggests, should screen advertisers to ensure that pharmaceutical companies don't use the site to promote their products, for example. Such advertisers should be a concern for a portal operated by a health plan or health plan subsidiary, adds Marsha Dolan, associate professor in the Dept. of Nursing at Missouri Western State University. While searching for information about a chronic illness on a competing Web portal recently, Dolan says, an advertisement for a medication for that condition popped up. "To a consumer, it could seem like [the Web site operator] is promoting that drug," she says.

Heimes counters that myOptumHealth.com is a free portal that is open to the public, and is no different than those operated by WebMD and Mayo, which both accept advertising from pharmaceutical companies. Such concerns might be valid if UnitedHealth Group accepted such ads for its myUHC.com site. "It's not true for myOptumHealth.com," he asserts. He adds that there will be some restrictions for advertisers, but didn't rule

out pharmaceutical companies. "We are in this business to be competitive, and we will be aggressive about attracting and delivering a valuable advertising marketing platform for our advertising customers," he says.

Beginning in 2009, Optum intends to launch an e-commerce portal. Also in 2009, Heimes says, his group will make some of its employer-based health and wellness programs, such as smoking cessation and chronic-disease management, available to consumers via subscription. In that space, he says, Optum will compete with other online wellness services, such as WeightWatchers.com, which sells monthly subscriptions to its online weight-loss programs. "We want to use the expertise in health and wellness we've gained over the past decade or more, and the experiences of 60 million consumers, and apply that to the sale of services directly to consumers."

PHRs Said to Be in Infancy

Despite the enormous potential of PHRs, a minuscule number of people have one, and physicians are skeptical of their value. There also is a fear among many physicians about the ability to maintain the privacy of PHRs, says Janet Bruno, M.D., medical director of OptumHealth Consumer Solutions, the division that operates the portal. "But physicians do realize that if it can get to a level where they feel the data is protected, it is going to phenomenally affect the way medical care can be delivered."

According to Solomon, most doctors are wary of PHRs because they do not control the quality of the information in the PHR and they don't recognize how the PHR fits into their practice.

Heimes admits that physicians have been slow to embrace PHRs, but adds that they are beginning to understand the potential value of their patients' historical backgrounds.

Another hurdle for health plans that offer PHRs is convincing consumers that their personal health information can't be used against them. "Health plans must have a clear and convincing story for how they will keep their members' information secure and will not use the information for any purposes without the member's permission," Solomon says, adding that health plans also have the challenge of PHR portability. "At this point, the PHR industry is suffering from a lack of interoperability and portability standards, although several national groups are working on this problem."

To achieve interoperability, insurers and other stakeholders will need to address differences in formats, content and other technical issues that are obstacles to interoperability.

Jerry Bradshaw, executive director of Arkansas BlueCross BlueShield's health information network, says efforts to establish national standards take time and co-

operation. Bradshaw is a committee member of Health Level Seven (HL7), an American National Standards Institute-accredited standards developing organization.

The Arkansas Blues plan introduced a PHR system to its members and network providers in 2007.

"As an industry, we still have a long way to go to make that an easy process," Heimes says. Developing higher levels of standards to share personal health information back and forth will help." He adds that Optum will become a Microsoft HealthVault partner in hopes of helping to develop a common language for PHRs.

In 2009, Optum will integrate QuickenHealth into its PHRs, and also will launch a downloadable application that will let consumers access their PHR via their cell phone. That will give patients the ability to e-mail or fax data from their phone to a physician's office.

"I believe PHRs will revolutionize the way medical care is delivered," Bruno says.

Contact Molly McMillen for Heimes and Bruno at molly.mcmillen@optumhealth.com, Darling at Darling@businessgrouphealth.org, Solomon at michaels@pocp.com and Dolan at dolan@missouriwestern.edu. ♦

HEALTH PLAN BRIEFS

◆ **Louisiana Gov. Bobby Jindal (R) last month unveiled a sweeping proposal to shift a large portion of the state's Medicaid recipients from fee-for-service (FFS) coverage into managed care.** But the plan already is meeting with resistance from some state legislators and health care providers questioning its timing — arising just prior to likely federal health reform efforts — and potential cost. When Jindal announced his "Louisiana Health First" initiative Nov. 14, he noted that Louisiana's Medicaid spending has increased from 8.5% of the state general fund to more than 16% now. He said the program, left unchanged, is expected to consume nearly 22% of available discretionary dollars by 2011. The governor's proposal was discussed during a day-long briefing Dec. 1. Under the proposal, which would require approval from state lawmakers and federal regulators, managed care pilot programs would be set up in New Orleans, Baton Rouge, Lake Charles and Shreveport, La., according to *The Times-Picayune*. Most Medicaid recipients would work with state-approved counselors to choose from two or more Medicaid managed care plans; those not making choices would be enrolled automatically in a plan. According to state officials, part of the Medicaid reform initiative's cost would be financed from money now going to the LSU Charity Hospital System for treating uninsured patients, and through savings from improved care coordination. Contact Jolie Adams in the Louisiana Dept. of Health and Hospitals at (225) 342-1532.

◆ **Puerto Rico-based Triple-S Management Corp. on Dec. 4 said it signed a non-binding letter of intent to acquire certain managed care assets of La Cruz Azul de Puerto Rico, Inc.** In addition, Triple-S asked the Blue Cross and Blue Shield Association (BCBSA) to transfer the licensing rights to the Blue Cross brand in Puerto Rico and the Blue Cross and Blue Shield

brands in the U.S. Virgin Islands to the company and Triple-S, Inc., its managed care subsidiary. Terms of the proposed acquisition are not yet finalized. The completion of the transaction is subject to a number of customary conditions, including final due diligence and approvals from the insurance commissioner of Puerto Rico and BCBSA. Triple-S says it intends to fund the acquisition with cash and expects to complete the acquisition by the end of the first quarter of 2009. La Cruz Azul de Puerto Rico is an independent licensee of BCBSA and is a wholly owned subsidiary of Independence Blue Cross. Visit www.triplesmanagement.com.

◆ **Blue Cross Blue Shield of Michigan said it provided more than 300 pages of financial and membership information to Michigan Attorney General Mike Cox (R) in response to his request for details about the plan's individual-market products.** The information, the company contends, confirms the Blues plan's escalating financial losses in the individual market as the state's last-resort insurer. The Blues plan said it lost \$111 million in its individual lines of business during the first nine months of 2008, and expects to lose \$166 million by year's end. The company projects losses in the individual market of nearly \$264 million in 2009. Moreover, the Blues plan said its reserves are falling. Measured by risk-based capital (RBC), the company said losses in the individual market will cause its RBC of 627% in 2008 to fall below 450% by 2011 (RBC is a measure of how much capital the insurer has in reserve considering the size and degree of risk taken by the insurer.). That reduction could bring scrutiny from BCBSA. The plan said its individual membership has grown to an average of 109,707 from January through June 2008, up 95% from an average of 56,324 from January through December 2006. Call Michigan Blues spokesperson Helen Stojic at (313) 225-8113.

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