

HEALTH PLAN WEEK

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

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Double-Digit Rate Hike for Popular Federal Option Could Lead to Member Migration

A double-digit rate hike for one of the Federal Employees Health Benefits Program's (FEHBP) most popular options could give members a reason to hunt for less costly health coverage during the upcoming open-enrollment season.

The Blue Cross and Blue Shield Association's Federal Employee Program (FEP) says premiums for its Standard Option will increase 15% for self-only coverage (12% for family coverage) in 2010. The second consecutive double-digit rate hike for that plan could prompt a migration into less costly offerings, including FEP's Basic Option. Rates for that plan will increase about 9%. A year ago, premiums for the Standard Option jumped nearly 13%, prompting an enrollment decline in that option of 90,000 in 2009. About 50% of those members switched to the Basic Option. But FEP says its overall enrollment increased. About 3.6 million members are now enrolled in the Standard Option, and 1.2 million are in the Basic Option.

"I think it's likely there will be a migration from the Standard Option to the Basic Option," says FEP Vice President Jena Estes. "We did see a slight migration last year... so I can't tell you that price is not a factor," she tells *HPW*.

The Standard Option, which offers a larger provider network than does the Basic Option, as well as coverage for out-of-network providers, tends to attract a less healthy and older (the average age is 62) population than do other health plans offered through FEHBP. Overall, premiums for health plans offered through FEHBP will increase an average of 8.8% in 2010, OPM said Sept. 29. Approximately 8 million federal employees, retirees and dependents have coverage through FEHBP — and about 60% of them have coverage through an FEP option.

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High Out-of-Pocket Costs for MS Drugs Can Hamper Member Compliance Rates

People diagnosed with multiple sclerosis (MS) have higher compliance with their self-injected medications when they get them from a specialty pharmacy as opposed to a retail pharmacy, according to a handful of new reports. But for health plans, it's not enough to simply turn over management of these patients to a specialty pharmacy, according to the results of another study. Payers also should take into account the out-of-pocket costs that they hold members accountable for, as OOP costs exceeding \$200 per prescription can hamper compliance rates, particularly among people who are newly diagnosed with MS. And patients who are noncompliant with their therapies are more likely to be hospitalized.

MS is a progressive debilitating chronic condition affecting the central nervous system that ranges in severity and symptoms among people. No cure exists for the disease, but there are some specialty drugs that can help slow the disease's progression and prevent relapses, which are episodes marked by a deterioration of a person's ability to move and function, says Edmund Pezalla, M.D., national medical director at Aetna Pharmacy Management. "These drugs require compliance to produce good clinical

effects," says Joe Singer, M.D., vice president of clinical affairs for HealthCore, the clinical outcomes research subsidiary of WellPoint, Inc. These therapies, however, come with side effects that can pose one of the biggest barriers to patient compliance, he maintains. Noncompliance, he says, does not strictly mean that a patient is not taking a medication but rather that he or she is not taking the drug in the way it is prescribed. Other factors, including anxiety about self-injecting, might play a role in patients' compliance with their therapy, says Pezalla.

The self-injected MS drugs have an average wholesale price of about \$2,500 per month, and thus an annual price tag of about \$30,000. According to the National Multiple Sclerosis Society, about 400,000 people in the U.S. have MS, and about 200 are diagnosed with it each week. Annual drug reports by various pharmacy benefit managers (PBMs) routinely rank these MS drugs among the top drivers of spend within the specialty drug category.

Specialty pharmacies interviewed for this article say their nurses, pharmacists and clinicians are trained spe-

cifically in MS, receive ongoing education and can provide high-touch management of MS patients. Rather than simply dispensing the drug, these pharmacies are able to provide continuing education and support to patients, which can boost compliance. Initial education includes talking to people about the drug or drugs they are taking, as well as the disease itself, says Rich Faris, vice president of health outcomes solutions at Accredo Health Group Inc., a subsidiary of Medco Health Solutions, Inc. Training patients on self-injecting and drug-handling methods and identifying any potential barriers or issues that may impact compliance are also critical early on, he says. "It's important to get the patient off on the right foot with understanding the process," he explains.

Following are some recent studies underscoring the importance of specialty pharmacies' role in compliance among people with MS:

◆ **A HealthCore** study showed that MS patients managed by specialty pharmacy PrecisionRx Specialty Solutions had a 47% lower risk of being hospitalized than did nonmanaged patients. The specialty pharmacy-managed patients incurred higher overall costs of care for one year, due to their compliance with medication — \$20,105 versus \$16,857. But the managed patients' medical (as opposed to pharmacy) costs actually decreased by \$270, while the nonmanaged patients' medical costs increased by \$1,245. The managed patients had 290 days of continuous therapy as opposed to 209 days by the nonmanaged group. And "productivity appeared to go up for the managed group," says Singer.

◆ **An Accredo** study showed 81.5% of patients who received their MS drugs from a specialty pharmacy were compliant, versus 71.2% compliance among people who received their drugs from a retail pharmacy.

◆ **An Aetna Inc.** analysis of eight conditions showed that Aetna Specialty Pharmacy had a 95.3% MS compliance rate for the first half of 2009. A separate study showed that there was a lapse between refills of MS drugs of 6.36 fewer days when patients used a specialty pharmacy as opposed to a retail pharmacy.

High Cost Share Can Prompt Noncompliance

However, OOP costs for patients can be an issue as well with compliance, particularly when people are initiating MS therapy, according to a study by PBM Prime Therapeutics LLC. Those data show that fill rates for self-injectable MS prescriptions among people presenting a new prescription (those without a claim for an MS prescription both 90 days before and 90 days after an attempted claim) to a pharmacy directly correlate with the patient's cost share for the drug.

The PBM analyzed so-called "decline-to-fill" rates. This happens, explains Patrick Gleason, Pharm.D., di-

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rector of clinical outcomes assessment at Prime, when a person takes a prescription to a pharmacy, and the pharmacy then sends an electronic claim to Prime that is adjudicated, with Prime affirming that the patient is eligible for insurance and notifying the pharmacy of what the member cost share is. But then rather than the prescription being filled, in this case the claim instead is reversed out, with the member declining to fill it.

According to the study, which looked at 7 million members from eight Blues plans, 82.4% of the members had OOP costs in the \$0-to-\$100 range. Patients with a cost share of \$150 or less had a decline-to-fill rate of slight-

ly more than 5%. The rate increased to almost 11% for cost shares between \$151 and \$200. But among people whose cost share exceeded \$200, the decline-to-fill rate jumped to 27%. Data show that early treatment directly correlates with how quickly a person's MS worsens, says Faris.

Prime's poster presentation also cites studies from PBM Express Scripts, Inc. and The Zitter Group showing that compliance among people already on these MS therapies starts to suffer at OOP costs of more than \$150 and \$180, respectively.

Prime, says Gleason, recommends an OOP maximum cost of \$100 to \$150 if the therapy is on the fourth

Health Reform Update

SFC Amendment Removes Teeth From Individual Mandate

While most of the city slept, members of the Senate Finance Committee (SFC) worked into the early morning hours Oct. 2 putting the finishing touches on the markup of its health reform bill, which now heads to the Congressional Budget Office for a complete financial "score." The amended bill will head to a full-committee vote the week of Oct. 5. More than 500 amendments were considered during the markup process. Earlier in the week, lawmakers voted down two amendments that would have created a public insurance option. A public insurance option, however, is part of the Senate Health, Education, Labor, and Pensions Committee's bill, which will be merged with SFC's more conservative bill. Senate Majority Leader Harry Reid (D-Nev.) said Sept. 30 that the debate on the merged bill could begin by mid-month.

Here's a look at three key amendments:

◆ ***Lower penalties for the uninsured:*** An amendment adopted in the final hours of the markup would make financial penalties less severe for people who don't purchase required health coverage. Under the original version of the markup, uninsured families could have faced an excise tax of up to \$1,900 a year. Under the amendment, families with annual incomes above 300% of the federal poverty level (FPL) would incur a maximum penalty of \$800 (individuals would pay up to \$750) with no penalties until 2014. That year, the maximum penalty would be \$200, and it would increase to \$800 by 2017. In a note to investors, Christine Arnold, an equities analyst with Cowen and Co., said the amendment "virtually eliminates the individual mandate." If enacted, she predicts, many people will opt to remain uninsured until a medical event.

◆ ***New subsidies for low-income individuals:*** States would be allowed to use tax subsidies to create a government-sponsored "basic health plan" for low-income individuals, who could purchase coverage outside of the new state-run insurance exchanges. In a note to investors, Matt Perry, vice president of equity research at Wells Fargo Securities, explained that the amendment, if enacted, would create something similar to the current Medicaid managed care business model. "By allowing the state to group thousands of people together, the SFC hopes that the states will negotiate lower premiums with health insurers," he wrote. "However, the states would not be allowed to use either Medicaid or Medicare fee schedules to set reimbursement. Provider reimbursement would be negotiated by managed care plans." Under the amendment, states would receive tax subsidies to purchase insurance for uninsured people who have annual incomes of between 133% and 200% of FPL. The state would negotiate rates with health insurers, and then the insurers would administer the plan for the members. Perry said selling to large blocks of potential members, rather than to individuals, would be "a modest positive" for health plans.

◆ ***Limited tax deductibility for health plan executives:*** An executive-pay amendment would allow health plans to deduct only \$500,000 a year in executive compensation — down from \$1 million under current law, *The Wall Street Journal* reported Oct. 2. The individual mandate called for in SFC's bill would likely boost enrollment significantly for some health plans, and lawmakers don't want insurance executives' pay to be too high as a result of that.

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tier. Other options the company recommends to try to contain costs include implementing utilization management tactics, such as prior authorization or step therapy; narrowing the network of where people can get their drugs; and using a specialty vendor to improve care management and disease management. Gleason says that product preferencing among the MS therapies can be an option as well, with the preferred product on the second tier of a formulary and the rest on the third.

Gleason points out that each of the past five years has seen a 20% price increase from the previous year for the self-injected therapies. And these costs show no sign of decreasing. Because there is no pathway for the FDA to approve biosimilar drugs, the MS drugs do not have any generic competition, which could offer less-expensive options. And numerous oral therapies are in the pipeline, with a handful expected to hit the U.S. marketplace within the next few years. Some of these newer drugs are meant to be used in conjunction with existing therapies, and their cost will be as much as or more than that of the products now available, says Gleason. Although he concedes that it's hard to know what the impact of these drugs may be, it's reasonable to expect that the \$30,000 annual price tag may double to \$60,000, he says.

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'Next Big Thing' in Plan Design Offers Rich Benefits to Ill Members

A startup health insurer aiming to incentivize behavior change for both healthy and chronically ill members will begin marketing its products to small employers in Fresno, Calif., this fall.

Unlike traditional health plans, SeeChange Health's value-based benefit model seeks out both the chronically ill and the "overlooked healthy (i.e., those at risk for developing a chronic condition) and offers them richer benefits in exchange for compliance in managing the condition. Martin Watson, CEO of the San Francisco-based insurer, says the concept is "the next logical iteration" in plan design. He left UnitedHealth Group's product-development division in March to help launch the company, which has received \$40 million in venture capital (VC) financing. He previously served as vice president, international at Aetna Inc.

The SeeChange concept is the first significant health insurance innovation since the early part of the decade, when account-based consumer-directed health (CDH) plans emerged, says Lisa Suennen, managing member

at Psilos Group, the California-based VC firm behind SeeChange. Psilos also provided significant funding to Definity Health, a CDH company that was acquired by UnitedHealth Group in late 2004 for \$300 million (*HPW* 12/20/04, p. 6).

"We've been studying the [health insurance] market since then. And what seems to be emerging as the next big thing is the concept of value-based health plans," she says.

Three Steps to Richer Benefits

SeeChange's six plan design options are built on a PPO chassis and begin with relatively high deductibles. One plan, for example, has a \$2,000 annual deductible for single coverage and covers 80% of eligible claims once the deductible is met. Annual premiums, Watson says, will likely be a little less expensive than more traditional PPO products available in the small-group market. But enrollees can boost their level of coverage (e.g., to a \$1,000 deductible and 90% coverage) by going through an annual wellness visit with a doctor, submitting to a blood test and completing a health questionnaire as part of registering a personal health record (PHR). If an enrollee is identified as having (or at risk for developing) one of five chronic conditions, the enrollee will receive a treatment program. Enrollees who comply with the program will not pay any out-of-pocket costs for eligible charges related to that condition, according to SeeChange.

"We would much rather you understand that you have a chronic condition and take care of it in the earlier stages before it progresses," Watson tells *HPW*. Annual claims costs for an enrollee in the early stages of Type 2 diabetes, for example, tend to be less than \$600. And early treatment can help prevent the enrollee from progressing to the next stage, which could cost more than \$7,000 in claims a year. According to Watson, it typically takes between five and seven years for someone to progress from stage-1 diabetes to "full-blown" stage-4 diabetes. And diabetes is one of the few chronic conditions that can be prevented if identified in the early stages. "If you have elevated glucose levels, if your cholesterol is high and it looks like you are pre-diabetic, we'll give you richer benefits to prevent you from even getting into stage 1," he adds.

Insurers, Watson asserts, often have intentionally complicated plan designs combined with poor customer service, which gives enrollees an incentive not to seek care. "We think that is a ridiculous model. Most everyone is going to get a chronic condition at some point, and we know what the cost differential is between a stage-1 diabetic and a stage-3 or stage-4 diabetic," he explains.

Because SeeChange is such a new company, industry observers contacted by *HPW* were unwilling to praise or

criticize the new concept. SeeChange offers “an intriguing model and we look forward to seeing how it performs,” says Patrick Johnston, president and CEO of the California Association of Health Plans. Henry Loubet, senior vice president and chief strategy officer at Keenan, a California-based health care consulting brokerage firm, says the health insurance industry is in need of innovative plan designs that encourage enrollees to seek appropriate levels of care. “I admire innovation in an industry that is sometimes short on innovation,” he says. Loubet is a former UnitedHealth Group executive.

SeeChange Pairs PHR With Tight Networks

Behind SeeChange is Health Insight, an information technology firm that combines an advanced PHR with a reporting tool that scours claims data and other information to assess each enrollee’s health status. Psilos acquired that company, formerly known as HNA/Triveris, in March 2008. Watson says Health Insight’s PHR architecture is being marketed to health plans as a turn-key engine for value-based product offerings and already is being used by United.

SeeChange combines that technology with narrow provider networks. As a member of United’s product-development group, Watson analyzed health care trends and explored the concept of using narrow networks to treat members. An insurance model that relies on narrow networks would be difficult for national health plans to replicate because they tend to use their vast provider networks to attract multistate employers and to compete against other national insurers, Watson explains.

SeeChange initially will contract with large individual practice associations (IPAs) in the area and says it will offer its product only in markets where there is a “density” of physician groups. In Fresno, SeeChange has signed up Community Medical Centers as its hospital partner and Santé Community Physicians for its physician network. Watson has identified Los Angeles and San Francisco as the company’s next markets. The company says it initially intends to target small employers (fewer than 50 employees) and will likely make its product available to the individual market in mid-2010. Watson predicts SeeChange will have as many as 200,000 members by 2013.

“Some people look at [health] insurers as the evil empire...but this is an example of a health insurer doing well by doing good,” says Suennen. “You are giving people something that helps them manage or improve their condition, and they receive the financial benefit of that.”

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Mass. Reform Law May Be National Model, but Costs Are Still Rising

Massachusetts’ landmark health reform law has led to near-universal health coverage since it was enacted in 2006 (*HPW 4/10/06, p. 1*), and much of the Senate Finance Committee’s just-released reform proposal is based on that state’s model. But critics say that the cost of coverage in the state remains among the highest in the nation and contend that the state is now struggling to contain medical costs.

At a panel discussion early last month in Washington, D.C., several people involved in the development and operation of Massachusetts’ reformed health system discussed its successes and challenges, and offered opinions about whether such a model could be adopted nationally. The conference was sponsored by the Kaiser Family Foundation.

Jon Kingsdale, executive director of the Commonwealth Health Insurance Connector Authority, told attendees that health reform is a moral as well as an economic issue. About 25% of the uninsured fail to fill their prescriptions, he noted. And those who develop cancer and other deadly ailments tend to be diagnosed in the later stages of the disease and tend to die earlier than those who have coverage, he added. The Connector is a quasi-government agency that operates insurance exchanges through which individuals and small employers can purchase health coverage from private health plans.

Employer-Based Coverage Expands

While Massachusetts had a relatively low uninsured population (10%, versus 15% nationally) prior to reform, the percentage has since been slashed to less than 3%, primarily due to an individual mandate paired with a guaranteed-issue requirement. Many who remain uninsured face financial penalties. Some panelists said they were surprised by a strong increase in employer-sponsored coverage after the reform law was enacted. While about 100,000 of the state’s pre-reform uninsured population is now enrolled in Medicaid, about 350,000 people have coverage through private carriers — and 150,000 of them are enrolled in coverage offered by an employer.

The state’s individual mandate is enforced through a special “health care” 1099 income tax form. According to Kingsdale, 98.6% of the state’s 4 million tax filers completed the form. All but the smallest employers are required to offer health coverage or pay a penalty.

The increase in employer-based coverage can be attributed, at least in part, to the level of commitment employers have for reforming the state’s health care system, said Celia Wcislo, assistant division director of SEIU United Healthcare Workers East and a member of the

Connector Authority board. "Not all states have the same kind of employers. If rolled out nationally, I think there would need to be some kind of payroll tax or penalty to keep employers...from finding a way to dump their obligation to provide coverage," she said. In Massachusetts, the minimum creditable coverage includes preventive coverage, prescription drug coverage and primary care visits. Amy Whitcomb Slemmer, executive director of Health Care for All, said mandated health coverage must be affordable as well as meaningful.

While people with annual incomes up to 300% of the federal poverty level can receive a subsidy to purchase health coverage, Wcislo said the gap between those earning 300% and 500% of the FPL remains a problem. And while some people are able to afford the cost of single coverage through an employer, they might not be able to afford family coverage. Wcislo said that adding more than 400,000 newly covered lives into the system has led to longer wait times for insured residents to see providers.

The mantra for Massachusetts' reform law was to address the uninsured first and then address the cost, says Carlton Doty, vice president and research director at Forrester Research, Inc. Since the legislation was passed, the state has struggled with long-term affordability and access to primary care, he says, adding that for a national reform effort, lawmakers need to address medical costs before working to increase coverage rates.

Richard Burke, division president of senior care services at Fallon Community Health Plan, agrees and says that while the reform effort was successful at virtually

eliminating the state's uninsured population, medical costs continue to grow.

"While we are pleased at the number of people who are now insured — many for the first time in their lives — we are equally concerned about the rising medical costs because of the increase of cost of medical services," he says. "As we saw the number of uninsured decrease, we also saw a continuation of rising increases in the cost of medical care. We need to find more opportunities to bend the medical cost trend and keep expenses as low as possible so that our successful gains in the past few years are not undermined with a crushing financial burden."

Sonja Brehm, director of business and product development at Fallon, says the state's reform law might have led to higher costs. "Although we have seen an increase in costs, we are still continuing to analyze how, or if, reform in Massachusetts has affected [our] rates."

While the reform effort has been criticized for going over its original budget, Kingsdale says the cost to cover the state's uninsured has been "pretty modest" (a little more than 1% of the state's annual budget). The 2006 state legislative conference committee estimated fiscal year 2009 spending for Commonwealth Care would be \$725 million. It came in at \$800 million, which is a deviation of only about 10%. About half of that cost is funded by the federal government.

According to Kingsdale, the annual cost to the state comes out to about \$1,750 per year for each newly covered person. "I'd compare that to Medicare Part D, which

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costs the federal government about \$5,000 per enrollee per year," he asserts.

Although the uptick in enrollment due to the individual mandate has translated into more premium dollars for participating health plans, there has been an unexpected downside for both enrollees and health plans, says Doty. Many of the newly insured purchased the lowest-cost option, don't fully understand it and sometimes are surprised by additional out-of-pocket costs. "They don't understand that a cocktail of individual mandates, guaranteed issue and premium caps creates stripped-down benefits packages," he explains. "Consumers just don't realize how much skin they have in the game...and their knee-jerk reaction is to blame insurers. It's a case of unrealistic expectations."

Kingsdale agrees that some enrollees had been surprised by their coverage limitations, but says people often don't spend a lot of time looking at the details of their health plan before they enroll.

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Big FEP Rate Hike May Spur Switches

continued from p. 1

While just a tiny percentage of federal employees typically switch carriers during the open-enrollment period (FEP boasts a 90% retention rate), rate increases could prompt bargain shopping. "We do expect that more federal employees will switch plans this open season," says Karen Schuler, a spokesperson for the Government Employees Health Association (GEHA).

Tom Bernatavitz, Aetna's vice president for federal plans, agrees and says the just-announced premium hikes — combined with a still-struggling economy and the fact that some participating insurers have left or reduced their service areas — will "force enrollees to shop." Enrollment in Aetna Inc.'s account-based consumer-directed health (CDH) plans for federal workers increased 80% to 52,000 between the end of 2008 and January 2009. While Bernatavitz declines to offer enrollment predictions, he says "it appears similar circumstances are prevalent" this year.

Rates for Aetna's HRA- and HSA-based options spiked in most of its markets, with premiums for the HRA-based plan jumping nearly 20%. Member-paid premiums for that plan (self-only) increased to \$48.57 — up \$8.09 per pay period for enrollees. Self-only coverage for the HSA-based option increased to \$34.50, up \$3.57 per pay period. Aetna says significant enrollment growth in those CDH products have led to increased utilization

and higher medical costs, which required the rates to increase.

Jennifer Simon, member education manager at the American Postal Workers Union (APWU) Health Plan, says last year's double-digit rate increase for FEP's Standard Option, combined with the extended enrollment deadline (*HPW 12/15/08, p. 1*), likely encouraged members to take a closer look at other plans. "We definitely noticed a shift in membership from BCBS as did a lot of other carriers," she tells *HPW*. For the 2009 plan year, APWU reported enrollment growth in both its High Option and its Consumer Driven Option, which includes a health reimbursement arrangement (HRA). Enrollee premiums for APWU's High Option plan will increase \$1.97 per pay period for single coverage (\$4.47 for family coverage) in 2010. Premiums for its CDH option will remain unchanged.

Schuler agrees that last year's FEP rate increase had an impact on enrollment for other carriers. GEHA's overall health plan enrollment increased 5% after the end of last year's open-enrollment period. Biweekly member-paid premiums for GEHA's high option will be reduced by \$11.95 for single coverage next year and will increase 72 cents for family coverage.

UnitedHealthcare saw a "significant" enrollment increase in 2009. "Any time the largest plan in the FEHBP has a meaningful rate increase, more enrollees [will] think, or talk, about their FEHBP plan and will look for value at open season," says spokesperson John Parker.

Self-only premiums for United's HSA-based plan increased 7.2% in most of its markets, while rates for its CDH plan rose 9.5%. Member-paid premiums for that plan (self-only) increased to \$45.15 — up \$3.95 per pay period for enrollees. Self-only coverage for the HSA-based option increased to \$37.79, up \$2.56 per pay period.

Feds' Formula Leads to Cost Shift

Premiums for FEP's Basic Option will increase by an average of 9%, and enrollees will pay \$46.50 per biweekly pay period (up \$3.84 from 2009). Those with family coverage will pay \$108.91 per pay period (up \$9 from 2009). Standard Option enrollees with single coverage will pay \$80.81 per pay period (up \$10.63) and \$185.06 for family coverage (up \$20.48). But Standard Option enrollees also will be asked to pay a steeper share of premiums in 2010 due to FEHBP's formula, which allows for increased cost sharing when a plan's premiums rise by more than the average, according to the American Federation of Government Employees. In 2010, the government will pay 67% of the Standard Option's family premium, down from 69% last year, according to AFGE, the largest federal employee union with 600,000 members. The Basic Option is not affected.

continued

HPW has learned that FEP will discontinue a pilot option that paired a health savings account (HSA) with a high-deductible plan. Fewer than 500 people are enrolled in the option, which was made available in four markets beginning in the 2008 plan year.

Aetna says enrollment in both of its consumer-directed options remains strong. Bernatavitz says its HRA-based plan has more than 27,000 subscriber contracts and

its HSA-based option has about 9,000. "Our HSA-based option will again be one of the highest-value, lowest-cost plans in the federal program for 2010," he asserts.

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HEALTH PLAN BRIEFS

◆ **On Oct. 1, the first day of marketing for Medicare Advantage and Stand-alone Prescription Drug Plans (PDP), CMS said MA enrollees in 2010 will pay an average of 22% more in premiums.** The average monthly premium will rise to \$39 from \$32 in 2009. In 2010, almost 87% of Medicare beneficiaries will have access to an MA plan that does not require a premium, according to CMS. For the 2009 plan year, 93% of beneficiaries had access to a Medicare Advantage prescription drug (MA-PD) plan with a zero premium. CMS did not supply a comparable figure for 2010 MA-PD premiums. Stand-alone Prescription Drug Plan (PDP) premiums will average \$30, a \$2 difference from 2009. The agency had initially anticipated an average premium for 2010 of \$32. CMS also said that only 7% of MA beneficiaries will have to switch health plans because of carriers withdrawing from markets. The agency added that most of these insurers operated private fee-for-service (PFFS) plans. There will be about 3,500 MA plans next year, down 18% from the 2009 level, and 1,576 PDPs, down 111 from this year, CMS said. The annual election period runs from Nov. 15 to Dec. 31. For state-by-state fact sheets on MA plans and PDPs, visit www.cms.hhs.gov/Partnerships/downloads/statefactsheets_all.pdf.

◆ **Minnesota Attorney General Lori Swanson (D) filed a lawsuit on Sept. 30 against Consumer Health Benefits Association (CHBA) for allegedly scamming individuals into believing that they were purchasing health coverage when they were really purchasing a noninsurance product.** The attorney general's (AG) office said that CHBA told consumers that its New Choice Health Plan was insurance or "just like" insurance, covered 80% of medical expenses, required only minimum copays for doctor and hospital visits, and had a vast network of doctors and hospitals. In reality, CHBA is a so-called "health discount plan," which does not provide insurance coverage or otherwise cover claims, but instead pur-

ports to offer certain discounts off the "retail price" charged by certain doctors and clinics, according to the AG's office. The lawsuit seeks injunctive relief, restitution for consumers and civil penalties. A call made by HPW to CHBA for comment has gone unreturned. Visit www.ag.state.mn.us.

◆ **On Sept. 24, Medica Health Plans launched Medica Solo and Medica Direct HSA for North Dakota residents interested in individual coverage.** The insurer said its Medica Solo premiums start at about \$59 to \$87 per month, depending on health history and the deductible selected, and coverage includes \$200 worth of immediate preventive-care coverage (before deductible or copayment), \$5 copays for generic drugs and various deductible options. Medica added that its Medica Direct HSA offers individuals and families the options of opening a federally qualified health savings account (HSA). Members will also receive a debit card to provide access to funds in their HSA accounts. Medica has 1.4 million members in the employer, individual, Medicaid and Medicare markets. Visit www.medica.com.

◆ **Private insurance as a percentage of total U.S. population dropped to 67% in 2008 from 70% in 1998 and has been steadily declining for the last five years,** according to Mark Farrah Associates (MFA). The research company also found that employment-based coverage fell from 62% to 58% during the same period. Private coverage in 2008 dropped by 999,000 people nationwide, with employment-based coverage falling 1.1 million and direct-purchase coverage increasing by 104,000, MFA found. Between 1998 and 2008, the percentage of uninsured Americans improved slightly, declining from 16% to 15%, the result of more people being covered by state Medicaid programs, according to the company. To read the full text of *Private Health Insurance Declines*, visit www.markfarrah.com.

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