

The Executive Report on Managed Care

Your Authoritative Management Briefing on Managed Healthcare

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U.S. Healthcare System Must Change Its Competitive Ways

Unless the U.S. healthcare system changes to become more value oriented it will continue to be dysfunctional and invite government intervention, according Elizabeth O. Teisberg, Ph.D., an economist and associate professor at the Darden Graduate School of Business at the University of Virginia.

She made this pronouncement at the 2005 America's Health Insurance Plans Business Forum this month in New York.

Teisberg and her colleague, Professor Michael E. Porter of the Harvard Business School, have been delivering this message since June 2004 when their article, "Redefining Health Care: Creating Value-Based Competition to Deliver Value," also the title of her talk, appeared in the Harvard Business Review.

She told Forum participants that the U.S. healthcare system is highly competitive, and in fact is the most competitive in the world. However, the problem is that the competition is wrong.

There is "zero sum" competition in healthcare which has all the players battling to shift and reduce costs to one another, increase their bargaining power and capture patients. Providers are broad based and eventually the patient suffers.

"Health plans are structured around a culture of denial," she said, denying claims and denying coverage.

Unless this underlying philosophy of doing business changes, the popular programs in healthcare now, consumer driven, health savings accounts and pay for performance will not work.

Readers:

Got a problem? Got a question? Got a story to tell? We want to hear from you. Call our Reader Hotline at (888) THE-MCIC and ask for John Russell or send an e-mail message to: jrussell@themcic.com.

She views the entire consumer driven movement as nothing more than shifting costs to members of plans and not a real improvement of the system.

As for “pay-for-performance” (P4P) Teisberg calls it “pay-for-compliance” which she said “does not drive results.”

The act of complying is not the same as improving results, Teisberg said.

She also said the “high value of disease management is a symptom of a fractured system.”

In her view, the entire healthcare system must change and focus on value for patients not costs.

Value must be at the heart of the system She wants doctors to compete with the goal of improving value. The same holds true for the other players including hospitals.

Teisberg also believes that the system should be organized around conditions. She cited the Cleveland Clinic as an example of this type of reorganization. More speciality hospitals, clinics and practices are emerging throughout the country.

The heart of driving improvements in this value-based competitive environment is the public reporting of results. Patients will have the results and prices of physicians and hospitals for a wide range of specific conditions. Patients then can compare and choose where and by whom they want to be treated.

Teisberg noted that doctors in Sweden compete on results and the results are published. Patients go to the doctors who deliver the best results.

In her opinion, if the profession competed in this manner in the U.S., P4P would not be necessary. The best in the profession would get more business. The increased business would be the reward.

In healthcare, quality and cost often improve simultaneously, according to Teisberg, which is different than other business sectors.

“Better quality inherently reduces costs,” she said, because better health is inherently less expensive (than poor health).

Value, she said, is driven by the provider experience and the scale and learning at the medical condition level. As the provider gets more experience

treating the same condition they get broader capabilities. Public reporting will drive rapid improvements and create the competitive atmosphere.

She also advised that competition should be regional and national, not merely local.

“Most people are eager to travel to be at a really good center” because “all healthcare services are not equal.”

Small steps are being taken to change the way the business is operating, she said. Once value-based competition begins working, improvements will not be optional and those who start early will have a leg up on competitors.

Teisberg and Porter’s book, based on the article, “Redefining Health Care: Creating Value-Based Competition to Deliver Value” is now available.

Addresses: Darden Graduate School of Business, University of Virginia, P.O. Box 6550, Charlottesville, VA 22904; (434) 924-3900, www.darden.edu. America’s Health Insurance Plans, 601 Pennsylvania Ave. NW, South Building, Suite 4500, Washington DC 20004; (202) 778-3200, www.ahip.org.

PacifiCare Shareholders Approve UnitedHealth Merger

The \$8.1 billion merger between PacifiCare Health Systems and UnitedHealth Group moved closer to completion when shareholders of PacifiCare overwhelmingly approved the acquisition.

PacifiCare reported 99 percent of the votes were cast in favor of the merger.

The merger is not without controversy. The American Medical Association has come out strongly against it to the point of asking the U.S. Department of Justice (DOJ) to open an investigation

State medical associations, including PacifiCare’s home state of California, have also voiced opposition to the merger.

Before the shareholder vote, one major stockholder, the California Public Employees’ Retirement System (CalPERS), the largest public

pension fund in the nation, said it would vote against the merger.

CalPERS wanted a separate vote on the \$345 million in executive bonuses that will be paid as a result of the merger of the two HMOs.

CalPERS made its decision after the release of PacifiCare's proxy statement that indicates PacifiCare management began merger discussions with UnitedHealth nearly six months before PacifiCare shareowners were asked to approve a very favorable compensation package for management and the board in the event of a change-in-control of the company.

CalPERS said PacifiCare's management failed to disclose to shareowners at the time of the vote that PacifiCare was in merger discussions with UnitedHealth, a merger that would cause the accelerated vesting of the new compensation package.

The CalPERS Board also directed its legal staff to look into whether the actions by PacifiCare executives breached any security disclosure laws.

UnitedHealth Group said it re-filed its pre-merger notification and report form related to the PacifiCare merger to the DOJ. DOJ approval is necessary for the merger to take place as is the approval of all 10 states in which PacifiCare has operations. Six states have approved the merger, according to the company.

Addresses: PacifiCare Health System, 3120 Lake Center Dr., Santa Ana, CA 92704; (714) 952-1121, www.pacificare.com. UnitedHealth Group, UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, MN 55343; (800) 328-3979, www.unitedhealthgroup.com. CalPERS, P.O. Box 942709, Sacramento, CA 94229; (916) 795-3829, www.calpers.ca.gov.

Confusion Reigns As Seniors Grapple With Medicare Drug Plan

Seniors across the nation are very confused as they come to grips with the choices and decisions they have to make to enroll in the new Medicare drug benefit.

Many seniors remain uncertain about how the law will affect them and unsure about whether they will enroll, according to a new survey by the Kaiser Family Foundation and the Harvard School of Public Health.

When asked how well they understand the drug benefit, more than six in 10 seniors (61 percent) say not too well or not at all; while more than one in three seniors (35 percent) say very or somewhat well.

When asked whether the Medicare drug benefit would help them personally, more seniors say it would not (49 percent) than say it would (39 percent).

Overall, more than four in 10 seniors (43 percent) report they do not yet know if they will enroll in a Medicare drug plan for 2006; 37 percent say they do not plan to enroll; and one in five (20 percent) say they plan to enroll.

Seniors without any drug coverage are most likely to say that they plan to enroll (28 percent, compared with 15 percent for those with existing drug coverage).

Most seniors substantially underestimate the number of drug plan choices that they will have, with just 5 percent correctly identifying that they will have more than 20 options for receiving their drug coverage. When informed that the government has announced that most people on Medicare will have at least 40 different drug plans to choose from, almost three in four (73 percent) say that having many plans makes it confusing and difficult to pick the best plan, while 22 percent say it is helpful and provides an opportunity to choose the best plan.

All major national health insurers are offering plans. In addition there are regional and state plans to add to the confusion.

The survey shows varying degrees of knowledge among seniors related to key elements of the new benefit. For example, nearly two in three seniors (64 percent) say correctly that, in general, seniors must sign up to get coverage, but one in 10 (10 percent) incorrectly say coverage would begin automatically and one in four (25 percent) say they don't know. In addition, more than four in 10 seniors either say that they don't know if there are financial penalties for late enrollment (27 percent) or say incorrectly that there are no such penalties (19 percent).

Addresses: Henry J. Kaiser Foundation, 2400 Sand Hill Road, Menlo Park, CA 94025; (650) 854-9400, www.kff.org. Harvard School of Public Health, 677 Huntington Ave., Boston, MA 02115; (617) 432-1000, www.hsph.harvard.edu.

Lawsuit Filed Against Medicare Drug Program

Eight organizations filed suit in federal district court in Manhattan, N.Y. seeking an order to assure that dual eligible Medicare and Medicaid beneficiaries do not lose their existing drug coverage under Medicaid.

Leading the effort is the Medicare Rights Center based in New York. The group claims that under current planning 6.4 million people enrolled in both Medicare and Medicaid will be denied their Medicaid drug coverage on Jan. 1, 2006 the day the Medicare Part D program begins.

The lawsuit seeks protections for the people who are not seamlessly and immediately transitioned to the Medicare program.

“The poorest, sickest and oldest Americans face grave risk of losing their life-saving medications once the clock strikes twelve on New Year’s,” said Robert M. Hayes, president of the Medicare Rights Center. “This lawsuit seeks to force creation of an essential safety net to protect the health and lives of the frailest Americans.”

“Countless” men and women “will fall through the cracks of this massive program transition,” the suit warns.

It also said the characteristics of the people at risk, nearly 40 percent are cognitively impaired and only 39 percent have a high school diploma, will prevent up to a million poor seniors from immediately mastering the complexity of the new Medicare drug benefit so they can maintain their access to needed medicine.

Address: Medicare Rights Center, 1460 Broadway, 17th Floor, New York, NY 10036; (212) 869-3850, www.medicarerights.org.

More Employers Turning To Consumer-Driven Plans To Reduce Health Spending

U.S. employers are increasingly turning to consumer-driven health plans (CDHPs) such as health savings accounts (HSAs) with the expectation they will help control rising healthcare costs, according to a Deloitte Center for Health Solutions survey of American employers.

The survey of 316 employers found that 43 percent of respondents either have a CDHP in place (22 percent) or will be offering one in the next two years (21 percent).

Another 51 percent said they are reviewing consumer-driven options and may offer one in the near future if they can be proven to be attractive to employees while saving money.

The survey by the Deloitte Center for Health Solutions and Deloitte Consulting LLP found that employers believe that giving employees more control over their healthcare dollars would make them more financially responsible, and therefore reduce overall healthcare costs:

- 77 percent of those surveyed said they expect consumer-driven plans to change employee purchasing patterns by making them aware of the true cost of healthcare, while 8 percent said they will not.
- 56 percent of those surveyed said consumer-driven plans will result in immediate employer cost savings, while 27 percent said they will not.
- 43 percent of those surveyed said consumer-driven plans will reduce the long-term health cost trend, while 24 percent disagreed.

CDHP typically complement other managed care plans also offered by employers. Examples of CDHPs include health reimbursement account (HRA) plans or high deductible managed care plans with HSAs.

Sixty-three percent of the respondents with plans in place offer a HRA plan, while 31 percent offered a HSA.

“Companies that have real-life experience with consumer-driven health plans are particularly upbeat about the current and future impacts of consumerism,” said Barbara Gniewek, a principal within Deloitte Consulting. “As more employers report early success with these plans, acceptance and understanding of this model will grow.”

Companies that already have consumer-driven health plans in place report widespread satisfaction among employees and managers.

Gniewek said it is important for companies to aggressively expand enrollment in CDHPs if they are to succeed. “We believe that unless a company can recruit at least 20 percent of its employees to join early on, the company may not reap the cost and quality benefits offered by these plans,” Gniewek said.

Address: Deloitte Consulting LLP, 1633 Broadway, New York, NY 10019; (212) 489-1600, www.deloitte.com.

P4P Improving Healthcare Quality And Changing Provider Behavior But Challenges Persist

“Pay-for-Performance” (P4P) programs can improve both medical care and quality of life, according to a long-term national study released earlier this month.

But the study cautioned that P4P is not a magic bullet and there are many challenges to overcome for it to sustain its effect on the quality of healthcare, including whether it can work in all healthcare settings.

The findings are the combined result of seven experimental projects designed to test a variety of P4P models. Known as the Rewarding Results program, the three-year effort is both the largest and most diverse of its kind.

The projects “provide some of the first tangible evidence that P4P incentives can raise the quality of patient care,” says Suzanne Delbanco, CEO of the Leapfrog Group, the organization providing technical assistance to the projects, which are supported by

grants from the Robert Wood Johnson Foundation, the California HealthCare Foundation and the Commonwealth Fund.

Delbanco cautioned that the findings also show that such programs can be complicated to implement. “P4P clearly has great potential for driving quality improvement, but challenges persist that can be overcome only with the kind of careful and independent evaluations these projects are undertaking to assess their progress,” she said.

One of the biggest questions is whether the P4P model can be implemented in non-managed care settings, such as preferred provider organizations (PPOs), where a majority of Americans get their healthcare.

However, through use of incentives, the Rewarding Results projects have:

- Significantly increased patient visits to the doctor for everything from adolescent check-ups to diabetic screening among privately insured and Medicaid patients.
- Pushed physicians and physician groups to embrace information technology and electronic medical records at a faster pace.
- Increased the numbers of patients who receive annual mammograms, well-check ups and other preventive screenings.
- Motivated physicians to monitor patient care more aggressively, particularly for chronically ill patients.

Despite those achievements, the projects are still working out what size financial rewards are needed to effect change and how to engage physicians continuously in quality improvement activities linked to P4P.

The projects are also researching whether the return on investment and the quality gains outweigh the financial and human effort.

Projects are being tested in a variety of states including Massachusetts, California, New York, Michigan, Georgia and Minnesota.

Address: The Leapfrog Group, c/o Academy Health, Suite 701-L, 1801 K Street NW, Washington DC 20006; (202) 292-6713, www.leapfroggroup.org.

More Costly Healthcare Is Not Necessarily Better Healthcare For Chronically Ill

More expensive healthcare is not necessarily better healthcare, according to a new study released this month of California hospitals.

The study, by Dartmouth Medical School, focused on chronically ill Medicare patients in the last two years of their lives and found that Medicare pays some California hospitals four times more than others to care for patients with similar chronic illnesses, with no gain in quality or patient satisfaction.

Hospital efficiency could have saved Medicare \$1.7 billion over five years in Los Angeles alone, according to the study.

Investigators examined Medicare data from the 226 California hospitals with more than 400 deaths from 1999 to 2003. Patients included in the study had at least one of 12 chronic illnesses. Two-thirds of patients were diagnosed with cancer, congestive heart failure and/or chronic lung disease.

The findings, along with a comparison of data from hospitals in five regions in California – Sacramento, San Francisco, Los Angeles, Orange County and San Diego – were also published in a Web Exclusive edition of the journal *Health Affairs*.

The study reveals that average spending per patient varied by a factor of four among hospitals in the state. The additional care provided in some regions and hospitals did not improve medical outcomes or patient satisfaction; in fact, as the volume of care increased, the quality of care and patient satisfaction declined. The study also found that improved

The California study was underwritten by the California HealthCare Foundation and the Robert Wood Johnson Foundation, a longtime funder of the Dartmouth Atlas project. The report and data released are precursors to the release early next year of a study and data on all U.S. hospitals.

The comparisons reveal where savings could be achieved without reducing quality by improving efficiency.

Among all California hospitals, Medicare spent amounts ranging from less than \$20,000 to more than \$90,000 per person on inpatient hospital care during

the last two years of life. Two-thirds of this variation was associated with the number of days patients spent in the hospital.

Only 39 percent of the variation was associated with the price of each day's stay. Thus, the volume of care received – how many times a patient was admitted to the hospital and how many days they spent there – was a far more important driver of total costs to the Medicare program than the daily rate charged by the hospital.

Total Medicare spending – hospital payments plus payments to physicians – ranged from \$24,722 to \$106,254 per person.

Los Angeles was the most costly region. The average Medicare payment for inpatient hospital care was \$43,506 per Los Angeles decedent during the last two years of life – 20 percent higher than the average in San Francisco, 36 percent higher than Orange County, 44 percent higher than San Diego and 67 percent higher than Sacramento.

Address: Dartmouth Medical School, 1 Rope Ferry Road, Hanover, NH 03755; (603) 650-1200, www.dms.dartmouth.edu.

Aetna Teams With Primary Care Physicians To Identify And Treat Depression Early

Aetna unveiled a new program to help speed a physician's diagnosis of depression in order to arrange for appropriate treatment more quickly and improve a patient's recovery.

The Aetna Depression Management program comes as Aetna Behavioral Health is launching a full-service behavioral health business by bringing in-house the Aetna portion of the business, about 11 million members, that has been administered by Magellan Health Services the past seven years. The transition to bring the Aetna portion of behavioral care business back from Magellan takes effect Jan. 1, 2006.

The new program, Aetna Depression Management, will be the first national program to integrate medical and behavioral healthcare at the primary care physician (PCP) office and provide incentives for screening and assessment as patients first enter the healthcare system.

Aetna's program will provide proven clinical tools for physicians, training for office staff, access to Aetna nurse case managers and support from Aetna's network of behavioral health specialists.

Importantly, the program increases reimbursement for PCPs who actively screen and talk with patients to diagnose depression.

Aetna has experience in managing depression in its disease and disability management programs. The company conducts phone screenings of chronically ill patients in those programs and has found that as much as 20 percent of that population is suffering from some form of depression.

National studies show that up to 10 percent of the population may suffer from depression, the fifth largest disability affecting the United States. Costs for medical care and productivity loss related to depression are estimated to exceed \$40 billion annually. Several recent national studies have highlighted the fact that the mental healthcare system is fragmented and in need of reform.

Aetna Depression Management will be a pilot program in Pennsylvania, New Jersey, Maryland, Virginia, the District of Columbia, Oklahoma and Texas.

Address: Aetna Inc., 151 Farmington Ave., Hartford, CT 06156; (860) 273-0123, www.aetna.com.

Court Upholds Maine's Law Regulating PBM

A federal appeals court upheld a Maine law regulating pharmacy benefit management companies (PBMs).

The U.S. Court of Appeals for the 1st Circuit in Boston rejected the appeal of the Pharmaceutical Care Management Association (PCMA), the trade group representing the PBMs, to block a Maine law requiring PBMs to disclose information about potential conflicts of interest and price negotiations with drug manufacturers.

The Maine law requires PBMs, which have been charged with pocketing significant rebates from drug manufacturers and not passing along savings to consumers, to disclose more information about their

business practices, including payments they receive from drug manufacturers.

PCMA lawyers argued that federal law preempts efforts by Maine, and a growing number of other states, to regulate the business practices of PBMs, and that the state law is unconstitutional.

Similar PCMA litigation is pending in federal district court in Washington, D.C. against a District of Columbia law. That case is scheduled to be heard in January 2006.

Address: Pharmaceutical Care Management Association, 6012 Pennsylvania Ave. NW, Seventh Floor, Washington DC 20004; (202) 207-3610, www.pcmanet.org.

Anthem Blue Cross And Blue Shield In Colorado Launches New Products

WellPoint, the parent company of Anthem Blue Cross and Blue Shield in Colorado, introduced four new products in Colorado recently.

Several other products will follow in early 2006, to join the new entries, Tonik, EmployeeElect, Blue View Vision and Voluntary PPO Dental. These products have been designed for individuals, small employers, or large groups.

Tonik is an original. Designed by – and for – “young invincibles” (20-somethings). Tonik covers everyday preventive needs (like routine doctor visits) as well as the more serious medical necessities.

Costs for Tonik range from \$96 to \$132 a month, depending upon the plan, the insured's age and where he or she lives.

EmployeeElect custom-fits plans to small businesses of one to 50. It is a new portfolio of 12 health plans. Employers can choose to offer one, a mix-and-match, or all 12 plans to their employees.

Anthem's Voluntary PPO Dental Plans for Large Groups consists of two standard PPO plans – one with orthodontic coverage and one without – and with two choices of dental networks allow employers to offer dental coverage to employees on a voluntary basis and with lower participation rate requirements than employer-paid dental coverage.

Blue View Vision Plans for Large Group
Employers ensure expanded access and competitive prices. The product features a variety of plan designs including 20 full service plans, 18 materials only plans, and eight exam only plans.

Address: Anthem Blue Cross Blue Shield of Colorado, 700 Broadway 7th Fl., Denver, CO 80273; (303) 831-2000, www.anthem.com.

Terms of the acquisition were not disclosed.

Address: Prospect Medical Holdings Inc., 6083 Bristol Parkway, Suite 100, Culver City, CA 90230; (310) 338-8677, www.prospectmedicalholdings.com.

Managed Care Market News

Prospect Medical Holdings Acquires Genesis Healthcare Of Southern California

Prospect Medical Holdings Inc., which manages the medical care of individuals enrolled in managed care (HMO) plans in Southern California, announced that it has acquired Genesis Healthcare of Southern California, located in Orange County, Calif., in an all cash transaction.

This expands to 11 the number of independent physician associations affiliated with Prospect Medical via acquisition and increases by approximately 16,000 the number of HMO-covered lives under management by the company. Prospect Medical served approximately 178,000 HMO enrollees at June 30, 2005.

Movers

CIGNA HealthCare Appoints Gary Earl To Lead Customer Strategy, Wilkins Promoted

CIGNA HealthCare appointed Gary Earl to lead customer relationship strategy for its national accounts segment.

A noted health and wellness expert, Earl is the former corporate vice president of benefits for Caesars Entertainment and brings more than 20 years of experience to this position.

In addition, Mary Wilkins has been promoted to senior vice president and head of sales and account management for CIGNA HealthCare national accounts to position the company for further growth.

Ken Sperling will have broader responsibilities as the head of sales performance and growth strategy, capitalizing on his expertise in the consumer-directed health plan market and helping CIGNA further build its national accounts segment.

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