

# Population Health

## INSIDER

### Public insurance is not the only issue for insurers

Summer months usually mean leisure and vacations, but health plan executives will surely not have a relaxing time this year.

Private health insurance faces a potential new competitor—the federal government—that insurers worry could put many of them out of business. But the issues for health insurers go beyond whether the feds grab a greater share of their market; declining membership and perceptions about insurance costs and profits are also acute concerns.

#### Public insurance

Private insurers and America's Health Insurance Plans (AHIP) have been vocal about their opposition of a public insurance plan. In hopes of killing the idea, AHIP has presented a health reform plan that features an individual mandate requiring that all Americans have health insurance, along with a guarantee that health insurers will

not reject any prospective member because of a preexisting condition or charge women higher premiums than men for their individual coverage.

**Robert Zirkelbach**, director of strategic communications at AHIP in Washington, DC, says the insurer group supports a comprehensive healthcare reform package that includes the individual mandate coupled with payment reform rewarding physicians for improving health outcomes rather than paying for volume of service, research to find which treatments work best, and improved health information technology.

"They are all under the broad

banner of reform," says Zirkelbach. "We believe we need health reform and we can address all the core concerns by building on what is working in the current healthcare system."

Insurers are afraid that a competing public plan with lower administrative costs and lower premiums would coax employer-based insurance members to flee for the public plan and crush private plans in the process.

In response to the public plan, **Ian Duncan**, president and founder of Solucia Consulting in Farmington, CT, says private insurers should promote the benefits of their offerings. "I would stress the positives that come from the current insurance system. Although nobody likes [the current system], you have the ability to strike individual contracts and strike individual bargains between payers/providers/patients," says Duncan. "That would go away under a government system. I don't see anyone standing up and saying what we have is not perfect, but there are some positives to it."

**Sam Nussbaum, MD**, executive vice president and chief medical officer at WellPoint, Inc., in Indianapolis,

**"The contraction of employment is hurting health plans."**

—*Ian Duncan*

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Recently filed legislation would create a demonstration project to test whether value-based insurance design can work in the Medicare population.

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Employers that utilize best practices tend to perform better than their peers, but how do you define best practices for companies with health management programs?

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## Public insurance

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says the healthcare industry and policymakers should develop a “meaningful healthcare reform” through such programs as pay for performance, bundled payments, and value-based insurance design.

“There is not one silver bullet here. There are many, many opportunities to improve health outcomes, to reduce costs, and to advance quality,” says Nussbaum.

“There are many strategies that need to take us to better healthcare for all Americans.”

## Declining health plan membership

Although the future is cloudy for insurers, the present isn't so sunny either.

Layoffs and employers cutting employee health benefits have hurt private insurer membership. A major health insurer client is losing 1/2% of its membership every month because of the economy and related job loss, says Duncan. That insurer has lost more than 6% of its members in a year.

“A health plan doesn't grow in normal times that much in a year,” says Duncan. “The contraction of employment is hurting health plans.”

Although more members are being forced out of employer-based plans, private health insurers and employers are not making massive changes to benefits. In fact, employers continue to push ahead with employee wellness programs, which surprises Duncan. “In a situation of reduced budgets, I would expect [employers] to go for that first.”

With the new Democratic-controlled White House and Congress, health insurers no longer have the support they enjoyed during the Bush administration.

That change in leadership also means that Republican-enacted attempts to control healthcare costs, such as consumer-driven health plans, high-deductible health plans, and health savings accounts (HSA), have fallen out of favor.

Rather than focus on cost containment, Democrats view healthcare access as the larger problem, says

**Devon Herrick, PhD**, senior fellow in healthcare at National Center for Policy Analysis in Dallas.

“The public health advocates that are advising the administration and members of Congress tend to view cost-sharing as a barrier to access,” says Herrick. “The way insurers have been trying to rein in spending and the way the Bush administration and the Republican Congress were trying to empower patients is really not a vision that is shared as much in the current administration and the leadership in Congress.”

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Herrick doesn't expect Democratic leaders to wipe out HSAs, but they may change regulations surrounding the accounts that would make them less attractive to prospective members.

**Changing misconceptions about costs**

In light of the health reform debate, health insurers have been vocal about the reasons behind increased healthcare costs. Some activists and policymakers have charged that health insurer overhead is the main reason and have subsequently been pushing for limits on an insurers' medical loss ratio.

But AHIP and the WellPoint Institute of Health Care Knowledge have come out with information that states otherwise.

In May, WellPoint Institute of Health Care Knowledge reported that only 3 cents of the health dollar goes to insurer profit. Meanwhile, 87 cents of every premium dollar goes to providing medical services, such as physician services, hospital costs, drugs, and other medical services. The other 10% goes to compliance, claims processing, and other administrative costs, according to the May report, *What's Really Driving the Increase in Health Care Premiums*.

Those findings go against public perceptions. In a survey of WellPoint members between 2005 and 2008, the insurer found that 60% of consumers surveyed thought insurers' profit margins exceeded 20%.

If health costs aren't rising because of health insurers, where is it coming from? WellPoint Institute of Health Care Knowledge suggests five reasons:

- Higher priced technologies and overuse of them.
- Price inflation for medical services.
- Patient lifestyles leading to obesity and chronic disease. (See Figure 1.)
- Regulation costs.
- Cost shifts from Medicaid, Medicare, and the uninsured to private payers, which WellPoint said increases premiums 15%–20%. (See Figures 2 and 3.)

**Figure 2: Average charge per inpatient day**

2002	\$7,132
2003	\$7,559
2004	\$8,753
2005	\$9,531
2006	\$10,217

Source: WellPoint Institute of Health Care Knowledge's *What's Really Driving the Increase in Health Care Premiums? May 2009*.

**Figure 3: Average charge per emergency room visit**

2002	\$1,132
2003	\$1,345
2004	\$1,626
2005	\$1,853
2006	\$2,085

Source: WellPoint Institute of Health Care Knowledge's *What's Really Driving the Increase in Health Care Premiums? May 2009*.

**Figure 1: Percentage of Americans with three or more chronic conditions**

Age bracket	1996	2005
45–64	13%	22%
65–79	n/a	45%
80 and older	38%	54%
All ages	7%	13%

Source: WellPoint Institute of Health Care Knowledge's *What's Really Driving the Increase in Health Care Premiums? May 2009*.

The industry should also analyze the 20%–30% of healthcare services that don't improve health outcomes, Nussbaum says. That is an area where healthcare could save money and, in turn, cover more people and provide preventive services. Finding that kind of information will lead to healthcare reform, he says.

"For meaningful health care reform to occur, policy-makers will need a clear and accurate understanding of the real [vs. perceived] factors that are actually driving the cost increases," wrote WellPoint Institute of Health Care Knowledge. ■

## Medical cost trend fairly stagnant, but consumers shouldering bigger load of healthcare costs

The total 2009 medical cost for a typical American family of four in an employer-sponsored PPO will increase more than 7% this year. These same families are paying an additional \$500 more for healthcare than they did in 2005, according to the fifth annual Milliman Medical Index (MMI).

Although employees are spending more in 2009, the increase is actually the lowest trend rate since the MMI started following trends five years ago and is the third consecutive rate decrease. (See Figures 4 and 5.)

Despite that bit of good news, employees will still pay nearly another 15% in employee payroll deductions for healthcare compared to 2008. Meanwhile, employee out-of-pocket cost sharing will increase by 5.4%. Employers will see the same increase, which is the lowest medical cost increase over the past five years.

Employers are increasingly transferring healthcare costs to employees through higher premiums and out-of-pocket costs.

As businesses have struggled in the current economy, they have transferred more health costs onto employees. With another 7% added to employee health costs,

**Figure 4: The average annual medical cost for a family of four in a PPO**

2005	\$12,214
2006	\$13,382
2007	\$14,500
2008	\$15,609
2009	\$16,771

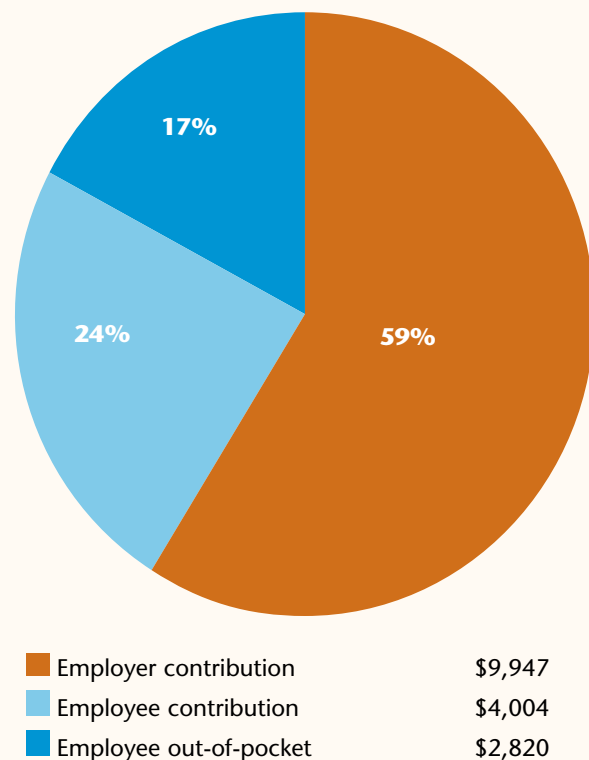
Source: 2009 Milliman Medical Index.

**Figure 5: Trend in Milliman Medical Index**

2005/2004	9.1%
2006/2005	9.6%
2007/2006	8.4%
2008/2007	7.6%
2009/2008	7.4%

Source: 2009 Milliman Medical Index.

**Figure 6: Relative proportions of medical costs**



Source: 2009 Milliman Medical Index.

have we reached a tipping point? **Ron Cornwell**, principal and consulting actuary at Milliman in Omaha, NE, says no.

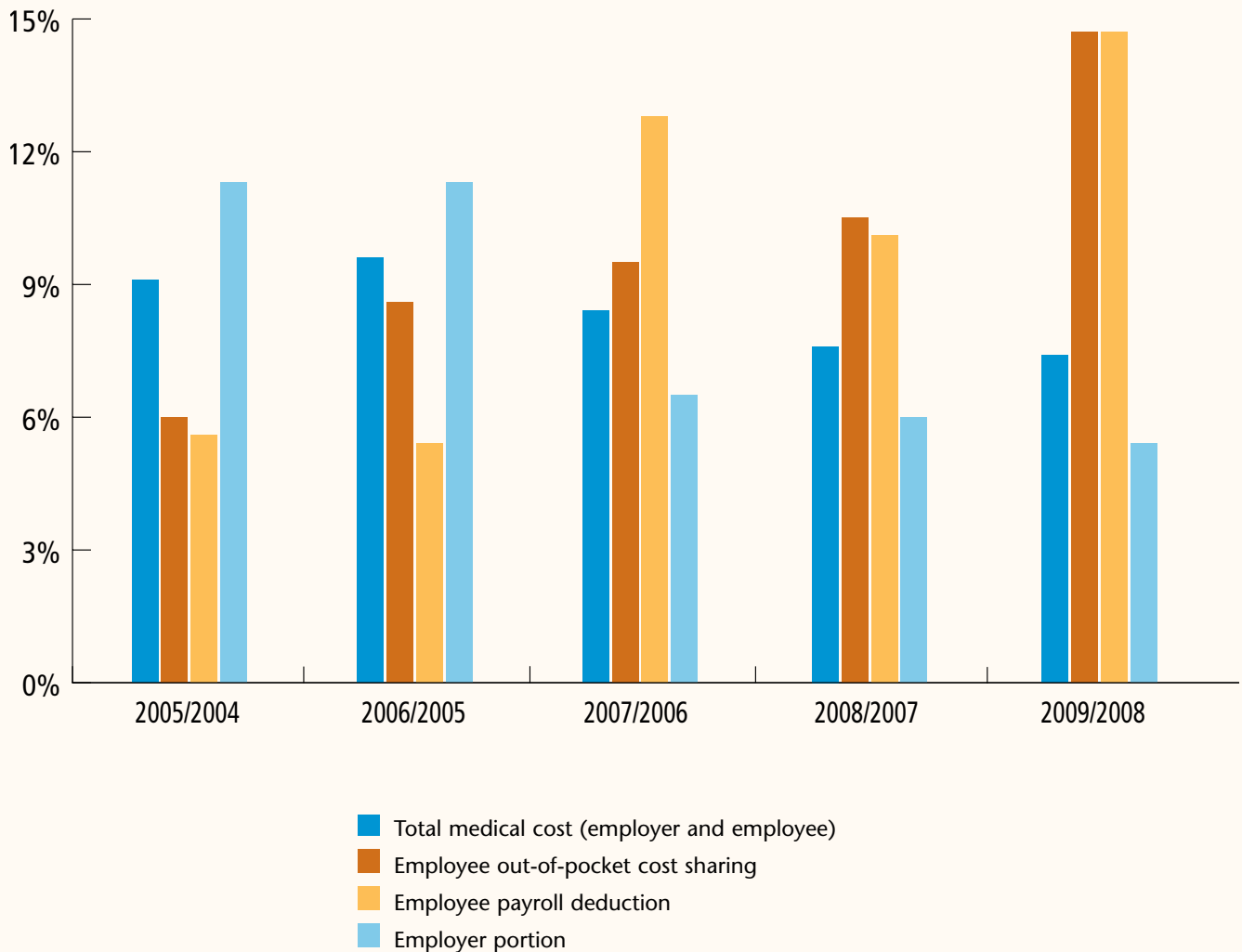
“Is there still room where employers are saying we can go farther? Yes. Is there a case where the majority of employees can say we can absorb more? Yes. But at the same time, for some employers it has reached a tipping point,” says Cornwell. “For some employees, it has reached a crisis stage. There are stories out there, but in the aggregate we still see there is still some room in the system to take on some of the burden of these costs right now.”

Employers still pay the majority of healthcare costs, contributing 59%, compared to 24% for employee contributions and 17% from employee out-of-pocket costs, according to Milliman. That said, this is the first year Milliman has seen employee costs outpace employer contributions by such a large margin. (See Figure 6 on p. 4 and Figure 7 below.)

“This statistic reiterates the struggle that employers are experiencing right now with this tight economy and rising healthcare costs,” says Cornwell.

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**Figure 7: Annual increase in spending split by employer and employee portions**



Source: 2009 Milliman Medical Index.

### Medical cost

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Although employers are shifting benefit plans toward greater employee responsibility, businesses are also laying off employees and cutting salaries as a way to achieve immediate cost savings. Milliman wrote:

*Because benefit plans are typically changed only annually, and because employees can choose to change plans only once each year, cost sharing is slower and more variable in its impact than other cost-saving strategies. In light of this, we find many employers are choosing to implement salary reductions or layoffs now in order to ensure their viability and will consider additional, perhaps more dramatic, changes to their benefit plans in future annual benefit cycles. In other words, we expect benefit plan changes to continue even after the recession subsides.*

### Macroeconomic effects on healthcare costs

The combination of sagging private business revenues, rising unemployment rates, decreasing government tax revenue, and lower healthcare provider gross revenues are affecting total healthcare expenditures.

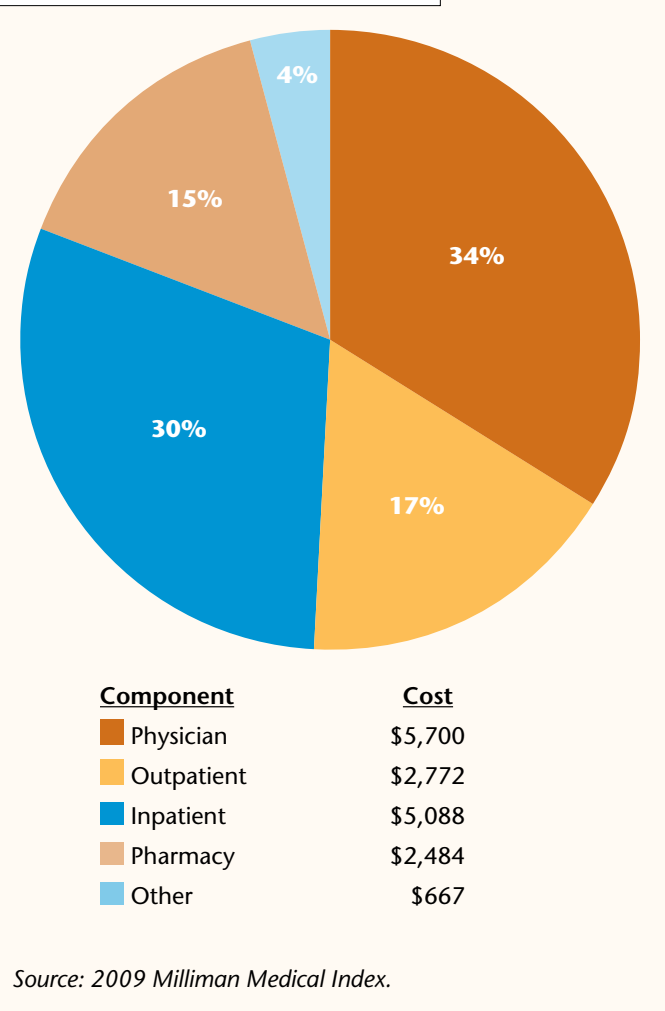
Milliman found that every category (i.e., outpatient, inpatient, physician, pharmacy, and other) had lower cost trends than inpatient and outpatient costs. (See Figure 8 at right.)

Over the past five years, outpatient and pharmacy have increased the most of the five areas. During that same time span, physician cost trends were one of the lowest components, although they still comprise the highest component of spending, according to the MMI.

The reason for medical cost increases are higher prices for services and not utilization of inpatient and outpatient hospital services. In fact, the utilization trend will be flat this year, according to Milliman. This is because insured people are delaying care due to higher out-of-pocket costs and economic instability, along with there being more uninsured Americans because of layoffs and employers cutting benefits.

Patients delaying care could lead to long-term health problems, which could cost the healthcare system more

**Figure 8: 2009 MMI components of spending**



in the long run. This could also force providers to increase costs in the short term, says **Lorraine Mayne**, principal and consulting actuary at Milliman in Salt Lake City.

“These utilization changes may temporarily keep the trend lower, but ultimately may put an upward pressure on the cost for service because healthcare providers will need to continue covering their costs and maintaining their incomes,” says Mayne.

Although costs are on the rise, the Milliman researchers found positive initiatives in regard to improving quality and efficiency. Some healthcare players

are reversing cost trends through inpatient efficiency and quality, commercial payers are focusing on inpatient utilization review, and Medicare is focusing on reducing readmissions and not paying for never events.

“On the employer front, we’re continuing to see a focus on prevention, wellness, and disease management services, but the purchasers are becoming more savvy,” says **Kate Fitch**, principal and healthcare consultant at Milliman in New York City, adding that employers are now demanding better reporting and vendors risk their fees by achieving specific outcomes.

Healthcare professionals are also promoting the medical home concept as a way to improve care and lower costs. The medical home has been touted as an alternative

to disease management and an enhancement of the programs, although questions remain about the concept.

“The verdict is still out whether the medical home delivery of care will reduce medical cost trend,” says Fitch.

### Miami tops costs

Of the 14 major metropolitan areas Milliman reviewed for MMI, Miami topped the list for 2009 with an MMI of \$20,282, which is 120.9% of the national percentage. New York City finished a close second with \$19,684 MMI or 117.4% of the national percentage. Phoenix and Seattle, meanwhile, were the lowest MMI, with \$14,857 (88.6% national percentage) and \$15,564 (92.8% national percentage) respectively. (See Figure 9 below.)

> *continued on p. 8*

**Figure 9: Geographic variations in health costs**

City	Milliman Medical Index	National percentage
Miami	\$20,282	120.9%
New York City	\$19,684	117.4%
Chicago	\$19,008	113.3%
Boston	\$18,119	108%
Memphis, TN	\$17,734	105.7%
Washington, DC	\$17,374	103.6%
Minneapolis	\$17,374	103.6%
Philadelphia	\$17,292	103.1%
Los Angeles	\$16,965	101.2%
Dallas	\$16,849	100.5%
Nationwide	\$16,671	100%
Denver	\$16,517	98.5%
Atlanta	\$15,979	95.3%
Seattle	\$15,584	92.8%
Phoenix	\$14,857	88.6%

Source: 2009 Milliman Medical Index.

## Medical cost

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The costs of services varied by area, Fitch says. For example, although Seattle enjoys the lowest inpatient costs, it ranks worse for outpatient costs. Phoenix, which has the lowest outpatient and physician costs, is in the middle range for inpatient costs.

The costs are related to many factors, Fitch says. Most important are the variations in provider practice

patterns and consumer purchasing patterns. To a lesser extent, regional variation in costs dealing with doing business in those areas, differing labor costs, and local regulations are a factor.

The cost differences between the highest and lowest MMI could have been greater if Milliman had included rural areas. ■

## Insurers are paying faster and denying fewer claims

Health insurers are paying physicians 5% faster and denying 9% fewer medical claims than last year, but there is still room for improvement for some payers, most notably state Medicaid programs, according to athenahealth's fourth annual PayerView Rankings.

The Internet-based provider of business services to physician practices evaluated 172 national, regional, and government payers in 40 states, which was the largest data set to date. The company used performance data from more than 18,000 medical providers, representing more than 41 million medical charge lines and \$7 billion in charges billed in 2008.

Athenahealth found that payers are collaborating more with physicians to automate claims and billing work as they reduce administrative costs and streamlining claims processing. That allows providers to focus more on delivery of care.

The findings underscore results from a study by The Commonwealth Fund and Robert Wood Johnson Foundation's Changes in Health Care Financing and

Organization that found physician practices spend as much as \$31 billion annually on administration and business transactions with health insurers. (See "Payers' administrative practices ... " on p. 13.)

**Jeremy Delinsky**, vice president of athenaNet Intelligence at athenahealth in Watertown, MA, says the rankings are not about winners and losers, but improving and streamlining administrative processes so physicians can focus on patient care. Health insurers should focus on reducing administrative waste from the healthcare system, Delinsky says, adding that it's up to stakeholders to remove inefficiencies, or someone else—such as the federal government and the public insurance option—will.

The problem is health insurers' varied policies and procedures for claims submissions and payment. Although some have streamlined the process and implemented real-time claim adjudication programs, others have created programs that add extra work for practices. Most health insurers see administration costs as a problem and want to make changes, Delinsky says.

Athenahealth divided the insurers into six groups: national payers, major nationals, regional payers, Blues, Medicare, and Medicaid. Some companies, such as Aetna, Humana, Cigna, and UnitedHealth Group, were in the national payers and major nationals categories.

The researchers found that major nationals achieved high marks in the areas of lowest days in accounts receivable (DAR), highest first-pass resolve (FPR), and

### Questions? Comments? Ideas?

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lowest denial rate. (See Figures 10–12). Delinsky says that’s because most of the major national insurers understand the importance of lower administrative costs and provider relations.

**Figure 10: Days in accounts receivable**

National payers	32.82
Major nationals	29.18
Regional payers	34.77
Blues	31.30
Medicare	32.55
Medicaid	68.57
2008 weighted average	38.20

Source: 2009 athenahealth PayerView Rankings.

“I think they take seriously that what’s good for their cost structure is good for the providers,” he says.

Athenahealth also found that some regional payers performed well. For example, Blue Cross Blue Shield of Rhode Island (BCBS-RI) had the lowest DAR at 15.4 days, making 2009 the third year in a row that BCBS-RI ranked the best in the category.

Athenahealth pointed to three reasons for the insurer’s success: it operates in a small state, it’s a dominant player in the market, and it has created a transparent system that lets providers know what is required to get claims accurately processed and paid. These three factors help providers understand what’s expected of them.

**Medicaid is a problem**

The group that consistently performed poorly in these three areas was state Medicaid programs. Medicaid had a twice longer DAR than other groups and denied more than one in every five claims.

According to athenahealth, there were several reasons for Medicaid’s results:

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**Figure 11: First-pass resolve**

National payers	94.47%
Major nationals	95.58%
Regional payers	93.57%
Blues	94.44%
Medicare	93.90%
Medicaid	82.97%
2008 weighted average	92.49%

Source: 2009 athenahealth PayerView Rankings.

**Figure 12: Denial rate**

National payers	7.66%
Major nationals	5.86%
Regional payers	8.72%
Blues	7.44%
Medicare	8.44%
Medicaid	21.73%
2008 weighted average	9.98%

Source: 2009 athenahealth PayerView Rankings.

## Insurers

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- Insufficient resources for providers, which include inadequate call center staff member training to research and/or follow claims, which leads to misinformation and requires additional phone calls to resolve the issues; outdated and difficult-to-find provider manuals and other documentation; and unavailable information obtained from eligibility checks that don't provide enough information to inform the provider's actions
- Greater response from providers in the area of fraud control, including custom claim form and original signature requirements
- An ever-changing landscape featuring programs that are continuously introduced or phased out based on

fund availability, which prevents a provider from understanding the program enough to properly manage his or her Medicaid patient population

"These issues manifest themselves in a higher than average denial rate, a higher than average DAR—due to claims remaining outstanding for a longer period of time, and finally a lower FPR, due to claims having to be submitted multiple times to address unclear billing requirements," according to athenahealth.

The New York Medicaid program ranked worst for DAR and FPR, which athenahealth suggested was because of complex authorization requirements, use of

**Figure 13: High and low performers**

Metric	Payer
<b>High performers</b>	
Low days in accounts receivable	Blue Cross Blue Shield of Rhode Island
High first-pass resolves	Blue Cross Blue Shield of Indiana
Low denial rate	Blue Cross Blue Shield of Rhode Island
High denial transparency	Affinity Health Plan of New York
Low medical documentation	Paramount Health Care
<b>Low performers</b>	
High DAR	Medicaid—New York
Low FPR	Medicaid—New York
High denial rate	Medicaid—Florida
Low denial transparency	Medicare B—Rhode Island
High medical documentation	Medicare B—California, Southern

Source: 2009 athenahealth PayerView Rankings.

**Figure 14: Payer rankings through the years**

Rank	2008	2007	2006	2005
1	Humana	Aetna	Cigna	Humana
2	Aetna	Cigna	Aetna	Medicare B
3	Cigna	Humana	Medicare B	UnitedHealth Group
4	UnitedHealth Group	Medicare B	Humana	Aetna
5	Medicare B	UnitedHealth Group	UnitedHealth Group	Cigna
6	WellPoint	WellPoint	WellPoint	Champus/Tricare
7	Champus/Tricare	Coventry Health Care	Coventry Health Care	WellPoint
8	Coventry Health Care	Champus/Tricare	Champus/Tricare	n/a

Source: 2009 athenahealth PayerView Rankings.

proprietary claim forms for paper submission, lack of acknowledgment from Medicaid for claims submitted, use of identical remittance codes to indicate denied and pended claim scenarios, and onerous enrollment processes. (See Figure 13 on Page 10.)

These results are quite different from Medicare, which received much higher marks in the rankings. Diving deeper into the findings, athenahealth found that Medicaid managed care programs, which are operated by private insurers, performed much better than state Medicaid programs.

One problem is that states faced with limited budgets often make cuts to Medicaid programs and/or stop paying claims, Delinsky says.

“That is essentially like taking an interest-free loan on the backs of medical providers. There has to be a better way to fund the system than to have providers essentially treat patients for free upward of 90 days. That just doesn’t feel like the states have responsibly managed their budgets if that’s happening. You can understand

why the provider wouldn’t want to participate in the program,” says Delinsky.

### Humana is tops

On the flip side of Medicaid is Humana, which topped the rankings for the second time in four years. (See Figure 14.) Humana topped the national payers in the areas of lowest DAR.

**Mark Smithson**, vice president of provider process and network operations at Humana in Louisville, KY, points to two reasons for the high marks: real-time claim adjudication and electronic remittance devices. Smithson says many health insurers say they have real-time claim adjudication, but still require physician offices to log on to the payers’ sites and reenter the information. This merely adds work to physicians’ offices. The key is to integrate the physician practice into the physician offices’ practice management system, he says.

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## Insurers

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By going through real-time claim adjudication, the office avoids batching the claims, mailing them, and having a third-party vendor intervene.

"We don't change dramatically how they put their charges in," he says. "Not only does it help at the patient collection window, it also speeds up the entire process."

Not that the changes are seamless. Smithson says the health plan and office must work to have the process

complement the work flow, but realize the changes will affect work flow. "What this does do is streamline all that so the person is no longer in the back office, but in the front office at the patient window, so it does somewhat disrupt their work flow," he says.

For example, one practice has color-coded Humana patient charts so the office employees know it has a different work flow. It is important to educate the physicians' offices from the start so they know what changes are needed. "The better the communications up front, the more smooth the whole transition is going to run," Smithson says.

It's Humana's strategy to be the easiest payer for providers to do business with, and athenahealth's results show that the strategy is working. Humana's mind-set is that it would rather pay pennies to process the claims through streamlined processes and avoid back-end phone calls, Smithson says, adding that each phone call avoided saves the company \$7.

**William F. Jessee, MD, FACMPE**, president and CEO of the Medical Group Management Association (MGMA), which represents 22,500 members, says fast, accurate payments are critical to manage business operations of physician practices. Although Humana tops the rankings, "there remains considerable room for improvement across the industry," Jessee says. "Humana has shown a willingness to reach out directly to MGMA and carefully listen to the needs of our members. Its ability to embrace new technologies and adapt to meet the needs of its group practice customers is clearly beginning to pay off."

Athenahealth's rankings look at administrative ease and efficiency, but the company would like to expand its program to include other areas, which Delinsky says will be more meaningful for providers. "I think you can probably make some correlation about administration efficiency if you had more data publicly about these companies, but it doesn't get into comparative payments yet. That is something we're likely to do in coming years," he says. ■

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## Payers' administrative practices costing physician offices as much as \$31 billion annually

Physicians spend three hours per week—43 minutes on average per workday—haggling over claims, credentialing, authorizations, formularies, and other issues with health insurance plans, according to a study released in *Health Affairs*.

*The Costs to Physician Practices of Interactions with Health Insurance Plans* found that total staff interaction time systemwide converted to dollars equals \$21–\$31 billion annually—an average of more than \$68,000 per physician per year.

“These data are yet another indicator of the dire need to streamline healthcare administration for physician practices,” says **William F. Jessee, MD, FACMPE**, president and CEO of the Medical Group Management Association (MGMA), which sponsored the study.

The study found that primary care physicians spend more time dealing with health plans than specialists. Nursing staff members spend nearly four hours per physician per day interacting with plans, and clerical staff members average 7.2 hours per day. Solo practitioners and their staffs spend up to 50% more time interacting with health plans than physicians in larger practices. Nonphysicians' staff time did not vary significantly by specialty.

**Douglas Henley, MD**, executive vice president and CEO of the American Academy of Family Physicians, says he's not surprised that primary care physicians and their staffs spend the most time haggling with insurers. “It's because of the diversity of their practices compared with subspecialty colleagues,” Henley says. “It's a huge burden for the whole system, but particularly for primary care.”

Some physician interactions with insurers save money elsewhere in the system with issues such as precertification, “but a large chunk of those dollars are for an unnecessary administrative burden that could clearly be streamlined,” he says.

Most primary care physicians contract with several health insurance companies, and each company may offer five or six different coverage plans, Henley says. “What is the copay? What is the deductible? How much of that has been paid? What drugs are or aren't on their formulary? What are the levels or different tiers of the formulary? It's all different,” Henley says. “We are talking about standardizing health information technology, and we ought to be able to standardize this type of administrative complexity and get beyond it.”

**“These data are yet another indicator of the dire need to streamline healthcare administration for physician practices.”**

—*William F. Jessee, MD, FACMPE*

**Robert Zirkelbach**, director of strategic communications at America's Health Insurance Plans (AHIP), says he can't dispute cost claims in the MGMA study “until I see what they calculated or how.” However, Zirkelbach says, AHIP is sympathetic to providers' concerns about the complicated, time-consuming, and expensive administrative processes that also waste money and time for health plans.

“This is not by any means a one-sided issue,” says Zirkelbach. “Everybody agrees that we have to do more in the areas of health information technology to improve efficiencies and make the system work better for everyone involved.”

In response to this issue, MGMA wants a three-step reform plan that could save about \$40 billion annually, Jessee says. The MGMA recommendations include:

- Promulgation of a national health plan identifier regulation by the U.S. Department of Health and Human Services, which would simplify and improve healthcare transaction routing and save an estimated \$8.8 billion annually
- Promulgation of the national electronic claim attachment regulation, which would eliminate lost paper

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## Payer cost

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claims, accelerate the adjudication process, and eliminate the costs associated with filing and mailing paper documents, saving \$9.4 billion annually

- ▶ Standardization of machine-readable patient identification cards, reducing claims errors and administrative costs and eliminate many costs associated with paper records for a savings of \$22.2 billion annually

The study classified interactions with health plans as authorization, formulary, claims/billing, credentialing, contracting, and quality data. Of those interactions, practices spend the most time dealing with formularies: Physicians spend 1.3 hours per week, and nursing staffs spend 3.6 hours per physician per week. Primary care physicians spend the most time—1.7 hours weekly—on formulary issues. Physicians and their staffs spend the least amount of time on submitting or reviewing quality data.

The problem could get worse if Medicare adopts reforms that will install the same administrative requirements as the private plans, such as for precertification, Henley says. “If they subdivide that in a certain way, that could create an additional and unnecessary administrative burden,” he says.

The health insurance industry is pushing for standardization and uniformity in information exchange and administrative procedures to “help physicians to interact with all of the health plans they contract with. This is an area that we have prioritized,” Zirkelbach says.

The survey includes responses from 1,310 primary care physicians, 580 specialists, and administrators from 629 group practices. The study does not distinguish between the interactive time spent with public and private health plans. ■

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## Report: States could save money by expanding Medicaid managed care

Medicaid managed care is providing a safety net of care coordination to millions of at-risk Americans and is improving patient outcomes and quality of care as it reduces states’ healthcare costs, according to a recent Lewin Group report that was prepared for America’s Health Insurance Plans (AHIP).

A state looking to cut Medicaid costs should not reduce benefits or lower payment rates, but expand its managed care program, according to the report.

The Lewin Group released a similar study five years ago and returned to the same subject, achieving similar results. In its latest report, The Lewin Group stated that Medicaid managed care health plans improve beneficiaries’ access to services and have earned high satisfaction ratings from enrollees, in addition to improving care and saving money. The researchers pointed out that although nearly half of Medicaid beneficiaries are enrolled

in managed care plans, more than 80% of national Medicaid spending is in the fee-for-service (FFS) setting.

“While it is difficult to accurately predict the level of cost savings that will be achieved in any given Medicaid managed care program, our synthesis of findings from a large body of research on the topic clearly illustrates that Medicaid managed care typically saves money and represents a highly attractive alternative to reductions in eligibility and benefits and/or provider payment cuts,” wrote The Lewin Group.

**Karen Ignagni**, president and CEO of AHIP, says Medicaid managed care plans coordinate care, offer patient outreach not available in FFS Medicaid, provide focused chronic care and disease management programs, offer preventive services, and give nonhealthcare assistance to beneficiaries in areas such as finding alternatives to nursing home care.

“The bottom line of The Lewin Report is that we are providing high value and cost-effectiveness for states at this time of economic crisis,” Ignagni says. “At this time, we are providing better quality, more access, and a higher degree of satisfaction to beneficiaries than traditional Medicaid programs. That’s quite a legacy.”

After analyzing 24 recent studies of Medicaid managed care programs, The Lewin Group reported that:

- The studies strongly suggest that the Medicaid managed care model typically yields cost savings. The results ranged from 0.5% to 20% savings compared to FFS Medicaid.
- The studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related population.
- Various studies demonstrate that states’ Medicaid managed care cost savings are largely attributed to decreases in inpatient utilization, which could be linked to care coordination.
- Medicaid managed care plans yield “noteworthy savings” in pharmacy. In comparing FFS programs’ drug costs versus Medicaid health plans, researchers found the costs per member per month were 10%–15% lower for the private health plans.

**James Carlson**, president and CEO of AMERIGROUP Corporation, which covers 6.7 million Medicaid beneficiaries in 14 states, says care coordination helps millions of Americans who would otherwise be lost in the health-care system, adding that more states understand the benefits of Medicaid managed care.

“I do think that we as an industry have matured to the point that the states understand that these programs have to be reasonably well funded because it would cost more if they didn’t have us ... More often than not, we’re finding states that appreciate the involvement of the private sector,” says Carlson.

Not every state has been satisfied with its Medicaid managed care program, most notably Florida. However, The Lewin Group highlighted other states which have experienced more positive results.

The Lewin Group wrote, “It is clear that—through carefully crafted managed care program design that is tailored to the state’s Medicaid populations and geographic landscape real opportunities exist for states to benefit from expanding the Medicaid managed care model to eligibility categories and services heretofore largely excluded from managed care.”

Rather than cutting eligibility, eliminating benefits, or reducing provider payments, The Lewin Group and Medicaid managed care

supporters say states should look to expand these programs, given current budget pressures.

In its report, The Lewin Group suggested that:

- States consider including SSI and SSI-related population in a Medicaid managed care program because the SSI subgroup has a larger percentage of Medicaid beneficiaries with disabilities
- States with Medicaid managed care should revisit their carve-in, carve-out decisions

“As states consider expanding their Medicaid managed care programs and as other states implement new Medicaid managed care programs, they may wish to include certain populations (e.g., SSI) and services (e.g., pharmacy and mental health services) that have often been excluded from Medicaid managed care due to quality and access to care concerns,” according to the report.

Given these positive results, AHIP supports a plan that would allow anyone under 100% poverty levels to be eligible for Medicaid, Ignagni says.

Those levels now vary by state and are not strictly based on income.

Carlson also suggests that states change laws to allow Medicaid beneficiaries to not have to recertify their eligibility every six months. ■

**“The bottom line of The Lewin Report is that we are providing high value and cost-effectiveness for states at this time of economic crisis.”**

—Karen Ignagni

## Health insurance industry seeks Medicaid drug rebate

### State Medicaid programs benefit from reduced drug costs

Private health insurance leaders are pushing Congress to allow them to benefit from the Medicaid Drug Rebate Program, which insurers say would let them pass drug savings on to the states while providing a high level of care coordination. The drug rebate was created in 1990 and requires a drug manufacturer to enter into an agreement with the U.S. Department of Health and Human Services to offer the rebate to Medicaid state programs. In 1992, the rebate program was extended to include the Veterans Administration.

Approximately 550 pharmaceutical companies participate in this program, which is available in 49 states and the District of Columbia, according to CMS.

The current law, which would be changed if legislation on Capitol Hill is approved, means that states need to decide between saving money through the drug rebate or benefiting from the health plans' care coordination.

About half of all Medicaid beneficiaries are now in managed care programs, which means private insurers that run those programs are losing out on the financial benefits because states are carving out the pharmacy program.

"This drug rebate has become an important issue because roughly half of Medicaid beneficiaries are managed under managed care, and the states don't have access to the rebates. If this bill is passed into law, those rebates

would go to the states, and it would add another \$11 billion for state budgets at a time when the states are under severe financial stress," says **J. Mario Molina, MD**, chair and CEO of Molina Healthcare in Long Beach, CA, which covers more than 1.3 million Medicaid lives in 11 states.

The Obama administration has targeted the Medicaid Drug Rebate Program as a potential area of savings and calls for saving \$8.8 billion over five years by mandating increased Medicaid drug rebates.

**Karen Ignagni**, president and CEO of America's Health Insurance Plan, says Medicaid managed care plans should receive the same drug rebates because they are in effect working as state agents.

States that want to take advantage of the drug rebate have carved out pharmacy programs from their private Medicaid managed care plans. On the down side, private insurers say this means the private Medicaid health plans aren't receiving the immediate pharmacy benefit management information that they could integrate into their member care, leaving out a piece of the whole person's care coordination.

For example, if a Medicaid beneficiary were placed under a particular medication, the health plan could immediately find out whether the private plan provides drug coverage and enroll the member in a disease management or wellness program. ■

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## Massachusetts healthcare reform's success comes from 'shared responsibility'

Critics of the Massachusetts healthcare reform charge that the program has not kept costs under control and forces Bay Staters to get health insurance, resulting in more customers for health insurers.

However, a new report released in May shows the state's costs to fund the reform "has been relatively modest and well within early projections." Massachusetts'

health reform's "shared participation" has reduced the number of uninsured residents while having "a marginal impact on state spending," according to the report, *Massachusetts Health Reform: The Myth of Uncontrolled Costs*.

The Massachusetts Taxpayers Foundation report found that the state's health reform spending will grow by a projected \$707 million between fiscal 2006 and fiscal

2010—half of which is being supported by federal reimbursements. In fact, the state has paid an extra \$353 million, or \$88 million annually, for health reform while adding more than 432,000 residents to health insurance, according to the report. (See Figure 15.)

The program's hallmark has been "shared participation," including transferring uncompensated care funds to subsidize coverage for low-income adults and children and encouraging enrollment in employer-sponsored and individual health insurance plans, wrote the nonprofit fiscal watchdog group.

"This 'shared participation' approach to reform was instrumental in solidifying support for Chapter 58 from a broad spectrum of stakeholders, including hospitals, physicians, insurers, employers, unions, and community groups, and it has helped keep the support solidly intact despite occasional but significant disagreements over some aspects of implementation," wrote the Massachusetts Taxpayers Foundation.

Since implementing the health reform program in 2006, about 148,000 newly insured residents enrolled in employer-based insurance, and another 169,000 joined Commonwealth Care, which is the unsubsidized state reform program. An additional 76,000 joined MassHealth, which is the subsidized state program, and 39,000 bought individual health insurance plans.

The health reform uses individual and employer incentives and responsibilities to "build on the state's historically high level of employer-sponsored coverage," according to the report.

The report states that "strong, steady growth in privately funded coverage has helped dispel concerns that public programs would replace, or 'crowd out,' private coverage. In fact, the foundation estimates that the added cost to Massachusetts employers for newly insured employees and dependents is at least \$750 million—more than double the \$353 million increase in state spending since health reform was enacted."

**Jon Kingsdale**, executive director of the Commonwealth Health Insurance Connector Authority, which oversees the Massachusetts reform program, says the report shows that shared responsibility is "really the theme of our landmark reform legislation, and it works."

"The financial framework is working as envisioned because everyone is sharing responsibility—individuals, employers, and government—[and] it is reasonably affordable," says Kingsdale.

The Massachusetts Taxpayers Foundation report comes after concerns were raised about whether the healthcare reform program can last. Government and industry officials have charged that the program may not be sustainable over the next five to 10 years if Massachusetts does not control health spending. In response, state officials are exploring a bundled physician and hospital payment system that would reward prevention and keeping people out of the hospital. Advocates for bundled payments believe changing the way the system pays doctors and hospitals could help control healthcare costs. ■

**Figure 15: Number of Massachusetts insured since healthcare reform**

Type of insurance	6/30/2006	12/31/2006	6/30/2007	12/31/2007	6/30/2008	9/30/2008	Increase since 6/30/06
Employer group	4,292,000	4,356,000	4,396,000	4,422,000	4,431,000	4,440,000	148,000
Individual purchase	40,000	39,000	36,000	65,000	76,000	79,000	39,000
Commonwealth Care	0	18,000	80,000	158,000	176,000	169,000	169,000
MassHealth	705,000	741,000	732,000	765,000	785,000	781,000	76,000
<b>Total members</b>	<b>5,037,000</b>	<b>5,154,000</b>	<b>5,244,000</b>	<b>5,410,000</b>	<b>5,468,000</b>	<b>5,469,000</b>	<b>432,000</b>

Numbers are rounded to the nearest 1,000.

Source: Massachusetts Division of Health Care Finance and Policy, Health Care in Massachusetts: Key Indicators Report, February 2009.

## Bill would test value-based insurance in Medicare

Recently filed legislation would create a demonstration project to test whether value-based insurance design (VBID) can work in the Medicare population.

Trumpeted by employers and health plans as a way to improve patient outcomes and lower long-term health costs, VBID lowers or eliminates copays for high-value prescriptions and treatments, such as medication for diabetes, asthma, and heart disease. The concept follows the logic that removing cost barriers will help at-risk patients follow their prescription regimens and not postpone doctors' appointments because they can't afford the care.

The bipartisan legislation was filed by **Sen. Kay Bailey Hutchinson** (R-TX) and Sen. Debbie Stabenow (D-MI). Hutchinson says the federal government has lagged behind the private sector in adopting VBID strategies.

"Value-based insurance design has the power to truly bend the healthcare cost curve in the right direction. By taking practical steps to lower healthcare costs and improve health, we can make insurance more affordable for all Americans. Ultimately, that is the single most important goal of healthcare reform," says Hutchinson.

VBID pilot programs have been successful in the commercial population. Marriott and Pitney Bowes, pioneers in the VBID movement, eliminated cost sharing associated with diabetes medications and achieved positive cost and quality outcomes.

Although many health insurers and employers have increased copays and created high-deductible plans as a way to lower their healthcare costs, VBID supporters say the concept is a more forward-thinking way to tackle spiraling costs.

"Cost containment efforts should not lead to preventable decreases in quality of care. The inclusion of value-based design into the Medicare program will show that an approach that encourages the increased use of high-value medical services will produce more health for every taxpayer dollar spent," says **A. Mark Fendrick, MD**, one of the creators of VBID and codirector at the

University of Michigan's Center for Value-Based Insurance Design.

### Could VBID work in Medicare?

A recent white paper by Avalere Health and the Center for Value-Based Insurance Design suggested that the government could implement VBID in Medicare. VBID addresses the objectives of cost containment and quality improvement by promoting fiscally responsible, clinically sensitive cost sharing, according to the white paper.

VBID advocates and policymakers think the concept could be a winner in the Medicare population. Twenty-three percent of Medicare's 26 million beneficiaries have five or more chronic conditions and account for nearly 70% of the program's spending. Medicare beneficiaries are more likely to have chronic illness than the commercial population and more apt to take multiple medications. Costs can create a barrier to medication compliance for beneficiaries. On average, the Medicare Part D population takes five prescription drugs per day and nearly 20% of them are not able to fill a prescription or delay filling a prescription because of cost, according to the white paper.

"You have the potential to have an even greater impact [in the Medicare population] because the sicker the beneficiary is and the more you can target a value-based insurance design, the better the outcomes are likely to be," says **Lisa Murphy**, manager at Avalere Health in Washington, DC, and coauthor of the paper.

The researchers reviewed five options for Medicare in *Value-Based Insurance Design in the Medicare Prescription Drug Benefit/An Analysis of Policy Options* and found that three of them can be implemented immediately with minor operational changes (see Figure 16 on p. 19):

- Reduce cost sharing for specific drug or drug classes
- Exempt specific drugs or drug classes from 100% cost sharing in the coverage gap
- Reduce cost sharing for chronic special needs plan enrollees based on the plan's target condition

The other two options that were reviewed would require policy changes, such as CMS revising its nondiscrimination clause to allow for reduced cost sharing for enrollees with chronic conditions or in medication therapy management programs.

**Tanisha Carino, PhD**, vice president at Avalere Health and coauthor of the paper, says her research

shows VBID’s potential in the Medicare population. VBID has the potential to help make Medicare a “more prudent purchaser of healthcare that meets patient needs,” Carino says. “These tools need to be considered in the context of health reform as they map directly into the administration’s goals of improving quality and preventing complications of illness.” ■

**Figure 16: Policy and operational changes required for implementation**

Policy options	Likely policy change needed	Likely operational change needed
1. Reduce cost sharing for specific drug or drug classes	No policy change necessary, but additional incentives may be required to promote greater adoption	Plans may create new formulary tier for targeted drugs
2. Exempt specific drugs or drug classes from 100% cost sharing in the coverage gap	No policy change necessary, but additional incentives may be required to promote more gap coverage options that cover high-value drugs	Plans must offer gap coverage for targeted drugs; plans may create new formulary tier for targeted drugs
3. Reduce cost sharing for enrollees with chronic conditions	Examine application of nondiscrimination clause; may require exemption through regulation or legislation; exempt value-based insurance design from uniform benefit requirement through regulation or legislation	Process to identify enrollees with particular chronic condition diagnoses and select drugs eligible for reduced cost sharing
4. Reduce cost sharing for enrollees participating in medication therapy management programs	Examine application of nondiscrimination clause; may require exemption through regulation or legislation; exempt value-based insurance design from uniform benefit requirement through regulation or legislation	Ability to monitor participation in managed therapy management programs
5. Reduce cost sharing for chronic special needs plan enrollees based on the plan’s target condition	No policy change necessary; some chronic special needs plans may already be doing this	None

Source: Value-Based Insurance Design in the Medicare Prescription Drug Benefit/An Analysis of Policy Options.

## Businesses with comprehensive health management programs enjoy better engagement, health outcomes

Employers that utilize best practices tend to perform better than their peers, but how do you define best practices for companies with health management programs?

StayWell Health Management recently completed a study exploring that topic to better understand which of its clients are using best practices and to explore the differences in engagement rates and health risk change when comparing best practice companies with standard practice program designs.

**Paul E. Terry, PhD**, president and CEO of StayWell Health Management in St. Paul, MN, says the idea was to explore the companies that went “from good to great.” Researchers found that the comprehensive approach is best.

### Figure 17: Best practices

StayWell Health Management listed the following best practices identified in published studies:

- Strong organizational commitment and leadership buy-in
- Identification of wellness champions
- Program linked to organization’s business objectives
- Effective communication plan
- Use of health promotion and demand management programs
- Staff members or vendors dedicated to delivery of programs
- Interdisciplinary team focus
- All employees, and sometimes spouses, are eligible for programs
- Comprehensive programs with a lot of variety
- Awareness-raising and targeted intervention programs
- Special programs offered for employees at highest risk
- Accessible programs
- State-of-the-art programs
- Effective incentives
- Use of biometric screening and triage
- Comprehensive evaluation, including process, effect, and outcomes

Source: StayWell Health Management.

“We advocate that the industry takes a comprehensive approach to get the results they want,” says Terry.

Through its research, the health management company identified several best practices, many of which have been promoted in these pages, such as strong organization commitment, identification of wellness champions, effective communications plans, and comprehensive programs with a lot of variety. (See Figure 17.)

The researchers reviewed 22 companies with a total of 767,640 eligible employees, spouses, and retirees to find out whether the businesses were actually using best practices. The study looked at nine components identified as best practices (see Figure 18 on p. 21), gathered information from the companies, rated companies on whether they utilized best practices, and calculated engagement rates and health impact measures.

StayWell found that:

- Every best practice company integrates incentives
- More than 80% of the best practice companies have comprehensive programs and communication and biometric screening
- More than half of the best practice companies use multiple modalities and population-based programs
- Half of the best practice companies have management support and a dedicated on-site staff

The companies using best practices enjoy better engagement rates and improved health risks. More than half of best practice company employees participated in a health assessment and completed health coaching. (See Figure 19 on p. 22.) Employees of those same companies also decreased their health risks, according to StayWell.

Companies that use best practices are committed to quality improvement and view health and wellness as a long-term investment, not just a nice program to have, Terry says. These companies have integrated wellness into their businesses’ culture, are outcome

### Figure 18: Best practices for health management programs

In its research, StayWell Health Management found the following best practices for health management programs:

Criteria	Definition
Comprehensive program design	Organization provides health assessment and targeted and population-based intervention programs to eligible populations.
Integrated incentives	Organization utilizes financial incentives that are integrated into health plan benefit design, such as health plan premium reimbursements and contributions to health savings accounts.
Integrated and comprehensive communication plan	Organization utilizes a comprehensive and integrated communication strategy with multiple communication pieces and delivery channels tailored to the employee population.
Strong senior management support	Senior and midlevel management support population health management initiatives as evidenced by documented communications, infrastructural initiatives, and health-focused policies.
Dedicated on-site staff members	Organization designates dedicated staff members to work on-site to provide coordination and implementation of health management programs.
Multiple program modalities offered	Targeted telephone-based, mail-based, and online-based risk reduction (coaching) programs are offered to populations with elevated health risk factors.
Awareness-building opportunities	Population-based health education and awareness-building campaigns are offered to a majority of the population, regardless of health risk status.
Biometric health screenings	Worksite biometric screenings are offered at no or minimal charge to participants. Screenings incorporate feedback on interpretation of screening values, and information on follow-up programs and data is integrated into health assessment data.
Vendor integration	Participation data are exchanged between vendors to facilitate an integrated population health management strategy, including warm transfers and referrals, and to promote vendor awareness of other programs that coaching participants have engaged in.

Source: StayWell Health Management.

oriented, test their programs and incentives to make sure they are working effectively, and provide numerous ways to reach out to employees about their health. One key is to take a whole-person approach, Terry says. The idea is to meet the individual at his or her level through targeted population health and focus on the person's interests, resulting in more engaged consumers. (See Figure 20 on P. 23.)

"We know that we need to come in the side door with employees, which means that if their issue this year is

stress, we deal with that first and then help to segue into other risks," he says.

One of the companies that has integrated health management into its business is DTE Energy, based in Detroit. **Doug Green**, benefits manager at DTE, says the company understands that employee health and wellness are connected to productivity and healthcare costs.

DTE has office workers and labor employees who work with heavy machinery. These vastly different work

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## Health management

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climates require DTE to create wellness programs to reach the different employees.

For example, a woman working in an office might be interested in Weight Watchers classes, but a man working on electrical lines might prefer a weight-loss contest. The company has three on-site StayWell representatives,

a program manager and two program assistants, who help run DTE's wellness campaigns and communicate with the plant manager and union officers.

DTE's wellness program includes walking programs and stress, nutrition, and weight management classes. The company created an online team competition

**Figure 19: Use of best practices**

	Percent implementing practice
<b>Comprehensive program</b>	
Standard practice	56%
Best practice	83%
<b>Integrated incentives</b>	
Standard practice	56%
Best practice	100%
<b>Comprehensive communications</b>	
Standard practice	13%
Best practice	83%
<b>Management support</b>	
Standard practice	50%
Best practice	50%
<b>Dedicated on-site staff</b>	
Standard practice	19%
Best practice	50%
<b>Multiple modalities</b>	
Standard practice	56%
Best practice	67%
<b>Population-based programs</b>	
Standard practice	6%
Best practice	67%
<b>Vendor integration</b>	
Standard practice	69%
Best practice	33%
<b>Biometric screening</b>	
Standard practice	38%
Best practice	83%

Source: StayWell Health Management.

**Figure 20: Engagement rates**

	Percentage
<b>Health assessment participation</b>	
Standard practice	47%
Best practice	68%
<b>Coaching eligibility</b>	
Standard practice	67%
Best practice	85%
<b>Coaching participation</b>	
Standard practice	34%
Best practice	48%
<b>Coaching completion</b>	
Standard practice	84%
Best practice	85%

Source: StayWell Health Management.

to spark employees to lose weight and maintain the weight loss.

They also offer gift cards to employees and spouses who take part in programs, such as biometric screenings and health risk appraisals.

The result has been a “tremendous amount of weight loss,” says Green. The company has learned from its well-

ness programs that businesses need to make wellness offerings fun. “It’s got to be interesting. It’s got to have tips and ideas that make sense for employees,” says Green. “You don’t want to put something out there that is not achievable ... It’s something that they can achieve, it’s something that’s interesting for them. If it was a real boring program, we wouldn’t get anyone to participate.” ■

## PBM sale highlights dilemma for health plans

In a move that will rocket Express Scripts to the upper reaches of the pharmacy benefit management stratosphere, the company announced recently it will buy WellPoint’s pharmacy benefits management (PBM) services for \$4.68 billion. The deal, which is expected to close in the second quarter of this year, includes a combination of cash and up to \$1.4 billion in stock.

The deal also features a 10-year contract for Express Scripts to provide pharmacy benefit management services to WellPoint, which is the nation’s largest health insurer by enrollment.

WellPoint’s PBM, which is called NextRx, is the nation’s fourth largest PBM by number of annual prescriptions managed, trailing Medco Health Solutions, CVS Caremark, and Express Scripts. It managed 268 million prescriptions in 2008 compared to Express Scripts’ 506 million prescriptions.

Combining the third and fourth largest PBMs will result in Express Scripts as the number two PBM, slightly behind Medco. The purchase comes two years after retail pharmacy chain CVS purchased Caremark.

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## PBM

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George Paz, chairman and CEO of Express Scripts, said in a prepared statement that the new larger PBM will promote trend management tools, such as generics, home delivery, and specialty pharmacy. Angela F. Braly, president and CEO of WellPoint, said in a prepared statement that the sale will allow members to enjoy integrated health benefits, deliver significant value to shareholders, and create health cost savings.

Healthcare experts are not surprised by WellPoint's decision to sell its PBM. Many analysts predicted that

**“The economy's impact is also being felt by health plans. Thus they are looking to sell noncore assets to raise cash.”**

—Joseph Paduda

large insurers such as WellPoint, Aetna, and UnitedHealth could sell their PBM businesses as a way to refocus

their offerings in this difficult economy.

**Joseph Paduda**, principal of Health Strategy Associates in Madison, CT, says the health insurance/PBM world is “consolidating horizontally,” meaning the large companies are getting bigger within each segment.

Paduda says there are two takeaways from NextRx's sale. “First, health plans are looking to focus on their core business,” he says. “PBM is growing increasingly specialized and complex; health plans are focusing on readying themselves for whatever form health reform takes. The economy's impact is also being felt by health plans. Thus they are looking to sell noncore assets to raise cash. Second, the PBM market is well into maturity. Mature markets consolidate, and that is precisely what we are seeing.”

Health insurers face a dilemma. Do they outsource PBM and disease management services and return to core business strategies, such as plan administration, claims payment, and member outreach? Or do they keep these services in-house and have more control over member information and a steady revenue stream from PBM business?

On the one hand, stand-alone PBMs can negotiate lower drug prices because of their size and have been more successful in lowering costs through mail-order business.

However, insurers with in-house PBMs say they can track members through immediate pharmacy claims data. This is especially helpful in the area of disease management.

Having up-to-date claims information allows an insurer to reach a member for health coaching if its PBM sees prescriptions that would lead them to believe the person needed immediate outreach, such as prescriptions for chronic disease-related drugs.

**George Van Antwerp**, vice president of solutions strategy at Silverlink Communications, Inc., in Burlington, MA, says health plans can benefit from having their own PBMs if they use them properly.

“I think that it's beneficial to plans to own their own PBM if they can integrate data and create a better member experience, make the tradeoff between increased pharmacy spend and lower medical loss ratio, and manage to get most of the economies of scale in terms of operations and negotiation,” says Van Antwerp. “That has proven hard to do within health plans, and therefore, there will be short-term interest in capitalizing on the valuation of the PBM business.”

With three large PBMs left after the pending purchase, Van Antwerp says the trio will “race to the bottom in terms of negotiating scale leverage.” He predicts the remaining PBMs will ultimately try to differentiate themselves by offering healthcare management through member engagement, greater transparency, and a renewed focus on health outcomes.

Paduda says the PBM market has become increasingly tough, adding that the market will ultimately feature a couple of giants and a number of smaller specialty PBMs—many of which will look to get acquired. “PBMs can only grow by taking business from each other or via acquisition so PBMs can expect continued price pressure,” he says. ■