

Population Health

INSIDER

Tailoring DM interventions could improve patient outcomes, lower utilization

One size does not fit all in almost every aspect of life, so why should healthcare think differently of population health and disease management (DM)?

But that's typically the case, as DM programs often differ depending on the disease rather than the individual. Not all diabetics are the same, but they are often treated the same way.

One way to better understand the individual is the Patient Activation Measure (PAM) developed by **Judith H. Hibbard, DrPH**, professor of health policy at the University of Oregon's department of planning, public policy, and management in Eugene.

By determining the individual's knowledge, skill, and confidence in managing his or her health and healthcare, coaches can tailor programs that accurately reach patients at their level. The PAM, which is now

licensed and marketed by Insignia Health in Portland, OR, consists of a 10- or 13-question survey that asks individuals about their beliefs, knowledge, skills, and confidence in engaging in a wide range of health behaviors. Based on the responses, each person is assigned an activation score and level.

There are four progressively higher activation levels.

At the lowest end are people who passively manage their health and may not see a connection between their behaviors and health

"We have learned that deploying targeted interventions rather than using a one-size-fits-all approach is a critical success factor."

—Mary Jane Osmick, MD

outcomes. At the other end are people who understand the relationship and self-manage their health.

The Center for Studying Health System Change released a study in 2008 that suggested that more than 20% of U.S. adults are at the low end of the activation scale, which makes caring for them and improving their health difficult.

Hibbard and her University of Oregon colleagues recently conducted a study with members of Irvine, CA-based health improvement company LifeMasters Supporters SelfCare, Inc., that looked at whether a DM program that used the PAM could improve patient outcomes. They compared patients who received standard telephone DM coaching with those who received tailored intervention based on their activation level.

The researchers found that patients with chronic disease who received tailored coaching based on their PAM level improved clinical outcomes, according to the study that was published in the June *The American Journal of Managed Care*.

IN THIS ISSUE

p. 5 Prevention could save trillions
Government health promotion and prevention programs for pre-Medicare and Medicare populations could save \$1.4 trillion over 10 years, according to a new report.

p. 6 BCBSA study shows low health plan administrative costs
Private health plans' administrative costs averaged 9% of premiums across all policies sold and are well below "vastly overstated" estimates offered by proponents of a government-run public plan, according to a new study paid for by the BCBSA.

p. 8 Insurers' rating outlooks take tumble
Health insurers are concerned that healthcare reform could damage their companies, but the mere talk of reform is also negatively affecting them.

HCP Pro

DM interventions

< continued from p. 1

In addition, findings suggest that tailoring coaching to patients' activation levels and using those metrics to track programs can improve patient outcomes and DM program efficiency. Patients who received coaching tailored to their level of activation showed greater improvements in their biometrics and adherence to recommended regimens. Those patients also showed greater reductions in hospitalizations and ER utilization than patients who were coached without use of the PAM.

Coaches who systematically assessed patient knowledge, skill, and confidence for self-management can be more targeted and efficient in allocating their time and effort.

And tailored coaching improved a patient's PAM score (i.e., activation level) in the intervention group more than the control group. (See Figure 1 below.)

Researchers also found that the coaching call talk times were similar between the two groups (see Figure 2 below), which shows that it's not the time spent with the patient that is important, but the quality of that time.

Patients in the intervention group improved A1c, blood pressure, and cholesterol levels (see Figure 3 on p. 3), as well as adherence to recommended treatments (see Figure 4 on p. 3) and fewer hospital visits (see Figure 5 on p. 4). In fact, patients who received tailored coaching experienced a 33% decline in hospital

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Figure 1: Change in Patient Activation Measure after six months

	Baseline	Post-intervention
Control (usual care)	65.6	67
PAM intervention group	64.3	68.9

Source: LifeMasters Supporters SelfCare, Inc., Irvine, CA.

Figure 2: Coaching call talk times (in minutes)

	Activation levels			
	1	2	3	4
Control (usual care)	16	17	17	16
PAM tailored coaching	18	17	16	16

Source: LifeMasters Supporters SelfCare, Inc., Irvine, CA.

Figure 3: PAM intervention group saw improvements

Indicator	Pre-intervention period, 2006*	Post-intervention period, 2007*
A1c	764.6	709.6
Blood pressure systolic, mm Hg		
Control	126.5	126.7
Intervention	126.4	126.2
Blood pressure diastolic, mm Hg		
Control	72.8	72.5
Intervention	73.8	72.7
Low-density lipoprotein cholesterol, mm Hg		
Control	85.8	87.1
Intervention	86.2	81.9

*Mean value

Source: LifeMasters Supporters SelfCare, Inc., Irvine, CA.

admissions compared to the control group, which remained flat, and a 22% decline in ER visits compared with a 20% increase in the control group.

Results point to lower healthcare costs

“Based on cost figures derived from the claims data used in this study, a decline of 0.02 average hospital admissions translates into a savings of \$145 per person per month (based on an average cost of \$7,259 for a hospital admission). Similarly, the average 0.02 ED visit reduction would yield an average savings of \$11 per person per month (based on an average ED cost of \$545),” the researchers wrote.

“We have learned that deploying targeted interventions rather than using a one-size-fits-all approach is a critical success factor,” says **Mary Jane Osmick, MD,**

Figure 4: PAM intervention improved patients’ adherence

Treatment	Pre-intervention period, 2006*	Post-intervention period, 2007
Influenza vaccine (all chronic conditions)		
Control	57.2	61.6
Intervention	53.1	64.6
ASA antiplatelet therapy (coronary artery disease)		
Control	83.5	84.1
Intervention	83.2	89.8
ASA antiplatelet therapy (diabetes)		
Control	68.5	58.1
Intervention	70.7	71.3
Antilipidemic therapy (coronary artery disease)		
Control	72.6	73.5
Intervention	70.2	75.6
Beta-blocker (coronary artery disease/chronic heart failure)		
Control	79.5	78.7
Intervention	76.4	79

*Mean value percentage

Source: LifeMasters Supporters SelfCare, Inc., Irvine, CA.

vice president and medical director at LifeMasters. “These findings reinforce our understanding that improved activation is an overarching measure of success that leads to significant clinical improvement and financial savings.”

Although pleased with the results, Osmick says it’s important to realize that infusing the PAM into health

> continued on p. 4

DM interventions

< continued from p. 3

coaching is not simple. “It requires a great deal of thought and guiding the patient, as well as nurse and coach, in how to use it,” she says.

“I thought of it just in the health arena, but it may be broader than that”

—Judith H. Hibbard, DrPH

interviewing and how to understand patients’ pre-behaviors, which greatly helps in understanding the in-

dividual and how to improve his or her health status and activation.

One of the biggest challenges is making accurate suggestions. The worst a coach can do is push a patient too much, which could cause the patient to fail and revert to a worse activation level.

To accomplish this, coaches must occasionally test the patients with the PAM to see whether they have moved on the activation scale.

“When people experience crises in their lives with their health or just in their lives, they often fall back on the activation level,” says Hibbard. “If the coach thinks that’s happened, it’s good to readminister whatever the time frame is and know where the person is so they can deal with the person appropriately.”

The secret sauce, so to speak, is tailoring interventions, working with the individual consistently, knowing the person’s activation level and possible fluctuations, and respecting the fact that not all patients will reach the highest activation level, says Osmick.

“The thing that is exciting about it is you can move activation,” she says.

Through her research of the PAM, Osmick has come to realize that it taps into an underlying construct. For example, something such as self-esteem is an underlying construct that affects various parts of a person’s life. The PAM is similar.

“If you knew about someone’s self-esteem, you would be able to predict how they behave in certain situations.

I think the PAM is also an underlying construct,” says Hibbard.

“I thought of it just in the health arena, but it may be broader than that. It might be more of a feeling control of your life. I don’t know, but that seems to be what that suggests,” she added. ■

Figure 5: PAM intervention affected patients’ utilization rates

Type of utilization	Pre-intervention period, 2006*	Post-intervention period, 2007*
Inpatient admissions per month		
Control	0.04	0.04
Intervention	0.06	0.04
ED visits per month		
Control	0.05	0.06
Intervention	0.09	0.07
Office visits per month		
Control	0.97	0.92
Intervention	1.14	1.04
Antilipidemic therapy (coronary artery disease)		
Control	72.6	73.5
Intervention	70.2	75.6
Beta-blocker (coronary artery disease/chronic heart failure)		
Control	79.5	78.7
Intervention	76.4	79

*Mean value percentage

Source: LifeMasters Supporters SelfCare, Inc., Irvine, CA.

Prevention and health promotion could save Medicare \$1.4 trillion over 10 years

Government health promotion and prevention programs for pre-Medicare and Medicare populations could save the country as much as \$1.4 trillion over 10 years—and add, on average, as many as six years on Medicare beneficiaries' lives, according to a new Center for Health Research (CHR) at Healthways report.

The report, *Potential Medicare Savings Through Prevention & Health Risk Reduction*, found that focusing on programs that keep people healthy, reduce health risk factors, and manage chronic conditions—before and during Medicare—can have long-term cost savings. In fact, although these programs could extend beneficiaries' lives, the researchers found the cost savings associated with keeping people healthier would offset the extra years of life and coverage under Medicare.

“In this report, we clearly showed that you can, in fact, reduce risk and this does increase life expectancy, but you can still achieve savings over the course of a lifetime,” says **Elizabeth Rula, PhD**, lead researcher at the CHR.

With baby boomers reaching Medicare age, the Medicare population is expected to jump from 45 million to nearly 80 million by 2030. Couple that fact with the healthcare reform debate in Washington, DC, and one can see why healthcare thought leaders and policymakers are searching for programs and cost savings to bend the healthcare cost curve.

In its research, the CHR worked with Ingenix Consulting in Eden Prairie, MN, to develop several scenarios that examined the effect of varying distributions of population risk for people entering Medicare at age 65 and varying rates of risk progression of all beneficiaries.

The model used Medicare Parts A and B data from the 5% Sample Limited Data Set for 2002 through 2006, Medicare Trust Fund enrollment projections, and Vital Statistics age/gender-specific mortality rates to provide estimates of average Medicare costs based on age and stratified health risk. The model found that the government

spends an average of \$174,000 per beneficiary over the course of his or her time in the program. In other words, the 37.5 million seniors in Medicare fee-for-service in 2005 will cost \$6.5 trillion.

The researchers found a range of potential savings through a combination of health promotion, prevention, and chronic care management initiatives before and after age 65. The gross savings estimates ranged between \$652 billion and \$1.4 trillion over 10 years (in 2008 dollars) and include:

- ▶ A modest scenario that reduces risk prior to and during the years of Medicare by increasing the promotion of low-risk individuals at age 65 from 54% to 65% and preventing 10% of upward risk transitions
- ▶ Larger savings that were found by increasing the low-risk population at age 65 from 54% to 75% and preventing 50% of upward risk transitions that otherwise occur during the Medicare years

Although the projected savings are gross and not net, Wilkins says costs of such wellness and prevention programs should not eclipse more than 30% of the savings.

The researchers did not recommend any specific prevention and disease management programs, but they did suggest smoking cessation, cardiac disease management, and health club memberships for older adults with diabetes. **Anne Wilkins**, executive vice president and chief strategy officer at Healthways, says the programs could be separated into three categories: keeping healthy people healthy; helping people with modifiable lifestyle risks, such as being overweight and lacking physical activity, change their behaviors; and assisting people who already have health conditions, such as diabetes, better manage their conditions.

“This paper opens up the discussion on prevention and wellness for the pre-65 population,” says Wilkins.

> *continued on p. 6*

Health promotion

< continued from p. 5

The researchers said the government has tried supply-side solutions, such as adjustments to payment and coverage, as a way to try to control costs, but it has been largely unsuccessful.

One barrier for prevention programs is that the Congressional Budget Office has cited that there is not sufficient evidence in the areas of preventive programs. The researchers said this is because there isn't a "clearly delineated model of what the impact of a successful program would be."

The researchers concluded that the scenarios presented in their study showed that a larger percentage of

healthy or low-risk individuals entering Medicare would lead to lower health costs. "Although the levels of risk reduction tested in these seniors could not be achieved immediately after implementation of health and wellness programs, they represented a spectrum of possible outcomes that could be achieved over time and make a case for implementing such programs in the near term so that savings can be realized as soon as possible," the researchers said. "If it can be demonstrated that the magnitude of these potential savings is significantly greater than the cost of the interventions needed, there would be significant net savings to the taxpayer." ■

BCBSA study shows low health plan administrative costs

Private health plans' administrative costs averaged 9% of premiums across all policies sold and are well below "vastly overstated" estimates offered by proponents of a government-run public plan, according to a new study paid for by the Blue Cross Blue Shield Association (BCBSA). The report, written by the Sherlock Company in Gwynedd, PA, states that previous studies showing that private health plans' administrative costs are two to three times higher than actual costs are based on old estimates that don't reflect changes in industry practices, including advances in electronic processing.

"Prior reports rely on outdated, decades-old estimates from when claims were paper-based and today's electronic processes were in their infancy," says **Douglas B. Sherlock**, president of the Sherlock Company. "This report demonstrates that health plan administrative costs have been vastly overstated." The study reviewed 36 health plans—mostly Blues—participating in benchmarking studies in 2008.

Advocates for a public plan maintain that the higher administrative expenses for private plans are one reason a public plan is needed. Health insurance industry officials say the Sherlock study undermines that claim.

"Some elements of healthcare reform can help reduce administrative costs, if done right. For example, state-based health insurance exchanges can make it easier for people to purchase health insurance and simplify administrative functions," says **Scott P. Serota**, president/CEO of the BCBSA.

The Sherlock report also claims private plans perform administrative functions for \$12.51 per member per month, compared to \$13.19 per month for Medicare, and that private plans perform more administrative functions than traditional Medicare, including care coordination and wellness programs.

However, **Cathy Schoen**, senior vice president at The Commonwealth Fund in New York City, says the Sherlock study is narrowly drawn. "It focused more on the Blues than the whole industry, and it is focusing just on what it narrowly calls the administrative costs, not profit margins," Schoen says. "When you talk about the share of the premium that is not being paid out in benefits, it's both administrative and profits."

Schoen says corporate reports from larger companies such as Aetna and UnitedHealthcare show pre-tax profits in the 6% range in 2008 and administrative costs as

a share of operating revenue running in the 15%–16% range. “UnitedHealth, out of all the revenue it took in, the amount it paid out was only 82%. So 18% was not paid out in medical benefits. In 2007, it was 19%,” she says.

The Blues also don’t count the average 5% commission that businesses usually pay the agents who write the insurance contract as administrative costs, Schoen says. “That is on top of the Blues’ marketing costs. From the employer’s perspective, that agent fee is part of it,” she says. “But the Blues’ don’t count it because they don’t pay the agent. The customer pays it though.”

Public and private health plans in the United States average about \$600 per person per year for insurance administrative costs, compared with an average of about \$200 for many countries in Europe, Schoen says. “Nine percent would be considered high in every country outside the United States. Fifteen percent would be considered unbelievable,” she says.

A recent Commonwealth Fund study states that the cost of administering the U.S. healthcare system totaled nearly \$156 billion in 2007, and that figure is expected to double—reaching \$315 billion—by 2018. In addition, the study claims costs incurred by physicians in

their transactions with health plans are estimated to be as high as \$31 billion per year.

About 12.4%, or \$96 billion, of the \$775 billion in privately insured healthcare spending went for administrative costs in 2007. That \$96 billion—representing what insurance companies received in premiums, minus what was paid in medical claims—included claims processing, advertising, sales commissions, underwriting, and other administrative functions; net additions to reserves; rate credits and dividends; premium taxes; and profits, the Commonwealth study states.

By contrast, about 6.1%, or \$60 billion, of the \$974 billion in public program healthcare spending went for administrative costs in 2007, the Commonwealth report claims. That includes federal, state, and local governments’ administrative costs for public health programs such as Medicare, Medicaid, and the State Children’s Health Insurance Program. Medicare prescription drug coverage, provided by private plans, has high administrative costs, but is included in public program administration figures. In addition, the Commonwealth study states that private Medicare Part D plans averaged 11.3% in administrative costs as a share of total drug spending. ■

BCBSA companies took loss in 2008

Blue Cross Blue Shield Association (BCBSA) companies posted an aggregate 40.9% year-over-year decline in income in 2008 because of realized losses and declines in underwriting and investment income, a new analysis by the credit rating firm A.M. Best Co. shows.

Best’s analysis of BCBSA plans found that:

- ▶ A 6.6% increase in net premiums written (NPW) was reported. The 2008 NPW growth rate was slightly higher than that of 2007 (5.9%) but lower than 2006’s 9.1% rise.
- ▶ Underwriting earnings declined for the third year in a row, although the 5.5% decrease in 2008 was much less than the 24.6% and 8.5% declines in 2007 and 2006, respectively.
- ▶ A 10.3% decline in capital and surplus—to \$41.6 billion—was reported, bringing that key measure back down to a level not seen since 2005.
- ▶ There was a 30 basis points decline in the sales, general, and administrative expense ratio in 2008, after remaining flat in 2007.
- ▶ The healthcare expense ratio improved 20 basis points to 85.9%.
- ▶ Given the 2008 financial market turmoil combined with the low interest rate environment, investment income declined by 19%.
- ▶ An unrealized loss of \$3.1 billion was reported for 2008, compared with gains of \$285.5 million in 2007 and \$1.9 billion in 2006. ■

Insurers' rating outlooks tumble

Health insurers are concerned that healthcare reform could damage their companies, but the mere talk of healthcare reform is also negatively affecting them.

In light of potential healthcare reform proposals, Fitch Ratings recently revised the rating outlook of six health insurers from stable to negative while maintaining six other insurers as negative.

Combining those two decisions, Fitch Ratings, which looks at fixed income and subsidiary insurer financial strength ratings, has 12 health insurers listed as negative.

The six health insurer groups that dropped from stable to negative are:

- Aetna, Inc.
- Blue Cross Blue Shield of Florida
- Blue Cross Blue Shield of Idaho Health Service, Inc.
- Cigna Corporation
- Coventry Health Care, Inc.
- Health Care Service Corporation

The six insurers who remained at negative are:

- Health Insurance Plan of Greater New York
- Health Net, Inc.
- Healthmarkets, Inc.
- Humana, Inc.
- UnitedHealth Group, Inc.
- Wellpoint, Inc.

Fitch Ratings stated that the negative outlook "reflects the strong potential for healthcare reform and its possible adverse implications on each company's financial strength and creditworthiness.

Although no bill has been finalized yet, and multiple policy schemes are possible, most of the alternatives being debated could weaken health insurers' financial profiles in Fitch's view. The negative outlook also reflects the high levels of uncertainty that currently exist with respect to the ability of individual insurers to adapt to a likely changing competitive and pricing environment resulting from reform."

Fitch plans to address the ratings again after a health-care reform package becomes finalized.

"Depending on the specifics of any final legislation, the net impact of healthcare reform could vary widely, falling anywhere from neutral to severely unfavorable for the ratings," according to Fitch.

The most detrimental scenario for health insurers would be a public plan option, especially one that mirrors Medicare reimbursement rates. This would lead to severely hurting the "outlook for health insurers' profit margins," wrote Fitch.

"Depending on the ultimate structure, the public plan could also lead to substantial enrollment loss for private insurers," Fitch added.

The company stated that there are three aspects of healthcare reform that could adversely affect insurers:

- Adverse selection
- Reduction of private insurance's ability to adequately price products relative to medical costs
- Shrinking the private sector's role in the health arena

"A combination of any or all of these developments could incrementally weaken the sector's earnings and cash flow generation capabilities," wrote Fitch.

Joseph Paduda, principal at Health Strategy Associates, LLC, in Madison, CT, says Fitch's analysis verifies the belief that a public plan option that forces providers to accept Medicare rates or its equivalent would "murder the private insurers," but he doesn't think that scenario is going to happen.

"There is zero chance of any reform measure passing that includes a public plan reimbursing at Medicare," Paduda says.

Paduda also questions Fitch's suggestion that there are risks associated with potential adverse selection and insurance price-fixing.

There is no chance of the government mandating premium levels and adverse selection, which could actually

help private insurers, who may want to drop sick members into a public plan “if the legislation isn’t carefully written,” he adds.

Paduda acknowledges that the health insurance industry is at risk, but also thinks there are opportunities for private insurers.

Smart health insurers will use health reform as a chance to gain millions of new members and slash administration

expenses by eliminating underwriting, refining marketing, and investing in population health.

“I’d note that Fitch now has all plans in negative status; I believe that is misguided, as there are clearly several that are better positioned to take advantage of reform if that happens,” says Paduda. “Their approach is too broad, too negative, and does not reflect the very real differences in approach among the plans.” ■

Small businesses could win big in House health reform bill

Small businesses—particularly those with 10 employees or fewer—stand to be the big winners if a public health insurance option such as the one now before the House of Representatives becomes a reality, according to a new issue brief by the Economic Policy Institute (EPI) in Washington, DC.

The study, “Health Care Reform, Big Benefits for Small Businesses” estimates that small businesses with 10 or fewer employees could save about \$3,500 per worker annually under a public plan similar to the House Tri-Committee’s proposal.

Elise Gould, director of health policy research at EPI and one of three authors of the issue brief, says the findings shouldn’t be surprising. “Small businesses bear a heavy burden in the current failing healthcare system,” Gould says. “Small businesses and their employees pay higher prices for less coverage. They are often priced out of the private market completely and, when that happens, it puts them at a great disadvantage when it comes to hiring and retaining employees.”

The EPI brief compares the House bill to a similar plan called Health Care for America, which was drafted under EPI’s Agenda for Shared Prosperity program. The House bill and the EPI plan create a new public insurance option and a requirement that employers offer affordable coverage to their workers or pay to defray the costs of enrolling in a national insurance marketplace.

“The gains to small business are likely to be even greater under the House version of the healthcare reform bill, as it is even more generous to small business,”

says **Josh Bivens**, EPI economist and coauthor of the brief.

Employer-sponsored insurance is the primary source of health insurance for nonelderly Americans, covering nearly 63% of U.S. adults. EPI premiums of \$532 billion in 2008 accounted for nearly one-quarter of all non-Medicare healthcare spending in the United States.

However, rising healthcare costs have been particularly tough for small businesses. Small employers hold little bargaining leverage with health insurance companies and have suffered relentless cost hikes that threaten to make health insurance too expensive. The brief notes that the ongoing decline in small business coverage for employees is responsible for much of the erosion in EPI coverage since 2000.

Nearly half of the uninsured worker population is employed by small businesses. In 2008, an employer survey by the Menlo Park, CA-based Kaiser Family Foundation found that 35% of small businesses offer health insurance to their workers, compared to 99% of large firms with 200 or more workers, and 63% of all firms.

Small firms that offer health insurance pass on a higher share of the cost of plans to workers; average contributions by workers in small firms are 30%–45% higher than in larger firms. Small businesses are paying, on average, 18% more than larger firms for identical health insurance policies, owing to higher and more variable health risks, a lack of competition among small-group market insurers, greater administrative expenses, and lower wages, according to the issue brief. ■

Eight tips to help get your business associates to comply with HIPAA

Your business associates (BA) must comply with the HIPAA security rule beginning February 18, 2010.

That mandate is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, signed into law by President Obama February 17.

If complying with the HIPAA security rule sounds like a large task for a small billing and coding company, that's because it is. Encryption. Destruction. Firewall protection. There's a lot to it. And your BA's problem is your problem. After all, it's your patients' information at stake.

If your BA is bad, well ... just picture the front page of your local newspaper with your facility's name next to the word "breach" in a headline. So where do your BAs begin? Hopefully, they've already started.

The following are eight tips you can share with your BAs to get them ahead of the HIPAA compliance deadline:

1. Perform a risk assessment. Determine your primary vulnerabilities. "Find what your biggest threats to the security of your PHI are," says **Rebecca Herold, CISSP, CIPP, CISM, CISA, FLMI**, privacy, security, and compliance consultant at Rebecca Herold & Associates, LLC, in Des Moines, IA. "You need to know where you are before you begin to form your policies and procedures. Check on the last time you had a security assessment, if ever, and start from there."

2. Make your own way. As a BA, you must understand that you are responsible for your compliance program, regardless of contract terms with a covered entity, says **John R. Christiansen**, lawyer at Seattle's Christiansen IT Law and chair of the newly formed HITECH Business Associates Task Force of the American Bar Association's Health Law Section and the HITRUST Business Associates Working Group of the Health Information Trust Alliance.

"You need to be responsible for your own security program with HIPAA," says Christiansen. Do not simply accept what is thrown your way, he says.

"Your program should be built based upon your organization's own unique risks," says Herold. "That's what your risk assessment will reveal."

3. Run a gap analysis on covered entity contracts. HITECH is new, and existing contracts will probably leave gaps. "We haven't been in this world before," Christiansen says. "Find your gaps and what you will do about them."

You may want to wait for further regulations before you finalize your contracts. However, you can start by consulting your legal team. You may need to provide a contract in the future, but the onus now is only on the covered entity, according to current law.

4. Don't rewrite the entire contract. "The changes to the BA contracts should be minimal," says **Chris Apgar, CISSP**, president of Apgar & Associates, LLC, in Portland, OR. Apgar suggests including a new short statement or paragraph indicating that the BA must now comply with the HIPAA security rule and the use and disclosure provisions of the privacy rule.

5. Add breach notification language to BA contracts. The language should require the BA to notify the covered entity within five days of a breach, says Apgar.

This aligns with the new California breach notification requirement regarding notification to the state that a breach has occurred and addresses the issue of when the 60-day notification clock starts.

"Also, I would recommend adding language requiring that the BA pay the cost of notification, which could get rather expensive if the breach includes a significant number of individuals," Apgar says.

6. Add language about the Red Flags Rule. Covered entities (primarily providers) should consider adding additional language to the BA contract requiring that certain BAs implement identity theft management programs, Apgar says.

7. Build your breach notification processes.

This is perhaps the biggest change for BAs. Christiansen says BAs must put a policy in writing in accordance with the HITECH Act.

“You need to be able to coordinate this by fall [of 2009] at the latest,” he says. “This is going to be a big issue for a lot of BAs.”

8. Train, train, train. Herold says she’s seen horrible training in the BA community.

“Make sure your policies document the need for regular training, along with ongoing awareness communications,” she says. “Then use effective training content. Just throwing words in front of your personnel is not training.”

Get your hands on HIPAA resources, such as training books, e-learning courses, and Webinars.

Check with your covered entities to see what they have done. ■

BA, covered entities should comply with HITECH now

Business associates (BA) and covered entities want to know what they must do to comply with the new HIPAA laws in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Actually, they must know. The compliance deadline is February 18, 2010, but many questions linger.

During an HCPro July 29 audio conference, “Business Associates and Covered Entities: Adapt Contracts to Comply With New HIPAA Law,” attendees asked several questions, including:

- ▶ Which is the BA when a medical device company sales representative is in the OR—the sales rep or the company?
- ▶ Can a covered entity, such as a Medicare-certified hospice program, also be considered a BA if it works on behalf of another covered entity?
- ▶ Will there be some guidance regarding whether updating the existing BAs is going to be required?

The questions probably won’t stop any time soon. However, case-by-case scenarios aside, there is an overlying message to all parties affected by the new HIPAA laws.

“The first thing both the covered entities and the business associates should do is try to understand the new requirements and analyze the gaps between their existing policies, procedures and practices, and what they should be doing—both under HITECH and anything

they’ve missed or avoided under HIPAA,” **John R. Christiansen**, lawyer at Christiansen IT Law in Seattle and chair of the newly formed HITECH Business Associates Task Force of the American Bar Association’s Health Law Section and the HITRUST Business Associates Working Group of the Health Information Trust Alliance said during the audio conference.

Chris Apgar, president of Portland, OR-based Apgar & Associates, LLC, also presented tips for compliance during the program.

The next step is to map out your expectations regarding contract revisions, as a last-minute approach will overwhelm each party.

“This could make for an unhappy holiday season and cancelled ski trips for folks in organizations which don’t start this process in the very near future,” Christiansen said.

After hearing the responses during and after the audio conference, Christiansen said some covered entities and BAs need to accept some basic denials, including:

- ▶ **HITECH covers more than EHRs.** The HITECH requirements do not just apply to EHRs or organizations using EHRs. “HITECH is intended in substantial part to promote implementation of EHRs,” said Christiansen. However, its requirements—particularly BAs complying with the HIPAA security rule and contract revision between covered entities and BAs—apply without regard to EHRs.

> *continued on p. 12*

HITECH

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➤ **Congress won't grant extensions.** The compliance date on the HIPAA security rule and contract revisions is February 18, 2010, and is "written in the legislation, which means only Congress has the authority to change it. I think given everything else on Congress' docket these days, relief on this point, which would be opposed by the privacy community and not understood by most other people, will not happen," Christiansen said.

➤ **HHS will look for violations.** Congress wants enforcement of HIPAA; it wrote into the new laws enhanced civil penalties, expanded regulatory authority, and auditing requirements. "You can't just assume noncompliance won't matter because nobody's looking," Christiansen said. "Congress wants [HHS] to look, and there are increased financial incentives for federal and state regulatory authorities to pursue penalties." ■

BCBSA puts bank up for sale

The Blue Cross and Blue Shield Association's (BCBSA) attempt at a healthcare bank appears to be coming to an end with the company's announcement that it is trying to sell Blue Healthcare Bank.

The bank, which offers healthcare banking through health savings accounts (HSA), organized in 2006 and received a Federal Savings Bank charter in 2007.

The bank offers HSAs to BCBSA members in qualifying health plans.

According to its Web site, the bank "combines healthcare experience with banking expertise in collaboration with the trusted Blue Cross and/or Blue Shield Plans. The bank delivers excellence in healthcare financial products and services for the growing consumer-driven healthcare [CDH] market."

When the Office of Thrift Supervision approved the bank's application for a Federal Savings Bank charter in 2007, Scott P. Serota, BCBSA president and CEO, said, "More and more Americans are taking greater control of their healthcare choices by enrolling in consumer-directed health plans [CDHP], such as health savings accounts. As this trend continues, consumers will be in greater need of reliable financial services. The Blue Healthcare Bank responds by providing consumers with access to a trusted and secure financial resource to help them efficiently manage their healthcare dollars."

Now, just two years later, the BCBSA has decided to seek a seller for the bank. But company officials say this doesn't mean the plans are stepping away from CDH.

Nevertheless, the news is still a negative for the consumerism movement. Trumpeted by Republicans and the Bush administration as a way to reduce costs because members would have more "skin in the game," HSAs have fallen out of favor in Washington with Democrats in control of the White House and Congress.

Although the future of HSAs and CDHPs are "somewhat unclear," **Martin Trussell**, senior vice president at First Horizon Msaver, an HSA provider, says he believes CDHPs will remain even after healthcare reform because President Obama and Congress have promised that Americans will be able to keep their current health insurance.

"Uncertainty about healthcare reform may have factored into the decision to sell the Blue Bank assets," Trussell says. "But added to that is an economy that has reduced health plan enrollments and, thus, revenues, and the fact that the bank was a latecomer to an industry where referral patterns have been pretty well established. The Blues plans apparently had no appetite for making the further investments necessary for the bank to reach the critical mass of accounts it would need to be self-sustainable." ■

Could a Massachusetts-style individual mandate work across the nation?

Can the federal government apply an individual mandate, such as the one in Massachusetts, across the country? And how would the government enforce such a rule in large states such as California, with a population of 37 million, where 34% of non-Medicare-age residents do not have health coverage? How much would the government charge uninsured Americans when they get sick, and how should it collect fines from them for not having insurance?

What about in Texas, population 24 million, where 42% of low-income residents under age 65 are now uninsured in a state where many don't appreciate government intervention?

Massachusetts managed to reduce its percentage of uninsured to 2.6% (a drop from about 12%) in just a few years by setting thresholds for people to purchase health insurance through their employers or from an array of state-approved plans. State officials say it's been a success thus far.

With all filings for the 2007 tax year complete—the first year that fines were assessed—only 70,000 who earned enough money to be required to have coverage didn't file the required 1099 HC form with their tax filings to prove they had it, officials say.

Those who didn't get their required 2007 health policies by December 31, 2007, through their employer, private insurance, or the Massachusetts system paid a \$219 fine, which was kept low during the first year of enforcement. There were only 2,400 eligibility appeals.

It's too soon to say what has happened in the 2008 tax year, when the maximum fine, depending on age and income, was \$912 for the year, because tax forms have not all been filed and reviewed, although state officials say they expect to find even better compliance this year.

Can the individual mandate work elsewhere?

Could other states get similar cooperation from its residents and see such dramatic reductions in their rates of

uninsured as Massachusetts has enjoyed? Yes, says **Linda Blumberg**, health policy analyst at the Urban Institute in Washington, DC, who has written extensively on health reform and the commonwealth effort. What are needed are sufficient subsidies for lower-income populations, exemptions for the truly poor, and grants to help social services agencies get people enrolled, says Blumberg.

Jon Kingsdale, executive director at the Commonwealth Health Insurance Connector in Boston, which

runs the Massachusetts program, concurs with that assessment. "Remember, there's going to be subsidies for people who can't afford it and exemptions for people who are too poor to have access to the subsidies or because the program costs too much," says Kingsdale. "The feds are talking about allowing that."

But **Ian Duncan**, a member of the 10-person Connector Authority Board, is extremely doubtful a Massachusetts-like plan could play well throughout the country, suggesting that it would be difficult to execute in most, if not all, other states.

Getting compliance in Massachusetts was relatively painless because the percentage of uninsured was already low and the state is relatively wealthy, Duncan says. "There were really no implications for 90% of the population," he says. "But there's several things that will make this an absolute nightmare to administer at the federal level. It would be a bureaucratic nightmare."

For starters, Duncan lists the difficulty for a larger state or federal government to determine what Massachusetts

"Having the government try to do this would be like putting the Department of Motor Vehicles in charge of healthcare. Can you imagine that? It seems to me to be an impending nightmare."

—*Ian Duncan*

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Massachusetts

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calls “minimum credible coverage.” That coverage must include certain drugs, and determining that nationwide would be problematic at best, he says.

Additionally, many employer plans that would otherwise qualify don’t offer drug coverage, “even though everything else about the plan is gold-plated,” Duncan says. “Go to a place like California, where 25% of people don’t have health insurance, and you can imagine what this would be like. [In other states], you’d have lobbying from people saying, ‘You can’t cover birth control and abortions.’”

In many states, the number of legal immigrants, or documented workers, is an enormous issue as well, much more so than in Massachusetts, which made a decision to drop about 30,000 residents from the program for budgetary reasons. Covering undocumented residents would be politically charged as well.

Duncan also says there’s the issue of deciding who should merit a hardship waiver and copay amounts for certain types of care.

“I think it’s something quite beyond the scope of government bureaucrats to regulate,” he says. “And because it’s government money, the government would have to regulate every single detail.”

Enforcement

Another problem is how to apply a requirement that people show proof of health insurance with a tax filing. “Do you really want the IRS to insert itself in people’s lives to figure out whether people have credible coverage?” Duncan says.

In addition, more confusion would arise from hundreds of thousands of employers asking whether the policies they provide their employees, who may not meet Massachusetts’ standards, qualify as credible coverage.

Duncan predicts endless regulations and bureaucracy that would lead to many people enforcing it.

“Having the government try to do this would be like putting the Department of Motor Vehicles in charge of

healthcare,” he says. “Can you imagine that? It seems to me to be an impending nightmare.”

Kingsdale and Blumberg do not agree with Duncan’s stance.

Blumberg says requiring citizens to show proof they or their employers purchased appropriate health insurance policies with their annual tax returns, or give income data showing they were exempt, is the best way to apply such a plan across the nation. “The first line of offense in implementing a mandate is to structure reform so that voluntary compliance is affordable and easy,” she says. That means not implementing a mandate that people think unfair and requires people to spend too much of their income, as well as having a subsidy program for the modest-income population and exemptions for those who are too poor.

Penalties

Should there be a penalty for not complying or ignoring the individual mandate? “Yes, because otherwise it’s not fair,” Blumberg says. “But no, we don’t put people in jail for not paying it. Will we get to 100% coverage? No. But we can get very close.”

If some of the suggested proposals now being discussed in health reform bills pass, there will be more uniformity of coverage. “It would bring all the states up to a uniform level and a much bigger expansion of the number of people eligible for public subsidies,” Blumberg says. With grants to hospitals and other healthcare providers to encourage enrollment, “safety net providers are enrolling people right and left, and that’s so the hospitals don’t lose out on their reimbursement,” she says.

Kingsdale also agrees that a universal mandate could extend across the country. “The process has worked very smoothly [in Massachusetts]. We have no security at our office, an open plaza, and no angry taxpayers with pitchforks have showed up,” he says. “Would it be simple, and easy? Probably not. I wouldn’t want to tell you that. But is it doable? Yes.” ■

ICD-10 implementation: Critical steps insurers must take

With a public insurance option hanging over their heads and a sputtering employer-based market, health insurers are rightfully concerned about the future. But there is another issue slated for 2013 that could prove to be as difficult for health insurers.

On October 1, 2013, the U.S. Department of Health and Human Services will mandate that healthcare companies comply with ICD-10 diagnosis and inpatient hospital procedure codes.

Health insurers are understandably edgy considering the breadth of this change, which will potentially touch nearly all operational systems and procedures, according to Deloitte Consulting, LLP, in New York City, which recently joined forces with America's Health Insurance Plans to serve as its ICD-10 and 5010 training partner.

ICD-10 implementation requires a "massive wave of system reviews, new medical coding or extensive updates to existing software, and changes to many system interfaces," said Deloitte in its report *ICD-10: Turning Regulatory Compliance into Strategic Advantage*. "Because of the complex structure of ICD-10 codes, implementing and testing the changes in EMRs, billing systems, reporting packages, and decision and analytical systems will require more effort than simply testing data—it will involve installing new code sets, training coders, remapping interfaces, and recreating reports/extracts used by all constituents who access diagnosis codes."

Exactly how large is the ICD-10 changeover? It should easily surpass the 1999–2000 Y2K system upgrades. **David Biel**, principal of the ICD-10 service offering at Deloitte in Chicago, says this is because health plans will have to deal with business processes and staffing. In other words, ICD-10 is more than technological improvements.

"These codes are embedded in all of their financial transaction systems as well as their clinical systems," Biel says. "In order to order a drug in a hospital, you need to have a diagnosis. All of those things are going to change.

This means huge people changes and huge training issues that they will have to deal with."

But with the ICD-10 changeover also comes an opportunity. Deloitte said ICD-10 could be a "potential platform for future strategic innovation." Although most health insurers will simply comply with the ICD-10 standards, Deloitte estimated that 10%–15% of health insurers will become innovators and these innovators will "approach ICD-10 compliance as a strategic initiative and, as a result, could increase patient satisfaction and quality of care, while moving their business and clinical model into new markets."

However, to become an innovator, health insurers will need significant capital and personnel investments, which many insurers might not be able to achieve. It is important not to think of the ICD-10 change as merely a bottom line concern, says Biel. "We're out in the market talking to a lot of insurers about ICD-10, and they're a number of them asking, 'What can I get out of this?' rather than just thinking of costs," he says.

One potential benefit for health plans is having more accurate and a wider breadth of health data, which could help insurers learn more about member health issues and allow insurers to break down the data for more targeted interventions. This could especially help disease management and care management programs find at-risk members and link them to programs to improve their health outcomes.

Whether a health plan wants to merely comply or become an innovator, the company must prepare now. The North Carolina Healthcare Information and Communications Alliance, Inc., and The Workgroup for Electronic Data Interchange recently released a timeline for ICD-10 preparation. The groups estimate that it could take four years for providers to implement ICD-10.

Biel concurs with the assessment. "Even though we're four years away technically, the magnitude of the change is large enough that if you don't start looking at

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ICD-10

< continued from p. 15

the impact now, then you won't have created a budget for 2010 to start the process," he says.

So what can health insurers do now? Biel suggests the following four steps:

- ▶ Review your technology to understand the affected areas and how they are embedded in your systems
- ▶ Conduct an operational assessment to see the business processes touched by this change
- ▶ Conduct a people assessment to see who will need training in ICD-10
- ▶ Conduct a strategic assessment and determine how your company wants to handle ICD-10 (i.e., comply,

collaborate, or innovate) and review what would go into each option

But don't wait to start this process. If your company has not already started ICD-10 implementation, you are already behind your competitors. You have to get to work now.

"I believe all health plans before the 2010 budgeting cycle should have an idea of what the impact is, what their road map is to compliance, and how much they need to budget over the next three years—especially the next year," says Biel. ■

Hospitals would see 32% payment drop with public plan

The public health insurance plan proposed under the House healthcare reform bill (HR 3200) would have "a substantial price advantage" over private insurance because it would pay providers using current Medicare payment methodology, according to an analysis of HR 3200 released by The Lewin Group in Falls Church, VA, part of Ingenix, a wholly owned subsidiary of UnitedHealthcare.

In particular, hospitals that accept Medicare and public plan reimbursements would see their payments for services reduced by an average of 32% below what private insurers pay for the same treatment, whereas physicians would see a 16% drop for their services, according to The Lewin Group. The physician payment reflects an additional 5% increase in payments under the House bill for physicians and other providers who agree to treat Medicare and public insurance plan patients.

The Lewin Group report disagreed with the Congressional Budget Office (CBO) about its cost estimates associated with the House bill's public plan option.

In particular, it said the CBO assumed that the public plan would only be about 10% less costly than private coverage. The Lewin Group said it estimated that the

public plan would be able to "offer an insurance product that would be 20%–25% less than what comparable private insurance coverage would cost."

If a health exchange was opened to all firms with a public option, The Lewin Group estimated that the number of uninsured people would be reduced by 32.6 million people (from about 49 million in 2011).

Enrollment in the expanded Medicaid program would increase by 12.6 million people, which would include about 15.5 million newly enrolled people minus about 2.9 million current enrollees who would become covered by employers who would offer coverage in response to the bill's employer mandate.

The Lewin Group analysis examined two scenarios that would result from decisions by the Commissioner of Health Choices, who would determine (as proposed under the House bill) who is eligible to participate under the health exchange with a public plan option.

In the first scenario, the commissioner would limit eligibility to individuals and employers with fewer than 20 workers. In the alternative scenario, the commissioner would permit all individuals and employers to enroll. ■

AHIP decries 'exorbitant' out-of-network charges

The health insurance industry's trade group wants state and federal policymakers to examine what it claims are "exorbitant" out-of-network charges by physicians that are detailed in a new industry-sponsored survey.

The America's Health Insurance Plans (AHIP) report, a survey of physician out-of-network charges in the 30 largest states, found what AHIP claims are wide disparities in the cost of various services that in some cases were tenfold higher than Medicare reimbursements for the same service in the same area. **Susan Pisano**, AHIP vice president of communications, calls the figures "pretty startling."

"It is important for this to be in the public domain simply because there is nothing from preventing somebody from charging that much. You basically can charge whatever you want," says Pisano.

The survey's release comes after President Obama leveled criticism at the private health insurance industry at a town hall meeting in Portsmouth, NH. The president said, "Right now, we have a healthcare system that too often works better for the insurance industry than it does for the American people. And we've got to change that."

Pisano says AHIP's new report was not an attempt to deflect the negative publicity from the president's broadsides. "Certainly, we have been publicly vilified, but there are bigger questions here," she says. "We've been having a lot of discussion about how much health plans pay doctors. We've been having a lot of discussions about what the appropriate levels are for out-of-pocket costs and cost-sharing limits for consumers. What we haven't been having a discussion about is what is being charged. If we are going to be having thoughtful policy discussions, we need to have all of that information. So far, it's been all from one perspective. What do you think that says about the discussion?"

Pisano says AHIP hired Dyckman & Associates, the Washington, DC-based consultants, to compile the survey after hearing repeated complaints from its members about exorbitant out-of-network charges. She says the survey findings should prompt state and federal policymakers to investigate out-of-network charges and

compare them with in-network charges, as well as fees charged for similar services in other countries.

In one state, the survey found, a physician billed a patient \$6,791 for cataract surgery with insertion of artificial lens, more than 1,100% of the Medicare fee of \$581. Pisano says similar examples were found in all 30 states, and there are many examples of even higher variation in charges. She says the survey was conservative, did not cherry pick egregious examples, and had been purged of dubious or extreme outliers.

Jon Skinner, healthcare economist at Dartmouth College in Hanover, NH, says he believes that "some truly high payments are floating around." Skinner noted similar findings in other studies, most recently a July 19 report by Health Reform Watch at Seton Hall University's School of Law, Health Law & Policy Program.

"The question of what providers charge is, of course, very, very important for the overall costs of healthcare," Skinner says. "However, I do not think that high prices charged by out-of-network providers are a large factor in why healthcare costs are so expensive. It is symptomatic of a more general problem with U.S. healthcare—the lack of information about and attention to prices."

The survey's release comes at a time of high anxiety for the health insurance industry, which has been the focus of sharp criticism from the Obama administration. The industry strongly opposes Obama's call for a public plan to compete with private insurers, which Obama says is needed to keep private insurers honest. However, private plans say they would be placed at a competitive disadvantage.

The president blamed reform critics for mischaracterizing the public plan as a government takeover. "This is not about putting the government in charge of your health insurance. I don't believe anyone should be in charge of your health insurance decisions but you and your doctor," he told the crowd. "I don't think government

> *continued on p. 18*

AHIP< *continued from p. 17*

bureaucrats should be meddling, but I also don't think insurance company bureaucrats should be meddling. That's the healthcare system I believe in."

Obama told the crowd that stronger oversight of the private healthcare sector is needed "just make sure that private insurers are treating you fairly so that you are not buying something where if you failed to read the fine print, next thing you know, when you actually get sick, you have no coverage. Under the reform we're proposing,

insurance companies will be prohibited from denying coverage because of a person's medical history. Period," the president continued. "They will not be able to drop your coverage if you get sick. They will not be able to water down your coverage when you need it. Your health insurance should be there for you when it counts—not just when you're paying premiums, but when you actually get sick. And it will be when we pass this plan." ■

Health insurers, employers could play key roles in tackling healthcare disparities

There are two stakeholders who hold enormous potential in reducing or eliminating racial and ethnic disparities in healthcare, and they're not physicians, nurses, or policymakers. Health insurers and employers have an opportunity to improve patient outcomes. This is more than a moral issue. By focusing on racial and ethnic disparities, there is also an opportunity to lower long-term health costs.

The way to do this is by working together to take the financial leap and invest in programs that focus on collecting and surveying vast amounts of patient ethnic and racial data, which would help insurers and employers know how to tailor programs to reach at-risk populations.

That's what they could do, but few employers and insurers are working together to tackle the issue for the following reasons:

- Many employers are ignorant of the problem
- Employers are concerned about the legality of collecting and sharing race and ethnicity data
- Businesses don't want to face the administrative burden and cost of collecting the information

Patricia Collins Higgins, coauthor of the recent brief, "Reducing Racial and Ethnic Disparities in Health Care: Partnerships Between Employers and Health Plans," and a

researcher at Mathematica Policy Research, Inc., in Princeton, NJ, says employers have so many competing priorities, especially in this economy, that they often don't see the connection between racial and ethnic disparities and the company bottom line.

But the connection is clear. Minorities are experiencing worse health, and their health costs are being transferred to payers. By examining where disparities exist, employers and health insurers can understand the problem and, in turn, create targeted programs that reach those members.

Instead, only 3% of employers say they are examining disparities in their workers' healthcare quality, according to Mathematica. The few health insurers and employers that have worked together on bridging the disparity gap have found they need to collect data through direct and indirect methods. Direct methods include self-reporting of race and ethnicity during enrollment or clinical interactions and via Medicare and Medicaid. Indirect methods include collecting information through geocoding and surname analysis.

The indirect methods have become more sophisticated, but having direct data from the individual is ideal. The problem is that many health plan members don't want to give personal information to their insurers because they think the company will use it against them. In fact, Mathematica said only about 30% of health plan members

provide that information. This is where employers come in. Unlike health insurers, employers are required to collect race and ethnicity data from their employees under the Civil Rights Act of 1964, so it's simply a matter of businesses and health insurers working together to share this information.

Although the vast majority of employers are not keyed into the problem, more employers are now asking how health plans are dealing with health disparities as part of requests for proposals.

There are some employers and insurers that have already started to work on the problem. The National Business Group on Health and Office of Minority Health have joined forces to promote the issue and Cigna is collaborating with a large employer to improve breast cancer screening.

Employers are also using evaluation tools, such as eValue 8, to assess how health plans are tackling health disparities. The survey tool allows employers to look at health plans' performance in areas such as health information technology adoption, communication, disease management, provider performance, and patient safety.

eValue8 also includes questions about how health plans are dealing with disparity-related activities, according to Mathematica.

Although there have been advances, most employers are still not aware of the problem. Higgins suggests four ways to reverse the trend:

- ▶ Health insurers must educate employers about the importance of the problem and the associated costs of the disparities
- ▶ Health insurers must educate employers about the legality of collecting information and sharing it with insurers
- ▶ Employers must understand the added up-front financial burden of surveying the data, but appreciate the long-term financial benefits associated with closing the health disparities gap
- ▶ National leaders must encourage more employer participation in programs that target racial and ethnic disparities

Addressing these problems is not just a feel-good issue. This is a bottom-line problem that the healthcare system will need to address as the face of the nation continues to change.

"Until employers recognize the business case for reducing disparities—lower healthcare costs and potentially a more productive work force—employer interest is unlikely to gain serious traction," says Higgins. ■

Health cooperatives can't replace public option

Consumer health cooperatives "are not yet ready for prime time" and "are certainly not a substitute for a public option" in health reform, Yale professor Jacob Hacker said in a teleconference for reporters in a conference organized by Campaign for America's Future, a left-leaning Washington, DC, political group advocating social reforms, including healthcare policy change such as universal coverage.

"Are cooperatives going to be effective in taking on these gigantic insurance companies? From everything I know from people who represent them, the answer is a flat no. Cooperatives, even if they're established after a

lengthy period of development, would be small and scattered and lack the means to restrain cost increases or implement delivery of payment reform on a broad scale," said Hacker, who is one of the leading proponents of the public insurance option.

And if the Senate Finance Committee endorses federally promoted health cooperatives, they should be understood for what they are: an effort to kill the public plan, and with it the prospects for a competitor to take on private insurance companies, he said. Hacker joined U.S. Sen. Sherrod Brown (D-OH), a member of the

> *continued on p. 20*

Cooperatives

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Senate Committee on Health Education, Labor, and Pensions, who decried efforts by special interest groups to undermine a public plan and several key provisions in health reform legislation by spreading rumors.

He spoke against what he called a “misinformation campaign” being circulated at town halls and other forums that President Obama isn’t a U.S. citizen, that health reform would constitute euthanasia of older, sicker Americans, and that the effort would amount to socialized medicine and a government takeover.

Brown, without directly accusing special interest groups of spreading those rumors, said in a response to a reporter’s question that Pharma, America’s Health Insurance Plans, and the American Hospital Association are special interests that are trying to defeat the bill.

“I appreciate that they have come to the table. I also know what they’re doing, what drug companies are doing on biologics, and what the health insurance industry is doing, trying to get a weak public option or no public option at all to basically decimate the public option,” Brown said.

“These interest groups are out there, as of course they would be, and they’re spending—the statistics I’ve seen are \$1.4 million a day, not just from drug or insurance companies, but they’re the main part of that. Don’t think these interests groups aren’t out there, fighting every day out there ... to keep their share and enlarge their share of the public healthcare dollar in this country.

“And they’re a big reason this is so difficult ... because there’s so much money at stake. The insurance companies and drug companies, if they always have their way with Republicans, I want to make sure that they’re less likely to have their way with progressive democratic majority and the progressive Democratic president,” Brown added.

Hacker said he was strongly opposed to the idea being floated by members of the Senate Finance Committee that a health cooperative might be a suitable substitute for a public option.

Brown said cooperatives aren’t a serious means of achieving the following three essential goals that a public plan is far more likely to accomplish:

- ▶ Providing a benchmark for cost and quality for private insurance
- ▶ Offering backup financial health security for those without workplace coverage and small employers without access to good group health options
- ▶ Creating a backstop to reduce spending through innovations in payment and delivery of care

“[Cooperatives] might be able to provide some backup in some parts of the nation,” Hacker said, “but ... they’re not going to have the reach or authority to implement innovative delivery and payment reforms in increasingly consolidated insurance and provider markets.” ■

Marketing and technology may soon play bigger roles in health insurance

Health insurers that are anxiously waiting for healthcare reform to shake out before moving forward may find themselves well behind their competitors.

It’s understandable that health insurance companies don’t want to invest in big-dollar projects, such as in the area of underwriting, without knowing how the industry

is going to change. If healthcare reform implements an individual mandate coupled with health insurers accepting all members—regardless of preexisting conditions—the underwriting process that has become health insurance’s foundation will evaporate. Investing in that area doesn’t make sense now, but **Dan Maynard**,

president and CEO of Connecture in Waukesha, WI, says health plans must use flexible technology solutions to prepare for the future. Health insurers shouldn't stay transfixed on the horizon, as there is a more pressing need—the destruction of the employer-based health insurance market, most notably the small group market. As more Americans are bounced from employer-based health insurance, they are flooding the individual health insurance market, which insurers realize is their present and future, but many are struggling with how to not lose money in individual insurance.

To survive healthcare reform and the decimated employer-based market, Maynard suggests a combination of technology and marketing, which he says will play a much larger role in the near future.

That's because the combination of an eroding employer-based health insurance market coupled with healthcare reform will force insurers to compete for members, as is commonplace in other industries.

What could health insurance marketing's future look like? Think car and life insurance. Television shows feature ads from Geico, Progressive, and Aflac. Health insurers may soon become as much a staple of television and will need marketing departments that understand what consumers want.

The technology/marketing push will help insurers develop new products, perform lead management, quote rates to consumers, improve enrollment, and retain members. Maynard says the future of health insurers is in the following four areas:

- ▶ Easy and flexible product configuration
- ▶ Multiple avenues for targeted outreach
- ▶ Real-time and user-friendly online enrollment
- ▶ Analytics that are easy to understand and attract and retain a carrier's targeted market

Soon, health insurers will need to create a platform that will allow insurers to promote products across various market segments. This technology will include a single location for prospective and current members to learn about product information and availability.

"It's one thing to have a marketing site, it's another thing to be targeted to different types of consumers providing different targeted campaigns around your quoting and your lead [generation] activities. Health plans are a long ways away from that kind of technology-supported targeted marketing on the Web or otherwise," says Maynard.

Of course, people receive information in different ways. This means health insurers will need to create outreach across multiple avenues. Whereas young adults appreciate Web communication through fast processes, senior populations may need additional considerations, including user interface that is compatible with screen-reading applications and flexibility in font size and site view. Seniors might also need additional support through phone calls or even face-to-face communication.

Fewer people with employer-based insurance means health insurers will need to invest in direct-to-consumer offerings as well as interactive Web sites, call centers, and maybe even retail stores.

Having fewer underwriting possibilities, insurers will benefit by creating Web sites with real-time underwriting processes that allow customers to enroll immediately and the health plans to use the information to design wellness programs tailored to the individual, Maynard says.

The fourth of Maynard's suggestions would seem like common sense, but most health insurers don't use analytics, and those that do are not doing enough. Insurers must make sure their Web sites are reaching all people, says Maynard.

Health insurance companies can check this by measuring the site's performance, collecting customer experience data, analyzing the most effective pages, and determining which marketing campaigns are most effective. With this information, insurers can find out where they are losing out on potential sales, he says.

"Certain analytics provide you a lot of that intelligence to do so. Many health plans now don't have basic reporting methods, let alone targeted analytics," says Maynard.

> *continued on p. 22*

Marketing

< continued from p. 21

Maynard says he and Connecture are recommending these four areas of improvement, but the health insurance industry is “very immature” in these targeted marketing capabilities, unlike other industries, such as the financial sector and other insurances. Implementing these changes will be difficult and costly for insurers, but those who

are focusing their energies solely on what’s happening (or not happening) in Washington are making a mistake. The loss of the employer-based system is a potentially devastating problem that is now before health insurers. And that momentum is not coming from Pennsylvania Avenue; it’s coming from Main Street. ■

HHS fires up rhetoric against health insurance industry

The Obama administration’s pugnacity toward the nation’s private health plans intensified with the release of a short but sharply worded U.S. Department of Health and Human Services (HHS) talking points memo detailing what federal officials say is the industry’s widespread discrimination against people with preexisting conditions.

The memo, *Coverage Denied: How the Current Health Insurance System Leaves Millions Behind*, is slightly longer than a typical press release, but it is striking for a confrontational tone that, for the most part, has not been seen in government advocacy reports since the heyday of Big Tobacco.

The report cites a 2007 Commonwealth Fund Biennial Health Insurance survey, which found that 12.6 million nonelderly adults—36% of those who tried to buy insurance on the private market—were discriminated against in the past three years because an insurance company said they had a preexisting condition, charged them a higher premium, or refused to cover their condition. Another Commonwealth Fund survey this year found that one in 10 people with cancer said they could not get health coverage, and 6% said they lost their coverage because of their diagnosis, the HHS memo stated.

“The insurance company practice of denying coverage because of preexisting conditions is not confined to serious diseases,” the HHS report stated. “Even minor problems such as hay fever could trigger prohibitive responses. An insurer could charge high premiums, deny

coverage, or set a restriction such as denying any respiratory disease coverage to a person with hay fever.”

The biggest point of contention between the White House and the health insurance industry is the Obama administration’s call for a public plan to compete with private insurers, which the president has said is needed to keep private insurers honest. The industry says a public plan would have inherent cost advantages over the private sector in areas such as advertising, marketing, and physician reimbursement, and would drive private insurers out of business.

“Our concern is the government-run plan, which has been the subject of a lot of concern over the country in the last few weeks,” says **Alissa Fox**, senior vice president of policy and representation at the Blue Cross and Blue Shield Association in Washington, DC. “We think that is a huge diversion. We want Congress to drop the government-run plan. We want them to include insurance reforms and other actions to make sure everyone is covered and costs are reined in.”

The HHS talking points memo comes as the Obama administration steps up efforts to bolster sagging support for healthcare reform. White House officials reportedly fear that opponents of healthcare reform are controlling the message. In late July, President Obama began referring to insurance reform rather than healthcare reform to better tap into perceived widespread public resentment toward health insurance companies. Recently, House Speaker Nancy Pelosi (D-CA) told a room of

reporters that the health insurance companies were the “villains” in the healthcare reform debate.

Karen Ignagni, president and CEO of America’s Health Insurance Plans, who last week complained of attempts to “demonize” her industry—took issue with the HHS report and insisted that her industry is leading reform efforts.

“Health plans last year proposed health insurance reform to make sure that no one is denied coverage because of a preexisting condition,” Ignagni says. “Our proposal includes new consumer protections and market rules to guarantee coverage for preexisting conditions, discontinue basing premiums on a person’s health status or gender, and get everyone covered through a personal coverage requirement.”

The HHS memo also accused the health insurance industry of rescission, which is the practice of reviewing patients’ health insurance applications for mistakes and omissions when the insurers are later presented with a bill for expensive conditions such as cancer. “If the company discovers that any medical condition, regardless of how minor, was not reported on the application, it could

revoke coverage retroactively for the patient and possibly all members of the patient’s family,” the report stated, adding that insurers can do this even if the condition found is not related to the expensive condition or if the person wasn’t aware of the condition at the time.

The HHS memo added that health insurance reform would prohibit insurers from refusing coverage based on someone’s medical history or health risk. Companies also would be barred from watering down coverage or refusing renewal because someone becomes sick. Companies would have to renew any policy as long as the policyholder pays the premium in full, according to HHS. Fox says the HHS memo doesn’t tell the complete picture. “There is a lot of talk that insurers can drop you when you get sick. That generally is not true,” she says. “Insurers are now required by federal and state laws to issue coverage on a guaranteed renewable basis. The decision to renew coverage is the individual’s, not the insurer’s.”

Fox declines to comment on the aggressive tone of the HHS report. “I’d rather deal with the facts,” she says. “We want reform. We want to see it enacted this year. We had the same platform in 1993 and 1994.” ■

Health card companies defrauding patients shut down

Lisa Truong’s \$28,000 bill from a San Francisco hospital is just one reason the California Department of Managed Health Care (DMHC) recently ordered two unlicensed companies offering fraudulent discount health cards to shut down and a third company selling health coverage to apply for a license or stop operating.

Additionally, the state plans to make a plea to hospitals, physicians, and clinics to have their intake workers report those instances when patients appear with such cards expecting they are covered, instead of letting the incidents slide unreported.

If the practice isn’t stopped, patients will continue to have their credit records tarnished for nonpayment, and hospitals and other providers will be left on the hook for increasing amounts of unpaid care, state officials said.

Truong, a 41-year-old legal secretary, has been paying \$60–\$209 monthly for six months to one of the companies, International Association of Benefits, whose agent told her that the health card she was buying would pay her bills, she said.

When she needed a kidney biopsy in November, requiring a two-night stay, California Pacific Medical Center took her card information and admitted her for the procedure.

But three months later, she learned the bill was not paid and she was getting letters from the hospital and her doctors stating that she owed them \$28,000.

The company apparently paid two physicians who treated her for \$75. But that’s all.

> *continued on p. 24*

Card companies

< continued from p. 23

The state ordered another company, Prudent Choice, to shut down. And a third company, DentalPlans.com, was ordered to seek a license and file an application by September 15, or else it too will receive a cease-and-desist order.

Cindy Ehnes, director of the DMHC, said in a statement that 150–300 such companies are operating throughout the state, “defrauding tens of thousands of Californians. Their primary victims are usually limited English-speaking, lower income, and minorities employed in small businesses. These people generally do not have as much of an awareness of their rights or who to call or what to do.”

The businesses, sometimes called “discount health card companies,” offer a membership program with lower fees for health providers (such as doctors, dentists, and hospitals), drugs, optical products, and “no preexisting condition” limitations.

Although some companies offer legitimate discount cards, the problem companies offer such deals in the absence of having any contracted arrangements with the providers.

In Truong’s case, the monthly premiums that started at \$67 one year ago and were upgraded one month later to \$209.95 were deducted from her debit card.

Companies of concern to the DMHC claim high discounts with risk-free cancellation policies and full refunds. Many use deceptive advertising as well.

“It’s almost impossible to know how big this is, because it relies on victims complaining and knowing they can complain to the DMHC,” Ehnes said. “The one thing we can say is that it’s significantly underreported.”

However, Truong filed her complaint, which was immediately investigated. Her case helped Ehnes take action against IAB, which had previously been ordered to get a state health plan license. And although it initially began the process, IAB has “since ignored repeated requests to make progress,” Ehnes said.

To date, the DMHC, the only stand-alone HMO watchdog agency in the nation, has filed cease-and-desist orders

against eight such discount card companies, some of which are headquartered outside the state, and is one of 14 states that have taken action against such fraudulent activities.

The DMHC has jurisdiction over such companies because it promises to provide payment for healthcare services in exchange for periodic payments, which must comply with laws governing health plans.

More than half of the nearly 1,000 consumers that have complained about such practices to the DMHC say they were told they were purchasing a health insurance card, “only to discover that it is merely a discount and does not protect them from large medical bills,” the DMHC said in a statement.

Much of the time, when consumers tried to use the card, they learned the provider had no contract with the company or offered the same or better discount to any cash-paying patient off the street.

Especially now, with more people unemployed and without health insurance, such companies are preying on people with promises that don’t hold up, said Ehnes.

“We’ve been able to get [the finances of the companies under investigation] and learned that they have been making a great amount of money,” she added.

For Ehnes, consumers such as Truong are the reason health reform is so important.

“The reality is, people are desperate for healthcare security and because of that, they are lip-smacking opportunities for these kinds of rip-off schemes,” said Ehnes. ■

Questions? Comments? Ideas?

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