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JANUARY 2014 VOL. 24 NO. 1
ADVANSTAR MEDICAL COMMUNICATIONS GROUP

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Capitalize on industry changes in 2014

You have reinvented your business for 2014, and here at MANAGED HEALTHCARE EXECUTIVE, we've done the same. As I'm sure you've already noticed, we've deployed our talent and resources to offer you a new design presentation for our print issues.

With a distinct business-oriented character, the look and feel of our must-read articles, industry intelligence, statistics and commentary from the front lines of managed care have evolved to reflect the industry attitude. We're bringing you more quick reads, trends and takeaway messages.

Plus, our print, digital and online spaces will continue to be packed with information and analysis that you can't get anywhere else. The free MHE app now includes more clickable features as well as snapshots of what you absolutely need to know.

As you navigate through the new era of health system transformation, interaction with your peers, thought leaders and industry observers will be invaluable. Let us be your channel of interaction to chew over trends and share success stories. We're anxious to bring all of our readers into the MHE discussion in blogs and features in 2014. It's easy to be a voice in the number-one*, award-winning publication in the managed care space.

New era, new opportunity

No doubt you're also deploying your resources to capitalize on opportunities related to health reform this year. With 45 million uninsured (and most of them projected to enter the health insurance market), there are growth opportunities for large and small plans.

Based on estimates created by Value Penguin, a consumer insurance and finance website, the uninsured are worth a potential $92 billion in annual premiums—paid by the enrollees and the federal government in the form of subsidies. After subtracting for the medical-loss ratio (MLR), what remains is $18.4 billion allocated to administrative expenses, marketing, overhead and profits.

Value Penguin also estimates a 2% to 4% profit margin on premiums, equating to $1.8 billion to $3.6 billion going to the bottom line. And this is only related to the newly insured entering the market.

Trends to follow

Leading through market changes is ultimately about making the best possible decisions with the information you have at the time—and having a back-up plan. There's no doubt 2014 will be a year of thoughtful decisions and nimble readjustments.

MHE will be bringing you front-line analysis in 2014 on:

- **Affordability;**
- **Profitability;**
- **Cost effectiveness;**
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- **Accountable care's promise;**
- **Member out-of-pocket responsibilities;**
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- **Medicaid growth; and**
- **The ultimate impact of ACA.**

Let MHE be your executive advisor throughout the year as we examine the trends and lead through change.

**Kantar Media, 2012, Table 101, Average Issue Readers, among 14 publications measured*

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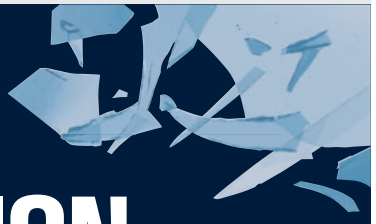

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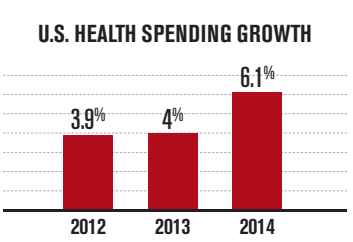

Source: Office of the Actuary, Centers for Medicare and Medicaid Services

Coordinated care organizations 5 / Oncology ACOs 6 / Plans scrub 834s 7 / Uninsured unprepared 7

SUPREME COURT TO HEAR ARGUMENTS ON CONTRACEPTIVE MANDATE

Discussion leaves a sense of uncertainty on how coverage rules will play out

JENNIFER WEBB
MHE CONTRIBUTOR

NATIONAL REPORTS — The Supreme Court's decision in late November to hear arguments in two cases challenging the federal government's contraceptive mandate should provide clarity as health insurers work to comply with the Affordable Care Act (ACA), according to a lawyer who advises managed care organizations.

George B. Breen, a partner in the Washington, D.C., law firm of Epstein Becker Green, says conflicting decisions in more than 80 pending lawsuits challenging the mandate's constitutionality have rendered a Supreme Court decision imperative. ACA rules require health plans to offer members coverage for FDA-approved contraceptives with no cost-sharing.

While religious organizations are exempt and religiously affiliated organizations have a workaround, private, for-profit employers do not. The center of the issue calls into question whether a corporation—perhaps one that is family-owned, such as retailer Hobby Lobby—can object to providing employees free contraceptives, based on religious objections.

A high-court decision either for or against the ACA mandate will impact claims adjudication, financial management, customer service, medical policy and more, Breen says.

"There are a number of potential repercussions that come into play in the event there is a decision made that it's unconstitutional or whether there's provision that there are certain types of contraceptive services somehow permitted to not be subject to the requirement. It creates further confusion in the industry at a number of levels," he says.

With regard to pricing, for example, plans are left to wonder how services will be provided and who pays for it.

"The law, as it stands now, says this is an essential health benefit that cannot have any cost-sharing on the part of the member," Breen says. "How do costs get accounted for if you now have a change in the law?"

It's a continuation of the confusion that insurers have faced. Breen says it leaves a sense of uncertainty as to how the contraceptive coverage rules will ultimately play out.

The court is expected to hear arguments this spring regarding two cases, *Kathleen Sebelius v. Hobby Lobby* and *Conestoga Wood Specialties v. Sebelius*, in which for-profit corporations claim that the mandate violates their company's religious freedom. Both companies take exception with four drugs the FDA classifies as contraception that prevent implantation of a fertilized egg, which those who believe life begins at conception say is tantamount to abortion.

In both cases, the firms argue that they are protected by the Religious Freedom Restoration Act (RFRA) signed into law in 1993. The act protects "a person's exercise of religion," and, according to Congress's Dictionary Act, a corporation is a person under the law.

At issue, then, are whether a for-profit corporation can be protected by RFRA, and whether it is a violation to require a business to provide insurance for contraceptives when that coverage violates the owners' personal religious beliefs, according to the Kaiser Family Foundation.

The decision, which is expected by summer, impacts most health plans, except those that are grandfathered.

CRITERIA FOR EMPLOYERS EXEMPT FROM PROVIDING NO-COST CONTRACEPTIVES

- Oppose providing for some or all of any contraceptive coverage because of religious objections
- Have not-for-profit status
- Hold themselves out as religious organizations
- Self-certify that they meet the first three criteria

Source: Kaiser Family Foundation Brief, December 2013

OREGON COORDINATED CARE PROVES COST SAVINGS

Oregon is the first state to transfer Medicaid populations into accountable care

FRED GEBHART
MHE CONTRIBUTOR

NATIONAL REPORTS — The state of Oregon has taken the leap and moved its entire Medicaid program into a system of regional Coordinated Care Organizations (CCOs). Considered accountable care organizations, CCOs integrate traditional outpatient and inpatient care, mental health, addiction services, social services and even competing managed care groups, into a medical home model with a single per-patient budget.

Oregon appears to be the first state to transfer its entire Medicaid population into CCO coverage, and experts say one-year results look good.

Primary care utilization increased by 18% and primary care spending by 7%, while emergency department utilization fell by 9% and emergency department (ED) spending by 18%. Hospitalization for congestive heart failure fell by 29%, chronic obstructive pulmonary disease by 28% and adult asthma by 14%.

Thirty-day readmissions following discharge fell by 12%. The overall rate of Medicaid spending growth is down by more than one percentage point, exceeding baseline goals set by the Centers for Medicare and Medicaid Services (CMS).

"We are still early in the experiment," says Erin Fair Taylor, director of CCO partnership and development for CareOregon, a managed-care Medicaid organization that is funding and coordinating regional CCOs across the state. "We are starting to see patterns of primary care utilization increasing as ED and hospital utilization drops, but we are still hesitant to draw a causal link. The medical home model may be helping prioritize our efforts to focus on our highest utilizers and divert them to more effective and more cost-effective utilization patterns."


ERIN FAIR

CareOregon, a not-for-profit plan, has long advocated for medical homes and brings primary care physicians together frequently for learning labs and the exchange of best practices.

HIGH UTILIZERS

The Oregon CCO program focuses on the 20% of Medicaid recipients who account for 80% of spending. They are typically individuals with dozens of ED visits and multiple hospitalizations every year.

The goal is to move these high utilizers, along with all other Medicaid patients, into primary care medical homes where providers can focus on chronic and preventive care. Advocates say the expected result is better patient outcomes, increased utilization of primary care services, lower utilization of ED and hospital services and lower overall spending.

A pioneer in accountable and integrated care, the Oregon CCO program is modeled on "hot-spotting." Using ED and hospital admission records, care specialists identify individuals with the highest utilization—the hot spots—then work on the root causes of the high utilization by focusing on the patient's total health status, not just medical issues.

Hot-spotting starts with the recognition that medical care is responsible for only about 10% of a patient's overall health status, says Rebecca Ramsey, BSN, MPH, director of community care for CareOregon. The other 90% is linked to socioeconomic issues, nutrition, social environment, living arrangements and other nonmedical factors that are beyond the control of clinical providers.

"We have deployed 'health resilience specialists' into the primary care process to work on those nonmedical factors that physicians may recognize but can't do anything about," she explains. "It is a very intentional engagement strategy."

BY THE NUMBERS

12%

Reduction in 30-day readmissions

For example, the specialists might go grocery shopping with a diabetes patient who keeps coming into the ED, and might even teach her how to cook, to improve her nutritional status and reduce ER usage.


REBECCA RAMSAY

"Our governor likes to talk about the example of buying an air conditioner for a congestive heart failure patient to keep him out of the hospital when the temperature goes up," she says. "An air conditioner isn't your typical Medicaid intervention, but it makes sense to spend $200 on an air conditioner and prevent a $100,000 hospitalization. It only takes preventing one or two hospitalizations to start showing significant cost savings."

ONCOLOGY ACOS OFFER INNOVATION FOR HIGH-COST POPULATIONS

Florida Blue creates single-specialty accountable care organizations

MARI EDLIN
MHE CONTRIBUTOR

NATIONAL REPORTS — As accountable care organizations (ACOs) gain footing, a few innovators are finding ways to enhance the prevailing models. The disease-specific ACO, still rather nascent, is now on the radar.

In May 2012, Blue Cross and Blue Shield of Florida (Florida Blue), and two providers, Baptist Health South Florida and Advanced Medical Specialists (AMS), built the Miami-Dade Accountable Oncology Program. AMS is a multi-specialty physician group focused on cancer care.

Jonathan Gavras, MD, senior vice president and chief medical officer for Florida Blue, says cancer care was ripe for attention. Oncology is the top disease category account for 80% of Florida Blue's medical spend.

"We knew we needed to do something different to achieve the triple aim: save money, improve outcomes and deliver patient satisfaction," he says.

Dr. Gavras says the three organizations studied costs associated with cancer treatment, projected trend and set a target for an appropriate reduction in expenses. He anticipates that if all quality measures are met, there will be savings to share. Providers are paid fee-for-service along with shared savings.

The program focuses on six types of cancer: breast; digestive system and peritoneum; female reproductive organs; lymphatic and hematopoietic tissue; male reproductive organs; and respiratory and intrathoracic organs. Thus far, the ACO's services have reached 500 members.

In the population identification process, the partners chose active cancer patients attributed to AMS during the prior year and calculated the average per-member, per-year expense within the population. They aligned financial targets with the medical Consumer Price Index, shared-savings percentages among the organizations and an effective date for the agreement.

> "We knew we needed to do something different to achieve the triple aim."
>
> —JONATHAN GAVRAS, MD
> FLORIDA BLUE

Key to the delivery of accountable care, says Dr. Gavras, has been an onsite clinical coordinator, along with after-hours care that allows for post-chemotherapy follow-up to prevent emergency room visits. Although there are not yet any firm results, Dr. Gavras says the ACO is on target to decrease readmissions, reduce ER visits, increase medication adherence and improve quality of care.

The ACO also has information exchange and scale to target a larger population. In the private market, accountable care models are proving more innovative than the Medicare ACOs. However, ACOs in general are designed to raise the bar on care across all populations.

Dr. Gavras says the oncology ACO is beginning to take a closer look at palliative care as a means to avoid inappropriate treatment, such as chemotherapy for a patient with a life expectancy of 30 days. Difficult end-of-life care continues to be a challenge from a cost and quality-of-life perspective.

Along the way, Dr. Gavras says the ACO has learned a few lessons:

- **Pick committed and aligned partners with common goals;**
- **Streamline data exchange early in the process; and**
- **Realize that a small population of patients can lead to large variations in data from one reporting period to another.**

In fact, Florida Blue has learned so much that it launched another oncology ACO a year ago with Moffitt Cancer Center in Tampa, a National Cancer Institute-designated facility. He expects the Tampa ACO to target a larger population to reduce variability.

This year, the insurer hopes to develop four more single-specialty ACOs.

BUNDLED PAYMENT

While the Miami-Dade Accountable Oncology Program represents an ACO that is disease-specific, others are contracting with different provider specialties to take advantage of their services.

Elliott Fisher, MD, director, Dartmouth Institute of Health Policy & Clinical Practice, says bringing specialists onboard in an ACO is the typical arrangement. He sees the role of the specialist as one who designs care pathways around a certain condition and provides support and knowledge to enable primary care physician teams and patients to deliver appropriate care.

To be successful, he says, an ACO needs to coordinate care among all providers targeting a defined population, share data and reduce costs.

Dr. Fisher says that a bundled payment arrangement might make more sense in the long run than forming a chronic disease-based ACO. ◘

HHS SAYS 834S ARE REACHING PLANS

The data is not necessarily perfect

JULIE MILLER
CONTENT CHANNEL DIRECTOR

NATIONAL REPORTS — According to the Department of Health and Human Services (HHS), the *healthcare.gov* 834 data transfer problem has improved to the point that the percentage of missing 834s is now "near zero."

HHS has repeatedly indicated that it is working with insurers to reconcile past 834s so consumers who signed up in the early days of open enrollment will not get lost in the shuffle. Further, HHS says it is contacting enrollees to remind them they must pay their premium to begin coverage.

Insurers are generally open to allowing members a 10-day grace period for paying premiums in order to begin coverage January 1.

In the first two weeks of open enrollment, nearly 10% of 834s from *healthcare.gov* never made it to insurers. The following two weeks saw a peak of more than 15% of total enrollments getting lost, but the percentage of "orphan files" has been dwindling in the weeks since.

"More than 70 of our software fixes over the past several weeks have focused on correcting software bugs related to 834 issues," says Julie Bataille, director of communications, Centers for Medicare & Medicaid Services.

HHS says it is working with insurers to alert them to potential orphan files so they can get a sense of the disconnects.

While HHS contractors are providing assistance and the fixes to the technology platform have helped, plenty of administrative hassle is falling to insurers. For example, WellPoint received 10,000 calls per day in early October in its call centers. And these waves of high-touch, manual interactions come at a time when insurers are already being pinched by medical-loss ratio floors.

Even when the orphan files are discovered and transmitted, there is no guarantee that the information is complete enough to process enrollment. Plans will continue to see issues typical with new enrollments such as incomplete fields and invalid addresses.

SummaCare, an Akron, Ohio-based health plan that is offering products on the *healthcare.gov* site, is receiving 834 data, and IT leaders for the plan say the information is 70% to 80% complete. ■

AMERICANS MORE INFORMED ABOUT ACA, UNINSURED LEAST PREPARED FOR COVERAGE MANDATE

Most will wait until the final days of open enrollment to make a decision

TRACEY WALKER
ADVANSTAR CONTRIBUTOR

NATIONAL REPORTS — As the deadline for open enrollment approaches, Americans are now more informed about the Affordable Care Act (ACA) and feel more prepared for its implementation. But that has not spurred action, according to a national opinion survey of more than 1,000 Americans (ages 18 to 64), conducted in November by Harris Interactive and released by Transamerica Center for Health Studies (TCHS).

Only 7% of the uninsured population feels "very prepared" to make health insurance choices, and only 35% feel at least somewhat prepared—up slightly from 30% feeling at least somewhat prepared in the firm's July survey. Likewise, 31% haven't even heard of the health insurance exchanges compared to 15% of the general population.

"[The survey] highlights what people know about their healthcare options and what actions they are taking to become ACA compliant; plans have a vested interest in understanding health consumer behavior," says Hector De La Torre, executive director of TCHS. "More Americans are informed and prepared for the March 31, 2014, mandatory health coverage date, but a significant number have yet to actually sign up for health insurance in the exchanges or in the traditional insurance market."

Early last month, 2 million exchange site visitors completed applications but had not chosen plans.

The uninsured continue to be the least active, which could be because they feel the least prepared. De La Torre says the great unknown is what the uninsured ultimately will do.

"This group of uninsured will probably wait until the real deadline of March to make a decision and take action," he says.

Also, while 60% of Americans feel informed about ACA and 72% feel prepared for the individual mandate requirement of the ACA—up from July's 48% and 63% respectively—59% have done nothing in the past 12 months to study their healthcare options.

Other survey findings include:

- **More than one-quarter (29%) of the general population reports a pre-existing medical condition;**
- **Seventy-one percent of those with a pre-existing condition were not hindered in their ability to obtain health insurance, but 29% said insurance was too expensive (19%) or they were not able to find coverage (10%);**
- **Among those who reported being unable to afford or access health insurance due to a pre-existing condition, 35% say they can now get coverage;**
- **A majority (55%) of the uninsured say they are "not sure" what they plan to do in response to the individual mandate.**
- **Only 10% of the uninsured feel "very informed" about their options and just 32% feel "somewhat informed." "This is a significant decrease since July, when 56% of those uninsured felt somewhat or very informed about their health insurance options," De La Torre says.**
- **Given their low level of satisfaction with the quality of the healthcare system they have access to (34% versus 84% among both privately and publicly insured individuals), it may benefit the uninsured to learn about these new healthcare options.** ■

BUDGET OPTIONS WILL RESHAPE HEALTHCARE

Changes will impact Medicare, Medicaid, tax policy and the competitive landscape

While the struggle continues in 2014 to provide effective and affordable coverage, administration and Congressional leaders will weigh a host of spending options important to coverage and delivery.

Federal outlays for healthcare and health-related federal tax benefits exceed $1 trillion a year, according to the Congressional Budget Office (CBO). These and related spending on discretionary public health and biomedical research programs add another $115 billion to federal spending. All outlays are slated to increase in 2014 as more people become eligible for Medicaid, and new federal tax subsidies kick in under the Affordable Care Act.

Policymakers are combing budget plans for opportunities to reduce payments to providers and insurers, revise incentives for employer coverage and discourage consumer spending on health services. As insurers play an ever-expanding role in serving Medicare and Medicaid populations, these decisions stand to shape industry revenues and finances significantly.

Key budget-cutting proposals

Restrict Medigap insurance and impose cost-sharing.
Cost-sharing for all Medicare beneficiaries would make individuals more sensitive to healthcare costs. Proposed changes would lower Medigap premiums, but also erode purchases as Medigap plans lose value for seniors. This would reduce federal outlays by more than $100 billion over 10 years (2014 to 2023), according to CBO projections.

Convert Medicare to a premium support system.
Advocated by Republican conservatives who believe that a defined-contribution approach is necessary to prevent bankruptcy, the change could save up to $275 billion—depending on the generosity of federal contributions, the range of beneficiary choices and whether traditional Medicare would continue as an option.

Integrate Medicare reforms.
Reforms would increase premiums for Medicare Parts B and D (saves almost $300 billion); bundle payments to providers (cuts nearly $50 billion); raise the age of eligibility to 67 (saves $20 billion); and require drug companies to pay rebates on Part D coverage for low-income Medicare beneficiaries (reduces outlays by more than $120 billion).

Cap federal contributions to state Medicaid programs.
This will limit open-ended federal financing to encourage states to be more efficient. The cap saves $100 billion to $600 billion, but also leads states to scale back programs.

Limit medical malpractice suits against doctors.
A number of reforms would save $64 billion by reducing physician outlays for malpractice insurance and curbing "defensive medicine."

Cut tax preferences for employment-based coverage.
This highly controversial move could lower federal spending by more than $500 million. It also would decrease employment-based coverage and leave more people without health insurance.

Add a "public plan" to exchanges.
Set to begin in 2016, this coverage option would attract some 2 million people, CBO estimates, and save more than $150 billion. By paying lower rates to providers, it could offer premiums 7% to 8% lower than private insurance, pressuring insurers to lower their own premiums to compete. This would translate into a reduction in exchange subsidies for beneficiaries, and access to lower-cost plans would spur more employers to offer coverage through the exchanges.

Also, ending exchange subsidies for people with incomes over 300% of federal poverty level would save more than $100 billion. This would affect some 1 million people, many of whom would find insurance unaffordable. ◘

ABOUT THE AUTHOR
Jill Wechsler, a veteran reporter, has been covering Capitol Hill since 1994.

END-OF-LIFE CARE REQUIRES NATIONAL DIALOGUE

Chronically ill patients in last years of life account for 32% of total Medicare spending

Our healthcare delivery and finance system spends an enormous amount of money providing medical care (not palliative care) in the last year of life. Although it is the third rail of healthcare reform, it must be discussed. Policymakers do us a disservice by pretending that it's an issue that can be put aside. Unfortunately, chants of death panels all but silenced any meaningful effort to address this important topic.

By all accounts, a meaningful portion of healthcare spending is for care of some kind during the last year of life. In fact, according to the Dartmouth Atlas of Care, patients with chronic illness in their last two years of life account for about 32% of total Medicare spending. This is only one of many studies that documents the large expenditures being covered for care of patients in their final days.

These numbers scream for a national dialogue about what medical care is owed to people who have reached an age when they face chronic medical maladies that require expensive treatment and often involve hospitalization and secondary illnesses, such as infections. What care is given in the last year(s) of life; who should decide what care is appropriate; how such care should be delivered; and who should pay for it are all questions that policymakers and citizens need to think about and act on if we are to strike a fair balance in end-of-life care.

It's wrong for the aged to die in hospital beds after suffering medical interventions that, in the end, cannot stop the inevitable. Or worse, die from painful infections picked up in a hospital.

For most people, the cost of end-of-life care for the elderly is paid for by a third party, and there is no real financial cost to the patient or his or her family. Given the enormous pull of wanting the patient to stay alive, no effort is spared—whether it makes the patient more comfortable or not.

"These numbers scream for a national dialogue about what medical care is owed to people who have reached an age when they face chronic medical maladies."

Health reform's effect

Although the Affordable Care Act does establish palliative care as an essential health benefit that must be covered by all insurance plans subject to the law, each state can decide how to meet this requirement and how, or if hospice will be a covered service. This presents a good opportunity for stakeholders in each state to address a number of important policy issues including the following:

- The purpose of medical treatment and intervention;
- The cost of alternative approaches to care;
- A patient's right to die with dignity;
- The role of nurses and nurse practitioners;
- The role of hospice and palliative care; and
- The role of family and other caregivers.

Many studies and reports contain not only objective data that must be considered, but also a host of important subjective observations and suggestions. End-of-life care in other countries offers helpful insights that are also worthy of study. Hopefully this subject will get the attention it deserves and policies will be refined and developed that will move our country forward to a more sensible, consistent, compassionate and cost-effective approach to end-of-life care. ◻

ABOUT THE AUTHOR

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MARKET DISRUPTION

REINVENT YOUR APPROACH FOR LONG-TERM SURVIVAL

By **JULIE MILLER**

EXECUTIVE VIEW

- Plans are competing at the retail level for the first time.
- Profit margins are static at 5%.
- Insurers have been cooperative with federal officials in the chaotic launch of major ACA provisions.
- Brands must market themselves as partners in care to enhance their historically negative image.

HEALTH PLANS HAVE LONG BEEN THE STAKE-holders at the table calling for a more affordable healthcare system. Under the Affordable Care Act, plans are also the stakeholders doing the most retooling to adjust to the large-scale market disruption.

"The insurance market has never been more chaotic than it is now, fueled especially by the almost meltdown of the exchanges at both the federal level and the state level," says David Nash, MD, dean of the Jefferson School of Public Health.

Dr. Nash says the biggest market alteration for insurers is more of a creative disruption that has driven managed care organizations to move from their traditional business-to-business marketing model to a business-to-consumer model.

"The retailization of health insurance is inevitable as we try to absorb 30 million to 50 million new customers into some kind of insurance coverage," he says. "I see large for-profit plans and national Blues plans all competing at the retail level for the first time ever in selling their products—from products for a young person through Medicare Advantage."

Part of health plans' retail roadmap for 2014 must encompass an improved patient engagement strategy, which might include anything from gamification and mobile apps, to affordability, to value based on quality. Engaging with members one-to-one opens up the opportunity for innovation while also challenging plans to find best practices. 2014 will likely produce pilot projects to test engagement.

But member education also must include navigation through the healthcare system itself. Few members understand, for example, what "coinsurance" means.

"That seems to be where the Obama administration really dropped the ball: inadequate and ineffective patient education about basic tenants of what insurance is, why we need it, and why it's such an important public good," Dr. Nash says. "The big challenge for 2014 is in patient education, beyond just the knuckle-headed health insurance exchange—which is a sideshow that will be fixed—the bigger issue is patient education."

Plans will be challenged to address:

- **The retailization of the market;**
- **Floors on medical loss ratios (MLRs) and fees/taxes that are eating into net profits;**
- **Lower enrollment numbers; and**
- **The age-old problem of health plans' collective reputations in the public eye.**

Getty Images/Blend Images/John Lund

ACA PROVISIONS CUT INTO PROFIT MARGINS

New cost pressures cloud the financial outlook

By **JULIE MILLER**

Industry observers have long characterized the Affordable Care Act (ACA) as a reform strategy targeted at health insurance rather than the broader system. Certain regulations essentially place limits on plans' ability to protect their reserves and build their profitability. Minimum medical loss ratio (MLR) requirements and new premium taxes and fees are clouding the financial outlook.

Requiring minimum MLRs has been the biggest reason for plans' narrowing profit margins. By placing a floor of 80% (small-group and individual products) and 85% (large group products) for MLRs, federal regulators have limited investment prospects.

America's Health Insurance Plans (AHIP) has long held that MLR rules have unintended consequences, such as penalizing insurers for investing in worthwhile programs. On top of that, the reporting structure itself causes additional administrative burdens, according to AHIP.

David Nash, MD, Dean of Jefferson School of Population Health, says the politics of health reform for plans are formidable.

"The industry as a whole gave up billions in the MLR and the tax conversation in order to cooperate with the White House and help get reform passed," he says. "They were at the table, via AHIP and other organizations, to be active participants in what we all hope will be the fix."

Dr. Nash believes the insurance industry will continue to be cooperative in reform and will create products that make sense in the changing market, even though many ACA provisions are operationally challenging.

"Reform would not have been possible without the collaboration of the insurance industry," he says. "It would have been dead on arrival."

ADMINISTRATIVE COSTS

MLR penalties are steep: Failing to meet the 80%/85% mark forces a plan to issue cash-back rebates to employers and individuals.

"There were some plans in certain markets that were already above the MLR floor, so the pressure on them may be less," says Todd Van Tol, partner with Oliver Wyman, a global consulting firm. "It is fair to say these ACA-driven changes are causing payers to pay closer attention to their administrative cost profile."

He says smaller plans are looking at outsourcing back-office tasks, such as IT. But in the longer term, he predicts more payer consolidation to achieve scale and operational efficiency.

MLR REBATES

Collectively, health plans issued $1 billion in MLR rebates in August 2012 and $500 million in August 2013. Debra Donahue, vice president of market analytics for Mark Farrah Associates, sees the downward trend continuing for MLR rebates issued in August 2014 for the 2013 plan year.

"The 2015 payouts should be really interesting because that's when reform kicks in," Donahue says. "That's when individual rebates are going to have to be paid and when small group rebates are going to come into play. I think that's where it's actually going to be a big deal."

She says the premiums for the 2014 plan year involved a lot of guesswork, so the forecast on those rebates is a big unknown.

"The plans don't have any claims history experience on the 30 million people who could potentially enter the system," she says. "They don't know what that risk profile is going to look like. They don't know the impact of high coinsurance and high deductibles."

At the very least, plans in the exchanges have the protection of risk adjustment, reinsurance and risk corridors in 2014. Donahue says her biggest question is how the allocation of reserved funds is going to play out for plans that underestimate premiums. The underestimators will receive funds from the collective pool, at the expense of the plans that did a better job in pricing.

"It looks like in the Federal Register there is some way the federal government is going to make monthly estimates to let the health plans know month to month what the number is supposed to look like," she says. "How they're going

> "Reform would not have been possible without the collaboration of the insurance industry."
>
> —DAVID NASH, MD

to be able to do that is a huge question in my mind. How can they possibly get a sense of what that number is going to be when it takes 60 to 90 days to get claims through a system?"

UNCERTAIN ENROLLMENT

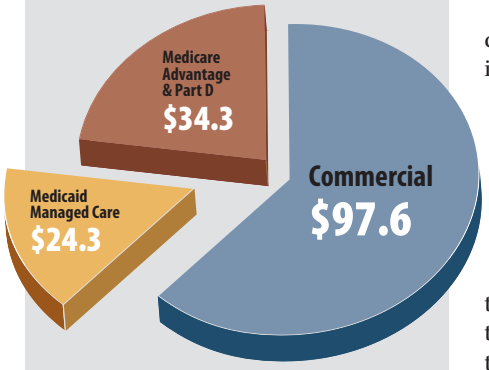
Plans took a seat at the table with federal regulators when health reform was designed. The promise of new enrollment in an otherwise stagnant or down-trending market might have seemed like a good position at the time, but today's enrollment outlook remains uncertain.

"They won't get the enrollment they were originally predicting—that 30 million," Donahue says. "I'm thinking it's going to be about one-third of that."

Much of the enrollment gap can be attributed to: technical issues with exchange websites; lack of consumer awareness; and hobbled navigator programs that were supposed to be instrumental in spreading the word and signing up new members.

HEALTH INSURANCE FEE BY MARKET, 2014-2023 (IN BILLIONS)

BASELINE GROWTH SCENARIO



Source: Milliman analysis for Medicaid Health Plans of America, January 2012

But Donahue says few of the for-profit insurers are participating in the exchanges to the extent that low enrollment is going to hurt their bottom lines significantly. Aetna, Cigna and UnitedHealthcare, for example, aren't investing heavily in exchange products. She says they've taken a more cautionary stance.

"Humana is one of the ones that is banking on exchanges, and they could have problems there," she says. "They already cut their outlook in terms of enrollment."

In early November, Humana plan officials announced they had cut their previous estimate of 500,000 new enrollments by March 31 to 250,000 because of the initial problems with the *healthcare.gov* website. However, the exchanges are just one market segment. Humana has done well in its Medicare Advantage business.

In the first half of 2013, major insurers gained enrollment in Medicare Advantage, managed Medicaid and commercial segments, both fully insured and administrative services only (ASO).

5% MARGINS

Historically plans were more profitable if they were better able to manage the cost of care, but the MLR rebates take away plans' ability to benefit from their cost saving efforts. Donahue says plans are hovering around 5% margins. Some plans were much more profitable than others in the past, but today, the gap is narrowing.

"Managed care has always had narrow margins; that's not new," she says. "But they have always had the ability to change that in terms of better management of care and in terms of reaping the benefits of preventive care."

As long as the averages remain steady, Donahue says she isn't too concerned. Roughly two percentage points separate the most and least profitable major insurance brands.

The larger plans have an advantage because they can spread operational costs over a larger population, but smaller plans and new entrants to the market will struggle with MLRs. More diversified organizations, such as UnitedHealthcare with its Optum unit, will fare better than pure managed care firms.

Additionally, in the past, plans could adjust premiums to recover from higher-than-expected claims costs. Although the premiums fluctuated for consumers and caused public backlash, plans were able to recoup lost reserves.

Under ACA, state and sometimes federal regulators are examining any premium increases above 10%, often expecting plans to justify and recast their increases. So premium adjustments are essentially capped, and thus, plans could be absorbing added costs with no offsets.

"Regulators are really holding the line in terms of 10% increases, and while that benefits the consumer and the industry overall, it ties the hands of managed care," Donahue says.

She believes health plans will adjust and most will leverage the positive shifts in care delivery on the ground to their advantage.

Van Tol says while traditional programs such as utilization management and prior authorization are classified as administrative costs under MLR rules, at the same time, plans have an incentive to invest in pay-for-performance, provider relationships, medical homes and other programs that can be classified as medical costs.

PREMIUM TAX/FEES

Beginning this year, ACA imposes new fees/taxes in the fully insured segment, totaling $8 billion in 2014, increasing to $14.3 billion in 2018, with increases based on premium trend thereafter. The Joint Committee on Taxation estimates that the health insurance tax could exceed $100 billion over the next decade.

Continued on page 25

Continued from page 20

Total fees will be divided up among insurers based on net premiums, minus some exclusions. Among not-for-profit insurers, including co-ops, only 50% of net premiums are counted, and plans that predominantly serve poor, elderly and disabled populations are exempt.

Managed care Medicaid for fully insured plans will also have to pay, driving up costs for state Medicaid budgets. A Milliman analysis for Medicaid Health Plans of America estimates impact on state and federal program funding between $36.5 billion and $41.9 billion over 10 years.

What's troubling is that the fees will be passed along to insurance-policy purchasers, including employers, families and individuals in the form of premium increases. Those increases will raise the bar on costs and thus cause higher taxes in later years.

An analysis by Oliver Wyman estimates the taxes/fees will add 1.9% to 2.3% to premium costs for consumers in 2014. Impact generally increases over time to add as much as 3.7% by 2023, according to the firm.

"There will be a pass-through effect in terms of a raising of premiums," says Van Tol, from Oliver Wyman. "As to the tax on the tax, that becomes a strongly diminishing effect."

He says plans will be managing on tighter margins.

AHIP has encouraged a bipartisan bill that would delay the premium tax by two years. Based on the way the ACA provisions have been jockeyed around in recent months, the delay in insurer taxes is a distinct possibility. Dr. Nash says he wouldn't be surprised to see a delay.

"The White House needs to rethink the tax to keep the insurance industry at the table and on track toward absorbing 40 million new customers," he says.

Profit margins | **Your image** | Retailization

PLANS MUST CAPITALIZE ON OPPORTUNITY TO POLISH THEIR REPUTATION

The focus on insurance exchanges gives health plans an opening to boost their collective image among consumers

By **JEFF BENDIX**

The rollout of the Affordable Care Act's (ACA) insurance exchanges has reminded many Americans why they dislike healthcare insurance companies. However, the ACA could also be an opportunity for the industry to repair its image, say marketing and public relations experts.

For example, in October, millions who were covered by existing healthcare policies in the individual market were notified that their policies were not being renewed because the plans did not meet the ACA's minimum coverage requirements. The discontinuations seemed contrary to President Obama's promise, "if you like your health plan, you can keep it," and caused consumer backlash at the president and insurers.

In the minds of many plan members, the notices also stirred memories of previous, seemingly arbitrary policy cancellations, double-digit premium increases, refusals to cover certain treatments, and other actions that gave the industry a negative perception in the public eye. While there may have been sound business reasons behind those actions, for many, they have created an impression of an uncaring industry that puts profits ahead of their customers' health and happiness.

Insurance, of course, is not a business that naturally generates a lot of consumer affection.

"The ultimate fact is nobody loves their insurance company. You buy insurance in the hope that you never have to use it," says J.B. Silvers, professor of healthcare finance at Case West-

BLUES PLAN WINS OVER MEMBERS

Blue Cross and Blue Shield of North Dakota improved its image in the community and with its members several years ago. In 2007, the company found itself subject to a barrage of criticism over executive compensation and incentive trips to the Caribbean for its marketing agents—at the same time that it was raising premiums and the national economy was heading into recession.

"These local stories got rolled into the whole national debate over healthcare reform, in which insurance companies were always held up as the bad guys," says Kimberly Wold Jenke, MBA, vice president of account planning and brand strategy for Flint Group, the plan's agency of record.

In response, BCBSND convened a series of town hall meetings around the state, at which customers were invited to express their opinions about the company. Many of those who attended left their telephone numbers, and in the following months, BCBSND executives followed up with personal calls.

"People were stunned. They couldn't believe someone actually responded to them," Jenke says.

The company also began using Facebook, Twitter, and other social media for the first time to give customers additional avenues for communicating. In addition, BCBSND formed an online member panel that it uses to get feedback on new products and services.

Based on the feedback received at the town halls and through social media, as well as ongoing market research, BCBSND launched a statewide marketing campaign emphasizing the benefits of the company's products and refuting some of the negative stories in the media.

As a result of the campaign, says Jenke, news coverage of BCBSND went from 76% negative to 76% positive between 2009 and 2012, while consumer attitudes shifted from 76% negative to 52% positive between 2011 and 2013.

Although North Dakota is a relatively small and homogenous state, Jenke believes the strategies BCBSND used to improve public perception can be used by health plans anywhere. The keys, she says, are research into consumer attitudes and desires, and a strong commitment from upper management.

"The top executives have to understand the importance of and buy into a customer-centric approach," she says. "People are smart, and they will see right through a flashy advertising campaign that has no substance behind it."

— Jeff Bendix

ern Reserve University's Weatherhead School of Management and former chief executive officer of a health plan. "That's a totally different experience from buying a car in the expectation of getting pleasure out of it. You buy insurance in the expectation of avoiding pain."

Even so, experts say, the industry has been notoriously bad at trying to change public perceptions and communicating its side of the story.

"Historically, health plans have not been good at educating consumers on what health insurance really is, and they haven't been good at proactively telling their story," says Kimberly Wold Jenke, MBA, vice president of account planning and brand strategy for Flint Group in Fargo, N.D., the agency of record for Blue Cross and Blue Shield of North Dakota (BCBSND).

"Most consumers don't understand the true cost of healthcare and how it drives the cost of their insurance," Jenke adds. "Their only interaction with it is usually in the form of their insurance premium. As we've seen the trends of [medical] costs going up faster than inflation, the villain becomes the people who are giving them that message: the health plan."

She says consumers take out their anger and frustration on their plans. Often payers are the only source communicating with patients about costs.

"We're just a reflection of the inflation in the [healthcare] industry," says Jared Chaney, executive vice president of corporate communications and sales and customer relations for Medical Mutual of Ohio. "Nobody wants to see prices go up, and we try to be honest about saying we have an essential product that is going to be unaffordable for some people. It's not a good situation, but it's the business we're in, and we try to do the best we can for our policyholders."

WORKING WITH PROVIDERS

Health plans sometimes needlessly add to their reputational problems by adopting an "us versus them" approach to their relations with hospitals and healthcare providers, says Rhoda Weiss, PhD, founding president of the American Hospital Assn.'s Society for Healthcare Strategy and Market Development, and a healthcare consultant who has worked with numerous health plans and health systems.

"When it comes time for renewing contracts, health plans often get into very public arguments," Weiss says. "But I think there's a real opportunity for change, and there are many ways companies can regain trust and be seen as the people protecting customers against financial loss due to medical conditions. I've seen it happen."

With their emphasis on comparison shopping for plans and essential benefits, the exchanges represent a chance for health plans to begin mending fences with their customers and the public at large.

"Things like the provider networks, copays, deductibles, those are now all known aspects" says Silvers. "As long as they're transparent and can easily be compared, then consumers at least know what they're getting."

In addition, some plans may decide to highlight the benefits of ACA provisions for members, such as guaranteed issue.

"There's an opportunity for them to make hay out of the things they now have to do that are socially positive," he says.

From her years of counseling health plans on their public relations and marketing strategies, Weiss has developed a list of steps a company can take to improve its public image. Foremost among these, she says, is to become identified as a leader in a health-related issue.

"Pick a topic, like combating obesity, and become the company that says 'we're going to partner with schools and employers and anyone else to combat it,'" she says. "Team up with partners that are respected in the community, whether it's healthcare organizations, schools or churches. The important thing is to stand for something."

Weiss also recommends plans develop good relations with physicians in the local area.

"Doctors have a tremendous amount of influence over their patients. So be seen as the health plan that doesn't hassle physicians, and pays them in a timely fashion," she says.

Along the same lines, it's important plans be helpful to the clerical and administrative people they interact with as well as non-physician providers that support doctors.

"They are often the ones on the front lines of dealing with insurance providers and will let patients know if they're unhappy with a health insurance company," she says.

SUPPORT THE COMMUNITY

An additional important step for polishing a health plan's public image is to develop strategic relationships with hospitals in a community, for joint marketing, immunizations or preventive screenings, for example. The goodwill generated by such collaborations can also help to protect healthcare insurers against public pushback should the plan opt for narrow-network products that only include those more effective providers.

Plans must make sure their own employees are engaged in the image strategy, too.

"Does your workforce—and I mean every member—really understand the ACA?" Weiss says. "Are they brand advocates and ambassadors for the plan? Are you using them to spread the word in PTAs and churches and other places in the community?"

Finally, Weiss says, health plans can become corporate sponsors of community events and organizations. But in doing so, they must also ensure that they are recognized for their support.

"I've seen many times a health plan sponsor an event because it's the CEO's favorite charity, but the company doesn't get any recognition for it. If you're going to support community organizations, you've got to make sure your name and your people are prominently associated with it, to get the bang for that buck," she says.

Profit margins | Your image | **Retailization**

RETAILIZATION HAS PLANS RETOOLING

Differentiate your brand as B2B becomes B2C

By **DONNA MARBURY**

With up to 30 million uninsured Americans potentially entering the market in the upcoming years, health plans must shift their marketing efforts toward individual consumers, while maintaining their relationships with business clients.

"The environment in which health plans operate today has rapidly shifted from a business-to-business (B2B) to a business-to-consumer (B2C) model," says Gregg Michaelson, CEO of Linkwell Health, a marketing firm. "In turn, health plans need new strategies to expand their brand through positive word-of-mouth, maximize member impact and increase loyalty among existing members. Health plans can capitalize on the enormous opportunity that state and federal health exchanges provide by marketing to individuals browsing for options that best fit their needs and lifestyle."

Michaelson says that because of the emerging consumer-centric landscape of healthcare,

20,000

The number of zombie-video views earned by RMHP marketing efforts.

VIDEO
http://bit.ly/19Y1ygo

plans must now offer useful, targeted services to differentiate from other plans.

"In the past, members chose health plans based on the choices offered by their companies, which was based on the health plans offering competitive rates to the sponsoring employers," he says. "Plans that adjust their marketing strategy to focus on the unique needs of the consumer will likely experience a tangible benefit."

EDUCATE CONSUMERS

With so many changes in healthcare from policy and procedure to wellness initiatives, health plans are at the forefront to disseminate information to current and future members.

"Plans have had to adjust their consumer responses and try to explain—to the extent that they could—what was and is happening, as situations continue to change almost daily," says Scott Overholt, vice president of healthcare markets for The Agency Inside. "While this situation remains very much a political one, health insurers have stepped up in a major way to educate and guide consumers during a challenging time."

As of now, the majority of people signing up on healthcare exchanges are Medicaid populations, and those with pre-existing conditions who need insurance the most. This can cause an imbalance that is risky for health plans.

"The plans that believe the 3Rs [risk adjustment, risk corridors and reinsurance] will shield them from financial loss have tried to acquire as many new members as possible," Overholt says. "Those plans that don't believe the 3Rs will protect them have embarked upon the hardest thing they've ever tried to do: that is, acquiring the population's healthiest and youngest consumers."

Capturing the attention of elusive "young invincibles" will be a challenge, however, they are more likely to respond to social media marketing, which is less costly than traditional marketing channels.

"They are a big part of the uninsured. We have to consider now that we are not seeing a lot of these people joining the exchange. They just aren't interested," says Neil Waldron, chief marketing officer of Rocky Mountain Health Plans (RMHP) in Grand Junction, Colo.

Attracting those customers will take marketing in a way that health plans may not have had to do before—using social media in addition to other web, print, television and radio channels to get the attention of consumers. Just participating on the exchanges and relying on collective marketing won't be enough to promote a plan's brand to the younger, healthier population. Most will shop on price.

Using Facebook, Twitter, and even Pinterest to provide eye-catching, shareable information does a lot for brand recognition and shows that you are a trusted source for consumers.

"This content, combined with coupons for 'better-for-you' products, encourages health plan members to make small lifestyle changes that will improve their health over time," Michaelson says. "Since health plans are directly connected to a consumer's wellbeing, content from this type of trusted source provides a unique opportunity to create a positive impact."

Waldron says that RMHP has done some out out-of-the box marketing, including an online zombie video that has earned more than 20,000 viewers, in attempts to capture a new, younger customer. But this is in addition to traditional advertising that highlights the company's values.

"In Colorado, our state exchange does a fair amount of advertising. But if you only rely on the exchanges, than you have to be more competitive," says Waldron, who adds that ultimately the lowest price will attract consumers who don't have much experience buying insurance plans.

MAKING A PURCHASE

Overholt agrees that exchanges will capture people's attention, but the plan's own branded site provides an opportunity to explain more nuanced information about the plan products being offered.

"Most plans have built sites to ensure shoppers have a 'competition-free' experience. When consumers visit a health plan's consumer portal, they find everything they need to know to make an informed decision—videos, FAQs, buying guides," Overholt says. "As far as getting consumers there, plans are using all media—mass and targeted, traditional and new. All media used ultimately drives consumers to the health plan's website."

Ultimately, successful marketing to a more educated health consumer will involve crafting a new strategy, and not relying on what worked in the past, Michaelson says.

"A one-size-fits-all approach generally doesn't work. It is key to customize and personalize, and to be sure that the content or offerings that members are receiving have real value," says Michaelson. "Repurposing obvious material or sharing irrelevant information to the group you are targeting is another mistake to avoid."

PLANS TAKE ON RISK WITH VULNERABLE POPULATIONS

Identify members in the community

by **NORM RYAN, MD**

With the expansion of Medicaid and dual eligible demonstrations, ACOs and health plans soon will be challenged with taking on the risk and responsibility of managing the care of vulnerable populations. This includes 10 million dual eligibles with over $300 billion annually in healthcare costs.

While being able to effectively care for vulnerable populations is crucial, discovering the best ways to reach and engage members is the primary challenge. All too often in poverty, homeless and suffering from mental health issues, vulnerables may be hard to locate and difficult to engage because of cultural and social barriers, illiteracy and lack of education.

Managed Medicaid organizations and states need the capacity to provide broad care coordination, as well as long-term support and services that address a high-density of complex medical, psychosocial, functional and behavioral issues.

Engaging Vulnerables

Locating members requires a range of activities, from sifting through claims and other data sources for the latest address on record, to speaking with people who might know where the member currently lives. Programs should stay up to date with the latest phone search engine technologies, as 80% of this population relies on mobile or smart phones to stay connected within their communities, and for Internet access, which they could not afford otherwise.

Even so, other measures will need to reach those without phones or who fail to respond to telephone outreach.

Many managed Medicaid and state organizations are partnering with community non-profits and churches to implement a "feet on the street" approach that involves finding identified members in their neighborhoods and talking with them face to face where they reside. What makes this approach powerful is that community organizations identify healthier members of the community who are willing to volunteer their time for training and outreach, to knock on the doors and have the conversations that lead to successful engagement. For instance, in ethnic or immigrant communities, multi-lingual volunteers who speak English act as translators to educate the members regarding their Medicaid benefits and services available to them.

Health programs focused on reaching this population could also offer the following:

- **Free mobile phones for indigent families to make it easy for them to stay in touch with their care providers;**
- **Multimodal approach for enrollment or engagement—whether text, telephone or "at home" services;**
- **Cash incentives in accordance with state mandates to get people to participate in lifestyle management programs for weight management and smoking cessation;**
- **In-kind incentives that have meaning to members, such as baby strollers for Medicaid moms or pediatric camps for children with diabetes; and**
- **Online information written at the appropriate literacy level.**

Providing optimum care to vulnerables includes the capacity to administer a large number of health risk assessments (HRAs) to quickly identify those at the highest risk with the greatest clinical needs driving the majority of healthcare costs. Community organizations can help administer HRAs, but advanced technologies are required to synthesize and analyze the data so that managed Medicaid organizations can effectively target their sickest members.

Other best practices include:

- **Development of care plans that meet each member's individual needs.** Experienced clinicians should spend time with members to create a plan

and guide them to the most appropriate healthcare services as soon as can be arranged, as well as community resources that might be needed to address issues like homelessness, substance abuse or mental illness.

Engagement with healthy behavior change. Vulnerables have many psychosocial issues to contend with, such as low incomes, poor housing and lack of access to healthy food. Clinicians trained to be culturally sensitive and to communicate with those at a lower literacy level can guide members to community and other resources, as well as help each person identify personal motivators for engaging in healthy behaviors, such as the desire to play a sport, learn a skill, or increase income. The focus should be on helping each person determine what poor lifestyle habits may stand in the way of their achieving well-being, and then offering guidance for setting realistic, manageable milestones to achieve their personal goals.

Clinical care coordination focused on appropriate utilization of healthcare services. Vulnerables at high risk or with chronic conditions are among the casualties of a fragmented system of care characterized by lack of care coordination, duplicate and unnecessary utilization and waste. Programs should provide an interdisciplinary care team approach with a primary care manager who coordinates each member's care across multiple care providers to ensure that all care providers have the same information and can work together to make optimal healthcare decisions that result in the best health outcomes possible.

Specialized services for members with the greatest clinical needs and highest costs. As health plans cover more of the disadvantaged population, it will become increasingly important to provide intensive case management programs to improve clinical outcomes and reduce healthcare costs for the sickest and costliest members. Programs should be available for high-risk pregnancies, NICU babies, complex and multiple chronic conditions and cancer.

Integrated care for members with serious mental illness (SMI). Those with serious mental illnesses such as schizophrenia, bipolar disorder and major depression often have comorbid chronic medical conditions that are poorly treated or untreated. This reality leads to SMI patients, as a group, dying 25 years earlier than the rest of the population. Consequently, SMI individuals need their medical and behavioral healthcare services to be well integrated and coordinated.

Maternity and high-risk pregnancy management services for high-risk Medicaid moms. New mothers covered by Medicaid are poor, lack access to healthcare, and often suffer from poor nutrition and other unhealthy lifestyle behaviors that place them at risk for an adverse pregnancy outcome. Considering that 60% of NICU admissions last about 20 days (averaging between $40,000 and $80,000), Medicaid has a tough battle to wage that is only going to worsen as more new mothers are covered. While Medicaid experiences 40% higher rates of NICU use, reducing those costs could save $400 million a year.

Long-term support and services. A vast majority (89%) of Americans over age 50 want to remain in their own homes as long as they can, but may need outside support. Health plans will need to provide comprehensive assessments to influence care plan development to ensure individuals at home receive appropriate support services and that those who can no longer take care of themselves are admitted to appropriate facilities.

Fully integrated system of care that enables members to take greater control of their health. The better Medicaid can connect members with their physicians, the greater the clinical and financial outcomes. This is where advanced technologies can make a difference. Informed healthcare decisions that result in better health outcomes and lower healthcare costs will be most efficiently achieved from the implementation of total care management systems that connect networks of physicians with their patients through electronic medical records, electronic care gap messaging services, at-home remote monitoring devices and care management services via secure health information exchanges.

Whatever is ultimately done, the healthcare industry needs to continue seeking innovative ways to reach and engage those with limited resources to make healthy behavior changes that improve their health and overall quality of life.

Norm Ryan, MD, *is senior vice president of health intelligence for Alere Health.*

CHILD IMMUNIZATION RATES HOLD STEADY

Fear and dosing schedules are barriers

by **MATT BOLCH**

The track record of childhood immunizations to prevent illness is impressive. More than 100 million cases of seven once-common diseases have been prevented in the last 12 decades through immunization, according to the Centers for Disease Control and Prevention (CDC).

The preventive care provision of the Affordable Care Act (ACA) that eliminated copays for many vaccinations is lowering the barriers for more Americans, but it is not the sole solution.

"We have very high levels of immunization and have maintained those levels for years," says Shannon Stokley, associate director of science in the immunization services division of the CDC.

Combating misconceptions

One of the biggest barriers to higher vaccination rates are the misconceptions that persist among some parents about the need for vaccinations or perceived negative effects. Despite overwhelming evidence that immunizations are not linked to an increase in autism rates, many parents still fear a connection.

Scott Krugman, MD, chairman of pediatrics at MedStar Franklin Square Medical Center, agrees that immunization rates are routinely high, but worries that spots of low immunization like those seen in parts of California and Vermont are causing unnecessary outbreaks. Despite being thoroughly discredited, a 1998 study by Andrew Wakefield that supposedly showed a link between the measles, mumps and rubella (MMR) vaccine and autism rates has affected a generation of parents, including some high-profile celebrities who have used their prominence to argue against routine vaccinations.

"Parents have never seen the effects of these diseases," Dr. Krugman says.

The risk of the diseases should, in theory, be motivation enough to have parents rethink their denial of the preventive care for their children. He credits Paul Offit, MD, with helping turn back the tide in favor of childhood vaccinations, particularly as they relate to the autism scare. Dr. Offit is the director of the Vaccine Education Center at Children's Hospital of Philadelphia and a Founding Board Member of the Autism Science Foundation.

"The medical profession is doing a better job of [public relations] these days, but there is still a lot of misinformation out there," Dr. Krugman says.

One trouble spot Stokley sees is the vaccination rates for human papillomavirus (HPV), which the Advisory Committee on Immunization Practices recommends for teen boys as well as girls.

According to CDC figures, 54% of adolescent girls have received one or more doses of the vaccine, while just one-third have received all three recommended doses. The standards are newer for adolescent boys, which may explain the lower rates of immunization. Only one in five boys have received one or more doses of the HPV vaccine, with just 7% receiving all three doses.

HPV vaccines should be given as a three-dose schedule, with the second dose given one to two months after the first dose, and the third dose six months after the first dose. The timing of the doses and the multiple office visits could present an adherence issue for many parents.

Because HPV is a sexually transmitted disease, another barrier to higher immunization rates may be parental fears that immunized teens may become promiscuous, despite studies showing no link.

Misconceptions about vaccinations can cause pockets of preventable diseases. The incidence of measles in the United States has nearly tripled in the past 11 months to 175 cases, with 20 of those requiring hospitalization. Most of those cases have been linked to overseas travel.

This year, Colorado health

CHILDHOOD VACCINE RATES

	MMR (1+)	DTP/Dtap (3+)	Polio (3+)	Hib (3+)	HepB (3+)	Varicella (1+)	PCV (4+)	Rotavirus	HepA (2+)
2010	91.5%	95%	93.3%	66.8%	91.8%	90.4%	83.3%	59.2%	49.7%
2011	91.6%	95.5%	93.9%	80.4%	91%	90.8%	84.4%	67.3%	52.2%
2012	90.8%	94.3%	92.8%	80.9%	89.7%	90.2%	81.9%	68.6%	53%

Source: Centers for Disease Control and Prevention

officials have seen more than 1,100 diagnosed cases of pertussis, or whooping cough. For each reported case, there are likely 10 more cases that go unreported.

The whooping cough outbreak is especially troublesome because infants don't receive their first dose until two months. However, Dr. Krugman notes that physicians are doing a good job of vaccinating pregnant women.

Some insurance plans have recognized provider procedure codes that identify physician-patient discussion of such topics as immunizations, which Dr. Krugman says have been sorely needed.

"It can sometimes take 15 minutes to talk to parents about immunizations when the whole wellness visit is supposed to be 15 minutes," Dr. Krugman says. In general, though, he says plans have been slow to recognize non-procedure based primary care.

As children become teenagers, the issue of privacy can stymie parental discussion of immunizations, says David Moromisato, MD, a pediatrician and chief medical officer at Cardon Children's Medical Center.

"Some health plans use patient portals to reach out to adults to increase their access and education," Dr. Moromisato says. "But children at some point become a gray area because of teen privacy issues."

ACA provision

"Immunizations are certainly a high priority for health plans," says Carol Wilhoit, MD, senior medical director for quality and outcomes at Health Care Service Corp. (HCSC).

The plan's approach varies by product line but includes mailers to parents; measurement of immunization rates at the physician group level; feedback to individual physicians; and twice-yearly physician get-togethers.

Dr. Wilhoit says physicians in HMOs and ACOs must take greater responsibility for education to increase immunizations since they are paid on a population basis.

"There is a little more structure and motivation to physicians to reach out to parents," she says.

Physicians who tell parents their child needs a vaccination see less resistance than if the physician asks.

"It's a wonderful thing—vaccinations covered under the Affordable Care Act—but it's too early to tell what the impact of ACA will be on immunization rates," Stokley says. ◻

Matt Bolch is an Atlanta-based freelance writer.

CATCH UP ON VACCINATIONS

Tools help patients and physicians

Fully half of American children fall behind the recommended vaccination schedule set by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics. The rates for adolescents and adults are even worse.

Getting patients back on schedule is no small task. That's why the CDC contacted researchers at Georgia Institute of Technology to help develop catch-up protocols that physicians could use to take the guesswork out of scheduling.

"Physicians are faced with catching people up on vaccinations more frequently than is recognized," says Pinar Keskinocak, PhD, co-director at the H. Milton Stewart School of Industrial & Systems Engineering at Georgia Tech.

Keskinocak and her team have developed tools for children, adolescents and adults that have been accessed more than 375,000 times since they were released for the public.

@ More online

The Catch-up Immunization Scheduler for Children ages 0 to 6 can be accessed at:
https://www.vacscheduler.org

The Adult Vaccine Scheduler can be accessed at:
www.cdc.gov/vaccines/schedules/easy-to-read/adult.html

The Interactive Adolescent Scheduler can be accessed at:
www.cdc.gov/vaccines/schedules/easy-to-read/preteen-teen.html

CONCENTRATED EFFORTS IMPROVE CARE COORDINATION

URAC recognizes best practices

by **JENNIFER WEBB**

As healthcare becomes increasingly complex and competitive, organizations are turning to creative solutions to improve care, reduce costs and engage consumers to take charge of their health.

URAC, a healthcare accreditation and education organization, honored 21 organizations in 2013 with Best Practices Awards in recognition of their efforts to advance consumer engagement and protection in measurable and reproducible ways.

■ KAISER PERMANENTE NORTHERN CALIFORNIA

Reduction of hospital-acquired Clostridium difficile infection

As hospitals across the country grapple with hospital-acquired Clostridium difficile infections, Kaiser Permanente Northern California developed a plan for its 21 hospitals, where rates had doubled from 2006 to 2008.

The program has five components: standardized hospital room cleaning and disinfection protocols; immediate isolation of infected patients and precaution to prevent spread of bacteria by contact; hand-hygiene protocols; proactive stewardship of antimicrobial medications; and reduction in usage of acid-suppressing gastric medication. The last item reflected a growing body of evidence that suppressing gastric acid increases risk of infection, so the system began to restrict use of proton-pump inhibitors outside the intensive-care unit, says Alan Whippy, MD.

A system also was developed for cleaning rooms in a specific manner, and employees were educated to understand their role in saving lives.

"In very short order we were able to show we had a very significant reduction in germs on surfaces in patient rooms," Dr. Whippy says.

Employees were trained in "deliberate practice sessions" to walk through the hand-washing protocols.

"To say everyone should wash hands before going in and out of patient rooms is easy, but it turns out there are some practices that make it quite difficult," she says. "If your arms are full of medications or you're rolling carts around, when does hand washing happen?"

The biggest hurdle has been creating a culture of good hand hygiene. Recent "secret shopper" results show 80% compliance—up from about 20% at the program's outset.

Since 2010, Kaiser Permanente Northern California has reduced the incidence of Clostridium difficile infection by 62%, prevented more than 2,855 cases and 485 deaths, and reduced hospital stays by 28,551 patient days.

"None of these strategies takes a lot of additional equipment or is hugely expensive," says Barbara Crawford, vice president for quality and regulatory services. "It really requires leadership being clear and precise about what you want people to do."

■ ROBERT YOUNG CENTER AND COMMUNITY HEALTH CARE

Coordination of care for severe mental illness

Mentally ill patients often fail to receive the physical care they require before their health becomes critical, leading them to incur a disproportionate amount of healthcare expenses. Although 11% of the Medicaid population suffers a major mental illness, they are responsible for 39% of healthcare expenditures, says David L. Deopere, PhD, president of UnityPoint Health's Robert Young Center (RYC) in Moline, Ill.

"Behavioral co-morbidity is a big deal in cost savings and a big deal in quality outcomes," he says.

The center partnered with Community Health Care (CHC) to establish a primary clinic at the RYC Community Support Program, creating healthcare homes for 385 people. RYC provided a mental health clinician, and the center hired 2.5 care coordinators who were "compassionate yet persistent and aggressive" to ensure patients stayed on track, Dr. Deopere says.

In about two years, the model led to a 46% decrease in emergency room visits; a 65% decrease in

payments for ER visits; a 50% decrease in psychiatric admissions per quarter; a 16.9% decrease in medical admissions per quarter; an 80% decrease in payments for medical admissions; and a 131% improvement in quality of life scores—while saving $8 million.

"The bottom line is, they are happier, they are healthier, and they're not spending as much money," Dr. Deopere says.

FAMILY HEALTH NETWORK AND SINAI URBAN HEALTH INSTITUTE

Improving asthma control

Economically stressed communities in the Greater Chicago area had an above-average number of Medicaid recipients with asthma, with some areas rising as high as 17%. Family Health Network partnered with Sinai Urban Health Institute to expand an existing program, training five community health workers to identify patients who needed extra help getting their asthma under control.

Since August 2011, more than 427 patients were referred to the program, which provided a series of visits in the home over 12 to 18 months. Community health workers were trained in interviewing techniques, engaging the child and adult, evaluating the home situation and giving them ways to control their asthma, says Barbara Hay, chief operating officer of Family Health Network.

The visits gave workers a chance to assess the potential triggers—such as dust in the home. In one case, a community health worker helped a family relocate.

"You have to be able to speak with them and educate them in a non-threatening environment," says Hay.

The program was able to reduce emergency department visits by 75%, with 91.4% fewer hospitalizations, 96% fewer hospital days and 50% fewer missed days at work and school, says Keith Kudla, president and CEO of Family Health Network. A similar program is in the works for diabetics.

> There's a big difference between transparency and clarity.
>
> —ROBIN GELBURD

"Supporting health through education and empowerment makes medical and economic sense and can result in a dramatic improvement in health outcomes," Kudla says.

FAIR HEALTH

Empowering consumers to understand their medical expenses

Born in 2009 from a settlement agreement, FAIR Health was established to construct a transparent, objective database and related methods for determining out-of-network reimbursement. It holds a repository of some $17 billion in health claims for 129 million lives nationwide, and it is used by health plans, consumers and researchers.

According to Robin Gelburd, president, consumers can use the website to determine their out-of-pocket costs for decision-making.

"There's a big difference between transparency and clarity," she says. "What we try to do is take all that data and create some order and some sense to it."

Unlike some cost calculators, FAIR Health's tool takes certain procedures, such as arthroscopy, and adds related procedures that will be needed, such as anesthesia.

"Consumers need to know all elements involving their care, including the cost, which was previously not a big part of the conversation," Gelburd says. "To really interface with the consumer, you have to approach that role very responsibly; you can't just push data out into the marketplace."

ACTIVEHEALTH MANAGEMENT

Member engagement

Conscious of the complexity of managing multiple chronic conditions and coordinating treatment by various physicians, ActiveHealth Management developed the CareEngine to identify gaps in care and alert members and physicians to opportunities to improve treatment plans. Using more than 1,300 algorithms, the organization studied the member claims, pharmacy and lab data for a client company with more than 350,000 members. ActiveHealth sent more than 196,000 letters to members and physicians to alert them to potential gaps in care, and followed up with automated calls.

Nurses, clinicians, wellness coaches and others were trained in soft phone skills to connect with members on individual health needs, scheduling appointments and following up on missed appointments. Each member was scored by risk to receive four to 12 contacts a year.

More than 200,000 members completed health assessments—compared with 20,000 who had done so prior to the program's roll out, says Wadida Murib-Holmes, ActiveHealth's executive director.

"We've never seen numbers like this before," Murib-Holmes adds.

ActiveHealth saw improvement in 22 of 28 measures, and members indicated a 93% satisfaction rate. ■

Jennifer Webb *is a Medina, Ohio–based freelance writer.*

PLANS SEEK SOLUTIONS TO OBESITY DISEASE

Intervention encompasses the entire lifespan

by **JOANNE SAMMER**

No matter how you categorize it, obesity is costly. The American Medical Assn. (AMA) has classified obesity as a disease, meanwhile, health plans struggle to find ways to manage its direct and indirect costs.

According to a report issued by the Trust for America's Health and the Robert Wood Johnson Foundation, "F as in Fat: How Obesity Threatens America's Future 2013," current healthcare costs for treating obesity range from $147 billion to nearly $210 billion annually. These costs include treatment for obesity-related diseases, including type 2 diabetes, heart disease, hypertension and certain cancers.

Based on current trends, healthcare costs for treating preventable obesity-related diseases are estimated to increase by $48 billion to $66 billion per year, with another $390 billion and $580 billion in annual lost economic productivity.

What concerns plans the most about projections like these is that there is currently no clear strategy for reducing long-term obesity.

"Health plans are coming around to the reality that not only is obesity a real problem, but it's a problem without a silver bullet," says Chris Wasden, global healthcare innovation leader with PwC in New York.

However, there is some qualified good news: Even a small reduction in weight among the affected population can have a significant impact on healthcare costs. More specifically, lowering average body mass index (BMI) by 5% by 2030 could cut projected costs by up to 7.9%, according to the Trust for America's Health and the Robert Wood Johnson Foundation report.

Behavioral change

Even though bariatric surgery and pharmaceutical options for treating obesity have existed for some time, none of these interventions have proven to be 100% effective at eliminating obesity.

"There are minimal clinical treatments available [to treat obesity], and those that are available often are not covered or are even explicitly excluded by health plans," says Scott Kahan, MD, director of the Stop Obesity Alliance. "That creates a barrier to access."

Although Kahan emphasizes that bariatric surgery can be a powerful intervention against obesity, he admits that it is often unrealistic to think that such a complex problem as obesity can be solved with any one-off treatment.

"Rather than trying to find one intervention, we need to find and implement approaches that help over the life course of patients or at least over a larger course of time," he says.

Most experts emphasize that effective obesity treatment relies on changing patient behavior. Although using available drugs and surgical procedures can kick start the process by helping people to make dramatic changes and begin to see results, "people still have to change their diets and activity levels to make permanent change," says Wasden. "Even people who have had bariatric surgery can still be obese."

Although bariatric surgery and other obesity treatments frequently include behavioral components, individual patient behavior remains a wild card.

"You can't control patient behavior," says Ann Peterson, vice president of physician network operations at Loyola University Health System. "You can only try to influence it through proper programs, screenings, feedback and education."

Therefore, it follows that efforts to reduce obesity would include expanding reimbursements to include these types of behavioral programs. For example, health plans can consider covering services that support behavioral changes in patients, such as follow-up calls to check on patient progress.

"This type of proactive patient management is not typically eligible for reimbursement," says Peterson.

Others would go beyond that.

"There should also be reimbursement for physicians who provide counseling on obesity

and related issues," says Kahan. "That would go very far in terms of doctors spending more time with patients to help with these issues."

Even the AMA's classification of obesity as a disease could yield new approaches. For example, some plans are integrating obesity-related disease management with programs for other diseases, such as heart failure and diabetes.

"Treating obesity as a disease provides a new opportunity for health plans to create legitimate disease management programs," says Wasden.

Changing the system

Whatever approaches health plans adopt, they are likely to focus on specific metrics, such as weight loss over a certain period of time, and whether patients keep the weight off.

"Just as plans will not pay for drugs forever if patients are not losing weight, they will only want to pay for programs that work," says Wasden. "There are some very innovative outcome-based programs that would allow health plans to pay for services like a gym membership if patients show that they are going to the gym on a regular basis and losing a certain amount of weight."

In many ways, these types of approaches mirror the efforts employers are taking when it comes to employee wellness.

"These programs focus on a lifetime of health and that requires a pretty significant change in lifestyle," says Helen Darling, president of the National Business Group on Health.

The best initiatives follow individuals' activity levels combined with a nutrition program and follow up to track whether an individual's risk factors improve, she says. For providers, the approaches require new business models.

"The reality is that the vast majority of providers have no idea how to provide these services and get paid for it. There is no business model for doctors to make money by prescribing patients activity and nutrition," says Wasden.

For plans, the shift leans toward creating more incentives to improve patient nutrition and activity levels. ◘

Joanne Sammer *is a Brielle, N.J.-based freelance writer.*

OPIOID USE INCREASES AFTER BARIATRIC SURGERY

Chronic use of opioids among obese patients prior to bariatric surgery continues after the surgery, according to recent Kaiser Permanente research.

"Despite a lack of evidence supporting long-term effectiveness of opioids for chronic non-cancer pain, long-term opioid use has increased recently," says Marsha A. Raebel, PharmD, senior investigator at the Kaiser Permanente Colorado Institute for Health Research, Denver.

Dr. Raebel and colleagues examined the electronic medical records and other clinical and administrative databases of 11,719 obese patients who underwent bariatric surgery between 2005 and 2009.

In the year prior to their surgical procedures, the researchers found that 56% of the patients in the study reported no opioid use for pain management, 36% used some opioids and 8% used opioids on a chronic basis. The study was presented in the October *Journal of the American Medical Association*.

Seventy-seven percent of the obese patients who exhibited chronic opioid use prior to surgery continued to use these medications chronically one year after their procedure. Chronic opioid use among these patients also increased by 13% the first year after surgery and by 18% across three years after surgery.

Prescription opioid consumption and mortality are correlated and opioid abuse, accidental overdose, and death have increased, with overdose deaths rising in 2010 for the 11th consecutive year in the United States, she adds.

"No published studies assess chronic opioid use in the bariatric surgery population, and information is needed on whether weight loss attained after bariatric surgery is associated with reductions in opioid use," Dr Raebel says. "Therefore, we undertook this study."

There are limited options for pain management available to bariatric surgery patients because non-steroidal, anti-inflammatory medications increase the risk of gastric perforation, particularly after bariatric surgery and acetaminophen is less effective, according to Dr. Raebel.

"Given the increasing chronic usage of opioids we found after bariatric surgery relative to before surgery, it's clear that we need to develop better pain management programs for patients who use opioids long-term following bariatric surgery," she says.

Chronic opioid use was defined as having 10 or more prescriptions over at least 90 days or at least a 120-day total supply of medication sometime in the year prior to surgery. Some opioid use was defined as one to nine prescriptions over 90 days, or less than a 120-day supply.

—Tracey Walker

ELECTRONIC CIGARETTE USE AND IMPLICATIONS

Comparison to cessation therapies unknown

by **DIANA M. SOBIERAJ, PHARMD**

Clinical practice guidelines for treating tobacco use and dependence were most recently updated in 2008. They urge clinicians to ask patients about their current smoking status and to advise current smokers to quit.

For patients who qualify, seven first-line pharmacologic therapies are recommended: nicotine replacement therapy (NRT) including the patch, gum, lozenge, nasal spray (Nicotrol NS®) and the oral inhaler (Nicotrol®); Zyban® (bupropion SR) and Chantix® (varenicline). Using six month abstinence, Chantix was found to triple odds while all other first-line therapies doubled or were close to doubling the odds, all in comparison to placebo.

Many trials that evaluate these therapies also provide counseling and behavioral interventions, so some of this benefit is drawn from these co-interventions. Each therapy is associated with unique adverse effects ranging from local skin irritation from patches to psychiatric and cardiovascular risks with Chantix.

There has been increasing awareness and use of electronic cigarettes (e-cigarettes) in the United States. National survey data suggests that from 2010 to 2011, adult awareness of e-cigarettes increased from 40% to 57.9% while ever-use increased from 2% to 3%, to 6.2%. The recent uptake of e-cigarettes in addition to encouragement from Attorneys General across the country has prompted the FDA to take measures to propose expansion of what the current definition of "tobacco product" is to include e-cigarettes. Tobacco products currently under FDA regulation include cigarettes, cigarette tobacco, roll-your-own tobacco and smokeless tobacco. Once the proposal is finalized, the same regulations in Chapter IX of the Federal Food, Drug and Cosmetic Act that regulate these tobacco products will apply to e-cigarettes.

Two randomized-controlled trials have recently provided efficacy and safety data for e-cigarette use as a smoking cessation aid. The first trial evaluated 300 healthy, middle-aged smokers who smoked on average 20 cigarettes per day for 20 years and were unwilling to quit. Patients were treated for 12 weeks with either one of two nicotine e-cigarette arms or placebo e-cigarettes. Although there were significant declines in actual cigarettes smoked per day in all three groups through 52 weeks, there were no differences between groups. There were a significantly greater number of subjects who quit smoking in the nicotine e-cigarette groups versus the placebo e-cigarette group (14% vs. 4% at 12 weeks; 11% vs. 4% at 52 weeks). Side effects associated with smoking cessation or withdrawal such as hunger, insomnia, irritability, anxiety and depression were reported in 6.5%, 4%, 3.5%, 3% and 2% of subjects respectively.

A second trial evaluated 657 middle-aged adults smoking on average 18 cigarettes per day for 15 years who were randomized to receive nicotine e-cigarettes, nicotine patches or placebo e-cigarettes. Unfortunately, the abstinence rates in the trial were much lower than anticipated, which led the trial to be underpowered to determine if e-cigarettes were superior to nicotine patches. However, nicotine e-cigarette users reduced the mean number of cigarettes smoked per day by two more than nicotine patch users at six months, and a greater proportion reduced their daily cigarette smoking by more than 50% at six months compared to nicotine patch users. There were no significant differences in adverse events across groups.

Based on current literature, it appears that e-cigarettes help smokers decrease the number of cigarettes they smoke per day without any concerning risks when used for up to 12 weeks. However, how e-cigarettes compare to approved smoking cessation therapies is still unknown and will be a subject for future research.

PART D'S HISTORY PROVIDES HINTS FOR ACA

Will ACA exchanges earn 90% satisfaction?

by **MARI EDLIN**

Some industry observers believe the rollout of the insurance exchange marketplaces harkens back to the 2005 kick-off of Medicare Part D. While seniors might have been unfamiliar with private insurance plans offering drug coverage then, today's consumer is equally confused about health coverage and why it's necessary.

Those entering the market for the first time in 2014 face a wider range of options than the Part D seniors had. Unfamiliar with provider networks, cost sharing and metal levels, many consumers will likely base their choice on premium cost alone.

Part D's initial enrollment period was plagued by technical glitches with call centers and poorly trained staff members—similar to what consumers are experiencing now with the exchange enrollment process. However, Jack Hoadley, research professor at Georgetown University's Health Policy Institute, says that did not deter people from signing up.

Today, Part D earns a 90% satisfaction rating from seniors.

As Medicare Part D enters into its eighth year, the number of beneficiaries has grown from about 22.5 million to 36 million. About 63% are in stand-alone Prescription Drug Plans (PDPs); the balance are enrolled in Medicare Advantage Drug Plans (MA-PDs).

The number of available plans, however, has followed a different trend, starting at 1,429 in 2006, and peaking in 2007 at 1,875. There will be 1,169 Part D choices in 2014.

Some plan departures have been at the mercy of federal regulators. For example, they halted new enrollments and marketing for CVS Caremark's SilverScript Medicare prescription coverage last year, threatening to shut down the plan after an operational system glitch left "tens of thousands" of seniors unable to get their medications, Medicare officials say.

Hoadley says fewer plan choices should make decisions easier for seniors. He notes that many plans have exited the market because they did not have enough enrollees or were acquired by other plans.

Part D has faced a variety of other changes over the years, from the introduction of five-star ratings to the closing of the coverage gap, better known as the "donut hole."

The average monthly Medicare Part D premium will remain steady at $31, up $1 from the three pervious years, according to the Centers for Medicare & Medicaid Services (CMS).

2014 should be a good year for Part D beneficiaries with expectations for lower premiums—anywhere from 15% to 38%—and lower out-of-pocket costs, says Ellen Duffield, senior vice president, government programs for Catamaran, a pharmacy benefits manager.

She attributes some cost reductions to the use of preferred provider networks. Duffield also anticipates that the online Medicare Plan Finder tool will make it easier for seniors to apply for Part D and decide on the plans that best fit their financial and health needs.

Retain members

But Hoadley says premiums have not had as big an effect on enrollment as would be expected.

"During any given enrollment period, most beneficiaries remain in the same plan because they are satisfied or find it too confusing to make a change. This should be a signal to plans that they can increase premiums without losing market share," he says.

In addition, plans with lower member costs may have innovative designs, such as a limited pharmacy network or fewer drugs covered.

Part D deductibles have fluctuated over the years, starting at $250 in 2006. The deductible is $310 for 2014, which is down $15 from last year.

The Donut Hole

In 2014, the donut hole falls between $2,850 and $4,550. Part D enrollees will continue to receive a 52.5% discount (50% paid by the drug manufacturer and 2.5% paid by the Medicare Part D plan) on the total cost of their brand-name drugs, as well as a 28% discount on generic drugs while in the gap.

Starting in 2011, CMS began phasing out the donut hole, reducing the coinsurance for brand name and generic drugs in the donut hole.

Since the Affordable Care Act (ACA) was enacted, 7.3 million beneficiaries who reached the donut hole in their part D plans saved $8.9 billion on prescription drugs—about $1,209 per person. In just the first 10 months of 2013, 3.4 million people saved 2.9 billion, an average of $866 per beneficiary, according to CMS.

An estimated 19% of seniors will enter the donut hole this year.

Chuck Clapton, partner in the law firm of Hogan Lovells, cautions that closing the donut hole has the potential to eliminate incentives to use generic drugs.

Preferred networks

According to the Kaiser Family Foundation, notable trends for 2014 include a growing share of PDPs using preferred pharmacy networks. In 2006, only a few PDPs used this type of pharmacy network.

More than 70% of plans are using lower-cost preferred networks, says Hoadley, and they will reduce federal Part D costs up to $870 million in 2014 alone, according to Milliman.

Another strategy to keep Part D costs in check is the five-tier design. In 2006, most plans had three tiers. By 2014, 77% of PDPs will offer five tiers, splitting the generics into preferred and non-preferred, according to the Kaiser Family Foundation.

Avalere Health says specialty tiers will be included for 93% of plans in 2014, with varying numbers of coinsurance levels. CMS set a 25% maximum coinsurance (after the deductible is met and before the initial coverage limit) or 33% when no deductible is required. The threshold for specialty tier drugs is $600 per month.

Hoadley says there is more distinction in cost sharing for Part D beneficiaries now than in previous years.

Star Ratings

One of the more noteworthy changes in Part D has been the Medicare five-star rating system. According to an analysis of star ratings by the Q1Group, stand-alone PDPs averaged 3.4 stars for the 2014 plan year, and Medicare Advantage Part D plans averaged 3.66 stars. In total, 11 plans gained a five-star rating.

This year, plans need to be more diligent about achieving higher ratings because plans that score three or fewer stars for three consecutive years will likely lose their CMS contracts. However, CMS is currently working with plans to raise their ratings, according to the agency.

Duffield predicts that lower performing plans will focus more on increasing adherence to chronic disease medication and changing formularies to support ratings. Studies have shown that enrollees are swayed by higher star ratings.

He says that plans are limiting the availability of high-risk medications and supporting the use of more appropriate drugs in their formularies to conform to Medicare star rating requirements.

Part D offers some flexibility in formularies, requiring at least two drugs in 148 categories, but CMS is not dictating which drugs.

PDP and MA-PD sponsors must cover "all" or "substantially all" drugs in six protected drug classes identified by CMS, such as antidepressants, for example.

In 2013, barbiturates used for all medically appropriate diagnoses and benzodiazepines joined the other classes of drugs on Part D formularies. Benefits also must be designed to not discriminate against any subset of beneficiaries.

Another recent change is allowing subscribers to fill new prescriptions with a short fill (less than 30-days' supply) at a pro-rated price. The aim is to reduce waste when an initial drug therapy proves ineffective for a patient.

Satisfaction at 90%

Satisfaction with Part D overall remains high: 90% of enrollees are either somewhat or very satisfied with the program—primarily because costs are reasonable—according to KRC Research. The satisfaction level does not vary much by demographics, political alignment or whether beneficiaries are low-income, dual-eligible or disabled.

Those with low out-of-pocket costs and low premiums are predictably the most satisfied. As many as 90% say their plans are convenient, easy to understand, work well, offer good customer service and deliver on their promise. That same number would recommend Part D coverage. ◘

Mari Edlin *is a freelance writer based in Sonoma, Calif.*

ADVERTISER INDEX

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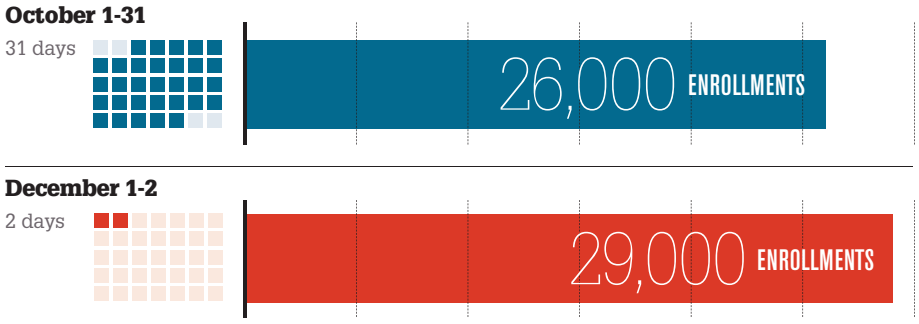
ENROLLMENT FIGURES FOR *HEALTHCARE.GOV*



After some 400 "punchlist" fixes to the troubled *healthcare.gov* website, traffic, functionality and enrollment all improved. The Department of Health and Human Services had set a self-imposed date of November 30 to dramatically enhance the experience for "a vast majority of users." A two day enrollment total after the fixes were implemented eclipsed the enrollment for the first 31-day period. Open enrollment runs through March 31, and officials are aiming for 7 million sign ups.

Source: Department of Health and Human Services

PROVIDERS

MinuteClinic, has expanded to its 28th state with the opening of six new clinic locations inside select CVS/pharmacy stores in New Hampshire, in collaboration with Dartmouth-Hitchcock. Under the agreement, Dartmouth-Hitchcock physicians will serve as medical directors and collaborate on patient education and disease management initiatives.

BUSINESS

Aetna and PinnacleHealth System announced an accountable care agreement for Aetna members in the Harrisburg, Pa., area. The Aetna/PinnacleHealth co-branded products will offer an array of plan designs and funding options. The first product, for groups of more than 51 employees, will be available in April. A small-group product for groups up to 50 employees will be introduced in July.

HEALTH MANAGEMENT

Healthways has signed an agreement with Excellus BlueCross BlueShield (BCBS) to continue administering the HealthyRewards online incentive program to its HealthyBlue plan members through 2015. HealthyRewards encourages members to take more active roles in managing their health by offering financial rewards that support and recognize positive behaviors. Healthways has administered the program for Excellus BCBS since 2008.

HEALTH MANAGEMENT

First Choice Medicaid plan by Select Health of South Carolina has launched "Can We Talk," a statewide initiative to reduce language barriers between plan members and providers. It is designed to increase awareness of free telephonic interpretation services available to First Choice members in more than 200 languages, 24 hours a day. Research showed that First Choice providers and members were not aware of the free language services offered through the plan. The campaign includes education and outreach to providers and their office staffs, as well as members. Select Health is part of AmeriHealth Caritas Family of Companies.

ANALYSIS

The California Public Employees' Retirement System's use of reference pricing on hip and knee replacements motivated other hospitals to lower prices, but limitations may hamper the cost savings potential for other services or for other purchasers, according to a study by the Center for Studying Health System Change (HCS). http://bit.ly/18oFGgK

BUSINESS

Anthem Blue Cross and its ACO partners showed across the board improvements in quality measures in the first full year of Anthem's program the treatment of patients in 2012, including a 35% increase in the number of mammograms performed and a 44% increase in the appropriate prescribing of antibiotics for bronchitis treatment. Results are notable as they were achieved for PPO enrollees who have the freedom to see doctors outside of the ACO.

BUSINESS

Deloitte's 2013 Survey of Employers showed that 80% say their healthcare costs have risen over the last three years, estimating 30% growth during that period. They estimate passing an average of 26% of the cost increase to their workers. In fact, the top strategies used by U.S. companies to manage costs are employee cost-sharing (54%) followed by wellness programs (36%), plan design changes (28%). http://bit.ly/1d3qfwa.

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