It’s Survival of the Fittest, Not Necessarily the Biggest

By Frank Diamond

Health care’s pillars might as well rest on the San Andreas Fault these days, what with major players wondering just how to fit into the ACA world and a marketplace that would have garnered Charles Darwin’s attention as a living, breathing, and evolving ecosystem. Welcome to the future.

In our cover story on page 21, contributor Jan Greene talks to experts who say that while much attention has been paid to pending megamergers (Aetna–Humana, Anthem–Cigna) that will turn the Big Five into the Big Three (including UnitedHealth Group), there are still regional powerhouses and even startups who insist on not going gentle into that good night. And those are just the ones that can be called health plans, a label growing more malleable.

Even august institutions feel shaken. What in the world is going on with AHIP? It’s been rocked by defections of two major members (UnitedHealth Group and Aetna), resignations of top officers, and a funding shortage. Richard Mark Kirkner’s Q&A with AHIP’s new CEO, Marilyn Tavenner (page 28), goes hand-in-hand with our story on whither AHIP (page 25). We take a look at what’s going on with self-insurance (page 31), the grousing by some insurers regarding ACA exchanges (page 34), and the growing resemblance of CMS ACOs to MA plans (page 13). We also sneak a peak at what some envision primary care will look like in the future (page 46). Hint: different.

Next month we examine another major player: the pharmaceutical industry. A decent primer is the Wall Street Journal’s February 21 Q&A with Kenneth C. Frazier, Merck’s CEO. He remembers the ’90s, when society looked up to drug companies.

“It’s hard to imagine a pharmaceutical company getting the kinds of accolades we used to get then,” he tells the newspaper, adding that “the entire pharmaceutical industry has a lot of work to do to restore public trust.”

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COVER STORY

Giant Insurers Only Part of the Fauna
The big commercial insurers want to get even bigger, and they dominate some markets. But health plans of all shapes and sizes are operating in a growing number of niches; it's a jungle out there. Many are figuring out ways to thrive.

AHIP Sails on Through Rough Seas
Former CMS chief Marilyn Tavenner, the trade association's new leader, wants to get the mojo back. That might take some doing, after a stretch of defections, deficits, and staff departures.

Q&A: Marilyn Tavenner Won’t Back Down
AHIP's new CEO wants to coax UnitedHealth Group and Aetna back into the organization, but that's only part of her to-do list. Mainly, it's "how do we help the insurance industry as it undergoes a great deal of change?"

Self-insurance Winning Converts
More companies are self insuring—and it's not just large employers that are striking out on their own. Self-insurance may give employers more control over benefit packages, and stop-loss protects them against uncapped liability.

Critical Illness Policies Carve a Niche
Coverage kicks in if someone has a major illness like a heart attack or stroke. And because critical illness policies are a voluntary benefit, they help employers cut costs to avoid the Cadillac tax on health benefits.

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Primary care’s evolution underway.
Ohio State University researchers began to study a pay-for-performance (P4P) program at a pediatric accountable care organization (ACO) with some preconceptions. “We hypothesized that the community physicians receiving P4P incentives would improve their performance more over this period than either the non-incentivized community physicians or the salaried hospital physicians.” They were a bit off-mark, as they pointed out in their study, published online January 25 in *JAMA Pediatrics*. Quality did indeed improve for the ACO doctors, but only moderately, and quality for the salaried hospital-affiliated physicians improved more.

The study compared pre-incentive outcomes (2010–2011) with post-incentive outcomes (2012–2013). The three groups were Partners for Kids (PFK), an ACO for Medicaid managed care children; physicians in the community not affiliated with PFK; and doctors working for Nationwide Children’s Hospital in Columbus. Doctors who were contracted with PFK were paid on a fee-for-service basis plus an incentive bonus for reaching certain benchmarks.

The data capture 2,966 individual physicians in at least 132 practices. There were 203 incentivized physicians, 2,590 nonincentivized physicians, and 173 nonincentivized hospital physicians. PFK doctors received 50 cents per member per quarter (PMPQ) if they accepted at least 500 Medicaid patients per physician averaged over the practice. They were paid an additional 50 cents PMPQ for completing a certification program, and another 50 cents PMPQ for being recognized by the NCQA as a patient-centered medical home. Most of the incentive money was distributed based on HEDIS scores. The quality payments ($40.18 in 2012 and $41.39 in 2013) were made per successful patient and were paid to the patient’s attributed physician group, according to the study.

Almost all measures improved for all physician groups. The incentivized measures included well-child visits, asthma care, and immunizations.

Researchers wanted to see just how ACOs might affect physician performance. Most P4P programs are initiated by a payer, not a physician-driven entity such as an ACO, they noted. Previous research suggested that a physician-centric, ACO-developed P4P program may win greater physician acceptance. The Ohio State researchers mentioned that the research on how to develop P4P programs is limited, and the role of new factors—such as the introduction of electronic health records—has yet to be fully accounted for.

The PFK doctors did a little better than the doctors in the community, but the salaried doctors at the hospital did better than everyone.

The takeaway: “Our results suggest that P4P can work in a pediatric ACO but that it may not deliver the magnitude of improvement in quality that organizations seek.”

The researchers speculate that the size and duration of the incentive might help P4P efforts, and there may be ways other than incentives to motivate physician change.

“The involvement of physician leadership in helping determine the incentives may have been useful in engaging physicians and increasing acceptance,” the study says. “The physician-led nature of ACOs should position these organizations to create programs of greater impact. At present, there [are] insufficient data about the structure of medical leadership in ACOs to draw conclusions about best practices.”

**Disparities Found In Diabetes, Outcomes**

Blacks receive worse care and suffer worse outcomes than whites when it comes to diabetes, according to a study in the *Journal of Clinical Endocrinology & Metabolism*. In a retrospective study published online January 6, researchers at Emory University in Atlanta examined ICD-9 data from 2012 and 2013 on 35,866 adults, about 40% of whom were black.

“Black patients have higher rates of hyperglycemia and diabetes, worse inpatient glycemic control, and greater frequency of hospital complications compared to whites,” said the Emory research team.

Their research showed that 34.5% of hospitalized black patients had diabetes and 42.3% had hyperglycemia, compared with 22.8% and 36.7% of white patients, respectively. The cause for disparities is not known, they cautioned, but they dangled several possible explanations: genetic predisposition for more severe disease, diff-
ferences in income and health insurance, and less access to diabetes care.

The Emory researchers found that HbA1c levels were higher among black patients than white patients, and insulin therapy was given to 38% of black patients, compared with 33% of white patients in the entire cohort. Among patients with a known diagnosis of diabetes prior to admission, a higher share of blacks received insulin than whites (75.6% vs. 72.6%).

Yet the risk for myocardial infarction, pneumonia, bacteremia, respiratory failure, acute kidney injury, and death was greater among black patients compared with whites.

The study identified nondiabetic blacks with hyperglycemia as a particularly vulnerable group who were less likely to receive insulin (62.7%) compared with whites (66.1%).

The study continues: “Blacks have 2–4 times the rate of renal disease, blindness, amputations, and amputation-related mortality. In addition, after adjusting for confounders, blacks with diabetes have higher mortality rates compared with whites.”

Black patients tended to be younger, have a higher BMI, and a higher proportion of obesity. They were also more likely to be admitted to medical services rather than surgery services.

No One Knows Why Birth Defect on Rise

Incidence of gastroschisis, a rare birth defect, grew 30% between 1995–2005 and 2006–2012 across all racial and ethnic groups, according to the CDC. Gastroschisis is a condition in which the intestines (and also sometimes the stomach and liver) protrude from a hole in the baby’s stomach. Fixing the problem requires surgery soon after birth and the organs can become infected from exposure to amniotic fluid, causing life-threatening problems.

Data were collected from 14 states and divided into two groups: 1995–2005 and 2006–2012, stratified by maternal age, race, and ethnicity. There were 4,369 cases among 12 million live births between 1995 and 2005; 4,497 cases among 9.3 million live births between 2006 and 2012, which works out to about 1 in 2,000 births. Babies born to black mothers ages 20 or younger between 1995 and 2012 had a 263% increased chance of gastroschisis.

No one quite knows what causes gastroschisis, though the CDC study says that risk factors include lower socioeconomic status, lower body mass index and other indications of poor nutrition (lower intake of high quality nutrients and dietary fats), smoking, use of illicit drugs, alcohol, or analgesic medications, and genitourinary infections. The study was in the January 21 issue of the CDC’s Morbidity and Mortality Weekly Report.

Babies born with the defect often spend up to six to eight weeks longer in the hospital (often in the NICU) than those without the condition and cost about $80,000 more to treat.

The number of children being born with gastroschisis is increasing internationally, not just in the United States, CDC researchers note.

“The association between young maternal age and gastroschisis was first reported in the late 1970s, and this risk factor has been documented consistently in subsequent studies,” the study states. “However, the increased prevalence of gastroschisis is not because of an increase in teen births, which have declined in recent years, or to a change in the distribution of births to teen mothers, as birth rates have decreased among women of all ages <20 years.”

Briefly Noted

Consumers want PPO plans but premiums for the silver-level plans sold on the ACA exchanges are getting pricier, according to a Kaiser Health News analysis. Kaiser analyzed costs in three dozen states for policies for a 40-year-old. The average premium for the least-expensive PPO or other silver-level, open-access plan grew from $291 in 2015 to $339 this year, a 17% increase, according to Kaiser’s numbers. Providers who use a health information exchange (HIE) to view patients’ electronic health records appear less likely to order unnecessary imaging tests, according to a study published in the Journal of the American College of Radiology. Researchers at Weill Cornell Medicine looked at data for 12,620 patients in the Rochester, N.Y., area and found that 5.5% of imaging tests were repeated within 90 days when the regional HIE was accessed vs. 6.7% when the HIE was not accessed. But not a lot of money was saved. The researchers figure the
ACA cited as uninsured rates decrease

The nation saw an uninsured rate of 9.1% in the first nine months of 2015, according to the latest release of the National Health Interview Survey by the CDC. Estimates are based on data collected from 79,847 people. “In the first nine months of 2015, 28.8 million persons of all ages (9.1%) were uninsured at the time of the interview—7.2 million fewer persons than in 2014, and 16 million fewer than in 2013,” before the ACA’s coverage expansion kicked in.

Among adults ages 18–64, the number of people who were uninsured dropped from 39.6 million in 2013 to 25.3 million in the first nine months of 2015. States that expanded Medicaid coverage under the ACA saw the greatest drop in uninsured, from 18.4% in 2013 to 10% in the first nine months of 2015. States that did not expand Medicaid saw the uninsured rate drop from 22.7% in 2013 to 17.3% in the first nine months of 2015. (See page 21 for more ACA coverage.)

Savings per year was $32,460…. More than half (52%) of Americans turning 65 in the next three years will need long-term care services and support some time in the future, according to an issue brief by HHS’s Assistant Secretary for Planning and Evaluation. Most of the needed services involve assistance with activities of daily living (ADL), such as bathing. Mainly because women live longer, on average, than men, the expected costs for women are much higher: $180,000 compared with $90,000 for men. . . . Telehealth provided by mobile stroke treatment units might do a better job of treating stroke patients than ED visits, according to a study in JAMA Neurology. Studying 100 patients, researchers found that intravenous thrombolysis was administered to patients 32 minutes after being assisted by staff through the mobile health unit. Patients rushed to the ED via ambulance had to wait 58 minutes. . . . A drone that can fit into your hand (if you can catch it) might be the next weapon in the arsenal that tries to allow people to age in their homes, according to the New York Times. “Even though fully functioning robot caregivers may be a long way off, roboticists and physicians predict that a new wave of advances in computerized, robotic, and Internet-connected technologies will be available in coming years to help older adults stay at home longer,” the newspaper reports. . . . One of the reasons patients don’t adhere to medication regimens is fear of side effects. An AMA Wire report cites data showing that 25% of new prescriptions are never filled. Fear of side effects is 1 of 8 reasons cited by the AMA. The others are cost, a lack of understanding about just how the drug can help, taking too many medications, lack of symptoms, concern about becoming dependent, depression, and mistrust of a doctor’s motive for prescribing the drug…. Big Brother isn’t just watching. He’s weighing and checking numbers as well, thanks to a court ruling in Wisconsin that allows companies to decline to pay health insurance for workers who refuse to participate in health screenings, reports Bloomberg Business. The case garners national attention because this is where privacy rights collide with wellness, and more legal challenges should be coming. Worker advocates argue: Aren’t wellness programs supposed to be voluntary? Stay tuned.

—Frank Diamond

### ACA cited as uninsured rates decrease

Percentage of adults ages 18–64 without health insurance

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Is health care a free market? Legislators in Florida and Virginia want it to be, so they are moving to scrap the laws that require health care providers to get state approval before they expand or add services. Meanwhile, hospital interests in several states are fighting to preserve some measure of state control.

Known as certificate of need (CON) laws, the mere existence of these statutes has managed to do the otherwise undoable: bring Republican legislators and one governor to embrace an Obama administration goal.

The dawn of CON

The state-level CON laws are a legacy of a 1974 federal law that required each state to issue a certificate of need before hospitals or other providers could move forward on major expansions. The idea was to reduce health care costs and improve access by avoiding duplication and oversaturation of services.

However, the laws didn’t quite work as designed, says Christopher Koopman of the market-oriented Mercatus Center at George Mason University. By 1987, Congress repealed the CON mandate along with its funding. But not all states backed away from CON. Today, 36 still have some form on the books, according to the National Conference of State Legislatures, although, as Brock Slabach of the National Rural Health Association notes, they’re not as strict as they once were.

Three decades on, the Obama administration took notice, maintaining that CON laws do not conform to the ACA. The Department of Justice (DOJ) antitrust division and Federal Trade Commission (FTC) have urged state officials to “avoid adopting—or to reform existing—rules that unnecessarily limit” health care competition, DOJ antitrust chief William Baer told a health care conference at Yale University in November. Baer held out Virginia as an example of how the DOJ and FTC are working with states to convince officials that CON laws “create barriers to entry and expansion, limit consumer choice and stifle innovation.” Just last year, Hospital Corporation of America overcame a 14-year legal battle to open the first new hospital in Loudoun County in a century—and Loudoun County, which is an hour west of Washington, is not some sluggish economic backwater. The county’s population has tripled, to 350,000, in the past 20 years.

If formulating legislation is akin to making sausage, dismantling laws can be messier. In October, the DOJ and FTC issued a joint statement calling for the repeal of Virginia’s certificate of need law. But then FTC Commissioner Julie Brill backtracked in a separate statement to a Virginia legislative working group exploring various ways of revising the law.

“Empirical evidence on the success or failure of COPN to obtain their numerous objectives—in Virginia or beyond—is limited, and we lack evidence on the broader impact of COPN repeal,” Brill said in the statement. (In Virginia, the CON law is called the certificate of public need law, so the acronym is COPN.) She acknowledged that neither the justice department nor FTC has done a “close, statewide analysis” of Virginia’s laws and that conclusions in the joint FTC–DOJ statement “appear unsupported by a solid empirical foundation.”

Mechanism for ongoing review

The Virginia working group spent about a year to come up with recommendations to reform Virginia’s statute—to “modernize and update” the law and create a mechanism for ongoing review, says Julian Walker of the Virginia Hospital & Healthcare Association. Those recommendations called for process reforms to the
the state’s COPN law. However, the legislature’s lower House of Delegates has moved forward two bills that all but ignore the working group’s recommendations and offer varying degrees of repeal instead. Those bills are pending in the state Senate, but whether they ever become law is unclear. Virginia Gov. Terry McAuliffe, a Democrat who ran former President Bill Clinton’s 1996 campaign and Hillary Clinton’s 2008 presidential campaign, has said he’s against total repeal.

In Florida, the free-market advocates have a clearer path to repeal. Gov. Rick Scott, a Republican, has advocated for it. The House is considering a bill to repeal in full the state’s CON law, says Lindy Kennedy of the Safety Net Hospital Alliance of Florida. The Florida Senate is considering a more nuanced approach, according to Kennedy.

The legislation would allow builders of new health care facilities to forgo CON review if they agreed to certain thresholds of charity care and pay into the state’s Medicaid fund and small business employer insurance marketplace or pay fines. Whether the two houses can reconcile their bills by the end of their session remains to be seen.

Restricting entry

For free-market proponents, the evidence for the anticompetitive effects of CON laws is plain. The Mercatus Center—the Koch brothers are major benefactors and Charles Koch sits on its board—has done several studies of CON laws in individual states, including Virginia and Florida. “What we’ve found is that states with certificates of need have fewer hospitals overall, fewer rural hospitals, fewer ambulatory surgery centers overall, and fewer rural ambulatory surgery centers,” says Koopman, a research fellow at the center. “The idea that certificate of need, by restricting entry into the market, is somehow going to increase access is difficult to justify in theory, and the evidence doesn’t seem to be there to support that it’s actually happening in practice.”

Koopman cites a study funded by the Health Care Cost Institute that shows that hospitals that have a market monopoly have prices that are 15.3% higher than hospitals in areas with four or more hospitals. CON advocates say that health care does not function like a free market, but Koopman dismisses that with this explanation: “Most of that is because of these cascading government interventions over the past 50 years; you have so many government programs involved in health care that in its current iteration it doesn’t look like a free market.”

Safety net threatened

Yet that imperfect market is the one that today’s hospitals and providers have to compete in, hospital groups say. “The challenge is that decades of government decisions have put health care providers in the position of having to provide substantial amounts of care to people that are uninsured, underinsured, or in government-subsidized programs,” says Walker, at the Virginia hospital group. “That means a burden of substantial free and discounted charity care.”

The Virginia hospital association conducted a study last year that showed Virginia’s per capita health care costs were lower than 10 of the 16 non-CON states and that Virginia’s costs are below the national average of $6,555. In its January–February 2016 newsletter, the association held out Pennsylvania as a counter-example to the argument that repealing CON statutes encourage competition. According to the Pennsylvania hospital association, a decade after the CON law was repealed, Pennsylvania ended up with 29 fewer general acute hospitals but with 133 more ambulatory care centers.

In Florida, safety net hospitals worry that an oversupply of hospitals will cause some to cherry-pick healthier patients with commercial insurance and dump complicated cases and Medicaid and uninsured patients on them. “Repealing certificate of need laws jeopardizes our safety net hospitals by luring insured patients from hospitals that provide highly specialized but often unprofitable procedures regardless of a patient’s ability to pay,” says Kennedy of the safety net hospital group in Florida. That could compromise specialized, high-level care like perinatal and neonatal intensive care units, burn centers, trauma centers, and transplant programs, she says.

In those specialty units is where the realities of health care are colliding with free market principles, but the latter may prevail thanks, in part, to the strangest of bedfellows.
Medicare Advantage’s Influence Felt in Accountable Care Model

ACOs are providers while MA plans are insurers. Still, CMS’s Next Generation ACOs have a familiar look and feel.

By Robert Calandra

It may not seem like such a big deal, but one of the important changes CMS made when it unveiled the Next Generation ACO program in January was to the financial benchmarks used to determine whether the ACO is saving money. CMS’s other ACO programs have used national expenditures going back three years to determine benchmarks. The new program’s benchmarking—which uses a one-year historical baseline that includes some adjustment for regional prices—resembles how Medicare Advantage (MA) plans get paid.

The “synchronization” of ACO and MA payment practices by CMS “suggests strategic thinking,” says Robert Berenson, MD, a fellow at the Urban Institute. The agency, he says, appears to be trying to figure out how the two programs can fit together in a coherent approach—and perhaps defend traditional Medicare in the process. “I think it is reasonable that traditional Medicare is trying to develop new innovative approaches to be competitive with Medicare Advantage plans.”

Capitation coming to ACOs

Chris Dawe, a managing partner for Evolent Health, an Arlington, Va., consulting firm that advises ACOs, worked for HHS for several years when the agency started to frame up its ACO policies. CMS’s Innovation Center, the agency’s incubator for experimental research and programs, has been tinkering with the ACO concept since 2012 when the Medicare Shared Savings Program (MSSP), the federal government’s largest ACO program, and the Pioneer program, itself a creature of the innovation center, got off the ground.

“What they said was, ‘We have this base program [MSSP] so let’s use the Innovation Center to continually redefine what the next iteration will be,’” says Dawe. Next Generation, the latest version, “is being pushed up the curve toward MA,” in his opinion. “CMS is bringing the best of what works in MA into the much larger, mostly unmanaged traditional Medicare population,” Dawe says. Of course, there is a fundamental difference: MA plans are insurers and ACOs, providers, although even that division is getting fuzzier by the day because of the growing number of provider-sponsored MA plans.

MA and the Next Generation ACOs are beginning to look alike when it comes to payment and risk. Capitation, which is how MA plans are paid, is one of the four payment options in the Next Generation program. The Next Generation ACOs can also elect to take on full, 100% two-sided risk similar to the way that MA plans assume financial risk for their enrollees.

People running ACOs may look at the MA plans with some envy because there’s more certainty to MA. An MA plan can put together networks that help them manage the care of their enrollees. CMS’s ACOs are grafted onto traditional Medicare, so beneficiaries are free to get their care from any provider that accepts Medicare. “In MA you can go and design your network,” Dawe says. “In Next Gen they are keeping it wide open fee for service.” MA plans manage care within revenue from set premiums while the targets for Next Generation ACOs are yearly benchmarks arrived at through complicated formulas.

The Next Generation and other CMS ACOs are not powerless and do have some ways to steer patients so they get their care from providers who have signed up with the ACO. The idea is to use incentives and referral patterns so patients will choose to get their care within the ACO’s network, even if they don’t have to.

Dawe says the Next Generation program added a couple of elements “to drive some affinity between the beneficiaries and the ACO.”
For example, beneficiaries get $35 twice a year—bumped up from the $25 that was originally proposed—if they get most of their care within the ACO’s network. Other add-ons include a waiver from the rule that requires beneficiaries to be in the hospital three days before getting into a Medicare-covered skilled nursing facility (the ACOs like that because it will presumably lead to fewer in-patient hospital days and lower costs). The Next Generation program also has rules that encourage broader use of telemedicine.

**ACO ceiling**

Dawe’s company has advised several of the Next Generation ACOs, and he conveys the consultant’s enthusiasm. “Next Gen”—as the cognoscenti call it—is “the gold standard of ACO deals,” says Dawe, offering health systems and physicians the opportunity to “focus on value and bend the cost curve.” But he acknowledges that there’s a limit to how much Next Gen—or any ACO program for that matter—can do to pull down the oft-mentioned cost curve.

That’s because MA’s ultimate advantage is the controlled network. MA plans have say over which beneficiaries receive care and where. As long as the CMS ACOs are positioned as being part of traditional Medicare, they will lack that advantage. “There is always going to be that limitation until Congress restructures Medicare and allows you to create a population of beneficiaries that are in the ACO,” Dawe says.

Long before ACOs and in the early days of managed care, a physician at a small community hospital in California was asked by a health plan to create and manage a physician group practice.

Over the years Richard Merkin, MD, has built that single group practice into the Heritage Provider Network, one of the country’s largest ACOs with 70,000 physicians in southern, central, and coastal California.

“He felt that it was important to demonstrate that if you surround independent Medicare physicians with the kind of infrastructure and capabilities that a large care organization like Heritage has, you could move the needle and improve consistency and quality,” says Mark Wagar, president of Heritage Medical System. “Dr. Merkin made a principled and strategic decision to enter [the ACO program] even though people had questions,” says Wagar, president of Heritage Medical System.

Part of CMS’s Pioneer program, Heritage is one of the 21 organizations that has agreed to participate in CMS’s Next Generation. While Next Gen is “the next logical step” for ACOs, Wagar says that it’s important for CMS to move more quickly to value-based population payments for all providers.

“We would like to see more physicians with us and other organizations move more strongly in accepting levels of risk,” Wagar says. “The Medicare Shared Savings Program is a good starting point for people to get used to it, but it sort of allows people to hedge their bet and not really do anything aggressive.”

CMS could coax more physicians to jump on the ACO bandwagon by streamlining its payment method, in Wagar’s opinion. Smaller physician groups don’t have the financial resources to wait months or even years to be paid for services. If they are doing all the right things “they should get paid now,” Wagar says.

“It is difficult for them to devote the resources and then wait 18 months” to be paid, he says. “Larger organizations like Heritage are demonstrating that if you give us more of the money upfront, that is where the biggest positive changes in quality and on the cost side occur.”

Because of its size and 31 years of experience, Heritage has the infrastructure and the resources necessary to improve the quality of care for beneficiaries in ACOs while driving down cost. It’s also very much in the Medicare Advantage world, managing the care of 1 million MA beneficiaries—800,000 of whom are fully value-based—for insurance companies in California, New York, and Arizona.

To attain its goal of greater access, high quality care, and cost saving, CMS will need physicians to buy into the ACO concept—that’s Wagar’s opinion. And the best way to get that buy-in is with upfront population payments, he says:

“You have an environment where the government, private payers, and providers all really want to do something that is much better. We have to encourage that and keep evolving the policy so that we don’t slide backward into doing the same old thing.”

Heritage exec: Want doc groups in ACOs? Show them the money

Medicare and its buying power are increasingly seen by Congress and health care policymakers as a way to change all of health care.
a defined network in standard Medicare,” says David Muhlestein, senior director of research and development at Leavitt Partners. “And there is always going to be that countervailing preference for a lot of beneficiaries to choose that wide open market.”

Medicare as a lever
But judging CMS ACOs only by their near- and medium-term effect on the health care cost of the Medicare beneficiaries attributed to them may be missing the point—and the larger picture. As odd as it might seem, Medicare and its buying power are increasingly seen by Congress and health care policymakers as a way to change all of American health care. Even “Obamacare” gainers have to appreciate the Innovation Center and CMS’s attempts at making the value-based care and payment more than another empty catchphrase.

“Medicare is now being viewed as a policy lever whereby payment models can be used to influence the broader delivery system,” says Muhlestein. “And that is a pretty important change.” Moving providers and beneficiaries away from fee for service and into a population-focused system where providers assume more risk is the focus of that change, he says. In Muhlestein’s view, CMS is more interested in creating a buffet of risk-bearing programs than in blurring the differences between MA and its ACOs.

Keep your skis together
ACOs are not the only way that the federal government is trying to wean American health care off of fee for service. Last year, Congress junked the Sustainable Growth Rate payment law and replaced it with the Medicare Access and CHIP Reauthorization Act (MACRA). Starting in 2019, MACRA will move Medicare payments to physicians to the Merit-Based Incentive Payment System (MIPS), which links payment to measures of quality, clinical practice improvement, resource use, and meaningful use of electronic health records. In an interview with Medical Economics, Berenson at the Urban Institute described MIPS as being like the Physician Quality Reporting System “on steroids” and that it, along with other factors, will put additional pressure on small practices and feed the trend toward consolidation. The headline on the interview is “MIPS: The Death Knell For Small Practices?”

Still, Berenson told the publication that the independent practice association model is still thriving in some places and that ACOs based in independent practices can be successful. It’s a good sign, he said, that about half of all ACOs are physician-run organizations.

Muhlestein says the health care reform chapter that has yet to be to be written is delivery reform: “Payment reform only gets you part of the way.” The real work has to be done by hospitals and providers, he says, and they will have to develop the new processes and protocols needed for delivering care differently.

For now, Congress and CMS’s strategy is to continue working the payment lever to move people away from fee for service and drive delivery reform. Muhlestein likens the process to a downhill skier—one ski can’t get too far ahead of the other:

“The payment models are progressing faster than the delivery models and we have to wait for the delivery models to catch up.”

Next Generation ACOs

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Please email your submissions to:
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By Jan Greene

It’s hard not to gawk when the giants that stalk the earth join forces and become even bigger, and fewer, and more dominant. That’s certainly the case with the U.S. health insurance market. All eyes are on the drama of Aetna buying Humana and the proposed acquisition of Cigna by Anthem. If these moves are approved, the Big Five will be the Big Three, controlling an estimated 44% of the private health insurance market (anything handled by a private insurer, including employer-sponsored health plans plus Medicare and Medicaid managed care). Add the 36 Blue Cross Blue Shield plans, and the lot of them account for 80% of the private market.

But there’s more to health plan strategy than “bigger is better.” There are hundreds of health insurers in 50 states with local market conditions that differ widely. Health plans are sponsored by giant for-profit companies, small not-for-profits, Blues plans and, increasingly, health systems. And the markets they’re operating in are increasingly diverse, ranging from self-insured employers to the ACA public exchanges to Medicare Advantage and Medicaid managed care.

The ACA, of course, has been the prime mover behind the reshaping of health insurance and its markets. It has created public exchanges and changed the ground rules for health plans, requiring guaranteed issue and eliminating exclusions for pre-existing conditions. Meanwhile, federal payers such as Medicare have made bold moves to shift the payment and delivery systems from pay-for-volume to pay-for-value, prompting much wider use of managed care principles such as global budgets. Insurers are responding to these changes in any number of ways—by consolidating, by diversifying, by partnering, by investing in technology, and by moving into new markets.

Small plans can compete if they have good provider relationships, says Greg Scott of Deloitte Consulting. Big national insurers need a sizeable share of a provider’s patients.

Analysts see the traditional health care market changing fundamentally from a circumscribed one in which each of the players—provider, insurer, payer, consumer—had a clear role and stayed within it. They describe the emergence of a new health insurance economy, one in which the players’ roles are morphing and merging, with completely new types of businesses being created. And they urge insurers to be open-minded about where that could take them.

“Health plans pursuing innovation should adopt a more encompassing definition of ‘product,’” Greg Scott, U.S. health plans sector leader and vice chairman of Deloitte Consulting, recommended in his 2015 health plan outlook. He noted that even if health plans have not traditionally been known as big innovators,
Consumer advocates and state insurance departments used that argument to support their mergers, saying there’s still plenty of competition to keep costs down. The industry’s big players have increasingly diverse, “says Elizabeth Carpenter, vice president of Avalere. The Affordable Care Act, the insurance market looks in-creasingly diverse,” says Elizabeth Carpenter, vice president of Avalere. The industry’s big players have used that argument to support their mergers, saying there’s still plenty of competition to keep costs down. Consumer advocates and state insurance departments may not agree; they note, for example, that Avalere’s research on provider health plans was sponsored by Aetna.

Carpenter and other analysts point out that while consolidation by bigger players is real and has resulted in the loss of some smaller insurers over the past 15 years, competition is not being snuffed out, in part because of new market opportunities and new players. For instance there’s Oscar, a venture capital-founded tech insurance company that uses quirky marketing and an easy-to-understand website to draw younger members. Oscar has expanded to selling on the public exchanges in four states and has 125,000 members, with a strategy of keeping provider networks limited to high-quality, progressive health systems.

Meanwhile, Fidelity Investments is starting a private health insurance exchange, expanding its reach from retirement plans. It joins a number of large benefits consulting firms (Willis Towers Watson, Aon, Mercer) in running private exchanges, which have an estimated 8 million members nationwide. A Kaiser Family Foundation survey found that 17% of employers are thinking about using a private exchange, an option that allows a great deal of flexibility in how employers and

New market opportunities

So there’s a lot going on besides the attention-grabbing stomping about by big national companies. A 2015 study from Avalere, the consulting company, noted that new players are actively moving into markets where they hadn’t offered products before, particularly Medicare Advantage. “When [these are] combined with new start-ups and other options created by the Affordable Care Act, the insurance market looks increasingly diverse,” says Elizabeth Carpenter, vice president of Avalere. The industry’s big players have used that argument to support their mergers, saying there’s still plenty of competition to keep costs down. Consumer advocates and state insurance departments

Consolidation’s not just for the big for-profits as Kaiser, Group Health announce engagement

Group Health Cooperative’s proposal to merge with Kaiser Permanente illustrates the strong appeal of consolidation as a way to access the resources a modern health plan needs to crunch data and build digital connections with consumers and members.

If any local health plan could succeed on its own, Group Health would seem to be the one. With a 70-year history and a loyal following in Seattle and other markets in Washington state, it has had a strong reputation for being responsive to its members. And as an integrated system it has a long history with the provider–payer model that others are aspiring to. Group Health also has bona fides, decades in the making, for innovation and research aimed at improving the quality and coordination of care.

But the organization found itself falling behind in the digital race, a particularly important piece of the puzzle for a health plan based in one of the most tech-oriented markets in the country, home to Microsoft and Amazon. “In Seattle, we’re very sensitive to trends in technology,” says Dawn Loeliger, Group Health’s executive vice president for strategic planning and deployment. “The tech companies have taught consumers to have new expectations of anyone who is offering them goods and services. That stuff costs money, and if we don’t offer this to our customers, we’re not offering them a level of experience and care our competitors are offering.”

Group Health was looking at big investments to create digital connections to its members— and to ensure the security of patient information, Loeliger says. “The right answer for us was to identify a very like-minded health care organization with values like ours that could offer us that opportunity to scale,” she said. “We believe we’ve found that in Kaiser.”

Kaiser Permanente operates in eight states and the District of Columbia, with 10 million members, but has a very small presence in Washington (just the Portland suburbs and in Vancouver), so their markets don’t overlap. Because Group Health is a cooperative, its members have to approve the sale, and then state regulators get a say. The need for technology smarts was just one of the motivating factors for Group Health, Loeliger said. There was also new pressure to keep premium prices low as more consumers are buying directly on exchanges and shopping around.

Another factor, she said, was drug costs, as they rise and as new specialty drugs come on the market. “With the scale of negotiating power you have with a larger organization, they have to pay attention to you,” Loeliger explains. “They can’t say, ‘This is our price, take it or leave it.’”
their workers use their benefits dollars. Postponement of the “Cadillac” tax may cool off some of the interest in private exchanges.

Other new activity includes Medicaid managed care specialists Centene and Molina branching out and selling policies on the ACA public exchanges; the launch of ACA-spawned co-ops in 23 states (although many of the co-ops have failed); and the growth in the sales of services and stop-loss policies to businesses that self-insure.

Whether they’re big or small, local or national, health insurers are dealing with some common trends now that the ACA has fundamentally altered the playing field: pressure to keep cost structures limited and premiums competitive; sophisticated use of value-based payment mechanisms; data crunching to closely track delivery models and patient outcomes; reaching consumers directly and digitally.

Insurers of various sizes are looking for advantages through acquisitions, partnerships, and entry into new markets. Paul Keckley, managing director in Navigant’s health care practice, says larger health plans—the national companies, the Blues, and some larger regional insurers—are following several strategies, including monetizing their claims data by selling analytics; acquiring providers and integrating their own delivery systems in selected markets (such as UnitedHealth Group’s expansion of its Optum unit that provides output care, data analysis, and pharmacy benefit management); and expanding into markets outside the United States, including Europe and South America.

There are a lot of variations on the theme of consolidation and acquisitions to gain key capabilities. “There’s not just consolidation in the traditional [mergers and acquisitions] asset deal manner, but also different sorts of alliances and partnerships and joint ventures and collaborations,” says Keckley. These arrangements are common among the Blues, he says, which expand their traditional capabilities to more innovative digital capabilities that allow consumer and provider engagement. Deals also offer entry into new markets, such as Medicare Advantage or Medicare Part D drug benefit plans, which is the thinking behind the Aetna–Humana merger.

In pursuing these strategies, insurers are chasing the savings offered by greater scale, which keeps down per-member-per-month administrative costs. Health plans are also challenged to put up the cash to buy information systems that can manage new payment schemes and provide sophisticated analysis. “The operating margins in combination with labor costs and supply chain costs are making it much more difficult for smaller players to survive,” says Keckley, and that applies to both health plans and providers. “The plans have a shrinking traditional market and are having to change their focus and diversify.”

Smaller players may not survive. “We do worry about regional plans, often single-state Blues plans, that don’t have access to the capital required to invest in the technology to work productively and successfully with providers in value-based care arrangements,” says Deloitte’s Scott.

At the same time, size isn’t everything. Local market scale generally trumps national scale in provider contract negotiations and collaborations, notes Scott. If a national plan doesn’t have a sizable share of a provider’s patient panel, their ability to influence medical practice may be limited.

“It’s that sort of scale that really matters when you’re trying to capture the attention and shape the behavior of physicians and hospitals,” says Scott. “What really matters is not that a health plan has 10 or 20 million covered lives across the country. If a regional plan has 300 of its members on Dr. Smith’s panel, and a national plan covers only 10, then Dr. Smith is more likely to make favorable arrangements with the regional plan.”

**Providers compete as payers**

Among the most significant new arrivals to the insurance marketplace are health systems that are starting their own health plans. Because new payment models have hospitals and provider groups taking on greater amounts of risk as time goes on, they will need many of the attributes of an insurer anyway, they figure, so they may as well take the leap.

During the first managed care revolution in the mid-1990s, hospitals and physician groups tried this strategy and, for the most part, it was a financial disaster. The risk-bearing groups of that era often did not have the data-analysis capabilities to manage risk.

Things will be different this time, analysts say, mostly because the big government payers (Medicare, Medicaid) are not just supporting pay-for-value models, but insisting on them. Information systems have also come a long way since then. Most hospitals and doctors have electronic medical records now, and...
it's easier to hire or contract for data analysis. Some provider-sponsored plans carry out the risk management piece on their own, while others take the short cut of partnering with an insurer.

**Insurers of various sizes**—not just the big guys—are looking at the advantages of acquisitions, partnerships, and entering into new markets, says Paul Keckley of Navigant.

It will be interesting to see how well provider-sponsored plans perform; analysts say there is a threshold number of members to keep premiums competitive—about 400,000 is a break-even point, says Keckley. According to a recent McKinsey report, some of the provider-sponsored plans that cross that threshold include HealthPartners in Minnesota, University of Pittsburgh Medical Center, Intermountain Healthcare, Henry Ford Health System, and Geisinger Health System. “They can operate successfully at scale in a region and don’t necessarily have to be a national plan,” Keckley says.

An important factor in health plan survival is managing provider networks. Provider-sponsored health plans may gain an advantage in the insurance game if state governments adopt strict standards for network adequacy, argues Keckley. Rules that require health plans to offer providers located relatively close to their members will foil strategies by the big insurers to narrow their networks and provide an advantage to health-system plans with wide provider networks.

Provider-sponsored plans have already made a big push in Medicare Advantage; about half the new plans that entered that market in the past five years and stuck with it are provider-sponsored, according to Carpenter. They are also in a good position to sell their prepackaged integrated delivery systems directly to employers, bypassing traditional insurance companies.

“Every substantial health system in the country will own and operate one or more health plans—that’s fairly certain,” says Keckley. Given that half of Medicare payments will be in value-based payment models in two years and 39 states are contracting Medicaid through managed care organizations, they may feel they have no choice, he says. “There’s kind of a loaded gun pointed at you right now. You can’t afford not to get on the train.”

Jan Greene is a veteran health care journalist based in northern California. Her work has appeared in the Los Angeles Times, Health magazine, Hospitals & Health Networks, and many other publications.
Maybe she doesn’t seek it out. And she isn’t the maker of it. But trouble does seem to have a way of following Marilyn Tavenner around. In the nascent days of the ACA, when she was director of CMS, the Healthcare.gov website had its epic meltdown. While HHS Secretary Kathleen Sebelius faced the cameras, Congress, and much of the heat, Tavenner and CMS oversaw the website and were charged with fixing it.

Now Tavenner is CEO of America’s Health Insurance Plans, or AHIP, as it prefers to be called. Days before she started the job last July, UnitedHealth Group, the country’s largest insurance company, quit the organization. Five months later, Aetna did the same. And three key senior staff have quit since last May. So Tavenner is leading a group that purports to represent the country’s health insurance industry without having two of the five largest insurers in its ranks, important vacancies in the executive suite, and a budget deficit that in 2014 ballooned to $2 million (2015 tax records are not yet available). Throw the uncertainty of the upcoming presidential and congressional elections into the mix, and you have a cocktail that might unnerve even a seasoned executive like Tavenner and call into question the clout of an inside-the-Beltway heavyweight like AHIP.

Neither seems to have happened. Tavenner, 64, answers an interviewer’s questions directly in a measured, even Virginia drawl, congenial—“Call me Marilyn, please”—yet businesslike. “Marilyn is a superb leader,” says Dan Mendelson, Avalere Health founder and CEO and a former Clinton administration aide. “She knows from experience how to navigate both the states’ and federal governments, and I think they’re really lucky to have found her.” The AHIP board sees Tavenner as the “the insider of all insiders,” says a policy analyst who didn’t want the statement attributed to him. He adds simply: “If she can’t solve our problems for us, who the heck can?”

And AHIP is not about to be relegated out of the major leagues of health care politics—and that’s not just Tavenner’s opinion. “AHIP as an organization will continue to thrive,” Mendelson says. “When senior White House officials want a comment on a matter that affects the future of health plans, they will call Marilyn. I can tell you from having sat in that seat that you’re not going to call 10 health plan CEOs to get their opinions about things.”

Two developments
Joseph Antos, a health care policy expert at the conservative American Enterprise Institute, points to two developments some insiders read as possible solutions to AHIP’s problems.
signs of waning AHIP clout: the failure to preserve risk corridors for not-for-profit cooperative plans and Democrats’ lack of interest in fixing the ACA. “But do they mean AHIP has really lost influence? I wouldn’t say so,” Antos says. “Without a UnitedHealth, without an Aetna, that puts a crimp in their gigantic budget. But it doesn’t necessarily mean that AHIP’s influence is less because the views of everybody else in AHIP pretty much reflect the views of UnitedHealth and Aetna, at least on technical issues.”

A major player

With offices on Pennsylvania Avenue about halfway between the White House and the Capitol, AHIP and its antecedents have been major players in American health care politics for the past several decades. The ACA’s lack of a public option on the exchanges was a concession to health plans that Tavenner’s AHIP predecessor, Karen Ignagni, helped engineer. The organization has also successfully fought cuts to Medicare Advantage, and, more recently, helped postpone the increasingly unpopular “Cadillac” tax on expensive health plans. In the ’90s, AHIP’s predecessor, the Health Insurance Association of America, spent up to $20 million on the “Harry and Louise” television ad campaign that helped derail the Clinton administration’s health reform plan. When Hillary Clinton raised questions about the Anthem–Humana and Aetna–Cigna mergers last fall, AHIP fired back that “policymakers should focus on addressing the real cost challenges facing patients—the soaring prices of prescription drugs and medical services—that drive up the cost of coverage and out-of-pocket costs for millions across the country.”

With the depth of pockets that gets people riled up about the power of special interests, AHIP can afford to spend millions every year on lobbying on behalf of its members. According to the Center for Responsive Politics, the organization has spent $65 million on lobbying over the past seven years. About $9.5 million of that was in 2015, down from a peak of $10.4 million in 2013.

In an interview with Managed Care, Tavenner said one of her top priorities is to bring both Aetna and UnitedHealth back into the AHIP fold. “How that starts is, obviously keeping the lines of communication open with both Aetna and UnitedHealth,” she says, noting that she has “long-term relationships” with both Aetna CEO Mark Bertolini and UnitedHealth CEO Stephen Hemsley. “We are still in regular dialogue.” (For extended excerpts of the interview with Tavenner, see Page 28).

To bring them back, Tavenner acknowledges that AHIP has to address the issues that drove them away. She lists dues and governance as problem areas. AHIP must balance the interests of large members like Anthem and Cigna with smaller plans and even members who aren’t in mainstream health insurance, such as dental and vision plans, Tavenner says. The organization is also working on strategies that will help members navigate delivery system reform and develop relationships with consumers, she adds. The goal is to resolve those issues within a couple of months, then go back to Aetna and UnitedHealth and other members.

Tavenner is also working on getting AHIP’s finances in order. The organization’s budget deficit widened in 2014, even though AHIP took in almost $3 million more than it did in 2013; its spending budget was around $68.6 million in 2014, according to its tax filing. Over the past two years, AHIP spent about $2.75 million more than it brought in, the filing indicates. “While they’re not huge losses, we don’t want to continue in a loss; we want to get back into a positive account balance,” Tavenner says. “We’ve been looking at everything from the conferences we do to the consultants we employ to make sure it all supports our strategy.” In 2014, AHIP spent $13.6 million—about 20% of its budget—on five consultants. Roughly $6.4 million of that went to the Locust Street Group, a Washington communications firm headed by David Barnhart, who advised, among others, Tavenner’s former boss in Virginia, then-Gov. and now Sen. Tim Kaine. Another $4 million went to Apco Worldwide, another Washington-based communications firm.

Antos notes that it’s common for large trade organizations like AHIP to experience some ebb and flow in membership. But the financial impact of the defections of large companies like UnitedHealth and Aetna can be significant, and getting them back into the fold would probably go a long way toward solving AHIP’s budget woes, he says.

Turnover expected

The departures of key executives have also fed perceptions of an AHIP in turbulence. Ignagni was AHIP’s CEO for 12 years and CEO of the American Association of Health Plans, one of AHIP’s predecessors, for 10 years before that. She left AHIP in May to take the helm at Emblem Health, a $7 billion New York not-for-profit that lost $500 million last year. Ignagni’s total compensation at AHIP was $2.1 million in 2014.

Dan Durham, AHIP’s then-executive vice president for strategic initiatives, served as interim CEO during the search that led to Tavenner getting hired. At about the same time as Tavenner started at AHIP, L.D. Platt left as vice president of external affairs to take a similar job with UnitedHealth. That was just a few weeks before his new employer quit AHIP. In
Mergers are in AHIP’s family tree

AHIP is the result of several mergers. The current organization is a product of the 2003 merger of the Health Insurance Association of America and the American Association of Health Plans. And before that tie-up, the American Association of Health Plans was the result of two groups that represented managed care organizations, the Group Health Association of America and the American Managed Care and Review Association.

December 2015, Durham also left AHIP to take a similar post at the Biotechnology Innovation Organization, and Mary Beth Donahue, longtime executive vice president, resigned. Donahue has not revealed her plans.

Tavenner is taking the departures in stride and says turnover in top positions is to be expected when a new CEO is hired. Mendelson of Avalere Health seconds the notion: “Karen [Ignani] was in the seat a very long time.” And like all new leaders, when Tavenner came in she needed to build her own team, Mendelson says. Still, appearances matter, and the exodus of the familiar faces and UnitedHealth and Aetna doesn’t look great for AHIP.

Advancing Medicare Advantage

AHIP’s board met last fall to set an agenda, and the AHIP media office says the priorities it set for 2016 are fixing Medicare Advantage, repealing the “Cadillac tax” on health insurance, and influencing policy for Medicaid managed care, drug pricing, network adequacy regulations, and delivery system reform.

For now, Medicare Advantage is AHIP’s overriding priority, according to Tavenner. Her previous employer has used what she calls “the antiquated fee-for-service methodology” for Medicare Advantage—a methodology that runs counter to the value-based care that is supposed to reward providers for good outcomes and a positive patient experience. “As the program grows, it’s getting harder and harder to tie it back to fee-for-service,” she says. “We shouldn’t be looking at fee-for-service for our comparison, which gets to the issue of things like risk adjustment. We should look at Medicare Advantage as its own program, and use it to drive delivery system reform and coordinated care.”

Notably absent from AHIP’s stated agenda: salvaging the state and federal exchanges, which could be a divisive issue for AHIP members. Tavenner has taken some criticism for being too close to the Obama administration and the flawed exchanges. “They have to decide to what degree—and I think this is where the fracture is—do we invest political capital, lobbying capital in trying to rescue these exchanges?” says John Graham, a senior fellow at the conservative National Center for Policy Analysis and former vice president of the Advanced Medical Technology Association.

Tavenner says she believes in the exchanges, although she acknowledges that they need more work. “Most health plans understand that the exchanges are new—they’ve only been in existence for three years—and they’re trying to support and work with them.”

This gets to what Tavenner says is AHIP’s goal to speak to “the consumer-driven part” of health insurance. “Plans have to make sure the premiums are correct, that individuals stay in these plans, and that they understand that health insurance is a continuous obligation, not just for when you’re sick and then you exit again.” AHIP has pushed for limiting special enrollment periods. Companies that sell policies on the exchanges have complained that allowing signups outside the normal open enrollment period has confounded their risk calculations because it encourages people with expensive health problems to enroll.

But the fog descending on the way forward for AHIP—and almost everyone else in health care—is the craziness of this year’s presidential election. What would a Trump presidency mean for the ACA? And even if a Republican wins the White House, undoing the ACA won’t happen overnight, despite the campaign rhetoric. “The writing of legislation will not be a walk in the park just as writing the Affordable Care Act wasn’t a walk in the park,” notes Antos at the American Enterprise Institute. But AHIP will play a key role in shaping American health care policy, regardless of who wins, he says.

Election turmoil notwithstanding, Tavenner says she has AHIP on a course to use this year to plan for 2017 and beyond. “Regardless of who is president, regardless of how Congress looks, health care is not going away as an agenda item,” she says. “The issues of coordinated care, the issue of tying payment to quality outcomes, they’re not going away; they’re bipartisan. And when I talk to members of Congress pretty much daily or definitely weekly, everyone understands that the model has to change, that coordination of care—particularly when you’re dealing with an aging population, a population with chronic illness—has to change.”

For AHIP, the goal will be seeing that members have the data to support that and the technology to collect and crunch the data, Tavenner says. “That’s going to happen regardless.”

Richard Mark Kirkner has been writing about health care for over two decades.
CMS veteran Marilyn Tavenner oversaw a rocky debut for HealthCare.gov. Now she’s at the helm of AHIP as some major members need to be coaxed back into the fold.

Interview by Richard Mark Kirkner

Marilyn Tavenner, MHA, was hired as president and CEO of AHIP last July, succeeding longtime predecessor Karen Ignagni. Just weeks before she took the job, UnitedHealth Group left the organization, and Aetna followed suit a few months later. Tavenner had been administrator of CMS after Donald Berwick resigned in 2011. Her time at CMS was noteworthy for the rollout and epic crash, and then recovery, of the HealthCare.gov website. A nurse and former executive with Hospital Corporation of America, she served as Virginia’s secretary of health and human resources for four years before becoming principal deputy administrator at CMS. These excerpts are from a telephone interview conducted in February.

You’ve said one of your priorities is to bring United Health and Aetna back into the AHIP fold. How does that start, and what are the next couple of steps? How that starts is, obviously, by keeping the lines of communication open with both Aetna and UnitedHealth. I’m fortunate in that I’ve got long-term relationships with both Steve [Hemsley, UnitedHealth Group CEO] and Mark [Bertolini, Aetna’s CEO]. We are still in regular dialogue.

The issues at hand really go back to three things. One is dues, and that is more of a mechanical piece about how do we fairly apply them to companies that merge or companies that end certain products or enter new markets. So it’s not just about Aetna and United. It’s about the entire industry, which is undergoing a great deal of change.

The second issue is governance. How do we fairly balance the role of the board and the role of the executive committee to make sure that we have that balance between those publicly traded companies, the Blues, and other product lines?

We’re also taking a look at the board; that started in November. Working with the board, we have created working groups around various issues. We will pretty much resolve those in the next couple of months and then, obviously, I will reach back out to both Aetna and United and other members.

Long-term, I think the bigger question for AHIP is: How do we help the health insurance industry as it undergoes a great deal of change, both in delivery-system reform and government work, and in reaching out and developing customer relationships with consumers?

AHIP in 2014 had a budget shortfall of about $2 million; in 2013 it was roughly $750,000. It seems that, regardless of Aetna or UnitedHealth, you need to come up with a plan for righting the financial ship. While they’re not huge losses, we don’t want to continue in a loss; we want to get back into a positive account balance. We’ve been looking at everything from conferences we do to the consultants we employ to make sure it all supports our strategy. We’re very fortunate that we have a very strong strategy, and a lot of that involves both federal and state engagement.

A lot of the work we do in conferences supports that strategy and educates the membership. We’ve already made some modest changes, but we will continue to keep an eye on the budget.
There has been discussion of a management shakeup at AHIP. Dan Durham left, Mary Beth Donahue left. Both were important executives, well known in the industry. How have you explained those departures to AHIP board members? Or are these natural occurrences as the organization moves on? Certainly it was explained to the board that they were seeking other job opportunities. It's a natural occurrence. They worked for a previous CEO. When a new CEO comes in, these changes happen.

There has been criticism that you are too close to the federal government and CMS. How have you responded to that? When I took the job, people were aware of my previous job; everyone's got a job history. It's kind of hard to have experience and not have some kind of natural or perceived conflicts. Part of being a Senate-confirmed appointee requires that I not reach out to either HHS or this administration for two years, so I'm one year through a two-year ban. I'm not having contact with CMS. We have a strong team in Matt [Eyles, executive vice president for policy and regulatory affairs] and Carmella [Bocchino, executive vice president of clinical affairs and strategic planning] and others that keep up those relationships.

The so-called “Gang of Five,” the five big health plans, reportedly had a meeting last year about their issues with AHIP. As you alluded to earlier, there's a lot of diversity among AHIP members in terms of their business lines. What is the commonality that binds big players like Aetna and Anthem and United Health and the broad diversity of other AHIP members? AHIP is seen as the voice of industry by members of Congress and the White House and by HHS. It's important to have that single voice, and I think that's why people with diverse backgrounds are happy and support AHIP. They see that single voice as important.

The other thing that binds all of our diversity is that everyone is serving consumers in some way. It may be vision, it may be dental, it may be a huge company like UnitedHealth, or it can be a tiny plan. AHIP is seen as the voice of industry by members of Congress and the White House and by HHS. It's important to have that single voice, and I think that's why people with diverse backgrounds are happy and support AHIP. They see that single voice as important.

What we object to is comparing Medicare Advantage to what I'll say is the antiquated fee-for-service methodology.

right now, and that was part of the issue with the lack of risk corridor funding. A lot of plans were dependent on that in some way to help stabilize the exchanges.

Most health plans understand the exchanges are new—they've only been in existence for three years—and they're trying to support and work with them. Plans have to make sure the premiums are correct, that individuals stay in these plans, and that they understand that health insurance is a continuous obligation, not just for when you're sick and then you exit again. We're working on things like the special enrollment periods. We obviously worked hard on risk corridors, but we weren't able to get funding for that. What Congress passed in a bipartisan way and what the White House supported was a delay in the health insurance tax. The consumer-driven part of this is making sure consumers have the best premium they can have.

Based on priorities the AHIP board established last year, Medicare Advantage is the biggest focus for the association in the near future. What does AHIP
hope to accomplish in this regard? From now through April, Medicare Advantage will be a priority for us. We believe in Medicare Advantage, and consumers believe that it’s a good program. Consumers are happy with the quality. They’re happy with the coverage, and the program continues to grow.

What we object to is comparing Medicare Advantage to what I’ll say is the antiquated fee-for-service methodology, which members of Congress and members of this administration are basically moving away from. As the program grows, it’s getting harder and harder to tie it back to fee-for-service.

We’re saying we shouldn’t be looking at fee-for-service for our comparison, which gets to the issue of things like risk adjustment. What we should do is look at Medicare Advantage as its own program, use it to drive delivery system reform and coordinated care, whether you’re talking about dual eligibles or regular Medicare beneficiaries.

We have over 2 million consumers on the ground who are voluntarily helping us talk about the importance of strengthening the program. The time has come to move forward and not compare it to fee-for-service.

What lessons did you learn at CMS that you think will be valuable as you guide AHIP through this period? I spent the last five years learning how insurance works. I didn’t have that background; my background was in nursing, then it was working for a hospital provider, then it was in state and federal government.

So I understand how state and federal governments work. I certainly understand Medicaid from my time with Sen. Tim Kaine when he was governor of Virginia. I didn’t understand health plans as well, so that was an important lesson.

I learned the pros and cons of regulation, which will be helpful as we continue to work with Medicare and Medicaid. And obviously, I learned a lot about the exchanges.

The exchanges are like every other insurance plan or government plan. Medicare and Medicaid have been changed almost every year. I suspect that once this election is over, there will be changes to the ACA and the exchanges as well. And hopefully, I can identify and help to make those types of improvements.

Is there anything you would like to add? I would just stress the importance of health plans helping to reform the delivery system and working with consumers. Because all these plans are changing. Whether you’re talking about Aetna or UnitedHealth or much smaller plans, they’re all going through this. That’s something that AHIP can help with.

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Selfie Health Insurance Is All the Rage

A desire for more control and the ACA seem to be fueling the long-term trend.

By Peter Wehrwein

It is not often that the words elegance and health plan end up in the same sentence, but Steve Gransbury says self-insurance can bring them together—and not just in a sentence.

“The real cause of unaffordable health insurance is the cost of health care,” says Gransbury, president of the accident and health division of QBE, an Australian company that is a global business and one of the largest medical stop-loss insurers in the United States. “The self-insured plan is an elegant solution for managing those costs.”

There are dissenting views. Some see self-insurance as an end-run around state-level insurance mandates, although as a practical matter many self-insurance plans match the benefits that states require. In Wisconsin, Republican Gov. Scott Walker’s push to have the state self-insure 250,000 state and local employees is drawing fire from state employee unions (Walker made his reputation by taking on unions) and the Wisconsin Association of Health Plans, which worries about its members losing a sizable chunk of its cus-

Percentage of covered workers in partially or completely self-funded plans, by firm size, 1999–2015

Average premium contribution paid by covered workers for single and family coverage, by firm characteristics, 2015


Tomers. Wisconsin has a strong tradition of relatively small regional health plans that are sponsored by regional providers.

But there’s really no denying the appeal of self-insurance and its growing popularity among employers. According to last year’s Kaiser Family Foundation–Health Research & Educational Trust (HRET) survey on employer health benefits, the percentage of employers who fully or partially self-insure has increased from 44% in 1999 to 63% in 2015. Among employers with 5,000 or more workers, self-insurance has become the rule with the rare exception, according to the survey, which found that 94% of employers that size self-insure. The percentage goes down as the number of employees decrease. That’s not the least bit surprising because of the cash reserves needed to self-insure and the actuarial volatility of smaller groups.

Still, among employer groups of every size the proportion of companies self-insuring is trending up. In 1999, 13% of small employers (defined in the Kaiser-HRET survey as employers with between 3 and 199 workers) were self-insured to some extent. By 2015, the proportion had inched up to 17%.

Average premium contribution paid by covered workers for single and family coverage, by firm characteristics, 2015

“More clients of all sizes are kicking the tires,” says Gransbury.

There are several reasons for the interest. Mike Ferguson, president of the Self-Insurance Institute of America, says self-insurance allows employers to tailor their benefits to their employees instead of buying an “off the shelf” plan from an insurer. Gransbury elaborates on the selling point: An employer with a workforce dominated by baby boomers may want more coverage for chronic conditions, whereas the employer that has a preponderance of millennials on the payroll may elect to beef up family-planning benefits.

Another reason, says Ferguson, is data. More precisely, when employers self-insure they have control and ownership of claims data. And in this day and age of powerful data analysis, having that information could yield some insights into how to best manage benefits and control health costs.

The Kaiser-HRET survey doesn’t show a big ACA inflection, but Ferguson and Gransbury say the health care reform law has whet the appetite for self-insurance. In Ferguson’s telling, self-insurance provides refuge from a health insurance that becomes unstable because of the ACA. “Everyone wants to be insulated for that instability,” he says.

Uncapped liability

Gransbury says the market for stop-loss has grown because of the ACA prohibition on annual or lifetime coverage limits. The elimination of limits left employers with the problem of an uncapped liability that stop-loss solves, he explains. Gransbury said even very large employers that have a good handle on their claims experience are buying stop-loss policies these days because of the lack of coverage limits. QBE recently sold stop-loss policies to two employers with more than 20,000 employees. “That part of the market, the large employer, has grown for us—and I imagine for our competitors as well,” says Gransbury.

A growth market attracts competition, and the number of insurers competing for the self-insurance business is increasing. Gransbury says stop-loss providers like QBE will often partner with companies that operate as the third-party administrators that process claims.

Are traditional insurers being left out in the cold? Far from it. Most have started business lines that tap into the self-insurance market. And insurance brokers play matchmaker: “The broker marries our stop-loss to that fully insured carrier’s ASO offering,” say Gransbury. ASO is insurance speak for administrative services only.

Of course the growth in self-insurance has been noted in the health insurance industry, but it hasn’t stirred up much political action. That may be changing. It’s a very public fight in Wisconsin that is being waged with dueling consultant reports. Local news accounts say that Deloitte estimated the switch to self-insurance could possibly cost the state $100 million, while a more recent report from Segal Consulting projected $42 million in savings.

Ferguson, head of the self-insurance institute, notes that insurance law allow states to regulate some aspects of stop-loss insurance, even if self-insured plans are not subject to state insurance mandates. Blue states tend to regulate more heavily than red states, he says.

Ferguson’s group is gearing up politically. In February, the institute announced that its political action committee would be holding a series of dinners to bring attention to its “Washington Impact” campaign, which is designed to improve the group’s “political and advocacy activities” in the nation’s capital.

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Ferguson’s group is gearing up politically. In February, the institute announced that its political action committee would be holding a series of dinners to bring attention to its “Washington Impact” campaign, which is designed to improve the group’s “political and advocacy activities” in the nation’s capital.
Today, some 400 integrated delivery networks in this country are getting ready to don both the provider and payer hat. Booz & Co. estimates that half of networks have applied, or are intending to apply for, an insurance license. In many large metropolitan areas, these organizations have deep roots, deep pockets, strong reputations, and many doctors and important hospitals under their control. They are counting on their strength as providers in transferring to a new role as payer and marketer of health plans.

In some cases, providers and payers are motivated by frustration, with entities on either side of the traditional provider–payer dividing line in finding their colleagues on the other side to be uncooperative or vying for advantage. This dynamic was seen recently in the Pittsburgh market, where the major payer and provider groups felt they could no longer work together, forcing each other to become payer–provider organizations through acquisitions.

But even in the absence of acrimony, providers have become interested in assuming the payer role as they become ACOs, accept bundled payments, and enter into other kinds of value-based care agreements. Value-based care is anchored in the “triple aim,” defined by Donald Berwick and others as (1) improving the health of populations, (2) improving the patient experience, and (3) controlling the cost of care.

For several reasons, hospitals and the integrated health networks that are serious about organizing the delivery of health care according to the triple aim will find it easier to do so if they assume payer responsibilities.

Two developments
Combining the role of payer with provider gives these health systems an incentive to invest in population health-improvement initiatives that don’t involve putting “heads in beds” and expensive medical interventions. Unless they are payers, health systems won’t have the resources for these population-based programs. Furthermore, any success that they might have in population health would come at their own expense: A healthier population means lost revenue for providers paid on a fee-for-service basis.

Payers often have difficulty influencing providers because providers typically deal with many payers, so the influence of any payer is diluted. If American health care was organized so that providers and payers were the same organization, the payer side of that organization would have considerable influence on providers, allowing greater focus and responsiveness to improving the patient experience, including quality and patient satisfaction.

Combining the provider and payer roles into single entities should also work toward removing volume as incentive and excess charges as a temptation. The result would be more cost-effective health care.

And what about the role for payers? They will need to adapt to these changes either by becoming providers themselves or, the more likely route, working as close partners with providers. Packaging and selling administrative and financial services to providers may be a new and important role for payers in a health care landscape dominated by payer–provider organizations.

Too much power?
Presumably, a health care system that brings providers and payers together and shoots for the triple aim would benefit patients. But there’s also legitimate concern that these payer–provider organizations could wield too much power. New regulatory authority may be needed. And despite all the promise of payers and providers becoming one, the reality may be less rosy. A study published in 2013 in Health Services Research painted a picture of a future we don’t want: Not only did payer–provider plans have higher premiums, they didn’t improve on quality benchmarks.

Perhaps these results can be chalked up to growing pains, and over the longer term, the outcomes will match the high expectations set by the triple aim and value-based care. Only time will tell.

Richard Stefanacci is a medical director for AtlantiCare Post-Acute Services and is a member of Managed Care’s Editorial Advisory Board.

Richard Stefanacci, DO
Some Health Insurance Plans Groan About Not Making It on Exchanges

UnitedHealthcare, Aetna, and Humana all lose money, but Cigna’s CFO says that’s just the price for getting started in a new market.

By Frank Diamond

Updating what’s going on with the ACA exchanges these days is a little like giving weather reports; predictions have a shelf life of about five minutes, and 99% of the audience not only hates you, but thinks it can do a better job. Some health insurance plans on the exchanges claim to be losing their shirts and want to pick up their datasets and go home.

Meanwhile, the CFO of at least one major player, Cigna, wonders why all the Sturm und Drang when everybody knew going in that the market might not stabilize for a few years.

Not really major players

UnitedHealthcare says it is considering getting out while the getting’s not so good and could get even worse, reportedly telling investors earlier this year it lost about $475 million in ACA plan business in 2015. Small loss, countered a Robert Wood Johnson Foundation report sponsored by the left-of-center Urban Institute, arguing that UnitedHealthcare’s ACA plans “have not been major players in many markets and their exits will not be overly disruptive.” (United has not responded to requests from MANAGED CARE for comment.) United’s stated reasons for pulling out don’t quite add up for the Urban Institute, which called the move by the country’s largest insurer “surprising” given that United’s “participation is growing significantly this year.”

The report, which was published in January, also says not to fret about the effect of failing co-ops. Twelve of 23 have been shuttered. “Co-ops are not playing a major role in driving price competition in many ACA marketplaces, and their exit will not cause significant disruptions outside a very limited number of areas,” the report states. The co-ops are supposed to provide a low-cost alternative to private health plans on the insurance exchanges. Why so many have gone belly up is a complicated tale. The Urban Institute repeats a point that others have made:

Insurer participation and frequency of being one of the low-cost silver insurers in 81 U.S. rating regions, 2016

<table>
<thead>
<tr>
<th>Insurer Type</th>
<th>Number of plans offered on exchanges</th>
<th>Share of regions where insurer is one of two lowest-cost insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ops</td>
<td>22</td>
<td>17.3%</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>48</td>
<td>18.5%</td>
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<tr>
<td>Aetna</td>
<td>31</td>
<td>16.0%</td>
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<tr>
<td>Humana</td>
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<td>6.2%</td>
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<td>Cigna</td>
<td>7</td>
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<tr>
<td>Blue Cross plans</td>
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<tr>
<td>Medicaid</td>
<td>48</td>
<td>54.3%</td>
</tr>
<tr>
<td>Local/regional insurers</td>
<td>43</td>
<td>21.0%</td>
</tr>
<tr>
<td>Provider-sponsored plans</td>
<td>51</td>
<td>28.4%</td>
</tr>
</tbody>
</table>

*aIncludes Coventry.  *Includes Anthem.  *Includes insurers participating in Medicaid but not in private insurance markets before 2014.  *Includes Kaiser Permanente.
They have been hampered by federal limits on how much marketing they can do.

Winners may be hard to find, but there are still plenty of players, says the Urban Institute: “Our basic conclusion is that marketplaces are increasingly driven by competition among Blue Cross-affiliated insurers, Medicaid insurers, provider-sponsored insurers, and in fewer rating regions, [by] local or regional insurers.”

But look at the private insurers and it’s hard to be sanguine. Humana last month told the Wall Street Journal it expects to lose $176 million in the individual health plan market this year. The WSJ article on February 10 noted that Aetna is also struggling with ACA individual plans, seeing a negative margin of 3% to 4% last year.

Jeff Goldsmith, president of the consulting company Health Futures and member of our Editorial Advisory Board, has been skeptical of the ACA’s ability to fulfill its promises, and the recent turmoil over insurer participation in the exchanges doesn’t surprise him. United-Healthcare faced pushback because it spoke out first, he says, “but now you have Aetna and Humana basically saying, ‘We’re having serious problems in this business as well.’”

The Blues are struggling too. Citing a J.P. Morgan analysis, the WSJ said that the Blues incurred about $20.7 billion in medical claims, while collecting $20.4 billion in premiums over the first three quarters of 2015. Insurers have complained of higher expenses from consumers who sign up for coverage outside the annual open-enrollment period. Earlier this year, the Obama administration promised to tighten enrollment rules.

The administration is also considering making it more difficult for people to drift in and out of coverage. It remains to be seen whether that will spur enrollment. According to a Kaiser Family Foundation poll, nearly two thirds (65%) of uninsured Americans say they plan to get health insurance in the next few months, despite the fact that nearly half (46%) say they have been without coverage for two or more years.

**Growing up is hard to do**

But all of this is just growing pains, Cigna CFO Tom McCarthy told the Hartford Courant last month. “We knew these early years on the exchange would be volatile,” he said. He added, jokingly that “we expected a plan where we would lose money these past few years, and by golly, we’ve delivered on that plan.” That “does not undermine the long-term attractiveness of the market,” says McCarthy. “I expect that over time, that market will evolve to be attractive for the industry generally, and for Cigna in particular.”

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**Many miss out on ACA financial assistance**

Insurers complain that people who sign up for their ACA products after the enrollment period has ended—sometimes waiting until they’re sick—has helped to throw those plans into the red. A Kaiser Health Foundation tracking poll of more than 1,200 adults ages 18 and older confirms that most uninsured have not taken steps to determine their eligibility. Over 7 in 10 say they have not tried to figure out if they qualify for Medicaid or for financial assistance to purchase health insurance in the past six months.

Among the uninsured ages 18–64, percentage who...

- say they have tried to seek out more information about getting or changing health insurance: 43%
- say they have been personally contacted about signing up for health insurance or Medicaid in the past 6 months: 32%
- say they have tried to figure out if they qualify for Medicaid: 28%
- say they have tried to figure out if they qualify for financial assistance to purchase health insurance: 21%
- are aware that January 2016 was the deadline to enroll in health coverage: 15%
- are aware that the fine for people who don’t get insurance in 2016 is $695 or 2.5% of household income: 1%

Source: Kaiser Health Tracking Poll, January 2016
Critical Illness Policies: An Antidote or a Band-Aid for Health Care’s Financial Toxicity?

Coverage kicks in if someone has a major illness like a heart attack or stroke. And because critical illness policies are a voluntary benefit, they help employers cut costs to avoid the Cadillac tax on health benefits.

By Joseph Burns
Contributing editor

Shifting costs to employees gives them an incentive to keep health care costs down. That’s the “skin in the game” theory behind high-deductible health plans. The only problem with this theory is that it leaves a great swath of American households vulnerable to a crushing load of debt in the event of a serious illness. And studies show that employees don’t usually shop for care on the basis of price anyway.

But American health care abhors a vacuum almost as much as nature does. Insurance companies are stepping in and taking some of that skin out of the game with critical illness policies that provide coverage for a variety of significant health conditions, including heart attack, stroke, and cancer. Those three conditions account for 75% of all serious (and costly) medical conditions, says Gary Harger, vice president of voluntary products in UnitedHealthcare’s Specialty Benefits division. “Employees are looking for financial certainty, and employers want to help fill that need,” he adds. “That’s why we’re seeing insurers offering critical illness policies and, as more insurers move to high-deductible plans, these plans become more attractive.”

Avoiding the Cadillac tax

Critical illness policies come in two basic models, with or without an employer-paid coverage floor. Employers that offer these policies and who want to ensure that employees have some basic protection available to them may pay for a base portion of critical illness coverage, usually $5,000 to $20,000. Employees can buy more coverage on top of that if they choose, usually up to $40,000. More often, though, employers do not contribute and employees pay for the entire policy. When employers don’t kick in, employees tend to buy $15,000 to $20,000 in coverage.

For employers, one of the primary attractions of these plans is that the indemnity coverage they provide generally is not subject to the ACA excise tax on premiums. Until the implementation of the so-called Cadillac tax was delayed late last year, employers had been paring their offerings to avoid the tax by shifting costs to employees with high deductible coverage and by offering a variety of voluntary benefits employees can buy that do not count toward the benefit value used in the Cadillac tax calculation.

These factors help to explain the growth of critical illness policies. In its annual National Survey of Employer-Sponsored Health Plans, Mercer reported that 45% of employers with 500 or more workers offered employees critical illness policies in 2015. In 2009, one year before the ACA was signed into law, 34% of these employers offered such policies.

This year, employers that had maintained a rich benefit but were trying to reduce their exposure to the excise tax are looking hard at the advantages of voluntary benefits, including critical illness policies. A Willis Towers Watson survey of more than 300 benefits professionals found that a third believe that voluntary benefits were important to their total rewards strategy in 2015, but more than half (56%) predicted such benefits would be important in 2018, the year the excise tax was scheduled for implementation, according to Amy Hollis, voluntary benefits leader with the company.

In December, the Obama administration delayed the Cadillac tax until 2020, bowing to pressure from unions and employers. Unions argued that the tax would penalize their members by taxing benefit packages that came at the expense of wage gains. Employers oppose the tax because rich benefit offerings are part of total compensation to attract and retain talent.

Growing popularity

In the Willis Towers Watson survey, 44% of responding employers said they offered critical illness policies in 2015 and 73% expect to do so by 2018. Clearly, employers were looking to avoid paying the excise tax. Perhaps looking ahead to the original implementation date of the Cadillac tax, WTW said in its 2016 report, “Voluntary benefits offset the reduction in benefit value by closing coverage gaps. Organizations are not yet capitalizing on this opportunity, although we expect this to change as 2018 approaches.”
Attractive to older folks
But aside from the ACA and the Cadillac tax machinations, critical illness policies have the virtue of giving employees more choice, Harger says. Since they are part of employers’ offerings of voluntary benefits, critical illness policies allow employees to select coverage à la carte. Older employees who recognize they have a greater chance of experiencing a serious illness can buy additional coverage while younger workers are more likely to take a pass.

Tim Weber, who runs Mercer’s voluntary benefits consulting business, says experience with critical care coverage has gone as expected, meaning it’s mostly an older person’s buy. “The likely purchasers are primarily 40 to 49 years and then 50 to 59,” he adds. “Those who are 30 to 39 don’t purchase as rapidly or as much coverage as those who are older.” The purchasers are also disproportionately women, notes Weber. “Women tend to see the value of health insurance because they’re more concerned about covering risks.”

Likely purchasers of critical illness policies are primarily ages 40 to 49, says Tim Weber of Mercer. Then comes ages 50 to 59. Younger people are less likely to buy.

Premiums vary. When employees purchase critical illness coverage for themselves through their employers, the premiums for a policy that would pay $5,000 start at about $60 per year, depending on factors such as the employee’s age, location, and industry, according to Harger. Weber, at Mercer, also noted that premiums differ depending on many factors, including whether the insured is a smoker, whether his or her dependents are covered, and the percentage of employees who buy the critical illness coverage. If an insurer believes enrollment conditions make it more difficult to buy a policy, the insurer may set higher rates because of concerns about selection risk, notes Weber.

When companies buy some base coverage for their employees, they typically pay $5 to $10 per month per employee for $5,000 worth of coverage and employees pay $15 to $20 per month in premiums for additional coverage of between $15,000 and $20,000, according to Weber.

In addition to offering policies covering cancer, heart attack, or stroke, Harger says UnitedHealthcare’s base critical illness plans cover costs associated with many other conditions, including amyotrophic lateral sclerosis, Alzheimer’s disease, and Parkinson’s disease and child illnesses such as cerebral palsy, cystic fibrosis, and muscular dystrophy.

“With that number of illnesses, you have a solid base of coverage for what many employees will see,” says Harger. “Some insurers will offer coverage for fewer conditions and some will offer plans for more conditions. Our goal is to cover the most common conditions.”

Buyer beware
Many companies sell critical illness coverage, including AFLAC, Cigna, MetLife, Transamerica, and Unum. Interest among employees is strong because of rising deductibles, says Weber. “That’s what drives awareness and causes employees to think twice about how to pay if something happened. They see that they have a huge cost exposure. And these plans are a source of funds to cover expenses for a critical diagnosis,” he says.

Many employees know that a critical diagnosis may require them to travel to get the best care, Weber comments. “When you hear the bad news about a cancer diagnosis, you want to find the best place to get that care whether it’s Mayo, the Cleveland Clinic or some other highly regarded treatment center,” he says. Once the employee gets a diagnosis for a covered condition, the insurer sends a check for the full amount and there are no restrictions on how the money is spent, Weber says, so people use the money to pay for travel, hotel costs, or household expenses if the employee is out of work for an extended time.

So are there downsides to these policies? If you believe that high deductible plans could infuse some needed price sensitivity into health care, maybe so, although critical illness is an area where market forces may not work. A recent Kaiser Health News article suggested that employees approach these critical illness policies with a healthy caveat emptor attitude and ask a lot of questions. Will they be covered for a recurrence of a pre-existing condition? Are certain conditions such as noninvasive breast or prostate cancer tumors excluded? Are there waiting periods before coverage begins? Are payouts limited by age?

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Patients With Metastatic Bladder Cancer Have an Unmet Need

Bladder cancer research has seen few advancements over the past 30 years. No new agents have been approved for metastatic bladder cancer since 1998.¹⁻³

Metastatic Bladder Cancer:/n
- Approximately 4% of new diagnoses represent metastatic disease (stage IV)
- 5-year relative survival rate of patients with metastatic disease is 5.4%
- Mortality rates for metastatic disease have remained relatively constant since 1975

“Against the background of no new drug approvals for advanced bladder cancer in decades, immunotherapy research is giving new hope to patients and physicians.”

–Michael R. Harrison, MD, Duke Cancer Institute

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REFERENCES
If you want to understand cancer treatment from the patient’s point of view, Wit is a good place to start. You can watch the first-rate HBO version of the one-act play by Margaret Edson online for free. Emma Thompson plays Vivian Bearing, an English literature professor and expert on John Donne and metaphysical poetry who has stage IV ovarian cancer; “published and perished,” remarks Thompson. The title has several meanings, but what would otherwise be an utterly dreary and depressing story is elevated by Bearing’s delightful dark humor—her wit. One of her wry observations is about the “How are you feeling today?” greeting she gets from doctors and nurses. “I have been asked ‘How are you feeling today’ when I was throwing up into a plastic washbasin,” says Bearing. “I was asked when I was emerging from a four-hour operation with a tube in every orifice.”

Cancer specialists say they want to replace the empty, reflexive “how are you feeling today?” question with meaningful concern for—and data collection from—patients in the throes of cancer treatment (“My treatment imperils my health—and herein lies the paradox,” says Professor Bearing). One aspect of this intention to be more heedful of patients goes by the name “symptom monitoring.” That doesn’t sound very caring, creative, or important, but it changes how cancer is treated and how the treatment is judged. In health care today, nothing seems to gain traction unless it is a) measured and b) can be tied to payment. Symptom monitoring is well suited for both.

“It’s just getting started, but we’re doing some work in defining measurement tools that more accurately reflect the patient voice, the patient report of symptoms, and patient experience overall,” says Robert S. Miller, MD, the senior director of quality and guidelines for the American Society of Clinical Oncology (ASCO) and medical director of CancerLinQ, ASCO’s big data project.

It may take several years for the full complement of performance measures of the patient experience to be ready to use, says Robert S. Miller, MD, of the American Society of Clinical Oncology.

Symptom Monitoring Improves Cancer Care
Cancer patients talking to doctors doesn’t work very well: Half of all symptoms go unreported. Computerized systems and email prompts may do a better job.

By Peter Wehrwein

Miller says it may take several years for a full complement of performance measures of the patient experience, including symptom monitoring, to be researched, analyzed, and made ready for use. He definitely has a foot on the brake: ASCO, says Miller, doesn’t want to lend its imprimatur to questions of patients that later need to be reworked—or junked entirely—or settle on a platform (PCs, say) that turns out to be based on faulty assumptions and not the best choice for collecting this type of information. “We want to get this right,” he says, the implication being, of course, that getting it wrong is a distinct possibility.

Yet Miller also notes that ASCO may put some decisions about patient experience measurement and symptom monitoring on a faster timetable perhaps in the next year, as part of its push to improve the quality of care. And the pressure is on to come up with the metrics that underlie quality of care and value-based payment that rewards it. Miller references the HHS announcement early in 2015 that set a goal for this year of having 30% of traditional Medicare fee-for-service payments paid through alternative payment models such as ACOs and bundled payments and linking 85% of the payments to some kind of measure of quality or value. Incorporation of performance measurements that are supposed to reflect the patient experience “is happening and it’s only going to increase,” says Miller. “ASCO wants to be active in this because we want to say to our members, ‘We want to work with you to create the best metrics that make a difference, that really resonate with patients, that give our members the answers they need to help us direct their care better.”

Automation helps
That sounds nice—and maybe a bit too aspirational and abstract. Taking a look at Ethan Basch’s research lends some nuts and bolts to what Miller is talking about. Basch, MD, is director of the cancer outcomes research
program at the University of North Carolina’s Lineberger Comprehensive Cancer Center and a leading expert on symptom monitoring. Basch says symptom monitoring is the cornerstone of quality cancer care—“symptoms related to cancer. Symptoms related to the treatments we give.”

It’s not that oncologists are oblivious to their patient’s suffering or cavalier about symptoms (although some might be). But traditionally, symptoms have come up only during the in-person patient visit. Often it falls to the patient to mention problems with symptoms, and the clinician, understandably, may be focused on the details of the patient’s treatment. According to Basch, studies have shown that about half of cancer patient symptoms go unreported.

In the kind of twist that we’ve gotten used to, an impersonal, computerized system for collecting information on symptoms may do a far better job than the in-person encounter. In February, Basch and his colleagues reported the results of a study in the Journal of Clinical Oncology that showed an association between a computerized system for monitoring symptoms and an assortment of desirable outcomes, including some that would attract the attention of payers: better quality of life, fewer visits to the emergency department, fewer hospitalizations, and longer time on chemotherapy. Basch conducted the study among 766 patients at Memorial Sloan Kettering Cancer Center. The intervention used the web-based Symptom Tracking and Reporting (STAR) system, which asks questions based on a National Cancer Institute list of 12 symptoms commonly experienced during chemotherapy, including nausea, vomiting, pain, and constipation. Patients graded their symptoms on a 5-point scale, ranging from 0 (not present) to 4 (disabling).

The intervention had three interesting elements that may shape such programs once they leave the cocoon of the research project. First, and most fundamentally, patients reported the symptoms themselves by tapping on a computer screen rather than asking questions. Second, patients who were experienced with computers could receive email prompts to report their symptoms. Third, nurses were notified if patient-reported symptoms worsened by 2 points or more, or reached the absolute score of 3 or more. Automation is key, says Basch: “Rather than having 1,000 patients call the clinic on a Friday afternoon you develop a system that will not only prompt patients but also sort out things that warrant a nurse’s attention.”

The difference the symptom monitoring intervention made in emergency room visits (34% vs. 41%) and hospitalizations (45% vs. 49%) weren’t stunning. But consider the costs, and they start to look pretty good. Basch didn’t crunch the numbers for this study but he says they are modest. His take: “The differences are greater than the drugs that are getting approved and that we are spending $10,000 to $12,000 per month on.”

Basch has two grant proposals in the works to the Patient-Centered Outcomes Research Institute to test some of his findings in a larger national study. ASCO and several other organizations are working with him.

**Window of opportunity**

Using computers to have patients self-report their symptoms—it’s pretty basic and not that new. The STAR system has been around awhile. The recruitment of Memorial Sloan Kettering patients into Basch’s study started in 2007. But Miller, at ASCO, says interest in systematically collecting data on the patient experience and symptoms is escalating for a confluence of reasons: the democratization of medical information, the smartphone and the ease with which symptoms can be reported and the data analyzed (in stark contrast to the paper survey), and the expense of today’s oncology drugs. “The question now that’s increasingly being asked: What is their value?” says Miller. “So, I think we’re finally at the point where we recognize that the patient’s perception of value as characterized by their own physical and emotional reactions to treatment or to cancer is probably the most important question, rather than what their doctor thinks is happening to them.”

Vivian Bearing might agree.
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Three Breakthroughs Usher In New Era of Cholesterol Control

Alirocumab, evolocumab, and sebelipase alfa further fuel the discussion about just how to go about covering exciting, but costly, high-priced agents.

Thomas Morrow, MD

Cholesterol would not be the household word it is today if treatments hadn’t been discovered. In the '70s, Japanese researchers identified compactin, which inhibited cholesterol synthesis and lowered LDL levels. But in large doses, compactin caused cancer in dogs, so compactin research hit a dead end. Still, the promise of an agent that reduced “bad” LDL cholesterol level was tantalizing. Merck launched a large-scale trial of lovastatin in 1984, and the FDA approved the drug, sold as Mevacor, in 1987. The statin era, which transformed the prevention of heart disease and remade the pharmaceutical industry, was upon us.

Now we may be starting another chapter in the cholesterol saga, but this time cost may be an antagonist. Last year, the FDA approved two new cholesterol-lowering agents, alirocumab (Praluent) and evolocumab (Repatha). These are fully humanized monoclonal antibodies that inactivate proprotein convertase subtilisin–kexin type 9, hence the shorthand, PCSK9 inhibitors. They are indicated for two groups: those with a rather severe form of hypercholesterolemia called heterozygous familial hypercholesterolemia, and those with atherosclerotic cardiovascular disease who need additional lowering of their LDL. Sure, the PCSK9 inhibitors would have garnered some attention as a new class of drugs, but it’s their price—roughly $1,000 a month—that vaulted them into the headlines and the current storyline of high-priced medications and what are we going to do about them.

Late last year, the FDA approved a cholesterol-related drug that will be even more expensive. Sebelipase alfa, marketed by Alexion under the brand name Kanuma, is a hydrolytic lysosomal cholesteryl ester and triacylglycerol-specific enzyme. It’s approved as a treatment of patients with a diagnosis of lysosomal acid lipase deficiency (LAL-D), a rare autosomal recessive genetic disease affecting between 1 in 40,000 and 1 in 500,000 people.

LAL is an enzyme responsible for the breakdown of cholesterol esters and triglycerides in the liposomes, the small organelles that function as recycling centers inside our cells. Lack of LAL activity leads to an accumulation of these compounds within cells. The liver, spleen, and gastrointestinal tract are particularly affected. Damage to the LAL gene, which sits on the 10th chromosome, can lead to either partial or complete absence of LAL activity.

Survival is rare

In infants born with complete LAL inactivity, symptoms occur within weeks after birth, causing vomiting, diarrhea, poor weight gain, and massive enlargement of the liver and spleen. These infants seldom survive past their first birthday. This presentation is named Wolman disease after the doctor who first described it in 1956.

If the gene is less damaged, it is called cholesteryl ester storage disease (CESD) and symptoms vary according to how much residual LAL activity is left. Some patients aren’t diagnosed till they are middle aged. CESD is easily mistaken for other forms of hypercholesterolemia first diagnosed in middle age such as heterozygous familial hypercholesterolemia, the genetic disease treated with PCSK9 inhibitors.

Kanuma’s developer has chickens to thank for its product. The treatment agent is derived from the eggs of genetically engineered chickens. Human LAL DNA is spliced into the genome of

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chicken embryos. When they mature, they lay nonfertilized eggs that contain human LAL DNA in the egg white that is then isolated and purified in ways similar to other biotech drugs. This line of chickens is sustained by artificially inseminating females with semen collected from roosters that have been genetically engineered.

All of this happens in what has got to be one of the world’s most closely watched, high-tech henhouses. Each producing hen is maintained in a productive mode for 90 days, and then tagged with a unique identification number. Eggs are collected daily for harvest of the egg white and isolation of the LAL. Few chickens have been measured and observed so closely, and extensive data were provided to the FDA on their health and well-being.

Kanuma was studied in two groups of patients. The first study was an open-label, escalating-dosage, non–placebo-controlled study of nine rapidly progressive LAL-D patients who presented in the first six months of life. At one year, 6 of the 9 patients were still alive as compared with a historical expectation of none surviving to one year.

The second study was a multicenter, double-blind, placebo-controlled trial in 66 pediatric and adult patients with LAL-D, but not the rapidly progressing kind. Kanuma was given as an IV infusion at a dose of 1 mg/kg every other week for 20 weeks in the double-blind period. At the start of the trial, 94% of these patients had LDL levels of 130 mg/dL or greater, and 58% had levels of 190 mg/dL or more. About 1 in 4 of those in the high-cholesterol group were on statin therapy. At the completion of the 20-week trial, a statistically significant improvement in LDL was observed in the Kanuma treated group as compared with the placebo group.

The average reduction in LDL levels was 33 mg/dL. A LDL level of less than 130 mg/dL was achieved in 13 of 32 patients treated with Kanuma, compared with only 2 of the 30 placebo-treated patients. But the effect of Kanuma on cardiovascular morbidity and mortality has not been established.

The studies hint of some liver benefits from Kanuma. People taking the medication experienced a drop in alanine transaminase values and liver fat content. But it’s just a hint, and it’s uncertain how those effects relate to the progression of liver disease.

About 3% of patients experienced hypersensitivity reactions consistent with anaphylaxis. One in five patients experienced signs and symptoms that may be related to hypersensitivity. Other adverse events were diarrhea, vomiting, fever, rhinitis, anemia, headache, and a host of nonspecific reactions.

But the real toxicity might be a financial one. A single, 20 mg vial is priced at $10,600. The dosage is 1 to 3 mg/kg every week for rapidly progressive disease and 1 mg/kg every other week for pediatric and adult forms of LAL-D. The price tag for a year of treatment for a child could easily be $250,000 and for a typical adult it could be three or four times as much.

The progress made over the past 60 years is simply remarkable. Since the first description of Wolman disease, scientists have identified the chromosome affected, the exact nature and DNA sequence of the LAL gene, and a number of specific mutations of this gene that account for various presentations of LAL-D. They isolated a normal human LAL gene, transferred it into a chicken, and created a way to isolate the exact enzyme responsible for this genetic condition.

But it’s also easy to get caught up in technological feats and the march of progress and lose sight of how much patients really benefit. Only 13 of the 66 patients in the mild LAL-D trial were able to reduce their LDL levels to 130 mg/dL or less. One in three of the infants with the severe form of the disease still died in the first year of life. The most striking deficit is lack of proof that administration of Kanuma over long periods makes a meaningful difference in progression of liver disease or decrease of cardiovascular morbidity or mortality. This evidence will take years to accumulate, making this a continuing story for Tomorrow’s Medicine.
Fixing Utilization Management To Fit With a Value-Based World

By Tammie Phillips, RN
Vice President of Business Consulting for McKesson Health Solutions

It was the shot heard ’round the health care world. In January 2015, CMS committed to making alternative payment 30% of Medicare reimbursement by 2016 and 50% by 2018. That was the moment, it could be argued, when the transition from fee-for-service to value-based models changed from a pilot for reimbursement change into a mandate.

Value-based health care has two overriding goals: Improve the quality of care and reduce unnecessary cost. Utilization management is one of the ways payers have tried to do just that. But the current way of doing utilization management is designed for a fee-for-service world. It’s also disliked by providers and patients alike. Utilization management as we know it today positions providers and payers against each other.

Get rid of adversarial relationship
Providers end up resenting care decision approvals, many of which occur after care is already provided, and payers get cast as prioritizing cost containment over quality. There’s no place for such an adversarial relationship in value-based care, which frequently depends on providers and payers sharing risk. Payers need to engage providers in the process of cost savings and high quality care. And trust must be part of the equation, something sorely lacking in the current utilization management system.

Value-based care also requires collaboration, yet during the claims process—the primary engagement between providers and payers—every step is transactional and sequential, not collaborative. We need to invert that. Providers should be ensuring medical appropriateness and considering issues of member benefits while care is being delivered.

It’s no secret the U.S. health care system wastes billions on manual transactions and remediation. A study published in 2013 in the Journal of the American Board of Family Medicine said that the mean annual projected cost for preauthorization activities ranged from $2,161 to $3,430 per physician. Cornell researchers published a study in Health Affairs that found that provider office nursing or administrative staff spent 13.1 hours per physician per week on preauthorization, far more than any other type of administrative interaction. This time is due to the back-and-forth interactions between a payer and the provider office to determine the final outcome of authorization requests.

Is this producing results? The Health Affairs study points out that, “although it is easy to portray administrative costs as ‘waste’, it is important to emphasize that these costs can never be zero and that the interactions that generate these costs may produce benefits as well.”

Prior authorization and formulary requirements may reduce costs and improve the quality of care “to the extent that they reduce inappropriate provision of services and promote the use of appropriate procedures and medications.” Dealing with multiple health plans can generate “the benefits that can flow from competition, including innovation and increased patient choice.”

On the other hand, a Kaiser Family Foundation study reported that the United States spends significantly more on health care than other nations, both on a per-capita basis and relative to its wealth. Moreover, U.S. spending on health care was 42% higher than Norway, the next highest per capita spender.

Despite spending considerably more, U.S. health care system performance ranks last in comparison to other industrialized countries, according to the Commonwealth Fund.

We have a utilization management process. We have guidelines. We have evidence. But we’re not using them effectively. Who wants to be admitted to a hospital if they don’t have to? Who wants spine surgery if it’s not warranted? Certainly providers and payers are conceptually aligned on what matters: Providers want to deliver the right care and payers want to pay for the right care. When researchers run the numbers, however, it becomes clear that traditional utilization management isn’t living up to its full potential.

That’s the bad news. The good news: By employing a new process designed for a value-based world, payers can influence decisions as they’re being made, streamline the administrative burden, and better engage providers in a collaborative relationship that supports value-based care.
How do we get from a broken traditional utilization management system to a new one that will work in value-based care? Payers need a way to apply automation to authorization based on data—the latest medical evidence, provider utilization patterns, and value rankings—and do so in real-time with little to no burden on providers. Likewise, providers need to share information collaboratively with payers and adjust when care patterns reveal insights on efficiency and patient outcome.

**Point of decision**

This new, real-time model that McKesson has developed and implemented successfully at over 20 customer sites uses data to automate much of today’s onerous authorization processes.

This improved process helps ensure that communication among stakeholders happens at the point of decision through the use of health care technology in the cloud. This kind of utilization management doesn’t require a review of every transaction. Instead, it is exception based, meaning the vast majority of approvals happen automatically and instantly. Only the exceptions—those transactions that can’t be determined automatically based on clinical and business rules—are manually reviewed. This new approach may also reward physicians who practice evidence-based care by giving them more freedom and dramatically reducing the administrative cost and burden.

Instead of the current manual authorization process, providers in the exception-based model can access a payer’s clinical guidelines and payer rules automatically, informing their care decisions. A provider will get an immediate automated approval or denial, or be notified that a claim has been tagged for manual review.

The level of prior authorizations required are based on how well a provider’s practice patterns align with evidence-based practices. Payers can set looser requirements and lower hurdles for those providers who are frequently approved. Meanwhile, tighter requirements can be set for those providers who frequently request care that the evidence indicates is not medically necessary.

Once authorization requests are being submitted consistently to the system, the payer can query the database to see how often care decisions are being approved for any particular provider and identify outliers. Data analytics identify practice patterns and variations. The hope is that underperformers can eventually be brought into alignment with the clinical guidelines and payer rules, further reducing the need for manual interventions.

Compare this new exception-based model to the current system, where payers and providers incur significant administrative costs and burden on prior authorizations that, in the end, are approved, often delaying patient care. Now it can take just a few minutes to get an approval, instead of days or weeks. And once providers are practicing in line with evidence and a payer’s policies, approval may become automatic or may not even be required.

When payers and providers can collaborate on care instead of being trapped in a transactional relationship, that’s a true advancement. Prior auth starts to look like a notification from the provider rather than a request for approval. The provider might spend 20 seconds on an authorization instead of hours, days, or weeks. Better still, the provider is no longer in the long-derided “Mother may I?” role.

For payers, using exception-based utilization management can take an enormous load off the system, freeing staff to focus on those fewer providers causing waste or areas where there is great variation. Payers only touch transactions when they’re slated for further review or when an intervention is required.

Why now for this exception-based utilization management? First, we finally have the technology available to make it happen. Cloud-based technology that combines contemporary connectivity with stakeholders’ existing care management systems, payer portals, and IT infrastructure is now available. This cost-efficient, service-oriented, “embrace-and-extend” approach quickly and easily connects a provider’s and payer’s workflow.

**Transformation accelerates**

Second, the tide has turned away from fee for service toward value-based care. As the pace of the value-based payment transformation accelerates, the payer-provider relationship must be aligned and collaborative. Technology and information must be shared. Payers can earn the trust of providers who are practicing based on the medical evidence and reward them for it with utilization management that makes review the exception rather than the rule. And providers will be able to deliver quality care faster and for less cost.

Automated, exception-based utilization management is in step with the future of reimbursement and makes optimal use of the robust technical capabilities at our disposal today. It might well be one of the biggest steps we can take to help payers and providers meet CMS’s ambitious value-based payment objectives and the larger goal of a value-based health care system.

_Tammie Phillips of McKesson Health Solutions speaks frequently about how to manage value-based care._

**MARCH 2016 / MANAGED CARE**

**45**
WHERE THE MONEY GOES

Percent of U.S. health care spending by 7 core health consumer segments

SNAPSHOT

FRAIL ELDERLY
Over 75, living at home and facing health issues related to falls or dementia and suffer generally poor health.
% of population: 1.9%
- Spending per capita: $16,010
- Out-of-pocket spending: $2,050
- Office visits: 13.9
- Retail drug spending: $2,558
- Scripts per capita: 34.4

COMPLEX CHRONIC DISEASE
One or more chronic diseases affecting multiple body systems.
% of population: 7.9%
- Spending per capita: $11,284
- Out-of-pocket spending: $1,197
- Office visits: 10.2
- Retail drug spending: $3,894
- Scripts per capita: 30.3

CHRONIC DISEASE
Problems affecting a single body system such as hypertension.
% of population: 56.2%
- Spending per capita: $4,803
- Out-of-pocket spending: $709
- Office visits: 6.2
- Retail drug spending: $951
- Scripts per capita: 12.0
HEALTHY FAMILIES
Households with healthy dependent children under age 18.
% of population: 19.8%
- Spending per capita: $1,135
- Out-of-pocket spending: $167
- Office visits: 1.4
- Retail drug spending: $53
- Scripts per capita: 0.7

MENTAL ILLNESS
Depression, mood disorders, PTSD, addictions, and suicidal ideation.
% of population: 3.0%
- Spending per capita: $2,490
- Out-of-pocket spending: $526
- Office visits: 5.3
- Retail drug spending: $712
- Scripts per capita: 6.9

Source: PricewaterhouseCoopers, “Primary Care in the New Health Economy: Time for a Makeover,” November 2015
### Per capita annual spending for 7 core consumer health markets

<table>
<thead>
<tr>
<th>Market</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail elderly</td>
<td>$16,010</td>
</tr>
<tr>
<td>Complex chronic disease</td>
<td>$11,284</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>$4,803</td>
</tr>
<tr>
<td>Mental illness</td>
<td>$2,490</td>
</tr>
<tr>
<td>Healthy families</td>
<td>$1,135</td>
</tr>
<tr>
<td>Healthy adult skeptics</td>
<td>$603</td>
</tr>
<tr>
<td>Healthy adult enthusiasts</td>
<td>$1,291</td>
</tr>
</tbody>
</table>

### Total U.S. retail drug spending by 7 core health consumer segments

(in millions)

<table>
<thead>
<tr>
<th>Market</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail elderly</td>
<td>$14,762</td>
</tr>
<tr>
<td>Complex chronic disease</td>
<td>$96,912</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>$167,607</td>
</tr>
<tr>
<td>Mental illness</td>
<td>$6,665</td>
</tr>
<tr>
<td>Healthy families</td>
<td>$3,315</td>
</tr>
<tr>
<td>Healthy adult skeptics</td>
<td>$659</td>
</tr>
<tr>
<td>Healthy adult enthusiasts</td>
<td>$3,037</td>
</tr>
</tbody>
</table>

### Care needs for the 7 core consumer health markets

- **Frail elderly**: Intense care management and coordination. Ideal candidates for 24/7 remote monitoring and clinician house calls.
- **Complex chronic disease**: Intense care management and coordination, 24/7 remote monitoring, clinician house calls, patient-centered medical homes, and nurse-managed clinics.
- **Chronic disease**: Population-based care teams, specialized nurse clinics, and retail clinics that offer disease management.
- **Mental illness**: Medical homes with integrated behavioral health services, on-demand telehealth.
- **Healthy families**: Digital options; convenient care clinics; and preventive, wellness, and integrative services.
- **Healthy adult skeptics**: Digital health options, retail clinics, clinician house calls.
- **Healthy adult enthusiasts**: Digital options, convenient care clinics; and preventive, wellness, and integrative services.

Source: PricewaterhouseCoopers, “Primary Care in the New Health Economy: Time for a Makeover,” November 2015
What physicians think about new primary care models

<table>
<thead>
<tr>
<th>Convenient care (retail clinics)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases patient satisfaction</td>
<td>47%</td>
</tr>
<tr>
<td>Increases access</td>
<td>69%</td>
</tr>
<tr>
<td>Do not now partner with or plan to partner with a retail clinic</td>
<td>83%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concierge care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concierge care will increase over the next decade</td>
<td>71%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Digital health</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Would rely on certain DIY test results to prescribe medicine</td>
<td>42%</td>
</tr>
<tr>
<td>Implementing technology to teleconsult with patients and families</td>
<td>16%</td>
</tr>
<tr>
<td>PCPs will rely more on mobile apps and wearables</td>
<td>85%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Independent practice nurse-led care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse practitioners/physician assistants should lead their own patient panels</td>
<td>56%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>House calls</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonphysician house calls will increase over the next 10 years</td>
<td>79%</td>
</tr>
</tbody>
</table>

What consumers think about new modes of primary care

<table>
<thead>
<tr>
<th>Convenient care (retail clinics)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Visited a retail clinic in the past year</td>
<td>36%</td>
</tr>
<tr>
<td>Satisfied with care</td>
<td>95%</td>
</tr>
<tr>
<td>Would recommend retail clinics</td>
<td>89%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concierge care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value high patient-satisfaction scores when choosing providers</td>
<td>76%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Digital health</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Open to a virtual doctor's visit</td>
<td>60%</td>
</tr>
<tr>
<td>Would use a DIY diagnostic test</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Independent practice nurse-led care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Would see a nurse practitioner or physician assistant for care</td>
<td>75%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>House calls</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested in in-home care</td>
<td>66%</td>
</tr>
</tbody>
</table>

DIY=do-it-yourself.