

# MCOL MONTHLY

MCOL Monthly is an e-magazine exclusively for MCOL Paid members, providing a compilation of key articles and features from the MCOL paid member web site and paid member e-newsletters.

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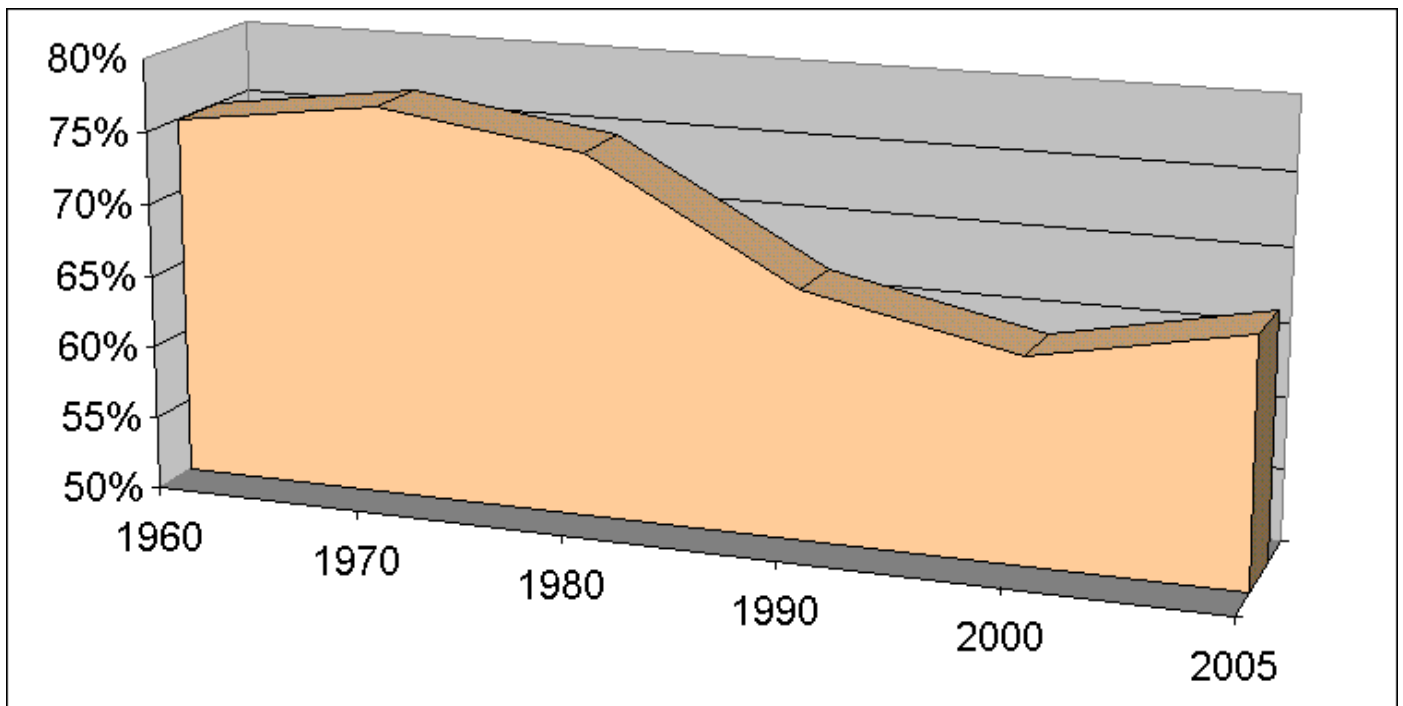


# Trends

A featured trend compiled by MCOL • Appearing in the MCOL Paid member web site for December, 2008

## Community Hospital Occupancy Rates

United States: 1960 – 2005

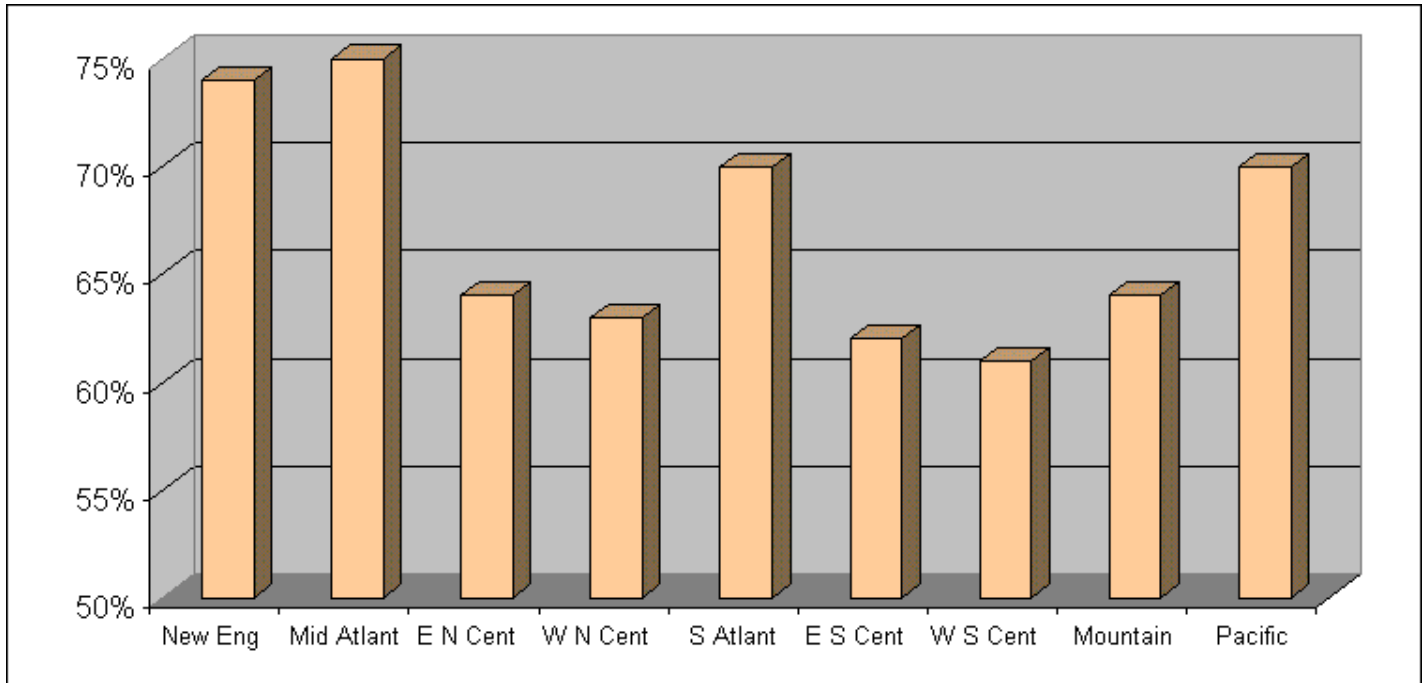


**Source:** National Center for Health Statistics, CDC, DHHS: Health 2007; Table 116. Occupancy rates in community hospitals and average annual percent change, by geographic division and state: United States, selected years 1960–2005; <http://www.cdc.gov/nchs/data/hus/hus07.pdf#116>



## Trends continued

### By Region: 2005



### Table

Region	1960	1970	1980	1990	2000	2005
New England	75%	80%	80%	74%	70%	74%
Middle Atlantic	78%	82%	83%	81%	74%	75%
East North Central	78%	80%	77%	65%	61%	64%
West North Central	72%	74%	71%	62%	60%	63%
South Atlantic	75%	78%	76%	67%	65%	70%
East South Central	72%	78%	75%	63%	59%	62%
West South Central	69%	73%	70%	58%	58%	61%
Mountain	70%	71%	70%	61%	61%	64%
Pacific	71%	71%	69%	64%	65%	70%
United States	75%	77%	75%	67%	64%	67%

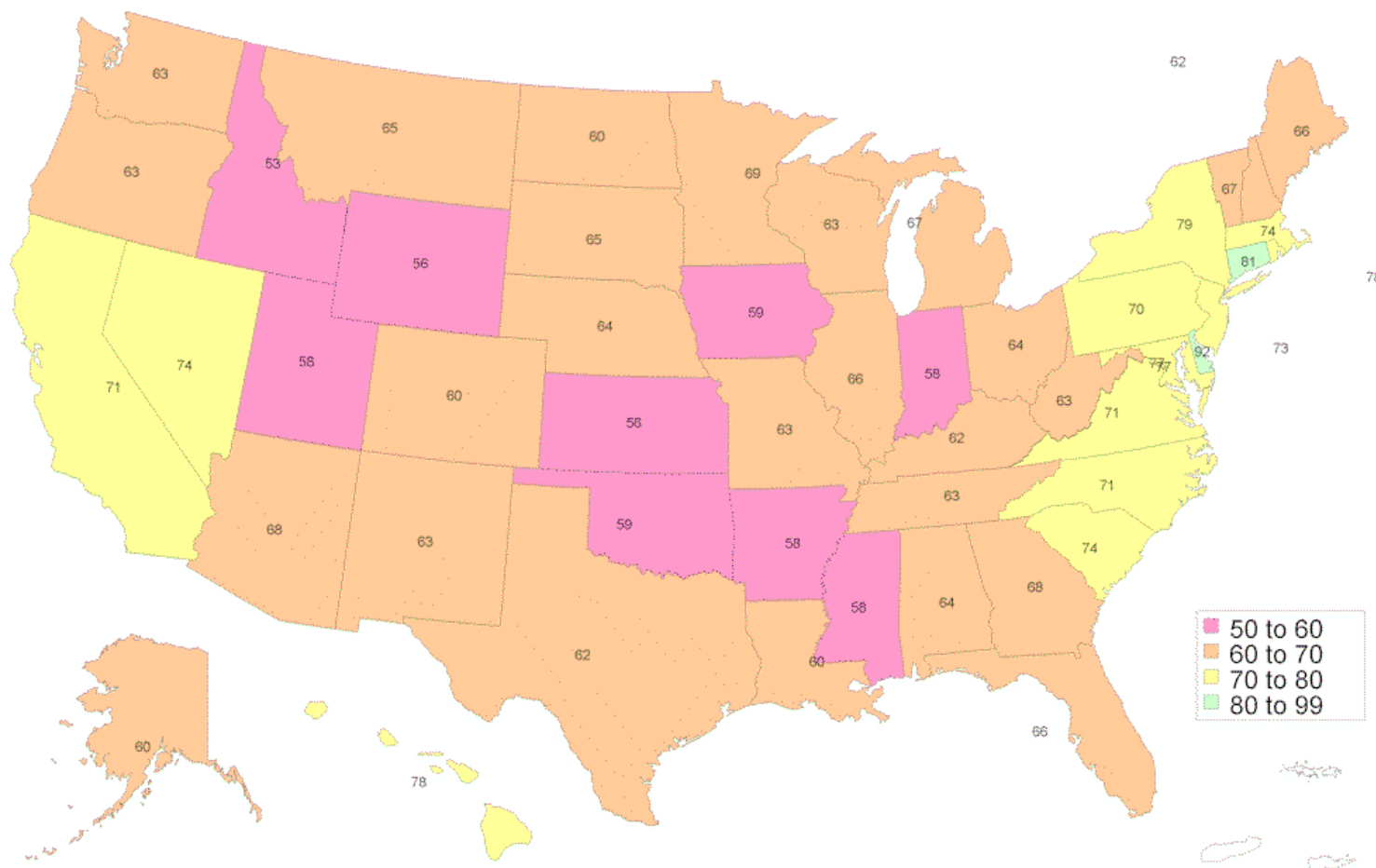


# Data Map

A featured data map compiled by MCOL • Appearing in the MCOL Paid member web site for December, 2008

## December 2008

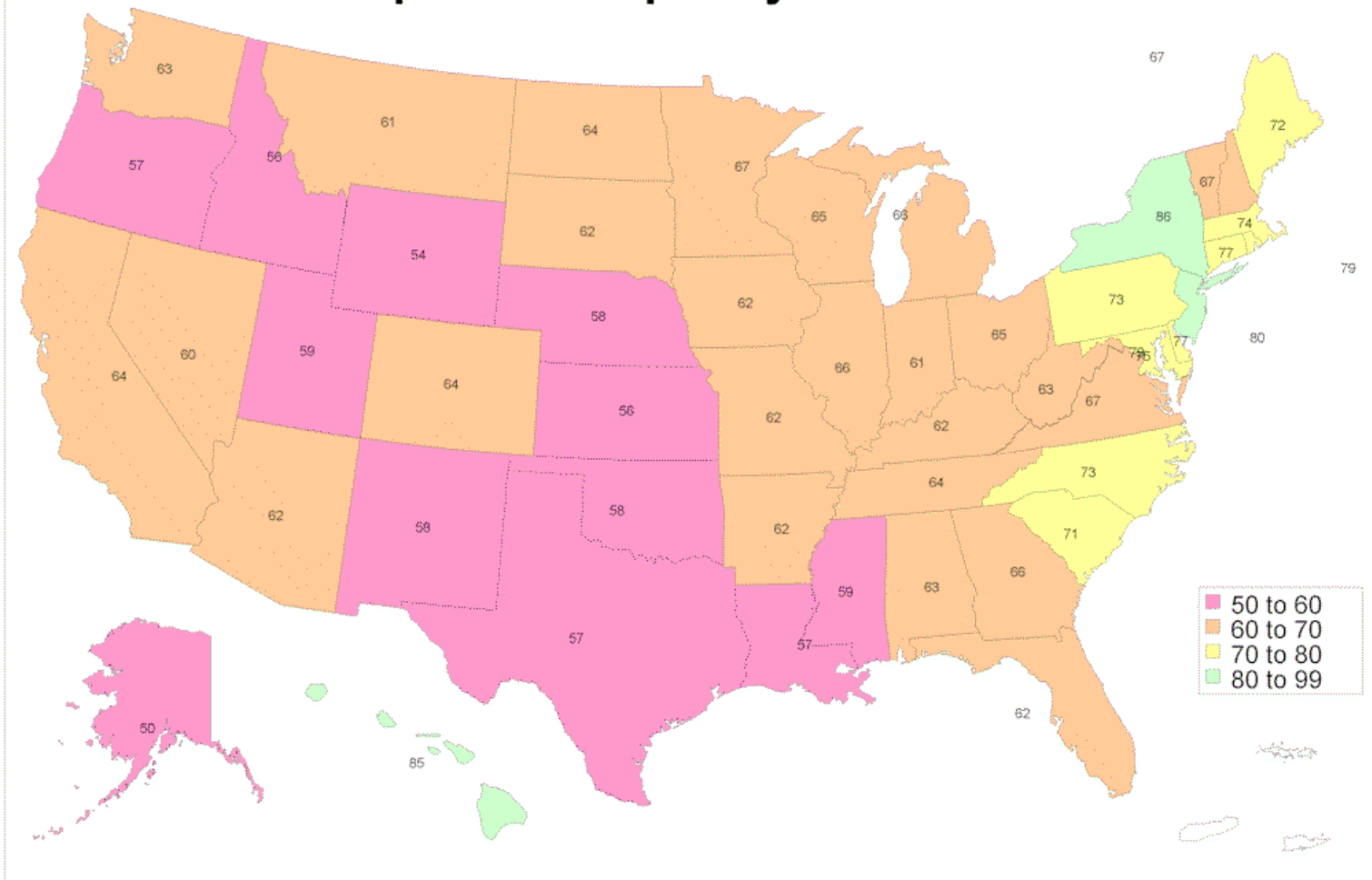
### Hospital Occupancy Rates 2005





**Data Map continued**

## Hospital Occupancy Rates 1990





## Data Map continued

**Table:**

State	1990	2005	State	1990	2005
Alabama	63%	64%	Missouri	62%	63%
Alaska	50%	60%	Montana	61%	65%
Arizona	62%	68%	Nebraska	58%	64%
Arkansas	62%	58%	Nevada	60%	74%
California	64%	71%	New Hampshire	67%	62%
Colorado	64%	60%	New Jersey	80%	73%
Connecticut	77%	81%	New Mexico	58%	63%
Delaware	77%	92%	New York	86%	79%
DC	75%	77%	North Carolina	73%	71%
Florida	62%	66%	North Dakota	64%	60%
Georgia	66%	68%	Ohio	65%	64%
Hawaii	85%	78%	Oklahoma	58%	59%
Idaho	56%	53%	Oregon	57%	63%
Illinois	66%	66%	Pennsylvania	73%	70%
Indiana	61%	58%	Rhode Island	79%	78%
Iowa	62%	59%	South Carolina	71%	74%
Kansas	56%	56%	South Dakota	62%	65%
Kentucky	62%	62%	Tennessee	64%	63%
Louisiana	57%	60%	Texas	57%	62%
Maine	72%	66%	Utah	59%	58%
Maryland	79%	77%	Vermont	67%	67%
Massachusetts	74%	74%	Virginia	67%	71%
Michigan	66%	67%	Washington	63%	63%
Minnesota	67%	69%	West Virginia	63%	63%
Mississippi	59%	58%	Wisconsin	65%	63%
			Wyoming	54%	56%

**Source:** National Center for Health Statistics, CDC, DHHS: Health 2007; Table 116. Occupancy rates in community hospitals and average annual percent change, by geographic division and state: United States, selected years 1960–2005; [http://www.cdc.gov/nchs/data/07.pdf#116](http://www.cdc.gov/nchs/data/hus/07.pdf#116)



# How-To

Tips on health management and managed care methodologies • From the Nov/Dec 2008 @How-To e-Newsletter

## Deductible Management

### In this Issue

Mercer has just released results from their 2008 National Survey of Employer Sponsored Health Plans, which indicated the median individual PPO deductible has increased to \$1,000. This figure was just for traditional PPO plans, and not even include data from consumer driven high deductible health plans. Certainly the ongoing increase of consumer cost sharing built into plan design, and the growth in consumer driven high deductible health plans that has paved the way for the trend and acceptance in higher deductibles in traditional PPO plans as well.

In this issue of @How-To, we discuss the concept of Deductible Management from a plan perspective, and address a number of topics related to understanding and addressing the deductibles. This issue updates and expands upon content from the December 2006 edition of @How-To. We address the topics of:

- Deductible Management
- Deductible Requirement
- Deductible Consumption
- Factors in Deductible Consumption
- Deductible Plan Design
- Deductible Distribution Data

### Deductible Management

The traditional health plan approach to managing member medical costs and resources might be less effective during the phase when members have not met their deductible requirement. Because the deductible requirement is focused solely on a dollar amount, the focus of deductible management must also be on the cost, versus units of service and resources.

Because the member bears financial responsibility for services rendered until the deductible requirement is met, and these services are the first to be rendered (for applicable benefits) to the member during a plan year, the focus must also be consumer oriented.



## **How to continued: Deductible Management**

The concept of Deductible Management is to ensure certain consumer centric tools are in place, including price transparency, provider selection, and account status, and to promote plan resources that can further support members to most effectively use resources during the deductible consumption phase. Furthermore, a Deductible Management for a plan should proactively provide disease management and other services during the deductible consumption phase for targeted members, and strive to encourage members to receive needed medical services instead of deferring them solely for economic reasons.

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### **Deductible Requirement**

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A deductible requirement in a health plan policy provides that payment for covered benefits will be net of a fixed dollar amount stipulated to be the deductible. For purposes of this discussion, Deductibles will be considered to be an annual requirement. (There are also specific service “deductibles” in various health policies that are per incident or episode, but these really function as a copayment.) By definition, an annual deductible requirement means that no payments for any applicable covered benefits will be applied during a plan year until covered cumulative claims for services exceed the full deductible amount during the course of that year. When a new plan year begins, the cumulative claims are reset to zero.

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### **Deductible Consumption**

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Deductible consumption refers to the portion of the deductible requirement that has been met at a given point in time (the cumulative claims to date during a plan year compared to the deductible requirement.) Typical analysis of deductible consumption for a plan member population identifies the percentage of members that fall between assigned dollar ranges of cumulative claims per member (or family) after the close of a plan year. Unlike calculations of annual medical costs per member, (which is expressed as the sum of utilization per member \* cost per unit for all categories of covered services;) deductible consumption can't always be broken down for analysis into both a utilization and cost per unit component. Instead the analysis must focus on dollars consumed, based upon multiple factors potentially affecting the consumption.

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### **Factors in Deductible Consumption**

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- Plan Design - other plan design features will impact deductible consumption. For example, exclusions and restrictive limitations on coverage reduce potential consumption. Deductible plan design(s) (discussed below) can have a significant impact, particularly when multiple deductible features are incorporated into the same plan.



## How to continued: Deductible Management

- Type of Service – The type of service rendered that is being applied to a deductible largely dictates the other variables involved in deductible consumption. The nature of a service establishes the general price range, utilization and potential patient behavior involved. For example, a typical hospitalization is going to be priced significantly higher than a typical prescription, and the utilization rates for hospitalizations per person per year are going to be significantly lower than prescriptions per person per year.
- Pricing – Pricing for a given service can vary widely by the provider selected. Pricing for certain services are much more readily available and accessible on a prospective basis than others.
- Contract Rates – In nearly all managed care policies, contract rates still apply to services rendered by contracted providers that fall under the deductible requirement. Contract rates are typically not as publicly available as retail pricing, although some health plans have recently undergone initiatives to make certain contract rates available to their members.
- Utilization – The larger the deductible requirement, the greater the impact of utilization will be on deductible consumption. Furthermore, the lower the price per unit of a given service, the greater the impact of utilization will be on deductible consumption.
- Behavior – Several aspects of potential member behavior can impact deductible consumption. In general, an assumption can be made the a member can be more financially prudent and motivated in seeking provider services when the member is aware they will be paying for the services due to the deductible requirement. Thus both price (through provider selection and price comparisons) and utilization can be affected. The corollary to this however, is that members might defer needed medical services due to economic reasons. As a member nears completion of a deductible requirement, the opposite can sometimes be true, particularly if it is near the end of a plan year: A member might seek services they had been undecided about receiving in order to get benefit value from the plan. Furthermore, various Behavioral Economics concepts can impact member deductible consumption.
- Regionalization- pricing and utilization are impacted by regional market and health delivery characteristics. Thus deductible consumption based upon the same exact services for patients of the same health condition and demographic categories will still experience variations based upon these regional factors.
- Open enrollment - when multiple plans and or plan options are provided in annual open enrollment periods that involve different plan designs including varying deductible amounts, deductible consumption for a given plan option will be impacted by the demographic of the members selecting that option, in regard to the variances of that demographic in consumption compared to other enrollees for that group.



## How to continued: Deductible Management

### Deductible Plan Design

- General Deductible – A general deductible applies the deductible requirement to all, or nearly all covered benefits under a plan
- Specific Deductible – A specific deductible applies the deductible requirement to just a specific benefit, such as inpatient hospitalizations.
- Individual and Family Deductibles – Plan typically have two separate deductible requirements: an individual deductible for members with single coverage, and a higher family deductible for members with family coverage.
- Aggregate Deductibles - For family deductibles, some plans require an individual deductible for each family member (typically up to a specified maximum number of family members), while others arrange an aggregate (cumulative) deductible that applies to the entire family, regardless of which family members applied expenses towards the deductible.
- Tiered Deductibles – Many plans will tier deductible requirements when there are tiered benefits in that plan. For example, a PPO plan might have a lower deductible requirement when services are received from participating providers and a higher deductible requirement when services are received from non participating providers.
- Other first dollar coverage – Plans will sometimes have specific services that are exempted from a general deductible requirement. For example, many consumer driven health plans provide a first dollar wellness benefit that is not subject to the deductible requirement.
- Coordination of Benefits – If the member is also covered by a second policy, coordination of benefits may occur providing coverage in some situations from that second plan for the services subject to the deductible requirement.
- Embedded Deductibles – An example of an embedded deductible is a family deductible requirement of \$1,000 that limits the deductible requirement for any individual to \$500. In this case the \$500 individual deductible is “embedded” in the family deductible requirement.
- Carry Over Deductibles – Many plans include a carry over deductible provision, allowing expenses incurred in the last defined period (often 90 days) of the previous plan year to count towards the deductible requirement in the current plan year.
- Doughnut Hole - this refers to a secondary deductible, such as in The Medicare Part D prescription drug benefit. For example, for Medicare Part D in 2009, the standard benefit involves a \$295 deductible, with 75% coverage/25% coinsurance between \$296 to \$2,700 in covered services. Then the “secondary” deductible applies from \$2,701 and \$6,153.75 in covered services; and finally 95% coverage is provided after the “secondary” deductible requirement is met (or a copayment of \$2.40 for covered generics and \$6.00 for covered brand-name drugs—whichever is greater)



## How to continued: Deductible Management

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### Deductible Distribution Data

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The following addresses the distribution and prevalence of deductibles in employer sponsored health plans, with data from the Kaiser/HRET Survey of Employer -Sponsored Health Benefits, 2008 <http://ehbs.kff.org>

- 20% of single HMO coverage employees, and 21% of family HMO coverage employees have a general deductible requirement
- 68% of single PPO coverage employees, and 68% of family PPO coverage employees have a general deductible requirement
- The average single coverage general deductible amount for employers with under 200 employees is \$917 for PPOs, and 1959 for High Deductible Health plans. The average single coverage general deductible amount for employers with over 200 employees is \$307 for HMOs, \$413 for PPOs, and \$1,599 for High Deductible Health plans.
- The distribution by deductible level for employees with single coverage under PPOs is 52% under \$500; 30% \$500 - \$999; 13% \$1,000 - \$1,999 and 4% \$2,000 or more.
- For families with deductible requirements, 71% with PPO or HMO coverage have an aggregate deductible and 29% have individual deductible requirements for each family member; and 93% of High Deductible Health Plans use an aggregate deductible and 7% have individual deductible requirements for each family member.
- The average aggregate family coverage general deductible amount for employers with under 200 employees is \$2,367 for PPOs, and \$3,897 for High Deductible Health plans. The average aggregate family coverage general deductible amount for employers with over 200 employees is \$626 for HMOs, \$948 for PPOs, and \$3,089 for High Deductible Health plans.
- The distribution by aggregate deductible level for employees with family coverage under PPOs is 11% under \$500; 38% \$500 - \$999; 32% \$1,000 - \$1,999 and 19% \$2,000 or more.
- The following service are not subject to the general deductible requirement (thus having first dollar coverage) for the applicable % of covered employees with a general deductible: Prescriptions (82% HMO, 92% PPO, 82% HDHPs); Preventive Services (85% HMO, 89% PPO, 91% HDHPs); Primary Care Visits (87% HMO, 76% PPO).
- For HSA HDHPs, the distribution of employees with single coverage by deductible level is 38% under \$1,500; 24% \$1,500 - \$1,999; 30% \$2,000 - \$2,999 and 9% \$3,000 or more. The distribution for family coverage is 17% under \$2,500; 13% \$2,500 - \$2,999; 28% \$3,000 - \$3,999; 10% \$4,000 - \$4,999 and 32% \$5,000 or more



## How to continued: Deductible Management

- 57% of employees with HMO coverage and 30% with PPO coverage have a specific deductible or separate set copay for each hospital admission. .50% of employees with HMO coverage and 26% with PPO coverage have a specific deductible or separate set copay for each outpatient surgery episode.
- The average specific deductible per hospital admission is \$495 for HMOs, and \$354 for PPOs.

In regard to expenditure distribution, the most recent data from the AHRQ Medical Expenditure Panel Survey indicates the following percentage of persons with total health expenditures above selected thresholds by age for services incurred in 2005:

Age	>\$7,500	>\$15,000
<18	2.5%	1.0%
18-44	6.2%	2.4%
45-64	14.0%	6.2%
65+	29.5%	14.8%
All Ages	10.2%	4.6%

Source: Medical Expenditure Panel Survey

<http://www.meps.ahrq.gov/mepsweb>

MEPS Statistical Brief #217, August 2008, Agency for Healthcare Research and Quality

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Faculty:  
**John Linss**  
President & CEO,  
MedicaView International





# Tips

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In getting the most out of your MCOL paid membership

- MCOL Paid Members get a complimentary pass to the Future Care Web Summit, which includes a live webinar Thursday January 22<sup>nd</sup>, plus features available 24/7 including additional faculty downloadable podcasts, an article library, the future care e-poll and more.
- The new HealthExecMobile e-newsletter has been formatted for readability with your PDA, iPhone or other mobile device, but is still fully useful and functional when viewing from your laptop or desktop.
- Track daily news for managed care and other health care topics from the paid member web site by clicking “Daily News” from the main menu, where you can select from nine daily news features offered from six leading services. Choices include:
  - “News Round the Web” compiled by MCOL, with news summaries and full text links to a wide variety of media sources and a particular emphasis on managed care, hospital and HIT issues
  - FeedDirect Health Management, Insurance Industry, Pharma, and Clinical News for MCOL, with each of these four FeedDirect features providing domestic and international headlines and full text links for their daily stories
  - “Benefits Buzz” from BenefitsLink.com with a menu of twenty benefit related topics, each with story summaries and full text links
  - “BusinssWire's Healthwire for MCOL”, where you can browse and select from any of the past seven day's Business Wire health care related releases.
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- If you're looking for specific content in the member web site and aren't sure how to find it, feel free to e-mail or call MCOL anytime and we'll assist you with your search, free of charge.



# Blog

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A selected Blog entry from the month of November, 2008 from MCOLBlog.com

## 15 Big Health Care Business Questions for 2009 and beyond

By Clive Riddle

*The impact of reform, recession, technology and emerging initiatives*

Here's a list of 15 questions to ask as we start to ponder the upcoming new year which will close out this decade:

1. Reform: What final health care reform package will emerge from the new administration and Congress, what will be the timing, and what portions of it will get adopted, given the current recession/financial crisis?
2. Regulation: Will significantly increased regulation ensue, with the compliance environment become even more stringent?
3. Medicare Advantage: Assuming Medicare Advantage health plan compensation is further targeted, will plans accelerate mass market withdrawals as they did prior to the MMA increases?
4. Consumer Driven Plans: Will the Democratic congress and the new administration diminish the viability of account based consumer driven health plans?
5. Patient Collections: How deep will be the impact of provider collection problems with higher consumer cost sharing in the current financial climate, and will there be any new initiatives from the hospital industry or other provider in response?
6. Patient Deferral of Care: In a recession environment, will consumers further defer and adjust their health care utilization and spending, even at long term detriment to their health?
7. Funding Wellness: Will immediate health benefit cost pressures trigger reduced support for initiatives that require longer term ROI, such as wellness incentives?
8. Tighter Managed Care: Will health benefit cost pressures fuel a demand and acceptance for a return to more stringent managed care delivery and care management?



## **Blog Continued: 15 Big Health CareBusiness Questions for 2009, continued...**

9. Payment Reform: How widespread will provider payment reform initiatives evolve, advance and be adopted?
10. Medical Homes: To what degree will medical homes take hold, and how different vs. standardized will medical home initiatives evolve?
11. Fights over the Shrinking Pie: Will specialty physicians associations organize to more actively combat medical home, p4p and other payment reform initiatives if they are perceived as realigning distribution of physician compensation more towards primary care or further reducing income?
12. Investment Income: How deep will the ultimate impact of reduced investment income be upon health plans and health care institutions, and will it cause fundamental changes in investment portfolios, rate increases or reduced staffing or services?
13. Mergers and Acquisitions: Will the fallout of financial pressures cause an acceleration in Mergers and Acquisitions in the various health care industry components, or will tighter financial markets and conditions combined with increased regulatory scrutiny dampen the M&A environment?
14. EHR spending conundrum: A conundrum exists over the need for massive infrastructure and conversion spending on EHR initiatives and related issues such as ICD-10 coding in order to make the health care system more efficient, versus the immediate need to reduce cost pressures in the current financial climate: So will these initiatives lose or gain momentum?
15. Health Portals: Will one or more consumer health portals/web personal health records, such as Microsoft's Healthvault or GoogleHealth emerge to achieve the same level of consumer significance as online banking/bill payments or social media such as Myspace/Facebook?

So what questions can you add to the list for 2009?



# Blog

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A selected Blog entry from the month of November, 2008 from MCOLBlog.com

## What can we deduce about Deductibles?

By Clive Riddle

### ***Mercer's Study finds the median individual deductible jumps to \$1,000***

Mercer just released results from their 2008 National Survey of Employer-Sponsored Health Plans, with headlines declaring "\$1,000 health plan deductible was the norm in 2008." And this was just for traditional PPO plans, not counting consumer driven high deductible health plans. And this was the median figure, not the mean which is more susceptible to skewing upwards given the wide range of benefit design out there. And this was for individual, not family coverage.

Certainly the ongoing increase of consumer cost sharing built into plan design, and the growth in consumer driven high deductible health plans that has paved the way for the trend and acceptance in higher deductibles in traditional PPO plans as well. As Blaine Bos, of Mercer tell us, "The introduction of the HSA may have changed employers' thinking on just how high a deductible can go without causing employees to revolt. Raising the deductible has become the fallback for employers faced with cost increases they can't handle. It's the easiest way to reduce cost without taking more out of every employee's paycheck."

But not so fast, there's a little more to the deductible story than just \$1,000 individual deductibles. Deductible amounts are quite different for small versus large employers. Mercer found the median deductible for large employers is just \$300. Other surveys have borne this out as well. The Kaiser Family Foundation/HRET Employer Health Benefits Annual Survey yielded lower deductible amounts for traditional PPOs, but with the same separation by size: a mean of \$560 overall, but \$917 for small employers and \$413 for large employers.

It also shouldn't be glossed over that the KFF/HRET study found the mean deductible at \$560, a far cry from \$1,000. Too bad KFF didn't share what the median was, but they report the following distribution: 52% under \$500; 30% \$500 to \$999; 13% \$1,000-1,999; and 4% \$2,000+.

The trend for first dollar coverage of wellness and certain value-based benefits should be noted as well. While deductibles are rising fast, more employers are adopting plans designs with first dollar coverage for specific wellness and "value based" items. This at least make a larger deductible a little more palatable, and allows plan design to influence desired objectives.



# Tidbits

A featured column in each edition of the MCOL Weekend e-newsletter

## Investment Income Woes for Health Plans

Appearing in the November 1, 2008 MCOL Weekend

Third Quarter reports are streaming out from the major health plans, and as expected, investment income has been pummeled, resulting in lowered net income and revised earnings per share guidance:

- Aetna lowered its Earning Per Share guidance for the full year 2008 from \$4.00 to between \$3.90 and \$3.95.
- CIGNA lowered its Earning Per Share guidance for the full year 2008 from between \$4.05 and \$4.25 to between \$3.40 and \$3.50.
- Humana lowered its Earning Per Share guidance for the full year 2008 from \$4.35 to \$3.85.
- WellPoint lowered its Earning Per Share guidance for the full year 2008 from between \$5.42 and \$5.57 to between \$5.43 and \$5.49.
- UnitedHealthGroup's revised Earning Per Share guidance for the full year 2008 is between \$2.57 and \$2.60.

Here's a financial summary from some of the major plans releasing reports so far:

(millions)	3Q08	3Q07	YTD08	YTD07
<b>Aetna</b>				
Investment Portfolio	\$18,520.5	\$16,162.7		
Investment Income	\$229.8	\$262.1	\$731.7	\$864.9
Total Revenue	\$7,624.5	\$6,961.3	\$23,191.4	\$20,455.2
Net Income	\$277.3	\$496.7	\$1,189.4	\$1,382.6
% Invest Inc/Rev	3.0%	3.8%	3.2%	4.2%
% Invest Inc/Net Inc	82.9%	52.8%	61.5%	62.6%
<b>Humana</b>				
Investment Portfolio	\$6,455.9	\$6,690.8		
Investment Income	(\$16.7)	\$82.4	\$154.0	\$227.9
Total Revenue	\$7,148.2	\$6,319.6	\$21,458.7	\$18,951.2
Net Income	\$183.0	\$302.4	\$473.1	\$590.5
% Invest Inc/Rev	-0.2%	1.3%	0.7%	1.2%
% Invest Inc/Net Inc	-9.1%	27.3%	32.6%	38.6%
<b>CIGNA</b>				
Investment Portfolio	\$17,821.0	\$17,530.0		
Investment Income	\$272.0	\$281.0	\$802.0	\$840.0
Total Revenue	\$4,852.0	\$4,413.0	\$12,284.0	\$13,168.0
Net Income	\$171.0	\$365.0	\$501.0	\$852.0
% Invest Inc/Rev	5.6%	6.4%	6.5%	6.4%
% Invest Inc/Net Inc	159.1%	77.0%	160.1%	98.6%



## Tidbits continued: Investment Income Woes for Health Plans

(millions)	3Q08	3Q07	YTD08	YTD07
<b>WellPoint</b>				
Investment Portfolio	\$17,500.0	NA		
Investment Income	(\$348.4)	\$268.2	\$28.5	\$768.3
Total Revenue	\$14,961.0	\$15,242.0	\$46,181.5	\$45,597.9
Net Income	\$820.7	\$868.0	\$2,159.3	\$2,486.3
% Invest Inc/Rev	-2.3%	1.8%	0.1%	1.7%
% Invest Inc/Net Inc	-42.5%	30.9%	1.3%	30.9%
<b>UnitedHealthGroup</b>				
Investment Portfolio	\$20,000.0	NA		
Investment Income	\$143.0	\$302.0	\$662.0	\$865.0
Total Revenue	\$20,156.0	\$18,679.0	\$60,732.0	\$56,726.0
Net Income	\$920.0	\$1,283.0	\$2,251.0	\$3,438.0
% Invest Inc/Rev	0.7%	1.6%	1.1%	1.5%
% Invest Inc/Net Inc	15.5%	23.5%	29.4%	25.2%

Aetna and CIGNA of course rely more heavily on investment income due to their non-health product lines. Still for all companies, the above summary helps illustrate the importance of investment income as a component of net income, and thus the impact of the current financial markets has had on health plans.

For More Information:

CIGNA Reports Third Quarter 2008 Results

CIGNA Press Release, October 30, 2009

[http://newsroom.cigna.com/article\\_display.cfm?article\\_id=971](http://newsroom.cigna.com/article_display.cfm?article_id=971)

Aetna Reports Third-Quarter 2008 Results

Aetna Press Release, October 29, 2008

[http://www.aetna.com/news/newsReleases/2008/pr\\_3rdquarter2008\\_earnings.html](http://www.aetna.com/news/newsReleases/2008/pr_3rdquarter2008_earnings.html)

Humana Reports Third Quarter Financial Results, Provides 2009 Financial Guidance, Comments on Capital and Liquidity

Humana Press Release, October 27, 2008

<http://www.businesswire.com/portal/site/humana/>

WellPoint Reports Third Quarter 2008 Results

WellPoint Press Release, October 22, 2008

[http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle\\_general&t=Regular&id=1215484&](http://phx.corporate-ir.net/phoenix.zhtml?c=130104&p=irol-newsArticle_general&t=Regular&id=1215484&)

UnitedHealth Group Reports Third Quarter Results

UnitedHealth Press Release, October 16, 2008

<http://www.unitedhealthgroup.com/newsroom/news.aspx?id=2d00b7e3-26ed-455e-972c-eeebcf11906f>



# Tidbits

A featured column in each edition of the MCOL Weekend e-newsletter

## Consumers and Health Policy Leaders Focusing on Health Care Costs in Response to Financial Crisis

Appearing in the November 8, 2008 MCOL Weekend

Perhaps lost a bit in the election news shuffle this week were results from two surveys that comment on the impact of the financial crisis on any impending health care reform.

The Commonwealth Fund, in a joint survey with Modern Healthcare of health care thought leaders, concludes: that the financial crisis forces an even greater focus on controlling health care costs, that the current provider payment system is the major source of problems in controlling costs, and thus reform of the provider payment system is required.

The Deloitte Center for Health Solutions surveyed consumers, measuring their health care attitudes in relation to post election health care reform. Like health care leaders, consumers give the current system failing grades, ranked controlling costs above access and quality issues and cite a high level of fear that the financial crisis will affect their ability to pay medical bills.

The Commonwealth Fund/Modern HealthCare Health Care Opinion Leaders Survey was conducted by Harris Interactive, with responses compiled from 1,078 identified health policy opinion leaders, and delivery and finance innovators. Here's a summary of their results:

Effectiveness of the current fee-for-service payment system at encouraging quality and efficient care:

- Not effective: 69%
- Somewhat effective - 22%
- Effective - 5%
- Very effective- 2%
- Not sure - 2%

Effectiveness of policy strategies in improving system performance:

Strategy	Effective	Very Effective	Sub Total
Fundamental payment reform with broader quality/efficiency incentives	40%	45%	85%
Bonus payments for high performing providers	41%	14%	55%
Public reporting of provider quality/efficiency information	35%	18%	53%
Consumer incentives to choose high performing providers	27%	15%	42%
Increased provider competition	18%	10%	28%
Increased regulation of providers	16%	9%	25%
Increased consumer cost sharing	14%	5%	19%



**Tidbits continued: Consumers and Health Policy Leaders.....**

Effectiveness of payment approaches in improving system efficiency:

Payment Approach	Effective	Very Effective	Sub Total
Blend of modified FFS/bonus and bundled per patient payment systems	37%	25%	62%
Bundled per patient payments	32%	19%	51%
Modified FFS with bonus payments for high performers	18%	5%	23%

Which payment approach option do you prefer:

- Blend of modified FFS/bonus and bundled per patient payment systems - 53%
- Bundled per patient payments with bonus for high quality - 23%
- Modified FFS with bonus payments for high quality/efficiency - 9%
- The current FFS payment system - 1%
- None of these - 11%
- Not sure - 3%

Level of support for specific payment re-alignment approaches:

Payment re-alignment:	Support	Strongly Support	Sub Total
Revise RBRVS to increase primary care payments	22%	63%	85%
Pay for transitional care services	41%	36%	77%
Pay monthly per patient medical home fees	31%	43%	74%
Eliminate payments for 'never events'	29%	38%	67%
Reduce fees for unusually high priced high volume services	32%	33%	65%
Global fees for hospital acute care episodes	35%	26%	61%
Reduce DRG payments for highly profitable services	27%	29%	56%
Hospital Incentives/penalties based on 30 day re-admit rates	38%	16%	54%



## **Tidbits continued: Consumers and Health Policy Leaders.....**

Meanwhile, the Deloitte Center for Health Solutions Consumer study involved an online survey of a nationally representative sample of 4,010 U.S. adults conducted between October 2 and 10, 2008. Here's what they found:

- Approximately 8-% fear that the current financial crisis will affect their ability to pay their medical bills
- Only 6% of Americans surveyed believe their family is completely prepared to handle future health care costs.
- Approximately 70% believe the financial crisis will make it harder for those who are uninsured to receive medical treatment.
- 47% said their household's spending on health care products and services has increased during the past 12 months, and 63% said it limits their spending on other essentials.
- 22% said they have an outstanding medical bill that is more than 90 days past due.
- Of the survey respondents who reported delaying or skipping care in the past 12 months, 27% said they did so because they could not afford the cost.
- 67% said that reducing costs; 56% said increasing access; and 57% said improving quality were important to them in selecting a president.
- 37% graded the system a D or an F and 51% believe that at least half of all money spent in the U.S. health care system is wasted.

For More Information:

Survey Finds Widespread Dissatisfaction with Current Health Care Payment System  
Commonwealth Fund Press Release, November 3, 2008

[http://www.commonwealthfund.org/newsroom/newsroom\\_show.htm?doc\\_id=716273](http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=716273)

Health Care Opinion Leaders' Views on Payment System Reform  
November 3, 2008 | Volume 13

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=716275](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=716275)

Financial Crisis Looms on Minds of Voters; Affordability of Health Care Major Concern as They Head to the Polls

Deloitte Center for Health Solutions Press Release, November 3, 2008

[http://www.deloitte.com/dtt/press\\_release/0,1014,sid%253D2283%2526cid%253D232091,00.html](http://www.deloitte.com/dtt/press_release/0,1014,sid%253D2283%2526cid%253D232091,00.html)



# Tidbits

A featured column in each edition of the MCOL Weekend e-newsletter

## **Busy Medicare Advantage and PDP Week at CMS**

Appearing in the November 15, 2008 MCOL Weekend

CMS had a busy week tending to Medicare Advantage and Prescription Drug Plan business this week, in which they:

- Issued revised compensation requirements for sales agents and brokers
- Defined the chronic conditions applicable Medicare special needs plans must use to identify the eligible beneficiary populations
- Prepared for 2009 Open Enrollment Season which starts November 15th

On Monday, CMS released interim final rules modifying Agent and Broker compensation regulations issued September 18th, which required that compensation be paid on a six-year cycle, comprised of an initial enrollment year and five renewal years, and that the renewal rate be paid for a beneficiary changing plans during the renewal years. Compensation was defined as including commissions, bonuses, sales awards and other applicable incentives.

While other applicable September 18th regulations still apply, the new rules specifically revised the certain September 18th regulations, by:

- Specifying that all compensation paid to agents and brokers reflect fair-market value based on the commissions paid in the past, adjusted for inflation for similar products in the same geographic area.
- Requiring that renewal compensation be no more, or no less, than half of the compensation paid for that beneficiary in the initial year of the six-year compensation cycle established in the Sept. 18 rule.
- Imposing similar limits on payments to organizations such as Field Marketing Organizations (FMOs). These entities are local or national companies that play an important role in helping plans market and sell their Medicare products by using agents and brokers. FMOs also train agents and brokers and help provide other services.
- Requiring plans to submit to CMS their compensation structures for the previous three years plus the compensation structure they are implementing for 2009. That information must also be provided to agents, brokers, and other third parties under contract to sell their plans. Those rates or structures cannot be changed without prior CMS approval.



## Tidbits continued: Busy Medicare Advantage and PDP Week at CMS

- To prevent churning CMS is still requiring that plans initially pay renewal rate compensation in 2009 rather than the initial year compensation amounts for all plan changes. Once CMS identifies an initial commission was warranted, plans are to retrospectively pay agents and brokers an additional amount for a total payment of the initial compensation rate as filed with CMS.

The Medicare Improvements for Patients and Providers Act of 2008 required CMS to convene a panel of clinical advisors to determine the specific chronic conditions that would comprise the definition of a severe or disabling chronic condition regarding eligibility for Medicare Advantage Special Needs Plans. Kerry Weems, CMS Acting Administrator tells us this list is “being put into place to ensure that SNPs remain targeted to a specific population, and do not expand their services to mirror more generalized Medicare Advantage plans.”

Beginning in 2010, MA SNPs must meet these new guidelines. The list incorporates the following 15 chronic conditions, which were all defined as “being medically complex, substantially disabling or life threatening, having a high risk of hospitalization or other adverse outcomes, and requiring a specialized delivery system across domains of care.”

1. Chronic alcohol and other drug dependence
2. Certain autoimmune disorders
3. Cancer excluding pre-cancer conditions
4. Certain cardiovascular disorders
5. Chronic heart failure
6. Dementia
7. Diabetes mellitus
8. End-stage liver disease
9. End-stage renal disease requiring dialysis (all modes of dialysis)
10. Certain severe hematologic disorders
11. HIV/AIDS
12. Certain chronic lung disorders
13. Certain chronic and disabling mental health conditions
14. Certain neurologic disorders
15. Stroke



## **Tidbits continued: Busy Medicare Advantage and PDP Week at CMS**

Finally, CMS was busy sending out reminders that the annual open enrollment period for Medicare Advantage and Medicare prescription drug plans runs from November 15 through December 31, 2008.

CMS noted that "for beneficiaries enrolling into Medicare Advantage (MA) plans only, they can make one change in enrollment -- enrolling in a new plan, changing plans or disenrolling from a plan -- between Jan. 1 and March 31, 2009. However, the Medicare Advantage open enrollment period cannot be used to start or stop Medicare drug coverage, or to enroll or disenroll in a Medicare Medical Savings Account Plan."

CMS will host over 100 Medicare Open Enrollment events in major cities that will be attended by CMS representatives, and another estimated 10,000 community-based events will be conducted. Information on events is available at:

<http://www.cms.hhs.gov/center/openenrollment.asp>.

For 2009 Prescription Drug Plan coverage, CMS noted that there is at least plan available in every state but Alaska with a premium of less than \$20 a month, and that national average monthly premium is projected to average approximately \$28.

For More Information:

CMS Identifies 15 Chronic Conditions for Medicare

CMS Press Release, November 13, 2008

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

2009 Open Enrollment for Medicare Prescription Drug and Medicare Advantage Plans

CMS Press Release, November 13, 2008

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

CMS Issues Agent Compensation Requirements for Medicare Advantage and Prescription Drug Programs

CMS Press Release, November 10, 2008

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)



# Tidbits

A featured column in each edition of the MCOL Weekend e-newsletter

## Endangered Species: Primary Care or Solo Practice - The Physicians' Foundation Survey Results

Appearing in the November 22, 2008 MCOL Weekend

The Physicians' Foundation this week released a report "The Physicians' Perspective: Medical Practice in 2008", providing results and analysis from surveys mailed to 270,000 primary care 50,000+ specialty physicians, by Merritt, Hawkins & Associates, with 11,950 responses. The Physicians' Foundation was founded in 2003 through settlement of a class-action lawsuit brought by physicians and medical associations against insurance plans. The Foundation seeks to advance the work of practicing physicians and since 2005, has awarded more than \$22 million in multi-year grants.

Here's a Summary of Key Findings from the physicians surveyed, as provided in the report:

- 78% believe there is a primary care physician shortage
- 11% stated they plan to retire in the next three years
- 13% stated they plan to seek a job in a non-clinical healthcare setting during the next three years
- 20% stated they will cut back on patients seen
- 10% said they will work part-time during the next three years
- 60% would not recommend medicine as a career to young people
- 63% stated non-clinical paperwork has caused them to spend less time with their patients
- 94% said time they devote to non-clinical paperwork in the last three years has increased
- 82% said their practices would be "unsustainable" if a 10%+ cut to Medicare reimbursement were made
- 65% said Medicaid reimbursement is less than their cost of providing care
- 36% said Medicare provides reimbursement that is less than their cost of providing care
- 33%+ have closed their practices to Medicaid patient
- 12% have closed their practices to Medicare patients
- 17% rated the financial position of their practices as "healthy and profitable"
- 45% would retire today if they had the financial means
- 6% described the professional morale of their colleagues as "positive."
- 42% stated the professional morale of their colleagues is either "poor" or "very low"
- 78% stated medicine is either "no longer rewarding" or "less rewarding"
- 76% stated they are either at "full capacity" or "overextended and overworked"



## **Tidbits continued: Endangered Species: Primary Care or Solo Practice**

Although the report doesn't emphasize the point, the results would seem slightly skewed towards specialists: 84% of the surveys were mailed to primary care physicians, but they accounted for 72% of the responses (responses: 27% family Practice, 20% general internists, 17% pediatricians and 8% Ob-Gyns.) The report does acknowledge a slight skew by age (52% of responses age 51+ compared to 47% of all physicians being age 51+) and sex (33% female responses compared to 27% of physicians overall being female.) However, it is interesting that in the back of the 85 page report, responses are broken out, primary care versus specialty, but the responses are consistently similar between the two.

But the most important skewing to note is acknowledged in the report: "The majority of respondents (61.56%) are owners or partners in their practices while the remaining 38.44% are employed. It should be noted that the survey was weighted toward physicians in private, independent practices in order to gauge the continued viability of this traditional practice model."

Given the above results are weighted towards independent, particularly solo practice physicians, a different picture is painted than if large system physicians (who skew younger) were more represented. This isn't to say that the results still wouldn't indicate long term issues for primary care, but the specific issues might have different emphasis.

The Foundation lays the high level of physician unrest at the feet of health plans and regulatory agencies. Sandra Johnson, a board member of The Physicians' Foundation states "Tens of thousands of primary care doctors face the same problems as millions of ordinary citizens: frustrations in dealing with HMOs and government red tape. The thing we heard over and over again from the physicians was that they're unhappy they can't spend more time with their patients, which is why they went into primary care in the first place."

The Foundation doesn't comment in the report on emerging medical home initiatives, and how they might address primary care issues. The term is only mentioned once in the report, by a single physician respondent quoted in the 10+ pages of respondent comments included in the report.

It might seem as if the survey is more focused on the impact of owning/operating a medical practice, and the issues for solo practitioners. The question is, is primary care is the endangered species, or is solo practice?

For More Information:

National Survey Finds Numerous Problems Facing Primary Care Doctors, Predicts Escalating Shortage Ahead

Press Release, The Physicians' Foundation, November 18, 2008

[http://www.physiciansfoundations.org/usr\\_doc/Press\\_Release\\_for\\_Website.pdf](http://www.physiciansfoundations.org/usr_doc/Press_Release_for_Website.pdf)

The Physicians' Perspective: Medical Practice in 2008

Survey Summary & Analysis, The Physicians' Foundation, November, 2008

[http://www.physiciansfoundations.org/usr\\_doc/PF\\_Report\\_Final.pdf](http://www.physiciansfoundations.org/usr_doc/PF_Report_Final.pdf)



# Factoids

Selected Factoids from the MCOL Daily Factoids e-newsletter

## EMR System Utilization Rates

Appearing in the November 13, 2008 Daily Factoid

	Percentage of Respondents Who Report They Use EMRs*
Have EMR (% of all respondents, 2006)	26%
Have EMR (% of all respondents, 2008)	30%
Use EMR, are not part of any healthcare system (2008)	27%
Use EMR, are part of a healthcare system (2008)	54%
Percentage small practices using an EMR (2008)	24%
Percentage mid-sized practices using an EMR (2008)	34%
Percentage large practices using an EMR (2008)	47%

\**electronic medical record*

Source: 2008 HIMSS Analytics. 2008 HIMSS/HIMSS Analytics Ambulatory Healthcare IT Survey Final Report October 2008.

## More Employers Giving Employees Incentives to Participate in Health Management Programs

Appearing in the November 25, 2008 Daily Factoid

	2006	2007	2008
Large Employers (500 or more employees)	19%	23%	26%
Jumbo Employers (20,000 or more employees)	32%	38%	45%

Source: Mercer 2008 National Survey of Employer-Sponsored Health Plans. [www.mercer.com](http://www.mercer.com)



# Announcements

Items of interest from MCOL



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# Quoted

From MCOL's Quotes of the Week during November, 2008

**"While we did incur investment losses this quarter due to the turmoil in the capital markets, Aetna is well-capitalized, with a strong balance sheet and excellent cash flows and liquidity... We have lowered our 2008 full-year operating earnings per share guidance primarily due to lower net investment income in the fourth quarter than we originally projected."** Joseph M. Zubretsky, Executive Vice President and CFO, Aetna

**"The current financial crisis has changed the nature of the debate over health reform. More than ever, it will be essential to craft a plan that will give more Americans health security while simultaneously controlling costs. ... Most leaders favor rethinking the way we pay health care providers, in order to attain better value and lower costs for the nation."** Karen Davis, President, Commonwealth Fund President

**"This year, because some beneficiaries will see changes in their plans' costs and coverage, it's important that people with Medicare take advantage of the enhanced tools we have available to review the coverage and costs of their health or drug plans for next year."** Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services

**"At a time when the new Administration and new Congress are talking about ways to expand access to healthcare, the harsh reality is that there might not be enough doctors to handle the increased number of people who might want to see them if they get health insurance."** Walker Ray, MD, Vice President, The Physicians' Foundation

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