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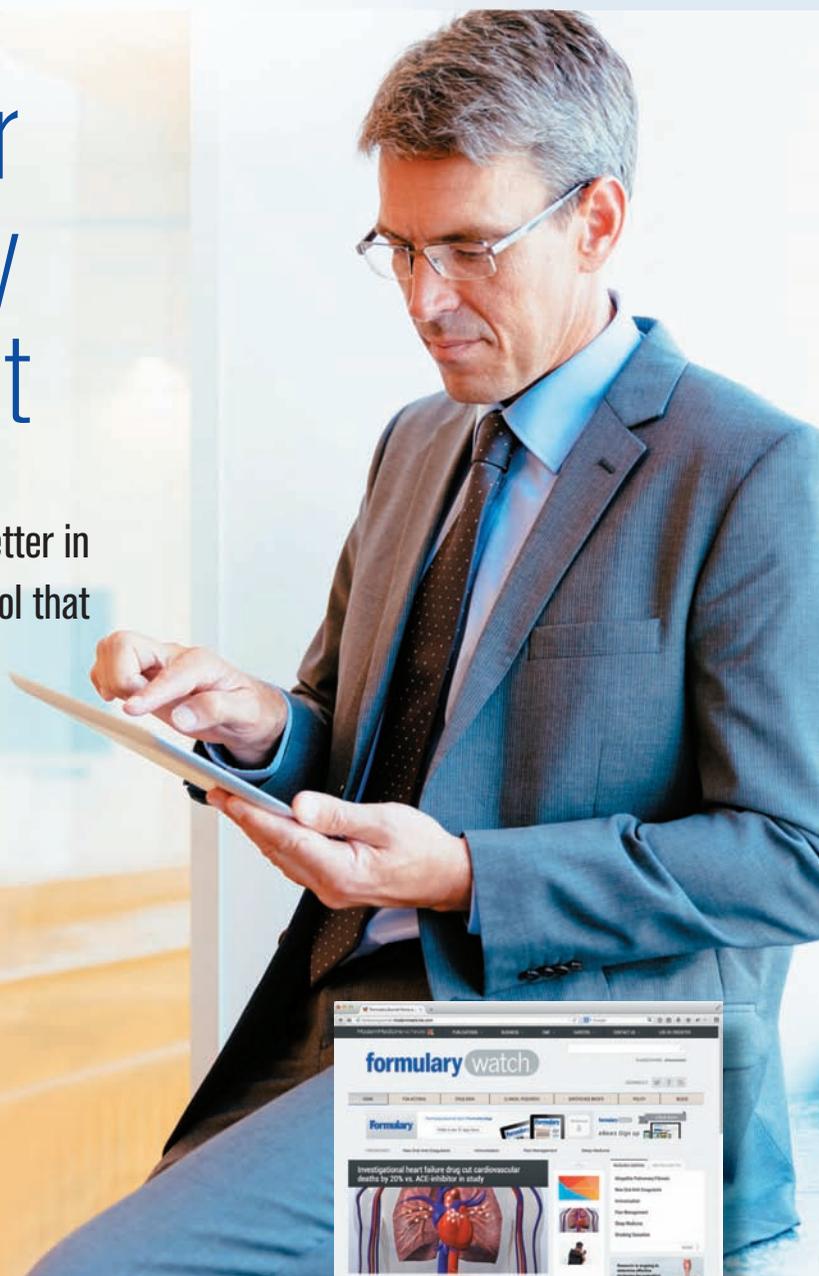


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TARGET MEDICAL DIRECTOR JOINS BOARD



Kevin Ronneberg, MD
Chief Medical Director
Target Corporation

Kevin Ronneberg, MD, chief medical director for Target Corporation, has joined the editorial advisory board of *Managed Healthcare Executive*.

In his current role, Dr. Ronneberg oversees the focus on providing high-quality, affordable and convenient care to guests in a retail setting, through Target Clinic and Target Pharmacy.

Prior to joining Target in 2012, he served as a medical director for Medica Healthcare, a Midwest regional health plan serving 1.6 million members. In that role, he led a health strategy and consultation team that worked directly with employers to improve employee health through better plan design, utilization of health management programs and onsite health offerings.

For more than 12 years, Dr. Ronneberg

practiced medicine with Fairview Health System in Wyoming, Minnesota. In 2001, he started and developed Fairview's sports medicine practice, now known as Fairview Sports and Orthopedic Care. His leadership at Fairview also included decreasing clinic wait times and improving quality reporting and scores in primary care clinics.

A board-certified family medicine physician who has focused on sports medicine and wellness for 12 years, Dr. Ronneberg also served on the board of directors for Fairview Lakes Regional Medical Center from 2004 to 2012, and as the associate medical director for the Twin Cities Marathon since 2004.

A father of two, Dr. Ronneberg is also an avid triathlete and runner and has completed more than a dozen triathlons, five marathons and numerous shorter races.



READ ABOUT TARGET'S NEW PRIMARY CARE CLINICS IN PARTNERSHIP WITH KAISER PERMANENTE IN MHE'S COVER STORY, PAGE 12.

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[BLOG] Pipeline advancement responsible for upturn in global pharma R&D

The world's leading 30 pharmaceutical companies spent a combined \$112 billion on research and development (R&D) in 2013, an increase of \$723 million over the previous year.

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DION

[BLOG] A better IV compounding strategy: Leveraging in-house advantage

In the wake of ongoing fallout and a 2-year crackdown on compounding centers by FDA, many hospitals are analyzing their current strategy and rethinking the pros and cons of outsourced IV compounding.

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“BAD APPLE” RULE UPDATED BY CMS

Changes impact enrollment and underscore compliance

The Centers for Medicare and Medicaid Services (CMS) recently issued a final rule that updates requirements for providers wishing to enroll in the Medicare program. The updates, effective February 3, 2015, are the latest in a longstanding effort by CMS to strengthen Medicare program integrity efforts.

Enrollment is a critical gateway to billing the Medicare program and, as such, is carefully scrutinized by CMS to ensure only legitimate providers enroll. The final rule makes several key changes impacting enrollment:

- Redefining “enrollment” to clarify a distinction between enrollment for the purpose of obtaining Medicare billing privileges and enrollment solely for the purpose of ordering or certifying items or services for beneficiaries;
- Extending circumstances under which CMS may deny enrollment based on unpaid Medicare debts, giving CMS authority to examine total debts owed to Medicare, not solely overpayments, and to consider whether an individual owner or provider had a prior relationship with an entity that owed a debt or had its enrollment voluntarily or involuntarily terminated;
- Expanding circumstances under which felony convictions can serve as a basis for CMS denying or revoking a Medicare provider’s enrollment;
- Permitting CMS to revoke privileges from providers engaging in a “pattern or practice” of submitting improper claims, based on:
 - Percentage of submitted claims denied;
 - Reason(s) for claim denials;
 - Whether provider has history of final adverse actions;
 - Length of time over which pattern or practice has continued;
 - How long provider was enrolled in Medicare program;

- Other information regarding provider’s circumstances that CMS deems relevant.
- Narrowing time period during which any provider other than a home health agency may submit post-revocation claims (from 27 months to 60 days);
- Limiting “backbilling” by ambulance suppliers;
- Fixing effective date of enrollment bar, to begin 30 days after CMS or a CMS contractor mails a notice of revocation;
- Limiting circumstances under which a provider may submit a corrective action plan, to cases where providers are determined not to be in compliance with enrollment requirements.

These changes underscore the importance of creating and fostering a “culture of compliance” within health-care, and encourage providers to conduct business with potential program integrity risks and consequences squarely in mind. Some key takeaways that payers, and providers in their networks, may find helpful include:

With whom are you doing business? As CMS reminds us, “[I]t is ultimately the hiring provider or supplier’s responsibility” to check backgrounds of any individuals or entities with which the organization is doing business.

Keep your eyes on the contractors. Pay close attention to this newly-strengthened billing revocation authority, because CMS and its contractors may use it with increased frequency as a tool in their program integrity arsenal. CMS’s ability to revoke a provider’s billing privileges is tantamount to payment exclusion and comes with administrative appeal rights that, for most providers, afford too few protections that are not available when needed most. Moreover, the combination of strong billing revocation authority and a potential 10-year look-back period for overpayments under the federal False Claims Act signals a critical need to take a cautious approach to assessing potential risks within organizations. In February 2012, CMS published a proposed rule regarding reporting and returning of overpayments; if it is ultimately finalized, it could create retroactive liabilities and is inconsistent with government and industry practice regarding document retention, Medicare’s longstanding “reopening” provisions for adjudicated claims, and even underpayment liability look-back provisions. ■

ABOUT THE AUTHORS ■

George B. Breen and Amy Lerman are members of Epstein Becker Green’s Health Care and Life Sciences Practice.

This column is written for informational purposes only and should not be construed as legal advice.



REFORMING REIMBURSEMENT

Robust, reliable, relevant data are key

As the healthcare industry undergoes unprecedented change, particularly in regard to payment reform, payers recognize a growing need for more comprehensive payment methodologies that adequately represent the true market cost of health services today.

Providers who have traditionally based their payment methodologies on a multiple of Medicare's fee schedule are beginning to recognize inherent limitations in a Medicare-based schedule that can affect their bottom line. Luckily, many limitations can be addressed by integrating independent, market-based data into a payment schedule. For example:

Non-covered procedures. Medicare does not provide a value for every service. In fact, more than 1,700 physician and laboratory codes do not have a Medicare fee. Some payers have chosen to fill this gap by using their own charge data, which may result in overpayments if their payments are based on a percentage of charges. Robust, independent data products can adjust market-based cost data to conform with the Medicare scale and provide reliable, geographically-specific dollar values for the procedures that Medicare omits.

Limited patient population. Because Medicare's fee schedule has been designed to meet the healthcare needs of the elderly and disabled, it is not fully representative of the type of healthcare services generally covered by private insurers for a younger population. Using both Medicare and data from private claims can

help payers to more accurately pay for the services that are most common for the population mix they serve.

Market rates. Medicare's fee schedules take into account certain public policy priorities which may not pertain to the true market rate for services. Independent data that reflect what providers are charging can help payers set fees that are in line with the true cost of services for their area.

Out-of-network reimbursement. Reimbursement formulas often result in higher out-of-pocket exposure for plan members visiting doctors outside their network. These costs can influence member satisfaction with the plan and increase the administrative burden on staff. Reliable data can help payers set a reimbursement formula that limits out-of-network costs.

Three-dimensional care. Medicare's fee schedules are based on the traditional fee-for-service model. Independent data facilitates planning for episodes of care that account for the covered services and fees for all of the providers that would typically treat certain conditions. These "three-dimensional" profiles can serve as the basis for bundled, episode and accountable care payment programs, reference-pricing initiatives, provider cost and quality analysis and more.

Inpatient versus outpatient services. The delivery of care that has traditionally been provided on an inpatient basis is shifting increasingly to outpatient facilities, including ambulatory surgery centers and urgent care. This raises the question of whether outside data accurately reflect where services are being performed. For example, do "outpatient" datasets exclusively represent charges from a hospital outpatient department, or do they include charges from a variety of outpatient care facility types? Data specific to settings such as ambulatory surgery centers facilitate appropriate payment for ambulatory services, based upon the setting.

To remain viable in this changing healthcare environment, payers of all types will need to make thoughtful, well-informed decisions about their reimbursement methods. Robust, reliable, and relevant data are the key to building a payment model that appropriately compensates healthcare providers. ■

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MEDICAL DEVICE TAX TARGETED

GOP senators, beneficiaries of lobby funds take aim at repeal

Consensus on the best regulatory framework under which providers, payers, pharmaceutical companies and medical device makers can operate has been elusive on Capitol Hill in the last few election cycles. That lack of consensus is expected to continue under the new Republican-controlled Congress, and a prime target will be dumping controversial provisions of the Affordable Care Act (ACA).

Healthcare stakeholders, who've been known to flip their support between parties, gave generously to Republican candidates during the 2014 mid-term election cycle, ultimately boosting the number of conservative lawmakers on the Hill. Most of the activities in the last few sessions of Congress have been House efforts to repeal or reduce funding streams that would pay for ACA provisions, with those bills ultimately stalling out in the Democratic-controlled Senate.

But for the first time in eight years the GOP, sworn in on a snowy day in January, is setting the agenda in both chambers of Congress, and one of the first healthcare policies they may consider is repeal of the 2.3% tax the ACA imposes on medical device makers. In effect since January 2013, the tax is expected to provide an estimated \$29 million over 10 years to offset health insurance subsidies for low-income Americans, as well as fund other ACA provisions.

Medical device manufacturers can deduct the tax as a business expense, lowering it to a net of 1.4%, and eyeglasses, contact lenses and hearing aids are exempt. Still, some device manufacturers say the tax will kill jobs and

stifle innovation, and in October 2013, some lawmakers discussed repealing it as a compromise to end the federal government shut-down.

In a November 2014 report, the Congressional Research Service (CRS) wrote that the tax won't kill jobs and increase costs: "The analysis suggests that most of the tax will fall on consumer prices, and not on profits of medical device companies. The effect on the price of healthcare, however will most likely be negligible because of the small size of the tax and small share of healthcare spending attributable to medical devices."

Nonetheless, the Advanced Medical Technology Association (Adva.Med), which says it represents 80% of medical technology firms in the U.S., has been actively lobbying for its repeal.

AdvaMed, along with device makers Boston Scientific, Direct Supply and Medtronic, contributed more than \$3.8 million to Republican candidates in the latest election, or 65% of the device industry's total campaign contributions, according to Federal Election Commission data compiled by the Center for Responsive Politics.

AdvaMed also disagrees with the CRS's analysis that the tax will have a negligible impact, calling that conclusion "flawed" because consumers don't buy medical devices.

"Rather, the buyers are institutions such as hospitals, clinical labs, and physician practices. In a highly competitive market such as the one for medical devices, such purchasers have the ability to refuse to accept price increases. In addition, they can delay or cancel large capital purchases or substitute less-expensive for more-expensive product alternatives," AdvaMed argued.

Medical device makers gave \$92,549 to support the reelection of U.S. Rep. Erik Paulsen (R-Minn.) a third-term lawmaker who introduced a bill targeting repeal of the tax in 2012. The bill passed the House but was not brought up for vote in the Senate.

In January, Paulsen introduced a new bill to repeal the tax, and this time it might succeed. Device makers gave their second highest donation to help re-elect Kentucky Republican and new Senate Majority Leader Mitch McConnell, who on more than one occasion has said that his party will make every effort to repeal the ACA. ■

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Consumerism increases **RETAIL** **OPPORTUNITIES** and access to coverage & care

By **JUDY PACKER-TURSMAN**

IN A NOD TO THE CHANGING FACE of healthcare, Target shoppers in San Diego can visit the in-store clinic operated in partnership with Kaiser Permanente for primary care services.

Members of CareConnect in New York who travel outside of the plan's service area can access care at CVS MinuteClinics as part of that plan's provider network.

And in Pennsylvania, Highmark welcomes customers seeking insurance options to its six retail stores, where sales grew 126% in the past year.

Spurred on by the Affordable Care Act (ACA), retailers, health plans and providers are staking strong retail positions that are increasing coverage opportunities and access to care.

EXPANDING THE RETAIL CLINIC BUSINESS MODEL

From the concept's beginning in 2000, retail clinics have grown substantially and numbered 1,868 as of January 1, 2015, up from 1,603 a year earlier, according to data by Merchant Medicine LLC, a strategic planning firm. Of the current total, roughly half, or 947, are CVS's MinuteClin-

ics, followed by Walgreens Healthcare Clinic, Kroger's The Little Clinic, Target Clinic, and Rite Aid RediClinic. (See chart, p. 13).

Growth in 2014 was topped by MinuteClinic's opening of another 156 clinics. But for giant retailer Wal-Mart, which closed a number of acute care clinics last year, future growth called for a change to its business model.



When retail clinics took off in 2006, Wal-Mart became interested because of its massive footprint and customer volume, says Jennifer LaPerre, senior director of health & wellness for Wal-Mart U.S. In 2007 Wal-Mart began working with local health systems, leasing space within its stores for clinics that grew to 260 locations. But by 2014, that number had declined to 95.

About a year ago, Wal-Mart realized the healthcare landscape was changing and looked at what it needed to do differently, LaPerre says. It also saw its potential influence in the healthcare market as an employer of 1.1 million people and a business serving 140 million-plus customers in its stores each week, she says.

According to LaPerre, Wal-Mart developed a new retail-clinic strategy focused on three objectives. First, it wanted to design a dual model to serve employees as a worksite clinic and to serve customers as a retail primary care clinic. Second, “the price had to matter,” as did price transparency. “We wanted to create a new retail price in the healthcare industry,” she says, which Wal-Mart translated to \$40 for a customer’s office visit and \$4 for an employee’s visit.

Third, Wal-Mart wanted to broaden the scope of services, moving beyond the traditional walk-in clinic’s model of caring for minor acute needs such as colds, to offering services for people with chronic illnesses such as diabetes. “We wanted to do more,” says LaPerre, “and 75% of healthcare spend comes from chronic conditions, so we wanted to offer an expanded scope of service.”

Using this approach, LaPerre asserts that the retailer’s primary care clinic model, known as Wal-Mart Care Clinic, is different from com-

petitors because it focuses on employees and customers, is “very price disruptive,” and offers more extensive services than many other retail clinics.

Thanks to a partnership announced last fall with Directhealth.com, its model also includes health insurance options. Patients without insurance can now shop for plans and gain coverage with the assistance of independent, licensed health insurance agents who can help them navigate options including Medicaid. “For years, our customers have told us that there is too much complexity when it comes to understanding their health insurance options,” Labeed Diab, senior vice president and president of Wal-Mart Health & Wellness, said last fall when announcing the partnership with Directhealth.com. “[Wal-Mart] addresses that complexity by bringing clarity and increased choice to the insurance enrollment process.”

Unlike its initial approach in 2007, Wal-Mart now is working with a single clinic operator, says LaPerre. “This is a new business for us, so we looked for an experienced partner to get these clinics up and operational,” she notes. In April 2014, the retailer partnered with QualMed, a Milwaukee-based worksite clinic operator that LaPerre says focuses on creating value for employers. Last April Wal-Mart began rolling out pilots and, as of January 23, it has Care Clinics in 17 locations in Texas, South Carolina and Georgia.

EXECUTIVE VIEW

- Retailers are expanding acute care models to encompass primary care;
- Health systems are launching plans and growing their networks through retail partnerships;
- Health plans are opening retail stores.

Retail clinic growth

Retail Clinics at Start of Year	01/01/07	01/01/08	01/01/09	01/01/10	01/01/11	01/01/12	01/01/13	01/01/14	01/01/15
CVS (MinuteClinic)	146	488	550	454	451	549	627	791	947
Walgreens	41	145	318	355	357	355	364	389	424
Kroger (The Little Clinic)	11	49	91	140	117	80	91	111	148
Wal-Mart	12	55	27	54	117	154	128	98	102
Target	8	23	28	29	36	44	54	69	83
All others	40	120	161	151	140	173	153	133	162
Total	258	880	1175	1183	1218	1355	1417	1591	1866

Source: Merchant Medicine LLC



“ [Target wants] to be a preferred provider, not to displace existing provider relationships.”

—KEVIN RONNEBERG, MD, TARGET MEDICAL DIRECTOR

LaPerre says Wal-Mart selects its primary care clinic locations based on several criteria: “We look for associate [i.e., employee] density, provider shortages, a high propensity of chronic disease” and in areas with significant numbers of the uninsured, underinsured and Medicaid eligibles. “We are trying to reach people who otherwise would not get care,” she says. “Either they can’t get access or they can’t afford care...We want to serve them.” She says roughly half of Wal-Mart’s clinic patients lack a primary care physician.

As for Wal-Mart’s plans for primary care clinic expansion, LaPerre says: “We will grow if our customers and associates want us to grow, and we’re finding that they do.” She says Wal-Mart is “getting good feedback” from Care Clinic users who are pleased with services and prices.

Where would Wal-Mart put new primary care clinics? The retailer has a large footprint in rural, underserved areas in the U.S., LaPerre says. But she describes it as “important to create density wherever we go” before considering further growth. For instance, in the Dallas-Fort Worth market, Wal-Mart has 140 stores and five clinics, notes LaPerre. But, she adds, “I don’t think we’re probably optimizing density at this point” in that market.

Asked whether Wal-Mart wants its clinics to stand on their own, LaPerre says the retailer wants “to be the destination for our customers’ and associates’ healthcare needs...so we’re looking at it from ‘an entire box’ perspective. We know there’s benefit to the pharmacy and to the box [from the clinic], so it’s creating value for Wal-Mart Stores, Inc.”

Despite its new direction, LaPerre says Wal-Mart values its relationships with those health systems still operating clinics in its stores. “At this point we’re not disrupting those relationships,” she says. “They’re very important to us.” Wal-Mart’s patients may need higher levels of service such as referrals to specialists, notes LaPerre. Whether people go to Wal-Mart clinics as their primary source of care or through their local community providers for after-hours care,

“We see ourselves as being part of the continuum of healthcare,” she says.

LaPerre describes the federal government’s health insurance programs—Medicare, Medicaid, and the military’s Tri-Care—as a big customer for Wal-Mart’s clinics. She adds that the retailer is

“working to become enrolled in the commercial space” to work directly with private payers.

MAJOR RETAILER, HMO BECOME PARTNERS

Target Corporation launched its first acute care clinic with a third-party vendor in 2001, brought the business in-house in 2006, and now has 84 retail clinics.

But like Wal-Mart, it also saw the value in expanding its clinic model to encompass primary care services. It chose Kaiser Permanente, a health partner with strong brand recognition, as its first partner because the brands share a similar philosophy, says Kevin Ronneberg, MD, medical director for Target. Four medical clinics offering primary care services have opened since the fall in southern California, where the not-for-profit HMO serves more than 3.7 million members.

The move represents Target’s entry into the California retail clinic market and Kaiser Permanente’s first foray into a retail setting. It’s also the first time that Kaiser Permanente’s providers will treat patients covered by other insurers.

“Part of our initial agreement is...clinic care has to be open to all Target guests,” Ronneberg says of the new arrangement. Target also wants “to be a preferred retail partner, not to displace existing provider relationships, and to seek new relationships with established organizations like Kaiser Permanente.”

As a result, it’s running its retail-clinic business on a dual track, he explains. Target’s acute care clinics focus mainly on vaccinations, treatment of acute illnesses and biometric screenings and are staffed by nurse practitioners and physician assistants. Target’s pharmacies also have “health-service rooms” to give vaccinations and review medications with customers, he notes.

Kaiser Permanente’s certified family nurse practitioners staff the new primary care clinics, relying on telehealth technology linked to Permanente physicians and ties to the system’s clinical infrastructure, including electronic

health records and lab services.

The clinics go beyond the basic “convenient-care package,” offering pediatric and adolescent care, ob/gyn care, chronic care management, and other services, says Paul Minardi, MD, medical director of business management for Southern California Permanente Medical Group. “It’s very holistic, and certainly for Kaiser Permanente members it’s the same offering we have in our other offices,” he says.



MINARDI

ente members it’s the same offering we have in our other offices,” he says.

Business at the four clinics is booming, says Minardi, who is also medical director of Target Clinics in Southern California. “In the little over 10 weeks we’ve been open,

we’ve seen a little over 2,000 patients,” he notes, adding that about 70% of clinic users have been Kaiser members and 30% have been community members.

People appreciate the convenience of being able to seek care at a retail store as opposed to a doctors’ offices, says Minardi. “It’s a perfect place to engage them in health and wellness” in

a personalized manner, he says.

But providing care is not a one-size-fits-all endeavor, notes Christine Paige, Kaiser Permanente’s senior vice president for marketing and digital services. “Some patients will love the convenience of seeing a doctor while they’re picking something up at the store, others will prefer to come into the office, while others will want to call or email so they don’t

have to leave the house,” says Paige. “We have to be sensitive to everyone’s preference.”

According to Minardi, Kaiser Permanente decided to work with Target because of their closely-aligned philosophies on helping customers achieve their health and wellness goals. In fact, the two brands’ similar philosophies became apparent at the start of talks.

Minardi calls Kaiser’s relationship with Target “synergistic”: Target “is well known for its customer experience and service, and is willing to participate together with us, as opposed to us being a vendor in their store,” and Paige agrees.



PAIGE

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Target Corporation has partnered with Kaiser Permanente to open four primary care clinics in southern California, with more expected to follow.

"Our guiding principle with any significant change we make within our organization is making sure that we provide the best member experience, while providing the highest quality care," says Paige. "Looking through this lens is incredibly important when it comes to the shift we're seeing with more healthcare organizations providing retail-like services."

In an effort to make consumers aware of their options, Kaiser Permanente also has a number of retail kiosks in its service areas where consumers can ask questions and learn about plans, notes Paige.

Minardi explains that Kaiser committed to five stores in its pilot program with Target, selecting stores based on Target's predictive modeling and analysis of Kaiser Permanente's system. Growth "is highly dependent on the success of the business model," he says.

Yet, Kaiser Permanente officials anticipate the model will eventually expand to encompass eight states and the District of Columbia.

Plans are also in the works for Target to contract with Medicare, Medi-Cal, Blue Shield of California and other major health insurance plans in the area for certain services, "Lots of things are in play," says Minardi.

USE OF RETAIL CLINICS LOW, CONSUMER AWARENESS HIGH

Despite retail clinics' dramatic growth, only 15%

of consumers responding to an Oliver Wyman survey in 2014 said they used such clinics. And while 57% of respondents said they would like to receive care in a retail clinic, 28% were interested only if the clinic was run in partnership with a local hospital or healthcare provider. Quality of care topped consumers' criteria for choosing a healthcare site, above cost and convenience, the survey found.

"Use [of retail clinics] is low, but [consumer] awareness is high. To me that implies a deficiency in the business model," says Graegar Smith, a principal in Oliver Wyman's health and life sciences practice and co-author of the April 2014 report, "Are Consumers Ready for Retail Healthcare?" (<http://owy.mn/1zUJN39>). The report concludes that the line between healthcare and retail is blurring, and retailers, payers and providers should work carefully together to maximize future opportunities.

"You have to emphasize the quality element as well as convenience" with respect to retail clinics, Smith says. "And the other element of



SMITH

the business model is experience and economics. It's still an industry that is finding how to make money...The numbers [of retail clinics] are impressive in terms of growth, but you still need to improve the economic model for the business."

Smith describes the early evolution of the retail clinic model as "quite adversarial" to the healthcare system. Some physicians thought retail clinics promoted fragmented care, he says, "but now it's version 2.0 of the model, and clinics and payers or providers are working more in lock-step." Closer alignment could help address quality gaps and free up new methods for payment, and it also could help to differentiate retail clinics in consumers' eyes, he says.

Aside from retail health, there's the shift to value within the healthcare industry, Smith says. For providers or payers thinking about costs, clinical outcomes and patient satisfaction, "retail options have a huge potential benefit if you can figure out the right model. If you're a provider system trying to make a play for population health [management], having a retail front-end makes sense."



CHARLAND

Tom Charland, Merchant Medicine LLC's chief executive officer, describes several sub-markets of primary care medicine: preventive medicine, chronic disease management, convenient care/retail clinics, urgent care, work-site clinics and telehealth. Combined, these sub-markets are critical as population health management and risk-based contracts proliferate.

Some clinics are already differentiating and are now being integrated into accountable care organizations and plan networks, notes Charland.

The big question is how to make the economics work, Smith says. While some retail clinics are profitable, he says, the question becomes whether it is actually the clinic itself, the clinic plus pharmacy scripts or the clinic plus the front-end store.

Most retailers, he notes, want to figure out a way to make the clinic—which uses valuable space—economically viable on its own; they don't see the clinic as a loss leader designed to bring in more pharmacy and front-end volume. Yet, payers and providers assume the clinic will be a loss leader.

Retail clinics tend to be underutilized, says Smith, with few reaching the 20-patients-a-day volume that would be considered reasonable. In order to make retail clinic ventures viable, Smith recommends that stakeholders find ways to increase volume by utilizing telehealth to adjust staffing levels, tweaking the size of the clinic's footprint in the store, targeting new sources of revenue by expanding the type of services offered, and securing appropriate contracts to ensure maximum reimbursement.

TAKING A RETAIL APPROACH FROM THE GROUND UP

When North Shore-LIJ Health System became licensed in July of 2013 to sell health insurance, plan officials knew up front they wanted to take a retail approach to the business, known as CareConnect Insurance Co.

"We looked around and said, 'Healthcare is the last industry that hasn't focused on customer service,' so that became a guiding principle for us," says company spokesperson Lisa Davis.

North Shore-LIJ has an annual operating budget of \$7.8 billion, 19 hospitals and affiliations with about 10,000 physicians. CareConnect's members have access to a network of

more than 20,000 physicians, including the system's affiliated physicians as well as doctors at several other hospitals, health systems and medical groups in the expanded service area.

"I often say CareConnect is a customer service company that happens to be an insurance entity," says Alan Murray, president and chief executive officer of North Shore-LIJ CareConnect Insurance Co. Inc.

In 2014, CareConnect sold individual, small group and group policies through state exchanges in several New York and Long Island communities. When it expanded into Brooklyn, the Bronx and Westchester County in September of 2014, it did so by extending its provider network with the addition of CVS' MinuteClinics.

"MinuteClinic is helpful for us because CareConnect is an EPO (exclusive provider organization), so there are no out-of-network benefits," Murray says. "So one of the hurdles we had to get over was what would happen if [members] travel outside of our service area." MinuteClinic "is retail. It's convenient" and walk-in health-care tides over members until they return to CareConnect's service area.

Murray stresses that walk-in clinics are part of the industry's larger effort to adapt to the consumer. "For me, retail is not necessarily about MinuteClinics," he says. "It's about the new focus on the individual and about what will make their lives easier. That's the challenge healthcare has to overcome: surrounding our industry around the individual, not having the individual fit into our industry."

As of January 1, 2015, CareConnect had grown to 18,000-plus commercial members and more than 1,500 members in Medicaid-managed long-term care. Murray says CareConnect's member retention rate was "well over 90%" between 2014 and 2015. He cites various contributors to this retention, including CareConnect's call center that fields customer calls within six seconds on average. "Eighty-eight percent of calls are resolved by the person picking up the phone, leaving customers very satisfied," notes Murray.

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MURRAY

“When a person walks in the store, there’s an extremely high conversion rate. When they come, they come to buy.”

— ANTHONY RYZINSKI, HIGHMARK’S VICE PRESIDENT OF MARKETING.



CareConnect is relatively easy to market, says Murray. Both “work hand-in-hand to make sure clinical pathways are the most opportune for our members.

“Care is coordinated with our doctors to ensure the right care at the right time at the right place.” Such an approach, says Murray, leads to a second advantage: administrative simplification. CareConnect’s denial rate for procedures and services requiring pre-authorization “is about 1%,” well below the industry average, he says, “because CareConnect’s clinical practice guidelines are taken from the health system, so we’re on the same page as our doctors.”

USING RETAIL STORES, POP-UP KIOSKS AND MOBILE UNITS

Blue Cross Blue Shield of North Carolina’s (BCBSNC) strategies include use of the Internet—the insurer recently introduced a new pricing transparency tool for consumers—and a brick-and-mortar presence. Its retail stores focus on supporting individual members and complementing its online presence.

The Blues insurer opened its first retail store in 2012 as a way to offer face-to-face help for

consumers preparing for the ACA’s first open enrollment period, says Ashlee Smart, BCBSNC’s director of new channel sales. Currently, the insurer has seven retail locations—staffed by customer service representatives and licensed agents—across the state.

BCBSNC also uses pop-up kiosks in malls set up near food courts during open enrollment



SMART

periods, Smart says, and a mobile unit that travels the state for one-day events that “allows us to meet the customers where they are....The customers have appreciated the convenience.”

Why add retail stores to the mix? “We feel it’s important to round out all of the other options we have available,” from online tools to community events, Smart says. “We offer all of these options so people can meet us where they’re most comfortable...[and] wherever it is most convenient to them.”

In 2014, BCBSNC says 257,704 individuals enrolled in its exchange plans, and an additional 57,138 enrolled in its plans outside the

Courtesy of Highmark

exchange. BCBSNC says it had 238,800 individual policyholders enrolled in grandfathered and transitional plans last year.

In 2012, BCBSNC began a strategic collaboration with FastMed Urgent Care, investing an undisclosed sum to help FastMed expand its network of physician-owned clinics across the state—there are now 50-plus locations—and also to launch programs for Blues customers. BCBSNC officials said working with FastMed was desirable because of FastMed's capability for a dual model of care—primary care during the day, urgent care at night—and because it offers suturing and bone-setting.

Through organic growth and acquisitions, FastMed projects that it will serve more than 1 million visitors in 2015 at its 87 clinics in North Carolina and Arizona.

Brian Caveney, MD, BCBSNC's vice president and medical director, says the insurer "actively promotes to our individual and employer group customers that we can help them get the right level of care from the most efficient resource, including finding a primary care home, using our Health Line Blue where a nurse is available to answer questions around the clock, retail clinics, urgent care centers, and emergency rooms when appropriate."

In 2014 BCBSNC saw its lowest emergency room utilization rate in the decade, Caveney says, which he partly attributes to the significant increase in members' use of urgent care centers and retail clinics. BCBSNC "has nurse care managers in high-volume FastMed clinics... [who] can help identify and close care gaps and streamline the process of additional services," he notes.

'BRINGING CUSTOMERS ALONG'

Over the past six years, Highmark, the Pittsburgh-based Blue Cross Blue Shield insurer, has opened six retail stores within its service area. In its stores, Highmark handles customer service for members and discusses products with potential customers, serving Medicare and the under-65 population alike. "It's interesting, because they have very different needs," says Anthony Ryzinski, Highmark's vice president of marketing. "We have great demand. We actually have capacity issues."

He estimates about half of Highmark's retail store business is Medicare, which he describes

as a substantial increase over its previous share. "We have 126% more sales this year [in 2015 over 2014], so the sales keep increasing," he says. "We also look at the mix of customers we bring in, because we want the stores to make business sense, and we're happy with where things are headed."

Indeed, Highmark anticipates further expansion of its retail stores. "We're looking at different geographies to figure it out, but we intend to expand," Ryzinski says. "All I do know is we'll retrofit existing stores to accommodate more people. That's a near-term adjustment." He says Highmark has made other adjustments, including a shift to longer hours during open enrollment periods and to seven days a week.

"When a person walks in the store, there's an extremely high conversion rate. When they come, they come to buy," he says. The bottom line? "People want a personalized experience... You have to bring your customers along with you, and they have to see a reason to engage." ■

Judy Packer-Tursman is a journalist based in Washington, D.C. who has covered healthcare issues for nearly 30 years.



CAVENEY



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ENGAGING MEMBERS

Getting patients involved leads to better health and lower costs, but how to do it? *by* **SUSAN KREIMER**

As research continues to indicate that patients who actively participate in managing their health fare better than those who don't, public and private insurers are seizing the opportunity to devise programs that promote preventive care and positive behaviors. For managed care organizations, healthier outcomes result in reduced costs, so patient engagement has become a key focus of plan designs.

But not all patients react the same to these efforts. "Some are very passive with regard to their health, and some of them are very proactive," says Judith H. Hibbard, DrPH, professor emerita at the University of Oregon in Eugene. Hibbard and her colleagues developed an assessment tool, the Patient Activation Measure (PAM), to evaluate an individual's capacity to take charge of his or her own health and treatments. By gleaning insight into a person's knowledge, skill and confidence for self-management, health plans are more effectively tailoring strategies for that member.

"A lot more organizations are using the patient activation measure to know how well they are engaging their patients," Hibbard says. "It is quite predictive of health behavior." The diagnostic tool allows health plans to meet patients at their level from

the outset and to gauge their progress—for instance, in following an exercise regimen, making better food choices or taking medications as directed.

With passive members, it's best to begin with smaller steps while fostering encouragement and a can-do attitude. "All the steps are really about building people's confidence that they can actually be successful in managing their health," Hibbard says. "That's what it's all about it."



HIBBARD

Case management is particularly important for members with expected high utilization of services. The reasons range from chronic diseases, acute impairments or transitions between levels of care, says Mary Jo Muscolino, RN, MPA, CCM, CASAC, manager of case management services at the Monroe Plan for Medical Care in Pittsford, New York.

The Medicaid-managed care company's nurses and social workers perform assessments via phone and face to face with high-risk members who meet specific monitoring criteria, such as high blood pressure, diabetes, HIV/AIDs, a prior stroke or coronary bypass. "In most cases, when possible, we will

go out and see the person for the initial visit,” Muscolino says, adding that nonverbal communication and a sense of the patient’s surroundings often tell a lot about the situation.

Before the visit, the case manager reviews claims history and attempts to identify “a utilization pattern that begins to give a story of who the person is and what kind of issues they’ve been dealing with,” she says. Preparation allows for more accurate application of the PAM self-assessment tool during the visit and strategies for partnering together toward better health. “This really gives us an opportunity to assess what the person is able and willing to do about their health at that point.”

Outreach workers assist case managers in locating transient members. The workers canvass communities “to do people finding.” They may ask someone answering the door at a member’s listed address where that person might be living. For diabetics, they typically check if the refrigerator is functioning and keeping their insulin cool, Muscolino says.

A case is usually open six months for follow-up, and about 60% of members demonstrate an increase in their PAM scores at the end of that period. At least 90% report satisfaction with the program and more capability in understanding and managing their conditions, she says.

Awareness of members’ psychosocial needs is an essential ingredient in successful engagement efforts. As part of an integrated care management model aimed at high-risk members with chronic diseases, addressing the psychosocial factor can help insurers reap a return on their investment. Significant savings



TONNEY

come from reductions in utilization of emergency rooms and hospital services and lower readmission rates, says Sam Toney, MD, chief medical officer and vice chairman of the board

at Health Integrated, a Tampa-based nationwide care management company.

In its most intense program, Synergy, the company employs licensed psychotherapists with master’s degrees to delve into the underlying psychosocial barriers

A health plan’s pilot engagement program produces real-world results

Shortly after Independence Blue Cross launched a member engagement initiative last fall with Accolade, an Accolade health assistant received a call from a woman whose baby was suffering from a facial deformity. The mom was seeking help with a grant application because the treating hospital refused to schedule more surgeries due to a \$7,000 balance from previous surgeries. The health assistant who took the call realized that the hospital billing was off by \$5,000. After advising the hospital of the discrepancy, the bill was adjusted, allowing the family to move forward with the surgery.

Another member called looking for an in-network ophthalmologist, but a health assistant, sensing something more, dug deeper. After initial reluctance, the member revealed she had a history of glaucoma and was seeing intermittent rainbows and halos. A nurse from Accolade joined the call, and the member revealed that she had run out of eye drops months earlier. Subsequently, a doctor’s appointment was scheduled and the member was connected with a pharmacy that could deliver the eye drops to her home. At her first appointment, her new doctor told her that, if treatment had been



SPANN



HILFERTY

delayed one more month, she would be blind.

In early December, a health assistant spoke to a member who rarely seeks care except for a quick biennial physical at work. He was inquiring about urgent care for worsening back pain, but discussion revealed that he had recently stopped taking his blood pressure medication because he “felt better.” Alarmed, the health assistant asked the member to check his blood pressure while on the line; a “very high” reading led to scheduling of a next-available doctor’s appointment, and the member was advised to resume his blood pressure medication. He now sees his primary care physician regularly to control his chronic hypertension, and the health assistant follows up with him regularly.

Making sure its members get the right care at the right place and at the right time is what drove Independence to launch the two-year pilot program last fall with consumer engagement firm Accolade.

Several months into the

Continued on page 23



“ We have to take a larger view of health. We’re not just an insurance company.”

—RALPH M. PROWS, MD

that may prevent a person from adhering to a treatment plan for a physical ailment. “Engagement is just at the front end of what we do,” says Toney, who trained as a psychiatrist. Specialized interventions facilitate behavioral changes while encouraging patients to view the world around them differently and to reframe perceptions of their own illnesses.

For scalability purposes intended to serve a lot of plan members, the Synergy program functions entirely by phone and spans about nine months. It typically piques members’ interest via mail or e-mail. Telephonic outreach follows, with the system transferring the call immediately to an engagement specialist, Toney says.

A dedicated clinician interacts with a member every two to three weeks at a scheduled time during the initial phase, then every four to six weeks. Calls average 35 to 45 minutes. “These are [almost] therapy-like sessions,” he says, while adding that the company has done multiple studies that demonstrate long-lasting behavioral changes after the program’s completion.

Tech-savvy consumers tend to prefer online communication, and insurers often favor



HONE

this lower-cost option for patient engagement. The result is a win-win situation, says Frank Hone, vice president of marketing and engagement at Indianapolis-based Healthx.com, which contracts with payers for care management. The trend is particularly pronounced among members in their 20s. “Phone calls just aren’t in their vocabulary,” Hone says. “They want to interact with their health plan digitally.”

While health plans cater more to modern

consumers, patient engagement sometimes resorts to an old-fashioned approach. “For those people who want to— or need to—talk on the telephone, that medium is still available,” he adds. “You’re never going to find a single medium that fits everybody all the time.”

The National Committee for Quality Assurance found that “patient engagement enabled by health IT is a major, untapped opportunity (particularly among marginalized communities) with the potential to improve inefficient communication methods and change the dynamic of the relationship between the patient and the healthcare system,” according to a report released in February 2014. However, “health IT design must be user-centric, starting with the needs and preferences of patients and their families. In addition to existing efforts to guide design priorities, an evidence framework to evaluate the quality and effectiveness of health IT tools specific to patient engagement will be instrumental in advancing interventions that are meaningful to patients.”

WHAT CONSUMERS WANT

To find out what people want from an insurance company, Oregon’s Health CO-OP held focus groups around the state, involving potential members from all demographic categories, says Ralph M. Prows, MD, president and chief executive officer. The process initiated more than a year before the new Portland-based company launched and enrolled members beginning in January 2014. About 2,000 Oregonians contributed suggestions, leading to the creation of meaningful programs that encourage people to stay healthy.

Members can access up to \$300 in re-

wards for participating in three programs—each with a \$100 incentive—to become more knowledgeable about their own health and to make improvements, Prows says. In the first program, members are rewarded for selecting and establishing a relationship with a primary care physician who steers them toward building a health plan collaboratively to receive immunizations, cancer screenings and other preventive services.

A second program offers \$100 for taking an online health-risk assessment and a patient activation measure. Members learn whether they are at risk for hypertension, diabetes or other medical conditions. The third program is an online educational tool that rewards members for reading eight articles and undertaking eight specific activities to address a particular health concern, such as weight management or factors that contribute to overeating.

The programs can be done in any order once per calendar year. Although it's too soon to calculate their impact, about 40% of Oregon's Health CO-OP membership has so far opted to participate. "They want to take a very active role in their own health," says Prows, an internist who volunteers at a clinic on a monthly basis.

Also in line with every focus groups' recommendations for patient engagement is the nonprofit health plan that brought naturopathic physicians into its panel as primary care physicians. In Oregon, naturopathic physicians are licensed to perform primary care, allowing them to write prescriptions, order tests and interpret results.

The company continues to seek new opportunities to make its offerings more relevant to potential members while hosting meetings anywhere from churches to night clubs.

"Each community has its own very unique health issues," Prows says. "We have to take a larger view of health. We're not just an insurance company." In a world where clean air along with good schools and jobs can make a difference, "we're trying to be a socially conscious company in all of these ways." ■

Susan Kreimer is a New York-based freelance medical writer.

Continued from page 21

program, the partnership has worked "amazingly well," says Daniel J. Hilferty, president and chief executive officer of Independence, the leading health insurance organization in southeastern Pennsylvania. "We're consistently hearing from members that they're happy with the service."

The pilot program serves 40,000 enrollees in 40 employer health insurance plans, says Hilferty, a *Managed Healthcare Executive* board member. Since its fall 2014 launch, it has engaged nearly half of those members. Tom Spann, Accolade's chief executive officer, notes that the number is "many times more than conventional solutions such as disease and case management, and we're steadily working our way toward the more typical 60% to 70% engagement rates that we've seen with our large employer customers."

When program members call Independence, they're automatically routed to Accolade, says Hilferty. Each member is then assigned an Accolade health assistant who, in turn, is supported by a team of nurses, doctors, social workers and other specialists. "From that point on, every time they call they are connected with the same assistant, who becomes a trusted advisor—learning the member's medical history and personal preferences and addressing their needs," he says.

Spann says that health assistants develop highly personalized and integrated plans that factor in the

Number of members in pilot program

40,000

Number engaged in 5 months

20,000

member's health status and emotional, financial, and social issues that affect care decisions.

Both companies are closely monitoring outcomes. "We're looking at the member experience and the financial impact on the cost of healthcare," says Hilferty. "We're also tracking the program's ability to reduce re-admissions and to find other ways to reduce or streamline costs and increase the quality of care."

Current member satisfaction rates "are nearing 99%," says Spann. Each month, members "share...perspectives about our service, and we read each comment to ensure that we're on track and continually improving."

"I fully anticipate increasing the number of Independence members that Accolade will serve," says Hilferty. "They get it, and our members welcome the personal touch. I am certain that our relationship with Accolade will grow exponentially." ■

DEMAND FOR PRICE TRANSPARENCY MOUNTS

High-deductible plans are a catalyst

by KAREN APPOLD

When consumers purchase a car, a piece of electronics or jewelry, they wouldn't think of agreeing to pay for it without first knowing the price. But when seeking medical care, some

patients must do exactly that.

When it comes to healthcare, including hospital services, the issue of price is a complex matter. This lack of price transparency has stemmed in part from the enormous growth of high-deductible healthcare plans. "Patients are now thinking twice about having a medical service when their physician recommends it, because they can't find out what the final price will be," says *Managed Healthcare Executive* Advisor Don Hall, MPH, principal, Delta Sigma LLC, Littleton, Colorado.

Back in 2006, only 4% of consumers had high-deductible plans—which were authorized by the Bush administration in 2003. But by 2013, 20% of U.S. residents had high-deductible health plans that were employer sponsored.

Neeraj Sood, PhD, director of research, Schaeffer Center for Health Policy and Economics, University of Southern California, attributes

the rise in high-deductible health plans to rising healthcare costs. "Employers are using this tool to



SOOD

control healthcare costs," he says. "The idea is if people have to pay more money out of pocket, they will reduce healthcare expenditures and

hopefully will do so in smart ways."

But consumers are pushing back as the trend grows. "There is suddenly a strong demand for understanding the pricing of healthcare," says Leah F. Binder, MA, MGA, CEO, The Leapfrog Group, Washington D.C. "So



BINDER

we will have to figure out how to get these prices into consumers' hands. But it's difficult because the healthcare

system isn't set up to do this. We don't know how to define price, let alone give consumers an accurate answer."

Hall says that retail prices are meaningless because virtually all providers discount retail rates—some by as much as 50% to 60% of what they initially asked for—so it appears that they are giving a

large discount. "But providers don't let health plans publish their rates, which would show what they negotiate," he says. "So consumers are in this conundrum, not knowing what the real price will be."

In May 2013, the Centers for Medicare and Medicaid Services (CMS) tried to improve transparency by releasing chargemaster data. "Unfortunately, no one pays this price," says Doug Ghertner,



GHERTNER

president, Change Healthcare, Brentwood, Tennessee.

"Therefore, it is relatively meaningless in the context of helping the consumer make an informed decision. Even individuals without insurance oftentimes are able to negotiate a discount off the 'retail' price if they ask."

The quality component, plus other factors

Adding to the complexity is the reality that cost isn't indicative of quality—although consumers often mistakenly believe that high-cost care equals high-quality care, Ghertner says.

When comparing different healthcare providers, some providers are paid thousands of dollars more than others for the same service in the same geographic area, regardless of the quality of such services. For example, the cost for maternity care at selected acute care hospitals in Boston, all of which rated highly on several quality indicators, ranged between \$6,834 and \$21,554 in July 2014.

This is because there are many factors that go into determining the cost of hospital services, and each institution has its own set of factors—or cost structure—to manage.

A study of more than 2,000 consumers published in the *Journal of Patient Safety* showed that if consumers were asked to shop by price only, they would pick the highest-priced provider because they thought they were the best quality. “But when they were able to view hospital safety score grades, regardless of price 97% chose the provider associated with the highest grades,” Binder says. “What the study shows is that price may be the first factor consumers consider, but quality is the most important.”

Determining real price/quality

A number of organizations are trying to address the increasingly loud call for healthcare cost and quality transparency. CMS, as well as a host of non-profit and for-profit organizations, are working to provide this data in an easy-to-digest, single viewing experience. “Side-by-side cost and quality information will become increasingly available in time,” Ghertner says. “But the real challenge will be engaging consumers to use it.” A recent survey by Catalyst for Reform found that 98% of the health plans surveyed have a transparency tool, yet only 2% of members use it.

Change Healthcare, for example, is working to bring price and quality transparency to healthcare in a consumer-friendly fashion.

“We take a proactive approach with our users through our proprietary set of claims-driven, preference-driven alerts,” Ghertner explains. “In essence, we are constantly analyzing user claims data and looking at utilization of individuals’ common and recurring services—things such as maintenance medications, physical therapy, and office visits—and we are shopping on their behalf. We then send an alert to that individual that says, ‘Did

you know you could save \$270 on your physical therapy? Click here to find out how.’ When we do this, roughly 60% of people log on to our platform or that of our client and do something with the information. This type of engagement has been proven to drive long-term behavior change—something that’s good for consumers, plan sponsors and the healthcare industry as a whole.”

In addition, Sood says there are state-run websites that report pricing information to varying degrees of accuracy by zip code and type of service. For instance in New Hampshire, which has a more advanced website, you can find out prices paid by patients depending on their type of insurance. In California, however, you can only get a rough sense of what charges are.

So just how much can patients save by using price transparency? According to a study by Sood and colleagues, patients who used an Internet price transparency tool cut their spending by 14% on lab tests, 13% on imaging and 1% on primary care clinical services.

The implementation of ICD-10 in October could help the situation.

“It will significantly improve efficiencies by giving providers the ability to document a patient’s condition, classify it by severity and even address non-compliance issues, all contributing to improved patient outcomes and, over time, the



LARSON

hope for improvements in quality,” says Cheryl Larson, vice president, Midwest Business Group on Health, Chicago, Illinois.

Business healthcare coalitions play a role

Along with consumers, business healthcare coalitions

have been demanding price transparency for years without success. Consequently, they have been taking this upon themselves.

Ghertner says employer and business coalitions have been instrumental in driving public opinion and industry efforts to make this data available to their members. “Given the complexity of assembling the analytic and consumer interfaces needed to be effective in this arena, we’ve seen those coalitions encourage health plans to either build their own tools or look to third-party solutions to bring these tools to the market,” he says.

But Binder says more cooperation is needed. “Business healthcare coalitions are frustrated that plans haven’t been as forthcoming as they can be in providing claims data.”

Hall says employers are coming together to try to use their collective size to put more pressure on healthcare providers and healthcare plans to provide more information.

Final thoughts

With the increasing popularity of high-deductible health plans and the growing focus on the individual market, consumers are expected to become decision makers in their own healthcare. “They are being told to make value-based decisions and to shop for healthcare like they would shop for a car or major appliance, but they don’t have access to the tools they need to do so,” Ghertner says. Consumers want help, and many of them are turning to their plan sponsors for it. In fact, an Accenture survey shows that 87% of consumers want tools to help project their healthcare expenses. ■

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CONSUMER FOCUS CREATES NEW STAFFING NEEDS

Acquiring and retaining talent for a new model

by **BOB PIEPER**

With a more consumer-oriented health insurance industry evolving amidst landmark regulatory and technological changes, insurance plans need skills that

have never before been demanded.

“Healthcare is looking to those employers who have a strong brand and excellent reputation for understanding the needs and wants of their customers; whether they be in retail, finance, hospitality, automotive or a whole host of other industries,” notes Lu Miller, senior vice president/principal at the healthcare executive recruiting firm Morgan Consulting Resources.

The new approach in many cases will require the establishment of C-level executive positions such as chief of retail operations, chief customer experience officer or chief quality officer, notes executive recruiter Miller. It also means new responsibilities for top executives, such as the plan’s chief information officer or chief compliance officer.

New leadership

Health plans are now recruiting outside of the industry and competing with the likes of Disney,

Google, and Southwest Airlines for top executive talent, says Jay D’Aprile, senior vice president for health insurance industry recruiting at Chicago-based Slayton Search Partners.

D’Aprile, whose firm specializes in cross-industry executive searches, says a number of the nation’s largest health plans have recently brought in new executives from Ford, Wal-Mart and American Express, to re-orient their marketing and customer service operations.

But enticing execs to sign onto a health plan can be a challenge. Too often, health insurance companies seem stodgy, boring or worse, D’Aprile notes. For many, the mention of a health plan may conjure up visions of heartless autocrats finding ways to deny care for needy patients.

In addition, few executives outside of the health care industry fully understand the transformation that healthcare is now undergoing to increase care access, improve quality and reduce costs, D’Aprile notes.

The key to attracting top marketing talent, say Miller and D’Aprile, lies in successfully explaining the true mission of the health plan and the challenges it faces.

“The person developing a health plan’s B-to-C [business

to consumer] initiative faces enormous challenges. This is three-dimensional chess. It is very complex. There is marketing, technology, regulation, privacy laws, analytics, statistics,” says D’Aprile.

He recommends that clients look for a candidate who thrives on complexity and challenges. “For executives seeking to change the world, the health insurance industry today can offer a once-in-a-lifetime opportunity.”

“Find executives who are mission-driven,” D’Aprile says. “Interest them in the mission of the health insurance plan and they will want to be part of it.”

“Health insurance is a good thing,” D’Aprile continues. “It makes people’s lives better. Health insurance plans really care about their members. That is not a message, unfortunately, that health plans are getting out there. Explain the mission of the health plan and how the [prospective recruit] can play a role in helping people.”

Miller emphasizes the need for clarity and consistency among current plan leadership as key factors in finding the right hires for newly-established positions such as chief quality officer.

“Plans need to ask themselves, ‘What is the goal with this hire, what talent is the organization really looking for in creating a new role or redefining the responsibilities of established positions such as CIO under a consumer direct marketing strategy?’” says Miller.

“Make sure your internal team is on the same page. Get input from your internal key stakeholders, those leaders who will work with or rely on this position. It is important to make sure you are looking for the candidate who has the right

experience and capabilities so they will have all the skills necessary for a successful consumer-oriented program.”

Attracting staff

As they begin to realign their organizational structure, top executives at most health plans are quickly realizing that their present workforce lacks the capabilities and skills necessary to operate in the new consumer-oriented environment, warns Deloitte’s recent Health Plan Retail Capabilities Survey. (<http://tinyurl.com/mpkvhyz>).

Particularly in demand over the coming years will be personnel with product development, pricing and data analytics capabilities, the report suggests. So will technical personnel with expertise in interactive and customized technologies like social media and mobile applications, bio monitoring, and remote monitoring communications that enable telemedicine.

Analytics staff who can assist in developing insight into customers’ needs and preferences to distinguish how plans engage the consumer will be particularly important, notes Paul Lambdin, Insurance Exchanges and Consumer Operations practice leader for health plans at Deloitte Consulting LLP.

As with top executive talent, health plans may be competing with employers like Google or Apple for highly prized programming and analytics personnel, as well as good mid-to entry-level technical, marketing and customer relations personnel, Miller notes. Many of the best candidates may be Millennials or Gen Xers with little interest in—or even an unfavorable opinion of—health insurance plans.

Again, Miller believes, effectively conveying a health insurance plan’s true mission is crucial. Polling consistently

AETNA SETS MINIMUM WAGE AT \$16/HOUR TO ATTRACT AND RETAIN TALENT

Aetna will increase the minimum hourly wage for workers as of April 1 to \$16 an hour and enhance medical benefits that lower out-of-pocket costs for employees, in part to attract and retain talent.

The wage change will impact 5,700 of Aetna’s 48,450 employees, resulting in an average 11% increase and as high as a 33% increase. Employees in areas that will benefit the most from the wage hike are largely in consumer-facing positions, including customer service, claims administration, plan

sponsor eligibility and billing.

Mark T. Bertolini, the insurer’s chief executive officer, told the *Wall Street Journal* that one reason for the wage hike is the changing structure of insurance markets, which are selling more policies to individuals. “We’re preparing our company for a future where we’re going to have a much more consumer-oriented business,” said Bertolini, adding that he hopes the move will lower turnover and attract high-caliber job prospects.

For executives seeking to change the world, the health insurance industry today can offer a once-in-a-lifetime opportunity.”

— JAY D’APRILE

shows Millennials and Gen Xers place an emphasis on work that is interesting and meaningful. In addition, they’re not overly loyal to employers and not hesitant to seek other employment if work becomes dull. To attract top technical and customer service staff, Miller suggests that plans emphasize, in recruitment material, the civic, charitable, and wellness initiatives they sponsor.

Ambassadors are another effective recruitment strategy, Miller says. Employees who have sincere enthusiasm for a health plan’s work can often relate well to young prospective hires. She

advises human resource officers to identify such individuals within the ranks of health plan employees and utilize them as advisors for potential recruits at job fairs and college campus visits. They can also be effective in providing tours of health plan offices for potential recruits or new hires.

Employee development programs have also proven effective in improving customer relations, the Deloitte report notes. Drawing considerable attention over recent years has been a Walgreens program to improve customer service, amid increasing competition from mail order and Internet retailers.

Under the program, the nation’s largest drug store chain provided district managers with additional support to improve engagement with employees and customers. In addition to meeting customer engagement objectives, the program helped identify managers who were early adopters and quick to adapt to new retail environments, the company reports. ■

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USING INCENTIVES TO CHANGE BEHAVIOR

Wellness programs grow in popularity

by JUDY PACKER-TURSMAN

When Oscar Health in New York started paying its members \$20 if they got flu shots, the number doing so doubled. It also pays members \$60 for a wellness

visit, and they can earn up to \$240 annually for meeting walking goals on a wearable fitness device.

Sentara's Optima Health in Virginia is offering members up to \$275 this year for walking while wearing a fitness tracking device. "We were looking at ways to reward people for being active," says John DeGruttola, Optima's senior vice president of marketing and sales. Research found people "had trouble relating to athletes and got discouraged," he says, "so we wanted to reward people for just getting up off the couch."

"We're not doing this to get the best risk," DeGruttola adds. "Anybody who signs up with us, we're trying to get to be proactive with their health." Through its member surveys, Optima Health has "found somewhere between \$50 and \$100 will make you at least think about" healthy behavior, he adds.

Employers have used similar tactics in workplace wellness programs for some time. But under Affordable Care Act (ACA)

provisions taking effect in 2014, employers became able to offer incentives, either rewards or penalties, comprising up to 30% of premiums, deductibles and other costs, and up to 50% for tobacco programs.

The question now being asked is: do the programs work? "I think the evidence is mixed on the success," says Gerard Wedig, associate professor at the University of Rochester's Simon Business School. "If you think people are already well-informed and know what they ought to be doing, you had better weigh those incentives and make sure they're strong enough to effect change."

The percentage of employers offering wellness incentives is steadily rising, according to the latest survey by the National Business Group on Health and Fidelity (NBGH). And managed care organizations able to help employers with those efforts have what another expert describes as "a huge competitive advantage."

Preliminary data show 80% of employers participating in the NBGH survey are offering financial incentives to workers in 2015, up from 74% in 2014. "We think it's continued strong interest and an uptick," says LuAnn Heinen, NBGH's vice president of workforce well-being, productivity and human capital.

Employers are also spending more on wellness programs: A

median of \$600 per employee for 2015, up from about \$500 in 2013 and in 2014. "It's significant dollars," Heinen says, noting the survey's figures don't include money spent on incentives for spouses.

Companies are setting up a variety of programs, some that offer financial rewards and others that use participation-based and activity-based incentives, she says. Other employers, including many hospital systems, have outcome-based incentives requiring employees to work toward certain biometric standards to receive financial rewards.

Some are also using penalties, with a tobacco surcharge being the most common type of penalty, and that has raised workplace fairness issues and at times led to litigation.

"There are just so many variations. We're seeing the designs are complicated, because there are so many ways to get at this,"



HEINEN

Heinen says. Employers might not financially reward employees for completing a health assessment, but the worker may

need the assessment for a Health Savings Account (HSA) or to get into the pool of incentives, she explains.

"Sometimes it's not about money changing hands," Heinen adds. "Sometimes it's points, sometimes it's a premium reduction, sometimes it's a contribution to reduce point-of-service costs for uncovered services to put toward your deductibles or copays. And it can be a combination of rewards and penalties."

Employers wellness incentive programs also differ depending on philosophies, Heinen says. For example, she says, "There are companies that don't use financial

incentives because they're all about supporting employee stress levels...and their focus is more on relaxation, healthy eating and physical activity." Others, including UnitedHealth Group, focus on biometric scorecards for employees, she says.

On the individual side, the aim of consumer-driven health plans (CDHPs) is to help people take greater control of their healthcare, sometimes by coupling HSAs with wellness programs.

"With consumer-directed health plans, the feeling is we need to manage our health as best we can," Heinen says. "And when you have a \$4,000 deductible and no coverage beyond preventive services until you hit the deductible, companies feel they're helping employees' budgets" with wellness components—and also aiming to improve the population's health as a whole.

"There are companies who say, 'You give someone a big enough financial incentive and they'll become engaged,'" Heinen says. Other companies "are really into social incentives: You get \$50 if you do something, and you get more if you do your entire work unit does it."

Heinen asserts most employers seem more interested in improving health risks than focusing on return on investment. She says it is difficult for employers to determine the cost impact, but some report positive effects on worker recruitment, retention, and worker productivity, along with less absenteeism.

Employers are also looking to health plans for expertise. "The health plan is in many cases the third party delivering this [wellness incentive program], or a vendor is—not the employer," adds Heinen.

Healthy corporate culture

A positive impact of the ACA is that it has prompted employers and plans to look at wellness and health promotion programs to

change behavior, says Ron Goetzel, PhD, vice president of consulting and applied research at Truven Health Analytics. "But the bad thing is that many have tunnel vision of what a wellness program is—and whether to pay people for not being obese...



GOETZEL

That may be a component, but that's not the whole program."

Goetzel, also a senior scientist at Johns Hopkins University,

stresses that incentive programs, whatever their design, are not the same as comprehensive health promotion programs. Moreover, he says, programs seem to work best when embedded in a "healthy" corporate culture where senior managers and staffers believe that having a healthy workforce is good for the organization, and with a high level of trust between the employee and employer.

MCOs "don't, unfortunately, control the culture," Goetzel says. "However, what the health plan can do is create a partnership with the employer...and say, 'We'll work with you to create policies, programs and practices to support health.'" Employees also should help design programs, he says.

Incentives are a relatively "new wrinkle" in the process, Goetzel says. Research indicates that participation-based incentives work to boost engagement but it is less clear whether outcome-based incentives help to change outcomes. "If that's all you're doing [i.e., paying to achieve certain health outcomes], I think you're bound to fail," he says.

"If you're paying people hundreds of dollars to change behavior, that's a huge expense. It's easier to have programs and policies that support healthy lifestyles," Goetzel asserts, citing appropriately labeled "healthy" cafeteria food, on-site fitness

centers and subsidized weight-loss programs as examples.

Each workplace will have its unique approach to wellness, and what works at Company A "may fall flat at Company B and vice versa...but there are best practices out there," he adds.

From individuals to employer groups

Optima's new rewards program, which includes nutrition, weight loss and physical activity components, is starting with individuals. In all, 200-plus individual and family plan members had completed personal health assessments from Jan. 1 to Jan. 13 as the first step to get the fitness device.

"The reason why we picked the individual population is they pay 100% of their premium, so they're more motivated," DeGruttola says.



DEGRUTTOLA

But he says the plan seeks to determine how the fitness-device program might also work for employer groups. Of Optima's 451,000

members, about 34,000 are individual and family plan; the rest are group members and in Medicare and Medicaid.

"We want to see the program grow," DeGruttola says. "We do see interest from employers... so once we know [the device's use] is scalable, we'll offer it to them.... We already have about 90,000 members in group wellness incentive programs, but without trackable devices."

"We know more than 40% of healthcare costs are due to modifiable behavior," he says. "... We're just trying to get people to be more aware of it," and become more fit. ■

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DRUG USE DIFFERS FOR EXCHANGE MEMBERS

Overall utilization rates are higher

by MARI EDLIN

Two recent studies show that members who obtain health insurance through state or federal insurance exchanges use more specialty and generic drugs than their counterparts in commercial plans.

Based on a national sample of more than 80 million de-identified pharmacy claims administered by Express Scripts between January 1, 2014 and July 31, 2014, Exchange Pulse shows that health exchange members are 59% more likely to have filled a prescription for a specialty medication.

Members aged 18 to 44 filled almost twice as many specialty drug prescriptions than members in the same age group with commercial insurance. HIV tops the list of specialty drugs for members aged 18 to 64, especially those with low median income. Low median income members consume 56% of all specialty drug claims under the exchanges. The expensive new drug for hepatitis C, Sovaldi, is also taking its toll on total drug spend for exchange members, whereas transplant drugs head the list on the commercial side.

Seven out of 10 of the most costly medications were specialty drugs under the exchanges compared to four out of 10 in commercial plans.

Specialty medications comprise 1.3% of prescriptions, or 38% of total pharmacy spend for members under the exchanges compared to 0.82%, or 28% of total drug spend, in commercial health plans, according to Exchange Pulse.

Julie Huppert, vice president of health reform for Express Scripts, a pharmacy benefits manager (PBM) based in St. Louis, Missouri, attributes the higher utilization of specialty drugs among exchange members to pent-up demand. Many exchange members were not previously covered by insurance, and as many as two-thirds of health exchange members now under the purview of Express Scripts did not have insurance prior to 2014.

In addition, she says that tax credit subsidies available through the exchanges have made it possible for many members to afford more expensive specialty drugs.

Express Scripts attributes some of the increase in HIV drugs to federally-funded programs for HIV patients, which have pushed most of the costs onto private health insurers.

A study by CVS Health, based in Woonsocket, Rhode Island, aligns with the Express Scripts report. The retailer analyzed 894,000 prescription drug claims from January to September 2014 comparing exchange members to commercial and managed Medicaid members.

The report found that exchange members utilized more specialty drugs (1.3%) than their counterparts in commercial plans (0.95%) and Medicaid plans (0.6%), resulting in higher spend as a proportion of total drugs costs for the exchange plans (35.8%), managed Medicaid (30.1%) and commercial (28.3%).

William Shrank, MD, chief scientific officer for CVS Health, notes that the higher use of expensive antiviral medications among exchange members affected costs, along with the availability of few generics for HIV and the high cost of Sovaldi.

As in the Express Scripts study, antiviral medications to treat HIV for CVS members headed the list in gross spending from January to June 2014, ranging from 17.7% (percent of gross specialty medication costs) in commercial plans to 35.2% for managed Medicaid, with exchange plans at 33.1%.

Cancer drugs ranked fourth on the list of highest gross spending among specialty drugs for all three types of plans. Although more cancer drugs were used than drugs for HIV and hepatitis C, there are more generic cancer drugs, thus keeping costs lower.

CVS Health suggests that many exchange members might not have had access to some oncology drugs prior to their enrollment.

Exchange members fill more generic Rx's

Express Scripts finds that across most therapy classes, age groups and income levels, health exchange members fill more prescriptions for generic drugs. Their overall 87% generic fill rate outpaced health plan members by 6%.

The Express Scripts study suggests that exchange members receive incentives to use generics, driven by a greater differential be-

tween generic, preferred and non-preferred brand tiers. In addition, they might be unable to afford higher-priced brand drugs.

While the number of claims for nine out of 10 chronic conditions is similar for those in and out of exchanges, a few exceptions stand out:

- Use of pain medication is 39% higher in health exchange plans;
- Use of depression medications is 12% higher in health exchange plans;
- Use of contraceptives is 32% higher in commercial health plans because members of exchanges are older and less educated about the importance of using contraceptives, Express Scripts suggests.

The CVS report indicates that, excluding specialty drugs, average total costs per claim were 22% less in exchanges than in commercial plans. CVS Health attributes the higher savings to a larger proportion of generic use among exchange members (88%), Medicaid (85%) and commercial (83%).

Shrank anticipates that the higher use of generics in exchange plans should lead to better compliance and less cost, and ultimately, improved outcomes.

Overall drug utilization

The Exchange Pulse report also indicates that nearly half of exchange members (49%)—even those who did not register until April 2014—used their pharmacy benefit and filed at least one claim, closing in on commercial members (55%) who have filed a claim.

When members joined the exchanges in 2014, more of them had chronic disease than their commercial counterparts. Huppert says that stands to reason because many of them were not insured and were held back by pre-existing conditions, which is no longer a barrier.

On the other hand, Shrank says he was not surprised to find that, based on the CVS study, there wasn't much difference in overall

utilization of drugs by members in the exchange compared to those in the commercial and Medicaid populations.

Nearly one-third (28.6%) of members in exchanges filled at least one prescription each month, similar to members in commercial plans (28.1%).

Use of 90-day prescriptions for maintenance drugs by exchange plan members increased since January 3, 2014 to 3% of all prescriptions, not quite as high as the 3.9% by commercial members.

Exchange members face higher out-of-pocket cost

Exchange members have higher out-of-pocket costs - 36% more than those in traditional health plans - but their overall plan costs are 10.4% less. The Express Scripts report indicates this might be due to cost containment achieved through home delivery, narrow networks and less robust benefits.

The CVS Health report coincides with the Pulse report, indicating that cost share is higher for exchange members. While average cost share decreased for both exchange and commercial members through June, the former was higher at 20.3% versus 17.9% for commercial members in January 2014; however, cost share in both types of plans decreased each month through June. CVS' Shrank says expectations were for higher costs per prescription drug claims than materialized.

The CVS study also shows that cost share for commercial members leveled out from June to September while cost share for exchange members continued to decrease. Those decreases were expected to continue through the remainder of 2014, dropping lower than for commercial members.

Shrank says that, while out-of-pocket expenses in the exchanges were initially higher than in the commercial plans, they decreased during the year as members gained

a better understanding of their pharmacy benefits.

CVS Health will continue to monitor drug utilization during the second year of the exchanges.

Caroline Pearson, vice president of Avalere Health, a healthcare analytics company based in Washington, D.C., says that an analysis by Avalere indicates that patients accessing specialty medications through the exchanges are more likely to experience higher out-of-pocket costs in 2015 than 2014. "In order to keep premiums down, exchange plans are increasing deductibles and offering skinnier plans," she says.

The number of silver plans charging coinsurance greater than 30% for specialty drugs has increased from 27% in 2014 to 41% in 2015. The number of bronze, gold and platinum plans using coinsurance of more than 30% also increased in 2015 over 2014—38% to 52%, 20% to 22% and 17% to 26%, respectively.

Both Shrank and Huppert recommend health management strategies for exchange members to control costs. "We need to apply more benefit management strategies, such as reinforcing the appropriate use of medications and adherence programs, to the exchange population [just] as we offer members in Medicaid, Medicare and commercial plans," Shrank says. "Exchange members are more similar to those in the other plans than they are different."

Adds Huppert, "Because exchange members have a higher utilization of specialty drugs, health plans should pay close attention to its patients with high-cost, complex conditions, offering them greater care support to ensure optimal outcomes—similar to programs and strategies that commercial plans are using." ■

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EXCHANGES NEED IMPROVEMENTS

With crises in the past, focus turns to upgrades

by **ANDREA DOWNING PECK**

When President Obama announced the launch of the federal insurance marketplace in 2013, he compared the new health-insurance-shopping experience to “buying a TV on Amazon.” Yet as healthcare reform enters its second year, health insurers and health insurance exchange vendors complain that data interoperability issues continue to plague the carrier-facing side of federal and state exchanges, forcing many health plans to turn to outside vendors to navigate connectivity issues and search for solutions.

“I rarely have a bad experience with Amazon,” says Stephen Goldstone, president and chief executive officer of Wyoming-based WINhealth. “If the exchange operated on Amazon’s level, I would be pretty happy.”

A year after its botched launch, HealthCare.gov, the website for the federally facilitated marketplace (FFM), continues to struggle with back-end technological issues.

“A year ago, we built procedures on the assumption the federal exchange would do certain things, which as it turned out, it didn’t do,” Goldstone says. “The exchange didn’t work for the consumer and it clearly didn’t work for the carrier. Processes we thought would be

automated weren’t, and for the most part are still manual.

“Much of the federal government’s efforts since the early days of the exchange have been designed to improve the consumer-facing side of the exchange,” he adds. “If you are an individual who goes to the exchange to enroll, you have a better experience in 2014 than you did in 2013, but on the carrier-facing side of the exchange, there still are many issues.”

One of the exchange’s main shortfalls is lack of a fully-automated back-end system that reconciles and updates member information and other key data. When people change their address or need to add a child to their coverage, for example, the Centers for Medicare and Medicaid Services issues a termination file and then re-enrolls them, creating additional work for the carrier.

“There is not a permanent reconciliation process between the health plans and the exchanges, so some of the regular maintenance—updating files, updating consumer information—is still being done in large part manually,” says Clare Krusing, spokesperson for America’s Health Insurance Plans. “More of the back-end system needs to be built out and reconciliation is part of that.”

While the HealthCare.gov website is operating better this year, the second enrollment period brings a new set of challenges, with more than 8 million people

renewing their policies through auto-renewal, changing plans or changing carriers.

“This is the first year of renewals and the auto-enrollment process, so we are in a bit of uncharted territory in terms of what sort of data and technology is needed moving forward, but we are gaining clarity every day into how those processes need to work,” Krusing adds.

Bruce Pomfret, vice president of NFP Health, says the inaugural year of the federal and state exchanges spotlighted a skills shortage—a lack of experts who understood how health plans collected, transferred and stored information ranging from enrollment data to financial data.

“You didn’t have a lot of people who understood how to put that together,” he says. “You had something like 17 state-based exchanges that needed to hire staff vendors, who needed to hire staff to create these interfaces with carriers. You had carriers that needed to hire staff to help interface with the exchanges on their side, and then you had the federal exchange needing to establish interfaces with hundreds of carriers across the country. What you ended up with were implementations that didn’t work.”

While much knowledge has been gained in year one, data reconciliation between the exchanges and the health plans is expected to be an ongoing issue. Some experts anticipate incremental rather than wide-sweeping improvements as long as the healthcare industry continues to rely on outdated technology for claims processing and other functions.

“The biggest challenge across the board is the pretty significant gap in the data the carrier has—either they are missing enrollments or they are missing terminations for enrollments that should have been terminated or they didn’t get updates on data that has been subsequently updated by the exchange,” Pomfret says. “Until we have a cleaner, more timely reconciliation process, you are going to have a gap between these things, and it is a multiplying gap. Reconciliation issues tend to pile up on one another.”

Pomfret says the role data reconciliation plays in an exchange’s success or failure is significant.

“Exchanges that we have seen that work well have people at the vendor level, the state level and the exchange level who understand how carriers consume data and how important it is to have timely and accurate data,” he says. “It sounds obvious, but it often isn’t.”

WINhealth turned to Softheon Inc.’s cloud-based marketplace integration platform to eliminate headaches it was experiencing with the FFM and to create a direct enrollment option.

“We wanted to be able to offer people the opportunity to directly enroll with us and not have to go through the exchange,” Goldstone said. Part of the reason they went with Softheon, he adds, is that they were “able to act as our interface with the exchange and us. They have become our intermediary and it’s working significantly better than it would have without their resources.”

While initially some vendors priced themselves out of the reach of smaller health plans, Daniel Buchanan, business development senior consultant at Dell, believes evolving pricing strategies will enable smaller carriers to hire outside assistance.

“Vendors, if they are smart, are

learning to re-price or repackage so they can reach down to those smaller, regional plans and the new co-ops that are popping up in most states, so expertise isn’t overshadowed by lack of funding,” he says.

Softheon founder and chief executive officer Eugene Sayan suggests vendors can be the game changers that provide long-term solutions to data interoperability issues.

“Vendors need to come together and agree on a protocol where we are able to take the data and share the data with other vendors,” he says. “We need to come up with standards that everyone follows to some extent. In the absence of standards, every one is inventing their own little ways.”

Goldstone, however, believes the “long-term fix is to reconfigure the process” so that carriers enroll members directly, determine a potential member’s eligibility for an advanced premium tax credit and the amount of the credit, and then feed that information to the exchange.

“The whole experience has to be rethought,” he says. “We, the carriers, should be the ones enrolling members directly and we should be feeding the information to the exchange, as opposed to having this unwieldy organization between the customer and us.”

Despite the bumpy beginning, Pomfret is optimistic the future will be brighter than the recent past.

“Things are running,” he

points out. “Nothing is outright broken now. Yes, that is a low bar, but each vendor is getting better, each carrier is getting more sophisticated. The lessons learned are being applied from a project management, technology and leadership perspective. I think you are definitely seeing a significant improvement in year two. By year three, the discussion will be around policy and all the noise about technology probably will fade into the background.”

A setback could be the Supreme Court challenge to Affordable Care Act tax subsidies. If tax credits are struck down when the court rules next summer on *King v. Burwell*, “there would be major disruption in the 37 states that are relying on the federal exchange,” predicts Joel Ario, managing director of Manatt Health Solutions.

“That kind of thing would be a real setback and, frankly, what we don’t need at this point because things are stabilizing,” says Ario, who served as director of the Health Insurance Exchange Office in the U.S. Department of Health & Human Services.

“We have more people covered today, insurance rates are down and we have the lowest healthcare inflation in 50 years. Something is going very right with the system. Can the Affordable Care Act take full credit for that? No, but they can take some of the credit,” Ario says. ■

Andrea Downing Peck is a freelance writer based in Bainbridge Island, Washington.

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