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❍ Two New National Organizations To Advocate ACOs

trendlines...

Health plan chains gave notice that they will not even bother to apply to participate in health exchanges in *half of all states*. The revelation at investor conferences is a warning that despite all the political verbiage most private carriers do not need (or want) a large book of business in the small group and individual markets, and have no intention of losing money to sell rich benefits to people with higher-than-average underwriting risk. The timing is *no coincidence*: many states are still deciding how much price competition they want to impose on the assumption that they will have lots of plans to pick from. But it's bad news for Blues plans and **Wellpoint,** often the carriers of last resort.

California will spend over one billion dollars on advertising and outreach programs to enroll the uninsured and pay their premiums in its new health exchange. In effect, CA is destined to be a test of how big a problem participation will be in smaller states with less funding or commitment. This week HHS gave out $1.5 billion in health exchange funding, almost half going to the Golden State. Others drawing funds were Delaware, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oregon and Vermont. Exchanges will actually start in just 9 months when open enrollment begins for the January 1 launch.

Providers And Vendors Favor Delays In HIT Last week **AMA**, **AHA** and the IT vendor association **HIMSS** came out of the closet and suddenly called for a sharp change in direction for federal HITECH regulations including 'more study' and evaluation, which experience shows means stalling the entire program. The comments of all three were practically cut-and-pasted from early 2011 comments opposing Phase II that resulted in a one-year delay. The initial draft for Phase III starting in 2016 expands on the first two stages which essentially allowed federal payments to go to vendors without requiring much use of the systems. The third stage would require much more use and precise tasks, but could force more providers to drop their old IT systems.

The last quarter before health reform kicks in was apparently as stable as the previous four years since 'ObamaCare' was enacted. United just reported 4Q 2012 earnings and revenues up steadily and slightly beating estimates except for a slightly lower investment income on reserves that were over-funded. The average *medical trend* reported by large public firms is expected to be just about even with earlier quarters at less than 6% net of cost-sharing, in line with our prediction two years ago that medical trend will keep slowing until mid-2013. After that all bets are off until the air clears on a dozen variables. As usual government 'experts' said the slowdown is merely a recession hangover.

★ MA Star Ratings Study In *JAMA* Finds Stars Work

A study in the January 15 JAMA by CMS researchers finds that MA plans with higher star ratings are attracting much more enrollment at a faster pace. After studying 7.5 million enrollees the researchers concluded that *each 1-star increase is worth 9.5%* greater increase in new enrollee membership, and 4.4% among benes already in another plan. Consumer groups applauded the findings and **Jack Hoadley**, Ph.D., of Georgetown University said it shows the star system is working and should be expanded.

market notes...

United Forms Big Data Project With Mayo Clinic

UnitedHealth Group and **Mayo Clinic** announced a surprising new research alliance allowing Mayo researchers to use United's massive claims repository as a source. Details and background on the alliance were completely missing, but it makes sense: Mayo has a huge building doing nothing but clinical research -- but has no very large population to compare and serves a heavily chronically-ill population. As it expands across Minnesota and Florida with clinics, that's changing. United for its part "needs to validate what they don't have: all the super specialty stuff," top consultant **William DeMarco** notes. "This is a perfect fit in the sense that big data research validation is the future."

Three large health plans this week showed the value of being big: **Group Health Cooperative**, **Marshfield Clinic** and **Scott and White Healthcare** were used by the **Center for Disease Control** to track the effectiveness of the flu vaccine to the entire U.S. population. The idea of big data across health claims is several years old but has been growing into a higher priority. An early effort was the 'Blue Intelligence' consortium of 39 Blues plans that in 2009 evolved into **'Consortium Health Plans.'**

Kaiser is the world leader in use of big data by health plans, a process that since 2008 has resulted in a list of major clinical breakthroughs. Lately KP has become the world leader in genomic sequencing of members, and is the largest clinical research population in perhaps a dozen areas including cancer research. A KP finding that stroke victim mortality rates can be cut in half simply by giving patients statins upon admission should by rights be adopted by every hospital world-wide. **See Box... p. 2**

CIGNA Expands Private ACO Portfolio To 22nd State

CIGNA is expanding its collaborative accountable care (CA) program through 10 new initiatives with physician groups in nine states, including the company's first CAs in Florida, Indiana, Louisiana and South Carolina. With the addition of these initiatives CIGNA now has 52 collaborative accountable care programs in 22 states covering nearly 510,000 customers, and remains on track to reach its goal of 100 initiatives for one million customers by the end of 2014. The company launched its first collaborative accountable care program in 2008.

Big Carriers Tap NYC Incubator For Inspiration

A large NYC tech incubator called **Blueprint Health** just added **Verizon**, **Humana** and **Aetna** to its list of 'partners,' allowing them to keep tabs on the world of VC-funded brainstorms without any commitment to funding any of the research. Most of the solutions so far are provider-oriented productivity tools, but payers are expected to provide a better research blueprint. At the big **CES** meeting in Las Vegas last week it became known that *VCs are unhappy* with first generation 'wellness' gimmicks: products like weight scales and wrist watches claiming that doctors can be replaced by m-health devices. The new approach: more innovation aimed at *provider productivity* tools, not cool toys (like a digital fork that gives off an alarm when you eat too much). The only health plan we saw at the CES this year was **OptumHealth.**

New ACO Association To Recommend Reg Focus

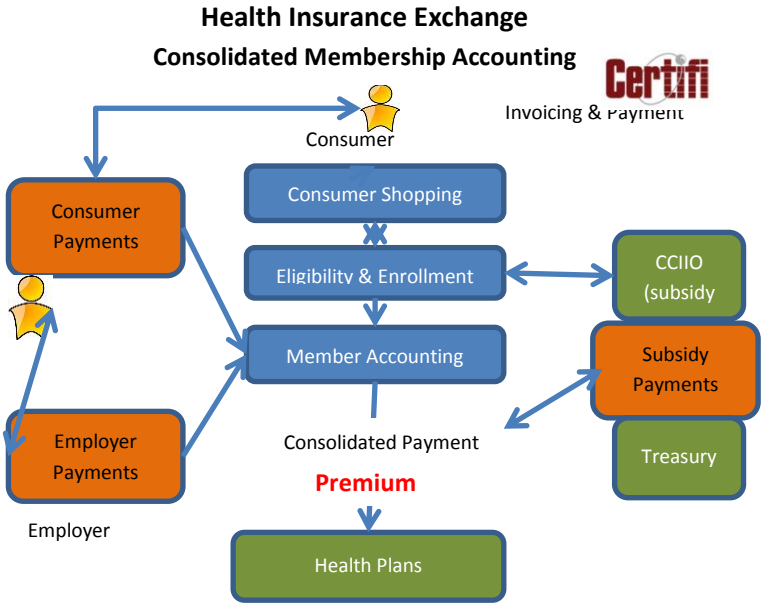
A new **National Association of ACOs** (NAACOS) is expected to ask **CMS** to consider more local risk adjusters for ACO payments as part of its mission, board members told *HPM*. Former CMS officials **Bruce Reid** and **Cliff Dodds** are directors and the group is holding its first policy conference in Baltimore on March 19-21. NAACOS is taking "FOUNDING MEMBER" applications via the Website. "Applications received by January 25th will be designated as Founders in the official history of the organization." Applications can be submitted electronically from the website or via a fillable PDF being distributed by email. **Jon Blum**, Deputy Administrator, CMS, is a confirmed keynote speaker.

New Commission To Zero In On State Budgets

A unique new *privately-funded* Commission will focus on what state governors can do to control health spending in their own jurisdictions. The *State Health Care Cost Containment Commission*, based at the University of Virginia but staffed by former **NGA** officials, will "develop a process and practical policies that states can adopt and implement to hold the growth rate of all health care spending in a state to a growth rate similar to that of the overall state economy, i.e., the Gross State Product." **Kaiser Permanente** chairman and CEO **George Halvorson**, a commission member, laid out the agenda: expanding ACOs and medical homes; real payment reforms such as global capitation for hospitals and in-network providers, and bundled payments for clinical procedures, such as making one payment to a surgical team rather than separate payments for each provider in a team.

Billions In Exchange Payments Still A Mystery

Health insurance exchanges will be making tens of billions in premium payments to hundreds of health plans next year, but there is no final system in place to route the money, leading technology contractor Certifi tells HPM. The U.S. Treasury will soon be sending the checks to states, but at that point it's anybody's guess how much will be deducted or adjusted before it actually reaches a health plan's bank account. Certifi does the newly-approved Utah exchange.



Medicare Advantage Safe For Next 2 Years

A realistic review of all the factors facing MA plans concluded that benchmarks will be stable in MA through 2016 and program growth will continue on its current trajectory. HPM is predicting after a private review that the 2014 benchmark cut at a minus 3.5% will be offset by various adjustments and star ratings bonuses, netting out at an *average 1.0% rise* in benchmarks. The biggest risk is that Congress will impose some kind of sequester cut on MA across-the-board, but that hasn't happened.

Medicare Stars Program Worked Great In 2012

The best MA plans are moving steadily higher in quality performance, making it unnecessary for any adjustment in the bonuses for 3-star contractors, HPM is finding as we prepare a follow-up study to last Fall's analysis of chain rankings. CMS is viewed by insiders as ready to shift more funding into bailing out lower-quality plans, but given the latest projections of benchmarks that will be a tough sell. We will release the findings January 29 at the World Congress forum in Washington on The *Business of Medicare Advantage*. Come visit our panel.

Public Firms Face Risk Of Sudden Earnings Hit

Signs are rising that the publicly-traded national chains are at risk of a sudden downdraft in their earnings this year and nobody is listening. **Aetna** chief **Mark Bertolini** was all over the airwaves dropping hints in December that carriers may be overpriced, but few were listening. Now signs are growing that he is right. *Among the indicators*: the flu season is going to be a real drag on earnings and the biggest firms are the most vulnerable; hospital bad debts are accelerating but ACA payment offsets may not catch up; and public or private exchanges many hit pricing. Stocks so far have kept above their 52 week highs. *Story p. 3.*

Major CDH Players Seeing Prosperous Times

First Data Corporation and **Webster Bank, N.A.** signed a new long-term deal extending their merchant services partnership. First Data will continue to provide merchant processing services to Webster's customers at its 167 banking offices throughout the northeastern United States, allowing Webster clients to gain access to First Data's full range of point-of-sale payment solutions..... *HSA balances* held by members of **HealthEquity** Inc. now top $1 billion, the company disclosed. HealthEquity works with more than 60 health plan partners and services more than 760,000 health care accounts for employees at more than 23,000 companies across the U.S. We will be doing the latest national HSA account study in the new few weeks...

United Officially Cleared By NAIC On 2007 Probe

The NAIC officially closed the books on the corrective action plan following UnitedHealth's 2007 claims backlog investigation – with *no further penalties assessed*. In 2007, the company reached a Regulatory Settlement Agreement with insurance regulators who oversee 26 entities owned by UnitedHealthcare in 41 jurisdictions to address past practices regarding timely payment of claims . The agreement included minimum standards against which UnitedHealthcare's performance would be measured in real time, escalating penalties for non-attainment, the payment of restitution when appropriate, and extensive assessment by an

independent examiner. A final report finds all standards were met and that "UnitedHealthcare has met all metrics and compliance benchmarks set out under the settlement agreement."

New Bank Card Allows Employers New Flexibility

A new 'dual purpose' health card was unveiled by **MasterCard** and **Medagate** this week in *ConsumerDrivenHealth*. The card allows employers to give both an HSA-HRA contribution and a limited purpose spending allowance on a single card. For instance, employers can give workers a defined contribution, then fund an HSA or HRA to go with it plus a wellness incentive fund in the form of a gift card stored value – all on the same MasterCard and available through *every pharmacy in the U.S.* At least four of the largest U.S. banks are expected to sign up immediately along with major TPA-vendor chains like **PayFlex** (Aetna).

CIGNA Adds Audax Social Media Innovation

Audax Health Aligns With CIGNA Audax Health, an end-to-end digital health company, signed a five-year strategic alliance to develop a customized digital engagement platform "designed to help millions of CIGNA customers improve their health through fun and engaging health related activities and information". HPM reviewed the Audax Health platform in *CDMR* last Fall and found that it represents a solid potential model for member interaction.

legal notes...

- Top health care law firm **Epstein Becker Green** (EBG) is moving to beef up its health care area. EBG hired **Linda Tiano** as a Member in the Health Care and Life Sciences practice. Tiano served as SVP and General Counsel for **Health Net** and **Empire BCBC**. Meanwhile, EBG attorney **Adam G. Solander** warned last week in an article that "employers should guard against making decisions about reducing service hours based on the word of employees who promise not to seek subsidized health insurance coverage in a state or federal exchange." Solander said "those types of employee promises written into contracts would not protect an employer from liability under ACA's excise tax rules if employees were to disregard the contracts and enroll in subsidized coverage through an exchange," adding that employers should resist that response to ACA's "pay or play" mandate, even if "it is something you feel you might want to do, especially for good employees."

Health Plans Brace For Wild Ride In Fall 2013
Actuaries Juggle Schizo Pricing Variables

About five years of stability in the health plan industry will be tested in the coming months as the final ACA health reform law structural changes kick in across private markets. Combined with a steady increase in private market self-reforms over the past decade, it will be a wild ride for the next 18 months or so.

United this week reported very strong results showing no signs of a change in its pricing variables and continued strong enrollment growth despite all the talk of a potential downside.

Recent predictions from industry leaders about exploding premiums are almost impossible to refute so far in 2013 due to an huge vacuum in useable data and at least a dozen pricing or other input variables, top actuarial firms tell *HPM*. "The known factors are both positive and negative, but the unknown factors are on a much larger scale," one well-known financial expert summarized the mood. "It's a funny situation after several years of expecting a spike in costs, but seeing a decrease instead."

Known factors that are positive for the earnings outlook short-term: *Medicare Advantage rates* will remain relatively stable over the next two years, employers will be very willing to move into lower-premium plan designs and shift costs to consumers, and overall medical cost trends are not rising much across the entire market, even hospital prices and even pharma spend. Basically, not much has changed over the past four or five years of predictability.

Now offsetting this are unknown variables with bigger impact: the sudden need to set aside reserves for the coming premium tax hit, the looming arrival of *guaranteed issue*, and rate band compression that will mean the likely exit of many carriers from the individual market in many states (even Blues plans). Health exchanges are not a real threat yet, but add in the unexpected flu epidemic and it's a crazy quilt of up and down factors. Nobody could honestly say they know for sure.

The good news: by this time a year from now the impact should be clear. If we had to hazard a guess it would be for a

Excerpt: *KP Inside* by George Halvorson

"Between patient reminders, call-backs, KP-initiated office visits, various follow-up advisory notices and care protocol triggers, the safety net program actually facilitated over 2 million successful patient interventions and patient follow ups last year that would not have happened in any care system that did not have an electronic medical record tool or that dataset or that safety net program.

"That is an amazing number. It is a blessing to our patients that our caregivers and our care teams have a set of follow-up tools that can make small and big improvements in their care 2,000,000 times in one year.

"There will be a time not far into the future when the world will look back on the care delivery reality and information flow that existed before all of those new care treatment tools were developed and put in place, and people will say that we had been living in a care-support dark age -- using a very primitive set of care-support tools that often fell far short of optimal care support."

longer rollout of the bad things than expected, and stronger rollout of the good things than expected. But that's just a guess.

Health Exchange 'Co-Op' Model Faces Extinction

The fiscal cliff agreement sounded the death knell for the formation of 'co-op' model health exchanges under ACA. The deal allowed current co-ops to finish spending the $2 billion allotment, but deleted all future funding for what was supposed to be the 'single payer' version of health exchanges. A total of 24 new co-ops have taken root, but almost all of them are small startups using existing provider networks or previously-funded NGOs. **The National Alliance of State Health CO-OPs** (NASHCO) argues that consumer oriented and operated plans are "an essential alternative to traditional health plans as premiums rise."

Most States To Use Same System With Different Logos
Health Exchanges Will Be Nearly Identical

The 18 states which are planning to be "state" health exchanges may soon realize that they won't be doing it themselves after all. Most of the major functions of a health exchange will be basically the same whether it's called state or federal, and all states will rely on Washington for most of their functions whether they like it or not.

The main chore state exchanges will have is picking a good name. After that the states which opted to supposedly "go it alone" will find out they are not exactly alone.

The "partnership" model for health exchanges is an example. It gives states the option of managing health plans, a sop to the state insurance departments who were feeling pre-empted by all this federal stuff. And it allows states to do more marketing and outreach, in effect transferring the cost from the federal to state budget. Most are saying no thanks.

But millions of Americans in "federal" states will be logging onto the "federal" website to find a health plan, or a cookie cutter website operated by the state. Realistically there will be almost no difference between exchange websites since they all do the same thing. All will use the same data for selecting plans, and most will use the same technology.

The real killer for all states will be coordinating payments. The U.S. Treasury will be sending a blizzard of checks to insurers for instance for subsidies, but the insurers will be face a huge challenge reconciling that with offsetting state payments. A huge mess is near. These payments will be made to local insurers, TPAs and employers for adjudication.

States which thought they were going to be independent will then find out that every person entering their exchange, using whatever website, will have to be passed along to the federal system – the same one that all of the states *not* doing their exchanges are using. They will have to have their income verified by the IRS, their employment status verified by the Labor Department, and their subsidy calculated by HHS. The same office in HHS will then tell all states how much the subsidy should be and OK sending a check. The Treasury Department will then send the checks, not the state exchange.

There are some things the 18 state exchanges will do locally, both very complex and costly. They will have to integrate their existing agencies like Medicaid, tax agencies, and labor departments with their exchange's computers. States without exchanges don't have to. And they can link their existing state agencies directly to the federal hub at lower cost.

There are two areas where *all* states will have big local chores whether they have their own exchange or not. First, they will have to aggressively push enrollment of the uninsured and expanded Medicaid populations. Some argue that is best done locally, which if true would favor state exchanges over the federal exchange. But for federal partners there will be much more of the cost picked up by the feds.

Consumer Reports: ACHP Members Are Best Groups

The **Alliance of Community Health Plans** is on a roll. Last week *Consumer Reports* released ratings of Wisconsin medical groups as part of a collaboration with the **Robert Wood Johnson Foundation**. The ratings cover 19 medical groups serving nearly half of the state's patients. Two groups — **Marshfield Clinic** (affiliated with **Security Health Plan**) and **ThedaCare Physicians** — earned the highest rating on all but one individual measure.

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