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Announcements

Quoted
Healthcare.gov Finished Strong Despite Rocky Start, Enrollment Data Show
Kaiser Health News reports: Administration officials said Thursday that enrollment through the health law’s online insurance marketplaces this year was sufficiently strong and wide to ensure a healthy risk pool “in every state.” Kaiser Health News, May 1, 2014

Each year, nearly 900,000 Americans die prematurely -- up to 40 percent preventable
UPI reports: Almost 900,000 Americans die prematurely from the five leading causes of death – heart disease, cancer, chronic lower respiratory diseases, stroke and unintentional injuries -- yet 20 percent to 40 percent of the deaths from each cause are preventable. UPI, May 1, 2014

Cigna Profit Surges on Improved Group Disability, Life Operations
The Wall Street Journal reports: Cigna Corp. said its first-quarter profit surged as the company posted higher revenue, particularly from its group disability and life operations. Wall Street Journal, May 1, 2014

Medicare Seeks To Stop Overpayments For Hospice Patients' Drugs
Kaiser Health News reports: New Medicare guidance taking effect today aims to stop the federal government from paying millions of dollars to hospice organizations and drug insurance plans for the same prescriptions for seniors. But the changes may make it more difficult for dying patients to get some medications, senior advocates and hospice providers say. Kaiser Health News, May 1, 2014

Report: Two-Thirds of Insurance Exchange Enrollees Paid Premiums
The Wall Street Journal reports: Around two-thirds of people who had picked insurance plans through HealthCare.gov paid their first month's premium by April 15, according to a report released Wednesday by Republican lawmakers using data from insurers. Wall Street Journal, April 30, 2014

States using federal marketplaces spent far less on enrollment assistance
McClatchy reports: State-run and partnership marketplaces spent vastly more on enrollment efforts than states that used the federal marketplace, according to a new report by the Robert Wood Johnson Foundation. McClatchy, April 30, 2014

New price transparency rules for hospitals
The Hill reports: Hospitals will be required to release a standard list of prices for their medical services under a new rule proposed by the Centers for Medicare and Medicaid Services (CMS). The Hill, April 30, 2014

House panel seeks improved Medicare fraud efforts
USA TODAY reports: Improper Medicare payments cost about $50 billion last year, a Health and Human Services official told a House panel Wednesday, testimony that prompted a rare display of bipartisanship in a usually divided House. USA TODAY, April 30, 2014
News around the Web Continued

**Obamacare puts a floor under U.S. economy in first quarter**
Reuters reports: As the U.S. economy teetered on the brink of contraction in the first quarter, one thing stood out. Healthcare spending increased at its fastest pace in more than three decades.
Reuters, April 30, 2014

**WellPoint Reports Lower Profit but Higher Outlook**
The Wall Street Journal reports: WellPoint Inc. on Wednesday said its first-quarter profit shrank a narrower-than-expected 21% as the health insurer reported a jump in administrative expenses.
Wall Street Journal, April 30, 2014

**No Medicaid expansion could create health care gaps**
USA TODAY reports: States that have not expanded their Medicaid programs as part of the Affordable Care Act risk larger-than-ever gaps in overall health between residents of their states and those that have expanded Medicaid, a report released Wednesday shows.
USA TODAY, April 30, 2014

**Urgent care centers can support, not replace pediatricians: docs**
Reuters reports: Urgent care centers can provide care for young people who are mildly or moderately sick or injured, but the centers should not replace children’s so-called medical home, according to a leading group of pediatricians.
Reuters, April 29, 2014

**Insurers: Millions more have coverage now**
Politico reports: A panel of health insurers agreed Tuesday that the number of insured people in the country has climbed by millions, despite arguments by some Republicans that the insured population has declined because of canceled plans.
Politico, April 29, 2014

**Officials Probe Express Scripts's Ties With Drug Makers**
The Wall Street Journal reports: Express Scripts Holding Co., which reported a 12% decline in first-quarter earnings, disclosed that it has received three subpoenas since February from federal and state officials related to the pharmacy-benefit manager's relationships with drug makers.
Wall Street Journal, April 29, 2014

**HCA sees 'encouraging signs' but no health reform benefit yet**
Reuters reports: HCA Holdings Inc on Tuesday reported quarterly earnings just shy of analysts' expectations, and its top executive said the U.S. hospital chain had not yet benefited from President Barack Obama's healthcare reform law.
Reuters, April 29, 2014

**Administration Begins Search for New Contractors to Run Health Care Site**
The New York Times reports: The Obama administration has begun a wide-ranging search for companies to run the online federal health insurance exchange, seeking new talent to prevent a repeat of problems that immobilized the website last fall.
New York Times, April 29, 2014
News around the Web Continued

**House passes bipartisan fix to health law**
The Associated Press reports: The House approved bipartisan legislation Tuesday to exempt U.S. health plans sold to expatriate workers from having to comply with requirements under the Affordable Care Act.
The Associated Press via the Washington Post, April 29, 2014

**Report: Health Exchanges' Drug Coverage Confusing**
The Associated Press reports: The hunt for a health plan that would cover a particular drug or a favorite doctor proved particularly frustrating for many consumers navigating the new insurance exchanges under the federal government's health care overhaul, according to a report released Monday.
The Associated Press via NPR, April 28, 2014

**Health Plans Scramble To Calculate 2015 Rates**
Kaiser Health News reports: With the results sure to affect politics as well as pocketbooks, health insurers are already preparing to raise rates next year for plans issued under the Affordable Care Act. But their calculation about how much depends on their ability to predict how newly enrolled customers -- for whom little is known regarding health status and medical needs -- will affect 2015 costs.
Kaiser Health News, April 28, 2014

**Health Law's Pay Policy Is Skewed, Panel Finds**
The New York Times reports: Federal policies to reward high-quality health care are unfairly penalizing doctors and hospitals that treat large numbers of poor people, according to a new report commissioned by the Obama administration that recommends sweeping changes in payment policy.
New York Times, April 28, 2014

**Millions Wasted on Broken Obamacare State Websites**
The Fiscal Times reports: The cost of Obamacare’s tech-troubled websites is starting to add up – and the numbers won’t make anyone happy
The Fiscal Times, April 27, 2014

**Oregon's broken healthcare exchange may move to federal network**
Reuters reports: Top officials for Oregon's troubled health insurance network, dogged by technical glitches that have kept a single subscriber from enrolling online, recommended on Thursday dumping the state website in favor of a federally run healthcare exchange.
Reuters, April 25, 2014

**With Medical Debts Rising, Doctors Are More Aggressive About Payments**
Kaiser Health News reports: Mid State Orthopaedic and Sports Medicine Center is hard to miss. The practice's new, 30,000-square-foot building is marked with an enormous sign along one of the main roads in this central Louisiana city of about 48,000 people.
Kaiser Health News, April 25, 2014

**Few have sought exemption from health-care mandate that they have insurance or pay fine**
The Washington Post reports: The government left the door wide open for millions of Americans to be excused from the Affordable Care Act’s requirement that most people must carry health insurance or pay a fine, but so far relatively few have asked for such a pardon.
Washington Post, April 25, 2014
What new innovation affecting any aspect of the delivery of healthcare excites you the most, and why?

Lindsay Resnick

The opportunities around mHealth, both connected devices and consumer applications, are set to change healthcare delivery as we know it today. From prescription-ready online eye exams to GoogleGlass operating rooms to consumer financial decision support tools, over the next 12-24 months mobile will take us places we could never imagine just two years ago. Personal health technology means more informed, smarter consumers who will push payers and providers toward delivering better outcomes.

Let's put mobile in context. There are approximately 6 billion mobile phone subscribers across the world. The average smartphone user checks their phone 150 times every day and most have their phone with them 22 hours per day. By 2015 an estimated 1 billion consumers will use mobile payment generating about $1 trillion in transaction value. Almost a quarter of Facebook's 1 billion users are "mobile only", it's almost 3x for Twitter. Millennials are sending an average of 88 text messages every day. Mobile is rapidly growing as the most important channel throughout the customer journey.

Healthcare companies get it! They recognize that today's always addressable consumer has a mobile mindset...an expectation that any desired information or service is available on any device at a person's moment of need. From a care delivery perspective mHealth is an exploding category. It includes both connected medical devices (monitors and trackers across a range of specific conditions or metrics (e.g., wellness wearables; weight loss or medication trackers; diabetes, sleep apnea or cardiac monitors) and mobile healthcare applications that perform a number of functions: inform, instruct, record, display, guide, remind, communicate.

mHealth means communication between patient and provider is no longer a one-way monologue, but rather a data-driven, personalized interactive dialogue that's portable. Here's an infographic looking at the impact trends surrounding the Mobile Mindset.
Cyndy Nayer
President,
CyndyNayer.com
Founder/CEO of Center of Health Engagement

The incredible release of data from CMS is absolutely the most exciting development of the past 2 years. Enabling plan sponsors to compare payments to their own outlays will push the wider transparency that is needed for our health system. For quite a few years our work has shown that employers, public entities (Cities, Counties, States as employer-plan sponsors) and others have been paying billions of dollars for health care coverage without appropriate management oversight, without prompt reports on population trends, and without understanding the "quality metrics" that have been promised. Engagement in programs has been consistent at an average of 20% or less; this is a clear waste of dollars that causes undue burden to the total health and productivity of the worksite and competitiveness of the company. The release of the data allows companies to benchmark themselves geographically, by condition/disease, and by provider specialty. They can return to their advisers and renegotiate contracts with quality and performance metrics that matter.

But even more important, as the geographic trends start to emerge, consumers will begin asking more questions. They have been told that providers' payments were reduced, yet the consumer's burden of payment has escalated each year over the past 7 years and beyond. So they are paying more without knowledge of where the money is going. The social media have been organizing in their calls for open notes, access to full health record, etc. Now, with still more cost burden transferred to the persons affected by geographic patterns of prescribing, the call for quality measures and choosing wisely will gain momentum.

The voices for quality are changing. I'd like to reiterate what I say at every presentation: there are no bad guys here. The real issue is that there are misaligned goals and correlated misaligned incentives. If we want effective, affordable health care, we all need enough data about our communities to be part of the quality-focused solution. The release of CMS data is a tremendous step forward.
The most unusual thing I am seeing is a serious effort to coordinate care. At the one end of the care process, the primary care diagnosis has to be correct or the whole process breaks down. Decision support tools are slowly emerging, helping the primary care doctor do a more efficient job of patient engagement to stratify need and act as a precursor to outcome, and care is becoming more accessible and convenient for patients.

In the PCP handoff to specialty there has always been a lot of frustration with incomplete records or timeliness of lab and X-ray reports. With better documentation to view the whole patient picture, referrals are becoming successful in both confirming diagnosis and establishing a rationale for further inpatient care. There was a time when everything was being done to avoid that specialist referral by the insurance industry, the theory being that all specialty referrals turned into admissions. Now we are seeing better use of guidelines to establish reasonableness for an admission and less reliance on emergency rooms in favor of outpatient visits. The specialist may still see a post-surgical admission as necessary but now is more inclined to use outpatient rehabilitation to recover from surgery. The entire spectrum of care choices following an illness or surgical intervention now include rehabilitation, home health, outpatient therapy and a vast array of telemedicine to keep the patient on track but outside of the hospital.

The most dramatic change is on the back end of the delivery episode where post discharge and transitional and long term care planning are becoming a very clear part of the process that is now managed by the insurer or the provider.

It will take more than guidelines and software to sort out responsibilities between provider and insurer for medical management, but as hospitals face fines for readmissions and intensify scrutiny over fraudulent billing and deeper quality reporting, they may see the advantage of working more closely with physicians and insurers.

By the same token insurance companies and HMOs are facing reimbursement cuts from payers including Medicare and therefore have a renewed interest in not just gathering claims based transactions but actually doing something with this data to reduce excess utilization and establish a quality metric that will keep patients happy with their choices.
Underneath this series of protocols, guidelines, pathways and care standards is a burgeoning industry of technology companies that are trying to build the ultimate end to end system to really get at and manage big data while making costs reasonable. If these systems are driven by clinical data and medical management they will eventually succeed. If it's just a matter of collecting more detail in the claims transaction they have a long way to go. Everyone, including the government, is looking for the ability to create a large comparator database to use as a means to compare live data on a market by market basis. The recent release of the physician claims database and the HHR database should make for some interesting Total Cost of Care (TCOC) comparisons that can be used as a way to adjust risk factors for populations and thereby show the real savings that coordinated care provides.

The area of healthcare innovation that I find the most exciting is the integration of wellness, condition management, and healthcare services delivery to create a comprehensive continuum of care and obtain improved outcomes and lower costs.

For this integrated health management approach to be most effective, a high level of engagement of the population in these services is required. The use of a number of innovative strategies and techniques to promote this member engagement, including state-of-the art technology and effective incentive designs is key to success and driving the best results.

New technology is being developed to make participation involvement in health management programs easier and more attractive for individuals. For example, the use of wireless devices to track physical activity and manage chronic conditions such as diabetes and other conditions in real time is quite beneficial to improved health outcomes. Organizations like TelCare and Feet First are examples of this type of approach. Mobile connection to wellness and healthcare services also enables individuals to stay more engaged with health coaches, physicians, and other providers to maintain an optimal level of health.

Employers are increasingly implementing incentive programs to encourage employees to take personal responsibility for their health and participate in the risk reduction and condition management programs. Many companies are experiencing high levels of engagement through a combined incentive strategy that includes lower medical premiums for individuals meeting certain health risk or participation criteria, along with rewards for other kinds of health management program participation. Such incentives are becoming the new norm, and we are beginning to see the resultant changes in the worksite environments as they transform to a culture of wellness.
A new innovation that will affect the delivery of healthcare that I find most exciting is the consumerization movement and initiatives that empower patients/individuals to become active versus passive consumers. This growing emphasis of involving the consumers of healthcare services in their care delivery and health management really is a collection of endeavors from all constituents and is igniting innovation in several aspects. The reason I find it exciting is that it will push healthcare towards more traditional consumer behavior while addressing the market failures that have driven inefficiency and led to subpar outcomes.

Some market failures that make healthcare different than other industries are:

- Imperfect information: the consumers in healthcare typically lack price and quality information and therefore do not select their healthcare providers/services based on value (quality of care/cost of care). Innovation: transparency tools

- Consumers typically are shielded from true cost of care: having insurance distorts the true cost of care for consumers, so patients are unaware of the extreme variations in costs for the same services. Innovation: HDHPs and increased cost-sharing in benefit designs

- Cost ≠ Quality: Unlike most other industries, in healthcare higher costs don't translate to higher quality of care delivered; there is ample literature that shows higher costs are not correlated with better quality or outcomes. Innovation: reimbursement reform to value and outcome-based models

- Principal-agent problem: Patients are most often not sufficiently educated to make their own decisions on their healthcare needs; because providers are trained in medicine, they drive consumer decisions/demand around consumption of their healthcare needs. This could potentially lead to misalignment of incentives when providers are reimbursed on volume of services provided. Innovation: initiatives that improve health literacy and patient education as well as incentives that promote value not volume; these include shared-decision approaches as well as criteria and measurements that support patient-centered care that many providers must adopt as part of changing delivery models (PCMH, ACO, Meaningful Use technologies, etc.)

If we look at each constituent in the delivery of healthcare we see this growing emphasis on consumerization efforts to make patients advocates of their own health and individuals more astute as they interact with the healthcare system, becoming more informed consumers just as they would in other purchasing decisions such as a new car, smartphone, or home.
I am excited by the multi-faceted approaches that employers are using to encourage employees to take responsibility for their own health and wellness. At Conifer Health, we’ve seen the shift in responsibility to the employee steadily increase within our client base and we’re using tools like our Population Engagement platform to provide one-stop-shops for employees to manage their health. It’s clear that the ubiquity of the wellness program is assured, as employers, stunned by sharp increases in the cost of benefits, develop resourceful ways to drive down the cost of health care.

Interestingly, as we discuss the provider’s role in the wellness equation, we forget that hospitals and health systems are often some of the largest employers in the community! Our approach to employee wellness should be the model for every other industry. However, we’re still behind the curve when you consider that hotels and airlines have used data analytics to seamlessly track-and-reward-select consumer behaviors for decades. Providers, employers, and myriad other stakeholders in health care, can take advantage of their experience using new and more powerful tools.

Today, the advent of big data and granular population health management strategies allow providers to go ever-further to put employees squarely in charge of managing their own health and wellness. Conversely, employees are becoming resigned to the fact that reducing the cost of health insurance is, in part, under their direct control. Stop smoking and reap the rewards of lower premiums. Continue to smoke and watch out-of-pocket costs rise-significantly.

Controlling health insurance premiums will always play an outsized role in motivating employees to take charge of their wellness, but the desire of individuals to be “healthy” cannot be underestimated. We need only look to recent news that 53% of smart phone users have used their devices to seek out health information, or self-measure biometrics such as blood pressure and heart rate.

Providers that are ready to test the limits of data and multiple engagement platforms are in the best position to serve as models for our industry. “Cracking the code” on the ultimate reward (or penalty) that will have a positive impact on individual health and wellness has immense potential to bend the cost curve in the right direction.
While not conceived of as a health care innovation, the smartphone has the broadest potential as a change agent in care delivery and financing. It has technological and algorithmic power. Most importantly, it is ubiquitous and thus has the reach to be a primary change agent.

Much of the opportunity to improve health status is in the wellness arena. The smartphone already gives vital sign and other readings. It is well suited to give feedback on diet and exercise.

It will be exciting to watch the multitude of ways that providers incorporate smartphone applications into diagnostics. The smartphone also promises to be the ultimate tool for attaining patient engagement goals.

Patient engagement is often the missing link in chronic care management. As a result, particularly as boomer users age, we can expect that chronic care regimes will make liberal use of the technology.

We would also be foolish to underestimate the future role and power of the smartphone in provider selection and in price bargaining. When a mother needs to make a care choice decision and she can receive preliminary diagnostic input, an immediate appointment and cost information through a simple query, the "on ramp" to patient care will have changed.

We can also expect Expedia/Price Line type competition to evolve as providers jump in with treatment quotes baking in insurance and copay information.

Remember, the medical consumer of the present and near future is shouldering material deductible and copay responsibility. She will welcome the assistance of new services bringing real time discount and quality information. That information will move market share.
Jeremy Nobel

The innovation that excites me most in healthcare goes beyond a single technology, care process, behavioral economic incentive or professional payment model. It's the growing recognition that health and healthcare pivot around the people (including ourselves) we imagine that the "system" serves, and the increasing focus on patient engagement and behavioral activation. There is no question that a person with the requisite knowledge, skills, motivation and confidence to design, manage and monitor their own "journey to health", is an essential partner to the health care professionals, technologists, benefits administrators, insurers and the myriad of other healthcare system stakeholders working to create a marketplace for high-value access to care.

As we turn the corner and climb "heartbreak hill" towards a person-centered healthcare model there is still an enormous amount of work to be done. The question still remains as to how best to engineer the operating models and payment models that facilitate progression towards a sustainable system where the attitudes, beliefs, behaviors and skills of patients/consumers are as central to outcomes-oriented system design as their blood pressure and medication list. Fortunately, regulatory and marketplace trends are already creating environmental conditions where leading institutions and organizations that are investing in person-centered healthcare design are reaping rewards, encouraging others to follow down this innovative path.
Tips

In getting the most out of your MCOL basic membership

- The MCOL Basic Membership site has been redone to provide easier navigation and enhanced features. Be sure to try it out by logging on at www.mcol.com.

- If you haven't joined already, you're encouraged to join the LinkedIn Managed Care On-Line group where you can network and discuss issues with other MCOL members. You'll find a link to the group in the paid member web site main menu.

- MCOL does not share your e-mail address with third parties, as stated in the MCOL member privacy policy, available at http://www.mcareol.com/mcoprvs1.htm

- If you ever would like any assistance or information regarding any aspect of your MCOL Basic membership, feel free to contact MCOL anytime at pattyj@mcol.com or call 209.577.4888. MCOL offices are open business days 8AM to 5PM Pacific time.

- You can follow MCOL on Twitter at http://twitter.com/M_C_O_L

- You can also follow Healthsprocket on Twitter at http://twitter.com/healthsprocket

- If you're looking for specific content in the member web site and aren't sure how to find it, feel free to e-mail or call MCOL anytime and we'll assist you with your search, free of charge.

- You might consider upgrading to a MCOL Premium membership for just $15 per month. Premium members receive many valuable exclusive e-newsletters and e-magazines, and a premium member web site with comprehensive features and resources. What's more, Premium members get 10% discounts on MCOL’s e-learning software and HealthQuest Publications, when ordering from the Managed Care Store (www.managedcarestore.com) Premium members also get a 50% discount when registering for Healthcare Web Summit events (www.heathwebsummit.com) Make sure you identify yourself as a MCOL member when placing these orders.

- Check out HealthSprocket, the home for healthcare lists. The healthsprocket community of health care professionals and others can read, rate, comment on, and post lists. Lists can be designated as fact or opinion based, and involve business or clinical aspects of health care, health insurance and all things related.

- If you’d like to have your healthcare opinions heard, please consider posting a video on healthshareTV or a list on healthsprocket.
Net Gain of 9.3 Million American Adults with Health Insurance Coverage

By Claire Thayer, April 18, 2014

With While the big news this week focused on the success of President Obama and the ACA enrolling 8 million Americans for health insurance through the federal marketplace, a new study from RAND estimates that there was actually a net gain of 9.3 million in the number of American adults with health insurance coverage from September 2013 to mid-March 2014.

The RAND survey, “drawn from a small but nationally representative sample, indicates that this significant uptick in insurance coverage has come not only from enrollment in the new marketplaces established under the Affordable Care Act (ACA), but also from new enrollment in employer coverage and Medicaid.”

A summary of the new RAND report is available for free here, with highlights below:

- Of the 40.7 million who were uninsured in 2013, 14.5 million gained coverage, but 5.2 million of the insured lost coverage, for a net gain in coverage of approximately 9.3 million. This represents a drop in the share of the population that is uninsured from 20.5 percent to 15.8 percent.

- The 9.3 million person increase in insurance is driven not only by enrollment in marketplace plans, but also by gains in employer-sponsored insurance (ESI) and Medicaid.

- Enrollment in ESI increased by 8.2 million.

- Medicaid enrollment increased by 5.9 million. New enrollees are primarily drawn from those who were uninsured in 2013, or those who had “other” forms of insurance, including Medicare, retiree health insurance, and other government plans.

- According to our estimates, 3.9 million were covered through the state and federal marketplaces as of mid-March 2014. This figure does not fully capture the enrollment surge that occurred in late March.

- Among the 7.8 million people who were enrolled in off-marketplace individual market plans in early 2014, 7.3 million were previously insured; 5.4 million were previously insured through an individual market plan.

The complete RAND study is available for download at no charge here.

Looking for an easy way to keep up on what’s happening in the health insurance marketplace? Health Policy Publishing now has several free resources on this topic, including Health Insurance Marketplace News, a twelve page monthly newsletter; a free bimonthly e-newsletter, Health Insurance Marketplace News Bulletin; a related Linkedin Group; Conferences; HIX Directory; and HIX Learning Kit. Learn more: http://www.healthinsurancemarketplacenews.com/resources.html
The Colossal Ship - The SS Rx Costs – makes a Course Correction

By Clive Riddle, April 17, 2014

Course corrections on mammoth shipping lines don’t happen in an instant – you watch them develop over a period of time. The same can be said for pharmaceutical costs as well as the entire healthcare sector, and the IMS Institute for Healthcare Informatics tells us we’re witnessing a slow correction right now.

Costs that have been stabilized this decade are gradually starting to tick upwards. The IMS Institute has just released a study: Medicine Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the United States in 2013 which found that “total dollars spent on medications in the U.S. reached $329.2 billion last year, up 3.2 percent on a nominal basis and a rebound from the 1.0 percent decline in 2012… Total spending on U.S. medicines increased 1.0 percent on a real per capita basis in 2013, while the use of healthcare services overall rose for the first time in three years.”

This doesn’t mean that costs are about to go crazy in an upward spiral just yet – remember that this is a big ship. Instead, Murray Aitken, executive director of the IMS Institute for Healthcare Informatics, tell us “following several years of decline, 2013 was striking for the increased use by patients of all parts of the U.S. healthcare system – even in advance of full implementation of the Affordable Care Act. Growth in medicine spending remains at historically low levels despite a significant uptick last year, and continues to contribute to the bending of the healthcare cost curve.”

So what is driving this gradual correction? The IMS Institute identifies these factors:

1. The reduced impact of patent expiries (“Patent expires in 2013 contributed $19 billion to lower medicine spending, compared with $29 billion the previous year.”)

2. Price increases for branded products added $4 billion more in spending growth last year compared to 2012

3. Higher spending on innovative new medicines (“while 36 New Molecular Entities launched in 2013, the largest number in a decade”)

4. Greater use by patients of the healthcare system (“Overall utilization of healthcare services grew slightly as consumers returned to the healthcare system – primarily through more office visits to specialist physicians as well as outpatient treatments – following several years of self-rationing.”
The IMS Institute shared these other key findings from their report:

- The number of patient office visits to primary care physicians fell by 0.7 percent in 2013.
- Visits to specialists increased by 4.9 percent overall and by 9.5 percent for seniors.
- Patients filled an average of more than 12 retail prescriptions last year, up nearly 2 percent year over year.
- Those aged 65 and over filled an average of 28 prescriptions annually, down slightly from 2012.
- Overall spending on medicines remained concentrated in traditional small-molecule pills dispensed through retail pharmacies.
- But higher spending growth was seen in biologics and specialty drugs – particularly in retail and mail-order settings.
- A total of 27 new oncology drugs have launched in the past three years.
- Additionally, clusters of innovation are transforming patient care in hepatitis C, multiple sclerosis and diabetes, as well as stroke and acute coronary syndrome.
- Seventeen orphan drugs – developed for patient populations of fewer than 200,000 individuals – launched in 2013, the most in any year since the passage of the Orphan Drug Act in 1983.
- Patients with insurance are incurring higher out-of-pocket costs for healthcare services despite lower co-pays for many prescriptions and additional discounts for preventive medicines.
- Prescription drug costs paid by most patients are declining, with average out-of-pocket costs falling below $5 for 57 percent of all retail prescriptions filled.
- At the same time, 30 percent of total patient out-of-pocket costs relate to just 2.3 percent of prescriptions, often high-cost specialty medicines.
- Twenty-three percent of prescriptions now carry no out-of-pocket costs, a dramatic rise in 2013 driven by common preventive medicines that include oral contraceptives.

Want to get more detail? The report can be downloaded as an app via iTunes.
A selected Blog entry from the month of April 2014 from MCOLBlog.com

Hacking a Better Health System

By Kim Bellard, April 9, 2014

Who knew hacking might help us reinvent our health care system?

I must be old-fashioned, or at least not a true techie, because I still thought of hacking as a bad thing. I was thus surprised to read in The Wall Street Journal that “hackathons” are a trend for the good in health care.

For others who are also behind this particular curve, hackathons are intense, all-night (or more) sessions when a small groups of programmers band together to attack tough specific problems with concentrated coding efforts.

The Journal article highlighted MIT’s Hacking Medicine’s Grand Hackfest, which is part of MIT’s Hacking Medicine initiative. MIT has been at this since 2011, seeking synergies between MIT’s technical expertise and the vaunted Boston-area medical community. They believe hackers can help health care with: Scaling Medicine, Accelerating Data, Identifying and Tackling Big Opportunities, Hacking Ethos for Lean Medical Innovation, and Infecting Non-Life-Scientists with the Mission.

Pretty lofty list of goals.

Health 2.0 has their own version, which they call Code-a-thons. They offer some $6.5m in prizes in their developer challenge, and have several events and challenges scheduled in the next few months.

Goodness knows that health IT has never been known for being either nimble or on the cutting edge, so some fresh blood with new perspectives certainly seems like a good idea, right? As one clinician whose mobile app benefited from solutions suggested at the MIT hackathon said, "Sometimes when you are too close to something, you stop seeing solutions, you only see problems. I needed to step outside my own silo."

Not to be outdone by Boston, New York-Presbyterian Hospital recently held what they claim was the first Hackathon for New York Hospitals, which the specific aim of helping them improve myNYP, their patient portal. Out on the other coast, UCLA-Berkeley has had three iterations of their own version, Hacking Health.

Just to rub us oldsters’ noses in it, there’s an organization called YTH (youth + tech + health) that believes the “#selfie generation” can do better. They just hosted their own Health Hackathon in conjunction with their YTH Live 2014 conference.

The trend is not limited to the United States. The British National Health Service has NHS Hack Days, in Canada there is Hacking Health, and in Europe there’s CPH Health Connect HackDay in Copenhagen and Hacking Health Stockholm.
**MCOL Blog: Hacking a Better Health System**

Looking back at last fall’s healthcare.gov debacle, or more recent reports of similar issues with various state exchanges, one has to wonder if they just should have held a hackathon.

PwC’s 6th Annual Digital IQ Survey found that healthcare CEOs were far ahead of other industries in championing information technology as an integral part of their strategy. I rather doubt that many health systems or payors are using hackathons for their big mainframe-based systems – like eligibility, billing, claims payment, or (most) EHRs – but mobile efforts are natural targets for this kind of approach.

There’s no shortage of targets. Payors are finding ways to use mobile technology to cut administrative costs, engage members, and manage patients’ care. Still, in a recent Robert Half Technology survey of CIOs, health care led the pack in lacking a mobile strategy.

No wonder they might be looking for hackers.

It’s great to bring in new ways of attacking the many problems of health care, but I do worry what happens when they hit the may brick walls health care has. I’ve been seen several instances where non-health care companies – especially financial services firms -- dipped in to health care, thinking they could bring their expertise to bear, only to be shocked at how messy much of the data is.

What I like best about the hacking in health movement is twofold – bringing in new kinds of expertise and an attitude that problems can be solved. Those have been sorely missing in health care. Or, as Mark Twain once put it, “all you need in this life is ignorance and confidence, then success is sure.”

Hack away!

This post is an abridged version of the posting in Kim Bellard’s blogsite. Click here to read the full posting.
April Fool’s Day Brings Some Humor to Healthcare

By Clive Riddle, April 4, 2014

The first of April marked the annual issuance of satirical lists from healthsprocket, zinging a range of current topics in the business of healthcare, which I can’t resist repeating.

First, let’s visit a list of predictions of future major news items, in a list entitled - Top Healthcare Headlines from Tomorrow’s News

1. Healthcare.gov server achieves singularity, assumes control of planet
2. Obesity Problem eliminated in United States thanks to Congressional Act to expand BMI ranges
3. Exchange enrollment count after March 31st deadline exceeds 400 million, last minute inclusion of uncovered domestic pets credited with enrollment surge
4. Influenza eradicated after development of oral vaccine distributed in Starbucks Coffee
5. National consulting lobby urges Congress and states to adopt new, confusing and conflicting healthcare legislation - say lack of new laws since Affordable Care Act is stifling consultant job creation
6. Medicare officially re-named "Johnsoncare" in keeping with Obamacare precedent

Here’s another list looking into the future, this time predicting what big problems lie ahead a year from now, with the Top Five Healthcare Crises Predicted for 2015:

1. Acute Shortage of available new healthcare acronyms
2. Global climate change causes the Cloud holding all healthcare big data to disappear
3. Demand for health coaches exceeds supply, causing raid on NFL, NBA and MLB staffs
4. Healthcare exchanges finally end up working smoothly, causing a wide-scale chain reaction of pundits and politicians heads to explode on national television
5. Lack of funding causes medical homes to downsize to medical apartments
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And one more list about upcoming events, this time narrowing the focus to upcoming month, as we consider Healthcare scandals that will surface later this year:

1. The "two ferns" in the Obama -Zach Galifianakis healthcare.gov interview were secretly switched out with alternative plants provided by medical marijuana lobby
2. Major healthcare analytics platform discovered to be vintage Magic 8-Ball
3. Move by major Health Savings Account (HSA) administrators to convert all accounts to bitcoins proves disastrous
4. Jointly funded XBox, Wii and Playstation study finding health benefits of exercise and fresh air to be vastly overrated, revealed to be based on SimCity and not actual data
5. High speed disclaimers at end of prescription television ads discovered to be spoken in Klingon language

Speaking of the “Two Ferns” video, next we look at a list that addresses the White House media blitz to promote signing up in the health insurance marketplaces, with New Television Shows Created to Attract the Young Invincibles to Obamacare:

1. How I Met Your Health Plan - A previously uninsured guy spends nine seasons explaining to his kids how he finally got coverage after years of searching
2. CSI: Covered Singles Insurance - Each week, investigators track down an uninsured single twentysomething, and bring their health coverage to justice
3. The Amazing Race - Young uninsured individuals hurry to sign up in a plan before the open enrollment deadline, despite obstacles placed in their path
4. Modern Family - Different dependent coverage scenarios are explored in each episode
5. Once Upon a Time - Evil witches try and convince the population to hold out for their fairy tale past of fee for service medicine, house calls, low costs, and happy doctors and patients

And finally, no discussion of the Affordable Care Act is complete without a few zombies thrown in the mix, as demonstrated by the healthsprocket list Upsides for the Affordable Care Act after a Zombie Apocalypse:

1. Web traffic will not overwhelm healthcare.gov
2. Annual ACA expenditures will come in under budget
3. That stubborn "young invincibles" demographic won't be so important
4. Consumer engagement strategies can be significantly simplified
5. More of the population will be walking and less sedentary
Selected Factoids from the MCOL Daily Factoids e-newsletter

Factoid

Centers for Medicare & Medicaid Services 2015 Rate Announcement and Final Call Letter for Medicare Advantage and Prescription Drug Benefit (Part D) Programs

The Centers for Medicare & Medicaid Services (CMS) issued the 2015 rate announcement and final call letter for Medicare Advantage and prescription drug benefit (Part D) programs. CMS estimates that the overall net change to plan payments between 2014 and 2015 to be +0.4 percent, compared to the estimated overall net change to plan payments of -1.9 percent for the proposals in the Advance Notice Individual plan payments will vary by plan based on, but not limited to, its location and star rating.

Beneficiaries in the Part D prescription drug coverage gap, or "donut hole," will benefit from greater savings on prescription drugs. As a result of the Affordable Care Act, in 2015, enrollees who reach the donut hole will receive coverage and discounts of 55 percent on covered brand name drugs and 35 percent on covered generic drugs, an increase from 52.5 percent and 28 percent, respectively, in 2014.

CMS intends to again use its authority, provided by the health care law, to protect Medicare Advantage enrollees from significant increases in costs or cuts in benefits, and, for the 2015 contract year, finalizing the permissible amount of increase in total beneficiary cost to $32 per member per month (down from $34 per member per month for the 2014 contract year). CMS also continues to require plans to refine their offerings so that beneficiaries can easily identify the differences between their options.

Source: Centers for Medicare & Medicaid Services

Factoid

New Entrants in U.S. Healthcare Market

New According to PwC's Health Research Institute (HRI), new entrants are poised to draw tens of billions of dollars in revenue from traditional healthcare's $2.8 trillion revenue pie as these market disruptors rapidly develop products and services like the innovations that transformed banking, entertainment and publishing.

Half of 2013's Fortune 50 companies are new entrants into healthcare - including seven retailers, eight technology and telecommunications companies and two automakers. HRI calculates that the U.S. market for fitness and wellness products and services adds an additional $267 billion to American health spending. This sector is being aggressively pursued by new entrants, attracting in particular startups and venture capital. Considering these two markets together suggests Americans spend over $3 trillion a year on health.

Source: PwC's Health Research Institute

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Fact Based List:

Barbara Gniewek: Questions employers should answer before going the private health insurance exchange route

1. What are you trying to do with your health care benefits; what’s your overall talent management strategy?
2. What are you looking for in an exchange; what kind of services are you trying to buy?
3. What are the criteria that are important to you when you evaluate exchanges?
4. How is the exchange structured: is it a single carrier or multicarrier exchange?
5. Does the exchange determine what the benefits are, or is there flexibility for the plan sponsor?

Source: [Employee Benefit News](#)

Fact Based List:

Jennifer Corbett Dooren: 5 Things Facing Sylvia Mathews Burwell at HHS

1. Politics: Ms. Burwell would become the next political face of the still unpopular health-law and is certain to be confronted by continued criticism of the law from Republicans.
2. Healthcare.gov: Much of the mop-up from open enrollment that ended on March 31 will be complete before Burwell takes over, there’s ongoing work on the website that serves Americas living in 36 states.
3. Mandates: The administration delayed implementation of many parts of the law including the employer mandate. Additional guidelines that address employers need to be issued from HHS and Treasury.
4. Medicare: HHS oversees Medicare, the health insurance program for older Americans.
5. Government Bureaucracy: The HHS Secretary oversees a giant department that is the parent of mostly independent agencies like the CDC that are headquartered far from Washington, D.C.

Source: [The Wall Street Journal](#)
Announcements

Items of interest from MCOL

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“Constraining health care costs doesn't have to mean shifting costs from one area to another. Over the past eight years, we at Cigna have seen that by improving health care quality and transparency, and by incentivizing healthy behaviors, we reduce the total cost by shifting behaviors, rather than shifting costs.” Matt Manders, President, Regional and Operations, Cigna

“The employer-sponsored medical plan landscape continues to shift in response to the ACA and, as a result, it's more important than ever for employers to effectively communicate plan changes to their employees. It's evident that companies are embracing typical health plan consumerism strategies that encourage a more thoughtful, cost-effective use of medical benefits by exposing plan participants to more of the upfront costs.” Cynthia Weidner, Vice President, Client Development, HighRoads

“With the continued rise in utilization and spend related to specialty medications, health care payers have a tremendous opportunity to reduce costs and improve care through a variety of approaches. Transitioning specialty medications from the medical benefit to the pharmacy benefit, as well as offering patients more convenient options by addressing where infusion care is administered, can produce significant savings.” Alan Lotvin, M.D., Executive Vice President of Specialty Pharmacy, CVS Caremark

“We were prepared for a last-minute surge of people coming to our website, but sometimes there's only so much you can do operationally. While we had hoped people would start the enrollment process earlier, we can't in good conscience turn people away who simply couldn't get onto the website on the last day.” Peter V. Lee, Executive Director, Covered California