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MCOL MONTHLY

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

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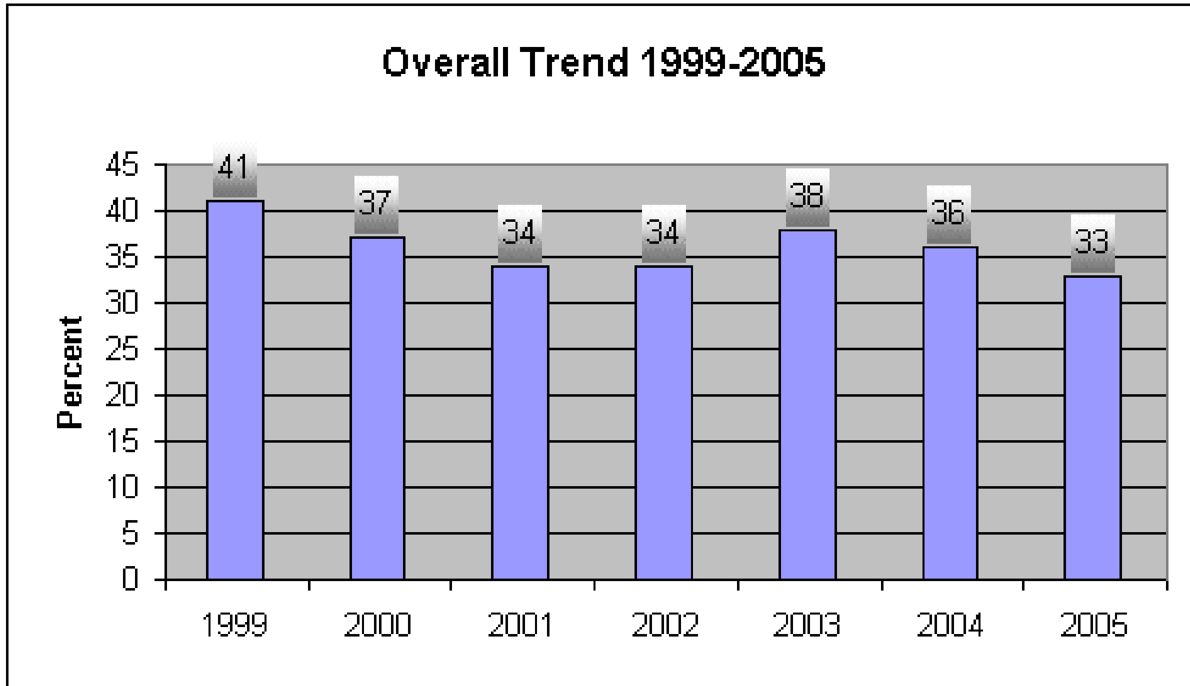
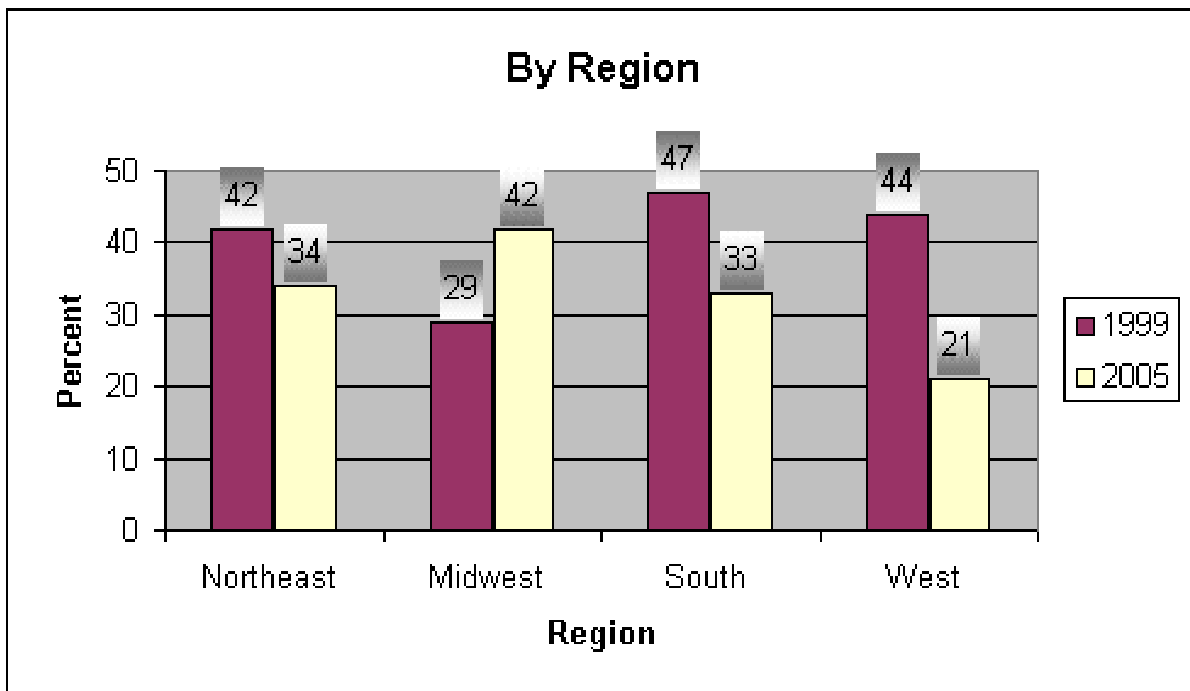
Trends

A featured trend compiled by MCOL • Appearing in the MCOL Paid member web site for November 2005

Percentage of Firms Offering Retiree Health Benefits, 1999-2005





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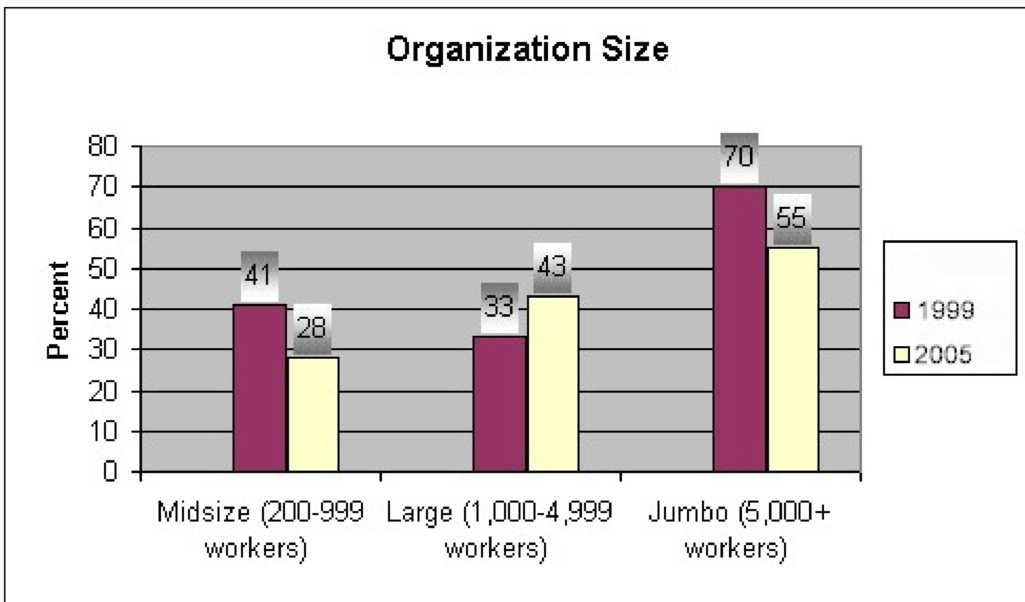
*T*rends continued



By Organization Type

	1999	2005
Mining/Construction/Wholesale	22	20
Manufacturing	27	40
Transportation/Communication/Utility	70	45
Retail	3	6
Finance	46	40
Service	57	29
State/Local Government	78	84
Health Care	21	22

Percent

Family Foundation and the Health Research and Educational Trust
http://www.kff.org/insurance/ehbs-archives.cfm

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*D*ata Map

A featured data map compiled by MCOL • Appearing in the MCOL Paid member web site for November 2005

Premium Comparisons for Each State as a Percentage of the Average US Premium

Single Premium Comparison of State vs. US

101% WA
97% OR
95% CA
96% ID
103% NV
101% MT
106% WY
96% UT
92% AZ
105% CO
97% NM
86% ND
97% SD
101% NE
98% KS
94% OK
98% TX
106% MN
94% IA
95% MO
90% AR
95% LA
108% WI
106% IL
105% MI
100% IN
98% OH
99% KY
103% TN
95% MS
91% AL
104% GA
103% FL
97% SC
98% NC
95% VA
109% WV
99% PA
103% NY
102% NH
103% VT
111% ME
100% MA
107% RI
106% CT
110% NJ
111% DE
107% DC
98% MD
115% AK
87% HI
PR
VI

80% to 90%
90% to 100%
100% to 110%
110% to 120%

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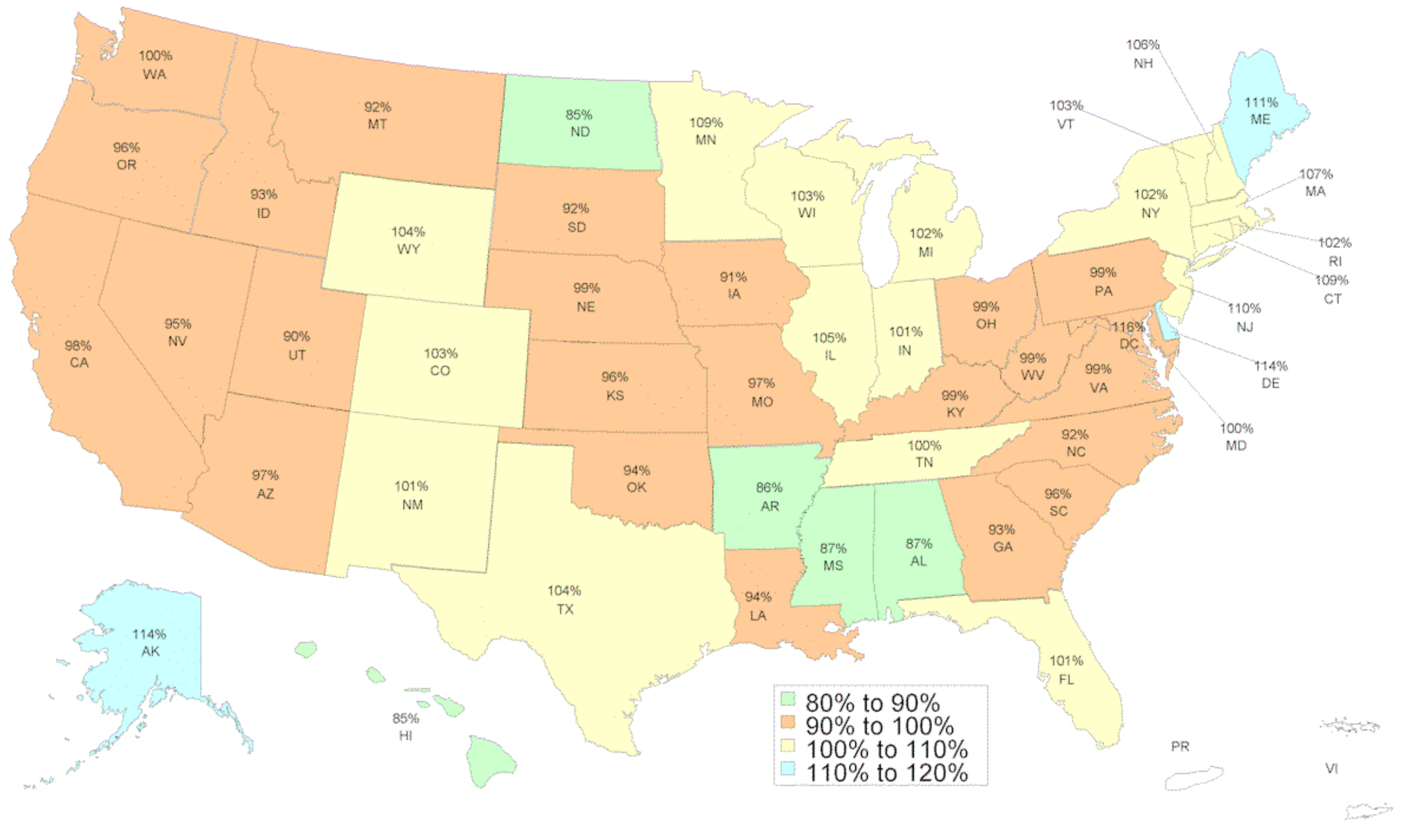
Data Map continued



Source:

Map compiled by MCOL from data from the Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey-Insurance Component, http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIC1.htm, August, 2003

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*H*ow-To

Tips on health management and managed care methodologies • From the October 2005 @How-To e-Newsletter

NCQA Health Plan Rankings

In this age of health care consumerism, published health plan rankings take on added significance. While many organizations publish such rankings, NCQA is often looked to as a primary source, and NCQA just published their annual rankings in collaboration with U.S. News & World Report.

In this issue of @How-To, we examine methodologies behind components of the NCQA health plan rankings, in order to provide a better understanding of what drives such comparisons.

Why should you care?

While comparative health plan rankings have existed for some time, the continued emphasis on health care consumerism has given such rankings added clout, and NCQA is perhaps considered the most credible and authoritative source of such measurements. As such, understanding what drives the NCQA health plan rankings methodologies is of importance to anyone using or affected by such comparative ranking data.

Overview

Only health plans that reported data to NCQA are ranked. Rankings are separated by commercial, Medicare and Medicaid populations. The health plan rankings are based on the following components:

- access to care
- effectiveness of care (prevention and treatment)
- member satisfaction
- NCQA Accreditation scores

Plans not reporting an applicable measurement (indicated with an NR designation in the detailed data) were assigned the minimum measurement rate for that item. Plans with too few members to appropriately report a measure (indicated with an NA designation in the detailed data) were assigned the average rate for that item.

Numerical measurements are compiled to develop a quality score, which is weighted correspondingly for each component. The weights can vary for each component base upon the applicable population (commercial, Medicare, Medicaid). This overall weighted numerical quality score is designed to fall between 0 and 100.

A rating scale is then applied to compare plan performance, with rankings assigned between 1(bottom plans) and 5 (top plans)

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*H*ow-To: NCQA Health Plan Rankings

Components

In addition to the NCQA Accreditation scores, Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures were used to develop scores for the applicable components:

- Access to Care : Includes CAHPS items about consumer experience with getting needed care, getting care quickly, and health plan customer service
- Effectiveness of Care- Prevention: Includes HEDIS measures of how often preventive services are provided (e.g., childhood and adolescent immunizations, prenatal care, mammography cervical, and colorectal cancer screening, chlamydia screening, avoiding antibiotic overuse, and well-child visits).
- Effectiveness of Care- Treatment: Includes HEDIS measures of how well health plans take care of people who have health problems, such as asthma, diabetes, heart disease, hypertension, osteoporosis, alcohol and drug dependence, mental illness and whether physicians advised smokers to quit.
- Member Satisfaction : Includes CAHPS® items on consumer perceptions about how well doctors communicate, as well as ratings of personal doctor or nurse, specialist seen most often and overall health care.

Weighting of Components

The following weights were applied to each component score for applicable populations, in order to develop the total overall quality score for each plan:

	Commercial	Medicare	Medicaid
Access to Care	8%	0%	11%
Effectiveness of Care	55%	58%	54%
Member Satisfaction	22%	27%	20%
NCQA Accreditation	15%	15%	15%

Rating Scale to Compare Plan Performance

After compiling the overall quality scores (between 0 and 100), NCQA compared each plans score for each applicable population to the national plan average and assigned a rating on a scale of 1 (bottom) to five (top). The scale was assigned as follows:

5 = The top 10 percent of plans based on the combined measures in the category
4 = The top one-third of plans (not in the top 10 percent)
3 = The middle one-third of plans OR any plan that is not statistically significantly different from average.
2 = The bottom one-third (not in the bottom 10 percent)
1 = The bottom 10 percent of plans.

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Data Elements Included

The following further describes the HEDIS and CAHPs data elements. Each item has a weight of 1 except in a portion of the Getting Better/Living with Illness category when a fraction is specified):

Category: Access to Care and Service (CAHPS composite data): Getting Needed Care; Getting Care Quickly; Claims Processing (Commercial only) and Customer Service
A. Subcategory: Access to Care for Children and Adolescents (No Medicare) Well-Child Visit in the First 15 Months of Life (6+ visits); Well-Child Visits in the Third, Fourth, Fifth and Sixth Year; Adolescent Well Care Visits; and Annual Dental Visit (Medicaid Only)

Category: Communication with Doctors: How Well Doctors Communicate (CAHPS Composite)
A. Subcategory: Member Rating of Care
Overall Rating of Personal Doctor or Nurse; Overall Rating of Specialist; and Overall Rating of Health Care

Category: Staying Healthy/Preventive Care
Medicare Only: Pneumonia Vaccination; Breast Cancer Screening; Colorectal Cancer Screening; Health Outcomes – Physical and Health Outcomes – Mental
A. Subcategory: Childhood and Adolescent Immunizations (Commercial and Medicaid) Childhood Immunization Status (Combo 2) and Adolescent Immunization Status (Combo 2)
B. Subcategory: Women's Reproductive Health (Commercial and Medicaid)
Prenatal and Postpartum Care (Timeliness of Prenatal Care); Prenatal and Postpartum Care (Postpartum Care); and Chlamydia Screening in Women (Overall rate); plus Medicaid Only: Breast Cancer Screening; and Cervical Cancer Screening
C. Subcategory: Cancer Screening (Commercial Only) Breast Cancer Screening; Cervical Cancer Screening; and Colorectal Cancer Screening
C. Subcategory: Antibiotic Overuse in Children (Medicaid) and D. Subcategory: (Commercial) Treatment of Children with Upper Respiratory Infection; and Testing for Children with Pharyngitis

Getting Better/Living with Illness
Commercial and Medicaid: Use of Approp. Meds for People with Asthma (combined rate all ages); (Classified as A. Subcategory for Medicaid: Age 5-9 1/3; Age 10-17 1/3; Age 18-56 1/3)
Medicare Only: Osteoporosis Management in Women Post-Fracture
A. Subcategory: Comprehensive Diabetes Care (classified as B. Subcategory for Medicaid) Hemoglobin A1c (HbA1c) tested 1/3; HbA1c poorly controlled (greater than 9.0%) 1/3; LDL-C screening performed 1/3; LDL-C controlled (LDL less than 130 mg/dL) 1/3; Eye exam (retinal) performed 1/3; Kidney disease (nephropathy) monitored 1/3

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*H*ow-To: NCQA Health Plan Rankings
Data Elements Included continued

B. Subcategory: Heart Disease (classified as c. Subcategory for Medicaid) Beta-Blocker Treatment After a Heart Attack; Controlling High Blood Pressure; Cholesterol Management After Acute Cardiovascular Events Screening 1/2; Control (LDL less than 100 mg/dL) 1/2; Medical Assistance with Smoking Cessation- Advising Smokers to Quit 1/3; Strategies for Quitting 1/3; Medications for Quitting 1/3

C. Subcategory: Mental and Behavioral Health (classified as D. Subcategory for Medicaid) Antidepressant Medication Management; Optimal practitioner contacts 1/3; Effective acute phase treatment 1/3; Effective continuation phase treatment 1/3; Follow-up After Hospitalization for Mental Illness (7 days); Alcohol and Other Drug Dependence Treatment-Initiation of Treatment 1/2; Engagement of Treatment 1/2

CAHPS Data

The following provides additional explanation of CAHPS data, portions of which are included in the NCQA plan rating methodology. Consumer Assessment of Healthcare Providers and Systems (CAHPS) involves health consumer surveys developed under cooperative agreements between Harvard University, RAND, Research Triangle Institute, and AHRQ. CAHPS surveys include:

- Ambulatory CAHPS
- Health Plan CAHPS
- Hospital CAHPS (HCAHPS)
- In Center Hemodialysis CAHPS
- National CAHPS Benchmarking Database
- Nursing Home CAHPS

The CAHPS Health Plan Survey is designed to collect information on consumers' experiences with health plans and the providers available through those plans. This survey has been in use since 1997. The current version of the survey is the CAHPS 3.0 Health Plan Survey. The current NCQA version of the survey, with some customizations, is referred to as version 3.0H. Use of the NCQA version is required for HEDIS reporting and for NCQA accreditation.

The CAHPS Health Plan Survey is made up of core items and supplemental items. Core items are questions that are applicable across populations and care delivery systems. These items must be included in the questionnaire to maintain standardization in measurement and reporting. Supplemental items are optional questions that address specific issues of interest for a specific population (e.g., Medicaid recipients or people with chronic conditions). The Core items include Composite Measures and Global Ratings

CAHPS Composite Measures refer to summary measures that combine the results for two or more related items into a single score. In the Health Plan Survey, there are five composite measures:

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How-To: NCQA Health Plan Rankings
CAHPS Data continued

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Courtesy, respect, and helpfulness of office staff
- Health plan customer service, information, and paperwork

There are four additional composite measures for children with chronic conditions
In addition to the reports on care, the survey has four separate ratings:

- All Health Care
- Health Plan
- Personal Doctor or Nurse
- Specialist Seen Most Often

The Supplemental items include the following topics for adults. Topics for children also include questions about well child care.

- Duration of health plan enrollment
- Problems with language
- Interpreter services (for hearing impaired and for non-English speakers)
- Dental care
- Behavioral health care
- Care for chronic conditions
- Pregnancy care
- Prescription medicine
- Transportation
- Specialist referrals
- Claims processing
- Medicaid enrollment
- Cost sharing
- Coverage by multiple plans
- Relationships between policyholder and others enrolled in the plan
- Topics required for NCQA accreditation (known as the HEDIS Set)

For commercial and Medicaid, there are Adult and Child versions of the survey. Adults are those 18 and older at the time of the survey. For the NCQA 3.0H survey, Children are those 17 and younger as of December 31 of the measurement year. When plans administer one of the Child Questionnaires, they will be asking parents or guardians about the care their child received.

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October 2005 Rankings

The actual rankings appeared in the October 3rd print edition of U.S. News & World Report, and are available in the magazine's web site at:
http://www.usnews.com/usnews/health/best-health-insurance/topplans.htm

October 2005 Rankings

The above information was compiled and often quoted directly from the following two source documents:

U.S. News and World Report/NCQA Ranking methodology
http://www.ncqa.org/Communications/SOMC/2005%20ranking%20methodology.pdf

The CAHPS Health Plan Survey
http://www.cahps-sun.org/Products/Healthplan/HP-CAHPSIntro.asp

*T*ips

In getting the most out of your MCOL paid membership

- Watch for a new Podcasts feature for paid members being introduced this November, including audio clip Interviews done in conjunction with selected editions of MCOL Weekend, an accompanying Sherlock Company interview with the new Quarterly Reports newsletter mentioned below, as well as other selected podcasts.

- MCOL Podcasts involve recorded brief interviews or presentations. The Podcasts are audio files that can be downloaded from the new Podcast menu page, or can optionally be delivered through your RSS feed reader and Podcast software. The audio files are provided in mp3 format, and can be downloaded and listened to with your PDA, iPod, or mp3 player, or through your desktop or laptop computer.

- MCOL's new e-newsletter "Quarterly Reports" is being introduced this November, which includes financial and statistical information extracted from numerous publicly held health plans quarterly performance reports. A Sherlock Company Podcast , providing some brief observations regarding quarterly performance in the industry will be provided in conjunction with each newsletter.

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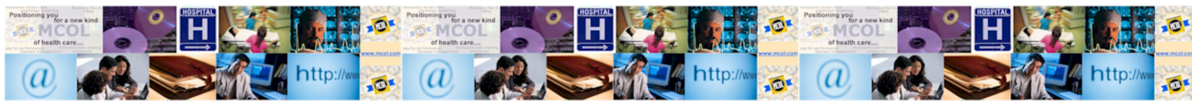

*T*idbits

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

Health Care ala Wal-Mart

Appearing in the October 29th, 2005 MCOL Weekend

Wal-Mart made the news on the health care front twice this week. Once, through a public - relations sanctioned initiative offering new low cost health plan alternatives for their work force; a second time generating some negative publicity regarding an internal memo to the board on how to reduce health care costs.

The internal memo cites that Wal-Mart has to be careful in how to further cut their health care costs, given their reputation in the media, and confirms that less than 45% of their employees receive company health benefits, and 46% of the children of Wal-Mart's employees were uninsured or on Medicaid.

Yet despite Wal-Mart's reputation as being miserly with health benefits, they too experiencing the pain of double digit inflation in health care costs, with their experience averaging 15% annually since 2002. A theme of the memo: "we need a healthier work force" can not be objectionable, and is indeed the objective of any corporate benefits department. However, some of the specific strategies set to writing are causing Wal-Mart a public relations black eye. Perhaps the most damning remark in the memo: "It will be far easier to attract and retain a healthier work force than it will be to change behavior in an existing one. These moves would also dissuade unhealthy people from coming to work at Wal-Mart."

Not that a number of other companies aren't adopting these same strategies- they just either aren't documenting them in memos to the board of directors, or suffering the historical health benefits miser reputation that Wal-Mart does. The memo states a central problem is The least healthy, least productive associates are more satisfied with their benefits than other segments and are interested in longer careers with Wal-Mart." The recommendations to the Wal-Mart board included:

- Increase the mix of part-time workers not eligible for benefits
- Increasing the mix of younger (typically healthier) workers
- Achieving the younger mix by reducing 401(k) contributions and cutting life insurance benefits (discouraging senior workers) offering education benefits (attracting younger workers)
- Promoting HSAs, which attract younger, healthier workers
- Increasing the required employee contributions for spousal/family coverage
- Restructuring all job descriptions to include some physical activity (such as all cashiers do some cart-gathering.)

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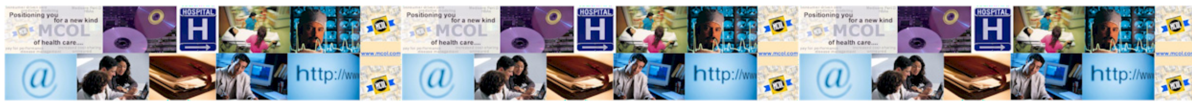

Tidbits: Health Care ala Wal Mart continued

Not all the memo proposals are negative for employees. They recommend reducing the wait time for part-time employees to qualify for health insurance. And like Target, and several other big-box stores experimenting with the concept, they recommend putting clinics in stores, among other reasons to reduce employee emergency and urgent care visit costs.

Wal-Mart did receive mostly favorable publicity this week for announcing innovative low priced health benefit options that might appeal to the currently uninsured portion of their work force. A total of 18 options in some locations are now available, with emphasis being placed on a new "value plan" with a $1,000 single / $3,000 family general deductible but the first three MD visits are not subject to this deductible; additional Rx and inpatient deductibles apply, a maximum annual benefit for the first year of $25,000 (lifted from year two on) and employee monthly premium contributions averaging $25 for singles/$60 families around the country and as cheap as $11 depending on the region. Separate HSA options are also being introduced.

Perhaps those criticizing Wal-Mart for not being up-front about emphasizing high deductible plans, and not more comprehensive coverage, didn't notice their opening statement in the health benefits section of their web site. "The foundation of our health benefits is to provide a choice of medical coverage options designed to protect associates from catastrophic medical costs."

For More Information:

Wal-Mart to Expand Health Plan for Workers
New York Times, October 24, 2005
http://www.nytimes.com/2005/10/24/business/24mart.html

Health insurance for $25
San Francisco Chronicle, October 25, 2005
http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2005/10/25/BUGV7FDB421.DTL&type=business

Reviewing and Revising Wal-Mart's Benefits Strategy
Memorandum to the Wal-Mart Board of Directors from Susan Chambers, October 2006
http://www.nytimes.com/packages/pdf/business/26walmart.pdf

Wal-Mart Memo Suggests Ways to Cut Employee Benefit Costs
New York Times, October 26, 2005
http://www.nytimes.com/2005/10/26/business/26walmart.ready.html?pagewanted=print

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*T*idbits

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

Mexican Health Care for Americans

Appearing in the October 22nd 2005 MCOL Weekend

An interesting by-product of health care consumerism is the rise in delivery of Mexican health care to people living in American border states, particularly in California. The market to date mostly consists of Mexican citizens working in the U.S., and American Latinos fluent in Spanish and comfortable with the Mexican health care system. There are a number of factors driving such interest. Historically, uninsureds sought cross border care driven by price alone, and the number of uninsureds continues to rise. Cheap prescriptions are also an allure. A health care system dedicated to the Spanish speaking is a draw. But in California, and emerging in other border states, the availability of cross border health plans is now striking employer interest.

Even before emergence of these cross border plans in California, cross border care was significant. Results from a 2001 California Health Care survey as reported by Alvaro Garza, MD in a presentation to the American Public Health Association indicated that an "estimated 324,000 California residents went to another country for medical care; 72% to Mexico. Approximately 670,000 residents bought medicines in another country; 86% in Mexico. The number and proportion of residents who went to Mexico for medical care or medicines was higher in regions closer to the Mexico border. Rural residents sought medical care and medicines in Mexico in higher proportions than urban residents. Non-citizens sought medical care in another country in the greatest number and proportion, but the U.S.-born bought medicines in Mexico in the greatest numbers (N=343,000). Latinos sought medical care in Mexico in the greatest number and proportion. A similar number of Latinos and whites bought medicines in another country, the majority in Mexico."

Of course there are perceived and real issues with quality of care standards in Mexico. But California now has three cross border HMO plans, enabled by a 1998 state law, that have to address these issues with their own provider networks. The California law allows for a different standard of care delivered by Mexican providers compared to California providers, but still applies numerous requirements and regulatory oversight. Several reports currently peg Californian membership in these cross border health plans at 160,000, with single premiums currently ranging from $18 to over $100 per month, and medical cost running 40% to 50% for similar services provided in the U.S. The plans include Blue Shield of California's Access Baja, Health Net of California's Salud con Health Net and Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA).

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*T*idbits: Mexican Health Care for Americans continued

The consumers coming across the border in many recent reports cite a more personal, less rushed system of care without the language barrier for the Spanish speaking. The L.A. Times, in a recent article "Mexico health care finds U.S. clientele" cited a typical Tijuana primary care physician that is part of the Access Baja network, and averages treating seven patients per day- a third to a fourth of typical American primary care physician daily patient loads.

Blue Shield described their Access Baja plan as follows" "We offer Access Baja HMO as a sole Blue Shield plan alongside another carrier. Additionally, we offer an innovative "split contract" option (the Dependent Plan) that allows employees to enroll in our core health plan (Access+ HMO, PPO, POS) for health care in California and enroll their eligible family dependents in Access Baja HMO for health care in Baja California. The Access Baja HMO service area is generally defined as the municipality of Tijuana or Mexicali, Baja California, Mexico and the area in California, U.S., within a 50-mile radius from the U.S.-Mexico border crossing point at San Ysidro and Calexico, CA. Care received through providers in Mexico in the Access Baja HMO Plan will be care that is consistent with generally accepted medical standards in Mexico....Medical Care in Mexico: Legal requirements and generally accepted practice standards of medical care in Mexico are different than those of California and elsewhere in the United States. Care received through the providers in Mexico in the Access BajaSM HMO Plan will be consistent with generally accepted medical standards of Mexico, not California. It is Blue Shield's policy to contract only with providers who meet all applicable laws, licensing requirements and professional standards of the organized medical community relating to professional and hospital services in Mexico. With the exception of out-of-area emergency and urgently needed services, as well as services for covered transplants, elective abortions, severe burns, acute rehabilitation, neonates requiring continuous cardiopulmonary support, pediatric cardiovascular and thoracic surgery and critical trauma cases, services under this plan are covered only when provided by the contracting plan providers in Mexico. Any member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the Access Baja HMO Plan."

Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) describes their plan as follows: "SIMNSA is one of the leading Health Maintenance Organization (HMO) programs in Northern Mexico with over 200 physicians along the U.S.-Mexico Border. In 2000, SIMNSA became the first Mexican HMO to be licensed as a health care service plan by the State of California. SIMNSA offers its members the option to receive care at a state of the art medical clinic conveniently located within a walking distance of the San Ysidro border crossing. Our network extends through the border cities of Tecate, Mexicali and Tijuana. SIMNSA covers emergency and urgent care services worldwide. Members may also access urgent care services through the Centro Medico Latino Urgent Care centers, which are conveniently located throughout San Diego and Imperial Counties. California law currently prohibits this Plan from offering coverage to employees who do not qualify as Mexican nationals. However, many Southern California residents choose to access care through our wholly-owned MEDYCA clinics on a cash-pay basis due to the escalating costs of health care in the United States."

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*T*idbits: Mexican Health Care for Americans continued

HealthNet's approach is a little different, using strategic partners including SIMNSA to deliver care, and using the cross border plan as component of a larger Latino care strategy. They describe their program as follows: "Salud Con Health Net selected partners based on their experience in providing quality health care that meets the needs of the Latino community. With state-of-the-art medical facilities in Tijuana, Mexicali and Tecate, the SIMNSA Network offers access to more than 140 physicians and eight hospitals. Médico Hispano provides access to medical clinics throughout Los Angeles County and to more than 200 physicians. As the largest hospital network in Southern California, Tenet HealthSystem offers access to leading community hospitals under Salud con Health Net. Los Angeles area Tenet hospitals include the following: Queen of Angels-Hollywood Presbyterian Medical Center, Greater El Monte Community Hospital, Encino-Tarzana Regional Medical Center, Mission Hospital of Huntington Park, Community Hospital of Huntington Park, Monterey Park Hospital, Garfield Medical Center, Suburban Medical Center, Lakewood Regional Medical Center and USC University Hospital."

For a sense of the financial difference with cross border plans, consider the following ratios for Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) that MCOL compiled from their 2004 annual financial statement filed with the California Department of Managed Health Care. The plan has 14, 486 members as of August 2005:

Premium PMPM	$83.76	Rx % of Revenue	22.1%
Medical Loss Ratio	69.8%	IP Days/1,000	174.5
Rx Expense PMPM	$18.49	IP Expense/Day	$453.67

For More Information:

Cross-border health insurance is a hit with employers and workers
Sand Diego Union-Tribune, October 16, 2005
http://www.signonsandiego.com/uniontrib/20051016/news_mz1b16mexico.html

Low-Cost Medical Care in Mexico Under Scrutiny
All Things Considered, NPR, September 27, 2005
http://www.npr.org/templates/story/story.php?storyId=4866199

Mexico health care finds U.S. clientele
Los Angeles Times, Sept. 11, 2005
http://www.azcentral.com/specials/special03/articles/0911mexico-health11.html

Health Net Announces Expansion of Cross-Border HMO
California Health Line, November 15, 2004
http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=107434&ClassCD=CL103

Californians who access health care services in another country
Alvaro Garza, MD, MPH,American Public Health Association
http://apha.confex.com/apha/133am/techprogram/paper_108462.htm

Access Baja
Blue Shield of California
https://www.mylifepath.com/producer/largegroups/products/health/baja/

SIMNSA Health Care
http://www.simnsa.com/

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*T*idbits

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

2006 Premium Increase Prognostications

Appearing in the October 15nd 2005 MCOL Weekend

Depending upon which major benefit consulting firm you listen to, 2006 health plan premium increases may or may not be double digit. All seem to agree that the rate of increases continue to slow, but that the increases and the cost of health care are still a major and now chronic economic problem for employers and employees to address.

Hewitt Associates this week released their 2006 projections, following Towers Perrin two weeks ago and Aon and Segal's projections this summer. The following is a summary of 2006 Health Plan Premium Increase Projections by Major Benefit Consulting Firm:

Plan	Towers	Aon	Hewitt	Segal
HMO	9.0%	12.9%	10.0%	11.6%
PPO	N/A	12.7%	9.5%	12.6%
POS	N/A	12.7%	10.5%	11.8%
FFS	N/A	14.6%	10.5%	14.4%
Consumer	N/A	12.4%	N/A	12.6%
Rx	N/A	13.1%	N/A	13.8%
OVERALL	8.0%	13.2%	9.9%	N/A

What do these premium increases translate into in actual dollars for 2006? According to Hewitt, the average annual premium cost per employee will be $7,752 for HMOs. $8,075 for PPOs, $8,091 for indemnity fee for service plans and $8,673 for point of service plans. Towers Perrin states that their overall projected annual premium cost for all plans in 2006 works out to $8,424.

What will employees end up paying? Hewitt projects that the average employee premium contribution in 2006 will be $1,612, representing 20 percent of the overall health care premium. Towers Perrin also pegged the employee premium contribution at 20%. On top of this, Hewitt estimates average 2006 employee out-of-pocket costs will be $1,524, meaning the total employee share of the bill in 2006 would be $3,136, up 12 percent from 2005. Towers Perrin also estimates that retirees will pay for 43% of the cost of their group retiree plan premiums.

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Tidbits: 2006 Premium Increase Prognostications

Major benefit firm surveys continue to indicate that trends vary by region. For 2005, Hewitt data reveals indicated the these markets had the highest overall increases in premium rates: Cleveland/Akron (12.2 percent), Boston (11.1 percent), Atlanta (11.1 percent), Houston (10.6 percent), Orlando (10.4 percent), Kansas City (10.4 percent), Orange County (10.4 percent), Sacramento (10.4 percent) and Tampa Bay Area (10.3 percent).

Speaking of 2005, last month the Kaiser Family Foundation released their annual employer benefit survey results which indicated an actual overall 9.2% premium increase. This compares to projections Benefit Consulting firms made last year for 2005 ranging from 8.0% (Towers Perrin) to 13.5% (AON).

What do these survey results indicate that employers are doing about these increases? Consumer driven health plans seem to be a popular response. Craig Dolezal, National Health Care Practice Leader, Hewitt Associates states that "To date, Hewitt has helped more than 100 organizations introduce consumer-directed plans and we're starting to see positive results. We're continuing to see a lot of interest in these plans and expect even more companies will offer them in the next few years, maybe as many as 25 to 30 percent of all large employers."

The Kaiser Family Foundation survey found that "20% of employers who offer health insurance now provide a high-deductible health plan option. Jumbo firms - those with 5,000 or more workers - are significantly more likely than smaller firms to offer a high-deductible plan option, with 33% offering one in 2005." Milliman, who still is pending release of their 2006 projection later this month, did issue results this week from another section of their survey, relating to consumer driven plans, which indicated "93% of those who responded to the CDH portion of the survey expect to offer employers a high deductible plan with an integrated employee account, i.e., Healthcare Reimbursement Account (HRA) or Health Savings Account (HSA)." Milliman did note that "CDH premium revenue will only be 2.5% of all commercial premium revenue in 2005. However, respondents expect this amount to double to 5.2% in 2006."

Hewitt identifies other current strategies as including:

- Contracting with plans that offer specialized or health risk management programs and focus on wellness and prevention.
- Requiring more quality data and price transparency.
- Changing prescription drug coverage.

Of course, overall, employers seem to feel that no strategy is working that well. The Kaiser Family Foundation survey found that "few employers have a lot of confidence in strategies to contain rising health-care costs.

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Tidbits: 2006 Premium Increase Prognostications

For example, 16% of employers say consumer-driven health plans are 'very' effective at controlling costs, while another 45% say they are 'somewhat' effective. Nearly as many view higher employer cost-sharing as very (12%) or somewhat (46%) effective, and view disease management as very (14%) or somewhat (38%) effective. Fewer see tighter managed-care networks as very (7%) or somewhat (37%) effective."

For More Information:

U.S. Companies Face Lowest Health Care Cost Increases Since 1999, According to Hewitt Associates
Hewitt Associates Press Release, October 10, 2005
http://was4.hewitt.com/hewitt/resource/newsroom/pressrel/2005/10-10-05.htm

Milliman 2005 Group Health Insurance Survey Sees Growth in Consumer Driven Products
Milliman Press Release, October 10, 2005
http://www.milliman.com/press_releases/FINAL_2005CDHRelease.pdf

Towers Perrin Projects An 8% Increase In Employer-Sponsored Health Care Costs For 2006 As Annual Cost per Employee Reaches $8,424
Towers Perrin Press Release, September 28, 2005
http://www.towersperrin.com/hrservices/webcache/towers/United_States/press_releases/2005_09_28/2005_09_28.htm

Survey Finds Steady Decline in Businesses Offering Health Benefits to Workers Since 2000
Kaiser Family Foundation Press Release, September 14, 2005
http://www.kff.org/insurance/chcm091405nr.cfm

Segal Predicts Continued Declines in Trends in 2006
Segal Press Release, August 5, 2005
http://www.segalco.com/pressreleases.html#080505

Aon Survey: Specialty Pharmacy Trend Rate to Rise 22.5 Percent in 2005; Significantly Outpacing General Pharmacy Rate's 13.1 Percent Increase
Aon Press Release, June 13, 2005
http://www.aon.com/about/news/press_release/pr_attachments/2005_Spring_HC_Trend_Release_Final.pdf

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*T*idbits

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

The State of Healthcare Quality 2005

Appearing in the October 8th , 2005 MCOL Weekend

NCQA this week issued their annual State of Healthcare Quality Report. One conclusion they made: the good news is that quality indicators continue to incrementally improve almost across the board. The bad news? Just 21.5% of plans publicly report their performance. NCQA stated that 289 commercial health plans that reported their data, with overall average performance improvements made over last year for 18 of 22 clinical indicators.

But the total covered commercial, Medicare and Medicaid members represented by publicly reporting plans was 64.5 million was actually a decline of 4.5 million from last year. The reasons: loss of marketshare to plans that don't report, particularly Consumer Driven Health Plans and traditional PPOs, which NCQA notes typically don't measure or report performance.

NCQA President Margaret E. O'Kane know what she wants consumers and employers to do about these non-reporting plans: "Any kind of health plan might potentially be an excellent plan, but realistically, only the ones that measure quality are going to achieve excellence. Today we see a lot of health plans that aren't measuring anything. The right response as a consumer to these plans is simply, don't buy them."

The growth in Consumer Driven Health Plan PPO accounts, and resulting loss of measurable reported data is going to be an ongoing problem for NCQA, regulators and purchasing groups to deal with. In particular, the growing movement towards pay for performance programs with providers, which depends upon applicable measurements and reporting, will suffer,

NCQA cites that Medicare is now putting its considerably big toe into the pay for performance pool. They quote Glenn Hackbarth, J.D., Chairman, MedPAC: "Right now Medicare pays by volume instead of quality. As a result, we buy a great deal of care of uneven quality. Expanding pay-for-performance gets the dollars flowing in the same direction as our desire for higher quality. As things now stand, Medicare often pays more for care of poor quality than it does for high quality care." NCQA also cites that there are well over 100 commercial P4P pilot projects currently underway. With all this momentum, the issue of P4P in the PPO sector, particularly the Consumer Driven sector, needs further attention.

NCQA also heralded their collaboration with U.S. News & World Report have collaborated to create new rankings of America's Best Health Plans, with details of the top 100 appearing in this week's magazine and the entire database available from the U.S. News web site. Below are their 2005 top 25 commercial plans, extracted from the NCQA press release:

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*T*idbits: The State of Healthcare Quality 2005

U.S. News/NCQA America's Best Health Plans Ranking (Commercial Plans)		
Rank	**Plan Name****	**State**
1	Harvard Pilgrim Health Care	MA
2	Harvard Pilgrim Health Care of New England	NH
3	Preferred Care	NY
4	Tufts Health Plan (HMO)	MA
4*	Tufts Health Plan (POS)	MA
5	Independent Health Association (HMO)	NY
6	ConnectiCare	CT
7	Care Choices (HMO)	MI
8	Blue Cross and Blue Shield of Massachusetts	MA
9	Capital District Physician's Health Plan (HMO)	NY
10	Health Alliance Medical Plans	IL
11	Security Health Plan of Wisconsin (HMO)	WI
12	Excellus BlueCross BlueShield	NY
13	Anthem Blue Cross and Blue Shield	CT
14	Univera Healthcare	NY
15	Geisinger Health Plan	PA
16	Capital Health Plan (HMO)	FL
17	Fallon Community Health Plan	MA
18	Oxford Health Plans of Connecticut	CT
19	Health New England	MA
20	MVP Health Care	NY
21	ConnectiCare of Massachusetts	MA
22	CIGNA HealthCare of New Hampshire	NH
23	Group Health Cooperative of South Central Wisconsin (HMO)	WI
24	Priority Health (HMO)	MI
25	BlueShield of Northeastern New York	NY

* Repeated rankings (e.g., 4, 4 or 38, 38) indicate a tie score between two plans. Tie scores sometimes occur when two or more related entities (e.g., an HMO and an affiliated POS plan) undergo a joint survey and share HEDIS and CAHPS results. ** All plans are HMO/POS combined except as noted. POS refers to an organization's Point of Service plan.

For More Information:
NCQA Report Shows Health Care Quality Up, But Enrollment Down In Plans That Report On Performance
NCQA Press Release, October 3, 2005
http://www.ncqa.org/Communications/News/SOHC_2005.htm

The State of Healthcare Quality 2005
Full Report, NCQA
http://www.ncqa.org/Docs/SOHCQ_2005.pdf

Best Health Plans 2005
US News and World Report Web Site
http://www.usnews.com/usnews/health/best-health-insurance/topplans.htm

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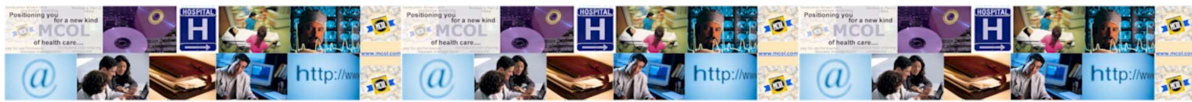

*T*idbits

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

Tidbits from the 15th Annual HFMA Conference on Managed Care

Appearing in the October 1st , 2005 MCOL Weekend

Some very random tidbits gathered from presentations during the 15th Annual HFMA Conference on Managed Care held this week in Southern California:

Jeanne Scott, talking head in chief of health-politics.com on why rise in the uninsured population during the past decades:

- 1975: General Motors was the largest single non-government employer in the USA - 2.2 million employees, and everyone of them had full womb-to-tomb health care paid 100% by GM
- 1985: ATT was the largest employer, 1.8 million employees, all with 100% employer-paid coverage
- 2005: Wal-Mart is the nation's largest employer, with 1.5 million US employees - less than 400,000 have health care and it costs them from $120-190/month for a high deductible limited coverage plan

Steven T. Valentine, President, The Camden Group, offered a wide variety of data trends, including these two:

Rise of Device Driven Surgery: the percentage of inpatient procedures using devices:

- Orthopedic: 2000 - 45% 2010(E) - 56%
- Cardiac: 2000 - 22% 2010(E) - 36%
- Neurosciences: 2000 - 4% 2010(E) - 34%
- Other Surgeries: 2000 - 3% 2010(E) - 21%

Office Visits Per Copay Level per member per year:

- $0: 2.88 pmpy
- $5: 2.56 pmpy
- $10: 2.29 pmpy
- $15: 2.11 pmpy

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*T*idbits: Tidbits from the 15th Annual HFMA Conference on Managed Care

Michael Mellenthin, MD of BENU, explained how their risk adjusted premium defined contribution health plan program worked

- BENU has two health plan partners: Cigna and Kaiser
- BENU targets mid size employer groups
- The two plans submit premium quotes for each group as if they will underwrite the entire group
- After 6 - 9 months, actual Rx data is submitted by the plans to BENU
- BENU plugs this data into predictive model to determine prospective risk factors per each member
- Weighted risk factors for enrollment under each carrier are determined, and premium is retroactively re-allocated

Looking for a list of of the core functionality required for EHR in a physician office practice? Nileen Verbeten, of the California Medical Association provided one:

- Health information and data
- Results management
- Order entry/order management
- Decision support
- Electronic communication and connectivity
- Patient support
- Administrative Processes
- Reporting and population health management

Finally, Dr Sam of Dr. Sam & the Managed Care Blues Band is looking for song title suggestions for their managed care and general health care song parodies, such as their classic "Why did you leave me Blue Shield?" If you have an inspiration, you can e-mail him at info@managedmusic.com

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*F*actoids

Selected Factoids from the MCOL Daily Factoids e-newsletter

Survey Finds HSA Insurance Plan (HDHP) Monthly Premiums Up To 36% Lower Than Comparable PPO Offerings in Most States

Appeared in the October 10th , 2005 Daily Factoid e-newsletter

According to a new survey released by HSAFinder, high deductible health insurance plans associated with HSAs are saving people close to 16% a month on monthly premiums for young singles and 36% a month for families with children on the policy. This new study compared monthly premiums for PPOs and high deductible HSA plans throughout the United States.

The average monthly cost to a 29-year-old single male for a PPO with a $500 deductible was $102.39 versus only $86.04 for a $2,000 deductible HSA. Though the average difference is only $16.35 a month (-16%), some states clearly have larger differences.

The average monthly premium cost to the family with small children for a $500 deductible PPO was $354.97 while the average cost for a $5,000 family deductible HSA was $226.12. That equals to an average savings of $128.85 a month or $1,434.12 a year (-36%).

Source: HSAFinder.com, October 5, 2005. For additional information, please visit www.hsafinder.com

Percent of Members Receiving Recommended Care for: Diabetes Care and Cholesterol Management

Appeared in the October 13th , 2005 Daily Factoid e-newsletter

Regional Averages: Commercial, 2004 *Lower rates are better for this measure.

	Cholesterol Management Control (LDL<130)	Comprehensive Diabetes Care - HbA1c Testing	Comprehensive Diabetes Care - Poor HbA1c Control*
East North Central	67.9	86.5	29.3
Middle Atlantic	72.4	86.8	28.9
Mountain	66.1	85.4	34.5
New England	71.0	90.5	26.2
Pacific	68.7	86.8	30.9
South Atlantic	67.9	85.4	31.6
South Central	62.7	84.5	35.8
West North Central	65.2	88.7	27.1

Note: Regions referenced are defined by the U.S. Census Bureau.

Source: The State of Health Care Quality 2005, National Committee for Quality Assurance (NCQA). For additional information, please visit: www.ncqa.org.

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2005 National Webcast on Pay for Performance Trends and Issues

An audioconference/ webcast on Thursday November 17th, 2005, 1 PM Eastern

Faculty:

Geof Baker, MBA
CEO
Med-Vantage, Inc.

Beau Carter
Health Policy and Strategy Consultant
Med-Vantage, Inc.

Pay for Performance (P4P) is the hottest issue in health care today. From local business coalitions to regional and national health plans to the Federal government, P4P sponsors across the country are experimenting with new ways to drive quality improvement through incentives.

MCOL and the authors of the 2003 and 2004 national studies on provider pay for performance (P4P) programs -- Geof Baker and Beau Carter from Med-Vantage -- invite you to attend their upcoming national webcast on the 2005 national P4P study results.

The webcast will cover trends in program design and strategy, measurement domains and weighting, scoring models and payment amounts, public reporting, and critical data issues, among other topics. The authors will also report on valuable lessons learned and recommendations from some of the more than 100 P4P sponsors (health plans, government, and employer coalitions) across the country. Webcast participants will receive complimentary copies of the comprehensive 2005 written report on P4P trends and issues when it is released later in the year.

Individual Registration Fee: $195 (50% Discount off this price for MCOL Paid Members) Web Summit CD-ROM: $20 for attendees; $225 for non-attendees after the event.

Live Audioconference

Powerpoint Presentation

Copy of 2005 P4P Study

CD-ROM Also Available

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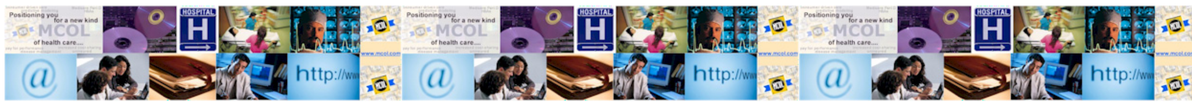

Quoted

From MCOL's Quotes of the Week during October

"Larger businesses that are exposed to severe price competition are limited in what they can pay for health care by the prices they can get for their products. This creates a particularly challenging problem for companies that rely on low-wage workers." Christopher Ohman, President, California Association of Health Plans

"Its a deeply troubling irony, that the United States boasts the most technologically advanced health care system in the world, but issues of cost and accessibility are driving Americans literally out of the country to seek health care." Dr. Robert K. Ross, President, The California Endowment

"While it is encouraging to see cost increases stabilizing, the rate of growth remains unsustainable and the magnitude of health care costs continue to be a major concern for employers' bottom lines and employees' wallets." Craig Dolezal, National Health Care Practice Leader, Hewitt Associates

"The new mantra for health care purchasers needs to be, 'show us your data.' Why trust your family's health to an organization that operates behind closed doors?" NCQA President Margaret E. O'Kane

"Any medical group out there today views Medicare Risk contracts as a gold mine. They can't get enough Medicare Advantage enrollment." Steven T. Valentine, President, The Camden Group

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We welcome your feedback anytime regarding this issue of MCOL Monthly or any other aspect of your membership.

Thank you for being a MCOL member!

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