DistilNFO – Health Plan

Monthly Competitive Intelligence

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www.distilnfo.com/payer

Dear Reader,

As everyone knows, the Affordable Care Act will create a large opportunity for health plans with significant growth in the individual market. Many health plans are being proactive today to position themselves for 2014. Our monthly competitive intelligence advisory focuses on four key healthplan strategies:

- Retail Strategy, Consumer Engagement and the Individual Market
- Accountable Care Organizations
- Technology and Innovation
- Product Development

In April 2012, more and more health plans entered the retail market. It is interesting to see the different channels that health plans are entering to get to the individual market. As you will read below, Humana has partnered with Walmart and Cigna has partnered with Costco. Why not partner with two retailers who know their consumers well and are experts in retail?

Leading health plans are also looking to bend the cost curve by entering into Accountable Care Organization (ACO) arrangements with providers. While ACO's are popular, they are still in the infancy stage and many plans are exploring different types of arrangements. Blue Plans and Cigna continue to aggressively invest into ACO arrangements.

Technology and innovation are always demanded by employer groups and are responded to with mixed results by health plans. However, with the move towards individual consumers, we have noticed that many plans are investing into tools to capture the individual market and to improve the "member experience." Health plans are attempting to tailor the experience and to specifically invest in mobile applications.

Finally, traditional products are still around. Health plans are still attempting to come up with innovative new products to keep their brand and products relevant. Most of the new products still have an eye towards the Affordable Care Act since they related to narrow networks and limited benefits.

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RETAIL & INDIVIDUAL MARKET

Aetna to Sell Insurance Coverage Through Costco

Associated Press, April 24, 2012

HARTFORD, Conn. (AP) — Health insurer Aetna Inc. has branched out to start selling individual insurance plans to members of the wholesale club operator Costco in nine states.

The Hartford, Conn., insurer said Tuesday that its Costco Personal Health Insurance program will offer five health plans online, providing major medical benefits, dental coverage and lower copays on prescriptions filled at Costco pharmacies.

Aetna said it will charge less for the insurance it sells through Costco than it normally does for individual plans.

It will sell the plans in its home state of Connecticut and in Illinois, Texas, Michigan, Virginia, Georgia, Arizona, Pennsylvania and Nevada. Aetna said it plans to expand the plan to more states later in 2012.

Costco Wholesale Corp. operates 601 warehouse club stores, including 434 in the United States and Puerto Rico, making it one of the two largest players in its sector of the retail industry.

Aetna is the third-largest private health insurer, with medical enrollment of about 18.5 million people at the end of last year. Most are covered through employer-sponsored health plans.

Insurers have been looking for ways to add more individual policies as the federal health care overhaul aims to offer coverage to millions of people who are now uninsured. The law will do this in part through online exchanges and by offering income-based credits to help people buy health insurance.

Morningstar analyst Matt Coffina said insurers like Aetna that have focused mostly on the larger employer-sponsored coverage market want to grow their individual business so they can remain competitive if more insurance is purchased that way in the future.

Shoppers can learn more about the plans by visiting www.costcopersonalhealth.com .

Aetna shares climbed 4 cents to close at $48.97 Tuesday, while shares of Costco fell 15 cents to close at $86.47.

Humana, Walmart Team on Prescription Program

Phoenix Business Journal, April 12, 2012

Humana Inc. has teamed with Wal-Mart to offer a new prescription drug plan that can save up to 20 percent in drug costs for employers and employees.

Humana's (NYSE: HUM) pharmacy benefits management subsidiary, Humana Pharmacy Solutions Inc., now will offer a Wal-Mart Rx Network. It also offers a new formulary, or approved drug list, called Rx4Value.

Both options are available to self-insured employers. The Wal-Mart Rx Network option is expected to be available to fully insured employers later this year.

William Fleming, a pharmacist and president of Humana Pharmacy Solutions, said this simple solution could help employers better predict costs and save money.

"Pharmacy is the most used health benefit, and providing new, unique pharmacy benefits services that best meet employers' and members' needs directly supports Humana's mission of helping people achieve life-long health and well-being," he said.

Savings are achieved two ways: By influencing where people buy prescriptions and what they buy, Fleming said.

The new formulary includes lower cost generic drugs and there is only one company in the entire network, which is Wal-Mart.

"If employers are willing to change where employees buy prescriptions and only have Wal-Mart in the network, there are significant savings that can come with that," he said. "We can guarantee those savings through the relationship we have with Wal-Mart to be able to drive those costs."

He said Humana has more authorization requirements around some of the high-cost medications that are not on the formulary.

"We do have more scrutiny in this product around those drugs that truly can help meet imminent needs for disease versus those treatments that don't meet imminent need but are an interest request."

Would you buy health insurance in a store?

Washington Post, April 25, 2012

Three years ago, Blue Cross and Blue Shield of Florida did something unexpected for an insurance company: It began opening stores.

They weren't clinics. They did not provide much in the way of medical care. Instead, the buildings housed something that feels almost antiquated: a place where consumers could walk in, meet a Florida Blue representative, and purchase an insurance policy.

In many ways, the Florida health plan was making an odd choice: The Internet already provides a nearly free storefront. Health insurance companies regularly talk about getting squeezed financially, as the health reform law requires them to spend at least 80 percent of every premium dollar on medical costs.

Why, then, put the other 20 percent towards brick-and-mortar buildings?

"Why did Apple decide to open stores, when they could sell everything they sell online?" asks Patrick Geraghty, CEO of Florida Blue Cross Blue Shield. "There's an experience attached to it. It puts a face on the organization."

The plan's movement into retail, in many ways, responds to the health reform law: Come 2014, the health reform law will expand the individual health insurance market by an estimated 16 million new customers. Individuals will become increasingly involved with purchasing their own health care, putting a greater premium on customer service.

"Traditionally, Blue Cross Blue Shield has been in a business-to-business environment," says the company's CEO, Scott Serota, when I spoke with him and Geraghty Tuesday afternoon. "Now our biggest challenge is to evolve into a consumer-focused company."

Right now, however, insurance companies aren't in a great place in this front. In surveys, consumers have ranked the health insurance industry as the most complex and confusing to navigate. Americans put more time and effort into researching dishwashers than they do shopping for an insurance plan.

Florida Blue Cross Blue Shield has opened nine "Florida Blue" centers so far, a number that will continue to grow. Two launched this year alone, with four more in the works by the end of 2012. The retail stores offer staff who can help

enroll in a plan, assist with claims and offer a wellness assessment. One of the stores, in Pensacola, recently added a primary care physician on site.

As the stores have opened, the demand seems to be there. When a Florida Blue storefront opened in Tallahassee recently, it had about 1,500 people come through over the first weekend.

"Our members are interested in our online tools, but sometimes need to be walked through that," says Geraghty. "You can come into this center with a stack of your claims that you have an issue with or a question about, and hand them over, and we walk through those claims and resolve those claims in front of you while you're there. It's very, very popular with our membership."

Florida Blue Cross Blue Shield was already on the way to retail stores before the Affordable Care Act passed, as fewer Americans received insurance through their employers may be turning to the individual market. The expansion of the insurance market, Geraghty says, only makes it more important for his insurance plan to have a strong retail presence moving forward.

"We think we're well positioned for that expansion," he says. "We know we have to advance retail capabilities. That's what you're seeing here. A real investment in the retail side of our business to connect to our members on that one-to-one basis."

Aetna and Mindbloom Gamify Wellness to Help Drive Healthy Habits

Consumer-friendly interactive Life Game from Mindbloom helps make life improvement fun, simple and effective

HARTFORD, Conn., and SEATTLE, Wash., April 11, 2012 — Collaborating to help individuals deeply engage in their personal wellness efforts, Aetna (NYSE: AET) and Mindbloom (www.mindbloom.com) announced today that they have made the premium Mindbloom Life Game available to all of Aetna's members, as well as Aetna employees.

The Mindbloom Life Game blends the principles of behavioral science with social gaming to offer a fun, simple and effective way for Aetna to inspire people to live healthy, productive and balanced lives. The premium Mindbloom offering includes all the benefits of Mindbloom's popular consumer Life Game, plus access to more music, an expanded gallery of images, and unlimited personal media storage.

"A significant amount of total health care costs stem from lifestyle choices such as lack of exercise, failing to eat properly and smoking," said Dan Brostek, head of member and consumer engagement at Aetna. "Mindbloom cannot only help users manage specific physical conditions but can also help them monitor areas often correlated to health outcomes but considered 'unmentionables' in the current health care system such as stress related to jobs or caregiving, relationship conflicts, unhealthy sex life or financial issues."

Aetna users also will have access to Mindbloom's inspiration reminder mobile app called Bloom*, which launched in November and has already garnered more than 250,000 downloads in the iTunes Store. The Bloom* app can help users keep what's important top-of-mind while on-the-go and remind

users to make healthy choices, stay connected with others, manage stress, strengthen their spirit, save money, advance their career, and enhance their creativity.

Helping People Improve Their Lives

Marvina Hirni, 47, for instance, suffers from Fibromyalgia and recently turned to Mindbloom to help manage her chronic disease. Hirni experiences debilitating pain, and simple tasks often become challenging. She uses Mindbloom to create and record her daily progress, which she then shares with her doctor.

"Fibromyalgia sometimes prevents me from stepping outside or even making a phone call to a friend. But after using Mindbloom, I've learned to appreciate the smallest accomplishments in life, record them and find strength to deal with my symptoms," said Hirni. "It sounds simple because it is but Mindbloom has been an incredibly powerful, yet enjoyable experience when having to manage this disease."

Since its official debut in September 2011, Mindbloom's Life Game for consumers has organically grown to more than 50,000 registered users who have successfully followed through on more than 1.5 million commitments to improve their quality of life. Utilizing gamification techniques, Mindbloom has been able to successfully inspire its users to define what's important, discover what motivates them, and take meaningful daily actions in all areas of their life. Members visit the site an average of nearly 4 times per week with an average engagement time of 14:41 minutes per visit, where they grow and maintain a virtual "life tree" and a forest of their family and friends, earn virtual rewards and most importantly make progress in their real lives. To date, Mindbloom Life Game users have followed through on more than 60 percent of their commitments to unlock rewards, new levels and content.

"After a decade designing an award-winning computer game like F.E.A.R., I found a more important purpose for my craft – engaging people in the quality of their lives in ways that are highly dynamic, extremely effective and very fun," said Chris Hewett, co-founder and executive producer of Mindbloom. "Our collaboration with Aetna takes our social game to a new level, and brings more people new ways to prevent or manage disease and improve overall wellness."

For an overview of how the Mindbloom Life Game works, visit http://www.youtube.com/watch?v=ezZxHCYezqM or check out the Bloom app at http://vimeo.com/31439840.

TECHNOLOGY & INNOVATION

myRegence.com Recognized for Transparency Innovation

Independent research firm concludes, "Regence Cracks the Transparency Code"

PORTLAND, Ore., April 23, 2012 /PRNewswire via COMTEX/ -- If consumers could shop for health care like they shop for groceries, could they find more affordable care? If they could talk to one another and share reviews about a doctor or hospital, would they be able to connect with the provider that's right for them? Regence believes in the power of information and Forrester Research, Inc. feels we've cracked "the transparency code."

Forrester, a market leader in research and forward-thinking advice, recently conducted an independent review of the transparency tools available to Regence members on myRegence.com. ("case study:Regence Cracks the Transparency Code)("case study:April 4)("case study:2012") Since 2005, members have been able to log on to compare hospitals, estimate treatment costs, search for nearby providers, review doctors, and socialize with other members looking for the exact same information.

The result, noted by Forrester, is higher member satisfaction, meaningful behavioral change and solid engagement levels from both members and providers. It's a triple bottom line that Regence sees as the starting point for a more personalized member experience devoted to improved health and reduced cost.

"To date, members have posted more than 69,000 provider reviews on the Regence site," wrote Forrester researcher Elizabeth Boehm. "Sixty percent of transparency solution users agree that Regence helps them control their health care costs, compared with only 29% of non-tool-users," she added.

Regence is committed to serving as a catalyst to transform health care, while creating a person-focused and economically sustainable system. These tools are fundamental to that Cause and allow members to take an active role in bending the cost curve as empowered health care consumers.

"An informed consumer is an empowered consumer, one who can better plan their total health care experience," said Vice President of eBusiness Solutions, Torben Neilsen. "Our transparency tools connect our members, in a very intuitive way, to the resources they need and have come to expect."

Regence is pleased to see its members utilizing these tools at such a high level of engagement, and others are taking notice. The result is a growing surge of sales across country, with other health plans purchasing these transparency tools for use with their own members.

About Regence affiliated companiesThe Regence affiliated companies serve more than two million members through Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah and Regence BlueShield (selected counties in Washington). Each health plan is a nonprofit independent licensee of the Blue Cross and Blue

Shield Association. The Regence affiliated companies are committed to improving the health of its members and communities and to transforming the health care system. For more information, please visit www.regence.com or follow us on Twitter.

Cigna launches new Global Health Options website

Cigna redesigns Global Health Options website: cignaglobal.com, Website reflects new global re-branding and customer centric focus, Customers get immediate, user-friendly access to quick and individualised pricing and product information

Glasgow (PRWEB UK) 23 April 2012

Cigna, a global leader in providing international health insurance to expatriates and other globally mobile individuals, has redesigned its website selling and servicing individuals' international health care needs through its business unit known as Cigna Global Health Options.

The revamped site – cignaglobal.com – went live last month and features the company's recent global re-branding, including a new logo and other design elements reflecting its customer and corporate mission. Direct from the landing page and throughout the decision-making and ultimately the purchase process, customers can now access quick pricing information and easily view "at a glance" product information.

"The refreshed site has a contemporary new look and feel which we believe will appeal to a global audience," says Phil Austin, Head of Cigna Global Health Options. "This transformation is about continuing to evolve and strengthen every element of our proposition, opening up and extending dialogue with our customers and responding to what they're looking for, and how we can facilitate their health care needs."

The site was developed in line with customer usability feedback and also utilized the experience and successes learned from Cigna's businesses and operations in the United States and elsewhere. Product enhancements and updated marketing collateral are also scheduled for imminent release.

"It's by listening to our customers and making continuous improvements like our new website that we live out our promise to supporting the health and well-being of the individuals we serve with access to high-quality health care worldwide and best in class service," said Austin.

UnitedHealthcare's New Bilingual Mobile Website Provides Hispanics with Culturally Relevant Health and Wellness Information

UnitedHealthcare Press Release, April 12, 2012

Easy-to-use website aims at improving health literacy among U.S. Hispanics

Unique feature enables users to toggle between English and Spanish on every page

MIAMI (April 12, 2012) – UnitedHealthcare's Latino Health Solutions today launched a bilingual mobile website that provides health and wellness information tailored to Hispanics' specific cultural and language needs.

The mobile website, which can be accessed by entering m.uhclatino.com on a smartphone browser, offers extensive, culturally relevant health and wellness information, tools and resources in both English and Spanish.

Rather than returning to a home page to switch languages, users of the new mobile website can toggle between English and Spanish on every page to access health content, including fitness tips, recipes, and a glossary of health and insurance terms. This feature makes it easier for all Hispanics – Spanish-speaking, predominantly English-speaking and bilingual – to share health information with relatives and friends. The website also offers tips for healthy living and audio podcasts with health messages in Spanish or English – all without having to use a computer.

In addition to valuable health information accessible to the public at large, the new mobile website enables UnitedHealthcare plan participants to contact bilingual customer service by just clicking on the number from their mobile devices.

Hispanics suffer disproportionately from chronic conditions like diabetes and obesity, and health literacy rates among Hispanics are lower than those of non-Hispanic white adults. According to the U.S. Department of Health and Human Services, the percentage of adults with basic or below basic health literacy is 65 percent for Hispanic adults, compared to 28 percent for non-Hispanic white adults.

"Better health and wellness education leads to better health. With Hispanics leading the charge in using mobile devices to access health information, the time was right for a mobile website that provides hundreds of pages of health information that Hispanics can relate to and can use while they are on the go," said Russ Bennett, UnitedHealthcare's vice president of Latino Health Solutions.

A study by the Pew Research Center shows that more than 80 percent of U.S. Hispanics own a cell phone. Hispanics rely heavily on mobile devices to access the Internet, stay up-to-date with the world, and connect with friends and family.

More than 25 percent of U.S. Hispanics have used a mobile phone to look up health information at least once, and 11 percent of Hispanics have a software application to help them track or manage their health, compared to only 7 percent of mobile users among the general population.

"Health literacy largely depends on ready access to information that is both easy to understand and engaging," said Bennett. "With that goal in mind, we developed a mobile website that is uncomplicated, entertaining and full of culturally relevant and practical health and wellness information that can be used instantly in Hispanic households."

For more information, visit www.uhclatino.com or access the mobile website from your smartphone browser at: m.uhclatino.com.

ACCOUNTABLE CARE ORGANIZATIONS

Cigna Works with Physicians to Bring Accountable Care to 65,000 More Individuals From Maine to Texas

Cigna Press Release

09 April 2012
Consumers benefit from improved care coordination and greater emphasis on preventive care
Primary care doctors are rewarded for improving patient health and lowering medical costs
Program includes registered nurse clinical care coordinators
Cigna on path to reach 2014 goal of 100 accountable care initiatives for 1 million customers

BLOOMFIELD, Conn., April 09, 2012 - Cigna has expanded its collaborative accountable care program through 10 new initiatives with physician groups in seven states – Colorado, Maine, New York, North Carolina, Tennessee, Texas and Virginia. With the addition of these initiatives, Cigna now has 22 collaborative accountable care programs in 13 states covering more than 270,000 customers and is positioned to reach its goal of 100 initiatives for 1 million customers by 2014. Cigna launched its first collaborative accountable care program in 2008.

These programs focus on expanding patient access to health care, improving care coordination, and achieving the "triple aim" of improved health outcomes (quality), affordability and patient satisfaction. Collaborative accountable care is Cigna's approach to accomplishing the same population health goals as accountable care organizations, or ACOs, with a strong focus on high-risk individuals, including people with chronic health conditions such as diabetes or heart disease.

The newest members of Cigna's network of collaborative accountable care initiatives are:

Kennebec Region Health Alliance, a large physician hospital organization (PHO) in Augusta and Waterville, Maine, that's affiliated with MaineGeneral Medical Center. www.mainegeneral.org

Penobscot Community Health Care, Maine's largest and most comprehensive community health center, with 15 practice sites in the greater Bangor region. www.pchc.com

The Jackson Clinic, the first multi-specialty group practice in Tennessee, with eight locations in Jackson and offices in four other West Tennessee communities. www.jacksonclinic.com

WESTMED Medical Group, the largest private group medical practice in central and lower Westchester County, N.Y. www.westmedgroup.com

Fairfax Family Practice Centers, a primary care family medical practice based in Northern Virginia. www.FairfaxFamilyPractice.com

Bon Secours Medical Group, the physician practice group of Bon Secours Virginia Health System in Richmond, Va. http://www.bonsecours.com/find-a-physician-bon-secours-medical-group.html

Key Physicians, an independent physician organization serving

Raleigh/Durham, N.C. www.keymedicalhome.com

Cornerstone Health Care, a large multi-specialty physician group in High Point, Winston-Salem and Greensboro, N.C., and surrounding areas. www.cornerstonehealth.com

HeathTexas Provider Network (HTPN), a large physician group in the Dallas/Ft. Worth Metroplex that's affiliated with Baylor Health Care System. www.healthtexas.com

Colorado Springs Health Partners (CSHP), a large multi-specialty physician group in Colorado Springs. www.cshp.net

Collaborative accountable care is already helping to improve the health of Cigna customers where the program has been introduced. For example, Celia is a Cigna customer in North Texas who had difficulty managing her diabetes and often had to go to the emergency room or be hospitalized. Her care coordinator at Medical Clinic of North Texas worked with a Cigna case manager to set up a home visit program for Celia and also scheduled weekly visits for lab work to monitor Celia's condition. As a result of this enhanced care, Celia's blood sugar levels stabilized and she avoided emergency room visits and hospitalization.

"Our existing programs are making excellent progress, so we're more convinced than ever that Cigna's collaborative approach to accountable care is the right model for how health care should be practiced in the U.S.," said Alan Muney, M.D., Cigna's chief medical officer. "Cigna sets the bar high for physician groups to participate in our collaborative accountable care initiatives and these 10 groups are excellent additions to the program. Each group is committed to putting the patient at the center of its practice, with expanded access to care, better coordination of care, patient education about chronic conditions and wellness, access to clinical programs for health improvement, and smart use of technology that improves the patient experience."

"Most employers will tell you that our nation's health care delivery system is broken and needs to be repaired," said Helen Darling, president and chief executive officer of the National Business Group on Health. "Employers and individuals continue to spend more and more for health care that isn't as coordinated as well as it should be, and doctors are rewarded for volume rather than for improved health outcomes. Cigna's collaborative accountable care holds great promise to deliver better quality at lower costs. I congratulate Cigna and these 10 physician groups for their efforts to reshape health care in the U.S. and create a delivery system that works for patients, consumers, health care professionals and purchasers."

Critical to the programs' benefits are registered nurses, employed by the physician practices, who serve as clinical care coordinators and help patients with chronic conditions or other health challenges navigate the health care system. The care coordinators enhance care by using patient-specific data provided by Cigna to identify patients being discharged from the hospital who might be at-risk

for readmission, as well as patients who may be overdue for important health screenings or who may have skipped a prescription refill. The care coordinators contact these individuals to help them get the follow-up care or screenings they need, identify any issues related to medications and help prevent chronic conditions from worsening.

Care coordinators also help patients schedule appointments, provide health education and refer patients to Cigna's clinical programs, such as disease management programs for diabetes, heart disease and other conditions; and lifestyle management programs, such as programs for tobacco cessation, weight management and stress management.

Cigna will compensate physicians for the medical and care coordination services they provide. The physician groups will also be rewarded through a "pay for performance" structure if they meet targets for improving quality and lowering medical costs.

The principles of the patient-centered medical home are the foundation of Cigna's collaborative accountable care initiatives. Cigna then builds on that foundation with a strong focus on collaboration and communication with physician practices. Cigna is now engaged in 28 patient-centered initiatives in 17 states, including six multi-payer pilots and 22 Cigna-only collaborative accountable care initiatives. The collaborative accountable care initiatives encompass more than 270,000 Cigna customers and more than 4,000 physicians. Cigna has been a member of the Patient-Centered Primary Care Collaborative since October 2007.

Big Health Insurers Acquire Health IT Horsepower to Support Their Accountable Care Organizations

Dark Daily

April 18, 2012

Until recently, most media coverage about nascent accountable care organizations (ACOs) centered on the plans of major hospitals and health systems to organize ACOs within their communities. Now comes news that major health insurers are making sizeable investments as they prepare to launch their own ACOs.

These developments could be auspicious for local clinical laboratories and anatomic pathology groups. It could mean that in many regions around the United States there will be ACOs operated by hospitals/health systems that compete against ACOs operated by health insurance companies. In turn, that would mean more customers for lab testing services in these cities and towns.

A string of healthcare information technology deals by large health insurance companies over the past eight weeks signals that private players intend to compete vigorously by operating their own ACOs. Announced on February 14, one deal saw three Blue Cross and Blue Shield health plans join forces with the HIT company Lumeris Corp. and announce plans to acquire NaviNet. Based in Boston, Massachusetts, NaviNet says it is the

largest real-time healthcare communications network in the United States.

The three BCBS plans are: Highmark, Horizon Blue Cross Blue Shield of New Jersey (Horizon), and Independence Blue Cross (IBC). The willingness of these BCBS organizations to partner with Lumeris to do an IT acquisition is significant. That's because, collectively, these insurers work with more than 70,000 physicians and insure 11 million people.

In the press release announcing the agreement, it was stated that NaviNet delivers "more than 50 kinds of administrative, financial and clinical transactions among three-quarters of America's physicians, 3,800 hospitals, and dozens of the nation's largest health insurers, including Highmark, Horizon and IBC."

Based in St. Louis, Missouri, what Lumeris brings to the party is a menu of cloud-based services and software that is designed to support population management needs for accountable care organizations.

Also on the same day, February 14, UnitedHealth Group's (NYSE: UNH) health services division, Optum, issued a press release announcing the launch of a cloud-based informatics system that would allow healthcare professionals to connect with patients' other providers. Optum executives explained that this capability was a necessary step for the company to fully participate in accountable care organizations (ACOs).

"Growing use of electronic health record (EHR) and health information exchange (HIE) technology is unlocking rich information about patient clinical experiences that has historically been confined to paper records. In a secure environment that protects privacy, Optum Care Suite marries this information with related health claims, patient-reported outcomes and Optum's analytics capabilities," noted the Optum press release.

These acquisitions and launches are a visible sign that health insurers are taking the development of ACOs seriously and they want to get in on the act. And, popular wisdom expects that ACOs will play a growing role during coming years. This will be accompanied by significant changes in how providers—including ACOs—will be paid.

Horizon Blue Cross and Blue Shield of New Jersey invested in Lumeris because "[It] fits into the Horizon business model, which calls for moves into accountable care and different payment methodologies," stated Douglas Blackwell, Senior VP and CIO at Horizon in a story published in Modern Healthcare.

"We see this as another opportunity to have an integrated platform," added Blackwell. "When you look at the geography of Highmark, Horizon and IBC, we're geographically aligned and it's going to make sense to do things collaboratively going forward."

Blackwell's comments demonstrate how health insurers are rethinking their role in a healthcare world where fee-for-service payment and fragmented care by different providers yields to new reimbursement models centered

around active management of a defined population of patients. The investments in healthcare informatics are a sign that clinical laboratories and pathology groups should have their own robust information technology capabilities in place to serve the fast-changing needs of both office-based physicians, but the private payers who are involved in these new healthcare delivery models.

Further, pathologists and medical laboratory managers should stay current with these developments. Hand-in-hand with physician adoption and use of EHRs in conjunction with the engagement of ACOs in care delivery will be the need for the clinical laboratory to interface the laboratory information system (LIS) with the electronic medical record (EMR) systems of their parent hospital/health system, as well as the EMRs of the office-based physicians in the community.

Wellmark Teaming Up with Health Care Providers, Des Moines Register, April 26, 2012

Iowa's largest health insurer is partnering with two of the state's largest hospital-and-clinic systems in a new kind of health care organization.

Wellmark Blue Cross and Blue Shield and Iowa Health System announced Thursday that they are forming an accountable care organization. Such organizations are being formed throughout the nation, with encouragement from the federal health reform law.

Later Thursday, Mercy Medical Center in Des Moines announced it also is forming such a partnership with Wellmark.

Under the model, a health care provider network agrees to accept responsibility for a group of patients, and an insurer provides financial incentives to the providers to keep the patients well instead of just treating illnesses. Proponents say the design rewards quality health care instead of paying more for a larger quantity of services provided. For example, better coordination of care is expected to cut down on the number of unnecessary or redundant tests done on patients who see multiple doctors.

University of Iowa Hospitals and Mercy Medical Center in Cedar Rapids announced this month that they are working to form an accountable care organization.

Wellmark Vice President Laura Jackson said consumers won't notice abrupt changes in their relationships with doctors or insurers. She said providers will continue to receive payment for each service provided and won't have incentives for withholding care. But they could be eligible to share in savings achieved through higher-quality care, she said.

Jackson said that although the health reform law encouraged formation of accountable care organizations, she believes the idea could go forward even if the law is overturned.

BlueCross BlueShield of Western New York and Kaleida Health to Partner in Medical Team,

BuffaloNews.com,
April 19, 2012

BlueCross BlueShield of Western New York, Kaleida Health and a physicians group announced Wednesday they will partner to offer medical care in new, more affordable health insurance plans marketed to employers.

How much cheaper the plans will be is unclear. Officials said they anticipate interest from eligible businesses if premiums are only a few percentage points lower.

Other partners will include Erie County Medical Center, Roswell Park Cancer Institute, Olean General Hospital and Hospice Buffalo, officials said.

This is the first exclusive network to form in the region in which hospitals, doctors and a health insurance company integrate to care for privately insured patients.

Although it will limit choice of doctors and hospitals, officials said they foresee acceptance by patients because of the breadth and depth of services available, as well as the urgency to rein in health costs.

What's happening represents an emerging trend across the country.

Hospitals, doctors, insurers and the government are moving forward with new models for delivering care.

Each looks a little different, depending on who is involved. But they share many of the same goals, such as basing medical decisions on what science says is best, avoiding unnecessary tests and procedures, tracking patients as they navigate through the system, using data to evaluate performance, and stressing preventive care.

"We are spending a lot of money in the U.S. on health care but not as wisely as we should. We need new ways of organizing that care," said Dr. Thomas Rosenthal, chairman of the University at Buffalo Family Medicine Department and a leader in the new initiative.

He cited studies that show the U.S. spends far more per person on health care than any other nation, yet ranks significantly below many other nations on such indicators of quality as preventive care, hospital readmissions, coordinated care and patient safety.

"Costs are spiraling out of control, and the only way to address this is as a team, with hospitals and insurers, to align the incentives and focus on patient care. We need to move from volume-based to value-based care," said Dr. Robert Gatewood, a cardiologist also playing a lead role in the endeavor.

Factors driving changes The changes have come partly in response to provisions in the new health reform law, the Affordable Care Act. But market forces and advances in medical information technology also are driving it.

"The old model is not working," said Alphonso O'Neil-White, president and chief executive officer of BlueCross

BlueShield of Western New York. "Our purchasers [employers] keep asking us what we're going to do about costs."
Aspects of the integrated network include:

È The parties plan to form a joint venture that will begin marketing health plans to employers this June for enrollment at the start of 2013.

È The new health plans will target companies that self-insure, meaning the businesses manage their own health insurance. The concept eventually could be offered for commercial health insurance, which represents 60 percent of the market, said O'Neil-White.

È There are about 150,000 employees in the region in self-insured health plans, including thousands of workers at Kaleida Health and BlueCross BlueShield.

È Officials say they also will be well positioned to offer a more affordable health plan for patients in the individual insurance market if health reform moves forward and millions of uninsured Americans obtain coverage.

È BlueCross BlueShield will continue to offer health plans that include other hospitals and physicians, and Kaleida Health will continue to provide care for patients with other health insurance plans.

È Nothing will change for current BlueCross BlueShield members unless their employer chooses one of these new plans.

"The partnership will allow us to offer Western New York a new approach to health care that creates significant value for physicians, their patients and the region's employers," said James Kaskie,

PRODUCT DEVELOPMENT

UnitedHealthcare Offers New Health Plan Featuring "High-Performance Networks" in California

SignatureValue Alliance gives California employers additional quality, cost-effective health care coverage options for their employees

CYPRESS, Calif., (BUSINESS WIRE) -- -- New plan portfolio features high-performance networks that deliver evidence-based, cost-efficient care

UnitedHealthcare is offering "SignatureValue Alliance" in California, a new health benefits plan featuring high-performance care provider networks committed to delivering effective, evidence-based and cost-efficient care.

The SignatureValue Alliance plan enables employers and plan participants to save on their health care costs through lower premiums while still having access to a wide range of traditional and deductible HMO plans.

The Alliance network includes six large physician groups in Southern California and parts of Northern California that include 90 hospitals and about 26,000 physicians and specialists. Participating Alliance physician groups include: HealthCare Partners Medical Group, Heritage Provider Network, Monarch HealthCare Medical Group, PrimeCare Medical Group, Sante Community Physicians, and Scripps Health.

"UnitedHealthcare SignatureValue Alliance offers the quality and value employers are looking for when choosing their health coverage because it combines the affordability of an HMO with access to high-quality health care professionals," said David Anderson, CEO, UnitedHealthcare of Southern California. "Plan participants enjoy comprehensive health benefits coverage and access to a wide, local care provider network of quality doctors and hospitals."

The participating medical groups were included based on technological sophistication, clinical performance and quality measures, and an ability to deliver health care cost savings. High-performance networks, which include physicians rated both on quality and efficiency measures, are becoming increasingly popular as a way to improve outcomes and more effectively manage costs.

"UnitedHealthcare's SignatureValue Alliance provides California employers with a new health plan option that is helping provide high-quality, cost-effective care," said Alissa Viggianelli, vice president, Marrs Maddocks & Associates, a Carlsbad-based health benefits broker. "This type of high-performance care provider network is both innovative and an important step in helping California employers continue to offer quality health benefits to their employees."

Humana Introduces Innovative Pharmacy Offerings That Guarantee Cost Savings and Predictability for Employers

Self-insured employers can save up to 20 percent1 on their annual pharmacy spend

LOUISVILLE, Ky.--(BUSINESS WIRE)--Humana Inc. (NYSE: HUM) announced today that its pharmacy benefits management subsidiary Humana Pharmacy Solutions, Inc. (HPS), is offering employers a new Rx4Value formulary and Walmart Rx Network that together guarantee up to 20 percent savings on employers' average prescription price1.

"We are proud to team with Humana on this innovative benefit."
The new options extend HPS's signature Average Script Price Guarantee, which guarantees the average prescription cost a self-insured employer will pay across all of its annual in-network prescriptions. Both new pharmacy benefits options are available now to self-insured employers. The Wal-Mart Rx Network option is expected to be available to fully insured employers later this year.

"In the midst of today's rapidly changing PBM landscape, we're proud to offer a simple, cost-effective solution that helps employers better predict costs and save money," said William Fleming, PharmD, president of Humana Pharmacy Solutions. "Pharmacy is the most used health benefit, and providing new, unique pharmacy benefits services that best meet employers' and members' needs directly supports Humana's mission of helping people achieve life-long health and well-being."

The new Wal-Mart Rx Network will allow employers to select a Wal-Mart-focused network for their employees to fill their prescriptions. The network offers self-insured employers an average of 10 percent savings on their annual average prescription price1. The new Rx4Value formulary provides comprehensive therapeutic coverage while saving self-insured employers an average of 15 percent on their members' annual average prescription price1. Both options are available individually and can be combined for compounded savings.

In total, self-insured employers who select both the network and formulary options will be able to save up to 20 percent on their annual average prescription price1, meaning that a self-insured employer with 1,000 employees could achieve savings of as much as $400,000 per year.2

"At Wal-Mart, we're committed to providing low-cost prescriptions and ensuring that people have affordable access to the medications they need to help them live healthier lives," said Dr. John Agwunobi, president of Wal-Mart U.S. health and wellness. "We are proud to team with Humana on this innovative benefit."

Humana Pharmacy Solutions Guaranteed Cost Savings: Benefits and Details

Wal-Mart Rx Network. Wal-Mart's commitment to health, an outstanding customer experience and lower costs, combined with Humana's expertise in managing health costs through innovative health benefit designs, result in a unique partnership that offers employers significant cost savings and predictability. The network includes the more than 4,400 pharmacies under the Wal-Mart, Neighborhood Market, Sam's Club, Wal-Mart Express and Wal-Mart on Campus banners, as well as Humana's RightSource mail order

pharmacy. The network is available today for self-insured employers, and is expected to be available to fully-insured employers later this year.

Cost-effective Rx4Value formulary. The new Rx4Value formulary replaces certain brand-name drugs with generic alternatives that are equally effective and provide greater cost-savings. The formulary is available today for self-insured employers.

Average Script Price Guarantee. Through its Average Script Price Guarantee, HPS guarantees upfront the average cost a client will pay across its prescriptions throughout the year. This guaranteed predictability diminishes risk and uncertainty that employers have traditionally had to bear when working with PBMs – allowing them to more effectively manage their budget.

"These three initiatives represent a unique, first-of-its-kind model that maximizes the value of pharmacy benefits for employers, including guaranteed savings of up to 20 percent on their pharmacy costs," said Fleming.

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