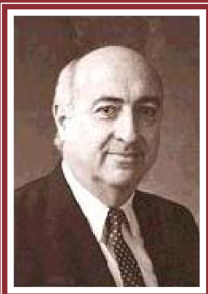
FYA For Your Advantage
INNOVATIONS
An Essential Tool for Healthcare Leaders
Volume 7, Issue 18
September 15, 2008
From TrendLeader Connections
Sponsored by PHNS The HealthCaring Solution



S. Harvey Price is editor of *For Your Advantage*. A health care industry strategist based in Boca Raton, Fla., Mr. Price has worked as an independent consultant since 1971. His clients are community hospitals, hospital systems and major corporations.

About FYA

FYA – *For Your Advantage*, is a free twice-monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

The newsletter is provided free to healthcare CEOs only. CEOs may use the material in any way they wish – except for the editorial content that is copyrighted by the author. You are welcome to print copies of FYA.

TrendLeader Connections
406-586-8775
www.ForYourAdvantage.com

Health Benefit Costs Could Ease Slightly in 2009

After three years of double-digit growth in the first half of the decade, annual health benefit cost increases slowed to about six percent in 2005 and have stayed there ever since. Preliminary survey findings released at the start of this month by Mercer, a leading benefit outsourcing and consulting company, indicate that cost growth is likely to slow a little further in 2009, to 5.7 percent – which would be the lowest increase in more than 10 years. Last year, Mercer's annual survey found that average health benefit cost per employee rose 6.1 percent in 2007.

Mercer's complete survey results won't be released until later in the year, but for the 1,317 employer health plan sponsors that have responded so far, the total cost to renew their current health plans – if they were to make no changes – would grow by nearly eight percent on average. Small employers (those with 10-499 employees) would see an even higher increase, of about 10 percent. However, the majority of respondents say they will take action to lower their actual cost increases.

"It's a relief to see cost growth trending down, even slightly," said Blaine Bos, a senior Mercer consultant. "But this is not an unqualified success story. While some employers are holding down cost growth with innovative methods of improving healthcare quality and efficiency, more typically, employers struggling with increases they can't handle resort to the tried and true method of shifting cost to employees."

Well over half (59 percent) of employers taking action to reduce their 2009 cost increase will raise deductibles, co-payments, coinsurance or employee out-of-pocket spending limits. Employee cost-sharing has risen sharply over the past five years: Between 2003 and 2007, the median family deductible for in-network services in a PPO rose from $1,000 to $1,500.

(Continued...)

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Health Benefit Costs Could Ease Slightly in 2009 (Continued...)

A smaller number of the employers – 19 percent – say they will lower their 2009 costs by adding a consumer-directed health plan (CDHP), which is a high-deductible plan with an employee-controlled spending account (a health saving account (HSA) or health reimbursement arrangement). Many of these plans give employees an incentive to take cost into consideration when seeking healthcare services by allowing them to save (on a tax-advantaged basis) account dollars they don't spend in a given year for future needs. While it's too early to make a final assessment of how well this new plan model works, among the survey respondents that currently offer a CDHP, the predicted 2009 cost increase averaged 4.5 percent, compared to 6.4 percent for respondents not offering a CDHP.

CDHPs are significantly less expensive than traditional PPOs or HMOs. Last year, 12 percent of all employers – and 20 percent of those with 500 or more employees – said they were "very likely" to implement a CDHP by 2009.

"This opportunity for saving is good news for employers committed to offering health coverage. But even though CDHPs cost about 20 percent less than a typical medical plan, the percentage of very small employers providing employee coverage keeps shrinking," said Mr. Bos. "This is one of the leading causes of the increase in the number of uninsured over the past few years, and a troublesome finding for policymakers who were counting on these plans – specifically HSAs – to reverse the trend."

These are preliminary findings from Mercer's National Survey of Employer-Sponsored Health Plans 2008. The survey is still in the field and complete results, including the actual cost increase for 2008, will be released by the end of the year. The preliminary results discussed above are based on employers who responded by August 25; these results are not weighted and represent only the 1,317 early responders. Ultimately, around 3,000 employers will participate in the survey and the final results will be weighted to be nationally projectable.

About

PHNS is an innovative healthcare services company providing strategic outsourcing services in information technology, health information management and receivables management to over 400 hospitals. PHNS is not a consultant, vendor or software company but a partner, a solution. PHNS understands healthcare because our partners are healthcare and healthcare only. Unlike its competitors, PHNS strategically aligns itself with a hospital's clinical and financial goals and objectives. Through its unique business model, PHNS reduces costs by aggregating, consolidating and sharing resources among its participating hospital partners. PHNS helps hospitals manage information systems, computer technology, patient records, coding and patient billing to improve patient care, safety and efficiency and increase profitability and efficiency. For more information, visit www.phns.com.

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Are Not-For-Profit Hospitals Being Monopolistic?

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

Are some not-for-profit hospitals using their regional clout in a monopolistic way to drive up healthcare costs? That's a charge increasingly being levied against not-for-profits.

A highly visible example is Carilion Health System in Roanoke, Virginia. According to a *Wall Street Journal* article on 8/24/08, the cost of care in the Roanoke Valley has gone from the lowest in Virginia to the highest in Virginia during the 20 years after the U.S. Department of Justice unsuccessfully tried to block the merger of Carilion and the other hospital in Roanoke because it would create a monopoly over medical care in the area.

The article stated that Carilion has used its market power to drive up prices (e.g., $4,727 for a colonoscopy, which is four to ten times what a local colonoscopy center would charge), and to restrict competition by asking its employed physicians not to refer patients outside the system in order to avoid referral "leakage." According to a *Roanoke Times* article (9/10/08) "Carilion officials have repeatedly claimed that it is misleading to blame Carilion's practice for the rising cost of health care…."

"The power of nonprofit hospital systems like Carilion over their regional communities has increased in recent years as their incomes have surged. Critics charge that this is creating untaxed local healthcare monopolies that drive the costs of care higher for patients and businesses," states the article.

Interestingly these types of anti-competitive, antitrust claims aren't just being brought up by the U.S. Department of Justice, but also by hospitals that claim that they're being hurt by anti-competitive actions of other hospitals in their marketplace.

For example, McKenzie-Willamette Medical Center in Springfield, OR, engaged in a bitter six-year antitrust lawsuit against PeaceHealth, which has hospitals in Oregon and Washington, alleging that PeaceHealth engaged in unfair business practices to muscle McKenzie-Willamette out of lucrative health insurance contracts. After a trial, a jury found that PeaceHealth had tried to monopolize the local hospital market, engaged in price discrimination and interfered with McKenzie-Willamette's relationships with health insurers, and as a result PeaceHealth was ordered to pay $16.2 million to McKenzie-Willamette. However, the battle continued at the appellate level and last fall the U.S. Circuit Court of Appeals overturned the verdict and sent the case back to the trial court. The battling hospitals finally announced a financial settlement this month in which PeaceHealth will pay an undisclosed sum to McKenzie-Willamette for community health programs and a residential hospice house. And that's just one of an apparent flood of similar anticompetitive, antitrust claims against not-for-profit hospitals.

Is this smoke or fire? – are not-for-profits using their market position and tax-free status to engage in anticompetitive practices and increased prices, or are these isolated examples? Do you have any opinions or examples to support either position?

I would like to hear your comments. Send them to:
Richard.Kneipper@phns.com

About

FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

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Importing Competition

More attention is being paid to the growing phenomenon known as "medical tourism." For a current attitude about this trend, we turn to the comments found in a recent issue of a British business magazine, *The Economist*. It's worth our attention.

Healthcare has long seemed one of the most local of all industries. Yet beneath the bandages, globalization is thriving. The outsourcing of record keeping and the reading of X-rays is already a multi-billion-dollar business. The recruitment of doctors and nurses from the developing world by rich countries is also common, if controversial. The next growth area for the industry is the flow of patients in the other direction – medical tourism – which is on the threshold of a dramatic boom.

Tens of millions of middle-class Americans are uninsured or underinsured and soaring health costs are pushing them and cost-conscious employers and insurers to look abroad for savings. At the same time the best hospitals in Asia and Latin America now rival or surpass many hospitals in the rich world for safety and quality. On one estimate, Americans can save 85 percent by shopping around and the number who will travel for care is due to rocket from under one million last year to 10 million by 2012 – by which time it will deprive American hospitals of some $160 billion of annual business.

The coming boom has its critics. Some worry that a flood of foreigners into developing countries will divert money and expertise from state health systems that are already overwhelmed – an internal brain drain that will worsen care for ordinary people. Others decry it as a distraction from the need to cut costs and improve quality in rich-world health systems.

But the private sector cannot be blamed for the failings of state-run health bureaucracies in developing countries, which neglected the poor long before medical tourists arrived. And the foreigners' arrival could improve things in developing countries, for the poor as well as the rich. Although the hospitals that cater to medical tourists will of course employ local staff, they will also create jobs, tempt home émigré doctors and nurses, encourage locals to train as medics, spread know-how and treat local people.

The flight of America's "medical refugees" is indeed a symptom of a troubled health system back home. Yet medical tourism need not be a distraction from necessary reforms, but could be a catalyst to them. The prospect of losing revenues to India or Thailand is already shocking hospital administrators and insurers into raising standards, increasing price transparency and lowering costs. It may even bring the growing political pressure for reform to a head.

If medical tourism is to live up to this promise, several barriers must first be swept away. In parts of America, arcane restrictions still forbid out-of-state doctors from consulting with patients on the internet or by phone, which inhibits follow-up care for medical tourists. Legal and insurance barriers make it hard for employers to give employees a financial incentive to choose medical tourism over local options – even though insurers are allowed to offer such incentives to prompt patients to pick cheaper doctors inside America.

In developing countries, the system for training doctors and nurses is often monolithic and state-financed. That makes it hard for the private-sector medical business to grow without depleting state coffers. A sensible model is the one employed in the Philippines, which allows nurses to work in the private sector or abroad if they repay their student loans. And part of the financial windfall which sick foreigners could bring to poor countries that welcome them should be spent on medical care for the poorest. If governments make the best of the boom, then medical tourism should improve the health of rich and poor alike.