

Healthcare Organizations: [Financial Management Strategies]

May 2009 Newsletter



The American Recovery and Reinvestment Act of 2009 - Discerning Financial Insights into Barack Obama's HIT Policies -

Welcome to the May issue of Healthcare Organizations [*Financial Management Strategies*]. This quarter we review the 1,100 pages of the American Recovery and Reinvestment Act of 2009 [ARRA] ... aka, "the Barack Obama Administration stimulus policy bill" and the amount of funding related to health information technology [HIT] for physicians, hospitals and healthcare organizations.

At about \$20 billion, there has never been such an investment in health IT at one time. Some money will flow into the current calendar year, some dollars will flow in subsequent years, and some funding will be available until spent. And, according to Steve Lieber, President of the Health Information Management Systems Society [HIMSS], these nine healthcare administration areas received HIT funding:

1. The Office of National Coordinator of HIT [ONCHIT] received \$2 billion to fund HIT initiatives later this year.
2. Medicare and Medicaid funded HIT initiatives to physicians and hospitals beginning in 2011.
3. \$1.1 billion allocated to the Agency for Healthcare Research and Quality [AHRQ] for clinical practice effectiveness research.
4. The Indian Health Service [IHS] received unknown funding.
5. Construction funds to the Health Resources and Services Administration [HRSA] for community health centers.
6. \$500 million allocated to the Social Security Administration [SSA] to upgrade HIT systems.
7. The Veterans Administration [VA] funded, in part, from the ARRA.
8. The Department of Agriculture received money for distance-learning and broadband health applications.
9. Finally, \$4.7 billion to the National Telecommunications Administration [NTA], for telemedicine diffusion.

Of course, time is of the essence if physicians and hospitals are to receive the full incentive payment for health IT adoption beginning in 2011. The monies are significant for physicians as full payment between 2011 and 2015 will range between \$44K and \$60K. For each year a physician is not in the program, the incentive payments decline by 1% each year. The ultimate calculation of payments to physicians is based on Medicare patient volume.

For further information, contact:
STP Specialty Technical Publishers
Phone: (604) 983-3434 and Fax: (604) 983-3445
E-mail: custinfo@stpub.com

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For hospitals, the incentive payment begins at \$2 million in 2011, with additional payments based on Medicare volumes. As with physicians, the incentive stops in 2015. In 2015, there will be penalties for providers not participating in the program. Thus, ARRA is not only an economic stimulus bill. It's an HIT stimulus bill for the early-adoption by providers.

Now, while we do not necessarily agree with all of the above earmarks, considering each line item is a prudent way to launch any health IT initiative. Nevertheless, most, if not all items, are - or will be - addressed in future issues of Healthcare Organizations [Financial Management Strategies].

PS: *Don't forget to review-read-rave and rant online at our web-blog and new communications forum.*

Fraternally,

David Edward Marcinko

Hope Rachel Hetico

WEBSITE: www.HealthcareFinancials.com

BLOG: www.HealthcareFinancials.wordpress.com

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HMO - PPO INDUSTRY SUMMARY FOR 2008Y*

By Richard Frye; PhD

Forte Information Resources, Denver, Co.

An overview of the 2008 managed care industry as a summary report on Health Maintenance Organizations, Preferred Provider Organizations and related Managed Care Organizations.

PPO Industry Summary

- Health care industry consolidation initially started by HMOs has also become prominent among PPOs. As more employer groups seek contracts with statewide and nationwide PPOs, the number of new, and likely locally based, PPOs has diminished sharply.
- In 2007, the share of PPOs that provided dental care benefits rose to 48.0% from 42.4% in 2006, the sixth straight annual growth. Since 2001 (30.3%), the share of PPOs offering dental care services has climbed by nearly 18 percentage points.
- In 2007, 46.7% of all specialty-only PPOs operating in the U.S. were owned by independent investors, down from 48.4% in 2006, the fourth straight annual decline. Since 2003 (70.0%), the share of all specialty-only PPOs owned by independent investors has undergone a notable drop.
- The number of owned, or self-developed, networks that independent investor-owned PPOs formed with providers declined for the fourth consecutive year in 2007, to 84 from 102 the year before. Between 2003 (140) and 2007, the number of owned networks formed by these independent investor-owned plans plunged 40%.
- Of the top 30 PPOs ranked by the number of states served by owned networks, 24 provided service to all 50 states and the District of Columbia (D.C.) in 2007, compared to 22 the previous year.

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- Between 2006 (95.8 million) and 2007 (101.8 million), the total number of eligible employees covered by PPO chains increased somewhat notably, marking the first time since 2003 (102.3 million) that the eligible employee count surpassed 100 million.
- After holding steady at 3.9 days for six consecutive years, the average length of stay (ALOS) per PPO medical/surgical hospitalization rose to 4.1 days in 2007.
- Following three consecutive years of decline between 2003 (232.3) and 2006 (226.1), the average number of hospital inpatient days per 1,000 PPO eligible employees increased more than 6% in 2007, to 239.8.
- The average network-access fee charged by independent investor-owned PPOs per eligible employee per month rose slightly in 2007, to \$3.85 from \$3.77 in 2006. For the eighth consecutive year, such charges were higher for independent investor-owned PPOs than for PPOs nationwide (\$3.33).

HMO Industry Summary

- Driven by the sharp growth in the Medicare portion of HMO enrollment (to 6.2 million from 5.7 million), overall enrollment in HMOs nationwide increased moderately, to 78.3 million from 76.3 million in 2006.
- The number of IPA-model HMOs declined slightly in 2007, to 238 from 242 in 2006, the ninth straight annual drop. Since reaching a high of 606 in 1998, the number of IPA model plans has plunged more than 60%.
- Largely owing to increased competition and consolidation among plans, the share of HMOs at least 10 years of age has risen notably in recent years. Since 2001 (53.7%), the share of HMOs in this age category has jumped nearly 28 percentage points.
- The merger-and-acquisition activity of major HMO chains continues to have a profound impact on the health care industry. Over the past eight years, the number of plans operated by the nation's HMO chains has fallen sharply, to 295 in from 505 in 1999.

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- The share of HMOs using bonus programs to reimburse physicians rose, to 15.6% in 2007 from 15.0% in 2006. In fact, since 2002 (7.5%), this share has more than doubled.
- Bonus programs were used by 15.0% of HMOs to reimburse physicians in 2006, up moderately from 12.5% in 2005, the fourth consecutive annual increase.
- In keeping with the decline in the total number of HMOs, the average number of physicians used per HMO increased for the eighth consecutive year in 2007, to 6,784 from 6,523 in 2006. Between 1999 (3,844) and 2007, this average climbed more than 75%.
- In recent years, it has become increasingly evident that the flexibility provided to members under triple-option plans has made them more attractive. For example, since 2001 (35.8%), the share of HMOs offering a triple-option feature has climbed more than 16 percentage points.
- Total point-of-service (POS) enrollment in the 25 largest individual HMOs climbed more than 20% in 2007, to 6.2 million from 5.1 million in 2006. This growth was sparked by notable POS enrollment at the five United Healthcare plans listed among the top 25.
- Between 2006 and 2007, the national HMO market penetration rate increased to 26.0% from 25.5%, reversing a seven-year decrease that began in 1999 (37.9%). National enrollment in HMOs likewise rose (2.6%) after falling for seven straight years, despite the continued consolidation in the total number of plans (to 443 from 448 in 2006).
- For the fifth year in a row, the number of Medicaid recipients enrolled in HMOs increased, to 15.4 million in 2007 from 14.4 million in 2006. This total has risen more than 20% since 2002 (12.8 million).
- The total number of HMOs enrolling Medicare risk members grew substantially between 2006 and 2007, to 217 from 184 the previous year, the fourth consecutive annual growth. Since 2003 (142), this number has climbed well over 50%.

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- Non-system HMOs averaged significantly more hospital days per 1,000 members than their system counterparts in 2007. Non-system HMOs reported 1,525.7 hospital days per 1,000 Medicare members, 7.6% higher than the average for system plans (1,417.5).
- HMO enrollment growth has been confined almost exclusively to the for-profit sector in recent years. In 2007, for-profit HMOs enrolled 45.6 million members, up from 43.9 million, while not-for-profit plans saw membership go virtually unchanged.
- The average number of annual physician encounters per non-Medicare HMO member was 3.8 in 2007, up more than 15% from 3.3 in 2006, and the highest average since 1998 (3.9). All four plan model types reported increases in this measure in 2007.
- By year-end 2007, 94.0% of all employer group-contracted HMO plans had been in operation for at least 15 years, up slightly from 91.0% in 2006. This share has now grown every year since 1998 (38.5%).

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