

MANAGED CARE

OUTLOOK

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At Presstime

Impact of Competitive Bidding Seen in National Benchmarks

As a result of strong competitive bidding by health plans and beneficiaries' choices, the national benchmark that determines Medicare's subsidy toward the cost of drug coverage will decline in 2007, the Centers for Medicare & Medicaid Services has announced. CMS also announced that the average cost of the Medicare prescription drug plans will remain stable or decline in 2007 and that the agency expects the actual average premium paid by beneficiaries to remain around \$24 or less.

While competitive bids for both standalone prescription drug plans and Medicare Advantage (MA) prescription drug plans have been lower than independent analysts projected last year, bids are notably lower for Medicare Advantage plans. The average Medicare Advantage prescription drug plan bid is 18 percent lower in 2007 than 2006, and Medicare Advantage drug premiums are expected to be significantly lower in 2007 for beneficiaries.

The benchmark notice can be found online at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/ptcd2007_20060815.pdf. ■

Web Site Looks to Draw in Consumers with Integrated Health Care Shopping Portal

Reba L. Kieke

Despite the fact that consumers seem to eagerly jump online to research the purchase of a new vehicle or computer or other large item, there still seems to be some reluctance to getting online and researching health insurance, even though medical procedures may end up costing three or four times as much as some of these other items. Consumers do have choices, however; a point many companies, such as Mountain View, Calif.-based Healthia, continue to stress.

Healthia, which was founded in 2005, allows businesses and consumers to research and select health insurance plans, health savings accounts (HSAs), hospitals, and doctors from across the country. It is free to the public and open to everyone.

(See Health Care Portal... page 3)

New Blues Tool Seeks to Offer "More Refined Method" for Identifying Trends

Reba L. Kieke

A new health intelligence resource aimed at enhancing quality by improving opportunities to share critical health information will soon be available, at least to participating Blues plans.

Earlier this month, Blue Cross and Blue Shield announced the creation of Blue Health Intelligence (BHI), a secure, HIPAA-compliant database comprised of claims information (with no personal identifiers) for 79 million lives. Access to the aggregate data is available only to those plans that choose to participate, which currently includes 20 participating Blues plans. (See Figure 1, p. 6)

(See Blue Health Intelligence... page 6)

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National Briefs

Survey Identifies Leading Success Factors in Consumer-Driven Health Care: Buck Consultants, an ACS company and one of the world's leading human resource and benefits consulting firms, has announced the results of a national survey of U.S. employers on consumer-driven health care (CDHC). Buck's study "HRA/HSA Survey for Consumer-Driven Health Care Plans" was conducted in the second quarter of 2006. It analyzed responses from more than 130 U.S. organizations on CDHC plans — those characterized by a high deductible health plan (HDHP) coupled with either a health reimbursement account (HRA) or a health savings account (HSA). Survey respondents consider the following components crucial to a successful CDHC program with an HSA: aggressive and coordinated education campaigns; employer contributions; claims integration; and multiple investment fund choices. The most frequently cited reasons for offering CDHC plans are reduced costs (85 percent) and exposing employees to the true cost of health care (56 percent). A recorded Web cast discussing the survey results and a PDF of the presentation is available on Buck Consultants' Web site (<http://www.buckconsultants.com>).

Report Shows Decline in Number of Uninsured Kids: Even though the total number of Americans without health insurance is on the rise, a new study analyzing government data suggests good news for the nation's children. The percentage of uninsured kids in America has decreased by 20 percent since the government-funded State Children's Health Insurance Program (SCHIP) was approved by Congress in 1997. The State of Kids' Coverage was released recently by the Robert Wood Johnson Foundation (RWJF) to kick off the Covering Kids & Families' Back-to-School Campaign, a nationwide effort to enroll eligible children in public health coverage programs during the back-to-school season. The full report, which is available at <http://www.rwjf.org/files/publications/other/KidsCoverage2006Final.pdf>, shows that the number of uninsured children has decreased by 2 million since the creation of SCHIP and recent expansions in public programs. The report also shows that fewer children are receiving private health insurance, which is supplied mostly through their parents' employer-sponsored health plans.

NCQA Seeks Public Input: The National Committee for Quality Assurance (NCQA) is working to help Americans better compare their health plan choices by developing a common set of quality standards to measure all health plans. The organization is reaching out to the health care industry, employers, consumers, public purchasers, and others to gain input on how best to align accreditation standards for several types of health plan and drive greater improvement in the performance of the U.S. health care system. Organizations or individuals interested in providing input should visit <http://www.ncqa.org/accred08>. ■

Health Care Portal ...

(from p. 1)

“What we are building is the first really practical comparison shopping portal for health care products and services,” explains Kurt R. Stammberger, vice president for content and services for Healthia. “We are assembling a set of tools that allow people to make the same kind of considered, intelligent decisions about health care that they do about other major purchases.”

Among other services currently available through the Web site, businesses and consumers have the ability to shop for insurance plans and compare them feature by feature — everything from HMOs to HSAs and high-deductible combinations. There are more than 3,500 plans in the database.

“Our search engine allows people to input the criteria that are important to them and then search for insurance plans that fit their needs,” explains Stammberger. “Then, when they have narrowed it down to a few that they might be interested in, they can actually drill down and see very specific details about those plans and see exactly what type of coverage those plans offer.”

Much has been written about the fact that businesses often struggle to afford the benefits many employees have come to expect. For some, this tool may offer a solution.

“Offering employee benefits is a key retention and recruiting tool for us, but the sky-rocketing prices and the expense of managing these plans is always threatening to make it cost-prohibitive to offer health benefits,” notes Girish Gaitonde, CEO at Xoriant, one of Healthia’s clients. “Using Healthia’s comprehensive site, we were able to choose the best plans for our employees, providing them better benefits and saving us thousands of dollars on plans and management fees.”

Healthia has a nationwide network of approximately 200 brokers. When folks eventually request quotes for insurance plans, Healthia finds the brokers that are physically closest to them or best match their needs and forward their information to those brokers.

The Web site is updated daily with new information. Each time the carriers issue a new brochure or publish something new on the Internet, that information is filtered to the Web site.

“We have a team of people who do nothing but update the data on the site,” notes Stammberger. “It’s very important for that information to be current, both for the consumers and certainly for the carriers, too. From a carrier’s standpoint, we are very much a marketing outlet for them. The more information we can provide on their plans, the more attractive we can make their products look to consumers.”

How Healthia Works

The Healthia site allows businesses and consumers to compare health plans by filling in a few fields such as company zip code, number of employees, average employee age, and the desired amount of deductible. The same fields apply to individual plans, which are similarly displayed.

The site also allows selection of doctors based on geography, specialty, average length of experience, and whether they are board certified or not. A “Reviews” tab allows shoppers to search for reviews of all selected doctors.

Healthia allows shoppers to combine information about one subject (*e.g.*, favorite doctors) with information about health plans covering those doctors. This integration of critical health care buying information ultimately will be extended to cover the entire spectrum of health care decision-making: doctors, hospitals, prescriptions, health care plans, procedures, and savings vehicles like HSAs.

Walk-Through Example

Consumers have a number of options on the Healthia Web site, including searches by individual/family health insurance, small business insurance, doctors, dentists, hospitals, and others. For the purposes of an example, a user can go to www.healthia.com and click on the tab for individuals/family insurance.

(See *Health Care Portal... page 5*)

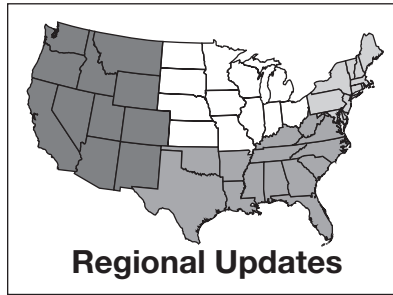
Northeast

Independence to Offer More Options Online: Independence Blue Cross (IBC) will launch an enhanced member and group Web site that lowers costs, simplifies employee benefit plan administration, and makes it easier and faster for members and employers to manage health care benefits. Through a contract with Benefitfocus.com, Inc., IBC will provide new Web tools to create a convenient online one-stop resource for health benefit management. These new online options, available in 2007, will provide online open enrollment tool for groups and members, support for the eligibility and enrollment activities for any health care carrier and third-party administrator, features to help consumers make decisions about health insurance, the capability for employees to self-enroll and maintain benefit options online, custom benefit management reports and human resource information system functions, and the option to integrate directly with an employer's payroll vendor.

Midwest

WellPoint Acquires QualChoice's Medicaid Business: WellPoint, Inc. has completed its acquisition of QualChoice Select, Inc., the Medicaid plan from QualChoice Health Plan, Inc., an Ohio-based managed care organization that was part of the University Hospitals Health System (UHHS). In addition, the Ohio Department of Insurance has approved QualChoice's endorsement of Anthem Blue Cross and Blue Shield as the insurer of choice for business customers of QualChoice's commercial insurance plans and individual policies. QualChoice will continue to serve these members through the end of this year, after which these commercial members will go through the normal process of evaluating their choice of benefits providers for the new year.

Integrated Health Card Gives Consumers All-in-One Access: To simplify how consumers manage and pay for their health care, and to help medical



professionals reduce their administrative burden, UnitedHealth Group is enhancing its health benefit card technology. The company's new technology will provide the information needed to promptly administer benefits and facilitate health transactions and payments, thus simplifying

the process for patients and providing health care professionals with an administrative resource. The card will also convey essential health records that support care interventions.

South

SC BlueCross Offers Fitness Program to State's Companies: BlueCross BlueShield of South Carolina is supporting employer efforts to help employees take charge of their health by offering companies its Walking Works planning guide and tool kit. Featuring walking as the activity of choice, WalkingWorks® is a structured fitness program that employers can implement at their work site. WalkingWorks teaches employees the importance of physical activity and how they can increase their current activity levels by adding more steps to their everyday routines. The planning guide provides step-by-step instructions for a company to launch its own WalkingWorks program. It also includes information about ordering pedometers at a reduced cost and using a free online tool or an Access database to track employee participation.

West

California Health Plans Continue to Support Defined Contribution Model: The defined contribution Employee Choice health coverage model, pioneered by CHOICE Administrators more than 10 years ago through its California-Choice program, continues to be supported by several of California's leading health insurance carriers, now serving over 160,000 members through more than 10,000 employer groups. Health carriers like Blue Shield of California, Health Net, Kaiser Permanente, Sharp Health Plan, and Western Health Advantage participate in a program based on defined contri-

bution which provides employers with cost control and budget predictability because they designate a specific monthly amount to contribute to their employees' healthcare insurance.

New Database Combines Health Care Lists in One 'Linkable' File: Pharmaceutical companies, medical equipment and supply firms, medical recruiters, health insurance firms, and pharmacies all have a new option for reaching multiple

health care contacts in a comprehensive database called the SK&A Provider HealthNet. Provider HealthNet is an "umbrella" database combining SK&A's physician, dentist, nurse, pharmacy, health care office manager, hospital, and nursing home databases in one comprehensive file, while linking the databases so users may see all appearances or locations of an individual search entry in one search result. For more information, visit www.skainfo.com. ■

Health Care Portal ...

(from p. 3)

At this point, the user enters his zip code and clicks "Get Rates," or simply hits enter. Next, the applicant enters his personal data and clicks on "Find Health Plan."

Healthia begins to search through thousands of plans and returns results based upon the criteria previously entered by the user. The search can be filtered further by entering desired deductible amounts or indicating if he or she wants an HSA-compatible plan or specific plan types, such as HMO or PPO.

Once the list of plans pulls up, the user clicks on the boxes next to the plans he wants to review and then clicks "Compare." Basic information about the plans pops up and allows the user to compare specific features of the different plans — such as deductibles, coinsurance amounts, coinsurance limits, out of pocket maximums, et cetera — without having to look at multiple sites or tools. Additional information about each provider in general is also available by clicking on "See Provider Details."

"It is possible to pull all this information together on your own, but it's very difficult to see it side by side instantaneously," notes Stammberger. "That's one of the things that makes Healthia so powerful."

In addition, users can browse by state and locale or look for a specific plan and go directly to that plan. Healthia also provides links to health plan brochures and offers opportunities to review plans. Users can submit and read reviews about

virtually anything in the system — carriers, plans, hospitals, procedures, doctors, dentists. In the near future, Healthia will be launching a couple of incentive programs to encourage people to review their plans and their doctors.

When searching for a hospital, a user once again enters some personal information, such as adult male/female, type of procedure, and then exact name of procedure. For example, if a user enters adult male, heart procedure, and balloon angioplasty, the search pull ups several items, including the name of the hospital in the country that charges the least amount for that particular procedure as well as the hospital that performs it the most frequently every year.

It also shows where hospitals are compared to the national average with regard to this procedure, and it shows several columns of information specific to the hospitals selected by the search. The first column shows what the hospitals want (*i.e.*, the hospitals' full retail walk-in rate, if the user is unfortunate enough to be uninsured.) The next column shows what the hospitals actually receive. It is an estimate of what the hospitals end up getting paid, either by a carrier or by Medicare for that procedure.

In the last column, if a patient has had this procedure and sees an amount other than what he paid, he can click on the "That's Not What I Paid" button. Healthia partners with a service that can renegotiate a patient's bills even after a procedure has been done and the bill has been paid.

For more information, visit www.healthia.com. ■

Blue Health Intelligence ...

(from p. 1)

“Blue Health Intelligence is the largest national data warehouse of claims information and contains both member information and provider information covering 50 states and 79 million lives,” explains David Plocher, MD, chief medical officer at Blue Cross Blue Shield of Minnesota. “That would make it two to three times larger than the nearest competitor data warehouse and twice the size of Medicare.”

Figure 1: BHI Participating Plans*

The Blue Cross and Blue Shield plans currently participating in Blue Health Intelligence (BHI) include the following:

- Arkansas Blue Cross and Blue Shield
- Blue Cross & Blue Shield of Rhode Island
- Blue Cross and Blue Shield of Alabama
- Blue Cross and Blue Shield of Florida
- Blue Cross and Blue Shield of Massachusetts
- Blue Cross and Blue Shield of Minnesota
- Blue Cross and Blue Shield of North Carolina
- Blue Cross and Blue Shield of South Carolina
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of Nebraska
- Blue Cross of Idaho
- BlueCross BlueShield of Tennessee
- BlueCross BlueShield of Western New York/BlueShield of Northeastern New York (HealthNow New York, Inc.)
- Capital Blue Cross
- CareFirst BlueCross BlueShield (DC, DE, MD)
- Excellus BlueCross BlueShield
- Highmark Blue Cross and Blue Shield
- Independence Blue Cross
- The Blue Cross and Blue Shield Plans in IL, OK, NM, TX (Health Care Service Corporation)
- The Blue Cross or Blue Cross and Blue Shield Plans in CA, CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, WI (WellPoint, Inc.)

*As of 8/04/2006. ■

BHI actually includes information for all 50 states even though there are only 20 Blues plans currently participating. This is due to employers with headquarters in one state but employees in multiple states. For instance, an employer may have its main office in Minneapolis, Minn. but have employees nationwide. BHI allows that employer to get claims information from all over the country.

Employers work with their local Blues plan to customize their reports. They work together to develop the criteria, scope, and contexts of those reports.

Let's go back to the example of the employer with corporate headquarters in Minneapolis, Minn. Perhaps this employer has employees in Pennsylvania and California. That employer will likely have different drivers for claims and costs for those two states.

Basically, Blue Health Intelligence allows the Blues plans to match unique cost drivers to specific geographical regions and apply solutions that are specific to those regions. In Pennsylvania it might be cardiovascular; in California it might be musculoskeletal. Once this has been identified, appropriate medical management programs and solutions can then be identified that will specifically target those geographies and those issues.

“I'll be able to tease out the differential contributors in Pennsylvania and California,” notes Plocher. “Once I find the unique cost drivers and trend drivers that differ in those geographies, I can apply different solutions, custom solutions accordingly. Historically, we've used averages — blunt instruments to do this — but now we can do it in a much more refined method.”

Historically, Blue Cross Blue Shield plans have had the ability to provide data and utilization to their customers, but it has been offered at the individual plan level.

“It's not that we don't know how to do medical management,” adds Plocher. “We simply want to apply the fix that's really needed in

each geographical area and not try to do a one size fits all set of programs.”

One feature that sets Blue Health Intelligence apart is its larger sample size, notes Plocher. “In many instances, if someone tries to compare or measure the performance of one site versus another using claims data, that individual is typically limited by small sample sizes and small volumes. Because we have larger sample sizes in any geographic area than anyone else, we can make a stronger statistical conclusion using standard deviations and p values and confidence intervals. That’s the power of the database, and that’s why it’s more precise than others.”

Information is always sent to employers in the form of aggregate data. For instance, a BHI report will identify what the diagnosis is for a particular range of zip codes, but it never identifies an employee personally.

Eventually, consumers will have access to comparative information, says Plocher. “We will be turning on Blue Health Intelligence for consumer transparency purposes later. We want to use the kind of comparative hospital and physician performance data that this can yield, and we want consumers to be better informed shoppers.”

As BHI evolves, the objective is to provide a number of benefits to employers, consumers, providers, and other stakeholders, including:

- Sharper insight into health care trends and best clinical practices;
- Information about the efficacy of certain treatments and new medical technologies as well as emerging trends in health care practice and delivery;
- Benchmarking data to assist in conducting comparative analyses across a number of health care components; and
- Opportunities for health services research.

Blue Health Intelligence is not the only database on the market. United Health Group, Aetna, and Mercer (Care Focused Purchasing) all have launched or will launch health care databases.

BHI is currently being pilot-tested and will be operational by 2007. The Blue Cross and Blue Shield Association is made up of 38 independent, locally owned and operated Blue Cross and Blue Shield companies that collectively provide health care coverage for more than 94 million —nearly one in three — Americans. For more information, visit www.BCBSHealthIssues.com. ■

Highmark Medicare Secondary Payer Settlement: New Mechanism, New Information, but Same Old Story

Eric M. Baim

On June 19, 2006, the U.S. Department of Justice (DOJ) announced the settlement of the *qui tam* (whistleblower) suit against Pennsylvania health insurer Highmark, Inc.¹ to resolve alleged violations of the Medicare secondary payer statute and implementing regulations (MSP laws).² Under the settlement, in which the DOJ had intervened on behalf of the United States, Highmark will pay approximately \$2 million, and the whistleblower will receive approximately \$819,000. Highmark had already paid an additional \$2.5 million in connection with a claim-by-claim review conducted during the course of investigation.

The Highmark settlement is noteworthy on a number of fronts. First, part of the resolution included what the DOJ accurately described as a “unique” settlement agreement, which incorporates model procedures related to the conduct under investigation. These procedures will be implemented on a go-forward basis.

Second, these model MSP procedures, which have now been posted to the Web site for the Centers for Medicare & Medicaid Services (CMS) help clarify obligations of employers, insurers, third-party administrators (TPAs), group health plans (GHPs), and other plan sponsors operating

under the complicated, and seemingly perpetually evolving, MSP laws.³ Finally, the settlement represents yet another example of CMS and the DOJ attempting to shape compliance and build “best practices” through enforcement rather than through clear rulemaking and open dialogue with the affected parties.

Background — Medicare Secondary Payer Laws

The MSP laws establish Medicare as the secondary payer to GHP coverage in specified instances of dual coverage.⁴ The MSP laws are, at best, inexact. As a result, employers, providers, and payors must continue to rely heavily on Medicare’s manuals, which frequently change without notice and comment.⁵

At issue in the Highmark case is what are known as the “working aged provisions” of the MSP laws, which rank among some the laws’ more complicated provisions. In a nutshell, they provide that where an individual is entitled

to Medicare based on age, and has group coverage based on his or her (or a spouse’s) current employment status, Medicare is the secondary payer to GHP coverage.⁶

There are a few exceptions to this rule. First, the MSP working aged provisions do not apply to individuals in GHPs sponsored by small employers (*i.e.*, employers with less than 20 employees, as calculated under the MSP laws).⁷

Second, for a multi-employer group health plan (MEP) — *i.e.*, a plan sponsored jointly by two or more employers (sometimes called a multiple-employer plan) or by employers and unions — Medicare is the secondary payer for all employees if the group has at least one participating employer with “20 or more employees” (again, as calculated under the MSP laws).⁸

However, if the MEP has at least one employer with 20 or more employees, the group health plan may “elect” to have the individuals who are enrolled in the plan through a small employer excepted from the MSP working aged provisions. This is generally referred to as an MEP election. Figure 1 shows a simplified example.

Highmark Litigation

Under the settlement of the case, which involved what the district court had labeled a “novel theory,”⁹ the United States asserted that Highmark “caused” providers to submit false claims to Medicare when Highmark improperly denied, or processed only for secondary payment, those claims where the small employer exception or MEP election did not properly apply in the government’s view. With respect to the small employer exception, the government alleged that Highmark had an obligation to calculate properly the number of employees of a given employer but failed to do so.

In connection with the MEP election, the government alleged that Highmark ignored the regulatory requirement that it “request” an exception for individual employers within a multi-employer GHP that have fewer than 20 employees. Thus, the government alleged, Highmark treated MSP claims of small groups within an MEP as Medicare primary, even

Figure 1: Example

A simplified example of the small employer exception and MEP election may be helpful. Suppose the Chamber of Commerce sponsors a multi-employer group health plan that is insured by Acme Insurance. The MEP has several participating employer members (including Joe’s Diner) that have less than 20 employees and some (including Carol’s Restaurant) that have 20 or more employees. In order for the Medicare-entitled employees of Joe’s Diner to be excepted from the MSP laws (and therefore take advantage of the likely lower rates offered by Medicare), the Chamber of Commerce must make the small employer exception election by submitting certain detailed information to the Medicare coordination of benefits contractor (the COBC), including information pertaining to coverage for the affected individuals at Joe’s Diner.

Once this election request is made and approved by the COBC, Medicare properly may be treated as the primary payer for the Medicare-entitled employees at Joe’s Diner. In general, unless some other exception applies, the multi-employer group health plan coverage through Acme Insurance remains the primary coverage for the Medicare entitled employees at Carol’s Restaurant (which has 20 or more employees). ■

though applicable law required that, in the absence of a formal request and approval, such groups be treated as Medicare secondary.

Settlement Agreement and the New Mechanism

The agreement identifies some of Highmark's actions during the investigation. For example, Highmark conducted a review to "capture actual employee count data from its customers" for purposes of determining whether Medicare should have been primary or secondary during the relevant time period. (This review resulted in the repayment of approximately \$2.5 million to CMS.) In addition, Highmark "voluntarily undertook to create new data capturing and utilization measures in order to obtain accurate employee count information."

As noted above, the agreement requires Highmark to comply with model MSP procedures, which are outlined in an exhibit to the agreement entitled, "Suggested Model Procedures for Multi-Employer/Multiple Employer Group Health Plan Small Employer Exception Issues." Under the agreement, an independent organization will verify that Highmark has established and maintained MSP procedures consistent with the model procedures.

These model procedures are subject to update and revision in light of any future changes in relevant federal regulatory requirements. Finally, Highmark's internal audit department must confirm that its MSP policies and procedures are consistent with the model procedures and Highmark must utilize an independent review organization for a period of three years to verify the findings of the internal audit department.

New Information

The short introduction to the model procedures identifies the statutory and regulatory citations that "govern" the MSP program, as well as the "guidance" available in the MSP manual and on the CMS Web site. With respect to the model procedures themselves:

[f]or clarification purposes, CMS is providing additional procedures which employers, insurers, TPAs, GHPs, other plan sponsors, or any other entity in-

involved in the administration or provision of health benefits for an employer *may elect to follow* in determining employer size for the purpose of complying with the MSP statute and regulations as they apply to small employers, multi-employer plan provisions and the small employer exception election.¹⁰ (Emphasis added.)

Shortly after the settlement was announced, the model procedures were posted — without announcement — to the small employer exception portion of the CMS Web site.¹¹ A few aspects of the model procedures are significant. For example, the model procedures reflect an apparent change in CMS' position in that the GHP may designate, by agreement or otherwise, another entity to make the MEP election on behalf of its members or clients. Prior to these model procedures, it had seemed settled that it was the responsibility of the multi-employer GHP to request the small employer exception.

In most respects, however, the model procedures do not represent a sea change with respect to various entities' obligations under the working aged provisions of the MSP laws. However, these entities certainly must now evaluate their processes against a new, detailed model setting forth what an insurer should do, "at a minimum," to "facilitate proper employee counts for purposes of determining whether Medicare is a primary or secondary payer."¹²

Conclusion

The recitals to the agreement acknowledge that "the current statutory and regulatory framework [to the MSP law] does not specify an insurer's obligation to collect employee data for its group health plan customers." The good news is that the Highmark settlement and model procedures provide additional guidance by CMS with respect to the MSP law. Moreover, Highmark crafted a resolution that — because it memorializes policies it helped developed — is far less onerous than a traditional corporate integrity agreement.

Future settlements, for other areas of law, may be modeled on this type of resolution. The bad news, however, is that the CMS "guidance" is once again provided in the enforcement context,

without the benefit of notice and comment or open dialogue with all affected parties. ■

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Footnotes:

1. United States ex rel. Drescher v. Highmark, Inc., E.D. Pa., No. 03-CV-4883 (settled 6/19/06).
2. See 42 U.S.C. § 1395y(b) and 42 C.F.R. part 411, subparts E to H.
3. Available online at <http://www.cms.hhs.gov/EmployerServices/Downloads/MSPModel.pdf> (model procedures).
4. The MSP laws also prohibit discrimination against Medicare beneficiaries in the offering of GHP coverage. The MSP laws generally require GHPs to offer members age 65 or older with current employment status (and their spouses) the “same benefits under the same conditions” as those individuals (and their spouses) under age 65. In addition, the MSP laws generally prohibit groups from “taking into account” that an enrollee has Medicare coverage based on age, disability, or end-stage renal disease. These aspects of the MSP laws were not at issue in the Highmark litigation.
5. See e.g., the “Internet Only” Medicare Secondary Payer Manual, Pub.100-05, available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.
6. 42 U.S.C. § 1395y(b)(1)(A)(i); 42 C.F.R. §§ 411.100(a)(1)(i), 411.172.
7. 42 U.S.C. § 1395y(b)(1)(A)(ii); 42 C.F.R. §§ 411.100(a)(1)(i), 411.172.
8. 42 U.S.C. § 1395y(b)(1)(A)(iii); 42 C.F.R. §§ 411.172(b). Of course, this is a complicated calculation. An employer is considered to employ “20 or more employees” if the employer had 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year. 42 U.S.C. § 1395y(b)(1)(A)(iii); 42 C.F.R. § 411.170(a)(2)(i). These 20 weeks do not have to be consecutive. In addition, once an employer meets this threshold in any given year, the GHP is required to offer primary coverage for the remainder of the year and throughout the following year, even if the number of employees subsequently drops below 20.
9. Memorandum Opinion Denying Motion to Dismiss at 11 (Feb. 20, 2004) (“Mem. Op.”), *Highmark* (No. 03-CV-4883).
10. Model Procedures.
11. Available online at http://www.cms.hhs.gov/EmployerServices/05_smallemployerexception.asp.
12. Model Procedures, § IV.B.

New Regulations Seek to Facilitate Adoption of Health Information Technology

HHS Secretary Mike Leavitt recently announced final regulations that will support physician adoption of electronic prescribing and electronic health records technology.

“Electronic health records help doctors provide higher quality patient care, improved efficiency and with less hassle,” said Leavitt. “By removing barriers, these regulation changes will help physicians get these systems in place and working for patients faster.”

Electronic prescribing enables a physician to transmit a prescription electronically to the patient’s choice of pharmacy or ancillary provider. It can improve patient safety by decreasing prescription errors due to hard-to-read physician handwriting and communication errors, automating the process of checking for drug interactions and allergies, and eliminating duplicative laboratory and diagnostic tests.

Electronic prescribing also enables physicians and pharmacies to obtain from drug plans information about the patient’s eligibility and medication history. Having access to this information at the point of care makes writing, transmitting, and filling prescriptions quicker and easier and also makes it possible for physicians to make informed decisions about the availability of lower-cost, therapeutically appropriate alternatives to the prescribed medication.

Electronic health records technology, when interoperable among health care providers in various settings, offers benefits similar to the benefits of electronic prescribing in terms of reducing medical errors, coordinating care, and improving efficiency.

The final rules create new exceptions and safe harbors to two key federal fraud and abuse laws for arrangements involving the donation of certain electronic health information technology and services.

The CMS rule creates two new exceptions to the physician self-referral law, which prohibits a physician from referring Medicare patients for certain designated health services (DHS) to entities with which the physician has a financial relationship, unless an exception applies. The law also prohibits the health care entity from billing for Medicare services that are furnished as a result of a prohibited referral.

Similar to the CMS rule, the OIG rule establishes two new safe harbors under the federal anti-kickback statute. Arrangements involving the provision of items and services that meet the requirements of the safe harbors are exempt from enforcement action under the federal anti-kickback statute related to electronic prescribing as well as electronic health records systems.

The rules finalize an exception and safe harbor for the provision of electronic health records information that is more expansive than the exception and safe harbor proposed by CMS and OIG on October 11, 2005. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) mandated exception and safe harbor for arrangements involving the provision of electronic prescribing technology and services were finalized as proposed.

The exceptions and safe harbors establish the conditions under which:

- Entities furnishing DHS (and certain other entities under the safe harbor) may donate to physicians (and certain other recipients under the safe harbor) interoperable electronic health records software, information technology, and training services.
- Hospitals and certain other entities may provide physicians (and certain other recipients under the safe harbor) with hardware, software, or information technology and

training services necessary and used solely for electronic prescribing.

“These final rules will improve care by giving doctors and other health care providers needed support for interoperable health records that enable them to increase quality and improve efficiency,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “Medicare plays a critical role in this important initiative, and we are committed to its success.”

The electronic prescribing exception was mandated by the MMA and signed into law by President Bush on December 8, 2003. As part of the MMA, Medicare will require prescription drug plans and Medicare Advantage MA organizations participating in the new prescription drug benefit to support electronic prescribing. Electronic prescribing will be voluntary for physicians and pharmacies.

AHIP Response

America’s Health Insurance Plans’ President and CEO Karen Ignagni issued the following statement in response to the announcement about the final electronic health records technology and e-prescribing rules:

One of the most important health care challenges the nation faces is to create an integrated health information technology system. Today’s HHS announcement of final regulations is a major step toward that goal. We believe these regulations will create a uniform template to support e-prescribing and the creation of electronic health records. In addition, the regulations will encourage the development of consumer-friendly, compatible systems and discourage anticompetitive practices. ■

For more information, visit the CMS Web site at www.cms.hhs.gov and the OIG Web site at www.oig.hhs.gov.

Health Care Decision Makers Weigh in on Electronic Health Records

Medical Record Institute, Inc. has released the results of its Eighth Annual Survey of EHR Trends and Usage. The Web results of the

EHR survey include both the results and the trends from 18 questions, including four questions on demographics.

The survey data includes responses collected from April through June 2006 via online and printed surveys, which were made available at the 2006 Annual TEPR (Towards the Electronic Patient Records) Conference. While there was a total of 1383 respondents, the total database survey size was pared down to 729, eliminating vendors and consultants in order to increase relevancy and reduce bias.

The MRI Survey of EHR Trends and Usage reveals insights into the following:

- Priorities for strategic decisions in information technology
- EHR applications and functions being implemented or planned
- EHR configurations for different environments
- Data capture methods being employed
- Major barriers to implementing EHR systems
- Mobile/wireless technologies used, concerns related to implementation, and impact on health care delivery
- Perceived effectiveness of information technology on patient safety

Some of the major findings from the survey include the following:

- The top three priorities for strategic decisions in information technology are the need to improve clinical processes or workflow efficiencies, the need to improve quality of care, and the need to share data.
- EHR systems within most health care institutions support both inpatient and outpatient capabilities.
- Most respondents have not been able to measure the return on investment of information technology for patient safety.
- "Remote access to lab results" is most cited as the most important EHR feature.
- The three most planned EHR implementations are alerts, warnings, or reminders generated by decision support; post-visit education; and pre-visit health screening, evaluations, or assessments.
- E-prescribing to commercial/retail pharmacies is most used for "drug allergy checking," followed closely by "access to drug reference information."

The full survey is available to the health care industry as a free service. To review or download the survey results, go to www.medrecinst.com. ■



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