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Healthcare Leadership & Management Report

A PRACTICAL STRATEGIC RESOURCE FOR HEALTH SYSTEM EXECUTIVES AND PHYSICIAN LEADERS

In This Issue

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AHA Advancing Health in America

Boomerang: As Medical Loss Ratios Dip, Health Plan Profits Soar

Are Patients, Hospital Bottom Lines Hurt?

By RON SHINKMAN

When Anthem Inc. and WellPoint Health Networks announced their intent to merge into the nation's largest healthcare plan, it immediately seemed a good fit. The Indianapolis-based Anthem is the Blue Cross and Blue Shield licensee in eight states, including Connecticut, Ohio and Colorado. WellPoint is a BCBS licensee in four states, including Blue Cross of California and Blue Cross and Blue Shield of Georgia. The merged companies would create a single giant entity with 26 million lives and $36 billion in annual revenue.

WellPoint Chief Executive Officer Leonard Schaeffer said the companies' combined vision was

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Capital Problem: Fund Access Declines

HFMA Says Financial Woes Mean Facilities Have Fewer Traditional Ways To Obtain Money

The amount of capital accessed by hospitals through traditional means dropped nearly $15 billion between 2001 and 2002, part of a trend the Healthcare Financial Management Association says could spark more mergers or facility closures in some parts of the country.

According to a recently released survey compiled by HFMA and GE Healthcare Financial Services, total capital accessed by hospitals in 2002 through bonds, bank loans, philanthropy, equity issues and leasing totaled $36.5 billion, a 29% drop from the $51.4 billion accessed in 2001. Additionally, many hospitals appear to be selling fixed assets to raise cash, suggested by a 22% increase in the

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Boomerang: Meaning of Medical Loss Ratios Debatable

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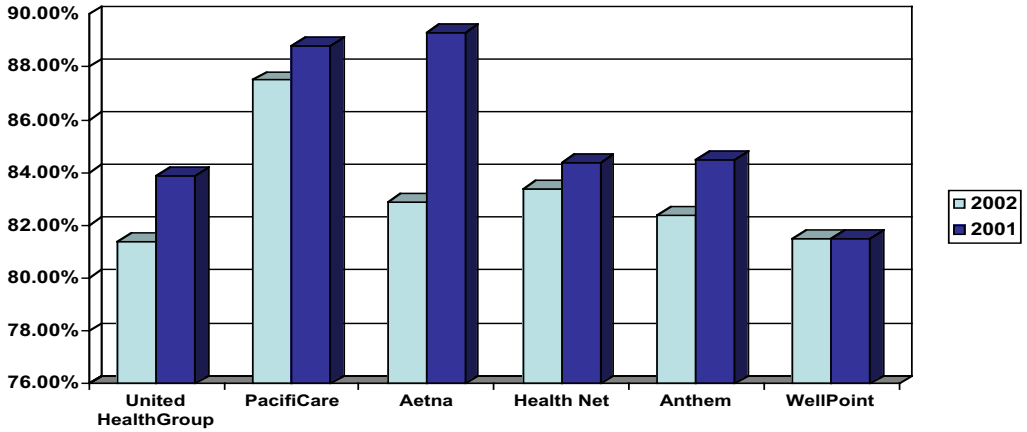
"to redefine the industry by providing more value to our constituents through innovative, choice-based products, significant service enhancements (and) simplified transactions."

Yet there is also another reason why the health plans would seem to mesh so well: WellPoint and Anthem have among the lowest medical loss ratios for commercial plans (percentage of premiums spent on medical care) in the industry, at 81.4% and 81.5% respectively. Anthem's MLR has been reduced three percentage points since 2001 alone. Its net income has soared during that period of time, from $342.2 million in 2001 to more than $549 million in 2002. It is on track to earn anywhere from $800 million to $900 million in 2003.

WellPoint and Anthem are no anomalies. The nation's six largest health plans have been steadily chipping away at their commercial MLRs, reducing them an average of more than four percentage points since 2001 (by contrast, contracts health plans administer to service Medicare or military personnel and their dependents tend to run 10 percentage points or more higher). In one instance, Aetna Health Plans reduced its commercial MLR nearly 15%. It has rebounded from a $2.7 billion loss for 2002 to a net profit of more than $468 million through the second quarter of 2003. Overall, the six health plans – Anthem, WellPoint, PacifiCare, Health Net, United Healthcare and Aetna — have earned nearly $2.4 billion during the first half of this year. They earned only $1.8 billion for all of 2001, and lost $577 million last year.

Health plan officials say that tracking MLRs is not a fair way to gauge the industry, since they

Medical Loss Ratio Trending For Major Health Plans



Source: SEC Filings, Annual Reports

Boomerang: MLRs At Center Of "Chicken Or Egg" Issue

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do not take into account such moves as increased deductibles for patients and changes in pricing, according to Susan Pisano, spokesperson for the American Association of Health Plans, the nation's leading payer lobby. Minor changes in the health of their enrollees can also cost health plans a bundle in the short-run, such as an especially severe flu season that leads to a higher hospitalization rate.

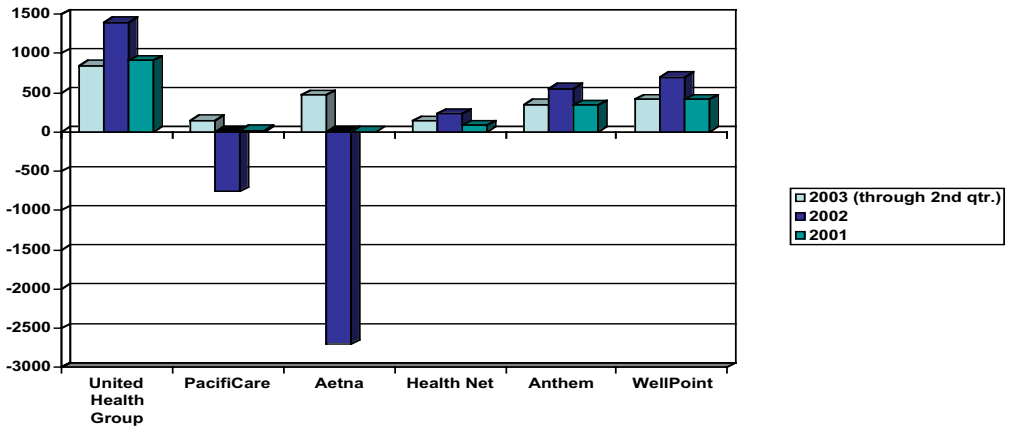
"If you look across the board, this is a business mix issue," says David Olson, senior vice president of investor relations for Health Net, which is based in suburban Los Angeles. As an example, Olson cited Health Net's exit last year from providing coverage for members of the California Public Employees Retirement System (CalPERS), a group significantly older and sicker than the population at large (CalPERS balked at honoring Health Net's request for a steep premium increase).

"What you're seeing is the movement toward a rational price structure, where everyone is treated fairly," Olson says.

According to Ken Sperling, a market leader for Lincolnshire, Ill.-based benefits consulting firm Hewitt & Associates, among the reasons for the sharp drop in MLRs over the past two years has been a byproduct of health plans pricing for medical costs that increased less than they anticipated. "When health plans set their 2003 premium rates in the spring and summer of 2002, they were looking back at 2002 as an indicator," Sperling says. "What they saw were healthcare trend rates running about 15%. What happened is that the cost curve started to moderate, driven by a moderation in hospital (price increases)."

Sperling attributes a number of factors to the miscalculation, but the most likely cause was fixed provider contracts with annual

Net Profit For Major Health Plans (In Millions)



Source: SEC Filings, Annual Reports

Boomerang: Premiums, Cost-Shifting Affect MLRs

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esacalation clauses that didn't exceed 10%. "They didn't have to deal with 15% of 20% cost escalations with hospitals, but the 15% trend assumption was locked into (their premiums). As a result, these health plans had a very comfortable premium increase during a time of declining cost trends."

According to research by *Healthcare Leadership & Management Report*, Aetna's steep drop in its MLR skewed the overall numbers somewhat. Yet the conclusion remains unavoidable: all six health plans examined have reduced their MLRs over the past two years, and all of them are now significantly more profitable.

Cigna, one of the few major health plan that has seen its MLRs rise during that period, has experienced only intermittent profitability.

Such a trend begs a "chicken or the egg" type of question: are the health plan MLRs lower because they're stripping cash out of payments to providers, or are lowered MLRs a product of dilution due to dramatically rising premium revenue?

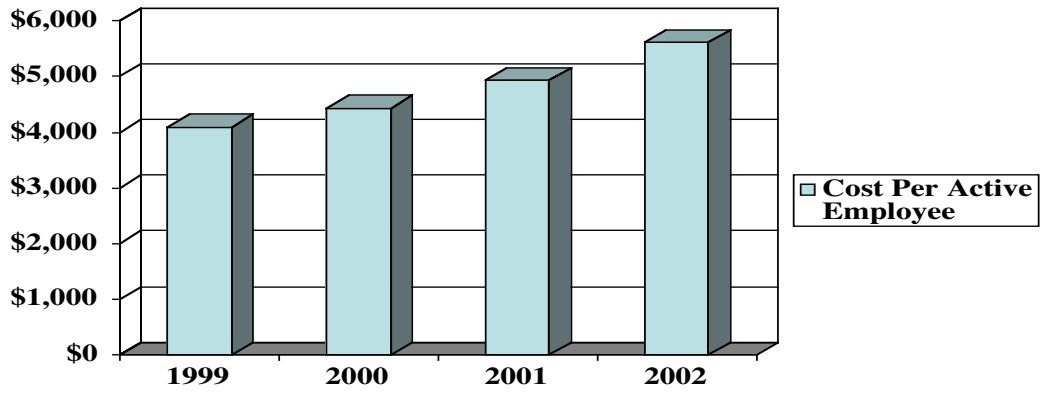
Whether or not the health plans are taking money out of the system that would ordinarily treat patients remains debatable. Rick Wade, senior vice president of communications for the Washington D.C.-based American Hospital Association, acknowledges that the health plans may be managing their costs better without neglecting care.

"We've seen a retreat from some of the worse restrictions of managed care in recent years…where the order of the day was low pay, slow pay or no pay," he says.

Yet Wade is rankled about the double-digit premium trending of recent years. "They're taking money out of employers, that's for sure," he says.

The major human resource benefit firms that track healthcare premiums all agree they have soared in recent years. According to Hewitt & Associates, healthcare costs increased an average of 14.7%

Per Capita Health Benefit Cost, 1999-2002



Source: Mercer Human Resource Consulting

Boomerang: Concerns Over Market Consolidation

in 2003 for employers. Although the firm reported earlier this month that the cost trend is "moderating," it still projects a 2004 cost increase of 12.6%. Moreover, Hewitt says cost-shifting also continues a dramatic rise, with the average employee contribution expected to reach $1,565 in 2004, a more than 20% increase from $1,276 this year.

According to Washington, D.C.-based Mercer Human Resource Consulting, the recent increases have approached what is considered a "threshold of pain" for many employers.

"We're starting to see the gloves come off in (employer) cost management efforts," says Blaine Bos, a consultant in Mercer's Minneapolis office. As a result, 45% of HMO plans now include a deductible for hospital stays, versus 35% in 2001. Moreover, the percentage of firms with 10 to 49 employees who continue to offer healthcare coverage fell from 66% in 2001 to 62% last year.

The increases and cost-shifting have gone so far as to spark some social unrest in Southern California. Separate strikes currently underway by transportation and grocery workers may be directly traced to the thinning out of healthcare benefits.

"The irony is everybody is screaming about healthcare costs going through the roof, but nobody is looking at health plans as being too greedy," says Jamie Court, president of the Foundation for Taxpayer and Consumer Rights in Santa Monica, Calif., an organization that has been a vocal critic of healthcare plans over the years.

"The irony is everybody is screaming about healthcare costs going through the roof, but nobody is looking at health plans as being too greedy." -- Jamie Court, Foundation for Taxpayer and Consumer Rights

Court says that the merger of many health plans during the early and mid 1990s and the recent resumption of such activity has consolidated too much power in the hands of payers. "There has been absolutely no attention by labor, employers and government toward the increased profitability and lower overhead costs of the (healthcare insurance) industry," he contends. "There has not been enough scrutiny by the federal government in that arena."

The proposed Anthem-WellPoint merger has raised concern in some quarters. Four influential Democratic members of Congress who sit on the House Ways and Means Committee have asked the Federal Trade Commission to thoroughly investigate the merger.

"We are concerned that the combining of the financial assets and market power of Anthem-Wellpoint would further increase consolidation and make it even more difficult for individuals to have access to affordable health insurance," say the four congressmen – Charles Rangel, Pete Stark, Jim McDermott and Max Sandlin — in a joint statement.

Health plans, for their part, have tended to blame hospitals for many of the increased costs. According to Health Net's Olson, payments to hospitals have been going up 15% or more per year. "It's pretty breathtaking," he says, adding that some not-for-profit hospital operators such as Sacramento, Calif.-based Sutter Health have enjoyed large run-ups in their surpluses. Sutter posted 2002 net income of $284 million in 2002, versus $99 million in 2001. Overall revenues were up about 17%, to $4.9 billion from $4.2 billion.

But is Sutter — a regional hospital system that also provides

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Boomerang: Providers, Payers In War Of Words

(Continued From Page 5)

more than $400 million a year in community benefits – a bellwether for hospital pricing? Data from some quarters would suggest otherwise. For example, Tenet Healthcare Corp. recently reported a third quarter loss of $308 million, linked primarily to swelling ranks of patients who lacked insurance or who had to bear larger co-payments. The result: Tenet had to reserve $522 million for doubtful accounts and take a $200 million charge. "This phenomenon is occurring throughout our portfolio of hospitals," says Tenet CEO Trevor Fetter, who indicated that the situation isn't expected to improve anytime soon. During a presentation made to discuss the financials, Fetter says Tenet expects "to face significant continued challenges in managed care pricing and renegotiations well into 2004."

According to a study issued earlier this year by Price Waterhouse Coopers, hospital service costs have increased about 6% per year over the past decade. That compares to a 12.4% annual increase for private health insurance plans, and 21.3% per year for pharmaceuticals. The survey concluded that nationwide expenditures for hospital services would decline from 31.7% of all healthcare spending in 2001 to 30.8% this year, and would eventually represent just 27.9% of all healthcare spending by 2012.

Another study by the nonpartisan Center for Studying Health System Change concluded that hospital inpatient costs contributed to just one-seventh of the recent overall increase in healthcare expenditures.

There is also little doubt that providers are rankled by the financial tactics used by health plans. The American Hospital Association (which owns a minority stake in this publication's parent company) has been in a war of words with the Blue Cross/Blue Shield Association over who is to blame for rising healthcare costs. A BCBSA-sponsored study released last fall contended that every 1% increase in a hospital's market share leads to a 2% increase in patient expenditures. The AHA fired back with a report of its own that called the BCBSA'"deeply flawed" (see *Healthcare Leadership & Management Report*, July 2003, page 1).

Yet as health plan profits rise and their MLRs decrease, there is some discussion that this trend, like all others, may be nearing the end of what has been a relatively brief run.

Hewitt's Sperling believes last year's pricing miscalculation regarding the forecast of hospital pricing will self-correct. "The industry can still make money with MLRs in the mid or high 80s," he says, but quickly adds that the Wall Street investment community is loathe to let MLRs creep any higher than that. "In a sense, the pricing environment self-corrects. Health plans may have missed the mark this year, but that likely won't be the case in the future."

One reason to strive for rating precision is the potential loss of customers. Larger firms are much more likely to self-insure if pricing becomes prohibitive. "Health plans actually make a lot more money with a well-price insurance contract than taking two or three percentahe points to manage a self-insured

"Health plans may have missed the mark this year, but that won't likely be the case in the future" -- Ken Sperling, Hewitt & Associates

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Capital Problem: HFMA Study Predicts Future Woes

(Continued From Page 1)

sale of medical office buildings last year.

"There is a concern about broad access to capital. Capital is the lifeblood of a healthcare organization, and some institutions may have a difficult time remaining the way they are," says HFMA Chief Executive Officer Richard L. Clarke.

"If they cannot access capital, hospitals are affected on several different dimensions. They may not be able to invest in the latest technologies, and their level of care may not be at a current level. As a result, they may eventually have to close (out of safety concerns)," Clarke adds. Among the biggest changes:

- The proportion of bank loans to hospitals decreased from $19.7 billion in 2001 to just $2.7 billion.
- The proportion of tax exempt bond financing increased from $19.8 billion to $21.2 billion.
- The proportion of leasing increased from $3.7 billion in 1997 to $5.8 billion last year.

Aside from the shifts in how hospitals accessed capital, there were also dramatic changes in the proportion of hospitals with less constricted access to capital. For example, the percentage of hospitals perceived to have broad capital access decreased from 42% in 1997 to 36% in 2002. Institutions with moderate capital access decreased from 47% in 1997 to 45% in 2002. And hospitals with limited access to capital increased dramatically, from 11% in 1997 to 19% in 2002.

Moreover, the financial position of all hospitals – particularly those with limited capital access — have deteriorated dramatically. According to the survey, the average operating margin for broad access hospitals declined from 5.2% in 1997 to 4.7% in 2001. The average limited access hospital had a negative 1.5% margin in 1997; that figure dropped to negative 7.3% in 2001.

According to the report, the more financially robust a hospital, the better access to outside capital it has. Those in the "broad access" category generally had operating margins exceeding 2%, while "limited access" facilities had on average less than five days cash on hand.

Busier hospitals with a higher focus on acute care and a more acute patient mix were also more likely to have better access to capital. Broad access hospitals had a 23% higher average daily census than limited access

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Study: Spreading Technology Drives Up Healthcare Costs

The availability of healthcare equipment by geographical areas drives increased spending, according to a recently released study by a group of researchers sponsored by the Blue Cross Blue Shield Association.

The report, entitled "The Relationship Between Technology Availability and Health Care Spending," was just posted on the website of the publication *Health Affairs*. Focusing on the utilization rates of Medicare recipients and enrollees in a commercial health plan that operates preferred provider organizations and point-of-service plans in all 50 states, it concludes that adding capacity in a geographic area for services such as magnetic resonance imaging (MRI), computed tomography scanners (CT) and specialty cardiac facilities can drive healthcare costs up for entire communities. The reason is simple: greater availability drives greater demand and usage.

Although the increases are minuscule per individual patient, the increases are considerable when an entire population is taken into consideration.

For example, the introduction of an additional freestanding MRI correlates to a cost increase of about $395,000 per year per million people. Adding one specialty cardiac unit correlates to an increase of spending of $1.3 million

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Capital Problem: Geographic Variations Play Role

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hospitals. Between 1997 and 2001, broad access hospitals only experienced an average 1% decline in average daily census; limited access hospitals saw their census decline by 12%. During that same period, broad access hospitals experienced a 6% increase in admissions. Limited access hospitals experienced no increases. Acute care days at broad access hospitals were also 8% higher, and increased overall by 2% between 1997 and 2001. Limited access hospitals experienced a 9% decline in acute care days during the same period.

Clarke notes that the nation's hospitals in general have seen their bottom lines eroded by lack of appropriate reimbursement from the Medicare and Medicaid programs and an increase in the number of uninsured patients. "There is a diminishing number of people who pay full freight and help pick up the slack elsewhere, and hospitals are caught in the middle as a result," he says. He adds that the statistics also show an operating environment where the gap between "have" and "have-not" hospitals is increasingly widening.

Geographic variations play a role as well, with hospitals in the Midwest generally faring better than institutions in the West, Southwest, Southeast and Northeast.

However, no state has been harder hit by an access to capital crunch than New York. A full 43% of the hospitals in that state are labeled limited access. Clarke linked that to the deregulation of New York hospital charges more than a decade ago. "Most of the hospitals survived well under a rate-controlled model because it translates to a fairly stable environment. Therefore those organizations did not have much in the way of financial

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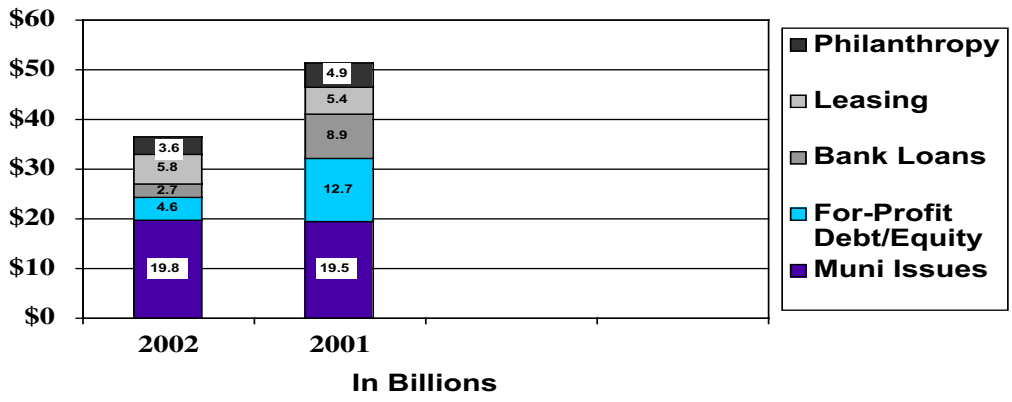
External Capital Raised By Hospitals



Source: HFMA

Boomerang: Days Of Big Health Plan Profits May Be Numbered

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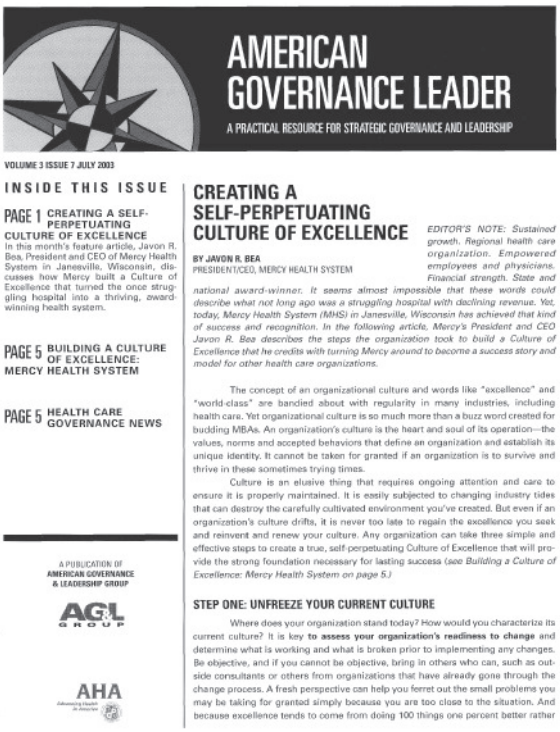
plan," he says. "They have to walk a fine line, and be careful.

Another indication of the changing environment may be the intention of WellPoint's Schaeffer to become chairman of the merged companies rather than CEO. According to a recent story in the *New York Times*, Schaeffer's decision to move to the sidelines – and pocket approximately $56 million in the process— may signal his belief the good times are coming to an end.

"The insurance industry is running out of the ability to charge 12% to 15% premium increases," industry consultant Jeff Goldsmith told the *Times*. "I think we're at the top of the underwriting cycle. This is a real good top-of-the-market signal."

Also From American Governance & Leadership Group


AMERICAN GOVERNANCE LEADER

A PRACTICAL RESOURCE FOR STRATEGIC GOVERNANCE AND LEADERSHIP

VOLUME 3 ISSUE 7 JULY 2003

INSIDE THIS ISSUE

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In this month's feature article, Javon R. Bea, President and CEO of Mercy Health System in Janesville, Wisconsin, discusses how Mercy built a Culture of Excellence that turned the once struggling hospital into a thriving, award-winning health system.

PAGE 5 BUILDING A CULTURE OF EXCELLENCE: MERCY HEALTH SYSTEM

PAGE 5 HEALTH CARE GOVERNANCE NEWS

A PUBLICATION OF AMERICAN GOVERNANCE & LEADERSHIP GROUP

CREATING A SELF-PERPETUATING CULTURE OF EXCELLENCE

BY JAVON R. BEA
PRESIDENT/CEO, MERCY HEALTH SYSTEM

EDITOR'S NOTE: Sustained growth. Regional health care organization. Empowered employees and physicians. Financial strength. State and national award-winner. It seems almost impossible that these words could describe what not long ago was a struggling hospital with declining revenue. Yet, today, Mercy Health System (MHS) in Janesville, Wisconsin has achieved that kind of success and recognition. In the following article, Mercy's President and CEO Javon R. Bea describes the steps the organization took to build a Culture of Excellence that he credits with turning Mercy around to become a success story and model for other health care organizations.

The concept of an organizational culture and words like "excellence" and "world-class" are bandied about with regularity in many industries, including health care. Yet organizational culture is so much more than a buzz word created for budding MBAs. An organization's culture is the heart and soul of its operation—the values, norms and accepted behaviors that define an organization and establish its unique identity. It cannot be taken for granted if an organization is to survive and thrive in these sometimes trying times.

Culture is an elusive thing that requires ongoing attention and care to ensure it is properly maintained. It is easily subjected to changing industry tides that can destroy the carefully cultivated environment you've created. But even if an organization's culture drifts, it is never too late to regain the excellence you seek and reinvent and renew your culture. Any organization can take three simple and effective steps to create a true, self-perpetuating Culture of Excellence that will provide the strong foundation necessary for lasting success (*see Building a Culture of Excellence: Mercy Health System on page 5.*)

STEP ONE: UNFREEZE YOUR CURRENT CULTURE

Where does your organization stand today? How would you characterize its current culture? It is key **to assess your organization's readiness to change** and determine what is working and what is broken prior to implementing any changes. Be objective, and if you cannot be objective, bring in others who can, such as outside consultants or others from organizations that have already gone through the change process. A fresh perspective can help you ferret out the small problems you may be taking for granted simply because you are too close to the situation. And because excellence tends to come from doing 100 things one percent better rather

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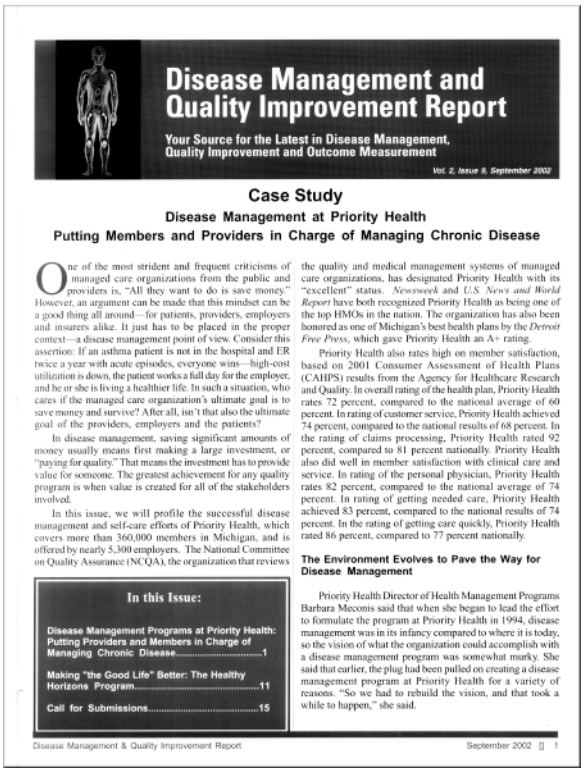
Disease Management and Quality Improvement Report

Your Source for the Latest in Disease Management, Quality Improvement and Outcome Measurement

Vol. 2, Issue 9, September 2002

Case Study

Disease Management at Priority Health

Putting Members and Providers in Charge of Managing Chronic Disease

One of the most strident and frequent criticisms of managed care organizations from the public and providers is, "All they want to do is save money." However, an argument can be made that this mindset can be a good thing all around—for patients, providers, employers and insurers alike. It just has to be placed in the proper context—a disease management point of view. Consider this assertion: If an asthma patient is not in the hospital and ER twice a year with acute episodes, everyone wins—high-cost utilization is down, the patient works a full day for the employer, and he or she is living a healthier life. In such a situation, who cares if the managed care organization's ultimate goal is to save money and survive? After all, isn't that also the ultimate goal of the providers, employers and the patients?

In disease management, saving significant amounts of money usually means first making a large investment, or "paying for quality." That means the investment has to provide value for someone. The greatest achievement for any quality program is when value is created for all of the stakeholders involved.

In this issue, we will profile the successful disease management and self-care efforts of Priority Health, which covers more than 360,000 members in Michigan, and is offered by nearly 5,300 employers. The National Committee on Quality Assurance (NCQA), the organization that reviews the quality and medical management systems of managed care organizations, has designated Priority Health with its "excellent" status. *Newsweek* and *U.S. News and World Report* have both recognized Priority Health as being one of the top HMOs in the nation. The organization has also been honored as one of Michigan's best health plans by the *Detroit Free Press*, which gave Priority Health an A+ rating.

Priority Health also rates high on member satisfaction, based on 2001 Consumer Assessment of Health Plans (CAHPS) results from the Agency for Healthcare Research and Quality. In overall rating of the health plan, Priority Health rates 72 percent, compared to the national average of 60 percent. In rating of customer service, Priority Health achieved 74 percent, compared to the national results of 68 percent. In the rating of claims processing, Priority Health rated 92 percent, compared to 81 percent nationally. Priority Health also did well in member satisfaction with clinical care and service. In rating of the personal physician, Priority Health rates 82 percent, compared to the national average of 74 percent. In rating of getting needed care, Priority Health achieved 83 percent, compared to the national results of 74 percent. In the rating of getting care quickly, Priority Health rated 86 percent, compared to 77 percent nationally.

The Environment Evolves to Pave the Way for Disease Management

Priority Health Director of Health Management Programs Barbara Meconis said that when she began to lead the effort to formulate the program at Priority Health in 1994, disease management was in its infancy compared to where it is today, so the vision of what the organization could accomplish with a disease management program was somewhat murky. She said that earlier, the plug had been pulled on creating a disease management program at Priority Health for a variety of reasons. "So we had to rebuild the vision, and that took a while to happen," she said.

In this Issue:

Disease Management & Quality Improvement Report September 2002 1

AG&L Group's newest publication, *Disease Management & Quality Improvement Report*, explores the disciplines of disease management and quality improvement that are transforming health care provision while improving patient outcomes and the bottom lines of the organizations involved. In-depth feature articles, expert commentary and real-life case studies on disease management and quality improvement are combined to make this an excellent resource.

Capital Problem: New York, California Under Pressure

(Continued From Page 8)

reserves when (deregulation occurred)," he says. "They went from a utility-style, rate-controlled market to a competitive open market without the appropriate financial infrastructure in place."

According to the July issue of *Hospital Watch,* a publication of the Greater New York Hospital Association, the average aggregate margin of New York City hospitals was negative .4% in 2001, compared to 3.4% nationwide. As a result, *Hospital Watch* identified 13 institutions it considered to be in financial "jeopardy""– at risk for closing–– a figure representing 37% of all hospitals operating within New York City. Another 20% of hospitals were identified as "at-risk."

The stress felt by New York hospitals has implications not only for patient care, but for the state's economy as well. According to the HFMA, the huge number of healthcare jobs in New York makes that a sector an important factor in the state's economy. The report expressed concern that healthcare job growth could slow as a result of the financial stress being experienced by hospitals statewide.

Another vulnerable state is California. Although it contained more broad access hospitals than any other state, it had the eighth-highest percentage of limited access hospitals. Clarke says initiatives to retrofit hospitals to meet new seismic standards and meet stringent new nursing staff ratios will continue to put pressure on California.

"These mandates add costs without adding revenue," he says, adding that leverage on determining reimbursement rates in California lie with payers rather than providers.

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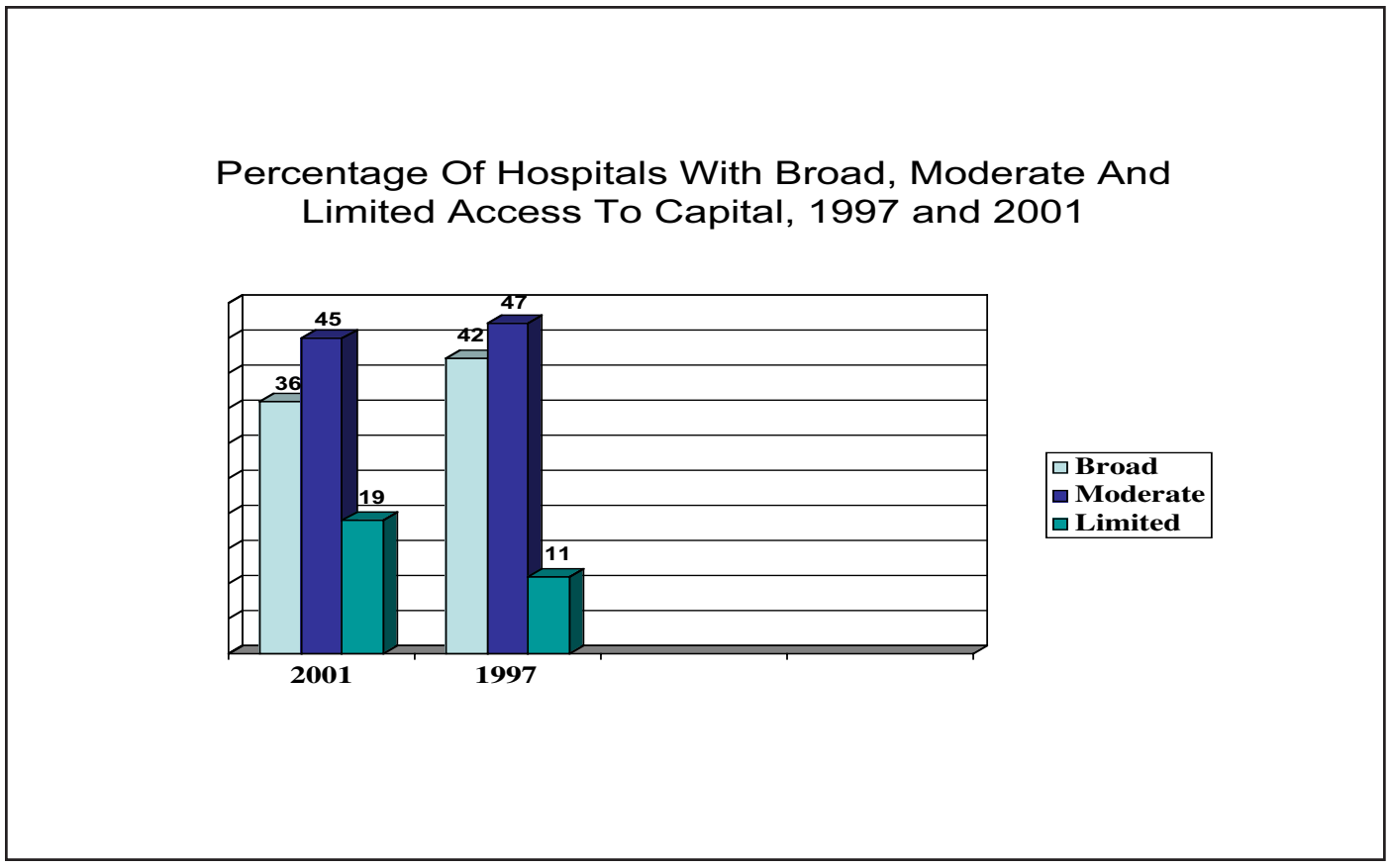

Study: Spreading Technology Can Drive Up Costs

(Continued From Page 7)

per year for each 10,000 Medicare cardiac patients. Adding a facility with the ability to implant cardioverter defibrillators correlates to a spending increase of about $1.1 million a year per 100,000 Medicare cardiac patients.

The study, however, did not find such strong correlations with the addition of such facilities as neonatal intensive care units and oncology units.

Additionally, piling on technology doesn't necessarily increase the per-unit price in tandem with usage. The introduction of a freestanding MRI drives a nearly 1% increase in usage, but only one tenth of a percent increase in spending.

"It need not be that the availability of every new technology will be associated with higher use and spending," declares the report, whose lead author was Laurence Baker, chief of health services research at the Stanford University School of Medicine. "Some technologies might be easily amenable to expansions in their use with higher availability. While for other technologies the opportunities for use might be relatively fixed."

The study did not make any specific recommendations for curbing costs, noting that limiting the spread of healthcare technology would merely drive up the per-unit price of existing services and devices.

"Higher spending need not be purely negative for society if the spending yields sufficient benefits," the study concludes. "It is possible, even likely, that a large amount of healthcare spending does not produce higher quality. It is…also likely that some new technologies produce value for patients."

The study did suggest employing greater cost-benefit research by providers looking to expand their technological offerings, and implementing non-specific health plan policies that would "help consumers better identify the costs associated with their consumption choices."

--Ron Shinkman

Affairs Of States

How Adding Technology Can Impact Costs

	Percent Increase In Freestanding MRI Units, 1999-2001	Percent Change In Spending, Overall Population	Percent Change In Outpatient Spending For MRI Population, 1999-2001
Alaska	100%	4%	48%
Massachusetts	38%	30%	67%
Nebraska	200%	17%	77%
Rhode Island	900%	34%	66%
Utah	200%	32%	52%
Washington	59%	51%	33%

Source: Health Affairs

JCAHO Launches Stroke Certification Program

Intent Is To Provide Uniform Care

The Joint Commission for the Accreditation of Healthcare Organizations is developing the first program of its kind in evaluating and certifying the care hospitals give to stroke victims.

About 700,000 Americans suffer a new or recurring stroke each year. The affliction is the third leading cause of death in the United States, with someone dying of a stroke every three minutes.

Protocols for evaluating stroke programs have been jointly developed by JCAHO and the American Stroke Association. The measure set is expected to be available by early 2004, officials say.

The stroke survey, which will be conducted under the auspices of JCAHO's Disease Specific Care Certification Program, will focus on whether hospitals are complying with national standards for stroke care; effective use of primary stroke center recommendations and clinical practice guidelines to optimize care; and general performance measurement and improvement activities. On-site surveys are expected to take about one day to conduct. Data will be reviewed by such clinical experts as neurologists and emergency room physicians, neuroscience and emergency department nurses, and stroke center administrators.

Stroke center certifications will be good for one year, with one-year extensions granted with the submission of an acceptable periodic performance review.

Capital Problems: Alternative Forms Of Financing Discussed

(Continued From Page 10)

"The dynamics there are somewhat like New York's."

Yet not all institutions should consider themselves victims of a changing regulatory or market environment. "Lenders don't avoid lending to hospitals based on changes in regulations…the real key is management's proven track record in responding to regulatory changes, relative to competitors," says Ray Sweeney, executive vice president of the Hospital Association of New York State.

For those hospitals lacking easy access to capital, the HFMA report indicates that not all avenues are constricted. It noted that the Federal Housing Administration's 242 program provides many loans for hospitals, even though its fees were higher and covenants more restrictive than non-government backed loans.

Hospitals can also consider monetizing its non-core real estate assets. They often serve to reduce leverage, which can increase ratings and capital access. "Except in strategic situations, many medical office buildings no longer need to be owned by the hospitals, so we're seeing more third-party models," says Pierre Bogacz, a vice president with Ziegler Healthcare Finance, a New York-based investment banking firm.

Officials also say that whether a hospital has broad or limited access to capital, it must plan its ventures carefully, keeping the overall mission of the institution in mind. "Debt capacity is not as formulaic as people would like it to be. It needs to be driven by strategy," says Jim Costello, senior vice president of New York-based investment banking firm Lehman Brothers.

--Ron Shinkman

Healthcare Futurist Russell C. Coile Dies

Predicted Evolution Of Insurance, Use Of Genetic Data

Russell C. Coile Jr., a self-styled healthcare futurist who was a longtime member of *Healthcare Leadership & Management Report's* national advisory board, died on November 10 at St. Joseph Regional Health Center in Bryan, Texas. Mr. Coile was 60 years old and had been suffering from brain cancer.

A regular speaker on the healthcare business conference circuit, Mr. Coile authored 10 books and had published a newsletter, *Russ Coile's Health Trends*, since 1990.

Mr. Coile used a combination of hard statistical data and marketplace facts to make often prescient predictions about the future direction of the healthcare industry. As a result, his annual "top 10" list of forecasted healthcare business trends boasted a 90% accuracy rate. Mr. Coile was ranked the 42nd most powerful person in the healthcare industry last year by *Modern Healthcare* magazine.

"He was a remarkable man with an uncanny ability to predict the future paths of the healthcare industry," says Jerry F. Pogue, publisher of *Healthcare Leadership & Management Report* and chief operating officer of American Governance & Leadership Group. "His presence will be sorely missed."

Beginning in the 1980s, Mr. Coile was among the very first people to predict that health insurance would become a top priority of individual Americans. In the early 1990s, Mr. Coile predicted that genetic information would be used in patient care.

Mr. Coile, who held an MBA in health services administration from George Washington University, was past president for the American Hospital Association's Society for Healthcare Strategy and Market Development; a founding board member of the Association of Professional Futurists; and a board member of the Center for Health Design and the Public Health Institute.

Mr. Coile is survived by his wife Nancy, son Zachary, daughter Courtney and two stepdaughters, Amanda and Ariel Angelotti.

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Author Policies

Healthcare Leadership & Management Report welcomes articles on subjects related to hospital and health system case studies, concepts, strategies, management, governance, clinical systems, and financing. The research journal is a mix of news, commentary and analysis designed to assist innovative leaders in making health care management strategies work. Articles can be submitted in three ways:
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The Give-And-Take Of Health Plan Profitability

By Jerry F. Pogue, Publisher

There is some debate about the meaning of medical loss ratio . To the naked eye, the MLR is supposed to represent the proportion of premium dollar that a health plan spends on the medical care of its enrollees.

When a plan's medical loss ratio drops, the presumption is that a smaller percentage of the money being taken in by the payer is being spent on patient care. The health plan is assumed to be pocketing a larger proportion of the premiums it collects.

According to James C. Robinson at the University of California Berkeley School of Public Health, equating low medical loss ratios with inadequate patient care "is politically the most volatile and analytically the least valid use of the statistic."

We will give Professor Robinson his due here. Still, the data published in this month's edition of *Healthcare Leadership & Management Report* shows a correlation between higher profitability and lower medical loss ratios. Perhaps more significantly, the MLRs of not-for-profit health plans tend to trend five points or more higher than their for-profit counterparts.

There are always factors beyond a health plan's contro, to consider, such as having to treat more patients during flu season. However, there remains the whispered accusations: that if there is a choice between coddling the patient and the coffers, the last option tends to win out.

A Tin Ear For Rust

By Ron Shinkman, Editor

A former employer of mine uses the cruious slogan "rust never sleeps" whenever it announces a change in personnel, policy or editorial content.

To me, it's a phrase that contains many ambiguities. The natrural presumption is that by changing, the organization is avoiding rust. However, the wording suggests alternate interpretations. For instance, is the publication itself rusty and proud of it? Is it becoming rustier by making these changes?

By contrast, there are no ambiguities in the mission and declarations of this publication.

Since I assumed editorship of *Healthcare Leadership & Management Report* in April, I have attempted to make it a publication that covers a broad range of relevant issues presented in a readable form, backed by exemplary journalism. The very first issue I edited contained a profile of hospital activist K.B. Forbes. Mr. Forbes was profiled on the front page of the *Wall Street Journal* just a few weeks after that. Last June, this publication was the first to report that a large part of the Cleveland Clinic's assets were invested in mutual funds that also held a sizable piece of the company founded by its late board chairman, Al Lerner. This publication has also reported on many cutting-edge issues, such as bariatric and bio-terror preparedness.

We're not going to rest on our laurels, however. In 2004, these pages will sport a completely new design, title and slogan. Those changes will be discussed more in length at that time, but this publication's readership will no doubt be impressed and excited by the changes. I also expect it will be the first of many larger steps aimed at boosting this publication's profile, prestige and circulation.

In other words, we don't even know what rust is around here.

Governance & Leadership Forum: You Talked, We Listened

The American Governance & Leadership Group is now offering a comprehensive package of programs and services for health care organization leaders. Based on needs identified in interviews with board members, CEOs and physicians around the country, the Governance & Leadership Forum was designed to offer one-stop shopping, easy-access, flexibility and choice for busy health care leaders.

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