MANAGING HIGH-COST TECHNOLOGY

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Q&A: Extolling Virtues of Not-for-Profits
Howard J. Berman of the Alliance for Advancing Nonprofit Health Care says that not-for-profits still provide services that no one else can or will, and that the nation needs them.

DM Standards Prove Elusive
Johns Hopkins University and American Healthways collaborated on a methodology to evaluate disease management programs. Industry acceptance is spotty.

Good Foundations To Stand On
HMOs and health foundations do not work together often, and that’s too bad. If what’s going on in California is any indication, health plans may be missing an opportunity.

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Boards and managers need to perform better for this sector to continue offering the best care to those who might otherwise fall through the cracks.

**Not-for-Profit Advocate Calls for Managerial Rigor**

Howard J. Berman believes in not-for-profit health care. He spent the last two decades building what is now Lifetime Healthcare, the largest not-for-profit health care company in New York State, built around a core of Blue Cross and Blue Shield plans in Rochester, Syracuse, and Utica. In addition to the now-combined Blues plans, which cover 2 million people under the Excellus name, the company owns a long-term care insurer that operates in 31 states and provides care to 170,000 upstate New Yorkers through its health centers and its home health and hospice care programs.

Berman retired as CEO last year, allowing him to devote more time to the wider cause of not-for-profit care through the Alliance for Advancing Nonprofit Health Care, which he helped launch in 2002. The alliance represents two dozen health systems and Blue Cross plans across the country.

Berman, who earned a masters degree in hospital administration from the University of Michigan, spent time with the Blue Cross Association and then the American Hospital Association in Chicago before moving to Rochester in 1985. He has written three books, The Financial...
Management of Hospitals, Shapers of American Health Care Policy: An Oral History, and most recently A Great Board: Building and Enhancing Non-profit Boards, published by AHA's Health Research and Educational Trust, to which he donates all proceeds. He spoke recently about the place of not-for-profit organizations in the American health care system with Senior Contributing Editor Patrick Mullen.

MC: What was the thinking behind forming the alliance in 2002?
BERMAN: In this nation, the not-for-profit sector is the soul of our communities. It’s an awkward kind of sector because to some extent we’re talking about business trying to do government’s job. As a result, there’s a fair amount of misunderstanding of not-for-profits. One consequence of that misunderstanding is that people don’t always appreciate the value of their community’s not-for-profit institutions. A group of us on the not-for-profit side of health care delivery and finance and related activities such as medical malpractice felt that we needed a stronger voice and a stronger focus on enhancing not-for-profits’ performance. We can’t let the current merger and acquisition activity blind people to the significant role of not-for-profits in health care. We created the alliance with that two-prong mission: to be a clear voice for not-for-profit health care and to focus on improving and enhancing the performance of not-for-profit health care delivery and finance. We recognize that being not-for-profit is no excuse for not having great performance.

MC: Is health care a public right, like education?
BERMAN: All things being equal, communities are best served by not-for-profit health care delivery and finance systems. That isn’t being doctrinaire. You can’t serve two masters, your community and a group of investors who might be outside of your community. Investors require a return on their investments. Some cost must be added to the health care equation to produce that return. A well run not-for-profit doesn’t have that extra cost.

MC: But you wouldn’t argue that there isn’t a place for for-profit companies in health care?
BERMAN: That’s correct. That’s a doctrinaire position, and it is not a pragmatic or politically realistic position. We recognize that for-profits provide marketplace discipline. The reality or threat of for-profits entering a market helps the whole system perform more efficiently. But at the same time, driving out or depreciating the value of not-for-profits in delivering and financing health care is un-sound. You can’t run a health care system on a community-wide basis if you have only for-profits. Not-for-profit organizations step in to take care of the sick and the poor who can’t take care of themselves.

MC: What areas will the alliance focus on this year?
BERMAN: We’re planning to focus on governance. Getting governance right so that boards govern and managers manage provides the basis for getting everything else right. Well-governed organizations perform well. The collapse of the Allegheny health system in Pennsylvania a few years ago shows the costs of lax governance. Those costs are unaffordable and intolerable.

MC: How does governance need to be improved?
BERMAN: We’re looking at how to make governance more disciplined and rigorous, so that boards understand that their job is to do everything legally, morally, and ethically allowable to help management successfully pursue the enterprise’s mission. Boards have to monitor performance and provide oversight of performance, but not dip down into managing day-to-day operations. They have to be a protective shield for management.

MC: How good a job do you think state and federal governments are doing at acknowledging the not-for-profit sector’s job as the provider of last resort?
BERMAN: It’s important to remember that the not-for-profit sector is more than just a safety net or provider of last resort. It is also the provider of first resort. Some of the nations best hospitals, health systems, and health care plans are not-for-profit. The not-for-profit sector can compete to produce excellence rather than profits for investors. State and federal governments can do more by recognizing that not-for-profits that perform well need economically affordable access to capital. We almost have to rediscover where we were 60 years ago when the Hill-Burton programs provided access to capital for bricks and mortar for hospitals. Now we need access to capital for technology. Not-for-profits lack the access to capital that for-profits enjoy. That disadvantage cannot be allowed to continue.

"We recognize that being not-for-profit is no excuse for not having great performance."
MC: Would something like a federally guaranteed revolving loan program designed specifically to provide capital for health care investment in IT make sense?

BERMAN: A federal guarantee starts to make capital affordable, but we're a pluralistic society. After you've seen one community, you've seen one community. We need to test multiple approaches against each other and pursue the ones that work best. A set of workable ideas will emerge out of that cauldron. We should be clear on the goal but agnostic as to approaches. We can't let the perfect become the enemy of the pragmatic.

MC: To what degree has the trend of not-for-profit health plans converting to for-profit status run its course?

BERMAN: While I don't know that it is over, people are beginning to say, "Wait a second, what's the real promise here and what are we losing as a consequence?" It is incumbent on not-for-profits to make the cost of these conversions clear to the communities involved and to demonstrate that the not-for-profit organizational approach is in a community's long-run best interest.

MC: Your own company has consolidated several Blue Cross plans in upstate New York. How much consolidation makes sense and at what point do you lose a sense of each community and its unique needs and variables?

BERMAN: Our experience demonstrates that some consolidation is useful. It requires sensitivity to differently than some of the banks that have consolidated. We emphasized local decision-making. Using that model, you can consolidate significant geographic areas.

MC: But you would not like to see your company become the size of Anthem and operate in states across the country?

BERMAN: I obviously can't speak for Anthem. My view is that having a small presence in many regulatory environments is not as good as having a large presence and a clear responsibility in a few places. The places where not-for-profit hospitals, for example, have made a significant difference in their communities is clearly where those hospitals have identified with their communities and taken responsibility for the health status of that community.

MC: How would you change the way this nation pays for health care, through an employer-sponsored system with a significant government component through Medicare and Medicaid? I don't get the sense that you would support a one-size-fits-all national solution, but what steps need to be taken next?

BERMAN: I want to be clear that that's not an alliance issue, and that I don't speak for Lifetime Healthcare anymore either.

MC: Understood. What do you personally think as someone who has been a close observer of this question for your adult life?

BERMAN: To paraphrase H.L. Mencken, for every human problem there is a quick, simple, and wrong solution. Health care financing is a complex problem that requires sophisticated answers. We have to recognize that it's not just a matter of taking a quick swipe, making this change and all will be good. The key is evidence-based care. Consistently providing that kind of care will take hard, serious work, but we're moving in the right direction. The work that the Institute of Medicine is doing in quality and patient safety is moving us in that direction. The work that Don Berwick and his team at the Institute for Healthcare Improvement have done is moving in that direction.

MC: What do health plans have to do to be part of the solution?

BERMAN: Health plans have to reach down into their hearts and find the courage to emphasize that they

"Not-for-profits lack the access to capital that for-profits enjoy. That disadvantage cannot be allowed to continue."
will pay for evidence-based care. Health plans have to become more demanding in assuring that they pay only for evidence-based medicine that meets the best practice standard, and once that care is identified, they need to pay well for it. Paying a little for something that doesn't work gets us nowhere. Then plans have to pay providers in a way that shows they're rewarding efficient effective performance. Plans need the courage to manage care.

MC: How do you define that courage?

BERMAN: Plans need to be able to manage in both directions, with patients and employers, and with the health care provider community. Plans must assure that their customers get the right care at the right time in the right order. Since demand exceeds need, that sometimes requires saying to the pa-

of those damaged relationships, and every scar leaves me with a sense of opportunities lost. The focus on effective evidence-based care should not be a point of contention. Physicians should argue that the care half of the equation that only effective evidence-based care be provided. Instead of having contention between health plans and physicians over this issue, I would argue that the energy I could that physicians should be demanding nothing less of health plans.

MC: Don't you think that what you're seeing from physicians reflects how they felt burned by earlier efforts like utilization review and denial of care? How seriously broken is the trust between physicians and plans?

BERMAN: I don't think it is irreparable. The physician is worried about a patient, while the health plan is worried about a population. Both want to provide and pay for care that is proven effective. Health plans can't survive without physicians. They have to recognize that physicians who practice evidence-based medicine in a sensitive manner are one of the community's great assets. We must nurture, protect, and encourage that asset.

MC: A case can be made that health care has reached the point where physicians can't exist without health plans.

BERMAN: So the question is how to get past mutually assured destruction. And I think the mechanism is to focus on evidence-based care.

MC: What responsibilities do plans have?

BERMAN: First-day, first-dollar coverage has insulated people from the cost of care. Therefore, on a day-to-day basis, people don't value health care as highly as they should. If something's free, how much could it be worth? Consumers have to value health care services. To do this, consumers have to become realistically engaged in the cost of their care.

MC: What are some ways that we can achieve that goal?

BERMAN: There are multiple ways of making consumers aware. I don't want to say there's a single answer. For some consumers, large deductibles, such as those you have on your automobile or your home, may be the approach of choice. Others may prefer large deductibles with full coverage of preventive services but lower pre-
mimums. For others, the solution may be cost-sharing based on copayments.

**MC:** What's your opinion of medical savings accounts?

**BERMAN:** They're part of the solution.

**MC:** You don't worry about pulling the healthiest people out of the insurance pool?

**BERMAN:** When they use services, they'll come back in. Risk-averse people won't feel comfortable with medical savings accounts, so it's almost self-limiting in its design. A large segment of the population won't want to go in that direction. But let's presume I'm wrong and a large segment does go in that direction. In this case, after a transition period, everybody is in the pool again.

**MC:** So you don't see the problems in our health care system as something that will be solved as a result of a presidential election somewhere down the road, but through a number of small steps being taken by many people over time?

**BERMAN:** That's what I would forecast. We are not a nation that does revolution. We are a nation that embraces evolution. We're a nation that embraces morality and innovation. We are creative, imaginative, and remarkably hard working. Out of that chemistry will emerge solutions. It will only be when we look backward that we will be able to say, "Here's when and how it changed."

**MC:** Have you seen any milestones so far that offer hope?

**BERMAN:** The evolutionary movement by employers toward increased cost sharing with their employees will be seen as an economic movement to engage consumers more in the health care equation. But generally, at least for me, it's very difficult to see the watershed points. It's only when you look at them in retrospect, decades later.

**MC:** Why do you think that health care on the delivery side has been so slow to adopt good information technology?

**BERMAN:** When I've asked a similar question, the answer has started with the physician's golden rule: First, do no harm. Therefore, physicians proceed very slowly. Health care providers are trained to proceed in the way that their teachers were trained. It's one teacher passing on techniques and approaches to the next generation. There is an innate conservatism in the process. But I also think that medical education is changing. Just look at how quickly use of computers is increasing among this generation and succeeding generations of medical students. This change will make the next generation of doctors both far more demanding of information technology and more comfortable in using it.

**MC:** Thank you.

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