

Aetna Defends Its System For Rating Physicians

BY ALICIA AULT

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SAN FRANCISCO — Speaking at the insurance industry's annual meeting, an Aetna executive defended the company's performance-based physician networks, saying that they were a way to keep costs down and to let patients know which physicians offered the best and most cost-effective care.

Dr. Gerald Bishop, senior medical director for Aetna's West division, spoke at the AHIP Institute, at a conference sponsored by America's Health Insurance Plans.

Preferred provider networks have been the subject of legal challenges around the country, most recently in Massachusetts and Connecticut. Physicians have claimed that the networks use inappropriate methodology to rate their performance.

In 2007, New York Attorney General Andrew Cuomo struck a settlement with several insurers in which they agreed to publicly disclose rating methods and how much of the ratings is based on cost, and to retain an independent monitoring board to report on compliance. Aetna was one of the first insurers to sign on to that settlement, and has continued to comply, Dr. Bishop said.

He noted, for instance, that Aetna reviews and updates its provider list every 2 years and notifies each physician in writing if there has been any change in his or her status. Physicians have the opportunity to appeal if there is an error—before any data are made public, he said.

The company also encourages physicians to submit any relevant information from medical records if they have a question about the rating.

Aetna first began developing its Aexcel network in 2002, Dr. Bishop said. The goal was to mitigate rising costs, ensure

patient access to specialists, and find a way to recognize the variations in costs and practices in each individual market, he said. The company found that 12 specialties represented 70% of spending on specialists and 50% of the overall spending: cardiology, cardiothoracic surgery, gastroenterology, general surgery, neurology, neurosurgery, obstetrics/gynecology, orthopedics, otolaryngology, plastic surgery, urology, and vascular surgery.

When considering which physicians are eligible for the network, Aetna looks at the number of Aetna cases managed over a 3-year period (there was a 20-case minimum). The company also uses nationally recognized performance measures to gauge clinical performance. Physicians who score statistically significantly below their peers are excluded.

The company also uses the Episode Treatment Group methodology to evaluate 3 years of claims for cost and utilization patterns. A physician is considered efficient if his or her score is greater than the mean for that specialty and that market, Dr. Bishop said.

The Aexcel network now exists in 35 markets, covering 670,000 members. Aetna members in most, though not all, those areas can log onto a secure patient Web site and see costs for various procedures and information on why his or her physician has been designated a preferred provider in the network.

Dr. Bishop said that Aetna has determined that physicians in the Aexcel network typically perform 1%-8% more efficiently than their peers. Each client could save up to 4% of annual claim costs if all its covered workers used the network, he said.

Although some physicians have been unhappy with the designations, "amazingly few physicians balk at this," Dr. Bishop said. ■

Patient Charter Sets Ground Rules for Physician Ratings

BY MARY ELLEN SCHNEIDER

New York Bureau

Under an agreement among physicians, consumers, employers, and large insurers, some health plans have agreed to have their physician rating systems audited by independent experts.

The announcement comes after physicians around the country have questioned the methods used by health plans to produce the physician performance ratings for consumers.

Under the voluntary agreement, health plans would disclose their rating methods. In addition, physicians would have a chance to review their performance data and challenge it prior to publication.

"Having that transparency is a huge change," said Dr. Douglas Henley, executive vice president of the American Academy of Family Physicians, which is supporting the agreement, known as the Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs.

Giving physicians a chance to ensure that the data are accurate makes the process fair, he said.

It's also beneficial for consumers who will be able to better rely on the information provided by their health plan, Dr. Henley said.

The project was led by the Consumer-Purchaser Disclosure Project, a coalition of consumer, labor, and employer organizations that support publicly reported health performance information.

Other principles of the Patient Charter state that the measures should aim to assess whether care is safe, timely, effective, equitable, and patient centered. The measures used should also be based on national standards, preferably those endorsed by the National Quality Forum.

The principles of the Patient Charter do not apply to pure cost-comparison or shopping tools.

This agreement provides a foundation for physicians to build on, said Dr. David C. Dale, president of the American College of Physicians, another supporter.

Now when any health plan establishes a physician rating system, physicians can ask whether it is standardized and how it stacks up against the requirements of the Patient Charter, he said.

The Patient Charter also has the support of the American Medical Association, the American College of Cardiology, and the American College of Surgeons.

And some heavy hitters in the insurance industry have agreed to abide by the principles of the charter, including trade group America's Health Insurance Plans (AHIP), as well as Aetna, Cigna, UnitedHealthcare, and WellPoint.

Other health plans are likely to follow suit, said Susan Pisano, AHIP spokeswoman. Third-party review of rating systems and allowing physicians to review and challenge data before they become public will likely become the industry standard, she said.

"We believe strongly that consumers both want and need good information on health care quality," Ms. Pisano commented.

Now that the Patient Charter has laid down the ground rules for how clinical performance measures should be used, the next step is to ensure that physician ratings accurately reflect all the care given, because patients are generally scattered across multiple health plans. Ms. Pisano said the AHIP Foundation is studying how to aggregate data from across different plans to provide a full picture of physician quality. ■

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That, she said, is something grossly lacking in this country. People are simply not saving money, especially for health care needs, and they're in for a rude awakening as they reach retirement age. "Most people do not budget for health care, and they don't understand their cost-sharing levels. People do not understand that Medicare does not cover everything."

Many baby boomers and Gen Xers will not be able to retire comfortably because they have not saved any money to do so. According to research from the Employee Benefit Research Institute, a majority of near retirees has already spent 95% of their preretirement income. The majority of workers aged 45-55 years have less than \$50,000 in savings.

With copayments, pharmacy costs, and out-of-pocket expenses on the rise, even people with relatively generous health plans are finding that they still come up short. A Kaiser Family Foundation survey in 2006 showed that 29% of families re-

ported that one or more members had difficulty paying medical bills.

Doctors often bear the brunt of Americans' lack of planning for health care expenses, Ms. Bierbower said. In a Humana survey of consumer attitudes, researchers found that many Americans are quite willing to leave their physicians holding the bag, in the form of unpaid bills. "They tell us that health care providers are the last ones they will pay. They say things like, 'We know the doctor will take \$10 a month.' They perceive that doctors are rich and don't really need the money."

She added that people are much more inclined to ignore a doctor's bills than a hospital's, for the simple reason that hospitals tend to pursue their payments more aggressively and they can hurt peoples' credit ratings, something they perceive that individual doctors don't do.

"We have to work with our employees and consumers to change this attitude. Doctors need to get paid," Ms. Bierbower stressed.

She said Humana, and many other insurance carriers like Aetna, Well-Choice/WellPoint, UnitedHealth Group, Kaiser Permanente, and Great-West have begun offering health care lines of credit to help people cover their out of pocket expenses, copayments, or gaps in existing coverage. The line of credit strategy is also a good option in conjunction with HSAs,

to help cover sudden large expenses or as a stopgap in cases in which patients have exhausted their HSA savings.

Humana's line-of-credit card is activated at the time of need, and can only be used to pay credentialed health care providers. The charges are interest free for

6 months. "We're not trying to encourage more credit card debt," Ms. Bierbower said.

Advocates of HSAs and other forms of consumer-driven coverage say that one of the primary virtues of these plans is that they push the end-user of health care services to become more cost conscious, and presumably more judicious, in their health care choices. In practice, this seems to be borne out.

A McKinsey survey showed that people enrolled in HSAs or other consumer-driven plans were 50% more likely to ask about overall costs of health care services, and 100% more likely to ask about drug costs, compared with people in traditional health care plans.

Similarly, a Blue Cross Blue Shield Association study showed that 33% of HSA enrollees asked about prescription costs, compared with only 18% of enrollees in traditional plans. Of those in HSAs, 20% asked about the costs of physician visits, versus 14% of those who have traditional insurance. ■

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