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THE WALL STREET JOURNAL.
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HEALTH INDUSTRY | DECEMBER 12, 2011

# The Future of U.S. Health Care

*What Is a Hospital? An Insurer? Even a Doctor? All the Lines in the Industry Are Starting to Blur*

By ANNA WILDE MATHEWS

Call it the united state of health care.

Amid enormous pressure to cut costs, improve care and prepare for changes tied to the federal health-care overhaul, major players in the industry are staking out new ground, often blurring the lines between businesses that have traditionally been separate.

**Audio Slideshow: Health-Care Sea Change**

Under pressure to cut costs and prepare for the federal overhaul, the health industry is changing. Read about how the changes are playing out and listen to interviews.

**More photos and interactive graphics**

WSJ's Anna Mathews joins the News Hub to discuss the changing face of health care in the U.S. as a result of pressure to cut costs. AP Photo.

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**It Has All Been Tried Before, Experts Warn**

Hospitals are bulking up into huge systems, merging with one another and building extensive new doctor work forces. They are exploring insurance-like setups, including direct approaches to employers that cut out the health-plan middleman.

On the other side, insurers are buying health-care providers, or seeking to work with them on new cooperative deals and payment models that share the risks of health coverage. And employers are starting to take a far more active role in their workers' care.

Such shifts have been gathering force for a while, but the economic downturn has accelerated the push for efficiency. The federal legislation, which creates new health-insurance marketplaces and requires most people to carry coverage, may unleash additional demand for health care once it fully takes effect in 2014. Even if the Supreme Court unwinds part of the law, the changes occurring now aren't likely to stop because the pressure to reduce the price of health coverage won't go away.

"We're seeing a marketplace reacting to an economic imperative," says Michael O. Leavitt, a former U.S. Secretary of Health and Human Services who is now chairman of a health-information company. "The new delivery models are far more integrated."

The trends have crystallized over the past year in a series of high-profile deals and quiet, under-the-radar developments. For a close look at what they mean, here are snapshots of five people—a doctor, a hospital CEO, an insurance-company official, a human-resources executive and a patient—on the front lines as

much of the $2.6 trillion U.S. health-care industry tries to remake itself.

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Their stories show where health care is trying to go. The picture wouldn't be complete without a reminder of where it has been. Many of these same efforts were attempted in the 1990s, and they often failed. Experts caution that there are many signs the current flurry of activity could result in the same problems, with less margin for error in today's unforgiving economic environment.

## *Getting the Doctors On Board*

Ultimately, the success or failure of efforts to change the health-care system may hinge largely on doctors like Dan McCullough.

Channing Johnson for The Wall Street Journal

McCullough is on the front lines of efforts to increase preventive care and cut costs.

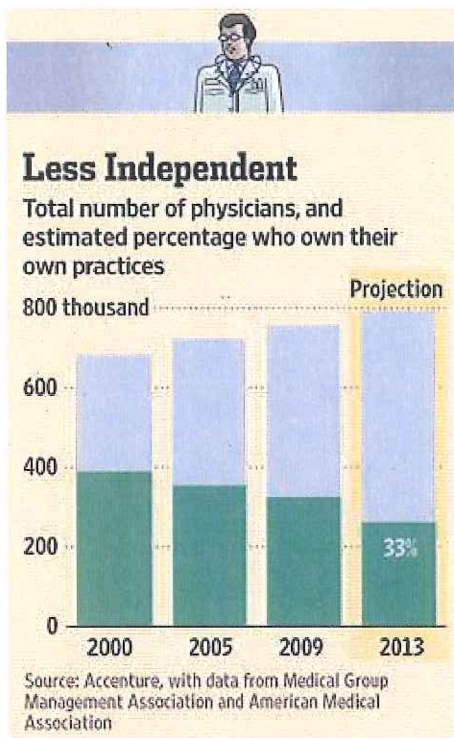
As a family physician, Dr. McCullough, who works for a hospital system in Beverly, Mass., is on the front lines of efforts by health-care providers and insurers to boost preventive care and rein in costs. Hospitals and insurers are both rushing to employ and ally with primary-care doctors in all of their new schemes to blend their various functions and integrate the health-care system.

But doctors, the gatekeepers of the system, often react sharply to efforts to control their practice styles. A survey this spring of medical administrators and doctors by health-staffing firm AMN Healthcare found that doctor and staff cooperation was the most frequently cited "serious obstacle" to creating accountable-care organizations.

In Dr. McCullough's case, around 28% of his pay for the fiscal year ended in September was tied to patient-satisfaction, quality and efficiency goals, a mix of his own results and those of the entire physician group affiliated with the hospital. The quality portion involves measures like patients' blood-pressure control and preventive care like mammograms. The efficiency part is tied to statistics including how often doctors refer patients to specialists outside the system and how often their patients go to the emergency room. But much of the rest of Dr. McCullough's pay is still tied to his productivity, a typical style of doctor compensation that parallels the traditional fee-for-service model.

Dr. McCullough's current pay structure took effect last year, when he started working under a contract with the state's biggest insurer, Blue Cross Blue Shield of Massachusetts, that enables providers to effectively earn more if they keep costs down and meet quality goals. Upping the ante, Dr. McCullough's employer, Northeast Health System, ties an additional chunk of his pay to quality and patient-satisfaction measures.

Dr. McCullough, 44 years old, says he likes the incentives. It used to be true that "quality doesn't pay the bills," he says. Now he focuses more on closely tracking the care of patients with chronic conditions, including hiring a new case manager. He says the new payment method also makes him think twice about allowing some services or specialty care from doctors outside his hospital's network. In the past, he "would just rubber-stamp the referral," he says."




Recently, he got a call from a doctor's office because one of his patients had gone there seeking surgery for chronic heartburn. Dr. McCullough refused to sign off. Instead, he called the patient and asked him to come in for an appointment. After he prescribed a stronger heartburn medication, the man, who had seen the surgery advertised, decided he no longer needed the procedure.

Peter and Maria Hoey

A doctor works for a hospital, paid partly on quality and efficiency measures.

Dr. McCullough, who has a master's degree in medical ethics, says he doesn't skimp on care that he believes will help patients. Indeed, many aren't even aware that his compensation has changed. Sometimes, though, patients question his motives. One woman wanted an ovarian-cancer test because a friend of hers had suffered from the disease, but Dr. McCullough refused to order it. The patient was "a little miffed," and she said "it's because the insurance company doesn't want to pay for it," Dr. McCullough says. He responded that there was no evidence she needed it. Still, he says, such encounters are "not the highlight of my day."

An older, recently widowed patient who kept going to the emergency room when he ran out of his asthma medication got a house call from Dr. McCullough, whose office then helped get the man into adult day care. The traditional fee-for-service model has no reward for that, he says. But "we got really aggressive with him not just because it's the right thing to do, but because we were incentivized to do it."

### *Mergers Help Hospital Bulk Up*

Jim Taylor, the chief executive of the University of Louisville Hospital, says his institution's future depends on an ambitious statewide merger with two other hospital systems. Now, he has to persuade others that he's right.

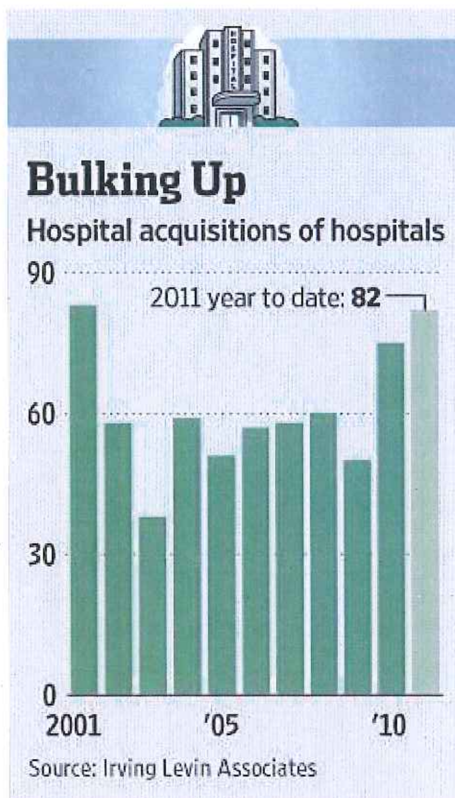
In June, Mr. Taylor helped unveil a plan to merge with nearby competitor Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System, an eight-hospital group based in Lexington, Ky., that is part of Catholic Health Initiatives of Englewood, Colo.

AJ Mast for The Wall Street Journal

Jim Taylor, the CEO of the University of Louisville Hospital, is working on a merger with two other hospitals.

If the deal is approved by the state's governor and the local Catholic archbishop, the nonprofit Catholic Health Initiatives will provide a $320 million infusion of cash and will hold 70% of the combined system. The merger would create Kentucky's biggest hospital network, with 14 facilities stretched across the state and $2.5 billion in annual revenue. It would also account for 22% of the acute-care beds in Louisville and 13% of those statewide.

Mr. Taylor says the money, along with the better bond rating the merged combination will get because of Catholic Health's backing, will provide a vital buttress for University Hospital. "We couldn't grow, and our role was going to decline as we face revenue pressures" from declining government reimbursement, says Mr. Taylor, 64, a second-generation hospital executive.




Mr. Taylor says University is in the black now but can't afford to buy advanced electronic medical records or upgrade and expand its main facility, built in 1980. University, which is the region's only adult trauma center and main safety-net hospital, is routinely overcrowded, particularly its emergency department, a spokesman says. Over the years, executives have drawn up plans to build a new $150 million patient tower and spend $33 million to expand emergency capacity, among other options, but had to shelve them. Mr. Taylor and other executives say the merger will achieve savings when duplicated functions are consolidated.

Nonprofit hospitals had their slowest revenue growth in at least two decades last year, according to Moody's Investors Service. The financial challenge is leading many to merge in hopes of cutting expenses and gaining leverage in negotiations with insurers. In the first three quarters of this year, there were 71 hospital mergers, compared with 53 at that point last year. The full number for 2010, 75, was already the highest since 2001.

Hospital deals can touch a nerve, because of the institutions' central economic and emotional position in their communities. Often, the debate centers around whether a for-profit company based elsewhere will continue to provide charity care and meet other local needs.

In Mr. Taylor's case, the controversy has mostly focused on whether University Hospital will be affected by Catholic care guidelines, which ban or restrict various reproductive procedures including abortion and sterilization. The buzz-saw of resistance has put Mr. Taylor in an unaccustomed spotlight after 15 years as the hospital's CEO. A community forum on the deal drew more than 200 questions. There are also dueling lawsuits over whether University Hospital merger documents are covered under state public-records laws.

Peter and Maria Hoey

A hospital tries to merge into a huge new system of hospitals and doctors.

"I don't think a hospital that belongs to the people of Kentucky should be merged and be dictated to by people who put restrictions on certain procedures," says Rep. Tom Burch, a Democrat who chairs the health and welfare committee in the state's House of Representatives. "It has hit a sore spot with people."

Mr. Taylor says the merger won't significantly affect service offerings at his hospital, which doesn't currently provide elective abortions. University Hospital has made arrangements for women who want tubal ligations to get them at a different facility, he says.

The new network will have more than 3,000 doctors. Though University Hospital doesn't employ its own physicians, the other two merger partners have significantly expanded their employed doctor staffs in recent years, including primary-care doctors, a common pattern in U.S. hospitals recently.

The new system will be able to integrate patients' care and to take on the financial risk tied to overseeing groups of patients, says Paul Edgett III, a Catholic Health Initiatives senior vice president. It will look at "warranty"-style payments, he said, under which a set sum is paid for an episode of care, including any complications. Such setups, under which hospitals can sometimes lose money if costs run too high, move hospitals into a space that has largely been the purview of health insurers.

Mr. Taylor said that on its own, his hospital is "poorly positioned" to do such deals, because it's "too small, too limited."

## *An Insurer Partners With Hospitals*

Negotiations between health insurers and hospitals typically focus on clashes over payment rates. Chris Day, an executive with Aetna Inc., is supposed to change that.

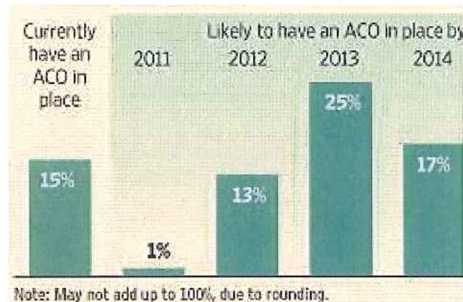
D.L. Anderson for The Wall Street Journal

Chris Day, Aetna Health Insurance

Mr. Day, 36, spearheads Aetna's efforts to create new cooperative deals with health-care providers. The details vary, but the main idea is that Aetna and the provider try to work together to trim costs and track the quality of care. In the most ambitious cases, they are creating jointly marketed health plans that effectively blur the line between insurer and provider.

Instead of Aetna simply paying the hospital for services, the two exchange patient data and may share the risk of coverage, acting more like an integrated company. These plans aim to leverage the hospital's local brand-name recognition and the insurer's back-office know-how.

They also may be the insurer's best shot at competing in many of the new state-based health-insurance marketplaces where some 24 million people are eventually expected to buy coverage. Chief Executive Mark Bertolini recently highlighted the new "HMOs on steroids" as a key Aetna initiative at an investor conference.




But after years of head-butting between the two industries, a warm-and-fuzzy partnership isn't always an easy sell. "When I walk in that room, I'm seen as a health-plan person," says Mr. Day, who estimates that he has met with more than 100 medical providers around the country. Sometimes he breaks the ice by referring to his own background, which includes running a sleep clinic and an early stint as a hospital data-entry clerk.

Aetna recently unveiled a jointly marketed health plan with Banner Health, a not-for-profit 23-hospital system based in Phoenix, Ariz., after more than a year of talks. At one point early on, Mr. Day had to keep some locally based Aetna executives out of key strategy meetings with Banner. After one of them raised the idea that Banner might need to grant some rate discounts, a Banner official suggested "we needed to find ways to keep the conversations strategic," Mr. Day says.

On the other side, Chuck Lehn, vice president of managed care for Banner Health, says Mr. Day earned his trust by sharing closely held information, including certain details of how the insurer sets premiums. Aetna also agreed it wouldn't build a guaranteed profit margin into providing administrative services for the new product, he says, though both sides will share its earnings.

"We shared a lot more information than we normally would" with an insurer, including detailed cost and utilization data, Mr. Lehn says. "I remember thinking, 'I'm putting my total trust and faith that they're not going to use this'" against Banner to winch down rates.

Peter and Maria Hoey

An insurer forges partnerships with health providers that can blur their traditional roles.

The two sides zeroed in on areas where they could potentially shave costs and improve care, such as relatively high use of imaging scans by some Banner doctors, Mr. Lehn says.

During a different effort to strike a deal with a provider, Mr. Day's talks broke down for months because a separate contract-rate negotiation between the hospital system and local Aetna executives got so contentious that details leaked to the local media. In another case, a mistrustful hospital executive demanded written pledges that his company's patient information wouldn't be used in setting the patients' insurance rates.

Like other insurers, Aetna is making moves into the business of providing services to providers partly to prepare for another change tied to the federal overhaul law. It requires health plans to spend a set share of premium dollars on health-care expenses, which can crimp insurance profits.

## *An Employer Gets Into Health Care*

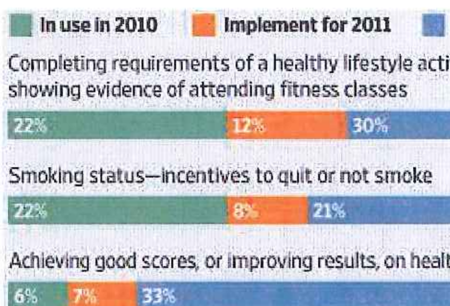
A few years ago, Robert Jacobs, a human-resources executive at MasterBrand Cabinets, felt he was running out of options to blunt annual double-digit health-coverage price increases. Employees had already shouldered as much as they could bear, he felt. He had hit the limit of discounts from health providers. Wellness programs like free health-club memberships had shown little impact.

AJ Mast for The Wall Street Journal

MasterBrand Cabinets ties its employee insurance contributions to their health risks. Pictured here, Robert Jacobs.

Then Mr. Jacobs read a research report that said about three-quarters of health costs are linked to lifestyle-related conditions. That persuaded him to try a radical new tack: Last year, MasterBrand, which has some 7,000 U.S. employees, started tying their insurance-premium contributions to their health-risk factors. Those who score poorly on measures such as cholesterol, blood pressure, body-mass index and tobacco use pay more each week.

"We had to do something more," Mr. Jacobs says. After wood and salaries, health care is the company's third-biggest expense, and "I can't pass that along to my customers in prices on kitchen cabinets."




The program at MasterBrand, a unit of Fortune Brands Home & Security Inc., is an example of companies' growing willingness to push workers toward better health, a role once left to health-care providers. MasterBrand, like others, offers the health tests right at the offices and factories where its employees work.

A survey this year by consulting firm Towers Watson and the National Business Group on Health found that 13% of U.S. employers are tying financial incentives to health outcomes like cholesterol-test results, and another 33%

plan to do so. Forty-three percent of the biggest employers are taking an even more direct path into health care by offering onsite clinics, according to a survey by Mercer.

Some of these efforts are controversial. In a letter to federal regulators in March, groups including the American Heart Association, the American Diabetes Association and the American Cancer Society's advocacy arm said such programs were backed by little evidence and risked discrimination against people based on their health.

Mr. Jacobs, a blunt-spoken 60-year-old who himself is managing elevated blood pressure, says he is giving employees accountability. "It's almost like going to a risk-based insurance like automotive," he says. "If you have a health risk you're not managing, you'll pay a little more."

Peter and Maria Hoey

An employer provides health tests and gives workers incentives to do well on them.

So far, MasterBrand hasn't set very stringent standards, he says. Also, the most a worker has to pay extra based on test results is $10.50 a week, while a person with the best health indicators gets a $2-a-week discount.

The program is administered by Bravo Wellness LLC, a vendor that oversees an appeals process that is supposed to let workers opt out without penalty or aim for alternative goals if they have a medical condition that makes it impossible to achieve the targets. Those who choose not to participate without a medical excuse pay an extra $37.50 a week in premiums.

Around a half-dozen workers got urgent calls after they took the health tests, warning they were in imminent danger of heart attacks, Mr. Jacobs says, and a couple had heart-related surgery.

He also points to employees like Sandra Kaufman, 47, who works in shipping at a MasterBrand facility in Goshen, Ind. She says she initially thought the program was "an invasion of my privacy." But she couldn't afford the penalty for refusing to participate, so before it launched two summers ago, she went to a doctor for the first time in years. When she learned she had high blood pressure, elevated cholesterol and diabetes, Ms. Kaufman started dieting and exercising, and she says she has lost about 50 pounds.

Mr. Jacobs says he fielded complaints when the program was started. One man asked him angrily, "Why are you doing this to us?" The worker didn't think the company should be imposing health standards. "That's personal," he said, according to Mr. Jacobs, who says he responded that MasterBrand had a stake as well, since it was paying around 80% of the cost of workers' health coverage.

The worker is now a "willing participant" in the program, Mr. Jacobs says.

### *A Patient Gets Care From His Insurer*

On a recent day, Louis E. Kauder Jr., an 86-year-old suffering from advanced diabetes, arrived at a storefront clinic in La Mirada, Calif., for his weekly checkup.

Nurse Eugenia Chang looked at his blood-sugar result and started quizzing him. What had he eaten? Mr. Kauder confessed to a dinner the night before of macaroni and cheese and chocolate chips. "Your sugar is a lot higher than normal," she chided, urging him to avoid desserts and eat more protein.

Dan Krauss for The Wall Street Journal

Then she zeroed in on his toe, which had a small sore. Was he wearing the protective shoes the clinic provided? She painted the toe with a disinfectant and wrapped it in gauze.

Finally, she examined a gaping six-inch-long wound on Mr. Kauder's left calf. That was improving, she said, and she would continue the daily home visits from a nurse to dress it.

Hospitals and doctors are increasingly promoting this type of health care – close, constant monitoring, with strong efforts to

Louis E. Kauder Jr., who has advanced diabetes, gets weekly checkups at a clinic run by Caremore Health Group, which takes an activist approach.

push preventive measures – as the best way to treat chronically sick patients.

But Mr. Kauder's clinic is different: It's owned by a health-insurance company, CareMore Health Group, that offers Medicare Advantage plans. CareMore says it can improve patients' health and save money in the long run by taking an active hand in their care.

**Year of Integration**

Insurers have recently been buying health-care providers.

| |
|---|
| **June 8** |
| **WellPoint** buys **CareMore Health Group**, a Medicare Advantage carrier and senior-health-care provider. Reported price less than **$800 million**. |
| **August 31** |
| **UnitedHealth Group's Optum** agrees to buy operations arm of **Monarch HealthCare**, a 2,300-doctor association in California. Terms weren't disclosed. |
| **October 24** |
| **Cigna** buys Medicare carrier **HealthSpring**, which works with doctors and owns clinics, for around **$3.8 billion**. |
| **November 1** |
| **Highmark** strikes final deal to acquire **West Penn Allegheny Health System**. Highmark will pump as much as **$475 million** into the hospital group. |
| **November 29** |
| **Humana** buys **SeniorBridge**, which provides care for complex chronic conditions. Terms weren't disclosed. |

Source: WSJ research

It's a bet that more insurers are making, hoping to trim costs and lock in some doctors in case the influx of newly insured consumers leads to a shortage. CareMore was bought in August for slightly less than $800 million by WellPoint Inc. The big insurer said it plans to more than double the number of "care centers" that CareMore operates and spread it across the country.

Last December, Humana Inc. spent $790 million for Concentra, an operator of urgent- and occupational-care clinics. And Humana late last month announced it would buy SeniorBridge, which focuses on care for complex chronic conditions.

UnitedHealth Group Inc.'s Optum health-services arm recently purchased the operations of Monarch HealthCare, an Irvine, Calif., association that includes some 2,300 doctors, the latest of several doctor groups in which the company has taken ownership stakes. Cigna Corp. announced in October that it would spend $3.8 billion to buy HealthSpring Inc., a Medicare Advantage carrier that works closely with doctors and owns some of its own clinics.

CareMore says the heavy upfront investment it makes in preventive care for patients like Mr. Kauder pays off because its members end up spending less time in the hospital than most traditional Medicare beneficiaries. They have fewer readmissions and lower rates of events like heart attacks, says the company's chief medical officer, Ken Kim.

A hospital stay can run $3,000 or more a day, Dr. Kim says. Amputation of a limb for a patient with advanced diabetes like Mr. Kauder can cost about $16,000, he says, and CareMore's amputation rate is about 60% lower than the average for traditional Medicare.

"We get to them at the front end" and keep medical conditions from worsening to catastrophic levels, he says. As a result, CareMore is more profitable than many rival Medicare plans, he adds.

Mr. Kauder started with CareMore last October. "They really take care of me," he says. He doesn't pay a premium for the CareMore Medicare Advantage plan, and he doesn't have out-of-pocket fees to see CareMore staff, though he does pay charges for some other things, like certain medications.

His case illustrates many of the challenges of managing chronically ill patients. After repeated medication tweaks and sessions with a nutritionist, Mr. Kauder's blood sugar level has improved, but it's still not at CareMore's target. The retired auto mechanic also has heart problems, and he had a bypass operation a few years ago.

A CareMore staffer asked a visiting wound-care nurse whether his home, where he lives alone, showed signs of neglect such as rotting food. On another occasion, when a visiting nurse spotted Mr. Kauder trying to clamber over a wall in his backyard, she informed clinic personnel. A case manager phoned Mr. Kauder to make sure he wasn't showing signs of dementia and booked him for an immediate checkup.

Still, Mr. Kauder's major leg lesion has lingered since February, a common circumstance for someone with advanced diabetes. It became infected, and his home-visit nurse started administering an intravenous antibiotic. In June, he ended up in the emergency room after he tripped and opened up the wound, which bled heavily. Doctors at the hospital urged him to consider amputating the limb below the knee.

"I said, no way," says Mr. Kauder, whose mother lost a leg to diabetes. After a night in the hospital, where CareMore doctors visited him, he returned home. Since then, he hasn't been in the hospital, and the wound has improved. He's off the IV antibiotic. The clinic tracks the wound's progress with weekly digital pictures.

Dr. Kim, the CareMore chief medical officer, who wasn't personally involved in Mr. Kauder's case, says the care almost certainly saved his leg.

**Write to** Anna Wilde Mathews at anna.mathews@wsj.com

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