Nightingale's Healthcare News

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inside

Editor's Note: To navigate *Nightingale's,* hyperlinks are provided for the above departments, the "continued on" jumps, and the "¤" mark at the end of articles. Websites and email addresses are also hyperlinked.

Now Tweet This

Healthcare Meets Social Media

by Lisa Jaffe Hubbell

When the first week of December turned unusually cold in the southwest, the morning tweets from Norman (OK) Regional Health System's tweeter in chief, Melissa Herron – usually a copy writer for the three-hospital group – covered such issues as staying warm and offered links to healthy soup recipes. Despite the fact that the hospitals in the system have a service area of less than 200,000, and that the three hospitals have fewer than 600 beds among them, Herron and her bosses have embraced a technology that just a few years ago was unknown to all but the hippest youths – indeed, they were the second hospital system in Oklahoma to adopt it and the first was from an even smaller town.

More and more healthcare organizations are starting to open Facebook and Twitter

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Healthcare Reform: Having it Both Ways

Quality and Cost Control Not Mutually Exclusive

by Steve Raphael

As the national healthcare reform debate rages over the tradeoff between healthcare costs and patient safety, efforts are quietly underway to find a balance between the two.

The Centers for Medicare and Medicaid Services (CMS) is sponsoring seven demonstration projects, labeled Value-Based Purchasing (VBP), with doctors, hospitals, and nursing homes. VBP reimburses healthcare providers for meeting quality and cost benchmarks. CMS wants to transform Medicare from a passive payer to an active purchaser of health care.

If the demonstration projects prove successful, it will pave the way for the private insurance industry to implement similar cost and quality programs, healthcare leaders predict. "That is exactly what we want to see," says Helen Darling, President of the Washington, D.C.-

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Four of Five Report Data Security Breaches

And the Fifth One Just Don't Know

by Lisa Jaffe Hubbell

When LogLogic came out in October with a survey of healthcare IT professionals and their opinions on health IT data security, it showed that four of five respondents said they had at least one data breach during the previous year. The study, done with the privacy and information management research company the Ponemon Institute, also found that patients may be even more at risk as the push for electronic health records accelerates at a rate faster than the limited supply of health IT professionals can secure them.

"Electronic Health Information at Risk: A Study of IT Practitioners" reported that along with those breaches, four percent had five or more such breaches. Other findings include:

- 70 percent say senior management does not view privacy and data security as a priority

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Now Tweet This, *from page 1*

accounts, using them to get the word out about their organizations, events, and key hires, as well as to monitor what others might be saying about them.

Ed Bennett of the University of Maryland Health System started a blog, Found in Cache, at his website, www.edbennet.org, about a year ago that looks at this phenomenon. "It took hospitals about five years after everyone else to figure out the web is here and important," Bennett says. "I saw social media as the next fundamental change in how people are using the net – as important as the Internet itself because this is how people interact with each other. We talk in networks and share information and have that dialogue."

Bennett keeps data on his blog that notes exactly what organizations are tweeting, blogging, and maintaining a presence on social networking sites like Facebook. Right now, about 10 percent of the industry is using some form of new media. Most of those are early adopters in just about any business or technological area – indeed the names of the Tweeters and bloggers and organizations involved sound familiar to anyone who follows healthcare: Paul Levy of Beth Israel Deaconess, who maintains a C-suite blog (http://runningahospital.blogspot.com), Lee Aase at Mayo, Scripps Health in San Diego, and Swedish and Virginia Mason in Seattle. The list is over 300 hospitals long for Twitter accounts, and 217 had YouTube channels at the end of November. There are more than 250 Facebook pages and more than 50 blogs. All in all, about 500 healthcare organizations are listed on Bennett's site – and he updates it regularly.

This is the first wave, according to Bennett, who, along with his blog and statistical research into social media in healthcare, still has a full-time position with the University of Maryland Health System. That first wave may subside someday, but the numbers look good so far. "The people who are here now are the ones who don't have to go through two years of committee meetings to get something done," he says.

But he isn't asking that every hospital or healthcare organization start blogging now. "You shouldn't do anything you aren't excited about. Paul Levy likes what he's doing and is good at it. He knows how to write a relevant post." It is easier to start with a YouTube account. "We did that here – we had a lot of video on our website and we had a cable TV show that our PR people did. We uploaded that and it's watched around 1,500 times a day." These aren't people looking for the health system he says, but rather people using YouTube to look up disease-specific information and finding the University of Maryland Health System there.

Start a fan page on Facebook next, says Bennett, and use Twitter as a tool for brand monitoring, crisis communication, and to build your reputation in a space. "We've had it up for a year, done through our web department, which is part of public affairs." Not that it has to come from PR. Bennett thinks that individual departments will eventually have their own presence apart from their hospitals' – the oncology department tweeting about mammograms or the emergency department writing about seminars for EMTs and emergency response workers. The things that used to go out in the mail – or even via email – will soon go out through social media.

Check out Bennett's website for links to some of the best tweeters, bloggers, and Facebook maintainers in the healthcare arena. One he particularly likes is Aase of Mayo, who has some 4,500 followers on Twitter and is in charge of a social media website that includes some great tutorials for those interested in moving in this direction (http://social-media-university-global.org).

Next month, *Nightingale's Healthcare News* will look at the benefits that some organizations have already seen from using social networking and new media as part of their community relations. ¤

Reform, *from page 1*

based Business Group on Health, representing more than 250 large employers.

Len Nichols, Director of the Health Policy Program for Washington, D.C.-based New America Foundation, says that Medicare and Medicaid can be "a catalyst for widespread efficiencies in the private sector."

As the nation's largest purchaser and payer of healthcare services, Medicare and Medicaid exert enormous influence on regulatory policies and help to shape the strategies of other payers, including private sector insurers. However, according to Nichols, "a Medicare-only reform effort would be far less productive than comprehensive delivery system reform that benefits all payers, patients, and providers that are willing to excel," although he adds, "Medicare can and should lead the way."

Stories abound of the additional cost burden the American public will be saddled with if healthcare reform is enacted. The Congressional Budget Office puts the price tag of pending Senate legislation at $848 billion, with the House version perhaps approaching one trillion dollars. Accounting giant Pricewaterhouse Coopers, in a study funded by America's Health Insurance Plans, says that if the government imposes new coverage mandates on the insurance industry while reducing its customer base, insurers will increase the premiums for families with existing coverage.

Healthcare reform will undoubtedly raise aggregate costs at first since whatever legislation is passed will expand coverage to a minimum of 96 percent of all Americans.

To pay for the expanded coverage, both the House and Senate bills contain revenue-generating measures, although there are some differences. Wealthy individuals would pay an income tax surcharge, and individuals would be required to buy insurance or face fines for non-compliance. Companies that don't provide their employees with insurance would be assessed penalties. Benefit-rich insurance coverage also would be taxed.

Although few doubt that the legislation will increase the aggregate cost of healthcare immediately, the hope is that costs can be driven down with a new payment structure derived from VBP and implemented by government and private insurers.

"There is no question in my mind about this. Lots of money will be saved," says Dr. Larry Casalino, a public health professor at the Weill Cornell Medical College in New York City. "How much is anyone's guess, but I suspect at least 10 percent of what expenditures would otherwise be. Quality would also be much better."

"The bottom line is that the status quo system of reimbursing hospitals is broken," adds Susan DeVore, President and CEO of Premier Inc., a national hospital quality measurement organization working with CMS.

With Premier, CMS kicked off the Health Quality Incentive Demonstration (HQID), one of seven VBP demonstrations, in 2003 and has since extended it to 2012 because of its encouraging findings. Currently more than 200 hospitals in 38 states participate.

HQID has served as a basis for CMS's proposal to Congress for a national VBP. The project has also been cited as a model for healthcare reform by the Senate Finance Committee.

HQID strives to improve the safety, quality, and efficiency of inpatient services by linking incentives to improve quality in five clinical areas: heart attack, coronary bypass graft, heart failure, pneumonia, and hip and knee replacement. Since the program's inception, patients are living longer and receiving recommended treatments more frequently, according to DeVore.

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Research Report

Who's Who in Warner Chilcott plc and Proctor & Gamble Company

by Francoise C. Arsenault

Warner Chilcott plc is a leading specialty pharmaceutical company currently focused on developing, manufacturing, marketing, and selling branded prescription pharmaceutical products in women's healthcare, gastroenterology, dermatology, and urology. Warner Chilcott manufactures and markets hormonal contraceptives, including Femcon FE, Loestrin, and Ovcon, and hormone therapies, including Estrace cream and femhrt, a continuous combined therapy for the treatment of menopause symptoms and the prevention of osteoporosis. In the area of dermatology, Warner Chilcott manufactures Doryx, an acne drug. The company, which is headquartered in Rockaway, New Jersey, and domiciled in Ireland, has manufacturing facilities in the United States, Puerto Rico, and Ireland. Warner Chilcott was founded in 1968 and has more than 1,200 employees, including a specialty sales force of more than 400 representatives, one of the largest sales forces devoted to women's healthcare and dermatology. In 2008, Warner Chilcott had sales of more than $938 million.

The Procter & Gamble Company (P&G) is a Fortune 500 American multi-national corporation headquartered in Cincinnati, Ohio. Founded in 1837, P&G is the world's leading manufacturer of household products. The company is divided into three global business units: Health and Well Being, Beauty Care, and Household Care. Twenty-four of P&G's brands have more than $1 billion dollars in net annual sales. P&G manufacturing operations are based in the United States, Canada, Mexico, Latin America, Europe, China, Africa, and Australia. The company had sales of approximately $79 billion in 2009 and has about 135,000 employees worldwide.

Under the terms of the transaction announced on August 24, 2009, Warner Chilcott agreed to acquire P&G's portfolio of branded pharmaceutical products for $3.1 billion in a deal financed entirely with debt. The acquisition included P&G's Asacol HD (mesalamine) Delayed-Release Tablets for ulcerative colitis, Actonel (risedronate sodium) for osteoporosis, and the co-promotion rights to Enablex (darifenacin) for the treatment of overactive bladder, as well as P&G's prescription drug product pipeline and manufacturing facilities in Puerto Rico and Germany. As a result of the acquisition, the majority of the 2,300 employees working on P&G's pharmaceuticals business transferred to Warner Chilcott.

For Warner Chilcott, the acquisition of P&G's pharmaceutical business expands its presence in existing specialty pharmaceutical markets and provides access to new physician offices in 14 countries. In addition, Warner Chilcott acquired P&G's pharmaceutical development capabilities and clinical pipeline, which is expected to broaden Warner Chilcott's product portfolio in future years. On a preliminary, unaudited basis, P&G's pharmaceuticals business had revenues of approximately $2.3 billion, and net income of approximately $540 million for the year ended June 30, 2009. Warner Chilcott financed the $3.1 billion acquisition with debt proceeds and senior secured debt facilities and a senior unsecured bridge facility received from a group of lenders.

Transaction Professionals

Roger M. Boissonneault is the CEO, President, and Director of Warner Chilcott. **Paul Herendeen** is Executive Vice President and CFO. **W. Carlton Reichel** is President, Pharmaceuticals. **Anthony D. Bruno** is Executive Vice President, Corporate Development. **Isumi Hara** is Senior Vice President, General Counsel, and Corporate Secretary.

Robert A. McDonald is the President, CEO, and a Director of Proctor & Gamble. **Jon R. Moeller** is the CFO. **Werner Geissler** is Vice Chairman of Global Operations. **Steven W. Jemison** is Chief Legal Officer and Secretary.

Davis Polk & Wardwell LLP served as the legal advisor to Warner Chilcott. **George R. "Gar" Bason, Jr.**, Chair of the firm's M&A practice, and corporate partner **Michael Davis** were assisted by finance partners **Michael P. Kaplan** and **Jason Krywood**; tax partner **Michael T. Mollerus**; benefits partner **Edmond T. FitzGerald**; and environmental partner **Gail A. Flesher**.

The U.K. law firm **Herbert Smith LLP** advised **Warner Chilcott** on the U.K. aspects of the acquisition. The Herbert Smith team was headed by partners **Alex Kay** and **Gareth Roberts**.

Covington & Burling LLP served as the legal advisor to P&G. **Scott F. Smith** and **Andrew W. Ment**, M&A partners in the New York office, led the team. Intellectual property partner **Andrea G. Reister**, regulatory partner **Grant H. Castle**, environmental partner **Corinne A. Goldstein**, IT partner **Albert L. Wells**, and employee benefits partner **Michael J. Francese** also worked on the acquisition. In the Covington & Burling London office, **Peter S. Cooke**, of counsel, provided employment advice.

The P&G in-house legal team working on the transaction included transaction specialists **Joseph A. Stegbauer**, a Director and Associate General Counsel for Global Transactions, and **Mary Pat McMahon**.

J.P. Morgan Securities Inc. served as the lead financial advisor to Warner Chilcott. **Jeffrey Stute**, co-head of North America Mergers & Acquisitions, worked on the deal.

Morgan Stanley & Co. Inc. also advised Warner Chilcott on financing and related issues. The Morgan Stanley team included **Peter N. Crnkovich**, Chairman of the Global Healthcare Industry Investment Banking Division, **Joseph Modisett**, Executive Director of the Investment Banking Division, **Whit Marshall**, a Managing Director, **Peter Zippelius**, a Vice President, and **Jeremy Gelber**.

Bank of America Merrill Lynch, Credit Suisse Securities (USA) LLC, **Barclays Capital**, and **Citigroup Global Markets Inc.** also advised Warner Chilcott and helped arrange financing.

Simpson Thacher & Bartlett LLP represented the financing providers and J.P. Morgan as financial advisor to Warner Chilcot. The team included partners **Arthur D. Robinson**, **John C. Ericson**, **L. Francis Huck**, **Peter J. Gordon**, **Robert E. Spatt**, **Robert E. Holo**, **Gregory T. Grogan**, and **Michael R. Isby**, senior counsel.

Goldman Sachs & Co. provided P&G with financial advisory services. The team was led by **Timothy J. Ingrassia**, the head of Goldman Sachs Mergers & Acquisitions in the Americas. ¤

Reform, *from page 2*

Based on the encouraging results of the six still-ongoing demonstrations, Medicare started a seventh program for nursing homes in July with 200 participating facilities in Arizona, New York, and Wisconsin. The demonstration runs through June 2012. To qualify for incentive payments, nursing homes must improve on or deliver quality care in four key areas: staffing, resident outcomes, avoidable hospitalizations, and reductions in the scope and severity of deficiency citations the homes may have received during past inspections.

Another VBP initiative looks at how incentives between hospitals and physicians can be better aligned to improve quality of care and overall hospital efficiency, and still another VBP pays participating physicians in small- to medium-sized practices double bonuses for submitting their claims using electronic medical records.

Cost control is the key issue for American business. "We definitely want national health reform to happen if the emphasis is on cost savings," Darling says.

Business is especially opposed to fee-for-service as "it does everything wrong," she adds. In its place, business is suggesting bundling payments to primary care doctors so they can coordinate care, using medical professionals working in their offices.

Darling says the private sector is trying to promote joint pilot programs between business and Medicare. "We don't know a lot about how [Medicare-type] programs work. Once we find what works, we want to see it work more successfully."

Nichols says there are other actions that can help lower costs like minimizing regulatory barriers to high-value health systems, adding loan forgiveness and other incentives to encourage more medical students to choose primary care specialties, and creating cost and quality data systems to better inform patient-clinician choices. ¤

Data Security Breaches, *from page 1*

- 53 percent say their organization fails to take appropriate steps to protect the privacy rights of patients; while less than half judge their existing security measures as "effective or very effective
- the average cost of a data breach, per patient record, exceeded $210 per compromised record, creating an opportunity for organized computer crime rings to traffic in stolen medical records

Survey respondents reported that the HIPAA rules, while not a perfect security solution, are a good start in improving the protection of electronic patient records. As the head of security of one of the West's largest hospital groups said in the survey response, "In the final rules for HIPAA, if you have a breach, you are by definition not compliant – none of the wishy-washiness of the original rules. This merges HIPAA privacy and security for the first time."

Bill Roth, Chief of Marketing at LogLogic, says that the fifth person who didn't report a single breach probably just doesn't know one has occurred. Many think that a breach only occurs when some Russian hacker tries to steal Social Security numbers. Rather, the bigger risks are internal and mundane – from lost laptops to stolen Blackberries, or employees who want to know what a famous personality is in the hospital for.

Mark Seward, the company's Director of Product Marketing, says that with a shortage of some 50,000 health IT people currently, it's possible that the problems stem from not having enough people, or enough of the right people in the right places to ensure such breaches don't occur. Another problem is the continued prevalence of paper in healthcare. "You need physical security for paper. That's not about worker shortages." Policies and procedures for paper records are lacking – that's why there are often stories about hospital dumpsters found full of old records that were supposed to be shredded. Electronic data is encrypted in transit. "I could get access and send the Octomom's sonogram to the *National Enquirer*, but if it was electronic, they couldn't use it. With paper records and a fax machine, what's to stop a janitor from going through the files looking for something interesting?" Seward asks.

That wasn't the only survey to set off alarms. The Health Information Management Systems Society (HIMSS) released a survey whose respondents say that health IT budgets don't include a whole lot of money for security – 60 pecent of them said their organizations spend just three percent of those funds for security purposes. Less than half have someone with title responsibility for data security, and fully a third said they had at least one instance of medical identity theft.

"There are always people who think it won't happen to them," says Harry B. Rhodes, Director of Practice Leadership at the American Health Information Management Association. "They may or may not invest the time and money needed."

Another survey by the California Department of Public Health reports 100 percent of respondents audit their security systems. "They audit firewalls, but what people are reporting is mostly internal, not external," Rhodes says. "There were only five breaches attributed to hackers in that study," he says. "That's what we're spending our resources on. But there were 127 instances of stolen equipment, including 99 laptops, a Blackberry, and three memory sticks."

The audits, by the way, are only electronic a quarter of the time according to the HIMSS survey. The rest of them are looking manually through paper to see if they can spot something fishy, says Rhodes. "That concerns me, that and the lack of ownership for the task. If you don't have someone who is the top security officer, then whose job is it? How far down the list is that security audit anyway?"

People have to start thinking beyond hackers, Rhodes says. "People forget about insurance cards when they are stolen – they have a limit of millions of dollars on them. So imagine if someone steals paper files with a whole bunch of medical ID numbers?"

Other tips from Rhodes:

- Do formal risk assessments, make it annual, and follow up on it. If you find a risk issue, don't wait a year to deal with it.
- When you give someone access to a system, keep a log of it. "Keep track of who has access to what systems. If there are a group of related tasks, like filing, processing, and depositing a claim, don't give it all to one person. The person who submits, processes, and deposits shouldn't be the same person."
- Keep track of access. If someone works remotely and is eventually terminated or leaves the company, make sure they no longer have access to the system from home. Rhodes says often people in data security don't know someone is leaving until the going-away party, and they may not know why someone is leaving. "You don't know if they are sitting in the living room traipsing through your network or not. Shut them down before they leave." Similarly, keep track of people as they move through an organization. They may be promoted over the years and eventually have access to the entire organization. "If someone gets disgruntled, you may have a problem."
- Know what people do. "Ask questions, ask what people are doing. If no one is paying attention, then you can have real problems."
- Don't forget about the basics. Rhodes tells the story of when his office was near a doctors' lounge which housed a whole slew of CPUs. It was at the end of a hall, near a door to the parking lot. One day he heard a tremendous crash. Someone was trying to steal the equipment and hightail it out of the building. Happily, Rhodes had talked the organization into buying cables to lock the units down. The giant noise was the cables preventing the would-be thief from getting out the door. ¤

Special Report

Selected Healthcare Market Research Firms

Firm	Management	Services	Clients
3d Health, Inc. Chicago, IL (312) 423-2670 www.3dhealthinc.com	M. Shane Foreman Richard Paulk Jon Geise	Outpatient Strategy, Imaging Strategy, Medical Staff Development, Physician Alignment, Hospital-Physician Joint Ventures, Outsourced Analytics	Hospitals, Health Systems, Physician Groups, Entrepreneurs
Active Imagination Healthcare Marketing Houston, TX (713) 528-6100 www.marketingforhealthcare.com	Adam Nisenson Beryt Nisenson Tuong Ngo	Brand/Product Positioning, Strategic Planning, Concept Development, Campaigns, Product/Corporate Naming, Consulting/Media Planning Using Print and Interactive Media	Hospital Systems, Specialty Clinics, Physician Groups, Medical Equipment Companies, Health-focused Media, Educational Institutions
Cooper Research Cincinnati, OH (513) 489-8838 www.cooper-research.com	Ronald Garner Michael Jones Lyn Kummer Robert Miller	Perceptual Mapping, Pricing Studies, Image and Attitude Studies, Segmentation Research, Tracking Research, Customer Satisfaction Studies, Employee Retention Programs	Healthcare Systems, Health Plans and Insurance Companies, Medical Device and Equipment Companies, Non-Profits, Pharmaceutical Companies
Franklin Street Marketing Richmond, VA (800) 644-8555 www.franklinstreet.com	William Flynn Stephen Moegling Tim Roberts	Communications Audit, Marketing Blueprint, Brand Development, Service Line Plans, Vital Sign Assessment, Interactive Development	Hospitals, Health Systems, Medical Centers, Healthcare-Related Businesses
Hammond Hill Acton, MA (978) 266-9466 www.hammondhill.com	Stephen Herskovitz Malcolm Crystal Susan Baltrus Wynelle Evans Eugene Lee	Branding and Positioning, Marketing, Market Research and Analysis, Marketing Communications, Strategic Planning, Managed Care	Hospitals, Health Systems, Managed Care, Pharmaceuticals/Biopharmaceuticals, Medical Devices/Diagnostics, E-Health
Market Strategies International Livonia, MI (734) 542-7600 www.marketstrategies.com	Andrew Morrison Janice Brown Reginald Baker Peter Carlin	Brand Development and Management, Message Testing, Market Opportunity Assessment, Customer Satisfaction, Advanced Analytics, Research Services, Online Research, Syndicated Services	Hospitals and Healthcare Systems, Healthcare Providers, Health Insurers, Healthcare Infrastructure Organizations, Traditional/Specialty Pharmaceuticals
McManis Consulting Greenwood Village, CO (720) 529-2110 www.mcmanisconsulting.com	Keith Moore Deirdre Byrne Don Arnwine John Misener Dave Stephens	Strategy Development, Market Research/Positioning, Governance, Relationship Management, Performance Enhancement, Finance	Hospitals, Health Systems, Medical Groups, Health Plans, Long-Term Care Providers, Specialty Providers, Healthcare Associations, Vendors to Healthcare Industry
Market Street Research Northhampton, MA (413) 584-0465 www.marketstreetresearch.com	Julie Pokela Lou Davis Elizabeth Denny Ingrid Steblea Roger Kazakiewich	Awareness and Image Studies, Market Feasibility and Competitive Intelligence, Product Testing and Pricing Research, Market Segmentation, Purchase Decision Dynamics, Customer & Employee Satisfaction Studies	Health Systems, Community/Teaching/Acute Care Hospitals, Medical Centers, Pharmaceutical Companies, Physician Practices, Mental Healthcare Organizations and Treatment Facilities
Reynolds & Company New York, NY (212) 826-1818 www.jxreynolds.com	Jim Reynolds Joel Rabin Michelle Monroe	Corporate and Business Unit Strategies, Financial Planning and Modeling, Clinical Product Line Development, Aligning with Physicians, Turnarounds & Restructurings, Mergers, Acquisitions, and Networking	Hospitals, Health Systems, Healthcare Associations and Organizations, Specialty Providers
The HSM Group Scottsdale, AZ (480) 947-8078 www.hsmgroup.com	Sheryl Bronkesh Stephen Brown Joan Cihak Ariella LaBell	Research, Economic Models, Strategic Marketing and Planning, Staff Development, Product Development and Marketing, Provider Relations, Hospital and Network Development	Hospitals and Health Systems, Healthcare Trade Associations, MCOs, Pharmaceutical Manufacturers, Medical Product Manufacturers
The Roberts Group Waukesha, WI (262) 549-6848 www.therobertsgroup.com	Barbara W. Thompson Mark A. Thompson Lori Bruss Tom Ketterhagen Heather Mangold	Strategic Planning, Market Assessments, Market Research, Communications Audit, Marketing and Communications Plans, Strategic Writing, Media, Public Relations, Issues Management	Health Systems, Physician Groups, Long-Term Care Facilities, Healthcare-related Companies Across the Industry
Turning Point Healthcare Advisors, Inc. Denver, CO (303) 752-1010 www.tpadvisors.net	Beverly Schulman Dennis Wilson Jaren Wilson Joyce Miller	Facility Planning and Development, Financial Analysis and Turnaround, Medical Staff Development Planning, Program and Service Development, Strategic Planning and Positioning, Partnerships and Affiliations, Operations Improvement	Hospitals, Health Systems, Medical Centers, Related Healthcare Organizations

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Worth Reading

Health Plan – The Practical Solution to the Soaring Cost of Medical Care

Author: Alain C. Enthoven

Publisher: Beard Books

Softcover: 211 pages

Price: $34.95

Review by Henry Berry

Since this book was first published in 1980, the problem it tackles – the high cost of medical care in this country – has become an even more vexing national problem. No one is more qualified to take on this subject than the author. In 1997, the governor of California appointed Enthoven to be chairman of the state's Managed Health Care Improvement Task Force. Enthoven also consults for the leading healthcare provider Kaiser Permanente, and holds leadership positions in several private and public healthcare organizations.

The main causes of runaway medical costs, which were identified by Enthoven in 1980, continue today. Among the causes are the growth of medical technology, an aging population, and the proliferation of physician specialists. Lax cost controls by health maintenance organizations and government health agencies are another cause.

Unlike many other critics, Enthoven does not advocate free-market practices in the healthcare field. He offers an approach that is more knowledgeable, nuanced, and practical. The author searches for the elusive goal of formulating a health plan that takes into account the altruistic desires of U.S. society to address the needs of all its members, while also accepting the reality of government regulation, a profit-driven industry, and a population with varied healthcare needs and objectives.

Enthoven names his comprehensive health plan the Consumer Choice Health Plan. The Consumer Choice Health Plan is ambitious and far-reaching, especially considering the inertia of the present healthcare system and its layers upon layers of vested interests.

Nonetheless, the author states that his plan is within reach and sustainable because it "function[s] with existing institutions operating in new ways." While healthcare delivery would be kept fully in the private sector, the government would have a formative role by managing the enrollment of organizations and companies in the plan on the basis of compliance with "a system of rules designed to foster socially desirable competition." Government would also help individuals take part in such a plan by offering tax credits and vouchers "based on both financial need and predicted medical need."

As the book progresses, one begins to see how the Consumer Choice Health Plan synthesizes and employs in novel ways parts of the healthcare system as it presently operates. Besides the formative role of government, the plan would involve "fair economic competition, multiple choice, [and] private underwriting and management."

Enthoven's Consumer Choice Health Plan is not radical. It calls for altering relationships among existing components of the health system, giving them new roles and purposes. The plan does propose one sweeping, though not radical, change, which is to "shift the basis for healthcare financing from experience-related insurance serving employee groups to community-rated financing and delivery plans open to all eligible persons in a market area." By shifting the financing of healthcare, providers and consumers are brought into close, and often direct, contact. To protect consumers from fraudulent and inferior health plans, the government would play a primary role in establishing enrollment standards and policies. The different health plans would compete among the respective consumer groups according to the main qualification that they be engaged in "socially desirable competition." Thus, the health plans that would be available in any market would operate much like branches of today's corporate health providers.

The government's role, then, would primarily lie in exercising oversight and enforcement responsibilities. The result would be a field of screened health providers offering health plans in a defined community/market. The most successful providers would be those offering the best services and prices.

As reasonable as Enthoven's recommendations are, he realizes that they cannot be applied immediately. Consequently, the author also offers a series of steps, some of which are options, that assist in fully implementing the plan. Among these steps are requiring employers to provide employees choices in medical plans, allowing tax credits for employers and employees for those plans offering good basic care (rather than more costly health plans), and working with influential government officials to reach the goal of the Consumer Choice Health Plan.

Some of Enthoven's recommendations have been introduced to areas of the healthcare system, and have achieved demonstrable, though limited, improvements. Many of his recommendations have been embraced by legislators and policymakers as requisites for a workable national health plan. Anyone wishing to have a relevant, productive role in devising such a plan will want to take this book to heart. ¤

Alan C. Enthoven's career spans more than 40 years in the public and private sectors, where he has held many top positions. During this time, he has been chairman and director of major healthcare organizations, and he continues to work to bring positive changes to the healthcare system.

Special Report

Outstanding Healthcare Antitrust Lawyers – 2009

Attorney	Firm	Outstanding Achievements
Mark Botti	Akin Gump Strauss Hauer & Feld Washington, DC Tel. (202) 887-4202 mbotti@akingump.com	Advised the AHA, Assn. of Health Insurance Plans, Pharmaceutical Mfrs. Assn., AdvaMed, and AMA on avoidance of antitrust issues. Represented Idaho Orthopedist Society and numerous Idaho orthopedists in defending a DOJ and Idaho Attorney General antitrust investigation. Represented UnitedHealthcare in successful antitrust review by DOJ of its acquisition of the New England health plan business of Health Net.
Christi J. Braun	Ober|Kaler Washington, DC Tel. (202) 326-5046 cjbraun@ober.com	Represents physicians, hospitals, ancillary care providers, trade associations and insurers in all phases of investigation and litigation arising from antitrust claims and other civil statutes. Obtained a favorable FTC advisory opinion for TriState Health Partners regarding proposed clinical integration program. Successfuly represented defendant on plaintiffs' appeal in *Little Rock Cardiology Clinic, et al. v. Baptist Health, et al.*
Debra H. Dermody	Reed Smith Pittsburgh, PA Tel. (412) 288-3302 ddermody@reedsmith.com	Representing Meridian Health System, Bayshore Community Health Services, and Southern Ocean County Health System in pending mergers. Providing antitrust counseling on DOJ's involvement in a trade group of orthopedic manufacturers. Counseling physician groups in negotiating a consent decree with FTC. Advising a health plan on antitrust issues in provider negotiations and relationships.
Lisa Jose Fales	Venable Washington, DC Tel. (202) 344-4349 ljfales@Venable.com	Recent accomplishments include representing a large healthcare provider and insurer in connection with an ongoing DOJ investigation alleging Sherman Act violations, defending an international pharmaceutical company in multiple FTC investigations for alleged antitrust violations involving patent litigation settlements, and defending the company in related private class action antitrust lawsuits.
Mark Lutes	EpsteinBeckerGreen Washington, DC Tel. (202) 861-3524 mlutes@ebglaw.com	Defended Carilion Clinic's acquisitions of an imaging center and ASC. Engaged after acquisitions produced high-profile FTC investigation. Represented competitors of hospital system alleged to have engaged in broad monopolizing conduct. Represented Qualitest, the nation's fifth largest generic pharmaceutical manufacturer, in context of major generic acquisition (Teva acquisition of Barr).
Leigh L. Oliver	Hogan & Hartson Washington, DC Tel. (202) 637-3648 loliver@hhlaw.com	Represented major health insurer in sale of pharmacy benefit management business. Counseled joint venture partner and shared drug licensor in acquisition of certain remaining interests of its licensing partner. Counseled hospital system in sale of certain member hospitals. Advised health insurer on potential strategic acquisitions and developments related to legislation to repeal the McCarren-Ferguson Act.
Leslie C. Overton	Jones Day Washington, D.C. Tel. (202) 879-4688 lcoverton@jonesday.com	Representative public matters include acting as transaction and antitrust counsel for Loyola University Health System in $90 million acquisition of Gottlieb Memorial Hospital, and providing antitrust advice to Blue Cross Blue Shield of Michigan in its acquisition of M-CARE, a health plan owned by the University of Michigan. DOJ ultimately cleared the transaction without issuing a Second Request.
Karen Silverman	Latham & Watkins San Francisco, CA Tel. (415) 391-0600 karen.silverman@lw.com	Representing Ovation Pharmaceuticals, now Lundbeck Inc., in antitrust lawsuits filed by the FTC and the State of Minnesota challenging acquisition of exclusive license to manufacturer and sell NeoProfen in the U.S. Representing California hospitals owned by Adventist Health in class action alleging conspiracy to suppress wages for nurses and respiratory care practitioners in violation of California antitrust law.
Bruce Sokler	Mintz Levin Washington, DC Tel. (202) 434-7303 bsokler@mintz.com	Antitrust counsel to CVS Corp. (now CVS Caremark) since 1986. Over the past year, served as the company's lead counsel in connection with FTC antitrust investigation into company's practices stemming from merger of CVS and Caremark. Representing Elliott Hospital, Manchester, NH, in connection with FTC review and investigation into acquisition of Catholic Hospital Center by Dartmouth-Mary Hitchcock.
Scott Stempel	Morgan, Lewis & Bockius Washington, DC Tel. (202) 739-5211 sstempel@morganlewis.com	Led team that successfully represented Pfizer in FTC's investigation of the company's $68 billion acquisition of Wyeth. The Commission voted unanimously to approve the deal, which was one of the most complex ever approved. With this transaction, has represented clients in two of the four largest pharmaceutical M&A transactions and two of the ten largest transactions of any type since 2000.
Christine White	Crowell & Moring Washington, DC Tel. (202) 624-2500 cwhite@crowell.com	Led team in responding to: multiple non-public civil investigative demands issued by state and federal antitrust enforcers; multiple non-public voluntary request letters issued by the federal antitrust agencies in connection with pre-merger filing notifications; an in rem proceeding instituted by the FDA. Represented several clients with regard to early investigations into proposed mergers and other third-party conduct.
Jane E. Willis	Ropes & Gray Boston, MA Tel. (617) 951-7603 jane.willis@ropesgray.com	Lead counsel for hospital system in connection with trade association activity allegedly causing nurse wage suppression, and healthcare company bringing claims against manager of senior living communities; successful representation of hospitals on affiliations, guiding clients through the FTC and state attorney general processes, and state department of public health approvals.

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In Focus

Leerink Swann

Founded in Boston in 1995, Leerink Swann provides investment banking, institutional sales and trading, equity research, advisory services, and private and corporate client services for the healthcare industry. A private company with around 200 professionals, it had estimated revenues in 2008 of $27.7 million according to Hoovers.

Among its knowledge assets is MEDACorp, a subsidiary of 35,000 experts, researchers, and specialists who are on hand to assist clients with technological and treatment issues, while Leerink Swann itself handles financial and transactional business. Together, the groups put on regular roundtable conferences to spotlight healthcare and bioscience breakthroughs and bring participants together with hedge funds, venture capitalists, and institutional investors.

As a healthcare specialist, Leerink Swann boasts a depth of knowledge it says other investment banks can't match and assists the firm in initiating strategic deals between companies or appropriate investors for clients. It helps private companies raise capital in private markets, using institutional and individual debt and equity sources. The company also underwrites both initial public and follow-on offerings and structures, places private investment in public equity and registered direct offerings, and guides it cliens in mergers and acquisitions, sales and purchases, joint ventures, and divestitures.

Since its founding, the banking team has executed over 200 M&A transactions, valued at more than $400 billion. The recession, however, appears to have had an effect. While in 2008 the company listed 18 transactions valued at over a billion dollars, only eight are listed from January through October 2009. Among those more recent – worth about $600 million – are a deal worth nearly $200 million with AGA Medical, and a $130 million sale of Sapphire Therapeutics to Helsinn. The company also lists several follow-on offerings with companies like MAKO Surgical, MAP Pharmaceuticals, and Momenta.

Leading his namesake company as Chairman and CEO is **Jeffrey Leerink**. He created the company as the first independent healthcare research firm providing investors with direct access to analysts, physicians, and medical professionals. In 1999, the firm ranked 30th in *Inc.* magazine's "America's 500 Fastest-Growing Private Companies." Each year since 2001, the company has been named Best of the Boutiques in a variety of healthcare categories by *Institutional Investor*. Leerink is on several health-related boards of directors, including Harvard Medical School.

Other key personnel include:

- **Daniel B. Dubin** – Vice Chairman of Leerink Swann and Founder of MEDACorp, Dubin is also a member of the management committee and chairman of the commitment committee for the firm. Formerly an instructor in Dermatology at Harvard Medical School, he has also held appointments at the Brigham and Women's Hospital and Dana Farber Cancer Institute.
- **James Boylan** – Boylan joined Leerink Swann this year as Senior Managing Director and Head of Investment Banking. Previously he was at Merrill Lynch for 12 years, where he worked as a healthcare origination banker and an M&A specialist. He has completed more than 80 transactions, including advising Celgene on its acquisition of Pharmion and the sale of Lifecell to Kinetic Concepts.
- **Brent Clough** – Clough also came to the company this year as Senior Managing Director and Head of MEDACorp. Previously he was President and CEO of IntrinsiQ, an oncology software and data analytics firm. Clough also put in time at Goldman Sachs in its investment research and electronic trading group. Previously, he spent eight years with First Call Corporation, eventually rising to the position of Managing Director of the Broker Dealer Division.
- **Joseph Gentile** – Chief Administration Officer Gentile joined the company in 2007. Previously, he was Chief Financial Officer of the Global Investment Bank at Lehman Brothers where he directed the accounting and financial needs within the Fixed Income Division, the largest operating division of Lehman Brothers. Prior to that, he served as CFO of the Global Corporate and Investment Bank at Bank of America, and spent more than 10 years with JP Morgan
- **Timothy A.G. Gerhold** – Gerhold has been General Counsel and Senior Managing Director of the Compliance Group since joining Leerink in 2006. His previous experience includes stints with BancBoston Capital, BankBoston Financial Corporation, and with the law firm of Goodwin Proctor LLP.
- **Michael Jenkins** – Senior Managing Director and Head of Strategic Advisors, Jenkins came to the company in 2008.Prior to joining Leerink Swann, Jenkins was a partner with Marakon Associates, where he served clients in healthcare and financial services for more than 15 years, and most recently led the firm's private equity practice.
- **John McPhee** – Managing Director and Head of the Private Client Group, McPhee joined the company at its inception. He was named to his current position in 2004 and in 2006 launched the middle market sales effort at Leerink Swann.
- **Stephen Weiss** – Senior Managing Director and Head of Institutional Equities, Weiss spent 20 years on Wall Street, including time at Lehman Brothers, Oppenheimer & Company, and Salomon Brothers.
- **Yoori Lee** – As Managing Director and Director of MEDACorp Services, Lee oversees the development and strategy of MEDACorp's products for Leerink Swann's clients. Lee was instrumental in building the MEDACorp network of consultants from its inception and has expanded the consultant base to more than 35,000 healthcare professionals.
- **Rene Mora** – Mora has served as Chief Scientific Officer for MEDACorp/Leerink Swann since 2000. He is responsible for all MEDACorp events and publications, including the Physician Conference Series, Innovation Series, Future in Focus and Regulatory Insights. He also structures proprietary research projects for a broad range of clients including public and private investors. Board certified in internal medicine and pulmonary and critical care medicine, Mora previously served as Director of the Medical Intensive Care Unit at Beth Israel Deaconess Medical Center in Boston, Associate Physician and Member of the Partners Asthma Center and Brigham and Women's Hospital in Boston, and Instructor in Medicine at Harvard Medical School.

Leerink Swann's website is www.leerink.com. ¤

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