



WellNetSource

Innovation for a Healthier Work Force

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Welcome to WellNet Source

This quarterly newsletter will feature news about WellNet, as well as other trends in the medical-benefit sector inclusive of interviews with WellNet executives and advice from industry experts. For our existing clients, we welcome feedback on WellNet Source, and please feel free to share the newsletter with your colleagues.

For prospective clients, we hope that WellNet Source provides you with some insights into our company's strategy that significantly lowers health-plan costs, and also gives you some useful information about the business of health care as you navigate the medical-benefit community.

How to Control

Point to Point Healthcare Unveiled



> To address escalating health-care cost increases, benefit plan sponsors increasingly are searching for new ways to improve plan management and reduce expenses. A new technology now links all key players in the health-care system on a single platform, allowing plan sponsors to play a significant and proactive position in managing their medical benefits. This results in plan sponsors saving hundreds of thousands to millions of dollars.

Point to Point Healthcare, a game-changing new tool for the health-care field launched by Healthcare Interactive and WellNet Healthcare, enables employers to take an active role in developing strategies to lower costs and improve the value of benefits for their members.

The innovative Point to Point technology and administrative platform will transform the U.S. health-care system by allowing all key parties in the system – health plans, insurers, employers, providers and individuals – to navigate the system on a single platform that delivers a comprehensive medical file and social network to users, not just information on an electronic health record.

Designed to eliminate rampant waste and excessive medical-benefit costs, Point to Point combines an individual's comprehensive Web-based medical profile with a health-care social network that allows individuals to collect and exchange information with all their providers so they can make more informed health-care decisions and save money.

Clearly, plan sponsors are rethinking their responses to chronic diseases, which are the root problem of escalating health-care costs.

Using Point to Point's HIPAA-compliant software platform, plan sponsors receive pharmacy and medical claims information on their computers and, once there, evaluate this data using predictive-modeling technology, while keeping patients' identities private.

This enables plan sponsors to more effectively design and manage medical benefits. At the same time, providers and insurers are better able to coordinate health care with patients. Employees lead healthier lives by managing their chronic conditions, and plan sponsors drastically reduce their health-care costs.



The only way to **measure and manage** medical benefits is with credible data, and Point to Point provides an avenue for collecting and analyzing this critical information. It's a **common sense** business approach to **slashing expenses** and getting people healthier.

Health COSTS

“Point to Point will, without question, revolutionize the health care industry,” says Henry Cha, president of Healthcare Interactive, a Glenwood, Md.-based software company that developed the program.

WellNet Healthcare, a data analysis and health management company based in Bethesda, Md., is the majority investor in Healthcare Interactive, and its clients across the country are Healthcare Interactive's first customer base to use Point to Point.

“We all see multiple doctors, but everyone is working in silos. Information is difficult to obtain and often not shared,” Cha says. “The only way to measure and manage medical benefits is with credible data, and Point to Point provides an avenue for collecting and analyzing this critical information. It's a common sense business approach to slashing expenses and getting people healthier.”

While other companies such as Google and Microsoft offer Web-based electronic health records, Point to Point is different because it allows all key stakeholders to exchange vital data in one secure, HIPAA-compliant workspace. This type of connectivity is essential to more effectively coordinate care, significantly improve individual patient health, reduce overall medical claims and lower administrative costs.

The Point to Point network seamlessly links patients to, among other things, their medical records, utilization data, schedules, a concierge-based account management and customer service chat, and industry research, allowing them to more accurately exchange medical information with providers and others in the health-care continuum.

“Employers will have the ability to incentivize their plan members to use less expensive medications and improved standards of care, as well as educate and engage employees about disease management and wellness programs, all based on rules designed around the medical benefit coverage,” says WellNet President Keith Lemer.

In addition, Healthcare Interactive has launched a developer network where outsiders are able to build their own applications that will reside on the Point to Point environment. “We have developed Point to Point on a platform called Healthspace that is designed to allow developers to rapidly create software services that interoperate in a standard method,” says James Birger, Healthcare Interactive's chief information officer. “This environment of standard interoperability ultimately simplifies a highly complex health-care system for the end user in a single interface.”

Currently, Point to Point is available in beta form to WellNet clients. Healthcare Interactive and WellNet will make Point to Point available to the general public in early 2009.

For more information or to request a demo of Point to Point, send an e-mail to info@wellnethealthcare.com or call WellNet at 1-800-808-4014.

Q / What is the key for employers as they attempt to rein in their skyrocketing medical-benefit expenses?

Employers must take proactive steps to have any chance of slashing their health-care costs. Businesses have to be proactive and rely on preventive measures to improve the chance of avoiding high-cost claims before they occur. The only way to do this is by developing strategies that are actually effective.

Q / What kind of health-care data should employers rely on?

Analyzing prescription-drug claims information alone is giving employers a much clearer understanding of what's emerging inside their health plans. This way plan sponsors may provide the best possible value for their members with regard to medical benefits. Data analysis driven solely by prescription-drug data is 95 percent accurate in predicting future risk.

Medical claims information is helpful, however, it often arrives up to 90 to 120 days late. Prescription-drug claims information helps employers develop proactive strategies to identify high, medium and low-risk members and take the necessary actions before catastrophic costs occur.

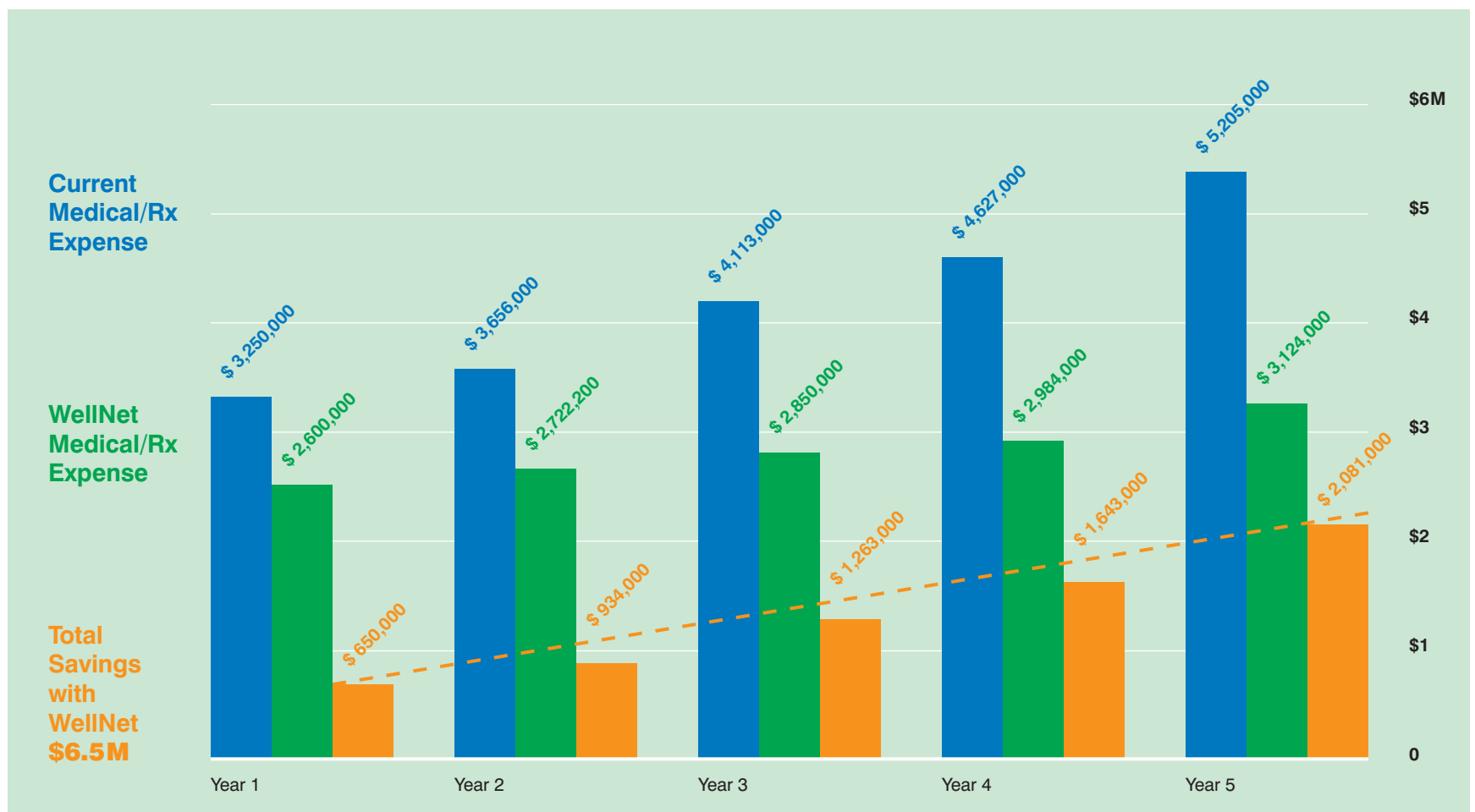
Q / What role does information play in helping employers lower their health-care costs?

The business community, and other organizations that pay for their employees' medical benefits, needs data so they may measure and manage their health-care costs in just the same way they measure and manage all their other business expenses. Health care is no different than these other costs.

Q / How challenging is it for employers to obtain this necessary health-care data?

It's often difficult to receive timely, accurate or interpreted information, as organizations that typically surround a client's health-care plan use this data to protect their revenue streams. Until, or unless, the vendors surrounding businesses' medical benefits are able and willing to supply measurable and manageable data to their clients, plan sponsors will never find themselves in a position of controlling their health-care costs.

Savings Projection per 500 Employees: \$6,500,000



Separating – or unbundling of medical, pharmacy, dental and vision benefits – is key to a competitive health-care marketplace where costs may get reduced.

Harry Kovar, WellNet Healthcare's CEO, recently delivered this message at a hearing in Philadelphia before Pennsylvania insurance regulators on the proposed merger of Highmark Inc. and Independence Blue Cross.

While IBC allows for the unbundling of benefits in the Philadelphia area, Highmark of Pittsburgh does not permit the unbundling of benefits.

“Should IBC follow the Highmark policy and unbundling not be permitted by the combined entity, competition ultimately will suffer,” Kovar said at the hearing.

Bundled benefits result in higher prices and fewer choices for plan sponsors as they search for new options to lower their medical-benefit costs.

“Unbundling the pharmacy benefit from the medical benefit allows plan sponsors with real-time pharmacy data to predict and manage their overall medical-benefit cost,” Kovar said.

The practice of bundling benefits is pervasive across the country. In the Washington, D.C., area,

MAMSI, a part of UnitedHealth Group Inc., will not permit any group to unbundle medical and pharmacy benefits, regardless of size.

In numerous U.S. markets, Anthem Inc. and its parent company WellPoint Inc. do not allow clients with fewer than 1,000 employees to unbundle their benefits. “Insurers don’t want to unbundle benefits because they fear losing the pharmacy portion of the overall health-care plan,” said WellNet President Keith Lemer.

Based on rigorous analysis of individual prescription-drug utilization information using technology developed by Johns Hopkins University and enhanced by WellNet, employers are able to identify plan risk in advance and develop an action plan to minimize costs before large medical claims occur. Utilizing sophisticated predictive-modeling technology, plan sponsors may help participants make informed decisions that lower overall medical costs by as much as 15 to 25 percent.

Key to this strategy is reliable and useful prescription-drug information. “Corporations need data to be able to measure and manage medical-

benefit costs as they would all other costs of doing business,” Lemer said. Analysis of prescription-drug claims data alone is helping employers better understand what’s happening inside their own health plans before high-cost claims are generated, so they may provide better value for both the plan and its members.

“Innovative, data-driven strategies, based on risk prediction using group-specific claims data sets, drive the development and implementation of approaches to keep people healthy and productive,” said Judy Mueller, president of WellNet Interactive, a new division of WellNet Healthcare that combines data analysis with proactive care management.

Pennsylvania Insurance Commissioner Joel Ario thanked WellNet executives for their comments and said that his department would seriously consider the issue of unbundling benefits in reviewing the proposed merger.

The full text of WellNet executives’ comments is available on WellNet’s site or on the Pennsylvania Department of Insurance’s site at www.ins.state.pa.us/ins/site/default.asp.

> **Benefits of Stand-Alone Rx Drug Plans**

Spending on outpatient prescription drugs has increased at double-digit rates for the past decade, according to the American Medical Association. Prescription drugs, which represent nearly 30 percent of total health claims, are the fastest-growing cost sector for most employer-sponsored health plans. In response, employers increasingly are “carving out” prescription-drug benefits in stand-alone plans separate from their overall medical benefits for the following reasons:

- Allows for better management of the prescription-drug benefit
- Reduces overall program cost
- Allows for more flexibility in plan design
- Gives greater access to program data and plan performance

The advantages of prescription-drug plans are expected to become even more important with the continued growth of specialty biotech drugs and personalized health. For more information on stand-alone prescription-drug plans, contact WellNet at **1-800-808-4014**.

> **Pantos Appointed as Senior Adviser to WellNet**

WellNet Healthcare has appointed longtime employee-benefits lawyer **George Pantos** its senior adviser. With more than 30 years experience in the benefits field, Pantos provides strategic planning and communications advice and outreach on issues affecting WellNet and its clients, including employer-sponsored benefit programs, the Employee Retirement Income Security Act (ERISA) and self-insurance.

A former partner in the national law firm Vedder Price of Chicago, Pantos co-founded and served as counsel to The ERISA Industry Committee (ERIC), a national coalition of 125 major employers concerned with ERISA benefits issues. For more than 13 years, he served as principal counsel to ERIC, drafting briefs in five major U.S. Supreme Court cases involving ERISA preemption.

Prior to entering private law practice, Pantos served in the U.S. government as deputy under the secretary of commerce, where he managed the legislative-relations program for a Cabinet-level federal agency. Earlier in his career, Pantos worked as an attorney for the U.S. Chamber of Commerce, the nation’s largest business association, where he concentrated on employer-policy issues before Congress.

“This is a big win for WellNet,” says Keith Lemer, the company’s president. “George Pantos brings to us a wealth of business and government experience. His knowledge of the insurance industry, the employee-benefits arena and the challenges faced by employers and health plans is extensive.”

E-mail him at gpantos@wellnethealthcare.com.

Industry News @nd Trends

> Heart Disease Risk Soars with Obesity and Diabetes

People who are both obese and have diabetes are highly likely to develop heart disease during their lifetime, according to a study published in the journal *Diabetes Care*. Researchers found that of more than 3,400 adults in a long-running U.S. heart study, obese and diabetic women had a nearly 80 percent chance of developing heart disease at some point. For their male counterparts, that figure jumped to nearly 90 percent.

(Reuters, 8/15/08)

> Drug Spending on the Rise

Spending on drugs is expected to accelerate in the coming years, reaching almost \$515.7 billion in 2017, more than double the \$231.3 billion projected for 2007, according to a study published in *Health Affairs*.

(Drug Benefit News/AISHealth.com, 4/10/08)

> New Minnesota Initiative Calls for Portable Personal Health Record

Minnesota Governor Tim Pawlenty has proposed giving all Minnesota residents access to a personal-health portfolio by 2011, and as a first step he is seeking proposals for a secure and portable online system for state employees by 2009. The initiative calls for a Web-based set of tools that allows individuals to access and coordinate their health information and share parts of that data with providers and others who need it.

(AISHealth.com, 8/18/08)

> Antidepressant Scripts Up 16 Million Over 3-Year Period

The number of antidepressant prescriptions written (not including refills) increased from 154 million to 170 million between 2002 and 2005, according to a report released by a U.S. government agency. The analysis by the Agency for Healthcare Research and Quality found that in 2005: 29 percent of prescriptions were written by psychiatrists; 23 percent came from general practitioners; 21 percent came from family practitioners; and 10 percent were written by internal medicine specialists.

(Forbes, 7/23/08)

> WellNet in the News

The launch of Point to Point Healthcare by WellNet Healthcare and Healthcare Interactive is featured in *Drug Benefit News*, an industry publication targeting the prescription-drug benefit sector. To read this story, please visit www.wellnethealthcare.com/news/.

> Predictive Modeling

Right now, predictive-modeling programs can analyze data on thousands, hundreds of thousands, or even millions of plan members, connecting the dots to identify potentially high-cost cases, and provide real, actionable information about why a particular member was selected. This helps teams of nurse-health coaches and disease-management workers hit the ground running to head off a medical disaster.

(Managed Care Magazine, 6/12/08)



No two people are alike. It's critical to build **customized care-management strategies** and not utilize off-the-shelf products or services. Rather than looking at diseases, it's vital to look at the **profile** of an individual.

WellNet Healthcare's analysis of prescription-drug claims data relies on technology developed by Johns Hopkins University and enhanced by WellNet. Here's a sneak peek into the Johns Hopkins University Adjusted Clinical Groups (ACG) system.

The ACG system provides a robust and innovative health-based risk adjustment approach used by health-care providers, health plans and public-sector agencies. This system has a uniquely clinical perspective on a patient's health that emphasizes the interrelationship of multiple diseases.

Johns Hopkins University, one of the world's most respected academic and medical-research institutions, developed, tested and supports the ACG system. This transparency and academic credibility is critical when trying to disseminate risk information to providers and purchasers of health-care benefits.

The ACG system grew out of clinical observations made by Dr. Barbara Starfield. Research by Dr. Starfield and her colleagues in the early 1980s examined the relationship between morbidity and health-care services utilization among children in managed-care settings.

The Johns Hopkins team's findings supported the hypothesis that clustering of morbidity is a better predictor of health-services use than the presence of specific diseases. This finding forms the basis of the current ACG system and remains the fundamental concept that differentiates the Johns Hopkins University system from other case-mix adjustment methodologies.

The ACG system measures the morbidity burden of patient populations based on disease patterns, age and gender. It relies on diagnostic code information found in professional and hospital insurance claims or other computerized records.

The ACG system is used to exchange billions of dollars on behalf of millions of covered enrollees in both private and public-sector managed-care programs.



> **Judy Mueller, President of WellNet Interactive, Discusses the Benefits of a Strong Health-Management Program.**

Q / What are some of the keys to successful health-management programs?

One vital factor is not just focusing on a few therapeutic areas, as many disease-management programs often do. Real-time data are key. So is information analysis and risk profiling.

It's never been about costs, but rather about long-term, proactive strategies that effectively minimize risk. Clients these days are looking for something other than cost shifting in their health-care plans. The only way to manage health-care cost increases, from our perspective, is to keep people healthy and engaged. Get them to take better care of themselves. It's better for the employer and the member. We look at it from a risk-based approach rather than a cost-based approach. Generally, as the population ages, and health care becomes more advanced, people will live longer and have more things wrong with them, physically speaking. If you can engage them early enough, their quality of life is enhanced. Big time. Worker productivity will go up. Medical costs will shrink.

Q / Why are health-management programs more effective than disease-management programs?

Disease-management programs have been around a long time. Insurance carriers frequently identify a few disease states using a data set, based on medical-claims information. This is the management of disease. We think a more effective route is to concentrate on the management of health. It's an antidote to get at risk before it happens. Identify the potential for big claims before they occur.

This lowers medical expenses and, over the long term, stabilizes medical trends. That's what we're in it for. Care management needs to be very individualized and very focused. We don't rely on medical claims. We use prescription-drug data, which are extremely accurate in predicting future risk and help identify problems before they happen.

Q / Why should health-management programs be tailored to an individual, not a set of diseases or chronic illnesses?

No two people are alike. It's critical to build customized care-management strategies and not utilize off-the-shelf products or services. Rather than looking at diseases, it's vital to look at the profile of an individual. A patient could be on a great treatment, but maybe it's not the right treatment.

With pharmacy data, you can see that a patient is on two or three drugs, but maybe hasn't been hospitalized. If you engage this patient, you can avoid a catastrophic, high-cost claim. Real-time pharmacy information comes to our attention as soon as a prescription is filled. Right away our care managers know about it. Medical-claims data come much later, after it's too late to proactively intervene. The horse is out of the barn at that point.



> About WellNet

WellNet Healthcare, founded in 1994, is a privately held company that designs, implements and administers employer-sponsored health benefits that save businesses money and improve member health by giving plan sponsors unprecedented understanding and control of their medical expenses.

To learn more about WellNet, please visit us at www.wellnethealthcare.com.

> Success Stories

[A Free 62-page Booklet of Client Experiences](#)

Learn how five organizations focused on their employees' prescription-drug data to make informed decisions, significantly reducing their expenses.

To receive this booklet, send an e-mail to info@wellnethealthcare.com.

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