BY JAY GREENE
William McGuire, M.D., sees the healthcare system as overly complex—gaps exist within socio-economic groups; costs are too high; and quality improvements are needed. As chairman and chief executive officer of the nation’s largest insurer, UnitedHealth Group, Minnetonka, Minn., McGuire wants to achieve economies of scale and provide a variety of health products.

As a result, UnitedHealth Group has grown like crazy. Its earnings on operations have risen 345% over the past decade to $5.4 billion in 2005 on $45.4 billion in revenue for an 11.8% margin compared with $742 million on $11.8 billion in revenue in 1996.

With the 2005 acquisition of PacifiCare Health Systems, UnitedHealth’s membership grew to 65 million last year from 61 million in 2004. Over the past four years, UnitedHealth has tripled its membership.

“Based on our strong position and

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business momentum entering 2006, we now anticipate a further increase in our earnings per share growth to a range of 21% to 23% over our 2005 results,” McGuire said in a Jan. 19 statement.

When the blunt-talking yet intensely private McGuire took over in 1991, UnitedHealth was a regional HMO. Over the past 15 years, McGuire, 58, has acquired more than 30 firms, turning UnitedHealth into one of the nation’s most diversified health companies.

While McGuire ranked No. 6 in last year’s poll, readers of Modern Physician this year voted him to the No. 1 spot on the magazine’s second annual ranking of the 50 Most Powerful Physician Executives. Through a spokesman, McGuire, who grants few interviews, declined to comment for this story. Instead, UnitedHealth offered Reed Tuckson, M.D., senior vice president for consumer health and medical-care advancement, for an interview, but Modern Physician declined.

William Jessee, M.D., 59-year-old president and CEO of the Medical Group Management Association, Englewood, Colo., who is ranked No. 19, says McGuire has a twofold reputation in the medical community.

“He is CEO of the biggest player on the block. Now they have done their merger with PacifiCare, some would say the biggest gorilla in town,” Jessee says. “There also is a lot of envy over his salary. An interesting question is does power relate to how much your compensation is?”

In 2006, McGuire cashed in $136.7 million in stock options “to support significant new and existing philanthropic commitments,” the company explained. This follows the sale of $114 million of his shares in 2004. In April, UnitedHealth said an independent committee has been appointed to review the insurer’s stock-option-granting practices, and independent counsel has been engaged to assist the committee. McGuire subsequently recommended that UnitedHealth stop awarding new stock options to its senior executives, including himself. The insurer’s board will consider the recommendation at its meeting this month.

Last year, McGuire’s most controversial accomplishment included rolling out a physician-performance rating system in 12 markets, including Chicago and St. Louis. The United Performance Plan is designed to help consumers choose high-quality and low-cost doctors. Based on their scores, as determined by UnitedHealth, doctors received stars next to their names on the company’s Web site.

After objections were raised by a number of hospital systems, physician groups and professional organizations, including the MGMA and the American Medical Association, UnitedHealth altered the program.

In an April 4, 2005 article in Modern Healthcare, Jessee said this of UnitedHealth’s

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The power of motivation
The IHI’s Berwick understands power comes from the ability to lead and motivate. Over the past two years, Berwick’s biggest challenge has been saving 100,000 lives by June 14. IHI’s 100K Lives Campaign, which asks hospitals to incorporate six healthcare quality-process changes, is more than 60% toward achieving the goal, he says.

“We could get there,” Berwick says. “We are using the word saturation to describe what we are doing. If we want to drive the standard of performance, everybody needs to be on board.”

Berwick admits that “everyone swallowed” when he first suggested the goal to senior IHI leadership during the summer of 2004. The 90-member staff and 200 associated faculty members already felt stretched thin, he says.

“We were pretty concerned in the first three months, and I wondered whether we would have trouble recruiting at least 2,000 hospitals to make this work. It looked impossible. Hospitals hardly do anything together except to lobby for higher payments,” Berwick says.

But hospitals surprised Berwick. “The response has been absolutely incredible,” he says, noting that more than 3,000 hospitals are participating. “By month four, the fax machine overheated with all the data coming in. The outpouring of interest and sincere meaningful enrollment has been inspiring.”

In June 2005, six months after beginning the project, Berwick says he read a newsletter from

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Healthcare’s 2005 list of the 100 Most Powerful People in Healthcare.

Born in Troy, N.Y., McGuire graduated with a medical degree from the University of Texas Medical Branch, Galveston, in 1974, the same year that UnitedHealth was formed. McGuire became chief resident in internal medicine at the University of Texas Health Science Center at San Antonio.

He practiced pulmonary medicine in Colorado Springs, Colo., from 1980 to 1985, when he became president and chief operating officer of Peak Health Plan of Colorado. He joined UnitedHealth in 1988 as executive vice president.

Interestingly, McGuire’s longtime hobby is studying butterflies. Considered a national expert, he even has several named after him, including a brown central Texas butterfly called *Euphyes mcguirei*.

“You influence people in different ways,” says Thomas Royer, M.D., president and CEO of Christus Health, Irving, Texas, who ranked No. 7. “Part of it is by actions and measuring outcomes. Part of it is coaching, mentoring, teaching, focusing on operations and creating a vision. I am the first to admit I am not doing all these things well. But being on the list gives me some reassurance that people within the organization are doing many things right.”

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Massingale says the movement to pay-for-performance will encourage more physicians to enter the executive ranks.

“It should be easier for us as clinicians to understand it and communicate it better to physicians and nurses,” says Massingale, who has led the contract-management firm for 26 years. “There is a lot of resistance of physicians to pay-for-performance. A lot of doctors feel it is pay for lower utilization. Some feel it is economic credentialing in disguise. I don’t personally believe that, but because of the power of the payers, we are headed that way.”

Making pay-for-performance work

While in academic medicine in the 1980s, AHRQ’s Clancy, 52, conducted a study that showed providing financial incentives to doctors and hospitals improved patient care.

“HMO patients had far fewer discretionary tests like chest X-rays,” Clancy says. “Now the focus is on pay-for-performance. The question is how to design these programs.”

Organizations such as AHRQ have provided encouragement to physicians because of their emphasis on clinical improvement.

“This year we want to do two big things: Implement the patient-safety bill and provide information on what works and what does not,” says Clancy, who has been with AHRQ for 16 years. She took over as director in 2002 after the sudden death of Director John Eisenberg, M.D.

After graduating from the University of Massachusetts School of Medicine in 1979, Clancy completed her internal medicine residency at Memorial Hospital, Worcester, Mass., in 1982. She was elected to the Institute of Medicine in 2004.

“I don’t come from a medical family. They had business backgrounds, but I knew I wanted to...
cine had become under managed care.

“...I had a lot of latitude to study care processes,” he says. “I learned that traditional quality assurance in healthcare is difficult and ineffective. It opened my eyes to quality improvement.”

But it was in 1999, when his wife, Ann, was hospitalized with symptoms of a rare autoimmune disorder of the spinal cord, that Berwick saw the flaws of the healthcare system from the patient’s and family’s perspectives.

“All of that was happening to me, and I hated it,” he says. In a speech a few months after his wife’s hospitalization, he said about quality improvement: “Before, I was concerned. Now, I have been radicalized.” Ann recovered and returned to her job as an attorney and environmental consultant.

A ‘journey to excellence’

Royer’s career spans jobs at Henry Ford Health System, Detroit, where he was senior vice president of medical affairs and chairman of the medical group from 1994 to 1999, and 18 years with Geisinger Medical Center, Danville, Pa., where he held posts as medical director and founder of the hospital’s emergency medicine residency program.

A surgeon, Royer completed his residency in 1972 at Geisinger, where he was chief resident and president of the house staff association. He earned his medical degree from the University of Pennsylvania in 1967.

Royer, 65, says his biggest challenge came when he joined Christus in 1999. It was only several months after the 40-hospital Catholic system was formed through the merger of Incarnate Word Health System, San Antonio, and the Sisters of Charity Health Care System, Houston.

“We looked at the overall matrix, and while..."
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we had some excellent areas, we were not very good overall,” he says. As a result, Royer initiated in 2000 what he calls “our journey to excellence.” The goal of the initiative is to achieve the 90th percentile in various national standards in four categories: clinical quality, patient service, business practices and community value.

“A lot of factors helped us move from the lower third to the upper third percentiles in these categories,” he says. For example, the effort to improve business practices helped Christus improve its operating margin from -7% in fiscal 1999 to about a 5% positive margin projected in fiscal 2006. It also improved clinical quality to the 90th percentile from the 75th percentile in measures that include mortality rates and re-admissions, Royer says.

“We realized we also needed to improve patient satisfaction because that impacts our financial performance and clinical quality,” says Royer, who authorized an employee incentive program. But what propelled them to the top percentile nationally was guaranteeing excellent care.

In 2003, Christus became one of the first systems to offer patients a written guarantee for exemplary service. The guarantee provides “apology gifts” to patients that include gift certificates, coupons for free health tests and gift baskets.

“We want to increase transparency in this organization so the community can see our financial picture and community value. If we do that, then we can be held accountable and we can’t be complacent,” Royer says.

Gabow earned her medical degree at the University of Pennsylvania Medical School in 1969 and completed her residency in internal medicine at the Hospital of the University of Pennsylvania, Philadelphia, and Harbor General Hospital, now called Harbor-UCLA Medical Center, in Torrance, Calif., in 1971.


“Our biggest accomplishment was when we left city government in 1997 to form an independent public authority,” says Gabow, who adds that she had to convince Denver’s mayor it was a good idea. “I was persistent. The mayor asked me if I was ever going to get off this issue. I told him until he said ‘yes.’ ”

Under Gabow’s leadership, Denver Health upgraded its facilities, and opened new neighborhood clinics to serve the poor and uninsured and new operating rooms.

Gabow, a nationally known researcher in polycystic kidney disease, continues to serve as a professor of medicine at the University of Colorado School of Medicine. From 1985 to 2001, she was the principal investigator of the world’s largest study of adults and children with autosomal dominant polycystic kidney disease, a study that led to treatment breakthroughs.

“I am most excited about launching an effort the past 18 months in part from AHRQ to begin system transformation,” Gabow says. “We would expect our costs to go down, our revenue go up, our employee turnover go down and see our excellence in quality go up.”

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