



# The Health Care Purchaser's Toolbox:

## Strategies for Improving Quality and Affordability of Care

Wednesday, February 16, 2005

San Francisco, CA

### Conference Summary

The alarming rate of increase in health care costs is on the minds of America's consumers, policymakers, and health care purchasers. Nearly every day brings fresh news of rising costs, the growing number of uninsured, and the challenge of uncompensated care. At the same time, there is a growing appreciation that the quality of care is not what it could be. Patients too often fail to receive care that we know works, and too often receive care that is of questionable clinical value.

Against this backdrop, different health care stakeholders are touting their preferred solutions to the cost and quality crisis – from disease management to health savings accounts, from tiered networks to pay-for-performance. To assess how these popular benefit strategies may impact health care costs and quality, a group of stakeholders who have studied or implemented such strategies came together in San Francisco on February 16, 2005, to share learnings with employers, labor representatives, health care professionals, consumer advocates, and researchers.

**“The Health Care Purchaser's Toolbox: Strategies for Improving Quality and Affordability of Care”** was co-sponsored by the Kaiser Permanente Institute for Health Policy, the Pacific Business Group on Health, the U.C. Berkeley Center for Health Research, and the HR Policy Association. The goals of the conference were:

- To bring to bear current evidence regarding the drivers of health care quality and efficiency at both the group and individual physician levels;
- To enhance purchasers' understanding of the relative merits and potential synergies of the current approaches to “value-based” health benefits purchasing; and
- To help purchasers, providers, and researchers identify concrete strategies for improving the quality and affordability of care.

The following is a summary of the conference. The agenda, speaker materials, and biographies can be found at [www.kpihp.org](http://www.kpihp.org).



## A Health Care Purchaser's Toolbox

To frame the day's discussion, **Peter Lee, JD**, President and CEO of the Pacific Business Group on Health (PBGH), and **Francis (Jay) Crosson, MD**, Executive Director of The Permanente Federation of Kaiser Permanente, outlined the dimensions and key drivers of the relentless rise in health care costs, which have far outpaced both overall inflation and workers' earnings. They also detailed mounting evidence of the shortfall in health care quality, noting that only about half of adults receive recommended care for a wide variety of common and costly conditions.<sup>1</sup>

According to Mr. Lee, one of the central efforts of PBGH is to create a more performance-sensitive market in which consumers will drive plans and providers to breakthroughs in efficiency and quality. That strategy relies heavily on the collection of specific plan and provider performance data related to the Institute of Medicine's six dimensions of performance (care that is safe, timely, effective, efficient, equitable, and patient-centered). Such data, when shared with consumers and used both in benefit design and in making variable performance payment, could drive potential premium savings of as much as 28.8 percent, according to Lee, who cited the Business Roundtable and Mercer HR Consulting.

Lee stated that performance data collection is relatively strong for plans and improving for hospitals. Pay-for-performance initiatives in some areas will provide useful data on medical groups, but data on individual providers are still lacking. Nonetheless, the use of such data for consumer decision making, while still low, may be nearing a "tipping point" that could accelerate the move to reengineer health care, said Lee, adding that a small but increasing percentage of consumers are now demanding and using performance information to make choices.

Jay Crosson cautioned that "consumer-directed health plans and HSAs (Health Savings Accounts) will not alone solve the problem" of cost and quality. He noted that such plans "control costs at the wrong end of the utilization spectrum" by appealing primarily to the relatively healthy majority of consumers who are responsible for only a small fraction of total health care costs. In addition, such plans' financial incentives (i.e., cost-sharing requirements) are focused on health care spending below a few thousand dollars; once an enrollee has a serious medical condition or event and exceeds the deductible, he or she has relatively rich coverage with little cost-sharing and little incentive to consider provider efficiency.

Truly sustainable solutions to the cost and quality crises may involve more flexible benefit designs, Crosson said, but they must also focus on the delivery system itself. The delivery system must be organized to provide the highest-quality, most efficient care, particularly for those who spend the bulk of health care dollars – the chronically ill. Competition properly focused at the delivery system level, he said, will ultimately drive greater physician consolidation and integration into successful multispecialty group practices. Such groups have the following advantages:

- Multispecialty coordination of care for costly, complex, and chronic conditions;
- Infrastructure to use evidence and systematic care processes to promote best practices; and
- Capability to deploy state-of-the-art clinical information systems.

## Keynote: What Will Drive Improved Health System Performance?

In a keynote presentation, **Stephen Shortell, PhD**, Dean of the School of Public Health at U.C. Berkeley, focused on evidence regarding the factors that drive

*"Consumer-directed health plans and HSAs will not alone solve the problem [of cost and quality]."*

*Francis Crosson, MD, Executive Director, The Permanente Federation*

health system improvement. He cited the “six challenges” from the IOM’s *Crossing the Quality Chasm* as imperatives for redesigning the care system:<sup>2</sup>

- Evidence-based care processes;
- Effective use of information technology;
- Knowledge and skills management;
- Development of effective teams;
- Coordination of care across conditions, services, and settings over time; and
- Use of performance and outcome measurement for quality improvement.

The keys to improved delivery system performance, he said, consist of a combination of incentives and specific system capabilities. On the use of incentives, he noted that the traditionally fragmented delivery system has “rewarded providers regardless of the outcomes of care,” but that the experience from almost 100 “pay-for-performance” pilots throughout the nation is beginning to change that in a positive direction.

Shortell identified the specific capabilities required for performance improvement as: a patient-centered culture, information technology, process improvement skills, team effectiveness, leadership, and the ability to partner. He cited his own and others’ research which demonstrated that the integrated, multispecialty group practice delivery model has shown “distinct advantages” in delivering on such capabilities, “but other organized care models have been able to achieve similar results.”

Despite the costly quality shortfalls noted by both Lee and Crosson, Shortell said, significant progress has been made over the past decade, as documented by HEDIS data. Shortell also noted impressive first-year results from California’s large-scale Pay for Performance initiative.<sup>3</sup> He cited findings from his own study of more than 1,000 physician organizations demonstrating that 12 multispecialty prepaid medical groups significantly outperformed all groups of comparable size on measures directly relating to the specific competencies he correlated with quality improvement.<sup>4</sup> (See Figure 1 for an example of competencies related to the management of chronic care.)

“It’s not just a matter of size,” he noted. “It’s the organizational form and how they use their size that makes the difference.”

Shortell also identified several key challenges to broader performance improvement among physician groups, including information technology implementation and interoperability, as well as the difficulty in influencing the organization and structure of smaller practices.

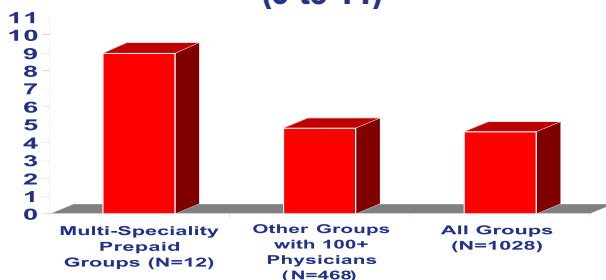
## Panel 1: Focus on Delivery System Organization and Financing: How Important is Integration?

To examine the role of delivery system integration in the quality and efficiency of health care, **James C.**

**Robinson, PhD**, professor of health economics at U.C. Berkeley, moderated a panel including **George Halvorson**, CEO and Chairman of Kaiser Foundation Health Plan and Hospitals; **Robert Margolis, MD**, CEO of HealthCare Partners medical group; and **Reed Tuckson, MD**, Senior Vice President of UnitedHealth Group.

George Halvorson argued that the primary problem underlying the health care cost spiral lies in the “very significant uneven distribution of health care costs” in which just 1 percent of consumers account for 30 percent of total costs, while the top 5 percent account for as much as two-thirds of all costs. (See Figure 2.)

**Figure 1**  
**Chronic Care Management Index\* (0 to 11)**



\*Patient self-management, linkages to community resources, delivery system re-design, decision support tools, etc. (Wagner et al, 1996, 2001).

Source: National Study of Physician Organizations and the Management of Chronic Illness, School of Public Health, University of California, Berkeley, November, 2002.



*"As long as people are immunized from any sense of financial consequences of the care they seek, it will be tough to engage them."*

*Reed Tuckson, MD, Senior Vice President, UnitedHealth Group*

But this also represents an opportunity, he said, to "identify the conditions that move people into that 5 percent, and then systematically bring to bear strategic, targeted, consistent, high-leverage interventions to keep them from moving to the high-cost end of the curve. Real systems of care possess these capabilities," whereas the nonsystems of care that make up most of the health care delivery world "can only do happenstance, incidental interventions."

Halvorson emphasized the need for sophisticated physician decision-support tools, including clinical information systems, to generate useful performance data, embed it in clinical practice, and report outcomes. He also emphasized the need for consensus on a broad set of performance measures.

Despite his view that the "current benefit model for high deductible health plans is a very crude one" in terms of reducing costs or promoting quality improvement, Halvorson said such benefit designs will prove useful to the extent that they get consumers more involved and informed about their own care and its cost.

However, he said, they will have a negative impact to the extent they create financial barriers to needed care. He also noted that future generations of such plans might address the need for effective chronic care management with greater

flexibility and sophistication, for instance by carving in care management for specific chronic conditions.

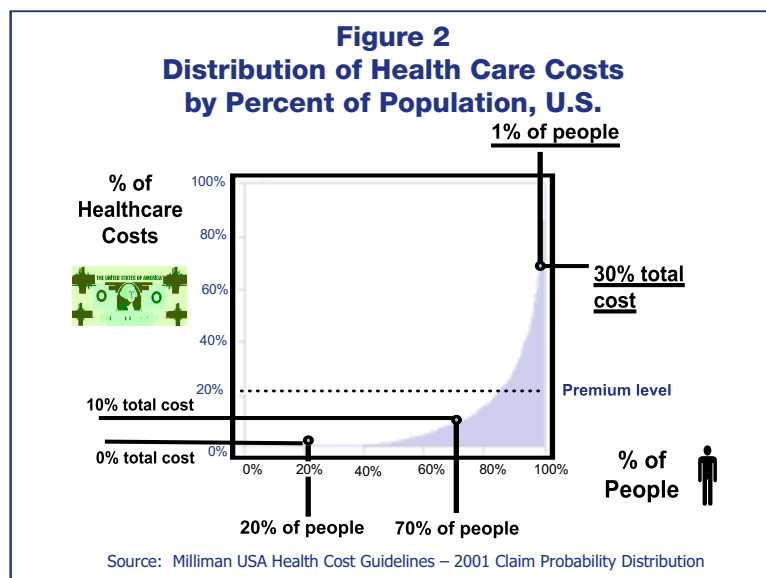
Robert Margolis, another strong advocate of organized systems, inveighed against the trend to high-deductible plans and PPOs, comparing them to "life rafts that are full of holes." The debate "ought to be focusing on how to create really effective and efficient delivery systems" as opposed to new benefit designs, he said.

Margolis noted that average HMO and PPO premiums in California still lag behind premiums nationally. Similarly, the state's hospital utilization rates are below national rates – advantages he attributed primarily to the impact of the "California capitated, delegated care model," under which a high percentage of consumers receive care through capitated, organized delivery systems. (See Figure 3.)

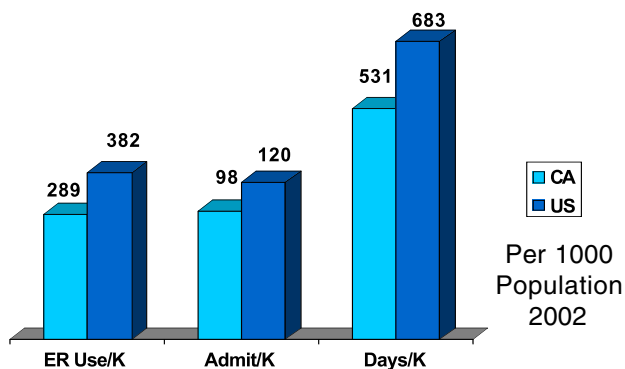
Margolis expressed concern that the shift to PPOs and high-deductible plans will ultimately diminish the use of preventive care and chronic care management tools and raise utilization rates for hospital and ancillary and specialty services. He urged instead a "marriage of the organized care model with consumer engagement strategies that would feature optimized provider networks, incentives for care coordination and consumer information, and, most significantly, a shift in low-

premium plans from high deductibles to first-dollar, long-term coinsurance, which would better spread risk across the entire population."

Reed Tuckson of UnitedHealth Group championed the trend toward greater consumer cost-sharing linked to better consumer support. "As long as people are immunized from any sense of financial consequences of the care



**Figure 3  
Hospital Use Rates,  
California and the U.S., 2002**



Source: Kaiser Family Foundation

Employees and Restaurant Employees International Union (HEREIU) Welfare Fund; **Terri Westbrook**, Assistant Executive Officer for CalPERS; and **Henry Loubet**, Chief Strategy Officer for Keenan.

Jeff Flick reviewed ways in which CMS has sought to become “a more active, intelligent, and engaged purchaser of health care” over the past four years by focusing on pay-for-performance demonstration projects, quality measurement and reporting, and consumer support and communication. Under the current administration, CMS has made significant impacts by publishing quality measures on nursing homes and home health agencies, and will soon do the same for hospitals. Pay-for-performance demonstration projects for hospitals will have a powerful

they seek, it will be tough to engage them,” he said. The trend, he added, will advance opportunities to build more effective decision-support tools, promote greater care coordination, and stimulate progress in measuring and reporting on physician and hospital performance.

The ability to realize those opportunities, he said, requires a uniform approach to performance measurement and speedy implementation of a certification process for electronic health record products. He agreed that the first generation of high-deductible plans needs to be studied carefully and refined on the basis of experience, “but we can never put the genie back in the bottle” by reverting to full third-party payment.

## Panel II: Focus on Purchaser-Driven Strategies for Improved Quality and Efficiency

The second panel, moderated by **Tom Williams**, Executive Director of the California-based Integrated Healthcare Association, sponsor of a major pay-for-performance initiative, featured case studies of purchaser-sponsored performance improvement strategies. The panel included **Jeff Flick**, Regional Administrator of the Centers for Medicare and Medicaid Services (CMS); **Elizabeth Gilbertson**, Director of Strategic Planning and Policy for the Hotel

impact, as will demonstration projects in the areas of end-of-life care and risk-adjusted payments to health plans.

“This is a very different Medicare from what we were all accustomed to,” he said, and the differences will become all the more striking when the lessons from the demonstration projects are incorporated into the national Medicare program. Flick predicted that new Health and Human Services Secretary Mike Leavitt will continue to press CMS to play an activist role in Medicare while also focusing more closely on improvements in the Medicaid program.

Terri Westbrook discussed CalPERS’ partnership with Blue Shield of California, including a new provider network designed to address extremely high hospital cost inflation. Those costs were identified as the chief driver behind an increase of over 50 percent in HMO premiums from 2001-2003.

Blue Shield’s analysis of claims data and quality information from its network hospitals found a wide disparity in costs, with no correlation between cost and quality. One of the network’s hospital chains was 80 percent higher than Blue Shield’s statewide average. As a result of the analysis, CalPERS and Blue Shield created a new provider network that eliminated 38 of the highest cost hospitals, beginning Jan. 1, 2005. Fourteen hospitals were ultimately restored to the network after meeting the new cost and quality criteria, or for access reasons.



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Assistant  
Executive  
Officer, CalPERS*

Westbrook said that "by including only hospitals that meet our new cost and quality criteria, we estimate savings of \$36 million in 2005 and \$45 million a year thereafter."

"This proves that large purchasers can use their leverage to change marketplace dynamics" she said.

Elizabeth Gilbertson described how the HEREIU Welfare Fund, which covers 120,000 generally lower-income employees and families in Las Vegas, restructured its PPO physician network based on cost and quality criteria to save \$24 million in the first year against a \$250 million annual total. Two thirds of that savings resulted from the network restructuring, and the remainder from benefit changes.

The Fund gathered episode of care data on all its PPO physicians to create an "efficiency score" for each. They found that episode of care costs for common treatments varied dramatically among the network's family practitioners. For instance, urinary tract infection treatment costs ranged from \$81 to \$778, and ear infection treatments ranged from \$46 to \$412.

The Fund used these data as a screening tool. Physicians who exceeded specified efficiency thresholds were subject to extensive further evaluation regarding practice patterns and other factors related to the network's capacity to provide adequate access to care. On these bases, 50 outliers were eliminated from the network. The Fund then evaluated the remaining 1,750 providers on evidence-based clinical quality measures to create a "Gold Star" program consisting of the most

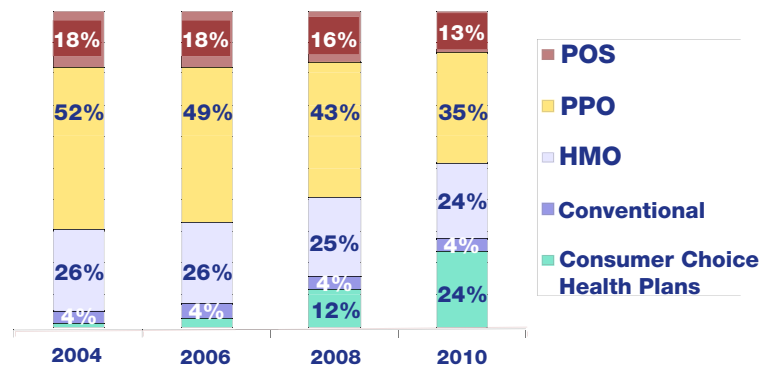
efficient, high-quality providers. These providers received bonuses of up to 10 percent of previous compensation and were identified to members as preferred practices.

"The good news is that physician network restructuring is a really powerful tool for reigning in health care costs," said Gilbertson. "But it takes a critical mass (of members) to do this. We can't replicate this success in places where we lack the critical mass."

In contrast to the previous presentations on provider networks and performance, Henry Loubet of Keenan, California's largest privately-held health benefits administration and consulting firm, focused on consumer behavior. He noted that data from the Centers for Disease Control indicate that "50 percent of all health care resource costs is driven by consumer behavior – something that we can control or influence." Consumers, he said, will make significant behavior changes and more rational and efficient health care purchasing decisions if they have the financial incentives and tools to do so.

Loubet noted that "consumer choice" plans (HRAs and HSAs) have begun to gain market share and are projected to account for a 24 percent market share by

**Figure 4  
Consumer Choice Health Plans  
Gain Market Share**



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Source: Forrester Research, Inc.

**Keenan**

2010, according to Forrester Research. This would make them equal to HMOs' predicted market share. (See Figure 4.) Member satisfaction surveys of Aetna's Health Fund Consumer Choice Health Plan have been very high, with 92 percent overall satisfaction. Loubet reported that United Health Care and Humana have seen similar results, with overall satisfaction generally higher than for traditional managed care plans.

Well designed consumer choice plans, he said, must provide incentives for wellness and self-care, personalized health risk assessments, and information to help employees understand costs and care options. Echoing the previous panel members, he said that such plans must also use a high-performing provider network to manage utilization and costs more effectively.

## Conference Wrap Up

Based on the day's discussion, Jay Crosson, MD, of The Permanente Federation summarized the key themes and recommendations regarding next steps for three stakeholder groups: purchasers (including CMS), providers, and state and federal governments.

### Purchasers:

- The 100 or more pay-for-performance pilots around the country are a key part of any cost and quality solution.
- There is growing interest in a return to full or partial capitation strategies or to innovative payment structures that encourage population-based performance improvement within the fee-for-service setting.
- Several speakers urged development of low-premium plans that spread out-of-pocket costs across the utilization spectrum. Coinsurance, rather than high deductibles, was favored by some.
- Network restructurings are a proven and effective tool for cost and quality improvement.

### Providers:

- Physicians need to organize themselves into more efficient and effective groups to match the performance of multispecialty group practices.

- Physicians and hospitals must deploy clinical information systems to generate better data for performance, research, and reporting purposes.
- The physician role must evolve toward one of "trusted guides" to help consumers understand costs and care options.<sup>5</sup>

### State and Federal Government:

- Several speakers urged state governments to consider mandated benefit designs for high-deductible health plans to remove financial barriers to necessary care.
- Interoperability standards and incentives for clinical information systems are needed to promote faster and broader implementation of the technology.
- Organizations advocating quality measurement and reporting must agree upon a common set of meaningful, useable measures.
- CMS should play a more active role in performance research and development, using the Medicare database.
- A national initiative in technology assessment is needed to mitigate the soaring cost of new technologies and pharmaceuticals.

Finally, as Crosson noted, purchasers, providers, and the government need to find better ways to work together to move the performance improvement agenda forward.

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### Endnotes

<sup>1</sup> E.A. McGlynn, et al, "The Quality of Health Care Delivered to Adults in the United States," NEJM, 348:26 (June 26, 2003), pp. 2635-2645.

<sup>2</sup> Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century, National Academy Press, Washington DC, 2001.

<sup>3</sup> See the Integrated Healthcare Association, [www.iha.org](http://www.iha.org).

<sup>4</sup> National Study of Physician Organizations and Management of Chronic Illness, School of Public Health, UC Berkeley, Nov. 2002.

<sup>5</sup> Robert Margolis, MD, Chief Executive Officer, HealthCare Partners



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