



Understanding and Responding to the Health Care Crisis

Prepared for the

**Indiana Employers Quality Health Alliance
Annual Meeting**

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For further information, contact

E. H. (Ned) Lamkin, Jr., MD, FACP
President

*Indiana Employers Quality Health Alliance
4145 Washington Blvd., Ste. 300
Indianapolis, IN 46205-2616
(317) 283-2780
Email: nlamkin@sbcglobal.net*

INDEX

Introduction	1.
Current Issues, National	2.
Current Issues, Indiana	3.
Contributing Factors	
Hard to control	3.
Subject to intervention	4.
True Stakeholders	4.
Proposed Responses	
The Free Market	6.
Governmental Regulation	6.
Silver Bullets	7.
Managed Care	7.
Employer Withdrawal	7.
Consumer Directed Care	8.
Pay for Performance – P4P	9.
Health System Steerage	11.
Single Payer System	11.
The Business Coalition Approach	11.
IEQHA	12.
The Alliance Community Approach	
Modernize Infrastructure	14.
National Collaboration	15.
Improve Health Plans	15.
Improve Patient Safety	15.
Create a new Delivery Paradigm	
Focus on Quality	16.
Partner with Physicians	17.
Involve the Hospitals	18.
Revise Benefits	18.
Restructure Administration	19.
Success Factors/Barriers	20.
Conclusion	21.

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Introduction

Over the last 1/3 of a century, concerned Employers have **tried, and continue to try, a lot of things to address their health care issues, but the issues remain.** However, the health care industry is extremely complex. One reason for the persistence of the issues may be a **lack understanding of the HC system** and how it operates. A couple years ago we conducted an overview of health care as a **board orientation.** At our last Board meeting it was suggested that it would be a good idea to do again.

So today, I am going to try to provide **“primer”** on health care issues, current approaches being proposed and an overview of our coalition approach.

No one is happy with health care today. **Employers** are concerned about cost; **employees** about limited options and increased cost; **physicians** about hassle, decreasing professional autonomy and compensation; and **government** about access and cost. Attempts to control health care costs over the last 15 - 20 years have eliminated some excess cost. However, these attempts have relied primarily on **rationing and discounting.** Rationing involved benefits restrictions, utilization management (pre-certification, concurrent review, and retrospective review) and incentives for primary care physicians to avoid testing, hospitalization, and the use of specialists. Discounting was predicated on physicians and hospitals accepting a reduction in compensation in exchange for more patients. These interventions were accompanied by undesired side effects: **restricted consumer choice, reduced professional autonomy, and significant questions regarding quality.**

These approaches **have now run their course.** Utilization patterns have altered and further rationing isn't realistic. Discounts have become universal. Negotiated fees are often the compensation desired by the provider – achieved by discounting off artificially inflated “usual charges”. Fees are not likely to be reduced further due to increased provider resistance. **Underlying upward pressures have not gone away** and are again forcing double digit cost inflation, above the level employers can pass through their cost structure. Costs continue to escalate. Quality and patient experience have not improved. Physician and hospital attitudes regarding health plans are almost universally negative, each seeking a better “payer”. The result has been a strong managed care backlash. In short, **the market needs a better product.**

The cost of services to those who actually pay for them, i.e., government and employers, continues to rise and threatens the financial status and competitiveness of both. Government and employers do not usually contract with individual providers, but rather

obtain their services through an intermediary, which is pressured to offer broad choice, has little solid information on provider performance, and has limited leverage to produce improvement. This “non-system” has been resistant to attempts to control spiraling costs and mediocre quality. Attempts to do so, primarily focused on rationing and policing, have in turn provoked animosity among patients and providers alike

In short, the health care “*non-system*” is broken and requires a new approach, one that “disrupts the industry” by recognizing the needs, desires, and goals of all affected parties, matching risks and rewards to achieve mutual goals, and seeking future progress by improving prevention and medical service.

The important message is that none of the problems that face us today exists in a vacuum, and that addressing any one of them will not fix the problems we face. **What we have is, in fact, a systemic failure, and it must be addressed in a systemic fashion.** So here are points I hope will be helpful to understanding the challenges and opportunities:

1. The complexity of the issues – the multiplicity of factors and parties that must be considered, the variety of potential interventions that can be applied –
2. The importance of a comprehensive, integrated approach rather than a focus on any one, single, magical cure – because none exists,
3. The need to involve the patient, improve efficiency, and reduce bureaucracy and hassle, and
4. The desirability of doing this in a way that will maintain the attractiveness of medical practice to our brightest and most highly motivated young men and women.

Current Issues - National

Cost

- Employer-sponsored health insurance rates rose an average of 11.2% in 2004, marking the fourth straight year of double-digit premium growth, according to a study released by the Kaiser Family Foundation and Health Research and Educational Trust. Although less than the 13.9% rate hike seen in 2003, the 2004 increase was still about five times the rate of both inflation (2.3%) and workers’ earnings (2.2%). In 2005 the rate is projected to be 9.2%, but **still 3 times wage growth and 2-½ times the rate of inflation**, and the increase is projected to have been higher in Indiana. Since 2001, the cost of health insurance has risen a total of 59%, employee contributions increased 57% to an average of \$558 for individual coverage and 49% to \$2,661 for family coverage during the same period.
- A recent report by Families USA found that healthcare costs consume one quarter of earnings for more than 14 million Americans. Now **the leading cause of personal bankruptcies.**
- Rising healthcare costs, already threatening many basic industries, **now consume 16 percent of the nation's economic output -- the highest proportion ever**, the government has said in its latest calculation. The nation's healthcare bill continued to grow substantially faster than inflation and wages, increasing by almost 8 percent in 2004, the most recent year with near-final numbers.
- This largest and least manageable cost for employers, **predicted by 2008 to equal corporate profit**, seriously impairs US competitiveness in world markets and contributes directly to a reluctance to hire and a lack of more vigorous job expansion

- **Medicare** trust fund is in danger of running out; **Medicaid** is contributing to financial crisis for State governments

Access

- **43 million** persons at one time or another in any year are **uninsured**.
- The World Health Organization listed the **US 43rd in health care** – primarily on the basis of access, but also such measures as life expectancy and infant mortality.

Quality (This will be addressed further later in this paper)

- The Institute of Medicine has estimated that **48,000-98,000 die of medical errors** each year
- It takes approximately **9 years for medical progress** to become part of medical practice
- An article in the Journal of the AMA alleged that **45% of the care today is unnecessary, inadequate, or wrong**
- The Midwest Business Group on Health estimated in 2002 that the **cost of poor quality health care was \$1700 per employee per year**

Indiana

According to a 2001 IEQHA Study (with no evidence of substantial change in interim), Indiana:

- **Ranked poorly in avoidable, reducible and treatable health risks**
Indiana was 3rd among the states in obesity, diabetes, and high cholesterol. (The Indianapolis Star reported on January 2, 2003 that Indiana ranked 6th in the country in the percent of citizens we were obese, 5th in the percent who smoke and 21st in the percent who engage in no leisure-time physical activity.)
- **Ranked high in the frequency and cost of treatment**
 - 22% more hospital admissions and 39% more surgeries than the national average
 - Costs per hospital admission were 22% higher than the US average
- **Did not perform well on prevention and risk reduction**
 - 50th among the states in breast exams, 48th in colon studies, and 36th in cholesterol checks

Factors Contributing to the Cost Crisis

It is a fact that, if you don't like the current status, it is not generally because bad people are making evil decisions, but rather that **good people are simply making rational decisions in response to the conditions and rules as they exist**. So what is the environment in which the current problems have developed?

A. First, consider those factors that will be **difficult, impossible or unwise to control**.

These include:

- **Ageing Population** – While a factor, this is not as significant as usually portrayed – most costs occur during the last 6 years, and more specifically the last 6 months, of life - regardless of age at the time of death
- **Life style choices** – Drugs, homicide, risky behavior, e.g., motorcycles without helmets, sexual liberation problems, etc.

- **Hospital Operating Costs** – Hospital operations are heavily labor intensive. Labor, Energy, and Food costs (which together represent a significant portion of hospital operating costs) all have gone up in excess of inflation and are reflected in the rise of health care costs.
- **Science: Technology & Pharmaceuticals** – In the last 4 decades, we have produced the following improvements in the United States:
 - Reduced infant mortality more than 50%
 - Increased life expectancy more than 5 years
 - Reduced cardiac mortality by more than 30% and stroke by approximately 50%
 - Moved people out of iron lungs, mental and TB hospitals
 - Enabled people with chronic organ failure to live normal, productive lives through transplants and pharmaceutical maintenance

Do we really want to get rid of all these new, and expensive, advances and go back to the health care of 40 years ago?

- **Increased expectation & demand** – As effectiveness of care has improved, the goal of a perfect existence has become commonplace. (Witness the “Extreme Makeover” fad.) Health care is supposed to eliminate any possible health-related problems that might interfere with that goal, producing increased demands, and costs, on health care.

B. Factors which may be **more likely to respond to intervention** include:

- **Malpractice** – While continuing to have its own difficult issues, this was addressed by Indiana Malpractice Act, which has made malpractice a lesser issue in Indiana than in most other states.
- **Redundancy** - Capital expansion of our hospitals and out patient treatment facilities, while upgrading the quality of their services, have increased competition for skilled employees, raising their wage expectations in addition to added amortization costs. The question is where are the cost reductions that should accompany these new investments?
- **Change in coverage** – Only recently has coverage included such problems as erectile dysfunction, drug addiction, alcoholism and obesity – a problem exacerbated by state and federally mandated benefits.
- **Intermediation/Administration** – A major contribution to cost and complexity occurs at the interface between payers and users of health care. Administrators (including health plans, TPAs and insurers), instead of simply processing claims and focusing on more efficient intermediation and support for their stakeholders, have increasingly sought to reduce costs through a variety of control measures. Such items as Network Access, Demand Management, Disease Management, Utilization Management, and Case Management have often added cost, reduced efficiency, interfered with care, and produced high levels of member and provider dissatisfaction.
- **Efficiency and effectiveness** – Improvement will require metrics to identify opportunities and produce reliable and actionable data and procedures to induce continuous improvement

One of the barriers to evoking true reform is that everyone is blaming someone else for the current crisis, and while most seek to develop their own solutions, it is usually through the actions of another party. Employers → Plans → Hospitals → MD's → Patients → Employers → etc. It is time for each stakeholder to accept its respective responsibility and, in concert with the others, move a real process forward.

The Real Stakeholders

There are really only 3 stakeholders who really make the decisions that impact health and health care (excluding government)

:

1. Patients

Patients, or consumers, have been insulated from the true costs of health care and have been provided no meaningful incentive, or education, in how to maintain personal health and spend the health care dollar wisely. From the patient perspective high and low-value care costs the same. But, we believe they will change behavior when given good information. Information to guide selection of high quality medical care providers, and incentives for doing so, has been essentially non-existent. It is important to “engage the consumer’s mind – and his wallet”.

2. Employers

Employers, the major private payers for medical care, have rarely had available any means of managing the need for expensive medical care. Nor have employers been offered health plans that differentiate between - and provide the distinctly different management required for - medical insurance (management of the risk of costs of problems that have not yet occurred) versus medical care (management of costs for presently existing medical problems). **Insurance risk has been largely unmanaged.**

3. Physicians/Hospitals

Physicians, the "engineers" of medical care, **have never been rewarded for producing good care at a reasonable price.** Nor do they have access to integrated health information (e.g., accepted guidelines and protocols – known as evidence-based medicine) at the time of patient treatment. Instead, within the clinical information available to them at the time, physicians have traditionally received maximum financial rewards by inducing demand for the largest possible number of medical services (which may be preferable to incentivizing them to avoid care, no matter how badly it is needed, which was a risk under capitation.).

Responses to the Challenge

Before detailing current and proposed “fixes” for the “health care system”, it is important to recognize that the term **“health care system”** is an oxymoron. – As a former coalition Chairman used to say, “there is no system”. Rather, American health care is a fragmented, complex, cottage industry comprised of individual hospitals, physician practices, pharmacies, laboratories and other providers who are servicing users who generally do not pay personally for their services, but still expect health care providers to remove any potential impediments to the highest quality of sophisticated personal health services and perfect well-being.

George Halverson, CEO of Kaiser Health Plan and Dr. George Isham, Medical Director of Blue Cross of Minnesota, state in their recent book, *Epidemic of Care*: **“Our health care delivery system in the United States is really a nonsystem with millions of independent, uncoordinated, separately motivated moving parts, each with its own**

economic priorities and self-focused financial goals.” To quote Margaret O’Kane, president of the National Committee for Quality Assurance, **“American health care has no central nervous system.”**

In the absence of a real health care system, **individual interventions** (such as our coalition efforts at profiling, patient education, and group purchasing) as well as **attempts** around the country to **“fix” health care** have been, like many public policy initiatives, **narrowly focused and generally ineffective**. Too often, we squeeze the balloon in one spot, only to have it bulge out in another. When you come right down to it, we are simply “nibbling around the edges” – seeking someone else to reduce *prices* (not the same as *costs*) and/or have someone else pick up the tab.

With that in mind, let us consider first some of the proposed **approaches to health care reform that are currently in vogue**:

A. The Free Market

“Let Competition work.” This is the usual solution proposed by many business leaders, and was the general approach of the late 20th century. It presumed that competition would lead to ever better products, as it does in most other sectors of the economy. The problem is that, in health care, the decision to purchase is often not elective, there is a disconnect between the purchaser and the payer, and there is poor information with which to make purchasing decisions. To quote a study by the Center for Health System Change, “findings again confirm that even **a competitive health care system does not function like most other sectors of the economy.**” Unregulated health care competition, in the absence of meaningful information, fails either to improve quality or lower price.

Rather it tends to **produce redundancy** (e.g., 5 cardiovascular surgical centers in Central Indiana) and **increased costs** (such as increased competition for nurses and other allied health care personnel). While trustees of hospitals and leaders of medical groups make reasonable decisions in the best interests of their institution or group, the decision frequently is to expand service offerings or geographic coverage, which in turn may duplicate the services of other hospitals or medical groups, adding to overhead costs that purchasers will ultimately bear. Of greater concern, patient volumes may be diluted **resulting in unit volumes below those required to maintain quality**. (The quality of care services provided by physicians and hospitals varies dramatically across markets. The cost impact from this variation is estimated at over 35% of current national healthcare costs).

In health care, introducing a mechanism to encourage **collaboration and even market segmentation** may make some sense. But to be effective, this approach requires some sort of intermediary or **market manager** to assure a value-based system of competition among providers and to provide required administrative support – overseeing the most appropriate allocation of resources, providing reliable and actionable data, and rewarding the highest value producers – i.e., no longer a free, but a managed market. The manager should, however, **not be a profit center generating investor returns and excessive executive compensation, but a cost center for the primary stakeholders** – incentivized by an opportunity to share in the savings it can create.

B. Governmental Regulation

An example might be **Certificate of Need**. Unfortunately, these have often proved to produce political logrolling and had little impact on costs.

C. Individual Interventions (Silver Bullets)

In a recent poll, employers proposed the following interventions:

1. Control the cost of **prescription drugs** - 22% (But studies have shown that, while effective in holding down pharmaceutical costs, these efforts have been uniformly associated with increases in overall costs.)
2. Provide more **government-sponsored access to health insurance** - 25% (This would increase access; but since nothing else changes in the system, would be expected to increase cost – to be discussed further later)
3. **Limit** payments for **medical malpractice** claims - 38% (Impacts less than 1% of costs)
4. **Decrease payments** to hospitals and physicians - 3% (Which would reduce access for lower income patients whom providers may not choose to see because of inadequate compensation, ultimately leading to increases in the number of uninsured.)
5. Higher **co-pays and deductibles** – may give a one-time benefit but may discourage patients getting needed care, and provide no long-term solution.

D. Managed Care

Managed care has, to a large extent, changed from the original intent to improve wellness and reward efficiency and effectiveness to **discounting, rationing, and regulation** – increasingly attempting to reduce costs through a variety of **control measures that have often added cost**, reduced efficiency, interfered with care, and produced high levels of member and provider dissatisfaction. As a result, enrollment has plateaued, and costs continue to escalate.

E. Employer Withdrawal, i.e., Shifting responsibility to the employee.

While involving the employee or dependent is important, it is **not a good idea for employers to withdraw** and put all the responsibility on the employee. Rather, as a substantial stakeholder, employers should take exactly the opposite approach. Some reasons are as follows:

- Withdrawal and shifting responsibility to the employee and his or her dependents **assumes that the consumer will make the right decisions**. Unfortunately, according to a study by the Agency for Healthcare Research and Quality, nearly half of all U.S. adults -- almost 90 million people -- have difficulty understanding and acting upon ... health information. A second report released in tandem by the Institute of Medicine, suggested that this problem with consumer understanding could lead to billions of dollars in avoidable healthcare costs.
- Leaving employees to fend for themselves would **eliminate the ability to spread risk and to negotiate arrangements** for larger groups of covered lives.
- And, finally, it would have the important potential to **remove control by employers of broader, indirect health impacts on the work place**, e.g., employee wellness and its implications on productivity (health impacts cost U.S. employers \$80 million/year), absenteeism (costs \$602 per employee per year), and disability (which runs 58% higher than direct group health costs). (A recent report on French television, where the employer is not as involved in health care management, detailed

abuses by physicians and employees where unnecessary medical leaves lasted up to 3 months at a time.) Human Capital Management is currently a hot topic. Relinquishing all control of health care decisions would make this a less easily addressed subject.

F. Consumer Directed Care

According to the Center for Studying Health Care Change, “Under the old paradigm, employers and insurers acted as consumers’ agents in the market, organizing and defining their choices. More and more, consumers are expected to act as their own agents.” The goal of this change is to get the consumer to have some “skin in the game”.

Under “Consumer Driven Health Care”, the employee and his or her dependents are given a set amount of money in a “Health Savings or Health Reimbursement Account” to be spent on his or her health care. He or she buys a high-deductible insurance policy, pays for care out of the **HSA/HRA** until a cap is met and the insurance kicks in. The enrollee gets to keep any of the money in his or her account that is not spent, thus discouraging unnecessary spending. There are a number of variations on this theme, but they are not the topic of this presentation.

While there is good reasoning and some real potential for this approach, suffice it to say that there are **flaws with the pure product**. They include:

- It provides a **wind-fall** for those who are young and healthy (50% consume only 3% of costs at average per person of \$350 – giving them a bonus of \$150 - \$650 a piece, depending on the HSA),
- **It discourages** a patient from spending on wellness and prevention,
- It provides very **little reward to those with chronic illness** who are likely either to blow through the deductible (6% of patients account for 55% of health costs @ >\$8000 a piece, 1% account for 27% @ \$28,000¹), or, in order to protect their HSA/HRA, avoid obtaining the care required if one is to minimize later problems and costs.
- With US savings rate falling to a minus 0.5%, it is **unlikely that those with limited resources will choose to contribute** voluntarily to the savings account

And I find I am not alone in raising these concerns. Since this is such a popular proposal today, it is worth quoting from a ***“Special Report - America’s health-care crisis” published by The Economist. On January 28, 2006.***

“The logic of consumer-driven health care assumes that unnecessary doctor visits and procedures lie at the heart of America’s health-care inflation. And it assumes that individual patients can become discerning consumers of health care. Both are questionable. **Most American health-care spending is on people with chronic diseases**, such as diabetics, whose health care **costs many thousands** of dollars a year, **easily exceeding even high deductibles**.

“Instead, critics worry that greater **cost-consciousness will deter people**, particularly poor people, **from essential preventive medical care**, a trend that

¹ Consumer-Directed Health Care: Will It Improve Health System Performance? Karen Davis, PhD., The Commonwealth Fund, HSR:Health Services Research 39:4, Part II, August 2004)

could even raise long-term costs. A classic study by the Rand Corporation in the 1970s showed that higher cost-sharing reduced both necessary and unnecessary medical spending in about equal proportion.

“Nor is it obvious that people actually behave like discerning consumers in health care, even when they have information. Proximity of hospitals and word-of-mouth reputation often matter more to patients than published quality indicators...

“The truth is that the shift to consumer-directed care and greater cost-sharing involves a **culture change that may take decades**. It will also come at the **price of greater inequality**. The burden of health spending will be shifted on to those who are sick, and not just because people will pay a greater share of their health costs themselves. High-deductible insurance policies are attractive to the young and healthy. But as these workers leave traditional insurance, **the risk pool in other insurance plans will worsen and premiums will rise even faster**. The real losers will be poorer workers with chronic illnesses....

“Mr. Bush’s health-care philosophy has a certain political appeal. It suggests incremental change rather than a comprehensive solution. It reinforces existing industry trends. And it promises to be pain-free. **Unfortunately, it will not work**. The Bush agenda may speed the reform of American health care, but only by hastening the day the current system falls apart.”

These concerns were confirmed by a study released on December 8, 2005 by the **Employee Benefit Research Institute** along with the **Commonwealth Fund** which found that Americans in new "consumer-directed" health plans are **less satisfied with them and more likely to delay or forgo care than people with regular insurance**.

Thirty-five percent in consumer plans reported that they delayed or avoided health care - more than twice the 17 percent in regular plans. The numbers were even higher among people making less than \$50,000 a year. The skimping included not filling prescriptions or skipping doses.

Further, only 42% of those surveyed who have a consumer-directed plan were "very" or "extremely" satisfied with their plan, compared with 63 % of those in more common health plans. Only 33% of those with high-deductible plans and no savings account were that satisfied.

The report concludes that **the survey should raise red flags for insurers and employers**.

G. Attempts to “induce” quality – Pay for Performance (P4P)

Two national P4P programs have been sponsored by groups of large employers:

- **Bridges to Excellence (BTE)** (sponsors include General Electric, Procter & Gamble, Ford Motor, and Verizon; staffing by MedStat) and
- **Care Focused Partnering (CFP)** (sponsored by 28 multi-state employers including 3M, BellSouth, Boeing, Sears, Lowes and PepsiCo and staffed by Mercer).

Both assess physician quality (CFP uses claims and BTE uses information self-reported by physicians from random chart abstracting and sent to NCQA for clinical proofing), issue “report cards” to employees and dependents, and both offer a “bonus” to physicians

meeting performance goals. Each requires a critical mass of local employers willing to pay for the programs.

Costs are:

- **Bridges to Excellence** = \$4.50 per patient per year plus the physician awards of \$50 – 80\$ per patient meeting specific outcomes measures in one of three categories - in-office-automation, cardiac care or diabetic care;
- **Care Focused Partnering** = \$135,000 per year to \$225,000 per employer per year, depending on the number of employees

However, here again there are **inherent problems** with these approaches.

1. Health care is truly local, and reform will be difficult to implement **effectively through a nationally imposed initiative**
2. **Report cards** – The literature suggests that **“Physicians hate them and consumers don’t use them”**. (Our experience with HMO and Hospital profiling confirms these observations)
3. **Claims data** for physician profiling
 - a. Even using fairly sophisticated severity adjustment systems, it remains **difficult to adjust adequately for biologic variation**. An excellent cardiovascular surgeon once told me that at the end of each year he would review his year’s experience. One year he was the world’s best surgeon, another he couldn’t figure out how things could have gone so poorly – same guy, same hospital, same team. Patients differ – even when they look the same.
 - b. It is exceedingly difficult to obtain **adequate numbers** for individual or small groups of physicians to reach **statistical significance** and reliable profiling
4. **Difficulty in evaluating performance by comparing with “evidence based care” (i.e., use of guidelines)**

For instance, a study reported in the JAMA of a hypothetical case of a 79 year old woman with chronic obstructive pulmonary disease, type 2 diabetes, osteoporosis, hypertension and osteoarthritis found that if every relevant guideline was adhered to, the patient would be prescribed 12 medications requiring 19 doses per day at a cost of \$400 per month. This treatment would also come with a list of recommended lifestyle modifications, and a host of potential drug-drug and drug-disease interactions. The article suggested that the **current emphasis on Pay for Performance (P4P) may force physicians to choose between good care and financial rewards**.
5. **Provider rewards** –

It is not clear that either the BTE or CFE approach offers a **sufficient incentive** for physicians to participate in the program and/or change their behavior. Recent JAMA article states that those who receive the bonuses are those already performing, while the others continue their current practice patterns, i.e., **there is no behavior change or any real change in overall quality, even though the employers are experiencing increased expenditure**.
6. **Poor Quality** –

Finally, since the inducements are awarded retrospectively, during the year **patients will be seeing** not only those whose practices merit the bonuses, but also **those whose practices prove to be, by definition, of lower quality.**

H. Health System Steerage

The goal of this approach, being used by the Indianapolis Forum, is to provide incentives for patients to use the health **system** that profile best on quality measures. While a step in the right direction, this approach has limitations:

1. First from the **difficulty using claims data** for this purpose, and – more importantly – from the fact that
2. There is **far greater variation in quality and efficiency within a given system than among the systems.**

Thus, any incentives to direct patients to the highest performing *system* may not necessarily assure that they will reach the best providers in that system. But these incentives *are* very likely to upset employees by predetermining the hospital systems which they will be encouraged to use with only limited assurance that they will achieve better services.

The Forum now has initiated an effort to measure individual physician performance in cooperation with local health plans and IHIE. It will be based on a **defined set of measures from claims and pharmacy data plus lab results from IHIE**, rather than a chart-based assessment of overall performance. (For instance, it is one thing to assure that Bypass Surgery is done appropriately, with appropriate length of stay and good outcomes. It is another to assure that it needed to be done in the first place.) Differences in this approach from that of the Alliance are as follows:

1. **Chief Medical Officers of Health Plans** will determine **standards of measurement**, possibly with limited participation by practicing physicians (Gateway is placing all quality assessment under respected practicing physicians in their respective specialties – with representation across hospital systems.)
2. Profiles will **not be available to employers** and patients for the time being (Gateway rankings will be immediately available)
2. Profiles will be **limited at the outset to primary care physicians** (Gateway will assess quality across all specialties)
3. Profiles **will not be used for 12 – 24 months** (the Gateway network will be formed as soon as quality assessments are completes.)
4. Patient **satisfaction surveys will be discontinued** (Gateway will continue to do satisfaction surveys on services rendered by the physicians, hospitals, administrators and by Gateway – with results of all of these available on the website).
5. Plans are agreeing to pay **\$0.31 per member per month** (i.e., not per employee per month) for this profiling process (very likely to be passed on to the employer). (Under the Gateway program, physicians assume responsibility for initial assessment, which will be paid subsequently from the access fee revenue (below the market, and the only source of income to Gateway prospectively.)

Additionally, the Forum approach will still suffer from the same shortcomings as other, previously described Pay for Performance programs, including:

- **A poor measure of overall performance,**
- **The same small numbers problems and**
- **Absence of prospective steering** (i.e., patients still see both the highly rated and not-so-highly rated physicians – at least in the short term.)

I. The Single Payer System

1. Often called “National Health Care”, the single payer approach focuses **primarily on financing**. It probably would assure coverage for those currently without health insurance. However,
2. It imposes a single national solution to all problems, no matter how dissimilar. It is **unlikely that the “one size fits all” approach is the best** answer to services that are rendered at the local level. If one concludes that public financing is appropriate, it might be preferable to delegate that responsibility to the laboratories of the states to see what might be most effective in addressing the issues. However, the results to date with Medicare are not very reassuring in this regard.
3. It risks producing **care by regulation and coercion**, rather than collaboration. And it is likely to involve **increased bureaucracy, reduced personal choice, rationing and other artificial economic constraints**, without really addressing existing process problems in health and health care delivery
4. If run by a **federal bureaucracy**, there is no guarantee that it would not demonstrate the kinds of problems and costs predicted by the opponents for the Clinton plan.
5. If **contracted to a private organization** for administration, there is no guarantee that it would avoid the problems existing in today’s managed care plans.

The Business Coalition Approach to Health Care

In order to put the activities of the Indiana Employers Quality Health Alliance into context, the following is borrowed from a presentation by Andrew Webber, president of the National Business Coalition on Health, in which he provides an overview of the coalition movement:

Coalition Definition

“An organization of private and public employers formed at the local, regional, or state level to advance high quality, affordable health care through value based purchasing.”

History and Profile

- Started in late 1970s
- Expanded in 1980s, early 1990s, corresponding with rising employer costs
- NBCH - Currently 70 coalitions, in 40 states
- 7,000 participating employers, 25 million lives
- Coalition employer members typically are regional, self-insured, mid-sized (in the 500-5,000 employee size)

Coalition Types

- Community coalition - An independent organization representing the broad health care interests of employers in a defined geographic area

- Direct purchasing coalition - A business enterprise contracting for health care services on behalf of a group of employers

Key Strategies

- Performance Measurement and Reporting
- Education
- Selective Contracting
- Incentives and Rewards
 - Consumers – e.g., through Benefit Design
 - Plans and Providers
- Collaborative Process Improvement

The Indiana Employers Quality Health Alliance - Where We Have Been and Where We Are Today -

Established in 1994 to address employer concerns about health care costs and quality, the Indiana Employers Quality Health Alliance, a member of the National Business Coalition on Health is an organization of Central Indiana public and private employers representing approximately 70,000 Indiana employees (approximately 30,000 in Central Indiana). Member companies range from large (General Motors and the State of Indiana) to quite small (3 companies have less than 50 employees).

The Alliance ***Vision*** is:

“The Indiana Employers Quality Health Care Alliance is committed to creating a quality focused Central Indiana health care system which will provide nationally competitive quality care, cost efficiency and customer service through partner health care providers.”

Its ***Mission*** states, in part:

“The Alliance will partner with physicians and hospitals to establish the new health care system.”

The Alliance has attempted a number of projects aimed at improving employers’ health care services. These have included employee education (Asthma and Pregnancy), provider profiling (Hospitals and Health Plans), group purchasing (HMOs), Community Collaboration (The Health Improvement Council and the Healthy Indy Partnership), and introducing member companies to new approaches and vendors. Participation in each of these was limited, and, in the case of the Health Improvement Council and the Healthy Indy Partnership the community failed to follow through. While it is likely the Alliance has had an impact on the community, it is difficult to document that Alliance members, per se, have taken sufficient advantage of these programs to be able to document a substantial return for their investment in the organization, or that the Alliance has significantly changed the local health care market.

Comparing the Alliance effort in the past to Andy Webber’s list reveals the following:

- **Performance Measurement and Reporting**

- **Hospitals** – After 4 years, hospitals only criticized their profiles and withdrew their cooperation
- **Health Plans** – Still occurring, but with reduced cooperation as will be noted later.
- **Education**
 - **Asthma** – 3 courses were created, but only 20 employees participated. Despite strongly positive reviews and impact, there was no interest in repeating.
 - **Pregnancy** – After extensive work with the Marion County Health Department and March of Dimes, of 3 different presentations prepared to be presented by Public Health nurses at no cost, only one course was provided one time by one employer – and not the employer pushing the program initially.
- **Selective Contracting**
 - **HMO Group Purchasing** – Due to very low employer participation, very little impact was made.
- **Collaborative Process Improvement**
 - **Healthy Indy Partnership** – Despite good community representation and a well developed portrait of the status of Indianapolis in numerous areas, including health and health care, the resulting document failed to make a significant impact
 - **Health Improvement Council** – Despite initial enthusiasm by participating stakeholders in this IEQHA initiative, the State Department of Health failed to move the effort forward after agreeing to do so.

The Alliance Community-based approach to Health Care Reform

Therefore, the current Alliance approach to member service and health care reform has become **focused in five primary areas:**

1. **Modernize the health care infrastructure**
2. **Collaborate with national efforts to improve the health care system (or non-system)**
3. **Encourage more effective health plan services**
4. **Improve hospital patient safety**
5. **Create an employer/provider partnership to create a high quality, efficient delivery system with aligned provider, employer and member programs and incentives.**

We have been asked whether our efforts consider problems of access or issues pertaining to **Medicare and Medicaid**. The answer is that our responsibility is first to employers. However, the issues with which these other areas are concerned are primarily financial. In all cases, **creation of a true systematic approach to reforming the delivery of health care services will offer benefits** to those wrestling with these other areas as well.

1. Modernize the Infrastructure

One of the successes of the Indiana Employers Quality Health Alliance has been our effort to put in place a **medical information infrastructure** – beginning with Clinical Messaging, i.e., making medical information immediately available when needed, regardless of where it was generated.

In response to a January 2000 conclusion of a meeting of 60-70 physicians that identified a single, common platform for the exchange of all clinical and administrative health care data as most likely to improve health care in Central Indiana, the Employers Alliance obtained a grant that allowed a planning group to develop the concept, focus on “clinical messaging” as their first project, and perform a return on investment study at each of the principal Indianapolis hospitals.

Their work eventually led to formation of a new organization, the **Indiana Health Information Exchange** which plans to develop the information platform, encourage economic development, expand research opportunities and improve health care delivery. IHIE has obtained over \$15 million in funding, hired full-time leadership and staffing, is effectively putting clinical messaging in place, is starting a project to acquire data for clinical performance profiling, and has become a recognized, cutting edge leader in the United States in health care information.

While moving forward on their first two projects, IHIE is considering a number of other initiatives that could improve health care. An example of a significant opportunity is ePrescribing. It has recently been estimated that **a shift by physicians and pharmacies from handwritten to e-mail prescriptions could cut the nation's health care costs by \$29 billion**. There were 3.7 billion prescriptions written in 2003, of which about 8.8 million resulted in serious illness from drug errors. Currently, only about 15 percent of physicians use electronic prescribing.

Thus, it is clear that we may see real quality and efficiency gains as the development, implementation, and expansion of this information technology infrastructure proceed. The Alliance continues to be represented on the Board and Executive Committee of IHIE, and also on the Business Advisory Board of the eHealth Initiative in Washington, DC.

2. Collaborate with National Employer-driven efforts to reform the Health Care System

The Alliance is an active member of the National Business Coalition on Health (NBCH). This "coalition of coalitions," headquartered in Washington, DC, represents the coalition movement in national health care forums, including government, and offers turnkey health care products and services to community coalitions and their member employers. Examples of programs available to Alliance members through NBCH include Pharmacy Benefits Management, Laboratory, and Vision Care. Additionally, NBCH provides information of interest to employers regarding trends in the field and proposed legislation or regulation through email, webcasts, seminars and courses, and its Annual Meeting.

6. Encourage more effective health plan services – eValue8 HMO Profiling

The eValue8 project, offered through the National Business Coalition on Health, has been conducted for approximately 6 years by the Alliance. This program seeks to **profile local managed care organizations** regarding their efforts to encourage improved health among their enrollees, higher quality of care among their providers, and constraint on the causes of increasing cost of care.

Requests for Information, developed by NBCH with annual feedback from the plans, are graded by NBCH consultants and then reviewed with the Plans by the Alliance and its consultants to assure that they understand the employers' interests and concerns and that the process appropriately recognizes the Plan's performance. Following a final review, the results of these surveys are made available to member companies for their consideration in contracting.

Because of the Alliance size and limited resources, and the limited participation of companies using the plans, this program has not been as effective in Indiana as it has in many other communities (for instance, the State of Minnesota and the Minneapolis coalition do this project statewide, with wide dissemination of its results.) Only two plans currently participate with the Alliance, a situation that could likely be improved with greater employer participation and more adequate funding.

4. Improve hospital patient safety – The Leapfrog Project

Leapfrog was established by a group of large national employers in response to the Institute of Medicine Report that suggested that from 48 – 98,000 patients die each year in US hospitals due to medical errors. Leapfrog focuses on 5 areas in which it hopes hospitals will achieve a high level of performance that may be expected to reduce this rate and improve quality improvement in specific areas. Hospitals self-report their progress in these areas, and their reports are then displayed on the national Leapfrog website. IEQHA has been selected to lead the Leapfrog roll-out in Central Indiana in 2006.

A Steering Committee leading this venture includes private employers, the State of Indiana, the City of Indianapolis, the Indiana State Chamber of Commerce, and the Indiana Manufacturer's Association. **154 employers, representing over 500,000 lives, have signed on as sponsoring employers.**

The formal rollout of Leapfrog in Central Indiana is underway and represents an excellent **example of cooperation throughout the community to improve hospital quality and patient safety.** Meetings with local **hospitals and the State Hospital Association have shown a strong and willingness to collaborate** in the project. The Alliance has also agreed to give strong recognition to other patient safety efforts being undertaken by local hospitals through their Patient Safety Coalition. We are targeting the hospitals in Marion and the adjoining counties in 2006. Additionally, we will be sending an informational letter of invitation to the remaining hospitals in the State so that they will be knowledgeable about

the project. We hope many will choose to participate. A local Alliance web site is under development.

5. Construct an employer/provider partnership to create a high quality, efficient delivery system with aligned provider, employer and member programs and incentives.

As described earlier, there are only three true decision makers in health care: **i.e., employees, employers and physicians.** A true systematic approach **requires that all three major stakeholders** come together in a win-win-win relationship, with incentives (rewards and penalties) for each to assume its individual responsibility to create the environment, organizational structures, processes and rewards that will lead to real health care efficiency and quality.

This approach has received **strong verbal support from physicians and employers.** In response to their support, a complex, integrated plan for creating community systems of care, under the oversight of local employers and physicians, was developed. The decision was made to place the initial focus on identifying high quality, efficient physicians prospectively, and providing incentives to patients to use them for their care. To that end the **Employers Alliance has entered into a partnership with Gateway Medical Resources,** a management organization with experience in this approach, to form this multi-hospital network that will include a broad, multi-specialty (including primary care) physician organization – based on documented quality.

a. Focus First on Quality

There are sound reasons for focusing first on quality. While more will be said later, the following speak to this decision:

1. There is excellent research documenting a **high degree of variability in process, quality and cost** among and within regions and institutions. Most notably a June 26, 2003 New England Journal of Medicine article documented a 55% incidence of inappropriate or inadequate care. Further, the Juran Institute and Dr. Wennberg at Dartmouth have identified a 40% rate of variation in interventions and costs among providers.
2. The Pacific Business Group on Health estimates that **premiums could be reduced by 7-12%** by shifting to efficient providers
3. **A Mercer-Union Carbide study** in West Virginia cut costs by asking primary care physicians to use a list of the highest quality, efficient specialists. The company saved money, and the physicians all received bonuses.
4. Less than 50 **surgical procedures** account of over 50% of surgery done, are frequently over utilized, and often lead to litigation because of unsatisfactory outcomes. Using surgeons who have been documented to know when and how to use these procedures will improve quality and outcomes and lower cost.

b. Partner with providers, starting with physicians

For these reasons, the Alliance will focus first on **prospectively selecting physicians and hospitals whose quality and efficiency can be documented,** and encouraging employers and administrators to offer them preferentially to their covered members.

Quality assessment would be done **in collaboration with selected physicians** in the community who would oversee the profiling, marketing, and rewarding of the physicians in the resulting high quality network.

Our assumptions are as follows:

1. There is an **unacceptable variation** in medical practice patterns for similar medical conditions among physicians in the same medical community. According to the Information Technology Association of America, **“better care for Medicare beneficiaries with chronic conditions could prevent some 1.7 million hospitalizations and save Medicare more than \$30 billion”**. Quality can be prospectively determined based on clinical measures determined by the best physicians in each practice area. Patients should be encouraged to use high-value (high quality at low cost) physicians and high value hospitals.

Clinical measures will be used to assess quality, including – under physician oversight – **office based chart audits**, abstracted by trained nurses and reviewed by peer physicians. The in-office approach gets around the problems with claims-based review and the issue of small numbers, allowing **accurate, reproducible profiling** of individual physicians.

2. **Physicians of demonstrated clinical excellence should guide** these efforts, including:
 - a. Defining best practices
 - b. Adopting guidelines and protocols
 - c. Designing and refining quality & efficiency metrics
 - d. Agreeing on performance evaluation processes and their application
 - e. Developing episode-based processes for systemic and achievable quality improvement
 - f. Resolving resistant quality of care problems
3. **Quality medical practice** is preventing and caring for illness. The least expensive medical condition is the one that never occurs; the second-least expensive is one that is **well managed to prevent progression and complications**. These chronic conditions cause a minority of covered lives to generate the majority of health care expenditures. However, **demand and disease management *are* the practice of medicine**, should be developed by physicians and integrated into their clinical practices at the point of care. Using physicians known to practice high quality medicine in a cost effective way can **eliminate the necessity of employers paying for add-on programs**, e.g., Precertification, Utilization Management, Demand Management, and Disease Management.

The goal is to **return professionalism to medical practice**, give the physicians control of clinical decision making, decrease the hassle they currently face, support their patient management efforts and assure that they are adequately compensated for their services. This process could assist physicians who participate in the program to participate in other performance profiling programs, such as BTE, with no or minimal additional cost or inconvenience. Further, we believe it can **reduce cost increases to employers by from 30 – 50%**.

c. Involve the hospitals

In a recent survey of quality in over 5000 non-federal hospitals, patients with diabetic acidosis and coma were **82% less likely to die in hospitals rated in the highest 15%** of those surveyed compared to those performing at the national average, and almost **93% less likely to die than in hospitals in the lowest 15%**. If all hospitals surveyed had performed during the three-year study period in all areas surveyed as well as the highest rated hospitals did, those conducting the study project that more than **273,000 lives potentially could have been saved**.

Physicians in the network must have **hospital performance profiles**, possibly using publicly available Medicare data – which has a > 90% correlation with all-patient data – and additional information such as the hospitals' efforts to improve patient safety and quality. Since physicians have an incentive to produce the best outcomes at the lowest cost, we expect them to take the lead in directing patients to the best hospitals and also in helping identify and implement improvement programs in the hospitals that do not profile as well. **Structural arrangements will reward hospitals for working with these select physicians to assure the highest quality, most efficient care in their institutions.**

d. Revise Benefits to assure employee empowerment and responsibility

The quality focus attacks the provider segment of the three primary decision makers. **To address the other two**, it is important that contracting employers **put in place as many incentives and support elements** as possible to bring the employee into synch with the employer and physician.

Therefore, with the advice and leadership of the physicians, we will develop **recommendations to employers regarding plan design features** that will identify members for intervention, emphasize effective self-management and avoid financial barriers to effective management by skilled physicians. Such features include:

1. **Automation of the enrollment process to provide data** electronically to important users
2. **Wellness programs** to identify and direct opportunities to reduce health risk and improve health quality and care – empowering and rewarding patients for effective preventive care services including selective, highly focused education and behavior-change coaching,
3. Financial incentives to use **high quality providers**
4. Incentives to **participate actively in physician-directed chronic disease management**
5. Complete **coverage of desired behavior**, both for prevention and chronic disease management (i.e., get rid of financial disincentives to good care that save in the short term and are expensive in the long term). An element of employee risk assumption, e.g., the HSAs (with bonuses for effective self-management) to discourage unnecessary expenditures and reward those who accept personal responsibility for their health should be included.

The objective is to improve members' health and reduce preventable expenditures through individual patient management programs for those with health risks, potential problems, and

chronic illnesses. Design features providing **incentives and support elements** in order to bring the employee into synch with the employer and physician are vitally linked to the effectiveness of the physician efforts and will directly impact the return on investment. The intent is to maintain maximal, informed provider choice for employees, but encourage them to use and cooperate with the most cost effective, high quality physicians and hospitals. To be effective, patients must understand the benefits of seeing high quality providers, and they should **pay less out-of-pocket if they select providers who have demonstrated their ability to provide high-value medical care.**

The partnership that the Alliance has undertaken will offer its high quality product for access fees that begin at the lowest levels in the market and then go down as employers participate in programs and design benefits that will further reduce health cost exposure. Additionally, there will be no utilization management or disease management, since high quality physicians will already have been documented to address these areas adequately, obviating the need for this additional bureaucracy and cost.

Nearly 2000 physicians have indicated their likely intent to participate. A number of the manager's current clients have expressed interest in the product, as have employer coalition members and a number of brokers and TPAs. Controlling, rather than creating, the market will be the primary need in order to assure that all support systems are functioning at a high service level. It is likely that this product will be available in the second quarter of 2006, with subsequent, planned expansion throughout Indiana, into neighboring states, into areas required to service Indiana companies in other parts of the country and to areas represented by other business coalitions, many of whom have already indicated interest.

e. Restructure Administration

It is clearly necessary to have an intermediary operating at the intersection between the patient, employer and provider to manage the health care interface, acquire and analyze data, and process claims. However, this is the level at which employers and physicians have both strongly stated that their real frustrations and problems occur. Further, the use of vendors for these services adds a significant amount of cost, but for often-questionable value.

It is our belief that:

1. That the **primary players** in the health care equation are the **employers and providers.**
2. That those who do **claims administration** should be focused on the prompt, efficient and accurate payment of claims, not seeking discounts and second-guessing physicians, and
3. That insurance companies have, to a great extent, become administrators and transfer agents and that they should **return to their role as insurers**, i.e., spreading risk over large numbers of insureds.

Consider some of the headlines that came over the computer in one month last summer:

- **Astrazeneca posts profit rise**
- **Bristol-Myers reports profit doubled for quarter**

- McKesson's second quarter profit soars to \$167 million
- Atena profits cheer investors
- Pacificare posts 20 percent profit rise for second quarter
- Pacificare executives to reap \$230 million in United Health deal
- President of United Health Care earned \$140 million in 2004

And then consider how providers felt when in the same time frame they read:

- Medicare to lower physician payments by 4.4%

It is our belief that the real stakeholders (employers and providers) will be better served by a **manager or intermediary working for the employers as a cost center**, rather than by one or more contracted vendors (including health plans) serving as profit centers generating investor return and, often, excessive executive compensation.

Applying all of these approaches begins to construct an essentially new and different **community health care SYSTEM** that will assure efficient provision of high quality services with a minimum of administrative cost by injecting higher standards into daily patient care decisions and identifying opportunities for improved quality of medical care.

- How do We Get There -

These are the factors NBCH's Andy Webber lists as essential to a coalition's success, and the barriers to that success:

Success Factors for Business/Health Coalitions

- Committed leadership from core employers
- Coalition membership represents significant market share to grab plan/provider attention
- Clear mission and strategic focus
- Ability to convene all stakeholders
- Ability to design and execute a group purchasing program
- Creation of sustainable business model beyond membership dues
- Leadership skills and business acumen of Coalition Director
- A demonstrated track record of success

Major Obstacles to Business/Health Coalition Success:

- Absence of employer leadership and participation
- Unwillingness of employers to participate in group purchasing activities
- Failure to create a sustainable business model
- Inability to identify DATA leading to ACTIONABLE INFORMATION
- Lack of evidence of ROI for coalition activity

To which I would add **the following obstacles, which are specific to Indianapolis:**

- Provider Skepticism
- Competition from the Indianapolis Forum
- Finance – The Alliance has essentially no financial resources.
- Membership – If we address this, the others should take care of themselves

Conclusion

We believe that, despite some fits and starts, **the Indiana Employers Quality Health Alliance has made an impact on health care in Central Indiana** – at a minimum through its contribution to bringing wellness, prevention, cost and quality issues into mainstream thought. Certainly, IHIE is a concrete example of its impact.

Most of us believe it is time to move this effort to the next level. However, not everyone agrees that the business community seeks such an impact. The following is a quote from an email I received from the CEO of a large health system in Central Indiana:

“I have now met with the leadership of virtually every major employer and trade association. So far, no one really is interested in a paradigm shift.”

It is not clear to me that the people he is speaking to truly represent their memberships. Nevertheless, it does emphasize the challenge we face. If I am correct that health care is of far greater concern to employers than this health leader perceives, the **Alliance is positioned to bring about such a paradigm shift** in Central Indiana Health and Health Care.

Step one was your acceptance of an expanded **Alliance board comprised of extremely knowledgeable and respected leaders, with great potential clout in the market should they choose to exercise it.** Nevertheless, although the Alliance has made substantial progress in the past, and has developed programs that should help achieve that goal, **the Alliance is still not sufficiently large to exert as much presence and leverage** in the marketplace as it should. If employers are going to be successful in changing health care through this coalition, **we need a significantly expanded membership** of those who share our concerns and vision, coupled with the active and publicly visible involvement of their leaders in this cause. Together, we can bring an end to the finger pointing, nibbling and quibbling and truly change health care.