Value-Based Purchasing
A newsletter from the College for Advanced Management of Health Benefits
May/2007
Vol 2 / Issue 1

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From the Editor

"Consumer Engagement": Great Expectations for Employees -- and Their Employers

Health care consumers of all stripes – young and old, healthy and sick, employed and retired – are increasingly being asked to take on more responsibility for their health and health care. Most current strategies for health care reform, including consumer-directed health plans and medical savings accounts, set high expectations for individual behavior. In this emerging era of "consumer engagement," individuals are being asked to take on a long and daunting set of "responsible behaviors." Just a partial list of these behaviors includes:

- Following recommendations for promoting personal health (such as diet, exercise, quitting smoking, limiting alcohol use, wearing seat belts, etc.)
- Getting screened at appropriate intervals (for cancer and other conditions)
- Establishing a relationship with a primary care provider
- Managing chronic conditions to prevent decline in health status
- Comparing coverage options when selecting health plans
- Selecting competent doctors and safe hospitals
- Choosing effective treatments
- Taking drugs as directed
- Interacting successfully with health professionals and institutions
- Maintaining accurate records of personal medical history

Clearly, the vast majority of people do not engage in these behaviors. Many do not even realize that they are expected to act in these ways. Others are unable to take on these expected behaviors because they lack the information, skills, cognitive or physical abilities, or material resources to do so.

If “consumer engagement” is to become more than just the latest catch phrase (or worse, an excuse for employers to shift the growing financial burden of health care to their workers), purchasers will need to take a much more aggressive role in equipping their employees and their dependents to assume the wide range of personal responsibilities increasingly expected of them. Specifically, employers and union leaders must work together to develop and implement an infrastructure of communication, information, incentives, and interventions that will inform, motivate, and support people in adopting these behaviors.

Growing expectations for consumer behavior mean even greater expectations – not less – for employers to provide needed information and support. The challenges and barriers are enormous, but there are promising models of successful initiatives to change consumer behavior in even the most difficult circumstances. For example, as reported in a previous issue of Value-Based Purchasing (Volume 1, Issue 1), the Hotel and Restaurant Employees International Union has found success in multiple interventions aimed at increasing consumer use of preventive services, managing chronic disease, adhering to prescribed medications, and selecting higher performing family doctors. Other successful examples, such as Pitney Bowes and the City of Knoxville, also have been profiled in VBP and in our regular course offerings.

In this issue of VBP, we are pleased to include an interview with Debra Ness, President of the National Partnership for Women and Families. Debra offers the perspective of one of the nation’s most influential consumer groups on the increasing role of consumers in making decisions about their health and health care. This interview highlights the importance of employers working with consumer groups to develop a united approach to engaging consumers in their health and health care. The benefits of doing so will accrue not only to individuals through better health and wellbeing, but to employers through increased control over costs and productivity, and to the nation as a whole through a safer, more efficient, and effective health care system.

Dale Shaller, Editor
Value-Based Purchasing

VBP Interview with Debra Ness

Dale Shaller, Editor, VBP

***Debra Ness** is President of the National Partnership for Women and Families, a nonprofit, nonpartisan organization based in Washington, DC that promotes fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family. Ms. Ness has helped position the National Partnership as one of the nation's most influential consumer groups advocating health policy reforms based on transparency, choice, and accountability. She holds advisory positions with numerous health care groups such as NCQA, JCAHO, IOM, the National Quality Forum, the Leapfrog Group, and the American Board of Internal Medicine. This interview was conducted in August 2006 with grant support from the California HealthCare Foundation.*

VBP: ***What are the key drivers or forces that have led to the increasing role of consumers in health care decision-making?***

Ness: I think there are numerous forces converging to increase the role of consumers in health care decision-making. First and

perhaps most influential at this time is the change taking place in health care benefit design. We are just at the tip of these changes, as purchasers and plans provide incentives for consumers to use information about cost and quality when choosing providers.

To the extent that good, comparative information about both quality and cost is available, such incentives may help steer consumers toward better quality care and help them spend their health care dollars more effectively. Benefit design that encourages consumers to choose high quality, cost-effective care—what might be called "value-based decision-making"—can also positively impact the way care is delivered. Many consumer groups, however, are skeptical of so-called "consumer-directed" health plans because they appear to be more about cost-shifting than consumer empowerment. Plans that simply incentivize consumers to choose cheap services, or to use less care, will ultimately backfire.

A second major factor is that we are increasingly an information-based and information-seeking society. We see more informed consumer decision-making in all types of services. People are getting used to, and in many ways have come to expect, the ability to evaluate quality and performance in all kinds of products and services. Even something as simple as the purchase of a cup of coffee is now a more "informed" and "value-based" decision.

Another factor is the increasing awareness among consumers that there are real differences in quality, efficiency, and safety among health care providers. We still have a long way to go, but there is growing awareness of variations in the quality, safety, and cost in health care.

Finally, there is just more information available now on quality and cost. It's still far from what we need, but it's on the rise.

VBP: ***What new or different forces are emerging, if any, that will shape consumer health care decision-making in the next 10 to 15 years?***

Ness: I think we will see a push for even greater transparency in health care. The National Partnership is working to bring more consumer advocacy groups to the table in order to ensure a strong and informed consumer voice for transparency. In the past, most health care advocacy groups focused on access, not quality. That is beginning to change. Other forces moving the transparency agenda forward include employers, health plans, the Administration, and Congress. Even the medical profession is looking at these issues differently. The question today is not <u>whether</u> but <u>how</u> quality measurement and reporting will be done.

I think health information technology (HHIT) also will help move us toward more informed decision-making. It will enable us to collect and report more information about health care quality and provider performance, and it will make such information more easily accessible to consumers. The adoption of electronic health records (EHRs) and personal health records (PHRs) will also enhance consumer decision-making.

As discussed above, benefit trends will also drive consumer decision-making. And, of course, the escalating costs of health care will affect consumers' decisions about their health care.

VBP: ***What are the major benefits or outcomes we can expect as a result of the expanding role of consumer decision-***

making related to choice of plans and providers, self-care and self-management, and shared medical decision-making?

Ness: Certainly, shared decision-making between consumers and health care professionals holds the potential for huge benefits. There is growing evidence that shared decision-making generally leads to consumers choosing more conservative, less invasive, and less costly services, often with better outcomes. But for this to happen on a large scale we will need a much stronger evidence base, and there will need to be significant changes in the way clinicians practice. One might also expect that consumers who participate in shared decision-making with their health care providers will be more likely to effectively manage their own health care.

More consumer decision-making based on comparative quality and cost information is also likely to lead to positive changes in provider performance with respect to both quality and cost. However, we shouldn't expect that consumer decision-making alone will re-shape the marketplace or drive down health care costs. Even armed with the best information, consumers on their own cannot "tame" the marketplace any more than employers have been able to do with all their purchasing leverage. More transparency and better consumer decision-making need to be accompanied by significant changes in the provider payment system.

VBP: ***What potential downsides or cautions are there to the expanding role of consumers in these types of health care decisions?***

Ness: First of all, there is the risk of creating the wrong incentives for consumers. A benefit design that pushes consumers to make decisions based on cost alone could result in consumers getting poor quality or inadequate care.

In addition to creating the right incentives, we will also need to change the consumer mindset to one that is more oriented to thinking about care in terms of appropriateness and value. To do that, we need to debunk a number of myths and misconceptions such as "more care is always better" and "more expensive care is better quality care." A lot of education, and perhaps re-education, must be done to get people to the point of believing that it is possible to get better care while spending less. Also, we need to promote understanding of the concepts of "appropriate care" and "evidence-based care."

VBP: ***How will the expanding role of consumer decision-making affect the future structure and delivery of health care?***

Ness: In combination with other strategies, consumer value-based decision-making can lead to positive changes in the way care is delivered. As providers focus on improving quality and efficiency, they will need to reengineer the processes of care and hopefully move to a system that delivers better integrated and coordinated care with more emphasis on primary and preventive care.

It's also important to realize that consumer behavior can help change the delivery system - whether or not the majority of consumers are actively on board and engaged in value-based decision-making. We will never have everyone engaged, but I am optimistic than we can get enough people engaged to foster significant change.

VBP: ***What are the major barriers to increased consumer decision-making in health care?***

Ness: There are many barriers we need to overcome. I've already mentioned the lack of evidence regarding treatment effectiveness. Sound evidence is essential to support shared decision making and to create incentives for consumers to choose the most appropriate and effective care.

We also have little evidence about the effectiveness of different benefit designs.

While availability of information on quality is growing, we lack good measures that are meaningful to most consumers.

Health literacy is a huge problem, and many consumers still lack access to the Web. Many providers lack the skills needed to provide "culturally competent" care or to transcend problems of health literacy and language barriers.

And there are still many providers who will resist the move to greater transparency and the need to adopt fundamental changes in the way they practice.

Finally, our payment system doesn't reward quality and efficiency. In fact, in many ways it discourages the very improvements in quality and efficiency that we seek.

VBP: ***What will be the impact of new technology on consumer decision-making?***

Ness: We need widespread adoption of HIT to provide the platform for the data collection and public reporting that would enable value-based decision-making by consumers. As comparative cost and quality information becomes more available, user-friendly, and actionable, we can expect consumers to increasingly use this information to make choices about providers.

The availability of both EMRs and PHRs will also enable consumers to better manage their own care and to be more active players in both seeking and receiving care from their providers. Also, we can expect continued growth in consumers' use of the Web as a source for health information of all kinds.

VBP: ***Which consumers are likely to benefit most from these new developments and which will benefit least? What needs to be done to include consumers who otherwise might be left out?***

Ness: All consumers will benefit from these developments. Certainly those who can access and understand this information easily will be the prime beneficiaries because they are most likely to use this information in their decision-making. But all consumers will benefit from the changes that result from increased transparency and accountability. There is plenty of evidence that making comparative quality and safety information publicly available drives improvements and changes in provider behavior regardless of consumer use. And, as I already said, consumer behavior can help change the delivery system, even if only a segment of consumers engage in value-based decision-making.

VBP: ***What critical steps need to happen to support effective consumer decision-making in the future?***

Ness: We must overcome the barriers I mentioned earlier -

- We need to expand the evidence base for treatment, and we must build an evidence base for benefit design to ensure that we create the right incentives.

- We must reform the payment system and align provider incentives in ways that encourage high quality and efficient care delivery.

- We need comprehensive adoption of HIT, including both EMRs and PHRs.

- We need greater transparency. We need standardized measures of quality that are meaningful to consumers, and public reporting of those measures in ways that enable consumers to assess differences and make value-based decisions.

Finally, to make all this happen, we need to have all the stakeholders at the table, especially consumers. We need their perspective, their buy-in, and their help in order to get to the kind of health care system we all want. There is a growing number of consumer advocacy organizations beginning to focus on these quality, transparency, HIT and payment issues. This will ensure that we shape a system that meets the needs of patients and consumers. It will also help us reach, inform and enable consumers to become better healthcare decision-makers and more engaged patients.

Letter from a Graduate of CAMHB

(From a recent letter to Jerry Burgess and Ed Moore – Healthcare 21)

"It is hard to believe, but it was 2 years ago that I attended your conference in Phoenix, AZ. I wanted to let you know that an HRA plan we implemented with Aetna in October 2005 was, in part, due to the information gained from attending that conference.

The HRA has been beneficial from many aspects – educating our employees and family members about the actual cost of different health care services, encouraging our employees to be more engaged in their choices, and enabling our employees to use online tools to learn more about this plan and all that it entails. We have a $500 employee fund and $1,000 family fund built into the deductible.

The HRA has been beneficial from both a budgetary and a renewal standpoint. Even though the out-of-pocket deductible amounts are higher than those employees were accustomed to, the idea that there is a maximum amount one would have to pay is easy to grasp. Many employees are putting money into a savings account just in case they need to pay the deductible. They like the idea that, if they don't need to use the savings for medical expenses, they are ahead of the game!

The HRA went from 50% enrollment the 1st year to 77% enrollment in the 2nd year. We were able to stay within budget and offer it without an extra charge both years. Our goal is to do the same again this plan year (October 1 – September 30). Also, our FSA enrollment increased in the past year, in part due to the HRA and the use of a debit card.
We have always been fully insured, but we are seriously considering self-funding and are taking proposals for both approaches this year. We also implemented a tobacco surcharge on our employees. We are hoping to include dependents this plan year.

It has been interesting to watch this process evolve. A neighboring city is implementing an HRA this summer, so the word is getting out. We have had several inquiries from other local governments who are curious about the plan and how it is being received by our employees.

There is still more we can do - we are getting there slowly but surely. All of those involved and connected with your organization have been a great help to me these last 2 years. I look forward to contacting you about future options and learning more about what we can do to better improve the health care benefits we so greatly need."

Karin Grindstad, Benefits Manager
City of Roswell, GA

Literature Review:

Health of the Nation = Health of the National Work Force

Janice Clarke, Managing Editor, VBP

Each year, the Secretary of the Department of Health and Human Services submits a report on the health of the Nation[1]. Compiled by the National Center for Health Statistics (NCHS) at the Centers for Disease Control (CDC), the report contains national health trends in chart and table form. Data is presented according to race, ethnic detail, socio-economic information (e.g., education, family income), and disability data.

The report for 2006 indicates that the health of the nation is improving overall as evidenced by a continuing upward trend in life expectancy, and a continuing decline in mortality from heart disease, stroke and cancer. Employers are keenly aware that these improvements come at a high price. The US spends more on health per capita than any other country – and the spending continues to increase rapidly. Hospital spending accounted for 30% of total national health expenditures, and spending for prescription drugs accounted for 10% of national health expenditures in 2004.

Much of the nation's health care spending is for care that controls or reduces the impact of chronic diseases and conditions.

Chronic Conditions and Risky Behaviors: The statistics show an increasing prevalence of chronic diseases and behaviors that lead to chronic conditions.

- *Diabetes:* In 2001-2004, 10% or persons aged 20 and over, and more than 20% of adults 60 years and over had diabetes. Diagnosed and undiagnosed diabetes prevalence increased with age from 11% among adults 40-59 years of age to 23% among adults age 60 and over.

- *Hypertension:* In 2001-2004, about 30% of adults age 20 and over had treated or untreated high blood pressure. In the 45-54 age group 30% of men and 33% of women had hypertension.

- *Arthritis and other musculoskeletal conditions* were the leading cause of activity limitation among working-age adults 18-64 years of age in 2003-04.

- *Overweight and obesity:* Recent increases in overweight and obesity are of concern because these are risk factors for many chronic diseases and disabilities including heart disease, hypertension and back pain.

- *Cigarette smoking:* The rapid drop in cigarette smoking over the two decades following the first Surgeon General's Report in 1964 has slowed in recent years. In 2004, 23% of men and 19%

of women 18 years or over were current smokers.

Impact of Health Insurance: Adults 18-64 years of age were the most likely to report not receiving needed medical care or delaying their care due to cost. In 2004, 20-21% of people under age 65 years who were uninsured for all or part of the preceding year did not receive needed health care in the previous 12 months due to cost. In contrast, only 2% of people with health insurance for the full year did not receive needed health care due to cost.

Overall, private health insurance paid for 36% of total personal health care expenditures in 2004. The remainder was funded by the Federal government (34%), state and local governments (11%), and "out-of-pocket" by individuals (15%). The percentage of the population with no health insurance fluctuated between 16-18% (1994-2004).

High "cost" of pain: Pain is a major determinant of quality of life that affects both physical and mental functioning. In addition to the direct costs of treating pain (i.e., diagnosis and treatment, drugs, therapies and other medical costs) it results in lost work time and reduced productivity and concentration at work.

Considerable health care resources are devoted to treating pain, and the amount has been increasing. For example, rates of hospitalizations with procedures to replace painful hips and knees have increased substantially in the last decade.

In 1999-2002, 26% of Americans age 20 and over reported that they had a problem with pain of some sort that persisted for more than 24 hours at some time during the previous month. With even greater use of pain relieving medications, surgical interventions and other treatments, in 1999-2002 more than 10% of Americans age 20 and over reported pain that had lasted for more than 1 year.

Consider the impact the following painful conditions have on a typical work force given these recent statistics –

- *Headache:* In 2002-2003, more than $4 billion was spent on prescribed medicine for headache (not including over-the-counter and inpatient drug expense). Fifteen percent of adults 18 years of age and over reported experiencing migraine or severe headache in the previous 3 months. The percentage of young adults 18-44 years of age who reported migraine or sever headache was almost three times the percentage for older adults.

- *Low back pain:* In 2004, more than ¼ of adults 18 years of age and over reported experiencing low back pain in the previous 3 months. Moreover, 28% of these adults with low back pain said they had a limitation of activity caused by a chronic condition (compared with 10% of adults who did not report recent low back pain). People with recent low back pain were almost five times as likely to have serious psychological distress as people without recent low back pain.

- *Joint pain:* Prevalence of joint pain increased with age in about 20% of adults, age 18-44 years. One-third of adults 18 years of age and over reported joint pain, aching or stiffness. The knee was the site of joint pain most commonly reported in all age groups.

- *Narcotic drug use:* Narcotic drug use for pain has increased from 3.2% in 1988-1994 to 4.2% in 1999-2002, driven largely by an increase in narcotic drug use among white non-Hispanic women and women 45 years of age and over.

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[1] National Center for Health Statistics. Health, United States, 2006, with Chartbook on Trends in the Health of Americans. Hyattsville, MD: 2006. Library of Congress Catalog Number 76-641496. For sale by Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Acknowledgement of Supporters

Funding support for this e-journal has been provided by Johnson & Johnson Healthcare Systems, which also supported development and updates to the College curriculum. The College also wishes to acknowledge annual program support from AstraZeneca, and 2007 regional meeting sponsorships from Sanofi-Aventis and Blue Cross Blue Shield of Tennessee.

Program Schedule

This e-journal, *Value Based Purchasing*, is a product of The College for Advanced Management of Health Benefits, a unique training program designed to help employee benefit managers meet the growing challenges of providing high quality health benefits and managing rising benefit costs. The College offers a practical, intensive program that focuses on benefits purchasing techniques and skills that emphasize improving the value, quality-cost ratio, and effectiveness of health care services purchased on behalf of employees. The program is a collaboration between the HealthCare21 Business Coalition in Tennessee, the National Business Coalition on Health, and the Department of Health Policy of Thomas Jefferson University.

Three College sessions are held each year. Remaining programs for 2007 are scheduled for:

- June 4-6 in Nashville, TN
- September 24-26 in Columbus, OH

For more information, or registration materials, please contact Jeannine Kinney, Program Coordinator, at jeannine.kinney@jefferson.edu, or 215-955-1709.