Sounding Board

Large Employers' New Strategies in Health Care

LARGE employers, disappointed by the stalled efforts of physicians, hospitals, and insurers to control the cost of medical care and improve its quality, are planning a substantial effort themselves. Since large employers (those with 10,000 or more employees) have huge health care expenditures, they have both the motivation and the influence to develop solutions to the current problems with the health care system. In response to the reemergence of double-digit annual cost increases, many of these companies are seeking better and less expensive approaches to health care coverage for their employees. Few employers believe that insurers have the ability to manage care more effectively, and in view of the backlash against managed care by patients and physicians, more intensive versions of this approach will probably be unsuccessful.[1]

In considering new strategies, employers rely on their view that a market-driven system can best address the widely recognized inefficiency and suboptimal quality of our current health care system.[2-4] They believe that the same approach that has worked in other parts of their business — providing financial incentives to improve quality and lower costs — can be adapted to health care.

Employers believe that consumer pressure is a powerful, underused lever for improving quality and efficiency. They believe that higher quality and lower cost will result if consumers have more responsibility for their health care expenditures and if providers respond by improving their performance. For this strategy to succeed, consumers will have to be motivated to seek more efficient, higher-quality care, and physicians will have to be rewarded for delivering such care. Two fundamental changes underlie this new strategy: greater responsibility for costs and decisions about care is being placed on employees, and measures of quality and efficiency to support these decisions are being extended beyond health maintenance organizations to include clinicians and hospitals. Employers know that accomplishing these goals will not be easy; a successful, consumer-driven initiative faces three key challenges: establishing financial incentives for consumers, measuring the efficiency and quality of care, and using measures of performance to improve care.

CREATING FINANCIAL INCENTIVES FOR CONSUMERS

Mechanisms to reward consumers for making economical choices have existed in various forms for several decades. In traditional indemnity plans, characterized by annual deductibles and copayments, employees pay less if they use fewer services. In the era of managed care, employers have used lower payroll deductions as an incentive for employees to join more economical networks of doctors and hospitals, as well as lower out-of-pocket payments at the point of care for choosing physicians in these networks. However, the savings realized by many managed-care plans have been limited to one-time price reductions. There has been little incentive for patients to choose providers that improve quality and efficiency by reducing misuse, overuse, and underuse of resources. The preservation of the status quo comes as no surprise, since patients have not had access to ratings of the quality and efficiency of care provided by physicians and hospitals and have been substantially shielded from the financial impact of their decisions about care.

Despite a flurry of interest in the use of a defined contribution — a fixed allowance per employee for individually purchased health care insurance — this approach is problematic for large employers. Widely recognized inadequacies in markets for individual health insurance and evidence that employees value the support of their employers in navigating the health care system[5] impede this approach. However, large employers and health insurers are developing new benefit plans that better align employees' financial incentives with information about the cost and quality of care, with the aim of rewarding the selection of more efficient treatment options and providers.

Several examples illustrate the power of financial incentives to influence choices made by consumers. In one study, the provision of incentives for consumers to select lower-cost medications (e.g., an increase in the copayment from 20 percent to 30 percent of the cost) led to a substantial increase in the use of more cost-effective drugs.[6] The majority of large employers offer plans with three tiers of copayments for medications, depending on their cost, with reported, if not yet proven, savings.[7] Several plans now feature two-tier payments for inpatient care, so that hospitals with lower performance ratings require a copayment of $100 or more, whereas hospitals with higher ratings require a lower copayment.

As another example, a national program that refers candidates for organ transplants to transplantation centers selected on the basis of quality and cost had a 75 percent rate of use, with a high level of user satisfaction, when linked to financial incentives for choosing it (Ziomek R: personal communication). A pioneering effort in the use of such incentives is a program established by Minnesota's Buyers Health Care Action Group,[8] which provides consumers with data on price and quality. The program has led to increased enrollment in provider groups with lower prices and

higher ratings for quality. Several large employers are offering plans that include personal care accounts,[9] which reward consumers for selecting economical options, such as participation in disease-management programs and other methods of improved self-care, as well as for selecting cost-effective providers. These plans generally couple a higher deductible with an employer-funded health account.[5] Consumers who make economical choices enjoy the tax advantage of accumulated unspent funds that can be used to pay for future out-of-pocket health care expenses.

Efforts to introduce incentives for consumers to select efficient, high-quality providers face considerable challenges, including the provision of adequate and comprehensible performance data, the administrative feasibility of such an approach, evidence that large deductibles discourage patients from seeking necessary care,[10] and questions of equity. Viable solutions must respect the prevailing view that people who are ill should be protected from financial hardship, and large employers will continue to include catastrophic coverage as part of every insurance plan.

To be effective, incentive programs must find a way to engage patients with acute or chronic diseases, who account for the majority of employers' health care expenditures, in weighing the efficiency and quality of providers. Potential options include using only positive incentives for employees who are seriously ill, such as reduced copayments for the choice of providers with high ratings for quality.

MEASURING EFFICIENCY AND THE QUALITY OF CARE

Over the past decade, multiple groups have attempted to measure the quality and efficiency of care provided by physicians and hospitals, including large employers, government, and most recently, physicians themselves.[11,12] However, the measurement of performance remains narrow in scope and methodologically imperfect, and there are important differences between measures developed for internal improvement and those intended for public release. Although doctors and hospitals argue that performance data should not be released until the measures have been refined, both states and private purchasers, frustrated by lackluster physician leadership and unwilling to let "the perfect stand in the way of the good," have pushed for the public release of performance data. Several states release performance data for hospitals.

In an effort to accelerate the implementation of a new strategy involving the use of performance data, several large employers formed the Leapfrog Group. This group, which now comprises more than 100 large private and public purchasers of insurance, worked with clinical experts in performance improvement and elected to use structural measures in hospitals to avoid many of the problems of process and outcome measures.[13] These structural measures include a hospital's use or nonuse of a computerized order-entry system for medications and the availability on intensive care units of physicians trained in critical care. Drawing on peer-reviewed literature, experts have estimated that adoption of Leapfrog's recommendations could prevent more than 60,000 deaths in urban hospitals annually.[14] Leapfrog's decision to use its purchasing clout to collect and release these data and to educate employees about them, despite criticism of their methodology by hospitals and physicians,[15] is an example of what large employers will be doing to help employees make informed health care choices.

The methodologic challenges of accurately measuring clinical quality, which have been summarized elsewhere,[16-18] include imperfections in risk adjustment, inadequate samples for the measurement of performance by individual physicians, inadequate representation of the actual patient encounter when electronic claims data are used, and problems in assessing the performance of individual physicians when multiple physicians have been involved in a patient's care. Attempts to address these challenges include supplementing performance measures with information reported by patients and audits of medical records,[19] measuring groups of physicians instead of individual physicians,[19] and developing more sophisticated methods of risk adjustment.

Providers have opposed the public release of performance data because of the cost of increased data collection and reporting, the use of imperfect measures, and the general dislike of being subjected to a public performance evaluation.[20,21] Providers are also concerned about increased liability, although the release of performance reports by national programs and pioneering states such as New York and Pennsylvania has not led to an increase in tort cases. Another concern is that some physicians will avoid providing care to patients with complicated disorders in order to protect their performance scores, but there is no definitive evidence of this response.[22] Finally, providers, along with consumers and regulators, are concerned about security with regard to health data.

USING PERFORMANCE DATA TO IMPROVE CARE

Will consumers use performance and cost data to select high-quality, efficient care? Even if they do not alter their choices, experience with the public release of information on quality suggests that hospitals and medical groups will be quick to respond.[23] After the release of national data on hospital mortality rates and the release of performance data in New York and Pennsylvania, numerous studies documented increased efforts to improve the quality of care.[24-29]

However, experience over the past decade has demonstrated that a certain level of consumer use is necessary to sustain such efforts.[23] To date, a minority of consumers have used health care performance ratings as a basis for choosing providers.[30-32] A persuasive argument can be made that these data are too complex and the circumstances in which decisions are made too emotional to expect much change.

However, few people consider prior efforts to measure performance an adequate test of feasibility. Most measurements have focused on health plans, whereas consumers have indicated that they are more interested in data on physicians and hospitals.[33] Experts have characterized current performance reports as far too technical and poorly formatted for use by consumers.[34,35] Some have argued that current performance data are so deficient that predicting their future use on the basis of past experience would be premature.[36]

Implementation of an important innovation, such as the use of performance data to choose providers, often lags considerably after its introduction.[37] Sixteen years after the Health Care Financing Administration's pioneering release of hospital mortality rates,[38] the Leapfrog Group is applying lessons from other consumer movements to encourage the use of performance comparisons. Working with experts in marketing and consumer behavior, the group used importance to consumers as a key criterion for choosing evidence-based measures. Leapfrog employers are sending these data to employees through their company intranets and are beginning to require their health insurers to deliver understandable, compelling information to employees about the quality of care provided by hospitals and physicians. Use of quality measures increases when consumers can easily distinguish between better and worse options.[39] Large employers are encouraged by a recent survey, sponsored by the Henry J. Kaiser Family Foundation, which showed a 50 percent increase in consumers' awareness of differences in performance among clinicians and a 25 percent increase in consumers' willingness to change providers on the basis of performance data, as compared with an earlier survey.[40]

Businesses are motivated to maintain the health of their workers and to control the cost of health care. Large employers, which provide health insurance for millions of workers and their families, no longer trust the current system to deliver these results. They argue that providing consumers with compelling performance data and increasing their responsibility for the costs of care will slow the increase in health care expenditures and motivate clinicians to improve the quality and efficiency of their care. Despite the paucity of data to guide this new approach and the substantial challenges involved in developing performance measures and rewarding providers for high-quality, efficient care,[41] large employers see no better way to improve the value of their health care purchases.

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We are indebted to Jerome Kassirer, M.D., for his review of and advice on this manuscript.

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