MCOutlook™

Conversations on The Changing Face Of Managed Care: **Insights From the 2006–2007 Podcast Series**

Hosted by Ian Morrison, PhD
Strategic Health Perspectives

- Transparency and the Managed Care Evolution – Margaret E. O'Kane, Peter V. Lee, JD, and Mark D. Smith, MD, MBA
- Pay for Performance – Tom R. Williams
- Electronic Health Information – David Brailer, MD, PhD
- The Future of Disease Management – David B. Nash, MD, MBA
- Medicare Part D – John Gorman
- Evidence-Based Benefit Design – Helen Darling
- Consumer-Directed Health Plans – Sara R. Collins, PhD
- Specialty Pharmacy Management – Debbie Stern, RPh

Continuing education credit for physicians and pharmacists sponsored by The Chatham Institute

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SELF-STUDY CONTINUING EDUCATION ACTIVITY

Conversations on the Changing Face of Managed Care: Insights From the MCOutlook 2006–2007 Podcast Series

A statement of credit is offered to health care professionals who read pages 2 through 30 of this publication, and submit the assessment and evaluation form on page 32. CME and CPE credit are offered. Estimated time to complete this activity is 2.5 hours.

A statement of credit will be awarded upon successful completion of assessment questions (70 percent or better). If a score of 70 percent or better is not achieved, no credit will be awarded, and the registrant will be so notified. There is no fee for this activity.

Target audience

This program is targeted to medical directors, pharmacy directors, and other managed care health care professionals.

Overview

As health care evolves, managed care payers must learn to adapt to a rapidly changing environment. Quality of provider care, appropriate access, stakeholder accountability, health care consumer education, privacy concerns, the unmet promise of information systems to improve care processes — all of these are perennial challenges for payers. The swift evolution of technology and treatment in recent years has magnified the degree of each of these challenges. The MCOutlook 2006–2007 Podcast Series presents insights by managed care thought leaders on these diverse challenges. These conversations were hosted by the internationally known author, consultant, and futurist Ian Morrison, PhD.

Educational objectives

After reading this publication, participants will be able to:

- Explore issues surrounding transparency and its impact on employers, health plans, and consumers.
- Evaluate the benefits, challenges, and expectations of physician incentive programs, such as Pay for Performance.
- Explain the impact of health information technology and e-prescribing on the future of health care in the United States.
- Identify the pros and cons and the value of disease management programs.
- Assess the accomplishments and limitations of the Medicare Part D Prescription Drug Program.
- Discuss the key challenges posed by evidence-based benefit design and consumer-directed health plans.
- Discuss the changes facing specialty pharmacy management.

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SUPPLEMENT TO
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MCOutlook – Conversations on The Changing Face of Managed Care: Insights From the 2006–2007 Podcast Series

A CONTINUING EDUCATION ACTIVITY

Ian Morrison, PhD, Host

This supplement is supported by an educational grant from Abbott. The material in this supplement has been independently peer reviewed. The grantor played no role in reviewer selection.

Introduction

Managed care executives are inundated almost daily with information, which they need to read and process to keep up with the rapid changes taking place in health care.

This supplement is based on a series of 10 podcasts that were conducted in late 2006 and the first half of 2007 to give health care professionals an opportunity to learn about new developments in managed care. The host for the series was Ian Morrison, PhD, an internationally known author, consultant, and futurist specializing in long-term forecasting and planning. Each podcast consisted of a discussion between Morrison and an expert on an issue important to the business and bottom line of managed care organizations.

Series Host

Ian Morrison, PhD, is a founding partner in Strategic Health Perspectives, a forecasting service for clients in the health care industry, along with joint venture partners Harris Interactive and the Harvard School of Public Health, Department of Public Policy and Management. Morrison is president emeritus of the Institute for the Future and chair of its Health Advisory Panel. He has authored several books, most recently Healthcare in the New Millennium: Vision, Values and Leadership.

Seeing Through Transparency: The Managed Care Evolution

Transparency — the full, accurate, and timely disclosure of information — has become a buzzword in health care in recent years. Many of the key players, including payers, patients, and providers, have been calling for standardized performance metrics and outcomes reports that are easily accessible and understood. Ian Morrison, PhD, conducted a series of interviews with experts who offered the perspectives of health plans, employers, and consumers on transparency.

A Health Plan Perspective

MARGARET E. O'KANE
Founder and President, National Committee for Quality Assurance

Ian Morrison: Most people think transparency is basically about the measurement of performance and public reporting. Is that accurate?

Margaret E. O'Kane: Yes. In a nutshell, it is about having a common definition of quality, measuring how often it happens, and making the information public.

Morrison: You have been a pioneer in the movement toward improving the quality of health care. The National Committee for Quality Assurance was founded, if I recall, in 1990, by you and other colleagues, and for a long time you focused on accrediting health plans. In meetings with you 10 or 15 years ago, I remember that you saw the coming movement of measuring performance and providing information that consumers could use. Where is NCQA headed now in terms of how you measure and improve quality?

O'Kane: We have a proud history of accrediting and publicly reporting on quality in health plans. We have a system of measurement called the Health Plan Employer Data and Information Set (HEDIS), which covers a broad spectrum of care and includes preventive measures as well. HEDIS measures how effectively a plan cares for people with chronic illness or other health ailments. The bottom line is that the plans that have been reporting to us these past 13 years have dramatically improved the quality of care for their members. We've seen improvements of more than 50 percent for many measures. Plans have used this information to work directly with patients and physicians to improve care. We are proud of that, because we're measuring things that are really important. We've prevented many deaths and certainly a lot of disability through improvements in health care quality.

Morrison: You have pointed to people with multiple chronic conditions as an example of where measurement has stimulated a response in terms of disease management and other interventions.

O'Kane: The great news is that not only do these people live healthier, longer, and more productive lives when their disease is well controlled, but their costs of care are reduced. It breaks the old paradigm that says for higher quality you need to spend more money. In health care, sometimes the opposite is true — it's disorganized care that is more expensive.

Morrison: There is growing evidence that high quality and low cost go together.

O'Kane: That's right. Quality measurement has transformed thinking in terms of how health care ought to work in the future.

Morrison: Transparency has been a motivator of improvement of quality in health care, but a lot of people view report cards as a mechanism for moving consumers to higher-performing providers. I'll tell you a quick story.

Margaret E. O'Kane has been named one of the Top 25 Women in Health Care by Modern Healthcare. *Under her leadership, the National Committee for Quality Assurance received awards from the National Coalition for Cancer Survivorship, the American Diabetes Association, and the American Pharmacists' Association. She was named Health Person of the Year in 1996 by* Medicine & Health, *received a Founder's Award from the American College of Medical Quality in 1997, and was elected a member of the Institute of Medicine in 1999.*

My wife, a former emergency room nurse, was thinking of switching physicians, and she spent 2 hours on the phone trying to find out whom she should see and what it would cost. She was trying to be the informed, intelligent, cost-conscious consumer, but she was told the information she sought was secret. Her experience shows that we don't have a true consumer system yet, and that we don't give people information on price and quality to make decisions. Is that a fair comment?

O'Kane: That's totally fair. We have challenges ahead of us in terms of measuring the quality of specialty care, for example. While we've done a nice job with primary care measures — and we've been involved in a lot of development of primary care measures for physicians — much of patient care, especially high-cost care, is done at the specialty level. We think about the proliferation of medical specialties and how to measure them. Many procedures are questionable in terms of efficacy or whether they're appropriate for a particular patient. There's a lot of complicated sorting out to be done. That will require some new architecture to move us forward effectively.

A second point is that report cards aren't the way to approach every situation. If you're in the hospital, you're not going to ask for a report card on the consulting specialist who comes to see you. If you're in an ambulance because you've been in a car crash, you go where the ambulance takes you. There are many situations where you don't have the time or discretion to choose among different providers.

Third, we have a huge health literacy issue. The Institute of Medicine estimates 90 million Americans are not as conversant with terms in health care as they need to be (Nielsen-Bohlman 2004). Let's face it: measuring quality is pretty far out on the literacy spectrum.

Transparency already has begun to transform medical licensing boards and specialty boards and ways in which medicine governs itself. We have to look more comprehensively at how transparency will change things; it's not just a simple consumer model.

Morrison: Is it a challenge to implement transparency at the physician level, particularly given that most doctors are still in one- and two-person practices, especially the specialists?

O'Kane: It is a challenge. Any doctor in general internal medicine, for example, will have a few patients with one condition and a few with some other condition, so there isn't a large enough sample to get the robust results we can measure at the health plan level. We even have small health plans whose populations aren't big enough to give us good numbers. Systems evaluation will be an important platform as we go to the physician level. NCQA has a program that measures systems in office practice — whether practices maintain registries to keep track of people with chronic diseases and follow-up systems to make sure patients are brought back following an abnormal lab result. Sometimes we get carried away with the idea of measurement as the solution to everything. Measurement is one factor in a larger armamentarium of tools for quality.

Morrison: Including reimbursement.

O'Kane: Absolutely. Our reimbursement system is designed to have people deliver more of whatever they're doing, and it cuts down on the ability to innovate, especially to deliver more efficient care. I know of a practice that uses a lot of phone, e-mail, and group visits. It's kind of an experimental practice of the future, but since it gets paid only for the traditional one-to-one doctor visit, its ability to push efficiency is limited. We need a complete overhaul of the payment system. A woman who runs a large hospital system told me that by using its congestive heart failure management program to keep patients well and out of the hospital, the hospital system has lost millions of dollars. Incentives are set up in the wrong direction.

Morrison: A final question: Looking ahead 5 years, what's the one big thing you hope will happen in the area of transparency?

O'Kane: We've built sophisticated measures for some of the areas of health care that we understand well. But we're missing measures in other areas, like cancer, which account for billions of dollars and many lives at risk. In these areas, there isn't enough consensus or guidelines to build a coherent measurement system. I would like to see the evidence base harvested in some of these crucial areas of care so that we would have a robust agenda for improvement.

An Employer's Perspective

PETER V. LEE, JD
CEO, Pacific Business Group on Health

Ian Morrison: As we look ahead at American health care, rising costs are top in the minds of people and, particularly, employers. But they also are concerned about value and quality. Employers play an important role in asking the provider community for greater transparency in what the health care system is delivering.

Peter V. Lee: We're in a world where consumers generally have no clue about what they're getting in health

care, in terms of either quality or what the cost is to them personally or to their employer. The challenge is to give consumers and employers a better picture of what they're buying.

Morrison: Please describe where you've been and where you're headed with respect to timely reporting and measurement and the issue of value purchasing.

Lee: Fifteen years ago, value purchasing meant the attempt by large employers to buy insurance from the best health plan. That was in the era of managed competition, when many people thought good health plans were the answer. Employers increasingly have recognized that the real action isn't only at the health plan level — it's also at the level of the providers — the individual doctors, medical practices, and hospitals. That's where we have huge variation in care and in what patients care about, and it's where we have the least information. Increasingly, employers' push for value purchasing is to make sure health plans give employees the tools they need to make the best choices possible at the level that matters — the choice of doctor and hospital. Value purchasing increasingly looks at the issues for patients on the choices they make day to day, rather than the meta-choice an employer makes in choosing plan X versus plan Y.

Morrison: Margaret O'Kane's original view at NCQA was to make health plans the unit of analysis and measurement to improve quality and care processes. Although it's important to keep measuring health plans, it's fair to say that the differentiation between health plans has been minimized as they've become larger and as their networks have overlapped. In a sense, they have become commodities. As you said, the real differentiation is in the provider community, which speaks to this question of variation. More and more evidence shows that quality and cost are correlated inversely — that higher quality is not necessarily achieved with higher cost. Is that a fair statement, and how do you see it from your perspective?

Lee: The role that employers expect their health plans to play has changed from 15 years ago, but it is anchored in this issue of transparency. We expect health plans to give standardized information to consumers so they can make better choices, and we expect plans to use information to change providers' behavior. Employers aren't saying that health plans are irrelevant or are not key players; rather, employers are changing their expectations of health plans.

Peter V. Lee, JD, oversees the efforts of the Pacific Business Group on Health to improve access to high-quality health care and to moderate costs. He is a member of the boards of the National Committee for Quality Assurance, the National Quality Forum, and the National Business Coalition on Health. Lee also co-chairs the Consumer/Purchaser Disclosure Project, a national effort to promote better transparency of health care provider performance.

Morrison: So the rules of engagement with health plans have changed. Instead of being interested simply in price and network size, employers now are more interested in the harder work of improving the delivery system. How can you use variation in price and quality to your advantage, and is there an inverse correlation between cost and quality?

Lee: In most areas, we Americans think that if you spend more money, you get a better product. A lot of data show that in health care, that's not true. Spending more money often means you've made mistakes. Hospital costs may be higher because there are more readmissions. If unnecessary tests are done, you're in the hospital longer. We're calling on health plans to give the tools to consumers to combat the notion that spending more equates with higher quality. It doesn't work just to tell consumers which hospitals are more expensive, because many consumers will think the more expensive hospital is better. Instead, we have to link information on quality and outcomes with the costs that consumers will pay out of pocket.

Morrison: A lot of evidence suggests that consumers have had difficulty using information to make better choices. What are the breakthrough elements that will help consumers make decisions?

Lee: We live in a health care culture in which providers have been keeping their costs behind the fence because consumers, particularly in managed care, haven't been exposed to those costs. One of the biggest drivers of increasing consumer interest in quality and cost information is that they're paying more out of pocket, which will increase dramatically over the next few years. That is driving health plans to put transparency tools in place. They are a lot better than they were 3 years ago, and 5 years ago, they didn't even exist.

Morrison: In some of the work I've been doing with colleagues at Harris Interactive and the Harvard School of Public Health, we see the same kind of optimism when we survey health plans, employers, and leaders. Although the tools may not be where we want them to be, they are getting better, and we are moving in the right direction. Your key point is that there's an incentive for consumers to get that information as we increase the amount of cost sharing.

Lee: From an employer perspective, we want health plans to link quality with cost whenever possible. The challenge is to bring them together in a way that is relevant to the specific circumstances of consumers, occur-

ring at the time they need to make a choice, and in a way that directly relates to their benefit design. It relates to how much they're going to pay out of pocket, the hospitals in their area, and their physician choices.

Morrison: How can high-performance networks and benefit design elicit the behavior you've just described?

Lee: In the 1990s, there was a huge amount of pushback to narrow networks. Today, many employers favor benefit designs that are far more about carrots than sticks, which will give employees incentives to select better doctors. If they choose a worse doctor, it will cost them more. That's a key change in benefit design. It gives consumers choice, anchored in information about cost and quality.

Morrison: Presumably, we will get better at targeting those decisions that consumers can say something about. I've always teased that it's tough to be cost conscious when you're unconscious. But you're saying that we will get better at designing incentives for the decisions consumers can make — where to go for elective surgery or whom to see in the first place for primary and specialty care.

Lee: Absolutely. Rather than say consumers should be steered for every condition, we need to identify the preference-sensitive conditions. What are the choices for a woman diagnosed with breast cancer or a man with prostate cancer? We want to make sure they are given the tools to have a range of choices. If you're in an ambulance, you aren't going to be asking about the efficiency of the hospital you're going to. But if you know you have diabetes, you can obtain a lot of information to help you decide which doctor to see for the next 5 years, what that will cost, and what the outcomes will be.

Morrison: The good news is that this isn't fiction. When you dig down, as you and your colleagues at the Pacific Business Group on Health have done, and look at the performance of West Coast physicians and hospitals, you find that there are variations, and there are substantial differences in cost as a result.

Lee: Transparency is a tool for providing incentives and engaging both consumers and providers. In California, the Integrated Healthcare Association has created the Pay for Performance initiative — seven health plans agreeing on common performance measures and using those measures to pay medical groups differently (see "Pay for Performance," page 10). We're seeing a real drive by private payers and Medicare to anchor payment in provider performance. This is a total change from what health care has been historically — performance-blind in terms of what it pays for. If anything, health care has rewarded poor care, because if you do something wrong, you get paid for fixing it. Moving to performance-based payment is one of the key wins obtained by having better transparency about standardized measurement of quality and efficiency.

Morrison: You're tying transparency to reimbursement. That is a sea change in how we think about health care and financing.

Lee: In late 2006, President Bush issued an executive order requiring the federal government, which represents about 50 percent of health care spending in the United States, to be a value purchaser through all its agencies. The government is being charged to measure quality in a standardized way, promote interoperable health information technology, use information to pay providers differently, and engage consumers. The federal government has put a stake in the ground, and in many ways is joining what some private purchasers have been doing for 15 years. I don't think there is any turning back with the expanded federal government role.

Morrison: Even if we had a Democratic administration, some of my colleagues on the liberal side of the aisle would agree that value purchasing and the kinds of initiatives that PBGH and the federal government are putting in place are the right paths for the future, regardless of political beliefs.

Lee: That's absolutely right. I've spent a lot of time on Capitol Hill meeting with both Democrats and Republicans. The issues related to transparency and promoting better health information technology rise above politics — they are not partisan issues. Where it sometimes becomes contentious is how transparency relates to health spending accounts. Some of the issues are pure market versus pure government. But no matter what your philosophy is in terms of the market's role versus the government's role, we need to pay for the right thing, give consumers incentives, and create a better information infrastructure for the entire health care system.

Morrison: That's well said. One last question: As you look ahead 5 years, what's the one big thing you hope will happen in the area of transparency?

Lee: We need to move from looking at micro units of service to rewarding doctors, and patients, for entire episodes or full years of care, based on both quality and efficiency. We need to move beyond the granular level and look at how to reward better quality — caring for a patient with diabetes or a hip replacement for a year, not just the time spent in the hospital. That's where we have good prospects in the next 5 years — shifting the use of transparency to the rewarding of more comprehensive and coordinated health care.

A Consumer's Perspective

MARK D. SMITH, MD, MBA
President and CEO, California HealthCare Foundation

Ian Morrison: Margaret O'Kane and Peter Lee have pointed to the fact that the action has shifted to the provider level — hospitals, physician groups, and even individual doctors. Payers see that they can exploit what many of us believe is an enormous and inappropriate variation in cost and quality. In fact, many go so far as to say that high quality can be low cost. It seems clear that measurement and public reporting can have a positive effect, encouraging providers to improve. What has been less clear is how much consumers can be motivated to make better value-based decisions. Experts believe it's somewhat situational, in that consumers can make decisions for some but not all things, and that better, more timely, and more consumer-friendly tools are needed. Is this a fair representation of the state of transparency today?

Mark D. Smith: Yes. This question of transparency in some way began in earnest in the mid-1990s with HEDIS. I was a member of the committee that worked on a version of HEDIS, and I remember well that we were working on things like rates of mammograms or flu vaccines. The interesting thing is that while that was and is still a good thing, much of the controversy over managed care was not that consumers thought they would be denied mammograms when they needed them, but rather that they would have problems when they were seriously ill.

Part of the reason for the growth of transparency at the health plan level in the mid-1990s was that plans were saying they would improve quality, and opponents of managed care were saying health plans would hurt quality. From both sides, you had this notion that health plans were going to change the way medicine was practiced, and that you could and should monitor the quality of care provided by these plans.

The lesson we learned, however, was that with the exception of staff-model HMOs, most health plans use the same networks of doctors and hospitals. It's not credible to most people that health plans are in the business to change the practice of medicine, particularly when a plan might have only 10 or 15 percent of the practice of a given doctor or hospital. It turns out that while it is helpful to monitor some things at the health plan level, the kinds of things that people are rightly concerned about — whether you live or die, whether you have a good or bad outcome from your surgery, and even whether you are treated with dignity and respect in a doctor's office or a hospital — isn't so much a function of the health plan but rather of the doctor and the hospital, or perhaps the surgical team that's taking care of you in a hospital. That's why attention is rightly turning to the question of measuring cost and quality at the level of hospitals and doctors. Work that we and others have done suggests that if you ask consumers what they want to know about, they really want to know about their doctors. That, as it turns out, is perhaps the most difficult thing to measure in terms of quality.

Morrison: What role can consumers play? The dream is to have fully informed consumers armed with cost and quality information who make sensible choices that improve their outcomes and also put some consumer discipline on providers. What's the state of the price information and quality information that consumers have access to?

Smith: Let's start with price information. This idea is just in its infancy, for two reasons. First, because most consumers are not confronted with the price of the service they are receiving, they are confronted with the price they pay, given their health benefits design and whatever discounts their health plan has negotiated with the

The California HealthCare Foundation is an independent philanthropy dedicated to improving the health of the state's people through three program areas: innovations for the underserved; better chronic disease care; and market and policy monitoring. Smith, a board-certified internist, is on the clinical faculty at the University of California–San Francisco, and an attending physician at the Positive Health Program for AIDS Care at San Francisco General Hospital. He is a member of the Institute of Medicine and serves on the board of the National Business Group on Health. Prior to joining the California HealthCare Foundation, Smith was executive vice president of the Henry J. Kaiser Family Foundation. He has served on the National Committee for Quality Assurance's Performance Measurement Committee and on the editorial board of Annals of Internal Medicine.

provider. Very few people walk into a pharmacy, doctor's office, or hospital and pay the rack rate.

Morrison: I call that "the demented Saudi prince price" — the price a demented Saudi prince turning up at the Mayo Clinic would pay, but that's not the price everybody else pays.

Smith: That's right, although, unfortunately, if you're uninsured, that's not the price they expect you to pay, but it may be the bill they send you.

Morrison: Indeed, that's why a lot of not-for-profit hospitals have come under scrutiny for using the demented Saudi prince prices. So price is one piece of this, and it's not transparent.

Smith: It's not. Furthermore, particularly for a hospital, most of us don't yet have the right unit (of analysis). A California law passed a few years ago requires hospitals to post their prices. It seems like a great idea. But what prices are they required to post? Things like the price of a Chem-20 panel. What does that mean? No one goes into a hospital saying, "I'd like a Chem-20 panel, please." You go into a hospital to have a hip replaced or a cataract removed. We don't even have the unit of analysis right. It's not just the room charge or the surgeon charge, it's also the anesthesia, bed charge, intensive care unit, and other services.

Another complication is that a given hospital may charge more for a longer stay, but care of the patient for a health condition is longitudinal. If I'm a payer, I'm interested not so much in how much I'm paying per day in the hospital, but rather how much I'm paying over the long term — how much it costs to take care of a diabetic for a year, or a patient with heart failure, or HIV.

Morrison: In other endeavors, people in the business community talk about total cost of ownership. You want to get at the total cost, not just the price for one slice of service.

Smith: That's right. With benefit designs that require consumers to pay more out of their own pockets, consumers are more liable for price variation among providers. We first saw that with tiered formularies, consumer behavior changes dramatically when confronted with those differences. Now you're seeing more exposure of consumers to the fact that hospital A may charge $2,000 and hospital B $3,000. The consumer may not pay that whole $1,000 difference, but the consumer will pay to go to hospital B than hospital A despite the fact, by the way, that there is little evidence of any difference in quality. So although exposure to more out-of-pocket costs is lamented in some quarters and clearly has some downsides, it also at least has the upside that consumers are aware of and increasingly affected by differences in prices.

Morrison: At the level of the individual provider, how difficult is it to give consumers meaningful information?

Smith: It varies. In some areas there are metrics that people in the field have accepted. Coronary artery bypass graft surgery is one. For all the debate, it seems the professional societies now think we have measures that are valid, reproducible, and meaningful. In the next few years, you'll see similar progress with procedures that are more industrial, if you will, and repetitive — hip, knee, and cataract treatments. The capacity to measure in a reasonable and responsible way, say, outpatient adolescent psychiatry or general pediatrics, is a ways off.

Some aspects of quality measurement, like consumers' experience with the doctor and the staff, are very valuable. For years, we have been publishing patients' experiences during hospitalization. Patient experience is a real, valid, and meaningful aspect of quality. Providers tend to pooh-pooh it, saying it's just bedside manner. But we have done surveys — as have other organizations — asking patients about pain control, whether anybody came when they pushed the button, whether prior to discharge anyone explained their medications. Those are real aspects of quality that you can learn about only by asking patients.

Morrison: So it's not just about happy faces. There are some patient experience issues that are valid measures of what doctors would regard as clinical quality.

Smith: That's right. I haven't met a patient or a doctor who would deny that adequate pain control during hospitalization is a real and important measurement of quality.

Morrison: Recently, there was a news item about an Ohio health plan that is doing what you're suggesting, getting at the procedure-oriented level of service and posting information on cost and quality. Presumably, we will see more of this over the next 5 years.

Smith: We will, but not without some struggle. It is still a relatively new phenomenon for doctors, and there are some substantial scientific challenges involved. I don't mean to minimize those, but I've never met a doctor who would want to refer a family member for an important procedure to just any doctor with a license. Whether based on data or personal experience, they all know who the good doctors are. We have to tell the professionals that if they wouldn't want a family member to choose a doctor at random, they shouldn't want the public to be in that situation, either. The question is not whether it will happen, the question is how quickly it will happen, and how we can get the measures right. In our experience, one of the most powerful uses of public reporting is to get providers to take account of how they are viewed and how they are improving. A recent article in *JAMA* found that if you ask providers to judge themselves on their own competency, they don't do a very good job (Davis 2006).

Assuming that all professionals want to do a good job but need objective data to do so, one of the most important reasons for public reporting is to give providers an objective sense of how they're doing compared with their peers and with the standards for their profession.

Morrison: You are a practicing physician and an AIDS doctor, and you see patients in San Francisco. How does it feel to be on the other end of this? How do you like being measured, and how do you incorporate the learnings from that measurement into your practice?

Smith: When you see how you stack up against your peers, your first inclination is to say the data are wrong, or my patients are sicker than others. But it's an important part of professional activity that physicians will have to get used to. The attitude of physicians, nurses, and hospitals is substantially different now than it was 10 years ago, when people argued over whether this was a good thing, whether it was possible, whether consumers had a right to it, and whether they would use it. Most of the argument now is about how and what to measure, and how to standardize the measurement. Arguing about *how* is a big step forward from arguing about *whether*.

Morrison: Two emerging areas in health care that will affect consumers and transparency are retail clinics and what some have called offshore medicine. Are these positive developments from the consumer perspective, and where are we headed with them?

Smith: I see both as responses to the increasingly unaffordable traditional delivery system. To the extent that they are offering consumers alternatives to a delivery system — which, for all its strengths, is pricing itself out of the reach of people who need it — it's a good thing. The retail clinic might be in a retail big-box store or a pharmacy, and you'd probably see a nurse practitioner. Without an appointment, you'd be in and out in 20 or 25 minutes for a flat rate covering a limited set of relatively minor conditions that can be diagnosed by rules where protocols exist. Does it serve every purpose? Of course not. Is it where I'd want to see someone taken care of if they have a serious ongoing chronic disease? No. On the other hand, it seems to me that if the question is whether your kid has an ear infection or a strep throat, or whether you have a urinary tract infection, or need a flu shot, those seem like reasonable places to get treatment faster and for substantially less money than in our traditional system. Whether the clinics proliferate will depend more on how profitable they are to the big-box store than on how good they are for health care.

As for offshoring, my own sense is that the world is increasingly flat. We know that lots of back-office functions, ranging from transcription to reading X-rays, will happen someplace else. Vast numbers of people probably will not go to Thailand or Mexico for surgery. But if you're uninsured, it's increasingly a credible proposition if you're paying 10 cents on the dollar to travel abroad to see someone who is board certified and was trained in the United States. You can afford a first-class ticket and 10 days in a hotel, have the surgery, and come back and still be 60 or 70 percent of where you'd be financially in a U.S. hospital. To some people this may seem insane, but it was only 20 or 30 years ago that people would have thought you were nuts if you said Japanese cars were of higher quality than American cars, or that Japan would come to dominate the U.S. auto industry.

While offshoring probably will never result in particularly high volume, I wouldn't discount its ability to raise serious questions about why health care services are so expensive here. People concerned about such things can either raise questions about it or obstruct it, or they can try to figure out how we can make those services available to people in this country in a way that is affordable.

Morrison: One final question: As you look ahead 5 years, what's the one big thing you hope happens in the area of transparency from the consumer's perspective?

Smith: That professionals get energized in helping to develop and promulgate standards of quality and cost. Until relatively recently, professionals for the most part have either opposed this movement or stood on the sidelines and thrown stones at all the inconsistencies and inadequacies. I wish orthopedic surgeons and their professional societies would get to work on developing standards of quality and cost for hip surgery and knee surgery, and similarly for other specialty and subspecialty societies, such that 5 years from now, consumers could be confident that the measures have been validated by the professionals in the field and have real meaning. That would help move this movement forward substantially and dramatically.

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Resources

HR Policy Association. This organization represents the chief human resource officers of more than 250 of the largest corporations doing business in the United States. «www.hrpolicy.org/memoranda/2006/06-129_Pharma_1-pager.pdf».

Health Care Transparency. This Web site, a service of the U.S. Department of Health and Human Services, provides information on transparency for consumers. «www.hhs.gov/transparency».

Pay for Performance

TOM R. WILLIAMS
Executive Director, Integrated Healthcare Association

Ian Morrison: A growing number of private and public health care payers are adopting pay for performance as a way to foster new behaviors by physicians that will improve efficiency, effectiveness, and patient outcomes. Pay for performance is perhaps the signature project of Integrated Healthcare Association, which has been a leader in promoting the concept nationwide. I have had the opportunity over the years to work closely with Tom and IHA's board of directors. Tom, how did IHA get started in pay for performance?

Tom R. Williams: It began in the 1990s, when we started to run into some bumps with managed care. Various stakeholders — plans, physician groups, hospitals — started voicing concerns as budgets tightened. Someone came up with the idea to create an integrated association that included the plans, physician groups, and hospitals, as well as other stakeholders. The idea was that instead of focusing on lobbying, as most of these associations were doing, we would collaborate on initiatives related to quality improvement, particularly the alignment of financial incentives.

Morrison: It must be close to 10 years ago when I was the facilitator of the first board retreat. IHA had a board drawn from a diverse group. I remember joking that the mission statement of the organization was to violently agree on the limited overlap of your deeply divided membership. So I applaud you and your colleagues for bringing together — in a very positive way — a group representing such different perspectives. Pay for performance is probably IHA's greatest achievement.

Tom R. Williams has served as executive director of the Integrated Healthcare Association since 2004. Operating throughout California, IHA is a not-for-profit collaborative leadership group that runs one of the largest pay-for-performance programs in the United States. In his 14 years with Aetna, Williams headed Aetna's west region and served as board president of Aetna California. Williams is pursuing a doctorate in public health at the University of California–Los Angeles.

Williams: Yes, without a doubt. It catalyzed the organization and helped transform it from what was, in some views, a friendly breakfast group into an action-oriented group.

Morrison: Margaret O'Kane, Peter Lee, and Mark Smith have all concluded that transparency, in and of itself, is not sufficient to move the market, and that the next logical step is to tie transparency to issues like pay for performance and reimbursement. Do you see transparency moving us toward better performance in health care, and that paying for performance is an important next step?

Williams: Absolutely. It begins with measurement. A principle of quality improvement is that we can't change what we can't measure. So we measure, and then we report. That's where transparency plays such an important role, by shedding light on what we've learned. Pay for performance then follows as a mechanism to provide incentives for those persons being measured to focus on improvement. Ultimately, pay for performance is a step toward more fundamental reimbursement reform.

Morrison: What is the status of the IHA's pay-for-performance initiative in California?

Williams: Our program has been in place for 5 years, and we continually develop new measures, put measures in place, facilitate data collection, and report out, which ultimately leads to payment by health plans. The program is evolving in terms of the measurement set. We continue to add clinical measures and to measure patient experience and to drive the evolution of what we call the information technology domain toward a domain focused on coordination of care. The big change on the horizon is the addition of a focus on efficiency. We've begun testing efficiency measures, and we'll roll them out next year.

Nationally and internationally, there are many excellent programs. The granddaddy, of course, is the program in the United Kingdom, which has received considerable attention and is probably the most dramatic. But there are many good examples in the United States, such as Bridges to Excellence. A recent article in the *New England Journal of Medicine* (Rosenthal 2006) gives a comprehensive overview of how much activity there is. Over half of the HMOs in this survey, representing about 80 percent of the HMO membership, had pay-for-performance programs.

Morrison: You mentioned efficiency measurement.

Presumably, that is not about simply lowering the unit cost of service, but rather achieving outcomes at a lower cost.

Williams: Exactly. Our intention is to measure cost and resource use along with quality. Efficiency measurement takes many forms, but to a large extent, it examines the use of resources and the cost of care around episodes of treatment. It's interesting how things come around. In the 1990s, linear utilization measures were the primary focus of incentive payments in managed care — hospital days per thousand, for example. Now we're seeing a return of utilization measurement, but with a more heightened sense of awareness about how we do it and a more intelligent view of that kind of measurement.

Morrison: What has been the hardest part of implementing pay for performance? If you had to advise others going down this path, what are the big lessons you've learned?

Williams: Number one is that stakeholders must have a clear sense of purpose at the front end, and that the program should be designed around that. That may sound elementary, but we've found it is essential to have and maintain that clarity to be able to align measures and rewards. The second lesson is that it's hard work. Implementing measures would seem fairly basic, but it is quite complicated. Therefore, having a systematic approach to identifying, testing, and implementing measures is critical.

Morrison: One thing about this process that strikes me hard is that, in many instances, performance is in the eye of the beholder. Health plans, medical groups, and hospitals might broadly agree that they want the best patient care and the best value, but how you measure things and what you measure can be quite contentious. Presumably, one of your challenges is to keep people at the table to move this process forward.

Williams: Absolutely. A tactic that has worked for IHA is first agreeing on some principles by which measures are to be selected. That approach has been very helpful when we have to make difficult decisions about what measures to add or not to add. We return regularly to those principles, and that has bailed us out of some difficult situations.

Morrison: Can you give me an example of what those principles are?

Williams: For example, measures need to be based on evidence and tested before implementation, and they need to be clinically relevant to the population. Chlamydia is a big problem in California, but there was a perception that it wasn't clinically relevant for certain populations. We ran into a problem when we quickly tried to add chlamydia screening as a measure before we adequately tested it. From that experience, we learned that we need to stick with our principles. Other principles stipulate that measures need to affect a significant number of people, and they need to be electronically collectable. These strategic selection criteria, along with IHA's other core principles, are detailed in our white paper, which is available on our website (IHA 2006).

Morrison: What do MCOs have to do differently to make pay for performance work?

Williams: Ultimately, plans have to give up innovating their measure set any way they want in the absence of standards. We've learned that the power of our program comes from the aggregation of data across plans and against a single measure set. In a sense, that's in conflict with the nature of a competitive health plan. Inherently, plans want to create their own measure set and to use it as a way to compete. But that just doesn't work today. Physicians can't reform, redesign, or improve their practice according to a measurement set if they have a half dozen different measurement sets and have to dilute their focus to meet many different agendas. That is where the hardest work comes for the plan, and that can vary by market and shares within a market. I hope we'll eventually get some sort of national standard.

Morrison: Yes, that is an important point. In some ways, and from a health plan perspective, pay for performance is a commoditizer. A lot of health plans have competed on wrinkles of measurement and grading in the past. To be effective, as you say, you have to build a standard that applies across payer groups *and* competitive health plans. Otherwise, you run into the situation that was the genesis of the IHA — a lot of competing methods of measurement that were driving providers nuts.

Williams: Exactly. A reflection of that was what we call "dueling report cards," in that each plan would issue its own report card. You'd have the same physician group receive the highest score on a specific measure with one health plan, but just an average score from another health plan on the exact same measure. The different results reflect sample size and other logistical issues.

Morrison: While it sounds a little nerdy to talk about sample size, it is an important issue, particularly as you drive to measure at the provider level. You can't do it without enormous data sets that bring together public and private payers, because there aren't enough observations to measure performance meaningfully.

Williams: Pay for performance gets nerdy very quickly. There are many nuances that are important to make it work. We're at a fairly early stage in the evolution of this sort of measurement.

Morrison: Before we leave this notion of what people have to do differently, what do providers have to give up or change as they adapt to a world of pay for performance?

Williams: In the short term, they have to give up their reluctance and fear of public reporting and transparency. Ultimately, information has to be validated and held as

reliable by providers, and once that occurs, it needs to get out in the public domain. To overcome their reluctance, providers need to be part of the process. We're not going to get improvements in quality and efficiency without fundamental process reengineering. That won't happen until we have reimbursement reform. There's no incentive for physicians and other providers to do that. Ultimately the practice of care will have to be turned upside down.

Morrison: That leads to the final question. As you look ahead 5 years, what is the one big thing you hope happens in pay for performance?

Williams: That in the not-too-distant future, both Medicare and Medicaid implement pay for performance on a broad scale.

Morrison: That's terrific, because we won't get fundamental change in the delivery system, which is the intent of pay for performance, unless the big dog — CMS — pushes this through on Medicare and Medicaid. Then we'll get everyone's attention. But I have to thank you, Tom, not only for talking with me about this topic, but also for the hard work that has gone on with IHA in terms of pushing this initiative in California and nationwide. I think it is a step in the right direction.

Williams: Thanks, Ian. You have been a key to IHA's success, and we really appreciate that.

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Resources

The Institute of Medicine, in a report called *Rewarding Provider Performance: Aligning Incentives in Medicare,* "analyzes the promise and risks of instituting a pay-for-performance program within Medicare to encourage a more effective health care system. Although focused on Medicare, this report also has significant implications for payers and purchasers in the private sector." Go to the website and scroll down to "free resources." «www.nap.edu/catalog/11723.html-toc».

Electronic Health Information

DAVID BRAILER, MD, PHD
National Coordinator for Health Information Technology, Department of Health and Human Services

Ian Morrison: There is broad bipartisan support for improving our national health infrastructure, and although there may be disagreement about how to pay for that investment, there seems to be agreement among policymakers and industry experts that we need to do something about health information technology. Where are we today? What progress have we made over the last few years, and what do you see happening over the next 3 to 4 years?

David Brailer: We have shown progress, but we have a lot more to do. One of my goals was to make sure that the public, policy, and private sector leaders understood both the potential and the reality of health IT. As a result, we have seen the adoption of inpatient electronic health records (EHRs) by large, corporatized, health care delivery entities increase substantially. The Centers for Disease Control and Prevention reported a 20 percent annual increase in EHRs in hospitals 2 years running. We have major challenges in ambulatory EHR adoption, however, because of the size of doctors' offices and the cost of products relative to the value that physicians realize.

The big issue is information portability, which is still in its infancy — the ability for information to follow patients through the health care system and to be available to physicians when they make treatment decisions. We will see in the next year or so whether the nation is committed to the principles of interoperability and portability of health information.

David Brailer, MD, PhD, was appointed the first national health information technology (IT) coordinator in 2004. Under an executive order issued by President Bush, Brailer is charged with facilitating the widespread deployment of health IT within 10 years to help realize substantial improvements in safety and efficiency. Brailer was a senior fellow at the Health Technology Center, in San Francisco, a not-for-profit organization that helps health care organizations cope with the impact of technology on health care delivery. He was also chairman and CEO of CareScience Inc., and he designed and oversaw the development of one of the first community-based health information exchanges in Santa Barbara County, Calif.

Morrison: Are physicians resistant to this movement, or have we turned a corner in terms of doctors seeing this as a tool for the future?

Brailer: One should not consider clinicians to be a homogenous group. There are various segments of physicians — sociologically, demographically, and technically. I break doctors into three groups with respect to this question. The first group is the innovators. They have been using health IT for a long time, and they make up perhaps 5 to 10 percent of doctors by various estimates. Another 20 to 25 percent of doctors are the vanishers, those near the end of their careers. They generally don't want to be disrupted, and they're not quite as open to technology or to new forms of dialog or relationships with their patients. As a rule, these doctors are resistant, although I have found some of the most wonderful innovators in that crowd.

The largest group is the questioning middle — those physicians who are mid-career and are struggling to continue to innovate and stay current with techniques of treatment and care. Two notable things about them: They know health IT will happen during their career, and they face numerous challenges — pay for performance, transparency, disease management interventions, and new issues related to prescribing. We've tried to help these doctors see health IT as a positive force. The evident interest and the high sense of inevitability in that audience reflect the fact that it's now a question of when, not if. It could be a number of years before they act unless there's a more top-down push, because this is not about adopting technology — it's about changing the process of care and the way it is delivered.

Morrison: In earlier conversations in this podcast series, we discussed transparency and pay for performance, and our next discussion will deal with disease management. All these topics are predicated on an electronic infrastructure. What has been the biggest set of barriers to establishing that infrastructure? Is it financing and the lack of payoff in the short run? Is it a lack of standards? Is it technical challenges or lack of will?

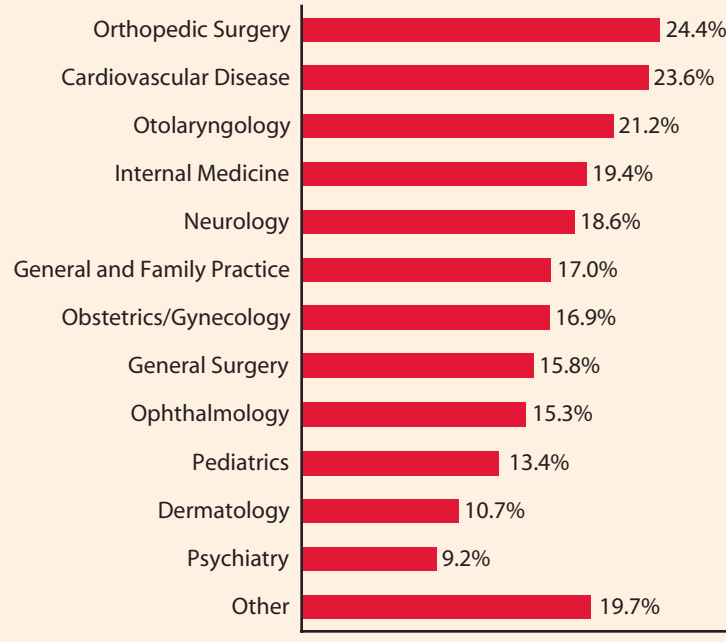
Brailer: The list you give is a good starter set. It's

clearly very expensive, and it's not just an operating expense, it's also a capital expense.

Health care has had significant issues in dealing with capital expense that is not reimbursed, or for which there is no public market. At the technical level, the lack of standards has been a challenge. With respect to the cost of the overall infrastructure relative to the benefit, the main issue is that these technologies create an information-rich, defect-free, consumer-directed market, where reimbursement rewards information ignorance, defects, and consumer apathy. This is the market pushing the industry against the status quo of economic interests.

We see health IT very much as a tool to begin probing not just the technical forms of the health care market, but ultimately new financial forms. Pay for performance and transparency, still in their infancy, need this infrastructure; in fact, they are symbiotic — they need the infrastructure, but the infrastructure needs the economic rationalization they bring. The health care industry wants to do the right thing, but you can't do the right thing if you don't know what that is. The federal government has failed in a number of policy areas over the course of many years in terms of not having a vision of where health care should go.

FIGURE
Average percentage of office-based physicians using electronic medical records by specialty 2001–2003



SOURCE: BURT 2005

Morrison: You were at the forefront of the creation of the regional health information organization, or RHIO. Everyone would agree that interoperability across the continuum of care is important for the future. Will we have the same solution everywhere, or will we see much variation? Where does the RHIO movement stand, and where will it take us over the next 2 to 3 years?

Brailer: I don't see IT as being immune to, or devoid of, the pressures that have shaped our health care industry. RHIOs, or state-based leadership, are a fact of life. The states regulate privacy, licensure, and the corporate practice of medicine. States have expressed a strong interest in having a role in how IT is shaped and played out, and it's appropriate. I've visited 35 governors representing both parties and with many views about the role of government. They see IT as a tool to improve population health, get more out of the health care system, and improve the technical skills of their population. They see that health care employs a large share of low-skilled workers. Health IT is not just about computers for doctors, it's about broad automation of an industry.

The ultimate balance between federal and state control over health IT is in play. A major privacy report will be released shortly that explores the question of how to develop privacy rules for the digital era of medicine and how to create state-based standards so states can work together to have a uniform infrastructure. It's helpful to the states, to the federal government, and, more importantly, to a mobile population.

Morrison: How can a personal health record maintained by an individual be coordinated with the EHR that a hospital-based system, for example, is generating?

Brailer: EHRs are the "productization" of a process — using information to automate the industry and promote accountability. We'll have many products, but it's the endpoint that matters. One of those endpoints is personally controlled information that is linked to better decisions made by consumers, better accountability, and better ability to shop and compare. Within that is the question of data ownership. In our federal system, it's unclear who owns a patient's data, but on a practical basis, the providers own it. They can, for example, take 90 days to release data to a patient if they choose to. We need a clear statement pertaining to the patient's control or ownership (if that has legal meaning) of their information as an enabler of personal health records that are not dispersed among many places, but are concentrated in a way so that the patient can use them. In the end, the reigning power in health care is the consumer, who is be-

coming increasingly restive, and this is one of several things the consumer will demand.

Morrison: Perhaps we'll see a push in both directions, such that consumers will have more access to the institutionally based record, while such enabling technologies as Yahoo!, MySpace, and Google will give consumers a starting point for their own individual health record.

Brailer: I think so, but we should be careful. As innovative as online health records might be, they are risky on a wholesale basis. Federal or state privacy laws do not cover them, so consumers could have undue reliance on how their data are protected or used. Also, as "untethered" devices that aren't connected to a patient's data stream, they would require patients to do a lot of manual input. Those patients who see the benefits of these records will spend the time doing it, like online banking. But, until the record is connected to an infrastructure that can sync it with many sources, we won't see significant uptake. The Office of the National Coordinator, U.S. Department of Veterans Affairs, Department of Defense, and other federal apparatuses are looking seriously at how we can extend the infrastructure that's being designed so that patients can access and manage their health information.

Morrison: Is e-prescribing a critical application where we can achieve an early payoff in deploying these new tools?

Brailer: E-prescribing is a high-value, high-cost complexity technology. It is high value because it touches quality, cost, and drug choice. It connects a variety of players — hospitals, doctors, health plans, pharmacies. That requires a complicated infrastructure, and that's why the overwhelming share of what is called e-prescribing today is still a doctor faxing a prescription to a pharmacy. Because of its complexity, I don't see e-prescribing as one of the early victories for our industry, but it is inevitable because of its value.

We are still in the early days of figuring out how to alert a doctor about which drugs are better than others, which might interact with other drugs or perhaps be improper for a patient because of an allergy, or which drugs raise a formulary issue. We don't know how to handle genomic information in prescribing on a large-scale basis. Doctors routinely turn off alerts because they are bombarded with them. So we still have to figure out how to streamline the information exchange between machines and doctors as this dialog happens so that it is welcomed by physicians and yet achieves better efficiency. In the end, pharmacogenomics will force e-prescribing and decision support. Doctors simply cannot know or recall all the metabolic variants involved in choosing not only the drug but the dose for a given patient.

E-prescribing is way down the road, but my hope is that we can accelerate toward it but at an appropriate pace.

Morrison: A final question: As you look ahead 5 years, what is the one big thing you hope happens with our national health infrastructure?

Brailer: I hope the vision is fulfilled — that the basics get done, hospitals have certified EHRs and a decisive share of doctors have EHRs, and the fundamentals for information sharing and portability exist. That is game changing. The next 5 years will make or break this effort. We're in the moment of maximum potential. I want to see the basic vision fulfilled, and I am optimistic that it will happen.

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Resources

AHIMA (American Health Information Management Association) is actively engaged in developing practice guidelines for electronic health records. «www.ahima.org/e-him».

For information on how President Bush's Health Information Technology Plan supports the development of electronic health records, visit «www.cchit.org».

The Future of Disease Management

DAVID B. NASH, MD, MBA
Chairman, Department of Health Policy, Jefferson Medical College, Thomas Jefferson University

Ian Morrison: David Nash is one of the persons I look to in the health care system who combines knowledge of the practice of medicine with the business of health care. The purpose of disease management is to improve health outcomes and better measure the value of provided services, and takes a patient-centered approach to providing care by addressing the psychological aspects, caregiver issues, and the treatment of diseases using nationally recognized standards of care. Disease management should help to lower costs by reducing unnecessary or redundant services, or avoiding costs associated with poor outcomes. As you look back over the last decade, David, what have we achieved in disease management?

David B. Nash: The greatest contribution of disease management has been to create awareness of the poor coordination of care and to improve access to care. Frankly, care coordination is too important to be left to the physician.

Morrison: Looking ahead, many health care observers believe we are about to experience what I've termed a "triple tsunami of chronic care" over the next decade. Three forces are in operation: obesity and the related heart disease and diabetes that go with it; depression; and cancer as a chronic condition. Do you agree with that assessment? And, what role do you think disease management will play in dealing with these chronic care trends?

Nash: I do agree. Obesity and heart disease are high on the public health agenda, and cancer is becoming a chronic condition. One of the key contributions of disease management is consumer education and empowerment. Through the technology of disease management — whether it's nurse outreach programs or online communication regarding blood pressure or serum glucose levels — we will enhance our ability to reach out to consumers in a focused, organized way. So mass customization of clinical information is one of the cornerstones of disease management, and it enables us to empower and educate the consumer.

Morrison: It has been said that when it comes to conditions like diabetes, the amount of time a patient is in front of a formal caregiver is infinitesimal compared with the time that patient has to think about and deal with the condition. What's your view of the evidence for a return on investment (ROI) for disease management? Is it cause for concern or a cause for hope?

Nash: There is tremendous cause for hope. Compelling scientific information shows that the ROI for different types of disease management programs ranges from $2 to $9 per dollar spent, depending on the population, geography, and specific disease. The DMAA recently published a white paper looking at the results of nearly 2 years of work on the part of an expert panel enjoined by DMAA to address the ROI question. It has done a super job organizing the literature, vetting it with outside expertise, and then publishing it via its web site.

Morrison: From your review of that work and your own experience, what are some of the best examples of successful disease management programs, and how can the lessons learned from them be used to implement innovation throughout the entire system? So often in medical care and health care policy, we know how to do certain things, but our problem is diffusing that knowledge across the system.

Nash: There's probably no single best disease-management vendor, private or public, profit or not-for-profit. We have to cherry pick the best aspects of programs from many different sectors. The big companies are able to target large populations and have really nailed the technology. They have the built-in ROI calculations, the

David B. Nash, MD, MBA, is an internationally recognized expert on disease management. He is the Dr. Raymond C. and Doris N. Grandon Professor and chairman of the Department of Health Policy at Jefferson Medical College, Thomas Jefferson University, in Philadelphia. Jefferson is one of a handful of medical schools in the nation with an endowed professorship in health policy. Nash founded the Office of Health Policy and Clinical Outcomes in 1990, and from 1996 to 2003, served as the first associate dean for health policy at Jefferson Medical College. He is editor-in-chief of Disease Management, *the official journal of the Disease Management Association of America (DMAA), and serves on the board of directors of I-trax, an integrated health and productivity management company.*

nurses, and the evidence-based guidelines. All of this has been developed, and based on solid science, over the last decade. For example, I-trax has gone back to the disease management model of the nurse on the factory floor who makes sure employees are taking their medicine and getting their blood pressure checked. But the individual companies are not as important as the armamentarium we have developed, from e-mail to the laptop, to phone calls from nurses, to follow-up educational materials. We have peer-reviewed, published evidence that each of these pieces, especially when they are coordinated by a disease management organization, really makes a difference. The typical managed care organization now has more than 20 disease states under a disease management umbrella.

Morrison: Medicare reform has given us new institutions and tools to manage the Medicare population, and there are some innovative chronic care demonstration projects now underway. What is your assessment of where we are with regard to disease management in the Medicare population, and where are we headed over the next 5 years?

Nash: You have Medicare Health Support, which has had several different names. I'm a consultant to the Research Triangle Institute, which has the contract from CMS to evaluate these programs. I'm hopeful that this program will be wildly successful, because I believe that if we coordinate care we will save money, and if we get seniors engaged appropriately in prevention, we will save money. I recognize how complicated it is for these vendor plans and their managed care and delivery system partners to do a good job. The challenge is that Medicare beneficiaries don't come into the physician's office saying "I have diabetes and just diabetes." The typical Medicare beneficiaries, even those who are reasonably healthy, have multiple comorbidities, and it's difficult to engage them in all aspects of their care.

Morrison: Am I right in thinking that something like 50 percent of the Medicare population has five or more comorbidities?

Nash: That's the generally accepted number, yes.

Morrison: Disease management is an area of health care where many new for-profit companies have become significant players. What role does the for-profit sector play, and is there any cause for concern from a policy perspective, particularly with the Medicare and the more vulnerable Medicaid populations?

Nash: The for-profit sector has been the great innovator in disease management or DM. They have created the marketplace, and there has been an evolution from small to larger for-profit firms and greater consolidation within the industry. I have no qualms with the for-profit aspect, because that's been the driver of innovation and new technology. The bigger question right now for provider groups and insurance carriers is whether to build or buy — whether to create their own DM programs and structures internally or to purchase them on the open market. It's probably a plan-by-plan decision. In certain markets, the large, publicly held DM companies are doing great. Of course, we want to make sure there are good evaluations of all these programs. That, in part, is why I'm so proud of our journal *Disease Management*, the official journal of the DMAA. Sunshine is the best disinfectant, and so we want to see evaluation of the for-profit and the not-for-profit programs to make sure the ROI calculations are real. The major way this entire field will mature is through a rigorous self-evaluation and research agenda.

Morrison: I agree. There's a lot of ideological claptrap on both sides about the for-profit or not-for-profit sector being inherently superior. I believe that it's performance that matters, not orientation. It's an encouraging picture, provided that we have, as you say, a research-based agenda in terms of oversight on the one hand and developing the field on the other. One final question: As you look out over the next 5 years, what's the one thing you hope happens in disease management?

Nash: I hope the Medicare Health Support Program is successful. It will lend credence to disease management, open the opportunity for greater Medicare support, grow the industry, and empower patients. I'm hopeful that these partnerships will demonstrate a good ROI and an improvement in clinical outcomes. I would also like to see a more vigorous research agenda. As editor of the DMAA journal, my vested interest is to get more people to submit more evaluations about what it is they're doing in the marketplace.

Morrison: That's terrific. Guests in this series who were discussing transparency also pointed to the important role of Medicare. Whereas we all agree that we may see innovation on the private side, if we can be successful in the Medicare population with some of these innovations in managed care, that will benefit all of us, especially since all of us are going to end up on Medicare.

Resources

The Disease Management Association of America (DMAA) is a not-for-profit organization that represents all stakeholders in chronic disease care. «www.dmaa.org».

NCQA (National Committee for Quality Assurance) has collaborated with DMAA to develop performance measures in clinical areas for disease management. «www.ncqa.org/communications/news/dmaa_measures.htm».

Medicare Part D

JOHN GORMAN
President and CEO, Gorman Health Group

Ian Morrison: The Part D initiative may be the biggest change in Medicare in a generation. There was a lot of criticism initially, but it is remarkable that no matter how we view the design of the program, it has been pulled off — a lot of people are being covered.

John Gorman: The first few months of enrollment were a mess, not unexpectedly for the launch of a program of this magnitude. After a rough first quarter, there was a turnaround, and as of July 15, 2007, 17 million beneficiaries had enrolled in prescription drug plans (PDPs). Only 6 million of those were automatically enrolled, so about 11 million voluntarily chose the program. We went from about 5 million enrollees in Medicare Advantage (MA) to 8.7 million today; those options had been available to perhaps two thirds of beneficiaries nationally prior to the launch of the program. Now, at least a dozen MA options are available to most beneficiaries in the lower 48 states. As for PDPs, today there is no place in the country where a beneficiary has fewer than 20 options.

A lot still needs to be done to get Part D where it should be. Four million beneficiaries qualify for the low-income subsidy, but aren't getting it. Some beneficiaries, especially the ones with disabilities, aren't having their needs met, and some sales agents are engaging in unethical behavior, none of which is unexpected. CMS actuaries recently took $100 billion off the 10-year cost of this program, in recognition of the fact that the competition it has inspired is working. The market is delivering this benefit at a lower cost than anybody anticipated and providing a much better benefit package than Congress expected. When you compare it with other major initiatives this administration has undertaken, it has been an unmitigated success.

The Gorman Health Group, founded in 1996, specializes in Medicare and Medicaid managed care. Gorman served as assistant to the director of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) Office of Managed Care, and was external liaison for the Medicare and Medicaid managed care programs during their period of greatest growth. Gorman was chief lobbyist on health care financing issues for the National Association of Community Health Centers, an organization of federally funded primary care clinics for the medically underserved. He also has served as staff director for Michigan Rep. John Conyers Jr., when Conyers was chairman of the House Government Operations Committee.

Morrison: Many in the political spectrum point to the coverage gap — the so-called donut hole — and the 4 million people who are eligible but not participating as potential political chips. Is there much capital to be gained with the coverage issue?

Gorman: Millions of beneficiaries fell into the donut hole in 2006, and likely more will this year. There wasn't a lot of utilization during much of the first quarter of 2006 as we worked through enrollment issues. You don't want to discount it as a structural flaw, but I don't know how much mileage you can get out of it as a political issue. Any attempt to eliminate the coverage gap would be hugely expensive. In a deficit situation, it's unlikely Congress could come up with the money to fill the gap. However, it does weigh heavily on beneficiaries' minds. In our surveys, it's clear that as a beneficiary approaches and then falls into the donut hole, it affects every measure of satisfaction. Beneficiaries wonder why they're paying a monthly premium, but suddenly get an arbitrary stoppage in coverage. It doesn't sit well with the elderly.

Morrison: Generally speaking, then, overall satisfaction with the program is pretty high until beneficiaries hit the donut hole.

Gorman: That's right. It is worth pointing out that in 2006, fewer people hit the donut hole than was anticipated. It was thought that as many as 27 percent of beneficiaries would hit the gap, but perhaps half of that percentage did. If the percentage rises this year, it may not rise much, because Part D sponsors are offering more robust benefit designs. Also, there has been an increase of almost 40 percent in the number of plans offering enhanced coverage, either first-dollar coverage or some coverage in the gap, or both. About 27 percent of plans offer at least generic coverage in the donut hole, up from 13 percent in 2006. The fact that the vast majority of plans now offer Part D coverage with no deductible is remarkable. The benefit offerings that the market has de-

livered have far exceeded anything Congress ever imagined.

Morrison: That may be a lesson for us in terms of broader health reform. Markets have an ability to do certain things when there's a viable set of competing options.

Gorman: The market works and can deliver on a big societal good, as long as it is aggressively regulated and monitored. As one of the biggest "limousine liberals" you can imagine, I got into Medicare managed care because I believe it is the path to single payer — that is ultimately where we're going to end up. This is the laboratory for national health insurance and how it will be administered.

Morrison: I've written about this in my book *Health Care in the New Millennium*. As I've said, I believe in competition within the framework of universal health coverage.

Gorman: The government made a massive investment in the managed care industry to deliver this program, the largest benefit expansion in Medicare history, without laying out any expectations in terms of quality, outcomes, or satisfaction on behalf of the end user. In the 1990s, when I was in HCFA, priority was given to developing a quality surveillance apparatus for Medicare managed care. We had it in place for 6 or 7 years, and it worked well. We tracked mandatory quality improvement programs inside plans and the reporting of HEDIS measures. But that apparatus was systematically dismantled under the current administration. It needs to be revisited. For the investment it has made in the Part D program, the government has every right to expect certain results, and when those results are not met, punishment should be swift and sure. That's how you successfully operate a program of massive private sector contracting with the government.

Morrison: The Democratic leadership in Congress has been fairly vocal about direct price negotiations between CMS and the pharmaceutical industry. Will there be any legislation, or is this mostly speechifying?

Gorman: A lot of it is posturing. Democrats get a lot of traction politically when they can frame big programs like this as a giveaway to the drug or managed care industry. The even money is on gridlock on this issue, especially given the fact that, despite the Democratic leadership, margins in Congress are tighter than they were before the election. It may have done reasonably well in the House, but this is a contentious issue in the Senate. When the Congressional Budget Office (CBO) says direct negotiations will generate zero savings, that tells the senators this isn't worth their time. With the CMS actuaries dropping $100 billion off the 10-year cost of the program, it's clear that contracting with PBMs and private-sector plans is having a dramatic impact on drug pricing for the elderly.

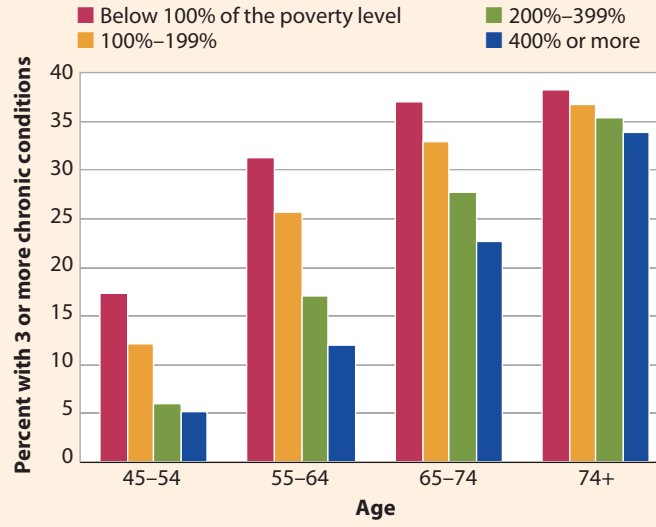
Morrison: Contrast that with the more recent estimates of substantial multiyear savings by limiting the subsidy for private MA plans. Will that $100 billion over 10 years be too big a temptation for Congress?

Gorman: It's a huge pot of money. When it comes to this program, Congress just can't keep its hands off. The root of this "overpayment" issue goes back to a statute that Congress passed in 2000 establishing minimum payment rates for Medicare managed care health plans as a way to attract investment in underserved areas, primarily secondary urban markets and rural areas. It was an unqualified success, because they built in 10 to 40 percent arbitrage over Medicare fee-for-service cost trends in those areas. Overnight, markets from Puerto Rico to Wisconsin to New Mexico became blockbusters in terms of markets for a Medicare managed care plan.

The CBO says that bringing reimbursements for MA plans in line with 100 percent of fee for service will result in a savings of $65 billion over 5 years and $159 billion over 10 years. That's irresistible when the government is faced with making choices about physician pay cuts and expanding health insurance for children. Inevitably, there will be some across-the-board reductions to MA plans this year, but that won't bring them down to 100 percent of fee-for-service Medicare, because that

FIGURE

Percentage of adults with ≥ 3 diagnosed chronic conditions, by age and poverty level



Percentage of adults who had ever been told by a physician that they had three or more of the following conditions: hypertension, heart disease, stroke, emphysema, diabetes, cancer, arthritis and related diseases, or current asthma.

SOURCE: NCHS 2006

would be devastating and would result in an exodus like we saw in the late 1990s. Any reduction will be debated in the Senate Committee on Finance. We have to look at the composition of that committee: Democratic Sen. Max Baucus, Montana, is chairman; Sen. Chuck Grassley, Iowa, is the ranking Republican, and Democratic Sens. Kent Conrad and John D. Rockefeller IV represent North Dakota and West Virginia, respectively. These are rural states where that policy has been of primary benefit. Committee members recognize that if they take a whack at the rates, they will hurt their constituencies.

Morrison: It is important to remember that the House and Senate have different geographic loyalties and that plays out in a very real way, as you pointed out.

Gorman: Even the more radical House Democrats have to consider that this is a constituency issue. In the late 1990s, managed care and Medicare were just a convenient choice. Now it's the backbone of the drug benefit delivery system. The majority of African American and Latino beneficiaries already are enrolled in MA plans. So reducing the rates these plans get from the government would have a direct impact on some of the constituencies the Democratic Party most cares about.

Morrison: How would beneficiaries grade these programs? How would you grade the various actors?

Gorman: Beneficiaries have spoken pretty consistently for the last several months. In almost every survey, 8 of 10 beneficiaries consistently have been happy with their plan. Now, as far as the other stakeholders are concerned, CMS has been a solid 8, possibly 8.5, on a scale of 1 to 10. For this agency to have brought a program of this magnitude off the ground as quickly and competently as it did is just remarkable.

As for MA plans, it depends on the product. HMOs have done well in integrating Part D into their offerings and making those products attractive and responsive to beneficiaries. Private fee-for-service plans, where most of the enrollment growth in MA plans has been, is somewhere in the 4-to-5 range. The big problem these plans are having is they are not reimbursing their providers accurately or in a timely fashion. We're seeing pushback from providers against private fee-for-service plans, which will cause significant issues for the private plan offering.

Special Needs Plans (SNPs) are still in their infancy, especially the chronic care plans, which didn't materialize in significant numbers until 2007. They will be a focus of intense debate in Congress as their authorization comes to an end in 2008. Attention will focus on what SNPs bring in terms of any value proposition to the Medicare program. I tend to be bullish about them. I love the idea of specialized health plans for specific disease states or economic circumstances, but the jury is still out on the question of how well they will deliver. It is unsustainable for about half of the 500 SNPs in the program to have fewer than 1,000 members, so there will be a lot of consolidation among SNPs.

PBMs receive a grade of 6 or 7. In their core business of administering drugs, they're doing fine and aggressively negotiating good prices with manufacturers. They're falling down on some of the operational issues that are new to them, whether it is getting through enrollment snafus, some of which persisted into 2007, or reconciling the reporting to CMS about the drugs they are administering. From what we've seen in our work in the field, it has been sloppy, and there will be a day of reckoning soon.

Morrison: One final question: As you look ahead 5 years, what's the one big thing you hope happens with Medicare?

Gorman: I hope we see a mass migration of beneficiaries out of PDPs and into MA plans. The notion of drug-only plans is an aberration in the insurance world. It represents a policy malfunction. It's best only for that population in the U.S. health system that we can be sure will get sick to have one-stop shopping for medical, pharmaceutical, and social benefits. As long as there are PDPs with mass enrollment, you'll get fragmentation of health care delivery. That isn't particularly good for the elderly, especially those with chronic conditions.

We're beginning to see lower-income and chronically ill beneficiaries migrating into SNPs. We're seeing the low-to-middle-income beneficiaries who are relatively healthy remaining in HMOs, and in rural areas, in low-cost, private fee-for-service products. As years go by, we will have a lot more diversification. Beneficiaries in upper-income brackets who are in PDPs and also buying Medigap insurance will migrate into private, top-tier, fee-for-service options; PPOs (which I remain convinced are the future of Medicare); and medical savings accounts. CMS is projecting that we'll have more than 15 million beneficiaries enrolled in MA by 2013, and if the reimbursement environment stays relatively stable, that estimate could be low.

Morrison: The goal is not just to boost the private sector. The goal is to get Medicare beneficiaries into organized systems of care that better coordinate their care.

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For proposed legislation on negotiating Part D drug prices, visit «http://waysandmeans.house.gov/media/pdf/110/HR4asintroduced.pdf».

Evidence-Based Benefit Design

HELEN DARLING
President, National Business Group on Health

Ian Morrison: As health care costs continue to increase, so does the importance of setting priorities in the allocation of medical care resources. Today, typical health care benefits are not necessarily based on what is known about effective practice. Evidence-based benefit design is used, along with value purchasing, to reduce the use of unproven or ineffective treatments, improve the health and quality of life of employees, and protect the health care investment of employees and employers. The National Business Group on Health and you, personally, are leaders in evidence-based benefit design. What brought you to focus on this issue? What have we achieved, and where do you think we're headed over the next 5 years?

Helen Darling: We were driven to establish a national committee on evidence-based benefit design by the growing amount of research demonstrating that patients receive research- or evidence-based treatment slightly better than half the time (McGlynn 2003). When you sit with corporate benefits managers who spend hundreds of billions of dollars on health care, you have to ask, "Why can't we do better?" We're spending twice what other rich industrial nations are spending, and yet we're not getting the evidence-based care that we should. So, we established this committee to identify the valuable programs and clinical services that are based on research, to encourage benefit design that supports effective treatment, and to encourage people to get the care they should be getting. In many instances, a service like colonoscopy may be covered 100 percent, but people still don't take advantage of it.

The National Business Group on Health is a not-for-profit membership organization that represents large employers on health policy issues and provides practical solutions to their health care problems. Darling serves on the National Committee for Quality Assurance's Committee on Performance Measurement; on the medical advisory panel of the Blue Cross Blue Shield Association's Technology Evaluation Center; on the Institute of Medicine's roundtable on evidence-based medicine; and on the board of the VHA Health Foundation. Modern Healthcare *has named her as one of "100 Most Powerful People in Health Care in the United States." Earlier in her career, Darling directed the purchasing of health benefits at Xerox Corporation for 55,000 employees, dependents, and retirees. She also served as an advisor to Minnesota Sen. David Durenberger, during his tenure on the health subcommittee of the Senate Finance Committee.*

Morrison: To what extent are these kinds of initiatives being implemented by the stakeholders? Are you seeing progress?

Darling: We think we are. A few months ago we published "The Purchaser's Guide to Clinical Preventive Services" (Campbell 2007), which is available on our Web site. It breaks down the highly recommended clinical preventive services into bite-sized pieces for benefit managers so they can find out, for example, whether a particular vaccine is recommended and for whom. Our recommendation might be that employers should reimburse it at 100 percent and encourage patients to get it. Even with consumer-directed health plans, we have seen that you may want to pay for 100 percent of those evidence-based preventive services before the deductible, which you're allowed to do under the law. We've created a spreadsheet that shows our members which preventive and diagnostic screening services they should make available to employees before the deductible and perhaps even up to 100 percent reimbursement. We're seeing changes being made by our members all the time.

Morrison: That's great. It's important to underscore that you're not trying to discourage consumers from using services, but actually are trying to encourage certain types of utilization, particularly by providing 100 percent coverage of preventive services.

Darling: A related development is that many of our members, including almost 80 percent of large employers, are paying for health risk appraisals. These employers are spending a lot of extra money to get employees and their adult dependents to take these assessments so they can get information about risk factors and become active in improving their own health. The information isn't given to the employer, but is sent to independent health professionals who will prepare a report about risk factors if the employee agrees to be contacted.

Morrison: I've heard the terms *evidence-based benefit design, quality-based benefit design,* and *value-based benefit design.* I've put them in the bucket of *intelligent benefit design,* because they all are trying to stimulate the right behaviors, not just shift cost to consumers. Are these terms synonymous?

Darling: Those terms are used interchangeably, but not precisely. I do think they are different. We want benefit design to be research-based. Evidence-based usually means research-based, but research-based is probably a better term and probably better understood by the public. The term *value based* is used a lot, but it is an "in-group" kind of term. To many people, terms like "value" and "affordability" sound like code words for "I'm not going to give you what you want." It's like managed care. Integrated delivery systems like Kaiser Permanente deliver wonderful care, but if you ask average people what they think about, say, managed care or primary care physicians and gatekeepers, they look at you like you've got seven heads. So, unfortunately, words like value and affordability may be used in the policy and benefits world, but they are perceived and heard differently by consumers.

Morrison: A lot of contemporary medical practice, particularly in oncology, is not backed by randomized controlled trials (RCTs). Some would argue that over half the utilization of oncology drugs is off-label. How is the field handling these issues?

Darling: We're very concerned. We think medical practice should be subjected to research in advance, whether it's the gold standard RCTs or observational studies. A difficulty in conducting RCTs is that patients increasingly don't want to be randomized to placebo, so it is difficult to enroll patients. In some situations, the number of cases is so small that it will take 10 or 15 years before you have meaningful results. So we can't rely on RCTs alone, but other things can be done. We would like medications and medical treatments to be subjected to rigorous research; but, when that's not possible, we would like any new treatment or diagnostic test to be followed for a certain period of time. We would certainly include the off-label use of drugs and devices. We need a process for ensuring that every time anything new is brought into the health care system, we have a way to study it while it's being used, so we can learn as soon as possible if there are any problems or to identify the circumstances under which it is most effective.

Morrison: In other countries, groups like the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom are charged to do technology assessment on a national scale. Certainly the Swedes and Germans, among others, also have been active in technology assessment over the years. Do we need an organization like that in this country?

Darling: Yes we do. The Institute of Medicine has its Roundtable on Evidence-Based Medicine, and I'm privileged to sit on that. It's chaired by Denis Cortese, MD, head of the Mayo Clinic, and its members include Carolyn Clancy, MD, director of the Agency for Healthcare Research and Quality. It has all the stakeholders. One of the purposes of the roundtable is to figure out the best organizational structure, the best government structure, the best modes of acting, and even things like standards of evidence.

It's clear that as a nation, we need an organization or a group of organizations set up to make certain that we efficiently and effectively gather evidence to support decisions. But this country is probably too complex and too big for that to be done by just one organization like NICE. We probably need an umbrella organization representing all the key stakeholders. That group could cover many subgroups. One would be all about evidence, while other groups would answer questions about what the evidence means for coverage. Even though something is effective, you may not want to cover it. On the other hand, we cover many things for which there is no evidence, and what do you do with that sort of thing? I would recommend that anybody who touches money in the health care system be required to set aside 1 percent of every dollar spent for these purposes. This would generate a constant stream of funding to help determine what is effective and when it's effective. The area where we have had the least amount of funding and attention is delivery of care. The National Institutes of Health and other organizations are putting out more and more research, yet some of it isn't getting into practice for up to 15 years. Because of this gap, the average American is not getting the best cancer care, for example. We need to invest at least 25 percent of that 1 percent in research that will translate scientific evidence about treatment and diagnosis into the delivery of care.

Morrison: Obviously, evidence-based benefit design is one tool for driving research-based care into the health care system, but it requires the consumer to be engaged. How successful have we been in engaging consumers?

Darling: I'm struck by how often I hear experts in health information technology and science say that if we don't get the consumer engaged and informed, we will continue to fail and waste billions and billions of dollars. There was a time when physicians were talking only to each other and didn't think about engaging the consumer in a dialog about their condition. I've seen a massive turnaround in that direction. In addition, you see more attention to clinical issues of care and diagnosis in consumer surveys. I recently saw a Massachusetts study in which consumers were asked about the information they want. For hospitals, the number one topic they wanted to know more about was the infection rate. That is a very sophisticated audience. Massachusetts is far ahead of most of the country, but it proves that if con-

sumers are exposed enough to some of the issues, they learn what things to worry about.

Morrison: That's a symbol of a much more educated and aware public, and it shows that as we provide both incentives and information, consumers will be more engaged.

Darling: Not long ago, the number of hits to health sites on the Internet exceeded hits to pornographic sites for the first time. Baby boomers are a totally different generation. They are Internet-savvy, they want to control things. Just like everybody else, they will learn that you have to pay attention to your health as you age because you will be noticing it in ways you never did before. When millions of people are using the Internet to acquire information about health, they will drive the use of products and services, especially if we help consumers understand why it's in their interest to have all this information and to understand why evidence is important. Once they figure that out, we will be in a totally different place.

Morrison: As you look ahead over the next 5 years, what's the one big thing you hope happens in evidence-based benefit design?

Darling: If we could devote 1 percent of health care spending to the development and application of evidence and evidence monitoring and tracking, we truly would transform the health care system.

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Consumer-Directed Health Plans

SARA R. COLLINS, PHD
Assistant Vice President, Program on the Future of Health Insurance, Commonwealth Fund

Ian Morrison: Consumer-directed health plans are based on the premise that consumers can be motivated to seek lower-cost providers and use fewer marginal services. These plans may be the latest big idea in health care, but I call them consumer-deflected health care, because it seems we're just deflecting the cost problem onto consumers. Other pundits term them consultant-directed health care, because they seem to satisfy the needs of consultants and employee benefits managers rather than consumers. Are consumer-directed health plans just high-deductible health plans with a few bells and whistles?

Sara R. Collins: Basically, a consumer-directed health plan combines a high-deductible health plan with a tax-exempt savings account, either a health reimbursement arrangement (HRA) or a health savings account (HSA). In theory, this lets people save for their health care as they manage their own first-dollar health care spending. There are no specific guidelines on deductible amounts for HRAs, which must be offered by employers. The 2007 criteria for HSAs require a minimum deductible of $1,100 for an individual and a $2,200 for a family and an out-of-pocket spending limit of about $5,500 for a single-person policy and $11,000 for families.

Morrison: So a consumer-directed health plan essentially is a high-deductible plan coupled with a tax-exempt savings account offered to boost enrollment.

Collins: That's right. In theory, the savings account gives people a greater incentive to be prudent users of first-dollar health care, and when they need care, to shop around for the best value.

Morrison: You often hear that U.S. consumers need to have "skin in the game." I find this funny, because Americans have more skin in the game, in terms of out-of-pocket spending, than do people in any other country. Is this just an expression of our frustration from not coming up with a better idea for cost containment?

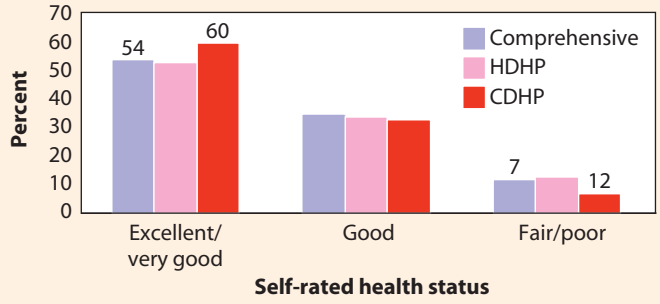
Collins: I think so. Employers are trying to cope with rising health care costs and premiums, and of late they have been increasing cost-sharing by employees. It's important to look at how the United States compares with other industrialized countries. Everybody knows our health care expenditures are very high compared with other countries — about $6,000 per person, or twice the median for industrialized countries. What is less well known is that U.S. families spend far more out of pocket on health care than do people in any other industrialized country. In 2002, out-of-pocket medical spending per capita in the United States was $800, twice the median among Organisation for Economic Co-operation and Development countries (OECD 2006), which raises questions about the ability of higher cost-sharing to rein in health care growth. It also raises concerns about adding to an already relatively burdened population in terms of their health care costs. Consumer-directed health plans are a desperate attempt by employers to come to terms with rising premiums, but they don't address the root cause of the problem. They also could exacerbate some health care cost problems in terms of people's inability to properly manage their chronic conditions.

Morrison: What does your research show about the growth of consumer-directed health plans?

Collins: For the second year in a row, the Commonwealth Fund, with our colleagues at the Employee Benefits Research Institute (EBRI), conducted a survey of consumerism in health care (Fronstin 2006). Paul Fronstin of EBRI was the lead author, and I was the coauthor. Our report is based on a nationally representative online survey of 3,158 privately insured adults ages 21 to 64. We defined consumer-directed health plans as plans with individual deductibles of at least $1,000 and family deductibles of at least $2,000, plus an account that could be rolled over at the end of the year, either an HRA or a HSA. Just 1 percent of adults, or about 1.3 million people, had

Sara R. Collins, PhD, is responsible for survey development and research and policy analysis, and program development and management for the Commonwealth Fund's health coverage and access programs. Previously, Collins was associate director and senior research associate at the New York Academy of Medicine, Division of Health and Science Policy, and was an associate editor at U.S. News & World Report, *where she wrote articles on economics and health care. She was also a senior health policy analyst in the New York City Office of the Public Advocate.*

FIGURE 1
Self-rated health status by type of health plan



Respondents in comprehensive health plans (n=1,506) had no deductible or deductibles of less than $1,000 for an individual and less than $2,000 for a family. Those enrolled in an HDHP (n=930) had deductibles of $1,000 or more for an individual and $2,000 or more for a family, but no HSA or HRA. Those enrolled in CDHPs (n=722) had deductibles of $1,000 or more for an individual and $2,000 or more for a family plus an HSA or HRA.

For values shown, $P \leq .05$ for difference between HDHP or CDHP and comprehensive health plans.

CDHP=consumer-directed health plan, HRA=health reimbursement arrangement, HSA=health savings account, HDHP=high-deductible health plan.

SOURCE: FRONSTIN 2006

such a health plan — a rate that is virtually unchanged from the year before. An additional 7 percent of the adult population, or 8.5 million people, had deductibles that were high enough to meet the threshold to qualify for an HSA but had not yet opened an account. So the majority of people with high-deductible health plans don't have an HSA.

Our data are consistent with other surveys. The Kaiser Family Foundation and the Health Research and Educational Trust found that, in 2006, the number of workers with consumer-directed plans had grown from about 2.5 million in the prior year to 2.7 million, with 1.4 million enrolled in HSA-based plans and another 1.3 million enrolled in HRA plans (KFF 2006). So we're not seeing rapid growth in these products.

Morrison: That squares with survey work I've been involved in. But it is important to underscore that frustrated employers believe they have no other avenue to control premiums.

Collins: That's right. We're seeing across-the-board increases in deductibles. People increasingly have higher deductibles, no matter whether it's an HSA- or an HRA-based plan. Also, out-of-pocket spending as a share of people's income is climbing.

Morrison: Many observers of the health insurance market feared that consumer-directed health plans would attract young, healthy people, causing a death spiral in the insurance pool that would leave the sicker and older folk in other kinds of plans. It appears that early adopters of consumer-directed health plans and HSAs tend to be middle-age, upper-income people. Who is signing up?

Collins: We found few strong demographic differences among people enrolled in these plans. People with consumer-directed health plans were more likely to be in better health than those in more comprehensive plans. They are more likely not to smoke, and slightly more likely to exercise. They tend to cluster around the age group 35 to 44 and to be single, white, and college-educated. We didn't find a lot of income differences. A striking finding that reflects cost pressures in the small group market was that people in consumer-directed and high-deductible health plans were more likely than those in comprehensive plans to be sole proprietors of or employed in small business firms.

Morrison: What impact do consumer-directed health plans have on the patient?

Collins: In our survey, about a third of adults in consumer-directed and high-deductible plans reported delaying or avoiding needed care because of cost compared with about 1 in 5 people in more comprehensive plans. Differences were also pronounced among people who had health problems. The other place where we're seeing worrisome results is that people in consumer-directed and high-deductible plans were significantly more likely to skimp on medications because of cost.

Morrison: Some would say perhaps they didn't need those medications in the first place. I don't necessarily subscribe to that view because your survey and another we've done show that these noncompliance effects hold up across a wide range of conditions. Do we have any evidence of the impact on outcomes of these plans?

Collins: A substantial body of literature suggests negative long-term health consequences from increased cost-sharing, particularly among people with health problems who are older and have lower incomes. So you have to evaluate the effects of consumer-directed health plans in the context of that literature. For example, a recent study (Hsu 2006) found that Medicare beneficiaries whose drug benefits were capped had lower drug utilization than those whose benefits weren't capped. Among the consequences were poorer adherence to drug therapy and poor control of blood pressure, so cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use. Another study (Tamblyn 2001) found that increased cost sharing reduced the use of essential and nonessential drugs among elderly and poor patients, and that it increased the risk of adverse health events like hospitalizations and admissions to the emergency room. These studies raise the question of

whether asking people to share more of the upfront costs — preventive and chronic care management — is an effective long-term cost-control strategy.

Morrison: What advice do you have for executives trying to sell these products? Is there a way to build a high-performing consumer-directed health plan that has better features and better benefits for patients and the people paying the bill?

Collins: Many employers do what the law allows, which is to exempt preventive care services from the deductible. You can qualify for an HSA if you have preventive care services covered within your deductible, and you can get reimbursement for preventive care services like a mammogram, for example. Many people appear to be confused about this — they don't know what preventive care means. The law could be altered to make it easier for employers to use these plans and for employees to understand the benefits. Exempting primary care as well as preventive services from the deductible, for example, might help clear up some confusion about the preventive care exclusion. In addition, the legislation could be changed to permit employers to offer lower deductibles so that lower-wage workers could still qualify for an HSA, or to guarantee a choice of a comprehensive plan to workers who are covered under employer plans, or to permit greater flexibility in benefit design.

Morrison: How much of an ideological motive lies behind consumer-directed health plans, particularly the tax-saving elements? Looking out 2 to 5 years, would a political change or political backlash against this cost shifting change the enrollment figures?

Collins: The cost pressures facing employers as well as their employees will continue. Nothing that happens on the political horizon over the next couple of years will change that fact. Employers still will be grappling with this issue. But there may be more broad-based efforts, like trying to deal more significantly with some of the root causes of the growth of health care costs.

Much of what we're seeing in the public's concern about health care is being driven by higher out-of-pocket costs, which are rising at the same time that their incomes are growing very slowly. A recent CBS News/*New York Times* poll found that two thirds of the public support expanding health insurance and are willing to pay higher taxes to achieve it (CBS 2007). This new sentiment on the part of the public and efforts by governors and Congress to deal with the insurance issue and rising health care costs reflect the pressures families are feeling with respect to health care.

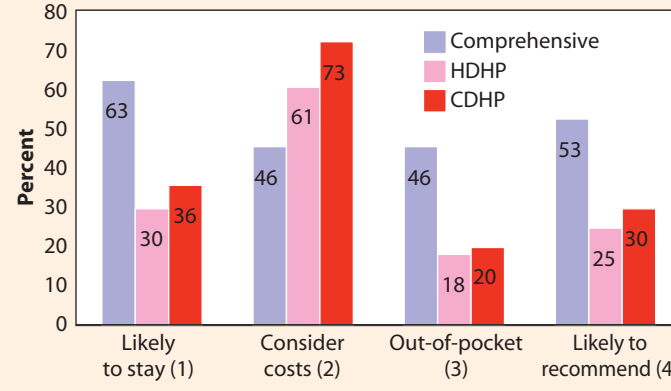
Morrison: Do you sense a cooling ardor for consumer-directed health plans?

Collins: We're finding that people in those plans continue to be less satisfied with them than those in more comprehensive plans. We find high dissatisfaction rates with respect to how much they are spending out of pocket. They also are less likely to recommend their plan to a friend or colleague, and they say they're more likely to change plans if they have the opportunity. These rates were much the same in 2005 and 2006, so you don't get a sense that people are warming to the plans over time. Certainly the benefit managers who are concerned about attracting and retaining employees will look hard at data like these.

Morrison: In my work, complaints get employers' attention. Cost issues obviously are huge, but if you have many people calling and complaining, that causes real problems. So what do we do? There is a frustration among employers — this sense that they think we need to get consumers engaged. On the one hand we've put more incentives in the hands of consumers, and on the other we haven't given them the tools. What can health plans do to engage consumers?

Collins: The more information consumers have about the quality and cost of their care, the better their decision making will be with respect to providers and treatment options. In small ways they can contribute to improving their health through exercise and knowing more about their treatment regimens and the overall costs of those

FIGURE 2
Satisfaction with health plans



(1) Extremely or very likely to stay with current health plan if they had the opportunity to change.
(2) Strongly or somewhat agree that terms of health plan make them consider costs before seeing a doctor or filling a prescription.
(3) Extremely or very satisfied with out-of-pocket costs for health care.
(4) Extremely or very likely to recommend health plan to friend or co-worker.

CDHP=consumer-directed health plan, HDHP=high-deductible health plan.
SOURCE: FRONSTIN 2006

regimens. But it's unrealistic to expect that even with the best information and good patient financial incentives that we will achieve transformational change through patient choice of provider or patient cost incentives. Patients are in the weakest position to demand greater quality and efficiency. Federal and state governments and accrediting organizations are in a much better position to demand high performance, high quality, and better efficiency.

Most health care costs are incurred by really sick patients, so shopping for the best physician or hospital is not practical when you're very, very ill. We need to look at more fundamental strategies to improve quality and efficiency in the health care system. That will require leadership on a federal level, such as encouraging Medicare to assume a leadership role in making cost and quality information by provider and by patient condition publicly available. Medicare should forge public/private partnerships to create a multipayer database, uniform quality metrics, and transparent methodologies for adjusting quality and cost. As for other strategies, the Institute of Medicine has recommended the creation of a National Quality Coordination Board to set priorities and oversee the development of quality and efficiency measures. We need to invest in health information technology to make sure the right information is available to patients, providers, and payers. We're far behind on that relative to other industries.

Morrison: Consumer-directed health plans may be the wrong agent to make all the changes that are necessary. Perhaps we should be doing more to encourage institutions to change their behavior, which may have a bigger impact than putting the burden on individual consumers.

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Resources

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Specialty Pharmacy Management

DEBBIE STERN, RPH
Vice President, Rxperts

Ian Morrison: Biotechnology in many ways has come of age. We've moved from understanding more about human biology in the research laboratory to creating biologics or specialty pharmaceuticals. These drugs have the exciting potential to improve outcomes for patients, but they are also very expensive. The specialty pharmacy industry is evolving at a rapid pace to manage the growing number of these products. Every health care payer and provider operating today will be affected by market changes brought about by the new biotech products, gene-based therapies, and injectable drugs. Where is this field headed over the next few years?

Debbie Stern: The trend in growth is about 20 to 25 percent per annum. The percentage of the total drug spending attributable to specialty pharmacy may be around 10 percent. Although specialty pharmacy is a small segment of the overall drug spend, its growth rate is of most concern.

Morrison: How do specialty pharmaceuticals differ from traditional medications?

Stern: There is no precise definition of specialty pharmaceuticals, but most have several characteristics in common. Typically, a specialty drug originates in biotechnology, is usually used to treat a rare chronic disease, and usually has some storage or distribution issues that limit it from being in the regular commercial marketplace. In many cases, it is an injected or infused product, but some oral products also are considered specialty pharmaceuticals. Some specialty pharmaceuticals can be self-administered, but many are administered in a physician's office, either by injection or infusion. Specialty pharmacy encompasses all aspects of health care delivery, including outpatient hospital settings.

The overarching commonality is cost, which can run $2,000 to $3,000 a month or more. The cost point at which a product generally is considered to be a specialty pharmaceutical is around $1,000 per month.

Morrison: What tools are used to manage specialty pharmaceuticals? Are any of the tools used in a typical PBM applicable to specialty pharmacy?

Stern: There are two ways to manage drug costs: decrease the acquisition cost or decrease utilization. Decreasing the acquisition cost often entails setting up special contracts with preferred specialty pharmacies that dispense the drug. By getting into these preferred relationships, or limiting drug distribution to only a few pharmacies, you maximize your leverage to get the best unit cost. In a few therapeutic categories, you also can reduce unit costs by obtaining rebates from pharmaceutical companies in exchange for preferred product designation.

Controlling utilization involves making sure that it is appropriate for patients to receive the drugs, that patients take them as prescribed, that they maintain therapy for the proper length of time, and that they discontinue therapy if it becomes inappropriate. That gets into a gray area of patient and drug management — working with the physicians to manage patients on these products. Health plans are becoming more involved at that level than they ever were in the traditional pharmacy benefit side of the business.

Morrison: Presumably, there must be close coordination with some of the care management and disease management initiatives that a health plan is involved with for patients on these drugs.

Stern: Many patients who are on specialty pharmaceuticals have rare chronic conditions that can be managed well under case management initiatives. But managing a patient's case or disease doesn't mean just managing the

At Rxperts, a managed care consulting firm in Irvine, Calif., Stern is responsible for designing and implementing comprehensive programs to meet the needs of managed care clients. Stern is a nationally recognized speaker, meeting facilitator, and consultant for the pharmaceutical and biotechnology industries, health plans, PBMs, and specialty pharmacies. Previously, she served as director of pharmacy services at Prescription Solutions, in Costa Mesa, Calif., where she was responsible for setting up the clinical, client services, claims administration, contracting, and finance departments. She received her bachelor of science degree in pharmacy at the University of Cincinnati, and is actively involved in the Academy of Managed Care Pharmacy, where she recently completed a two-year term on the board of directors.

drug. The best-managed patients are those who have a robust support system, both on the case management side as well as on the specialty pharmacy side. Some tactics used to manage traditional drugs can't be utilized by a specialty pharmacy. For example, there are no generic biopharmaceutical products, so generic substitutions cannot be made. In a few therapeutic classes, there may be opportunities to switch products to what we call preferred-status products based on cost and efficacy. The tools that are available to traditional pharmacy are not as readily available on the specialty pharmacy side.

Morrison: There is much speculation in the policy community and in the industry about the potential for generic biologics, if you want to use that term. Would legislation encouraging generic biologics have a big impact on the way people manage specialty pharmaceuticals?

Stern: At this point, it is questionable. There is a bill before the U.S. Senate and the House of Representatives called the Access to Life-Saving Medicine Act (S 623, HR 1038). This new bill would create a pathway for the approval of generic biologic products, and the U.S. Food and Drug Administration would have some flexibility in approving abbreviated applications for biologic products.

The underlying issue is that most biologic products are approved under the Public Health Service Act, not the Food, Drug, and Cosmetic Act, and there is no mechanism under the Public Health Service Act for generic drug approvals. Also, generic biologic products would not necessarily be considered bioequivalent. The terminology for these generic products varies. Follow-on biologics is the term used in the United States; in the European Union, they are called biosimilars. Until there is a definition of bioequivalence, I don't think the FDA will create equivalency categories similar to what we have for pill products.

Once the Access to Life-Saving Medicine legislation moves through the House and Senate, we may see follow-on biologics that are similar and will have similar outcomes, but would not be considered bioequivalent. The onus will be on physicians as to whether they want to place patients on one of these products. There is an opportunity for follow-on biologics to be less expensive than the branded products. The potential is that we could see savings of 10 to 30 percent off the standard product. That isn't what we're typically used to seeing with generics, but that has been the experience in the European Union.

Morrison: By many accounts, consumer engagement and cost sharing have been very effective in the design of benefit plans that encourage patients to use cheaper alternatives. To what degree is cost sharing viable with biologics? Where do you see that headed?

Stern: Cost sharing definitely has been a bit of a roller coaster from the perspective of benefit design in health plans and PBMs. The initial thought was that patients would share about 20 percent of the cost of these products. Some organizations have experimented with that design, but found that it was excessive for patients to pay $400 to $600 a month for a drug, especially when patients have other disorders and needs that also are expensive. Then there was the thought of capping cost sharing at $100 or $200 per prescription. And I have seen a shift to making it a flat copayment, something like $50 or $75. Health plans have realized that you can't pass on too much of the cost to patients, which is another cost management challenge. Through the survey work and interviews that I do, it appears that the majority of plans still have specialty pharmaceuticals in a dollar copayment tier, in the range of $50 to $75. They have somewhat shied away from the percentage co-insurance tiers, although not necessarily in all cases.

The ultimate payers, such as the federal government or private employers, are concerned with the cost of these drugs, although, typically, any given employer will not have very many patients who are affected. But as these drugs become more popular, employers probably will press health plans to create higher cost-sharing tiers or other mechanisms.

Morrison: How is this working within the context of Medicare? As I understand it, particularly in the oncology area, we have seen the shift away from, to put it crudely, the retailing of oncology drugs by physicians to a system based on the average selling price plus a 6 percent administration fee (ASP+6). How have these changes affected the use of specialty pharmaceuticals in the Medicare population? What influence has the Medicare initiative had on the broader private market?

Stern: Medicare's new reimbursement methodology somewhat caps the profitability of these particular agents for physicians. It has been in place for a while, and physicians seem to be accepting the reimbursement rate on the Medicare side. There have been attempts to capture similar reimbursement for commercial patients. The commercial models may be ASP+6 or a slightly higher percentage, along with some additional fees paid to the physician to administer the drugs.

As for cost sharing, Medicare Part D covers self-administered injectable products, and payers are allowed to create a special tier with a 25 percent cost-share component. But Part D limits a patient's liability, because once patients reach catastrophic coverage, they only have a 5 percent co-insurance. So that is somewhat self-limiting on out-of-pocket expenses. It is challenging to look at the different kinds of benefit and cost sharing designs and determine what's best for the patient and what's best for the payer.

Morrison: If biotechnology is the wave of the future, and if more and more of these products become available, the time may come when specialty pharmaceuticals

no longer are special in the sense of being in the minority, but, instead, have become the majority. Do you see that happening, and how will that change the pharmacy management business?

Stern: In 5 years or so, specialty drugs will probably approach 25 to 30 percent of total pharmacy costs, but the number of prescriptions for them still will be small. The drugs that we use to treat hypertension, high cholesterol, diabetes, and conditions like that, will pretty much stay in the traditional marketplace.

I think we will see growth in two areas. First is oncology. That will be the area that probably will have the most impact overall. The other area where we'll probably see a lot of growth is oral drugs that are considered biotechnology agents. Even though the pipeline is robust with injected and infused drugs, there are a lot of oral agents coming out for multiple sclerosis, hepatitis C, and even oncology. Currently the oral agents typically are managed under the pharmacy benefit, but it will be interesting to see how these new oral agents affect overall treatment. Within any disease state there are patients who don't seek treatment because they do not want to have an injection — whether it's multiple sclerosis, rheumatoid arthritis, or psoriasis, patients have refused treatment. The new oral agents will make treatment more accessible for many of these patients. So, we will see growth in the number of patients as well as increases in the number of therapies, resulting in a huge increase in overall utilization.

Morrison: As you look ahead, over the next 5 years, what is the one thing that you hope will happen in the area of specialty pharmaceuticals?

Stern: We need to develop some defined outcomes so we can validate and document the value of these products. Are we seeing an impact in overall health care outcomes and health care costs? Do patients have a better quality of life? If a new oncology agent increases a patient's longevity by 1 or 2 months, does that patient have a good quality of life and is that a good return on investment? How does that compare with oncology agents that might keep patients free of disease, allowing them to be on chronic therapy and have many more productive years of life and good quality of life? It will be very important to start documenting outcomes like these in the near future.

Resources

For information on the Access to Life-Saving Medicine Act, visit: «http://www.house.gov/waxman/issues/health/generic_biologics.htm».

CONTINUING EDUCATION POST-TEST

MCOutlook – Conversations on the Changing Face of Managed Care: Insights From the 2006-2007 Podcast Series

Please tear out the assessment/evaluation form on page 32. On the answer sheet, place an X through the box of the letter corresponding to the correct response for each question. There is only one correct answer to each question.

1. **Transparency is about:**
   a. Increasing health care services for health plan members.
   b. Lowering out-of-pocket costs for consumers of health care services.
   c. Reporting those physicians who do not provide adequate health care services.
   d. Measuring the performance of health care providers to achieve higher quality and public accountability.

2. **According to O'Kane, the use of quality measurements, such as HEDIS, has resulted in a general improvement in health care quality of:**
   a. 30 percent.
   b. More than 50 percent.
   c. Less than 25 percent.

3. **According to Lee, the move to performance-based reimbursement for health care providers is being expedited by:**
   a. The president's executive order mandating value purchasing by all federal agencies.
   b. Rising out-of-pocket expenses for health care consumers.
   c. Market factors that govern the health care system.
   d. Improvement expectations by employers.

4. **According to Smith, measurement of health care quality and cost is most critical at the level of:**
   a. Consumers.
   b. Health care providers.
   c. Health plans.

5. **According to Williams, the success of a pay-for-performance program is based on:**
   a. Aggregation of data across health plans.
   b. Satisfactory physician "report cards."
   c. Consistent standard of measurement across health plans.
   d. Reimbursement reform.

6. **In Brailer's opinion, major drawbacks to establishing a national health information technology (IT) infrastructure are:**
   a. High capital expense.
   b. Lack of IT standards.
   c. Resistance by health providers.
   d. All of the above.

7. **In Nash's opinion, disease management can be best provided by:**
   a. Private for-profit vendors.
   b. Public not-for-profit vendors.
   c. Specialized vendors.
   d. A combination of a, b, and c.

8. **In Gorman's opinion, although the Medicare Part D initiative has to date been hugely successful, a critical shortcoming is:**
   a. The number of Part D sponsors is limited.
   b. No standards have been set to assess quality, health outcomes, or satisfaction on behalf of the end user.
   c. The program does not meet the prescription drug needs of most Medicare beneficiaries.

9. **According to Darling, more scientific evidence to support health care decisions and coverage would most benefit the:**
   a. Off-label use of drugs and devices.
   b. Delivery of health care.
   c. Development of innovative drugs and treatments.
   d. Development of new diagnostic methods.

10. **According to Collins, consumer-directed health plans have not been successful to date primarily because:**
    a. They are not affordable for the majority of health care consumers.
    b. Evidence on improved health outcomes is lacking.
    c. Preventive care services are not supported.
    d. They are better suited to small businesses.

11. **According to Stern, in 5 years, specialty pharmacy spending will likely reach ___ percent of total health care costs.**
    a. Less than 25.
    b. 25 to 30.
    c. 50.
    d. More than 50.

CONTINUING MEDICAL EDUCATION ASSESSMENT/EVALUATION/CERTIFICATE REQUEST

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EXAMINATION: Place an X through the box of the letter that represents the best answer to each question on page 31. There is only ONE correct answer per question. Place all answers on this form:

	A.	B.	C.	D.
1.	☐	☐	☐	☐
2.	☐	☐	☐	
3.	☐	☐	☐	☐
4.	☐	☐	☐	
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐
11.	☐	☐	☐	☐

PROGRAM EVALUATION

So that we may assess the value of this self-study program, we ask that you please fill out this evaluation form.

1. Have the objectives for the activity been met?

1. Explore issues surrounding transparency and its impact on employers, health plans, and consumers. ☐ Yes ☐ No

2. Evaluate the benefits, challenges, and expectations of physician incentive programs such as Pay for Performance. ☐ Yes ☐ No

3. Explain the impact of health information technology and e-prescribing on the future of health care in the United States. ☐ Yes ☐ No

4. Identify the pros and cons and the value of disease management programs. ☐ Yes ☐ No

5. Assess the accomplishments and limitations of the Medicare Part D Prescription Drug Program. ☐ Yes ☐ No

6. Discuss some of the key challenges posed by evidence-based benefit design and consumer-directed health plans. ☐ Yes ☐ No

7. Discuss some of the changes facing specialty pharmacy management. ☐ Yes ☐ No

Was this publication fair, balanced, and free of commercial bias? ☐ Yes ☐ No

If no, please explain: _____

_____

Please use the following scale to answer the next four questions:

Strongly Agree 5
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Did this educational activity meet my needs, contribute to my personal effectiveness, and improve my ability to:

Treat/manage patients?
5 4 3 2 1 N/A

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5 4 3 2 1 N/A

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5 4 3 2 1 N/A

Other _____

_____
5 4 3 2 1 N/A

Effectiveness of this method of presentation:

Excellent	*Very good*	*Good*	*Fair*	*Poor*
5	4	3	2	1

What other topics would you like to see addressed? _____

_____

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Comments _____

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