

H&B Update

May 2007



NBGH/Mercer survey on HHS transparency initiative

This past August, President Bush signed an Executive Order directing federal agencies that administer or sponsor federal health insurance programs to:

- 1) increase transparency in quality of care
- 2) increase transparency in pricing
- 3) encourage adoption of health information technology (HIT) standards
- 4) create positive incentives that promote quality and efficiency in health care

HHS Secretary Mike Leavitt, through his Transparency initiative, is asking employers, on a voluntary basis, to support these “four cornerstones” of value-driven health care.

In February the National Business Group on Health and Mercer Health & Benefits LLC jointly conducted a survey of NBGH members and other large employers to assess employer awareness of, and support for, this value-driven approach to health care, and to learn what steps employers have already taken in this regard. This summary of findings reflects the responses of 120 employers, about half of which (56) have at least 20,000 employees.

Awareness of executive order

RELEASE OF MEDICARE DATA Most of the respondents (83 percent) said they were aware of the President’s executive order to publicly post information on the quality of care provided by hospitals, doctors and other professionals, and the amount Medicare pays them for specific services.

However, only two-fifths believe the public disclosure of information will be very useful to consumers as they make health care decisions, and only 39 percent believe it will be very useful to their own organization as a purchaser of health care. While most respondents believe the information will be at least somewhat useful, 17 percent of those with 20,000 or more employees say the information will not be useful to their organization (Figure 1).

Figure 1

Employer opinion about public disclosure of Medicare provider cost/quality information

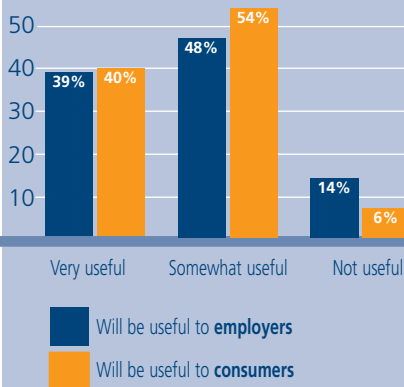


Figure 2

Most employers believe adoption of HIT standards will improve quality of care or cost efficiency

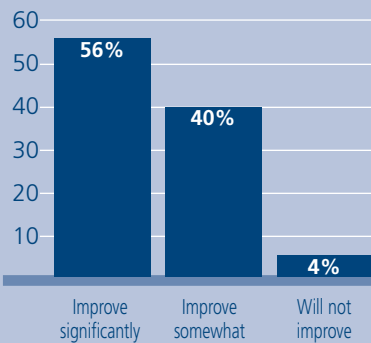
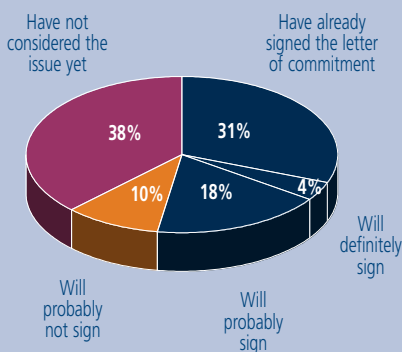


Figure 3

Support for HHS transparency initiative among the 61 percent of respondents who are aware of the initiative



Respondents were asked why they did not think the Medicare data would be useful. A typical comment from one who felt consumers would not find the data useful expressed doubt in consumers' ability to use the data: "Consumers may not take advantage of this information, nor know what to do with the information," and "Individuals tend to trust their doctors and will not really research quality issues."

Those who felt their organization would not find the information useful expressed doubts about whether Medicare cost information was meaningful, for example: "Medicare reimbursement does not equate with commercial reimbursement," and "Medicare/Medicaid rates are politically set and do not reflect the "true" marketplace."

HEALTH INFORMATION TECHNOLOGY Respondents were more positive about the requirement to adopt health information technology (HIT) standards. More than half (56 percent) believe HIT significantly improves the quality of care or cost efficiency of care; another 40 percent believe it will improve quality and efficiency somewhat (Figure 2). Respondents believe HIT will help reduce medical errors and improve safety (72 percent); eliminate unnecessary or redundant services (68 percent); and increase use of best-practice quality of care (67 percent).

Some employers have already taken steps to gain the benefits of HIT for their employees. Currently, 7 percent of respondents require their health vendors to adopt HIT standards or implement specific HIT technologies; another 25 percent say they plan to.

Support for transparency initiative

About three-fifths of respondents (61 percent) were aware of Secretary Leavitt's initiative to ask employers, other health care purchasers and health plans to join the federal government in making a commitment to advance the "four cornerstones of transparency." Larger employers were more likely to have heard of the initiative (68 percent of those with 20,000 or more employees, compared to 56 percent of those with fewer than 20,000 employees).

Of those, 31 percent have already signed the letter of commitment, and 4 percent say they will definitely sign. Another 18 percent will probably sign. Just 10 percent say they probably not sign; but 38 percent have not yet considered the issue (Figure 3).

Survey results demonstrate that many employers are already working collaboratively to address similar issues. Two-fifth of the respondents (about half of those with 20,000 or more employees) currently participate in a national or regional collaborative initiative focused on quality of care or cost efficiency; the most common being Leapfrog, Bridges to Excellence, and Care Focused Purchasing. Just over half (53 percent) say their health plan vendors participate in these or other collaborative initiatives.

Provider performance measurement

The first cornerstone – "promote transparency in quality of care" – and the third cornerstone – "create positive incentives to promote quality and efficiency" – both depend on the ability to measure provider performance. The survey asked employers about the extent to which they required their health plan vendors to measure the performance of network providers on compliance with quality of care standards and cost efficiency relative to network peers.

Figure 4

Are we ready to measure provider performance?

Employer opinion:

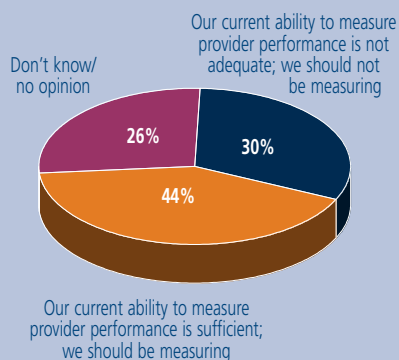


Figure 5

Priority placed on the release of Medicare claims data for use in performance measurement

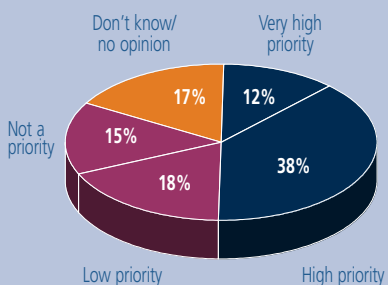


Figure 6

Most significant barriers in efforts to measure physician and hospital performance

Employers were most likely to require plans to measure on compliance with quality of care standards (30 percent for network hospitals; 28 percent for individual physicians/ medical groups). They were less likely to require measurement for cost efficiency (22 percent for both physicians/groups and hospitals). About a fifth require their health plans to identify and rank physicians and hospitals for quality of care and cost efficiency. Many more say there are planning to require the health plans to rank physicians and hospitals.

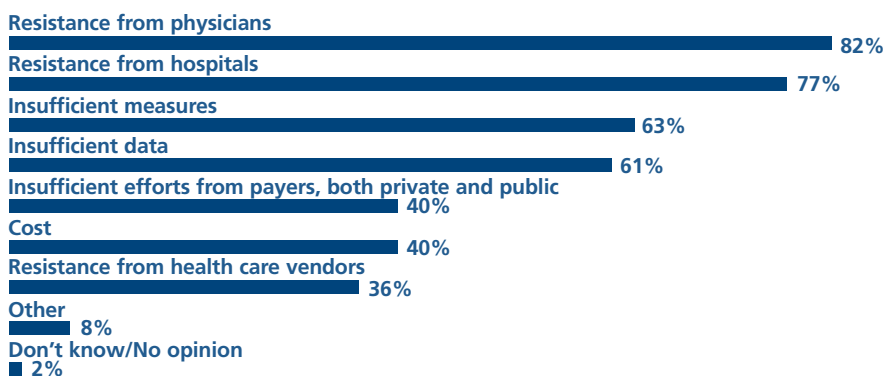
RESULTS OF EARLY PERFORMANCE MEASUREMENT EFFORTS Employers who have provided employees with provider cost/quality information or rankings were asked whether provider quality or cost efficiency had improved as a result. While very few could measure results, the 9 percent that did measure all said they had experienced improvement. Nearly half said that while they couldn't measure, they believed there had been improvement; 25 percent said they couldn't measure but doubted there had been much improvement. About a fifth simply didn't know.

EMPLOYER OPINION ON PERFORMANCE MEASUREMENT Few survey respondents (7 percent) believe that provider performance can be determined only from the medical record. About two-fifths believe it can be determined from medical and pharmacy claims; the largest portion (80 percent) believes that, when feasible, performance should be measured using a combination of claims and medical record data. Respondents were more likely to say that our current ability to measure performance is adequate and that we should be measuring (44 percent) than that it is inadequate and we should not be measuring (30 percent). About a fourth (26 percent) had no opinion.

A clear majority believes it is not necessary for providers to approve of all measures before they can be used to evaluate their performance (69 percent) or before public disclosure or use in product design (74 percent) (Figure 4).

Respondents were asked how high a priority their organization places on the release of Medicare claims data for use in performance measurement. Half (50 percent) said it was a high priority (Figure 5).

BARRIERS TO PERFORMANCE MEASUREMENT Most respondents believe that resistance from physicians (82 percent) and hospitals (77 percent) is one of the most significant barriers to provider performance measurement efforts; far fewer were concerned about resistance from health plans (36 percent). Insufficient measures were cited by 63 percent, and insufficient data were cited by 61 percent. Fewer (40 percent) thought cost was a significant barrier. (Figure 6)





Conclusion

The next generation of significant health care cost trend controls is going to come from the areas discussed in this survey. Experts estimate that health care spending could be cut by as much as 30 percent if the industry used interoperable health information technology to enable real-time sharing of patient data and had access to standardized information on provider quality and cost efficiency. The implications of being able to select and reward providers based on relative performance measures go far beyond cost; credible performance data should lead to tremendous quality improvements throughout the health care system. However, realizing the full potential of both health information technology and standardized performance measures will depend on the continued strengthening of collaborative efforts among employers, health plans, providers and federal agencies. The first step is educating all stakeholders to the importance of these efforts, and this survey was conducted with that goal in mind.

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