



The
eValue8
CORNERSTONE
Report

Measuring the Success of America's Health Plans

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<p>“As we work toward the goal of providing all Americans with easy-to-use information on health care quality and costs to make informed choices, health plans play a critical role in providing this information to consumers. HHS applauds NBCH’s leadership in working with coalitions and employers to report how America’s health plans are performing around the Four Cornerstones of Value-Driven Health Care.”</p> <p>U.S. Department of Health and Human Services Secretary Michael O. Leavitt</p>	
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NBCH WELCOMES FEDERAL CALL FOR VALUE-DRIVEN HEALTH CARE

By Andrew Webber



Andrew Webber is the president of the National Business Coalition on Health (NBCH), in Washington, D.C. Founded in 1992, NBCH has a membership of nearly 70 employer-led coalitions across the United States, representing more than 7,000 employers and approximately 34 million employees and their family members.

This year, the National Business Coalition on Health celebrates 15 years of leadership in value based purchasing. Over the last decade and a half, NBCH, a trade association of nearly 70 business and health care coalitions, has worked with our members to transform the health care delivery system, believing that, like politics, all health care is local. Truly reforming the way health care is delivered will require the collective leadership of all stakeholders in communities throughout the nation.

Although we have been advancing health care reform through value based purchasing for some time, never before has the work of coalitions been well recognized at a national level. That is until the summer of 2006, when President Bush issued an Executive Order, calling for the federal government to lead the transformation of the marketplace in how it purchases and contracts for health care services. By issuing Executive Order 13410, Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs, on Aug. 22, 2006, the President set in motion a series of events that energized the value based purchasing movement and established a public-private partnership for value-driven health care.

Less than three months after the order was issued, the Business Roundtable, NBCH, and other national and employer-based associations, now known as the Partnership for Value-Driven Health Care, conducted a joint summit with U.S. Department of Health and Human Services Secretary Michael Leavitt. At that meeting on November 17, 2006, the secretary challenged the private sector of the U.S. health care system to implement the Four Cornerstones of value-driven care:

1. Transparency of quality
2. Transparency of price
3. Incentives for high-value health care
4. Interoperable health information technology.

A first step by NBCH toward implementing the Four Cornerstones was to collaborate with the secretary and others to produce a toolkit for employers (www.hhs.gov/transparency) that urges them to send a consistent message to their health plan contractors by asking them to respond to 19 questions. These questions probe how plans are advancing the Four Cornerstones. NBCH responded to Secretary Leavitt's challenge by promptly embedding the 19 questions into NBCH's common request for information (RFI) for health plans—the eValue8 tool. NBCH is now pleased, on the one year anniversary of the President's Executive Order and the start date of Secretary Leavitt's Value-Driven Health Care Initiative, to issue *The eValue8 Cornerstone Report: Measuring the Success of America's Health Plans*.

eValue8 is a standardized health plan performance measurement tool that NBCH developed for member coalitions and their local employers to use when assessing a plan's ability to advance value based purchasing. Given the critical role that health plans play in driving transparency, payment reform, HIT adoption, and consumer engagement, NBCH-member coalitions and employers ask health plans to complete the eValue8 RFI each year.

NBCH member coalitions analyze eValue8 data from nearly 200 HMOs and PPOs in 44 states. More than 100 million Americans, or two of every three residents of the United States, are members of health plans that respond to the eValue8 RFI.

Cornerstone Report Findings

NBCH is issuing this report to establish a baseline of health plan performance that we can assess each year. We believe in the adage that says, “You can’t improve what you can’t measure.” And, so, we urge our partners in the health plan community to use this report as a call to action.

The key findings from the report are not surprising:

- There is wide variation in plan performance, suggesting that improvement is achievable and needed
- We are further ahead in quality transparency for hospitals than we are for physicians. Only 6% of health plans report standard physician performance measures to consumers on illness prevention, diabetes, and cardiovascular conditions. In contrast, almost 30% of plans provide reports to consumers about hospital quality in such areas as heart attacks and pneumonia.
- Price transparency is in its infancy
- HIT adoption and interoperability is similarly in infancy, although health plans are achieving significant progress in making personal health records and other online tools available to members
- About 50% of health plans pay providers financial incentives based on delivering better health care
- Health plans are beginning to provide incentives for members to choose better-performing doctors.

Health care quality and health economics researchers know what should be done to drive quality improvement and reduce the cost of health care services. To them, the landscape of plan performance against these benchmarks looks unimpressive. However, this Value-Driven Health Care Initiative represents the first time that private purchasers have collaborated with government to deliver a consistent message to health plans. By asking plans to respond to these 19 questions and make improvements each year, we are creating a true marketplace for health care services and eliminating the weaknesses in our nation’s health care system. In this way, we are transforming the system from one that is opaque and unresponsive to one that is more transparent and value-driven.

Conclusion

The National Business Coalition on Health applauds Secretary Leavitt for his leadership in advancing value driven health care. For 15 years, NBCH and its member coalitions have promoted a vision of health care reform, through value based purchasing, community by community and this vision is perfectly aligned with the Secretary’s efforts. With the issuance of this inaugural report, we look forward to working with our health plan partners to improve our ability to advance quality transparency, price transparency, incentives for providers and consumers, and HIT interoperability.

PARTNERS IN VALUE-DRIVEN HEALTH CARE

In addition to NBCH, the following organizations are members of the Partnership for Value-Driven Health Care:

- American Benefits Council
- Bridges to Excellence
- Business Roundtable
- Corporate Health Care Coalition
- The ERISA Industry Committee
- HR Policy Association
- The Leapfrog Group
- National Association of Manufacturers
- National Association of Wholesaler-Distributors
- National Business Group on Health
- National Federation of Independent Business
- National Retail Federation
- Society for Human Resource Management
- U.S. Chamber of Commerce

HEALTH PLANS MAKING PROGRESS IMPLEMENTING THE FOUR CORNERSTONES

After President Bush issued an Executive Order on August 22, 2006, U.S. Department of Health and Human Services Secretary Michael Leavitt asked private health care purchasers to implement Four Cornerstones of value-driven care:

1. Transparency of quality
2. Transparency of price
3. Incentives for high-value health care
4. Interoperable health information technology.

One way purchasers have responded to this request is through the use of the eValue8 tool, a product of NBCH, in Washington, D.C. eValue8 is a standardized request for information that employers and business-health coalitions use to gather health care data from health plans and health insurers. Employers, coalitions, and other health care purchasers use the data from eValue8 to rate the performance of health plans against evidence-based and best-practice standards. The data allow employers to select the best plans and work with these chosen plans to start inter-plan projects that raise the level of health for plan members and for the entire community.

NBCH and other organizations seeking to improve the delivery of health care developed eValue8 to allow purchasers and coalitions to focus the attention of health plans and health insurers on delivering the greatest value, meaning the highest quality at the lowest cost. Responses to the latest use of eValue8 were collected early in 2007. Later this year, NBCH will issue a report on all of the 2007 results. The results reported on these pages show how health plans are meeting some of the standards outlined in Secretary Leavitt's request that purchasers and health plans implement the Four Cornerstones.

Two of the cornerstones involve transparency, which means giving consumers more information about the quality and costs of health care providers. Health plans have made a good start at measuring quality, but many have not yet made information about quality available to their plan members. In fact, some health plans have used the data on health care quality that they have collected to offer financial rewards to physicians, but have not yet made the data available to plan members or to the public.

The effort to increase transparency is an important part of the Four Cornerstones project because making information available to consumers on the cost and quality of care allows patients to be more informed when choosing physicians and hospitals. Toward this goal, eValue8 encourages health plans to meet the secretary's request to share information with consumers about the quality of physician care. Among plans, 26% report patient experience information to consumers and 26% report whether physicians have achieved recognition from the National Committee for Quality Assurance. Far fewer (6%) report on available measures for specific conditions such as heart problems and diabetes. In contrast, many more plans (30%) report using available condition-specific measures to report hospital performance for conditions such as heart attack and pneumonia.

Plans also are asked if they pool information with other health plans on physician performance. This question is important because when plans pool such information, it enables reporting about more physician practices and makes the data much more reliable and useful to consumers. Some 33% of plans pool information with other plans using AQA measures (formerly known as the Ambulatory Quality Alliance).

Similarly, 11% of plans collaborate on the use of hospital performance measures from the Hospital Quality Alliance (HQA).

eValue8 asks plans if they use the HQA measures when evaluating hospital performance. Almost 50% of health plans use at least one HQA measure, but none use all of the standards.

The data also show that health plans publicly report more information on hospital performance than they do on physician performance. Health plans collaborate more to pool data about physician performance than they do to pool data about hospital performance because they use publicly available data on hospital performance. Health plans have little need to collaborate on hospital performance data because the combination of their own data and that of Medicare produce reliable reports.

But health plans don't have access to robust information about physicians in their markets. Physician panels in one health plan are too small to reflect reliable information. Plans must depend on each other to collect enough information about one physician to produce a credible physician profile.

Health plans also are investing in health information technology (HIT) and working to use their HIT systems to collect and report useful information to physicians and plan members. Such HIT interoperability is critically important as health plans, purchasers, and health systems seek to improve the coordination of care and patient safety. Having information technology that allows disparate segments of the health care system to communicate with each other can save lives. But many health plans are unable to share information with physicians about which prescriptions members are taking. When a physician treats

a patient in an emergency room, the physician does not have access to reliable information about drugs prescribed previously or recent lab tests and so risks drug interactions and unnecessary lab reorders.

To be sure, health plans are making improvements. For example, eValue8 data show that 41% of health plans use HIT interoperability standards for 75% of more their enrollment and eligibility transactions. Among plans, 27% make substantial use of interoperable HIT standards for claims and encounter data, and 18% accept lab results electronically.

The eValue8 data also show that consumers have access to HIT applications online from their health plans. Many plans (81%) have HIT applications that help consumers make treatment decisions, 64% help patients monitor chronic conditions, and 64% allow members to create and view personal health records online.

Other results from eValue8 show that:

- Less than 5% of health plans exchange clinical information by transmitting pharmacy data
- Less than 10% of plans promote electronic health record (EHR) vendors certified by the Certification Commission for Healthcare Information Technology (CCHIT)
- Less than 10% provide a financial incentive to providers to use CCHIT-certified EMRs
- Less than 5% provide any public recognition of physicians who have such systems.

Use of electronic records is important because such information forms the basis for clinical decision support, coordination of care, patient tracking, patient safety, and practice performance reporting.

TRANSPARENCY OF QUALITY

eValue8 Asks Health Plans How They Report Data on Health Care Quality

Employers, other health care purchasers, and consumer advocates agree that it is important to measure health care quality and report the results of these measurement activities publicly. While there is widespread agreement on the need to measure and report on quality, health plans are just beginning to use standardized measurement systems for quality reporting.

In the past few years, the AQA (formed in 2004 by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the federal Agency for Healthcare Research and Quality) has been developing standards designed to improve performance measurement, data aggregation, and reporting on outpatient quality.

Last year, the AQA (www.aqaalliance.org) began working with another organization, the Hospital Quality Alliance (HQA), to coordinate and promote quality measurement and transparency for the care of patients in both ambulatory and institutional settings. For more than two years, the HQA has been gathering and reporting data on the quality of care delivered to hospitalized patients who had a heart attack, heart failure, or pneumonia.

In June 2007, the HQA enhanced the information it makes available on the web (www.HospitalCompare.hhs.gov). These data are collected by the federal Centers for Medicare & Medicaid Services (CMS). The new information allows consumers to see how a hospital's performance compares against the national mortality rate for two common heart conditions. Consumers now can learn how heart attack and heart failure patients fared 30 days after being admitted to a hospital, including time after discharge. Also, the HQA will add more comprehensive information about steps taken to prevent surgical infections and pneumonia.

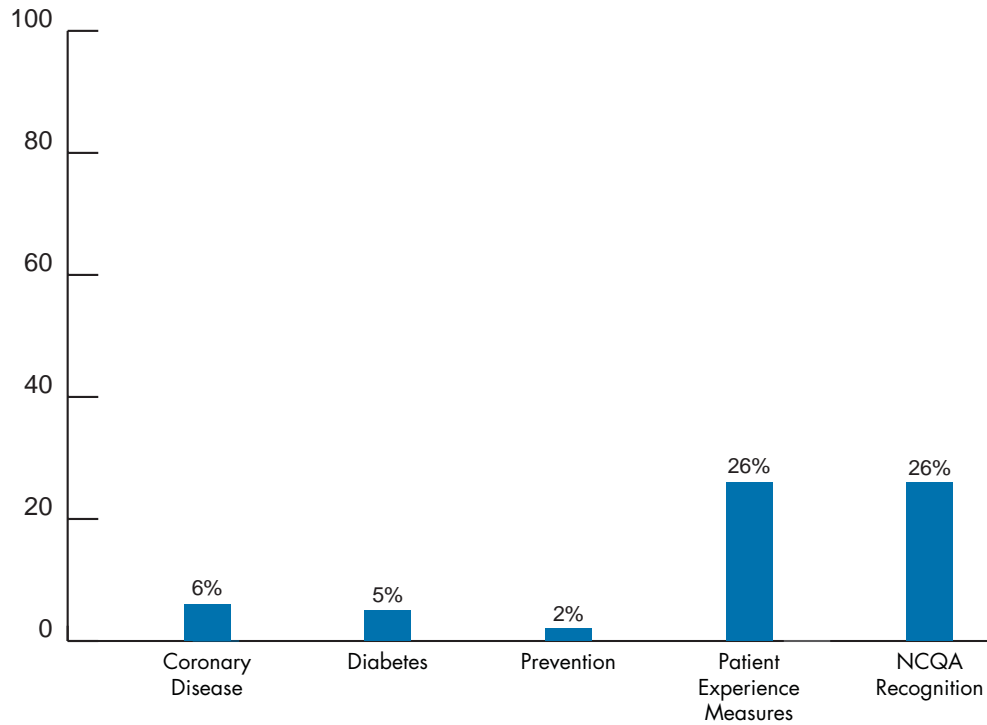
Measuring Outpatient Care Quality

eValue8 asks health plans if they measure quality performance using the AQA measures for individual physicians, for physician group practices, and for independent physician practice associations. The measures eValue8 asks about are the first 26 approved in a starter set of measures from the AQA. The AQA measures address care in the following areas:

- Prevention (such as breast cancer, colorectal and cervical cancer screening)
- Coronary artery disease (drug therapy for lowering LDL cholesterol and use of a beta blocker after a heart attack)
- Heart failure (ACE/ARB therapy and LVEF assessment)
- Diabetes (such as HbA1c and blood pressure management and lipid measurement)
- Asthma (use of appropriate medications)
- Depression (antidepressant medication management)
- Prenatal care (screening and immunization)
- Quality measures addressing overuse or underuse (such as appropriate treatment for children with upper respiratory infections).

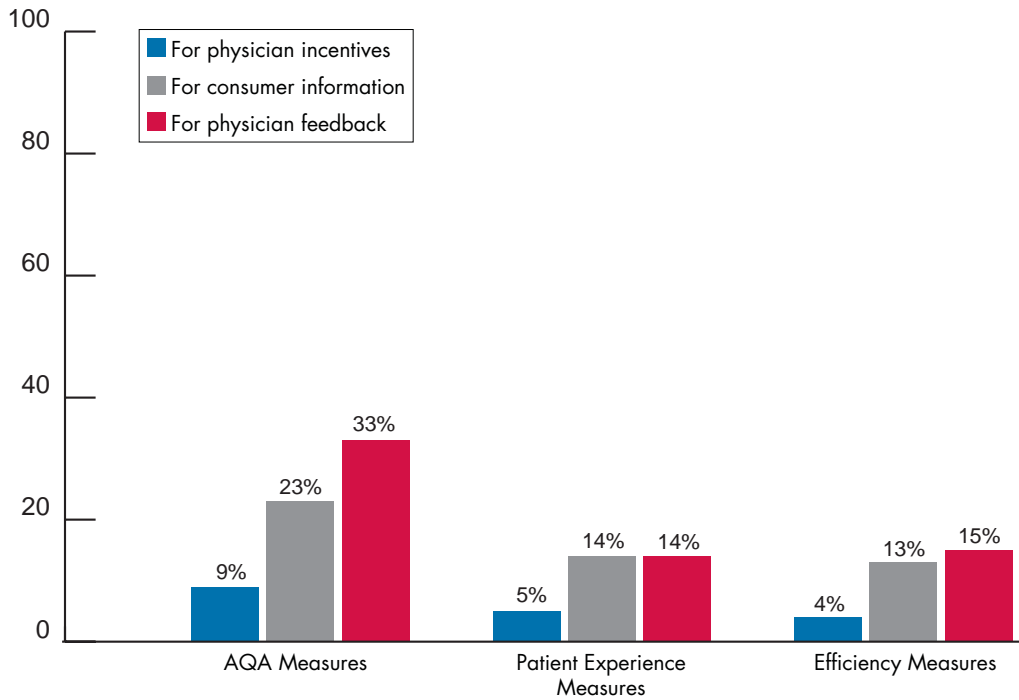
The AQA standards are important because physician organizations, health plans, and consumer advocates have approved them. Despite agreement on the value of these standards, the use of AQA standards varies widely. While almost half of health plans report using at least one AQA measure to evaluate quality, none of the plans reports using all of the AQA measures for reporting to consumers, and fewer than 10% of plans use available measures for the individual conditions of diabetes, coronary artery disease, and illness prevention. (See [Chart 1.](#))

**CHART 1: TRANSPARENCY OF PHYSICIAN PERFORMANCE:
PERCENT OF PLANS USING AVAILABLE MEASURES IN EACH GROUP**



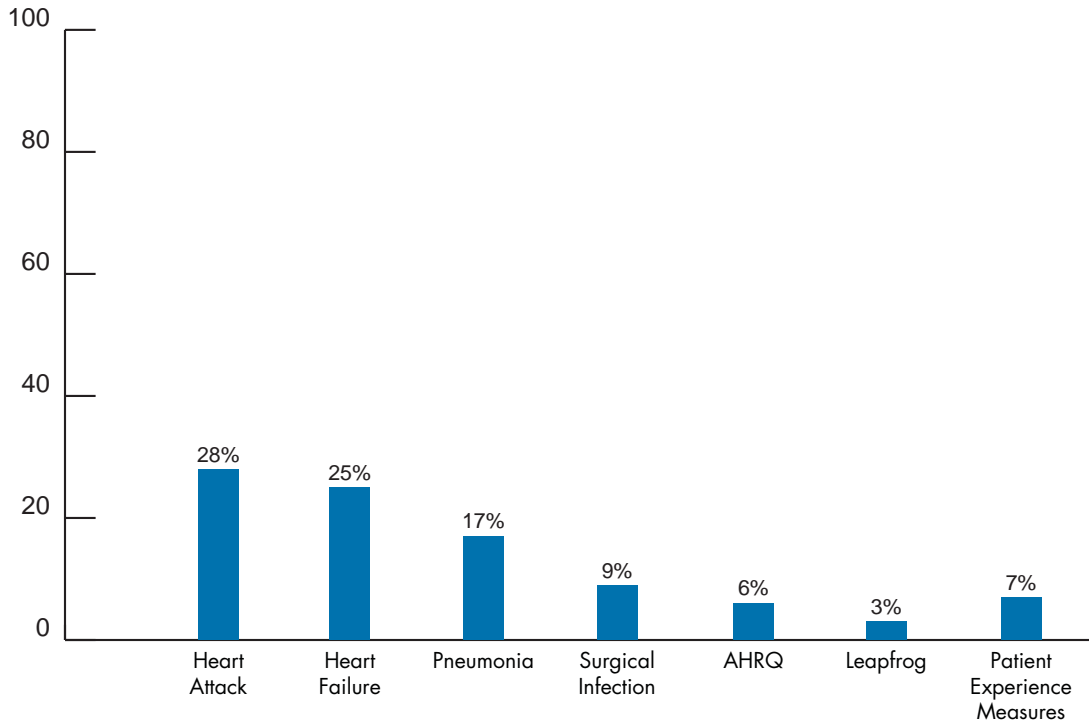
eValue8 asks health plans what standard performance measures they use to evaluate physician performance.

**CHART 2: COLLABORATION ON PHYSICIAN PERFORMANCE:
PERCENT OF PLANS POOLING PHYSICIAN PERFORMANCE INFORMATION**



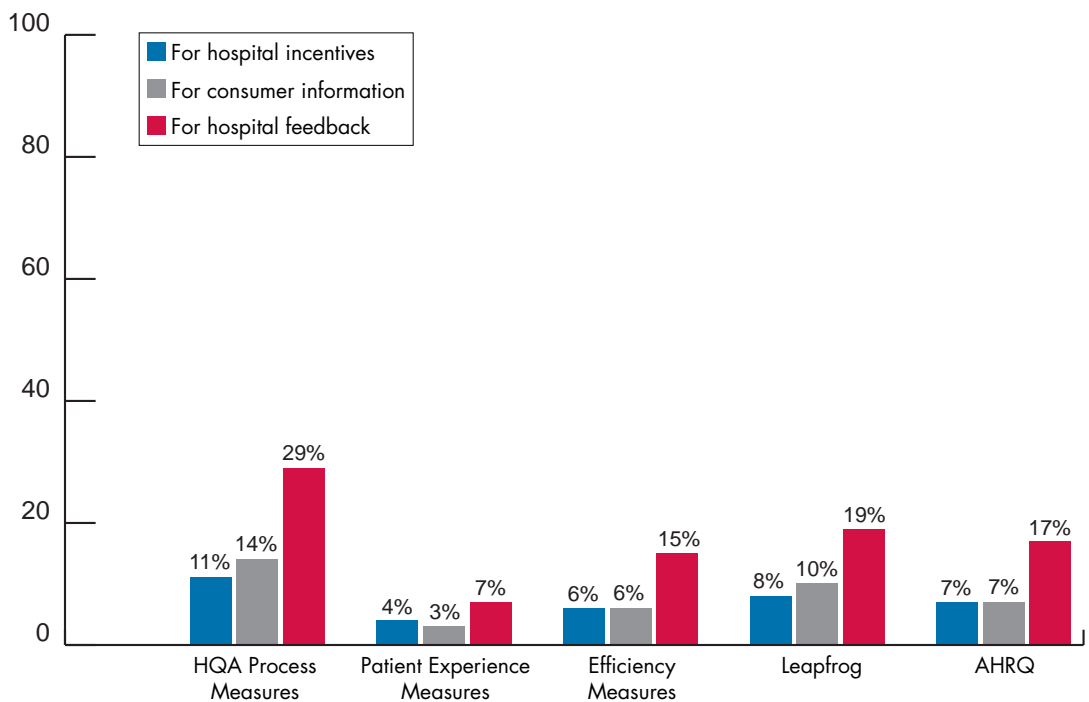
eValue8 asks health plans whether they collaborate with other plans in regional efforts to pool physician performance information and how that information is used: Is pooled information used for physician incentives, public reporting to consumers, or for feedback to physicians?

**CHART 3: TRANSPARENCY OF HOSPITAL PERFORMANCE:
PERCENT OF PLANS USING AVAILABLE MEASURES IN EACH GROUP**



eValue8 asks health plans what standard performance measures they use to evaluate hospital performance.

**CHART 4: COLLABORATION ON HOSPITAL PERFORMANCE:
PERCENT OF PLANS POOLING HOSPITAL PERFORMANCE INFORMATION**



eValue8 asks health plans whether they collaborate with other plans in regional efforts to pool hospital performance information and how that information is used: Is pooled information used for hospital incentives, public reporting to consumers, or for feedback to hospitals?

Using these measures for consumer reporting almost never means reporting physician-specific results for individual measures. In order to be statistically valid, such reporting requires more patients than a typical plan will have in a single physician practice. This shortcoming highlights the importance of health plan collaboration on practice reporting. (See Chart 2.) One exception is in Minnesota where plans have collaborated to form the Community Measurement Project (see sidebar). Until there is more collaboration among health plans on physician quality practices, the state of the art for practice reporting by single health plans will continue to consist of symbols (such as one, two, or three stars) for collections of measures displayed for a limited number of large practices.

eValue8 also asks plans if they use the HQA standards when measuring hospital performance. For instance, the eValue8 results on the use of the HQA standards are similar to the results from the AQA standards used to measure physician performance. Almost 50% of health plans use at least one HQA measure for reporting to consumers, but none use all of the HQA measures. Less than 30% of plans use all of HQA's heart attack, heart failure, and pneumonia measures. (See Chart 3.)

The use of hospital measures is somewhat more mature than the use of physician measures and is statistically less challenging. As a result, it makes sense that plans exhibit more use of available hospital measures for specific conditions than they do for physician measures. One important factor in this higher degree of transparency regarding hospital reporting is the ability to use Medicare inpatient data. For many years, the government has made the annual Medicare Provider Analysis and Review (MEDPAR) files available to researchers and the public. This collection of inpatient data typically represents about 50% of the revenue of most general hospitals and has fostered the development of several consumer reporting products that health plans use as reference tools for plan members.

eValue8 determines how each plan uses a number of performance measures among many that are

MINNESOTA PROJECT SHOWS VALUE OF QUALITY TRANSPARENCY

One example of a quality transparency project is the Minnesota Community Measurement program (www.mnhealthcare.org). On its web site, the MN Community Measurement program explains the value of quality measurement for consumers. "We all know quality health care is important, but did you know that quality can vary widely among provider groups and clinics?" the site asks. "Today, consumers face many health care choices and MN Community Measurement has information to help make those difficult decisions. What is the best care for diabetes and who in Minnesota delivers the best results? What about asthma or high blood pressure? Our web site offers quality comparisons among provider groups and clinics."

The 2006 Health Care Quality Report that the MN Community Measurement program issued in April 2007 features comparative data on provider group performance on key clinical measures and overall statewide results. The report also details data sources, methodology, and measurement specifications. Similar reports from 2005 and 2004 also are available on the site.

The Minnesota report is important because it shows individual indicators recorded at the practice level. Consumers can see information about practices that are performing well on a wide variety of measures. MN Community Measurement takes this collaborative project one step further by creating and reporting on composite measures. The report shows, for example, that physicians should take at least five specific steps when treating each patient with diabetes. A patient with diabetes can see how his or her physician scores on these five indicators and how one physician compares with other physicians. This sets a higher, but appropriate, bar for performance. Many practices score in the 90% range for individual measures, such as patients with diabetes that get recommended cholesterol tests. But when measured against the standard of all five steps being done and outcomes reached, the best performing practice reaches this goal less than one quarter of the time.

One factor that makes the data in the MN Community Measurement program so useful is that each physician's scores come from a variety of health plans. Having such robust data helps to make the data more useful and less subject to criticism from those who would challenge the validity of the data.

CORNERSTONE 1

available. Plans can use AQA, HOA, and other common approved measures to provide feedback to providers, to report performance to members (transparency), or to provide a basis for rewards for better performance (incentives).

Using this information as feedback to physicians allows plans to communicate performance benchmarks and expectations and allows physicians to see how they perform against these standards and in comparison with other physicians. Health plans can use these physician scores to rank physicians, to offer financial incentives to improve their scores, and to steer health plan members to better performing doctors. Such physician report cards are becoming more widespread nationwide as health plans use the measures to report quality scores on physicians to patients and consumers.

EVALUE8 PROMOTES USE OF HQA PNEUMONIA MEASURES

Health plans and hospitals should have standard protocols for treating all patients with pneumonia. While physicians know that each patient needs to be treated individually, there are certain minimum standards that each hospital should follow when a patient is admitted with pneumonia. In an effort to improve the care of all patients with pneumonia, eValue8 asks health plans to track, report, and improve on eight measures of performance:

1. Initial antibiotic received within four hours of hospital arrival
2. Assessment of the patient's ability to process oxygen
3. Pneumococcal vaccination status
4. Blood culture performed before first antibiotic received in hospital
5. Adult smoking cessation advice/counseling
6. Appropriate initial antibiotic selection
7. Influenza vaccination
8. 30-day mortality

While following these procedures and improving outcomes is primarily the responsibility of the hospitals in a plan's network, the plan has an important role to play through the power of the purse and public reporting. It has been shown that public reporting alone of hospital performance results in significant improvements even when consumer use of such information is uncertain.

TRANSPARENCY OF PRICE

eValue8 Asks Health Plans to Identify Physicians and Hospitals that Deliver Care Efficiently and at Low Cost

Health plans are beginning to publish data on the prices that hospitals, physicians, and other providers charge consumers. While the movement toward price transparency is laudable, many health policy planners believe that price information alone is not as useful as information on price combined with information on health care quality and efficiency. In fact, health plans must battle the common misperception that higher prices mean better quality, when the opposite is often the case. Some studies have shown that higher inpatient costs sometimes reflect lower quality. This result makes sense when one considers the cost of errors and poor care.

What's more, knowing the price of a given health care service is of little value without information on the total cost of caring for a patient's specific condition, often involving the services of several unrelated providers over a period of time. Ideally, price information should be a measure of efficiency, but since consumers are often shielded from the true cost of care, knowing the price of an individual procedure is simply one of many pieces of information consumers need to make educated decisions when choosing a hospital, physician, or other health care provider or service.

There are several challenges for plans seeking to engage and support members in making cost-effective choices of providers. Consumers with little knowledge of their health care environment may be happy with market average prices for a procedure such as colonoscopy. Others will want to know what the plan will pay for that procedure (as opposed to what local providers charge) and all will want to know what their out-of-pocket expense will be given their specific benefit design. Some will need to inquire about an episode of care such as knee surgery involving

several types of providers, including doctors, hospitals, and physical therapists, and extending over a period of time. Still other consumers will want to compare different doctors and hospitals with respect to both their efficiency and outcomes for that episode of care. Accommodating all of these levels of inquiry and transparency is a formidable challenge for health plans.

eValue8 asks plans to describe their ability to identify hospitals or physicians in their markets that are more efficient than others or that are low cost providers. While health insurance shields consumers from the true cost of care, many health plans recognize that consumers should know the prices that providers charge. Therefore, many health plans that participate in eValue8 provide consumers with information on what physicians and hospitals charge.

Some health plans indicate high quality providers by assigning stars next to the providers' names in the health plan directory, and they list high cost providers by placing dollar signs next to the providers' names. This information gives consumers some of the information they need to make informed decisions when choosing a hospital or a physician.

eValue8 determines what web-based cost estimation tools are available for consumers seeking hospital care, physician services, or the care of other health care professionals. A variety of navigational features also are captured, including whether the consumer can search for various conditions or procedures and compare alternative treatments (such as surgical versus non-surgical) and settings (meaning inpatient versus outpatient).

Perhaps one of the most common needs consumers have for information involves comparing prices and out-of-pocket liability for pharmaceuticals. eValue8 asks health plans to

indicate the type of pharmacy data available to enrollees on the web. Almost all plans participating in eValue8 make the plan formulary readily available to consumers. A formulary is a list of drugs a health plan covers for its members. eValue8 challenges health plans by expecting plans to provide comprehensive sets of information about every drug, including its purpose, alternatives, and the side effects, risks, and conflicts involved with using the drug in addition to the cost. eValue8 also asks plans if cost savings are possible through pill splitting and if a plan has a drug savings calculator that members can use to calculate savings by switching to generics or lower cost brand-name drugs.

By asking these questions, employers and other health care purchasers are encouraging health plans to get consumers more involved in the financial aspects of managing their health care. By allowing consumers to search by procedure and by condition, employers and health care purchasers aim to get health plans to provide cost-saving information and make search functions interactive as well. The more specific the information is and the more interactive the search

function is, the more useful the data will be to consumers. Employers believe searchable information is more useful to consumers than information that is simply displayed for comparison.

Given that some 10 million health care consumers in the United States are enrolled in consumer-directed health plans (CDHPs), price and quality information is becoming more important. Employers that offer CDHPs give their employees a certain amount of money in health savings accounts (HSAs) or health reimbursement accounts (HRAs) each year to spend on health care for themselves and their family members. HSAs and HRAs are designed to make employees more price-conscious consumers so that they will shop for the best value, meaning the lowest cost and highest quality.

Knowing what two different hospitals charge for the same procedure is certainly useful, for example, but consumers also should know the level of quality the two hospitals provide. In a report in June 2007, the Pennsylvania Health

PRICE TRANSPARENCY EFFORTS PROLIFERATE

As interest in the cost of care spreads, more facilities are reporting price information to consumers. Several of the best-known integrated health systems, such as the Mayo Clinic and the Cleveland Clinic, are developing price and quality transparency efforts. The Mayo Clinic has implemented a price estimator in Jacksonville, Fla., that allows patients to estimate their out-of-pocket costs.

Other price transparency efforts include the following:

- Blue Cross and Blue Shield of Minnesota offers price and quality information on the web (www.healthcarefacts.org).
- The Wisconsin Hospital Association displays prices for inpatient and outpatient services on the web (www.wipricepoint.org).
- The Healthcare Financial Management Association and other organizations have developed an educational program called Patient Friendly Billing that provides clear and concise financial information to consumers (www.patientfriendlybilling.org).

- The Pennsylvania Health Care Cost Containment Council offers prices and quality measures for the top 65% of all covered inpatient and outpatient procedures in the state (www.phc4.org).
- In California, a state law requires hospitals to disclose prices for the top 25 most common outpatient services and procedures. Information is available online (www.stayhealthy.com).
- The Florida Agency for Health Care Administration plans to publish pricing, quality, and performance data for consumers, purchasers, and health care professionals on a site it is developing (www.floridacomparecare.gov).
- The Massachusetts Health Care Quality and Cost Council provides information on the cost and quality of care (www.mass.gov/healthcareqc).

Source: *Health Care Price Transparency: A Strategic Perspective for State Government Leaders*, the Deloitte Center for Health Solutions, Washington, D.C., March 2007.

Care Cost Containment Council (PHC4) said one hospital in the state got \$100,000, on average, for heart bypass surgery while other hospitals received \$20,000 for the same procedure. Both facilities had similar lengths of stay and mortality rates. Among 20 hospitals in the Philadelphia area, two of the highest paid had higher-than-expected mortality rates.

Moreover, employers and other purchasers want hospitals and other providers to disclose charges for individual procedures, services, and episodes of care. An example of an individual procedure is coronary heart bypass graft surgery (CABG), which would be done in a hospital. An episode of care would include the cardiac testing and preparation before the CABG surgery, the surgery itself, and the requisite follow up care. The testing, preparation, and follow up care might be done in the hospital or in another facility, such as a doctor's office or rehabilitation clinic.

HEALTH PLAN SITE PUBLISHES PRICE DATA

In August 2005, Aetna, the large health insurer in Hartford, Conn., started a pilot program on price transparency on its web site. In this program, Aetna allowed its members to research what they could expect to pay for a visit to a specific physician. Prices for common procedures were listed for 5,000 physicians and physician groups in the Cincinnati area on a password-protected member web site (www.aetna.com). Rates were provided for the cost of an office visit, diagnostic tests, minor procedures, and other services, said Robin Downey, an Aetna senior vice president and head of product development. "In all, rates are offered for 25 services by specialty, and, considering the variations in services among specialties, the tool contains rates for 600 services in all," Downey said in testimony before Congress last year.

During the pilot project, Aetna found that 600 to 1,000 Cincinnati consumers visited the site each month for price information. "Increased usage happens at two specific times: as consumers choose their new benefits for the year ahead (typically in the fall) and as consumers begin to use their new benefits (typically in January)," Downey said. "While it's too early to say whether consumer behaviors have changed in Cincinnati, we believe that simply raising awareness about the costs of care is one more step in creating a marketplace for consumers as health care decision-makers."

The next step is to add information for consumers to make decisions about overall value, not simply price alone, Downey explained. Based on comments from physicians, Aetna began publishing information on quality and cost efficiency. In August 2006, Aetna expanded its initiative to include information on price, clinical quality, and efficiency in all or parts of seven states and the District of Columbia, and price transparency alone in three other states. The clinical quality and efficiency information is based on data from physicians participating in Aetna's Aexcel high performance network. "Marrying unit price with Aexcel data helps consumers and employers make decisions based on overall value," Downey said.

As of April 2007, the program was expanded to include clinical quality and efficiency information for more than 22,000 specialist physicians and specific prices for more than 100,000 physicians. The program is available in all or parts of Connecticut, Florida, Georgia, Indiana, Kansas, Kentucky, Maine, Maryland, Missouri, Nevada, Ohio, Oklahoma, Pennsylvania, Texas, Utah, Virginia, and the District of Columbia.

INCENTIVES FOR HIGH-VALUE HEALTH CARE

eValue8 Asks Health Plans What Incentives They Offer to Reward Physicians and Hospitals that Provide Quality Care

Purchasers and policymakers recognize the need to alter the current payment system that rewards waste and errors rather than outcomes and health. One way employers and other health care purchasers aim to reform the health care system is by offering incentives for high-value health care.

Incentives for high-value care can take many forms. Two of the most popular kinds of incentives are financial rewards for quality and mechanisms that steer members to high-value physicians, hospitals, and other providers.

eValue8 asks health plans to specify the measures they use to provide incentives to physicians and other providers

and determine the type of incentive offered: periodic bonus, elevated fee schedule, or a tiered network designed to encourage members to use high performing physicians and hospitals and other providers. eValue8 also asks plans to report the incentives they pay to the best doctors and hospitals.

Financial Rewards

Other financial reward programs include those from the Integrated Healthcare Association (IHA) in California for physicians and the Leapfrog Group for hospitals. IHA is a membership organization (www.iha.org) of health plans, physician groups, and hospital systems that promotes quality improvement, accountability, and affordability. Last year, seven California health plans paid a total of \$55

COALITION EMPLOYERS OFFER FINANCIAL REWARDS FOR QUALITY

A number of employers and NBCH member coalitions are participating in the Bridges to Excellence (BTE) physician reward program, including the Buyers Health Care Action Group, an NBCH-member coalition in Minnesota. Last year, the Colorado Business Group on Health (CBGH) started a BTE program with eight employers in Colorado Springs. The employers have a combined total of 50,000 employees and wanted to improve the care of employees and dependents who have diabetes. The employers expect the program will help them improve care and cut health care costs.

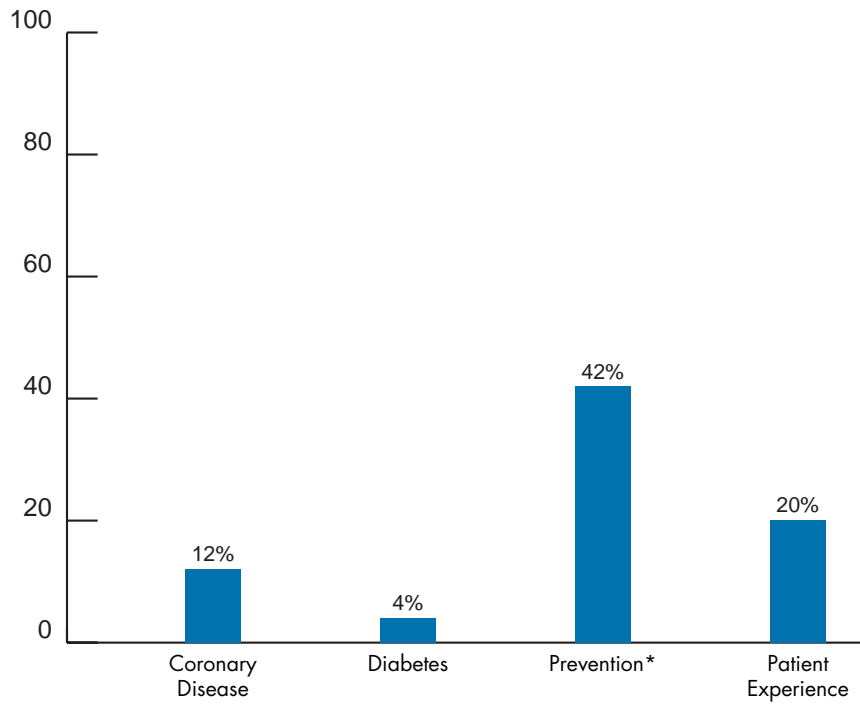
In addition to the eight employers, three health plans agreed to pay rewards under the BTE initiative. They are Anthem, Great-West Healthcare, and Rocky Mountain Health Plans. Collectively, the health plans added 15,000 lives to the project for a total of 65,000. Under BTE,

physicians who are top performers in diabetes care can earn as much as \$80 per year for each diabetes patient covered by a participating employer. To receive the increase in pay physicians must meet quality standards from the National Committee for Quality Assurance.

Bridges to Excellence (www.bridgestoexcellence.org) is a nonprofit organization created to encourage improvement in health care quality by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient, and patient-centered care.

Through March 2007, BTE had recognized 3,031 physicians in 275 practices and paid \$7.6 million in rewards. The program rewards physicians who provide care to patients with diabetes, heart disease, and who install information systems to facilitate the delivery of care.

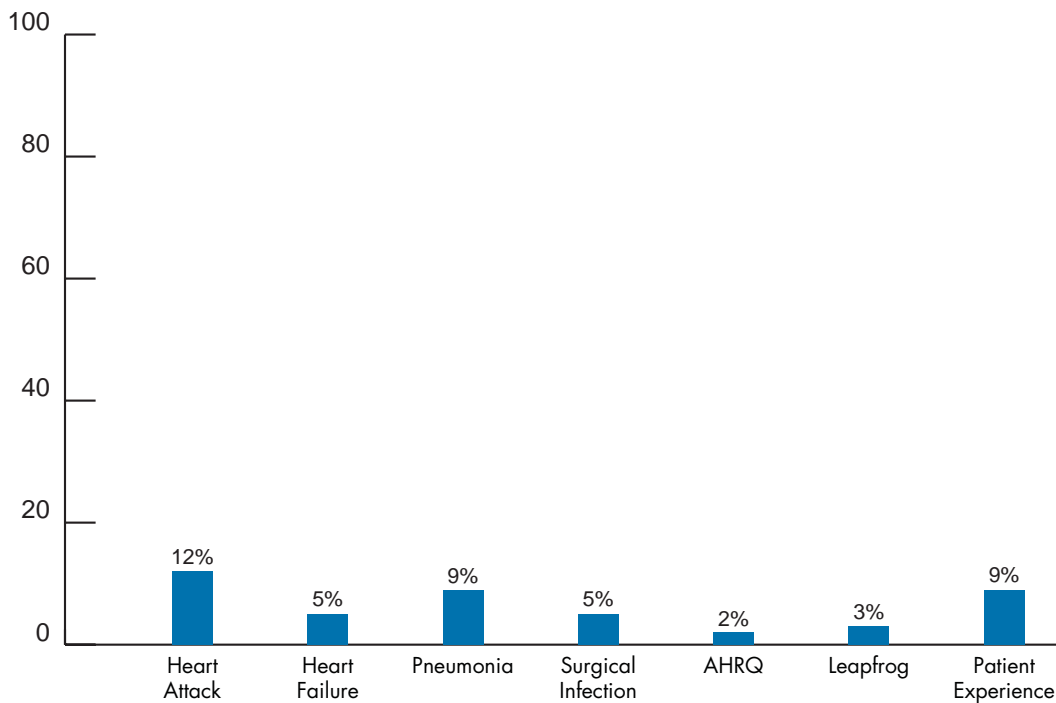
**CHART 5: PHYSICIAN INCENTIVES:
PERCENT OF PLANS USING AVAILABLE MEASURES IN EACH GROUP**



*Using at least one prevention measure.

eValue8 asks health plans to indicate measures used in determining financial incentives paid to physicians.

**CHART 6: HOSPITAL INCENTIVES:
PERCENT OF PLANS USING AVAILABLE MEASURES IN EACH GROUP**



eValue8 asks health plans to indicate measures used in determining financial incentives paid to hospitals.

million to physician groups participating in IHA's pay for performance (P4P) program that met certain measures for clinical care, patient satisfaction, and the use of information technology. Since IHA began measuring performance in 2003, health plans have made incentive payments to California physician groups totaling \$145 million. In the program, 35,000 physicians in 210 groups are eligible for such incentive payments.

"Traditional approaches to physician compensation don't reward appropriate care, but California's pioneering P4P program realigns incentives," said Donald J. Rebhun, MD, regional medical director of HealthCare Partners and chairman elect of IHA's board of directors. "It supports the need of physicians to have uniform performance measures against which to gauge indicators of quality, while also giving consumers information to guide choices."

In addition to participating in physician-reward programs, employers and NBCH-member coalitions also are working with the Leapfrog Group (www.leapfroggroup.org) to reward hospitals that deliver high-value care. The Leapfrog Group supports informed health care decision making among employers, consumers, and other purchasers by aiming to reduce preventable medical mistakes, and improve quality and affordability. It encourages hospitals to report their quality and outcomes scores to allow consumers and other purchasers to make informed health care choices. It also aims to reward doctors and hospitals for improving the quality, safety, and affordability of health care and to help consumers reap the benefits of making smart health care decisions.

One common form of incentive for high-value care is a financial bonus. P4P programs are proliferating. The federal Centers for Medicare & Medicaid Services is evaluating P4P programs in pilot projects for hospitals and for physicians. A number of large employers and coalition members of NBCH participate in the Bridges to Excellence program that pays financial rewards to physicians who meet certain criteria when caring for patients with heart disease and diabetes and for physicians who install electronic medical record (EMR) systems.

eValue8 asks health plans what kinds of performance measures they use to reward physicians. Health plans use many of measures including those from AQA. (See Chart 5.) Similarly, health plans also use a variety of measures to reward hospitals, including those from HQA. (See Chart 6.)

ANALYSIS SHOWS POSITIVE RESULTS FROM HDHPS

Members enrolled in high deductible health plans (HDHPs) offered through UnitedHealthcare (UHC) received necessary care at rates equal to, or better than that of members of traditional health plans, UnitedHealthcare says. UHC analyzed 2004 and 2005 data for 250,000 of its members in HDHPs and compared their results to an external, national benchmark population of 10 million traditional health plan members. The study examined consumer usage of preventive care services such as cancer screenings and well child care, as well as adherence to evidence-based care among individuals with chronic conditions, including diabetes, asthma, coronary artery disease, and congestive heart failure.

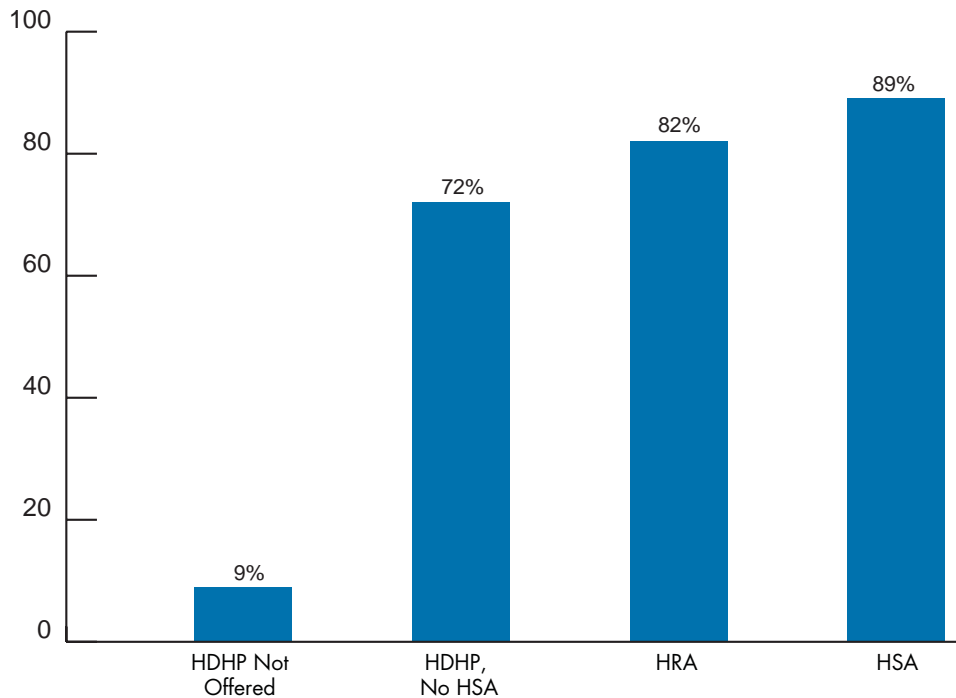
UHC has two million members in HDHPs.

Compared with the benchmark population, members of HDHPs were as likely to receive colon cancer screening and have mammograms, UHC says. Also, the members of HDHPs were:

- 16% more likely to have a cervical cancer screening
- 10% more likely to receive a cholesterol screening
- 16% more likely to receive a prostate screening
- 8% more likely to have well child visits.

eValue8 results show that the use of standard measures as an element of determining financial rewards may be slightly more common than their use for public reporting. In the case of the AQA coronary disease group, 12% of plans reported using measures for rewards, compared with 6% of plans that reported using them for consumer reporting. However, the reverse is true for hospital rewards. Plans are far more likely to use HQA and other measures for public reporting than they are to use them for financial rewards. (Data in the following table came from Charts 4 and 6.)

CHART 7: PERCENT OF HEALTH PLANS OFFERING HIGH DEDUCTIBLE HEALTH PLANS, HEALTH SAVINGS ACCOUNTS AND/OR HEALTH REIMBURSEMENT ARRANGEMENTS



eValue8 asks health plans the types of consumer-directed health products they offer. Does the plan offer high deductible health plans, health reimbursement arrangements, or health savings accounts?

USE OF HQA MEASURES

Measure	For Incentives	For Public Reporting
Heart Attack	12%	28%
Heart Failure	5%	25%
Pneumonia	9%	17%
Surgical Infection	5%	9%

Another way employers are reforming the delivery of care involves high-deductible health plans (HDHPs) (sometimes called consumer-directed health plans or CDHPs). HDHPs motivate consumers to make cost-effective choices of providers by allowing them to decide how to spend the first several thousand dollars that an employer would otherwise pay for health care each year out of a savings or reimbursement account and out of their own pockets. Over 90% of plans responding to eValue8 offer high deductible plan designs.

HDHP Enrollment

Between 8 million and 10 million Americans are enrolled in HDHPs, according to an analysis by the Kaiser Family Foundation (www.kff.org). These plans became more popular in 2003 when Congress established portable health-savings accounts (HSAs) and health reimbursement accounts (HRAs). Employers put money into these accounts on a pretax basis and the accounts can grow tax-free, giving employees an incentive to use their funds wisely by choosing high-value providers. (See Chart 7.)

UnitedHealth Group, the large health insurer in Minneapolis, said individuals in its HDHPs received needed care at rates equivalent to, or higher than, members of traditional plans. United analyzed 2004 and 2005 data for 250,000 of its consumer-driven plan members and compared it to an external, national benchmark population of 10 million traditional health plan members (see sidebar).

HEALTH INFORMATION TECHNOLOGY INTEROPERABILITY

eValue8 Asks Health Plans How They Collect and Use Data to Improve Care

The current health care system is fragmented. Important medical information cannot be shared easily among different doctors and hospitals, or even among physicians treating the same patient. Patients brought to an emergency department present significant risks when allergic reactions and current drugs taken cannot be determined. It is not uncommon for patients, especially the elderly, to be taking a number of medications prescribed by different specialists.

Health plans and self-insured employers often contribute to such fragmentation. Health plans and insurance companies oversee most aspects of care delivery, but often employers hire other companies to handle certain aspects of care. Disease management companies manage patients with specific diseases. Pharmacy benefit managers (PBMs) deliver drug benefits for plan members. Managed behavioral health organizations manage and maintain networks of behavioral health providers. The interactions are often disjointed among these ancillary companies, primary care physicians, specialists, and hospitals that manage and deliver care to patients.

This fragmented system lacks essential electronic links which tie one part of the health care delivery system to another, such as between the various parties that pay for and deliver care. This breakdown in communication is wasteful and puts patients at risk of injury or death. Physicians often need to reorder laboratory and expensive imaging tests because patients rarely have records of such previous tests when they need care. Redoing laboratory and imaging tests needlessly pushes up costs.

To improve the efficiency of the health system, health plans and other organizations are seeking to link medical science and clinical decision making at the point of care.

The technological capabilities that are commonly deployed in virtually every other sector of the economy can provide significant improvement in diagnostic and treatment decision making in health care. Some health plans and insurers have learned to integrate patient information with evidence-based decision rules to support physicians, guide them toward best practices, and avoid conflicting and out-of-date treatments.

Linking Fragmented Components of Care

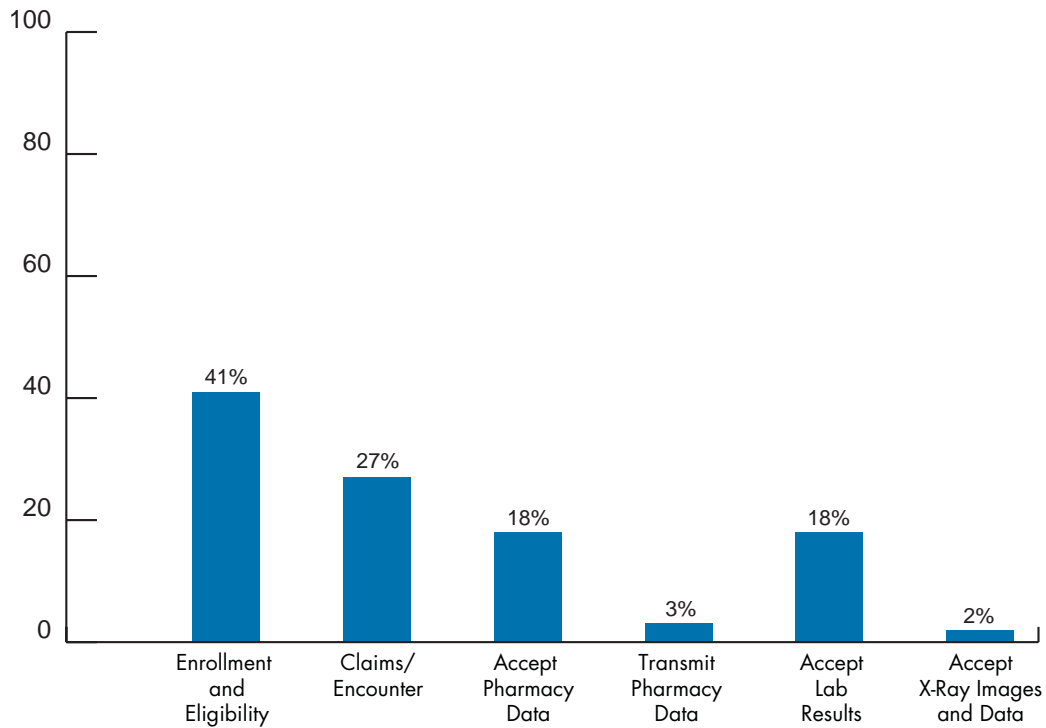
Health policy planners recognize that information technology has the potential to link these fragmented components of care in a way that could improve coordination of care and health care quality and promote patient safety. But for information systems to be useful, health care providers, insurers, and managed care organizations need to adopt and universally implement standard data formats.

Seeking to improve health information technology (HIT) interoperability, eValue8 determines to what extent plans use standard HIT formats permitting transfer of information among unrelated providers and incompatible applications.

In addition to the use of standards, eValue8 determines how connected the information is internally and what electronic applications are present to support doctors and consumers in making decisions about care management. Electronic applications can facilitate many aspects of care including self-management for patients and online clinical consultation for physicians, and also provide an easily accessible repository for data on the latest lab tests and imaging results done by unrelated providers.

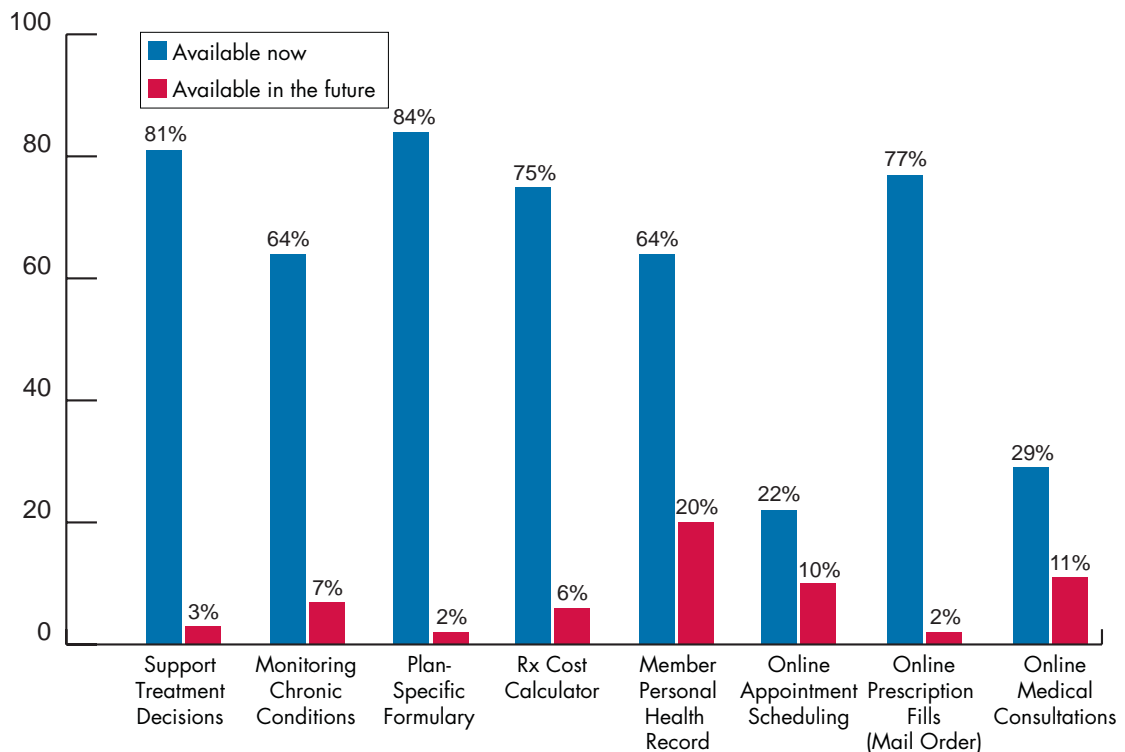
Results from eValue8 show that 41% of health plans exchange at least 75% of their enrollment and eligibility

**CHART 8: INTEROPERABILITY STANDARDS:
PERCENT OF PLANS MAKING SUBSTANTIAL USE OF HIPAA-COMPLIANT OR STANDARDIZED DATA FORMATS**



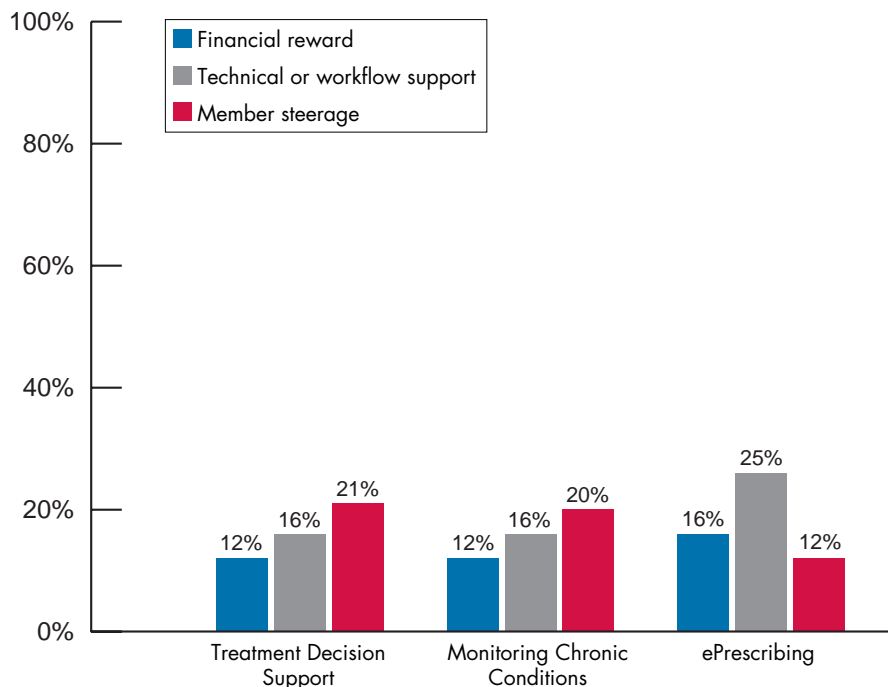
eValue8 asks health plans what transactions are in a standard data format and comply with HIPAA (the Health Insurance Portability and Accountability Act). In order for information to be transmitted electronically among different organizations, the data must be in an industry standard format and comply with federal patient privacy protection policies.

CHART 9: AVAILABILITY OF CONSUMER ONLINE APPLICATIONS



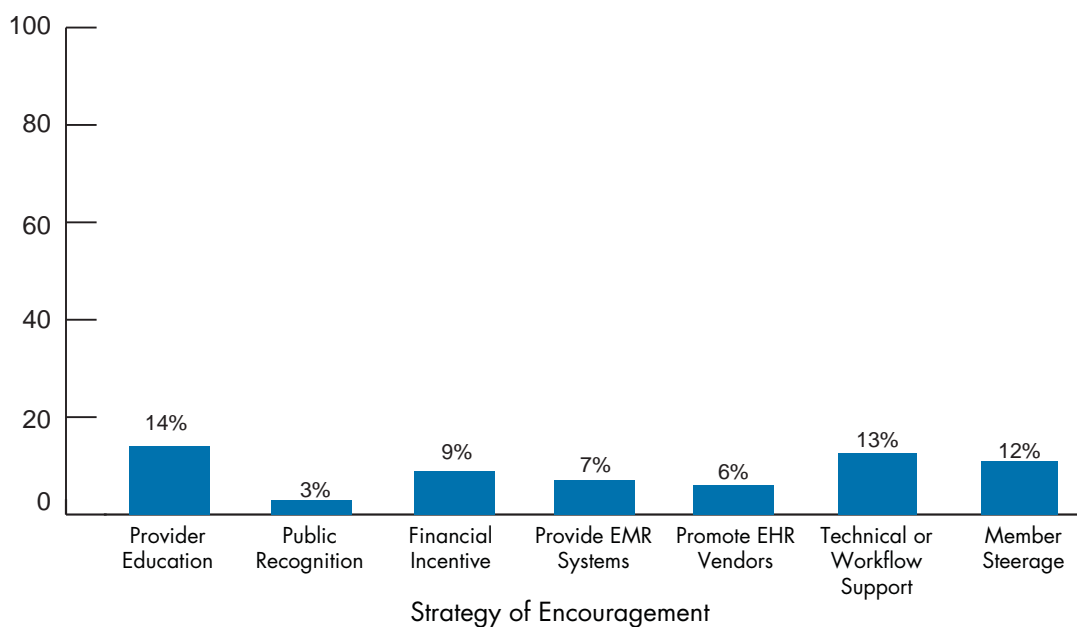
eValue8 asks health plans to indicate what online applications and tools are available to help consumers make good choices, stay healthy, and manage ongoing conditions.

CHART 10: INCENTIVES TO ENCOURAGE PHYSICIANS TO ADOPT HEALTH INFORMATION TOOLS



eValue8 asks health plans what incentives they use to encourage their physicians to adopt health information tools for improving the quality and outcomes of patient care. Health plans are asked to indicate whether they use financial rewards, technical or workflow support to implement HIT, or if members are encouraged to seek physicians who have adopted HIT.

CHART 11: PERCENT OF PLANS ENCOURAGING USE OF CERTIFIED ELECTRONIC RECORDS



eValue8 asks health plans to identify the ways in which they encourage physicians to use CCHIT-certified electronic record systems. Does the health plan educate its physicians on the importance of CCHIT and the benefits of certified health systems? Does the health plan publicly recognize those physicians with CCHIT-certified electronic systems with, for example, an icon in the provider directory? Does the plan promote certain vendors? Or does the health plan provide financial incentives by making it an element of performance payments or by directly supplying the system?

data using interoperability standards but less than 5% of health plans exchange clinical information by transmitting pharmacy data. (See Chart 8.) Health plans, physicians, hospitals, and patients need enrollment and eligibility data at the point of care. But the partners involved in value-driven health care also want health plans to be able to transmit pharmacy data, laboratory results, and other clinical information so that all appropriate providers will have important information at hand when treating patients. eValue8 results also show that plans can receive pharmacy data from outside sources, such as from a PBM, but few plans send out such data to physicians treating plan members. As a result, physicians often do not know what other physicians have prescribed for their patients and typically have no idea if their patients are filling the prescriptions they have written for them.

Engaging Consumers Online

Technology also is being used to engage consumers in their care. (See Chart 9.) More than 60% of health plans have developed personal health records (PHRs) for their plan members. Health policy planners believe having such records will allow patients to get more involved in their care and to have a record they can bring with them (or allow online access) when meeting with a new physician or being admitted to a hospital. Ideally, PHRs should contain a variety of data drawn from electronic databases that can be used to populate the record with data from the patient's physician visits, and from lab and radiology tests. Of those plans that offer PHRs, only a small fraction have established any mechanism, beyond a paper printout, for portability (transferring the record for use after leaving the plan).

There are two challenges for plans to provide a useful PHR. The first is using the information in its possession to pre-populate PHRs with members' history of visits, lab tests and results, pharmacy fills and so forth. The second challenge is to use this information together with information supplied by the member and evidence-based care guidelines to reach out to the member with customized information and reminders. If a patient fails to schedule a preventive screening (such as any male over age 50 who would be due for a colonoscopy, as some experts recommend), a PHR could generate a message and send it by e-mail. Or, if a patient fails to refill a prescription, a reminder could go to the patient, the patient's physician, and the health plan.

Electronic Prescribing

Unfortunately only a handful of practices nationwide have installed HIT that extends beyond billing support to facilitate decision support and to monitor patient compliance. Health plans can promote the growth of HIT capabilities among the physicians who are members of their networks. Through various means, plans can encourage advancement toward use of electronic records and electronic prescribing technology. They can offer financial support or rewards; they can provide technical assistance (often critical for practices that must reorganize the way they practice and face technical barriers to installation); and they can let members know through plan designs and information sent to consumers that they should consider a physician group's use of HIT as a factor when choosing a practice. (See Chart 11.) Only 9% of health plans include the presence of electronic medical records as an element in a program of financial incentives for physicians. In fact, many physicians today continue to use paper records, contributing to the fragmentation of care and increasing the cost and difficulty of extracting information about treatment decisions, patient tracking, and performance measurement.

Employers and other purchasers of health care have sent a strong message that health plans and insurers should invest in information technology to improve health care quality and patient safety. These employers and other purchasers believe health plans should be sending a similar message to practitioners.

Encouraging the Use of Certified EMRs

eValue8 asks plans how they encourage physicians and other providers to adopt standards-based interoperable information technology systems. The Certification Commission for Healthcare Information Technology (CCHIT) is the recognized certification body for electronic health records and networks (www.cchit.org). CCHIT seeks to accelerate the adoption of HIT by creating an efficient, credible, and sustainable certification program for IT. Employers and other health care purchasers believe health plans should encourage physicians to install EMRs, educate members and physicians about their benefits, publicly recognize practices with EMRs, and include the use of EMRs as an element of determining financial rewards. CCHIT began certifying ambulatory EHR systems last year (2006) and plans to release an inpatient EHR certification program this year (2007).

CORNERSTONE 4

ONE IMPORTANT BENEFIT OF HIT IS E-PRESCRIBING

For health plans, physicians, and pharmacies, one of the most significant benefits of HIT is e-prescribing. Not only would e-prescribing help improve patient safety, it would allow all parties to a transaction to exchange data electronically, increase efficiency, and improve data collection and management of pharmaceutical costs.

Physicians in the United States write about 3.2 billion prescriptions a year, yet less than 20% use e-prescribing. Saying medication errors kill 7,000 Americans annually, injure 1.5 million patients, and cost billions of dollars in unnecessary costs, the Institute of Medicine has called on all physicians to adopt e-prescribing by 2010.

A physician specialist seeing a patient for the first time needs information on what medications the patient is taking, for example. The specialist needs to know if the medication is safe for the patient given his or her patient history. The specialist also needs to know what other prescriptions the patient is taking and whether any contraindications or drug-drug interactions are possible. E-prescribing systems supply this information at the point of care.

eValue8 data show that less than 10% of HMOs and PPOs promote CCHIT EMR vendors. Less than 10% provide a financial incentive to providers to use CCHIT-certified EMRs. Less than 5% provide any public recognition of physicians who have such systems. (See Charts 10 and 11.) Some plans, primarily group health plans that own physician practices, take on the responsibility for providing EMRs to some or all of the physician offices in their networks.

Community IT Collaboration

Widespread use of HIT relies on cooperation and use by many health plans and multiple stakeholders. Information that supports care coordination and safety cannot be shared unless local information trading partners agree how it is to be done and what transactions will be affected. Employers and other purchasers expect health plans to participate in or help form multistakeholder efforts for community collaboration on HIT. eValue8 asks plans to help form and participate in community collaboratives involving health information networks in which authorized stakeholders could access clinical data across settings.

HEALTH PLANS PLAY AN IMPORTANT ROLE IN FOSTERING QUALITY

By Dennis White

Dennis White is the vice president of value based purchasing for NBCH.

Results from eValue8 show great variation in health plan performance with respect to the Four Cornerstones. The fact that some plans are very far along means that these results are achievable. The fact that few plans are very far along means that we have much work to do. Two of the health plans that consistently get the highest eValue8 scores each year are HealthPartners and Kaiser Permanente. HealthPartners is a health care organization (including both a health plan and health care delivery system) that serves nearly one million members primarily in Minnesota and Wisconsin. Based in Oakland, Calif., Kaiser Permanente is the nation's largest integrated health plan and has 8.7 million members.

HealthPartners President Mary Brainerd says, "We may be unusual among health plans in that we have used eValue8 to drive our strategic plan. We believe that if purchasers have a set of specifications for the health care services they're buying, it's incumbent on us as health care providers to do everything we can to meet those specifications. And, frankly, the eValue8 process makes sense to us intuitively as well. That's why eValue8 is a big part of our strategic planning process."

Gaining Momentum

Such forward thinking reflects an increased understanding among health plan executives about the importance of shifting from a transaction-based health system that cares for the sick to one that delivers the highest value by aiming to keep plan members healthy. One way to do so is by implementing the Four Cornerstones, Brainerd said. "The Four Cornerstones are absolutely gaining momentum," she commented. "Most leaders in health care, whether they are in a delivery system or purchasing care, agree that they are extremely important. In fact, the Four Cornerstones are

being discussed in every one of the state health reform initiatives being considered today.

"The work being done on health care technology is just one example," Brainerd continued. "We have momentum, the work is underway and now we're asking how quickly we can fully use health information technology to have an impact on improving care and lowering health care costs."

The Consumers' Role

Not only are health plan executives interested in value, but patients are as well. "We find that our patients like the fact that electronic health information helps them get lab test results quickly and allows them to keep track of their health care issues," Brainerd commented. "They care about being able to make appointments online, just as they would choose a seat on an airplane. They appreciate having the same capabilities for transactions with us as a health plan as they have with their bank. When patients have the choice of being able to access and use health care information in person, on the phone, or online, they want to have the choice just as they do in every other aspect of their lives."

Kaiser Permanente also finds that consumers value being able to get health information online. Louise Liang, MD, is Kaiser Permanente's senior vice president for quality and clinical systems support. She oversees Kaiser Permanente HealthConnect, the world's largest civilian implementation of an electronic health record. "Certainly our members and patients are interested in having access to their own health information and having choices in how care is provided," Liang says. "Also, our members have always wanted to understand the quality and cost equation. We have nearly 2 million members who can log on and get what they need. And, what has been impressive is how enthusiastic

our online users have been. Frankly, it has changed their experience with the health care system.”

Since 2005, Kaiser Permanente members have had access to their own personal health records (PHR) on www.kp.org. Through May 2007, more than 1.4 million Kaiser Permanente members had registered online to gain online access to secure KP HealthConnect features. In the past two years, Kaiser Permanente has recorded approximately 8.5 million visits to KP HealthConnect Online features. More than 35 million lab results have been released on Kaiser Permanente’s web site, and more than 1 million members have used this feature to view nearly 7.6 million lab test results.

In two years, more than 766,000 Kaiser Permanente members have sent more than 2.7 million secure e-mail messages to Kaiser Permanent providers.

“Our online features are a critical part of our consumer engagement strategy,” Liang said. “Because we can combine health plan and care delivery services into a common PHR platform that is directly linked to KP HealthConnect, we can provide our members with popular time-saving features. Not only does this benefit our members, but also there are direct benefits to employers, specific to the overall health and productivity of their employees. The ability to use our PHR to e-mail a doctor, schedule appointments online, refill prescriptions online, and link directly from those features to relevant health and drug encyclopedias allows our members to view health information and manage their health online.

“Typically the health care system is designed to suit those who work in the system,” Liang added. “But we are aiming to meet the needs of our members, patients, and other customers, such as employers who pay for health care.”

Like Brainerd, Liang recognizes the importance that health plans place on meeting the specifications that health care purchasers have set. “Today there are more activist employers than there have been in the past,” Liang commented. “And those employers and purchasing organizations such as the Pacific Business Group on Health, the Business Roundtable, and the National Business Coalition on Health, are asking health plans to become very sophisticated in terms of what data we provide on the care we deliver. They are using tools such as eValue8 to gather information on measures of clinical quality and on patient and member satisfaction. For many years, they have pressed us on the cost issue, but now they are also getting sophisticated about paying for quality and how we define quality. We welcome those requests and believe we have the robust data to answer those questions.”

It is important to note that this report is a baseline profile that records the status of health plans along a dimension (the Four Cornerstones) that was only recently announced. Like any other industry, health care will respond once the performance metrics are clear and their customers are aligned. So while it is true that many of the principles represented in the Four Cornerstones are not new, the alignment of customer messages has not been strong.

Commenting on the efforts of health plans such as HealthPartners and Kaiser Permanente, NBCH President Andrew Webber said, “Our data show that some plans such as HealthPartners and Kaiser Permanente have, at the request of NBCH and its member employers, implemented improvements successfully. We welcome these efforts and those of other market-leading health plans that are working with us and working with the employers in their cities and towns to foster a value-driven health care system.”



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