

Business Leaders Driving Health Care Reform

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Virginia Health Summit
May 21, 2008



My Goals Today:

- ❑ To have you better understand the potential **role of employers** in health and health care reform
- ❑ To have you embrace **value based purchasing** as a key strategy of health care reform
- ❑ To challenge **all stakeholders** to provide the collective leadership needed to dramatically improve health and health care

National Business Coalition on Health: An Introduction



National Business Coalition on Health (NBCH)

- **Membership of 60 business and health coalitions**
 - National network of thousands of employers and 25 million employees and their dependents
- **Mission:** Health and health care reform, through value based purchasing, community by community



NBCH at Work

- *Best Practice Distribution Network:*
 - eValue8 – Common RFI for health plans
 - Leapfrog Survey, Bridges to Excellence, Asheville Model
 - College for Advanced Management of Health Benefits
- *National Advocacy:*
 - Congress, CMS, CDC, AHRQ, NQF, QASC, HQA, AQA, Leapfrog, NCQA

The Employer Perspective on Health and Health Care



What Do Employers Want?

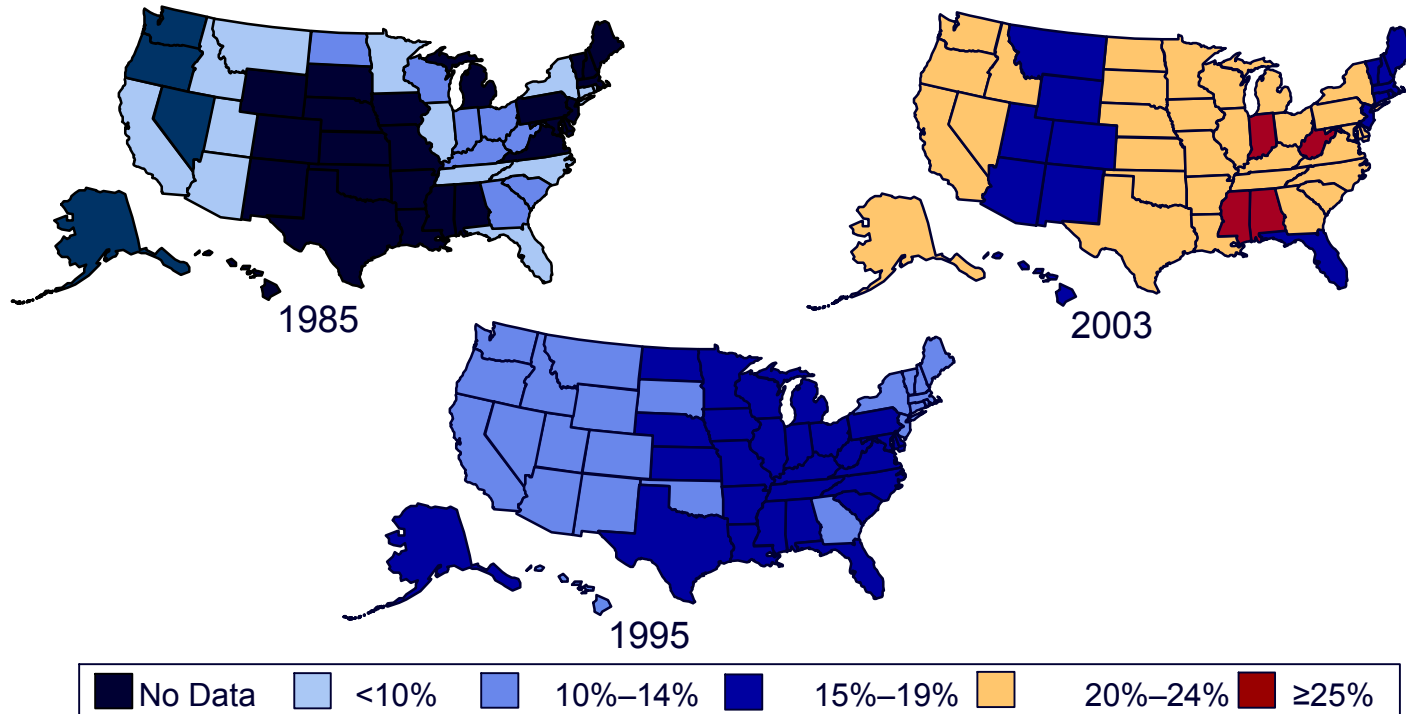
Two Things:

- ❑ Improved workforce health and productivity!
- ❑ As purchaser, better control of the direct and indirect cost associated with workforce illness

Both are Business Imperatives!

US Health Status: Opportunities Abound

Prevalence of Obesity Among U.S. Adults



Source: Behavioral Risk Factor Surveillance System, CDC

Is there Gold at the End of the Rainbow? YES!

“Modest reductions in avoidable factors – unhealthy behavior, environmental risks, and the failure to make modest gains in early detection and innovative treatment – will lead to 40 million fewer cases of illness and a gain of over \$1 trillion annually in labor supply and efficiency by 2023. Compared to the costs we project under the business-as-usual scenario, this represents a 27% reduction in total economic impact.”

**- “*An Unhealthy America*”
Milken Institute, Oct. ‘07**

Some Early Questions to Ponder:

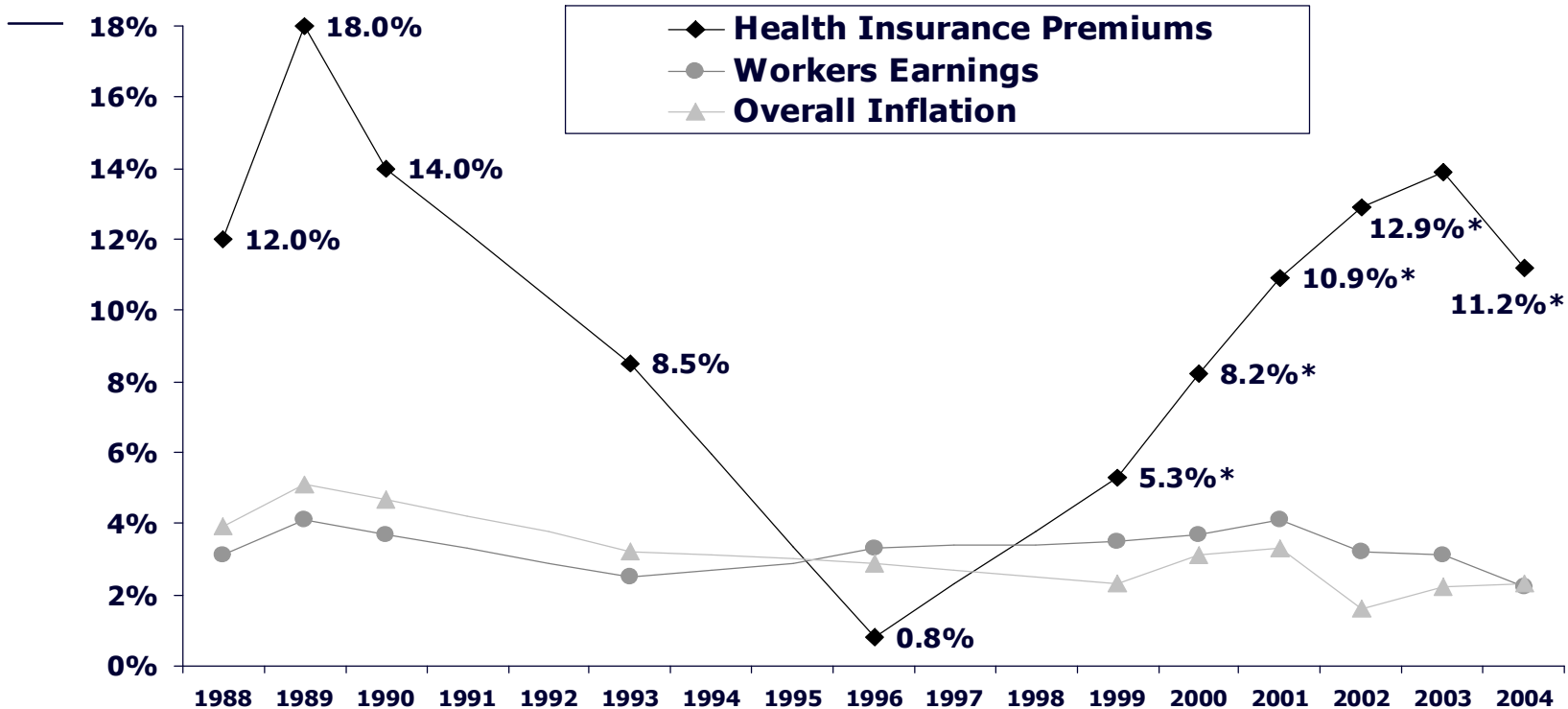
As key stakeholders, are we in the health business or health care business?

Should our real goal be the improvement of population health?

The US Health Care System (or Non-System): Opportunities Abound

- ❑ **Safety** - Tens of thousands die due to medical errors (IOM, 99)
- ❑ **Effectiveness** - 50/50 chance of getting appropriate care (McGlynn, 03)
- ❑ **Costs of Poor Quality** – 30% of direct expenditures due to overuse/misuse/waste (Juran & MBGH, 03)
- ❑ **Unexplained Medical Practice Variation** - (Wennberg, 1973 - present)
- ❑ **Fragmented Health Delivery**
- ❑ **Absence of HIT** (Brailer, 05)
- ❑ **Uninsured** - over 40 million people (IOM, 03)

And Unsustainable Cost Escalation



□ * Estimate is statistically different from the previous year shown at $p < 0.05$.

□ † Estimate is statistically different from the previous year shown at $p < 0.1$.

□ Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

□ Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2004; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2004.

But Employers Bewildered

A Tale of Two Cities:

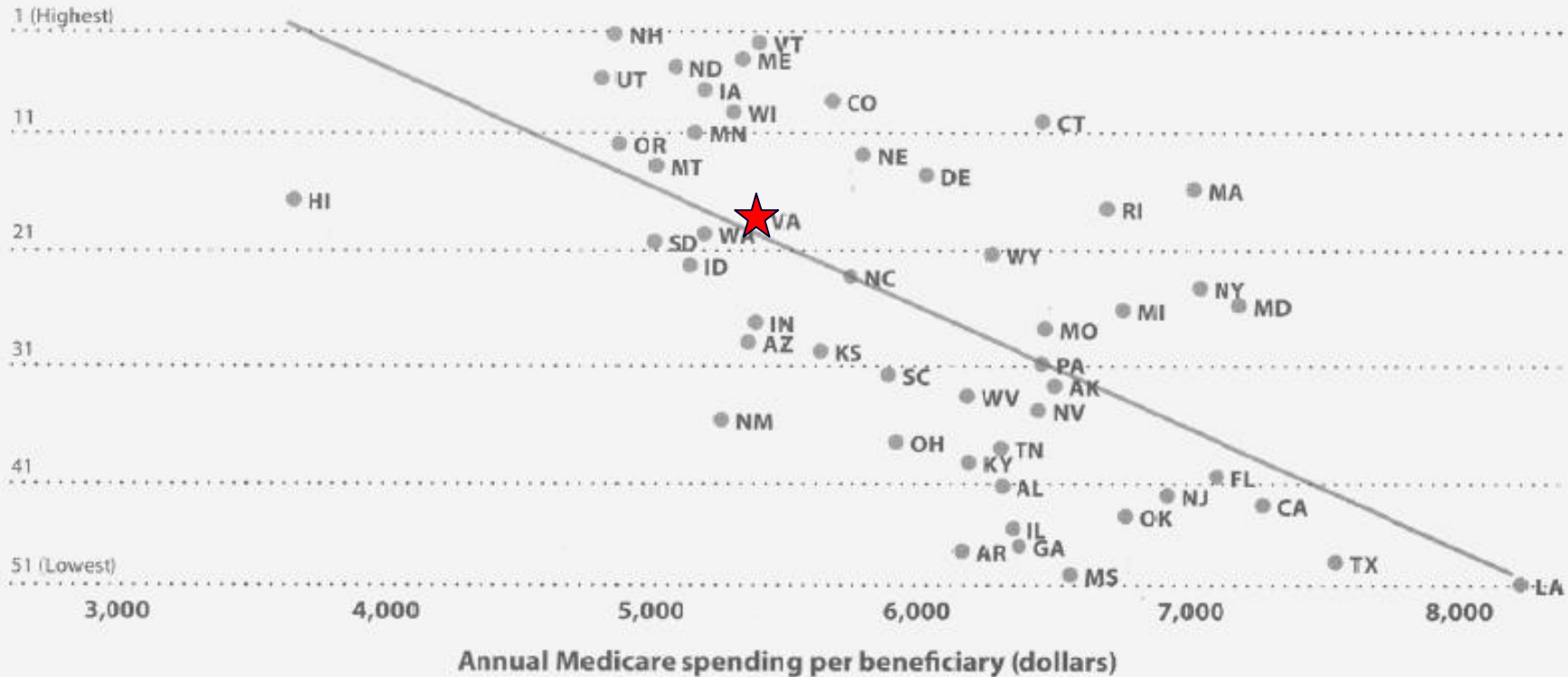
- **Worst of Times:** Rising health care costs put American Industry at a competitive disadvantage
- **Best of Times:** But industry leaders know that process reengineering and technology can drive improved quality and lower cost

Relationship Between Quality of Care and Medicare Spending

States with higher spending per Medicare beneficiary tended to rank lower on 22 quality of care indicators. This inverse relationship might reflect medical practice patterns that favor intensive, costly care rather than the effective care measured by these indicators.

Relationship between quality and Medicare spending, as expressed by overall quality ranking, 2000–2001

Overall quality ranking



Source: Medicare administrative claims data and Medicare Quality Improvement Organization program data, as analyzed by Baicker and Chandra (2004). The solid line shows that for every \$1,000 increase in Medicare spending per beneficiary, a state's quality ranking dropped by 10 positions. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare spending, the physician workforce, and beneficiaries' quality of care" (Web Exclusive), 2004. Permission conveyed through the Copyright Clearance Center, Inc.



And Employers to Blame!

For a Toxic Payment System that Pays for:

- Volume of services rather than outcomes
- Individual units of care rather than episodes of illness
- Acute care over prevention/primary care/care mgmt
- Medical errors and “do overs”
- With no performance based payment

And for a Consumer Entitlement Mentality:

- That insulates individuals from cost sensitivity because of 3rd party payment

No Business Case for Quality!

The Diagnosis and Prognosis in Summary

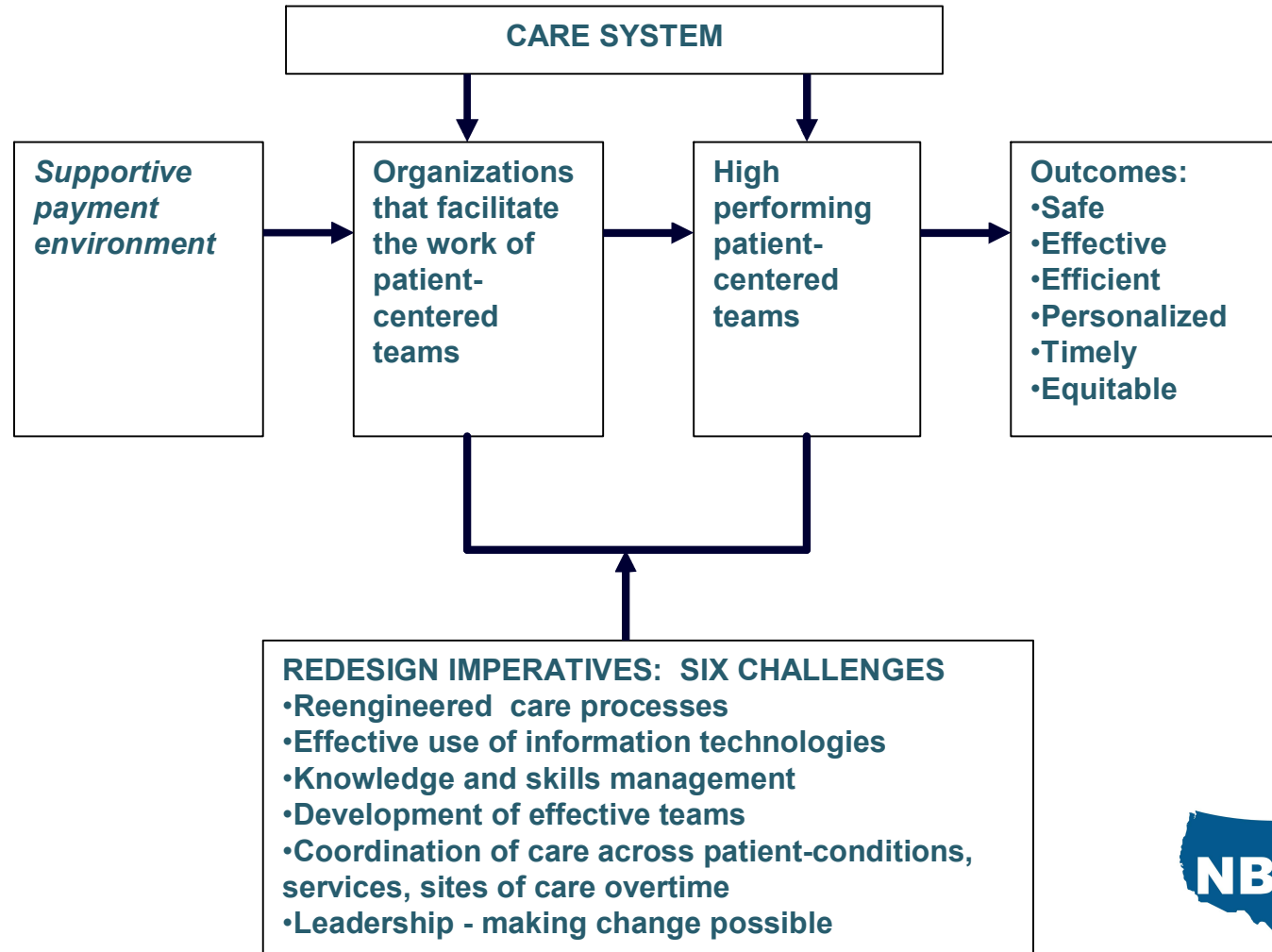
Two of My Favorite Quotes and Pop Quiz:

“Every system is perfectly designed to achieve the results it achieves.”

“Getting better at what we’re currently doing is not the answer.”

Value Based Purchasing: A Path Forward

The IOM Blue Print for Reforming the Health Care System



Value Based Purchasing: Measure, Report, and Reward

Four Pillars:

1. Standardized Measurement
2. Transparency/Public Reporting
3. Payment Reform
4. Informed Consumer Choice

*Accelerating the Pace to the Ultimate Goal:
Health and Health Care Improvement*

A Few VBP Pillar Sound Bites

Standardized Measurement:

- ❑ **Foundation** for both improvement and reward;
- ❑ Measurement needed for both **comparative effectiveness** of medical interventions and **comparative performance** of providers
- ❑ **Outcome and comparative effectiveness research** needed coupled with provider measures for **clinical quality, patient care outcome/experience, efficiency**
- ❑ Slow progress because of **limited societal investment** and the **complexities** related to risk adjustment, attribution, cost burden, data sources and data aggregation

A Few Sound Bites

Transparency and Public Reporting:

- ❑ Consumers have fundamental **right to know**
- ❑ It's how **competitive markets work**
- ❑ Public reporting **leads to improvement!**
- ❑ **No evidence** that public reporting alone leads to market shift to better performers – at least not yet - but hope that it will only take a few to move a market
- ❑ **Translation** of performance information for consumers a challenge

A Few Sound Bites

Payment Reform:

- ❑ The **largest mountain to climb** and certainly the most emotionally charged
- ❑ New **payment architecture** and **aligning payment with performance** needed
- ❑ Need to move from fragmented, visit-based, and individual resource use FFS to more **global/bundled payments**
- ❑ Need to rethink the “relative” **value of primary care vs. specialty care** as reflected in current reimbursement
- ❑ The largest public (Medicare), private payers (national health plans) and coalitions must lead – but **employers must insist** and providers must have seat at table

Informed Consumer Choice

The Goal: To influence the individual consumer to make informed choices at many levels:

- ❑ to live a **healthy lifestyle**;
- ❑ to seek **preventive services** and **care when sick**;
- ❑ to share in, and make the best, **treatment decisions**;
- ❑ to **comply** with treatment regimen and **self-manage**, particularly chronic disease;
- ❑ to **select** a high value plan, hospital, physician.

A Few Sound Bites

Informed Consumer Choice:

- ❑ Area of **greatest influence** for employers;
- ❑ Change the **entitlement mentality**;
- ❑ Focus on **front end health** not just health care;
- ❑ Establish a principle of **self-responsibility** but with **robust support**;
- ❑ Support strategy must include creative mix of **financial incentives, peer support, timely information, coaching/counseling**

The Future Employer Strategy: Value Based Benefit Design

- ❑ Basic health insurance benefit architecture should **tier** medical services by evidence of effectiveness - and providers by evidence of performance
- ❑ **Co-pay** levels (incentives) should vary by tiers in a way to help steer individuals toward effective services and high performing providers. And vice versa.
- ❑ Economic incentives, through value based benefit designs, can influence better consumer choices but should be **joined** with timely information, coaching, and peer support

Few More Questions to Ponder:

As key stakeholders, can we all embrace and actively support the market-based strategy and the specific four pillars of value based purchasing?

More importantly, what can you do to advance the VBP agenda?

The Unmet Challenge: Leadership and Action

So Great Battle Plan, but Where are the Employer Generals?

- ❑ **The unanswered question**
- ❑ **“Culture beats strategy every time.”**
- ❑ **Is it too much to ask?**
- ❑ **But without top employer leadership engagement, there will be no reform**
- ❑ **National and Community leadership required**

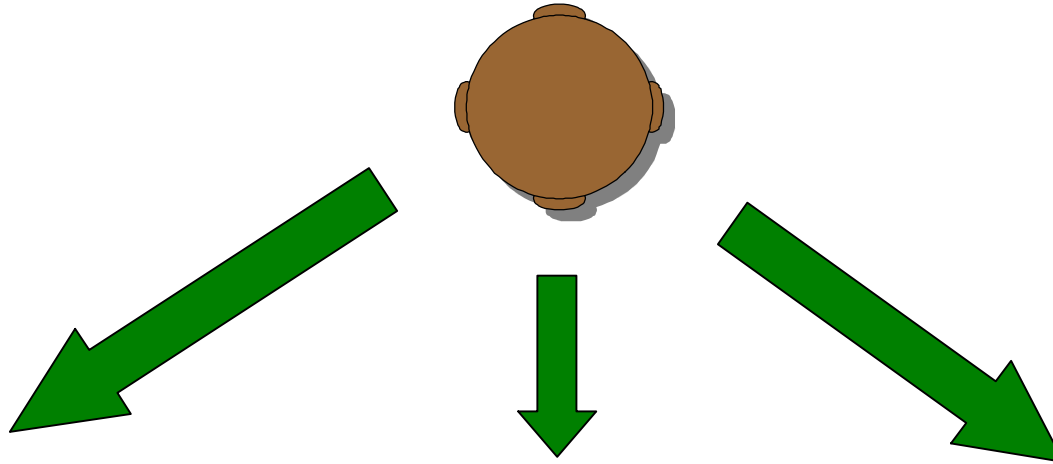
What are the Impediments?

- ❑ Not our business – **“We make widgets”**
- ❑ Health care dynamics **hard to master** and **frustration** for those that do
- ❑ **Corporate silos** – HR and Health&Safety – and little C-Suite engagement
- ❑ Many employers in the **business of health care**
- ❑ Hard to look beyond individual employer strategy to **collective engagement**

It's Springtime: Some Signs of Hope

- ❑ Secretary Leavitt's **Value Driven Health Care Initiative**
- ❑ A reenergized **National Quality Forum**
- ❑ Emerging best practice strategies – **eValue8, Leapfrog Hospital Survey, BTE, the Asheville Model, Medicare Compare and proposed P4P legislation.**
- ❑ Medicare policy of not paying for **hospital acquired conditions** and **hospital P4P plan** before Congress
- ❑ Federally designated **Chartered Value Exchanges**
- ❑ Robert Wood Johnson Foundation: “**Aligning Forces for Quality – The Regional Market Project**”
- ❑ **But VBP has little saliency** in the health care reform debate in the run up to the presidential elections!

Community Roundtable for Health Reform



Community Health Council



Quality Improvement Council



Value Based Purchasing Council



Future Leadership Challenges

- **All Stakeholders:** Embracing a common vision of improving health, transforming health care and building community leadership roundtables
- **Employers, Government Purchasers and Health Plans:** Building a business case for quality by advancing the value based purchasing agenda with emphasis on changing the economic incentives
- **Providers:** Developing cultures of continuous quality improvement and reorientation of the system towards prevention, primary care and care mgmt

Future Leadership Challenges

- ❑ **Federal Government:** Organizing a societal commitment to comparative effectiveness research and performance measurement.
- ❑ **Consumer Advocacy Organizations:** Recognizing that the health care reform agenda extends beyond the issue of universal coverage and access to care
- ❑ **Individual Consumers:** Taking greater responsibility for personal behaviors – the number one determinant of health care status

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NATIONAL BUSINESS COALITION ON HEALTH'S
13th Annual Conference

THE EMPLOYER CHALLENGE:
Connecting Health, Health Benefits, & Business Strategies

November 9-11, 2008
JW Marriott Pennsylvania Avenue
Washington, DC