United States General Accounting Office

GAO

Report to the Chairman and Ranking Minority, Special Committee on Aging, U.S. Senate

June 1998

HEALTH CARE QUALITY

Implications of Purchasers' Experiences for HCFA

GAO/HEHS-98-69

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-279631

June 18, 1998

The Honorable Charles Grassley
Chairman
The Honorable John Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

As you requested, we have determined how large purchasers use quality-related data to seek or promote better quality of care and lessons that can be learned from their experiences for the Health Care Financing Administration.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Health Care Financing Administration, appropriate congressional committees, and other interested parties. If you have any questions about this report, please call me at (202) 512-6543. Other major contributors are listed in appendix II.

Bernice Steinhardt
Director, Health Services and
Quality Issues

Executive Summary

Purpose

To help control costs associated with health care, public and private sectors have moved toward managed care. Medicare, the nation's largest purchaser of health care, contracts with nearly 400 managed care plans that serve over 5.5 million elderly beneficiaries—about 14 percent of the total Medicare population. Over the past several years, the number of Medicare beneficiaries enrolled in managed care plans and the number of plans contracting with the Medicare program have increased dramatically. With more and more beneficiaries enrolling in managed care, Medicare faces many of the same concerns that other purchasers face—particularly those that relate to quality of care. Some large corporate purchasers have begun to examine "value-based purchasing"—how best to achieve value as a balance between cost and quality. As they purchase care, some employers ask for quality-related data from health plans and find opportunities to take action on the basis of such data as they monitor plan performance.

To better understand how quality of care might be ensured for Medicare beneficiaries, the Chairman and the Ranking Minority Member of the Senate Special Committee on Aging asked GAO to determine (1) how large purchasers use quality-related data to seek or promote better quality of care and (2) lessons that can be learned from their experiences for the Health Care Financing Administration (HCFA) as it administers the nation's Medicare program. In conducting this work, GAO performed case studies of two national purchasers—one private and one public—and two regional purchasers. (See app. I for a brief description of each purchaser.)

Background

Title IV of the Balanced Budget Act of 1997 (P.L. 105-33) encourages increased enrollment of Medicare beneficiaries in managed care. HCFA will also be required to provide quality-related and other comparative information to beneficiaries to help them make informed health plan choices. In addition, the act requires plans to take action to improve the quality of care received by Medicare beneficiaries and to assess the effects of such actions.

Value-based purchasing, a concept being examined by large corporate purchasers to improve quality of care, is based on the idea that inexpensive health care has little value if employees get sick more often, stay sick longer, or suffer more disabilities due to poor quality care. To evaluate the quality of care received from health plans, doctors, and other professionals, the following must be determined: (1) the appropriateness of the care provided, (2) the technical excellence of the providers'

knowledge and their delivery of care, (3) patient accessibility to care, and (4) patient satisfaction with the care received. These purchasers are requiring plans to provide quality-related data and are taking action on the basis of such data.

Results in Brief

After collecting and making use of quality-related data, the purchasers GAO studied reported that in addition to cost savings, they saw improvements in access to care and health plan services, as well as in employee satisfaction with health plan performance. They realized such improvements by identifying opportunities to use quality-related data in selecting health plans, monitoring health plan performance, developing quality improvement initiatives with plans and taking other actions, and providing information on health plans to their employees.

While HCFA is a unique purchaser of managed care—by virtue of the size of the Medicare program and the freedom of choice provided to beneficiaries—a number of purchasers' quality of care strategies could be relevant to HCFA's administration of the Medicare program. Major lessons from large purchasers' experiences relate to the importance of (1) educating employees as to the meaning of quality-related measures when providing comparative information on health plan quality; (2) using collaborative- and compliance-oriented approaches to achieve improvements in plan performance; and (3) continually looking for additional opportunities to make use of quality-related data, such as developing standards and benchmarks for plan performance.

Principal Findings

Purchasers Use Quality-Related Data to Achieve Early Results

Purchasers can use quality-related data to inform their assessment of whether or not to contract with health plans; purchasers can also use such data to monitor plan performance and provide information to their employees. The purchasers GAO studied used a variety of quality-related data from different sources, including (1) evidence of accreditation from the National Committee on Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations; (2) reports on how well plans address selected measures from the Health Plan Employer Data and Information Set (HEDIS), a standardized set of performance measures; and (3) surveys of employee satisfaction with the quality of care received from

health plans. Purchasers have drawn on the resources of groups of employers banding together, known as business coalitions, and participated in a cooperative HEDIS reporting initiative to collect, analyze, and report audited data on HEDIS measures.

By reviewing data from multiple sources—especially those data related to employee satisfaction—purchasers have been able to identify problems with and improve health plan performance as well as realize cost savings. For example, one purchaser worked closely with plans to achieve improvements in customer service and referrals to specialists. The purchaser identified problems in these areas using a satisfaction survey administered to its employees, complaints data, and feedback from a committee established to improve communications between the purchaser and its employees. The same purchaser used HEDIS data from diabetes-related measures to encourage a plan to develop an educational project targeted to the purchaser's employees with diabetes.

In addition to collaborating with plans, purchasers have used financial incentives to reward or penalize plans for their performance. In one case, a purchaser noted that financial penalties motivated a plan to institute changes that improved employee satisfaction with plan providers. Another purchaser cited cost reductions as a result of using HEDIS and other data in rate negotiations, with a 4-percent decrease in premiums achieved at 21 health plans targeted as having below-average performance on selected HEDIS measures.

Two of the purchasers that we reviewed also used quality-related data in distributing health plan "report cards" on the characteristics and performance of plans, which employees can use to compare plans and make informed choices when selecting a health plan. In addition to providing the report cards, the two purchasers said they were careful to explain the meaning of the quality-related measures. After distributing this information, one purchaser saw a relatively modest shift by employees into a plan with a higher quality ranking. However, when the purchaser subsequently froze enrollment in plans with lower quality rankings, there was a more significant shift into the plan with the higher quality ranking. The other purchaser found that 66 percent of those responding to an employee survey viewed the purchaser's report card as very or somewhat important in assisting them in selecting a plan. This same purchaser used feedback from employees to make revisions to a subsequent report card.

Each of the four purchasers plans to increase its use of quality-related data in a variety of ways—some of which are already in use by other purchasers. Such use includes identifying poorly performing plans on the basis of quality-related data and declining to contract with them and linking plan performance to financial incentives for employees to encourage them to choose plans with higher quality rankings. In addition, purchasers may use quality-related data to contract with—and thereby monitor—fewer plans. Some of the purchasers have implemented standards and benchmarks for health plan performance—which, in some cases, are based on multiple types of quality-related data, such as HEDIS and satisfaction data—as part of an effort to provide comprehensive feedback to health plans on how their performance compares with earlier years and how they compare against other plans. Other purchasers plan to develop such standards and benchmarks.

The Balanced Budget Act Moves HCFA in the Direction of Other Purchasers

The Medicare program stands apart from other purchasers by virtue of its size and the freedom of choice provided to beneficiaries. Where the largest private purchaser that we visited serves 1 million people, HCFA serves over 5.5 million beneficiaries through Medicare health maintenance organizations (HMO). In making their health care decisions, Medicare beneficiaries have enjoyed more choice than much of the employed population under 65. They can choose fee-for-service or managed care, select any of the Medicare-approved HMOs in their area, and switch plans monthly.

Legislation has shaped and continues to shape how quality of care is monitored under the Medicare program through monitoring programs and reviews by peer review organizations—also known as quality improvement organizations. For example, any eligible organization that agrees to meet minimum standards may participate in the Medicare program. In contrast, employers can decide not to contract with plans. They have greater ability to command the attention of health plans because of their ability to exclude them from contracts and because employers can share quality-related data with employees that could spur plans to improve.

While the Medicare program will retain several of its distinguishing characteristics—most notably, its status as the nation's largest purchaser of health care—title IV of the Balanced Budget Act of 1997 begins to move HCFA in the direction already taken by the four purchasers GAO reviewed. While HCFA had authority and planned to provide comparative information

about Medicare plans to beneficiaries prior to the passage of the act, it now has specific time frames for doing so within the context of an annual open enrollment season. In addition, the act requires that Medicare-contracted health plans take actions to improve quality as part of their internal quality assurance programs. To address this requirement, HCFA is considering using standardized measures to determine whether plans are achieving results from their quality assurance programs.

With these changes, the experiences of the purchasers GAO reviewed become more relevant to HCFA. For example, the two purchasers that disseminated quality-related data in report cards also explained and interpreted the data to their employees, and they refined the information that they provide employees on health plans. All four have used quality-related data to provide feedback on performance to the plans as well as reevaluate how they provide plans with such feedback. In addition, the purchasers have used quality-related data to improve performance through collaborative- and compliance-oriented approaches. In order to implement certain purchaser practices in using quality-related data, such as the use of quality-related data to select and negotiate rates with health plans, HCFA would need new legislative authority.

Recommendations

GAO is making no recommendations in this report.

Comments From HCFA and Purchasers

HCFA and the four purchasers visited by GAO commented on a draft of this report. They agreed with our presentation of the information and our observations. They also provided technical suggestions, which we incorporated where appropriate.

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Abbreviations

CBO	Congressional Budget Office
FACCT	Foundation for Accountability
HCFA	Health Care Financing Administration
HEDIS	Health Plan Employer Data and Information Set
HMO	health maintenance organization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NCQA	National Committee for Quality Assurance
POS	point-of-service
PPO	preferred provider organization
WBGH	Washington Business Group on Health

Introduction

In the public and private sectors alike, concerns about quality of health care are intensifying as purchasers of health insurance shift from traditional indemnity plans to managed care. With plans' increased focus on controlling the skyrocketing costs of health care benefits, there are concerns about the value of the health benefits purchased. As a result, several large private purchasers have begun to examine "value-based purchasing." Key to value-based purchasing is the measurement of health plan quality using different types of quality-related data to hold plans accountable and encourage improvements.

Lessons learned from the experience of large purchasers may be applicable to the Health Care Financing Administration (HCFA), the nation's single largest payer for health care. HCFA administers the Medicare program, which provides care for about 38 million beneficiaries, over 5.5 million of whom are currently in health maintenance organizations (HMO). It purchases health care coverage for almost all of the nation's elderly population and more than 4 million disabled beneficiaries. Like purchasers in the private sector, the federal government has looked to managed care as a way to help contain costs associated with providing health care to Medicare beneficiaries. At the same time, the agency wants to ensure that the beneficiaries currently enrolled in health plans and those who enroll in the future are receiving high-quality care. With the passage of the Balanced Budget Act of 1997—a major piece of legislation affecting the Medicare program—HCFA will have more plans and more types of plans to monitor for the quality of care provided to beneficiaries.

Purchasers Shift to Managed Care

In an effort to curb the double-digit inflation in health care costs of the 1980s, large purchasers increasingly turned to managed care. The rise in managed care enrollment has been swift. From 1987 to 1996, enrollment in managed care provided through private employers nearly tripled. According to a 1997 survey of health benefits offered by firms with 200 or more workers,[1] only 19 percent of employees are still enrolled in indemnity programs, which allow a free choice of providers and reimburse physicians and hospitals with limited or no review of the appropriateness of services rendered. In addition, traditional indemnity coverage uses a fee-for-service payment mechanism to reimburse providers. The remainder of employees with health insurance receive care through a variety of

[1]KPMG Peat Marwick LLP, Health Benefits in 1997 (June 1997). KPMG conducts annual surveys of employer-sponsored health benefits in firms with 200 or more workers.

health plans. These can include (1) HMOs, (2) preferred provider organizations (PPO), and (3) point-of-service (POS) plans.[2]

HCFA has also seen a rapid increase in managed care enrollment in Medicare. However, unlike the private sector, the vast majority of Medicare beneficiaries still receive care through fee-for-service arrangements. In the early 1970s, the Congress encouraged commercial and Medicare use of HMOs by authorizing federal standards and oversight to ensure reasonable care and service. Between 1994 and 1997, enrollment in Medicare HMOs increased by 75 percent. There has also been a dramatic increase in the number of plans Medicare contracts with. Currently, HCFA contracts with close to 400 health plans to provide health care to over 5.5 million beneficiaries, about 14 percent of the total Medicare population.

With the passage of the Balanced Budget Act, even greater growth in Medicare beneficiary enrollment in managed care can be expected. The act permits contracts between HCFA and a variety of different managed care entities, including PPO and POS plans, which are similar to HMOs but are directly controlled by groups of providers. The Congressional Budget Office (CBO) projects that as a result of the passage of the act, all types of managed care organizations will account for 25 percent of Medicare enrollees in 2002, 38 percent in 2008, and about 50 percent by 2030.

Need to Monitor Quality of Care

With increased use of managed care, public and private purchasers must consider strategies to monitor plans and ensure the quality of the care they provide. The Institute of Medicine has formally defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[3] In evaluating plans, one or more of the following dimensions of quality can be measured:

- Appropriateness: Are providers giving patients the care they need?

[2]HMOs require patients to use a limited number of affiliated physicians who may be salaried, paid on a per-capita (capitated) basis, or reimbursed for each service. Typically, a patient's care, especially referrals to specialists and hospitalization, is coordinated by a primary care physician—often called a "gatekeeper." PPOs provide care to enrollees through a network of providers that are normally reimbursed at a discounted rate, generally with higher out-of-pocket costs to enrollees who choose to go to providers outside the network. Finally, POS plans generally resemble HMOs but, like PPOs, allow enrollees to see nonaffiliated physicians if they are willing to incur higher out-of-pocket costs. Fee-for-service payment is also used in PPOs and to some extent in POS and HMO plans.

[3]Institute of Medicine, Medicare: A Strategy for Quality Assurance, Kathleen Lohr, ed. (Washington, D.C.: National Academy Press, 1990).

- Technical excellence: How well are providers using medical science and knowledge to deliver care to patients?
- Accessibility: Are patients able to obtain care when needed and within reasonable proximity to where they live or work?
- Acceptability: Are patients satisfied with the care they receive?

Since the concept of quality is multidimensional, experts describe the importance of using different types of measures to evaluate care. For example, the Foundation for Accountability (FACCT)—a forum for consumers and purchasers, including HCFA—argues for the importance of balancing the use of quality measures to reflect (1) the results of care, (2) whether patients are satisfied with the care received, and (3) whether the appropriate processes have been followed.

Performance indicators are used to measure the various attributes of quality. For example, for clinical attributes, they can measure appropriateness and technical excellence—that is, providers' actions and the outcomes of those actions. Process-related indicators refer to clinical interventions, such as the diagnostic tests performed by a physician when examining a patient. In contrast, outcome indicators measure the results of providers' activities, such as mortality and morbidity. Outcome measures are critical to evaluating the quality of care, but experts recognize that these measures are not fully developed.

A number of questions have been raised about the reliability and validity of certain measures and the data sources for performance indicators. For example, data from computerized administrative databases maintained by managed care plans and from individual patient medical records kept in providers' offices may be inaccurate, incomplete, or misleading. This is because most administrative databases were designed for financial—not clinical—purposes. In addition, providers may enter incorrect information in medical records or not document certain interventions. In an earlier report, we expressed concerns about the reliability of satisfaction data, since most people lack the knowledge needed to adequately evaluate the appropriateness of the care that they receive or do not receive.[4] We also noted in the report that plan-reported data on access-related measures, such as what constitutes a sufficient provider network, do not necessarily ensure that access to care is received. Such data must be checked by independent and systematic monitoring efforts that go beyond plan-reported, paper-based indications of compliance.

[4]Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-96, May 16, 1997).

Some Private Corporations Move Toward Value-Based Purchasing

Despite problems in measurement, some large companies—concerned with absenteeism and reduced productivity from illness—have begun to apply value-based purchasing concepts when purchasing health plan services. For example, these companies have considered information about quality to assess, rank, and select health plans and to monitor ongoing plan performance against standards and negotiate rates based on these standards. In addition, these companies are providing information on plan performance to employees to help inform their selection of health plans. Large purchasers have spearheaded several initiatives as they search for credible tools to help them identify and demonstrate to others the "value" resulting from premiums paid to managed care plans. For purchasers, standardized measures can help them to set desirable goals or "benchmarks" for health plans in different areas of interest or concern to the purchaser, provide feedback to plans on the results of such performance, and monitor the progress of plans against these goals.

In the early 1990s, a committee of health plan representatives and corporate purchasers began to work on a set of standardized performance measures, which were later revised by the National Committee for Quality Assurance (NCQA)—a nonprofit institution that reviews and accredits health plans.[5] The result of these efforts, the Health Plan Employer Data and Information Set (HEDIS), is now in its third generation and currently covers the following categories: effectiveness of care, access and availability of care, satisfaction with the experience of care, informed health care choices, descriptive information on health plans, the cost of care, health plan stability, and the use of services.[6]

Another major effort by purchasers, with participation by HCFA and other government agencies, was the creation of FACCT to develop standardized outcome measures. In 1996 and 1997, FACCT endorsed comprehensive measurement sets for asthma, diabetes, breast cancer, major depression, as well as other areas; some of these indicators focus on outcomes. Now FACCT is coordinating efforts with NCQA and others to create

[5]NCQA was founded in 1979 by two trade associations that represent the managed care industry. It became independent in 1990 and now represents the interests of purchasers and consumers as well as health care organizations.

[6]As a measurement set, HEDIS has evolved over time. Early HEDIS indicators addressed quality, access and patient satisfaction, membership and utilization, finance, and HMO management. The indicators addressing quality issues generally focused on providers' actions rather than the outcomes of those actions. For example, the indicators measured the rate at which women received mammograms but not the 5-year survival rate of women diagnosed with breast cancer. NCQA has made subsequent revisions to HEDIS. The latest version includes a standardized patient satisfaction survey and more indicators bearing on high-prevalence diseases. Quality measures are still predominantly process-oriented.

comprehensive measures for children's health, HIV/AIDS, end-of-life care, coronary artery disease, and alcohol misuse. FACCT has also developed a "consumer information framework" for purchasers, which emphasizes the importance of a consistent and understandable framework for presenting quality-related information to consumers. One example of this information is the ability of health care organizations to maximize functioning and quality of life when a consumer faces chronic, incurable illnesses, such as diabetes and asthma.

Despite the involvement of some major purchasers in the development of quality-related measures, surveys conducted by the Watson Wyatt consulting firm with the Washington Business Group on Health (WBGH) in 1996 and 1997 concluded that cost still prevails as the principal concern when most employers evaluate a managed care plan.[7] The surveyed employers noted, however, that they are beginning to look more closely at issues such as plan coverage and access in judging health plan value. And a significant number of employers are requiring plans to report HEDIS data, with some making it a prerequisite for health plans that wish to contract with them. They also view accreditation as providing assurance that a health plan is attempting to manage the quality of care.[8]

While employers are beginning to make increased use of quality-related data in screening plans with which to contract, they may not necessarily be using it throughout the purchasing and monitoring process to the extent desired by proponents of value-based purchasing. A recent mapping of activities by individual employers and business coalitions concluded that only a limited number are actually implementing the principles of value-based purchasing.[9]

[7]In 1996, Watson Wyatt and the Washington Business Group on Health conducted the first employer survey of 384 U.S. employers on value purchasing of health benefits. A follow-up survey of 325 U.S. employers was conducted in spring 1997. See Watson Wyatt, Reality Check: Is Cost Everything? (Bethesda, Md.: 1996) and Getting What You Pay For: Purchasing Value in Health Care (Bethesda, Md.: 1997).

[8]Accreditation is a formal designation granted by a third party. NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) both accredit managed care plans. Accreditation has traditionally involved evaluating the extent to which health plans meet standards that specify the resources and organizational arrangements necessary to attain quality. Both NCQA and JCAHO now look at a health plan's efforts to continuously improve the quality of care and service it delivers.

[9]Jack Meyer and others, Theory and Reality of Value-Based Purchasing: Lessons From the Pioneers (Rockville, Md.: Agency for Health Care Policy and Research, Nov. 1997).

Objectives, Scope, and Methodology

The Chairman and the Ranking Minority Member of the Senate Special Committee on Aging asked us to study how large corporate purchasers use quality-related information collected from health plans and the applicability of purchasers' experiences to HCFA. Specifically, we agreed to describe (1) how large purchasers use quality-related data to seek or promote better quality of care and (2) lessons that can be learned from their experiences for HCFA in administering the Medicare program.

In conducting our review, we analyzed and synthesized relevant literature about managed care and discussed value-based purchasing and quality measurement with employers and with HCFA officials. We then conducted detailed case studies with four large purchasers of managed care for employees. During site visits with these purchasers, we discussed how they incorporated quality-related data into their purchasing and monitoring decisions and the results they believe are attributable to their efforts. We also reviewed available data on results achieved through these efforts.

For the purposes of the case study analysis, we defined "results" in terms of improved health plan performance on dimensions measured; increased health plan accountability to the purchaser or enrollee; and actions taken by purchasers, health plans, providers, or consumers in response to quality-related data. As such, we defined results not in terms of outcomes in the sense of clinical quality but rather those that indicated improvement in the performance of health plans in the dimensions measured by the purchaser.

We selected purchasers for case studies that met the following criteria: the purchaser had (1) received performance measurement information from managed care plans at least twice, (2) documentation of specific examples of data uses and results, and (3) experience with managed care markets in several regions of the country or was able to exercise major leverage as a purchaser in at least one market. Also, we sought large purchasers that were willing to allow us access to their information and to spend time responding to our questions. Given these criteria, we selected four purchasers that represented a range of characteristics and experience with managed care: the California Public Employees' Retirement System (CalPERS), Federal Express, Johnson & Johnson, and Southern California Edison.

Of the four purchasers we studied, Federal Express and Johnson & Johnson can be characterized as national, as they purchase care for large

concentrations of employees in multiple markets. Southern California Edison and CalPERS can be characterized as regional, as the vast majority of the employees for whom they purchase care are located in a single state or market. Two of the purchasers began offering managed care to their employees before 1994, and two began offering managed care since 1994. (See app. I for additional details on each purchaser.)

We performed our work for this study between August 1996 and May 1998 in accordance with generally accepted government auditing standards. We also provided a draft of the report to HCFA and the four purchasers we visited for review and comment. They provided technical suggestions, which we have incorporated where appropriate.

Quality Data Serve Employers, Influence Plan Behavior, and Inform Employees

The four purchasers we studied achieved results—in health plan access, service by health plans to employees of the purchaser, satisfaction, and cost savings—by making use of multiple types of quality-related data, primarily those relating to satisfaction with care. They used these data to negotiate increased services from health plans, improve health plan performance, and inform employees about their health care choices. This chapter examines more closely those uses that have achieved demonstrable results. To date, purchaser assessments of health plan quality have largely focused on issues of accessibility and acceptability and whether health plans effectively administer their daily operations. As the four purchasers evaluate the benefits derived from their and others' use of quality measures, they anticipate making even greater use of quality-related data.

Early Results From Requiring Health Plan Data

Purchasers can require quality-related data from health plans as a contracting requirement in order to focus the plans' attention on purchaser priorities and set the stage for subsequent quality improvement and accountability activities. To collect and analyze quality-related data, purchasers use different types of information from a variety of sources. Improvements in access to services and in health plan capacity to report on HEDIS measures are some of the results from these activities, according to the purchasers we visited.

Purchasers Use Different Types of Data From Different Sources

Purchasers use a variety of data sources to assess whether or not to contract with health plans, monitor their ongoing performance, and develop quality-related information to provide employees. Data sources range from formal data on whether health plans have met accreditation standards set by entities such as NCQA and JCAHO, how health plans perform on certain HEDIS measures, and surveys of employees satisfaction to more qualitative data gathered through the judgments made by health benefits staff in the process of assessing health plans during the selection process. According to the 1997 Watson Wyatt/WBGH survey, the use of health care data is a resource-intensive activity; therefore, most purchasers who do so are large companies. As of 1997, 62 percent of large employers said they use HEDIS data in making purchasing decisions. In contrast, only 7 percent of small employers (those with fewer than 1,000 employees) use HEDIS data.

Two of the purchasers we visited augment quality-related measures with site visits when selecting a health plan.[10] To screen and conduct initial rankings of plans, these two purchasers requested evidence of NCQA and JCAHO accreditation, various HEDIS measures, and patient satisfaction surveys. They also used benefits consulting firms to assist them in selecting quality-related measures and analyzing health plan performance against targets, using HEDIS and other data. Once plans were screened and ranked, benefits staff conducted site visits. For example, one purchaser that we visited used these visits to observe plan operations, touring plan facilities including the customer service and claims processing centers and receiving an overview of the plan's internal quality assurance processes.

Site visits can weight heavily when final decisions on health plan selection are made. For example, one purchaser ultimately selected a plan that had not received the highest quality rankings based on the analysis of quality-related data. According to the purchaser's staff, observations during site visits changed the ranking of the plans. For example, during site visits at one plan that had received a high ranking, the purchaser's staff found that medical directors at some locations in the state did not always know what medical directors at other locations in the state were doing. At a site visit at another plan, the purchaser's staff began to question the plan's commitment to customer service, given the plan's reaction to the purchaser's concerns about the process for employee selection of a primary care physician. As a result of these site visits, the purchaser did not select either of these plans.

Purchasers also acquire data from other sources, such as regional business coalitions. One purchaser we visited participated in a business coalition to augment quality efforts in areas with small populations of employees. Two other purchasers we visited said they benefited from a regional reporting initiative to collect, analyze, and report audited HEDIS data. One of these purchasers stressed a philosophy of building on information that is already publicly available rather than imposing another reporting requirement on health plans.

Data Are Useful for Improvements in Access and Health Plan Reporting

As purchasers move into managed care, their first step often is to ensure access to care. Purchasers consider data on access as well as customer service to be particularly important—both to their employees and as indicators of quality. The two purchasers that used quality-related data to

[10]The other two purchasers did not select their health plans using quality-related criteria, since this selection occurred before their formulation of a strategy for ensuring quality in managed care.

select health plans said they had required health plans to submit data on access-related measures. One purchaser, for example, required plans to report on the percentage of employees who would have access to at least two primary care physicians within 8 miles of their residence, the average time to obtain appointments, the percent of primary care providers who were not accepting new patients, and the timeliness of response to telephone and member inquiries. In this case, the purchaser required a commitment from plans to undertake actions to fill gaps in provider networks.

Several purchasers we visited required plans to continue to submit data on HEDIS measures to ensure the plans gathered and maintained data on quality. One purchaser found that the initial HEDIS data received from plans during the plan selection process may have lacked validity and reliability. After requiring HEDIS data for 3 years from plans and contracting with a consultant to perform a data quality assessment, the purchaser described significant improvement in the plans' ability to report and in the reliability of the data reported. For example, in 1993, only 50 percent of the managed care plans under contract could submit the HEDIS data requested, and purchaser officials described these data as only poor to fair in quality. In 1994, over 90 percent of the plans could provide HEDIS data of "fair quality." By 1995, 100 percent of the plans under contract reported HEDIS data, and the data submitted by all but three plans were judged to be of acceptable quality. The purchaser now plans to make more use of these improved data during performance monitoring.

Different Approaches Elicit Results in Health Plan Performance

The four purchasers we visited suggested that their philosophies about their relationship with health plans helped shape the approaches they use to hold plans accountable for providing quality health care and bring about improvements in plan performance. The four purchasers generally used a combination of collaborative- and compliance-oriented approaches. The collaborative approach, based on a "quality partnering" philosophy, is characterized by a close and informal relationship between purchaser and plan staff, frequent discussions about progress made against performance goals and benchmarks, and jointly developed plans for performance improvement. The compliance approach is characterized by techniques such as the establishment of specific and quantifiable performance standards, periodic assessment of plan performance against the standards, and financial penalties for failure to meet the standards.

Each of the four purchasers were able to identify results achieved from both approaches, including projects to streamline member access to specialty care and improvements in employee satisfaction and cost savings. While each purchaser tended to use a blend of both approaches—working collaboratively with plans to improve performance while holding the same plans accountable against contractual standards and penalizing them if they do not meet these standards—all four cited the importance of close interaction with plans to influence changes in behavior and said that close and continuous interaction is easier when dealing with a small number of plans.

Collaborative Approach Triggers Changes at Health Plans

In employing a collaborative approach, several purchasers we visited used quality-related data to highlight problems for discussion with health plans. These discussions then triggered actions for improvement at an individual plan or resulted in the dissemination of best practices at various plans. Results achieved through this approach included the creation of a provider directory to assist employees in accessing care, the development of joint projects between purchasers and health plans to enhance ease of referrals to specialists and to educate employees with diabetes, and streamlining of procedures for complaints and grievances.

One purchaser, for example, has been working closely with plans to improve in areas related to customer service and referrals to specialists. The purchaser identified problems in these areas using an employee satisfaction survey, employee complaints, and feedback from employee committees established to improve communications between the purchaser and employees. For example, approximately 20 percent of employees surveyed were very dissatisfied with the procedures for changing primary care physicians. The purchaser discussed these problems with the health plan during a site visit. One month later, the plan distributed listings of primary care physicians and specialists, including their hospital affiliation. The plan also committed to meet weekly with the purchaser to continue discussing the purchaser's concerns.

Another purchaser began a joint activity with a health plan after analyzing data from the purchaser's open enrollment survey and a member satisfaction survey. Results of the survey revealed, among other items, that only 55 percent of employees were satisfied with ease of referral to a specialist. In response to these concerns and the plan's own satisfaction data, the purchaser and one of its health plans designed a specialist referral project to streamline member access to specialty care. Telephone

surveys and focus groups were conducted with four provider groups and members receiving services from those groups to evaluate the impact of this project. All parties—providers, the purchaser, the plan, and member representatives—are currently meeting with provider groups to design solutions to member and physician concerns.

The first purchaser also addressed the issue of specialty referrals on the basis of data from a satisfaction survey. These data indicated that employees perceived specialty referrals as being too slow and too hard to get. In some cases, members had to wait for a review committee at the health plan to approve a referral to a specialist. The purchaser's analysis of satisfaction survey data, coupled with a health plan's own analysis, prompted the appointment of a task force to develop a referral system. The system developed by the health plan gives primary care physicians the authority to approve referrals on the spot.

This purchaser also collaborated with a health plan in developing a diabetes management program, designed to improve patient quality of life and to reduce emergency room visits. This program was developed in response to the prevalence of diabetes among employees and the purchaser's examination of quality-related data from HEDIS measures. After the purchaser initiated discussions with the health plan as part of its collaborative approach, the plan used its pharmacy database to identify diabetic employees of the purchaser. Employees recruited to participate in the program received educational materials on diabetes as well as the opportunity to participate in classes at various work sites. The plan subsequently surveyed participants to obtain information on their evaluation of materials provided and classes attended as well as outcome measures, such as perception of health status and diabetes-related quality-of-life measures.

The purchasers also used quality-related data to identify and disseminate best practices after holding discussions with a health plan. One of the four purchasers, for example, conducts annual visits at the various sites operated by the plan that serves most of the purchaser's employees nationwide. During these visits, the purchaser and plan managers evaluate plan policies and procedures, review HEDIS data, conduct clinical audits, and analyze satisfaction survey data. At one site, the purchaser's staff identified what they viewed as an exceptional process for handling appeals. After they suggested that this site share its process with other sites managed by the health plan, the process was implemented in other locations.

Compliance-Oriented Approach Holds Health Plans Accountable

Purchasers have also achieved results by using quality-related data to assess plan compliance with established contractual standards and to discipline or reward plan performance. After applying financial penalties, one purchaser said it achieved improvements in employee satisfaction. This purchaser also documented that it used HEDIS data as part of the rate negotiation process. Through this process, the purchaser communicated its unwillingness to accept higher rate increases from plans that had not performed as well as others.

Purchasers often held health plans accountable against contractually specified standards to meet the purchasers' goals. For example, one purchaser developed standards to meet its goal of enhancing the value of health care services delivered to its members by the year 2000. Purchaser standards measuring performance included timeliness of identification card issuance, evidence of coverage booklet distribution, speed of written responses, and average time for the telephone to be answered by a person and telephone abandonment rates. In the case of one plan, its performance deteriorated over 2 quarters on two specific standards: having a plan representative answer the telephone within 35 seconds after a caller opted to speak with the representative and a telephone abandonment rate of less than 5 percent.[11] As a result, the purchaser sent a letter to the plan requesting that it explain its poor performance and outline its corrective action. The plan was also asked to send continuing commentary on performance in these areas when submitting its quarterly results on required performance measures. The plan responded by consolidating the management of its member services and by improving the capability of its database and has since improved its performance. Other standards developed by purchasers to address areas of particular concern included identification card accuracy, appeal and grievance turnaround times, timeliness of data submissions, and physician turnover.

Two purchasers imposed financial penalties when specific contractual standards described in the contract were not met. The standards selected described, among other items, specific purchaser expectations related to the plans' ability to maintain or improve access and employee satisfaction. Purchasers also used the rate negotiation process to reward or penalize plans for their performance.

Since its 1994 move into managed care, one purchaser has required the five health plans covering a majority of its enrolled population to meet

[11]A telephone call is considered abandoned when a caller hangs up after requesting to speak with a customer representative but before the representative answers.

standards in the areas of appeals and grievances; customer service, including member satisfaction, call abandonment rate, and telephone response rate; and data reporting, including accuracy and timeliness. These standards are specified in a partnership agreement. The success of individual health plans at meeting these standards is subsequently captured in a purchaser scorecard on individual plan performance. A distinctive feature of this scorecard is a subjective, collective assessment by health benefits staff of how well plans respond to purchaser demands. If the standards are not met, this purchaser assesses a financial penalty equal to a designated small percentage of total revenues under the contract. According to the purchaser and health plans, this minor penalty has helped effect changes in the behavior of health plans, since they generally wish to avoid the embarrassment of a penalty.

This purchaser annually evaluates health plan performance with regard to how well the purchaser's staff thinks the plan responds to these and other concerns. The purchaser's staff base their ratings on their interaction with plan staff during weekly meetings. For example, for 1995, one plan was penalized about $9,000 because the purchaser was dissatisfied with, among other issues, its responsiveness to purchaser concerns. For 1996, the purchaser found the plan to be more responsive and no penalties were levied for the plan's failing to meet this performance standard. However, during the same 1995 to 1996 time period, the purchaser staff continued to be dissatisfied with the plan's commitment to customer service. For 1995, it was penalized approximately $6,000, and for 1996, it was penalized about $7,000.

Another purchaser also attributed improvements in quality to the use of financial penalties. As an example, this purchaser established a contract standard requiring plans to maintain an 85-percent satisfaction rate among its employees. Data submitted for the plan's midyear review showed that its rate fell from 91 to 84 percent. When the plan investigated, it found that the purchaser's employees felt plan providers lacked empathy. The plan instituted training for the providers. Six months later, employee satisfaction had risen to 93 percent.

Another tool used by purchasers to evaluate health plans at the end of a period is the annual contract renewal and rate negotiation process. Purchasers can use quality-related data to reward or penalize plans as part of this process and, as a result, believe that they are improving the value of their health care purchasing decisions. Officials at one purchaser said they were able to improve the quality of health care while holding the line on

costs because the purchaser's rates are based in part on rewarding health plans for high performance.

Beginning in 1996, another purchaser began to target plans that proposed rate increases but had low overall HEDIS scores for further conversation.[12] According to the consultant hired by the purchaser, the first year this strategy was used, four targeted managed care plans had proposed a 2-percent increase in premiums. After rate negotiations, the premiums decreased by 7 percent. For the next year, 21 targeted plans had proposed a 6-percent increase. A 4-percent decrease was achieved through rate negotiations. The purchaser attributes the premium decreases to the use of HEDIS data in negotiations in addition to the analysis of administrative fees, average charge per member per month, and a comparison with similar plans in the same geographic area and with their regional claims experience. The purchaser is currently studying the relationship between the cost savings achieved through rate negotiations and quality of care.

Purchasers Share Quality Data With Employees

In addition to taking actions to elicit changes at health plans, purchasers can also use data about quality to help employees make informed choices in selecting plans. Report cards provide the results of cost and quality indicators, as well as other descriptive information, comparing the performance of competing health plans. Some believe that as consumers become better informed and decide not to select health plans of lesser quality, such plans may be motivated to initiate improvements in the quality of care they provide. Research on report cards indicates that these formats are continuing to evolve as a way of presenting quality-related data. We found that of the two purchasers using report cards, one purchaser surveyed employees and concluded that employees found the information useful. The other saw only a modest increase in employee selection of the plan with the highest quality ranking in the report card.[13]

One purchaser that disseminated information to employees collaborated with the magazine Health Pages to report information about the quality of health plans the purchaser offered to its employees. Information in this magazine included general descriptions of the plans; characteristics of the plans; physician and hospital networks; information about preventive care,

[12]This purchaser contracts with over 40 managed care plans.

[13]For the purchasers that did not disseminate information, one concluded that it had exercised sufficient care in health plan selection and did not need to disseminate quality-related information to its employees. The other purchaser decided not to disseminate HEDIS information because of concerns about the reliability of self-reported data by health plans.

such as the rates at which plans administer childhood immunizations or perform cholesterol screenings; and satisfaction ratings. The other purchaser that disseminated information to its employees produced and distributed its own report cards comparing offered health plans during the open enrollment period. For example, one report card gave prospective enrollees comparative information on HEDIS measures in three areas: preventive health services (childhood immunizations and cholesterol screening), women's preventive health (prenatal care and pap smear and mammographies), and care for chronic illness (diabetic eye examinations). The report cards used by each purchaser also contained narrative material explaining the importance of such measures.

The purchasers using report cards to educate employees as part of the enrollment process saw some initial results from their decision to disseminate comparative information. For example, from an employee survey intended to assess the effect of its first report card on enrollment behavior, one purchaser found that 66 percent of those responding viewed the purchaser's report card as very or somewhat important in assisting members in selecting their plan.[14] The purchaser did not use a survey to assess the effect of its second report card; however, they did examine several hundred write-in responses returned on an enclosed tear-out sheet. The most frequent employee recommendation for future report cards was to include more data about the quality of each plan. Members also recommended providing (1) easy-to-read comparisons, such as those found in Consumer Reports; (2) feedback from existing or previous plan members; and (3) information on complaints filed against physicians or hospitals. A subsequent report card reflected the first two recommendations. This report card also contained information based on most frequently asked questions in such areas as administrative policies, prescription drugs, disenrollment statistics, type of physician specialties offered in the plan, and NCQA accreditation status. The purchaser has not evaluated if employees moved into health plans on the basis of report card information.

The other purchaser assessed the effect of providing employees with comparative information by examining the extent to which enrollees actually shifted into the plan with the highest quality ranking. The purchaser concluded that a modest shift had occurred. The purchaser

[14]However, an almost equally high percentage of respondents (63.9 percent) also cited recommendations of friends, coworkers, and family members as important sources of information in their decisionmaking process. The response rate to this survey was less than 50 percent (7,990 of 16,762 surveyed).

subsequently froze enrollment in plans with continuing quality problems and saw a more significant shift as a result.

Where Purchasers Are Headed With Quality Data

To achieve greater results from the use of quality-related data in the future, the purchasers we visited see future opportunities to rely on such data for selecting and monitoring the performance of health plans, rewarding or penalizing plans through rate negotiations, as well as informing and educating their employees. They have already begun or are planning to use quality-related data to (1) discriminate among and contract with fewer plans to make quality oversight and monitoring efforts more effective; (2) decide whether to renew contracts with plans; (3) translate performance goals into contractual standards; (4) present multiple types of data to health plans through combined formats, known as scorecards; and (5) negotiate rates with and provide financial incentives to employees to choose plans with higher quality rankings.

The purchasers we visited are also beginning to use quality-related data to more closely focus their efforts on issues of particular concern to them, such as provider and health plan relationships. Despite concerns over existing measures, several purchasers plan to make greater use of HEDIS measures. Another approach to care has been taken by a national purchasing coalition, which conducts in-depth reviews of costly and seriously ill cases for their purchaser members as part of ensuring health plan quality.

Health Plan Selection

Purchasers intend to make various changes in how they select health plans in the future. For example, one purchaser first focused use of quality-related data to select plans in areas where its employees are geographically concentrated. This purchaser now plans to begin using such data in selecting plans in areas with fewer employees. Other purchasers would like to use quality-related data to contract with fewer plans to make quality oversight and monitoring efforts more effective and cost efficient and to eliminate poorly performing health plans that are unable to demonstrate improvement. For some purchasers, quality-related data have not been sufficiently reliable and valid for decisionmaking. However, once these concerns are resolved, several purchasers may move to use quality-related data as a basis for not renewing contracts with poorly performing plans. Contracting with fewer plans may mean that the purchaser does not need to expend as many resources for monitoring.

Performance Monitoring

Purchasers see numerous ways to increase the use of quality-related data when monitoring health plan performance. Several purchasers we visited plan to develop new contractual standards to more effectively hold health plans accountable. For example, one purchaser plans to translate its existing performance goals into contractual standards. Originally, it had issued these goals with the expectation that health plans would continuously strive to address areas of importance to the purchaser regardless of whether the goals appeared in the contract. By translating performance goals into contractual standards, this purchaser hopes health plan accountability will improve.

For another purchaser, if a plan's general satisfaction performance falls below a certain level, the health plan becomes a candidate for quality improvement dialogues and may be selected for more in-depth surveys or reviews of employee satisfaction. This purchaser, which has had multiple measurement initiatives, also plans to analyze satisfaction, HEDIS, and other measures that need to be consolidated to create an overall scorecard—an approach already taken by another purchaser we visited. By assigning weights to various indicators of performance—including financial, clinical, and customer service—purchasers can give health plans an overall quality index score and present the results in a quality assessment instrument, or scorecard. The advantage of this approach is that multiple sources of information can be presented in a comprehensive format, which can be used by purchasers to discuss health plan performance. Intended to reflect an employer's specific health care benefits strategy, in some cases, these scorecards can be associated with rewards for good performance and incentives for improving poor performance. A purchaser other than the four we visited, for example, will use its scorecard to reward those plans that have performed well with incentive payments and give plans with low scores the opportunity to improve over a reasonable time frame. However, if such plans do not improve their performance, they could risk losing this company's business.

Rate Negotiations

The four purchasers we visited all recognize the need to incorporate additional performance and quality measures into the annual contract renewal and rate negotiation process. As explained by two purchasers, future negotiations of rates with health plans must achieve a balance between cost and quality. For these purchasers, a focus on costs to the exclusion of quality will result in a decline in the overall value of care. One purchaser plans to incorporate results of its health plan performance scorecard into rate negotiations.

Report Cards

As data improve, purchasers plan to improve their report cards that compare plan quality. Both our study and the Watson Wyatt/WBGH survey have found increasing use of these reports by large purchasers. We have reported that many purchasers are moving toward greater use of report cards and that others plan to do so in the near future.[15] According to the Watson Wyatt/WBGH survey, 33 percent of large purchasers give their employees information about accreditation status and 26 percent give their employees HEDIS information. While many purchasers are moving toward using report cards, there are concerns about performance reports, such as the reliability and validity of data, the need for more readily available and standardized information, and a greater emphasis on outcome measures.[16]

Preferred Pricing

One purchaser that published a report on plans for employees has not seen desired movement to the most highly ranked plan. Therefore, it intends to implement preferred pricing to encourage employees to move to more highly ranked plans by setting lower employee premiums for these plans. In the meantime, this purchaser froze enrollment in one plan, which had continuing quality problems. According to the Watson Wyatt/WBGH survey, 32 percent of the large purchasers who responded to the survey offered some type of financial incentive to employees to choose plans deemed to be of exceptional quality by the purchaser. This technique also rewards plans designated by a purchaser as being of high quality because it encourages enrollment in these plans. One purchaser that we did not visit attributes desirable results to preferred pricing. The purchaser ranked performance in eight selected quality categories for managed care plans and disseminated this information as part of a medical plan guide during the annual health care and benefits enrollment process. The purchaser claims significant enrollment increases in top-rated plans and decreases for below-average plans. According to a purchaser official, its efforts to reward workers for selecting good plans led to an almost 13-percent increase in enrollment for these plans.

[15]Health Insurance: Management Strategies Used by Large Employers to Control Costs (GAO/HEHS-97-71, May 6, 1997). Our review of large purchasers found that about half of the purchasers in our sample currently provide employees a report card on the HMOs that they offer, and others were planning to do so. These report cards focused on the results of employee satisfaction surveys and, to a lesser extent, health plan performance in delivering HEDIS preventive services, such as immunizations or cancer screenings.

[16]Health Care: Employers and Individual Consumers Want Additional Information on Quality (GAO/HEHS-95-201, Sept. 29, 1995).

Provider Issues

In considering the next step in the use of quality-related data, some purchasers plan to move from a focus on health plan quality to exploring the use of data related to provider quality. Two purchasers plan initiatives based on the use of satisfaction data to identify problems with specialist physician referrals. One purchaser, for example, will launch an initiative to collect quality-related data on providers and to later issue report cards on provider performance. In addition, this purchaser has begun conversations with providers to gain a better understanding of how health plans and providers could relate more effectively. The purchaser hopes to develop an approach that will financially reward health plans for prompting desired changes in provider behavior.

HEDIS Measures

The purchasers that we visited told us that they plan to make more use of data from HEDIS and other measures as they become available. One purchaser noted that NCQA's database of managed health care information, Quality Compass, will be helpful in producing user-friendly reports for employers. Quality Compass contains performance, accreditation, and patient satisfaction information from more than 300 managed health care plans throughout the United States.

In general, purchasers appear to have mixed views on the use of HEDIS measures. We have found that some purchasers are reluctant to disseminate information on HEDIS measures to their employees.[17] Purchasers have expressed concerns over self-reported data that are not independently audited, and a recent study notes that many health plans are struggling to provide data on all of the measures and some fail to produce any data.[18] However, NCQA recently announced that it will certify organizations to perform audits of HEDIS data. This may further improve the quality of data that purchasers receive from health plans.

Purchasers other than those we visited appear to have made much more extensive use of HEDIS measures. They use the data to select plans, monitor changes in performance over time, and establish benchmarks and minimum standards. According to one study, many work with their health plans to identify best practices and develop strategies for quality

[17]GAO/HEHS-97-71, May 6, 1997.

[18]Jack Meyer and others, Theory and Reality of Value-Based Purchasing.

improvement. Also, some companies have incorporated performance on HEDIS measures as part of their pricing strategies.[19]

The purchasers we visited plan to continue making use of HEDIS and other quality-related measures as they are refined and new ones become available. In contrast, a national purchasing coalition does not rely exclusively on existing quality-related measures but rather uses medical audits to determine whether managed care plans have the systems in place to respond to and appropriately manage patients with potentially serious and costly episodes of illness.

[19]Lise Rybowski, Putting HEDIS to Work: Employer Initiatives to Promote Quality in Health Care (Washington, D.C.: Employers' Managed Health Care Association, 1996).

Opportunities for HCFA to Benefit From Purchasers' Experiences

Although the characteristics of the Medicare program have distinguished it from other purchasers and shaped HCFA's major strategies for ensuring quality care for beneficiaries enrolled in HMOs, the passage of the Balanced Budget Act of 1997 makes the experience of other purchasers more relevant to HCFA. This legislation gives the Medicare program authority to contract with new types of managed care plans and calls for the program to provide quality-related and other comparative data to beneficiaries to promote a more informed selection of health plans. It is expected to result in more plans contracting with the program and more beneficiaries enrolling in plans. The legislation also requires managed care plans to take action to improve quality of care. As a result, HCFA will now begin to look more like purchasers that enroll most of their employees in managed care and those that provide comparative information on health plans to their employees as well as use quality-related data to prompt health plans to improve their performance.

The experiences of purchasers we visited have implications for HCFA in three ways: (1) educating beneficiaries as to the meaning of quality-related measures when providing comparative information on health plan quality; (2) interacting with health plans to take action, either through a collaborative- or a compliance-oriented approach, when problems with health plan performance are surfaced by quality-related data; and (3) continually looking for additional opportunities to make use of quality-related data.

HCFA Is Unique as a Purchaser

Perhaps the most striking difference between HCFA and other purchasers has to do with the enormity of HCFA's presence in the marketplace. Although HCFA is the nation's largest purchaser of health care, only a small percentage of Medicare beneficiaries have decided to enroll in HMOs, although this number has been rising sharply in recent years. Nevertheless, the sheer number of Medicare beneficiaries in managed care far exceeds the number of employees who would be enrolled in managed care by a private company. The purchasers we visited now enroll most of their employees in managed care health plans. The largest purchaser we visited serves 1 million people, while HCFA in its Medicare managed care program currently serves over 5.5 million beneficiaries, with potentially many more expected according to CBO estimates.

HCFA also differs from other purchasers in the freedom of choice enjoyed by Medicare beneficiaries who have had far more latitude in selecting options for health care than others. Much of the privately insured

population under 65 only has access to those health plans selected by their employer, and in many cases, the employer just chooses one plan. They also only have the option to enroll or disenroll during a specified "open season." In contrast, Medicare beneficiaries have been able to select any of the Medicare-approved HMOs in their area and may switch plans monthly or choose the fee-for-service program. HMOs have been able to market their plans to Medicare beneficiaries throughout the year, not only during the required 30-day open enrollment period.

The structure of the Medicare program, unlike private sector care, is determined by law and regulation. Any eligible health plan that agrees to meet minimum standards may participate in the Medicare program. In contrast, private sector purchasers can engage in "selective contracting" to select plans with lower costs and to use quality-related and other data in their selection decisions. As a result, they can exclude plans as part of the selection process. In contrast, HCFA does not have the flexibility of refusing to contract with plans that meet its minimum standards. In markets such as Los Angeles, HCFA contracts with 14 health plans; other large purchasers in that area contract with a smaller number of plans and claim that contracting with fewer plans enhances a purchaser's ability to more effectively oversee the quality of health plan performance. While other purchasers have more flexibility than HCFA in selecting plans, Medicare HMO beneficiaries in certain parts of the country have the ability to choose among more managed care plans than may be available to employees.

HCFA also differs from other purchasers in how HMO prices are set. Other purchasers can negotiate rates with health plans on the basis of performance measured against preestablished standards. In contrast, Medicare HMO rates are determined by statutory formula, which does not allow the flexibility of negotiation.[20]

Like other purchasers, HCFA monitors HMO performance but does so according to law. Its two principal strategies are its HMO monitoring program and review by peer review organizations. The monitoring program implements requirements ranging from financial solvency requirements to grievance procedures. After a Medicare contract is awarded, HCFA regional staff have the responsibility of monitoring HMOs against federal statutory and regulatory requirements as part of on-site biennial reviews. HCFA is also required to contract with peer review organizations, also known as quality improvement organizations, which

[20]The Balanced Budget Act of 1997 establishes a competitive pricing demonstration to begin in 1999. However, this project is temporary and limited to a specified number of geographic areas.

are physician organizations in each state that review HMO quality of care. In the past, these organizations attempted to determine instances of poor care through medical record reviews. In recent years, quality improvement organizations and plans have begun to conduct quality improvement projects in different clinical areas. For example, in one project, quality-related measures have been used to collect information, provide feedback to plans on their performance, and design interventions to improve the quality of care in outpatient diabetes management.

Purchaser Experiences Will Have Increased Relevance for HCFA

A goal of title IV of the Balanced Budget Act is to encourage Medicare beneficiaries to enroll in managed care health plans. CBO estimates suggest that HCFA's presence as a purchaser of managed care will become even more pronounced than at present and that HCFA will need to become more active in its oversight functions. In this regard, the information the purchasers provide employees and purchasers' monitoring experiences are especially relevant.

The Balanced Budget Act establishes specific time frames for HCFA to meet in providing beneficiaries comparative information on covered benefits, premiums, and quality and performance of managed care plans to guide their enrollment decisions. Although HCFA had the authority to provide beneficiaries with such information prior to the act, past work by GAO found that HCFA was not doing so and recommended that HCFA help elderly consumers choose among competing Medicare HMOs by distributing comparative information on HMOs.[21]

According to HCFA, the agency had already begun to move in this direction prior to the passage of the Balanced Budget Act. The new legislation, however, not only establishes specific time frames for HCFA to meet but also couples the provision of comparative information with an annual open enrollment season. By the year 2002, with limited exceptions, Medicare beneficiaries who enroll in a health plan will only be able to enroll in another plan during periodic coordinated open enrollment seasons, whereas at present they can switch at any time.[22] The reduced ability of Medicare HMO enrollees to freely change plans places an additional responsibility on HCFA for ensuring the quality of care that HMO enrollees receive.

[21]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

[22]From 1998 through 2001, Medicare beneficiaries can continue to enroll, if the plan is open to new enrollees, or disenroll on a monthly basis.

Purchasers have had a variety of experiences in distributing comparative information on health plans to their employees. One purchaser we visited surveyed employees on its report card and concluded that employees found the information to be useful. The purchaser later used feedback from employees to modify the report card and enhance its usefulness. The effect of the report cards, however, is not yet clear. For example, another purchaser found only a modest shift of employees into the plan with the highest quality ranking and decided to encourage changes in employee behavior by freezing enrollment in plans with continuing quality problems. In designing these report cards, both purchasers provided explanatory material so that employees would be able to better understand the meaning of the measures employed.

These experiences by purchasers are relevant to HCFA. Not only do they provide comparative information to their employees, but in using feedback from employee surveys and by assessing the impact of such information on employee behavior, purchasers demonstrate that they continually review the value and utility of the information they present to their employees. For HCFA, this implies continual monitoring of how consumer information is used. Other lessons for HCFA relate to the need for purchasers to educate employees on the meaning of the measures contained in the report card and how to interpret these measures when deciding between health plans.

In addition to providing quality-related data to employees, purchasers also provided this information to plans and expected the plans to take action on the basis of this information. The Balanced Budget Act provides a more explicit listing of required elements for plan quality assurance programs than had been required before. These elements include requirements for plans to take action to improve quality and assess the effectiveness of such action through systematic follow-up. In relation to this requirement, HCFA is considering how to use standardized measures to prompt quality improvement activities. Elements of this approach have already been present in collaborative projects between quality improvement organizations and health plans.

Again, the experience of the four purchasers we visited can inform how HCFA addresses the quality assurance provisions in the Balanced Budget Act. The four we visited did not simply provide health plans with data from HEDIS measures, satisfaction surveys, and other sources of information. They also met and took follow-up steps to ensure the plans were taking action to improve health plan performance and achieve what

they described to us as promising results. In addition, some purchasers used the information to penalize plans that were not meeting their standards. For example, one purchaser alerted employees to problems in health plan performance by freezing enrollments in a plan that had performance problems.

Purchasers emphasized the importance of interaction with plans and of blending techniques from two purchasing philosophies—one oriented toward quality partnering and the other toward ensuring compliance with standards set by the purchaser. In the same way that purchasers refine the information provided to employees, they continue to reevaluate the ways in which they provide information to health plans on their performance.

While HCFA can examine how other purchasers use quality-related data in some areas, it would need new legislative authority to implement other purchaser practices in using quality-related data.[23] These include the use of quality-related data to selectively contract and negotiate rates with health plans.

[23]"Health Care Purchasing Strategies," Internal HCFA Report (Dec. 1996).

Descriptions of the Purchasers GAO Visited

Tables I.1 through I.4 provide brief descriptions—including number covered, enrollee locations, purchaser goals, and managed care experience—of the large corporate purchasers we visited as well as the purchasers' quality strategies.

Table I.1: Brief Description of Johnson & Johnson (J&J)

Number of covered lives	72,000
Primary location of enrollees	California, Florida, New Jersey, and Texas
Health care purchasing goals	— Reduce the rate of increase in health care costs. — Offer employees a choice of quality medical plan options. — Ensure provider choice and access. — Ensure plan quality and employee satisfaction.
Experience with managed care	J&J first offered a managed care point-of-service option to its employees in 1995; it had previously offered a traditional indemnity option along with HMOs. By 1997, nearly 80 percent of the company's enrollees were covered by self-funded managed care health plans, including point-of-service and HMO options. J&J also contracts with fully insured HMOs in areas of the country with fewer employees and maintains its traditional indemnity plan.
History of quality strategy	J&J initially focused on selecting and monitoring plans that enrolled a majority of employees. J&J also required health plan account representatives to attend a training and orientation program. J&J assesses financial penalties when expectations are not met according to a performance scorecard. J&J also analyzes individual complaints to determine whether they are symptoms of an underlying, systemwide problem and demands documentation from health plans on how complaints are resolved.
Future plans	J&J plans to extend monitoring efforts by collecting more quality-related data on fully insured HMOs, use multiple sources of data in a balanced scorecard format, drop health plans for poor performance based on data, gauge enrollee satisfaction by reviewing enrollment trends, and develop a methodology for independent verification of quality-related and other performance data.

Table I.2: Brief Description of Federal Express (FedEx)

Number of covered lives	120,000
Primary location of enrollees	California, Florida, Illinois, Indiana, New Jersey, New York, Tennessee, and Texas
Health care purchasing goals	Improve value and provide employees with a choice of plans and providers.
Experience with managed care	In 1982, FedEx offered the first "local HMO" (an HMO serving a limited geographic area) in the New York area. Between 1984 and 1991, the company launched 46 local HMOs. Additional options were rolled out by market; California-based employees offered a self-funded POS/HMO option in 1993 with the same option extended in 1994 to employees in other locations. By 1997, about 78 percent of employees were enrolled in one of three managed care options: a self-funded POS/HMO, a basic preferred provider organization, or a fully insured local HMO; the remaining 20 percent were still enrolled in the basic indemnity plan.
History of quality strategy	FedEx established preferred pricing for its national plan and has worked extensively with a consultant to collect and analyze first utilization data. More recently, FedEx has used HEDIS data and provided feedback in "dialogues" if plans scored poorly either due to low HEDIS scores or incomplete data submissions. FedEx was also an early participant in the areawide business coalition that acheived improvements in quality at area hospitals.
Future plans	After achieving success in cost control through managed care, FedEx has reorganized its benefits function in a step to improve measurement and improvement of quality at health plans. FedEx plans to communicate more quality-related data to employees (with an emphasis on satisfaction data) and, through scorecards combining HEDIS and other types of quality-related data, provide consolidated feedback to plans.

Table I.3: Brief Description of Southern California Edison (SCE)

Number of covered lives	54,000
Primary location of enrollees	Arizona, California, and Nevada
Health care purchasing goals	— Manage costs. — Improve health plan quality and service. — Promote consumer education.
Experience with managed care	SCE introduced several HMOs in the mid-1970s and from 1989 to 1995 administered a self-insured PPO and acted as both purchaser and provider, with on-site doctors and clinics. In 1995, the PPO was replaced with seven plans offering standardized benefits. About 94 percent of the company's enrolled population is now covered by four health plans, three of which offer both a POS and HMO option.
History of quality strategy	SCE emphasizes a quality partnering approach, which it describes as relationship-driven, with continued refinement of its quality strategy over a 3-year period. Health plan site visits to discuss HEDIS, satisfaction survey results, complaints, report cards, and measurement of plan performance against the company's performance goals are a central tool of this strategy. SCE participates with a business coalition to administer a comprehensive member satisfaction survey and collaborates with other purchasers, health plans, and medical groups to obtain audited HEDIS data. SCE also uses report cards to present quality-related data to employees and holds meetings with consumer committees (representing employees, retirees, and union representatives) to discuss issues in health plan performance and emerging trends in the management of health care delivery.
Future plans	SCE plans to continue efforts to improve performance and accountability at the health plan, medical group, and provider levels and to communicate health plan and medical group quality indicators to plan participants. SCE may implement incentives to encourage enrollment in plans that are the highest performers.

Table I.4: Brief Description of California Public Employees' Retirement System (CalPERS)

Number of covered lives	1,000,000
Primary location of enrollees	California
Health care purchasing goals	— Ensure the availability of affordable, quality health care for all participants. — Provide leadership in health care purchasing and quality.
Experience with managed care	CalPERS has offered managed care since 1962. In 1989, its fee-for-service plans were consolidated into one PPO; in 1993, a second PPO product was introduced. Currently, 19 percent of covered lives are enrolled in PPOs and 81 percent in fully insured HMOs. In 1992, a standard benefit design was implemented to allow the purchaser and enrollees to make more meaningful comparisons of HMOs. The number of HMOs contracted has dropped from 23 to 10 due to changes in the health care industry, such as mergers; new plans will be added only if they cover previously unserved areas.
History of quality strategy	Successful cost containment efforts raised concerns over impact on quality care. CalPERS, however, found early efforts to measure quality were inhibited by lack of reliable, comparable data and characterizes its approach as "conservative and incremental." CalPERS distributed health plan report cards for the 1995, 1996, and 1997 benefit years, with the first presenting comparative HEDIS and satisfaction data; the second was expanded to provide survey results on why members changed health plans; and the third added answers to frequently asked questions by enrollees, including NCQA accreditation and other plan information. CalPERS participates with a business coalition in a comprehensive member satisfaction survey and collaborates with other purchasers, health plans, and medical groups to obtain audited HEDIS data.
Future plans	CalPERS plans to expand its use of report cards to include comparative disease management outcomes and complaint monitoring results. As data improve, CalPERS plans to increase its use of contractual quality standards and consider financial incentives for plans to improve.

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