

ISSUE BRIEF

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Health plans partner with purchasers in consumerism drive *Online tools are evolving to better answer cost, quality questions*

As consumer-directed health care expands its reach, health plans are partnering with employers and purchasers to improve consumer-oriented tools and structure benefits to drive consumers towards greater involvement in health care decision making.

A study released by Aon Consulting¹ tracks the growing trend among employers to offer HSA and HRA plans. The nationwide survey of 434 employers revealed that 28 percent currently offer a consumer-directed plan, up from 22 percent in 2005. The primary reason employers cited for offering the plans is to introduce consumerism into health care purchasing—a shift away from cost savings as the top purpose for choosing the new plans.

Consumer-oriented plans are still young upstarts in the larger health plan market, with plenty of opportunity to evolve and mature. Despite wide variation within the category, two words that will endure in their description will be *transparent* and *supportive*, said Vicky Gregg, chief executive officer of BlueCross BlueShield of Tennessee and a featured panelist at URAC's 7th Annual Quality Summit & Exhibit.

"The important thing to remember is that consumerism as we know it is going to change over time," Gregg said. "Today many people define consumerism as a consumer-directed health plan with an HSA and a checklist of tools to use. I don't know if consumerism is going to play out that way in the future."

Today's consumer-driven momentum is propelled by purchasers, who are leaning on health plans to help them introduce employees to a new mindset.

"When you look at the marketplace today, there's receptivity on the part of employers that consumers should have more skin in the game," Gregg said.

"We see a lot of demand from purchasers for ways to move in this direction. Most large groups we work with view this period as a transition and are asking us, 'what are the steps that take us towards a more consumer-directed plan?' But one of the key challenges we still face is the receptivity of the actual consumer."

Over the past thirty years, consumers have become accustomed to paying for only a small portion of

their health care—a way of thinking that won't change overnight.

"If you ask consumers what health care costs, most would tell you it's the cost of their co-payment," said John P. Weis, co-founder and chief executive officer of Quest Analytics, the software company that has linked with Health Grades, Inc. to provide a standardized method to measure and report quality outcome information on hospitals nationwide. Weis was a featured speaker at URAC's 6th Annual Quality Summit & Exhibit.

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Gregg acknowledges that health plans and purchasers bear some responsibility for the way consumers view health care as an entitlement. "We created a passive consumer," she said. "Changing that consumer mindset and getting consumers prepared to be engaged and take control of health care decision-making is a challenge."

Weis agreed. "It will take years of education and communication to



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get consumers to understand that the cost of health care is not a \$20 co-payment,” he said.

Regrettably, Weis said there is strong indication that consumerism now is focused primarily on cost, with little consideration for quality.

“Most consumers look at this as a way to save dollars on their health plan. I don’t think they’re switching to a high-deductible plan because they’re thinking, ‘I want to choose my providers based on quality.’ They’re choosing the plan because it’s less costly from the onset.”

“People don’t understand that higher quality in health care is going to cost less in the long run,” he added. “People think that high price equals high quality, like when they buy a car. But in many cases the reverse is true in health care. Some facilities have higher costs because they have more complications, higher mortality rates, longer length of stays—and that higher cost is going to translate into *lower* quality, not *better* quality.”

Providers not ready for prime time

Reluctance on the part of clinicians and hospitals to compete on the basis of quality is still a big gap on the road to greater consumer participation in health care. Health plans are often uncomfortably positioned between the demands of purchasers for more quality data and the desire of their own provider networks to keep the data private.

“Trying to work with the delivery system and increase its preparedness to deal with consumers

empowered to make choices is a challenge,” Gregg said. “Some of the challenge involves the technology infrastructure. Providers want to know how they can access information about what kind of plan an individual is enrolled in, and how they can affect outcomes in the way they’re going to be measured. Information is a big gap.”

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Many health plans are responding to purchaser demand for quality transparency by creating “high performance networks.” But the methodology health plans use to determine which provider qualifies for these networks is anything but transparent.

“How is that determination made? Is it by best discounts, or best outcomes for a list of particular procedures? Even if health plans made that quality information available to consumers, I don’t think consumers would understand the importance of the methodology they used,” Weis said.

The transparency challenge health plans suffer is tied to the push-back health plans feel from their network providers when quality information is divulged. “Health plans get pressure from the provider side, so they put information out there, but it’s not very useful,” Weis said. “It’s a

balancing act so they can provide some information to purchasers, but also so they don’t put off their providers.”

Weis’ company, Quest Analytics, works with consultants, health plans and large employers so they can directly compare quality outcomes across health plans on an apples-to-apples spreadsheet. Factors such as accessibility to providers in the plan network and quality outcomes by procedure are clearly comparable using the Quest Analytics tool.

“We started looking at tools that examine quality outcomes and saw a tremendous gap in being able to look at a health plan and being able to interpret which one fits the employer better from a quality standpoint,” Weis said. “Every health plan is going to say they have good quality providers in their network. What we do for the market is provide tools so the consultant or the health plan can respond to a purchaser with a report that shows a risk-adjusted comparison the same way across all the health plans in the report.”

Although the tool was developed to assist large purchasers and consultants, Weis said health plans are adopting the tool as well to use in contracting, network design and marketing. “Using our tool, they can demonstrate the strengths and weaknesses of their networks as compared to other health plans from an independent source, and clearly show the methodology. It gives them transparency from a neutral source.”

The data included in the Quest Analytics tool includes the Centers

for Medicare and Medicaid Services data set, plus data from the 19 states that currently release all payer data. Additional data is incorporated, where available, from AHRQ patient safety reports and Leapfrog Group measures.

Health plan as vendor, advisor and educator

Using publicly reported data is a solid first step to comparing quality outcomes, although consumer demand for more timely—and more extensive—data will likely follow.

“We talk about providing information to consumers about quality, but the reality we face is we don’t have the information flowing yet in ways to be able to have the kind of quality information you’d like to have in a perfect world,” Gregg said. “That doesn’t mean we don’t move forward with what we have, but we need to learn to reward providers in some ways for simply implementing processes to get there. Are they using health information technology? Are they using quality protocols? I think those are steps that will eventually lead us to that rich data base that gives us a clearer picture of quality, and will ultimately change the payments system to drive clinicians to do better work.”

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Gregg describes the transformation process as “a push-pull kind of strategy. We need push from the consumer in terms of benefit design and rewards to make decisions that are right for them, and the pull on the clinician side to reward them for

doing the things that will make the consumer part of the equation work.”

The role of the health plan in this environment is multi-faceted: vendor, advisor, and educator.

“What we see now is the employer asking us for advice,” Gregg said. “They want us to act as consultants to them as they try to navigate their strategy.” Gregg said health plans need to set expectations for purchasers that are realistic, but not set in stone. “We are entering a new phase, and our ability to predict outcomes is not as solid as it was with managed care,” she said. “Tolerance for risk-taking on the part of employers is going to be inherent in moving forward.”

Support for consumers via health plan tools

Consumerism has given rise to web-enabled tools health plans deliver directly to aid the decision-making process, at this time emphasizing cost differences.

In 2005, Aetna became the first large insurer in the Cincinnati area to reveal rates it negotiates with local physicians, and expanded that program in August 2006 to eight more areas. Other major insurers, including Cigna Corp., Humana Inc. and UnitedHealth Group Inc., are adding or expanding their own online pricing tools. State and local governments are also

providing more cost information: in June 2006, Medicare posted the ranges of what it pays hospitals for 30 common procedures and treatments. State governments and hospital associations are posting hospital charges via web

portals, including those in Florida, New Hampshire, Utah and New Mexico.²

Gregg said BlueCross BlueShield of Tennessee offers clients a web-based treatment cost estimator so consumers know what to expect for an entire episode of care among providers within their service area. An additional hospital cost tool ranks providers using a four-point scale, based on a common condition or procedure. “It gives you some sense of the price range for a particular institution, and we combine that with some quality information,” Gregg said.

BlueCross Blue Shield of Tennessee maintains a call center to walk consumers through use of its tools. Although the tools are available to enrollees in a variety of health plans, Gregg said the company has found consumer use of the tools is directly tied to the type of plan enrollees use: about 6 percent of enrollees are in a consumer-directed plan, and those are the consumers most likely to use the tools.

“The early adopters use the information to their benefit, and then word of mouth is going to lead other people to use that information, too,” Gregg said. “In the managed care world, we see a 10 percent tipping point for a trend to catch on. We may be getting closer to that point.”

More user-friendly, even user-prompted tools will accelerate consumer use.

“In the future, the real art is going to be taking the information and tailoring it to the individual,” Gregg said. “When I log on to Amazon.com, the web site begins to collect information about me as a consumer. It prompts

me, based on what it knows about me, to look at other things I would be interested in buying. The next generation of consumer support tools is going to do that: tools will take information based on your HRA and provide content for you—and, still using HRA data, give you that information formatted in the way you learn best.”

While many would argue that common and interoperable use of electronic medical records is the key to data mining and sophisticated consumer tools (à la Amazon.com), Weis notes that health plans on their own are lacking the impetus to develop those tools.

“It’s a two-way street,” he said. “Consumerism starts with education. Education about the importance of those tools first flows from the health plan to the employer, and then flows from the employer to the consumer.”

While health plans have a financial incentive to provide online provider directories and claims status tools (they reduce paperwork and call-center time, and thus reduce health plan costs), few are supplying provider quality comparison tools that are easy for consumers to access and to use.

“The challenge is trying to make those tools and that information easy to find and easy for the average consumer to use,” Weis said. “That’s where the market is going. Consumers want to know what provider is the best, or they want a ranking of best to worst—something easy to understand. At some point consumers will demand that this information is out there and easily available, and they will vote with their wallets.”

A first step to better online quality tools is to enhance the way health plan portals currently operate, he said.

“I see portals expanding to become more integrated decision support tools. Most consumers are used to going to a health plan’s website to type in a zip code and look for a doctor. Now that they’re comfortable looking for a provider based on proximity, there’s a way to integrate quality indicators at that same time by prompting the consumer with questions: ‘Would you like to know the immunization rates for this provider? Would you like to know who is a high quality provider, or is board certified?’ It’s a baby step approach, and it is something that needs to happen.”

“Standards will need to be in sync as the tools evolve. Early standards become a baseline, and every few years the bar is raised. As the sophistication is elevated, revised standards will drive us to do better and do more.”

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Accreditation is carrot to spur improvement

Organizations such as URAC are in a strategically significant position to steer health plans towards greater consumer empowerment.

“A health plan wants that gold accreditation star on its web site because employers who are making a benefits decision say that is a distinguishing factor,” Weis said. “Organizations such as URAC can really influence how a health plan should be exposing this information to consumers.”

“Standards help us drive our performance,” Gregg agreed. “My folks can tell me our consumer support tools are great, but then I can ask, ‘How do we compare, and do we meet the standards?’ That’s a far harder measure.”

BlueCross BlueShield of Tennessee now holds URAC accreditation in five programs, and is currently seeking Consumer Education and Support accreditation for its web-based consumer tools.

“Accreditation helps us from the standpoint of knowing what the standards are, what is considered to be state-of-the-art, so we can put the resources behind the organization to try to meet those standards,” Gregg said. “Resources are scarce, and as a leader you want to make sure you’re investing in the right things so I can hold people in my organization to them.”

In the rapidly evolving environment of consumer education and support, URAC accreditation needs to stay nimble and ready for change, she added.

“Standards will need to be in sync as the tools evolve. Early standards become a baseline, and every few years the bar is raised. As the sophistication is elevated, revised standards will drive us to do better and do more. URAC can be visionary in driving all of us to achieve what the standards will be, moving forward. From a health plan perspective, URAC accreditation should be viewed as a differentiator as long as it stays flexible and innovative.”



Vicky Gregg is president and chief executive officer of Chattanooga-based BlueCross BlueShield of Tennessee (BCBST), the largest health care provider in the state. Prior to becoming CEO, Gregg occupied several senior leadership positions in the company, including president and chief operating officer, executive vice president, and chief executive officer of Volunteer State Health Plan, the company's Medicaid HMO. Before joining BCBST, Gregg worked for a decade for Humana Health Plans, where, as vice president, she oversaw operations, strategic development, acquisition, and health plan service area expansion. A nurse by education, Gregg has more than 25 years' experience in diverse health care environments including clinical care, hospital administration, long term care, and health care benefits and financing.

In 2004, Senate Majority Leader Bill Frist (R-TN) appointed Gregg to the United States National Institutes of Health Commission on Systemic Interoperability, which was tasked with developing a strategy for building a nationwide electronic health records network. In 2006, Tennessee Governor Phil Bredesen appointed her to the newly-created E-health Advisory Council, a 16-member panel tasked with making recommendations for establishment of an interoperable health care data exchange in Tennessee. Gregg also currently serves on several national boards, including America's Health Insurance Plans (AHIP), the BlueCross BlueShield Association, the Council for Affordable Quality Healthcare (CAQHC), the National Institute for Health Care Management (NIHCM) Foundation, and she is a member of the Healthcare Leadership Council.

John P. Weis co-founded Quest Analytics in 2003 to bring standardized software tools to the market that measure and report quality outcome information for hospitals nationwide. Weis has spent nearly two decades working in the health care industry, providing technology solutions to help evaluate health plans and communicate provider information to consumers. Prior to forming Quest Analytics, Weis held senior management positions with GeoAccess, where he worked in business development, strategic product

direction, and sales and marketing. While at GeoAccess he led the initiative to offer online directory solutions to health plans, employers and benefits consulting outsourcing firms. Weis's thought leadership transformed the use of information tools online from finding a provider based on proximity to researching and choosing a provider with updated data combined with quality attributes. This resulted in hundreds of health plan, employer and benefits outsourcing provider search sites.

About URAC

URAC, an independent, non-profit organization, is a leader in promoting health care quality through accreditation and certification programs. URAC's standards keep pace with the rapid changes in the health care system, and provide a mark of distinction for health care organizations to demonstrate their

commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in setting meaningful standards for the health care industry. For more information, visit www.urac.org.

Resources

- [1] "More Employers Offer Consumer-Driven Health Plans to Employees, Says Aon Consulting and the International Society of Certified Employee Benefit Specialists," June 27, 2006. Online at http://www.aon.com/about/news/press_release/pr_004D83C3.jsp.
- [2] Rubenstein, Sarah. "Patients Get New Tools To Price Health Care." *Wall Street Journal* 13 June 2006.



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