Findings and Conclusions

Regional Health Care Quality Reform Initiatives

Agenda for Accountability

John D. Butler
Chair, Regional Health Care Quality Reform Initiatives
Executive Vice President, Administration
and Chief HR Officer
Textron, Inc.

August 2005

Contents

Chairman's Foreword

This document represents the initial work product of the Regional Health Care Quality Reform Initiatives Coalition.

The Coalition engaged in a feasibility study to determine whether large employers collaborating at the chief human resource officer level could achieve needed health market reforms by collaborating at the regional level on a continuing basis. In most major health care delivery market areas, HR Policy Association member companies collectively employ a substantial percentage (typically anywhere from 5 to 15 percent) of the workforce.

We knew from the beginning that changing long-established relationships among health plans, providers, and large employers beyond the comfort of the status quo would be challenging, and we were not disappointed. The original concept was to bring large purchasers together in a particular region to accelerate the measurement, reporting, and dissemination of health care provider quality and efficiency data while simultaneously expanding access to small employers priced out of the health care market. After a number of meetings, discussions, and considerable staff work over the past year and a half, there are clear lessons to be learned from this experience and tough choices to be made by the members of the HR Policy Association. It is clear that to achieve results at this level ultimately depends upon whether the purchasing community has the will at the highest levels of the companies to make the changes necessary to achieve them.

On the positive side, we were impressed with the number of reform initiatives being pursued by companies both individually and collectively, by employer associations and coalitions, and by consulting organizations, among others. These include such efforts as The Leapfrog Group, Bridges to Excellence, the Consumer-Purchaser Disclosure Project, National Business Group on Health, The National Quality Forum, and the regional work of such organizations as Pacific Business Group on Health, among others, along with various initiatives by the federal government. In the course of this study, we have had extensive interaction with companies and organizations in a number of regions, particularly Phoenix, Detroit (where the efforts include, among others, Ford, General Motors, Daimler-Chrysler, DTE, the Renaissance Group, and the Greater Detroit Area Health Council), Atlanta, and Peoria. In Phoenix, we have been fortunate to work with one of the nation's leading health care plans, CIGNA, which is working with employers in the area to establish a demonstration project for a collaborative effort to achieve greater transparency in health care provider performance, an essential element of health care market reform. This effort has expanded to include many other major national plans and employers.

From this experience, it is clear that where the work of organizations such as these can be brought into close alignment and where agendas are set and results demanded by those in senior corporate positions, the potential exists for significant market reforms.

In addition, however, the Coalition's work raised awareness of an issue more significant and more fundamental than our objective to give consumers greater insight into quality medical providers—a vacuum of leadership. First, everyone agrees that the status quo in health care is no longer acceptable and that continuing along the paths that purchasers, consumers,

and providers are now on will eventually trigger a political reaction and governmental mandates. However, to avoid this negative result, it will be necessary to overcome a high level of resistance to changing the status quo within each of these communities, including the purchasing community. The purchasing community wants significant reform, but is typically hesitant to embrace reform that includes dramatic changes in plan designs, subsidies, and vendors on a broad collective basis. If this resistance is not overcome, then the current untenable situation in health care is likely to continue to deteriorate even further.

Second, and most importantly, the key to achieving reform is through a more accountable process for developing and executing purchasing community initiatives.

This document, then, is a call to action to those in the senior leadership of their companies who are primarily responsible for health care, including the chief human resource officers (CHROs). Health care has been the number one concern of CHROs for the past several years and is likely to remain a priority concern for several years to come. However, until now, the prevailing model has been for senior executives to delegate involvement in collaborative efforts to those at a lower level within the company. Those individuals are critical to the success of such efforts but, without the involvement of key strategic decision-makers, there are limits to what they can accomplish. It is essential, therefore, that CHROs and other senior executives become much more involved in setting benchmarks for the purchase and delivery of health care on a broad collaborative basis, ensuring that those standards are followed, evaluating and ensuring the proper execution of market reform strategies, and creating a climate of accountability to minimize turf wars and focus all players on the consensus objectives. The symptoms of the health care crisis are very well chronicled by dozens of health care experts, health care organizations, and think tanks, among others. The ultimate solution lies in setting a vision for the purchasing community, reaching consensus on objectives, and executing a collaborative strategy. This can only be achieved by the direct involvement of those at the highest levels among purchasers.

This document is intended to make the case for an Agenda for Accountability. In most of our member corporations, the chief human resource officer is among those responsible for authorizing what becomes, in the aggregate across the Association, billions of dollars in terms of health care expenditures. The report suggests that these individuals are the ones who have the authority to bring discussions to a close, reach consensus with their peers on which initiatives have merit, and drive execution. At the same time, the health care market reform movement is searching for leadership and those willing to invest the time to perform these important functions. This document makes a series of suggestions regarding how an Agenda for Accountability could be realized. The document also contains background information on how the Coalition was formed, a brief discussion of the failings of the current model of health insurance that is driving double-digit health care cost trend rates, and a discussion of the elements needed by CHROs to pursue transformational health care market reforms at both the regional and national level.

Meanwhile, it is important that we not lose sight of the importance of maintaining a national perspective as well. The reality is that, while change is often a great deal more achievable at the local level, the broad structure of our health care system—currently an employment-based model—will still likely be a national paradigm, enormously influenced by how federal dollars are collected and spent. For this reason, it is of equal importance that chief human resource officers play a role at that level as well. That involvement ought not be simply reactive. Rather, it should entail the shaping of a vision of the ideal future role of employers in the health care system with the formulation and promotion of federal policies that achieve that ideal.

Thus, we are recommending a set of contracting principles which, if collectively embraced and implemented by the HR Policy Association membership, would drive system-wide health care market reform to an unprecedented degree. These were developed by our Task Force on Contracting for the Future, after receiving significant input from a number of leading health care plans, consulting organizations, and reform organizations. We are also recommending the development and endorsement of a common health plan RFP/RFI, as well as common contract language, to help implement these reforms.

As a participant in this project, we appreciate your support of our Feasibility Study, and we encourage you to consider the recommendations that it makes. We also believe that all members of the HR Policy Association stand to benefit significantly from the work that you have funded, and this document will be distributed to each member of our organization. If, after reviewing the commentary herein, the reader is not convinced of the significant need for change in terms of the way health care issues are dealt with by his or her company, then we will have not achieved our objective.

John D. Butler
Chair, Regional Health Care Quality Reform Initiatives
Executive Vice President, Administration & Chief HR Officer
Textron Inc.

Background Information

The Regional Health Care Quality Reform Initiatives Coalition was created by the Health Care Policy Roundtable of the HR Policy Association. The Association represents the chief human resource officers of more than 250 large employers doing business in the United States. The majority of Association members are purchasers of health care, although the membership also includes major hospital chains, health care insurance carriers, and pharmaceutical manufacturers.

The number one concern among HR Policy members is the unsustainable increases in health care costs and deficiencies in health care quality that threaten the viability of the nation's employment-based health insurance system.

In 2003, the HR Policy Association Board of Directors created the Health Care Policy Roundtable to take decisive action using the collective influence of America's largest private employers to address health care cost and quality issues that plague both private employers and government payers. Chaired by J. Randall MacDonald, Senior Vice President of Human Resources for IBM, the Roundtable is composed of the chief human resource officers from a broad cross section of American industry's largest employers. Its strategies are premised on the recognition that HR Policy member companies, which employ more than 20 million employees worldwide, can use their collective buying power to leverage health care market reforms within existing public policies. In turn, these reforms may provide guidance to policymakers in addressing needed changes in U.S. health care policy. The Regional Health Care Quality Reform Initiatives Coalition, chaired by John D. Butler, Executive Vice President, Administration and Chief HR Officer of Textron, Inc., is a critical component of the Roundtable's reform agenda.

Since its inception, the Health Care Policy Roundtable has operated under the premise that the status quo for both purchasers and providers of health care services is unacceptable. The United States spends significantly more on health care, both in terms of dollars per capita and a percentage of gross domestic product, than any of our trading partners, yet it is difficult to make the case that sufficient value is being derived to justify the enormous cost. At the same time it is the private sector that bears the financial burden for this difference with our trading partners, and for that we suffer the competitive consequences. Health care purchasers face double-digit increases each year with no sign of a decline in costs or more manageable inflation in the foreseeable future. As such, health care is crippling America competitively and draining our federal budget.

Of equally great concern, even the huge resources we plow into our health care system do not provide access and high quality care for all. It is estimated that 45 million Americans are without health insurance coverage, an issue that if not adequately addressed will eventually lead to a federal/state takeover of health care and the loss of our employment-based system of health delivery. Simply layering our existing, opaque, health care system across 45 million uninsured Americans is not the solution. This would increase overall cost without addressing the systemic flaws in our health care system. In order to provide affordable coverage and access for today's uninsured, we need to work towards meaningful system reform.

In addition to a coverage gap, there is a serious quality gap that is discussed thoroughly throughout this document. A fundamental component of the solution to these quality

deficiencies lies in greater transparency and disclosure about cost and quality throughout the system, and engaging consumers who have a stake in the financial as well as clinical outcome. Ultimately, purchasers must take a leadership role to promote performance transparency for America's doctors, hospitals, and health plans, and fundamentally change how we purchase health care to promote dramatically improved quality and efficiency.

The nation, including the large employer purchasing community, cannot continue down the path it is now on. The following outlines an Agenda for Accountability.

Regional Health Market Reform Objectives, Rationale, & Initial Concept

Regional Health Care Quality Reform Initiatives is one of three Roundtable coalitions developing health care market reform proposals for HR Policy Association. The Initiative's over-arching goal is to assess whether health care market reforms can be achieved on a regional basis through large employers with a significant presence in those regions acting in concert to leverage their collective buying power to achieve improvements in the cost and quality of health care. Within that larger goal, the Coalition developed a number of ideas involving the specific collaborative measures that could be taken, primarily:

- Establishing purchasing coalitions of HR Policy member companies in specific regional markets with exclusive arrangements with health insurers to achieve reductions in administrative expenses and increased flexibility in underwriting terms for participating employers.

- Attacking the problem of the uninsured by broadening those purchasing coalitions to include access for smaller employers who are at risk of dropping coverage for their employees, while retaining the unique plan designs and maintaining the separate claim risk for those large employers.

- Establishing or working with existing regional coalitions to increase consumer awareness by accelerating the dissemination of provider quality and efficiency information developed by existing organizations such as The Leapfrog Group and Bridges to Excellence.

Eventually, reforms achieved at a regional level could be emulated within other regions with variations based on the unique social, cultural, and economic characteristics of those regions. Ultimately, the lessons learned from these reforms would form a basis for developing broad national health care market reforms.

The Rationale for a Collaborative Approach

During the past three decades, nearly every aspect of our economy has been driven to figure out more efficient and cost-effective ways to provide greater value in the products and services offered. In the face of these economic forces, nearly every company that has survived has transformed its manufacturing, procurement, logistics, marketing, delivery, human resource, and every other aspect of its organization. Despite the fact that health care has become one of the largest components of the U.S. economy, both the commitment to improve and the pace of improvement in health care lag far behind other sectors of the U.S. economy. At the same time, the members of the Regional Coalition and HR Policy Association generally recognize that if this trend does not change soon, large employers along with other segments of our society can be expected to come to the conclusion that the current system of employment-based health care no longer works for them and their employees.

At a minimum, health care purchasers and consumers want to lift the veil to find out who the best health care suppliers are—including hospitals and physicians—for specific procedures. This information can then be used to provide incentives to consumers to use high-performing providers and the best treatment alternatives. Right now, large employers are actively attempting to manage health care costs that are driving double-digit trend rates. These costs are being driven

by a variety of factors, including demographics, innovation and marketing in the pharmaceutical industry, the failure to eliminate or greatly reduce inefficient use of health care resources, a general lack of consumerism, the value of relying on managed care discounts as a primary vehicle to contain cost increases, cost shifting from the public sector, a rising uninsured rate, and an irrational health care economic model. Not only do employers continue to pay more for health care, but they also buy into a system with pervasive quality problems and reimbursement structures that fail to create incentives for quality and efficiency improvement. On top of poor quality, the lack of provider performance transparency contributes to the inability of employers and their employees to purchase health care differentially based on quality and efficiency. At the same time, consumers are denied the ability to make informed choices about the care they receive.

Against this backdrop, employers are pursuing a variety of market reform visions (e.g., defined contribution models, consumer-driven health care, advanced disease management programs, provider reimbursement schemes tied to performance, and provider performance transparency). What is clear, however, is that these visions will be difficult, if not impossible, to implement without large employers collaborating and leading the way. Experience has clearly shown that individual employers developing independent private purchasing and public policy strategies is inefficient and does not allow for the coordinated efforts necessary to reform the health care market. Only by acting together can they leverage their collective buying power to achieve genuine reform.

Initial Collaborative Solution Offered to Coalition Members

With this premise in mind, the Coalition sought to develop a model for a regional purchasing coalition that would accelerate the measurement, reporting, and dissemination of provider quality and efficiency data while also addressing the growing uninsured problem by expanding access to small employers who found themselves priced out of the market for health care.

Specifically, the Coalition sought to promote the formation of regional coalitions to achieve four objectives:

1. Consolidated large employer volume would be used to drive reporting and disclosure of quality and cost efficiency measures from providers and health plans. Specific provider-level data required would be defined by current leading edge public reporting initiatives (e.g., The Leapfrog Group patient safety recommendations, measures endorsed by The National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), Bridges to Excellence, Centers for Medicare & Medicaid Services (CMS), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)).

2. While not mandatory, participating employers would be given credible data to equip them to offer providers economic incentives based on their performance and offer design incentives to employees who use these providers (i.e., implement a “pay for performance” model based on the provider data delivered in each market).

3. Small employers in health plan markets of a regional initiative would be offered access to more affordable coverage by working with exclusive health plan partners to reduce small employer administrative expenses (economy of scale savings extended to the small employer from the large employer coalition) and generate more flexible underwriting terms for the small employer.

4. Savings would be generated for large employer participants that would be independent of design and subsidy changes through the use of exclusive regional contracting agreements with health plans. These savings

would be generated through lower plan administration costs (economy of scale reductions) and deeper discounts with network providers based on expected market leverage concentrated with one plan.

These regional health care quality reform initiatives would be a first time-attempt to consolidate employers' active and pre-65 retiree populations under exclusive arrangements in markets in order to drive reform. The primary objective of many historical purchasing coalitions has been short-term unit cost reductions that are ultimately unsustainable in an inefficient market system. In this instance, the premise is that focused multi employer leverage can lead to improved provider transparency that can easily be applied to employee communications and plan design as well as increased access to health care coverage for the small employer population. All participants, small and large, should reap both short-term and long-term financial savings. We sought to reassure employers who committed to an initiative of this kind that they would not be required to revise existing plan designs or subsidy strategies. Also, employers would not be placed in a position where they were sharing claim risk with other large or small employer participants. The expected underwriting mechanics of this model would include self-insured large employer contracts with an exclusive plan by market and a pool of insured small employer contracts with a separate set of design options and underwriting requirements (more liberal than the current small group pricing model). The success of this model would be dependent upon the large employer volume by market and a tight commitment to both the provider transparency and small employer improved access goals.

Thus, our original concept was very ambitious. As we began to examine the realities of existing relationships between employers and health plans, as well as the unique dynamics of each region, the components were modified to reflect these realities. What follows is a discussion of the lessons we have learned, while recognizing that our original concept of reform through collaboration remains steadfast.

What We Have Learned Thus Far

Over the past year and a half, the Coalition has explored the merits of the objectives described in the previous section and the feasibility of achieving them. In doing so, it has become clear that most of the objectives described above have considerable merit. What we have learned in pursuing these falls into two general categories: 1) broader lessons about health market reform generally, and 2) lessons about the specific collaborative solution initially proposed. We will begin with the first category.

Broad Lessons

In promoting fundamental health market reform, one cannot overstate the challenge involved. Initially, the problem of the uninsured was a key focus of our regional initiatives. However, early on, we realized that the goal of addressing the uninsured would be best achieved through another Roundtable effort—the Affordable Health Care Solutions Coalition. Through the National Health Access program developed by the Affordable Health Care Solutions Coalition, chief human resource officers have made a solid start towards demonstrating how a shared commitment to bold action can produce results—in this case creating the potential to help uninsured employees gain access to affordable coverage. The Regional Health Care Reform Coalition focus shifted to the other glaring deficiency in our health care system—the quality gap. We decided to address this by developing a structure that could be used by HR Policy Association members and other large employers to encourage reform of the health care marketplace by driving the disclosure of a standard set of national provider performance measures and linking those measures to consumer and provider incentives to promote dramatic improvements in quality and efficiency. In addressing this, we learned that the achievement of genuine health care market reform requires a fundamental change in how the large employer community approaches the purchasing of health care.

Senior human resource and other corporate executives must take a more active leadership role in organized regional and national efforts that drive improved health care quality and cost containment. Among other things, this entails active involvement in evaluating the myriad proposals intended to promote health care reform, selecting those that hold promise, building industry-wide relationships to achieve critical mass, and ensuring that the selected efforts are supported, promoted, and executed. Moreover, in addition to participation in collaborative efforts, large purchasers must do a better job of purchasing health care and managing the purchasing function.

The task of controlling health care costs and reengineering delivery systems is far greater than any single company can expect to achieve, no matter how large that company may be. At the same time, any effort by purchasers to seek transformational health care reform is likely to face large, entrenched interests highly resistant to change both within the purchasing community itself as well as by those providing products and services to that community. In most cases, only by senior HR executives working with their peers in other large organizations on an ongoing basis to develop and implement best practice programs and reform strategies will market transformations occur.

Promoting a quality reform effort on either a regional or national basis is no easy task. Moreover, it has become clear

that individual employers developing independent private and public policy strategies does not allow for the coordinated efforts necessary to reform the health care market in time to avoid costs that are no longer sustainable. Therefore, if meaningful reforms are to be achieved, it will require the collective and combined effort of many organizations, institutions, associations, and health care experts. Moreover, a key element will be some ongoing process to develop, achieve, and sustain progress.

All of these considerations lead us to the general findings and recommendations listed below.

1. Senior corporate executives need to take a more active leadership role in the selection of health care market reform strategies, their design, and their execution.

Health care market reform strategies are developed in a variety of ways, but the principal players in the development process are corporate benefits executives, HR consulting organizations, trade associations, and health care experts. Typically, CHROs and others at the highest levels of the company have played only a minimal oversight role in this process. Organizing these interests together with health plans and providers to collaborate for the purpose of driving effective reform at both the regional and national level can be challenging, particularly where there are no clear lines of accountability. Experience has shown, for example, that for a variety of reasons it is difficult to organize and maintain a critical mass of purchasing power at the local level to drive regional reform. At first the bloom is on the rose with a high level of commitment to the effort at all key levels of the organization. Then the rose fades as other priorities emerge, and the momentum is lost. While there are some examples of successful regional efforts, many have had limited impact, and several others have failed altogether.

A reform effort by definition is one calling for change—a change in behavior, plan design, purchasing practices, use of a particular plan or plans, adherence to certain metrics, and the like. The effort can also be expected to challenge deeply rooted interests that not only may be staunchly committed to maintaining the status quo, but also willing to throw large resources at achieving that objective. For these reasons, a purchaser-led market reform of any significant consequence is larger than any single company, no matter how large that company may be. Instead, a true reform is premised first and foremost on the collaboration and leadership of key large employers and the individuals within those employers who have the authority to make critical decisions supported by the highest levels of the corporation, commit resources, and win the cooperation of their peers in other organizations. The question then becomes, what role should those highly ranked individuals play in terms of health care market reform?

Major purchasers of health care are intensely interested in searching for solutions, and that demand has stimulated a large supply of market reform proposals. Our review of the health care reform marketplace during the past year reveals an impressive array of ideas, initiatives, reform proposals, and players in the market reform process. Much of what we saw shows great promise. On the other hand, a lack of leadership and clear lines of accountability often causes friction at best and conflict at worst, stymieing any hope of change. For these reasons, we recommend far greater involvement by those at the highest levels of the company in—

- first agreeing to collaborate with their peers in terms of becoming involved in the development of market reform strategies;
- evaluating the merits of these reform proposals;
- selecting the proposals to be pursued;

- ensuring their support, both financially and by the CHRO's peers;

- maintaining an ongoing process to ensure that the selected strategies are being properly executed, timelines are met, and objectives achieved; and

- taking appropriate action when the strategy falls off track.

From our review, we were struck by the dichotomy between large employers expressing strong dissatisfaction with the status quo while at the same time strongly resisting any change to the status quo. On the other hand, we saw benefits directors within the purchasing community looking for clear direction and leadership for their efforts. In addition, plans and providers held out the lack of leadership and multitude of overlapping efforts as a barrier to reform. Senior human resource executives, therefore, should take an active role to promote action in their own companies that advances quality improvement and cost control as well as to use their influence to assure that these efforts are coordinated with one another to promote maximum value and influence on the market.

2. By engaging the chief human resource officers, HR Policy Association, working through the Health Care Policy Roundtable, should promote collaborative and individual efforts by its member companies to ensure progress in terms of health care market reforms.

The Health Care Policy Roundtable was formed in July 2003 and met for the first time in November of that year and most recently in January 2004. During that time it created a public policy agenda, wrote and published a monograph entitled Leadership Action Plan on the Uninsured, and established three Coalition activities—the Affordable Health Care Solutions Coalition, the Direct Pharmaceutical Purchasing Coalition, and our Regional Initiatives Coalition. The Roundtable staff has been working at a furious pace since then, and excellent progress is being made in certain aspects of the Roundtable's agenda. But more needs to be done to ensure continued progress.

As described above, there are a multitude of uncoordinated and often competing initiatives, organizations, and players in the health care arena serving the interests of large employers, but their activities have limited direction, focus, or leverage. As a result, despite their health care responsibilities in their companies, the senior human resource vice presidents of large employers are not always certain who all these players are, which deserve support, and which should be monitored closely to ensure their objectives are being met. We find that to be a troubling situation when in the aggregate the HR Policy Association member companies routinely authorize the payment of billions of dollars to health care institutions.

A perfect example illustrating this point is the promising but somewhat limited success of The Leapfrog Group despite having a membership of more than 160 private and public sector purchasers, clear goals, and a well-respected position in the health care community. Leapfrog's leaders point to the surprising difficulty in getting the sustained attention of purchasers. In a January/February 2005 Health Affairs article, they noted that "[e]ven the most progressive purchasers are reluctant to change their purchasing behavior sufficiently to send clear market signals about quality to providers. Employers' hesitation to restrict employees' choice of providers makes it hard to convince providers that high quality will increase their market share."

Thus, there are several specific subjects that the Coalition believes the Roundtable should address:

a. There are a number of actions that employers can and should take individually as well as collectively to drive reform and quality improvement.

In addition to collaborating with like-minded companies and organizations to pursue health care market reforms, there are a number of specific actions that employers can take on their own to promote reform. In our review of health care policies and practices both within and associated with large employers, we were struck by the dramatic differences in practices utilized by large corporations to purchase and deliver health care. While there is room for innovation and it is not necessary for all employers to purchase health care in the exact same manner, varying practices should all be designed to drive their employees to high-quality and efficient plans and providers using consistent metrics to assess provider performance.

We see tremendous opportunities if the nation's largest employers developed and adhered to a set of best practice standards in purchasing and in the delivery of health care, supported by a system to encourage their peers, suppliers, vendors, and others to utilize these practices. For example, employers should routinely put their health plan contracts up for competitive bid through an RFP process, and include specific requirements in the RFPs. Such requirements would ask plans to adopt standard provider-level performance measures that are linked to substantial incentives through benefit design and provider contracting. In addition, employers should include explicit performance guarantees in their health plan contracts pertaining to cost containment, quality, and customer service.

b. A consensus set of provider-level performance measures must be quickly achieved.

In the 2005 Chief Human Resource Survey conducted by HR Policy Association, 74 percent of the membership agreed with the statement that "the key to lowering health care costs lies in increasing health care quality and efficiency through greater availability of information regarding health care provider performance and in employees and their dependents using that information to act as better health care consumers." We see transparency and performance measurement as a core need to promote reform at both the regional and national level. This is particularly true in view of another question listed in the survey in which two other questions were asked. Nearly 80 percent of the membership agreed with the statement that the "constant increase in the cost of health care in the United States is a significant factor in nearly every business strategy our company implements." Seventy-seven percent also agreed with the statement that "our company either has or is giving serious consideration to moving away from a traditional health care plan towards a more consumer-driven health care plan." For these plans to work, it is essential that the consumers have access to information regarding provider performance that will enable them to act as good consumers.

Right now, there is a veil of secrecy regarding the relative cost and quality of doctors and hospitals. While there is significant activity underway by many organizations to promote transparency, the lack of a consensus set of measures is a significant barrier. The amount of information on provider performance available at present falls far short of what is ultimately needed. The lack of a clear message from employers on which measures should be used is a significant

barrier to reform, and we encourage CHRO involvement in holding all those playing a part in the standards development process to reach common ground on a sound set of metrics as quickly as possible. This is particularly important when large employers are looking to employees and their families to do a better job of driving health care costs through their daily decisions about which doctors, hospitals, and treatments they choose. Employers should do more to inform their employees about the importance of making informed health care choices based on both cost and quality and that can only be done if employers reach consensus on adopting and publishing standard measures of cost and quality for health care providers.

Currently, there are several different efforts underway, including multiple players within the purchasing community alone, to develop a consensus set of measures, but consensus has not yet been reached. In addition, the association representing health care plans is working with national provider organizations and the federal government to develop a set for doctors, and individual health care plans are working on standards of their own.

Providers want to limit the scope of the measures used, so that no doctor is burdened with undue reporting expense or data is not being used for unknown purposes. There are some employers and health plans that believe their protocols around performance measurement is stronger than others, and they are pursing their own independent agenda. Many health plans believe the core data, aggregation methodology, and resulting product design represents a differentiating competitive advantage that would prohibit participating in an industry-wide common initiative. And the Centers for Medicare and Medicaid Services has embarked on the laudable goal of espousing performance measurement for Medicare program providers, and has recently begun making this important body of data available to the public, albeit to a highly limited extent.

It is important to note that the metrics of performance do not differ substantially between these organizations; each recognizes groups like The National Quality Forum and the National Committee for Quality Assurance as the gold standard in consensus-based measurement. Yet there is substantial energy being expended to own the agenda of quality measurement. While each stakeholder group has its own individual motivations for endorsing one set of measures over another, the end result is confusion that has the potential to freeze any meaningful initiative in its tracks. Maintaining rigid positions is not productive and only perpetuates the quality failings of our health care system. The inability of all the factions to act on common ground underscores the desperate need for senior leadership in this area. CHROs and other senior corporate executives must step in and demand that all of these efforts work together to improve the health care that they spend billions on every year.

c. <u>Both employers and health plans should create substantial incentives to promote improved quality and efficiency.</u>

Employers and plans must do a far better job of linking pay to performance to make the business case for providers to improve their quality and lower their costs. Without this, efforts to measure and report performance will have a limited impact on provider behavior. Health care does not act like other sectors of the economy because purchasers have failed to direct money to the hospitals and doctors that have the highest quality at the lowest cost. Employers should

adopt strategies to reward the best caregivers through public recognition, direct financial incentives, and benefit designs that encourage employees to use the best hospitals and doctors.

d. <u>There are promising reform efforts underway that deserve employer understanding, recognition, and support.</u>

There are many promising, but inadequately leveraged efforts underway to advance regional health care quality reform. Human resource executives are uniquely positioned to promote more effective coordination and wider adoption of these efforts. Such leading-edge efforts include The Leapfrog Group, Bridges to Excellence, The Consumer-Purchaser Disclosure Project, the National Business Coalition on Health's eValu8 tool to assess health plans, the National Quality Forum, and the Pacific Business Group on Health. We see organizations like these as essential to any successful reform effort. As described below in a separate part of this document, HR Policy Association is also working with select members such as Ford, General Motors, Daimler-Chrysler, Detroit Edison, Honeywell, and CIGNA to initiate regional reform projects in Detroit/southeast Michigan and Phoenix. Early discussions are underway with Caterpillar to start a complementary regional reform effort in central Illinois.

e. <u>Price and quality transparency should be mandated across all services, including the purchase of prescription drugs through pharmacy benefit managers (PBMs) and health plans.</u>

True market reforms cannot occur when purchasers and consumers are unaware of the true cost of certain health care services and products. Employers and employees must be exposed to the real net cost of the product or service without side payments, rebates, or preference due to financial incentives that conflict with the delivery of affordable, clinically effective treatment.

f. <u>Consumer-based health care plan designs should be encouraged.</u>

The Roundtable should encourage consumer-based plan designs, ones that include linking copayments and coinsurance to the true cost of provider services and treatments, offering HSAs or account-based products, encouraging the development of and implementing tiered or concentric networks based on value criteria, and encouraging prevention as well as participation in condition management programs.

g. <u>Public policy and public purchasers are a critical element to support reform.</u>

There are several public policy actions that should be considered and promoted by the Roundtable. All focus on improving health care quality by increasing transparency in the health care system so that purchasers and patients have the necessary information and incentives to select high-quality and efficient providers. They include:

- Encourage government initiatives to increase transparency and reward high quality and efficiency. The federal government exerts considerable influence over our health care market as the largest single payer of health care services through the Medicare and Medicaid programs. In this role, it can lead efforts to transform payment systems toward pay for performance, and educate beneficiaries about the hospitals and doctors who are the most efficient and effective in delivering

care. The Centers for Medicare and Medicaid Services (CMS) is already moving in this direction through encouraging pay for performance and quality requirements for certain providers, allowing more choice for beneficiaries to choose providers and plan designs, and requiring the disclosure of quality data for hospitals to receive increased payments. The Roundtable should support CMS with these efforts and encourage it to accelerate these initiatives. Injecting consumerism and quality improvements into government programs will facilitate the changes that private purchasers seek. Employers should encourage state and local governments to adopt transparency and pay-for-performance concepts as well—using national standards to measure provider effectiveness.

- Make use of the Medicare claims database. The best efforts of private purchasers and plans to collect information using administrative claims data about providers to measure the effectiveness and efficiency of providers would have limited use without including data from Medicare and Medicaid claims. Very few, if any, individual private sector purchasers, or health plans, have enough claims experience in any one location for accurate measures. Even the collective information of coalitions pales in comparison to the wealth of information available in the Medicare claims database. The Medicare administrative and claims data would provide an ideal resource for collecting measures to improve quality because most practicing physicians treat a large number of Medicare beneficiaries. It is unclear whether CMS has the full authority to provide access to this information or would need statutory authority to open the database. However, health policy experts and some members of Congress agree that the database should be used as a resource to provide public information on provider efficiency and quality measures. Obviously, this would have to be done in a manner that protects the privacy of individuals and is fully compliant with the Privacy Act and HIPAA. The Roundtable should actively support use of the Medicare claims database as an important tool for disseminating information that can improve health care quality.

- Support for improvements in health care IT. A major deficiency in our health care system is the inadequate usage of proven information technology such as the use of electronic medical records, computerized physician order entries, and electronic prescribing. Health policy experts have pointed to the deficiencies in IT as partly responsible for thousands of medical errors that have lead to unnecessary illness, death, and economic loss. Numerous proposals to address this problem have come from across the ideological spectrum and the President has created the Office of the National Coordinator for Health Care Information Technology headed by Dr. David Brailer. Many providers cite the lack of financial incentives and risk of incompatible systems as barriers to more widespread investment and use in IT. Policymakers have put forth legislation to provide resources in the form of grants and loans to groups of providers, state and local governments, and plans to facilitate the use and sharing of health care information across settings. The Roundtable should identify those proposals that would most effectively promote the expansion of IT within the health care industry and support them

- Support medical error/patient safety legislation. A 1999 report by the Institute of Medicine (IOM)—To

Err is Human: Building a Safer Health System—stated that as many as 98,000 people die each year in the United States from preventable medical errors in America's hospitals. The President recently signed into law the Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41), legislation that enhances research on improving patient care by increasing the disclosure of medical errors. The law facilitates the voluntary reporting and collection of "patient safety data"—i.e., information on adverse events, medical errors, and near misses—into a single database or network of patient safety databases. Providers may voluntarily report patient safety data to certified patient safety organizations in a format that prevents identification of a provider, patient, or reporter of the data. To ensure providers do not fear legal reprisal for reporting errors, the legislation includes specific civil and criminal protections for reported patient safety data. The Roundtable should support speedy implementation of the Patient Safety and Quality Improvement Act as a positive step toward reducing medical errors and creating depositories of information that should be helpful in developing system improvements to improve care.

The reality is that employers alone cannot reform America's health care system without a policy environment that supports their efforts. Employers are taking an active role in advocating state and federal public policy reforms that promote dramatic improvements in health care quality and efficiency, and the Roundtable should help focus these education efforts.

3. Employers should give serious consideration to ensuring that all their employees and persons associated with the employer have access to some form of affordable health care benefits.

The growing ranks of uninsured Americans results in a number of consequences deserving the attention of large employers. For example, there is no question that providers and plans shift the cost of uncompensated care to employers who do provide coverage to their employees. The large ranks of the uninsured also drive higher health care costs and lower productivity by creating barriers for employees to access preventive and other services on a timely basis. In addition, employers cannot expect governmental institutions to ignore indefinitely the millions of working Americans without access to employment-based health care. Already states and localities are grappling with huge Medicaid costs growing worse each day because of, among other things, working Americans without health insurance benefits. If this problem continues unabated, it could be only a matter of time before states begin issuing mandates directed at employers not providing care, as is seriously being considered in a number of states. We recommend that employers consider options currently available to them to provide greater access to care as a means of forestalling governmental mandates that will affect all employers, including those already providing benefits to their employees. The National Health Access program developed by the Association's Affordable Health Care Solutions Coalition is one deserving very careful consideration.

4. Time is running out.

Rising health care costs and the continuing growth in the size of the uninsured population are threatening the future of employer-based health care. Unless dramatic changes occur in the next few years, employer-based coverage will continue to erode, leading to more serious discussions of alternatives to our current reliance on employer-based coverage. If dramatic

improvement does not occur, more and more employers may be pursuing exit strategies through individual actions and public policy changes.

Lessons Regarding Specific Collaborative Solution Proposed

The following provides specific commentary on the components of the initial proposal for collaborative action.

1. Develop partnerships with insurers to drive health care market reforms.

We are very pleased to report that two health care insurers were willing to work with the Health Care Policy Roundtable in terms of both provider transparency data and the uninsured. Both UnitedHealth Group and CIGNA have agreed to adopt the Roundtable's E2 data set for measuring hospital and doctor effectiveness and efficiency. These principles require health care plans to agree to collect and disseminate The Leapfrog Group's patient safety standards for hospitals; Bridges to Excellence standards for measuring clinical effectiveness in treating diabetes, heart disease, and overall connectivity of the physician's office; and the standards outlined in the CMS-Premier Hospital demonstration project. This initial data set is to be expanded in future years to achieve a comprehensive dashboard of performance measures, encompassing claims-based outcomes data, provider-reported chart information, and patient experience of care surveys. In the National Health Access program, this will manifest itself in better consumer decision support tools for participants, and ultimately a modified plan design that provides incentives for participants to seek the best combination of high-quality and cost-efficient providers.

In addition, CIGNA, United HealthCare, Pacificare, Humana, Aetna, and Blue Cross and Blue Shield of Arizona are actively engaged in discussions to promote a standard set of performance measures as part of the Coalition's regional reform effort in Phoenix.

2. Work closely with existing market reform forces such as The Leapfrog Group and Bridges to Excellence to increase consumer awareness by accelerating the dissemination of provider quality and efficiency information.

The Leapfrog Group's 150 members are committed to increasing the level of patient safety in our nation's hospitals. But Leapfrog is a voluntary effort, and many hospitals refuse to participate; it is viewed as a time-consuming endeavor with limited downside risk if the hospital does not report. CHROs need to make compliance one of their key buying criteria—this will galvanize the health plan community to make this a priority, as well as creating both the business risk and business opportunity necessary for hospitals to participate.

Bridges to Excellence (BTE) is a physician-based measurement and rewards system that was launched by UPS, Verizon Communications, General Electric, Proctor & Gamble, and Ford Motor Company in the areas of diabetes management. Using a measurement set developed and endorsed by NCQA in close collaboration with CMS, BTE combines both physician and consumer rewards for effective chronic care management. Programs have been expanded to include diabetes and cardiovascular disease as well as the Physician Office Link, measuring the degree of connectivity and electronic recordkeeping in a physician's office. Pilot locations include Cincinnati, Louisville, Albany, and Boston, with several additional locations under development. Emerging data suggests the cost savings from effective chronic condition management, even after providing the monetary rewards, are significant and sustainable.

The end state of provider measurement standards must encompass both hospital and physician metrics and be

coordinated in approach and methodology. We would suggest that Leapfrog and Bridges to Excellence combine into a single, far-reaching market standard of provider-reported performance data, to be combined with claims-based outcomes measures and patient experience of care surveys for a robust and comprehensive dashboard that can be aggregated in a consumer-friendly format. We are seeking to achieve that goal in our Phoenix Regional Quality Reform initiative.

3. Establish purchasing coalitions of HR Policy member companies in specific regional markets.

Health care is delivered locally, from doctor to patient. Competitive dynamics differ from market to market, and there is wide variation in market share across even national health care organizations. From our study of the situation over the past year, we believe that establishing a national clearinghouse of provider performance data, and gaining broad acceptance to report, aggregate, and disseminate this information across the United States, is a noble goal. However, we also believe that it is an unrealistic one in the absence of a federal mandate enforceable by legal action. We continue to believe that real progress will be made by large purchasers banding together in locations where they have substantial market presence and where the quality agenda is at the forefront of their buying criteria. Urban locations with more competition between health plans and providers will generally move faster than rural locations. Areas where employers have more flexibility to change plan designs or vendors are more fertile than heavily unionized environments where this flexibility is more limited. The competitive market will respond to business opportunity and risk, and a regional approach allows employers to concentrate their leverage to become a catalyst for change. Finally, it is essential that an organization like the Health Care Policy Roundtable, which represents the senior decisionmakers in large organizations, take a more active role in reviewing regional efforts and providing guidance on appropriate missions, objectives, and timetables.

4. Create exclusive arrangements between health insurers and purchasing coalitions to drive reform.

Employers will maximize their leverage by forming regional coalitions and driving volume to an exclusive health plan that meets aggressive purchasing requirements that promote regional reform. By focusing on a single strategic partner, employers increase the likelihood of finding a health plan partner that will take bold actions to advance transparency, promote pay for performance, and improve quality, efficiency, and access.

5. Retain unique plan design for large employers.

Employers require flexibility to establish unique plan designs for competitive positioning, behavior change strategies, overall affordability targets, and collective bargaining. There is no "one size fits all" plan design that will be appropriate for all employers in all industries. We believe that employers collaborating on a regional basis can do so without giving up their plan design. However, the original collaborative proposal envisioned retention of unique plan designs while also moving all the participating employers into a relationship with a common vendor, thus increasing their leverage. The practical limitations on doing this became clear to us early on. Nevertheless, we still believe that the use of a common vendor would be even more effective in generating a sufficiently large book of business to move the market in dramatic ways.

6. Maintain separate claim risk for participating large employers.

The variance in total health care spending per employee across large employers can be as high as 50 percent. Differences in employee demographics, geography, health

risk, and plan design all combine to determine an employer's overall cost. Employers can share common objectives, purchasing strategies, and vendors, but coalitions where there are clear winners and losers are destined for failure. Each large employer should be responsible for its own claim risk, so that efficiencies one employer is able to achieve are not transferred to others.

7. Eventually expand purchasing coalitions to include access for smaller employers who are at risk of dropping coverage for their employees.

The problem of the uninsured grows worse as small employers become increasingly unable to afford to provide subsidized coverage for their employees. The employee of a small company that has dropped coverage may very well seek insurance from a spouse employed at a large company, creating a direct impact to HR Policy Association members. The small employer may also be a supplier of the large employer, and increases in health care premiums become embedded in the prices large companies must pay for outside services and supplies. From our research we still see the viability of employers with more than 50 employees participating in a regional activity. For employers with less than 50 employees, state small business insurance laws make coalition activity of this kind highly problematic.

8. Achieve reductions in administrative expenses and increased flexibility in underwriting terms for participating employers, large and small.

There are clear economies of scale in health care administration. Where a large company may pay 6 to 8 percent of total cost on administration, smaller companies typically have 20 to 30 percent of the premium dollar devoted to administration. Smaller companies are also subject to very restrictive underwriting requirements, as a single individual's claims can have a detrimental effect on the overall experience of the group.

As volume grows, the cost of administration (as a percentage of the total) shrinks, and a single claim can be absorbed by the stable experience of the large group. Participating companies would need to agree on a set of standards that will allow for more streamlined administration, but it is possible to build differentiation from a standardized platform and create economies for all.

As discussed above, the inability to move all participating employers to a common vendor effectively prevented us from achieving these administrative savings. We continue to believe it is a laudable goal if this resistance can be overcome.

Regional Works in Progress

In the course of this feasibility study, we have engaged in numerous contacts with regions throughout the United States where there is either budding interest in developing a regional reform initiative or efforts are already underway. Because of our active involvement in two of these and the significant progress they have made, what follows is a description of reform efforts in the Phoenix and Detroit areas.

Phoenix Regional Quality Reform Demonstration Project

Soon after the Health Care Policy Roundtable formed the Regional Health Care Quality Reform Coalition, CIGNA Health Care and the Coalition began discussions about partnering with HR Policy Association members to advance a regional health care quality reform initiative in the greater Phoenix area that could serve as a demonstration project to provide lessons for regional efforts throughout the country. The objective of the initiative (the Phoenix Project) is to establish a broad partnership of employers, health plans, hospitals, and physicians who will work together to implement a comprehensive set of performance measures for hospitals and doctors in the greater Phoenix area Employers and health plans will then use those results to reward the best providers, consistent with the objectives of the Affordable Health Care Solutions Coalition. As a result of initial conversations, CIGNA agreed to use a standard set of measures and make the results of those measures available to all employers and plans in the region. Collaborators hoped that this unprecedented transparent approach by a health plan would serve as a catalyst to jump start change. On February 14, CIGNA, the HR Policy Association, The Leapfrog Group (Leapfrog), and Bridges to Excellence (BTE) announced a joint commitment to pursue a regional health care reform effort in Phoenix (see Appendix II for a copy of the press release).

Partnering organizations in the Phoenix Project laid out specific tasks that each would undertake to facilitate greater reporting of quality measures and quality improvement in the region. Through the Roundtable, HR Policy Association has committed to encourage its member companies with employees and retirees in the region to support and participate in the Phoenix Project, and to publicize the effort in internal and external communications. In addition to releasing the results of performance measures publicly, CIGNA has agreed to incorporate the Leapfrog Hospital Quality and Safety Survey data, as well as the scored data from the Leapfrog Hospital Rewards Program and Bridges to Excellence, in its current and future efforts to provide consumer information about provider performance on quality measures. CIGNA has also committed to initiate efforts to link performance measures to network development and benefit design that rewards physicians who do well on the performance measures. CIGNA also agreed to encourage CIGNA's participating hospitals and physicians to report data to support public reporting of the measurement set and participate in both Leapfrog's and BTE's programs.

As nationally recognized entities dedicated to identifying and rewarding high-performing physicians and hospitals, BTE and Leapfrog bring significant value to the Phoenix Project. Both BTE and Leapfrog have agreed to encourage employers to participate in and support the project, to support CIGNA's hospital measurement approach (Hospital Centers of Excellence) regarding effectiveness and efficiency and its physician measurement approach (CIGNA Care Network)

regarding effectiveness and efficiency. They have also agreed to keep all Phoenix Project principal participants informed of any relevant changes in BTE measures and survey/data collection methods that would have a material impact on the project. In addition, Leapfrog agreed to incorporate CIGNA's role in the project into scoring for its Leapfrog's Health Plan User Groups, an initiative to encourage health plans to adopt Leapfrog purchasing principles—which are aligned with the Regional Health Care Quality Reform objectives.

CIGNA's early commitment of making measures publicly available was the key to gaining the attention and interest of other health plans and employers. The Roundtable, with CIGNA's support, was committed to broadening the involvement of organizations that would participate in the Phoenix Project. The Roundtable, CIGNA, BTE, and Leapfrog held two webcasts and hosted one meeting in Phoenix in March 2005 to inform employers, physicians, and hospitals of this effort and invite their participation and support. Approximately 100 physicians, and representatives from hospitals, health plans, and employers attended. Since its inception, the number of organizations and employers participating in the Phoenix Project, as well as the goals, have broadened.

Participants: As of June 2005, the organizations, in addition to the Roundtable, that are engaged in moving the project forward has grown to include the following:

- Employers/Employer Groups–Roundtable, IBM, Honeywell, Intel, Salt River Project, and Verizon

- Health Plans–CIGNA, Aetna, BlueCross BlueShield Arizona, Humana, Pacificare, and United Health Group

- Nonprofit Organizations–St. Luke's Health Care Initiative (St. Luke's) and the Health Services Advisory Group (the local quality improvement agency (QIO) under contract with CMS to promote provider quality improvement).

Objectives: All participants have reached tentative agreement to take the project on two paths: (1) a short-term goal of promoting performance measurement and pay for performance through existing programs such as BTE for doctors and Leapfrog for hospitals; and (2) a longer-term goal of expanding measures of quality and provider efficiency, and making that information publicly available. By simplifying and publicizing quality information, employers and employees will be able to better evaluate the quality and efficiency of hospitals and doctors. The initial response from providers in the Phoenix area is that they would welcome greater consistency and transparency in measures. The specific initial objectives for this unique collaborative effort were to:

- Promote the implementation and reporting of an initial set of hospital and physician quality measures that include:

    - NCQA recognition programs used in Bridges to Excellence for physicians, and

    - Leapfrog Hospital Rewards Program and Quality and Safety Survey for hospitals.

  These are the same measures that are included in the HR Policy Association's Affordable Health Care Solutions Coalition Initiative. They are also the same as the measures that are included in the measurement set defined for the Southeast Michigan Regional Health Care Reform Initiative.

- Support and promote efforts by CIGNA and other health plans to use network and benefit design to encourage members to use physicians and hospitals who perform well on these measures.

- Support and promote efforts to implement direct-to-provider incentive programs for physicians and hospitals modeled after the Bridges to Excellence program for physicians and the Leapfrog Hospital Rewards program.

As more participants became involved, it was clear that there was potential to take the initiative to new heights of quality improvement. St. Luke's has made significant investments to advance its mission to improve health care quality in the region, but lacked name recognition among employers, and had a limited ability to command the attention of national health plans. St. Luke's is also supporting a project to collect and aggregate health care administrative data from providers, health plans, and employers to create a public use data warehouse for use in quality improvement efforts. Partnering with them would bring the recognition and employer attention of HR Policy, while they could bring the continuity and local involvement that the effort needs as well as the resources that they are willing to provide. As a result, St. Luke's has stepped into the role as coordinator of the Phoenix Project, which is likely to make it much easier to recruit additional health plans and local employers.

Challenges: Despite the promise that the Phoenix Project holds, it is susceptible to the same challenges that all regional quality improvement initiatives hold as well as some that are unique to the region. Specifically, participants will have to find ways to effectively engage providers and overcome the stigma that many attach to previous failed efforts to "profile" them as good or bad doctors and hospitals. Phoenix has a limited provider capacity that will minimize the ability of market share shift to be a significant motivator for providers to participate in quality reporting. Finally, Phoenix has a significant number of small and medium employers in the region and their involvement and support would be a significant advantage even if they cannot provide the same leverage that large employers can to drive change. It is critical to find a way to engage them, as they do not have access to the same channels of communications as large employers.

Next Steps: The Phoenix Project represents the first time that the national health plans and local provider leaders have agreed to collaborate with national and local employers to promote a shared pay-for-performance, public reporting, and quality improvement agenda on a regional level. Involvement of the regional CMS QIO in this kind of effort is also precedent setting. In June 2005, St. Luke's hosted a meeting of principal participants and additional health plans and employers interested in the Phoenix Project. They have agreed to collaborate to pursue the following revised goals:

- Improve community health
- Give providers data to support quality improvement
- Publicly report provider cost and quality
- Build infrastructure such as data warehousing and IT to support quality improvement and accountability
- Promote consumerism

Participants are developing a detailed work plan that will include agreement on a final measurement set, a strategy for collecting data and reporting results, and a budget. Though the Phoenix project will begin as a local endeavor, it can serve as a model for other regional efforts in the sharing of data and information among employers, consumers, and other health plans.

Southeast Michigan Regional Quality Reform Initiative

In 2004, the Roundtable began collaborating with Ford Motor Company, General Motors, Daimler-Chrysler, and DTE to promote a regional quality reform initiative in Southeast Michigan. These four employers have established four shared objectives for this collaborative effort.

Collaboration and Shared Accountability: They are working to collaborate with key stakeholders to create a system where all have an opportunity to benefit from the transformation of health care in southeast Michigan. This will be done by promoting shared accountability and the common interest of all parties to promote the best quality, effective use of resources, informed decisionmaking, and rewarding superior performance.

Transparency: Purchasers will work to transform the health care system to increase quality and generate substantial financial savings in southeast Michigan by promoting and implementing a comprehensive set of standards, publicly reported performance measures for hospitals, and physicians, integrated delivery systems, and plans on the relative safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness of care.

Aligned Incentives: These measures will be used to drive improvements in health care quality and affordability. This goal will be achieved by adopting and promoting payment models directly linking provider reimbursement to quality and efficiency measures, with additional incentives driven by benefit design and provider network development.

Promoting National and Regional Action: The initiative will actively participate in and promote national and regional efforts that advance its vision, including efforts such as Save Lives—Save Dollars, The Michigan Health and Safety Coalition, The Leapfrog Group, The National Quality Forum, and other relevant efforts.

The fundamental strategies for achieving these goals are to promote a robust set of performance measures while linking those measures to substantial incentives for consumers and providers to drive quality and efficiency improvements.

The HR Policy Association and these employers have defined a recommended core set of measures for hospitals and doctors to be implemented over a three-year period. These measures include indicators to assess provider safety, timeliness, effectiveness, efficiency, equity, and patient experience. They include the measures that are included in the HR Policy Association's Affordable Solutions Request for Proposals. These measures include those in use by The Leapfrog Group, Bridges to Excellence, CMS, NCQA, and the Joint Commission for Accreditation of Healthcare Organizations. The measures are also being drawn from those that have been endorsed by the National Quality Forum.

The employers are exploring alternatives to use a variety of incentive approaches, including financial recognition for superior providers through direct cash incentives and market-share. Non-financial provider incentives such as quality awards and public recognition are also being considered. Consumer incentives will also be examined to encourage beneficiaries to use high-performing providers.

Incentive arrangements will be designed and selected to comply with the following Guidelines for Incentive Programs:

Guideline I: Documented positive return on investment: Programs must have a documented return on investment that promotes net financial savings through more efficient use of resources and improved health care quality.

Guideline II: Substantial incentives: Incentives must be substantial enough to promote and reward improvement.

Guideline III: Financial and non-financial incentives: Both financial and non-financial incentives should be adopted to reward and recognize performance.

Guideline IV: Equitable shared savings: Savings associated with incentives and rewards programs should be equitably shared among purchasers, consumers, and qualified providers.

Guideline V: Use of standard performance measures: Performance measures used for provider and consumer incentive programs should be based on standard measures in compliance with the Consumer-Purchaser Disclosure Project's Guidelines for Purchaser, Consumer and Health Plan Measurement of Provider Performance.

Guideline VI: Transparent methods: Methods for measuring performance and determining incentive and reward amounts should be transparent.

Guideline VII: Multistakeholder input: Incentive and rewards programs should have input from all major stakeholders, including purchasers, consumers, and providers.

Guideline VIII: Continuous review and update: Incentive and rewards programs should be continuously reviewed and updated to stay current with medical science, standard national measures, and adoption of documented best practices to promote quality and efficiency improvement through incentives and rewards.

One of the primary vehicles being used to advance transparency and pay for performance is the Greater Detroit Area Health Care Council's Save Lives—Save Dollars initiative. This collaborative effort includes all of the region's major health plans and provider organizations that are working with employers to implement a set of performance measures consistent with those included in the measurement set established by the HR Policy Association, the three auto companies, and DTE. The Save Lives—Save Dollars initiative has also endorsed the Guidelines for Incentive Programs referenced earlier. As set of community-wide quality improvement collaborative efforts have also been identified. The goal of the Save Lives—Save Dollars project is to generate documented savings of $500 million over the next three years.

The employers participating in the Southeast Michigan Regional Reform Initiative have also developed a consensus Statement of Commitment that they are requesting that health plans agree to to support the programs and objectives developed through the Save Lives—Save Dollars initiative.

Building a Successful Regional Reform Project

In terms of our Association's commitment to health market reforms, we believe the most promising steps to be taken in the near term can be characterized by using a slightly modified version of a familiar phrase: "Think nationally, but act regionally."

When it comes to the actual delivery of services, health care is done primarily on a regional basis. Among other reasons, in the vast majority of instances consumers receive their services within driving distance of their residence, and community and regional market characteristics profoundly influence delivery dynamics. These fundamental realities necessitate that regional health care systems need to be a central focus of any serious reform effort.

For all the reasons mentioned elsewhere in this document, the driving force behind a regional reform effort must be the chief human resource officers or other appropriate senior executives of the major employers in the region. In most regions, their companies will employ a significant percentage of the customer base for health care providers located in that region. As the largest payers for health care services in the region, they are able to bring to the table the degree of clout needed to effectuate genuine reform. However, occasional meetings with interesting speakers alone are not likely to change the market. Rather, reform can only be accomplished by purchasers forming a coalition with a result-oriented organizational structure and agenda.

The creation of an effective regional health care coalition involves several steps. There are no hard and fast rules in terms of building successful regional health care reform coalitions, but we believe the presence of each of these elements would facilitate that success:

1. Identification of Coalition Membership.

At the outset, a handful of senior executives of key employers must take it upon themselves to begin the process. Through their own networks, they identify and gather a critical mass of employers, represented by their CHROs or other senior executives, to form the membership of the coalition. The number will vary by region. Participation, if any, of mid-size and smaller employers must involve individuals with genuine leadership in the business community who can effectuate results among their peers. The most critical aspect of the coalition is that it be limited to employers and not dilute its ability to reach consensus among coalition members by including other players in the health care arena who may have different agendas. This is not to say that an ongoing dialogue and interaction with providers and plans is not absolutely essential to the success of the coalition. But the final word must be that of the employers, the ones paying the bills.

2. Formation of Steering Committee.

Because the coalition will necessarily involve a large number of individual employers, it is essential that, at the outset, a manageable subgroup of senior corporate executives be designated to guide the coalition. As with any other leadership group, this should include individuals whose decisions will be respected and who have a strong enough network to know where their peers stand.

3. Establishing Financial Support.

In order to maintain its independence, the organizational structure and activities of the coalition should be financed by the participating companies and their affiliated foundations with no financial participation of any significant kind from the targets of reform in the regional health care market.

4. Hiring Coalition Staff.

The coalition will need to hire a staff person to handle the day-to-day functions of the coalition while also identifying the issues to be presented to the coalition for resolution. This need not be a large staff but it should have an executive director who, ideally, has a keen understanding of the culture and dynamics of the regional health care community. In some coalitions, much of its work is performed by the corporate staffs of the coalition members. This can work well as long as all the personalities blend and there is no over-delegation of work. Problems can arise, however, when personnel changes occur in the parent corporations and continuity is lost. Ultimately, it is the CHRO or other senior corporate executive who will be accountable, and their hands-on involvement is essential to ensure that friction among all the players is kept to a minimum and objectives are being met.

5. Formulating a Clear Set of Objectives.

The first order of business for the coalition should be to identify a clear set of market reform objectives to which the membership of the coalition will be committed and that will be understandable to the plans and providers. The challenge in formulating these objectives will be achieving the right balance between being visionary and realistic. If the coalition establishes objectives that are overly idealistic, it will lose its credibility with the health care community as well as the coalition membership and will eventually fail. If, on the other hand, it commits itself to nothing more than an incremental refinement of the status quo, it may easily achieve those objectives while accomplishing very little.

6. Determining Strategy and Timetable for Achieving Objectives.

Objectives without a strategy and a timetable for achieving them are an empty promise. These should be decided at the outset by the steering committee, with counsel from the executive director, and must be constantly fine-tuned as the effort proceeds. The importance of a timetable cannot be overstated. Those who will need to deliver in order to effectuate reform will undoubtedly be individuals and organizations with many competing demands for their time. Knowing that a date is approaching and that they will be held accountable for delivery by that date is the key to ensuring performance.

7. Evaluation and Selection of Reform Proposals.

Once objectives and strategy are identified, the coalition will need to issue a request for proposals for each of the components of the strategy that cannot be fulfilled internally by the coalition. While the executive director and his or her staff will be responsible for the logistics and initial evaluation of these proposals, it is critical that the steering committee be actively engaged in the evaluation and selection process.

8. Utilization of Existing National Resources.

While the coalitions being discussed are regional, there are national resources available to them that have a proven track record of effectiveness and an eagerness to engage at the regional level to further their own objectives:

- National Quality Forum. The National Forum for Health Care Quality Measurement and Reporting (NQF) was

created to develop and implement a national strategy for health care quality measurement and reporting. NQF is a public-private partnership, with broad participation from all parts of the health care system, including consumers, employers, health care providers, health plans, accrediting bodies, labor unions, and supporting industries. The goal of NQF is to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement.

- Bridges to Excellence. Bridges to Excellence (BTE) is a collaboration of employers, physicians, and measurement specialists, aimed at creating incentives for physicians to reengineer their practices in order to deliver quality patient-centered care. The program, funded by participating employers, awards both physicians and employees who demonstrate compliance with recommended health care quality protocols. At present, BTE has three specific programs underway: Physician Office Link, Diabetes Care Link, and Cardiac Care Link. Currently, BTE is fully operational in five large markets and has secured the commitment of coalitions and health plans to launch the effort in another 15 to 20 markets in 2005.

- The Leapfrog Group. The Leapfrog Group is a coalition of more than 165 Fortune 500 companies and other large private and public sector purchasers of health benefits. The group, funded by coalition members as well as the Business Roundtable and the Robert Wood Johnson Foundation, works to trigger "leaps" in the safety, quality, and affordability of health care by supporting informed health care decisions and promoting high-value health care through incentives and rewards. Where Bridges to Excellence focuses on physician performance, Leapfrog concentrates on hospital quality and safety. Leapfrog has identified and refined four hospital quality and safety practices: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and The Leapfrog Quality Index, based on the NQF-endorsed Safe Practices.

- Consumer-Purchaser Disclosure Project. The Consumer-Purchaser Disclosure Project (CPDP) is composed of leading employer, consumer, and labor organizations working to ensure that all Americans have access to publicly reported health care performance information by January 1, 2007. CPDP is seeking to avoid a "Tower of Babel" effect by ensuring nationally standardized NQF-endorsed measures for clinical quality, consumer experience, equity, and efficiency. In early 2005, the CPDP published consensus Guidelines for Purchaser, Consumer and Health Plan Measurement of Provider Performance. These guidelines set forth recommendations to promote the adoption of uniform performance measures for hospitals and doctors. The Measure Guidelines also set forth recommendations for coordinating data collection for performance measurement.

- National Business Coalition on Health. The National Business Coalition on Health (NBCH) has a membership of nearly 90 employer-led coalitions across the United States, representing over 7,000 employers and approximately 34 million employees and their dependents. NBCH is a "coalition of coalitions" that are committed to community health reform. NBCH provides expertise, resources, and a voice to its member coalitions across the country and represents each community coalition at the national level. NBCH's eValue8 ™ tool is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. The eValue8 tool uses a standard annual request for information survey to gather hundreds of benchmarks in critical areas (e.g., adoption of health information technology, disease management).

- National Committee for Quality Assurance. The National Committee for Quality Assurance (NCQA) seeks to improve health care quality everywhere through its voluntary accreditation and certification programs. NCQA accredits a variety of organizations from HMOs to PPOs to Managed Behavioral Healthcare Organizations (MBHOs). More than half the nation's HMOs currently participate and almost 90 percent of all health plans measure their performance using the NCQA's Health Plan Employer Data and Information Set (HEDIS®), a tool used to measure performance in key areas like immunization and mammography screening rates. The information is made publicly available to inform consumers' and employers' enrollment or contracting decisions. NCQA's Health Plan Report Card is an interactive tool designed to help employers and employees find the best health plan.

Each of these organizations has achieved an impressive degree of success and provides a useful resource for any regional coalition either as an active participant or in an advisory capacity.

9. Monitoring of Performance.

As suggested above, the observance of timetables and the continuing oversight of the performance of the selected reform proposals must be ensured by the CHROs or other senior corporate executives of the coalition members. If deliverables are not being received or are not sufficient to further the objectives of the coalition, it is up to these senior officials to make sure the situation is corrected.

10. Calibrating the Course of Action.

The most important thing that the leadership of an organization provides is the definition of the path to be taken. Those who work for them will typically continue down this path until told otherwise even if it becomes clear that it is leading in the wrong direction. As they do in their own organizations, the CHROs and other senior executives need to constantly reassess whether the direction is the right one and, if not, change it.

An example of a highly successful coalition is the Pacific Business Group on Health (PBGH) whose president and CEO is Peter V. Lee. It is comprised of 50 large purchasers providing health care coverage to more than three million employees, retirees, and dependents. By partnering with the state of California's leading health plans, provider organizations, consumer groups, and other stakeholders, PBGH works on many fronts to promote value-based purchasing in health care. PBGH's Negotiating Alliance promotes value-based purchasing through an annual Request for Proposal (RFP) and rate negotiation process on behalf of nearly 400,000 active and retired Californians. The alliance leverages the purchasing power of large employers to achieve competitive pricing while fostering health plan accountability for quality and care improvements. The alliance also collaborates with other coalitions and large national employers to create standard measures for cross-market comparisons. The Negotiating Alliance work is funded from dues contributed by members participating in this collective purchasing group and by general PBGH members.

Using This Report to Promote Regional Health Care Quality Reform

The body of this report highlights the business case for large employers to take actions to promote regional health care quality reform. It also provides an analysis of leading efforts to promote regional reform, along with recommended tools that large companies can adopt to advance the eight strategies recommended above.

Numerous resources and tools are included in the appendices for use by human resource executives to support their company's overall strategy to promote reform. A convenient reference table of these resources and tools to support them is found in the appendices.

The evolution of the regional reform initiative has been an eye-opener as to what the real problems are with our health care system and what it takes to address them. We started out with a concept of regional purchasing coalitions to try to address the problem of the uninsured. While the Healthcare Roundtable is addressing the problem of the uninsured through its National Health Access initiative, we have recognized that our efforts at the regional level can be far more effective when focused upon the broader problem of the quality deficiencies in the system, which will have to be addressed as part of any long-term solution to the uninsured problem. As expressed previously in this document, it has become clear to us that these deficiencies will not be addressed unless the payers force the solution, which can only be done if they work together and exercise their collective clout. That kind of collaboration will never occur if left exclusively to corporate benefit managers whose primary focus in most companies is meeting the company's benefits needs in the year at hand and putting something workable in place for the following year. Just as the overall direction of the company is set by those at its highest level, the company's role in the future direction of health care must also be shaped at that level.

The reality is that, just as comprehensive regional reform of the health care system can only occur through CHRO and other top executive involvement, the same will be true of any reshaping of our national health care system. There is widespread agreement that the system is broken but little consensus as to what should replace it. Nevertheless, there is a sense of inevitability that, within the next decade or so, absent significant improvements in accessibility, cost, and quality, it will be replaced with something. The only question is whether the decisions as to what replaces it are left exclusively in the hands of government or whether employers and other stakeholders play a decisive role as well.

Defining the Ideal Health Care System

Any future vision of the health care system has to grapple with five major issues:

- funding;
- choice of providers, plans, and coverage levels;
- portability;
- quality; and
- employer role.

All of these are interconnected so, to effectively deal with any of them, a holistic approach must be fashioned.

Funding. The current system is funded largely by employers and the government, with consumers picking up very little of the direct costs, though they pay indirectly through deferred wages and other benefits and higher taxes. This has not only resulted in enormous fiscal pressures on both employers and the government to maintain the system, but it has also caused most consumers to pay little or no attention to costs, which, in turn, drives up the price of the system.

To some extent, this problem is already being addressed through cost-shifting, higher-deductible programs, the formation of Health Savings Accounts, and other consumer-driven health care reforms. However, the more fundamental issue is whether the current employment-based system should continue to be sustained by the tax code. The tax preferences for employment-based health insurance—which currently costs $100 to $130 billion per year—make sense as long as employer-based coverage provides the backbone that finances our health care system for the majority of American workers. However, as more and more individuals have to fend for themselves in the individual market, the resulting inequity becomes intolerable. Hence, the movement towards "tax parity," which, in its most radical form, would eliminate all tax preferences for employer-provided insurance. A more modest approach is to simply provide tax benefits for the individual market, starting with income-based refundable tax credits. However, doing this without touching the employer-based preferences creates even more revenue loss at a time of huge budget deficits.

Federal policymakers are starting to grapple with these fundamental issues, with several prominent voices endorsing full tax parity. Although it is unlikely that dramatic changes are imminent, this long-term debate is critical to the future shape of our health care system and it is incumbent upon large employers to seek to reach a consensus on whether the tax preferences for our employment-based system should be maintained in their current form.

Choice (Provider, Plan and Level of Coverage). A common criticism of the employment-based system is that—in addition to employees having no "skin in the game"—they also are denied any choice as to what kind of insurance they have. Typically, they are limited to the carrier chosen by their employer. Their choice is often further limited to the mixture and level of coverage offered through their employer or no coverage at all. Choice of hospitals, doctors, and prescription drugs may also be limited. A significant number of employees opt out of the coverage, either because they believe they are healthy and want to use their money for something else or because they don't think they can afford the employee share of the premium. In contrast, consider the Federal Employees Health Benefits Program (FEHB), which provides employees a wide range of carrier and coverage options with a fixed amount of employer subsidy. The federal government can offer this because it has nine million employees, among other reasons. A single employer does not have that kind of market clout. Employers will need to act in an entirely new way to foster the kind of choice of health plans and coverage that federal workers currently enjoy if they want to provide more options while maintaining the ability to negotiate effective contracts with health plans.

Portability. The workforce mobility trends that began in the latter part of the twentieth century are continuing at an even more rapid pace. In addition to more mobility between employers, more and more individuals are choosing non traditional relationships with employers—independent contractors, part-timers, etc. The current employment-based system—structured around long-term, full-time job tenure—does not adequately serve this growing population. The Roundtable's National Health Access program is a major step towards addressing this need but even under this program, the individual must continue his or her attachment to the participating employer to ensure continued coverage.

Quality/Transparency. It goes without saying that any future vision of the health care system must address the serious quality deficiencies of the current system. This problem will have to be attacked from several angles but a key element of the solution is increased consumerism. Thus, an ideal health care system would include greater transparency of provider performance (which includes consumer access to the essential information) and a connection between provider compensation and performance. As we have discussed extensively in other

sections, this is already a major focus of our reform efforts. Both of our regional reform efforts in Southeast Michigan and Phoenix are placing significant emphasis on promoting quality improvement through improved transparency.

Employer Role. Each of the aforementioned areas will be influenced to a substantial degree by the role of the employer in whatever future model of health care is embraced. Absent a dramatic shift to a single-payer, government-run model, there is likely to continue to be some role for employers, though it may differ significantly from the current system.

This role is likely to fall somewhere within a continuum. At one end, the employer's role would be purely administrative and/or financial. Under this model, the employer provides some defined contribution to the employee to help meet his or her health care needs and provides the administrative support for ensuring that enrollment occurs and premiums are paid through payroll deductions. Beyond that, the employer plays little if any role in seeking to address cost containment and ensure the value of the health care "product" that the dollars are going towards.

At the other end of the continuum, the employer is actively engaged in strategically managing the health care spend to ensure maximum value. Through vigorous vendor management, the employer holds plans accountable for performance. In addition, the employer promotes better consumerism by its employees through incentives, evidence-based benefit designs, pay for performance, etc.

Potential Models. The recent health care crisis has generated numerous proposals ranging from incremental reforms in the system to wholesale restructuring. Employers are understandably concerned when discussions of alternatives to our existing system center upon an employer mandate or a so-called single payer approach where the government assumes the exclusive role of funding the system. In both instances, the concern is that the underlying problems in the system would not be addressed and that cost and quality issues would continue to mount. However, there are other models proposed that suggest that we should not have to embrace the status quo merely to avoid a far worse alternative.

For example, one view of the future of health care would build upon what is being initiated with National Health Access. Instead of the current structure of fragmentation among several insurance companies with thousands of employer/payers each having their own individually tailored program, there would only be a handful of plans competing for much larger pools of similarly situated individuals. Thus, risk pools would no longer be employer based, but would be defined by commonalities in the employment situation of those in the pool—hours worked, wages paid, size of employer, existence of employer subsidy, industry, etc. Employers would join together to facilitate the formation of these pools by combining their similarly situated populations, and working with the plans in developing coverage models and price points. They would provide access to their employees and some administrative support in the enrollment process as well as payroll deductions. The plans offered would provide guaranteed issue. In addition, data concerning provider performance would be available to participants as well as a pay-for-performance component.

In addition to providing access, the structure would also provide a greater degree of choice. As with National Health Access, to accommodate affordability, the design choices within the plan could vary so that, depending on what they felt they could afford, employees would have the option of purchasing essential coverage (office visits, prescriptions drugs, etc.), essential coverage plus catastrophic, and ultimately, the most comprehensive coverage.

Some have suggested that the solution to the problem of the uninsured lies in mandating that individuals who can afford to

do so be responsible for ensuring that they are covered either through an employer-provided program or through the individual market. While we are not endorsing this proposal, we would point out that, with the availability of more affordable options to individuals, an individual mandate would be more viable, particularly if it were combined with tax preferences that were not attached to an employer subsidy. At the same time, to further spread the risk for the most expensive cases, a reinsurance program for catastrophic cases could be created either by the federal government (as suggested during his presidential campaign by Senator John Kerry) or as a quasi-governmental entity (as suggested by Senate Majority Leader Bill Frist). Even though everyone would share the costs for this in some other form, it would hopefully have the effect of lowering premiums overall.

As can be seen, there are many alternative directions the future of health care can take without locking into a single payer or employer mandate model that exclusively focuses on addressing the funding and access issues. Although it is premature to suggest an employer consensus at this stage, it is incumbent upon employers to begin thinking about how we want the system to evolve, lest we wind up with the kind of dictated result that is among our worst fears.

A Blueprint for the Future: Driving Reform Through Health Care Contracting

Although the picture of an ideal health care system is at this point far from clear, there are certain improvements in the existing system that we believe can be forged through large employers working together. This document has primarily addressed the need for action at a regional level but we also believe progress can be made through collaborative action taken at a national level as well.

This does not necessarily require the formation of a purchasing coalition. Similar results could be achieved if the HR Policy membership were to agree upon a set of actions, such as guidelines for contracting for health care, to which all would adhere. As has been noted by GE Director of Corporate Health Care Robert S. Galvin, MD, who also serves as the Roundtable's Director of Health Care Value Initiatives:

> *Effective purchasing by a majority of large employers would lead health plans to develop products that drive provider improvement, which could then be adopted by mid-sized and smaller employers. If quality and efficiency specifications were to be integrated into RFPs and contracts, this would provide powerful support to the actions of many public purchasers. Individual commitments must be multiplied to have effect, and while The Leapfrog Group and others have provided employers with roadmaps and tools and technical guidance, implementation by a critical mass has yet to be achieved.*

This view is expounded upon in an article Dr. Galvin has co-authored with Suzanne Delbanco, Ph. D., CEO of The Leapfrog, in a forthcoming issue of *Health Affairs*.

To help us develop a blueprint for collective actions that could drive reform, we formed a Task Force, Contracting for the Future [Appendix C], composed of the top benefit managers from HR Policy Association member companies that have committed themselves to health care market reforms. In addition, Chairman John Butler sent a letter [Appendix D] to leading health care plans, consulting firms, and health care reform organizations inviting their recommendations as to collective actions the HR Policy Association membership could take to drive needed reforms.

The responses we received [Appendix E] were both encouraging and enlightening and were followed by an all-day

meeting of the task force in Washington with the respondents: Aetna; Bridges to Excellence (BTE); Care Focused Purchasing (CFP); Mercer Human Resource Consulting; CIGNA; The eHealth Initiative (EHI); Humana; Leapfrog; National Business Coalition on Health (NBCH); and Towers Perrin. We have incorporated a number of the specific proposals from the respondents into our overall strategy for reform.

In addition to the specific suggestions, there was a common theme among all the respondents that the engagement of chief human resource officers and other senior corporate executives is the missing component that could finally catalyze long overdue reforms in the health care system. To direct this engagement and ensure that it has the maximum impact, we recommend that the membership of the HR Policy Association adopt certain common contracting principles that, if adopted by enough large companies, could create the needed critical mass for reform.

Employer Contracting Principles

The recommended contracting principles are segmented into four key components: (1) health plans and other vendors; (2) health care providers; (3) beneficiaries; and (4) public policies.

1. Health Plans and Other Vendors

- **Promote competition:** Employers should place their business out to bid on a regular basis (*e.g.,* every three years) through Requests for Proposals and other contracting vehicles that assess both price and quality. We recommend that the Roundtable develop and endorse a standard RFP/RFI that could be adopted by HR Policy member companies, who employ 19 million employees worldwide and 12 percent of the U.S. private sector workforce. This was recommended by Leapfrog, NBCH, BTE, EHI, Care Focused Purchasing, Aetna, and Cigna. We also recommend the creation of a Value Based Purchasing Toolkit that documents best practices and available tools (such as the standard RFI/RFP) for employers, consultants, and brokers to employ to advance market reform principles. This was recommended by Leapfrog, BTE, NBCH, and EHI.

- **Demand accountability**: Financial performance guarantees should be established to reinforce health plan and vendor contract commitments and establish financial consequences for failure to meet guarantees. We recommend that the Roundtable develop and endorse standard health plan contract language that could be used by employers' consultants and brokers to ensure these commitments. This was recommended by Leapfrog, NBCH, BTE, EHI, and CFP.

- **Support standardization:** Health plans should be required to adopt standard methods for claims submission, data transfer, and measuring and reporting their cost and quality and demand that consultants use standard methods for assessing health plan and vendor capabilities (*i.e.*, standard measures, collaborative data collection and warehousing, and requests for proposals.) This could be facilitated through the standard RFP/RFI and endorsement of a core provider performance measurement set (as recommended by CFP), as well as the NCQA health plan accreditation process and HEDIS measures.

- **Require transparency**: Plans and other vendors should be required to publicly report their performance using standard quality and cost measures. Health plan performance indicators should be published for use by beneficiaries and plans and other vendors should be required to use transparent methods to measure provider performance. Employers can promote transparency in pharmaceutical purchasing by joining the Roundtable's

Direct Pharmaceutical Purchasing Coalition and by contracting with pharmacy benefit managers (PBMs) that meet the Coalition's transparency requirements.

- **Pay for performance**: Employers should contract with and drive volume to health plans and other vendors that demonstrate the highest quality and lowest cost. Employers should adopt benefit designs, networks, and provider reimbursement arrangements that promote improvement and reward high-performing health plans and providers by focusing on overall value, not just unit cost of service (*e.g.*, provider discounts). This can be facilitated through consumer-directed health plan designs, health savings accounts, tiered networks based on provider performance, and hospital and physician incentive programs.

2. Health Care Providers

- **Support standardization:** Health care providers should be required to adopt standard methods for measuring and reporting their cost and quality. Employers should embrace standards for health information technology and electronic medical records as well as standard prescription drug formularies and preferred drug lists (as recommended by CIGNA). We recommend that the Healthcare Roundtable collaborate with Care Focused Purchasing, Mercer Human Resource Consulting, Leapfrog, Bridges to Excellence, and the National Business Coalition on Health to develop "Version 2" of the measurement set that was recently developed by the Affordable Solutions Coalition.

- **Require transparency:** Doctors, hospitals, and other providers should be required to publicly report their performance using standard quality and cost measures. Employers should participate in regional efforts (such as those in Detroit and Phoenix) as well as national efforts to promote performance reporting by providers. In addition, as noted previously, employers should require that healthy plans include provider contract language that promotes public performance reporting. There are a number of available tools to facilitate these steps: Leapfrog hospital measures; Leapfrog regional roll-out sites; BTE performance reporting requirements; CFP administrative data warehouse; and report card vendors and health plan report cards that use standard provider performance measures.

- **Pay for performance**: Employers should adopt benefit designs, networks, and provider reimbursement arrangements that promote improvement and reward high-performing providers by focusing on overall value, not just unit cost of service (*e.g.*, provider discounts). Tools available to facilitate these steps include the Bridges to Excellence physician incentive program and The Leapfrog Hospital Rewards Program.

3. Beneficiaries

- **Educate and inform:** Employers should communicate with employees and other beneficiaries about the importance of comparing and choosing providers based on their cost and quality and managing their own health. The Leapfrog Enrollee Communications Toolkit is a useful device for implementing this.

- **Align incentives:** Employers should offer benefit designs and financial incentives to promote healthy lifestyles and selection of high-performing plans and providers. This can be achieved through tiered networks designed to reward high-performing providers, consumer-directed health plans, direct incentives for managing health, and disease management programs (*e.g.*, obesity, asthma, diabetes, coronary artery disease). The Bridges to Excellence

consumer incentive program is an effective tool for implementing this.

- **Facilitate access to coverage:** Employers should provide access to affordable coverage, either individually, or through creative alternatives offered through coalitions and health plans. The members of the Roundtable's Affordable Health Care Solutions Coalition are achieving this through the National Health Access and Retiree Health Access programs.

4. Public Policy

- **Support public policy to promote reform:** Employers should play an active role in supporting local and national public policy actions that advance these purchasing principles for public and private purchasers. This includes the following critical policy areas:

    - electronic medical records and connectivity standards;
    - Medicare data repository and public reporting of provider performance;
    - Medicare pay for performance;
    - NIH funding for applied research to assess clinical effectiveness for treatments and therapies;
    - creation of a patient safety repository;
    - promotion of health care literacy;
    - creation of a national program for standard technology assessment;
    - revision of tax policy to promote equity, portability, access, and coverage; and
    - clarification of the so-called Stark provisions to promote adoption of health information technology.

The adoption of these principles by the HR Policy Association membership will provide a critical first step toward the needed reforms. However, we emphasize that this ultimately must mean more than simply paying lip service to a set of goals. Rather, the real work will come in actually implementing the steps needed to fulfill these principles. We fully recognize that the real heavy lifting is yet to come.

We have prepared a brief reference document in Appendix F that includes the purchasing principles and recommended tools that chief human resource officers should encourage their benefits managers to adopt to promote implementation of the purchasing principles.

Appendix A—Summary Chart of Existing Resources

Group Description	Objectives	Tools
Bridges to Excellence ***www.bridgestoexcellence.org*** Bridges to Excellence (BTE) is the result of collaboration between employers, physicians, and measurement specialists. Its focus is to create incentives for physicians to reengineer their practices in order to deliver safe, timely, effective, efficient, equitable, and patient-centered care. It also includes consumer incentives to improve how they manage chronic diseases.	BTE awards both physicians and employees who demonstrate compliance with recommended health care quality protocols. Physicians can earn cash bonuses for how they provide cardiac care, diabetes care, and by demonstrating how effectively they are adopting office systems and information technology to promote improved quality through three specific programs: Physician Office Link, Diabetes Care Link, and Cardiac Care Link. Employees can earn credits for use in the purchase of medical supplies by demonstrating that they are effectively managing their health.	Employers can participate in Bridges to Excellence in a number of ways: • Plan contracting – Employers can ask their health plans to implement BTE on its behalf. • Local coalitions – Many health care coalitions across the country, from Massachusetts to Arkansas to Colorado and Nebraska, are in the process of implementing some or all of BTE's programs, and employers should check the BTE web site for updated lists of markets and contact information. • Self-initiated – Any employer can launch BTE in a market where they have a sufficient presence (between 10% to 15% of all insured)—either working alone or in partnership with other employers in the market.
Consumer-Purchaser Disclosure Project ***www.healthcaredisclosure.org*** The Consumer-Purchaser Disclosure Project (CPDP) is a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly	CPDP's vision is that by January 1, 2007, Americans will be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency.	CPDP published consensus Guidelines for Purchaser, Consumer and Health Plan Measurement of Provider Performance. These guidelines set forth recommendations to promote the adoption of uniform performance measures for hospitals and doctors. The Measure Guidelines also set forth recommendations for coordinating data collection for performance measurement. CPDP supports three primary drivers of improvements to the health care system: (1) consumers using valid performance

Group Description	Objectives	Tools
reported health care performance information.		information to choose providers and treatments, (2) purchasers building performance expectations into their contracts and benefit designs, and (3) providers acting on their desire to improve, supported with better information. CPDP has also issued principles for physician pay for performance, which are being advocated for revising how Medicare pays physicians and hospitals to link reimbursement to quality and efficiency.
The Leapfrog Group ***www.leapfroggroup.org*** The Leapfrog Group (Leapfrog) is a national non profit coalition of more than 165 Fortune 500 companies and other large private and public sector purchasers of health benefits. The group works to trigger leaps in the safety, quality, and affordability of health care by supporting informed health care decisions by those who use and pay for health care, and by promoting high-value health care through incentives and rewards.	Leapfrog is working to initiate breakthrough improvements in the safety, quality, and affordability of healthcare for Americans by: • supporting informed health care decisions by those who use and pay for health care; and • promoting high-value health care through incentives and rewards.	Leapfrog has identified and refined four hospital quality and safety practices that are the focus of its health care provider performance comparisons and hospital recognition and reward: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and The Leapfrog Quality Index, based on the NQF-endorsed Safe Practices. Leapfrog works in three main ways to create improvements in the quality of American health care. • Building Transparency: Through fielding a voluntary survey—The Leapfrog Group Hospital Quality and Safety Survey—to hospitals that asks them whether they meet four quality and safety practices or "leaps." • Incentives and Rewards: Leapfrog helps employer members either directly or through their health plans to provide incentives and rewards to hospitals that improve the quality of the care they provide to patients by implementing Leapfrog's quality and safety practices.

Group Description	Objectives	Tools
		• Creating Consistency and Leverage for Change: Working with other organizations to develop and recommend other quality and safety initiatives for both hospitals and physician offices.
National Business Coalition on Health ***www.nbch.org*** The National Business Coalition on Health (NBCH) has a membership of nearly 90 employer-led coalitions across the United States, representing over 7,000 employers and approximately 34 million employees and their dependents. These business coalitions are composed of mostly mid- and large-sized employers in both the private and public sectors in a particular city, county, or region. NBCH member coalitions are committed to community health reform, including an improvement in the value of health care provided through employer-sponsored health plans and to the entire community.	NBCH promotes community health reform based on the following principles: Value-based health care purchasing —obtaining the highest quality care at the most reasonable cost; Measuring the comparative quality and efficiency of hospitals, physicians, and health plans in the community to identify the best value; Creating incentives to provide higher-value care through integrated delivery systems and continuous quality improvement; and Improving the overall health of the community.	The National Business Coalition on Health's eValue8 ™ tool is widely used by business health coalitions, their purchaser members, and national employers to assess and manage the quality of their health care vendors. The Value8 tool raises the bar for health care performance and moves the market to deliver greater value for the purchaser's health care dollar. Initially offered exclusively to NBCH members, eValue8 is expanding its scope and influence through an official partnership with Watson Wyatt Worldwide. Starting in 2005, Watson Wyatt and NBCH will conduct a joint annual national health plan survey using eValue8 and will disseminate the data collected to their participating Watson Wyatt clients and NBCH member coalitions.
National Committee for Quality Assurance ***www.ncqa.org*** The National Committee for Quality Assurance (NCQA) is an independent, 501(c)(3) non profit organization whose mission is to improve health care quality	NCQA accredits a variety of organizations from HMOs to PPOs to Managed Behavioral Healthcare Organizations (MBHOs), and each accreditation program is distinct. The goals of these various accreditation programs, however, is the same; in each case, NCQA conducts an independent, objective review against a set of standards and, based on that	NCQA evaluates health care in three different ways: through accreditation (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEDIS®—a tool used to measure performance in key areas like immunization and mammography screening rates); and through a comprehensive member satisfaction survey.

Group Description	Objectives	Tools
everywhere. NCQA evaluates health care through a variety of different formats. Although participation in NCQA accreditation and certification programs is voluntary, more than half the nation's HMOs currently participate.	review, develops information that is then made publicly available to inform consumers' and employers' enrollment or contracting decisions.	
National Quality Forum ***www.qualityforum.org*** The National Forum for Health Care Quality Measurement and Reporting (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. Established as a public-private partnership, the NQF has broad participation from all parts of the health care system, including groups representing consumers, public and private purchasers, employers, health care professionals, provider organizations, health plans, accrediting bodies, labor unions, and organizations involved in health care research or quality improvement. Together, NQF members work to promote a common approach to measuring health care quality and fostering system-wide capacity for quality improvement.	NQF endorses quality measures for national use and also promotes the use of quality information, and develops a research agenda to advance quality improvement. NQF has established four primary strategic goals: • NQF-endorsed standards will become the primary standards used to measure the quality of health care in the United States; • NQF will be the principal body that endorses national health care performance measures, quality indicators, and/or quality of care standards; • NQF will increase the demand for high quality healthcare; and • NQF will be recognized as a major driving force for and facilitator of continuous quality improvement of American health care quality.	Member organizations of the NQF have the opportunity to take part in a national dialogue about how to measure health care quality and report the findings to consumers, purchasers, providers, and policymakers. Members vote on NQF leadership and participate through one of four Member Councils: the Consumer Council, Purchaser Council, Provider and Health Plan Council, and Research and Quality Improvement Council. NQF measurement sets are available through its web site at *www.qualityforum.org*.

Group Description	Objectives	Tools
Pacific Business Group on Health ***www.pbgh.org*** Pacific Business Group on Health (PGBH) is comprised of 50 large purchasers that collectively spend billions of dollars on health care coverage for more than three million employees, retirees, and dependents. By partnering with the state of California's leading health plans, provider organizations, consumer groups, and other stakeholders, PBGH works on many fronts to promote value-based purchasing in health care.	PBGH seeks to improve the quality and availability of health care while moderating costs. PBGH responds to the needs of its member companies and their employees. Mindful of its role in the community, it strives to accomplish the following: • value based purchasing; • quality measurement and improvement; and • consumer engagement.	PBGH's Negotiating Alliance promotes value-based purchasing through an annual Request for Proposal (RFP) and rate negotiation process on behalf of nearly 400,000 active and retired Californians. The alliance leverages the purchasing power of 19 large employers to achieve competitive pricing while fostering health plan accountability for quality and care improvements. The Negotiating Alliance: • negotiates annually with both commercial and Medicare + Choice HMOs; • fosters employer collaboration in developing a focused negotiation strategy and establishing common goals; and • places 2 percent of premium at risk for negotiated targets to promote health plan improvement in customer service, satisfaction, and quality.

Appendix B—Phoenix Press Release

News Release

Contact: Gwyn Dilday
(818) 500-6370
Gwyn.Dilday@cigna.com

CIGNA JOINS MAJOR EMPLOYERS IN GROUNDBREAKING HEALTH CARE QUALITY INITIATIVE
Effort to take Place in Greater Phoenix Area

Washington, DC, February 16, 2005—CIGNA HealthCare today announced that it is joining with the HR Policy Association, an organization of the nation's leading employers, to enhance the depth of information about provider quality and efficiency available to employers and consumers. The two organizations will work with The Leapfrog Group and Bridges to Excellence, both non-profit organizations focused on improving health care quality and efficiency and patient safety. With the rise in interest among health care consumers for quality information, education and data, CIGNA said the initiative is both opportune and important.

The initiative will begin in Phoenix and serve as a model for the sharing of data and information among employers, consumers and other health plans. Informational meetings are in process to encourage additional participation in this program.

Working together, the organizations will broaden access to standardized quality and efficiency measurements that will include Bridges to Excellence physician quality measures and The Leapfrog Group's hospital performance measures. The program will also encourage adoption of The Leapfrog Group's Hospital Rewards Program.

“Our member companies are committed to promoting regional reform efforts to improve the quality and affordability of health care in America,” said John Butler, executive vice president, administration and chief human resources officer for Textron Inc., and chair of Regional Health Care Quality Reform Initiatives for the HR Policy Association. “We are excited about the opportunity to collaborate with one of the nation’s leading health plans to show how employers and health plans can work together to promote health care quality improvement.”

“CIGNA knows that providing robust data about costs, quality and efficiency enables employers as well as their employees to better manage their corporate and personal health care resources,” states Noël Obourn, senior vice president, CIGNA HealthCare, national segment. “We look forward to being part of an initiative that will help us develop even better consumer decision-support tools and benefit plans that reward efficiency and encourage the use of providers who meet or exceed quality measures.”

HR Policy Association, The Leapfrog Group and Bridges to Excellence all support CIGNA HealthCare’s measurement approach with regard to hospital and physician quality and efficiency. The initiative draws data from several sources, including public information, CIGNA claims data and measurements from The Leapfrog Group. “The keys to advancing dramatic quality improvements are measuring and rewarding hospitals based on how well they care for their patients,” said Suzanne Delbanco, chief executive officer of The Leapfrog Group. “This innovative partnership addresses both these needs.”

In addition, the program includes Bridges to Excellence measures that address physician quality. “Bridges to Excellence fits very well into this effort,” said Jeff Hanson, Verizon, chair of Bridges to Excellence. “Combining our efforts with those of Leapfrog, and partnering with CIGNA HealthCare and the HR Policy Association to advance quality improvement in Phoenix creates a powerful and comprehensive approach to regional quality reform for care that can be emulated in other markets across the country. We encourage others to join our efforts and promote the use of a common set of quality measures.”

“We welcome all comers to this initiative,” adds Butler. “That includes additional health plans, regional coalitions and employers of all sizes. The more companies and organizations we have, the better our chances are for success in Phoenix and in other markets.” For more information about the upcoming seminars or the initiative, please contact the participating organizations or go to www.cigna.com, www.hrpolicy.org, www.leagfroggroup.org and www.bridgestoexcellence.org

About the program participants:

CIGNA HealthCare, headquartered in Bloomfield, Connecticut, provides medical benefits plans, dental coverage, behavioral health coverage, pharmacy benefits and products and services that integrate and analyze information to support consumerism and health management. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation (NYSE: CI). Products and services are provided by these operating subsidiaries and not by CIGNA Corporation.

HR Policy Association is the public policy organization of senior human resources executives of more than 250 of the largest employers in the United States. Our mission is to assist our members in using the collective leverage of the membership to further critically important business and societal objectives. The focus on health care quality, availability, and cost for both current and retired employees has become the number one concern of senior HR executives. The Association formed the Health Care Policy Roundtable to bring together a select group of its HR vice presidents representing most of the major economic sectors in the Fortune 500. In addition to pursuing public policy initiatives, the Roundtable is currently driving several innovative health care projects in the private sector, including efforts to drive greater transparency and improvements in provider effectiveness and efficiency.

The Leapfrog Group is a national non-profit coalition of more than 165 Fortune 500 companies and other large private and public sector purchasers of health benefits. The Group works to trigger leaps in the safety, quality and affordability of healthcare by supporting informed health care decisions by those who use and pay for health care, and promoting high-value health care through incentives and rewards.

Bridges to Excellence coalition is a not-for-profit organization created to encourage significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care.

###

Appendix C—Task Force on Contracting for the Future

John D. Butler, Chairman

Executive Vice President, Administration & Chief HR Officer
Textron Inc.

Jane Barlow, MD, MPH, MBA
Well-being Director, Health Benefits Operations
IBM Corporation

Jill A. Berger
Vice President, Health & Welfare Plan Management & Design
Marriott International, Inc.

Michael L. Davis
Vice President, Compensation, Benefits and Staffing
General Mills, Inc.

Gregory S. Folley
Director, Compensation & Benefits
Caterpillar Inc.

Robert Galvin, MD
Director, Corporate Health Care and Medical Programs
General Electric Company

Ned Holland, Jr.
Vice President, Human Resources
Sprint Corporation

Kate A. Kohn-Parrott
Director, Integrated Health Care/Disability
DaimlerChrysler Corporation

Peter V. Lee
President & Chief Executive Officer
Pacific Business Group on Health

Ron St. Pierre
Director of Benefit Programs
Textron Inc.

Dale Whitney
Corporate Health Care Manager
United Parcel Service

Terrell Womack
Executive Director, HR Strategy, Compliance and Policy
BellSouth Corporation

Appendix D—Letter from John Butler Inviting Reform Proposals

TEXTRON

John D. Butler
Executive Vice President, Administration
& Chief Human Resource Officer

40 Westminster St.
Providence, RI 02903-2596

T (401) 457-2401
F (401) 457-2556
jbutler@textron.com

June 6, 2005

<Prefix> <First> <Last>
<Title>
<Company>
<Address 1>
<Address 2>
<City>, <State> <Zipcode>

RE: Invitation to Submit Proposed Market Reform Initiatives

Dear <Prefix> <Last>:

As Chairman of the HR Policy Health Care Policy Roundtable Regional Health Care Quality Reform Initiatives Coalition, I am pleased to invite your organization to submit ideas on how large employers who pay a significant share of the health care costs in the United States can work with your organization to use their collective buying power to leverage long-overdue health care market reforms at the national or regional level. In addition to your organization, we are contacting several large health plans, benefit consulting firms and selected leading health care reform organizations to invite them to submit their ideas by July 1, 2005. Enclosed with this letter is a more detailed discussion of our objectives and the process for considering how we might partner with your organization to advance mutually beneficial market reform concepts. Recognizing the relatively short time frame involved, at this point we are looking for high-level concepts rather than highly-detailed propositions.

The Coalition was created by the Health Care Policy Roundtable of HR Policy Association. (See enclosed Roundtable membership roster.) The association represents the chief human resource officers of more than 250 large employers doing business in the United States. The majority of association members are major purchasers of health care, although the membership also includes major hospital chains, health care insurance carriers, and pharmaceutical manufacturers. The number one concern among HR Policy members is the unsustainable increases in health care costs and deficiencies in health care quality that threaten the viability of the nation's employment-based health insurance system.

The Roundtable firmly believes that there are certain improvements in the nation's health care system that can be forged through large employers working together. We also believe that we can establish effective partnerships with key stakeholders such as benefit consulting firms and health plans to advance reform goals. Thus far, our coalition has focused upon the need for action at a regional level but we also believe progress can be made through collaborative action at a national level as well. This is already being done through the Roundtable's Affordable Solutions and Pharmaceutical Purchasing Coalitions addressing two of the most serious problems in the system—the problem of the uninsured and the costs and pricing of prescription drugs.

However, we believe there are other issues that could be addressed in a collaborative manner. For example, broader reforms might be achieved if the HR Policy membership were to agree upon a set of guidelines for contracting for health care. Another example may be value-based purchasing through the routine and systematic use of standard RFPs for selecting the plans. Meanwhile, employees may be engaged through the implementation of consumer-based plan designs and condition management programs. Another priority area is advancing a standard set of national performance measures for health care providers that can be linked to incentives and rewards to promote quality improvement, efficiency, and consumerism. These and other principles could be agreed upon as steps toward driving the system toward the "Six Sigma" standards that the members have embraced within their own organizations.

Your organization's proposals on how needed health market reforms could be achieved through the contracting process or any other aspect of corporate health care spending are invited. We are seeking creative ideas advancing reforms directed at improving:

- funding;
- choice of providers, treatments and coverage levels;
- portability;
- value/transparency/pay-for-performance; and
- the role of employers.

All suggestions will be reviewed by the Coalition's Task Force on Contracting for the Future, which will meet in Washington D.C. on July 14 with a select group of those who respond. Following that meeting, we will make specific recommendations to the Health Care Policy Roundtable regarding adoption and endorsement of ideas judged to be aligned with the Roundtable's goal of using the purchasing power of its members to promote dramatic improvements in the health care system. Those ideas will then be presented to the HR Policy Association membership for approval at our September 8 membership meeting, which will be attended by the chief human resource officers of the HR Policy Association member companies.

Because of your position as a major stakeholder in our health care system, our coalition would benefit immeasurably from your ideas on how we can collaborate to address our nation's unacceptable health care deficiencies. To promote breakthrough opportunities, we encourage you to be highly creative in developing your ideas for consideration by our members.

We sincerely hope that your organization will choose to participate in this process by providing suggestions on how needed health market reforms could be achieved through the contracting process or any other aspect of how major corporations manage their health care strategy and expenditures.

Sincerely,

John D. Butler
Executive Vice President, Administration & Chief HR Officer

Enclosures

HR POLICY ASSOCIATION
The Association of Senior Human Resource Executives

HEALTH CARE POLICY ROUNDTABLE

Invitation to Submit Proposed Market Reform Initiatives

The Regional Health Care Quality Reform Initiatives Coalition of the Health Care Policy Roundtable is inviting ideas on how large employers who pay a significant share of the health care costs in the United States can work with one or more health plans, benefit consulting firms and health care reform organizations on a national or regional basis to use their collective buying power to leverage long-overdue health care market reforms.

The Coalition is interested in creative ideas on how we can collaborate with your organization to address our nation's unacceptable health care deficiencies. One possibility would be for the HR Policy membership to agree upon a set of guidelines for contracting for health care that all would agree to adhere to, such as value-based purchasing through the routine and systematic use of RFPs for selecting the plan. Your organization's proposals on how needed health market reforms could be achieved through the contracting process or any other aspect of how major corporations manage their health care spend are invited.

Proposals are due July 1, 2005, and will be reviewed by our Task Force on Contracting for the Future, who will meet with a select group of respondents in Washington, DC, on July 14, 2005.

Background

Health Care Policy Roundtable. In 2003, the HR Policy Association Board of Directors created the Health Care Policy Roundtable to take decisive action using the collective influence of America's largest private sector employers to address health care cost and quality issues that plague all payers. Chaired by J. Randall MacDonald, Senior Vice President of Human Resources for IBM, the Roundtable is composed of the chief human resource officers from a broad cross section of American industry's largest employers. Its strategies are premised on the recognition that HR Policy member companies, which employ more than 20 million employees worldwide, can use their collective buying power to leverage health care market reforms within existing public policies.

The Roundtable has developed a number of initiatives. Our Affordable Health Care Solutions Coalition, in partnership with UnitedHealthcare, Humana and Cigna, is attacking the problem of the uninsured with the National Health Access program, which will offer health insurance to employees and other individuals associated with our member companies who are not eligible for those companies' health insurance programs. Our Direct Pharmaceutical Purchasing Coalition is working with pharmaceutical service providers to develop greater transparency in the pricing of drugs. Both of these initiatives are being advanced through partnerships with Hewitt Associates and many of the nation's leading health plan and PBM companies. The Regional Health Care Quality Initiatives Coalition has worked with a number of companies and organizations in specific regions to accelerate the measurement, reporting, and dissemination of health

www.hrpolicy.org
1015 Fifteenth Street, NW
Suite 1200
Washington, DC 20005-2605
E-mail: info@hrpolicy.org
Tel: 202.789.8670
Fax: 202.789.0064

care provider quality and efficiency data. What follows is a discussion of the Coalition's experience, which is highly instructive to our efforts going forward.

Regional Health Care Quality Reform Initiatives Coalition. The Coalition is engaged in a feasibility study to determine whether large employers joining forces at the chief human resource officer level could achieve needed health market reforms by collaborating at the regional level on a continuing basis. In most major health care delivery market areas, HR Policy Association member companies collectively employ a substantial percentage (typically anywhere from five to fifteen percent) of the workforce.

In the course of this study, we have been impressed with the number of reform initiatives being pursued by companies both individually and collectively, by employer associations and coalitions, and by consulting organizations, among others. These include such efforts as The Leapfrog Group, Bridges to Excellence, the Consumer-Purchaser Disclosure Project, National Business Group on Health, and the regional work of such organizations as Pacific Business Group on Health, among others, along with various initiatives by the federal government. In addition, we have had interaction with companies and organizations to advance regional reform in a number of regions, particularly Phoenix, Detroit, Atlanta, and Peoria.

From this experience, we believe there is substantial potential for CHROs and their companies to work closely with organizations such as health plans, consultants and other leading reform organizations to promote significant market reforms. Health care has been the number one concern of CHROs for the past several years and is likely to remain a priority concern for several years to come. It is essential, therefore, that CHROs and other senior executives become much more involved in setting benchmarks for the purchase and delivery of health care on a broad collaborative basis, ensuring that those standards are followed, evaluating and ensuring the proper execution of market reform strategies, and creating a climate of accountability to minimize turf wars and focus all players on the consensus objectives. The ultimate solution lies in setting a vision for the purchasing community, reaching consensus on objectives, and executing a collaborative strategy. This can only be achieved by the direct involvement of those at the highest levels among purchasers.

National Focus. Thus far, the Regional Health Care Quality Initiatives Coalition has focused its efforts at the regional level, where an immediate impact is most feasible. However, the reality is that, while change is often a great deal more achievable at the local level, the broad structure of our health care system—currently an employment-based model—will still likely be a national paradigm, enormously influenced by how federal dollars are collected and spent. For this reason, it is of equal importance that chief human resource officers play a role at that level as well. Moreover, just as regional reform of the health care system can only occur through CHRO and other top executive involvement, the same will be true of any reshaping of our national health care system.

Defining the Ideal Health Care System

Any future vision of the health care system has to grapple with five major issues:

- funding;

- choice;
- portability;
- value/transparency/pay-for-performance; and
- employer role.

Funding. The current system is funded largely by employers and the government, with consumers picking up very little of the direct costs, though they pay indirectly through deferred wages and higher taxes. This has not only resulted in enormous fiscal pressures on both employers and the government to maintain the system, but it has also caused most consumers to pay little or no attention to costs, which, in turn, drives up the price of the system. More rational and stable funding alternatives are needed that more effectively engage consumers to make value-based purchasing decisions while promoting affordable and equitable access to health care services.

Choice (Provider, Treatment, Plan and Level of Coverage). A common criticism of the employment-based system is that—in addition to employees having no "skin in the game"—they also are denied any choice as to what kind of insurance they have. Typically, they are limited to the carrier chosen by their employer. Their choice is often further limited to the mixture and level of coverage offered through their employer or no coverage at all. Further, choice of providers and treatment options is also often limited. A significant number of employees opt out of the coverage, either because they believe they are healthy and want to use their money for something else or because they don't think they can afford the employee share of the premium. In contrast, consider the Federal Employees Health Benefits Program (FEHB), which provides employees a wide range of carrier, provider network and coverage options with a fixed amount of employer subsidy. The federal government can offer this because it has 9 million employees, among other reasons. A single employer does not have that kind of market clout.

Portability. The workforce mobility trends that began in the latter part of the Twentieth Century are continuing at an even more rapid pace. In addition to more mobility between employers, more and more individuals are choosing non-traditional relationships with employers—independent contractors, part-timers, etc. The current employment-based system—structured around long-term, full-time job tenure—does not adequately serve this growing population. The Roundtable's National Health Access program is a major step towards addressing this need but even under this program, the individual in most instances must continue his or her attachment to the participating employer to ensure continued coverage.

Value/Transparency/Pay-for-Performance. It goes without saying that any future vision of the health care system must address the serious quality and efficiency failure of the current system. This problem will have to be attacked from several angles but a key element of the solution is increased consumerism supported by publicly reported provider performance measures and redesigned payment systems to reward high performing providers. Thus, an ideal health care system would include greater transparency of provider performance (which includes consumer access to the essential information) and a connection between provider compensation and performance. Public and private purchasers would use consistent measures of provider performance, and would

collaborate to revise payment systems to align incentives for both publicly and privately funded programs. As you may know, this is already a major focus of our reform efforts.

Employer Role. Each of the aforementioned areas will be influenced to a substantial degree by the role of the employer in whatever future model of health care is embraced. Absent a dramatic shift to a single-payer, government-run model, there is likely to continue to be some role for employers, though it may differ significantly from the current system. This role is likely to fall somewhere within a continuum. At one end, the employer's role would be purely administrative and/or financial. Under this model, the employer provides some defined contribution to the employee to help meet his or her health care needs and provides the administrative support for ensuring that enrollment occurs and premiums are paid through payroll deductions. Beyond that, the employer plays little if any role in seeking to address cost containment and ensure the value of the health care "product" that the dollars are going towards.

At the other end of the continuum, the employer is actively engaged in strategically managing the health care spend to ensure maximum value. Through vigorous vendor management, the employer holds plans accountable for performance. In addition, the employer promotes better consumerism by its employees through incentives, evidence-based benefit designs, pay-for-performance, etc. An additional interest of employers is in maintaining a healthy workforce, which not only helps control health care costs but also helps employers maintain a high level of productivity. An employer who follows the strategic engagement model described above may also wish to create incentives for healthy lifestyles.

Contracting Principles and Other Reforms

Although the picture of an ideal health care system is at this point far from clear, there are certain improvements in the existing system that we believe can be forged through large employers working together.

As noted previously, this is already being done through the Roundtable's Affordable Solutions and Pharmaceutical Purchasing Coalitions addressing two of the most serious problems in the system. However, there are other issues that could be addressed in a collaborative manner. This does not necessarily require the formation of a purchasing coalition. Similar results could be achieved if the HR Policy membership were to agree upon a set of principles for contracting for health care that all would agree to adhere to. One example may be value-based purchasing through the routine and systematic use of RFPs for selecting the plan. In addition, the contracts with the plans may include standard efficiency and effectiveness measures along the lines of those that have been incorporated within the National Health Access program. Meanwhile, employees may be engaged through the implementation of consumer-based plan designs and condition management programs. These and other principles could be agreed upon as steps toward driving the system toward the "Six Sigma" standards that the members have embraced within their own organizations.

Your organization's proposals on how needed health market reforms could be achieved through the contracting process or any other aspect of how major corporations manage their health care spend are invited.

Task Force on Contracting for the Future

Proposals will be reviewed by the Task Force on Contracting for the Future, composed of the following representatives from HR Policy member companies:

- Dr. Jane Barlow, Well-being Director, Health Benefits Operations, IBM Corporation
- Jill Berger, Vice President, Health & Welfare Plan Management & Design, Marriott International, Inc.
- Mike Davis, Vice President, Compensation, Benefits and Staffing, General Mills, Inc.
- Greg Folley, Director, Compensation & Benefits, Caterpillar Inc.
- Dr. Robert Galvin, Director, Corporate Health Care and Medical Programs, General Electric Company
  Director, Health Care Value Initiatives, Health Care Policy Roundtable, HR Policy Association
- E.J. (Ned) Holland, Jr., Vice President, Human Resources, Sprint Corporation
- Kate Kohn-Parrott, Director, Integrated Health Care/Disability, DaimlerChrysler Corporation
- Ron St. Pierre, Director of Benefit Programs, Textron Inc.
- Dale Whitney, Corporate Health Care Manager, United Parcel Service
- Terry Womack, Executive Director, HR Strategy, Compliance and Policy, BellSouth Corporation

In addition, Peter Lee of the Pacific Business Group on Health, a coalition of health care purchasers that includes several HR Policy member companies, will participate in the Task Force. Primary staff support for this effort is being provided by Dan Yager, Senior Vice President and General Counsel for the HR Policy Association. Additional staff support will be provided by Steve Wetzell, Vice President, Health Care Initiatives, Health Care Policy Roundtable.

This group will thoroughly review the proposals received in response to this request and develop a set of recommendations for the Roundtable to present to the HR Policy Association membership. Hopefully, with the commitment of our more than 250 members to embracing and implementing these processes, we can continue to harness our collective market power to achieve the reforms needed to elevate our health care system to the same high standards they seek in their own companies.

Criteria for Evaluating Proposals

Recognizing the relatively short time frame involved, at this point we are looking for high-level concepts rather than highly-detailed propositions. The following criteria will be applied to assess the merits of your proposals:

Feasibility: The coalition wants to pursue regional and national reform initiatives that are actionable in the near term with little or no legislative or regulatory relief required. Initiatives that do not create significant operational or financial hurdles for employers to implement them will also receive favorable consideration.

Scalability: Ideas that are readily transportable to a broad geographic market and multiple industry segments would be ideal. Also, concepts that can be adopted by public purchasers, as well as large and small employers will also be considered optimal.

Potential Benefits: Proposals that score high on addressing many or all of the five major reform issues listed earlier will be given strong consideration. You are encouraged to share expected outcomes and ROI that will support reform that addresses the five reform issues.

Commitment of Resources: Organizations that demonstrate a meaningful commitment of resources to support the successful implementation of their ideas will receive favorable consideration.

Timetable for Action

- June 6, 2005 – Distribution of Invitation
- July 1, 2005 – Invitation Responses Due
- July 14, 2005 – Meeting of Task Force to Review Responses
- August 19, 2005 – Finalize Task Force Recommendations to Coalition/Health Care Policy Roundtable
- September 8 – Presentation of Coalition/Health Care Policy Roundtable Recommendation to HR Policy Membership

Responses must be forwarded no later than **5:00 p.m. EDT** on **Friday, July 1, 2005** to:

Denise Giles
Health Care Policy Roundtable
1015 15th St., NW
Suite 1200
Washington, D.C. 20005
Tel. (202) 789-8607
Fax (202) 789-0064
Email: dgiles@hrpolicy.org
(1 hard copy and electronic version)

Questions

Questions should be directed to Dan Yager (dyager@hrpolicy.org; 202- 789-8622) or Steve Wetzell (swetzell@msn.com; (952) 938-1788).

Appendix E—Responses to Butler Letter

Overview of Responses to Request for Proposals

Aetna

For Aetna, James K. Foreman, Senior Vice President of National Accounts and Aetna Global Benefits, submitted a comprehensive overview of the steps needed to be taken to reform the system. Aetna highlighted as the most important element the "collective will on the part of all key stakeholders—employers, health plans, providers, and consumers—to band together on a national basis to insist on meaningful reforms."

Aetna divides its suggestions into three categories: quality of care, consumer empowerment, and universal coverage:

Quality of Care In the area of patient safety, Aetna recommends creation of a central repository for the penalty-free reporting of medical errors, where root causes would be identified and analyzed, and solutions identified. Patient safety can also be improved by integrating clinical data available from pharmacy, behavioral health, and dental plans with data from medical plans. With regard to evidence-based medicine, Aetna describes a CareEngine System from ActiveHealth Management, a company recently acquired by Aetna, in which a virtual medical record is created from health plan claims data, drug claims data, lab test results, and other available data, while continually comparing the data to the latest evidence-based clinical guidelines, to identify treatment improvement opportunities—called Care Considerations—for those most at risk, which are then communicated to the treating physician and member.

In the area of electronic medical records, Aetna points out that an essential component must be personal health records (PHRs) put directly in the patients' hands for them to share with their clinicians. Aetna notes that it is working with AHIP to develop standards for PHRs.

Aetna strongly endorses pay for performance noting that it requires "a united front across employers and payers" and that employers should insist on such a system "built by employers, payers and providers."

Consumer Empowerment Aetna states that the key to empowerment is knowledge and suggests the development of an "industry-wide Consumer's Guide to Health Care" and "an educational reform initiative which, if developed jointly, could further educate and prepare consumers for their health care responsibilities."

Universal Coverage Aetna states that it is time to "seriously consider" a requirement that all individuals have health insurance, noting that details that will need to be addressed include "subsidies for low and moderate income individuals, components of basic benefit packages that would be guaranteed to all, and methods of enforcement."

Care Focused Purchasing

Care Focused Purchasing (CFP) and Mercer Human Resource Consulting (Mercer) have collaborated to submit a joint proposal to work with the HR Policy Association to reform the national health care market. The proposal includes existing CFP activities and services, as well as additional optional activities direct by Mercer that consistent with the current framework for CFP but outside its current scope. The task force is invited to consider both the CFP and Mercer services, or to act independently on each.

The proposal includes action steps in the following areas:

- procurement and contracting guidelines;
- consumer-based plan designs;
- standardized measurement criteria;
- consumer access to provider performance information through data aggregation; and
- roles for employers

Procurement and Contracting CFP employers have established a set of standard carrier specification for CFP member employers to use in health plan negotiation and contracting. CFP proposes the following:

- share RFP specifications with HR Policy Association members;
- work with our members to update and refine the specifications to meet employer needs;
- develop model language for key contractual provisions; and
- build the RFP specifications into BenefitPoint, a web-based purchasing tool for employers and payers.

As an optional feature, Mercer would work with interested HR Policy Association members to use their leverage to collectively purchase products and services from health plans and specialty vendors that best meet specifications. Mercer would act as a clearinghouse on an ongoing basis to ensure consistency and accuracy of health plan and specialty vendor alignment with the specifications.

Consumer-Based Plan Designs CFP employers with the assistance of Mercer have developed four inter-related plan design models including consumer centric designs, high-performance networks designed to steer beneficiaries to high-performing providers, behavior-based incentives to promote improved health, and evidence-based medical protocols. The models are broad templates that can be modified by health plans or employers to meet their needs.

CFP proposes to work with HR Policy Association members to refine these existing models and potentially develop additional standard designs for adoption by purchasers and payers. In addition, Mercer can perform financial modeling to determine the projected financial impact of plan designs for employers. Mercer can also work with the HR Policy Association to develop member communication templates.

Standard Measurement Criteria CFP is working to promote an industry standard set of provider performance measures. It has developed CFP Version 1.0 Measures that includes measures that have significant overlap with the measurement set used by the Healthcare Roundtable in its RFP for National Health Access. Currently, CFP relies on health plans to deploy provider performance results to consumers. CFP is considering deploying provider performance information through an independent resource. No final decision has been made on this concept.

CFP proposes to work with the HR Policy Association to develop Version 2.0 of its measurement set. It also proposes to partner with the Association to pursue an independent provider quality web site.

Data Aggregation A core objective of CFP is the aggregation of non financial claims data to enable a more robust and credible application of provider performance metrics. Computer Science Corporation (CSC) has been selected to perform this function and several carriers have agreed in principle to contribute their data and fund the data aggregation effort (contract negotiations are underway).

CFP recognizes that this national data warehousing initiative will be most effective when coupled with a local/regional implementation effort. CFP proposes that the national and regional efforts be connected by:

- having regions, along with their local health plans, contribute data to the CFP national database;
- giving regions access to the aggregated de-identified data set for the region in which the data was contributed; and
- having regions take the lead to deploy the data in the local health care market to drive regional reform and improvement.

CFP proposes the following action steps:

- work in tandem with Roundtable membership to recruit additional carriers to participate and fund the data warehouse;
- work with the Roundtable in existing regional markets such as Detroit, Phoenix, and Peoria to engage health plans and employers to utilize performance measures from the national data set and warehouse; and
- request that Roundtable members join CFP and contribute their self-insured claims data to the data warehouse.

Several examples of proof of concept accompanied the proposal that demonstrate positive ROI for CFP employers who have adopted some of the concepts included in the joint Mercer/CFP proposal.

CIGNA

Ken Sperling, Senior Vice President National Accounts, outlines several proposals and suggestions:

Pay for Performance CIGNA believes that the plans, not the employers, should be responsible for funding performance rewards and penalties (which should have a zero sum effect) but notes that, for competitive reasons, CIGNA cannot be the only plan engaged. Thus, "if HR Policy Association companies drive either value-based purchasing principles that support P4P contracting and/or an all-payer strategy that levels the competitive playing field, CIGNA will be a willing and energetic participant."

Electronic Health Records The Roundtable is encouraged to consider multi-employer, multi-payer initiatives on a local or regional level to accelerate the adoption of electronic health records, through either provider incentives (such as Bridges to Excellence's Physician Office Link program) or tiered network steerage. CIGNA provides the example of the North Carolina Healthcare Information and Communications Alliance (NCHICA), in which IBM is also playing a leading role, and encourages the Roundtable's alignment with the initiative or expansion upon it in other markets.

Cost Transparency CIGNA notes that patient access to provider fee schedules should not just be retrospective upon adjustment of claims. They should also have prospective on-demand access to specific provider cost information—especially if they are footing the bill under an HRA or HSA account-based program. CIGNA suggests that the Roundtable can make this happen either directly through the health plans or by sponsoring a "data warehouse on behalf of its member companies to be accessed by participating employers, employees, and dependents."

Standardized RFPs CIGNA proposes a "single, industry-endorsed RFP" to add "efficiency to the sales process and allow all health plans to devote resources to more productive pursuits." However, it cautions against a single template that "effectively commoditizes the capabilities of the broker/consultant and the health plan." CIGNA expresses a willingness to work cooperatively with a subgroup of Roundtable companies to develop an RFP template that "streamlines the current process, promotes cost-efficient, high-quality health care, and yet allows each health plan to clearly articulate its value proposition for the employer's consideration."

Pharmacy Benefit Formulary Development CIGNA proposes expanding upon the work of the Roundtable's Pharma Coalition to develop "an objective, clinically-based preferred drug list unencumbered by market pressure, manufacturer rebates and other financial incentives." To do this, CIGNA suggests convening "a panel of subject matter experts (on which CIGNA would be honored to serve) to objectively create a standard formulary based on clinical evidence and safety criteria alone. This formulary would be widely available for any employer to adopt, with the hope that every PBM would make this option available to its customers."

Research Projects CIGNA suggests that the Roundtable become a source of independent health care research, funded by subscription fees from interested members. Suggested examples of potential research, which the Roundtable would commission, are:

- the impact of increased pharmaceutical utilization on overall health care cost;
- the financial and clinical impact of consumer-driven health plans; and
- return on investment of wellness and health promotion programs.

In one passage worth noting, CIGNA expresses its concern regarding investing in initiatives that "reduce our competitive position in a price-driven (not value-driven) market. While we have been recognized by consultants and employers for our achievements in this area, we continue to struggle to 'do the right thing' in an environment where our competitors sit on the sideline in order to minimize

their overhead and subsequently win the business of the unit cost-driven purchaser. We encourage HR Policy Association members to change the health plan purchasing model, giving more than lip service to the areas of quality and value."

Humana

With an accompanying letter from President and CEO Michael B. McCallister, Humana submitted a broad description of reform proposals and efforts—many of which are already underway—segregated by four key audiences: consumers, employers, providers, and government. Mr. McCallister's letter describes these as "actionable in the near term at the regional and national levels" as well as "scalable and deployable by purchasers of all sizes and industries in both the public and private sectors." These "relate directly to Humana's strategy of engaging and guiding consumers to lower costs and a superior health plan experience."

Needless to say, most significant to our own deliberations are those proposals targeted at the employer audience. Humana proposes the creation of "a standard set of purchasing criteria and performance measures" consistent with the Roundtable's market reform goals, promoting collaborative partnerships, aligning interests, and fostering value-based purchasing:

> The Roundtable should develop required, standard criteria that health plans must meet in order to be awarded their business. In turn, these criteria should be incorporated into the procurement process for both renewal and new business requests for proposals. As part of the proposal and selection process, health plans should be asked to demonstrate their experience in achieving the established criteria as well as their willingness to develop new and innovative solutions that further advance the Coalition's reform goals. New and more meaningful health plan performance measures relating to market reform criteria and goals should be jointly developed and put in force.

Humana lists several examples of potential criteria, such as a "demonstrated capability to design and manage health plan design models that effectively promote and guide consumer engagement in the health care system."

Humana also proposes that the Roundtable support the development of a standard set of provider performance measures that create a common set of metrics supported by a common payment mechanism on which all providers can be evaluated equally.

Humana also recommends support for a number of public policy proposals, such as release of Medicare's 100% claims file (patient-protected), and studying an all-payer reimbursement system, as a solution to numerous emerging health care issues.

Leapfrog/Bridges to Excellence/eHealth Initiative

A joint submission was provided by Leapfrog (Suzanne Delbanco, CEO) Bridges to Excellence (Francois de Brantes, Director), and eHealth Initiative (Janet Marchibroda, CEO), noting that the Roundtable's goals "mirror our collective mission to trigger giant leaps forward in the safety, quality and affordability of health care," while bringing "the engagement of the vice presidents of human resources in the nation's largest corporations." They note that, while the system may ultimately shift to an individual basis, at present

it is only with employer involvement that there will be "meaningful strides toward measurement and reporting on physician and hospital performance or that of health plans or treatments." All three organizations have made significant progress but need more active participation from employers to accomplish their goals. They underscore that partnering with the members of HR Policy is "highly concordant with our mission" and "therefore, the organizations would devote considerable resources to supporting the effort."

Specifically, the three organizations propose:

- working with the National Business Coalition on Health (NBCH) to create "a common health plan RFI and contract language that would be available in modules for employers to use in negotiating and finalizing relationships with health plans." The focus would be on safety, quality, and efficiency, and "would either be an extension of or build on NBCH's eValue8 tool, which currently is available to employers only through their participation in local health care business coalitions." In addition, Leapfrog will explore providing partial membership rebates to Leapfrog members who use these tools.
- working with the Roundtable to "select markets of interest to HR Policy members and where all of our market transforming programs could be implemented simultaneously."
- expanding Leapfrog's health plan user groups to include participation by HR Policy Association members.

National Business Coalition on Health

Andrew Webber, President and CEO, proposes a national value-based purchasing strategy that is built on a partnership between the HR Policy Association, NBCH, the Leapfrog Group, and Bridges to Excellence. These four organizations would coordinate and synchronize their actions through a formal leadership and planning structure that is supported by a complementary implementation and execution strategy in regional and local markets throughout the country

The Leadership Structure A value-based purchasing steering committee would include representatives of Leapfrog, BTE, NBCH, and the HR Policy Association. CMS would be invited to participate in this leadership group to encourage coordination between private purchasers and the federal government. The steering committee would:

- establish a framework, principles, and goals for a national value-based purchasing strategy;
- help organize and direct the establishment of regional and local value-based purchasing councils in communities throughout the nation;
- provide technical assistance and evaluate the success or failure of value-based purchasing strategies being implemented through purchasing councils with support from a National Value-Based Purchasing Institute established to develop best practices and a learning network; and
- influence national policy development related to health care topics.

Regional/Local Value-Based Purchasing Councils Implementation of strategies and tactics approved by the steering committee would be the responsibility of regional/local value-based purchasing councils. These councils would build off existing coalitions where they exist, including NBCH members and Leapfrog regional roll-out sites. In communities where no existing employer-led infrastructure exists, HR Policy Association would be requested through the steering committee to take leadership in identifying and organizing "anchor" employers who would be willing to lead local/regional efforts. The goal would be to establish, at a minimum, value-based purchasing councils in every major and most metropolitan areas. Some of the specific areas of focus for the regional councils would be:

- develop local consensus on a set of provider performance indicators derived from national measurement sets;
- create data aggregation and public reporting strategies;
- design and implement pay for performance and benefit designs to reward high-performing providers and drive improvement;
- enforce broad principles established by the steering committee for pay for performance and benefit design strategies;
- adopt a standard tool for evaluating health plan performance based on NBCH's existing eValue8 tool; and
- assess the specific value of local/regional actions using a common assessment methodology developed by the steering committee.

Leveraging Existing Tools and Strategic Relationships NBCH proposes to leverage several existing solutions and strategic business relationships to support this overall approach, including BTE, Leapfrog, eValue8, and the College for Advanced Management of Health Benefits. NBCH and its member coalition have established a relationship with BTE to promote regional adoption of the turnkey BTE program. The majority of Leapfrog regional roll-out sites are lead by NBCH member coalitions. NBCH members are also promoting the new Leapfrog Hospital Rewards Program. About 96 health plans are currently submitting data through NBCH's eValue8 Health Plan RFI/RFP. NBCH has also created the College for Advanced Management of Health Benefits in partnership with Jefferson Medical College and HealthCare 21 (a local coalition based in Tennessee.) The college is structured to build a consistent knowledge base of value based purchasing and to build the capacity and skills of employers of all types to lead and participate in regional/local value-based purchasing councils.

Towers Perrin

Dave Guilmette, Managing Director of Towers Perrin, submits four proposals: (1) HMO value purchasing; (2) care management performance standards; and (3) quality networks for chronic conditions; and (4) affordable health care benefits for pre-Medicare retirees.

HMO Value Purchasing Towers is proposing to optimize the value of existing HMO networks and products by identifying existing HMOs that offer value (based on existing cost, quality, and efficiency performance metrics), and matching them with a selected cohort of the HR Policy Association collective populations. Those selected would be encouraged to join the HMOs through appropriate plan design, contributions, and engagement incentives. Towers Perrin has already committed significant resources to the HMO efficiency benchmarks.

Care Management Performance Standards Towers proposes creation of a uniform set of performance standards for vendor-based care management models. This is to address the need for a well-designed care management program focused on the specific health risks of a given population that engages them in health care decisions which improve the cost and quality of care.

Quality Networks for Chronic Conditions Towers asserts that, because competition for large employer members occurs at the plan level, rather than the provider level, this inhibits the development of differentiated provider networks. Towers proposes that the Roundtable form a large employer exchange to drive competition for patient care by chronic condition state (diabetes, asthma, etc.) at the provider level. To accomplish this, Towers would develop a common set of guidelines to be used in contracts and establish a database for reporting clinical outcomes achieved by the designated providers. Participating companies would promote use of the designated providers through plan design incentives and other non financial marketing techniques.

Pre-Medicare Retirees Towers proposes an initiative to provide access to retiree health benefits for pre-Medicare retirees. This is duplicative of the Retiree Health Access initiative already underway by the Roundtable.

Appendix F—Health Care Contracting Principles

Employer Contracting Principles for Achieving Health Care Market Reforms

Purpose: The HR Policy Association's Health Care Roundtable has developed the following purchasing accountability guidelines for employers to use their purchasing power to promote dramatic improvements in health care quality and cost. Employers are encouraged to abide by these principles and use the accompanying recommended set of tools. To maximize their effectiveness as purchasers, the Roundtable recommends that Chief Human Resource Officers request that their benefit managers/directors assess how effectively they are following each of the following recommended guidelines.

Health Plans and Other Vendors

- **Promote competition:** Employers should place their business out to bid on a regular basis through Requests for Proposals and other contracting vehicles that assess both price and quality and promote competition between plans that they offer to their beneficiaries based on both risk-adjusted price and quality.

- **Demand accountability**: Establish contract terms including financial performance guarantees to reinforce health plan and vendor contract commitments.

- **Support standardization:** Require health plans to adopt standard methods for claims submission, data transfer, and measuring and reporting their cost and quality and require consultants to use standard methods for assessing health plan and vendor capabilities.

- **Require transparency**: Require that plans and other vendors publicly report their performance and the performance of providers using standard quality and cost measures.

- **Pay-for-performance**: Contract with and drive volume to health plans and other vendors that demonstrate the highest quality and lowest cost including robust methods to reward high performing doctors, hospitals and other providers.

Health Care Providers

- **Support standardization:** Require health plans and others to use standard measures of provider cost and quality.

- **Require transparency:** Require that doctors, hospitals and other providers publicly report their performance using standard quality and cost measures.

- **Pay for performance**: Adopt benefit designs, networks and provider reimbursement arrangements that promote improvement and reward high performing providers by focusing on overall value, not just unit cost of service (*e.g.*, provider discounts.)

Beneficiaries

- **Educate and inform:** Communicate with and require plans to communicate with beneficiaries about the importance of comparing and choosing providers based on their cost and quality and managing their own health.

- **Align incentives:** Offer benefit designs and financial incentives to promote healthy lifestyles and selection of high performing plans and providers.

- **Facilitate access to coverage:** Provide employees and retirees with access to affordable coverage, either individually, or through creative alternatives offered through coalitions and health plans.

Public Policy

- **Support public policies to promote reform:** Take an active role to support local and national public policy actions that advance these purchasing principles for public and private purchasers.

Health Care Policy Roundtable Purchasing Principles

Purpose: Chief Human Resource Officers are encouraged to share the following recommended actions and tools with their benefit managers/directors. Although not all need to be adopted, all of these actions should be considered for adoption. (Tools endorsed by the HCPR Task Force on Contracting for the Future are in **Bold Print**)

Accountability Guideline	Action	Tools
Health Plans and Vendors		
• **Promote competition:** Employers should place their business out to bid on a regular basis through Requests for Proposals and other contracting vehicles that assess both price and quality and promote competition between plans that they offer to their beneficiaries based on both risk-adjusted price and quality.	• Issue regular requests for proposals to health plans and other vendors (e.g., every three years) • Assure that RFPs address core performance expectations • Publish performance indicators for use by beneficiaries • Implement risk-adjusted payments to plans to reward performance instead of risk avoidance	• **HR Policy Association endorsed standard RFI/RFP (to be developed)** • **NCQA health plan accreditation** • **NCQA HEDIS measures** • NCQA health plan report cards • NBCH eValue8 common RFI/RFP
• **Demand accountability**: Establish contract terms including financial performance guarantees to reinforce health plan and vendor contract commitments	• Establish performance guarantees with plans and vendors that include financial consequences for failure to meet guarantees	• **HR Policy Association standard health plan and vendor contract language (to be developed)**
• **Support standardization:** Require health plans to adopt standard methods for claims submission, data transfer, and measuring and reporting their cost and quality and require consultants to use standard methods for assessing health plan and vendor capabilities.	• Promote health plan adoption of standard claims forms • Adopt standards for health information technology • Use standard health plan RFIs/RFPs • Adopt standard health plan and provider performance measures • Require consultants to use standard methods for assessing health plan and provider capabilities (i.e., standard measures, collaborative data collection and warehousing, and requests for proposals).	• **HR Policy Association endorsed standard RFI/RFP (to be developed)** • **HR Policy Association endorsed provider performance measurement set** • NBCH eValue8 common RFI/RFP

• **Require transparency**: Require that plans and other vendors publicly report their performance and the performance of providers using standard quality and cost measures.	• Require that plans publicly report provider performance using standard measures • Require that plans and other vendors use transparent methods to measure provider performance	• **Contract with PBMs that meet the HR Policy Pharmaceutical Purchasing Coalition's transparency requirements (Transparency in Pharmaceutical Purchasing Solutions --TIPPS)** • **Join the HR Policy Pharmaceutical Purchasing Coalition** • Report card vendors with requirement that they adopt standard measures and use transparent provider rating methods
• **Pay-for-performance**: Contract with and drive volume to health plans and other vendors that demonstrate the highest quality and lowest cost including robust methods to reward high performing doctors, hospitals and other providers.	• Adopt consumer directed health plan designs • Hold health plans accountable for designs that reward value such as tiered networks based on provider performance • Support hospital and physician incentive programs • Use tools to support informed consumer choice of plans	• Adopt tiered network plans and other benefit designs that use standard provider measures to establish tiers and incentives for beneficiaries to use high performing providers • Consumer choice tools and report cards

Accountability Guideline	Action	Tools
Health Care Providers		
• **Support standardization:** Require health plans and others to use standard measures of provider cost and quality.	• Adopt standard measurement sets • Promote adoption of standards for health information technology and electronic medical records • Adopt standard prescription drug formularies and preferred drug lists	• **HR Policy Association provider measurement set** • **National Quality Forum endorsement measures** • **HR Policy Association recommended formulary/preferred drug list (to be developed)** • Ambulatory Quality Alliance measurement set • Hospital Quality Alliance measurement set
• **Require transparency:** Require that doctors, hospitals and other providers publicly report their performance using standard quality and cost measures.	• Participate in regional and national efforts to promote performance reporting by doctors and hospitals • Require that health plans include provider contract language the promotes public performance reporting	• **Participate in and support Leapfrog Regional Rollout sites** • Leapfrog hospital measures on Leapfrog and other websites • Care Focused Purchasing administrative data warehouse • Report card vendors and health plan report cards that use standard provider performance measures
• **Pay for performance**: Adopt benefit designs, networks and provider reimbursement arrangements that promote improvement and reward high performing providers by focusing on overall value, not just unit cost of service (e.g., provider discounts.)	• Adopt tiered networks designed to reward high performing providers • Adopt pay-for-performance programs • Publicly recognize high performing providers	• **Bridges to Excellence physician incentive program** • Leapfrog Hospital Rewards Program

Accountability Guideline	Action	Tools
Beneficiaries		
• **Educate and inform:** Communicate with beneficiaries about the importance of comparing and choosing providers based on their cost and quality and managing their own health.	• Require health plans to demonstrate how they are engaging beneficiaries and promoting consumerism • Promote informed consumer choice of health plans, treatments, and lifestyles	• Leapfrog Enrollee Communications Toolkit
• **Align incentives:** Offer benefit designs and financial incentives to promote healthy lifestyles and selection of high performing plans and providers.	• Adopt tiered networks designed to reward high performing providers • Offer consumer directed health plans • Offer direct incentives for managing health • Offer disease management programs (e.g., obesity, asthma, diabetes, coronary artery disease)	• **Bridges to Excellence consumer incentive program** • Contract with a consumer directed health plan • Offer disease management programs
• **Facilitate access to coverage:** Provide employees and retirees with access to affordable coverage, either individually, or through creative alternatives offered through coalitions and health plans.	• Offer coverage options to employees and retirees	• **Participate in the HR Policy Association's Affordable Health Care Solutions Coalition** • **Offer HR Policy Association's National Health Access and Retiree Health Access programs to beneficiaries**

Accountability Guideline	Action	Tools
Public Policy		
Principle	**Action**	**Tools**
• **Support public policies to promote reform:** Take an active role to support local and national public policy actions that advance these purchasing principles for public and private purchasers.	• Join organizations that effectively shape health care policy • Advocate for specific policy changes	• **Join the HR Policy Association** • Join The Leapfrog Group • Join the National Quality Forum • Join effective regional health care coalitions • Support Medicare reform, including provider transparency and pay-for-performance • Support legislation to promote standards for health information technology and adoption of electronic medical records • Support funding of applied research to assess clinical effectiveness for treatments and therapies • Support tax policy revisions to promote coverage and consumerism