Enrollment in Consumer-Directed Plans Still Low

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Consumer-directed health plans remain popular with large companies despite a lack of enthusiasm among their workers, according to the results of a biennial national survey.

"Employers and health plans continue to be … quite optimistic about the future for these plans despite the fact that to this point enrollment growth has been possibly slower than expected," Jon Christianson, Ph.D., said at a conference sponsored by the Center for Studying Health System Change (HSC).

In the interview-based survey conducted in 12 communities across the country, researchers working with HSC found that cost-sharing arrangements continue to be popular, although growth in the level of cost sharing has begun to level off. For most large companies, health care spending is rising at a slower rate than 4 years ago so that there is less pressure to share the pain. Some employers also reported that they have pushed cost sharing as far as they can.

"We were told by some employers—not a large number, but some employers—that they felt that they had moved deductibles up to the point … where any further increases they could contemplate probably wouldn't have much of an impact on utilization and in changing people's decision making," said Dr. Christianson, professor of health policy and management at the University of Minnesota, Minneapolis.

For some employers, setting up these types of tools is an interim step toward implementing consumer-directed health plans.

However, employers increasingly are encouraging their workers to make lifestyle changes that will potentially improve their health and reduce their need for medical services. Companies also are urging health insurers to provide more price information so that their workers can make informed decisions about health care when they do seek it.

That said, "There's still very little evidence on return on investment" on health promotion and price transparency, said Debra Draper, Ph.D., an associate director at HSC. "Employers really believe that these are the right things to do for their employees. And for some employers, setting up these types of tools is … an interim step toward implementing tools like consumer-directed health plans."

Insurers simply respond to market demand, said Karen Ignagni, president and CEO of America's Health Insurance Plans, an industry trade group.

"Our job is to be agnostic about what people purchase. Our job is to offer a portfolio of products so that we can be nimble enough to give purchasers the alternatives that they want and consumers the alternatives they want," she said at the conference.

Both employers and employees want lower premiums. To get there, health plans are developing strategies that not only penalize individuals who fail to takes steps to manage their chronic conditions but also reward those who maintain good health, Ms. Ignagni said. ■

Tiered Plans Cut Drug Use; Enrollees Spend More

BY MARY ELLEN SCHNEIDER
New York Bureau

Cost containment strategies, such as tiered drug plans, reduce overall prescription drug utilization and increase the use of generics, according to an analysis of prescription drug use by Medicare-eligible retirees.

But even with decreased utilization, individuals enrolled in three-tiered drug plans, which charge higher copayments for certain medications, spent more money out of pocket than did individuals enrolled in single-tiered plans.

The study, conducted by researchers at Mathematica Policy Research Inc. and RTI International, included 352,760 Medicare beneficiaries with employer-sponsored drug coverage and dependent spouses aged 65 or older (Health Serv. Res. 2007 Sept. 11 [Epub doi:10.1111/j.1475-6773.2007.00774.x]).

The study is further confirmation that the retiree population is sensitive to price, "but we don't know what that means in terms of health outcomes," Boyd H. Gilman, Ph.D., a senior researcher at the Cambridge, Mass., office of Mathematica, said in an interview.

On average, individuals in single-tiered plans filled 46 prescriptions a year, compared with 38 prescriptions among those enrolled in three-tiered plans. But enrollees in singled-tiered plans used fewer generics, the researchers found. Nearly 39% of the drugs purchased under single-tier plans were generics, compared with nearly 44% in three-tiered plans.

Drug plans spent about $1,943 per individual in single-tiered plans, versus $1,354 in three-tiered plans. Individuals who were enrolled in single-tier plans spent about $245 a year, compared with $469 spent by individuals enrolled in multitiered plans.

The study was funded by an internal grant from RTI International. ■

Adoption of Health IT Varies Widely, Depending on Specialty

Adoption of health information technology varies significantly among physicians in different specialties, according to a new study from the Center for Studying Health System Change.

Only 12% of physicians overall have adopted comprehensive electronic medical records, but physician uptake of specific health IT functions, such as obtaining guidelines or writing prescriptions, varies depending on specialty. For example, 74% of emergency physicians have health IT systems that can access patient notes, compared with just 36% of psychiatrists.

The findings are based on the Health System Change (HSC) 2004-2005 Community Tracking Study Physician Survey, a nationally representative telephone poll that included responses from 6,628 physicians.

As part of the survey, physicians were asked about practice-based availability of information technology across several clinical areas, including—retrieving patient notes or problem lists; writing prescriptions; exchanging clinical data and images with other physicians; and exchanging clinical data and images with hospitals.

—Mary Ellen Schneider

The full report is available at www.hschange.com/CONTENT/945.

Pay for Performance Programs May Not Do Much for Quality

BY JEFF EVANS
Senior Writer

WASHINGTON — The few studies that have examined the effectiveness of incentivized pay-for-performance programs have found a mix of moderate to no improvement in quality measures, which, in some instances, have led to unintended consequences, Dr. Daniel B. Mark said at the annual meeting of the Heart Failure Society of America.

There are more than 100 reward or incentive programs that have started in the private U.S. health care sector under the control of employer groups or managed care organizations, but congressionally authorized programs by the Centers for Medicare and Medicaid Services have received the most attention, said Dr. Mark, director of the Outcomes Research and Assessment Group at the Duke (University) Clinical Research Institute, Durham, N.C.

During the last 20 years, incentivized performance programs have shown that "what you measure generally improves and what gets measured is generally what's easiest to measure. But the ease of measurement does not necessarily define the importance of the measurement," he said.

A systematic overview of 17 studies published during 1980-2005 on pay-for-performance programs found that 1 of 2 studies on system-level incentives had a positive result in which all performance measures improved. In nine studies of incentive programs aimed at the provider group level, seven had partially positive or fully positive results but had "quite small" effect sizes. Positive or partially-positive results were seen in five of six programs at the physician level (Ann. Int. Med. 2006;145:265-72).

Nine of the studies were randomized and controlled, but eight of these had a sample size of fewer than 100 physicians or groups; the other study had fewer than 200 groups. "If these had been clinical trials, they would have all been considered extremely underpowered and preliminary," Dr. Mark said.

Programs in four studies appeared to have created unintended consequences, including "gaming the baseline level of illness," avoiding sicker patients, and an improvement in documentation in immunization studies without any actual change in the number of immunizations given or effect on care.

Another study compared patients with acute non–ST-elevation myocardial infarction in 57 hospitals that participated in CMS' Hospital Quality Incentive Demonstration and 113 control hospitals that did not participate in the program to determine if a pay-for-performance strategy produced better quality of care (JAMA 2007;297:2373-80). There was "very little evidence that there was any intervention effect," according to Dr. Mark.

In the United Kingdom, family practice physicians participated in a pay-for-performance program in 2004 that focused on 146 quality indicators for 10 chronic diseases as well as measures related to the organization of care and the patient's experience. The National Health Service substantially increased its deficit that year because the greater than predicted success in achieving the quality indicators (83% achieved vs. an expected 75%) led to an average increase in the physicians' pay of about $40,000 (N. Engl. J. Med. 2006; 355:375-84).

Other investigators noted that in the 1998-2003 period prior to the NHS project the quality indicators had already been improving, "so it's not clear how much the program's achievements can actually be attributed to the program itself," he said (N. Engl. J. Med. 2007;357:181-90). ■