

## ***How the FEHBP Could Drive Value in Health Care***

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I would like to present a value proposition from the Pittsburgh Regional Healthcare Initiative which I chair:

- Better health care is possible at lower cost.
- It requires work redesign at the point of service to eliminate waste, inefficiency, and error.
- It rewards evidence-based best practices, producing better outcomes of care.
- It requires good information on both cost and quality, requiring financing, accounting, and clinical measurement systems that are superior to what we have today.
- Providers compete on value and deliver on value.
- It is founded on this truism: **what is good for the patient is good for the payer!**

**What is the ideal? A quality-driven healthcare system, where systems designed for safety result from streamlined work processes, evidence-based practice, and a sparing use of resources. The result is low-cost, high-quality health care.**

Let me give you four other key propositions from Michael Porter's article on "A New Competition" from the *Harvard Business Review* of June, 2004.

1. "The most fundamental and unrecognized problem in U.S. health care today is that competition operates at the wrong level... It should occur in the prevention, diagnosis, and treatment of individual health conditions... Providers should be rewarded for the **best value** care for particular conditions or diseases."
2. "Information is integral to competition in any well-functioning market. It allows buyers to shop for the best value and forces sellers to compare themselves to rivals. In health care, though, the information really needed to support value-creating competition has been largely absent or suppressed."
3. "The healthcare system can achieve stunning gains in quality and efficiency. And employers, the major purchasers of healthcare services, could lead the transformation."
4. "Health insurers should be rewarded for helping customers learn about and obtain care with the best value."

FEHBP has long been a leader in leveraging its massive scope to make health plans more consumer-focused. As the direction and specific changes needed radically advance quality and efficiency in American health care become increasingly clear, FEHBP can, through aggressive

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The Pittsburgh Regional Healthcare Initiative is a consortium of the institutions and people who provide, purchase, insure and support healthcare services in the region. Our partners include hundreds of clinicians, 42 hospitals, four major insurers, dozens of major and small-business healthcare purchasers, corporate and civic leaders, and elected officials. Our goals are achieving the world's best patient outcomes by creating a superior health system through the identification and solving of problems at the point of care.

action, "tip" the nation on the critical issues of beginning to link payment to the quality of care provided and arming consumers with the critical information they need to be value consumers.

In 1997, Paul O'Neill, a number of colleagues and I asked ourselves why American health care, for all the miracles it produces, was so expensive, so poorly delivered, and so fraught with waste and error. We asked an audacious question: *Why can't the great medical institutions of Pittsburgh deliver health care flawlessly?* Intrigued by the question and by the notion of healthcare systems learning from one another—then further spurred by the eye-opening Institute of Medicine Report of 1999—45 hospitals, along with insurers, providers and plans eventually came together under the leadership of O'Neill and Feinstein to form the Pittsburgh Regional Healthcare Initiative. The work we've undertaken at PRHI suggests that great change is possible and confirms what more and more policy studies have concluded: that we can provide care of dramatically higher quality—and we can do it at half the cost.

**Our recommendations flow from our core conviction: improve quality and safety and you will lower cost, save lives, and produce a healthier labor force!** First of all, we are realizing that improving the quality of care delivery is central to solving the problems plaguing American health care. Skyrocketing healthcare costs, diminishing access to health insurance and health care, increasing harm to patients, the malpractice crisis, the nursing shortage and numbing morale problems across health care disciplines—all of these problems emanate from a system often distracted from delivering quality at the point of patient care. From the current hodge-podge system has emerged phenomenal waste and its evil twin, error.

Here is a graphic example of a system gone awry (Figure 1).

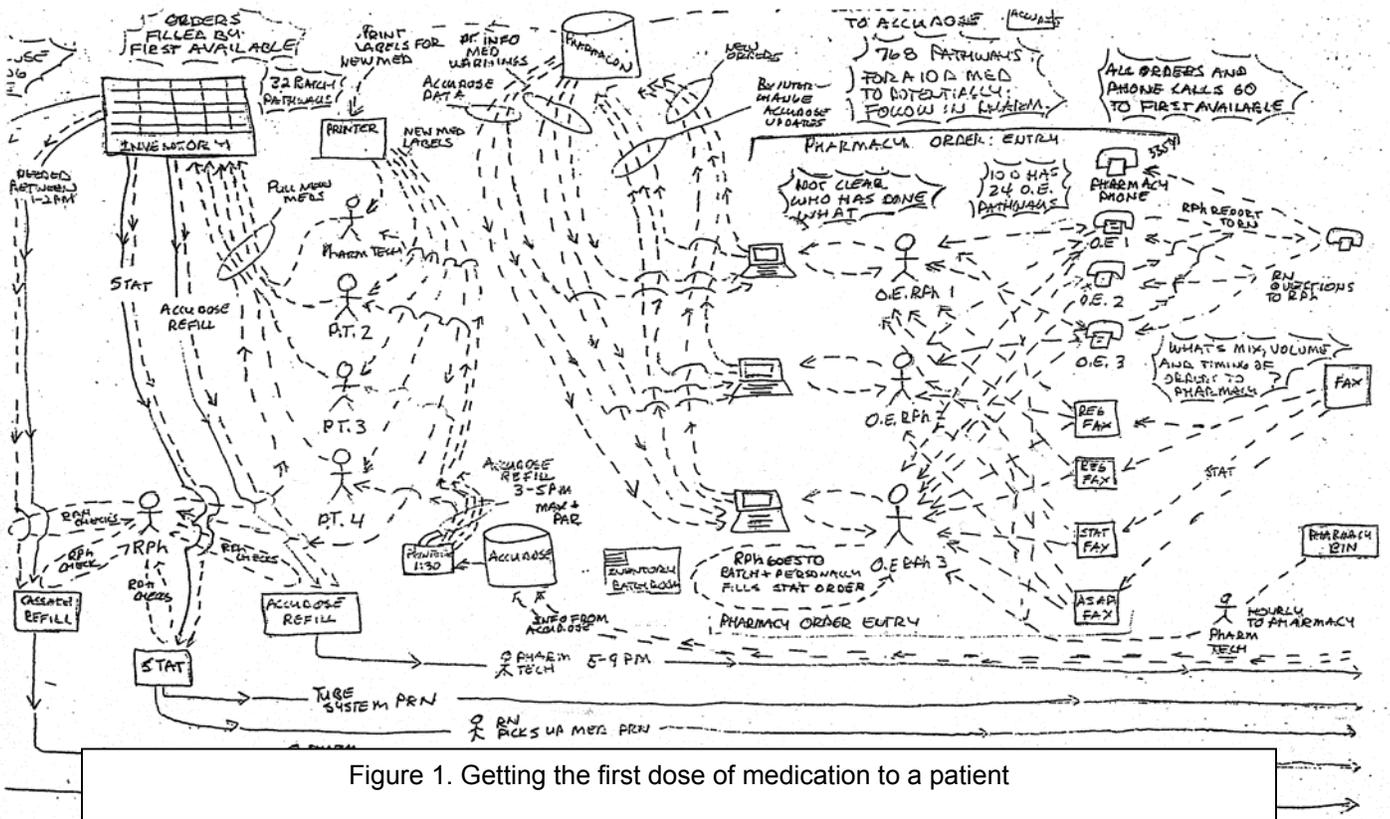


Figure 1. Getting the first dose of medication to a patient

This drawing was made during an observation in a hospital, and it is typical. It shows the steps necessary for a patient to get a newly ordered medication. Counting all the different ways the order can be conveyed, received and passed along, there are over 700 steps in the process. That is, there are 700 opportunities for error. Only through the dedication of heroic professionals do most patients receive the right medication in the right dose at the right time. When you contemplate the effect that such a system has on quality, cost, patient satisfaction and worker morale, you begin to see how interrelated the problems are.

This is a revolution that has to be accomplished on the ground, “at the point of patient care.” Accordingly, we have engaged the entire delivery system community in aggressive attacks on infection, medication error, and many other symptoms of the system’s dysfunction.

But health plans can play a critical role in setting and maintaining the conditions necessary for excellence. They have in Pittsburgh, and the FEBHP can nationally.

We have four major action recommendations:

- 1. Require plans to pay providers more for good and safe care, and not to reward errors and waste.**
- 2. Require plans to provide their members with available outcomes data from providers, and drive the creation of more consensus, uniform outcomes reporting across the nation. FEHBP can also be a leader in requiring that consumers have access to accurate price information for medical care.**
- 3. Accompany outcomes information with cost comparisons and highlight the high quality low-cost providers.**
- 4. Reward, as a plan, VALUE.**

Hospitals should do better than break-even when they get treatment right the first time, and a healthcare-associated complication should also be a bad financial outcome for the institution. Detailed financial analysis of our own safety gains is beginning to show that there are “perverse” payment incentives for certain conditions under which if a hospital performs perfectly, it makes no profit; if they perform badly, they can make a substantial profit. (Thankfully, in more areas, such as certain hospital-acquired infections, professional carelessness hurts the bottom line profoundly.)

While the idea of “pay for performance” is beginning to catch on, current quality incentive programs typically involve less than 1% of annual revenue for a hospital, when hospital CEOs will tell you that at least 5% would be required to “get their attention.” Also, incentives that focus on process and not an outcome will have less impact over time. In addition, the standards of performance in the existing programs are not very ambitious. *FEHBP could use its leverage to radically expand the scale and scope of pay for quality efforts to hospitals, primary care and other settings alike, and to require participating plans to ensure that they are **not** rewarding providers for healthcare-associated complications.*

Leading plans are beginning to emerge, which FEHBP can require others to emulate. We have been particularly impressed by Pacificare’s Quality Incentive Program, which is tied to their Quality Index, and has increased from \$14 million to \$21 million over the past two years. Our local Blue Cross plan, Highmark, also has a growing incentive program. Nationally, Aetna seems to be moving rapidly in the “pay-for-value” direction. FEHBP can add even more value by pushing for these incentive programs to be tied to uniform, public measures (see below).

Let's not forget that today chronic disease accounts for 75% of all health care. *Why can't we* shift payment incentives toward inexpensive, effective primary care that can prevent the progression of more serious diseases? Over the past 5 years, the Veteran's Administration has done so, and the result is this: their per-patient costs have stayed steady, while the rest of American healthcare increased 50%; and a recent study confirmed that the VA is providing the nation's highest quality primary care. FEHBP could see that America's public health plans use their dollars to copy the VA's success. It will take political courage; specialists don't like to see their rates reduced and shifted toward primary care.

First, the recent JAHCO/AHA/CMS consensus quality measures in critical areas of hospital care such as heart attacks, heart failure and diabetes are a major step forward. FEHBP should ensure that such data on providers is in the hands of every plan member as soon as it is published. (It was enlightening to us to see that despite the scientific rigor and consensus agreement about the validity of the measures, only a few dozen hospitals participated when it was entirely voluntary. When Congress attached a payment increase to it, virtually every hospital in the US agreed to participate.) Here again, there are leaders among the nation's health plans in getting quality information to consumers.

Second, FEHBP should work to expand the range of critical health areas with such consensus national outcomes reporting, and require that those additional areas also be regularly reported to each plan member.

Third, FEHBP can further promote value purchasing by rewarding plans that get actual pricing information regarding medical procedures into consumer hands, as well as quality data. Preferably, this would be required. Historically, health plans have fiercely resisted disclosing their payment agreements with providers. This has only exacerbated the enormous waste created by the "black box" of health care finance. As Paul O'Neill and, more recently, Michael Porter have argued, transparency is required to drive value creation in health care. Hospitals need incentives as well to move to the kind of activity-based cost accounting systems that would permit the better transparency regarding the actual costs of episodes and procedures.

It has been an honor to testify before this panel. FEHBP has been a model program, and can through decisive action "tip" the nation's healthcare system toward a much sounder structure for high performance. The PRHI is prepared to offer more information on the critical function of health plans in promoting value.

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