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Family Matters

Improving Health Care Quality and Cost Efficiency

A Family Impact Seminar Newsletter for Wisconsin Policymakers

Dr. Arnold Milstein was recently recognized by the National Business Group on Health for being one of the most effective national leaders in health care innovation. He received the prestigious Award for Excellence and Innovation in Value Purchasing. Given the interest of state legislators in health care issues, the Family Impact Seminar staff interviewed Dr. Milstein about what he has learned over the past 20 years about reforming the health care system.

Dr. Milstein grew up in Bayside, Wisconsin, and lives in San Francisco. He has an MD and a master's degree in health care evaluation. Milstein is the U.S. Health Care Thought Leader at Mercer Human Resource Consulting, and the Medical Director of the Pacific Business Group on Health (PBGH). PBGH is the country's largest regional business coalition. It includes 50 large health care purchasers in California that provide health care coverage to over 3 million employees, retirees, and dependents.

Question: Is health care reform a family issue?

Dr. Milstein: Health insurance premiums are increasing four times faster than the earnings for an average American worker. What this means for families is that each year, more Wisconsin families are unable to afford health insurance premiums and still pay the rent. Today, the rising cost of health care threatens the economic viability of lower-income Wisconsin families; tomorrow, it will threaten middle-income families. Perhaps no action that the Legislature can take will have a bigger impact on the living standard of Wisconsin families than legislation to make health insurance more affordable.

Question: What is the major challenge that the health care industry faces today?

Dr. Milstein: The major challenge facing the health care industry and those interested in its improvement is this: physicians are recommending and implementing evidence-based care successfully only about 50% of the time. What's more, roughly 40% of health care spending is not contributing to patient health. In engineering terms, the health care industry has on average a 50% failure rate in quality and a 40% failure rate in cost-efficiency.

Question: Why has the health care system been so difficult to reform?

Dr. Milstein: The health care system has two structural problems that stymie reform:

(1) Quality failure is invisible. In most other industries, it is obvious when quality fails. For example, planes crash into mountains, cars don't start, or hotel rooms are noticeably unclean. However, when performance fails in health care, it is typically invisible to the patient and the provider. For example, both doctors and patients may be unaware when a doctor writes a prescription for an inferior medication, prescribes the wrong dose, or doesn't provide a dietary warning. If poor performance was plainly visible to either party, it wouldn't be tolerated.

(2) Health care spending is inefficient. People who are making decisions about how to spend health care dollars, by and large, are not spending their own money. Patients and physicians are spending "the insurance company's" dollars; thus, health care is a market where there is no built-in mechanism for conserving pooled insurance dollars collected from workers and retirees.

Question: What new approaches exist for reforming the health care system?

Dr. Milstein: To address each structural problem, policymakers could start with two primary solutions.

(1) Make performance failure more visible. We need scientifically-valid measures of quality and cost-efficiency for doctors, hospitals, and treatment options. Most insurance companies already have reasonable measures for ranking hospitals on how much they spend for common conditions like pregnancy. Most insurance companies, however, don't have enough data to rank individual physicians with precision. The only way to obtain more precise measures of physician-level quality and efficiency is through (a) cooperation and claims data pooling among insurance companies; (b) supporting proposed federal legislation that would enable insurance companies to access Medicare claims data (without identifying individuals); and (c) gradually increasing the amount of clinical information in electronic rather than paper form.

(2) Make health care spending more efficient. Purchasers can offer tiered or narrow network insurance plans that provide incentives for patients to select doctors, hospitals, and treatment options that rate higher on quality and cost-efficiency. Tiered network plans offer consumers lower co-pays for selecting higher-quality, cost-efficient providers within the plan's provider network. Narrow network plans limit consumers to a smaller group of providers that offer higher quality and cost efficiency.

Question: What can a state like Wisconsin do to become a leader in health care reform?

Dr. Milstein: The most important thing that Wisconsin policymakers could do is create a system that is more sensitive to quality and cost efficiency. States can accomplish this in their roles as purchasers of health benefits plans for their employees or as insurance market regulators.

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http://www.uwex.edu/ces/familyimpact/wisconsin.htm

Family Matters is on the web at:
http://www.uwex.edu/ces/familyimpact/newsletters.htm

As a purchaser, Wisconsin could require any insurer, as a condition of doing business with the state, to collaborate with other insurers to create an adequately-sized claims database. This data could be used to compute standardized quality and cost-efficiency rankings for doctors and hospitals. Information about provider performance could then be used to narrow or further tier the health plans that Wisconsin already offers its public employees. Better selection of providers saved Pitney Bowes 17% of their per person spending. For rural areas with fewer providers, the state could ask that insurers initiate pay-for-performance programs, whereby rural providers who deliver higher-quality and more cost-efficient care would be paid more (see the Family Impact Seminar newsletter at http://www.uwex.edu/ces/familyimpact/newsletters.htm).

As regulator, Wisconsin could make its health provider licensing, malpractice premiums, and health insurance industry's benefit designs more sensitive to quality and cost efficiency. To obtain a license, doctors and hospitals would have to submit quality and cost-efficiency scores, using standardized and audited measures. These scores could be calculated by the doctor or hospital, an insurer, or a specialty certification board. If scores fall below a certain level, licenses could be made conditional, with a specified time to improve. To make this work, licensing boards would need to consist of an equal number of health care professionals and experts in performance measurement, such as engineers and health services researchers.

Second, malpractice insurers could be required to offer tiered premiums. Just like automobile insurance, premiums could be lower for physicians and hospitals that report high quality and more cost-efficient practices. Third, the Legislature could pass a "clinical sunshine act" to shed light on the performance of all Wisconsin health care providers. Health insurers operating in the state would be required to (a) contribute the claims data they already collect to a common data pool; and (b) support a process whereby doctors and hospitals will be ranked regularly on comprehensive measures of quality and efficiency.

Question: What strategies are needed to bring about the changes that you are describing?

Dr. Milstein: Wisconsin is blessed with many physician groups and hospitals that meet national quality standards. However, the momentum cannot come solely from Wisconsin's many excellent doctors and hospitals. Nor will it come solely from recently-merged large health insurers, who are generally able to pass along cost increases to their customers. Only through citizen and political leadership will change of this magnitude happen.

Wisconsin leaders would need to partner with those who are being squeezed by rising health care costs and those who are concerned about low quality care. Legislators could knit together a coalition of allies such as employers, organized labor, retirees, and working families. For example, employers recognize the value of health benefits in attracting and retaining competent workers. Yet employers fear losing their competitive edge to businesses or countries that don't offer equally-expensive health care benefits. For senior citizens living on fixed incomes, health-related expenses ate up half of their 2004 increase in Social Security income.

For many working families, rising health care costs hold down both salary increases and job growth. For example, the UNITE-HERE Labor Management Trust Fund provides health care to 120,000 hotel and restaurant workers and their families in Las Vegas. By implementing many of the transparency, quality, and cost-efficiency solutions that I have mentioned, these workers received significant wage gains for the first time in three years, gains that otherwise would have been unaffordable.

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