Medicare Prescription Drugs Improvement and Modernization Act of 2003: What Do Employers Think?

Robert S. Galvin, MD
Medicare Prescription Drug Congress
February 26, 2004

What The Bill Isn't

Perfect

What The Bill Is

"The Triumph Of Experience Over Hope"

Apologies to Samuel Johnson

- *Government Can Act on Health Care*
- *Employers Included in Dialogue*
- *Favors Competitive / Market Approach . . . But With Safety Net*
- *Pushes Transparency / Quality Agenda*
- *Encourages Consumerism . . . Creates Possibility of New Solutions*

The Devil (And The Angel) Is In The Details

- *Details of 'Actuarial Equivalency'*
- *FASB Guidance*
- *HSA Design*
- *Rules for PBMs and Health Plans*

Employer Options

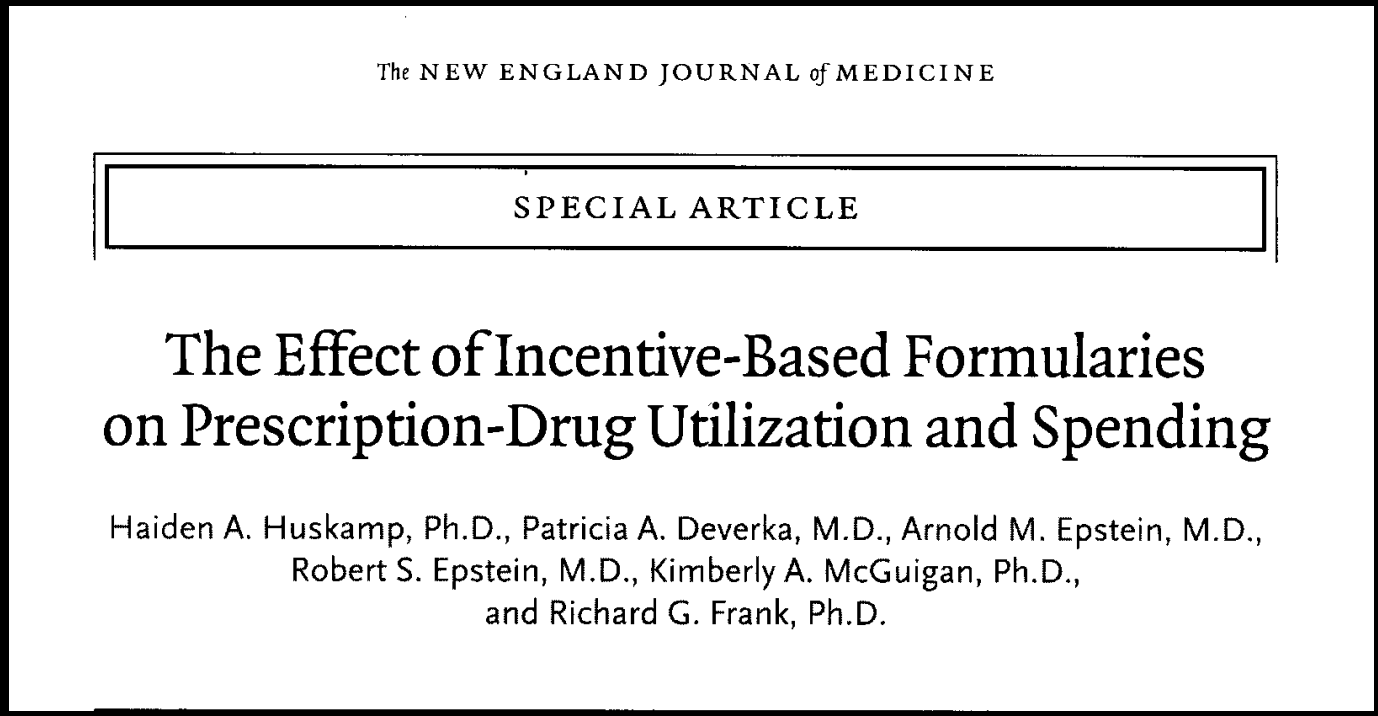
- *Drop Retiree Coverage: Government Safety Net*
- *Take Employer Subsidy*
- *Coordinate With Medicare As Primary*

Why Is No One Talking About the "U" Word?

Cost = Price x Use

	Price	Use	Mix
'99	5	10	8
'00	2	12	4
'01	5	6	3
'02	6	9	4
'03	5	4	4

Cost and Quality Must Be Integrated



The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending

Haiden A. Huskamp, Ph.D., Patricia A. Deverka, M.D., Arnold M. Epstein, M.D., Robert S. Epstein, M.D., Kimberly A. McGuigan, Ph.D., and Richard G. Frank, Ph.D.

- ***Paying More Means Using Less . . . Without Regard To Quality***
- ***More Gradual Change Avoids Quality Problems***

Why Is No One Talking About the "Q" Word?

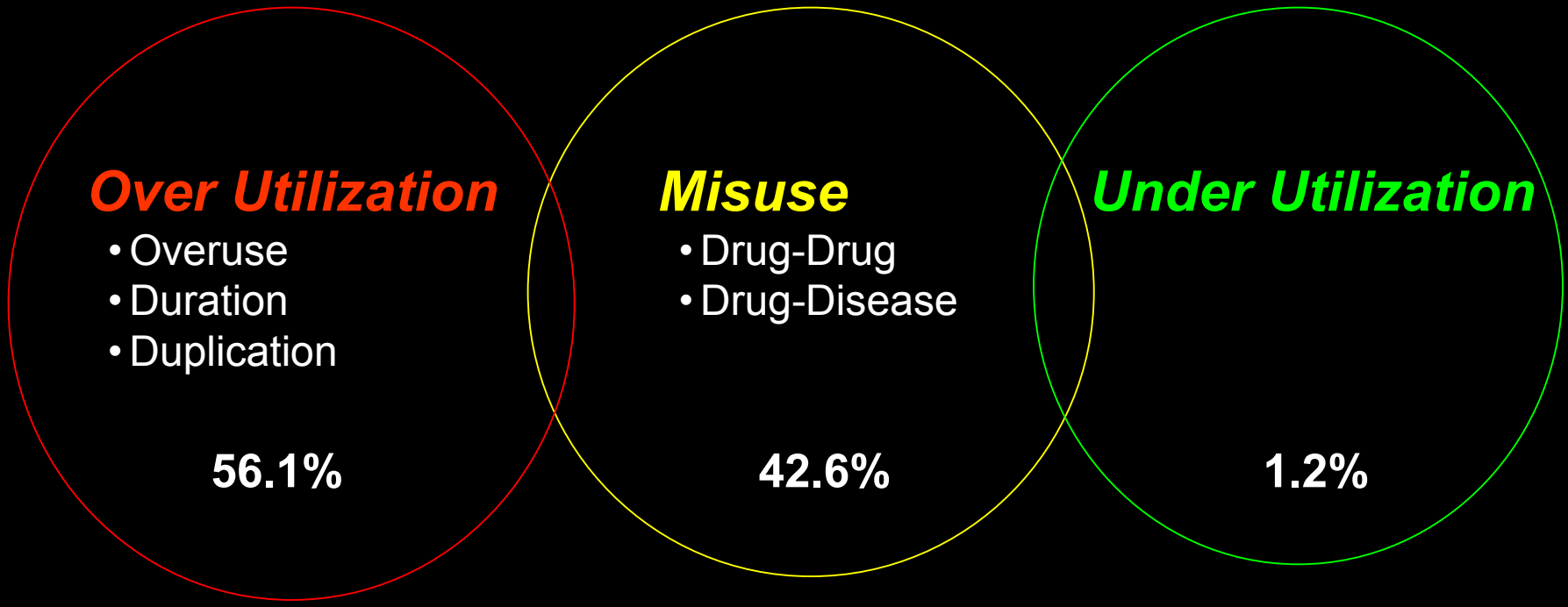
Use = Price Sensitivity x Compliance x Quality

(Appropriateness)

Risk Days
Days Where Necessary Therapy Was Lacking 118,206
Days Where Unneeded Therapy Was Provided 8,904,000
Therapy Dispoused 84,000,000

→ Sigma = 2.75
Defect = 11%

What Kind of Risk?



Quality Saves Money

Results

Conflicts Tracked:	81,423
Changes Made :	29,864
Change Rate:	37%

Source of Savings (Approx) by Defect

Duration	40%
Drug Disease	25%
Overuse	25%
Drug Interaction	5%
Duplicate Therapy	5%

'03: $10MM Saved

'04: Send Letter to Physician and Patient

Wall Street Journal
December 4, 2004

Informed Patient / *By Laura Landro*

Medicare Seeks to Close Quality Gap

ALONG WITH ITS sweeping drug plan for seniors, the new Medicare legislation includes the most-ambitious national effort yet to encourage and reward quality improvement in both hospitals and doctors' offices.

In an effort to close the "quality chasm" that plagues U.S. health care, the new law authorizes Medicare to offer new pay-for-performance programs that reward physicians who take better care of patients with chronic illnesses like diabetes and heart disease. The Center for Medicare and Medicaid Services will provide financial incentives for doctors who adopt information-technology systems to better track results. And CMS will boost the payments to hospitals that participate in a voluntary program to report publicly the quality of their care, with the aim of making it easy for consumers to get data on how their local hospital stacks up.

The bill also authorized Medicare to launch a number of demonstration projects, and contract with expert groups such as the network of voluntary Quality Improvement Organizations. The QIOs

Motivational Therapy

New Medicare incentive programs to improve health-care quality

PROGRAM	DESCRIPTION
Pay for performance	Medicare will ask the National Academy of Sciences' Institute of Medicine to evaluate existing quality-performance measures and develop a strategy for aligning payment and performance within Medicare.
Encouraging hospitals to report on performance	Financial incentives to encourage hospitals to participate in the Centers for Medicare & Medicaid Services' voluntary Hospital Quality Incentive Data initiative; hospitals that participate in the project will receive 0.4% larger payments for inpatient care than those that don't.
Research on changing physician behavior	A five-year demonstration project to evaluate how providing financial incentives or distributing guidelines can change the way physicians practice. Medicare will pay a per-beneficiary amount to each participating physician who meets or exceeds specific performance standards regarding clinical quality and outcomes measures.
Improving care for the chronically ill	Development of demonstration programs to improve care for the chronically ill while reducing costs for beneficiaries with one or more chronic conditions such as heart failure, diabetes and chronic obstructive pulmonary disease.
Information technology provisions	Grants to help doctors pay for the purchasing, leasing and installing of software and hardware–including hand-held computer technology–for electronic prescribing.

A Market Approach to Costs

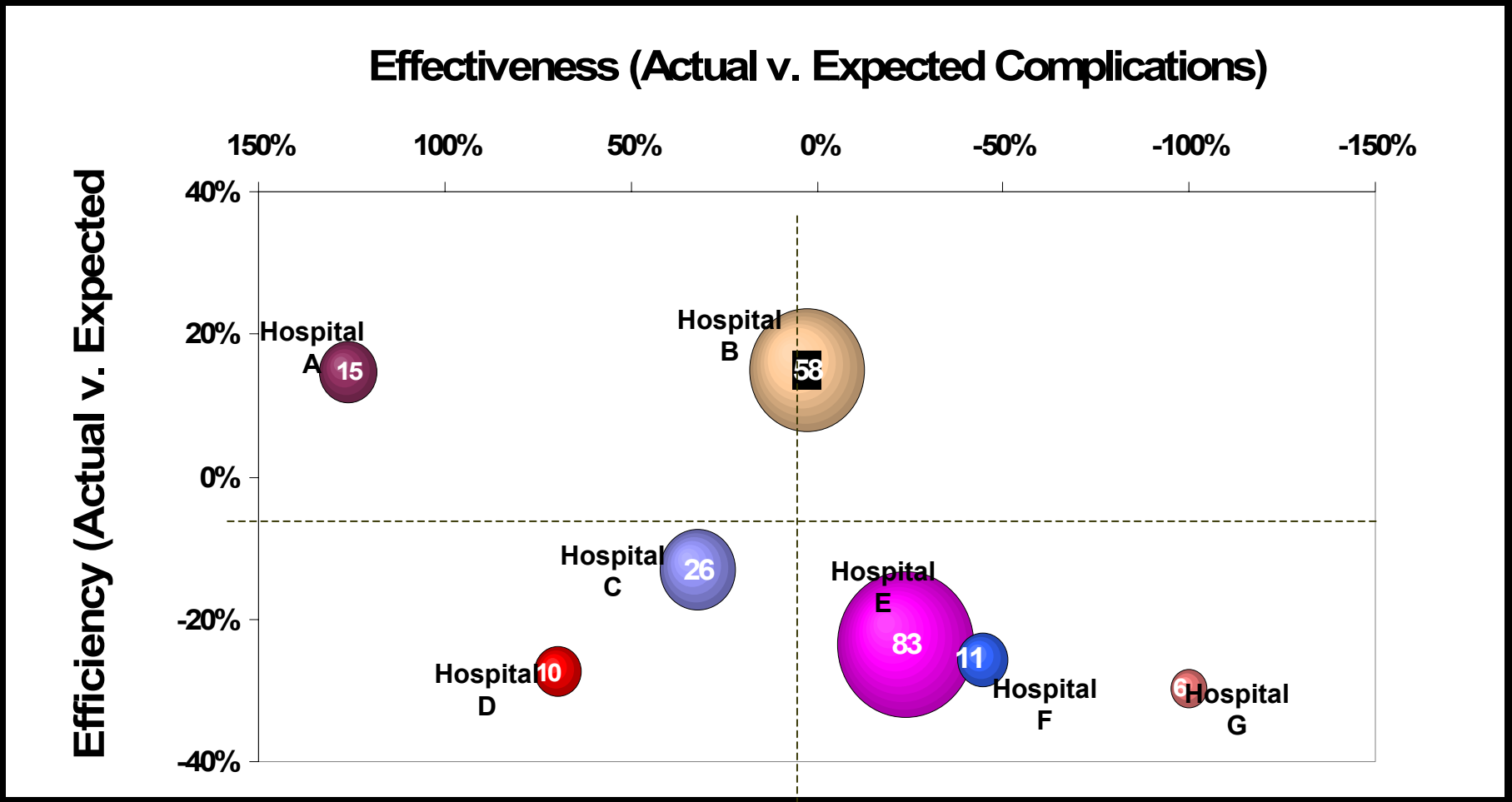
"Employers believe that consumer pressure is a powerful, underutilized lever for improving quality and efficiency. They believe that higher quality and lower cost will result if consumers spend more of their own money for services they believe are high quality, and if providers respond by improving their performance. For this strategy to succeed, consumers will have to be activated to seek more efficient, higher quality care and physicians will have to be rewarded for delivering it."

Sounding Board
NEJM, September 19, 2002

THE LEAPFROG GROUP
for Patient Safety
Rewarding Higher Standards

- ***Transparency***
- ***Incentives and Rewards***
- ***Focus on Quality and Efficiency***

Efficiency and Quality Create Value



What Policies Will Accelerate Us Getting To The Right Lower Quadrant?

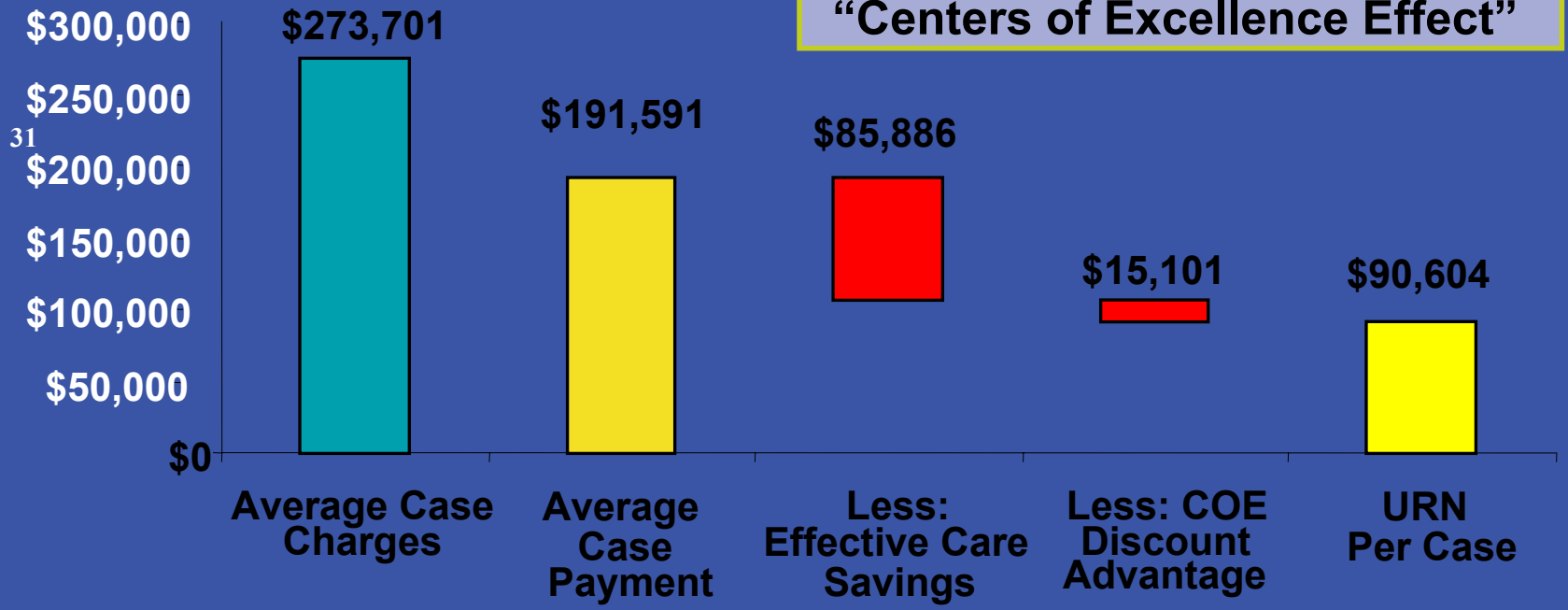
National Centers of Excellence: An Example

United Resource Network

"Traditional Health Plan Experience"

United Resource Networks

"Centers of Excellence Effect"



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