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HEALTH CARE

Employers and Individual Consumers Want Additional Information on Quality

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Health, Education, and
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The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

Dear Senator Kennedy:

Employers and individual consumers are no longer concerned only about the escalating cost of health care; they are increasingly concerned that efforts to reduce health care costs may now also be reducing its quality. Some cost-control efforts might unduly encourage providers to withhold care. Other cost-control efforts restrict or eliminate individuals' choice of provider. As employers negotiate for lower premiums or limit employees' access to providers, they want to ensure that their employees still receive quality care. Individual consumers want to be assured that they have access to quality providers and that they make the right health care decisions. As a result, both employers who purchase health care and individual consumers have demanded more information about quality.

In response to these demands, some states, large employers, and health plans have been publishing performance reports describing the quality of health care providers. These "report cards" include information such as the frequency with which preventive services are provided and the degree of success in treating certain diseases. The federal government, as the nation's largest health care purchaser, has also become increasingly involved in the movement to develop and publish performance reports, especially for Medicare and Medicaid beneficiaries.

Little has been known, however, about how useful published reports have been or how they could be made more helpful. As a result, you asked us to study (1) how consumers use available published comparative data and (2) what information consumers want.[1]

To obtain the views of individual consumers, we attempted to contact over 1,000 persons who had requested a report card published by a state agency or health plan. We were not able to obtain usable information from most of these persons—some did not respond to our attempts, some were unavailable, some did not remember receiving the report card, and some

[1]Employers are consumers of health plan services to the extent that they use administrative services, including data. Recognizing that, some plans include both employers and individual consumers in their customer satisfaction surveys.

had used the information for work-related research rather than to select a provider or plan. We conducted telephone interviews with the remaining 153 people who had requested the report card for use in making health care purchasing decisions. We also conducted 7 group interviews with a total of 64 employees at 7 locations.[2] These consumers may not have had previous experience with report cards.

To obtain the views of employers, we interviewed representatives of 65 businesses around the country with health coverage for fewer than 5 to over 100,000 employees. Because the employers and individual consumers are not nationally representative, their experiences and opinions cannot be generalized to all employers and consumers.

We conducted our review from November 1994 to June 1995 in accordance with generally accepted government auditing standards. (See app. I for a more detailed discussion of our scope and methodology.)

Results in Brief

Many employers and individual consumers we interviewed are using information that measures and compares the quality of health care furnished by providers and health plans when making their purchasing decisions. For example, employers are using report cards to select and monitor the performance of providers and plans furnishing services to their employees, negotiate with insurance carriers, and market managed care plans to employees. As one employer remarked, "We'd like to get some kind of value-based decision for purchasing health care." Individuals are using report cards to choose providers or plans, to enhance their knowledge of providers or plans, and to reassure themselves of their own or their employers' provider choices.

Employers and individual consumers we interviewed wanted performance reporting efforts to continue. In fact, they are requesting more data than are publicly available. However, they believed the information would be more useful if their concerns about the reliability and validity of the data were addressed. For example, some individual consumers used terms such as "self-serving," "one-sided," and "nontrustworthy" to describe the reports they received from health plans.

Employers and individual consumers we interviewed also reported that the most useful information would measure health care outcomes. One

[2]Four of these worksites were federal agencies. Many private sector employers we contacted refused our request to discuss health plan purchasing decisions with their employees.

comment was, "The number one thing people ask . . . is not . . . . 'Am I going to get that mammogram?' it's . . . . 'Am I going to die?'" However, they acknowledged that it is very difficult to attribute outcomes to quality of care rather than to factors such as the patient's health or lifestyle choices. They also said they want standardized and comparable health care information to assess health care providers' or health plans' performance equally.

Many of the employers we interviewed are getting some of the data they want through business coalitions, consultants, and their own data collection efforts. But these sources are not available to individual consumers, and few employers were sharing these data with their employees. One employer said, "I don't know if the data we'd be giving them would be the complete picture." Although some employers stated that their employees did not want or would not understand data comparing quality, their employees told us such information would be helpful.

Background

Employers have been the driving force behind the growing move to compare health care providers and plans on the basis of their performance. These employers have worked both individually and collaboratively with providers, health plans, and government to produce information that will allow them to assess the quality of the care they purchase. Health plans have been publishing reports comparing their performance to their peers or to a national standard. State governments have published comparative information, often focused on specific procedures performed in hospitals. Although the federal government was responsible for the first widespread public disclosure of hospital performance data in 1987, it discontinued this practice in 1993. As a payer of health care services on behalf of Medicare and Medicaid beneficiaries, the Health Care Financing Administration (HCFA) lags behind others in making performance data public.

Report cards can include a variety of performance indicators, either structural, process, or outcome based. Structural indicators measure the resources and organizational arrangements in place to deliver care, such as the ratio of nurses to inpatient beds. Process indicators measure the physician and other provider activities carried out to deliver the care, such as the rates of childhood immunization. Outcome indicators measure the results of the physician and other provider activities, such as mortality, morbidity, and customer satisfaction.

Employers Took the Initiative in Report Card Development

In 1989, a group of employers initiated one of the most significant efforts to identify uniform and standardized performance indicators. This effort resulted in the creation of a performance measurement system known as the Health Plan Employer Data and Information Set (HEDIS). Several business coalitions and health care organizations used the first HEDIS measures in 1991. The nonprofit National Committee for Quality Assurance (NCQA) has led the effort to revise the measures, issuing HEDIS 2.0 in 1993 and HEDIS 2.5 in 1995. Current HEDIS measures focus on process indicators. (See table 1 for a list of some key HEDIS measures.)

Table 1: Selected HEDIS Performance Measures

Quality/access	Utilization	Physician network	Membership/ finance
Childhood immunization	Coronary bypass rate	Physician turnover	Membership disenrollment
Cholesterol screening	Angioplasty rate	Board certification	Medical loss ratio
Mammography	Cardiac catheterization rate		Administrative loss ratio
Pap smear	Hysterectomy rate		Revenue requirements per member per month
Prenatal care visit	Prostatectomy rate		
Diabetic retinal exam	Laminectomy rate		Tier rates
Major affective disorder follow-up	Cesarean section rate		
Members visiting provider	Obstetrical hospital stay		
Asthma admission rate	Readmission for chemical dependency		
Low birthweight rate	Hospital days/ 1,000 enrollees		

Source: NCQA Report Card Pilot Project Technical Report (Washington, D.C.: NCQA, Feb. 1995).

Using HEDIS as a base, some employers have begun to distribute to their employees educational materials that include outcome measures. For example, the California Public Employees' Retirement System (CalPERS) recently distributed to its employees a performance report about the health plans it offers. Although it had furnished some comparative information to its employees in previous years, the information generally

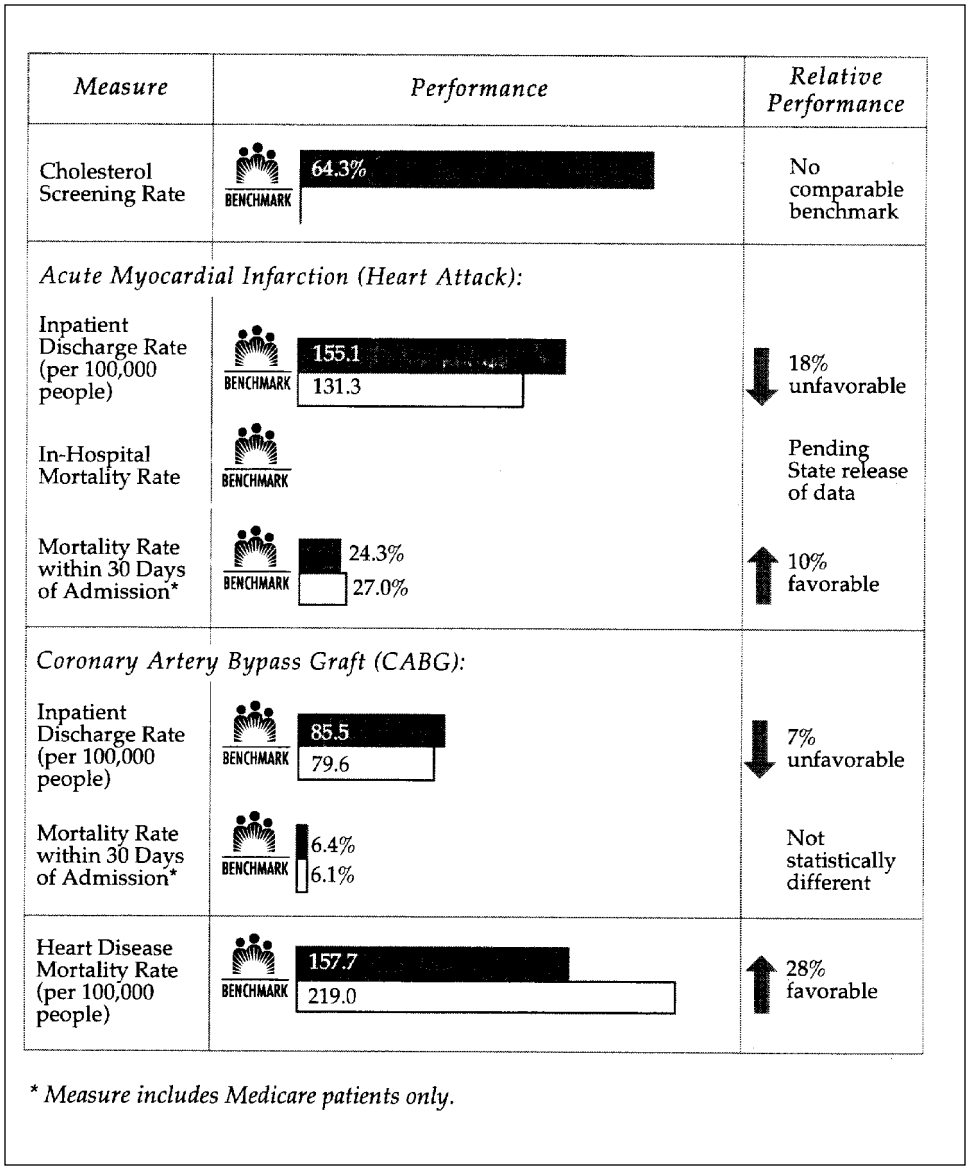
featured cost and benefits. CalPERS' May 1995 Health Plan Quality/Performance Report is its first effort at distributing comprehensive information that includes both specific quality performance indicators and member satisfaction survey results. The quality performance data are based on HEDIS indicators measuring health maintenance organizations' (HMO) success with providing childhood immunizations, cholesterol screening, prenatal care, cervical and breast cancer screening results, and diabetic eye exams. Employee survey results include employee satisfaction with physician care, hospital care, and the overall plan, and the results of a question asking whether members would recommend the plan to a fellow employee or friend.

Some employers are using third-party health care accrediting organizations to measure health plan performance using structural indicators. These employers are requiring the health plans they contract with to be accredited by organizations such as NCQA and the Joint Commission on Accreditation of Healthcare Organizations. Furthermore, some accrediting agencies publicize their accreditation decisions, which allows employers and individual consumers to consider accreditation status in their health care purchasing decisions. For example, a consortium of employers has elected to exclude a Florida HMO from new business with its employer-sponsored health plans because of the HMO's failure to obtain accreditation.

Health Plans Make Performance Data Public

Health plans have published comparative information intended to assist individual consumers in their health care choices and health care providers in their quality improvements. For example, in 1993, Kaiser Permanente Northern California Region released a report on 102 performance measures divided into the following categories: childhood health, maternal care, cardiovascular disease, cancer, common surgical procedures, other adult health, and mental health/substance abuse. (See fig. 1.) Although Kaiser was one of the first health plans to publish this kind of information, an increasing number of health plans are now providing similar information.

Figure 1: Example of Health Plan Presentation of Comparative Health Care Data



Source: Kaiser Permanente, Northern California Region, 1993 Quality Report Card (Oakland, Calif.: Kaiser Permanente, 1993).

Health plans have been exploring new ways to make information readily available and understandable to individual consumers. For example, on September 15, 1995, HealthPartners, Inc., will initiate a consumer-oriented

program using touch-screen computers.[3] Initially, at least 50 computers will be installed permanently at 50 employer sites, and at least 100 computers will be rotated among other employers. This will allow employees to obtain details about any one of the plans' primary care sites, such as its physicians' credentials, on-site services offered, and specialists to which its physicians refer. Because health plan members are expected to enroll in a specific care delivery system—a set of primary care sites with affiliated specialists—HealthPartners will furnish data about each care system to help plan members make a decision about which one to join. Currently these data include preventive screening rates and patient satisfaction measures. HealthPartners anticipates expanding the availability of touch-screen computers to more public spaces, such as shopping malls, after physician concerns about data confidentiality and other matters are resolved.

State Legislatures Mandate Public Dissemination of Data

The states have also been active in providing information about provider performance to the public. Forty states have mandated the collection, analysis, and public distribution of health care data, such as hospital use, charges or cost of care, effectiveness of health care, and performance of hospitals.[4,5] For example, Pennsylvania has released four report cards on the hospitals and physicians in the state performing coronary artery bypass graft surgery (CABG) since 1992. Providing both costs and mortality rates, the reports are publicized through the local media and are available free to consumers. (See fig. 2.)

[3]HealthPartners, Inc., is the parent company of health care organizations that include group and staff model HMOs located in Minnesota's Twin Cities. They provide health care services and coverage to more than 650,000 members.

[4]The 10 states that have not mandated these activities are Alabama, Alaska, Hawaii, Idaho, Louisiana, Michigan, Mississippi, Montana, Nebraska, and Wyoming. Colorado's legislature eliminated funding for its state data commission as of July 1995, and North Carolina's program will cease in October 1995.

[5]A self-insured company that administers its own health plan may not be under any obligation to report its performance. In Employer-based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995), we reported that the National Governors' Association believed that the Employee Retirement Income Security Act of 1974 (ERISA) prohibited their states from developing standard data collection systems applicable to all health plans.

Figure 2: Example of Pennsylvania State Comparison of Health Care Providers

Hospitals in which Coronary Artery Bypass Graft Surgery was Performed
Treatment Effectiveness & Average Charge

Hospital	Total Patients	Patients who Died: Actual Number	Patients who Died: Expected Range	Patients who Died: Statistical Rating	Average Charge
Hospitals with fewer number of deaths than expected					
Allegheny General Hospital	954	10	18 - 35	+	$55,879
Altoona Hospital	462	3	4 - 14	+	$37,895
Temple University Hospital	346	5	7 - 18	+	$85,310
Hospitals with similar number of deaths as expected					
Albert Einstein Medical Center	604	22	14 - 30	Δ	$84,746
Bryn Mawr Hospital	289	6	1 - 9	Δ	$63,742
Conemaugh Valley Memorial Hospital	357	15	6 - 17	Δ	$52,670
Crozer-Chester Medical Center	150	3	1 - 7	Δ	$92,435
Geisinger Medical Center /Danville	430	17	6 - 18	Δ	$39,756
Graduate Hospital	290	9	5 - 14	Δ	$102,637
Hahnemann University Hospital	960	35	20 - 38	Δ	$75,967
Hamot Medical Center	541	11	9 - 22	Δ	$52,654
Harrisburg Hospital	506	10	5 - 16	Δ	$51,578
Lancaster General Hospital	502	9	8 - 21	Δ	$29,481
Lankenau Hospital	685	14	13 - 28	Δ	$59,151
Lehigh Valley Hospital	822	20	18 - 35	Δ	$50,773
Medical College Hospitals /Main Campus	250	10	3 - 12	Δ	$76,313
Mercy Hospital of Pittsburgh	749	24	12 - 27	Δ	$46,967
Penn State University Hospital /Hershey	186	8	1 - 8	Δ	$38,487
Pennsylvania Hospital	192	5	2 - 10	Δ	$62,447
Presbyterian Medical Center of Philadelphia	616	16	10 - 24	Δ	$52,517
Reading Hospital and Medical Center	513	9	6 - 17	Δ	$28,392
Robert Packer Hospital	308	5	2 - 11	Δ	$26,000
Saint Francis Central Hospital	315	14	6 - 17	Δ	$51,135
Saint Francis Medical Center	438	20	9 - 22	Δ	$61,270
Saint Joseph Hospital /Lancaster	118	1	1 - 6	Δ	$30,610
Saint Joseph Hospital /Reading	70	3	0 - 3	Δ	$45,396
Saint Luke's Hospital of Bethlehem	451	17	11 - 25	Δ	$33,775
Saint Vincent Health Center	451	16	7 - 18	Δ	$56,931
Shadyside Hospital	905	22	17 - 33	Δ	$62,804
Thomas Jefferson University Hospital	307	8	5 - 15	Δ	$64,865
University of Pittsburgh Medical Center	234	16	6 - 16	Δ	$93,743
Washington Hospital	65	0	0 - 3	Δ	$54,524
Western Pennsylvania Hospital	888	18	11 - 27	Δ	$61,178
Wilkes-Barre General Hospital /WVHCS	403	9	6 - 16	Δ	$32,526
Williamsport Hospital	86	4	0 - 4	Δ	$37,077
York Hospital	469	8	4 - 15	Δ	$33,487
Hospitals with greater number of deaths than expected					
Episcopal Hospital	242	12	3 - 11	-	$55,732
Hospital of the University of Pennsylvania	227	12	2 - 11	-	$86,509
Mercy Hospital of Scranton	416	21	8 - 19	-	$32,461
Polyclinic Medical Center	510	25	11 - 24	-	$49,981
Westmoreland Regional Hospital	106	5	0 - 4	-	$54,267
STATEWIDE TOTAL	17,413	497			$54,569

Hospitals and physicians may have commented on this report. Copies are available upon request.

Legend

+ The hospital had significantly fewer deaths than expected.
Δ The hospital's number of deaths was within the expected range.
- The hospital had significantly more deaths than expected.

Source: Pennsylvania Health Care Cost Containment Council, A Consumer Guide to Coronary Artery Bypass Graft Surgery, Vol. IV (Harrisburg, PA: June 1995). Statistics were based on 1993 data.

Federal Government Is Moving Slowly

In 1987, HCFA initially publically released hospital mortality information, but did so only in response to a request under the Freedom of Information

Act (5 U.S.C. 552). The published information, collected as part of HCFA's oversight efforts, included the observed and expected mortality rates for Medicare beneficiaries in each hospital that performed CABG surgery. HCFA published the information annually until 1993, when the HCFA Administrator discontinued the reports. He cited problems with the reliability of HCFA's methods to adjust the data to account for the influence of patient characteristics on the outcomes. HCFA has not published any other information about the performance of Medicare providers.

HCFA's responsibility to Medicare beneficiaries in the selection and oversight of Medicare contract HMOs is similar to that of employers to their employees in selecting health plans. However, HCFA does not routinely provide beneficiaries the results of its monitoring reviews or other performance-related information such as HMO disenrollment rates. In August 1995, we recommended that HCFA publish (1) comparative performance data it collects on HMOs such as complaint rates, disenrollment rates, and rates and outcomes of appeals and (2) the results of its investigations or any findings of noncompliance by HMOs.[6]

Our recommendation that HCFA publish performance data was consistent with the views of experts we interviewed about the federal government's role in ensuring that Medicare beneficiaries receive quality care. These experts cited the need for gathering health plan information such as (1) performance measures, (2) patient satisfaction, and (3) assurances that basic organizational standards have been met. Furthermore, they believed that when the information is obtained, it should be shared with beneficiaries to assist them in their health care purchasing decisions.[7]

Although HCFA has not been publishing data on Medicare providers, it is collaborating with others to publish performance information about Medicaid providers. HCFA has been participating with NCQA and the American Public Welfare Association on behalf of the State Medicaid Agencies Directors Group to tailor HEDIS to the particular needs of state Medicaid agencies, health plans that serve Medicaid recipients, and the recipients themselves. In July 1995 the work group released the first draft of Medicaid HEDIS[8] and is expected to release a final version of the document in Fall 1995 after considering comments received.

[6]Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

[7]Medicare: Enhancing Health Care Quality Assurance (GAO/T-HEHS-95-224, July 27, 1995).

[8]Draft Medicaid HEDIS: An Adaptation of the Health Plan Employer Data and Information Set 2.0/2.4, NCQA (Washington, D.C.: NCQA, July 1995).

Public/Private Partnerships Form to Produce and Disseminate Outcome Data

Like HEDIS, many of the most recent initiatives to provide data involve a partnership between private and public players. For example, a more recent public/private initiative that includes some of the major employers involved in developing HEDIS is the Foundation for Accountability (FAcct), created in June 1995. At a meeting of the Jackson Hole Group, some of the nation's largest employers and HCFA, together representing more than 80 million people, or almost a third of the U.S. population, agreed to combine their expertise and purchasing power. This action grew out of employer frustration with current performance data that focus on plan and provider structure and process rather than outcomes of care. FAcct intends to recommend measures of health care quality that can be easily understood by the general public so that people can make informed decisions when choosing a health plan. FAcct also hopes to encourage the common adoption of these standards to establish uniformity and minimize health plan reporting burdens as well as develop a means of educating diverse audiences about the significance and applications of health plan accountability.

Little Is Known About What Information Is Needed or Wanted

Experts have noted that studies performed to determine how consumers make decisions when no comparative information on quality has been available may not be helpful in determining what information consumers would actually use. Adding to the conclusions of numerous researchers that individual consumers give more weight to information from acquaintances than to expert opinion, researchers at Brandeis University reported in 1994 that Massachusetts state employees they surveyed valued information about quality but did not value report card information. From this apparent contradiction, the researchers concluded that survey respondents view quality as something other than what is described in report cards.[9]

In 1995, NCQA reported that almost all consumers participating in focus groups NCQA sponsored stated that they would use better evaluative information if it were available to them.[10] In addition, when NCQA provided participants with sample report cards, NCQA noted that in every group, participants were able to critically evaluate the information, raising the same questions about the validity of the data that experts debate.

[9]Brandeis University: The Heller School, Consumer Information: Decisive Factors in Health Plan Choice (Waltham, Mass.: Aug. 15, 1994).

[10]NCQA Consumer Information Project Focus Group Report: Executive Summary (Washington, D.C.: NCQA, Spring 1995).

In 1994, we reported that while performance measures or report cards could be a useful tool to educate consumers about the health care that plans provide, the report cards being developed may not reflect the needs of some users.[11] Employers have been the primary users of information comparing quality of care; little is known about the extent to which this information is meeting individual consumers' needs.

The sections that follow discuss in more detail the results of our efforts to determine, from the consumers' perspectives, the extent to which they use quality of care information in making health care choices and the types of information consumers find useful in arriving at decisions.

Consumers We Interviewed Use Information Comparing Quality in Health Care Decision-Making

Many of the employers and individual consumers of health care we talked with are increasingly using information that compares the quality of care furnished by health care providers or health plans to make purchasing decisions and to encourage providers and plans to improve the quality of their care. However, some of those we interviewed told us they are not using the information because they are unaware that it exists, they have not been able to find it in some markets, they believe the available information does not meet their needs, or they lack the resources or time to find and use the information. Further, they stated that the information would be more useful if their concerns about the reliability and validity of the information were addressed.

Use of Quality Information Varies

Most of the employers we spoke with were either actively seeking or using information on quality or stated that they would use it if it were available to help choose health plans or individual providers for their employees. Many employers told us that because they limited the employee's choice of provider by using an approach that restricted or encouraged the use of specific providers, they felt a greater need to ensure that they provided access to quality providers. For example, the human resource manager of a midwestern manufacturing firm told us that

"we'd like to get some kind of value-based decision for purchasing health care. The pure pricing arrangements, the deals . . . have not really been a complete answer for us. Those arrangements don't address quality, and we're coming to believe that that's got to be the cornerstone of your health care plan."

[11]Health Care Reform: "Report Cards" Are Useful But Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Employers' use of the data varied considerably. Some of the larger self-insured employers were using data to select individual providers to include in their own network. Other self-insured employers preferred to leave the selection of providers and quality assurance functions up to either the HMO or the plan administrator with whom they contracted. In the words of the benefits manager for a major Northeast financial services employer,

> "I think that they [HMOs] should be in the business of comparing hospitals, picking out the high-quality, cost-effective providers; that's what I'm paying them to do. I just want to make sure they're doing it, and feel comfortable that they're doing it."

These employers used the comparative data as a "red flag," signaling a possible decline in quality. For example, one large southeastern self-insured employer stated that he watched for trends in performance measures that might serve as a warning that a problem was developing.

Some smaller employers reported that they had neither the resources nor the time to find or use report cards but wanted the information to be available to the insurance agents or purchasing alliance staff they relied on to make health insurance recommendations.

Employers told us that they are also using the data as a tool to market a specific plan to their employees or to negotiate contract terms with the insurance carriers. Numerous employers told us that providing employees with data comparing quality of care was particularly helpful in convincing their workers that managed care plans do not compromise the quality of care provided. Employers stated that they use the data to influence providers and plans to improve quality. For example, one employer told us that during contract negotiations, data were used comparing hospitals on specific procedures, such as hysterectomies, to encourage hospitals to reduce unnecessary surgeries.

The individual consumers we talked with in Pennsylvania, California, and Minnesota who had requested and received specific report cards generally used the information and found it to be very helpful in making health care purchasing decisions. These consumers received either (1) information about patient outcomes for physicians and hospitals performing specific procedures or (2) information on a specific plan.

More specifically, individual consumers in Pennsylvania and California reported using the procedure-specific reports to

- select the best surgeon or hospital because they or someone in their family anticipated having the surgery described in the report,
- select the best surgeon or hospital for procedures other than those described in the report,
- review the ranking of the surgeon who had performed their surgery before they had obtained the report,
- ask more informed questions of their doctors,
- increase their general knowledge,
- provide advice to others, or
- satisfy their curiosity.

Individual consumers using a plan-specific report card told us that they used the information to select a health plan or to increase their knowledge about the health plan chosen by their employer, such as the services provided or the financial health of the plan. Consumers using either a plan- or procedure-specific report card who had no choice of provider reported that the information gave them reassurance.

Although most individual consumers we interviewed found the report card helpful, some did not. Some consumers reported that they did not use the information because it focused on one procedure or health plan, or because it was limited to a specific state or area. Other consumers told us that they were unaware the information existed until after they or a family member no longer needed it. For example, a Pennsylvania woman stated that she wished she had known about this information before her mother died after heart surgery, because it might have helped her select a provider.

Consumers' Concerns About Comparative Data Limit Data's Usefulness

Both employers and individual consumers echoed many of the same concerns expressed by health care experts and previously reported by us that comparative information may not be measuring what it is intended to measure. Experts have varying beliefs about what information should be included in a report card because of acknowledged difficulties with the reliability and validity of data sources and systems designed to measure quality. Areas of concern for purchasers we interviewed focused on risk adjustment, age of data, subjectivity, and bias.

More specifically, consumers, both corporate and individual, questioned whether procedure-specific data were properly adjusted to account for differences in patient characteristics that might contribute to adverse outcomes. They were skeptical about whether factors such as age, severity

of condition, and functional status[12] could be accounted for to ensure that outcomes were an accurate reflection of provider quality. We have reported previously that severity-adjusted performance measurement systems are in a relatively early stage of development and may not provide information for accurately comparing hospitals' performance. We concluded that additional information and methodological improvements are needed to provide more useful data on which to base purchasing decisions.[13]

Numerous individual consumers commented that the report card data they had received were too old to accurately reflect current provider or plan performance. For example, a consumer using plan-specific information stated that the information was not helpful because it was already 2 years old when published. Another commented that even in a short time, cost data can become outdated. A consumer using health-plan specific information told us that

"they [the report cards] are to reassure the public, but they can't be used to make health care decisions because they are too general and outdated from the time the data was gathered until the decision is made."

Some consumers stated that selecting a health care provider is a subjective decision that is difficult to quantify. In the words of a Pennsylvania consumer, while the report card was a good publication, "it is limited by trying to objectify something that will always be subjective." For example, consumers differ in what they want from a provider. Some consumers mentioned that it is more important for some patients to feel at ease with their doctor than it is for others. Although many consumers stated that they wanted information on customer satisfaction, others felt it was of limited value because "just because you're happy with your doctor doesn't mean I would be happy with him or her." Another individual consumer questioned a patient's ability to assess a doctor's medical knowledge, technical skills, and ability.

Some employers explained that the subjective nature of the health care purchasing decision results in their reluctance to use quantitative data to select providers for their employees. As expressed by a representative of a major East Coast manufacturer:

[12]"Functional status" is the extent to which people are able to perform activities of daily living and their basic social roles.

[13]Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems (GAO/HEHS-95-1, Oct. 3, 1994).

"Quality is in the eyes of the beholder . . . . It is not appropriate for the employer to place a value on one outcome over another. It is up to the patient to place that value. Is it more important that I be alive but it's okay if I'm hurt or I'd rather die than be [incapacitated]?"

A representative of a medium-sized manufacturing firm stated that

"you know I think that a big part of the problem, and we're guilty of it too, is imposing our own tastes or beliefs on other people . . . . In health care we do a lot of deciding of what's good for people on the basis of our own beliefs, and the issues that [concern] a $9 an hour person are not the same ones that I'm contending with . . . . The highly paid person may not have any problem in going out of network—may be able to afford to go to Mayo's [the Mayo clinic] and decide, 'hey, that's where I'm going with this problem. I'm not going to stick around [city deleted].' Whereas somebody on the shop floor has got to stay in [city deleted]."

Individual consumers questioned the objectivity of the health care data produced and distributed by the provider or plan. Many consumers stated they would be less likely to believe the information if it is gathered and reported by the provider or plan rather than an independent third party. For example, one individual stated that "an unscrupulous provider could make sure they hit home runs on all of these particular items [the quality measurements] . . . ." Individual consumers who requested and received report card information from health plans used terms such as "self-serving," "one-sided," and "nontrustworthy" to describe the report. These respondents saw the purpose of the reports as a provider's public relations effort to "blow its own horn" or use the report as a "marketing tool" rather than to provide information to the consumer.

Consumers Want More Information

Consumers we interviewed want more information than they currently have. Both employers and individual consumers want information that emphasizes outcomes rather than process or structure measures of quality. They want standardized information that allows them to compare providers and plans. Few employers we interviewed are sharing unpublished data with employees, and they differ from one another on whether or not they believe their employees would use it to make decisions. Individual consumers generally stated that they wanted reports on quality to make decisions, but many emphasized that such reports would never be the sole source of information; they would only augment the advice of others.

Consumers Want Outcomes More Than Other Kinds of Measures

When emphasizing that they want information on the outcome of health care provided, consumers are asking for a measure that allows them to select providers who will improve their health status or that of their employees. For example, in describing the need for outcome data, one employer stated that rather than just knowing how many women received mammography screening for breast cancer, he wanted to know if the number of women who died or were incapacitated from breast cancer was being reduced.

A major northeastern food manufacturer used outcomes to relate quality assurance in health care to its manufacturing quality assurance program to explain that "outcome data . . . is the only way to measure quality . . . . Once you have the outcome, you can go back and look at the processes themselves."

A large West Coast employer stated that what the company really wants is information on health status.

"What we'd like as a measure is we'd like to know that the plan has improved the health status of the population served . . . . That might be different for some subpopulations. So, [we would like to see reports] moving much more to population-based approaches."

A medium-sized manufacturer stated that

"in general, you're looking for quality and you're looking for value, so maybe [we need] more of a functional analysis. There is some subjective information that needs to be obtained along with the length of stay and cost of stay and some of these other factors that we're just not getting yet . . . . You need to do a kind of functional analysis as well, to say 30 days after that angioplasty was that patient back at work, and were they working 40 hours per week, and were they doing their job . . . . How's your quality of life after you've had this?"

A large northeastern financial services firm said

"the number one thing people ask . . . when they're considering an HMO . . . is not like gee, 'Am I going to get that mammogram,' it's 'What if I get sick, am I going to die, are they going to take care of me?'"

Both employers and individual consumers stated that although data reflecting the outcomes may be the best measure of provider quality, it is

very difficult to know whether outcomes result from quality of care or factors such as the patient's condition or lifestyle choices.[14]

Data Must Be Standardized and Easily Comparable

Both employers and individual consumers told us that they want standardized data that could be used to compare health care providers' and health plans' performances. Though noting that efforts such as HEDIS exist, employers told us that these measurement systems are still in the developmental phase. They also said that without standardization, such as in definitions of disease or methodology for analyzing data, this information is not comparable regionally or nationally. Numerous employers were participating in standardization efforts such as the Midwest Business Group on Health's efforts to standardize customer satisfaction surveys. Many of the larger employers we interviewed hire consulting firms that provide them with some level of standardization and comparability. An official at a medium-sized manufacturing firm stated that

"the government should prescribe some standards and force providers to adhere to these standards in the publishing of information. The government should say, 'You're going to code this disease this way, and you do it consistently and uniformly . . . .'"

Individual consumers stated that the way the information was presented was very important to them. For example, some wanted to have providers or plans compared side-by-side on one or two pages. Consumers using the procedure-specific reports uniformly praised the table format that provided this kind of direct comparison. (See fig. 2 for an example of a table providing a comparison of providers from a procedure-specific report.)

Some individual consumers wanted the information to cover a wider geographic area, and others emphasized the need for community-specific data. For example, some Pennsylvania consumers stated that the report card for that state pertained only to providers in Pennsylvania. Consumers living in Philadelphia would like to have had this type of information for surrounding states because their providers, while close to their homes, were located in other states. The same concern came up in a midwestern city that bordered two states.

[14]Some experts estimate that it will take 10 to 15 years and millions of dollars to develop a technically sophisticated measurement system that is able to accurately attribute outcomes to care.

Employers Have Sources of Data Not Available to Employees

Many employers are getting some of the quality of care data they want through business coalitions, consultants, and their own data collection efforts. This information is generally unavailable to the individual consumer, and few employers we interviewed were sharing these data with their employees. Employers differed in their opinion of whether or not their employees would use these data in making health care choices. Some employers stated that they do, or would, share information on quality with their employees because such information would help their employees make informed decisions. For example, a midwestern service employer stated that it would be important to

"hav[e] some report card concepts that the employees could understand the information, user friendly . . . consistent . . . . I want to have a tool for the employees to make that decision. If the employees are making that decision, they are going to change the marketplace. They are going to improve the quality of the system because the doctors and the hospitals are going to have to alter their practices because of the information that has been gathered and is presented and understood by employees. They are then making intelligent decisions as far as where to get their health care . . . . Empower the people to make the decision."

A major employer located in the Northeast stated that

"if we are going to have value-based purchasing which would drive a competitive marketplace in health care, we have to involve consumers who make the ultimate choice. Therefore the information has to be relevant for them."

Other employers believed that their employees did not want or would not understand data comparing quality. A large East Coast manufacturer stated that

"I think it's not speaking to how they make decisions. I think we'd overwhelm them . . . . Also, I don't know if the data we'd be giving them would be the complete picture."

Another large East Coast manufacturer stated that

"I've been in health care benefits for 15 years. I don't know how to make the choice. What happens to poor Harry the Huffer working on the shop floor when you give him . . . the morbidity in this hospital is here, and you know the readmission rate is this, and the reinfection rate is this, and the guy says, 'I don't know what I should do.' Because what they do to our counselors is say, 'I don't want to make choices.'"

Nevertheless, employees we interviewed disagreed with those employers who said that employees would not use the information. Employees' concerns included issues of validity and reliability such as risk assessment and accuracy rather than their ability to understand the data. Most of the individual consumers who had requested the published reports found them to be easy to understand, using terms such as "clear," "concise," and "well organized." They found the charts and tables particularly useful. For those who had some problems understanding the reports, additional assistance was useful. For example, a Pennsylvania consumer who had been unable to fully understand the published report on her own had no trouble after it was explained by the state agency that had produced the report. Another Pennsylvania consumer stated that the first report card she received was difficult to understand but that by the third report she received, she found it very useful.

Many individual consumers emphasized that published information would never be the sole source of data for their health care decisions but would be used in addition to other information such as personal consultation with their physician, friends, family members, or coworkers.

Conclusion

Data comparing health care plans and providers helped the consumers we interviewed make their health care purchasing decisions. However, performance reports have not yet achieved their fullest potential. Consumers said they needed more reliable and valid data, more readily available and standardized information, and a greater emphasis on outcome measures.

Meeting the information needs of individual consumers continues to lag behind meeting the employer needs. Attention must be paid to ensuring that individual consumers have access to health care data. While employers themselves have initiated efforts to cooperate with one another, few we interviewed are making complete health care data available to assist individual consumers in making purchasing decisions. Relevant stakeholders have not yet addressed the issues of disseminating performance data to individual consumers so that they can make responsive, informed decisions about their health care coverage.

We are sending copies of this report to interested congressional committees and other interested parties. We will make copies available to others on request.

This report was prepared under the direction of Carlotta C. Joyner, Associate Director. Other major contributors to this report include Sandra K. Isaacson, Assistant Director; Susan Lawes; Lise Levie; Lesia Mandzia; and Janice Raynor. Please call me on (202) 512-6806, or Dr. Joyner on (202) 512-7002, if you have any questions.

Sincerely yours,

Janet L. Shikles
Assistant Comptroller General

Scope and Methodology

To obtain information on how consumers use data comparing the quality of health care providers or health plans and what information they want when making health care purchasing decisions, we interviewed both employers and individual consumers. To obtain the view of employers, we interviewed officials at over 60 businesses. The size of these businesses ranged from under 5 employees to over 100,000 employees. These employers were selected on the basis of the following criteria: (1) size of workforce (small, medium, and large); (2) geographic variability; and (3) variation in whether or not they used published report cards. "Small" employers were defined as those with fewer than 50 employees, "medium" as having 50 to 499, and "large" as 500 or more employees. Because the businesses were not randomly selected, their experiences and opinions cannot be generalized to all employers. We also interviewed a major private sector management consulting firm that supplies comparative health care data to employers.

To obtain the views of individual consumers who had received a report card, we conducted telephone interviews during January, February, and March 1995 with 153 consumers who had requested and received published report cards to determine how they used the information (see table I.1). The report cards they received were published by either California or Pennsylvania state agencies or by health maintenance organizations in California and Minnesota. These report cards were selected because they were the most recently available in which the issuing entity had a record of requesters and the state or HMO was willing to assist in the study. The consumers we talked with had received this information sometime during 1993 and 1994. The reports published by the state agencies contained only procedure-specific indicators, while the health plan reports focused on various plan and procedure quality indicators related to the individual health plans.

Table I.1: Summary of Telephone Survey With Individual Consumers

State or health plan	Number of individuals who requested report card information	Number of individual consumers we interviewed[a]
Pennsylvania	633	120
California	43	6
Medica	338	22
Kaiser Permanente (HMO)	73	5
Total	**1,087**	**153**

[a]These do not include those consumers who requested the report solely for their work, those who did not receive or could not recall the details of the report, or those who chose not to or were unable to participate.

Although we attempted to contact all 1,087 individuals who had requested the report cards issued by those states or health plans, many of these individuals did not choose to participate, could not recall receiving the information, or had requested the information for reasons other than making health care purchasing decisions, such as for school or work. Because we spoke with only a small number of individuals who had requested information for consumer-related purposes and they were not chosen at random, their experiences and opinions cannot be generalized to the entire consumer population that requested report card information.

We also conducted interviews with seven groups of employees around the country who may not have had previous experience with such reports. We conducted these interviews with employees from four federal government agencies and three private corporations—manufacturing, sales, and service. These employees were selected because their employers offered them more than one health insurance plan to choose from when making their health care insurance purchasing decisions. The number of participants in each group ranged from 8 to 10 and included employees with varying marital, family, and age status as well as employees enrolled in both indemnity and managed care plans.

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Medicare: Enhancing Health Care Quality Assurance (GAO/T-HEHS-95-224, July 27, 1995).

Health Care: Employers Urge Hospitals to Battle Costs Using Performance Data Systems (GAO/HEHS-95-1, Oct. 3, 1994).

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

Access to Health Insurance: Public and Private Employers' Experience With Purchasing Cooperatives (GAO/HEHS-94-142, May 31, 1994).

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