MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: SAVING MONEY, SAVING LIVES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

APRIL 2, 2009

Serial No. 111–27

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

67–824 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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WITNESSES

SUBMITTED MATERIAL

MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: SAVING MONEY, SAVING LIVES

THURSDAY, APRIL 2, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:07 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Frank Pallone Jr. (chairman) presiding.

Members present: Representatives Pallone, Dingell, Green, DeGette, Capps, Schakowsky, Baldwin, Matheson, Castor, Sarbanes, Sutton, Braley, Deal, Shimkus, Shadegg, Pitts, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff present: Karen Nelson, Deputy Staff Director for Health; Karen Lightfoot, Communications Director; Jack Ebeler, Senior Advisor on Health Policy; Stephen Cha, Professional Staff Member; Tim Gronninger, Professional Staff Member; Purvee Kempf, Counsel, Anne Morris, Legislative Analyst; Virgil Miller, Legislative Assistant; Camille Sealy, Detailee; Miriam Edelman, Special Assistant; Lindsay Vidal, Special Assistant; Alvin Banks, Special Assistant; Allison Corr, Special Assistant; Brandon Clark, Minority Professional Staff Member; Marie Fishpaw, Minority Professional Staff Member; Clay Alspach, Minority Counsel; Melissa Bartlett, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR.

Mr. PALLONE. The meeting of the subcommittee is called to order.

Today we are having our final hearing in this series on marking healthcare work for American families, and today we will examine how to get more value out of our healthcare dollars by improving quality and lowering costs. Earlier this week the Department of Health and Human Services issued a report on rising healthcare costs and the impact these costs are having on American families, businesses, and the Federal Government. According to this report the U.S. spent $2.2 trillion on healthcare in 2007, or $7,421 per person, and this comes to 16.2 percent of the gross domestic product, which is nearly twice the average of other developed nations.

If healthcare costs continue to grow at the current rate, they will account for 25 percent of GDP in 2025, and 49 percent in 2082. Clearly, this level of healthcare spending is simply not sustainable.

So we need to figure out to change the trajectory of healthcare costs. Bending the cost curve even the slightest degree will help mitigate further growth and generate significant savings to our healthcare system. The difficult part is figuring out how, and that is why we are here today.

Part of the problem is how we pay for healthcare services. There is an old saying that you get what you pay for. In this country we pay for the quantity of healthcare services provided, not the quality of the service. So it should come as little surprise that as utilization rates increase, healthcare costs rise and quality suffers.

But this isn't the story across the board. There is a lot of variation in the delivery of healthcare throughout our Nation. In parts of the country certain healthcare services are seeing tremendous growth and utilization. Yet in other parts there are concerns that patients aren't receiving enough of recommended care. So we need to understand better what explains this variation and how it is impacting our healthcare system in terms of both cost and quality.

Significant work has been done in this area by researchers at Dartmouth, including Dr. Jonathan Skinner, who we will hear from today. I think it is also important to note that these problems are prevalent throughout the healthcare system. A lot of people like to point to public programs like Medicare and Medicaid and use them as a scapegoat for healthcare costs run amuck, but the challenges we face with costs and quality aren't endemic to just public programs. Private insurers and employers must also begin to rethink the way they pay for healthcare services. Changes to Medicare payment policies can help drive that change.

And finally, I want to mention that we will also be examining the role of transparency when it comes to the delivery and purchasing of healthcare services. This has been a priority for our Ranking Member, Mr. Deal. I agree that consumers have the right to know what they are paying for when they see a doctor or enter a hospital, but that right also extends to other areas such as purchasing healthcare coverage. I think we need to be cognizant that transparency, while certainly a good thing, does have its limits. It is not realistic to expect transparency to be a panacea to controlling healthcare costs. Some, if not most, patients simply won't be in the position to use this information or shop around for the best healthcare.

I want to thank our witnesses for being here today. I am looking forward to your testimony.

And I now recognize Mr. Deal for the purposes of his opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL

Mr. DEAL. Thank you, Mr. Chairman. I want to thank you, and I want to thank the witnesses in both panels today for your appearance.

Certainly the first panel today will raise a number of issues facing Congress. Chronic care is consuming a larger share of healthcare spending, treatment remains uncoordinated and oftentimes duplicative as a result of fragmented care and escalating costs threaten the coverage of millions of American families.

I am particularly appreciative that the chairman is willing to hold a panel hearing today on the second panel relating to healthcare transparency. As most of you know, I am currently making final revisions to my legislation Healthcare Transparency Act of 2009, which seeks to address many of the issues stemming from the exorbitant cost of medical items and services. My legislation addresses a core problem in our healthcare delivery system, which affects millions of American families.

Medical bills remain the leading cause of personal bankruptcy in this country, and with these concrete hard facts in mind it bears asking why anybody would want to inhibit more transparent fair price healthcare market, fair prices in the healthcare market.

I have some charts, and I am going to ask if someone would put those charts up while I make a few more statements. The first reaction of many people in Washington would be to create thousands of pages of new pricing regulations to help solve the problem. I want to make it clear that I believe the best solution would be to simply follow President Obama's call for increased transparency and require any healthcare provider receiving federal funding to publicly disclose the price they charge to uninsured, to under-insured, and other self-pay patients. Given the efficiency created in today's internet-based marketplace, particularly as the healthcare industry makes dramatic steps towards wide adoption of HIT and EMR technologies, the task would be simple and would empower millions of Americans with critical information about the cost of their healthcare.

Another equally important component of the proposal would be to require health insurance companies to provide more information to patients before services are rendered. As you know, there are a number of factors which affect reimbursements provided by insurers such as deductibles, co-pays, and co-insurance rates and whether or not the provider is established as an in-network or out-of-network provider. And I think people should know before they receive the services exactly what those services are going to cost.

Now, the charts that you see here are pictures made by staff members on a trip to Tanzania, Africa, and they are in Tanzanian shillings, and one United States dollar equals approximately 1,300 Tanzanian shillings. Now, the brown chart there is taken at a community hospital in Tanzania, and it is in, the chart is located in the front of the reception area at the hospital. As you might be able to translate there, ultrasound there is the equivalent of costing four U.S. dollars. Now, that is a little deceiving because the GDP and the gross domestic product of Tanzania is very low.

The white chart is a list taken outside the outpatient ward at a community health clinic. Now, it seems a little bit surprising to me that in what we would definitely call a third-world country their people going to their health providers have the right to know what the cost of their services are going to be, and they are publicly posted. I challenge you to find very many comparable environments in the United States where these prices are posted for the public to know before they receive the services, and think that is a shame and something that should be addressed, and we hopefully in this healthcare reform that we will undertake will have the opportunity

to do that. We shouldn't criticize third-world countries when they have greater transparency than we do.

So thank you, Mr. Chairman. I appreciate your indulgence, and thank you for having both of the panels here today.

I yield back.

Mr. PALLONE. Thank you, Mr. Deal. Our Chairman Emeritus, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL

Mr. DINGELL. Thank you, Mr. Chairman, and I commend you for holding today's hearing.

In the healthcare reform debate which we are now engaged everybody can agree on at least two things; we must reduce the cost of our healthcare system so that it doesn't bankrupt our families and businesses and even government at all levels, and we must increase the quality of care so that we can get a better value for our dollar. This means a way must be found to see to it that we can control these costs and reduce the acceleration in growth of the costs that is moving forward.

The cost of our healthcare system is an unsustainable path, and we must now act to bend the cost curve before it is too late. We have created a system that makes money by running more tests, doing more surgeries, prescribing more drugs, even if the data doesn't back up the particular course of treatment, and of course, it involves buying large amounts of enormously expensive equipment as essentially a business promotion device.

One of our primary goals in drafting healthcare reform legislation will be to provide ways to incentive value of care over volume of care. We must reform our healthcare system in a way that rewards providers for quality healthcare, reduces the number of hospital re-admissions, incentives primary care, and moves providers in the direction of creating integrated healthcare systems. And wellness must be a concern of ours as we go about this business.

We must recognize the need for consideration of evidence-based data in determining treatment plans in an effort to highlight treatments which are most cost effective. We should not be led to believe that only the most complex and most expensive procedures are the most effective. Most times this is not the case.

Studies show that standardizing certain procedures can save lives. For example, training staff on a simple matter like proper hand-washing procedures is still one of the best ways to prevent hospital-caused infections. Marking surgical sites on the patient's body is another way to reduce medical errors, and this committee has had to address questions involving amputation of the wrong leg or removal of the wrong breast from patients in treatment errors of the most outrageous sort.

Pre- and post-surgical checklists ensure that patients are receiving the best practices as developed by the medical community instead of invariability and quality of care are a necessity.

Finally, we must create transparency in the healthcare marketplace. Transparency efforts must include a wide variety of information that allows patients, consumers to make well-informed decisions about insurance plans, services, and providers. A national health insurance exchange could be a very helpful event in this re-

gard. Such an exchange which would offer a range of private insurance options in addition to a public insurance plan could simplify paperwork and make the difference among plans, including costs and services offered more transparent to the advantage of the patients and to the advantage of the system.

I look forward to hearing the testimony of our witnesses today about how we can improve the quality of our healthcare system, while also reducing the overall costs. Their incitement will be valuable in our meeting of the challenges ahead of us.

I thank you, and I yield back the balance of my time.

Mr. PALLONE. Thank you, Chairman Dingell.

The gentleman from Illinois, Mr. Shimkus.

OPENING STATEMENT OF HON. JOHN SHIMKUS

Mr. SHIMKUS. Thank you, Mr. Chairman, and one thing great about, especially this subcommittee is we have active members who are in the healthcare profession, doctors, we have got Lois, who is a nurse, and they really bring a great benefit of actually practitioners versus us who are just laypeople trying to figure out this very complex process. So I do—I have said it a couple of times, it is really a joy to be back on this subcommittee.

The—I think there is a new concern. Mr. Deal in his opening comment talked about, you know, government forcing transparency because we are in the process of being a big payer, and as you see with the TARP and Wall Street bailout and GM now with the Administration being able to tell the CEO to leave, I would expect more of that for anybody who gets government money of any size, shape, or form. I am not sure this is good for the country, but we are in a new era. And so if you are getting government money, expect government to start making decisions all the way down as to one of the bills we had on the floor last night said that we may be able to determine the salary of the janitor in a corporation that accepted TARP money.

So figure out how that is going to affect healthcare in this for the Medicare and Medicaid, and I think you have to look at it, because as most people say, Medicare and Medicaid is a driving factor on health insurance reimbursements. So you can't discard the underpayment by the government on these two provisions.

I am not sure how much time—I don't know if I have gone that quickly, but if it is then I will yield back if—unless—if you hit the timer.

Mr. PALLONE. Thank you.

Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN

Mr. GREEN. Thank you, Mr. Chairman. I want to thank you for holding this hearing today on the health reform and access to care.

Currently there are 47 million uninsured in our country. Overall healthcare is consuming an ever-increasing amount of our resources. Healthcare estimates are now 16 percent of our GDP, and this rate could hit 20 percent by 2017, and as our chairman said, 25 percent later. Current estimates show that we are spending approximately $8,000 per person on healthcare per year. Unfortunately, we are paying more for the cost of healthcare but individ-

uals are receiving less care for their money. Even though we have access to the most advanced technologies, fewer individuals seek treatment due to costs.

The current economic times highlight the fact that more individuals are uninsured simply because their companies cannot afford health insurance or the employees cannot afford the premium. Premiums are high because we have a reimbursement rate policy, including SGR, which does not accurately cover the cost of treatment. We also have a fee for services to reimburse physicians for volume, which often rewards physicians who perform more procedures instead of focusing on better outcomes.

As we work to improve our healthcare system we hope we will finally address our payment system to encourage better health outcomes and treatment. I believe this is the root of our high-cost healthcare and unfortunately prevent individuals from having access to quality and affordable healthcare.

I want to thank our witnesses for appearing today, and I look forward to the testimony. I would also like to submit on behalf of my colleague, Representative Engel, written testimony for the record from the National Home Infusion Association, Mr. Chairman, and I yield back my time.

Mr. PALLONE. So ordered without objection.

The gentleman from Pennsylvania, Mr. Pitts.

OPENING STATEMENT OF HON. JOSEPH R. PITTS

Mr. PITTS. Thank you, Mr. Chairman, for convening this hearing.

As we discuss healthcare reform, I can, I think we can all agree that patients should be more involved in their own care and treatment, but we will never drive down the out-of-control costs of healthcare if individuals do not take personal responsibility for their choices and behavior.

Too often, though, individuals' hands are tied. In many cases they do not have the one tool that might arguably be most important for driving prices down and quality up, to helping them make the very best decisions for their own lives and that is information.

What is the true cost of an emergency room visit or CT Scan? What about the same CT Scan in the country next door? Of the two hospitals nearest my home, which has a lower hospital-acquired infection rate or a lower error rate during surgery? If I am a self-paid patient, what am I paying compared to the person next to me who has private health insurance? None of us would accept this lack of transparency in other areas of our lives. I can pick up items in a supermarket, compare them using nutrition labels, all the information I need to decide which item is healthiest is right there. We all know that knowledge is power, and that is why I commend Ranking Member Deal on his draft legislation, the Healthcare Transparency Act, designed to get consumers the information they need to make informed choices about their healthcare.

Mr. Chairman, I look forward to hearing the thoughts and testimony of the witnesses and thank you and yield back.

Mr. PALLONE. Gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Mr. Chairman, I think this is a very important hearing, and I will waive my opening statement in order to get more time on questioning.

Mr. PALLONE. Gentleman from Georgia, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY

Mr. GINGREY. Thank you, Mr. Chairman. We have heard a lot of testimony over these past few weeks concerning the critical problems our healthcare system is currently experiencing.

Healthcare costs are rising faster than inflation and wages, and those costs create barriers to care for many, both insured, underinsured, uninsured, and of course, including lower-income families and those with chronic illness and the disabled.

We do need to fix healthcare so that everyone has the ability to see a quality doctor or to receive life-saving treatment. We also need to reform long-term care, pay providers based on quality of care they give patients and not just volume. We need the in defense of medicine through meaningful reform and support the creation of a complete system of electronic health records. I think this goes hand and glove with my colleague from Georgia, Ranking Member Deal, on his Healthcare Transparency Act.

This Congress is now on the verge of considering legislation that could fundamentally change the way we access healthcare in this country. Both sides of the debate want to make our current system of healthcare better. One side, though, believes that reform should happen through direct government control. The other side, our side, believes that in order to make our system better, we need to fundamentally strengthen what works in healthcare and strengthen the doctor-patient relationship.

My hope is that this Congress works together in a bipartisan way to achieve meaningful reform that strengthens the doctor-patient relationship for every American and makes healthcare accessible and affordable for every American.

Thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you.

Subcommittee Vice Chair, Ms. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS

Ms. CAPPS. Thank you, Chairman Pallone, and welcome to all of our witnesses, and thank you for taking the time to be with us.

Today's hearing is particularly important because it asks the question that is at the heart of our health reform debate. How do we improve the health of Americans while decreasing the skyrocketing costs of healthcare? The answer lies in how we define and reward healthcare delivery.

We must stop persisting with a complicated, cobbled-together system that really basically treats illnesses. Instead, we need to create a streamlined and comprehensive system which at its core strives to prevent illness and maintain health.

In order to make that change in healthcare we so desperately need, information-based, coordinated care that finds some way to reward prevention is important. This, I believe, is absolutely essential and a way to bring down costs as well.

So I look forward to hearing from our witnesses today, and I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee, Ms. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN

Ms. BLACKBURN. Thank you, Mr. Chairman. This has been an interesting, very interesting series of five hearings, and so you all are the ones that are going to finish this up for us today, and we welcome you all. I especially would like to welcome Mr. Smith, who is on the first panel and has been so diligent in helping me with healthcare issues in Tennessee, and I appreciate that. And Dr. Herzlinger, who has also been someone I have gone to for advice through the years.

Because in Tennessee we have had the system of TennCare, and as many of you know and have heard me say during this series of hearings, the mismanagement, very serious mismanagement issues that surrounded this program have caused some serious financial budgetary implications for our State. And I am one of those that as we have worked through this hearing it has reaffirmed to me how important it is that we have consumer empowerment, transparency, increased accountability, and the healthcare delivery systems. Without that we are going to see continued mismanagement of programs such as the TennCare Program.

Mr. Chairman, I will have to tell you the hearing title was curious to me, saving money, saving lives. I wish we had said, saving lives while saving money and expecting better outcomes in healthcare delivery.

Welcome to you all, and I yield back.

Mr. PALLONE. Gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR

Ms. CASTOR. Thank you, Mr. Chairman, and welcome to all the witnesses.

You know, there is this great new technology that is available to members of Congress and others where we can hold telephone town hall meetings, and I did that Monday night, and the call goes out to everyone in your district, and they can just stay on the line or they can hang up if they are busy. We did it on the economy because folks are really struggling right now, and in my community where unemployment is over 10 percent and we have a very high foreclosure rate, I answered question after question on healthcare. The affordability, and we did this online poll where people can just press a button. Where do you get your healthcare, and we had one, we had about, we had over 4,000 people on the line, and it wasn't very scientific but most receive their healthcare through their employer, employer-based health insurance, but every question was we just can't afford it any longer. It is out of control.

The parent who had healthcare through the employer but their son was blocked, prevented because of a pre-existing condition from participating, left them out, just completely out in the lurch. The retired school teacher who still has benefit through the school district is struggling with how to pay for prescription drugs, and that really hit home because that morning I was at a community health center with a pharmacy that had 340B pricing lowest, and I could not, I can't rationalize the difference there.

So this is the front burner issue, and I look forward to your expert testimony and how we make healthcare more affordable for Americans. Thank you.

Mr. PALLONE. Thank you.
Gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS

Mr. BURGESS. I thank the chairman. We do have really a distinguished panel, two panels before us this morning. Of course, Dr. Goodman from down in North Texas, being a representative from Fort Worth, I won't say Dallas, but nevertheless I am so glad to see you here, because I think your wisdom will be great. Dennis Smith, obviously has been a great help to me in crafting some of these things. Dr. Cassel, we have crossed paths numerous times before and certainly appreciate your testimony this morning. Dr. Herzlinger, Ron Bachman, appreciate you being here as well.

I support transparency and competition. I think our efforts must not drive behavior into the shadows but should truly try to better our care and empower the patient. If we want to move into a robust system of consumer-directed healthcare, clearly transparency is going to be a critical issue.

I had introduced legislation on this in the last Congress and perhaps will do so again. I realize it is a somewhat contentious task when you are dealing with all the stakeholders, but I do believe it is worth the effort.

Just a word on comparative effectiveness, I think we need to be realistic about how we use comparative effectiveness. Realistically, we need to use it as a reference for how physicians treat their patients, but it should not supplant the individual physician's judgment as a hard and fast rule for healthcare delivery.

Let us not forget when Medicare was introduced some—in 1965, that in the statute itself it said nothing in this legislation, shall construe that the Medicare legislation will interfere with the doctor's ability to treat the patient. I think we would be wise to keep that in mind today as we go through this.

I will yield back the balance of my time.

Mr. PALLONE. Thank you.
Gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I just wanted to point out that no longer is the problem of the cost of healthcare, access to healthcare a reserve for the 47 million people that don't have health insurance but is really affecting so many more.

First, we know that only giving someone an insurance card is not going to fix our healthcare problems. The Commonwealth Fund estimates that 25 million insured people can't afford the gap between what their insurance covers and what their medical bills demand, and that number is growing exponentially every day.

Second, in 2007, healthcare accounted for 17 percent of our GDP, but our healthcare system ranked last or next to last on five dimensions of a high-performance health system; access, efficiency, equity, quality, and healthy lives. And so we have to be starting to pay for quality care.

And finally I want to talk about transparency. With all our current technological advances there is no reason why we cannot ac-

cess information about insurance practices. As Diane Archer will outline in her testimony, it is impossible to hold insurers accountable without knowing, for example, how they calculate premiums and other cost-sharing requirements, their denial rates, loss ratios, their prescription drug rates, the in-network versus out-of-network care rates. My office recently met with a group of insurance agents who complained of being unable to get this type of insurance from insurance plans. That was insurance agents. How can insurance agents accurately represent and sell insurance products if they don't have all the relevant information consumers need to make coverage decisions.

We can create a system that is not only accessible, one that is efficiently and properly focused on providing quality care.

Thank you, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you.

Gentleman from Iowa, Mr. Braley.

OPENING STATEMENT OF HON. BRUCE L. BRALEY

Mr. BRALEY. Mr. Chairman, thank you for holding this hearing on the issues of cost and value in our healthcare system.

Creating a healthcare system that emphasizes quality of care over quantity of patients seen has been a long-standing priority of mine. Studies regularly show that the State of Iowa ranks right at the top of our Nation in terms of quality of care, but Iowa healthcare providers receive some of the lowest Medicare reimbursements in the country. The current fee for service system incentivizes the quantity of patients seen over quality of care, which results in higher costs and an emphasis on the bottom line rather than patient outcomes.

A system that provides clearance centers for quality of care would also improve access to care for patients in rural America. Despite the well-documented success of Iowa's healthcare system, Iowa healthcare providers lose millions of dollars due to outdated geographic practice indexes. These antiquated figures ensure that some parts of the country receive drastically-lower Medicare reimbursement rates than other parts and have led to a shortage of doctors and medical personnel in rural America. There is already a physician shortage in Iowa, and the existence of these gypsies provides further disincentives for treatment of those who need it most, Medicare patients.

We need a system that emphasizes quality, efficient care with value-based measures. This will reduce costs and improve America's quality of care.

And I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN

Ms. BALDWIN. Thank you, Mr. Chairman. I really want to commend you, Mr. Chairman, for this series of hearings that you have held, making healthcare work for American families. We have touched on a wide array of issues of great importance as we look at national healthcare reform.

Over a period of a few months President Obama during the transition invited Americans to host and participate in healthcare community discussions to talk about how to reform healthcare in American, and these discussions showed us, showed that more than anything Americans are worried about costs. And it is no matter whether they have insurance or not. The financial burden of healthcare is a daily concern. It is something that keeps them up at night.

This situation obviously cannot persist, and we have this tremendous opportunity in front of us right now to reform our system and rebuild it for the next generation.

And Mr. Chairman, I look forward to the opportunity to work closely with you over the coming months to produce comprehensive healthcare reform legislation that addresses these very significant concerns of our constituents. So thank you for this series of hearings and our hearing today. Thank you to our witnesses.

Mr. PALLONE. Thank you.

Gentlewoman from Ohio, Ms. Sutton.

OPENING STATEMENT OF HON. BETTY SUTTON

Ms. SUTTON. Thank you very much, Mr. Chairman, and thank you for holding this important series of hearings.

Today's hearing, saving money, saving lives, will address the cost of healthcare and transparency in our healthcare system. You know, we have all, we are all aware that American healthcare is the most expensive in the world. The Kaiser Family Foundation's March, 2009, report on healthcare costs notes that the U.S. spends 90 percent more than any other industrialized country on healthcare.

With such high costs one would think that our healthcare system would be exceptional, but as indicated in previous hearings there are serious access issues in this country resulting in 47 million Americans without healthcare. Families USA estimates that each day in Ohio two Ohioans die because they lack health coverage.

I look forward to hearing from our panel today as they address ways in which our healthcare system can cut down on costs while maintaining and even enhancing quality. I also look forward to hearing from our panelists as they address the role of transparency in our healthcare system, and I thank you, again, Mr. Chairman, and yield back my time.

Mr. PALLONE. Thank you.

Our Ranking Member, the gentleman from Texas, Mr. Barton.

Mr. BARTON. Mr. Chairman, I am just going to submit my statement for the record, but how can we oppose a hearing entitled, "Making Healthcare Work for American Families: Saving Money and Saving Lives?" Can't get any better than that.

Mr. PALLONE. Thank you for a compliment on our message.

Mr. BARTON. Glad to be here, and I want to especially welcome Mr. Goodman, who is a good friend of mine, and we are glad to have a conservative viewpoint on this panel.

Thank you, Mr. Chairman.

Mr. PALLONE. I think that concludes opening statements by members of the subcommittee.

We will now turn to our panel. A word of warning. We might have a vote and have to interrupt but hopefully we will get, you know, we will get through the whole panel.

Let me welcome you and also introduce each of you. Starting on my left is Dr. Jonathan Skinner, Professor of Economics at the Dartmouth Institute for Health Policy and Clinical Practice. And then we have Dr. Christine Cassel, who is president and CEO of the American Board of Internal Medicine and the ABIM Foundation. Dr. John Goodman, who is President and CEO of the National Center for Policy Analysis. Dr. Bruce Sigsbee, President Elect of the American Academy of Neurology. Dennis Smith, who is Senior Research Fellow in Healthcare Reform at the Heritage Foundation. And Dr. Jerry Avorn, who is Professor of Medicine at Harvard Medical School.

We have—each of you, we ask you to give 5-minute opening statements, which obviously become part of the record, and then when you are done, we will have questions from our members again.

Dr. Skinner.

STATEMENTS OF JONATHAN SKINNER, PH.D., PROFESSOR OF ECONOMICS, THE DARTMOUTH INSTITUTE FOR HEALTH POLICY AND CLINICAL PRACTICE; CHRISTINE K. CASSEL, M.D., PRESIDENT AND CEO, AMERICAN BOARD OF INTERNAL MEDICINE AND ABIM FOUNDATION; JOHN GOODMAN, PH.D., PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS; BRUCE SIGSBEE, M.D., M.S., PRESIDENT ELECT, AMERICAN ACADEMY OF NEUROLOGY; DENNIS SMITH, M.P.A., SENIOR RESEARCH FELLOW IN HEALTHCARE REFORM, THE HERITAGE FOUNDATION; AND JERRY AVORN, M.D., PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL

STATEMENT OF JONATHAN SKINNER

Mr. SKINNER. Thank you, Mr. Chairman, and distinguished members of the committee for the invitation to join you today.

Variations in per capita healthcare spending are now well recognized.

Mr. PALLONE. We will have you speak and then we will have to break after you. So please continue.

Mr. SKINNER. Less well known is that growth in spending has also varied dramatically across the United States as we have shown in slide one.

[Slide shown.]

Had Miami Medicare spending during 1992, to 2006, been as restrained as San Francisco's, its cumulative savings would have been enough to buy a new Cadillac Escalade for every elderly person in Miami, thus solving both the problems of Medicare and the problems of the auto industry.

The variation in growth rates may appear small, ranging from 5 percent in Miami to 2.3 percent in Salem, Oregon, but compounding makes a huge difference. If all U.S. regions scaled back their growth rates by just over 1 percentage point as San

Francisco already has done, the Medicare Program would save more then $1 trillion by 2023.

What explains higher spending? Almost all of the differences in spending across both regions and academic medical centers are due to the greater use and what we refer to as supply-sensitive services.

[Slide shown.]

Next slide. Medicare royalties in higher-spending regions are hospitalized more frequently for conditions that could be treated outside the hospital, see physicians more frequently, are referred to specialists more often, and have more physicians involved in their care.

And more care isn't always better care. Patients in high-spending regions report being less satisfied. Physicians describe greater difficulty communicating with other physicians or maintaining adequate continuity. Health outcomes such as survival following a heart attack are no better or worse, or sometimes worse in high-spending regions.

What is going on? We believe that the lower-quality care is largely because the payment system reinforces the fragmentation of care. Many medical decisions are in the gray area where judgment is required and physicians follow local norms. Income pressures on both hospitals and physicians motivate the purchase of new, profitable technologies and the referral of more patients to specialist or to the hospital.

To discourage these expensive treatments with little benefits, it is important to get the prices right. But it is also important to pay attention to quantities. Until the Dartmouth Atlas came along, no one knew that an in Elyria, Ohio, the rate of cardiac stents, a common and expensive procedure to reduce blockage in the heart, was three times the rate in neighboring Cleveland and seven times the rate in Pueblo, Colorado.

On average Medicare enrollees at the NYU Hospital spend more than a month of their last 6 months in a hospital bed compared to just 15 days at the University of Rochester. The current Medicare system is like contracting with a new homebuilder, agreeing on the price per square foot, but letting him decide whether to build you a mansion or a cottage.

What is the solution? I think a necessary first step is the formation of accountable care organizations or ACOs. An ACO is a local network of providers that can manage the full continuum of care. It must be sufficiently large to accurately measure quality and expenditures, yet small enough to be manageable. Primary care or multi-specialty networks and intergraded delivery systems are all examples of shovel-ready ACOs. Our research has shown that the formation of ACOs would require little disruption of current physician referral patterns and that almost all physicians and hospitals could feasibly participate in such networks.

My colleague, Elliott Fisher, has written about the path forward in creating these networks. I want to talk about the potential of ACOs in extracting some of that $700 billion in estimated waste for U.S. spending on healthcare.

The obvious sources of savings are the high-cost regions where per capita Medicare expenditures are nearly double the national

average. One could cap payments for a small number of outlier hospitals with off-the-charts expenditures or cut reimbursements for high-cost providers who don't participate in ACOs. I expect few hospitals will find these restrictions binding since there are so many avenues for high-cost hospitals to scale back spending and thus avoid penalties.

Another approach is to restrain the growth rate in spending. Elsewhere, we have described a plan to share savings with ACOs able to ratchet back growth in healthcare costs. This approach encourages cost-saving technology and discourages investment in gray area healthcare with high-profit margins and uncertain benefits. These policies have the advantage of not penalizing even high-cost providers, but they do not deliver cost savings until future years.

In sum, I believe that accountable care organizations are central to claiming some of that $700 billion in wasted healthcare spending. While I recognize the practical challenges, it is hard to see any other approach generating the magnitude of savings we need.

[The prepared statement of Mr. Skinner follows:]

The Implications of Variations in Medicare Spending for Health Care Reform

Jonathan Skinner, Ph.D.
Department of Economics, Dartmouth College
The Dartmouth Institute for Health Policy and Clinical Practice
The National Bureau of Economic Research

Invited Testimony
Committee on Energy and Commerce
United States House of Representatives

April 2, 2009

Thank you Mr. Chairman and distinguished members of the Committee for the invitation to address you today.

Rapidly rising health care costs pose a serious threat not only to the future of public and private health insurance coverage but also to the sustainability of efforts to expand coverage to the nearly 50 million uninsured Americans. Many policy experts have concluded that excessive growth in health care spending is a foregone conclusion, driven by inexorable forces. Most blame advancing technology. And some conclude that only by rationing beneficial care will the U.S. be able to achieve a sustainable and affordable future.

Data recently released by the Dartmouth Atlas Project call each of these assertions into question. Figure 1, reprinted from a recent commentary we wrote in the New England Journal of Medicine [1], shows average age-, sex-, and race-adjusted per-capita Medicare spending in five U.S. hospital-referral regions over the past 15 years. During this period, overall Medicare spending, adjusted for general price inflation, rose by 3.5% annually. But there was marked variation across regions. Per-capita inflation-adjusted spending in Miami grew at 5.0% annually, as compared with just 2.3% in Salem, Oregon. A total of 26 hospital-referral regions (including Dallas) had more rapid spending growth than Miami, and 16 regions (including San Diego) had slower growth than Salem, Oregon.

The variation in growth rates may appear small, but compounding makes a difference: if all U.S. regions can scale back their growth rates by just over 1 percentage point – as San Francisco already has done -- the Medicare program would be approximately $1.4 trillion dollars better off by 2023 than under current growth rates.

This testimony draws heavily on previous testimony by Elliott Fisher, MD, MPH, but focuses in greater detail on the potential for gaining real cost savings from health reform. Below, key findings of our research on variations in Medicare spending are summarized, and the implications of proposed "accountable care organizations" on quality and costs are discussed.

Variations in Medicare Spending

Over thirty years ago, John Wennberg published his seminal article documenting the remarkable variations in practice and spending across small areas of Vermont. [2] With core support from the Robert Wood Johnson Foundation, and more recently from the National Institute of Aging, we applied these methods to the Medicare population and found variations of a similar magnitude. [3] Most of the variation in spending across regions or hospitals and the populations they serve are not explained by differences in illness levels or by differences in prices (although these do account for some portion of the variation). [4]

Most of the differences in spending are due to greater use of what we refer to as "supply-sensitive services", which we define as services - such as physician visits, hospital days, intensive care days, etc - where the local supply of the specific resource

has been shown empirically to be strongly associated with the use of the services delivered by that provider.[5] Figure 2 compares the utilization of services across each of the U.S. regions highlighted in the first figure. Medicare beneficiaries in higher spending regions are hospitalized more frequently for conditions that could be treated outside the hospital: hospitalization rates in the Medicare population for Ambulatory Care Sensitive Conditions are twice as high in Miami as in Salem. Among Medicare beneficiaries with serious chronic illness, the frequency of physician visits is nearly twice as high in Miami as in San Francisco. Lower spending regions have a much higher proportion of care provided by primary care physicians. And higher spending regions have much more fragmented delivery systems: a much higher proportion of the population has 10 or more different physicians involved in their care during a given year.

Two critical questions are raised by these studies. What are the benefits, if any, of higher spending and greater use of supply sensitive services across US regions and hospitals? And, what are the causes of the differences we observe?

What are the benefits of higher spending?

Over the past 10 years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care. The findings are consistent: higher spending does not generally result in better quality of care, whether one looks at the technical quality and reliability of hospital or ambulatory care[6-8], survival following such serious conditions as a heart attack or hip fracture[9, 10], or patients' perceptions of the accessibility or quality of medical care and their experiences in the hospital. [8, 11, 12] Even physicians in high spending regions report that they have greater difficulty providing good care. Remarkably, in regions where the numbers of hospital beds and specialists are *greater*, physicians are *more* likely to have difficulty getting their patients into the hospital or a specialist referral. [13] Access is worse where there are more medical resources – a "paradox of plenty."

What's going on? Why are access and quality worse in high spending regions?

Recent studies have examined the causes of differences in practice and spending. Patients' preferences for care vary only slightly across regions. [11, 14, 15] Malpractice is reported by many physicians to influence their practice, but differences in the malpractice environment explain only 10% of state variations in spending. [16]

As suggested above, differences in supply are clearly important. In a payment system where provider incomes depend upon the volume of services they provide, patients in regions with more physicians have more frequent visits to physicians and patients in regions with more hospital beds per-capita are hospitalized more often.[8] Local supply thus explains a substantial share of regional variations in spending. But some recent work also points to the key role of the discretionary decisions doctors make.[17, 18] These studies found that physicians' decisions in higher spending regions were similar to those in low spending regions in cases where there is strong evidence for a treatment course (such as whether to refer a patient with chest pain and an abnormal stress test to a cardiologist). But in cases where judgment is required (such as whether to admit a patient with heart failure to the hospital, how frequently to see a patient with high blood

pressure, and whether to refer to a specialist for heartburn), physicians in high spending regions were much more likely to intervene than those in low spending regions.

A likely diagnosis. Current clinical evidence exerts an important but limited influence on clinical decision-making. Most physicians practice within a local organizational context and payment environment that profoundly influences their clinical decisions, especially in discretionary settings. In most locales, hospitals and physicians are rewarded for expanding capacity (especially for highly profitable services) and for recruiting additional procedure-oriented specialists (such as interventional cardiologists or radiologists). When there are more specialists or hospital beds available, primary care physicians and specialists will learn to rely on those specialists and use those beds – because it is more "efficient" from their perspective to do so, given the current payment system and lack of support for primary care. The consequence is that what seem to be "reasonable" decisions collectively lead to higher utilization rates, greater costs, and, inadvertently, worse quality of care and worse outcomes.

Harm could occur through several mechanisms.[19] Greater use of diagnostic tests could find more abnormalities that would never have caused the patient any problem. Because most treatments have some risks, providing those treatments to patients who don't need them could cause harm. (Hospitals are dangerous places to be if you could have been safely treated outside the hospital.) And as care becomes more complex and more physicians are involved, it will be less and less clear who is responsible for each aspect of a patient's care: Miscommunication -- and errors -- becomes more likely.

Quantities and Prices

To discourage these expensive treatments with little benefit, it is important to "get the prices right." But it's also important to pay attention to and measure *quantities* of health care services. Until the Dartmouth Atlas came along, no one knew that in Elyria, Ohio, the rate of cardiac stents – a common and expensive procedure to reduce blockage in the heart – was three times the rate in neighboring Cleveland and 7 times the rate in Pueblo, Colorado. (These and other figures are from www.dartmouthatlas.org.) On average, Medicare enrollees at the NYU hospital spend more than a month of their last six months of life in a hospital bed. By contrast, Medicare enrollees at the University of Rochester Medical Center spend just 15 days in the hospital. The current Medicare system is like contracting with a new home builder, agreeing on the price per square foot, but letting him decide whether to build you a mansion or a cottage.

What is lacking in the U.S. health care system is accountability for the cascade of treatments and services in local systems, each of which might appear rational at the micro-level, but in the aggregate results in considerable inefficiency and waste. What type of organization would discourage this unconstrained growth in expensive health care treatments with uncertain benefits?

Accountable Care Organizations – a piece of the puzzle

We have proposed the development of Accountable Care Organizations (ACOs) as one approach to meeting the goal of supporting healthcare providers' attainment of

better quality at lower cost. Working with Mark McClellan and others, we have developed design specifications and approaches to shared-savings payment that would support the development of Accountable Care Organizations as a key element of moving toward more integrated delivery systems and toward slowing the growth of spending. [20]

An Accountable Care Organization is a local network of providers that can manage the full continuum of care for all patients within their provider network. They must be of sufficient size to allow accurate measurement of both quality and total costs. An ACO must have a defined administrative structure that is capable of meeting reporting requirements for the quality measures that will be expected and for receiving and distributing shared savings payments. Examples of current organizations that could meet these requirements include multispecialty group practices, independent practice associations, physician-hospital organizations and academic medical centers. Our research has shown because most physicians already practice within relatively coherent and well-defined referral networks around one or more hospitals,[21] the formation of ACOs would require little disruption of current physician referral patterns and that almost all physicians and hospitals could feasibly participate in such networks. [20, 22]

Because the natural referral networks upon which ACOs are likely to be built provide a large proportion of the care to their Medicare beneficiaries, there would be no need for beneficiaries to be "locked-in" to their ACO. As the early experience of the Physician Group Practice demonstration suggests, this provides an incentive for the ACO to provide high quality, patient centered care and to reach out effectively to their patients and other providers outside the ACO to effectively coordinate care.

Can We Recover Some of the Estimated $700 Billion Wasted in the U.S. Health Care System?

Elliott Fisher has testified earlier about the challenges of, and opportunities for, setting up an ACO system. I want to talk about the potential of ACOs in extracting some of that $700 billion in wasteful U.S. health care spending.[8,9] The obvious sources of savings are the high cost regions where per capita Medicare expenditures are nearly double the national average. One could cap payments for a small number of "outlier" hospitals with off-the-charts expenditures, or cut reimbursement for high-cost providers who don't participate in ACOs. But I expect few hospitals will find these restrictions binding in practice, since there are so many avenues for high-cost hospitals to scale back spending and thus avoid any penalties.

Another approach is to restrain the *growth rate* in spending. Previously, we have described a plan to share savings with ACOs able to ratchet back growth in health care costs (with the possibility of penalizing ACOs with unrestrained growth).[20] This approach encourages cost-saving technology and discourages investments in "gray-area" health care with high profit margins and uncertain benefits. Focusing on incentives relating to cost *growth* (instead of levels) carries the distinct political benefit of not penalizing existing high-cost providers today. On the other hand, the large savings arising from lowering growth rates don't occur for several years. By contrast, scaling back payments to "outlier" hospitals or regions, as suggested above, yields immediate

savings.

As well, low-cost regions may perceive as unfair systems that rewards on the basis of growth rates. An allowed 5% growth rate in Miami provides far more additional federal dollars than a 5% growth rate in Salem, OR. However, it is certainly possible to design blended growth allowances. For example, in 2006 the national average of per-capita Medicare spending was $8,304. Five percent of this would be $415. Providing an equal dollar amount to each region (perhaps adjusted by the CMS wage index to allow for cost-of-living differences) would result in a smaller percentage growth in high cost regions and larger percentage growth in low cost regions. This dollar-weighted approach would lead to a gradual convergence in regional Medicare expenditure targets over time.

The good news is that small inflections in annual per-capita growth rates have enormous implications for the long-term solvency of Medicare and the sustainability of expanded insurance coverage. Using data from the 2008 Medicare Trustee's Report on projected revenues and total Part A and B spending, we estimated that Medicare will be $660 billion in the hole by 2023. Reducing annual growth in per-capita spending from 3.5% (the national average) to 2.4% (the rate in San Francisco) would leave Medicare with a healthy estimated balance of $758 billion, a cumulative savings of $1.42 trillion.[1]

Conclusion

The marked variations in spending levels, and in spending growth rates across regions, suggest that it should be possible to achieve sustainable and affordable spending growth, even under the current fee-for-service system. This will require providing incentives that encourage providers in low cost and low growth regions to continue their current trends while providing incentives for those in high growth and high cost regions to avoid further growth in capacity and in the intensity of services they provide to their patients.

Regardless of the actual structure of the final legislature, I believe that a necessary component of any successful health reform is to create accountable care organizations, reward them for providing high quality care that patients want, and for cutting costs with no discernable benefits.

Figure 1.

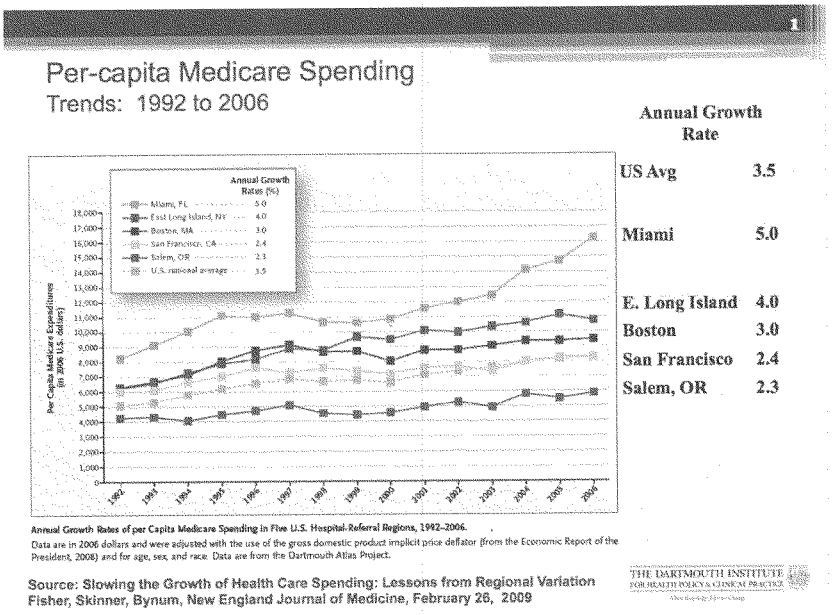
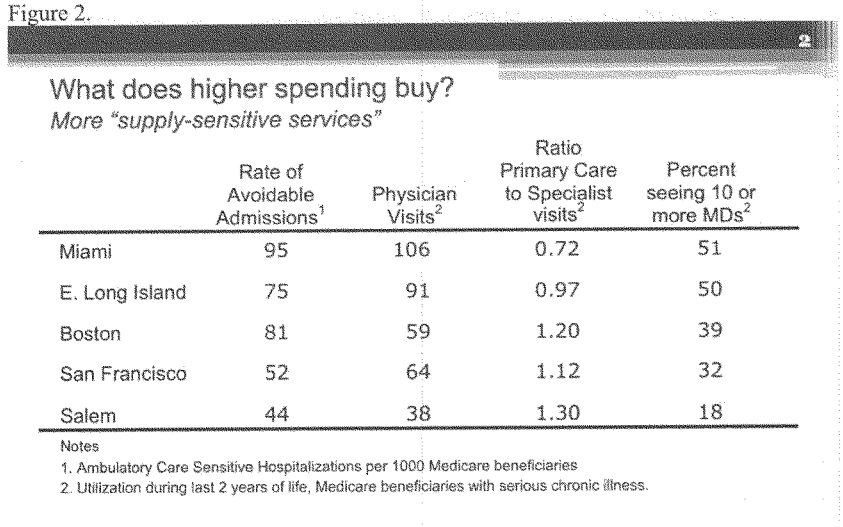


Figure 2.



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Mr. PALLONE. Thank you, Dr. Skinner.

We have three votes, so probably about half an hour. Five? Five. OK then. We are talking about probably at least 45 minutes, maybe even an hour. Maybe even an hour. But obviously we need you to stay here, so we will reconvene after the five votes.

The subcommittee stands in recess.

[Recess]

Mr. PALLONE. The subcommittee will reconvene. We left off with the—and I apologize. I thought an hour but it ended up being more like an hour and 15 minutes, I guess. We heard from Dr. Skinner, so next is Dr. Cassel.

STATEMENT OF CHRISTINE K. CASSEL

Dr. CASSEL. Thank you, Chairman Pallone and Ranking Member Deal. I really appreciate the invitation to testify about approving healthcare value. My name is Christine Cassel. I am a board-certified internist and geriatrician and president of the American Board of Internal Medicine and ABIM Foundation.

ABIM certifies about one-third of all practicing physicians in the United States. We have the largest of the 24 certifying boards that constitute the American Board of Medical Specialties. The certifying boards are independent, non-profits that do not accept industry funding. We test, monitor, and certify that individual physician specialists have the knowledge and skills required to practice in their designated specialty.

Because growing research demonstrates that higher standards for doctors means better quality for patients, board certification standards are recognized as an important component of the accountability frameworks of both public and private payers.

So I very much appreciate the committee's leadership in examining the link between quality, cost, and value in our healthcare system. I want to make three points in my testimony today.

First, while there are abundant opportunities to improve value across the healthcare system, the gap is widest and most distressing among those with multiple chronic conditions and those facing the end of life. Second, well-designed delivery system innovations can help to close that gap, and third, the success of delivery system innovations stands or falls in large part on the shoulders of highly-trained and accountable physicians and teams of healthcare professionals.

More than half of Americans have at least one chronic illness, and chronic diseases as this committee knows accounts for a third of the years of potential life loss before age 65 and is the single biggest challenge in our growing elderly population. As we know, the problem is not the lack of spending. More than 75 percent of our $2 trillion healthcare bill is spent on chronic disease care. Too often the problem is failure to deliver the right care at the right time and importantly, to coordinate care across the complex care needs involving multiple providers and settings in a patient-centered way.

In fact, according to MedPAC, Medicare could save $12 billion a year by reducing unnecessary hospital readmissions, improving care transitions and care coordination, and enhancing primary care. A more patient-centered approach, especially to palliative and

end-of-life care could also contribute greater value to our healthcare systems. Research shows that when patients' needs and preferences are the focus of care decisions, fewer resources are spent on aggressive and futile technical interventions. Patients receive more timely referrals to hospice care, and patients and their families have better quality of life in the days that remain.

Payment reform needs to support the physician who has the skills, the evidence base, and the relationship to make this happen.

As this committee also knows models to improve care for patients with chronic conditions and those at the end of life are now being developed and tested, and we are hearing about some of those today.

In 2008, the American Board of Internal Medicine, along with ten other specialties, began recognition of a new specialty of medicine in palliative and hospice care so that patients and payers could be more confident of the provider's skills. Patient-centered medical homes also hold out the potential to simultaneously reduce costs and improve quality. The concept promotes efficient use of office practice design as well as professional recognition and remuneration of the primary care physicians and geriatricians who are needed to manage and lead such practices.

However, these very same professionals are in very short supply. A study last year showed that 2 percent of graduating medical schools, graduating medical students expressed interest in seeking careers in primary care internal medicine. Given this reality medical homes and related models are going to need to make the very best use of the generalist physician skills that we can get to manage these complicated patients and to use the talent and experience of other members of the clinical team to support prevention and coordination. Those team skills are also not in common supply in our medical world or in our medical—or taught well in our medical schools.

The medical home model to date has focused mostly on system-level improvements like health information technology. These are necessary, but they are not sufficient. For the medical home concept to deliver on its promise, the designers have to create incentives for long-term relationships and effective utilization of care between the highest-need patients and their physicians.

Primary care and geriatric physicians will need the tools, both incentives and accountabilities, skills, and experience to support care coordination beyond the confines of their practices. The seven to ten to 15 other specialists that the patient is also seeing also need incentives to share the information that they have with that medical home, and the medical home also needs two-way communication, not just with physician specialist, but with hospitals, nursing homes, rehab centers, and other community resources.

Finally, I would like to suggest that specialty board certification and maintenance certification offers a way to enhance, improve the physician's skills and to ensure that they can continue to keep up to date to manage complex patients. What we require of physicians to maintain their certification includes regular, formal skills testing, practice monitoring, and self-evaluation and quality improvement, including tests of diagnostic skills, clinical judgment, systems management, and the translation of medical knowledge and

evidence into practice. All of these tools use national quality forum endorsed measures where they exist.

Now all leading health plans put a premium on physicians who participate in this process in their reward and recognition programs. We have also been involved recently in discussions with Senate staff to recognize this process of maintenance and certification in the pathways within the Medicare PQRI Program, and we look forward to working with you and would ask the House leadership to give this idea similar consideration as a way of reducing the burden on doctors of redundant measurement requirements and a way of enhancing evidence-based approaches to setting levels for quality of care.

So in conclusion stronger infrastructure, better connectivity, and physician payment reform are all essential elements of the patient center medical home, as well as effective healthcare reform. But at the end of the day my message to you is that the quality and value of healthcare for complex patients also rests in great part on the skills and judgment of the physician in relationship with the patient.

Thank you very much.

[The prepared statement of Dr. Cassel follows:]

Statement of Christine Cassel, M.D., M.A.C.P President and CEO American Board of Internal Medicine (ABIM) and ABIM Foundation

Before the U.S. House Committee on Energy and Commerce, Sub-Committee on Health; April 2, 2009

Hearing on "Making Health Care Work for American Families: Saving Money, Saving Lives"

Chairman Pallone and Ranking Member Deal, thank you for the invitation to testify about improving health care value. My name is Christine Cassel, and I am a board certified internist and geriatrician and President and CEO of the American Board of Internal Medicine (ABIM) and ABIM Foundation.

ABIM – which certifies about a 1/3 of practicing physicians – is the largest of the 24 certifying boards that constitute the American Board of Medical Specialties (ABMS). The boards – all of which are independent non-profits that do not accept industry funding – were created to assure the public that physicians have the necessary knowledge and skills to practice in a given specialty. Collectively, the certifying boards' investment in enhancing quality is significant, totaling about $150 million per year. We are increasingly able to demonstrate through research that higher standards for physicians mean better quality care for patients.[1] Consequently, we believe that our standards should continue to be incorporated into and aligned with the accountability frameworks of both public and private payers.

I very much appreciate the Committee's leadership in examining the link between quality, cost and value in our health care system. Particularly in this challenging economy, unnecessary health care spending is burdensome to patients, families and businesses – as well as to government. Physicians feel this burden as well when patients cannot afford the care that we recommend for them. There is ample evidence of waste and unnecessary spending on overutilization of services in the U.S. health care system.[2] Unnecessary care can also be harmful to patients – every medication carries risks, every procedure has potential complications and every hospitalization exposes patients, especially the elderly and others who are vulnerable, to infections, falls and other harms.

My testimony today is intended to inform the Committee about three key points:

- Why it makes sense to target care for patients with multiple chronic conditions and those at the end of life in order to realize significant gains in quality and value for the nation's healthcare system;
- How innovations – such as patient centered medical homes and other models – can facilitate changes in medical practice and increase value provided they target high cost, high need populations and have built-in accountabilities; and
- The need to support highly-skilled generalists (such as primary care physicians and geriatricians), who are in short supply, so that they can effectively deliver on the promise that these models hold out to simultaneously save money and save lives.

The need to enhance care for those with chronic conditions and care at the end life is abundantly clear.

- Almost half of Americans have at least one chronic condition, and chronic diseases account for 70% of all deaths in the United States and one-third of the years of potential life lost before age 65. The problem is not a lack of spending on services: medical care costs for people with chronic diseases account for more than 75% of the $2 trillion our nation spends on medical care each year.[3] In too many cases, the problem is a failure to deliver the right care at the right time, and to coordinate complex care needs across multiple providers and settings in a patient-centered way. In fact, the Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare could save $12 billion dollars per year through reducing unnecessary hospital readmissions, improving care transitions and care coordination and enhancing primary care.[4] Most important, if these changes were made patients would benefit with enhanced outcomes and higher satisfaction with their care.

- Palliative and end of life care are areas that could contribute to increasing value in our health care system since medical costs increase sharply for patients in the last two years of life.[5] Research shows clearly that when patients needs and values – rather than services – are the focus of care decisions, fewer resources are spent on fruitless care and patients and their families experience improved quality of life and mental health. One study found that patients with advanced cancer who reported end of life conversations with their doctors had lower medical costs in their final week of life compared with those who did not, which the

authors attribute to more limited use of ineffective, intensive interventions. Another study found an association with end of life discussions and both less aggressive technical interventions near death and earlier hospice referrals. The authors also found that aggressive care actually causes harm (in addition to increasing costs) – it was associated with worse patient quality of life and worse bereavement adjustment for family members.[6] In my experience as a geriatrician, I have seen how aggressive interventions have a way of stripping from a very sick patient the last vestiges of autonomy and control. When there really is no hope, it is a very sad exit from the world.

A number of models that could be used to improve care for patients with chronic conditions and those at the end of life are being developed and tested, including the patient-centered home model (PCMH), accountable care organizations (ACOs) and other innovations. I would like to focus my remarks on the medical home and other ambulatory focused models since my colleague Dr. Skinner will provide testimony on ACOs. I think medical homes have the potential to simultaneously reduce costs and improve quality, while promoting efficient office practice design, professional recognition and remuneration of primary care physicians and geriatricians who are needed to create, manage and lead such practices.

This Committee has likely heard the strong case for supporting more robust primary care:

- A Commonwealth Fund study comparing communities across the country found that the highest performing regions have fewer practicing physicians and are more reliant on primary care, are less likely to re-admit patients to hospitals, and, overall, use fewer hospital and intensive care services.[7]
- A multivariate analysis found that higher proportions of primary care physicians are independently associated with fewer hospital admissions, emergency department visits and total surgeries. This same study showed that a modest 1 percent increase in the proportion of primary care physicians in a region resulted in 3.83 fewer emergency department visits on average per 1,000 people in a given year.[8]

Rebuilding primary care has taken on new urgency as primary and geriatric care have become vanishing specialties. A study last year showed that only two percent of graduating medical students were planning careers in general internal medicine.[9] Given this reality, I would like to offer the Committee three ideas about how the PCMH and other ambulatory care focused models can make the best use of generalist

physician skills and simultaneously leverage the talent and experience of other types of clinicians.

First, services that primary care physicians provide should be targeted to the highest cost and highest need populations:

- Internal medicine, family physician and geriatrician specialists need to focus the majority of their time and talent on managing, coordinating and integrating the care of those with complex and multiple chronic conditions. They need a broad understanding of multiple specialties and organ systems in order to effectively manage the care of these patients.
- This means that other members of the clinical team will have an active role in prevention, wellness care and providing ongoing care to those with less complex chronic conditions.

Patients, particularly those with complex needs, will ideally have a longstanding relationship with their physician.

- The presence of a primary care physician – including a longstanding relationship – results in better care, less illness and death and more equitable distribution of health among various populations.[10]
- Medicare and private payers will need to figure out how to establish and nurture such relationships while recognizing patient desire for choice and the ability to "vote with their feet."

Primary care and geriatric physicians will need to be given the necessary tools – both accountabilities and incentives – to support coordination beyond the confines of primary care practices.

- In order to manage patient care across settings, physicians and other providers need to have much more robust information sharing and have in place accountabilities and related incentives to coordinate and integrate care,[11] for example, making payment to specialists contingent on the primary care physician receiving the specialist's consult notes.
- Referrals to specialists and tests is another area that needs better management. Many patients and payers are reluctant to return to a gatekeeper model, but there must be a way to connect all of the specialists a patient sees to ensure that there are not gaps, redundancies and contradictions in treatment. Unnecessary use of specialists and tests drive up U.S. costs as compared to the health systems of other industrialized nations.[12]

These ideas – targeting high need patients, supporting an ongoing relationship between patients and physicians, and attending to the role and accountabilities of physicians outside the medical home – need better incorporation into a model that to date has largely focused on practice infrastructure, for example, health information technology (HIT), and payment reform, in order to effectively reach our goals for enhanced quality and value.

Finally, I would like to suggest that board certification and maintenance of that certification through regular, formal skills testing, practice monitoring, and self-evaluation, offer ways to enhance the skills of physicians – both those who are in the midst of their training and those who are in practice – and to ensure that physicians can manage complex patients. Leading health plans have recognized this critical benchmarking and have put a premium on physicians who are involved in ongoing re-certification or maintenance of certification (MOC) in their reward and recognition programs. The certifying boards have also been involved in discussions with Senate staff to recognize MOC as a pathway within the Medicare PQRI program and we would ask the House leadership to give this idea the same consideration.

Very briefly, the kind of knowledge and skills assessed by board certification programs include:

- **Diagnostic acumen** – Research has shown that up to 15 percent of medical errors and 40,000 to 80,000 hospital deaths are attributable to faulty diagnoses.[13] Our current accountability frameworks, which are largely reliant on performance measures, assume that a correct diagnosis has been made;
- **Clinical knowledge/judgment** – Keeping up with the ever expanding medical knowledge base is critical for diagnosis and for determining treatment. Board tools assess a physician's ability to synthesize and incorporate new medical knowledge (this knowledge can also be augmented with important investments in comparative effective research);
- **Systems thinking and QI capability** – The investment in HIT via the stimulus package is critical for providing necessary infrastructure for physician practices to coordinate and integrate care. That said, the promise of such investment will only be realized if physicians understand how to incorporate HIT into their practices – both with respect to redesigning work processes and care delivery. Further, physicians need to understand how to change their practices based on the performance data that HIT will be able to provide;
- **Translation of knowledge into practice –** Finally, board certification programs assess whether physicians translate their

knowledge about practice in a given specialty into practice via tools that incorporate NQF performance measures – the same measures already integrated into existing reward and recognition programs. These board tools also require that physicians design and implement a QI intervention in response to an identified practice weakness.

Stronger infrastructure, better connectivity, and physician payment reform are essential elements of the PCMH. However, at the end of the day the quality of medical care for complex patients – indeed for all patients – rests on the skills and judgment of the physician in whose care the patient is entrusted. Board certification programs demonstrate and hold physicians accountable for the very skills that innovative care delivery models need to achieve the ultimate sweet spot of enhancing quality and value.

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Mr. PALLONE. Thank you, Dr. Cassel.
Dr. Goodman.

STATEMENT OF JOHN GOODMAN

Mr. GOODMAN. Thank you, Mr. Chairman, members of the committee. I promise to stay on time.

All bureaucratic systems tend to show a similar pattern, whether it is the National Health Service in Britain or Medicare in Canada or the Texas Public School System or the U.S. Healthcare System. In all these systems what you tend to find is a sea of mediocrity punctuated by little islands of excellence.

In healthcare people point out that if everyone in America went to the Mayo Clinic for his healthcare, we could cut the national healthcare bill by a fourth, and quality would go up. If everyone went to the Intermountain Hospital System in Utah, we would cut spending by one-third, and quality would go up.

So invariably in all these systems people ask, well, why can't everybody else be like the islands of excellence. There are two characteristics of these islands. Number one, they tend to be randomly distributed, and that is because there is no reward for excellence and no penalty for mediocrity, and two, whatever makes them good is originating on the supply side of the market and not on the demand side. And the problem for us is that we don't understand why the good organizations are good, we don't know how to replicate them, and we don't have any model that tells us how to manipulate them.

Now, despite this fact there is huge interest in pay for performance systems in Washington elsewhere around the country, and yet we have been doing this in education for almost 2 decades now, certainly in my State of Texas we have been doing it, and I can't see that we have had any positive results.

Now, if it is true that everything that anybody can point to that they like in healthcare is originating on the supply side of the market and no one can point to any example where a demand side reform is causing any commendable response, then it would seem to me that we ought to focus on how we get these kinds of supply-side changes, and I have three recommendations.

First, we should stop penalizing what we like. When Mayo Clinic saves money for Medicare, it is losing money for itself. Same for Intermountain. When the Geisinger Health System, which was in the Washington Post just this week, offers a warranty on its heart surgery so that the buyer doesn't have to pay again if they screw up and there's a readmission to the hospital, Geisinger is saving money for Medicare, but it is losing money for itself.

So we need to turn this around. Medicare ought to be willing to say at least we will pay 50 cents on the dollar when you are saving us money. So that is reform number two.

The second thing Medicare needs to do is tell all the other hospitals what it has done. We want other hospitals to know that we have rewarded innovations that improve quality and reduce costs, and then invite all those other hospitals not to copy what Geisinger has done because we don't know that Geisinger is really doing it the best way, but to come forward with their own suggestions for repackaging and repricing their services.

And number three, we need to extend this offer to every hospital, every doctor, everybody on the provider side. Medicare ought to be open for business. It ought to be open to hear from any provider who suggests a different way of being paid with three rules. Number one, cost to the government cannot go up, the quality of care to the patient cannot go down, and they need to tell us 6 months out or 12 months out how we are going to measure all this to make sure we have abided by rule one and two.

This is a totally different approach then that pay-for-performance approach. What I am suggesting is let the supply side of the market which knows far more than anybody on the buyer's side, let them to decide and propose how we improve quality and reduce costs and every doctor in America can think of ways that you can reduce costs and eliminate waste. It is just under the current system they have no incentive to do so.

Both in education and healthcare we have the same fundamental problem. The entity that pays the bills is not the entity that benefits from the services, and that is the source of the inefficiency that we find. In healthcare wherever there is not a third party, wherever there is no Medicare, no Blue Cross, no employer, things actually work pretty well. If we look at those markets like cosmetic surgery, lasik surgery, the walk-in clinics in shopping malls, tele-doc, which does telephone consulting, the concierge stocks, medical tourism, and all these markets where it is just patient and doctor and no third-party payer. You always find price transparency, you often find quality transparency, you have cost control, you frequently have electronic medical records, electronic prescribing. Doctors often are using telephone, e-mail. In other words, doctors dealing with patients on their own tend to deal with patients the way other professionals; lawyers, engineers, accountants, and so forth, deal with their clients. We need to open up the supply side of the market and encourage this.

This morning, Mr. Chairman, I have talked about freeing the doctor in this system. We also need to free the patient, and I have written about that elsewhere. Thank you.

[The prepared statement of Mr. Goodman follows:]

Statement of

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on

MAKING HEALTH CARE WORK FOR AMERICAN FAMILIES: Saving Money, Saving Lives

Energy & Commerce Subcommittee on Health
United States House of Representatives
April 2, 2009

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Mr. Chairman and members of the Subcommittee, I offer these comments for your consideration as you debate options for increasing the quality of health care and lowering the cost. I represent the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

To confront America's health care crisis, we do not need more spending, more regulations or more bureaucracy. We do need people, however, including every doctor and every patient. Every American must be free to use their intelligence, their creativity and their innovative ability to make the changes needed to create access to low-cost, high-quality health care.

I. Free the Doctor

Doctors today are forced to practice medicine under an outmoded, wasteful payment system designed for a different century. They should instead be given access to payment systems available to other professionals.

Problem: Typically, doctors receive no financial reward for talking to patients by telephone, communicating by e-mail, teaching patients how to manage their own care or helping them be better consumers in the market for drugs. In fact, doctors who help patients in these ways will end up with less take-home pay. To make matters worse, as third-party payers suppress reimbursement fees, doctors are increasingly unable to perform any task that is not reimbursed.

Solution: Let Doctors Be Doctors. In Medicare and Medicaid, it should be as easy as possible for providers to get paid in better ways. We should be willing to reward doctors who raise quality and lower costs — including improving patient access to care, improving communication and teaching patients how to be better managers of their own care. What is needed is not pay-for-performance, but performance for pay — with ideas and proposals coming from the supply side of the market (which is more knowledgeable about potential improvements than the demand side).

Any doctor should be able to propose and obtain a different reimbursement arrangement, provided that (1) the total cost to government does not increase, (2) patient quality of care does not decrease and (3) the doctor proposes a method of measuring and assuring that (1) and (2) have been satisfied.

In the *Handbook on State Health Care Reform*, for example, the NCPA proposed a radically different way to pay for chronic care, with the state paying a flat monthly fee to cover "fixed costs" (*e.g.*, coordination of care, maintenance of electronic medical records) and patients paying, say, from Health Savings Accounts, for the "variable costs," including paying doctors for their time (*e.g.*, face-to-face, e-mail and telephone consultations). Practitioners will no doubt think of many variations and improvements on this idea.

Problem: All too often providers face perverse incentives. When they make changes that raise quality and lower costs, their income goes down, not up.

Example: Geisinger Health System in central Pennsylvania gives heart patients a "warranty" on their surgeries. Patients who have to be readmitted because of complications pay nothing for the second admission. Yet in providing higher quality and lowering patient costs, Geisinger loses money. That's why other hospitals do not follow its example.

Example: Studies show that if every patient went to the Mayo Clinic for health care, we could lower the national health care bill by one-fourth — and quality would improve. If everyone went for care to the Intermountain Hospital System in Salt Lake City, we could lower our health care costs by one-third — while improving quality. Why don't other hospitals copy these exemplars of low-cost, high-quality care? Because they would be severely penalized financially under the current system.

Solution: Let Hospitals Be Hospitals. Facilities that figure out how to lower patient costs, raise quality and offer warranties and other guaranties should be rewarded for doing so — just as they would in any other market. Accordingly, the same three reimbursement rules proposed for doctors above should also apply to hospitals.

Problem: Entrepreneurs are creating new products to meet needs not being met by traditional health insurance. For example, people can pay with their own money for telephone and e-mail consultations. They can purchase blood tests via the Internet and get results in 24 hours. They can get low-cost care with very little waiting at walk-in clinics in shopping malls. Yet all too often these services are hampered by outmoded, unnecessary government regulations. Amazingly, doctors are prohibited from owning and operating walk-in clinics that refer patients to their regular practices!

Solution: Let Entrepreneurs Be Entrepreneurs. We should welcome and encourage new ways of meeting patient needs, rather than stifle these efforts with unnecessary, outmoded laws and regulations. As with providers and facilities, promising innovations should be expedited and approved quickly. For example, walk-in clinics that charge half as much and match the quality of traditional care, with electronic medical records and electronic prescriptions to boot, should be approved outright.

II. Free the Patient

Patients also suffer when payments to doctors and hospitals are based on outmoded formulas. Whereas suppliers compete to meet customer needs in almost every other market, this happens all too rarely in health care.

Problem: Many patients have difficulty seeing primary care physicians. All too often they turn to hospital emergency rooms where there may be long waits and where the cost of care is much higher. When they do see doctors, all too often patients get inadequate information. The problem is made worse by the inability to communicate by telephone or e-mail.

Solution: Patient Power. We need to explore new ways to empower patients — especially the chronically ill, allowing them to manage more of their own care and more of their own health

care dollars. Also, patients should be able to purchase services that are not paid for by traditional health insurance, including telephone and e-mail consultations and patient education services.

Example: Studies show that diabetics, asthmatics and other chronic patients can manage their own care as well as or better than conventional physician care and at lower costs. Yet to do this patients need training, easier access to information and the ability to purchase and use in-house monitors.

Example: More than half the states have "Cash and Counsel" programs for homebound, disabled Medicaid patients — allowing them to manage their own health care dollars and hire and fire the people who provide them services, instead of having these decisions made by an impersonal bureaucracy. Patient satisfaction in these programs is almost 100 percent.

III. Free the Employees

Our health insurance system evolved at a time when many workers expected to work for the same employer for their entire work lives. Clearly, that assumption is no longer valid.

Problem: When employees switch jobs, they are usually forced to switch insurance plans. This often means a switch of doctors, which means no continuity of care. Also, their new insurance may not have the same benefits as the original. To make matters worse, many employees are trapped in jobs they cannot leave because they cannot afford to lose their health insurance.

Solution: Personal and Portable Health Insurance. We should move to a system in which employees can take their health insurance with them when they travel from job to job. Transition to a new system may take many years. A good place to start is with baby boomers who retire early.

Problem: People who do not get health insurance from an employer must pay for it with after-tax dollars, making insurance as much as 50 percent more expensive.

Solution: Tax Fairness. People who obtain health insurance should enjoy the same tax relief, regardless of how the insurance is purchased.

IV. Free the Employer

Employers are also trapped in a system designed for a different age.

Problem: In ways that are sometimes subtle and sometimes not so subtle, too many employers are trying to avoid hiring employees (and employee dependents) with high health care costs, much like a game of musical chairs.

Problem: By default, employers have been put in the position of having to manage their employees' health care costs — an activity for which most have no experience or expertise. While some large employers do an adequate job, small employers are incapable of doing it well.

Solution: Personal and Portable Insurance. Portable insurance would be a boon to employers as well as employees. Employers could make a defined contribution to each employee's health insurance; yet the insurance would be owned by the employees and travel with them on their journey through the labor market. In an ideal world, employers should be able to hire employees based solely on their ability to produce, irrespective of expected medical costs.

Example: The United Mine Workers, NFL football players and many other workers have better arrangements. Although employers pay all or most of the health insurance premiums, the health plan is largely independent of any particular employer and coverage is fully portable — traveling with employees whenever they switch jobs.

V. Free the Nontraditional Workplace

Most of our labor law, tax law and employee benefits law was enacted years ago and was based on the assumption that employees would be full-time workers, typically with a homemaker telecommuting. Today, one-third of the workforce consists of part-time workers and independent contractors. Many are telecommuting from their own homes. These changes are partly the result of the most important economic and sociological change of the past half-century: the movement of women into the labor market.

Problem: Two-earner couples are common in the labor market. They need employee benefits, including health insurance, but they don't need duplicate benefits. An employee covered by a spouse's health plan should be able to choose higher wages rather than an unnecessary second health plan. Yet today employers cannot give her that option.

Problem: Many part-time employees face the opposite problem. They would willingly take less pay if they could be enrolled in their employer's health plan. Yet employers generally are not allowed to give employees this option either.

Solution: Flexible Employee Benefits. Public policy should be on the side of helping people meet their needs rather than creating bureaucratic obstacles. Employers and employees should be free to adjust their employee benefit policies to meet the needs of a changing workplace.

VI. Free the Insurer

Like doctors, patients, employees and employers, insurance companies are also trapped in a dysfunctional system.

Problem: All too often insurers operate under regulations that encourage them to avoid the sick and attract the healthy. Even worse, they may face incentives to under-provide care to the sick and over-provide to the healthy. These perverse incentives are as bad for the insurers as they are for the patients.

Solution: A Market for the Care of Sick People. We need to encourage insurance markets in which health plans specialize in various conditions — especially chronic illness. Plans should

compete to see who can better solve the needs of the people with the most severe health problems.

Example: In the Medicare Advantage program the federal government uses a highly sophisticated payment system that pays higher premiums for sicker, costlier enrollees. As a result, patients with health problems are just as attractive as healthy people to insurers. In fact, some health plans specialize in insurance for people with multiple health problems.

VII. Free the Uninsured

One reason why there are so many uninsured in America is that we encourage people to be uninsured.

Problem: Most uninsured people do not have the opportunity to obtain tax-subsidized employer-provided health insurance. As a result, if they buy insurance on their own they must do so with aftertax dollars. In this way, the tax law discourages private insurance.

Problem: If the uninsured need medical care and can't pay their bills, they receive free care — an amount equal to about $1,500 per uninsured person per year — or $6,000 for a family of four. Since these funds can generally not be used to purchase private insurance, free care programs around the country encourage people to be uninsured.

Solution: Insure the Uninsured. We can use money already in the system to give people who would otherwise rely on the free care safety net a tax subsidy to purchase private health insurance instead.

VIII. Free the Kids

Many in Congress want to push children into a State Children's Health Insurance Plan (S-CHIP), paid for by taxpayers. Both the children and the taxpayers would be better off if kids were enrolled in their parent's private health insurance plans instead.

Problem: Studies show that every time government spends an extra $1 on S-CHIP, private insurance contracts by 60 cents. Either families drop their private insurance in order to take advantage of free government-provided health insurance or employers drop coverage and pay higher cash wages instead — knowing that free health insurance is an option for their employees. Because of a very high crowd-out rate, S-CHIP expansion is very costly to taxpayers and produces small social benefits. To make matters worse, children are leaving private plans where they have access to a broad array of doctors and facilities to enroll in public plans where their access is often no better than the access of the uninsured or Medicaid enrollees.

Solution: Private Insurance for Children. Instead of encouraging people to drop private coverage for a public plan, we should reverse the incentives: use S-CHIP money to encourage parents to enroll their children in their employer's plan or another plan of the parents' choosing.

IX. Free the Parents

Under the current system, a child could be enrolled in S-CHIP, a mother could be enrolled in Medicaid and a father could be enrolled in an employer's plan. Medical outcomes are likely to be better for all three if they are in the same health plan.

Problem: As in the case of S-CHIP, Medicaid has a very high crowd-out rate. Public dollars substitute for private dollars. And access to care inevitably diminishes when people make the transition.

Solution: Private Insurance for Low-Income Families. If we truly want universal access to health care, low-and moderate-income families must be able to see the same doctors and enter the same facilities as other citizens. That will never happen unless they participate in the same health insurance plans as other citizens. Instead of cordoning people off in a plan that underpays providers and rations care by waiting, we should use Medicaid and S-CHIP funds to subsidize private health insurance for all who want it.

X. Free the Grandparents

More than 40 years ago our country decided to segregate seniors into a separate health insurance system called Medicare. In the beginning Medicare copied the standard Blue Cross plan of the day. With the passage of time, however, Medicare lagged behind the improvements in other insurance products.

Problem: The basic Medicare package (Parts A & B) is distinctly inferior to the kind of insurance most other Americans have. (It is even inferior to coverage for poor families under Medicaid.) For example, seniors are exposed to far more out-of-pocket risk and they do not have coverage for preventive care. Shockingly, the basic Medicare package will pay for the amputation of diabetic's leg, but it will not pay for drugs that would have made the amputation unnecessary.

Problem: To fill the gaps in their basic coverage, most seniors obtain Medigap coverage — which means that must pay two premiums to two plans. Even then, seniors usually do not have the coverage for drugs that most nonseniors have. So they must pay a third premium to a third plan (Medicare Part D) to get the same total coverage other people obtain by paying a single premium to a single plan. Paying three premiums to three plans is wasteful. Studies show that if the first two premiums were paid to a single, comprehensive health plan, the third premium seniors are paying would be unnecessary.

Problem: Even with comprehensive coverage, Medicare is still the least modern of all the health insurance plans. Medicare is the least likely to pay for telephone or e-mail consultations or for health care services obtained outside of the country. It also refuses to pay for convenient care in walk-in clinics in drugstores and shopping malls, although even Medicaid is beginning to pay for these services for low-income families in some states.

Example: The Medicare Advantage program has been a highly successful innovation. For only a modest premium (in addition to the Part B premium) and in some cases for no additional

premium, seniors are able to enroll in comprehensive health plans similar to the health insurance most nonseniors have. Compared to traditional Medicare, these seniors get about $825 of additional benefits per year.

Solution: Access to the Full Insurance Marketplace. Seniors who are happy with their current arrangement should be allowed to stay there. But millions of seniors could have more care and better care for less money if we expanded the range of options. Other citizens have access to PPO plans, Health Savings Account plans and other hybrids. Seniors need these same options as well.

Thank you for considering these comments.

Mr. PALLONE. Thank you, Dr. Goodman.
Dr. Sigsbee.

STATEMENT OF BRUCE SIGSBEE

Dr. SIGSBEE. Good morning, Mr. Chairman, Ranking Member Deal, and members of the committee. I am here to talk about this morning or actually now this afternoon about how realigning incentives within the healthcare delivery system will lead to better quality of medicine and will service the Medicare population.

As an introduction, I am a practicing neurologist. I am also medical director for a nearly 50-physician multi-specialty group and responsible for quality in that group, and I am also incoming president of the American, president elect of the American Academy of Neurology.

Right now as many have already pointed out this morning we have misaligned incentives within the healthcare delivery system and payment structure. And in a very real sense we have procedure-centered care, not patient-centered care. And the focus should be on what is important for the patient, for the individual patient. I am not suggesting that we cut payment for proceduralists, but what I am suggesting is that we need to adjust the payment system so we have a balanced workforce.

There are certain consequences of the current incentives that have been reviewed before, and I am sure you have heard testimony on, but at least from my own perspective as a neurologist where we are responsible for taking care of diseases that are important to the Medicare population such as Alzheimer's, ALS, Parkinson's, stroke, we are suffering the same workforce crisis that primary care is suffering.

Also, intrinsic in the current fee schedule is actually not just a lack of incentive but barriers to quality. Certainly it is not all valued by the payment structure. I have had physicians tell me that they did not want to get involved with quality efforts because it took them away from revenue generated at activities.

And also, if you look at it, ambulatory quality systems are still in their infancy. Unlike hospital quality systems that have developed over the last several decades, we are still trying to figure it out. It takes a great deal of effort and energy to make these systems work. And they also are quite costly. Health information technology is an important tool. You also need healthcare coordinators and others to really make it work.

PQRI in my view is an abject failure. Pay for performance as it currently exists does not encourage, as it is viewed as ineffective quality measure, but quality can be done very effectively, and I would like to give you at least my own personal story on this. I am a member of a three-physician neurology group. We have a joint commission stroke center at our hospital. Before we went through the certification process, we thought we were doing a great job of taking care of stroke patients until we actually started measuring what we were doing, and we were not doing as well as we thought or expected of ourselves. By placing the quality systems in place, by constantly monitoring, by developing a system of care that includes EMTs out in the field, all the way through rehabilitation, we are taking very good care of those patients. We consistently exceed

national stroke center benchmarks in terms of the quality of care that we provide. And it is that kind of in-the-community effort that is really required for effective health, for quality measures.

And as far as an example, and to really look at a payment structure and at least in terms of the incentives, what is really important, and you have heard about accountable healthcare organizations, medical home, but what you are really trying to do is create a system where you are trying to incent the behaviors that are really important for patient care. Certainly productivity is important, not sort of the hamster mill of turning but you need certainly enough physician work to have access for the Medicare population. Quality is critical, patient satisfaction and really a good experience with the healthcare delivery system and confidence in the care that they are getting, but also you need to encourage the physicians to work on improving the systems of care. Care is no longer just one physician and one patient. It is across the whole system of care. For example, the stroke center, we have trained the EMTs so they can recognize stroke and deal with it appropriately.

So you really have to have a whole system involved, and it has to be patient-centered care. And how do you create those incentives? There is a lot of discussion about healthcare delivery systems. In fact, in the last four or five years there has been a great deal of experience with creating physician compensation systems, which we are really talking about, and creating a balanced way of trying to incent physicians to do exactly the kinds of things that I am talking about.

In fact, they have developed and most places that now employ large groups of physicians have moved to what they call a blended compensation system, which includes both a salary component as well as an at-risk component that can be determined not based on only productivity but also on quality, patient satisfaction, and also what is termed citizenship, which is contributing to healthcare delivery systems.

And no matter what system you involve, if you don't implement the proper incentives in that system, it will not really be an effective way and really incurs the kind of healthcare that we would like. So based on this experience I am recommending that no matter what system we move ahead with that there be a blended payment structure that includes the right incentives which not only will be good in terms of cost control but will be good for patients.

Thank you.

[The prepared statement of Dr. Sigsbee follows:]

Testimony of Bruce Sigsbee, MD, FAAN
Member - Board of Directors
American Academy of Neurology Professional Association

House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC

April 2, 2009

Good morning, Mr. Chairman, Ranking Member Deal and Members of the Committee. Thank you for the opportunity to talk about how Congress might change the payment structure it provides for medical care and how realigning incentives might lead to better quality care and a more structured physician workforce designed to meet the needs of the Medicare population.

My name is Dr. Bruce Sigsbee, and I am a neurologist representing the American Academy of Neurology, a medical specialty association with more than 21,000 members. I am also in private practice at Pen Bay Physicians and Associates in Rockport, Maine, where I serve as medical director. I am responsible for quality and until recently physician contracting and budgets.

Neurology is responsible for caring for a large spectrum of significant diseases in the Medicare population including Alzheimer's, Parkinson's, ALS, and stroke among many others. Not only are these disorders large contributors to the societal burden of long-term care and consumption of resources, in the future with the aging of the baby boomers, the burden will be substantially increased and will require skilled management to improve quality of life and constrain inappropriate resource utilization.

Where I practice in Maine, we have a mix of patients and payers, of insurance and Medicare, of specialists and primary care providers. We use an electronic medical health record for all of our hospitalized patients and are in the process of implementing an EMR for office patients. We believe that we practice high quality, evidence-based medicine in a group setting. However, in reality, no one who interfaces with the healthcare delivery system is happy, including the patients, physicians and those that pay for the care.

The misaligned incentives of the current Medicare fee schedule are now well appreciated and its consequences include expansion and overuse of some healthcare services and underuse of others. The focus should always be on what the best available evidence indicates the individual patient needs. The Dartmouth Atlas insights indicate the potential savings from a correctly crafted compensation system without sacrificing quality or even improving quality.

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An example of the misaligned incentives is the current crisis in primary care. Both family practice and internal medicine US residency slots are only 50% filled by graduating US medical school seniors at a time that the number of graduating seniors is expanding. For those that select internal medicine, less than 5% elect to go into primary care as compared to 60% in 1996. These numbers are similar for cognitive service dependent specialties such as neurology that are in the same crisis. As pointed out in a recent Journal of the American Medical Association (JAMA) article 52% of neurology residency slots are filled by US graduating seniors. There is a current shortage of neurologists across the country. In my own practice, we have been recruiting for over four years without success. As a consequence, we may be unable to continue the Joint Commission Stroke Center, currently only one of two in the state. This imbalance leads to a problem with patient access to care for primary and cognitive care.

For Medicare, balance of specialties is crucial to providing the vast array of medical services needed by patients. An ideal system would include a physician and a team set up to coordinate the care of patients by providing the care necessary and eliminating unneeded, duplicative, or defensive care that costs the Medicare program dearly.

We think that Congress has recognized this need and is set to take steps to improve the incentives for residents entering primary care. The Academy of Neurology supports these efforts and stands ready to help when Medicare patients need more than primary care for diseases such as Alzheimer's disease for which primary care practitioners are not trained. Unlike other specialties, those in primary care residency have little or no exposure to neurology and some other specialties. Despite the array of diagnostic testing available, patients with neurologic problems require a sophisticated history, examination and integration of the diagnostic tests to arrive the correct diagnosis and select appropriate management. The primary care community depends on neurology to provide consultation or to provide ongoing management of these patients. Often, neurologists become the "principal care" providers for these Medicare beneficiaries.

We think that one of the main goals of health reform should be to return to a greater emphasis on face to face time between physician and patient, with more time for preventive care, counseling, and support for adjustment to illness, encouragement of lifestyle changes and less reflexive prescriptions, diagnostic tests and referrals. If successful, the result would be higher quality patient care, better outcomes, and lower cost.

At this time, however, procedures such as colonoscopy, stress test, minor out-patient surgical procedures or cystoscopy among many others, receive higher compensation on a per unit time basis compared to evaluation and management services, or face to face patient care. As a result, those specialties that provide the bulk of their services as evaluation and management services are less well compensated than those that are procedure based. The Medicare fee schedule is a national fee schedule since most payors adopt the fee schedule and payment rules of Medicare. This fee schedule must be viewed as an incentive program. The current problems of excessive procedures and services with escalating costs are the results of those incentives built-in to the current system. In other words, Congress is getting what it pays for, which is more and more procedures. This is not to suggest that procedure based services be

cut, only that incentives be provided to encourage new physicians to go into primary care or any specialty he or she wishes.

Workforce: This fact has a profound impact on the physician workforce. Medical school seniors with substantial educational debt burden often select specialties with higher anticipated income so they can retire their debt. As noted above, a recent JAMA article details the fill rate of residency slots by graduating U. S. medical school seniors. Neurology's fill rate is between that of family practice and internal medicine. As a result, the number of available physicians in neurology and other cognitive specialties is declining at a time when it is anticipated that there will be a substantial increase in demand for medical services for the Medicare aged population as the baby boomers enter their 70s and 80s. For neurology, it is anticipated that there will be a substantial demand for services for people with stroke, epilepsy and neurodegenerative disorders of the nervous system such as Alzheimer's and Parkinson's disease and other age-related disorders affecting the nervous system. On consultation with a number of patient advocacy groups, they universally note that there is already an access problem and a lack of sufficient neurologists to manage the disease complexity.

Research: The same disparity in anticipated income impacts the specialty choice of bright young physicians with an interest in research. Department chairs note that often there is less support for researchers, research space and support staff because the specialty brings little revenue to the institution. Intensive research is needed for these neurologic based diseases to provide improved quality of life and reduce the cost burden to society. As only one example, nearly 50% of individuals who are 85 and older have Alzheimer's disease. This burden on entitlement programs and society as a whole has the potential to overwhelm available resources unless effective interventions are identified.

Quality: A culture of quality and safety should be embraced by the medical community. Best practices leading to the best possible outcomes for patients should be a primary concern for everyone. However, there is currently no incentive to focus on quality within the fee schedule; rather, there are disincentives to doing so.

No physician thinks that he or she practices at a less than excellent level, yet there are many studies that document mediocre quality of medical care across the country, such as the RAND Corporation study which shows that patients get recommended care about 50% of the time. Why this disparity? First of all, medical information doubles every eight years. It is difficult to keep up. The American Academy of Neurology has addressed this information gap by developing over 110 clinical practice guidelines. The AAN takes this task seriously. Our guidelines are based on the evidence—not opinion—and are meant to be used together with our members' experience and knowledge of their patients in order to improve care. Rigorous policies manage conflicts of interest and no pharmaceutical funds are used. Independent reviewers (including a study done at Johns Hopkins University) praise AAN guidelines, which meet all of AHRQ's criteria for high-quality guidelines. Neurologists share this commitment to quality; 81% use the guidelines in their daily practices.

The second major reason for gaps in care is that quality improvement requires measuring care and making needed improvements. Both of these steps require resources not valued in the current system.

Quality systems in ambulatory medicine are in their infancy and those systems that exist require time and expensive support staff and systems such as electronic healthcare records. As a personal example, my group of fellow neurologists successfully met Joint Commission requirements for a Stroke Center, one of only two in Maine. Prior to the monitoring of quality measures we were not performing at the level we thought or expected. With monitoring and feedback, our performance consistently exceeds stroke center performance.

Although we have been successful, there is no incentive provided by Medicare to make this commitment. In fact there are substantial disincentives. As one family medicine physician queried recently to me, "How much are you willing to have my productivity decline to focus on these quality initiatives, 10%, 20%, 30%?" The barriers include the effort of establishing complex systems that are accurate and monitor the right elements, the cost of those systems and the lost patient care revenue. Physicians are focusing on the complexities of patient care and are very sensitive to anything that threatens their ability to focus on patients.

As a medical director responsible for quality in a multispecialty group I find engaging physicians in quality initiative extremely difficult. It is not valued as a productive use of time. While all physicians agree that quality care is important, only a few are committed to the effort required. If one views the financial recognition of an endeavor as a measure of the value placed in that endeavor, the current Medicare fee schedule does not value quality.

Therefore, it is essential that quality programs are low burden and provide actionable information. In this regard, the PQRI as an incentive program has failed as currently implemented. Feedback is delayed to well after the completion of the year and individuals in my multispecialty group still do not know how they performed. Where quality measures have worked, the patient care monitored contributes to outcomes and quality of life, a survey is done frequently and physicians are given constant feedback and suggestions and support systems to improve performance. The stroke center is an excellent example. The key elements include a physician champion, order sets that included all the needed elements and a coordinator that constantly monitors results.

There is a realistic perception that quality initiatives are often a thinly veiled effort to control costs. Most pay-for-performance programs are based on claims data. That data is limited for quality purposes but is excellent for assessing costs and resource utilization. Those programs are often a proxy for cost containment, not quality. I believe that neurologists would participate if programs are low burden, provide actionable information, and primarily seek to improve quality. The AAN is participating in national efforts that have these goals, such as NQF, AQA, and the AMA's Physician Consortium for Performance Improvement (PCPI). AAN has developed measurement sets on stroke and epilepsy and is working on more. We are well poised to contribute high quality measures to programs that truly seek to improve care.

Origins of Imbalance in Current Medicare Fee Schedule

It is worthwhile reviewing the origins of the current fee schedule. A key consideration is whether or not the current system of maintenance can be salvaged and can serve as a mechanism to correct the distortions within the schedule. RBRVS (Resource Based Relative Value Scale) arose out of recognized substantial variations in payments for the same service based on geography and out of a recognition that primary care was not adequately recognized in the then existing usual, customary and reasonable payment system. In other words, basing the payments on inputs, work, expense and malpractice with the same national schedule intended to create a fair and equitable method of compensating physicians.

The original studies that set the work component of the RBRVS were based on magnitude estimation. Magnitude estimation established the rank order and magnitude of work for sample procedures within specialties. Within specialties the results were consistent, achieving a high degree of correlation. However, the linkage across specialties was problematic. Focus groups established links across specialties but did not have the same rigor.

Several problems arose almost immediately. First, physicians protected what they viewed as important revenue sources to protect the viability of their practice. Second, the linkage across specialties became problematic, which continues today.

The Centers for Medicare and Medicaid Services (CMS) is charged with maintaining the RBRVS. However, CMS depends heavily on the AMA Relative Value Update Committee (RUC) to offer provider input into new and revised codes and to correct rank order anomalies. From the inception, there have been problems with this process. At the very core is that once the RBRVS became the basis for payment, the economic consequences of changes in work RVU values was immediately evident. Specialty societies represented their constituents and attempted to protect or augment their income. Since the RUC is dominated by procedural specialties, it is those specialties that have benefited by new procedures and analysis of rank order relationships. The survey process was never statistically valid and was contaminated by the economic implications of determinations. Further, approximately one half of the work RVUs for major surgical procedures represent evaluation and management services before and for 90 days after the procedure. There are no documentation requirements for these services and the level is based on assertion. Given the economic implications, the reported frequency and level of these services is difficult to validate. More recently, extant databases, never intended for compensation determination, are now accepted for determination of work RVU values and to establish rank order. These databases are relevant only to procedural specialties and do not exist for evaluation and management services. While not malicious and in large part based on the understandable responsibility of representatives to protect their specialty, the RUC process is notably flawed and has contributed to the current imbalances. The original researchers raised the concern that the RBRVS would progressively disadvantage evaluation and management specialties such as primary care and cognitive specialties shortly after implementation.

However, the major contribution to the misaligned incentives probably arises not so much from inter-specialty distortions, it probably actually arises from the use of RVU values. There is ample evidence

that high volume and relatively low RVU value out-patient diagnostic tests are the major source of the imbalances, even within specialties. For example, in urology, a physician is rewarded far more for performing several cystoscopies than for performing a complex all-day radical prostatectomy with a 90-day global follow-up period which is included in the fee. For large RVU numbers, a material difference is immediately evident. For small numbers substantial differences are not as evident. For example, the difference between 1.50 and 2.25 work RVUs does not seem all the great, but a 33% greater payment over many procedures can make a substantial difference. The base process for maintaining the work RVU system does not easily address services with relatively small RVU numbers. Combined with a survey process that is not statically valid and the use of databases available to only certain specialties, this results in a maintenance process that is flawed if not broken.

In sum, medicine and procedures change. The current system is materially flawed and cannot be relied upon to correct the imbalances and is not a reliable mechanism for maintaining the Medicare fee schedule into the future.

A Fee Schedule Based on Patient Care

The fee schedule should be based on the physician effort to provide direct patient care rather than providing volume of care.

Physicians should be recognized for the services they actually perform and should be held to the same standards as others for requirements such as documentation. Currently, there are material flaws in the comparisons across specialties, flaws in the rank order of procedures within specialties, use of methodologies that do not reach statistical validity and use of actual RVU data which contaminates any result with economic considerations resulting in a fundamentally flawed process. Changing the composition of the RUC would not correct the current imbalances. Some inequities would be corrected but many would not. To correct the imbalances that infuse the whole schedule would require a total revision. Such an effort should be expended on a payment methodology that focuses physician efforts on direct patient care rather than volume. The ultimate goal should be to find a method that, while not perfect, serves patient care, provides proper incentives and recognizes the great responsibility and effort represented in the role of being a physician.

Characteristics of a Future Payment System

Many possible payment methods are raised by policy makers, including the medical home, bundled payments and accountable healthcare organizations. Any one of these could probably work. Currently, there is not adequate information to identify the preferred method.

Perhaps we all need to take a step back. The goal is to provide high quality, patient focused care. Within that goal should be fair recognition for physician work and incentives that encourage excellence and improve outcomes and quality of life.

There are different ways to compensate physicians. Physician compensation may be salaried, purely based on productivity or a blended method. A major decline in productivity is observed when physicians are salaried. Physicians that are on a purely productivity method of compensation focus on keeping productivity and emphasize their individual efforts but are less likely to focus on systems of care, peer review and quality. Most groups are successfully using a blended system that includes a base salary which not only requires a certain level of productivity but requires participation in the medical community. Some refer to this component as "medical citizenship." Up to 35% of the compensation is variable or at risk. The metrics for this at risk component typically are heavily weighted towards productivity but also includes measures of quality performance, patient satisfaction and medical citizenship. Lessons for a compensation system can be taken from both the practical experience of healthcare systems as they compensate physicians and the body of literature on this topic.

We suggested that this same blended approach to physician compensation be included in any reform and be based on the experience that currently exists to help design a system without decades of demonstration projects and pilots that delay correction of the currently flawed system. In order for this type of system to work, it would have to provide incentives for coordinating the care of Medicare beneficiaries, especially those with chronic disease that incur a large percentage of Medicare resources. The result will be that physicians will be encouraged to provide high quality care that reduces the use of unnecessary care and improves the quality of life of the patient.

As medicine becomes more complex, good outcomes and efficient use of resources requires not only physician engagement, it requires the establishment of effective systems of care. Any method of physician compensation must include recognition of both the individual physician's efforts but also the role of that physician in a larger medical community necessary to deliver that care. The payment system and the incentives inherent in that system will be critical to the evolution of healthcare delivery in this country.

Mr. PALLONE. Thank you, Dr. Sigsbee.
Mr. Smith.

STATEMENT OF DENNIS SMITH

Mr. SMITH. Thank you, Mr. Chairman. It is a great pleasure to be with you again. First let me hasten to say new views, my testimony are my own. They don't represent the position of my current and certainly not the position of my former employer, the Federal Government.

I do perhaps have a little bit different perspective than my colleagues here on the panel in terms of the experience of actually running these programs for the last 10 years or so of my life. It gives me perhaps a different perspective seeing Medicare and Medicaid, two government health plans, up close and personal.

And one of the things that I think is striking to me is that they have to be part of the equation as well. Medicare and Medicaid account for approximately 45 percent of healthcare spending today. They are going to go up to 50 percent. So any idea that we can do this without involving, reforming the entitlement programs would seem to me it doesn't work.

It has been 15 years since Washington tried this sweeping types of reform that is being currently discussed today, but in that time states have been trying to do this. We have states as diverse as California, Massachusetts, Oregon, Tennessee, Hawaii, Maine, and Washington have all struggled with universal care. I suggest that we learn from them since they have already tried it and see what lessons there are, and then certainly we have Medicaid itself, the experience of the last several years in dealing with the great growth in eligibility and Medicaid, et cetera. So there is a great deal to learn from.

I think one of the things also is the expectations. Right now and I think in all of these states the promise was being made to the people not only those who were uninsured but the people who were insured as well. The promise to them was this was going to be cheaper for everybody, and everybody's going to save. We are hearing that today. The President has made the promise that the average family is going to save $2,500 on average. That is $2 trillion over a 10-year period of time. In recent, the last few weeks and months we have made commitments to spend another trillion dollars over 10 years on healthcare, so it seems to me right off the bat we are $3 trillion apart from where the American people think we should be in terms of addressing the issues of healthcare.

Again, I think we need to try an approach of lowering the cost first then it will become more attractive to people and that they will actually purchase it. I think the experience especially in California and Tennessee are very important lessons of the day.

First, dealing with the issue of mandates, what does that do to the cost of care. I think the discussion in California was very reflective since we have that in recent memory where you started off with mandates, mandate participation, then you were mandating a particular type of coverage, then you were also mandating how much people were actually going to spend on it. You became, you started a circular affect in which the mandates actually kept driv-

ing the price tag even higher yet. And I think that that in itself contributed in large part to why reform in California failed.

Tennessee as well. Tennessee, the story of TennCare was not started as a healthcare issue. It was started as a budget issue, and accordingly, TennCare from the very beginning I think was crippled and doomed to failure. It took a lot of years. It spent a lot of money before the program itself was dramatically changed.

So in terms of solutions, where do we look? From my way of thinking look at what model is actually being very successful in getting people covered, although in recent years we have had some struggle, but the dynamics anyway of employer-sponsored health insurance. What advantages do they have? First, they have the advantage of the tax code in which individuals have a tax advantage to buy it through the employer. So level the playing field between the individuals buying it on their own and individuals who are buying it through employers.

Secondly, the dynamics of group purchasing. Individuals when they go to the marketplace on their own, they are all on their own. They are all by themselves. Well, in group purchasing, in employer sponsored, you are in a group. You get the discounts that is offered to the group, and you do not have the underwriting that goes on in the group setting.

The entitlement reforms themselves, as I said, Medicare and Medicaid in my mind have to be a large part of it. My colleague at the end of the aisle talked earlier about the disparance in Medicare payments between Florida and hospitals, between Florida and San Francisco, but he didn't say why. The reason why is government actually interferes in the marketplace. We see time and time again in Medicare and in Medicaid where government artificially steps into the market, allows one hospital, for example, to leap three counties away so they get the higher reimbursement of an MSA from a higher payer.

So we are interfering in the market all the time is part—so I think part of the solution is resisting that temptation. We have plenty of quality initiatives in Medicare. We have got I think in many respects the things that we are discussing today have been discussed for a great, for a long period of time. There is in many respects nothing new under the sun in types of those issues, but I think the one thing that would be particularly helpful is transparency.

People should know what they are actually paying for, what they are actually buying. We tried this in the Deficit Reduction Act of 2005, where we tried to bring transparency to prescription drugs and ended up being sued by the pharmacy community who didn't want those drugs to become public. So the transparency itself I think is a great advantage, a very important element that is absolutely missing.

And finally I think the long-term care in Medicaid, we are unnecessarily paying, spending too much on long-term care for services that people don't really want. Talking to people with disabilities, they want to be in their own homes, in their own communities, not in institutional care. So we have to fix the F-map in Medicaid to rebalance the system.

Thank you very much.

[The prepared statement of Mr. Smith follows:]

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CONGRESSIONAL TESTIMONY

Making Health Care Work for American Families: Saving Money, Saving Lives

Testimony before
Health Subcommittee
Committee on Energy and Commerce
United States House of Representatives

April 2, 2009

Dennis G. Smith
Senior Research Fellow in Health Care Reform
The Heritage Foundation

My name is Dennis Smith. I am a Senior Research Fellow in Health Care Reform at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Thank you for the opportunity to participate in your important series of hearings, *Making Health Care Work for American Families.* I will focus my remarks on savings and quality in Medicaid as they relate to the discussion of a government health plan and offer some specific recommendations to include Medicaid long-term care as part of reform that will contribute to the theme of this hearing, *Saving Money, Saving Lives.*

One of the goals of health care reform, as repeated in the title of this hearing, is to save money. President Obama has previously promised that health care reform will save the average family $2,500. To deliver on that promise will mean reducing the cost of health care by over $2 trillion over the next ten years. According to the Milliman Medical Index, the total medical cost for a typical family of four covered by an employer-sponsored preferred provider organization (PPO) was $15,609 in 2008, a 7.6 percent increase from 2007.[1] The cost of private insurance includes the individual's own utilization of health care services, risk of future use, and cost shifting that occurs from indigent care and low provider reimbursement in government programs. In addition to the cost of their own health care, families also subsidize those on Medicaid. Medicaid costs about $5,000 per family that has income above the poverty level. Thus, families are understandably excited about promises to lower the cost of health care.

Medicare and Medicaid account for approximately 45 percent of health care expenditures which will increase to more than 50 percent in the near future. Any serious attempt to lower the cost of health care must therefore include reform of the entitlement programs. It is important to remember in today's environment that health care in the United States is already highly regulated at the federal, state, and local levels. For example, recent regulations now govern compensation that can be paid to agents or brokers under Medicare Part C and Part D plans.[2] Government regulates both supply and demand through provider enrollment, certificate of need, eligibility requirements, and a myriad of other ways.

Health care is also heavily subsidized. For example, Medicare beneficiaries pay only 25 percent of the cost of their Part B premiums. Most states charge little or no cost sharing in their Medicaid and State Children's Health Insurance Programs (SCHIP), relying almost exclusively on taxpayer subsidies. Taxpayers rightfully expect that government assistance programs are administered as efficiently as possible. When we lament what "run-away" health care costs are doing to family, state, and federal budgets,

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[1] Milliman Research Report, 2008 Milliman Medical Index, May 2008, p. 3.

[2] Centers for Medicare and Medicaid Services, Federal Register, Vol. 73, No. 221, November 14, 2008. Compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards and finders fees. Compensation does not include the payment of fees to comply with State appointment laws, training, certification, and testing costs; reimbursement for mileage to, and from, appointments with beneficiaries; or reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials.

we need to acknowledge how governments' own roles as financiers, regulators, purchasers, and competitors contributes to those costs.

As Congress considers the role of a government health plan in health care reform, it would be helpful to look at the history of government as a health care provider and that of Medicaid. Historically, state and local hospitals, nursing homes, and clinics have participated as health care providers. Public hospitals experienced a boom after World War II aided by government-financed construction. Use of hospital outpatient departments increased more than 300 percent between 1944 and 1965.[3] The delivery of health care entered a new phase in the 1960s as population shifts occurred between urban and suburban areas. As a result, "... many of the largest public hospitals became stages of conflict where physicians, nurses, and hospital staff struggled to provide adequate care in deteriorating physical plants that were often ill-equipped and poorly provisioned."[4] The impact of Medicare and Medicaid hit public hospitals in the early 1970s as health care choices expanded. Given a choice of hospitals and doctors, millions of Americans voted with their feet and left the public hospital system. During the 1970s and 1980s, many governmental entities determined that they could no longer afford the significant public subsidies necessary to govern or support large government facilities. Government officials were also concerned about the cost of future obligations associated with retiree benefits. In some cases, the value of the land on which many government facilities were located was viewed as potential source of revenue and economic development and thus provided an incentive to sell assets. Across the country, for these reasons and others, government divested itself from the direct delivery of health care.

Where government health care institutions lingered in states as diverse as California, Louisiana, and New York, state and local governments struggled with quality and cost issues at major institutions even in recent years. After years of failing quality of care surveys, Martin Luther King, Jr. Hospital (MLK Hospital) in Los Angeles was dramatically downsized and all but closed in August 2007. Burdened with massive debt associated with decades of denial and refinancing, New York ultimately adopted the December 2006 recommendations of its Commission on Health Care Facilities in the 21st Century. By the end of the transformation process in 2011, one-fourth of all hospitals in New York will be reconfigured. Approximately 2,800 nursing home beds will be eliminated.[5]

Some have argued that a new government plan modeled after Medicare is essential to health care reform because "... public insurance has a better track record than private insurance when it comes to reining in costs ...".[6] The premise that government will be more business minded or better negotiators than the private sector and therefore will dispassionately lower costs below the market is highly questionable. Proponents are

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[3] National Association of Public Hospitals and Health Systems, *The Safety Net*, Spring 2006, p. 9
[4] Ibid, p. 9.
[5] See New York State Department of Health, *Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century*, 2008.
[6] Jacob Hacker, Ph.D., Institute for America's Future, *The Case for Public Plan Choice in National Health Reform, Key to Cost Control and Quality Coverage*, 2008, p.1.

asking us to suspend decades of experience to the contrary. Conversely, if the benchmark of reform is controlling costs, and one thinks Medicare is superior to the private sector, then Medicaid must be even better yet because Medicaid pays its providers even less than Medicare. Medicaid's record at controlling costs includes the facts that there are major gaps in access to care and that providers leave the program. Just this week, Reuters reports that major pharmacies in Washington State are pulling out of the Medicaid program.[7]

In the current discussion over whether a government health plan should be created as an alternative to private plans, we would do well to consider why states are moving away from traditional Medicaid towards increased use of contracts with the private sector. The very reason states are changing their strategies seems to have been lost in the debate. They are doing so to improve quality and lower costs compared to the traditional model of government run health care under which government defines the benefits, recruits providers, sets payment rates, and determines how much individuals will pay for coverage.

There is no shortage of quality initiatives pursued by federal and state governments in Medicare and Medicaid. We are not suffering from a lack of ideas nor lack of regulation in Medicare and Medicaid. How regulations can stifle quality is rarely discussed. Furthermore, Federal, state, and local officials are often presented with competing interests, including that someone benefits financially from inefficiencies in the delivery system that so many now oppose. The Centers for Medicare and Medicaid Services (CMS), for example, had an initiative to put the delivery of durable medical equipment out for competitive bidding. Such efforts were eventually blocked. Officials are confronted with enforcement dilemmas when deciding about what action will cause the least amount of harm. Closing a poorly performing nursing home, for example, presents real risks to patients from the process of relocation. MLK Hospital remained open for years despite public outrage over high profile deaths and injuries. A two-tiered system of care persisted for years in Louisiana despite widespread concerns over patient care. The notion that running health care decisions through a government filter will purify the outcome or always protects the public interest simply does not reflect reality.

Nor does more money does not mean better quality. The Nelson Rockefeller Institute of Government recently issued a report, *Medicaid and Long-Term Care: New York Compared to 18 Other States*. It concludes, "[u]nfortunately, New York's broad range of services and higher spending have not produced a higher quality of care. The state is about average or slightly above average on measures of quality. The comparisons in this report show that New York has room to improve quality and lower costs."[8]

We certainly see every day how poor quality increases costs. The journey into the long-term care system often begins with a senior who is on too many prescription drugs becomes disoriented, falls and breaks a hip. A person with a disability who did not get

[7] Reuters, "Walgreen to cut Washington state Medicaid business," March 30.
[8] The New York Health Policy Research Center, Medicaid and Long-Term Care: New York Compared to 18 Other States, prepared for the New York State Department of Health, February 2009, p. 14.

the properly equipped wheelchair is at risk for skin problems that can lead to pressure ulcers and hospitalization. In one study, the actuarial firm Milliman, Inc. estimated that 25 percent of hospitalizations for Wyoming's long-term care population were avoidable.[9]

Transformation of Medicaid Long-Term Care Should be Included in Reform. Long-term care is an important but all too often overlooked component of health care reform. About one-third of Medicaid spending, or about $100 billion in FY 2007 went to long-term care.[10] Over the next 10 years, Medicaid long-term care spending is projected to grow at an average rate of 8.6 percent per year.[11] At this rate, Medicaid will spend a cumulative total of $1.7 trillion on long-term care between 2008 and 2017.

Fortunately, we now have more than 25 years worth of experience in home and community based services (HCBS) waivers. Today, every state has at least one HCBS waiver and there are approximately 300 such waivers in operation. New Jersey was one of the original "cash and counseling" states. Arizona and Texas are leaders in integrating long-term care and acute medical care through managed care contracts. Within Medicaid, there has been some shift in where long-term care dollars are spent. In FY 2000, 72 percent of Medicaid long-term care expenditures went to institutional care and just 28 percent to community based services.[12] The overall distribution of FY 2007 expenditures had changed to 58 percent institutional and 42 percent community-based.[13]

The AARP Public Policy Institute has recently published its *2009 Across the States: Profiles of Long-Term Care and Independent Living*. Among its ten key findings, AARP estimates that, "[o]n average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing home."[14]

Reform should offer more alternatives to Medicaid in order to divert people from needing Medicaid in the first place and Medicaid itself must be rebalanced. In this respect, Vermont provides a model for serious consideration. Patrick Flood, Deputy Secretary of the Vermont Agency of Human Services, has described how Vermont has abandoned the out-dated Medicaid structure of long-term care, and leveled the playing field between institutional and home care with the option of self-direction:

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[9] Bruce Pyeson, Kathryn Fitch, and Susan Panteley, *Medicaid Program Redesign: The Long Term Care and Developmentally Disabled Programs*, Milliman, Inc., September 15, 2006, p. 12.
[10] Office of the Actuary, Centers for Medicare and Medicaid Services, 2008 Actuarial Report on the Financial Outlook for Medicaid, October 17, 2008, p. 10.
[11] OACT, p. 17.
[12] Suzanne Crisp, Steve Eiken, Kerstin Gerst, Diane Justice, Medstat, *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*, prepared for the Centers for Medicare and Medicaid Services, September 29, 2003, Appendix 1, p. 15.
[13] Brian Burwell, Kate Sredl, and Steve Eiken, Thomson Reuters, *Medicaid Long-Term Care Expenditures in FY 2007*, September 26, 2008, p.1.
[14] Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, *AARP, Across the States: Profiles of Long-Term Care and Independent Living*, 8th Edition, p.17.

In 2005, Vermont received approval from CMS for an 1115 Waiver to re-design our Medicaid long term care system. The goals for the Waiver were to:

- Provide equal access to either a nursing home or home based care services
- Serve more people
- Manage the overall costs of long term care.

Three years later, it is clear that the Waiver has succeeded beyond what Vermont hoped for. We are serving many more people than we could have under the old system. The number of new persons we can admit each year to our home based alternative programs has grown 2-3 times over what we could in the old system. Nursing home use continues to decline gradually. Overall costs of the system have remained manageable.[15]

Flood summarized the Vermont experience: "The beauty of Vermont's approach is that it turns out our theory is correct: more people, given the choice, will choose home based care, and less money will be spent on nursing homes. Thus we can shift money from the nursing home side of the ledger to the home based side and not spend more than was planned, but still serve more people overall."[16]

Millions of Americans served by Medicaid are also clients of other government programs such as the Supplemental Security Income (SSI) program, Food Stamps, housing assistance, mental health, aging, and even transportation programs. All of these programs are part of the long-term care continuum and we should view them as a cohesive system rather than individual, unconnected parts which is the way these programs are currently organized. Better coordination of current coverage would certainly increase access, improve quality, and lower costs. Milliman observes that, "[m]uch of the data collected and information reported about the LTC and DD programs are intended to demonstrate compliance with entitlement rules rather than support care management. A future that provides more efficient, better quality care will have strong capabilities to manage care processes."[17]

There clearly are differences between the elderly and people with disabilities in the use of long-term services and supports when we examine the length of time the two populations use LTSS and the array of services. However, policies for both populations should be the same: they should be person-centered and money should follow the person. Young adults with disabilities are more likely than seniors to be interested in supports that will led to employment, for example. But at the federal level, we should avoid making artificial policy distinctions that could impede the choices and preferences of either population. Some current federal policies unnecessarily complicate the delivery of services to those who rely on them. For example, a person's benefits can change solely because he had a birthday.

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[15] Statement of Patrick Flood at The Heritage Foundation, "Workable Solutions for Long-Term Care," September 24, 2008.
[16] Ibid.
[17] Pyenson et. al., p.2.

Community care for the developmentally disabled has progressed more rapidly than for the elderly and physically disabled. Community based care for the developmentally disabled now accounts for 63 percent of Medicaid long-term expenditures on their behalf while 69 percent of long-term care expenditures for the elderly and physically disabled still go to institutions.[18]

Why has community care progressed more rapidly for the people with developmental disabilities than for our seniors? A better understanding of these changes and differences will assist in identifying how current policies should be changed.

First, the overwhelming credit goes to families. The shift from institutional care to community services reflects their preferences and demands. Families spoke and states responded, though some states faster than others. Long-term care should be properly viewed as a matter of personal liberty and freedom, a family issue, and a social issue as well as a health care issue. They have moved their loved ones out of institutions and, in many cases, on to self-direction. When long-term care is still viewed as a medical model, the progress has been slower. Choice and self-direction improves access and quality while lowering the cost. That is a successful formula that families embrace.

Second, the financial relationships are different. Government needs to acknowledge that its own fragmentation of programs and philosophy of dependency in which providers, rather than people themselves are the decision-makers may be contributing factors as to why the majority of funding for the elderly and physically disabled still goes to institutional care. The institutional bias of Medicaid in which a nursing home bed is an entitlement but supports at home are optional are reinforced by financing advantages of institutions and relationships between institutions. In many states, institutions themselves help finance the cost of Medicaid through upper payment limits and provider taxes. Because they can be a source of the nonfederal share of the cost of Medicaid, they have an advantage when it comes to making budgetary decisions at the state level. Furthermore, institutions, especially in many rural areas in particular, nursing homes are major sources of employment, giving the mutual business interests of owners and workers a powerful political voice.

A third reason is the professionalization of community based services within the developmentally disabled community. Organizations have moved out of someone's basement or the church daycare into sophisticated operations. There are other reasons as well, but whatever the reason is, the central focus should be on leveling the playing field between institutional and non-institutional care. To achieve this, Title XIX itself will need to be amended and reorganized. Long-term care should have its own distinct part within Title XIX. The current distinctions between "mandatory" long term care services and "optional" long term care services should be eliminated. After more than 25 years of experience with home and community based waivers, it is time to recognize the obvious. Home and community based care works and states should not have to rely on waivers

[18] Burwell et. al., Table, "Distribution of Medicaid Long Term Care Expenditures for DD services, Institutional vs. Community-Based Services, FY 2007"and Table, Distribution of Medicaid Long Term Care Expenditures for A/D services, Institutional vs. Community-Based Services, FY 2007.

from Washington to provide it. However, the budget scorekeepers at the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) generally view greater state flexibility in Medicaid will increase costs. Thus, flexibility will need to be coupled with financing reform as well.

Broad-based solutions will require improvement in all of the current efforts in long-term Medicaid, our retirement systems, and private long-term care coverage. Part of the solution to easing the pressures on Medicaid is for Americans to better prepare for their own retirement needs.

There is great attention to the aging of the "baby boomers" and to the rapidly growing population over the age of 75 where the need for long-term care increases. The age and functional abilities of the person are not the only determinant in whether a person will seek long-term care services and supports. What happens to someone else also matters. That is, family members are the greatest source of support, typically, one spouse caring for the other or an adult child caring for her parent. Broad based solutions should focus on keeping families together for as long as possible.

Better transition planning can lower costs. System redesigns should focus on delaying entry into institutional care or reducing the length of stay in an institutional setting. We should also help ensure a sense of security for families by helping a person with disabilities build assets for their future needs. Today, the message from Medicaid and SSI to individuals and families is don't work, don't build assets, don't plan because if you do, you will lose eligibility. We should reverse this by creating special accounts for people with disabilities to build assets. The Bush Administration proposed such accounts called Living with Freedom, Independence, and Equality (LIFE) Accounts. LIFE accounts would be tax exempt and would not be counted in determining eligibility for Medicaid or SSI. Families could draw some funding out of the Account for incidental items, perhaps 10 percent annually, without penalty. The Account would then be used for future cost of care if the person needs to go into an institutional setting.

LTSS Grant Under New Part B of Medicaid. Reform should assist in the transformation of long-term care from institutional to person-centered supports and services. The current mandatory/optional services for long term care should be replaced by a new Part B of Medicaid under which long term services and supports (LTSS) are offered on an equal basis as under the Vermont model. States should be allowed to move away from the institutional level of care to a functional needs assessment system based on prevention, low, intermediate, and high needs. States should be required to offer families the opportunity to self-direct their long term services and supports. Federal rules on important policies such as spousal impoverishment protections, eligibility, and nursing home quality standards would be preserved to continue to hold providers and states accountable.

Medicaid long-term services and supports would be funded through a dedicated but capped LTSS grant that is stable, predictable, indexed, and guaranteed. States would have the incentive to adopt new delivery options through the conversion of the current

matching system to a maintenance of effort requirement (MOE). States therefore could improve service delivery and save state dollars without losing federal dollars.

States need a more flexible financing arrangement within existing funding levels to be able to level the playing field that also provides them with the ability to work outside the lines of current federal law and regulations. There can be good reasons to want to deviate from the current payment rules. For example, government generally does not want to pay providers for an empty bed. But to shift to community care while maintaining quality within institutions, a state would benefit from flexibility which would allow it to offer a funding stream that puts some nursing homes on a glide path to closure. The federal government would be more favorable to states experimentation with "pay for performance" if it did not have to take the risks connected with open-ended funding commitment.

The current match system works against the interests of what we should be trying to accomplish—greater value at lower costs. States are under tremendous pressure to maximize federal dollars. Medicaid needs a neutral approach in which states can reform their long term services and supports system but maintain a guaranteed stable and predictable source of financing from the federal government. Investment in information and education will provide families with greater emotional security that there will be a continuum of care that supports the health, security, dignity, and individuality of their loved ones.

Response to Concerns over Capped Funding. Over the years, criticism of and opposition to funding caps in Medicaid have generally focused on three areas:

1. states would be handicapped to respond to unforeseen events that would increase eligibility. Hurricane Katrina, SARS, and HIV/AIDS have been offered as reasons to oppose capped funding.
2. there could be medical breakthroughs that could be very expensive, putting states at risk for high cost technology.
3. states have little control over the cost drivers of health care making capped funding an unacceptable risk.

None of these objections particularly apply to the area of long-term care. These three reasons pose little risk in long-term care in which populations are stable and predictable. Long-term care is more high touch than high tech. And in the area of long-term care, states have considerable control over how long-term care is delivered, which is why there are such great differences among the states in per capita spending and the distribution between institutional and community-based care.

Summary. The Health Subcommittee has it right—the debate over health care reform should focus on how much families will save. Our lives and liberties are at stake. Unfortunately, President Obama's pledge to save $2,500 for American families seems to have been misplaced. The current timing and process for considering health care reform has it backwards. Congress is focused on the budget resolution that frames how much the

federal government will spend. The details of policy should be clearly laid out first so the Congressional Budget Office, the Office of the Actuary, and outside actuarial experts such as Milliman and Lewin can model the impact on savings, costs, sources of financing, and enrollment well in advance of floor action in either the House of Representatives or the Senate. For savings to be realized, Congress should concede now that the entitlement programs must also be reformed instead of pushing off those realities for another year. Medicaid's current financing and benefit structure is an impediment to transformation of long-term care from an institution-based, provider-driven medical model to a person-centered, consumer-directed model.

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Mr. PALLONE. Thank you, Mr. Smith.
Dr. Avorn.

STATEMENT OF JERRY AVORN

Dr. AVORN. Mr. Chairman, members of the committee, thank you for the opportunity to testify today at this very important time for the Nation's healthcare system. My name is Jerry Avorn. I am a professor of medicine at Harvard Medical School, and for nearly 30 years my research has focused on the effectiveness, safety, and affordability of prescription drugs and how those drugs are used by doctors and by patients. I have taught and practiced geriatrics and primary care internal medicine at several of the Harvard teaching hospitals since 1974, and I am the author of the book, "Powerful Medicines," which deals with many of these concepts.

We doctors badly need more information about the drugs we prescribe. Our ability to take the best possible care of our patients is severely hampered by a lack of this information. There is also a need for our patients to be astute consumers of the medical choices available to them, and the Nation increasingly expects those who pay for healthcare to be able to make the smartest possible choices. The information gap I will discuss today limits decisionmaking on all of these fronts.

My history and by law the FDA is not mandated to evaluate new drugs or devices against other treatment options. Its enabling legislation requires it to approve a drug for marketing if the manufacturer demonstrates effectiveness, which may simply mean that it works somewhat better than a dummy pill.

But I have never had a patient say to me, Dr. Avorn, please prescribe me something that is a little better than nothing. Patients and doctors want to know the best treatment for a particular condition, but that isn't the evidence that the pre-approval testing system was ever designed to collect. Many observers feel that changing the legal standards for the drug approval process would be infeasible, and many others argue that it would be undesirable.

In any case, once a product is marketed, important new information about its safety or effectiveness could be collected, which would be very important for doctors and patients to know about but which is beyond the purview of the initial approval process itself. Once a new product is on the market its manufacturer is likely to launch a massive sales campaign. The pharmaceutical industry spends much more of its revenues on marketing and on promotion than it does on research and development. The most costly new products are the ones that are most aggressively advertised to doctors and to patients whether they represent a real advance or not. A time-tested generic drug may be the most effective treatment for conditions like high blood pressure or diabetes, and generics often have the most well-established safety records as well and are likely to be the best value economically by a long shot.

But the profit margins on generics are wafer thin, so their manufacturers don't have the resources to take out expensive ads on the evening news or to send perky salespeople to doctors' offices to offer us free meals and gifts to persuade us to prescribe those drugs.

This skews the use of medications as well as other interventions towards the costliest choices, even when they are no better than

the alternatives and may even be worse. Other economic incentives can take hold when expensive treatments or tests like chemotherapy or MRI testing become profit centers of their own for the doctors who prescribe them or order them.

The manufacturers of drugs and devices are investor-owned companies, not public health agencies. That is not a moral judgment. It is just an economic fact. Given these companies' responsibility to maximize return to their shareholders, you would be naive to expect these companies to be a good source to fund and disseminate studies which could sink one of their products.

There is a clear and embarrassing track record of drug makers actually suppressing the results of research if it showed problems with their products. This has happened with anti-depressants like Paxil, the cardiac surgery drug Trasylol, the cholesterol medication, Bacol, and many others. And there are examples of this problem from nearly every field of medicine.

At the beginning of this decade my own research group wanted to study the apparent link between Vioxx and heart disease while that drug was still on the market. We had to seek funding for the research from its manufacturer, Merck, since there was so little federal support available to do this research. When our study found a clear link between Vioxx and heart attack well over a year before it was taken off the market, Merck tried to persuade us to deemphasize some key results, take a co-author off the paper, and then they dismissed the very methods that they had previously supported. Clearly this not the ideal way to fund studies of drug safety and comparative effectiveness.

Until now it has not been anyone's job to determine how well alternative treatments work and how safe they are compared to each other. We are often totally in the dark as doctors when we try to choose between several drugs for the same condition since those studies are rarely done. Our patients probably think that we are playing with a fuller deck than we are. Perhaps members of Congress think so as well. We are not. As bad as the situation is for drugs, this informational gap is even worse for other kinds of healthcare intervention. A new medical device like a pacemaker or defibrillator or artificial hip mostly needs to show that it is not dangerous. Not how well it works or whether it is better than existing products. And new surgical procedures or new imaging studies like MRIs and CAT Scans don't have to show that they benefit patients at all.

The worst consequence of this information deficit is that it prevents us from taking the best possible care of our patients. But at a time when the Nation can't afford to provide healthcare for all of its citizens and even people with insurance as we heard earlier have problems paying for that care, the economic aspect of this problem is also quite important.

The U.S. as you heard earlier today has per capita healthcare costs that are the highest in the world by a great deal. Yet our medical outcome data are overall no better than those of many other industrialized countries and often much worse. In these rough economic times when more and more people have to pay for healthcare out of pocket, high costs can mean no care at all, and for Medicare and Medicaid not knowing which treatments work

best and which have the best value and which are safest leads to patient outcomes that are worse than they need to be and costs that are increasingly unaffordable for the Federal Government and therefore the taxpayer as well as for the states.

There is a solution for this problem. It is based on the same concept that underlies all of modern medicine, and it is the reason that we are not still using leeches and purgatives to treat most diseases. It is the idea that well-conducted scientific studies can show us which treatments work best for a given medical problem and are the safest. This information can be gathered through well-established methods of randomized trials, as well as observational studies. The latter kind of research, which my group at Harvard performs, can review the clinical experiences of millions of people to learn how well similar patients did with different treatments.

These kinds of observational studies can also enable us to ask questions about special sub-groups of patients such as minorities or children or the very old; the very groups that are often under-represented or even excluded in the clinical trials that drug manufacturers perform to win FDA approval.

This kind of research is a public good like clean air and good highways, which needs to be supported by government. The private sector is simply not going to do the research to identify drugs that are absurdly mis-priced or toxic any better than the private sector was able to identify financial instruments that were absurdly mispriced or toxic.

This kind of applied research is not something we should fold into the missions of the National Institute——

Mr. PALLONE. Dr. Avorn, I am sorry.

Dr. AVORN. Yes, sir.

Mr. PALLONE. You are 2 minutes over, so if you could kind of summarize.

Dr. AVORN. OK. I will wrap it up.

There is a way that we can get this information to physicians as well as make sure that it is out there in the literature. For a number of years my colleagues and I have been doing a process called academic detailing, in which we bring information to doctors much as sales reps do for the drug companies. The idea is that the states, in this case several states in the northeast, support nurses, pharmacists to go to doctors' offices and bring information that is not about sales but is just about the best possible way of taking care of patients. And we have shown over the years that this is a way of improving care and actually paying for the program's cost.

In summary, there are ways in which we think that we as physicians can take better care of our patients and save money for the healthcare system at the same time. Sandra Cole on the Senate side has introduced a bill to support this academic detailing outreach to doctors. I am pleased that members of this committee, Representative Waxman and Pallone, have also introduced a bill that would do the same thing on the house side. The goal is to get us doctors the information we need to take better care of patients, improve those outcomes, and save money at the same time.

Thank you.

[The prepared statement of Dr. Avorn follows:]

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Testimony of Jerry Avorn, M.D.

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Brigham and Women's Hospital, Boston
April 2, 2009

Introduction:

I appreciate the opportunity to testify today at this pivotal time for the nation's health care system. My name is Jerry Avorn, and I am a Professor of Medicine at Harvard Medical School. I did my undergraduate pre-medical work at Columbia University, then attended Harvard Medical School, and completed my training in internal medicine at its teaching hospitals. For nearly thirty years, my research has focused on the effectiveness, safety, and affordability of prescription drugs, and how those drugs are used by physicians and by patients. I lead a 25-person research unit, the Division of Pharmacoepidemiology and Pharmacoeconomics, in the Department of Medicine at the Brigham and Women's Hospital in Boston, one of the main teaching and research institutions at Harvard. I have taught and practiced geriatrics and primary care internal medicine at several Harvard teaching hospitals since 1974, and have a particular interest in the use and outcomes of prescription drugs in the elderly. I am the author of *Powerful Medicines: the Benefits, Risks, and Costs of Prescription Drugs,* which was first published by Knopf in 2004 and is currently in its 10th printing.

The problem:

We doctors badly need more information about the drugs we prescribe. Our ability to take the best possible care of our patients is severely hampered by a lack of this information. There is also a need for our patients to be astute consumers of the medical choices available to them, and the nation increasingly expects those who pay for health care to be able to make the smartest possible choices. The information gap I will discuss today limits decisionmaking on all these fronts.

By history and by law, the FDA is not mandated to evaluate new drugs or medical devices against other treatment options. Its enabling legislation requires it to approve a drug for marketing if the manufacturer demonstrates "effectiveness," which may simply mean that it works better than placebo, a dummy pill. But I never had a patient say to me, "Dr. Avorn, please prescribe me something that's a little better than nothing." Patients and doctors want to know *the best* treatment for a particular condition – but that is not evidence that pre-approval testing was ever designed to collect. Many observers feel that changing the legal standards for the drug approval process would be infeasible, and many

others argue that it would be undesirable. In any case, after a product is marketed, important new information about its safety or effectiveness could be collected which would be important for doctors and patients to know about, but which is beyond the purview of the initial approval process itself.

Once a new product is on the market, its manufacturer is likely to launch a massive sales campaign. The pharmaceutical industry spends far more of its revenues on marketing and promotion than on research and development. The most costly new products are the ones that are most aggressively advertised to doctors and to patients, whether they represent a real advance or not. A time-tested generic drug may be the most effective treatment for conditions such as high blood pressure or diabetes, and generics often have the most well-established safety records as well. They're also likely to be the best value, by a long shot. But the profit margins on generics are wafer-thin, so their manufacturers don't have the resources to take out expensive ads on the evening news, or send perky salespeople to doctors' offices to offer us free meals and gifts to persuade us to prescribe them. This skews use of medications (as well as other medical interventions) toward the costliest choices, even when they're no better than other alternatives – and may even be worse. Other perverse economic incentives may also prevail when expensive treatments or tests, like chemotherapy or MRI testing, become profit centers of their own for the physicians who order them.

The manufacturers of drugs and devices are investor-owned companies, not public health agencies. That is not a moral judgment, it is an economic fact. Given their responsibility to maximize return to their shareholders, it would be naïve to expect companies to be a good source to fund and disseminate studies that might sink lucrative products. There is a clear and embarrassing track record of drugmakers actually suppressing the results of research which revealed problems with their products; this has occurred with the antidepressant Paxil, the cardiac surgery drug Trasylol, the cholesterol medication Baycol, and many others. There are examples of this problem from nearly every field of medicine. At the start of the decade, when my own research group wanted to study the apparent link between Vioxx and heart disease while that drug was on the market, we had to seek funding for the research from its manufacturer, Merck, since there was so little federal support available for such work. When our study showed a clear link between Vioxx and heart attack well over a year before it was withdrawn from the market, Merck tried to persuade us to de-emphasize some key results, remove a co-author from the paper, and then dismissed the very methods they had previously supported.

Until now, it has not been anyone's job to determine how well alternative treatments work – and how safe they are – compared to one another. We are often totally in the dark in trying to choose between several drugs for the same condition, since those studies are hardly ever done. Our patients probably think we are playing with a fuller deck than we really are. Perhaps members of Congress think so as well. We are not.

As bad as this situation is for drugs, the informational gap is even worse for other kinds of health care intervention. A new medical device such as a pacemaker or defibrillator or artificial hip primarily needs to show that it's not dangerous – not how

well it works, or whether it's better than existing products. And new surgical procedures, or new imaging studies such as MRIs or CAT scans, don't have to show that they work at all.

The worst consequence of this information deficit is that it prevents us from taking the best possible care of our patients. But at a time when the nation can't afford to provide health care for all its citizens, and even people with insurance have problems paying for their care, the economic aspect of this problem is also important. The United States has per-capita health care costs that are the highest in the world, by a great deal. Yet our medical outcome data are overall no better than those of many other industrialized countries, and often much worse. In these rough economic times, when more and more people have to pay for health care out of pocket, high costs can mean no care at all. For Medicare and Medicaid, not knowing which treatments work best, and which have the best value, leads to patient outcomes that are worse then they need to be, and costs that are increasingly unaffordable.

Generating the information we need:

There is a solution to this problem. It is based on the same concept that underlies all of modern medicine, and it's the reason we're not still using leeches and purgatives to treat most diseases. It is the idea that well conducted scientific studies can show us which treatments work best for a given medical problem, and are the safest. This information can be gathered through well-established methods of randomized trials and observational studies. The latter kind of research, which my group at Harvard performs, can review the clinical experiences of millions of people to learn how well similar patients did with different treatments. It also can enable us to ask these questions for special subgroups of patients, such as minorities, children, or the very old – groups that are often underrepresented or even excluded in the clinical trials that drug manufacturers perform to win FDA approval.

This kind of research is a public good, like clean air and good highways, which needs to be supported by government. The private sector is not going to do the research to identify drugs that are absurdly mis-priced or toxic, any better than the private sector was able to identify financial instruments that were absurdly mis-priced or toxic. This kind of applied research is not something we should fold into the mission of the National Institutes of Health, which has a fundamentally different goal of supporting studies to understand the basic mechanisms of biology and disease. The idea of comparing alternative treatments ought to be embraced by people on both sides of the aisle. If you favor marketplace choices in health care, then consumers, doctors, and insurers need this information to help them make prudent purchasing decisions. If you favor fiscal responsibility, now that the federal and state governments are the largest purchasers of health care, then the nation seriously needs such data to enable it to spend its health care dollars intelligently. No self-respecting corporation would spend millions of dollars – no less hundreds of billions of dollars – without determining which of its purchases were of the highest quality, and the best value.

Avandia for diabetes and Vioxx for pain were both drugs on which Americans spent over $2 billion per year, and much of that was public money. Both drugs were on the market for five years before we knew that they each raise the risk of heart attack compared to similar treatments that work just as well. Learning that fact just a year or two sooner could have saved billions of dollars – and tens of thousands of heart attacks. It is fiscally and morally irresponsible not to support this sort of research.

Delivering the information to improve patient care:

But gathering such information will not in itself be enough; we need to to make sure it gets translated into better patient care decisions. In addition to our research on drug safety and utilization, for 30 years my group at Harvard has been studying how to help doctors prescribe better. The drug companies are very adept at influencing what we doctors prescribe. They send affable people, known as "detailers," to our offices to talk to us; they come bearing engaging, clear printed materials to underline their selling points, and end their visits with clear recommendations about what we should prescribe. By contrast, those of us in the academic world may have a fuller grasp of all the evidence, and may not be focused on pushing a particular product, by we are usually terrible communicators. As a result, prescribing is driven much more by attractive sales reps than by evidence-based experts.

In 1979, the predecessor of the Agency for Healthcare Research and Quality issued a request for proposals on improving the quality and economy of medication use. Recently out of my residency, I sent in a grant application with a simple premise: What would happen if we equipped people working in academic institutions with the same effective communications strategies that the drug detailers used so well? Couldn't we put those tools in the service of improving appropriate prescribing, rather than just increasing product sales? I named the approach "academic detailing," and proposed testing it in a randomized controlled trial in four state Medicaid programs. The grant was funded (for a little over $100,000), making it possible to implement and test this approach. It worked, and my colleague Steve Soumerai and I published the results in *The New England Journal of Medicine* in 1983. Since then, we and others have shown that such "academic detailing" can improve prescribing in a wide variety of clinical settings. We also found that in addition to improving care, it can produce savings that cover the costs of the program.

Academic detailing programs have now been established all over the world. In 2005, Governor Rendell of Pennsylvania asked me to set up a program in his state, to improve the quality of care and help contain the state's growing drug costs. In this program, my colleagues and I review the entire medical literature covering a common problem such as depression or high cholesterol, we package the information into a user-friendly format, and then send out specially trained nurses or pharmacists or physicians to meet with doctors in their offices to present recommendations about the best care. We place all our materials on line at www.RxFacts.org for public access. The Pennsylvania program has expanded, and the governments of Massachusetts and the District of Columbia last year asked us to establish academic detailing programs there as well. We

do this work through a non-profit organization for which I serve as an unpaid consultant. We are now helping to train academic detailers in state-funded programs in New York, South Carolina, Vermont, and several other states. Academic detailing makes it possible to take the next step beyond developing the information about what works best, and puts that information into the hands of doctors. It provides practitioners with a service that I would have liked to have had when I was practicing primary care: an evidence-based, non-commercial means of getting the very best current information about our therapeutic choices, not distorted by any sales agenda.

Senator Kohl has introduced a bill to provide such a service on a wider scale nationally, and Congressmen Waxman and Pallone are co-sponsoring a similar bill in the House. Funding research comparing treatment alternatives and then delivering that information to doctors through academic detailing can go a long way in improving the care we deliver to our patients. The comparative studies can clarify which treatments work the best, are the safest, and the most affordable; and academic detailing can provide the vital link to practice by getting this information out to doctors in a way that will directly improve front-line patient care decisions. I appreciate the leadership of this subcommittee in helping to move both of these vital health care agendas forward.

Mr. PALLONE. Thank you, Dr. Avorn. Thank all of you.

We will take questions and start with myself. In each case we have 5 minutes.

My questions actually are of Dr. Skinner. I am trying to get two in here; one about the—his startling statistic about $700 billion in healthcare spending each year is wasted, which is about the size of the economic recovery package that we enacted, and it represents about a third of all health spending.

Now, my understanding is when you talk about $700 billion it is money spent on services that are not effective or that may even be harmful. But if I you would explain. Where does this estimate come from, what do you mean by wasteful spending, and why is this so large?

Mr. SKINNER. Thank you. That is a great question. That is a big number. We had done some studies at, from Dartmouth that looked at outcomes of say heart attack patients, hip fracture patients, a very large number across the country where we had very good detailed information on how sick they were when they arrived. Heart attack patients are—everybody is admitted to the hospital, you have some good information on how well they are doing, and what we observed some areas spent 60 percent more on these patients, but they didn't do any better. If anything, they did a little bit worse, and so we added up the number and came up with a number between 20 and 30 percent for the Medicare population.

We extended that to the general population, the under 65 population, which—and also we, we also viewed this as sort of a lower bound in some way because probably even the most, what we found to be the most effective, cost-effective areas could also probably improve a little bit as well. So——

Mr. PALLONE. So it is private as well as public? It is not——

Mr. SKINNER. Yes. We don't have direct information on private, but we made inferences based on the Medicare population.

Mr. PALLONE. Now, what do you suggest we do to avoid this waste in passing health reform? I mean, I know you talk about the creation of ACOs, Accountable Care Organizations, that would reward physicians and hospitals for effective management and costs and quality. How would that address the problem? Is that your answer?

Mr. SKINNER. Well, I think of ACOs in some way as a very flexible approach that enables whatever kind of health reform that comes in to at least get at what we see is the fundamental problem in healthcare, which is nobody is accountable in the system, that primary care physicians are overworked, they get patients, they send them to the ER if they are, you know, if they can't deal with them in their offices. There are one or two patients. There is a lot of fragmentation. All of these problems basically are allowed to grow and to cost us money and to result in bad care, and the ACOs are ways to try to solve that.

Mr. PALLONE. And how would they solve it? Because, you know, I don't want just another managed care organization. How are they going to help us?

Mr. SKINNER. Absolutely. I think the last thing we want is to live through the 1990s again with the problems of managed care. I think the improvement over managed care is that this is an exam-

ple of providers, highly-skilled physicians and other providers working together to try to basically sit down, maybe this primary care physician that I mentioned earlier who may not have admitting privileges at the hospital in sending their patients to the ER, they could actually get together with the people at the ER and figure out more effective ways, more cost, you know, ways to save money when they get difficult patients that come into their door.

Mr. PALLONE. But are you going to do it by changing the payment system or—I mean, what is the mechanism? What is the enforcement mechanism?

Mr. SKINNER. Yes. No. It is two things. One is you have to get the prices right. This is easy for me to say as an economist, but you also have to pay for the right things. Right now we are paying per MRI, we are paying on the basis of quantities, and so basically Medicare pays whatever people decide to do. What we need to do is pay on the basis of—is reward on the basis of total expenditures. That is prices and quantities.

Mr. PALLONE. You know, there was an article, I am going to ask unanimous consent to put this in the record. It is an article that is today's New York Times about this study that finds that many on Medicare return to hospitals.

Without objection so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. But are you familiar with that? I mean, is that an example of how we could—that is something that needs to be addressed obviously. Right?

Mr. SKINNER. Yes. I mean, right now, I mean, another example—that is a very good example. Another example was when a hospital figured out that when people came in with back pain, that if they sent them to see a nurse practitioner, rather than send them home and have them wait to go see the surgeon, then, in fact, most of them, most of the back pain suffers got better and went back to work. But the problem was that the hospital was losing so much revenue because it wasn't doing as much back surgery. And so they actually——

Mr. PALLONE. The bottom line is you are going to have to create some sort of financial incentive. I mean, this article talks about a financial incentive for hospitals that, where the person, where they don't have such a return rate.

Mr. SKINNER. Yes.

Mr. PALLONE. And you would do the same thing with doctors and group practices and all that?

Mr. SKINNER. Exactly.

Mr. PALLONE. All right. Thank you.

Mr. Deal. Dr. Burgess. Oh, you want to see it? Sure. Yes. Sure. Go ahead. It was in today's New York Times, and it is, basically says that, you know, that there are a lot of hospitals where they have a high readmission rate under Medicare because they don't give people proper services when they leave so they come back. And one way of addressing it is to, you know, create a financial disincentive for that, for the hospitals.

You are OK? All right. I didn't hear you. I am sorry. Dr. Deal.

Mr. DEAL. Thank you. Well, you all have been interesting, and you all have indicated the complexity of the issue that we face by

the diversity of the subject matter that you have addressed, all of which was within that umbrella of healthcare reform, and I thank you for your testimony.

But it is hard for us to get a handle on all of this, as I think you all understand. I think part of it is that we are trying to figure out objective standards to apply against subjective matters. For example, we have interfered with the private marketplace to the extent that in the private marketplace a patient used to go to the doctor because they knew what his reputation was. You know, he was a better doctor than the other doctor who was in town, and so, therefore, they gravitated to him.

Nowadays, there—and this is the transparency issue in another format, nowadays patients don't know what their Medicare doctor got paid, they get those billing forms, they can't decipher that. Even in the private insurance market all they really know is what their co-pay was and what their deductible might be for the whole year. Nobody knows what providers are being paid for. They have no objective matter of judging the results, and what we are doing is we are saying we are going to transfer the ability to make those judgments to either the government through Medicare, Medicaid, and modifications of the reimbursement system based on results. Certainly I think results ought to be what—good results is what we all ought to be looking for and trying to achieve.

Now, in that regard, Mr. Smith, you referred to the fact the President says we are going to save every family $2,500 a year in their healthcare costs. How do we do that?

Mr. SMITH. Mr. Deal, I think it means moving backwards from where we are because I think what we are—the approach thus far that I have been hearing about is actually going to increase costs rather than lower costs. But I think to start with that a pledge of $2,500, which I think is, that is what is getting the American families interested in healthcare, and I think they expect to deliver on that.

I think we have to change the dynamics of our current entitlement programs. I think that we have to bring about the changes that left to the market will help lower those costs.

As I said earlier, so many times we actually interfere in the market. One of the things, for example, is the tremendous growth in Medicaid and in SCHIP. We have actually taken healthy families and money out of the market. When we did that, we raised the cost for the people who were left in the market. This is the crowd-out affect that we talked so much about in SCHIP.

So I think part of that is to return people back into the market rather than segmenting people off. The beneficiaries I think would benefit that, from that in terms of the continuity of care. I think we unnecessarily drive up costs when you get on Medicaid for the first time, for example, then a child is supposed to go for a checkup. No matter that he just had a checkup a month ago. We are going to insist that we actually drive up the cost of care.

So I think that is a large part of it, and in Medicaid, I mean, we are talking about 45 million lives to put that back into, to put those lives back in the market I think would be at least a stabilizing affect on the market.

Mr. DEAL. Let me ask Dr. Goodman. Would you comment about the same thing? How do we save every family $2,500 a year?

Mr. GOODMAN. Well, all of the proposals that I heard from the healthcare advisors, President Obama, all the items they mentioned have been costed out by the Congressional Budget Office, and CBO says there will not be savings in these programs. These are all to my opinion demand-side attempts to try to change how doctors practice medicine. As I said in my testimony, I don't believe you can have great savings coming from the demand side of the market. We need to free the doctors and the hospitals. They know where the waste is. They know how efficiency improvements can be made, and we need to give them an incentive to do so.

And that, I think what that means is empowering the secretary to allow every hospital to come to Medicare and have a different deal, have a different arrangement. Readmissions—let the hospital have a warranty and so Medicare doesn't pay for the readmission. But we have to pay more for the initial surgery, and we should be willing to do that because a warranty is worth something.

Mr. DEAL. Are some the stark anti-kickback provisions an impediment to doing exactly some of those things?

Mr. GOODMAN. They are huge impediments. They may be doing some good, but they do a lot of harm, and so if we are going to renegotiate and let the providers come forward and say we want to be paid a different way, there has to be a way of getting around those stark restrictions.

Mr. DEAL. Thank you.

Mr. GOODMAN. That is essential.

Mr. PALLONE. Thank you.

The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman.

Dr. Skinner, your data that shows the variations by region is astonishing, and I am very sensitive to it coming from the State of Florida. South Florida is just infamous. So that we have high-spending regions and low-spending regions, and we can't really explain this by the difference in illness or prices. There is no guarantee the folks in south Florida are getting, you know, much better quality of care.

So I am particularly interested in your finding that the lower-spending regions rely on primary care physicians to a greater extent. Can you give us a few examples of this and why do you think primary care is more available, or is it more widespread in those regions? Is it simply that in those regions people need more, they have access to a better workforce? Could you lay that out in some detail?

Mr. SKINNER. Great question. I think understanding where physicians settle is—and where they decide to live and decide to practice is a fascinating but as yet somewhat not well understood question, because there is a free market in where physicians go.

But it seems to be that in, I guess it seems to be that the approach of the primary care physician is to look at an individual and to think there may be, for example, for chronically-ill patients, there may be different organs which are failing, but let us think about how we can coordinate that care and think about treating the individual.

Whereas I think sometimes the emphasis of a specialist is on that part of the body to which they are most highly trained to understand, and in many cases you want to have a specialist on the job, but I think it can also lend to a large number of—in regions with lots of specialists you can get many, many people treating the same—many different physicians treating the same patient. And there are these what economists actually call network externalities in which I may be doing something as a physician which I think is best for my patient, but I don't know what all of the other physicians are doing as well, and sometimes the things I do may interact with what they day, resulting in not better outcomes.

And so I think that is the best way I can think of to explain why in some areas, even within Florida, which is sort of a microcosm of these variations, you can find some regions where lots of people are being treated by multiple physicians, but they don't seem to be doing any better.

And obviously there is a balance. You need to have specialists in any system, but, on the other hand, in some sense you also want this idea of a medical home where somebody is coordinating all of that care.

Ms. CASTOR. And Dr. Cassel, I have met with a number of physicians, and they will share cases where a patient has come in and gotten a diagnosis and gotten tests, but they want a second opinion, so they go into another physician, they get another set of tests. They go another place. Is there—there must be some answer to controlling, you know, if we are going to have, encourage a medical home but you still want patients to have some flexibility, but there must be something we can do in cost structure and reimbursement structure.

What do you recommend?

Dr. CASSEL. Well, thank you for that question. There is, indeed, and the medical home concept and the accountable care organization actually are linked, because they have to do with giving somebody the accountability to make sure that that coordination happens.

So, for example, the patient with many complicated illnesses who is seeing ten different specialists, and those specialists don't communicate with each other, could be taking medications that interact, they could be missing major things, you could end up in unnecessary hospitalizations and readmissions, et cetera. So, you know, you can actually make a patient sicker by too many doctors.

Now, on the other side of the coin, the point that you point out, which is that the informed patient, it is a good thing that patients are asking for second opinions in my opinion. I think that is what we want patients to do to be asking of a surgeon how many of these procedures have you done and what is your complication rate, et cetera. And particularly in the diagnostic arena to making sure that they get the right diagnosis. I believe physicians ought to be open to that, and they ought to welcome that.

In a well-functioning system, though, you would have an electronic record, and you would have relationships with those specialists where you wouldn't need to do the same test over again just to get another doctor's opinion. You would share your records with the other doctor, and why should they have to order the same test

all over again? Put the patient not only to the expense but to the risk that every medical intervention entails.

So I think you can create an accountability system around this. Part of the problem with both of these notions we are trying to solve is that 50 percent of the physicians in the United States don't practice in Geisinger or Mayo. They practice in single, solo practice or very small practices where they don't have that connectedness with their colleagues. We need to create some incentives for them to do that and to share records and to share the wellbeing of the patient around organizing that patient's care.

Mr. PALLONE. Thank you.

Gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

Dr. Goodman, as you know, I am sure many large employers are feeling the brunt of ever-rising healthcare costs, and many companies such as Safeway among others have created innovative ways to lower costs and improve health.

Unfortunately, because many small employers fall under HIPAA requirements they are not able to take advantage of this same opportunity. I would like to know your thoughts on this. Should we change HIPAA to let small businesses take advantage of these opportunities? If so, you know, how would you change the law?

Mr. GOODMAN. I think we should, and in particular I think we need some pretty important changes in how we deal with the chronically ill, because that is where most of the money is spent. And we need to be able to—employers need to be able to make risk adjustment deposits to the accounts of the chronically ill so the diabetic patient, for example, can manage his own money or the asthma patient can manage his money. A lot of care can be managed by patients in their homes. A lot of care can be self-managed, but if we are going to ask patients to manage their own care, they need to be managing the dollars.

To make that possible you need for the employer to be able to give different amounts of money to different employees, depending on their condition. And we also need a change in health savings account rules so we can get rid of this idea of a deductible. We need to just carve out areas of care and say the patient is going to be responsible for certain things. We are going to put money in the account so he can do it.

And the model for this, interestingly enough, comes from the Medicaid Pilot Program, Cash and Counsel, which is, I think, now in all 50 states. It is hugely popular; patients like it, and I haven't heard a single criticism of it.

So that needs to be done, and we need clarification from Congress on what employers can do, the large ones as well as the small ones.

Mr. PITTS. You also advocate making insurance portable. I believe—how would you or how would allowing people to purchase insurance across state lines at cost, do you believe that, you know, the people can choose the plan that best fits their needs or they need help? How would you change it?

Mr. GOODMAN. Well, I do think we need a national market for health insurance, and of the two questions you asked that is the

easier one. Just let insurance sell across state lines the same way life insurance sells across state lines.

The harder issue and the far more important one is how do we make health insurance portable, because I think that is the next really big issue is healthcare, and in some ways for employers the sick patient is like a game of musical chairs. And it is intolerable for the employer, it is not good for the employee.

So much better if employers could make a fixed dollar contribution to a plan that is owned by the employee, which he takes with him from job to job. It travels with him through the labor market, and we proposed a way to do this for the State of Texas, Blue Cross of Texas, and we think it is one way to do it nationwide. Probably I would let the states experiment with ways to convert the small business, small group market into a market for portable care, but that is really, really important, and I think portability is maybe the most important healthcare issue that you all are you looking at.

Mr. PITTS. How about risk pooling?

Mr. GOODMAN. Well, you know, the risk pool is there because we are failing on affordability side, and we are always going to need a risk pool if somebody falls through the cracks and for some reason doesn't have insurance, has health problems, and so that is a way to get health insurance to those people.

But if you are in a system where you are insured, and you stay insured, and you take your insurance with you, you don't—you will never need the risk pool. So the risk pool should be there, but they should be used infrequently.

Mr. PITTS. Thank you.

Mr. Smith, could you speak as to the issue of government plans competing along with private plans and your thoughts on that?

Mr. SMITH. Yes, sir. I think it is an oxymoron. Government plans can't compete against the private plans because sooner—then eventually there will be no private plans, because the government plan will eat them all up. There is—it is not a level playing field between government being a competitor in there where it can control benefits, it can control how much somebody is paying, et cetera. All of the advantages are on their side of it. They clearly would want to advantage itself, and it would create the rules to do so.

So eventually the private plans would not be able to compete. So we would end up later, if not sooner, under a government plan, which I think would be a huge mistake. We have seen experiences of government plans, and I think that the private sector—and when there is real competition and I had mentioned earlier, I think part of our problem is we keep interfering with the competition and say we don't want competition in many respects. Whether it is specialty hospitals to where doctors can go out and form a group and provide a superior process, government comes along and says, no, we don't want you to do that. In many respects we don't want competition against our community hospitals, so we change the rules and bend the rules to advantage somebody else.

So fundamentally I think there is not a level playing field when a government plan is involved.

Mr. PITTS. Thank you. I see my time is up.

Ms. CAPPS [presiding]. Thank you.

Now I turn to Mr. Sarbanes of Maryland for your questions.

Mr. SARBANES. Thank you, Madam Chair. Thank you all for your testimony. There are two geriatricians I think at the table. I spent 18 years working with seniors in the healthcare arena, and so I am very focused on that. Also, I have a district that includes one of the most rapidly aging populations in the country in one portion of it.

So on the question of the workforce, specifically today if you were trying to encourage somebody to go into that line of work, what are three or four or five things that you would offer them, that you would change that you think would incentivize them to pursue that kind of a career?

Dr. Cassel and Dr. Avorn.

Dr. CASSEL. Thank you, Congressman Sarbanes. Great question and particularly at this time where all of these models of reform are based on the idea of not just better outcomes but also more efficiency. You are going to have to have somebody who really understands that complexity of the science based and the evidence base and all the skills of working with a team that, as you know well, geriatric medicine involves.

Right now—so the answer is how do you create those incentives? I would say value, respect, and doability, and so value really is reimbursement. I mean, there is—geriatric medicine is now the only subspecialty I know of internal medicine, you know, we have internists who train and they become cardiologist, and they become critical care specialists, and every time they get an additional training, they make more money. In geriatrics after you do your internal medicine training, you get more training in geriatrics, and you make less money than the internist makes. And so it is amazing anybody does it at all. But the few dedicated people who do it do it because they really find huge rewards in that, and it makes sense to them that the aging population needs this.

So we have to find a way in the payment reform discussions to appropriately value that additional training and that additional skill, and I think there is lots of ways that we can do that, and I would be happy to talk with you and the committee staff more about that.

And the second is respect, and you might find it odd that I put that in there, but I think Dr. Avorn can reinforce this that within the medical profession part of how you are respected is kind of by what the public thinks and what you are paid and that value equals something, some combination of that. And if other specialists really believe that what you bring to the table adds value, then that adds a lot to the respect. Right now it is such a small and in some ways embattled specialty that most specialists don't have any experience of working with a geriatrician, they don't know how, what that can value. The people who understand this now are aging baby boomers who have gone through this now with their parents, and if they can find a geriatrician, they say, oh, my God. I didn't know they made doctors like that.

Mr. SARBANES. Uh-huh.

Dr. CASSEL. So we somehow need to create systems, an accountable care organization might be one example of that, where there would be a defined role for that person really taking advantage of their skills, taking care of the most-difficult patients and the most challenging patients. So that is the second thing.

And the third is doability, and this gets back to delivery redesign as well, because right now in the fee-for-service system, in order to actually even just make the expenses of your practice and take home a reasonable salary to support a family, most geriatricians who are in private practice are doing things like Botox and you know, laser skin surfacing, because of what Medicare pays them for that complicated coordination of care, helping that patient and family find ways to stay out of the hospital, stay out of the nursing home, keep themselves as functional as they can with their Parkinson's Disease and all of their conditions, nobody pays them to do that.

Mr. SARBANES. Right. Right.

Dr. CASSEL. So instead they are wasting all that training doing Botox. So that is a real misuse it seems to me, so I think it actually wouldn't be that hard to do within some of the things that I know the committee is considering within the payment reform.

Mr. SARBANES. Thank you. We just have a few seconds left, Dr. Avorn, if you want to add anything.

Dr. AVORN. Yes, sir. Just very briefly, my answers are exactly parallel to Dr. Cassel's. It has a great deal to do with reimbursement. Students come into medical school wanting to be primary care doctors, take care of the elderly, deal with chronic disease, and they come out of medical school looking for residencies in dermatology and plastic surgery. It is because they see their role models and the people who are doing well and being rewarded by the system, both public and private, are the folks who are doing procedures. And the doctors who are simply taking care of chronically-ill people are reimbursed in a manner that makes it virtually unaffordable to do that kind of work.

So I think Medicare and Medicaid, as well as the private systems could do a great deal in moving from a procedure-based reimbursement system, particularly invasive procedures, and toward a comprehensive care of the patient kind of system. And we have heard about that for a number of ways today.

And then the last point is it also would help if we had a healthcare delivery system that was structured so that the geriatrician like the primary care doctor didn't feel that he or she was out there waving in the breeze. If there was some integration of the system so that one was really part of the care network as opposed to somebody out there in left field, that would also make it a little bit easier to do what is probably the hardest job in medicine and the least paid, well paid.

Mr. SARBANES. Thank you. That is a great point, and I know Congresswoman Capps and I are very focused on school-based health centers with respect to children, but there is also delivery models you can pursue with respect to seniors, community-based clinics, where do we reimburse, et cetera, that I think can advance the ball so——

Dr. AVORN. Absolutely.

Ms. CAPPS. Thank you.

Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, and thank you all really. It has been a fascinating discussion this morning. I have got a number of questions I want to ask. If I interrupt you during your answer, it is not

because I am being rude, but I do have a lot of things I want to get through.

First, Dr. Skinner, I want to talk just a little bit about the accountable health organizations. I spent a fascinating morning in December down at the Center for Health Transformation talking to four of the clinics that have participating in the physician group practice demonstration project where they are talking about things that sound very similar to the accountable care organizations. In fact, one of the things that came up on the discussion was rehospitalizations and giving someone a hospital, I mean, a doctor's appointment with a primary care physician within 5 days of their discharge from hospital for decompensated congestive heart failure, resulted in an almost disappearance of the rehospitalization. So a very low-cost activity with a very high yield on the other end. So clearly these are areas that it is incumbent upon us to explore.

One of the things that came up, you know, how do we force doctors into these types of practice models, and I am not a big one for forcing, so I put forth another idea, and I would just like to get your thoughts on it.

Medicare, of course, is a federal program. It is not a state program. It runs across the country. If we have groups that conform to all of the parameters set forth for accountable care organizations and granted, this will be flexible, and this will change over time, but if we have groups that are willing to do that, the doctors within that group, could they, if they were offered protection from liability under the Federal Claims Act like we might do with a federally-qualified health center, it seems to me that is a way to bring doctors into that type of practice. In fact, you might see accountable care organizations set up just to see Medicare patients so that they would be provided that cushion from liability.

Do you think there is, that that is an idea worth exploring?

Mr. SKINNER. Absolutely. I think that that is a win, win. I think, I don't like to think about forcing doctors into ACOs, but I think there is also this, that many physicians are concerned about SGR payment cuts, and that is another way to incentivize maybe making it worth physicians' while to start thinking seriously about whether there is a potential for an ACO in their area as well.

But the more that these organizations grow up, spring up out of existing physician hospital networks the better.

Mr. BURGESS. Let me go on. Dr. Cassel, I wanted to ask you just a couple of questions. Actually, it relates to some testimony Dr. Skinner gave about the high cost of end-of-life care, the amount of money we spend within the last few weeks of a person's life with not really being certain that we are doing much to provide value.

Now, Dr. Smith talked about how we do sometimes do things, and we make ourselves do things that aren't necessarily a good return on investment. When we did the Medicare Modernization Act, we required that everyone coming into Medicare now have an EKG on their welcome to Medicare physical, even if they have had an EKG just a year or two before for—in conjunction with a surgical procedure.

What if we were to offer, not require, but offer an educational module on advanced directives on that welcome to Medicare physical. We could do it right after the EKG, in fact. The patient is

there, putting their clothes back on, and could have this educational module. Sure, pay the doctor, pay the gerontologist for their expertise in proving this education, maybe even incent the patient with some sort of break on the part B premium or some other thing of value that we could return to them.

But what do you think about exploring that as an opportunity for getting more people into thinking about planning for what happens at end-of-life care?

Dr. CASSEL. That is a very interesting idea, Congressman Burgess, and I think I would like to consider it with you. I think that it is—I could imagine the physicians not exactly liking that idea for most healthy, you know, let us remember the Medicare age group between 65 and 85——

Mr. BURGESS. It is the new 40.

Dr. CASSEL [continuing]. Most are very healthy.

Mr. BURGESS. Well, they are getting the Botox.

Dr. CASSEL. And yes. They are the ones there for the Botox. That is right. So they might be kind of put off by that, like why are they doing, why are they making me look at this.

Mr. BURGESS. Again, it is not a requirement but an offer.

Dr. CASSEL. Right, but an offer, there are very good models of shared decision making, and, again, the group at Dartmouth has been very involved in these and others as well that show that when patients have all of the information and interact with their caregiver around that information, they make, they almost always make more conservative choices about their care.

Mr. BURGESS. I am going to interrupt you, but I have one last thing I want to get to, and I do want to work with you on that concept

Dr. CASSEL. So it is a good idea.

Mr. BURGESS. What about the concept, we had some other testimony earlier in the past couple of weeks regarding Alzheimer's Disease, and if you look at the numbers, if people are correct in some of their projections, the numbers are just absolutely staggering from a public health cost. You talked about the gerontologist being out there kind of on their own and sometimes it is a lonely existence.

But with the interconnected world in which we live and we are constructing, what would be the—would there be an opportunity for creating essentially a virtual center of excellence for the long-term management of the Alzheimer's patient, perhaps even considering some early diagnostics with things perhaps we can do with genomics, the monoclonal antibodies offering some, perhaps some real choices for early treatment.

Is there a place in what we are looking at in the road ahead for developing this type of virtual center of excellence so that the practitioner is not kind of left out there by themselves on this?

Dr. CASSEL. So this is, this would be a clinical center, not necessarily a basic research center?

Mr. BURGESS. Well, certainly you could have a physical basic research center, but a lot of practitioners who are in medium-sized communities may have a population of say Alzheimer's patients within their larger sphere of patients.

If they could link in with other practitioners in a virtual center of excellence, Alzheimer's patients are not likely to require surgery to improve their condition——

Dr. CASSEL. Yes.

Mr. BURGESS [continuing]. But the medical management, the long-term management is really so critical.

Dr. CASSEL. And much of the reason is that geriatricians as Mr. Sarbanes pointed out are not widely available, so you don't even have that expertise, and many physicians don't know what to do, they don't pick up early symptoms of Alzheimer's Disease, and you know, so—and if they do, they are not sure what to do about it.

Mr. BURGESS. Right.

Dr. CASSEL. So—and they may prescribe medication unnecessarily, et cetera. So I think it is a wonderful idea. As you may know, I was part of the Alzheimer Study Group with Newt Gingrich and Bob Carrey and Justice O'Connor and others.

Ms. CAPPS. Dr. Cassel.

Dr. CASSEL. And that was one of our recommendations was that there be resources for community providers.

Mr. BURGESS. Right.

Ms. CAPPS. Thank you.

Mr. BURGESS. Let us work on this. Thank you.

Ms. CAPPS. Thank you. And I recognize myself now for 5 minutes.

I will start with you, Dr. Avorn. Because you speak a great deal about comparative effectiveness, and it has been a pretty hot topic around here. I am particularly interested in your comments about translating information into better patient care decisions, and I wondered if you would mind using my piece of legislation, a bill I have introduced, as an example.

It is called the—and it is an acronym, Heart for Women Act, and among other things it would require the FDA to collect and make available information about how drugs and devices work differently in patients of different sex, race, ethnicity, so forth. The goal being that a health professional could determine which drug might be most effective in their particular patient.

Could you explain how this might be helpful for effective, comparative effectiveness research and why it is important that we have a data collection or information like this for quality of care and outcome?

Dr. AVORN. Sure. Right now we have a perhaps efficient, perhaps skimpy approach to approving drugs such that if it is better than let us say a dummy pill over a brief period of time in healthy or people that we know will take it in achieving perhaps a lab test change instead of a clinical change, the drug gets approved. That leaves kind of in the dark patients who may be excluded from those trials. Often they are minorities, often they are women, often they are other vulnerable groups, and the elderly, for example, and the doctor faced with trying to care for those people does not have the information from the clinical trials that we would like to be able to really make a scientifically-based decision for that patient, not the patients who are like the ones in the clinical trial.

And so where comparative effectiveness research would help would be that it would make it possible to fund studies that would

zero in on particular at-risk groups. Let us say a group of scientists, physicians, consumers would say, we don't really know enough about the management of let us say congestive heart failure in blacks or atherosclerosis in women or how Asians metabolize drugs differently. And we would identify on the basis of the medical need for the information, studies that could be done——

Ms. CAPPS. May I interrupt to just—I want to move to another topic as well, but would you kind of locate such a place at FDA or it might even be multi-disciplinary in terms of different——

Dr. AVORN. The FDA's job is to approve new drugs and——

Ms. CAPPS. Right.

Dr. AVORN [continuing]. We should have——

Ms. CAPPS. Where would you locate this?

Dr. AVORN. I would locate this in a trans NIH, AHRQ setting, that is a healthcare research, biomedical research entity that would then be able to make recommendations scientifically.

Ms. CAPPS. I hope we can follow up on this topic.

Dr. AVORN. I would be happy to.

Ms. CAPPS. Just opened it up, I know.

I want with the rest of my time to address you, Dr. Cassel, because you spoke a great deal about the importance of coordinating care and the role of the entire clinical team in providing preventative care. That is a very important topic to me.

But so many people talk about a medical home, which is in itself a fairly new phenomenon or label. I would like to propose that we discuss it and talk about it as a health home. When we think of the word, medical, we think of medical doctors and medicine and techniques. Rather I believe we could be talking about the health of the patient as the sort of core, and all of the panoply of health professional involved.

And I wondered if you would sort of give a couple of ideas of how this might work. I am a nurse, and so I am thinking of the different participants on this team and how that might be coordinated, but I also want to have you close by talking about the structure, how the reimbursement would work in such a model.

I am aware that in oncology there is a whole team already, oncology nurses, who deliver much of the care, for which there really is no designation.

Dr. CASSEL. Thank you, and first of all, I completely agree with you. I think that the term medical home grew up in this model from pediatrics, which you are probably familiar with, which was where it first began. And it is to my mind unfortunate because particularly from the perspective of a geriatrician, it is all about the team and things like care coordination function I don't think can actually be done by a solo physician or two physicians in an office with a medical assistant. I actually think—I can't imagine how they could actually effectively do that unless they outsourced it something like that.

So to my mind you actually need this larger team to qualify for being a medical home. Now, that is not in the Medicare demo legislation. There is a lot of reasons why you want to be able to have those small doctor practices.

Ms. CAPPS. If we—I only have a few seconds. If we can demonstrate that this is important, how, I mean, it only will work if people get reimbursed.

Dr. CASSEL. I think there has to be some kind of bundled or global payments rather than—because right now Medicare pays for doctor, and you couldn't have Medicare pay every different health professional and still have that add all out to everybody being accountable for working as a team. We know this from private industry. If you want to have people work as a team, you pay them as a team, and then you have the team figure out a lot about the reimbursement. So some mixed model that involves some degree of global payment would be my answer.

Ms. CAPPS. Thank you.

Mr. SHIMKUS. Madam Chairwoman, I would like to defer to my colleague, Mr. Shadegg, and then I will take the next one. Thank you.

Mr. SHADEGG. I thank the gentleman for deferring, and I thank the Madam Chairman.

Dr. Goodman, I would like to begin with you. You spent a lot of time in your prepared testimony discussing with how the system isn't working well for doctors, patients, employees, employers, people in the non-traditional workplace, insurers, the uninsured, and I tend to agree with you, and I want to kind of explore that. I want to explore—first of all, I assume the reason that it is not working very well is the structure isn't suited to make it work very well for those people. Is that correct?

Mr. GOODMAN. Yes. It is an institutionalized, bureaucratic, system. It doesn't work like a normal marketplace, and therefore, people don't have the opportunities to improve services and lower costs and raise quality the way they would do in say the market for other professional services.

Mr. SHADEGG. Indeed, it certainly doesn't operate like a normal marketplace, because in this marketplace the consumer of the good doesn't buy the good. That is kind of bizarre, isn't it? I mean, I am the consumer of my healthcare, I am the guy that goes and sees my doctor, I did over the Christmas break, went and saw a doctor, but I didn't hire that doctor, and I didn't hire the plan that hired that doctor. I just signed up to work here at the Congress. Is that a part of the distortion of this marketplace, and is there even a marketplace in healthcare?

Mr. GOODMAN. Well, that is the fundamental cause of the distortion. As I said earlier in my testimony, it is also the fundamental cause of the distortion of the education market, which has many of the same problems. The entity that benefits is not the entity that pays the bill. There are, if I can just say, there are emerging healthcare markets where third parties aren't involved; cosmetic surgery, lasik surgery, the walk-in clinics, the concierge's doctors. All of those areas are where the market is working well. You have price transparency, you have price and quality competition.

So if we contrast those two markets, you can see radial differences.

Mr. SHADEGG. I would argue the problem we have in the current healthcare market for most Americans is that it is all controlled by third parties. I am a ploy or one just kind of pawn being moved

around, and my doctor is one also, and the whole thing is being controlled by my employer, who doesn't really care too much about, you know, he would like me or she would like me to have a good healthcare but that is about it. And then by the plan that my employer buys.

I sent my staff an e-mail a little while back where I said, oK. Let us assume that going to work in Congressman Shadegg's office meant that Congressman Shadegg was going to provide you free lunch every day. And I supposed that for one of my employees I would go buy him a ham sandwich every day, and for another one I would go buy them a salad. The problem is that the employee that I bought the ham sandwich for actually hates ham, and the employee for whom I bought the salad can't stand salads.

That is kind of the way the market, the so-called healthcare market works, isn't it?

Mr. GOODMAN. Well, that is why I entitled those sections free the doctor, free, the patient, but also free the employer. He is not happy with this either.

Mr. SHADEGG. He is not happy with it. We have a situation—I think the problem in healthcare in America today really comes down to two things. The uninsured, and I think we need to cover them all, every single one, and I have drafted a bill to do that, and cost, and costs are spinning out of control.

I kind of drew this up. Here are the costs of inflation in our society, and here are the costs of healthcare or health insurance. Health insurance is rising exponentially faster or health costs or rising exponentially faster than any other area. Right?

Mr. GOODMAN. Twice as fast as income growth. And by the way, it is not just the U.S. problem. That is happening all over the developed world.

Mr. SHADEGG. Including places, other places where they have divorced the consumer from——

Mr. GOODMAN. Everywhere all over the——

Mr. SHADEGG. I just have a question for you. In auto insurance I happen to note that I can't go home one evening and watch TV and not see two, three, four, five auto insurance commercials where the little gecko comes on and says he wants my business or the State Farm guy comes on and says he wants my business. But I note that I never see a commercial like that from United Healthcare or any of the healthcare companies.

Is that related to this problem?

Mr. GOODMAN. Well, I do see some insurance commercials, but these are commercials for buying insurance in the individual market. They are not commercials for group insurance.

Mr. SHADEGG. And what percentage of the American people get their healthcare in the individual market?

Mr. GOODMAN. Well, less than 10 percent.

Mr. SHADEGG. And what does the government tax policy do to those people?

Mr. GOODMAN. It discriminates against them. If you are self-employed, you get to deduct your premium, but you don't get relief from the payroll tax, and if you are just off on your own, you get virtually no tax relief.

Mr. SHADEGG. You get smacked. You get smacked right in the face. You get told, well, you can buy health insurance, and we think you should because we really don't want you to show up at the emergency room where you can get free care, but since we have told you we want you to go get health insurance, we are only going to charge you one-third more for it, roughly one-third more for it, because you got to buy it with after-tax dollars. Right?

Mr. GOODMAN. Yes. The uninsured who happen into an emergency room more often than not get charged more than any other payer in the emergency room.

Mr. SHADEGG. How well does a system of that type and the fact we have now where you have divorced the payer from the consumer, and you put these people in-between them, how much would that be helped by substituting the government for where the employer and the insurer or the plan is right now? Instead of having the plan, how much by contrast would it be helped if we made a direct connection between consumers and providers, hospitals or doctors, by allowing people to have the money they need to buy the plan that suited their need?

Mr. GOODMAN. Well, not very much help by the government, because in my opinion the private insurances is almost as bad as government insurance. Half the people in the country are on a government plan and——

Mr. SHADEGG. Fifty-seven percent I hear.

Mr. GOODMAN [continuing]. The private plans pay the same way the government plans pay. So there is really not all that much difference. The markets where you really see a lot of difference are the emerging markets where there are no third-party payers at all, and those are working remarkably well.

Mr. SHADEGG. Kind of like auto insurance where people can buy directly from the auto insurer and get their car repaired.

Mr. GOODMAN. Yes, but I was thinking of markets where people pay directly for care.

Mr. SHADEGG. Good enough for me. Thank you very much. My time has expired.

Ms. CAPPS. Mr. Shimkus for 5 minutes, please.

Mr. SHIMKUS. Thank you.

Dr. Avorn and I am not sure who else talked, and I can get very deeply in this, but I am concerned about this cost-effectiveness issue, and it was raised earlier. What in a cost-effectiveness ratio fighting aggressive cancer for 10 months or allowing the person to die because they have aggressive cancer in 2 weeks? If that was scored out budgetarily, what would cost more?

Dr. AVORN. First I think it is important to distinguish between collecting the information about what works and what is safe for patients and what is a good buy, on the one hand, versus coverage decisions which are really quite separate so that one can imagine collecting the data about which treatments are the safest and the most effective versus their price. That is separate from what Medicare or Medicaid or a private insurer may choose.

Mr. SHIMKUS. Well, let me tell you why I mention this, and because I was, you know, I, like everybody does, we meet with folks, we may have personal relationships of things that are going in everybody lives like this. I talked about my concern of a rationed care

system developing under cost. I was, again, at a student forum, and one of the students popped up and said, you know, well, it doesn't make sense to fight aggressive cancer for 10 months. The cost benefit analysis doesn't score out.

So for us to say that that is not part of a debate which I think eventually we move to—if we don't keep private insurance as a very important option in this country, if we move to a public option which destroys the private insurance, you know, provision and then we go to a one-payer system, that is my concern; a rationed care system which will decide when you get care based upon budgetary aspects. And that is why those of us who are—comparative analysis, cost effectiveness, that is where our concern comes from, and I just wanted to throw that out to talk about that.

And let us just kind of segue, and this will be—I think the chairman submitted this for the record, the New York Times article. Is that correct? On—so my question is going to be related to the Medicare and really segue into Medicaid. One of the provisions that is being discussed here is Medicare for all. And now if you believe this article, doctors are opting out of Medicare, and if you go around your Congressional districts and talk to physicians, this is what we know is occurring. With this growing access to care issues, if we add millions of people to the Medicare system, a Medicare for all, does that help or hurt this problem of doctors fleeing?

Anyone want to comment? Dr. Goodman.

Mr. GOODMAN. It hurts it. What happens now is Medicare is paying below market, let us say 30 percent below market, but not everybody can get below market. If you are a doctor, the first patients you want to see at the beginning of the day are the ones who pay market, and Medicare would be next, and Medicaid, which pays below Medicare, would be at the end of the line.

If you try to put everybody into a system that is underpaying, then you exacerbate the supply side, and yes, it will make the rationing problems worse, and rationing by waiting is not access to care.

Mr. SHIMKUS. Anyone else want to comment? Mr. Smith.

Mr. SMITH. Yes, and in my opening remarks I did suggest that people look at the experience of Medicaid over the past several years which resorts at the end of the day very much to price controls, to where you have access, real access problems for the Medicaid population. One-third of all Medicare ambulatory visits are to the emergency room to an outpatient hospital facility.

So this is where a single payer system ultimately drives you to because you have now overburdened the system. As we have seen in the states, then the reaction to that is to squeeze back against the providers to try to lower the cost that way.

Mr. SHIMKUS. I am sure, did the Medicaid question get asked? Does anyone want to swap their current insurance policy for Medicaid? Did that get asked of the panel? Can we go through Dr. Skinner all the way down? Who would—let us start with Dr. Skinner, and I will end with that question. Would any of you opt out to go to Medicaid over the insurance product that you currently have? You don't need to direct him, Dr. Cassel. Let Dr. Skinner ask—answer.

Mr. SKINNER. I happen to have a pretty good plan, so I was not——

Mr. SHIMKUS. So you would not accept Medicaid as an alternative.

Mr. SKINNER. Everybody is so fortunate.

Mr. SHIMKUS. Dr. Cassel.

Dr. CASSEL. I am not sure why, what is the background of that question.

Mr. SHIMKUS. The question is the debate of if we have uninsured and we provide them access to Medicaid——

Dr. CASSEL. Uh-huh.

Mr. SHIMKUS [continuing]. As an option. Would you personally be willing to give up your current insurance product for a Medicaid—the question is is that a good deal?

Dr. CASSEL. Well——

Mr. SHIMKUS. But the real question I am posing is with the insurance——

Dr. CASSEL. Right.

Mr. SHIMKUS [continuing]. That you personally have, would you trade that if offered Medicaid in a trade?

Dr. CASSEL. No. If I were uninsured——

Mr. SHIMKUS. OK. Thank you.

Dr. CASSEL [continuing]. You bet I would.

Mr. SHIMKUS. Dr. Goodman.

Ms. CAPPS. I don't think we are going to make it through the end of the line.

Mr. SHIMKUS. Well, I think we will. If they would answer the question.

Mr. GOODMAN. Of course not and I wouldn't try to——

Mr. SHIMKUS. Thank you.

Dr. SIGSBEE. I am going to be distinctly different. I would. In my area——

Mr. SHIMKUS. We had one last week that said they would.

Dr. SIGSBEE. And Medicaid pays for all medications. You don't have to have anything out of pocket, so that I would actually. From a provider standpoint, though, Medicaid pays below the cost of providing the service. So it would be——

Mr. SHIMKUS. You might have some access issues then with doctors not wanting to——

Dr. SIGSBEE. Right. You would have some serious access problems, and it would be unsustainable to be in medical practice.

Mr. SHIMKUS. Mr. Smith.

Mr. SMITH. No. In Medicaid there are 56 different Medicaid programs, and in due respect to my colleague here, I mean, there are states that say you can have four prescriptions a month. So you don't have unlimited access to prescription drugs.

Mr. SHIMKUS. Dr. Avorn.

Dr. AVORN. There are 47 million Americans who would say absolutely yes.

Mr. SHIMKUS. No. The question is you.

Dr. AVORN. Well, I happen to be an affluent American who has good——

Mr. SHIMKUS. So your answer is?

Dr. AVORN. I would not want——

Mr. SHIMKUS. Thank you very much.

Ms. CAPPS. And now it is time to say thank you very much. Your—the panelists have been amazing in your forbearance of all the questions, but also your testimony is valuable as we go about making some very important decisions in Congress affecting healthcare. Thank you very much.

We will excuse you and give you a break and ask for our second panel to take places at the table.

In the interest of time we have three of our four panelists, and one will be here shortly. I will introduce the three and then we will ask you to begin, Dr. Ginsburg, and I will introduce Mr. Bachman when he arrives.

We are pleased that you are here with us this afternoon. Paul Ginsburg, President of the Center for Studying Health System Change, to be followed by Dr. Regina Herzlinger, Professor of Business Administration at Harvard Business School. I will jump over to Diane Archer, Director of the Health Care Project, Institute for America's Future.

And Dr. Ginsburg, you may begin your 5 minutes of testimony.

STATEMENTS OF PAUL GINSBURG, PH.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE; REGINA HERZLINGER, PH.D., PROFESSOR OF BUSINESS ADMINISTRATION, HARVARD BUSINESS SCHOOL; RONALD BACHMAN, F.S.A., M.A.A.A., SENIOR FELLOW, CENTER FOR HEALTH TRANSFORMATION; AND DIANE ARCHER, J.D., DIRECTOR, HEALTH CARE PROJECT, INSTITUTE FOR AMERICA'S FUTURE

STATEMENT OF PAUL GINSBURG

Mr. GINSBURG. Thank you, Madam Chairman, Mr. Deal, and members of the subcommittee.

Ms. CAPPS. You might want to turn on your microphone and pull it a little—there.

Mr. GINSBURG. Appreciate the invitation to testify on price and quality transparency of healthcare services.

In theory, more information on provider prices and quality can lead to lower prices and higher quality. Those consumers who choose differently will benefit, and if enough people make different choices, providers will be motivated to reduce their prices and increase their quality, extending the benefits beyond those acting on the information.

But today the reality does not line up well with the theory. Few consumers use such information to make choices. The tools to measure and communicate price and quality information are primitive at this point, and most consumers are not incentivized to consider price and not aware of the variation in quality among providers.

Focusing first on price transparency, the key factor limiting the potential impact today is the lack of incentives in today's insurance benefit designs. There is little reward for choosing lower-priced providers, and this is even a problem in high-deductible plans with savings accounts. Much of the information that is available to consumers is not in forms that they can use. Hospital care is not

priced in units that are meaningful to patients such as per stay or per episode. Some information now provides ranges per episode, which is progress.

The same issue with physicians. Fee levels do not provide insight into what services will be provided, and information that state governments and the Federal Government has provided are not reflective of people's health insurance. Also, there is a legitimate unwillingness by consumers to choose providers on the basis of price when they have little, if any, information on provider quality.

There are some risks of unintended consequences of additional price information. For one, if the information discloses contracts between hospitals and insurers, this risks driving up prices. This is an accepted perspective and anti-trust policy throughout the world that when markets are highly concentrated, disclosure often leads to higher prices.

And another unintended consequence is that some consumers, particularly those who don't have incentives to look for lower prices, will use price as an indicator of quality and go to the higher-priced providers.

There are opportunities to do better. If we reform provider payments, this would create much more meaningful prices for consumers to respond to. Now, insurer high-performance networks can be seen as a first step in this direction, although success has been limited by the use of different measures by difference insurers and lack of engagement of physician leaders. Information on charges by out-of-network providers and on what insurers pay for these services can be helpful. There are large differences in what patient pays between in-network and out-of-network providers, and the database to be developed in the State of New York will support an important increase in transparency about out-of-network care.

Now, quality transparency is much more challenging than price transparency. The measurement is very complex. Much of the measurement of quality these days is based on processes rather than outcomes because of such limited data on outcomes, and processed measures of quality are inevitably going to be limited by our lack of knowledge about effectiveness. We need to know what processes really do improve outcomes.

Providers are a key audience for quality information so that even if consumers don't use it, there is a lot of potential with providers. They are highly responsive to quality measurements, and they take steps to improve quality even if there is no pressure from consumers. And the example that Dr. Sigsbee on the first panel mentioned in his practice is a great example of the phenomenon.

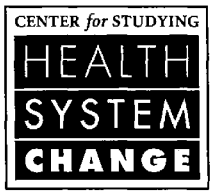
There are important roles for governments in advancing quality transparency in addition to the reporting that governments are doing now. They can convene provider leaders and insurants who agree on common measurements. This would enhance the credibility of measures to providers and also avoid excessive burden on providers from multiple reporting requirements.

Sponsoring effectiveness research to strengthen, will strengthen the ability to assess quality, and there is potential for the private sector to analyze and communication the public data such as trusted not-for-profit organizations like consumers' union or commercial data vendors like Web MD.

In conclusion, transparency has the potential to increase the value from our underperforming healthcare system, but benefits are probably very small now, but there is potential to increase in the future. But we could lose in pursuing transparency by overselling its potential and deluding ourselves that other steps to increase the value in healthcare are not needed.

Thank you very much.

[The prepared statement of Mr. Ginsburg follows:]



Price and Quality Transparency of Medical Services

Statement of Paul B. Ginsburg, Ph.D., President
Center for Studying Health System Change (HSC)

BEFORE THE U.S. HOUSE OF REPRESENTATIVES
Committee on Energy and Commerce
Subcommittee on Health

Hearing on Making Health Care Work for American Families:
Saving Money, Saving Lives

April 2, 2009

Statement of Paul Ginsburg, Ph.D., Center for Studying Health System Change, Before the U.S. House of Representatives, Energy and Commerce Subcommittee on Health, April 2, 2009

Chairman Pallone, Representative Deal and members of the Subcommittee, thank you for the invitation to testify on price and quality transparency of medical services. I am Paul B. Ginsburg, an economist and president of the Center for Studying Health System Change (HSC), a nonpartisan health policy research organization funded in part by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research, Inc. HSC's mission is to track and analyze changes in the financing, organization and delivery of health care and the impact of those changes on people. HSC conducts and analyzes periodic surveys of households and physicians and site visits of a representative sample of communities. HSC has conducted research on health care price and quality transparency for many years, with funding from the California HealthCare Foundation, the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation.

Turning passive patients into active consumers who factor cost and quality into decisions about which doctors or hospitals to choose and which treatment options to pursue remains an elusive goal in the U.S. health care system. Despite well-intentioned efforts in recent years by government, employers, health plans and others to foster health care price and quality transparency, most Americans still choose doctors and hospitals the old-fashioned way—they rely on recommendations from friends and families and physicians.[1]

Despite extensive evidence that the quality of U.S. health care is uneven at best and that Americans pay more for health care than citizens in any other industrialized nation with worse results,[2] health care price and quality transparency in the United States has yet to capture a significant consumer following.

On the cost front, insured Americans face few incentives to consider price when choosing providers because they typically pay the same out of pocket if they use an in-network provider. On the quality front, few consumers believe that quality differs significantly across providers and that these differences can have serious—even life-or-death—consequences. For public and private payers seeking to encourage consumers to use quality information when choosing physicians, hospitals and other providers, a critical first step is to raise consumer awareness of the existence and serious implications of provider quality gaps.[3]

If consumers come to believe that ignorance of provider quality can be hazardous to their health, then there will be a much firmer foundation on which to build transparency initiatives that help patients choose providers wisely and inspire physicians, hospitals and other providers to improve their performances.

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[1] Ha, Tu, and Johanna Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, Research Brief No. 9, Center for Studying Health System Change (December 2008).

[2] McKinsey Global Institute, *Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, (December 2008); Anderson, Gerald F., and Bianca K. Frogner, "Health Spending in OECD Countries: Obtaining Value Per Dollar," *Health Affairs*, Vol. 27, No. 6 (November/December 2008).

[3] Hibbard, Judith J., and Gregory L. Pawlson, "Why Not Give Consumers a Framework for Understanding Quality?," *Joint Commission Journal on Quality and Safety*, Vol. 30, No. 6 (June 2004).

The move toward greater transparency in health care reflects the confluence of two major trends. One is a development throughout society that institutions need to conduct themselves in a more open and accountable manner. The other is the health care consumerism movement, which envisions consumers assuming more responsibility for and control over their health and health care. To move from the vision of health care consumerism to reality will require credible and accessible information on a wide range of issues, from evidence on what diagnostic and therapeutic strategies are effective to how providers compare on dimensions of cost and quality.

Unlike price transparency, where consumer needs vary greatly depending on whether they are insured or not, and if they are insured, how their benefits are structured, theoretically all consumers can benefit from the same information on the quality of care provided by individual physicians, medical groups, hospitals and other providers. To that end, the potential audience for credible, understandable and actionable health care quality information is significant.

Policy makers on both sides of the aisle believe that more information on provider prices and quality could lower costs and improve the quality of care. But there are striking differences among policy makers about the magnitude of the near-term and longer-term potential of greater transparency in health care. I continue to be concerned that the promise of transparency is being oversold and overhyped by some, creating the illusion that other steps need not be taken to address our country's serious problems with health care affordability and quality. Increased transparency is, in most cases, a good thing, but increased transparency alone cannot remedy the underperforming U.S. health care system.

PRICE TRANSPARENCY

In theory, price transparency is a powerful tool. Consumers could save money by using price information to choose a lower-priced provider. If enough consumers change providers on the basis of price, providers that lose patients will be motivated to reduce their prices, in many cases by increasing efficiency. This market dynamic could benefit many additional consumers—even those that don't consider prices when choosing providers.

But many factors limit the potential of price competition for medical services. Most insured people have benefit designs that do not reward choice of lower-cost providers. Modest-sized deductibles and copayments of any size mean that what the consumer pays does not vary by the provider used. Coinsurance, which is becoming a more significant feature of benefit structures, provides some incentive to consider provider prices, but price differences are typically diluted by the 70-80 percent of the bill paid by insurance. Even very large deductibles are typically exceeded by most hospitalized patients, and out-of-pocket limits blunt the incentives of coinsurance. Indeed, we know that over a year, 10 percent of persons account for 70 percent of spending, meaning a large portion of medical spending is probably accounted for by patients beyond the influence of these price incentives.

Much of the price information available to consumers is not provided in a useful and actionable form. A patient contemplating a knee replacement does not want to know the price of each service that will be provided in the hospital, but rather the total cost of the procedure, including the hospital stay, physician services and any needed rehabilitation after discharge. Fortunately,

efforts to provide hospital price information have evolved from lengthy price lists to ranges of costs per admission for a small number of common procedures. Likewise, the individual price of a physician visit or other service is not very helpful to consumers because the cost of physician care varies both by the number of services provided and the price of services. A physician can have low fees but be an aggressive prescriber of diagnostic tests, especially those that can be provided by her practice.

Many state governments and the federal government have attempted to provide information to consumers on price. This tends to be irrelevant to the large majority of insured consumers, where what they pay depends on their benefit structure and the prices that their insurer has negotiated with providers. Even those without insurance are increasingly offered discounts by hospitals that are unlikely to be picked up in these data. Sometimes, the data are simply not accurate enough to be useful. An effort by the state of Florida to provide retail prices of common prescription drugs at retail pharmacies was hobbled by incomplete data.[4]

Lack of Quality Transparency Hinders Price Transparency

One of the most significant barriers to the effectiveness of price transparency is the limited information available on provider quality. People are understandably reluctant to choose a provider on the basis of price when they do not have sufficient quality information. Although consumers are used to making trade-offs between price and quality when buying many goods and services, few are willing to do this when their health is at stake. Indeed, with experience outside of health care that lower prices are often associated with lower quality, many consumers will be reluctant to choose the lower-cost provider without assurance that the quality will not be lower. So the impact of price transparency is likely to be limited by the state of quality transparency, which, as I discuss below, is improving but still rudimentary and not very consumer-friendly.

Consumer attitudes about the relationship between quality and price underscore a potential unintended consequence of greater price transparency. Some consumers will see price as an indicator of quality and shift toward higher-priced providers—the opposite of the intended effect. This risk is greatest at the present state of price-transparency development because current benefit structures don't discourage using higher priced providers—patients typically pay the same out of pocket whether they use a low- or high-cost provider—and there is little useful information available on provider quality.

Too Much Transparency Can Lead to Higher Prices

Another unintended consequence of price transparency is the potential to impact market dynamics in a way that leads to price increases. It is well known in U.S. and international antitrust circles that in concentrated industries, price transparency can lead to higher prices.[5] When prices are posted, sellers know that price cuts are more likely to be matched by

[4] Tu, Ha T., and Catherine Corey, *State Prescription Drug Price Web Sites: How Useful to Consumers?*, Research Brief No. 1, Center for Studying Health System Change, Washington, D.C. (February 2008).
[5] Ginsburg, Paul B., "Shopping For Price In Medical Care," *Health Affairs*, Web exclusive (Feb. 6, 2007).

competitors, so the opportunity to raise revenues by cutting prices and gaining market share is diminished.

To avoid disclosing negotiated prices directly, some insurers have developed tools to allow enrollees to estimate their expected out-of-pocket costs for a number of common inpatient and outpatient procedures and diagnoses. These tools typically bundle the physician costs, facility costs, anesthesia, labs and other ancillary services for an episode of care. For example, the Anthem Care Comparison demonstration tool provides this information based on negotiated provider payments for common procedures at in-network hospitals and outpatient facilities by geographic area. The tool also has a guide instructing consumers how to apply the specific copayment and coinsurance provisions in their benefit structure, allowing them to estimate their out-of-pocket costs at different hospitals or outpatient facilities.

The state of New Hampshire goes the farthest by publishing data on per episode hospital costs specific to each of the major insurers in the state, although its initiative is controversial because of the risk that hospital access to insurer-specific payment information could lead to higher prices. HSC is beginning a study of this initiative to examine market responses to the price transparency.

Physician Ranking Programs

Many national insurers have developed physician ranking programs, or some type of narrow, tiered or high-performance provider network. The underlying premise of these initiatives is to measure physician performance based on quality and cost metrics that can be assessed using plans' claims data and making the results publicly available to enrollees. Most often, the results are used only to inform consumers; in some cases, consumers have incentives, such as reduced copayments, to use the higher-performing physicians.

In these programs, quality and efficiency improvements are achieved to the extent that patient volume shifts to higher-performing physicians as a result of changes in physician referrals and consumer choices and lower-performing physicians improving the care they provide. These initiatives have been limited by fragmentation in the insurance marketplace. With each insurer developing its own methods for classifying physicians and having only its own claims data to draw on, the effort has not been credible with physicians.[6]

There are a number of opportunities for government and insurers to make price transparency more effective. For example, if insurance benefit designs emphasized incentives for choosing lower-cost providers, price data would become relevant to many more consumers. And if insurers, including Medicare, pooled claims data on physician performance and used common measures and protocols to designate physicians as higher performing, a much more accurate assessment of physician performance would be possible.

[6] Draper, Debra A., Allison Liebhaber and Paul B. Ginsburg, *High-Performance Health Plan Networks: Early Experiences*, Issue Brief No. 111, Center for Studying Health System Change, Washington, D.C. (May 2007).

Out-of-Network Price Transparency

Many insured consumers are enrolled in preferred provider organizations (PPOs) or other types of health plans that allow them to seek care from providers outside their insurer's network. When consumers use non-network providers, they typically have higher cost sharing and are at risk for balance billing, or paying the balance of provider charges that exceed the usual and customary payment allowed by their insurer for out-of-network care.

Insured consumers going out of network for care have little information about what physicians charge or how much their insurance will pay. The recent settlement in New York over allegations that many insurers artificially suppressed out-of-network payments resulted in funding an academic center to analyze charge data from insurance claims and could lead to better consumer information on typical charges for out-of-network services. Insurers could provide value to their enrollees by providing better information to enrollees about their expected out-of-pocket costs when using out-of-network providers.

Payment Reform and Price Transparency

Interest is growing in moving away from fee-for-service payment, the dominant payment method now used by Medicare and other payers. Provider payment reform could make price transparency more effective. Medicare is well positioned to lead efforts to move toward so-called "bundled payments," where instead of paying piecemeal for care, payment for major acute episodes of care would be combined to cover all services of physicians, hospitals and other providers. Likewise, there is growing interest in moving toward partial capitation, or a fixed per-patient, per-month payment, to compensate physicians and others for time spent more proactively managing the care of patients with chronic conditions. Upcoming Medicare demonstrations of the patient-centered medical home concept will take this payment approach.

Private insurers could either follow Medicare's lead in adopting such methods or work with Medicare on these changes. A reformed payment system would provide much more meaningful units for pricing and permit benefit designs that more effectively engage consumers in comparing provider prices.

QUALITY TRANSPARENCY

Providing data on quality is much more challenging than providing data on prices, but the potential rewards are large. The challenge comes from the complexity of measuring quality. Meaningful outcome measures are often lacking, shifting the quality focus to measures of process, or how often patients receive recommended treatments associated with better results; provider credentials; and patient satisfaction. The wide range of process measures is difficult to condense into summary measures that are meaningful for consumers. Much more information is available on hospital care than on services provided by physicians. A particularly important challenge is that patients have not shown a great deal of interest in quality data. As stated earlier, research suggests a lack of awareness by consumers about the extent to which quality varies from one provider to another is a major barrier to greater consumer use of comparative quality information.

Inspiring Providers to Improve Performance

Until consumers are motivated to use quality information to choose providers, the main value of public quality reporting will likely be to motivate providers to improve their performance. For example, the Centers for Medicare and Medicaid Services provide reporting hospitals with more detailed comparisons of their quality indicators to national norms than are available to the public. This is designed to support hospitals' efforts to improve quality. Experience with publication of provider quality data that providers are very responsive in the sense that they take steps to improve whatever dimensions of quality they are being measured on. For example, HSC site visit research has found that hospitals devote substantial resources to improving aspects of quality that are reported to the Medicare program or to the Joint Commission.[7]

The potential for providers to make use of quality data will expand in the future. For example, if reliable data were available on the quality of care of specialist physicians, primary care physicians would have a stronger basis for making referral recommendations. Health plans have begun to use quality data to support incentives for enrollees to choose among physicians in their network, but they could go much further with more useful quality data.

Roles for Government and Private Sector

Government has an important role to play in advancing quality transparency. Public reporting requirements or incentives generate the necessary raw material for transparency. Government tends to have more credibility in this area than other entities, especially when providers and consumers have "a seat at the table" when programs are designed. Government can also play the role of convener. For example, to prepare for payment reform, the federal government could convene provider leaders and private insurers to work together on such projects as developing episode groupers that would be used by all payers. Providers would be more accepting of these reforms if they played a role in developing the measures and believed that all payers would use them.

The private sector can also play a role in quality transparency by analyzing publicly available data and communicating it. Opportunities exist for both not-for-profit organizations, such as Consumers Union, which is trusted by many consumers, and for commercial data vendors, such as Web MD. Indeed, private insurers often contract with these commercial data vendors to communicate publicly available quality data to their enrollees.[8] Outsourcing the activity to entities with more experience in communicating to consumers is one motivation, as is the brand name that these entities have with consumers.

Although outside of the scope of this hearing, I want to raise the connection between quality transparency and effectiveness research. With quality transparency measurement so focused on

[7] Pham, Hoangmai H., Jennifer Coughlan and Ann S. O'Malley, "The Impact Of Quality-Reporting Programs On Hospital Operations," *Health Affairs*, Vol. 25, No. 5, (September/October 2006).
[8] Tynan, Ann, Allison Liebhaber and Paul B. Ginsburg, *A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency*, Research brief No. 7, Center for Studying Health System Change, Washington D.C. (August 2008).

processes, it is limited by the current state of evidence on which diagnostic or therapeutic strategies improve patient outcomes. There are risks that quality measurement will push medical practices in directions that ultimately turn out to be at odds with evidence not yet discovered. So progress in developing the evidence base for medicine will increase the value of engaging consumers and providers to respond to quality and price transparency.

CONCLUSION

In conclusion, increased price and quality transparency has the potential to increase the value obtained from our now underperforming health care system. But both are at very early stages—where the benefits are probably very small. These tools will get better and may have more impact over time, especially if government takes wise steps to support them. Progress in other key policy areas, such as provider payment reform and effectiveness research, will be very important to realizing the potential of greater transparency. But there is also the risk of overselling the near-term or long-term potential of greater transparency so that we delude ourselves that other steps are not needed.

Ms. CAPPS. Thank you.

And now we turn to Regina, Dr. Herzlinger.

STATEMENT OF REGINA HERZLINGER

Ms. HERZLINGER. Thanks so much, Madam Chairwoman, Ranking Member.

Ms. CAPPS. Is your microphone on?

Ms. HERZLINGER. Thanks so much, Madam Chairwoman, Ranking Member Deal. I am used to screaming in a classroom, so I thought I was all right. I am honored to be here.

What does healthcare reform mean? Sure, most people want to buy reasonably-priced health insurance policies, especially if they are threatened with unemployment as sadly we are in this economy, but many people don't want government to control the process. So I think there is going to be a lot of wrangling as these two opposite points of view get sorted out.

But there is a healthcare reform that can be much more readily implemented, and that is transparency. Everybody wants the government to help them make buying decisions by providing good information. They like FCC data about corporate financial performance, EPA data about cars' pollution, and USDA and FDA data about whether our chuck roast is prime or choice grade and the cleanliness of the supermarket.

Expert clear communicators help consumers interpret these sometimes arcane data ranging from consumer reports for cars to media business gurus for stocks. When it comes to our troubled healthcare sector, Americans want government to provide information, too. Why do we know more about the quality and prices of our chuck roasts and supermarkets than about our surgeons and the hospitals in which they practice? Americans do not want the government to use these data to evaluate the cost effectiveness of products or to buy on their behalf.

Franklin Delano Roosevelt, the great president, understood the distinction between government-enabling information and government making decisions on our behalf when he opted for transparency to cure the stock market's collapse during the depression. FDR was advised by his counselors that the government evaluate all securities. He rejected that advice. Instead he created the Securities and Exchange Commission. He called it the Truth Agency. It was going to tell the truth about the corporate sector to require corporations to disclose their results using that which were audited by independent, certified public accountants.

The FCC armed the—was armed with hefty enforcement power. The FCC has been a miserable failure in its regulatory function, but extensive academic research demonstrates how successful its truth-telling mission has been. Transparency has lowered the cost of capital because when investors are uncertain about performance, they require high returns. Transparency helps protect against misappropriation of shareholder returns by managers. You see it right now with the current outcry against CEO compensation. Most importantly, it enabled appropriate allocation of our resources. Investors reward productive, socially-responsive firms more than others.

In contrast, we know virtually nothing about the quality and cost of medical providers or about the performance of our hospitals and

our insurance. Transparency would enable a woman who is contemplating a mastectomy to know the death and disability rates of potential surgeons, infections, clots, medical errors like leaving a sponge, rates of readmission, infection rates, and the prices they charge for similar kinds of patients.

Transparency would also enable consumers to better evaluate their insurance firms through information, for example, about the number and types of complaints the firms receive from irate customers or medical care providers and their responsiveness to them.

This kind of transparency will enable properly-informed consumers to reform healthcare by selecting the providers and insurers that give them the best value for the money. Some contend that transparency leads to price collusion. If this were true, every yogurt on your supermarket shelf would bear the same price. It doesn't, because the yogurt industry is highly competitive. Collusion is possible only in the highly-concentrated allagopolistic markets. Transparency facilitates the government's prosecuting price fixing competitors in these industries.

You are all too young to remember the NASDAQ scandal where dealers rounded up to the nearest eighth of a penny. The reason that we know about that scandal is that information was transparent and academic researchers found the collusion that led to a $1 billion payout by the colluding allagopolistic securities firms.

Voluntary disclosure dose not work. How do I know that? We have no information. As demonstrated elsewhere in our economy transparency through a truth agency will go a long way to reforming healthcare. Representative Deal's bill captures the essence of what this kind of health reform is all about.

Thank you.

[The prepared statement of Ms. Herzlinger follows:]

A Health Care SEC:
Sunshine is the Best Disinfectant

Regina E. Herzlinger

Nancy R. McPherson Professor of Business Administration

Harvard Business School

April 2, 2009

Testimony before U.S. House of Representatives

Committee on Energy and Commerce

A Health Care Securities and Exchange Commission[a]

Regina E. Herzlinger
Nancy R. McPherson Professor of Business Administration
Harvard Business School
April 2, 2009

Dear Chairman Waxman and honorable committee members.

Thank you so very much for giving me the opportunity to testify on private-public health care transparency. I am going to address the creation of a new agency, a health care SEC whose purpose is to enable Americans to know the quality and prices of their health care providers—hospitals, doctors, and so on—and insurers.

It would, for example, enable men contemplating prostate surgery or women about to undergo a mastectomy to know the death and disability rates achieved by potential surgeons—infections, clots, medical errors like leaving a sponge in the patient, impotence, rates of readmission for complications after surgery; the infection rates of the hospital unit in which they practice; and the prices they charge patients with similar medical characteristics, such as age, gender, and health status. Transparency would also enable consumers to better evaluate their insurance firms through information about the number and types of complaints the firm received from irate customers or medical care providers and their responsiveness to them.

This kind of transparency would enable properly informed consumers to reform health care by selecting the providers and insurers that give better-value for the money. It would also lower the health-

[a] This paper is based on "The Sticks," Chapter 10 from Regina E. Herzlinger, *Who Killed Health Care* (New York: McGraw-Hill, 2007), pp. 227–246.

care sector's cost of raising capital, as investors, lenders, and donors gained greater clarity about an institution's real clinical performance.

Americans want government to help them make buying decisions by providing such good information. They like SEC data about corporate financial performance, EPA data about cars' pollution, and USDA and FDA data about whether our chuck roast is prime or choice grade and the cleanliness of supermarkets. Expert, clear communicators help consumers to interpret these sometimes arcane data – *Consumer Reports* for cars and media business gurus for stocks.

When it comes to our troubled health care sector, Americans want government to provide information too. Why do we know more about the quality and prices of Raisin Bran cereal and supermarkets than about our doctors and the hospitals in which they practice?

What does not get measured does not get managed.

In this paper, I discuss how to reform our health care system through the creation of a new federal government agency that requires and enforces transparency.

The Impact of Information on Markets

Information makes ignorant people smart.

I confess: I have only the dimmest notion of how a car functions. After all, a car is a high-tech device, studded with microchips. I am alone in my ignorance. When I see someone in an automobile showroom peering under the hood of a car, I think to myself, "What the heck are you looking at?"

Nevertheless, I can readily find the kind of car I want at a price I am willing to pay. My quality choices have increased substantially since 1966, while the cost of a car has decreased as a proportion of income:[1] As a result, 48 percent of the poor own cars and 14 percent own more than one.[2]

How is it that an ignoramus like me can easily find cars that are better and cheaper?

And, as only one person in a vast sea, why am I not pillaged in the automobile market?

The answer to these questions rests in an understanding of how markets work. Two ingredients are crucial:

One is information. It enables me to be an intelligent car shopper, despite my ignorance.

I peruse the rating literature for a car that embodies the attributes I value: safety, reliability, environmental friendliness, and price. Objective, trustworthy information about these attributes is easily available to me. When I studied *Consumer Reports* for cars with these attributes, two brands satisfied my requirements: Volvo and Buick. I skipped the earnest reviews of how the engines work, fuel efficiency, comfort, handling, styling, and so on. Safety, environmental quality, reliability, and price—these are what interest me.

When *Consumer Reports* rated Volvo high on safety, it grew from an obscure Swedish brand to a nationally recognized car in the US .[3] Volvo's rivals saw that a meaningful number of customers were interested in safety and reliability and introduced these qualities into their cars. By 2005, U.S. cars exceeded European ones in reliability, and the Japanese cars had only a small edge.[4] Quite a change from 1980 when U.S. cars were three times as unreliable as Japanese ones and twice as unreliable as European vehicles.[5]

So information made me smart and caused car manufacturers to improve their products. But why should the car manufacturers from cut their prices or improves their quality for me? After all, I am only one person.

The critical second ingredient to an effective market is a small group of marginal, tough-minded buyers. At a high price, there are only a few buyers who are more or less price insensitive. The good news for businesses is that these customers are willing to pay a very high price. The bad news is that there are only a few of them. To attract more customers, suppliers reduce their prices. The increased volume of customers more than compensates for the reduction in price. Suppliers continue to cut prices until they hit

a brick wall: the last picky, tough-minded customers who clear the market. The price these tough-nosed buyers are willing to pay is roughly equal to the marginal cost of making the product. The rest of us benefit from the assertiveness of the last-to-buy crowd. And it is a relatively small group. A McKinsey study showed, for example, that only 100 investors "significantly affect the share prices of most large companies."[6]

These hard-nosed buyers are highly adept in finding, interpreting, and using information. They are the show-me crowd, the marginal consumers bloodlessly depicted on the bottom of the Economics 101 downward sloping demand curve. This relatively small group of demanding consumers rewards suppliers who reduce price and improve quality. The car market illustrates their impact. Currently, automobile prices are the lowest in two decades. In 1991, the average family required 30 weeks of income for the purchase of a new vehicle; by 2008, a new vehicle required 22.8 weeks—a 24 percent decline from 1991.[7,8] Simultaneously, new-vehicle quality has improved dramatically (33% in the last 10 years alone).[9,10] The range of choices is better too, as the quality differences between the best and worst manufacturers have declined.[11]

Health Care Consumers of Information

As in the automobile market, smart, informed consumers—consumers who have access to good information and the freedom to choose health care plans and providers optimized in classic Economics 101 fashion—for example, will make our health care system better and cheaper. The satisfaction and cost data collected by the Buyers Health Care Action Group (BHCAG), the Twin Cities' employer coalition encouraged patients to leave high-cost/low-satisfaction plans for lower-priced/higher-satisfaction plans, thereby prompting physicians to offer more bang for the buck. The program led to a nearly 20 percent drop in high-cost/low-satisfaction plans and a 50 percent increase in low-cost/high-satisfaction plans.[12]

Even in the absence of consumer control, the gathering and dissemination of information exerts powerful effects on suppliers.[13] In accounting, this phenomenon is known as the *audit effect:*[14] Firms improve their management in anticipation of an accounting audit. In health care, many of the reviews of the impact of published performance data on physicians, hospitals, and insurers have concluded that they resulted in improved outcomes and/or processes.[15] One study found higher condition-specific performance on a national quality reporting program associated with lower risk-adjusted mortality for each of the three conditions.[16,17]

Yet health care policy analysts argue that a consumer-driven health care system cannot work because average consumers will be stymied by the process of selecting among differentiated health insurance products.[18,19] These analysts may fail to appreciate the impact of those tough-minded buyers on a market. Nevertheless, their argument does raise a question: Does a marginal group of tough-nosed, market-clearing consumers exist in health care?

Current generations are much better educated: In 2004, 27.7 percent of the population had attained a college education or more, and 85.2 percent were high school graduates.[20] In 1960, in contrast, fewer than half the people were high school graduates, and only 7 percent had a college education.[21]

Higher levels of educational attainment increase not only income and ability but also self-confidence (referred to as "self-efficacy" in the health policy literature[22]). Affluent Web surfers embody this self-efficacy—they spend more time than others searching for information on the net before making a purchase and are much more likely to buy, once they have found a good value for the money.[23] Those who focus only on their affluence miss the point: Affluent or not, they eat the same bread, buy the same appliances, and wear the same jeans. The same Honda is sold in poor inner-city areas and affluent suburbs. The activism of the affluent Web surfers improves these products for everybody.

Consumers surf the Web for health care information. Harris Interactive's latest data showed 81% of internet users and 66% of all adults were health information seekers.[24] Some even study medical information, such as the millions of people who spent an average of 20 minutes at the government's National Institutes of Health Web site, studded with arcane medical journal articles.[25] A few even express their activism directly by mastering medical skills, such as CPR and the use of external defibrillators.[26]

The assertiveness and self-confidence that typify marginal consumers are evident in these health care Internet users. They agree more than average U.S. adults with the following statements: "I like to investigate all options, rather than just ask for a doctor's advice" and "People should take primary responsibility and not rely so much on doctors."[27] Their pragmatism is apparent too. They do not search idly. More than 70 percent want online evaluations of physicians,[28] and when they obtain the information, they use it.[29] Consumers are willing to change hospitals in response to information about their quality.[30] Nor is consumer assertiveness limited to the United States. For example, 70 percent of Canadian doctors note that their patients are briefed by Internet information.[31]

Thus, although *average* buyers of health care are not experts, individual consumers can reshape the health care system. As with the automobile markets, the markets that make up the health care system will be guided not by average consumers but by the *marginal* customers who drive the toughest bargain. What they need is information.

The Role of Government in Creating Transparency

The role of government in providing transparency is surprisingly controversial. In the view of Nobel economics laureate George Stigler, the truth will out in markets as competitors expose each others' weaknesses or market analysts unearth it.[32] Stigler's analyses revealed that government regulation of information disclosure is not essential to the efficiency of markets.[33] Although his claims and similar

research have been widely tested,[34] the empirical research examining the necessity of government action to ensure an efficient market has not yet settled the question.

Some more recent research indicates that in countries that have an SEC-like agency, transparency lowered the cost of capital, because when investors are uncertain about performance, they require higher returns.[35] Transparency also helped protect against misappropriation of shareholder returns by managers, as attested by the current outcry against CEO compensation. Most importantly, it enabled appropriate allocation of our resources: investors reward productive, socially responsible firms more than others.

The Failure of Voluntary Transparency

Voluntary transparency does not work. Consider the case of the voluntary Cleveland Coalition, a group of local area businesses who joined forces to collect hospital performance data. The effort was widely lauded. For example, one hospital claimed that the significant decrease in its rate of caesarean sections was "purely driven by the Cleveland Coalition."[36] An evaluation concluded that reductions in risk-adjusted mortality rates and lengths of stay were linked to the performance reports.[37]4

Nevertheless, the effort collapsed when the famous Cleveland Clinic left the group, allegedly because it did not like the performance ratings' process.[38] And the employer group that sponsored the effort did not actively use its results. The only hospital to achieve great results expected that the data would yield many new patients as employers referred their enrollees there; but the predicted surge never materialized. Noted one employer "We weren't that aggressive."[39] The bureaucratic and paternalistic human resources staff who relied on limited choice to control health care cost, may worry that information may disprove the wisdom of their choices..

The Impact of the U.S. Securities and Exchange Commission (SEC) on Financial Transparency

When the federal government required transparency, we got it! The story of how the U.S. SEC's requirement for transparency transformed the money markets is told below:

Virtually every interest group that has been required to measure its outcomes claims its work is so diffuse its impact cannot be measured. Such claims delayed the measurement of the performance of businesses until the mid-1930s. The stunning absence of information at that time is analogous to the situation in today's health care system: In 1923, only 25 percent of the firms traded on the New York Stock Exchange provided shareholder reports.[40] Investors were flying blind then, just like today's health care consumers.

The absence was all the more surprising because accounting, the measurement tool for business performance, has existed since the middle of the fifteenth century when double-entry bookkeeping was first codified.[41] But business executives' claims that accounting could not accurately measure company performance and that the cost of measurement exceeded its benefits prevented widespread disclosure of information about the economic performance of the firms they led.[42]

In the 1930s, U.S. President Franklin Delano Roosevelt (FDR) promulgated the laws that created the SEC. Bucking powerful business opposition, state government involvement, and his own advisors' counsel that he promote laws to grade the firms in the security markets, FDR instead created the SEC to compel audited disclosure about the performance of publicly traded firms, using generally accepted accounting principles (GAAP).[43,44]

The SEC is a genuine private-public partnership. The governmental SEC requires disclosure, but the auditors and the organizations charged with creating and implementing the audit rules (including the promulgators of GAAP) are housed in private organizations such as the Financial Accounting Standards Board (FASB).

The SEC has failed in its regulatory function. The corporate accounting and governance problems of public U.S. businesses in the twenty-first century were exacerbated by weak SEC enforcement.[45,46]

But the transparency created by the SEC enabled the broad participation of average Americans in the securities markets and the markets' efficiency.[47] (*Efficiency* in this context is the degree to which information is so broadly disseminated throughout a market that no participants can benefit from having access to special information available only to them.) Financial reporting reduces the investor's risk, narrows the differences between sophisticated and less sophisticated investors, and reduces the firm's cost of capital. Currently, the U.S. SEC serves as a worldwide model: for example, foreign firms that switch to U.S. transparency practices and standards benefit financially.[48]

All measuring tools improve with use. Accounting was not nearly as accurate a measure of economic performance in 1934 as it is today. No doubt, accounting will improve in the future. In 1687, Newton first measured gravity. By 2000, physicists could measure the minute energy of a *tau nutrino* buried deep within an atom.[49] In 1953, Crick and Watson first measured the structure of DNA. By 2007, biologists could manipulate the structure of individual genes.[50] Today's health information measures will also be refined with practice and time.

A Health Care SEC

U.S. securities markets feature the characteristics that health care consumers want: (1) Prices are fair in the sense that they reflect all publicly available information, and (2) buyers use this information to reward effective organizations and penalize ineffective ones. Thus, in the financial markets, positive disclosure of results lowers the firms' cost of capital and improves resource allocation.[51]

If these characteristics were present in health care, they would divert resources from health providers that offer a bad value for the money to those that offer a good one. Poor-value-for-the-money providers would shrink or improve. Good-value-for-the-money providers would flourish.

Current health care consumers have little information about the quality of their providers. Indeed, they have better information on raisin bran cereals—they need only read the label—than they have on the surgeon who will operate on their breast or prostate cancer tumors. Publication and widespread dissemination of data about the quality of individual providers, as measured by generally accepted health care outcome principles and audited by certified, independent appraisers of such information, will help ameliorate this problem. Eventually, independent analysts will use this information to compile readily accessible ratings of providers, similar to Morningstar's excellent system for classifying and rating mutual funds.

The key to achieving these desirable characteristics in health care is legislation for a health care SEC that replicates these essential elements of the SEC model:

1. *An independent agency with a singular focus:* The SEC is an independent agency charged solely with overseeing the integrity of securities and the exchanges on which they are traded. Because of these clear goals and organizational characteristics, the SEC's mission is not muddied, and it can be held clearly accountable for its performance.
2. *Private-sector analysis:* The evaluation process is primarily conducted by private-sector analysts, who disseminate their frequently divergent ratings. To encourage similar private-sector health care analysts, the new agency should require public dissemination of all outcomes for providers, including clinical measures of quality and related transaction costs.
3. *Focus on outcomes, not processes:* The SEC and FASB focus on measuring the *performance* of organizations. FDR firmly rejected dictating business *processes* or rating businesses as appropriate roles for the SEC.

4. *Penalties:* The SEC requires firms that trade their securities in interstate markets and all such market makers to register with the agency. A corresponding health care agency would oversee the integrity and require public disclosure of information for entities that provide health insurance and services. Like the SEC, it would be armed with powerful penalties for undercapitalized and unethical market participants, including imprisonment, civil money penalties, and the disgorgement of illegal profits.[52]

   The SEC is essentially a profit center, generating a substantial surplus from its filing and penalty fees that offsets its billion-dollar budget.[53] A health care version of the SEC could be similarly self-financed, offsetting its expenses with filing fees and fines collected from its constituency.

5. *Private-sector disclosure and auditing:* The SEC relies heavily on private-sector organizations that contain no governmental representation. The new health care agency should similarly delegate the powers to derive the principles used to measure health care performance to an independent, private, nonprofit organization that, like the Financial Accounting Standards Board, represents a broad nongovernmental constituency. The agency would require auditing of the information by independent professionals, who would render an opinion of the information and, because they are organized as partnerships, not corporations, bear personal legal liability for failure to disclose fairly and fully.

The Health Care SEC is one of the most important health care reforms that the U.S. Congress can create.

Thank you.

Appendix

How Not to Make Health Care Transparency Happen

Unfortunately, many well-intended proposals undermine one or more of these essential SEC characteristics.

Private-Sector Analysis

All too often, these proposals require that the health care regulators evaluate and micromanage health insurers and the markets in which they operate.[54] But these suggestions place inappropriate responsibility on the regulator. One organization should not simultaneously assure the release of accurate data and its analysis. After a while, the organization might be sorely tempted to skew the data so that the analysis is proven correct. As an example of the kind of pressure that a government agency can exert on analysis, 15 percent of the Federal Drug Administration's scientists have said they were inappropriately asked to exclude or alter information in their conclusions.[55]

In the financial markets, neither the SEC nor the FASB assess the quality of the output produced by corporations. Instead, they ensure the provision of reliable, useful information. Private-sector intermediaries including firms such as Morningstar and Bloomberg can then analyze the information and present it to consumers.

Other proposals include the government as a participant in private, nonprofit FASB-like entities such as the National Quality Forum.[56] This kind of organizational structure places government on both sides of the table, allowing it to act as both regulator and standard setter. It thus compromises the checks and balances that exist between the private-sector FASB and the governmental SEC.

Measuring Outcomes Not Process

The SEC focuses on measures of financial *outcomes*—such as profitability, liquidity, and solvency. It does not dictate *process*—how businesses should achieve these results.

The pay-for-performance (P4P) movement is a worrisome example of the confusion between the two kinds of measures.[57] A focus on measuring process may deter innovative improvements in quality. For example, one expert concluded that "in diabetes the emphasis on measuring preventative processes of care, rather than assessing outcome measures such as blood pressure and [the markers of sugar in the blood of diabetics] may have the unintended consequence of diverting resources and attention from [the] clinically more productive tasks."[58]

An Independent Agency with Singular Focus

Some proposals would compromise the focus and independence that characterize the SEC's organizational structure. They recommend, for example, that an SEC-like agency be housed under the Department of Health and Human Services (HHS),[59] which oversees the government payments for Medicare and Medicaid, among other activities. This organizational setting could compromise the mission. Because HSS accounts for a large fraction of U.S. health care payments, a health care SEC housed under its wings could be focused on serving the interests of payers, rather than consumers.

Further, the clear accountability of a free-standing agency would be lost in this setting. President George W. Bush's first SEC commissioner was forced to step down because of the SEC's failures in ensuring transparency in the financial markets. Because the SEC was a separate agency, he was clearly responsible for its failing; but who in HSS was held responsible for similar failings with implementation of its drug plan?[60] Although 5 percent of all Medicare recipients who called its drug plan help line were

disconnected and nearly a third found the advice difficult to use, inappropriate, or erroneous, no one was held responsible for these failings.[61]

Opposition to Transparency about Health Care Prices and Quality

We live in an information age, surrounded by ubiquitous newspapers, televisions, telephones, computers, radios, magazines, and books, available worldwide, round-the-clock. They address three of our senses—sound, vision, and, for the vision- and hearing-impaired, touch. In 2004, the 8 million people who said they had created a blog were visited by 14 million viewers.[62] The ubiquity of information responds to people's desires: When there is no demand, there is no supply.

The best sources combine information and accessibility: *Morningstar's* and *Zagat's* restaurant guides' pithy reviews, J.D. Power's powerful brand name, and *Consumer Reports*' accurate, comprehensive ratings typify these qualities. But those who do not like these sources can find many others: If investors judge *Morningstar* excessively terse, the SEC's EDGAR system contains much more information about publicly traded corporations.[63] If they prefer professional restaurant reviewers to *Zagat*'s amateurs, they can turn to the *Boston Globe*'s "Food" section or its equivalent in their own hometown paper. If they question J.D. Power's objectivity or feel that *Consumer Reports* is biased against American cars, they can turn to the federal government's data about cars and airlines, such as those provided by the National Highway Traffic Safety Administration and the Federal Aviation Administration,[64] or *Car & Driver Magazine* and *Consumer's Digest*. The point is that there is a wealth of information available, and interested consumers can drill down into it as little or as much as they need.

The providers of information help themselves too. In 2006, Google's founders became billionaires because they helped people achieve greater productivity by answering their questions easily and

efficiently. Michael Bloomberg also gained billionaire status because he provided information that helped people to invest in financial instruments with confidence.[65]

Many complain about the absence of similar consumer-driven health care quality information.[66] The wired generation is especially demanding—80 percent of respondents have noted that the absence of quality information was the most negative aspect of e-health plans.[67] When information is available, health care consumers have stated they would use it.[68] Prescient entrepreneurs and wannabe billionaires are already providing them with some of the information they want. The market value of the WebMD consumer health care portal, for example, doubled in four months after its September 2005 IPO.[69]

But many powerful opponents, including the academics and providers discussed above, constrain its development.

Health Care Providers' Opposition to Information

Providers who like the theory of consumer-based choice and information may dislike the reality—the requirement that they be accountable for their performance. More than two-thirds of surveyed physicians have said that the general public should not have access "to information on clinical outcomes."[70]

To urge their cause, some may claim that performance is intrinsically unmeasurable. But if the performance of medicine cannot be measured, there is no basis for teaching, research, or clinical practice in the field. Others may claim that only they can correctly interpret the data. In this claim, they misunderstand the role of marginal consumers in making markets work.

Yet other providers note the cost and difficulty of obtaining reliable data about the performance of providers who see few patients with a particular medical condition. For example, one *Journal of the American Medical Association* article explained that the cost of collecting the data no doubt exceeds its

benefits.[71] The cost? "As much as $0.59 to $2.17 per member per month." And the benefits? The article does not address the question, perhaps because the benefits easily exceed the data collection costs. For example, if quality data improve the costs of treating a diabetic by as little as 1 percent, the data collection costs will be repaid fiftyfold in less than one year.[72]

The same report also notes that many data cannot be reliably measured for most doctors because they treat so few of the sick. For example, "a physician would need to have more than 100 patients with diabetes... for a profile to have a reliability of 0.8 or better, while more than 90 percent of all primary care physicians at the HMO [he studied] had fewer than 60 patients with diabetes."[73] A hospital-based study similarly concluded that "the operations for which surgical mortality has been advocated as a quality indicator are not performed frequently enough to judge hospital quality."[74]

But the purpose of performance measurement is to protect the patient, not the physician or hospital. Physicians who see many diabetics are more likely to develop the expertise needed to care for this complex, challenging disease. If quality data were published, the low-volume physicians and hospitals that cannot generate statistically reliable data will likely lose their patients to those who are achieving excellent outcomes, in part because they see so many diabetics.

The Quality of Health Care Information

A serious but correctable objection is voiced by those who point out that physicians and hospitals should not be held responsible for things they do not control.[75,76] It is a correctable objection because there are industries that have a long history with management control systems, which are used to evaluate managers. They design them to focus on those outcomes that managers control.[77] Their experiences could be adapted to health care.

Others worry about the quality of the information. First, much of the language for measuring health care quality has yet to be defined. Second, the risk adjusters that would make it possible to compare the performance of high-risk specialists to those who treat less-severely-ill patients are not yet fully developed.[78] Third, the raw data are flawed. For example, the federal government's data bank of the adverse actions taken against physicians and dentists has repeatedly been cited for severe flaws, including errors and substantial underreporting of problems.[79]

These are substantial concerns. In the absence of solutions, the information will be seriously distorted. For example, a study that compared the rates of caesarean sections in hospitals, with and without adjustment for the fact that some hospitals might just have more patients prone to caesareans, found that adjustment caused the performance of a fourth of the hospitals in the study to change dramatically; among other changes, 10 percent of those originally classified as especially high or low users of these surgeries were reclassified as normal and some that were classified as normal were reclassified as having greater or lesser rates of surgery than the average.[80] Physicians may also be dissuaded from caring for very sick patients if outcome measures do not correctly reflect the severity of illness. With imperfect adjustments, physicians will look much better if they care for only those patients who are more likely to recover from their illnesses.

Measurement issues like these are typically resolved with time and experience. The continual evolution in measures of performance of investment management—such as generally accepted accounting principles and *beta*, the measure of risk of different investments—provides an example. Beta has been continually refined since it was first suggested in 1952. Similarly, the system used by Morningstar to rate the investment performance of mutual funds evolved over time. For example, it was changed to allow for the difficulty of generating earnings in different types of investments. It now permits mutual funds operating in poorly performing sectors, say, technology, to earn high ratings if they performed substantially better than their peers, a form of risk adjustment.[81]

As the refinement of the measures of financial performance continued, investors had ever-better data with which to evaluate their mutual funds and stocks. Patients who put their health on the line deserve no less. The best way to improve the quality of these data is not to suppress them but rather, to open them to the public.

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Ms. CAPPS. Thank you very much, and I would like to welcome to the panel Mr. Bachman, Ronald Bachman, Senior Fellow at the Center for Health Transformation. You are recognized for 5 minutes.

STATEMENT OF RONALD BACHMAN

Mr. BACHMAN. Thank you. Ron Bachman, Senior Fellow at the Center for Health Transformation, and my mission in life is to solve the uninsured problem, and so the transparency issue before us today is very much a part of that in my opinion.

Transparency means the public disclosure of honest, meaningful decision making information. Clearly the public has a right to know key information to maintain their health and safety. When up to 98,000 patients die each year from hospital errors, citizens have a right to know where these are occurring. When 9,000 deaths occur from medication errors each year, the public has a right to know the facts. When hospital-created complications and provider-induced viruses are more deadly than the original medical conditions, patients have a right to know.

The best way for the public to change poor business behaviors is to improve—and to improve quality and lower costs is for the guilty businesses to lose customers. Unfortunately, in healthcare the consumer is rarely the customer. The consumer is the one who uses the service. The customer is the one who buys the service and pays the invoice. In healthcare the customer is usually the third-party payer, the insurance company, the HMO, or the group plan.

New generation health plans are financially empowering health consumers and transforming them into health customers. To become an effective health customer, one has to have both a financial stake in purchasing and the information to make informed decisions. You cannot have a quality healthcare in any system without both.

Financially-empowering plans with savings options increase 5 percent in 2007, and 8 percent in 2008. Employers with three to 200 workers are the fastest growing group, up 13 percent. With account-based plans individual worker premiums are 40 percent less than other plans. Family premiums are 30 percent lower. The average employer account funding was over $800 for an individual and over $1,500 for family coverage each year. In 2008, 71 percent of employers offered incentives for health and wellness or disease management programs up from 62 percent in 2007. The incentives averaged $192 per person per year.

Account-based plans are not just for the healthy and wealthy. In 2009, young families, 25 to 40, had balances averaging over $7,000 in these accounts. By the end of 2008, the average savings accounts total over $8,000 for individuals and over $10,000 for families. The newest products are developing more information to help individuals make informed choices with those dollars.

Historically transparent cost and quality information has been hard for plans and the public to access. Providers have maintained the argument of confidentiality, proprietary needs, and competitive advantage. With empowered individuals these arguments rapidly dissipate. National insurers, some providers, especially vendors and state governments, have been taking the lead in requiring disclo-

sure of provider cost and quality information. Each insurer or hospital has limited data. States differ on the reporting requirements. Budgets limit the expansion of publicly-funded information access, and inertia of the status quo slows progress in meeting patient information needs.

The Federal Government can advance the cause of empowering individuals with the information by passing basic national standards for provider and insurer transparency. Congressman Nathan Deal's legislation is on the right path.

A governor of Georgia once said that that to have better prisons we needed better prisoners. Today that parallel may be to have better health and lower costs we need better patients. The CDC tells us that behaviors determine 50 percent of health. By far the individual turns out to be the most important variable in the healthcare cost equation. It is not doctors, hospitals, pharmaceuticals, or other care providers. Access to care has only a 10 percent impact on health status, genetics, 20 percent, environment, 20 percent make up the remaining factors.

Congress is a powerful legislative body, but you cannot change the laws of human nature. You cannot make recalcitrant patients take medications or comply with physician orders. You cannot make citizens eat properly, exercise regularly, or seek preventative care. The bottom line is you cannot legislate personal responsibility.

Congress can, however, create an open, transparent information-rich environment that supports greater engagement by individuals in their own health and healthcare decisions. In general, individuals will not take care of themselves just for the sake of good health. If that were true, we would not see the rampant growth in obesity and epidemic of diabetes. We are typically American. We want to be paid to do the right thing. We want incentives, rewards, and recognition. We want some financial control, and we need information and help with making the right decisions.

Blue Cross, Blue Shield studies show that patients with financial and information support have more than three times the number of members engaged in smoking cessation, more than three times the number of members engaged in stress management programs, more than double the number in diet nutrition education programs, and nearly two and a half times more likely for those patients to be in exercise plans.

A major interest in Congressman Deal's legislation is the disclosure of self-pay charges. When I started to negotiate provider network reimbursements back in the early 1990s, the expected discount from hospital charge masters, their so-called retail price, was typically 5 to 15 percent. The discount game had led to artificially-high retail price lists where discounts are now 80 to 90 percent off of those charges. No one pays the retail prices except the uninsured. Those most vulnerable and least able to pay are charged the list rates. Many who cannot or do not pay these artificial charges are hounded by collection agencies for monies that are ten times or more above the cost of actually providing the services.

As with the Georgia governor's call for better prisoners, it is time to free consumers from the dark prison of ignorance. You can make information easier to find and easier to understand. You can elimi-

nate arbitrary price discrimination against the uninsured. The need is to pull back the curtain of secrecy on costs and quality. Congress can make a difference in saving lives and saving money by supporting the individual's right to know.

While the country debates reform of healthcare, on one fact you should all agree. The need for transparency is critical to the outcome in that debate.

[The prepared statement of Mr. Bachman follows:]

Transparency:
Helping Consumers become Customers

Transparency means the public disclosure of honest meaningful decision-making **information**. Clearly, the public has a "right to know" key **information** to maintain their health and safety. When up to ninety-eight thousand patients die each year from hospital errors, citizens have a right to know where these are occurring. When nine thousand deaths occur from medication errors each year, the public has a right to know the facts. When hospital created complications and provider induced viruses are more deadly than the original medical condition, the patients have a right to know.

The best way for the public to change poor business behaviors and to improve quality and lower costs is for the guilty businesses to lose customers. Unfortunately in healthcare the consumer is rarely the customer. The consumer is the one who uses the service. The customer is the one who buys the service and pays the invoice.

In healthcare the customer is usually the third party payer: the insurance company, the HMO, or the group plan. New generation health plans are financially empowering health consumers and transforming them into health customers. To become an effective health customer, one has to have both a financial stake in purchasing and the **information** to make informed decisions. You cannot have quality healthcare in any system without both.

Financially empowering plans with savings options increased 5% in 2007 and 8% in 2008. Employers with 3-200 workers are the fastest growing group, up 13%. With account based plans, individual worker premiums are 40% less than other plans. Family premiums are 30% lower.

Average employer account funding is over $800 for an individual and over $1500 for family coverage.[1] In 2008, 71% of employers offered incentives for health and wellness or disease management programs, up from 62% in 2007. Incentives averaged $192 per person per year.[2] Account based plans are not just for the healthy and wealthy. In 2009, young families (25-40) had balances averaging $7,220. By the end of 2008, the average savings account totaled $8,148 for individuals and $10,178 for families.[3]

The newest products are developing more **information** to help individuals make informed choices. Historically, **transparent** cost and quality **information** has been hard for plans and the public to access. Providers have maintained the argument of confidentiality, proprietary needs, and competitive advantage. With empowered individuals these arguments rapidly dissipate.

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National insurers, some providers, specialty vendors and state governments have been taking the lead in requiring disclosure of provider cost and quality **information**. Each insurer or hospital has limited data, states differ on their reporting requirements, budgets limit the expansion of publically funded information access, and inertia of the status quo slows progress in meeting patient information needs.

The federal government can advance the cause of empowering individuals with **information** by passing basic national standards for provider and insurer **transparency**. Congressman Nathan Deal's legislation is on the right path.

A governor of Georgia once said that to have better prisons, we need better prisoners. Today's parallel may be that to have better health at lower costs, we need better patients. The CDC tells us that behaviors determine 50% of health. By far, the individual turns out to be the most important variable in the healthcare cost equation. It's not doctors, hospitals, pharmaceuticals, or other care providers. Access to care has only a 10% impact on health status. Genetics (20%) and environment (20%) make up the remaining factors.

Congress is a powerful legislative body, but you cannot change the laws of human nature. You cannot make recalcitrant patients take medications or comply with physician orders. You cannot make citizens eat properly, exercise regularly, or seek preventive care. The bottom line is you cannot legislate personal responsibility.

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BCBS studies show that plans with financial and **information** support have more than 3 times the number of members engaged in smoking cessation, 3 times the number engaged in stress management programs, more than double the number in diet and nutrition education programs, and nearly 2.5 times more likely to be participants in an exercise plan.

A major interest in Congressman Deal's legislation is the disclosure of self-pay charges. When I started to negotiate provider network reimbursements back in the early 1990's, the expected discount from hospital charge masters (their so called retail price) was typically 5 to 15%. The discount game has led to artificially high retail price lists where discounts are now 80-90%. No one pays the retail prices except the uninsured. Those most vulnerable and least able to pay are charged the list rates. Many who cannot or do not pay these artificial charges are hounded by collection agencies for monies that are 10 times above the cost for providing the services.

As with the Georgia governor's call for better prisoners, it is time to free consumers from the dark prison of ignorance. You can make **information** easier to find and easier to understand. You can eliminate arbitrary price discrimination against the uninsured. The need is to pull back the curtain of secrecy on costs and quality. Congress can make a difference in saving lives and saving money by supporting the individual's right to know. While the country debates reform of healthcare, on one fact all sides should agree - the need for **transparency** is critical to any outcome of that debate.

Ms. CAPPS. Thank you, Mr. Bachman.
And now we turn to Diane Archer for 5 minutes, please.

STATEMENT OF DIANE ARCHER

Ms. ARCHER. Madam Chairwoman, Mr. Deal, thank you for inviting me to testify about transparency in the private health insurance system and how it can help American families.

At the Institute for America's Future we studied the issue extensively and concluded that the private healthcare system will never work well for American families without significant changes in the current disclosure practices with the private insurance industry.

Here is why. If you wanted to buy a car, you would have a vast array of public information about differences among them, from fuel efficiency to annual maintenance costs to crash test performance. But what can you find out about the various makes and models of private health plans? Practically nothing it turns out.

So what is the value of having so many choices? Even the most sophisticated among us have little idea what we are paying for when we buy insurance. Does it cover Tamoxifen if I am at risk for breast cancer? How much is the average out-of-pocket cost for typical prenatal care? What percentage of total claims were denied last year? What will a particular service cost me?

Private insurers in sharp contrast with the public Medicare Plan have been able to keep confidential claims, costs, and quality data on the ground they are business trade secrets. We can't find out what specific services will be covered and when or average out-of-pocket costs for typical conditions, let alone which insurers deliver the best value for our premium dollars.

Informed consumer choice is a myth. To build an efficient healthcare system we need insurance company performance information. I have spent the last 20 years helping people navigate both Medicare and private insurance, for a long time as president of the Medicare Rights Center. I want to take you briefly through the structural issues that may preclude needed transparency from the private insurance industry, the data we need from private insurers, and how healthcare reform can address these issues.

In America today people can't compare health plans based on value. The health insurance market is broken. In a competitive market insurers would be marketing to healthcare users, demonstrating why they deliver the best value healthcare for people with cancer, diabetes, and heart disease. Their message would appeal to the 20 percent of the population who consume 80 percent of healthcare dollars.

Instead, if they deliver great care to people with costly needs, they don't want people to know. Twelve years ago in a New York Times magazine cover story that I keep by my side, Helen Darling, now president of the National Business Group on Health, made this point very succinctly. "I have been sworn to secrecy by one plan that has the best AIDS program in the world. They don't want people knowing about it. They couldn't handle the results. Ideally, if we lived in a wonderful world, we would want to plan to win prizes for their wonderful care, but in reality that would kill them." To maximize their profits health plans compete for enrollees least likely to use their product. Therefore, health plans do not advertise

to specific treatments and tests covered but conditions under which they are covered or the crisis services.

This is precisely the information we need to know. Different private plans offer different value healthcare. The best of them help ensure doctors deliver good care, yet coverage decisions are largely considered proprietary and unknown. And we don't know whether insurers are adding value or simply increasing their profits.

A New York State Medical Society survey revealed that 90 percent of doctors said they have had to change the way they treat patients based on restrictions from an insurance company, and 92 percent said insurance company incentives and disincentives regarding treatment protocols, "may not be in the best interest of patients." Are insurers spending our premium dollars wisely? Are they helping to ensure that our doctors provide us reasonable and necessary care? We don't know.

What data is needed to evaluate health plans and help people make informed healthcare choices? The kind of data we get from the public Medicare Plan, the specific services they cover, and the amounts they pay, claims data and denial rates. Members and perspective members also need to know the average out-of-pocket costs for treating different conditions. This data will help give us meaningful choice, and over time will help us in efforts to compare health outcomes for people with different conditions in different health plans.

As important, disclosure of this data would promote better insurer behavior. Right now the countless reports of insurer abuses suggest that the lack of transparency allows insurers to delay and deny care and reimburse inadequately for services renders, seemingly arbitrarily.

Up until now we have bought into an opaque and inefficient private health insurance model that has not met our healthcare needs. Regulations will never address the insurer's obligation to put profits first, but we can drive accountability if we require far greater transparency from the insurers.

A public health insurance option is also essential. A public health insurance option sets a benchmark for coverage, drives competition among insurers to reign in costs, and through its willingness and ability to be transparent and accountable can promote the value and system-wide change that is needed to guarantee everyone in America quality, affordable healthcare.

Thank you.

[The prepared statement of Ms. Archer follows:]

INSTITUTE FOR AMERICA'S FUTURE
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Statement of

Diane Archer, J.D.
Director, Health Care Project
Institute for America's Future

House Committee on Energy and Commerce
Health Subcommittee

Making Health Care Work For American Families: Saving Money Saving Lives

April 2, 2009

Mr. Chairman and Members of the Committee,

Thank you for inviting me to testify about transparency in the private health insurance system and how it can help American families. At the Institute for America's Future, we have studied the issue extensively and concluded that the private health care system will never work well for American families without significant changes in the current disclosure practices of the private insurance industry.

Here's why. If you wanted to help out the coming economic recovery by buying a new car, you'd have a vast array of public information about differences, from fuel efficiency, to annual maintenance costs, to crash test performance. But what can you find out about the various makes and models of private health plans? Practically nothing it turns out.

Even the most sophisticated among us have little idea what we are paying for when we buy insurance. Private insurers, in sharp contrast to the public Medicare plan, have been able to keep confidential claims, cost and quality data, on the ground they are business trade secrets. We can't find out what specific services will be covered and when, or average out-of-pocket costs for typical conditions, let alone which insurers deliver the best value for our premium dollars. Informed consumer choice is a myth.

To build an efficient health care system, we need not only doctor and hospital performance information, as AHIP has called for,[1] but insurance company performance information. We need to know how much insurers are spending on health care and on what, in order to be able to assess whether or not the amounts spent are worth it.

I have spent the last 20 years helping people navigate both Medicare and private insurance, for a long time as the founder and president of the Medicare Rights Center. In the next four minutes, I wanted to take you through 1) the structural issues that may preclude needed transparency from the private insurance industry, 2) the data we need from private insurers to drive value and bend the cost curve, and 3) how health care reform can address these issues.

I. The private health insurer business model

In America today, people can't compare health plans based on value—cost and quality, not simply customer service and premiums. Though there is some HEDIS data, it is self-reported and inadequate.

The health insurance market is broken. In a competitive market, insurers would be marketing to health care users, demonstrating why they deliver the best value health care for people with cancer, diabetes and heart disease. Their message would appeal to the 20% of the population who consume 80% of health care dollars. Instead, if they deliver great care to people with costly needs, they don't want people to know. It's like the automobile companies marketing their cars to people who don't drive much.

Twelve years ago, in a New York Times Magazine cover story, Helen Darling, then manager of health care strategy and programs for Xerox and now President of the National Business Coalition on Health made this point very succinctly: "I have been sworn to secrecy by one plan that has the best AIDS program in the world. They don't want people knowing about it. They couldn't handle the results. Ideally, if we lived in a wonderful world, we would want a plan to win prizes for their wonderful care. But in reality that would kill them."[2]

To maximize their profits, health plans compete for enrollees least likely to use their product. Therefore, health plans do not advertise the specific treatments and tests covered, the conditions under which they are covered or the price of services. This is precisely the information we need to know.

Different private plans offer different value health care. The best of them come between doctors and their patients to ensure good care is received. Yet, their medical necessity and utilization review decisions are largely considered proprietary and unknown. And, we don't know whether their interventions add value, or simply increase their profits. For one example, a September New York State Medical Society survey revealed that 90% of doctors said they have had to change the way they treat patients based on restrictions from an insurance company; and 92% said insurance company incentives and disincentives regarding treatment protocols "may not be in the best interest of the patients."[3] We need to be able to understand the conditions under which insurers direct the care doctors provide their patients and the extent to which insurer behavior reins in costs and drives value or keeps people from getting needed care.

II. The data we need from insurers

Imagine that you were trying to choose a health plan. To determine whether you were getting value for your money, you'd likely want to know how much of your premium dollar goes to health care costs. If the answer were 51 percent, as the Harris County Medical Society discovered, you might decide it wasn't good value. And, you might wonder why their Blue Cross policy went up 12.4% that year.[4] You might also question why, unlike Medicare, private insurers do not have to disclose how their premiums are determined and often have no external constraints on them.[5]

Premium rates aside, are the insurers spending our premium dollars wisely? Are they paying for quality and not quantity? Are they helping to ensure that our doctors provide us reasonable and necessary care? And, are they securing the best provider rates for in-network care?

Finally, unlike Medicare, insurers often won't disclose the particular services they will pay for, or how much we will owe the doctor and how much they will cover.[6] Even FEHB plans, it appears, are not required to disclose such information. One new Congressional staffer recently was forced to stay on his family's COBRA policy rather than take the risk of inadequate coverage from the government because the FEHB plan

would not tell him what services they would cover or how much he would be obligated to pay. It's like not being able to find out how well an automobile's brakes work.

What data do researchers need to help people make informed health care choices?
1. The data and formulas used to calculate their premiums.
2. Their claims data (stripped of patient-identifying information) and denial rates
3. Their coverage protocols, including their medical necessity and utilization review edits
4. Their network-negotiated provider rates as well as their rates for out-of-network care
5. Their prescription drug rates
6. Their average cost of covering someone with a particular condition
7. Their members' average out-of- pocket costs for different conditions
8. And, ideally, the demographics of the population they serve

Today, this data would provide invaluable information. I have attached, as Appendix A, a list of basic questions insurers generally won't answer either in advance of our buying a policy or even once we are enrolled in their plans. Over time, this data would help us in efforts to compare health outcomes for people with different conditions in different health plans and how their outcomes correlate with different subpopulations. If we should know how well different cars protect us, shouldn't we know the same about insurers?

As important, disclosure of insurer medical and cost data would drive accountability from the private insurers and promote better behavior. Right now, the countless reports of insurer abuses suggest that the lack of transparency allows insurers to delay and deny care and reimburse inadequately for services rendered, seemingly arbitrarily.

Making this data available should be relatively inexpensive for insurers. As with Medicare, it should all be in their computer systems already. Coverage as well as provider rate information should be available for the general public and claims data should be available to researchers so they can correlate cost data to quality and outcomes data and report their results. Aetna is already posting provider negotiated rate information in 57 markets for its members.[7]

III. How health care reform can address the lack of transparency in the market

Up until now, we have bought into an opaque and inefficient private health insurance model that has undermined our ability to control costs, drive value and meet our health care needs. What we need is insurance that is transparent and accountable, driving delivery and payment system reform that reins in health care costs and improves quality.

Regulations will never address the insurers' obligation to put profits first. But we can drive accountability if we require the insurers to disclose their claims and denial data, their provider rates, their medical necessity and utilization review protocols.

A public health insurance option is also essential. A public health insurance option sets a benchmark for coverage, drives competition among oligopolistic insurers to rein in costs and, through its willingness and ability to be transparent and accountable, can promote

the value and system-wide change that is needed to guarantee everyone in America quality, affordable health care.

End Notes

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[4] Ken Ortolon, "Where's the Money Going? Physicians Want Employers to Ask How Premium Dollars Are Spent," May 2008, http://www.texmed.org/Template.aspx?id=6699.
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[6]Centers for Medicare & Medicaid Services, "Medicare Overview," 2009, http://www.cms.hhs.gov/mcd/overview.asp?from2=overview.asp.
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Appendix A

Basic questions most insurers will not provide answers to in advance of your buying a policy and may not answer even once you have the policy.

1. Do you cover a glucometer if I have diabetes? Do you cover diabetic supplies?

2. Do you cover tamoxifen if I am at risk for breast cancer? How much do I have to pay for it?

3. How much would I have to pay out-of-pocket for an appendectomy in-network? What are fees for surgeon, anesthesiologist and hospital? What do I have to pay for mammogram? colonoscopy?

4. How much is the average out-of-pocket cost for typical pre-natal care and low-risk in hospital birthing?

5. If I am hospitalized in network, can I count on using in-network doctors and using an in-network lab?

6. What is the highest annual/lifetime cap on hospital care available through one of your individual policies?

7. What is the monetary cap on Intensive Care Unit (ICU) coverage through one of your individual policies?

8. What percentage of total claims did you deny in 2007?

9. What is my maximum out-of-pocket costs, including copays, if I am diagnosed with high blood pressure, breast cancer or stroke through your most generous policy?

10. Does the amount you pay for a particular service or test depend on the policy I buy or do you have a standard rate across all your policies?

11. How can I find out how much a service is going to cost me before I receive it?

12. How can I find out how much a drug is going to cost me before I receive it?

Ms. CAPPS. Thank you, and now we—and I thank each of you for this interesting panel.

Mr. Deal, why don't you begin with your 5 minutes of questioning.

Mr. DEAL. Thank you, and thank you to all of you for waiting this long to be here for this. Obviously, as you know, transparency is an issue that is of importance to me.

You know, almost every other thing in life we know what the cost of it is. Healthcare we don't know. We don't know the results. We don't know what the effectiveness is of hospitals or of individual practitioners within the medical community. So transparency on all of those fronts I think is an important ingredient.

For those who would say that just because people don't pay for things out of their pocket that doesn't mean that—it means that they are not concerned about the cost, I would like for them to have been in conversations where family members, when they have a relative who has been transported to the hospital, the one thing that they always complain about is the $700 ambulance fee charged to transport their loved one for less than a mile. Now, you can believe they focus in on those kind of things, and they want to know why public programs are paying what they consider to be exorbitant prices. The trouble is they don't know those kind of things in their healthcare in general.

So I appreciate the testimony that we have received.

I think, Mr. Bachman, you almost sounded like I wrote your speech for you there. I think I agreed with virtually everything that you said. How do we deal, though, with this question of disclosure of pricing, price transparency? How do we get a handle on that? How do we best accomplish that objective?

Mr. BACHMAN. Well, there are a number of areas. First, I would like to say that the transparency that I believe is appropriate goes beyond even what has been suggested in your bill here. I think transparency on service costs, how well you are being treated, the time in the waiting room, bedside manner, things that are not clinical but are more service oriented is important disclosure.

The way we get at it is a couple of things. One of the issues that was not mentioned in the earlier panel, I didn't mention it, and I hadn't heard the words here is the internet. We are now seeing a tremendous growth in what is called web2.0, people talking to other people about their experiences with providers and physicians. So we are having people talking to other people that is creating a disclosure. That is one thing.

The second thing is the growing interest, it is slow, but there are vendors out there that are beginning to encourage providers to create package pricing so that you have one price. How much is it going to cost to treat my diabetes for the next 12 months? And that way if there is a package pricing, it is sort of a combination of the old capitation rates and fee for service mainly, but it is where the provider says I can take care of you for this amount of money, and the services don't have to fall into the traditional CPT codes or ICD9 or DRGs. It is what the hospital can show and demonstrate will work best, and employers are buying into that. But that is only at the beginning stages.

The third area that is going to push that is that is what is actually happening. I think your chart showed a third-world country. Well, that is actually happening today in most of the areas like Singapore and other countries that are getting medical travel and medical tourism, if you will, and hundreds of thousands of people are going across the ocean in order to get services that are one-tenth the cost at better hospitals, more modern hospitals, many of them managed by the major brand-name facilities in this country, and they are being treated by doctors that are trained in the United States as well. So—and they are being approved by quality organizations that approve quality hospitals in the United States as well.

So I think there is a gathering of a number of forces to push this in the right direction.

Mr. DEAL. Dr. Herzlinger, we heard Dr. Ginsburg talk about pricing on a per-episode basis, and I think we are hearing a lot of talk about how do we refigure compensation for services and episode-based, you called it package pricing. I presume it is sort of the same concept.

Dr. Herzlinger, how as we, I think we will certainly look at that issue very closely because it appears to be coming from a variety of sources, how do we make that kind of pricing information available, not just the fact that the services are being bundled but the costs associated with that bundling?

Ms. HERZLINGER. If you are asking about the administrative model——

Mr. DEAL. Yes. You suggested something similar to the FCC, I think.

Ms. HERZLINGER. Yes. Well, the most transparent market in the world is the financial market, and it has led to what is called deficiency in the markets. It doesn't mean that it is perfect. We know it is not perfect, but it is the most transparent market. There are countries all over the world that are adopting the FCC model, and the reason they are adopting it for their own financial markets is that that model creates the best transparency.

The FCC model has two parts. One is the Iron Fist. That is the FCC. The FCC has tremendous enforcement power. The Velvet Glove is an organization that is now called the FASBE, and that is a group of stakeholders. They are experts in measurements, accountants, people from the business community, CFOs of companies, and consumers. And then Velvet Glove is the one that actually determines what should be measured.

Companies have to comply with these standards. If they don't, the Iron Fist, the FCC, comes along. It has been a fantastic model that countries all over the world emulate. We should use it for healthcare. It works.

Mr. DEAL. Madam Chairman, I know my time is out, but I would ask unanimous consent to include a letter from the executive branch of the State of South Carolina supporting the concept of transparency.

Ms. CAPPS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. CAPPS. And now I allow myself 5 minutes to ask my questions, too, and as you may have noticed, the buzzer rang, and we

do have votes on the floor at the same time. We can wrap this up, but we won't be able to go to a second round, which is unfortunate.

Dr. Ginsberg, you testified that one of the key barriers to making price transparency work is the lack of transparency on quality of care. It is clear that hospitals' prices may be low because they are understaffed or they use cheap medical devices and so on and so forth. As you have pointed out, consumers may assume that high-priced providers are high-quality providers, an assumption that may have no basis in fact.

So where do we stand, this is a large question for a short amount of time, in producing information on provider quality that could be accurate and usable by consumers. If we require quality transparency tomorrow, would there be any standard? Would there be information available, and what should we be doing now or taking some steps in this direction as we seek to reform healthcare?

Mr. GINSBURG. Well, in the case of hospitals we do have some——

Ms. CAPPS. You may turn on your——

Mr. GINSBURG. Yes. I think it is on. In the case of——

Ms. CAPPS. OK.

Mr. GINSBURG [continuing]. Hospitals we do have some quality data. I think a lot has been accomplished when the Medicare Program offered an incentive to hospitals. If you would report on these measures, we will pay you a little bit more. Virtually all the hospitals have done this.

I don't think consumers are making much use of it now. It is pretty fragmented, but when it comes to the hospitals themselves, everything that they are reporting to Medicare or to the Joint Commission they are focusing on improving. An example we had on the first panel about when physicians and hospital leaders see low quality in their practice, they are very motivated to do something with it.

So I think in the next few years we can get a lot of mileage out of quality reporting and transparency just from the provider reaction to it, even if consumers using it I think is many years down the road.

And as far as price transparency, I don't have, you know, problems with it in general. I think there is potential for it definitely down the road, and my main caution was that we shouldn't get too wound up in how much it will accomplish in the short run. There are a lot of other things that have to be done to improve our healthcare system.

Ms. CAPPS. Thank you. I know there is more follow up because I am also interested in how consumers can benefit by this as they make their decisions and out into the community settings, clinics and so forth, which is where a lot of decisions get made.

But I want to turn because there are just a couple of minutes left to you, Ms. Archer. You—a key feature that consumers are interested in for most products is the warranty or guarantee. They want to know if something goes wrong there is a way to get the problem resolved. In the health insurance market, we have heard story after story about denial of claims, some very egregious appeals rights in place on paper but really not very effective.

The problem is consumers don't even know about their rights before they purchase health insurance. Can you describe what information about appeals and grievance procedures would, should be there, available to consumers in language they could understand? And do you think that more transparency on appeals and grievance procedures will be—is the way we should go in terms of ensuring that consumers, that insurers will do the right thing?

Ms. ARCHER. Yes. Thank you for that question. Actually, we have a big lesson to learn from Medicare on this front. The way Medicare works, its data about what it covers, and under what circumstances are all on the web, and if a doctor performs a procedure that is medically unreasonable or unnecessary and delivers it, it is the doctor who actually gets stuck holding the bill, because the doctor can go online and find out in advance what is covered.

If the doctor thinks it is really necessary, the doctor can tell the patient, yes, I think you should have it, but Medicare won't pay for it and have the patient sign in writing that he or she is willing to pay privately. If Medicare doesn't pay, the patient can then appeal and has gotten a written notice about it.

So the patient isn't stuck with a lot of bills from insurer denials that often patients in the private insurance marketplace face because no one knows, including the doctor in many instances, ahead of time whether the insurer is going to cover the claim or not.

So I think that model is a model that could easily be adopted to the under 65 population to help patients in terms of protections financially. If a service a doctor wants to give on this——

Ms. CAPPS. Could this be accepted by the private sector?

Ms. ARCHER. It should be accepted by the private sector, because it is the fairest way to protect the patient from receiving medically-unreasonable and unnecessary care from a doctor. Why should the patient receive the service if it really is unnecessary? Everybody is on notice that is what the insurer thinks. If the insurer is wrong, if the outside world says the insurer is wrong, the insurer is going to come under attack, under public scrutiny, and will have to change its practices. If it is appropriate and what the doctor is doing is inappropriate, then the patient shouldn't be absorbing the cost of the care.

Ms. CAPPS. I wish I had time to ask others what you think, but you believe, Ms. Archer, that Medicare does provide at least some kind of model for doing this.

Ms. ARCHER. An excellent model. And then I think, just to your second question, I think the denial and grievance information needs to be public so that, again, it can be scrutinized and people can understand what insurers are doing.

Ms. CAPPS. Thank you again very much all of you. This is abrupt because of our call to the floor, and I appreciate very much your testimony. The reason the microphone is needed is that this is part of our record now, and we appreciate that as I state, we go about making some important decisions.

[Whereupon, at 2:30 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
Making Health Care Work for American Families:
Saving Money, Saving Lives
Subcommittee on Health
April 2, 2009

I want to thank Chairman Pallone for holding this hearing.

This is the last in our series of overview hearings on health reform.

In important ways, today's hearing returns us to where we began one month ago.

At our first hearing we heard from the Congressional Budget Office, the Medicare Payment Advisory Commission, and the Institute of Medicine about the poor performance of our very expensive health care system.

Dr. Atul Gawande, a surgeon and distinguished writer, spoke eloquently about the failures of clinical decisionmaking and provision of care that too often lead to avoidable death and suffering.

He laid out a path for change over the next four years that can reduce major complications and deaths from surgery by at least one-fourth, and reduce the number of infections picked up in hospitals by 50%. This will save money and save lives.

Since then, we have heard about the need to ensure affordability of coverage, especially for working families of modest means.

We have heard about the failure of the individual insurance market to make affordable, reliable coverage available to individuals with health conditions.

We have heard about unacceptable racial and ethic health disparities — disparities that, as former Surgeon General David Satcher reminded us, result in at least 83,500 excess deaths among African Americans each year.

We have heard about the shortage of primary care physicians and nurses that has to be addressed if we are to improve the performance of our health care system.

And two days ago we heard of the crucial role that community preventive services play in addressing public health challenges like obesity and HIV/AIDS.

Which brings us full circle to this morning's hearing: "Saving money, saving lives."

We're spending A LOT of money on health care — more than twice as much, per person, as the typical developed country on health care.

And we're not getting as much for it as we should. For starters, there are still 46 million Americans without any health insurance coverage at all.

We know from the work of the Institute of Medicine that lack of insurance coverage can be lethal. Overall, uninsured adults are 25% more likely to die prematurely than adults with health insurance.

We also know, from the testimony of Dr. Gawande and others, that health insurance is essential but not sufficient to ensure access to quality care.

For example, even patients with insurance have their blood sugar checked less often than they should.

The cost in human lives and suffering from these quality failings is immense. Poorly controlled diabetes contributes to heart disease, amputation, and kidney failure.

And the economic consequences are enormous. Patients not treated properly for diabetes cost far more to treat when they develop those additional diseases and require expensive hospital care.

Despite these multiple failures in our health system, there is a way forward.

Many doctors in this country get it right, and can provide high quality care at reasonable cost.

We'll hear today from three of the nation's leading physicians — Dr. Jerry Avorn, Dr. Christine Cassell, and Dr. Bruce Sigsbee — how better information, better organization, and better support for our physicians can save money and save lives.

This hearing will be a fitting launch to the next phase of our Committee's work — designing and enacting health reform that meets President Obama's principles.

I look forward to today's testimony, and I look forward to working with Chairman Pallone and my colleagues to enact health reform.

April 2, 2009

Study Finds Many on Medicare Return to Hospital

By REED ABELSON

The nation spends billions of dollars a year on patients' return visits to the hospital — many of which are readmissions that could be prevented with better follow-up care, according to a study published Wednesday in the New England Journal of Medicine.

As many as a fifth of all Medicare patients are readmitted within a month of being discharged, according to the study, and a third are rehospitalized within 90 days.

Half the patients who returned to the hospital within 30 days of undergoing treatment other than surgery apparently did not see a doctor before they went back.

The high rate of hospital readmissions is "one of the fruits of an increasingly fragmented health care system," said Dr. Stephen F. Jencks, a former Medicare official who is an author of the study, which analyzed Medicare claims information for 2003 and 2004. He estimated that the cost of the unplanned return trips was $17 billion in 2004 alone.

Policy analysts say that while high return rates have long been a problem, controlling those costs is increasingly urgent.

"Given the current financial situation, this is no longer something we can ignore," said Dr. Anne-Marie J. Audet, a policy specialist for the nonprofit Commonwealth Fund, a health research foundation that helped pay for the recent study.

The Obama administration, as it seeks money to provide health care for more Americans, has already identified hospital readmissions as a source of potential cost-cutting. The president's budget calls for $26 billion in savings from readmissions over 10 years, which includes lowering payments to hospitals with high numbers of patients who are readmitted.

Many elderly patients who leave the hospital with a chronic illness like heart failure or diabetes are left to cope largely on their own. They often do not receive clear instructions on what medications they should be taking, and they frequently have difficulties making doctor appointments to continue their treatment outside the hospital.

"When you get out of the hospital, you need to have an active interaction with the health system," said Dr. Audet of the Commonwealth Fund, which also provided a grant to the nonprofit Institute for Healthcare Improvement to work with states to try to reduce the number of times patients go back to the hospital. "The patient has to be seen."

Some hospitals have already shown they can reduce readmissions by taking seemingly simple steps to make sure patients get necessary follow-up care when they go home or to a nursing facility.

At Geisinger Health System, a network in Pennsylvania that has been a leader in improving the quality of hospital care, doctors say they are taking varied approaches to reducing readmissions rates, depending on why the patient was initially hospitalized.

With surgery patients, for example, Geisinger has focused on educating people before they come to the hospital about what they are likely to experience and what they should expect when they leave. The effort could reduce readmission rates by as much as 20 percent, said Dr. Ronald A. Paulus, a senior executive at the health system. Geisinger's early findings, he said, indicate that if patients "are not ready by the time they come in, it's too late."

Geisinger has also found it effective to alert the patients' doctor about the hospital visit, including a brief summary of the patient's discharge plan that is sent the doctor within 72 hours of the patient's departure. That kind of simple step, Dr. Paulus noted, does not require an overhaul of the current system.

Successful measures elsewhere have included working more closely with patients or their caregivers to better manage conditions like diabetes, said Dr. Eric A. Coleman, one of the study's authors and a policy specialist at the University of Colorado at Denver. Coaching patients to be more diligent about taking their medicine and recognizing when their condition is deteriorating helps people stay out of the hospital, he said.

But Dr. Coleman also said doctors needed to take more responsibility for their patients' continuing care. "Physicians haven't really been stepping up to the plate and taking on this accountability," he said, although he said several professional societies were expected this spring to clarify the doctors' roles.

Many policy analysts say that insurers like Medicare must change the way they pay hospitals and doctors — rewarding medical providers that help patients get and stay better. Under the current system, reducing the number of returning patients can work against the financial interests of a hospital needing to fill empty beds. About one in four of the nation's hospitals derive 25 percent of their admissions from return visits by patients, according to the study.

"Reducing admissions in a hospital is quite punitive in today's environment," said Dr. Amy E. Boutwell, a policy specialist at the Institute for Healthcare Improvement. The institute is working with states including Massachusetts, Washington and Michigan to determine how to change the payment system to encourage hospitals to work more closely with doctors and others to prevent needless round trips.

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

April 1, 2009

The Honorable Nathan Deal
U.S. Representative
2133 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Deal:

On behalf of the South Carolina Department of Health and Human Services (SCDHHS), the agency tasked with administering our state's Medicaid program, I am writing in support of the tenets behind the Health Care Transparency Act of 2009. Rep. Deal and the Committee on Energy and Commerce should be commended for their efforts to explore the very timely issue of spending and billing transparency. I want to share some of our efforts to make details of South Carolina's Medicaid program more accessible to the public. While the specifics of these initiatives are not identical to the bill under consideration by the committee, the underlying principles are similar.

With an annual budget of approximately $4.8 billion, our agency serves 900,000 beneficiaries each year through a network of about 30,000 health care providers. In a relatively poor state like South Carolina, Medicaid is an integral part of the lives of many residents and a key component of the state's health care economy. Since we are wholly dependant on the support of taxpayers to fulfill the critical mission of providing health care services to underserved populations, it is appropriate that we disclose what these dollars are purchasing.

Anyone familiar with Medicaid will attest that the program's financing is extremely complicated, and at times byzantine. It is often challenging to present financial information in a way that can be easily understood by those outside of Medicaid. But I believe this fact should not be used as an excuse not to try.

We began our efforts in 2008, initially exploring ways to make our own administrative expenditures available to the public. The first phase of our initiative was to post our administrative expenditures on our agency website. This searchable database lists of all our travel expenditures, expenditures for office supplies over $100, and contractual expenses over $100. While this was a good start, more was necessary since administrative expenses only account for only about 3 percent of our total budget.

In July 2008, SCDHHS launched the Medicaid Provider Transparency Tool. This tool is a searchable database compiled from more than 25 million claims paid to health care providers throughout the state each year. The site can be searched by name, provider type (physicians, dentists, nursing homes, hospitals, etc.) or by provider location. The Provider Transparency Tool lists the dollar amount individual providers received, the number of patients they served and the average paid per visit. Hospital data also includes Disproportionate Share payments. All enrolled Medicaid providers are included by name, unless

they serve so few Medicaid patients that the inclusion of data could be used to identify individual patients. Importantly, information on the site is footnoted to minimize confusion and better explain the data.

I should note that the creation of this site was not without controversy. The agency heard from many health care providers who were initially uncomfortable with the idea that the public would know how much they had billed Medicaid for services. A few providers even threatened to stop seeing Medicaid patients as a result of this initiative. Fortunately, that did not happen and I believe the majority of providers understood the spirit in which this information was being made available to the public. Some of the feedback we received from providers was used to enhance the way information was initially presented. Since its launch last summer, the site has been visited about 60,000 times. The upcoming inclusion of a second year's worth of data likely will drive additional traffic to site.

Members of the public are using this tool for a variety of purposes, including bringing to our attention issues of potential Medicaid fraud and abuse. Just this week we received a letter from an individual detailing potential billing irregularities concerning two providers. The writer used the Transparency Tool to identify the suspicious activity.

Finally, I think it is worthwhile to view the issue of transparency in the context of the exciting and potentially revolutionary movement to health information technology. HIT promises not only to make health care more efficient, but also improve health outcomes. The long-term success of these initiatives will partly depend on patients and a citizenry that trusts the integrity of our health care institutions. Initiatives like the Health Care Transparency Act could contribute to increased public confidence in that stewardship.

Thank you for the opportunity to comment on this important legislation.

Sincerely,

Emma Forkner
Director

EF:jp

Statement of the National Home Infusion Association

to the

Committee on Energy and Commerce,

Subcommittee on Health

United States House of Representatives

April 2, 2009

Hearing on

"Saving Money, Saving Lives"

For the Record

100 Daingerfield Road • Alexandria, VA 22314 • Phone: 703-549-3740
• Fax: 703-683-1484 • www.nhianet.org

The National Home Infusion Association ("NHIA") is pleased to present this written statement for the record in connection with the Health Subcommittee of the House Energy and Commerce Committee's April 2, 2009, hearing entitled, "Saving Money, Saving Lives." NHIA represents and advances the interests of organizations that provide infusion and specialized pharmacy products and services to the entire spectrum of home-based patients. We are dedicated to advancing the health and interests of our patients who are suffering from serious acute or chronic conditions.

This is an ideal time for Congress to examine potential delivery system reforms that can lower health care costs while improving the quality of care we provide. With health care costs rising at an unsustainable rate, higher morbidity and mortality associated with hospital-acquired infections, and patient preference for care provided outside an institutional setting, policymakers should consider health care reforms that would incentivize the use of less expensive alternative sites of care. If these types of reforms are implemented effectively, we should realize lower costs, lower incidence of hospital-acquired infections, enhanced quality, and higher patient satisfaction rates.

Home Infusion Therapy: A Seminal Example of Delivery System Reform

The first step in this reform process is to remove existing barriers to home and community-based care. NHIA would like to call to the committee's attention one such barrier in the Medicare program: an administrative interpretation and payment policy that forces Medicare beneficiaries in need of infusion therapy into hospitals and skilled nursing facilities when the accepted standard of care and practice is to deliver the care at home whenever possible.

By way of background, infusion therapy involves administering medications into the patient's bloodstream via a needle or catheter. It is prescribed to treat serious infections, cancer, congestive heart failure, arthritis, digestive disorders, and other diseases and conditions that cannot be treated effectively by oral medications. Infusion drugs must be:

- Compounded in a sterile environment;
- Maintained in appropriate conditions to ensure sterility and stability;
- Administered at exactly the right dose and on the right schedule;
- Administered using the appropriate vascular access device (often a long-term device) which is placed in the correct anatomical location based on the expected duration of therapy, the pH, and osmolality of the medication;
- Administered using an appropriate drug delivery device;
- Flushed with the proper flushing solution between doses; and
- Monitored for adverse reactions and therapeutic efficacy.

To ensure safe and proper administration of infusion drugs as outlined above, home infusion pharmacies provide the following services:

- Comprehensive assessment that considers patient history, current physical and mental status, lab reports, cognitive and psychosocial status, family/care partner support, prescribed treatment, concurrent oral prescriptions, and over-the-counter medications;
- Maintenance of appropriate procedures for the compounding and distribution of sterile infusion products as outlined in the national standards and state and federal regulations;

- Drug interaction monitoring and identification of potential drug, dose or drug-catheter incompatibilities;
- Comprehensive admission procedures that include patient education of medical and disposable equipment use, medication storage and handling, emergency procedures, vascular access device management, recognition and reporting of adverse drug reactions;
- Comprehensive care planning that considers actual or potential drug or equipment-related problems, therapy monitoring with specific patient goals, and coordination of activities with other providers such as home health agencies and physicians;
- Ongoing patient monitoring and reassessment activities to continually assess for response to treatment, drug complications, adverse reactions, and patient compliance;
- Laboratory report reviews, as applicable, and subsequent consults with care professionals to adjust medication orders if necessary;
- Maintenance of appropriate physical facilities for storage, preparation, dispensing, and quality control of all infusion medications and equipment;
- Ongoing employee education and competence validation activities; and
- Performance improvement programs that include collection of clinical outcomes data, patient perception data, trending and analysis of these and other performance measurement data, and root cause evaluations of all sentinel events.
- Availability 24/7 to respond to patient needs or emergencies.

Decades ago, this type of treatment was only available in the hospital setting. However, over the last twenty-five years, innovations in medical care have enabled patients to receive infusion therapy safely and effectively in their homes, where they prefer to be. The technologies to deliver the infused drugs have made the process much more user-friendly. Commercial payers have been offering home infusion to enrollees with great success. In doing so, they have reduced or eliminated hospital stays, avoided nursing home admissions, decreased costs, and lowered the incidence of expensive and deadly hospital-acquired infections. This is a case study in saving money and saving lives.

Unfortunately, Medicare beneficiaries who require infusion and are capable of receiving this therapy in their homes are not being adequately served by Medicare Part D. The problem stems from the fact that the Centers for Medicare and Medicaid Services ("CMS") has interpreted and implemented the Part D benefit largely as a retail drug benefit. The structure that can work well for dispensing pills and other prescriptions at the retail pharmacy level is not feasible for more complex intravenous therapies that require more extensive clinical services, maintenance of highly sophisticated clean rooms, care coordination, equipment, and supplies for proper administration.

CMS's final Part D rule limited coverage of infusion therapy to the cost of the drugs alone and a retail-like dispensing fee. The regulation expressly disallowed coverage for the professional services, supplies, or equipment necessary to safely provide home infusion therapy, which typically represent more than half the cost of caring for these patients. The vast majority of patients cannot afford to pay these costs out-of-pocket and are forced to seek care where these expenses are reimbursed. Thus, CMS's interpretation has produced the indefensible outcome of requiring Medicare to pay for all costs associated with providing infusion therapy in hospitals and nursing homes while effectively denying coverage in the setting that is far less expensive,

more convenient for the patient, preferred by the treating physician, and less likely to result in secondary infections – the patient's home.

Dual-eligible beneficiaries typically had full coverage of home infusion therapy under Medicaid prior to their enrollment in Part D. Once enrolled in Part D, however, many dual-eligible beneficiaries initially experienced a disruption in care due to the states' uncertainty as to their role in providing Medicaid "wrap-around" coverage to fill in the gaps left by the drug-only coverage offered by Part D. CMS has worked with the states to resolve these issues, and this has helped to minimize disruptions in care. However, dual-eligibles continue to be adversely affected by restricted formularies, cumbersome prior authorization processes, inadequate coordination of care, and a lack of access to qualified providers in Part D home infusion networks. These issues have led to unnecessary hospital admissions and hospital discharge delays that continue to this day.

Medicare Advantage beneficiaries generally have better access to home infusion coverage because CMS permits MA plans to bundle infusion drugs, services, supplies and equipment as a supplemental Part C benefit. In addition, private health plans cover and pay for home infusion as a medical benefit, not as a retail drug benefit, and thus private enrollees can receive all of the necessary components of home infusion therapy. However, to the extent that proposed reductions in Medicare Advantage reimbursement are expected to cause some beneficiary movement away from MA and back into fee-for-service Medicare, the home infusion access problem will worsen.

For Medicare fee-for-service beneficiaries, Part D coverage limitations can pose a very real threat to health and safety for all Medicare beneficiaries. Part D does not provide for quality standards for home infusion therapy. Consequently, Medicare beneficiaries are at risk of receiving infusion drugs from entities that do not meet well-established standards of care. There were initial reports that some non-infusion pharmacies were sending non-compounded intravenous drugs by mail to beneficiaries, without educating the patients on how to mix and administer the drug, without any clinical oversight that should be provided based on community standards of care, and without the necessary supplies and equipment that are integral to the drug's safe and proper administration. Fortunately, CMS was quick to recognize the serious safety concerns and took steps to minimize or eliminate these occurrences. While these efforts have helped to address the worst abuses observed during the early weeks of Part D, the root causes of poor quality of care remain intact: a fundamental coverage shortfall, a lack of appropriate quality standards, and an alignment of incentives that do not foster quality patient care.

Putting a Face to the Problem

Mr. Diciderio Molina of Lubbock, Texas has first hand experience with the dilemma facing Medicare patients in need of infusion therapy. In 2007, doctors had to amputate Mr. Molina's right leg due to infectious complications of his diabetes. He subsequently was readmitted to the hospital with a swollen right knee caused by a staph infection. He was prescribed a prolonged course of intravenous antibiotics. Because Medicare would not pay for the services, equipment, and supplies necessary for him to receive infusion therapy at home, Mr. Molina was forced to remain in the hospital for almost two months to receive antimicrobial infusions. The result was considerable disruption and hardship for the Molina family and tens of thousands of dollars in added cost to the Medicare program. Mr. Molina is not alone.

Alaina Evans's story further illustrates the problems that can occur as a result of inadequate Medicare coverage. Alaina would be a typical 30 year old mother with an active 4-year old child at home, except Alaina suffers from cystic fibrosis (CF). CF is a chronic disease that leads to pulmonary deterioration and causes infections that require frequent IV antibiotic treatment. Before becoming totally disabled, Alaina worked as a teacher with private pay insurance that covered her home infusion treatments. This all changed when her disease worsened, she could no longer work, and she became eligible for Medicare. Now, when Alaina requires antibiotics to treat her infections, she is forced to receive her care in the hospital, at a much greater cost to Medicare. In addition, the human cost to her family is tremendous. Each time she is admitted to the hospital, her husband misses work to care for their child.

Proposed Reform

Congress can ensure meaningful delivery system reform for Medicare beneficiaries by expressly authorizing coverage under Medicare for home infusion therapy professional services, supplies, and equipment. The Medicare Home Infusion Therapy Coverage Act of 2009 (H.R. 574/S. 254), introduced by Subcommittee Members Eliot Engel (D-NY), Tim Murphy (R-PA), and Tammy Baldwin (D-WI), would accomplish this objective. This bipartisan legislation would continue to cover infusion drugs under Part D but would cover home infusion services, supplies and equipment under Part B. The bill also would require the Secretary of Health and Human Services to develop and enforce appropriate quality standards. If enacted, this legislation would lower costs and produce better outcomes. We applaud the leadership of Representatives Engel, Murphy, and Baldwin, and all the cosponsors of this legislation, in recognizing the need to address this unintended, yet serious, coverage gap for Medicare beneficiaries.

Reforming our nation's health care system is a monumental undertaking. But the complexity of financing and structuring legislation to ensure coverage for the 45 million uninsured Americans should not stand in the way of smaller, common-sense reforms that will lower the cost and improve the quality of care for a group of individuals who are no less deserving of Congress' attention. Every day that passes without meaningful Medicare coverage of home infusion therapy is a missed opportunity to bring cost-effective care in the most convenient setting to beneficiaries.

Thank you for your thoughtful consideration of these issues. NHIA stands ready to work with the Subcommittee on its efforts to ensure universal coverage and access to quality care for all Americans.

For further information, please contact Russell Bodoff, President of NHIA, at 703-838-2678, or russell.bodoff@nhia.org, or John Magnuson, Vice President of Legislative Affairs at 703-838-2664, or john.magnuson@nhia.org.

CHRISTUS Health System
Written Testimony
Energy and Commerce Committee
April 2, 2009

Making Health Care Work for American Families: Saving Money, Saving Lives

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Mr. Chairman, Ranking Member, and Members of the Committee, I am honored to provide you with this written testimony demonstrating how CHRISTUS Health System works every day to save lives by providing high quality care, while also providing cost effective care. We believe quality starts internally and radiates outward through a variety of plans, programs, protocols, processes and measures. At CHRISTUS Health, quality is everyone's responsibility. CHRISTUS supports adherence to quality metrics; effective use of technology; and expansion of Community Health Centers and School-Based Health Clinics. In addition, CHRISTUS believes that the most costly populations, including the uninsured and those with multiple chronic diseases, can be better cared for at a lower cost by incorporating the use of Community Health Workers.

HOW CHRISTUS ACHIEVES QUALITY

Quality is achieved by practicing process management ("hardwiring") and using practices that are proven effective ("evidence-based practices"), supported by technology. CHRISTUS is committed to continually improving our quality processes to create sustainable, positive outcomes for our patients, residents and customers. We define quality as a system of coordinated care processes that minimize errors, avoid harm and provide efficient use of resources for optimal clinical outcomes and satisfied customers.

In FY08, CHRISTUS Health demonstrated significant improvement in the quality metrics on our Balanced Scorecard. Core measures are a set of indicators jointly created by Centers for Medicare and Medicaid Services (CMS) and The Joint Commission in five patient care areas: Acute myocardial infarction (heart attack), pneumonia, heart failure, pregnancy and surgical infection prevention/surgical care improvement. CHRISTUS Health has shown consistent improvement in these measures in FY08. However, because our patients and residents turn their lives over to us daily, we believe they have the right to know as much as possible about us. This includes transparency not only in these clinical quality areas but also our financial performance and community benefit.

In a testament to CHRISTUS' high quality of care on an international scale, Joint Commission International, a prestigious international health care accreditation organization, accredited CHRISTUS Muguerza Alta Especialidad Hospital in September 2007, granting it the Gold Seal of Approval. This made Alta Especialidad the first hospital in Mexico to obtain Joint Commission International accreditation.

In summary, CHRISTUS agrees with many of the proposals being considered by Congress which would reward quality care and increase transparency of the quality of care provided. Nevertheless, the only way to truly achieve this model universally is to ensure appropriate reimbursement and incentives for adopting processes that lead to high quality care. CHRISTUS works toward this goal often at its own expense, but all providers are limited in what they can do by the existing system of reimbursement which does not always support quality care models.

UTILIZING TECHNOLOGY TO PREPARE FOR THE FUTURE

Through our Unity Project, CHRISTUS Health is working to ensure that our technical resources are positioned to help us to provide the best patient care possible. We are especially focusing on technology consolidation, standardization of data, process improvement, leveraging of best practices, providing better data sources for business intelligence and enhanced access to information for clinical decision making. To this end, we successfully completed our first major upgrade to the Unity systems early in the year and continue to evaluate our evolving vision for

the next phase of the Unity Project. As the health care environment continually shifts in response to changes in regulation, legislation, consumerism, aging "baby boomer" populations, increasing numbers of uninsured and advancing technology, we must work to optimize our current systems, deploy technologies and processes that reduce operating costs, improve revenue and avoid risk where the opportunity exists and increase clinician use of existing data sources to improve clinical quality and patient safety.

CHRISTUS Health broke ground on a Tier III Information Technology Center located in San Antonio in November 2007. As we move forward to support almost 350 services and facilities, the new center will help us provide innovative technology to deliver the most efficient care possible for the thousands of patients we serve. Construction on the 47,000-square-foot facility was completed in 2008. The facility will contain office space for a Service Desk, network Operations and Security Operations Center for an anticipated staff of 80 Information Technology specialists. The design of the facility will allow the structure to expand to 150,000 square feet as the technology needs of CHRISTUS and our patients continue to grow. The data center was constructed to promote tree and natural flora preservation, and all infrastructure equipment utilizes new technologies to promote efficient energy utilization and reduce operational costs. CHRISTUS currently operates eight regional data centers primarily in Texas and Louisiana, a Tier III enterprise data center in San Antonio and a disaster recovery center in Georgia.

CHRISTUS Health has taken significant early steps to incorporate health information technology (HIT), and is very appreciative that Congress provided a down payment to hospitals and physicians as incentives to continue upgrading their electronic health record systems. HIT is a priority for CHRISTUS, and these funds will facilitate early adoption of much-needed upgrades. CHRISTUS has nominated its Chief Information Office, Mr. George Conklin, for the Health Information Technology Policy Committee which will make recommendations to the National Coordinator for HIT. We stand ready to provide our expertise in the implementation of national policies that will facilitate the universal adoption of HIT.

IMPROVING THE HEALTH OF OUR COMMUNITIES

At CHRISTUS Health, we believe health care is a basic human right. But in many of the communities we serve, too many people have little or no access to health care services, which carries repercussions for uninsured individuals and society at large. All too often, the uninsured or underinsured postpone or forego preventive and primary care services because they cannot afford them, which can lead to avoidable Emergency Department visits, hospitalization, disability and economic hardship.

As a major health care provider committed to extending the healing ministry of Jesus Christ, CHRISTUS Health bears an enormous burden in providing care to the uninsured, and we believe strongly in the importance of engaging the entire community in efforts to expand access to health care. Our goals are to:

- Provide access to care by establishing or expanding medical homes and developing community health "building blocks;"
- Manage care for the chronically ill through our Care Partners program, which utilizes Community Health Workers to help clients navigate the health care system and more effectively control their chronic illnesses;
- Manage acute care through the development of clinical pathways, implementation of strategic pricing and communication plans.

In response to the rising number of the uninsured, their high utilization of Emergency Departments (EDs) for primary care and the increasing incidence of chronic health problems, CHRISTUS has implemented the CHRISTUS CarePartners program in five of our regions during the past three years. As of June 30, 2008, 12 community health workers have assisted 194 uninsured, chronically ill patients. Among the patients served, hospitalizations have been reduced by 30 percent, ED visits have been reduced by 49 percent and costs of care have been reduced by 58 percent. This innovative care management program utilizes Community Health Workers (CHWs) who act as bridges between the uninsured and the health care system. They also collaborate with health care professionals to build healthy communities. CHWs can help clients locate a doctor or dentist for treatment or access medication they may otherwise be unable to afford; provide resources for food, housing, transportation, counseling and job training; and connect them with preventative health services.

Although community health workers effectively lower costs of treating the uninsured, this service is not reimbursed, and therefore the model has challenges being replicated outside of our system. We believe that this model could also be effective for insured populations, and hope that Congress will consider a reimbursement model for it under health reform.

Community health building blocks include a wide range of health or social services that contribute to the health and wellbeing of the uninsured and underinsured. CHRISTUS works with our communities to identify gaps in local services and collaborates to construct, strengthen and sustain essential community resources.

During FY08, CHRISTUS and its community partners have helped establish Federally Qualified Health Centers (FQHCs) in Beeville and Beaumont, Texas, and expanded primary and dental care through the FQHC in Kngsville, Texas. We have also helped expand primary health care services in Texarkana, Texas, through collaboration with a local health education center. In addition, CHRISTUS has assisted in the expansion of programs providing access to prescription drugs and durable medical equipment to communities in South Texas. CHRISTUS is a strong advocate and provider of school-based health clinics, which is not only cost effective, but has on many occasions proven to save the lives of children with undiagnosed ailments such as a brain tumor.

CHRISTUS supports the expansion of programs such as FQHC's and school-based health clinics as cost effective ways to bring care to underserved communities. These strategies are consistent with the medical home model of care.

COMMITTED TO OUR MISSION

Three of the states CHRISTUS serves have among the highest rates of poverty and the largest uninsured populations in the nation. Thus we are called to serve many communities with some of the most challenging health indicators. Although New Mexico has poverty levels higher than Texas or the nation, it ranks among the best in terms of preventable hospitalizations. Data on the proportion of the low-income populations enrolled in FQHCs suggests that this may be because health issues are being properly managed in another medical home.

CHRISTUS Health is committed to improving the health of the communities we serve. We fulfill our mission by going beyond offering the highest quality traditional health care. We also support broad array of community-based services that facilitate access to care with special concern for the health status of individuals who have low incomes and are uninsured or underinsured.

CHRISTUS stands ready to work with Congress to put care within reach for all Americans. Innovative ideas such as community workers and medical homes must have a place in the reform debate to ensure that quality care is available. We believe the experience of other providers will mimic our experience -- that quality care can also translate into significant cost savings while meeting the Committee's goal of saving lives.