

House Committee on Ways and Means

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Testimony Before the Full Committee
of the House Committee on Ways and Means

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Chairman Rangel and members of the Committee, thank you for the opportunity to be with you today. America's employers recognize the need to dramatically overhaul our nation's health care system. That recognition comes from the challenges we face on a daily basis providing health care coverage to over 160 million Americans. We greatly appreciate that this Committee, Congress and the Administration are seeking to craft reforms that will change how health care is delivered and make it more affordable.

The Pacific Business Group on Health makes these comments as a nonprofit association of many of the nation's largest purchasers of health care, based in California. PBGH represents both public and private purchasers who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. The Pacific Business Group on Health represents large and small employers in efforts to improve the value of health care. We help our large purchaser members "buy smarter," and for many years we operated one of the largest small employer purchasing pools in the nation.

There is no more a single "employer perspective" on health reform than there is a single "American perspective" on reform. Employers hold a variety of positions on the big issues of financing and payment, as well as on issues such as the "public plan" and the role of government. There are, however, some core beliefs about health reform shared by virtually all businesses that we believe should guide the Committee on Ways and Means and reform discussions in general. Those core beliefs include:

- We must ensure that all Americans have health insurance by building on the current system of employer-sponsored, individual and public programs;
- We must address health care costs which are driving individual Americans to bankruptcy, making our companies less competitive internationally, creating long-term structural deficits that are breaking the banks of states across the country, and imposing unacceptable liabilities on our children;
- We must address the persistent differences between how public and private systems measure performance and pay for care. These differences lead to confusion for consumers and providers, create unacceptable price pressures on employers and engender disconnected incentives between public and private payers;
- Health care reform must support and encourage clinicians and hospitals in delivering better quality, more "patient-centered" care – which will entail doing a better job measuring what works, changing how we pay for health care and making better use of information technologies;
- We need to promote wellness and prevention, instead of focusing only on intervening after the fact; and
- All Americans – as engaged patients, caregivers and consumers – need to be given better tools and incentives to participate in getting the right care at the right time.

Americans believe in value – we seek to get the best quality possible for their money. Yet, no one is getting good value for their health care dollar. Our health care system is broken. Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients. Payments reward quantity over quality and fixing problems over prevention. Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and which are not. Consumers lack information to make the choices that are right for them. Health reform must address these underlying issues and we are heartened that the proposals in the Discussion Draft recognize and address many of these problems.

Core Employer Belief: We must ensure that all Americans have health insurance by building on the current system of employer-sponsored, individual and public programs.

The vast majority of employers continue to believe that reform should build on the employer-based system that works for millions of Americans. Employers see health benefits as a crucial tool that fosters a more productive workforce. The Discussion Draft affirms the role of employer-sponsored coverage by building on the existing system and seeking to expand coverage through small business in Exchanges across the country. Employers that offer coverage believe that the costs of insurance for their employees is substantially higher than it should be because of cost-shifting from hospitals and doctors seeking to recoup costs of caring for the uninsured and receiving underpayment by public programs (both Medicare and Medicaid). With expanded coverage, employers are hopeful that the cost-shift from the uninsured will be greatly reduced.

Particular elements of reform – especially the possibility of employer mandates – will have support or opposition from the employer community in direct relation to whether the broader package of reforms promote meaningful improvements in the cost and quality of care.^[1] As well articulated in the *Position of the HR Policy Association Regarding Reform of the U.S. Health Care System* (April 2009), large employers support the voluntary nature of the nation’s employer-based system and would consider the potential employer play-or-pay mandate only insofar as it is well-crafted, part of a wide array other reforms and fully considers “the interplay of all elements of the package necessary for reform.”

Core Employer Belief: We must address health care costs - which are driving individual Americans to bankruptcy, making our companies less competitive internationally, creating long-term structural deficits that are breaking the banks of states across the country, and imposing unacceptable liabilities on our children.

There is broad recognition that we must slow the rise of health care costs. In the Discussion Draft, several proposals have the potential of reining in out of control health care costs while simultaneously fostering higher quality care. Among the reforms proposed that are essential to reining in costs and fostering quality and access are those that support national rules to create a more competitive and affordable insurance marketplace for individuals and small businesses; developing better performance measurement; changing payment and aligning incentives for higher quality; and expanding investments in wellness and prevention.

President Obama has repeatedly underscored that health reform that does not control costs is not health reform. Similarly, Peter Orszag has been eloquent in articulating that “health care costs are the key to our fiscal future.” There is much discussion in Washington today about whether the ten-year “bill” for reform is \$1 trillion or \$1.5 trillion. These are indeed big numbers. But these costs need to be considered in the context of the projected national health expenditures for the next 10 years are expected to total \$45.2 trillion which will be borne by taxpayers, employers, and individual patients.

America's business community is looking at the scoring done by the Congressional Budget Office and shares the concern that we have not yet achieved the bottom-line savings needed. As I have noted, the Discussion Draft has in it many elements that can reform the delivery of care and make it more affordable. We believe costs are driven by inadequate prevention, poor chronic care coordination, and overuse of supply-sensitive care. To achieve sustainable cost control, the health system needs to overhaul how care is delivered and the incentives that today reward more not better care. Also, compared to many other countries one of the key reasons for our higher costs is that in America we pay more for the same services. While addressing many of these elements are part of the reform proposals, employers share the concern evidenced by the CBO's scoring that not only are we coming up short on paying for expanded coverage, we are not seeing how the reforms will achieve the \$2 trillion to \$3 trillion in savings from trend that are needed to create a sustainable health care system.

We need to be serious about reducing costs while recognizing that we cannot restructure almost one-fifth of the nation's economy overnight. As we put in place the reforms that will change how we deliver care, to be credible not just to the Congressional Budget Office but to the American people, we need to chart out the steps we will take in the coming years if – through private and public sector actions – we fail to bend the cost curve. As the Committee for a Responsible Federal Budget recently said, *“we believe that given the emphasis on crafting a plan designed to generate longer-term health care savings, the final bill should include a commitment to a certain level of longer-term health-care savings with and enforceable budget mechanism to ensure the savings are realized. Such a mechanism could include automatic reductions in Medicare and/or new taxes if projected savings are not realized. A similar type of Medicare trigger has been ignored in the past, and a new budget mechanism would have to include real teeth and have the support of Congress to be effective.”*^[2] Any budget mechanism, however, needs to consider not “just” federal spending, but the total health care expenditures of the nation. Congress must recognize that its actions to reduce costs cannot merely shift costs to the private sector. If we cannot reduce current cost trends, the nation must be ready to discuss solutions such as all-payer pricing or global budgeting.

Core Employer Belief: We must address the persistent differences between how public and private systems measure performance and pay for care. These differences lead to confusion for consumers and providers, create unacceptable price pressures on employers and engender disconnected incentives between public and private payers.

There is a need to align public and private programs on multiple fronts. The same measures of health care performance should be used to send consistent signals to providers and consumers to guide improvement, assist consumer decision-making and incent high quality and efficient care. The Discussion Draft recognizes the need to align public and private programs in a range of ways, including the efforts to align Medicare's measurement and payment practices with those of the plans in the Exchange.

Public payers such as Medicare and Medicaid tend to pay significantly less for healthcare services than do private payers. Sometimes referred to as “cost-shifting,” the actual dynamics are more complicated, as evidenced by innovative research undertaken by MedPAC. From the perspective of many employers and purchasers of healthcare, they face bargaining situations with hospitals and doctors that are stacked against them: Medicare and Medicaid, with their below-market fixed prices, result in providers seeking additional above-market prices from private purchasers. In addition, the payment models used by Medicare have, historically, incented volume over value. Private purchasers then face the dual challenge of managing not only the value of the services they pay for, but also need to overcome the deeply-embedded incentives offered by public programs' use of the fee-for-service system and lack of volume controls.

Over time, we must redress this imbalance of payment models and payment levels. Our physicians and hospitals face a bewildering array of conflicting quality incentives, payment strategies, and oversight mechanisms. As large employers evaluate proposals for a “public plan,” they are deeply concerned that such a plan could lead to cost-shifting or increased misalignment between public and private payments to providers. While policy options are complex and fraught with hazards in this space, our priority should be to align the payment models across public and private purchasers to ensure that providers are rewarded consistently for safe, high quality, and efficient care.

Core Employer Belief: Health care reform must support and encourage clinicians and hospitals in delivering better quality care – which will entail doing a better job measuring what works, changing how we pay for health care and making better use of information technologies.

As noted earlier, the Discussion Draft includes an array of proposals to improve the delivery system such as better performance measurement; changing payment and aligning incentives for higher quality; and expanding investments in wellness and prevention. Employers view these as essential building blocks of reforming our health care system.

Promoting Measurement and Quality Improvement

In the past months there have been many collaborative proposals developed to reform health care. Two groups, in particular, have come together to advocate for concrete ways that quality and value can be built into reform efforts.

First, over 200 groups under the name “Stand for Quality” – representing an array of consumers, employers, clinicians and other providers, hospitals, health plans and more – have come together to call for dramatically increased federal leadership in aligning priorities, developing performance measures to fill gaps, and engaging stakeholders in how those measures are used by the public sector (see www.standforquality.org). These recommendations call for the development of robust, independent systems for collecting and reporting performance results on patients’ outcomes, cost and patients’ views of care, and whether the right processes of care are being delivered by doctors, medical groups, hospitals, nursing homes, and other providers.

Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care. There are a range of concrete policy options that can foster better measurement – which is the foundation for all efforts to improve the value of our health care system. I want to acknowledge and note my appreciation for the fact that the Discussion Draft embraces many of the Stand for Quality recommendations, including developing processes for setting national health care priorities, supporting the development of performance measures and funding quality improvement efforts at the point of care.

I would encourage the Committee to build on its initial proposals by looking at the agreement reached by this diverse range of stakeholders. Additional actions should include increasing the level of support for developing measures in key areas such as functional status and resource use; promoting the use of standardized measures; and supporting consultative processes that assure that consumers, employers and providers can provide meaningful input to CMS in how measures are used for public reporting and payment.

Beyond the common support for expanded measurement, employers strongly support the Discussion Draft’s proposal to expand our national commitment to comparative effectiveness research so that patients can have better information to use with their doctors when deciding which

treatment is right for them. We need an ongoing, independent and robust comparative effectiveness process that will assure that decisions about care are driven by the evidence and what is in the patient's interest.

Your Discussion Draft also recognizes the importance of releasing Medicare data – referring to the new Assistant Secretary for Health Information being charged with making available Medicare datasets. Beyond that action, CMS should be directed to routinely make available the Medicare claims database to qualified “Quality Reporting Organizations” via HIPAA-compliant agreements. This would enable employer-sponsored and individually-sponsored health benefits plans to use aggregated public and private claims data to generate provider-specific health care performance results which will ultimately lead to lower premiums and higher quality of care.

Reforming Payment

Our health care system pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It does not reward better quality, care coordination or prevention nor encourage patients to get the right care at the right time. As Dr. Abraham Verghese said so well in a recent Wall Street Journal Article, we have “a skewed reimbursement scheme set up by Medicare, ... that pays generously when you do something *to* a patient, but is stingy when you do something *for* a patient.”^[3] A second broad collaborative – the Center for Payment Reform (www.CenterforPaymentReform.org) – has identified six core principles that should guide both public and private payment policies:

1. Reward the delivery of quality, cost-effective and affordable care
2. Encourage and reward patient-centered care that coordinates services across the spectrum of health care providers and care settings
3. Foster alignment between public and private health care sectors
4. Make decisions about payment using independent processes
5. Reduce expenditures on administrative and other processes
6. Balance urgency to implement changes against the need to have realistic goals and timelines

Your Discussion Draft clearly recognizes the critical role that payment reform must play in creating better value for Americans and reflects many of these principles. In particular, I applaud the inclusion in the Discussion Draft of an array of payment reforms, many of which seek to bridge Medicare and Medicaid and promote alignment with private plans. These include:

- Increasing payments for primary care in a range of ways. Fee-for-service payments do indeed need to be modified to promote primary care, better coordination and more efficient care. We need to rebalance the payment equation to better compensate providers engaged in preventive care, time spent coaching patients and coordinating care for those with chronic conditions; and relatively decrease payments for procedures and testing.
- Extending the Physician Quality Reporting Initiative and calling on that program to better integrate clinical reporting of performance through electronic health records;
- Establishing a robust set of pilot programs for accountable care organizations;
- Establishing a program to reduce payments for avoidable hospital readmissions;

- Moving away from today's quality-blind fee-for-service and "pay for quantity" approach towards support for accountable care organizations, bundled payments for post-acute care and medical homes.

As these models are implemented, however, I urge you to build in accountability mechanisms to provide a check against providers' potential financial incentives to either seek to serve only healthier individuals ("cherry-picking") or skimp on care, particularly for the most vulnerable, at-risk beneficiaries. It is critical that we build in the means to assess whether these models are enabling us to achieve better quality, more efficient, and more patient-centered care.

Revaluing Services – Considering Patient and Societal Value

The Discussion Draft recognizes that CMS should be directed to assess and fix how payments may be misvalued. Getting valuation of services right is important for Medicare and because these values are often applied by private health insurance plans. The current relative under-valuation of primary care and care coordination functions bodes ill for the aging population that will need more support.

Beyond the assessment the called for in the Discussion Draft, CMS should be directed to establish a mechanism to develop and implement a multi-year, multi-sectoral payment policy review and approval process. This mechanism would be charged with developing an integrated approach to updating existing and emerging payment models to assure aligned incentives across providers, and in the context of any state-driven and/or private sector-driven trends and initiatives.

This new mechanism should solicit input from external stakeholders through a formal multi-stakeholder advisory process that addresses all provider segments, including post-acute providers, through an annual notice and comment process. Under the current CMS processes, the overwhelming majority of comments are submitted by affected providers. While patients and their advocates and third-party payers can and do comment, the highly technical nature of the rules and policies, coupled with the limited impact of payment policies on any single patient or payer has inadvertently resulted in an unlevel playing field. As a result, CMS staff, in reviewing comments, often lack meaningful input from stakeholders outside of the provider community. [\[4\]](#)

A means to ensure meaningful input from other stakeholders is urgently needed. As a discrete complement to CMS' regulatory decision-making process, we recommend establishing a federally chartered body that includes patients, third-party payers and provider representatives to inform CMS' annual update processes. A standing Consumer and Health Care Purchaser and Provider Update Committee (CHUC) would be charged with providing independent input to CMS in its decision-making role with respect to Medicare payment levels, across all provider sectors. The new advisory group should include patients, purchasers, providers and payers – with majority representation by those who receive and pay for care -- and serve as a forum for broader multi-stakeholder input, as well as collection and analysis of relevant information. This new group would be advisory only, but it could provide a needed and fresh perspective for CMS and for Congress.

Changing Payment Decision-Making

Current payment policies – beyond the regulatory process are also too inflexible and susceptible to the focused interests of the recipients of payment. Congress should consider creation of a new entity with independent authority to implement broad direction provided by Congress. Regardless of the specific structure adopted, new processes needs to be put in place to assure that flexibility, transparency, and meaningful stakeholder input are in place to assure that changes to payment

policies are considered in the context of their impact on patients, providers, and health care purchasers.

- Congress should set the broad goals and targets for federal health care payments, but the specific decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole. The decision-making body should be structurally independent, with mechanisms in place to insulate it as much as possible from political influence in order to ensure evidence-based decisions and to engender stakeholder trust.
- Payment decisions should be guided by evidence and should balance the perspectives of consumers, purchasers, payers and physicians and other health care providers – but the perspective of those who receive and pay for care should have majority control instead those who receive payments.
- Processes and rules for making payment decisions should be simple, standardized and align value (to the extent possible) across physician, hospital and other types of health care payments.
- Payment decisions should promote consistency across private and public payers.

Assuring Competition While Promoting Payment Reform

While employers support payment reforms that encourage coordinated and integrated care delivery, we also recognize the need for policies that assure there are functioning markets – where informed patients and purchasers can fairly negotiate terms with independent providers. Health reform needs to assure there is an appropriate balance between coordination and competition.

Aligning incentives across providers and sites of care is essential to the appropriate focus on “end-to-end” quality, affordable care. In many markets, providers have formed multi-provider organizations, ostensibly to advance their clinical and financial goals, forming multi-hospital systems, multi-physician organizations, and combined hospital-physician entities. In some cases, these collaborations have resulted in higher quality and lower costs for payers and patients by focusing on generating clinical and financial efficiencies. In some instances, however, these new organizations have leveraged their market power in ways that may increase costs to patients, payers, employers and other health plan sponsors, with ambiguous impacts on quality.

Because of the concerns about potentially anti-competitive impacts of some forms of integration and coordination, there are a broad array of laws and regulations governing competition, anti-kickback, self-referral, and related issues. Some argue that portions of existing law and regulations need to be “loosened,” as they inhibit providers’ ability to coordinate care effectively. However, many others suggest that loosening existing laws and regulations is unnecessary to deliver more efficient care and could result in both higher costs and reduced choice for consumers.

Given the complex inter-relationship between competition and coordination, we support the recommendation of the Center for Payment Reform that there be established a framework that will assure that both goals are promoted. The Secretary of Health and Human Services should be directed to produce or commission a report to Congress that shall examine how policies and payment can best balance the need to both promote coordination and competition. In doing so, the Secretary should engage representatives of the Attorney General, the Federal Trade Commission, the Comptroller General, CMS’ Office of Inspector General and the Agency for Healthcare Research and Quality as well as representatives of consumers, private purchasers and providers. The report should be provided within 12 months and should address, at a minimum, the following:

- Are new laws or regulations needed to guard against the provider-based entities having or exercising market power to the detriment of consumers' interest in higher quality, less costly health care?
- Do existing anti-trust laws and pro-competitive regulations need to be revised or amended?
- Are there existing state or federal laws that have the affect of creating inappropriate barriers to healthy competition that need to be examined?
- What is the empirical research on health care markets and market competition that should inform policy development?
- What is the role of promoting transparency with respect to quality and price in fostering better market functioning?
- How can the regulatory and legal oversight promoting competition best be structured?

Core Employer Belief: We need to move to promoting wellness and prevention, instead of focusing only on intervening after the fact.

There are few areas around which there is as much agreement in the employer community as in the importance of investing in wellness and prevention. The majority of America's employers are making these investments, with over 90% of large employers supporting wellness and chronic care programs. The importance of moving from a sick-care system to one that promotes wellness and prevention is clearly articulated in the Discussion Draft, which includes proposals for a Public Health Investment Fund and for the Secretary to develop a National Plan for Prevention. As a nation, we need to get beyond the fragmentation that results in separate planning and strategies for health care delivery, public health, community prevention and planning, worksite wellness and other programs. As we move beyond this fragmentation, employers and consumers need to be at the table as priorities are shaped and strategies developed.

Core Employer Belief: All Americans – as engaged patients, caregivers and consumers – need to be given better tools and incentives to participate in making sure that they get the right care at the right time.

Health care consumers must be able to compare the quality or efficiency of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Americans need tools and incentives to help them make good health care decisions. Some of the routes that your Discussion Draft supports in this area includes bolstering the federal role of making sure that there is valid information consumers can use to compare quality and cost-efficiency of medical treatments and providers. Creating that information should allow for any users – public and private – to build on that information as long as patient privacy is protected.

The Discussion Draft recognizes the importance of considering the role consumer incentives play by proposing that Medicare remove cost-sharing provisions for Medicare beneficiaries. Medicare should join the private sector in going further. For example, Medicare should provide information and incentives for wellness and the selection of higher value providers. Private health plans are increasingly offering not just tools, but incentives for their enrollees to improve their health and make better choices among providers. Medicare should follow the same path, perhaps by requiring that restructuring the standard Medicare Supplement plans offer information and tools to facilitate patient choice.

Similarly, Medicare should learn from the cutting edge work of providers and private sector groups that are making sure that patients can fully participate in their own health care. One way that we can be sure that care is indeed patient-centered is for Medicare to support shared decision-making processes. This support can take the form of providing incentives to patients to get coaching and/or reducing payments to providers in cases where preference sensitive care (i.e., care for which there is more than one medically reasonable choice, with choices that differ in risks and benefits – such as treating chest pain from coronary artery disease or early-stage prostate cancer) was delivered in the absence of patient participation in decision-making.

Conclusion

Health reform must be about making high quality care more affordable. The employer community will work with you to develop a coherent package of reforms that foster cost control, and improves health through health promotion, prevention of illness, and effective treatment of disease and injury. We look forward to working with this Committee and with so many other Americans who share this goal.

[1] A recent survey of senior health benefits executives for large companies identified strong support for government playing a role in making insurance products available for individuals and small businesses (with over 55% supporting this role). At the same time, those surveyed held a range of views, but with more than two times as many having a negative view of the “play or pay” requirement for employers (38% strongly negative; 19% strongly positive) and establishing a “public plan” (40% strongly negative; 21% strongly positive). *Corporate Health Care Policy Forecast Survey*, Miller & Chevalier/American Benefits Council, June 2009.

[2] Committee for a Responsible Federal Budget, June 1, 2009. The concept of a budget mechanism was also recently supported by Health CEOs for Health Reform, a group of leaders representing providers and payers who made a series of proposals in “Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers” and in “Crossing Our Lines: Working Together to Reform the U.S. Health System,” by Senators Baker, Daschle and Dole.

[3] The Myth of Prevention, Dr. Abraham Verghese, Wall Street Journal, June 20, 2009, W1.

[4] While this phenomenon is present in all payment systems, it is most apparent in the area of CMS’s annual efforts to update the Physician Fee Schedule and resource-based relative value scale (RBRVS). The relative values of the services are determined by CMS using its rulemaking authority. In practice, CMS relies heavily on recommendations (provided through the notice and comment rulemaking process) by an outside committee housed by the American Medical Association (AMA): the Relative Value Scale Update Committee or the RUC. The RUC is made up of physicians that represent nearly every specialty. Many of the RUC’s recommendations are based on expert panels and qualitative, subjective assessments of the physician work and practice expense components of the RVU value. In response to CMS’ request for comments, the RUC offers its recommendations on values for new services, and recommends adjustments to values for existing services on a periodic basis.

Given the cost of analyzing and proposing new or revised RVU values, great weight is given to the RUC’s recommendations. (In March 2006, the Medicare Payment Advisory Commission

(MedPAC) noted that CMS's five-year review "does not do a good job of identifying services that may be overvalued." They further stated, "CMS has relied too heavily on physician specialty societies to identify services that are mis-valued." Five-year reviews have led to "substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time." (MedPAC, *Medicare Physician Payment*. March 2006.) All too often the perspectives of other healthcare stakeholders are notably absent and the broadly dispersed "public good" of assuring valuation for physician services that meets patient-centeredness and affordability goals is not a business priority for any one interest group.