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Committee on Ways and Means, Subcommittee on Oversight
Hospital Pricing and Health Care Costs
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Thank you for the opportunity to speak on behalf of the Pacific Business Group on Health, which includes many of the nation's largest purchasers of health care. 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 members of PBGH range from large public and private purchasers such as Bank of America, CalPERS and FedEx, to thousands of small businesses in California that we serve through our small employer purchasing pool – PacAdvantage. I welcome the opportunity to speak to you about how leading purchasers are working with consumers and providers to create market solutions for a very troubled health care system.

The Problem of Rising Hospital Costs and Quality Shortfalls

Rising hospital costs are a problem nationally, but California has been in the news recently on two fronts related to hospital pricing and the impact on consumers and purchasers. Last year, the big story was the pricing and patient selection practices for cardiac care of a Tenet hospital in Redding, California; more recently the news has been about the action of one of our members, CalPERS, to exclude some high cost hospitals from one of its HMOs offered to beneficiaries. Both stories underscore the need for change and dramatize three industry-wide issues – staggering cost increases, huge variations in the cost and quality of hospital care, and failure of the market to address these issues.

In California, hospital costs are growing at almost twice the rate of the national average. Expenditures for inpatient services in California rose at an annual rate of 11.3%[1] from 1998 to 2001, the second highest rate in the nation, almost twice the average of 5.9%[2] and nearly four times the general inflation rate of 2.9%. The picture is even worse for employers and their employees with commercial insurance – they have faced hospital cost increases of up to 20% as cost-shifting from uninsured or underfunded public programs hits employers and their employees.

Reasons for California's growing hospital costs include:

- Staffing costs, especially the shortage of nurses combined with a staff ratio mandate;
- Need for investments in infrastructure and new technologies – driven in part by need for seismic retrofit, but also by a period of underinvestment in '90s;
- Increased admissions and lengths of stay;
- Hospital consolidation, which has stifled market competition; and
- Lack of transparency differentiating hospital quality and efficiency.

Why are high costs a problem? Health care consumers, our members' employees, are footing the bill, whether through increased cost-sharing, larger contributions to their employer's premium, or a smaller paycheck. Hospital consolidation and the

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[1] Hay, Joel. Hospital Cost Drivers: An Evaluation of State-Level Data. University of Southern California. October 15, 2002. Page 14.
[2] Ibid. Page 1.

rapid acceleration of hospital cost trends not only impacts affordability, but access. Rising hospital costs drive a cycle of cost-shifting: as hospitals and doctors raise rates to recover the cost of unpaid or under-paid services. As we see cutbacks in support for public programs, the commercial market picks up a disproportionate share of hospital cost increases. Subsequent cost shifting onto premium-paying employers and consumers accelerates a vicious, self-perpetuating cycle as large employers struggle to maintain comprehensive coverage and some small employers drop coverage altogether, leading to higher rates of uninsured. Again, this is particularly true in California, where Medi-Cal – our Medicaid program – has one of the lowest reimbursement rates in the nation.

The problem is not just high cost – it is the variation in cost, and the fact that there is a total disconnect between cost and quality of care. We see variations between and within communities that defy a rational explanation and signal insufficiently competitive markets for hospital services. Gall bladder or heart surgery costs three times as much in Sacramento as in San Diego; Caesarian-section costs twice as much in Sacramento as in Los Angeles.[3]

We also see enormous cost variations within a single community. According to data collected by the state and reported by HealthShare Technology – based on billed charges:[4]

- The average charge in Sacramento (before insurer discount) for a hysterectomy ranges from $13,921 at the lowest-charging hospital to $43,931 at the highest;
- For gall bladder surgery, from $17,826 to $61,095;
- For kidney transplant, from $115,096 to $184,183; and
- For bypass surgery, from $131,735 to $225,678.

And, there is no indication that these cost differences have any relation to different levels of quality of care. Wide cost variations reveal insufficient market competition and the gap is just as large when we look at hospital quality:

- A patient is about twice as likely to have a wound infected in the bottom 25% of hospitals as in the top 25%;[5] a similar likelihood exists for getting pneumonia after surgery and other avoidable complications;
- We now have a limited set of hospital outcomes data, such as for heart surgery, which also shows wide variation in quality;
- And we know that the extent to which hospitals have in place systems to avoid medical errors, such as having adequate intensivist coverage in intensive care units or computer physician order entry, varies dramatically and is generally insufficient.

Consumers and purchasers need—and are beginning to demand—transparent cost and quality information on individual hospitals and doctors. We want to know whose care leads to better clinical outcomes. We want to know whose care leads to how

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[3] Rapaport, Lisa. Region feels pain of high hospital bills. Sacramento *Bee*. November 10, 2002.
[4] Sacramento Hospital Comparison: Full Year 2000 Inpatient Data. HealthShare Technology, Inc. November 14, 2002.
[5] Kane, Nancy M. Siegrist, Richard B. Understanding Rising Hospital Impatient Costs: Key Components of Cost and the Impact of Poor Quality. August 12, 2002. Page 30

much total spending for a hospital procedure or a year's chronic illness care, and why. We need to be able to know when high hospital or physician fees enable lower total health insurance spending over an episode or year of illness and when they merely "pile on" or exacerbate higher total health insurance spending.

Solving the problem of hospital cost and quality variation will require participation by all parties. Hospitals and physicians must embrace a culture of accountability in which their payable charges, "longitudinal efficiency" with respect to total health insurance spending, and quality are transparent to consumers. Purchasers must create an environment where hospitals compete on and are paid for performance excellence.

The Market is Failing to Assure Excellence by Hospitals and Physicians
Large employers and consumer organizations agree with the Institute of Medicine's reports in 1998, 1999 and 2001 that there is a wide gap between the health care that Americans are getting and what health care could and should be. The following figure summarizes current research and expert opinion on the approximate percentage point size of the gap.

Gap Analysis: Estimating Our Opportunity

- **50 point gain in quality reliability**
- **40 point gain in direct cost**
- **30 point gain in frequent user satisfaction**
- **20 point gain in indirect cost**
- **10 point gain in avoidable patient suffering**

References: Shuster (Rand), Wennberg (Dartmouth), Juran Institute, Schauffler (UC Berkeley), Goetzl (Medstat), Brook (Rand)

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Large employers also agree with the Institute of Medicine that closing the gap requires that purchasers and insurers correct serious flaws in the market for doctor and hospital services via two actions: (1) creating precise streams of public performance measurement of doctors and hospitals; and (2) rewarding doctor and hospital excellence via *performance-based payment*; and/or *insurance plan designs* which encourage consumer selection of better performing providers.

To accelerate these two foundations of a market solution to weak health care industry performance, large American employers launched two linked "pro-competitive" initiatives: the Consumer and Purchaser Disclosure Project ("the Disclosure Project"); and the Leapfrog Group.

The Disclosure Project is an informal partnership of *large employers, business coalitions* and *consumer advocacy and labor* that includes AARP, General Motors, Motorola, the Pacific Business Group on Health, the AFL-CIO, the Employer Health Care Alliance Cooperative ("The Alliance") in Madison, WI, the American Benefits Council, and the National Partnership for Women and Families. These groups share a commitment to health care performance accountability and the Disclosure Project's goal that *"by January 1, 2007, Americans will be able to select hospitals, physicians, integrated delivery systems and treatments based on public reporting of nationally standardized performance measures for clinical quality, patient experience, equity and efficiency."*

The Disclosure Project is promoting the National Quality Forum's (NQF) multi-stakeholder consensus process to define valid and feasible standardized performance measures and assure routine reporting by doctors and hospitals. If NQF-mediated progress proves insufficient, Disclosure Project members are committed to pursuing other options for performance reporting. The personal and economic consequences for consumers and purchasers of continued performance-blind selection of hospitals, doctors and treatments have become intolerable.

The Leapfrog Group is a private, non-profit organization of more than 130 of America's largest private and public employers and unions that provide over $56 billion in health benefits annually. Members commit to encouraging their employees to select, and/or their insurers to reward, better-performing hospitals, doctors, and treatment options. The "Frogs" initially focused on identifying and rewarding hospitals that excelled in three important patient safety features. The Leapfrog Group is now expanding its focus beyond patient safety and aligning its market rewards with doctor and hospital excellence across all of the performance domains advocated by the Disclosure Project.

The Disclosure Project and the Leapfrog Group are creating the national groundswell that is being translated into real first steps for both consumers and providers. I heartily recommend MedPAC's June report, which not only highlights innovative strategies undertaken by purchasers, but underscores how Medicare – like much of the private market – falls short by providing few incentives to providers or consumers; and does too little to encourage efficient delivery and organization of care.

Solutions To Reforming the Market

Purchasers look to the health plans we contract with to ensure that hospitals are not being overpaid, are being rewarded for better performance, and to provide valid tools so consumers can make better-informed choices. Nationally we should have the same expectation of CMS in its administration of Medicare. And, the good news is that in recent years we have seen CMS step up to this challenge in important ways. The four elements needed to promote higher quality and more efficient care delivery in our nation's hospitals are:

1. Expand the Availability of Standardized Performance Information

We currently have a Tower of Babel of conflicting and incomplete measures to report on hospital performance. The path to resolve this problem is to support and accelerate the National Quality Forum's efforts to identify consensus performance standards. Core funding for the National Quality Forum's efforts should come from the federal government. At the same time, CMS should not only be applauded for its focus on the importance of performance transparency, but urged to accelerate its efforts to insure that useable information on hospital and physician performance gets into the hands of consumers, providers and purchasers.

The National Quality Forum has endorsed 39 measures for hospital performance, as well as a set of 30 patient safety practices. The National Quality Forum has also endorsed 15 nursing sensitive measures and 28 serious reportable events, such as wrong-site surgery. Ten of the NQF's measures of hospital performance are currently being used for the National Voluntary Hospital Reporting Initiative (currently addressing three conditions – heart failure, pneumonia and acute myocardial infarction). States are also embracing these standards – lead by Minnesota, which requires all hospitals to publicly report on NQF's serious reportable events.

To move beyond the Tower of Babel we need to:

(1) Rapidly adopt a standardized hospital patient experience survey and quickly get H-CAHPS into the market – building on the independent good works done by CMS and AHRQ;
(2) Expand endorsed hospital measures that provide better global pictures of hospital quality, such as surgical infection rates;
(3) Develop standards for measuring the relative efficiency with which care is delivered. While this hearing is titled "Hospital Pricing" – we need to get beyond looking at mere unit price, to assess the full associated health insurance costs or "longitudinal efficiency" with which care by hospitals and doctors is delivered. Such a measure would reflect not only the price charged for an admission or procedure, but also costs related to readmission, complications and post-hospital care; and
(4) Make routinely available to the private sector, patient identity-encrypted version of the full Medicare claims data base, so private health plans can more precisely measure hospital and physician performance over longitudinal periods of illness (which most private sector plans do not have sufficient data to do on their on).

2. Reward Better Hospital Performance

There are large-scale pay for performance programs that are starting to change the market by rewarding better performance of individual physicians and medical groups. The Integrated Healthcare Association's pay-for-performance initiative in California brings together seven health plans with purchasers and over two hundred medical groups – with an estimated $100 million in bonus payments based on common measures of clinical performance, patient experience and IT reengineering. Another example is the Bridges to Excellence program – a collaborative of national employers and some health plans, that uses nationally standardized certification

projects from NCQA to reward better performing physicians in the areas of diabetes and cardiac care, as well as for their overall office practices.

At the hospital level, the Leapfrog Group has lead the way in identifying better performing hospitals based on valid comparative information – these Leapfrog measures are increasingly one of the core elements of health plans' efforts to include quality dimensions in hospital tiering or design of narrow networks – as has been done by numerous health plans, such as Blue Shield of California, PacifiCare and Health Net.

Nationally, CMS's Premier Hospital Quality Incentive Demonstration is important both because it will reward hospitals based on their performance related to six common and expensive conditions, but also it is setting the stage for sharing with consumers information that they can and will use. The recent efforts of CMS point to a promising future if CMS continues to not only innovate and explore how best to reward higher value providers, but does so in concert with private and state-based public purchasers.

3. Provide Information and Incentives to Consumers

Across the country there is a growing array of tools being provided to health care consumers to help them make better choices. Many members of the Pacific Business Group on Health, such as Wells Fargo, the University of California and Intel, provide their employees with health plan chooser tools. These tools help consumers weigh the financial impact of their choosing a particular plan – based on their likely health care utilization – along with physician availability information, and plan quality. In addition, many employers are looking to their health plans to provide tools to help consumers choose and understand treatments.

In the hospital arena, we are using first generation tools that give consumers information on how hospitals meet Leapfrog standards and provide other information such as patient experience data, when available, or complication rates. At the same time, CMS is testing how it can best convey comparative hospital performance information to consumers. Consumers want and need this information; our task is to ensure that these tools provide valid reflections of hospitals' performance – either globally or by particular treatment.

While we develop the full dashboard of performance information – purchasers must be working today to bring together cost and quality information for their employees. We cannot pretend that all hospitals are delivering the same performance. CalPERS, a member of PBGH and the third largest purchaser of health care in the United States, is continuing its leadership in health care by recently making the decision to exclude 38 hospitals across California from their Blue Shield HMO based on these facilities being substantially higher cost than comparable available hospitals – considering a dozen quality indicators in their determination. Through this action, CalPERS created a "virtual tiering" since beneficiaries that wanted these higher cost hospitals could still get them through their PPO – but they would pay more.

4. Allow the Market to Function

Finally, we need to be sure that comparative performance information can indeed be used to help consumers make better choices and to reward better performing hospitals. There is a danger in many communities that hospital consolidation will hinder these efforts. Hospitals creating networks for their joint purchasing and negotiating is fine IF those consolidations allow the market to work. A working market means:

- Allowing individual hospitals within a network to be priced differently, whether through tiers or coinsurance. Conglomerates should not be able to prevent separate tiering by quality and efficiency;
- Conglomerates of hospitals should not be able to use their market power to prevent health plans from using their data to better define higher value hospitals;
- Conglomerates of hospitals should not be able to set one rate for all of their hospitals – different quality and cost should be able to show through; and
- Conglomerates should not be able to require inclusion of *all* hospitals in their network as a condition for accessing any of them.

Sadly, the examples of intensified market competition catalyzing hospital performance breakthrough remain the exception rather than the rule. For those Americans fortunate enough to have health coverage, the vast majority are totally disconnected from the true costs of care and are making life and death choices with virtually no information. They have neither incentives nor information with which to make better hospital choices. Similarly, hospitals – like other health care providers – are not recognized or rewarded if they deliver higher quality care more efficiently.

We are still almost performance blind. The market's invisible hand requires standardized performance information for hospitals across the six IOM performance domains – safety, timeliness, effectiveness, efficiency, equity and patient-centeredness. The good news is that we are making progress and much of the credit for this lies with CMS' engaged commitment, demonstrated through their work with the National Voluntary Hospital Reporting Initiative; developing the national standard patient-experience survey – H-CAHPS; testing consumer presentations of quality information; and promoting pay for performance demonstrations.

Most consumers today don't have the information to make informed decisions about treatments or providers. Most providers are paid the same whether they deliver the highest quality or the lowest quality care, irrespective of their cost-effectiveness. The only solution to reforming health care over the long term is to change these two dynamics – consumers must have the information and incentives to make the best choices for them; and providers need to be rewarded for doing a better job. Thank you for the opportunity to be with you today.