Catalyzing a Better, Leaner American Health Care System

Employers, Unions, Insurers, and Consumer Organizations Could Greatly Improve Health Insurance Affordability and Quality via Improved Physician Performance Transparency; Access to Measurements of Physician Performance Based on Analysis of CMS Claims Data is Pivotal; Medicare's Sustainability Would Also Improve

Testimony of Arnold Milstein MD, MPH

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I am Arnold Milstein, Chief Physician at Mercer Health & Benefits and the Medical Director of the Pacific Business Group on Health (PBGH), which serves over 50 large California employers. My testimony incorporates my work with employer-funded health benefits plans operating in Nevada, Washington, Massachusetts, and California. It does not represent the positions of these organizations.

As American employers, unions, and taxpayers struggle to tame a long-standing 2.5 real percentage point gap between annual health care spending growth and GDP growth, one tool of great power remains widely unused: the measurement of individual physicians' and physician groups' relative propensity to consume health insurance "fuel" when treating an episode of acute illness (such as a broken leg) or a year of chronic illness (such as advanced diabetes). Other terms for this dimension of physician performance are "total cost of care," "all-in cost," "longitudinal cost-efficiency," or more simply "relative affordability."

After adjusting for differences in the mix and severity of illness that they treat, physicians in the same community and same medical specialty typically vary by roughly 2X in the average total dollar amount of health insurance "fuel" that they "consume" per episode of treatment. This inter-physician variation in health insurance fuel consumption is not exclusively driven by differences in physician fees or in the volume of services provided directly by a physician. Rather, it is due to differences in the many factors that physicians influence through their uniquely powerful role in recommending or incurring office visits, drugs, imaging studies, lab tests, specialist consultation, hospitalizations, and healthy behaviors. Today, the practice pattern

of more affordable physicians consumes the equivalent of 30 miles per gallon of health insurance fuel; others function as the medical equivalent of large SUVs. These affordability differences do not correlate with quality of care. Attachment A demonstrates in an illustrative community this wide difference in physician-associated health insurance fuel consumption. *Variation in affordability of physician practice patterns persists at every level of measured quality of care.*

Most physicians are unaware of the relative affordability of their pattern of practice. When physicians' relative affordability is measured, payers can use the results in four ways to encourage physician improvement. Arranged roughly in ascending order of their likely power to improve affordability, these uses are:

A.	FEEDBACK FOR MD USE IN PERFORMANCE IMPROVEMENT	Sharing affordability and quality measures with physicians and relying on their professionalism to improve the affordability and quality of their practice pattern, as was advocated for Medicare by MedPAC in 2005.
B.	PUBLIC TRANSPARENCY	Publicly releasing affordability measures, along with quality measures, so that consumers may select more affordable, high quality physicians.
C.	PAY-FOR-PERFORMANCE	Using affordability measures, along with quality measures, in physician pay-for-performance programs.
D.	PHYSICIAN NETWORK NARROWING OR TIERING	Using affordability measures to create insurance products that reward consumers with lower cost-sharing if they select more affordable, high quality physicians.

Critics of physician affordability measures reasonably question whether a physician's affordability score primarily reflects differences in (a) patients' severity of illness, health behaviors, or health care preferences; (b) the accuracy/completeness of claims data submitted by physicians; or (c) the impact of other providers. To answer this question, a number of employers, union-administered multi-employer benefits trusts and insurers have applied the ultimate test of the validity of such measures: they incentivized their enrollees to switch to quality-credentialed physicians who scored in the more affordable range (method D, above), and then measured whether per person health care spending growth slowed compared to other insurance plans in the same local area. In Attachment B, I have summarized their results: in brief, *all achieved substantial savings,* roughly in proportion to their degree of physician selectivity and salience to local physicians.

Other private sector health benefit plan sponsors are beginning to follow these pioneers. For example, Wellpoint in California is now offering a PPO plan based on a network of more affordable, quality-credentialed physicians. Its premiums are on average 9% lower than for its less selective PPO plan. However, *very few private sector health plans have enough claims experience to measure with confidence the affordability or quality for a majority of individual physicians in a community.* This leaves private sector health benefits plan sponsors with unattractive choices: (a) select physicians from among a minority of physicians with whom they do have enough claims experience; (b) select physicians based on marginal or outdated claims experience; or (c) merge claims data with other insurers. Due to inter-payer differences in claims data bases and anti-trust concerns, option (c) is very difficult and slow. That said, under the leadership of the Massachusetts state employee benefits plan, "the GIC," six of Massachusetts's seven largest insurers merged their claims data and measured individual physician affordability and quality statewide in consultation with the Massachusetts Medical Society. Health insurers began offering less costly new plans to GIC members in July 2006, based on preferential use of more affordable physicians with favorable quality scores. In other states, over 50 large employers and 6 partnering multi-state insurers participate in "Care Focused Purchasing." CFP is pursuing a claims data merger that will enable similar solutions in multiple urban areas effective January 1, 2008. HHS' BQI ("Better Quality Information") initiative will document the feasibility of merging of regional CMS and private sector claims data bases, in partnership with CMS, AHRQ and other organizations, including PBGH. However none of these pioneering efforts offer a near-term national private sector alternative to the three unattractive choices (a) – (c) described above.

Private sector progress could be greatly accelerated if CMS routinely made available the Medicare claims data base to a small number of qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This has been proposed in the Medicare Quality Enhancement Act – S.1544 sponsored by Senators Gregg and Clinton. Except for pediatric and maternity care, the Act would enable employer-sponsored and individually sponsored health benefits plans to lower premiums and raise quality of care via all four methods A-D listed on page 2, above. The single permitted use of the data would be to generate health care performance measurements, based on the aggregated claims of multiple beneficiaries. This approach to CMS claims data availability has been supported by the *New York Times* editorial board, the Business Roundtable, the SEIU, AARP, the American Federation of Teachers, and other diverse purchaser and national consumer organizations.

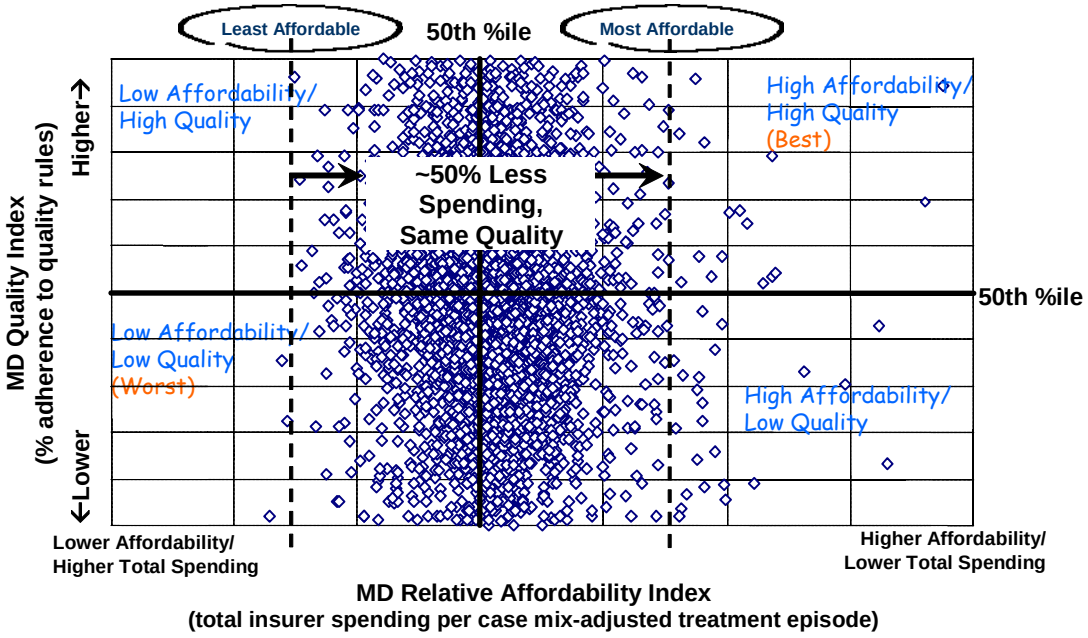
The full power of these measurement tools in America's battle to tame health insurance affordability and poor quality lies not in the one-time opportunity for pioneering employers, unions, or insurers to reduce spending 2-17% by incentivizing enrollees to link to more fuel-efficient, high quality physicians. *Rather, it lies in the motivational power of performance transparency in any industry, including the physician services industry, to propel continuous gains in affordability and quality, once consumers and/or prices begin to favor better, leaner service providers.*

To open this pathway to a higher quality, waste-free American health care system, CMS need not expend additional funds. Under S.1544, requestors of the data would pay Quality Reporting Organizations competitive prices for fulfilling each requested performance report; and the Quality Reporting Organizations would reimburse Medicare for its cost in supplying CMS claims data. Moreover, CMS, other federal agencies and their beneficiaries would reap substantial benefit, since resulting improvements in physician performance would also lift the financial sustainability and quality of care for the Medicare, Medicaid, Tri-Care, and FEHBP programs.

No one has more influence on clinical and financial outcomes than physicians do. Today's American health care market is only beginning to awaken to the error of primarily incentivizing high volumes of high margin services, rather than encouraging physician excellence in quality and "all-in" affordability. Instead of endlessly passing the hot potato of health care spending growth between payers, consumers, and providers, let's unlock the capacity of American physicians to lead continuous innovation in value for their patients in both office and hospital settings.

Attachment A

At Every Level of Quality, MDs with the Most Affordable Practice Patterns Incur Up To 50% Lower Insurer Spending Than Least Affordable MDs (each dot is a Seattle MD)



Adapted from Regence Blue Shield; for Seattle MDs

Attachment B

Proof of Concept by Pioneering Purchasers and Insurers
% Reduction in Per Capita Spending Compared to Similar Local Plans via Composing MD Networks Based on Relative "All-in" Affordability, Rather Than on Lowest Fees; Quality of Care Measures Were Unchanged or Improved

Pitney Bowes, 1995 Connecticut [1]	**17%**
Culinary Union Trust, 2003 Nevada [2]	**7-8%**
PacifiCare, 2005 Multiple States [3]	**6%**
Aetna, 2006 Multiple States [4]	**2-3%**

[1] Appendix II in "Improving the Value of Health Benefit Plans Thro ugh Consumer -Driven Health Care," Mercer Human Resource Consulting, April 25, 2002

[2] Slide 2, Testimony of Peter V. Lee before the House Subcommittee e on Health Promoting Quality and Efficiency of Care for Medicare Beneficiaries, March 15, 2005

[3] e-mail correspondence from Dr. Samuel Ho, PacifiCare, May 3, 2006

[4] e-mail correspondence from Dr. Donald Storey, Aetna, April 26, 200 6