

Testimony of Debra L. Ness
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Hearing on the Challenges and Opportunities for Health Care for All Americans
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Good morning. Chairman Kennedy, Senator Enzi, and members of the Committee: thank you for the opportunity to testify today at this important hearing on health care reform. My name is Debra Ness and I am President of the National Partnership for Women and Families. The National Partnership for Women & Families is a non-profit, nonpartisan advocacy organization with more than 30 years' experience promoting fairness in the workplace, access to quality health care, and policies that help women and men meet the competing demands of work and family. Over the past decade, the Partnership has advocated for sound reforms for our health care system to help the uninsured and promote quality health care for all Americans.

Our health care system is broken. The costs are unsustainable, and the burden falls most heavily on consumers. Since 2000, average premiums have risen 87%, while workers' earnings have only grown 20%. As a result, our employer-based system of coverage is unraveling, and we are faced with historic levels of Americans who lack health insurance, or live in fear of losing the coverage they have.

We must act, and we must act quickly. But costs, quality and coverage are inextricably linked, and if we don't both control costs and improve health care quality, we can never successfully extend coverage to all Americans. There are four tasks we must accomplish to achieve that goal: We must fix our payment system; increase transparency by measuring and publicly reporting quality; implement nationwide, interoperable health information technology (HIT); and help consumers make better health care decisions through the right kind of tools, information, and health plan benefit design.

I. Fixing Our Payment System

Our current system of paying for health care is in need of dramatic changes. In too many cases, the system perversely rewards the very things that drive up health costs and undermine quality, causing millions of patients to get care they don't need, or, worse, care that makes them sicker. Today, fully 1/3 of our health care spending is wasted on payment for medical mistakes and poor quality care. We also have a system that values expensive technology over the basic primary and preventive care that keeps people from getting sick in the first place, rewards volume of care over outcomes or appropriate care, and makes no distinction in payment based on quality or health outcome.

As our population ages and a growing number of Americans suffer from multiple chronic conditions, it is critical for our health care system to ensure that people get high

quality primary care and that there be good coordination of care. But the reimbursement methodology of Medicare and private insurers advantages specialty care at the expense of primary care and care coordination, resulting in exploding costs as they pay huge sums for services and technologies to treat diseases that could have been prevented or controlled. For example, technology has made it easier and faster to perform colonoscopies. Many gastroenterologists will perform thousands of them during the course of their careers, as many as 10 in a day. And they are rewarded by a system that provides a gastroenterologist with a payment that is 274 times the amount a family practitioner would get for the same 30 minutes of time. And that family doctor could be treating a patient suffering from diabetes, heart disease and asthma, requiring extensive patient education, coordination of care, and monitoring.

In addition, our payment system rewards providers for delivering a high volume of procedures and services, regardless of whether those procedures and services are necessary or appropriate. For example, in Elyria, Ohio – recently tagged as the “stent capital” of the United States -- Medicare beneficiaries are receiving angioplasties at four times the national rate. While no one is claiming doctors in Elyria are intentionally providing inappropriate care, there is no evidence that their patients are better off than patients in other parts of the country who are treated less expensively and less invasively. We do, however, know that Medicare is paying \$11,000 for each angioplasty.

There are many such examples of extraordinary geographic variations in care, costs and outcomes throughout our country. For example, Medicare pays twice as much to care for beneficiaries in Miami as it does for beneficiaries in Minneapolis. And yet the outcomes in Miami are no better than those in Minneapolis – in fact, by some measures they are significantly worse. Assessed on 3 main categories of care – heart attack, pneumonia, and congestive heart failure – the Miami area was among the 5 worst regions of the country for the care of heart attacks and pneumonia, and was only 29th out of 40 regions for the treatment of congestive heart failure. In analyzing these types of regional variations, researchers have concluded that the volume of services patients receive and the cost of care in an area are highly correlated with that area’s concentration of specialists. Miami, for example, has 50% more specialists than Minneapolis.

Study after study has shown that unnecessary care is rampant. But our payment system encourages it, and it is clear that care is often influenced as much by financial incentives as by medical decisions. For example, when the state of Florida lowered provider payments for workers’ compensation treatment, doctors responded by finding more treatments to perform on each patient. I do believe that most physicians want what is best for their patients, but given the way our payment system is structured, is it any wonder that providers act, and patients often think, that “more is better”?

Our payment system also makes no distinction between good and bad quality care. We pay the same amount even if poor care is provided. And we often pay more for errors that result in extra days in the hospital or in readmissions. For example, research in Pennsylvania showed that individuals who acquire infections while in the hospital cost on average \$185,260 to treat, and remained in the hospital for an average of 20.6 days.

At the same time, individuals who did not acquire such infections cost on average \$31,389 and stayed in the hospital an average of 4.5 days. The Centers for Medicare and Medicaid Services (CMS) has taken some steps in the right direction. Under the Deficit Reduction Act of 2005 (DRA), starting in fiscal year 2008, they are required to adjust payments for hospital-acquired infections. CMS is also reviewing its administrative authority to reduce payments for “never events,” and to provide more reliable information to the public about when such events occur.

In recent years, there have been numerous initiatives to reform the system by linking payment to quality. Such efforts are often referred to as “pay for performance.” A CMS-run demonstration project with the Premier hospital system has provided groundbreaking evidence that changing payment incentives can generate better patient care, reduce costs, and save lives. Hospitals in the demonstration were required to report on their performance on a series of quality measures for patients with conditions such as heart disease and pneumonia. Those hospitals that performed the best received a higher payment than others. The results were dramatic. In just one category alone, coronary artery bypass grafts (CABG), the results showed that better care costs less to treat (an average of \$30,000 as opposed to \$41,000), patients were seven times more likely to survive, had fewer complications (4% versus 11%), and spent less time in the hospital (9 days versus 13.5 days). The Premier demonstration strongly suggests that true payment reform can not only save billions of dollars but also drive significant improvements in quality.

It is time to re-align the incentives in our payment system to ensure that we encourage and reward delivery of the right care, at the right time, for the right reason, and at the right price.

II. Transparency

Payment and quality are inextricably linked. “Quality” is really making sure that every patient gets the right care, at the right time, for the right reason. And improving the quality of care is essential if we are going to control our exploding health care costs.

Unfortunately, quality in our health care system today is, in a word, lousy. The average American patient has no more than a 50-50 chance of receiving the right care for his or her condition. Every year, close to 100,000 lives are lost because of medical errors. And 1/3 of our health care spending is wasted on unnecessary or poor quality care.

The good news is that there are strategies that we know can improve quality. Measuring quality and publicly reporting the results have been shown to drive dramatic improvements in our system. “Measurement” must, of course, be premised on evidence-based best practices, and the measures used should provide meaningful information to consumers. Quality information should be publicly reported in a manner that enables comparison and helps consumers make better choices about providers.

Measurement and public reporting are proven strategies. For example, individuals enrolled in health plans that measure and publicly report performance data were more likely to receive preventive care and have their chronic conditions managed in accordance with clinical guidelines based upon medical evidence. In 2005, for patients enrolled in private health plans accredited by the National Committee for Quality Assurance (NCQA), there was improvement in 35 of 42 nationally accepted (HEDIS®) measures. And in many cases, the improvement was dramatic. In 1992, 62% of heart attack patients received a beta blocker upon discharge. Today, 96% do.

Similarly, just three years after New York adopted a public reporting system for data and outcomes on coronary artery bypass surgery, the mortality rate dropped by 41%. And as I mentioned, the Premier demonstration data from year 1 show significant improvement in the quality of care across the five key focus areas of: acute myocardial infarction, heart failure, CABG, pneumonia, and hip and knee replacement.

III. Adoption of Interoperable Health Information Technology

To effectively improve quality, we need comprehensive adoption of interoperable, secure and confidential health information technology (HIT). It is the essential platform for transparency. Specifically, it will speed the development of quality measures that are useful to providers, patients, and payers, ensure the automation of public reporting of current and future measures, and accelerate the clinical decision support that can actually improve performance. Further, emerging technologies offer us an unprecedented ability to provide accurate and actionable medical information in a secure and private form when and where it is needed, whether by patients themselves or the clinicians who care for them.

HIT can also reduce medical errors and generate huge cost savings. Researchers at RAND found that computerized physician order entry (CPOE) could eliminate 200,000 adverse drug events and save about \$1 billion a year if installed in hospitals. And about two-thirds of preventable adverse drug events could be avoided through widespread use of ambulatory CPOE. The same study concluded that HIT could generate savings for both inpatient and outpatient care of \$77 billion or more per year.

But the development and adoption of HIT is futile without the trust and cooperation of patients. For this, assurances that electronic health records are kept private and secure are essential. Yet today, consumers have little such assurance. To date, the Department of Health and Human Services (HHS) has received over 23,000 complaints about privacy violations under the federal Privacy Rule promulgated under the Health Insurance Portability and Accountability Act (HIPAA). Yet the agency has failed to impose a single civil fine. Is it any wonder that consumers don't have confidence that their medical information will be protected if it is entered into an electronic record? Any policies affecting the development and adoption of HIT must include appropriate safeguards to ensure the privacy and security of individually identifiable health information. Further, any violations of privacy or security that violate HIPAA should be actively investigated and enforced.

IV. Consumer Decision-Making

All consumers should be in a health benefit plan that creates incentives for patients to get the right care, at the right time, for the right reason. The plan should encourage and reward patients for seeking primary and preventive care, and should encourage providers to provide appropriate care coordination and follow best medical practices for the care of chronic conditions.

But not all so-called “consumer directed” health plans are created equal. Many of us approach “consumer directed” health care such as health savings accounts (HSAs) with cynicism, because little about it is truly consumer driven. Rather, much of it appears to be simple cost shifting from employers or health plans to individuals. This kind of approach not only does not solve the problem of rising costs and poor quality in our health care system; it actually makes it worse. First, encouraging HSAs won’t help us reduce the rising costs in our system because so much of health spending is non-discretionary. Studies have shown that 5% of our population is responsible for almost 50% of our health care costs. These are not people deciding whether to spend their deductible on a flu shot or dentist appointment. These are individuals with chronic, complex conditions who would quickly exhaust the deductible in any high-deductible plan. Further, research has shown that consumers in HSAs tend to get less care, especially the kind of primary and preventive care that can help them stay healthy or avoid more serious illnesses. And because of their tax incentives, HSAs tend to attract the wealthy and healthy, skewing the risk pool for those in traditional insurance, and leaving those most in need behind.

Some say that consumers need “skin in the game” in order to help bring health costs down. Presumably the notion is that consumers who have a greater financial stake in their care will not seek unnecessary treatments and choose providers who are the most cost-efficient. But consumers can’t make good choices without good information, and good information just doesn’t exist today. Consumers have access to almost no comparative data on either the price or quality of care. Patients can learn more about the quality of a toaster oven than they can about their local hospital or doctor. This is wrong, and consumers have a right to know where they can get the best care for their family.

In the absence of other information, consumers will rely on their doctor’s advice. But we know that our payment system often encourages doctors to have a “more is better” mindset; a mindset often passed on to patients. We need to better educate consumers so they can participate in shared decision-making with their physician. Research has shown that when consumers have accurate information about treatment options and alternatives, they tend to make more conservative, less invasive, and less costly decisions. And those decisions often result in better outcomes.

Consumers need good, reliable information about both the cost and quality of health care. They simply cannot make educated decisions without it. And we cannot ask

consumers to decide solely based on cost information. Would anyone ask a new mother to just go out and find the cheapest pediatrician? Or a heart attack victim to find the cheapest cardiologist? Good information about both quality and cost must be available for consumers to make true, value-based decisions about how and where to spend their health care dollars.

V. Conclusion

I believe everyone here today has the same goal: for every American to have access to high quality, affordable care. And I would urge you, if there is one thing you remember from the hearing today, remember that lasting health care reform must tackle cost, quality and coverage as a package deal. If we focus on the four things I discussed today: fixing our payment system, promoting transparency, implementing HIT, and helping consumers make better decisions, I believe we can make enormous progress toward achieving our common goal.

Mr. Chairman, members of the Committee, thank you for the opportunity to join in this roundtable today and I look forward to our discussion.