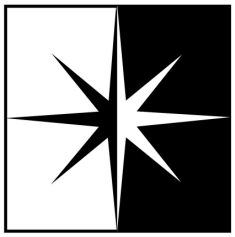

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STATEMENT OF LEN M. NICHOLS, PH.D.

DIRECTOR, HEALTH POLICY PROGRAM

NEW AMERICA FOUNDATION

SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

COMPETITION IN THE HEALTHCARE MARKETPLACE

JULY 16, 2009

NEW AMERICA FOUNDATION

1899 L STREET, NW SUITE 400

WASHINGTON, DC 20036

INTRODUCTION

Chairman Pryor, Ranking member Wicker and other distinguished members of this committee and subcommittee, thank you for inviting me to offer my thoughts today about how to improve the performance of health service markets. My name is Len M. Nichols. I am a health economist and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect an evidence-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have access to high-quality, affordable health insurance and health care that is delivered within a politically and economically sustainable system. The best way, though not the only way, to accomplish these goals is to ensure reform legislation earns bipartisan support. I am happy to share ideas for your consideration today and hereafter with you, other members of the Committee, and staff.

The United States has some of the best clinicians and facilities in the world. We are the source of much of the world's innovations in health care products and services. Yet, despite the fact that more than 16 percent of our population is uninsured,[1] we spend almost twice as much per person as our competitors. In addition, the United States has considerably shorter life expectancy and performs poorly on other population health summary measures. The World Health Organization ranks us number 32 (between Slovenia and Costa Rica) in terms of overall system performance, countries with 64 percent and 23 percent of our per capita GDP respectively.[2]

In economic terms, we pay more on average than the cost of efficient production. In fact, much of our production is amazingly inefficient. As a consequence of both problems, many patients receive care that is of sub-optimal quality. In short, we get very poor value for our health care dollars.

U.S. HEALTH CARE MARKETS

Why do U.S. health care markets underperform?

Asymmetric information among insurers, clinicians, and patients, third-party payment incentives, and local provider market power are known to be the root causes of poor health service market performance.[3] These causes are very complicated to explain. Indeed, since

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[1] The uninsured also receive roughly half as much as care as the insured.

[2] International Monetary Fund, "World Economic Outlook Database – April 2009," Accessed on July 12, 2009. Data refer to the year 2008.

[3] Martin Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" *National Bureau for Economic Research*, April 5, 2006; Paul B. Ginsburg, "Cut Medicare with a Scalpel," *New York Times*, July 12, 2009; Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs* 23, no. 2 (March/April 2004): 8-21.

"one person's excess cost is someone else's income,"[4] our cultural reluctance to intervene in markets allows this poor performance to perpetuate itself.

In addition, our health care markets lack a natural self-correcting mechanism to help drive prices to the efficient cost level and quantities to optimal quality quantities over time. In most markets, deviations from optimal price and quality levels are reduced or erased by new competitors, changes in market share, or technical innovations that lower the cost of production over time. In the U.S. health care system, however, poor market performance is perpetuated decade after decade after decade

To what extent do U.S. health care markets underperform?

Algebra can help us estimate the order of magnitude of our sub-par performance. Let P be the average price level of health services, and P* be the level we want. Let Q be the quantity of services, and Q* the optimal quantity of appropriate quality services. Let C be the average cost of a unit of Q, and C* the efficient cost of producing Q. In textbook equilibrium, P* = C*.

Table 1. Health Care Spending Variables

Variable	Definition
P	The average price level of health services. This tells us what a given procedure is likely to cost.
P*	The optimal price level of health services. This is the price level that would maximize the efficiency of our health care markets—where prices would be equal to costs. The goal is to move from price level P to level P*.
Q	The quantity of health care services currently provided. Q measures how much health care is provided within a marketplace.
Q*	The optimal quantity of appropriate quality health services. This quantity of services would be the most efficient level where we are still receiving high-quality care.
C	The average cost of a unit of Q. In effect, this measures the cost to provide a unit of health care, which is distinct from the price we pay for a unit of health care.
C*	The efficient cost of producing a unit of Q. This would be the cost at which we are providing enough, high-quality care at the most efficient cost.
PQ	Actual health spending (price times the quantity of health care provided).
P*Q*	The optimal level of health spending (optimal price times the optimal quantity of care provided).

In a perfectly competitive market that is performing optimally, prices would be driven to the efficient cost level.[5] Spending would be P*Q* = C*Q*. By contrast, actual health spending is PQ. Therefore, the ratio of actual health spending to optimal health spending is

[4] A wonderfully apt phrase first coined by Prof. Uwe Reinhardt of Princeton University.

$$PQ/C^*Q^* = (P/C)(Q/Q^*)(C/C^*)$$

This is a symbolic way of illustrating that our excess spending can be split into three distinct parts:

- **Non-competitive pricing:** the ratio of price to cost (P/C)
- **Poor quality:** the degree to which quantity or the wrong quantity does not make patients healthier (Q/Q*)
- **Inefficiency:** the ratio of actual average cost to efficient average cost (C/C*)

Specific research quantifies each of the three areas:

- **Non-competitive pricing:** the McKinsey Global institute estimates that our health service and product prices are 50 percent higher than those of other countries (P/C = 1.5)[6]
- **Poor quality:** researchers at Dartmouth, the National Academy of Engineering, and the Institute of Medicine agree that about 30 percent of our services do not improve health (Q/Q* = 1.3)[7]
- **Inefficiency:** the Medicare Pricing Advisory Commission (MedPAC) estimates that efficiency in our hospital sector, which represents the single largest share of our health dollars, varies by at least 25 percent (C/C* = 1.25)[8]

It is not unreasonable to argue that we pay roughly 2.4 times more than we should for health care when you combine these estimates by using the equation developed above.

$$PQ/C^*Q^* = (P/C)(Q/Q^*)(C/C^*)$$

$$2.4 = (1.5)(1.3)(1.25)$$

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[5] Where cost includes a normal profit to cover the cost of capital.
[6] Note: I assume other countries are not efficient producers either (C > C* there, too); McKinsey Global Institute, "Accounting for the Cost of U.S. Health Care: A New Look at Why American Spend More," November 2008.
[7] Elliott S. Fisher et al, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138 (2003): 273-287; Elliott S. Fisher et al, "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138 (2003): 288-298; National Academy of Engineering and Institute of Medicine, *Building a Better Delivery System*, (Washington D.C.: National Academies Press, 2005).
[8] Medicare Pricing Advisory Committee, "Report to the Congress: Medicare Payment Policy," March 2009.

Tools for Reform

This decomposition – non-competitive pricing, poor quality, and inefficiency – helps illustrate that it will be necessary for specific policies to be aimed at each element of our excess spending problem. It also shows how cost, quality, and prices are linked.

When prices are stuck far from the efficient cost level, policy makers have three basic tools at their disposal:

(1) Change rules related to market entry and structure to engender more market competition (e.g., antitrust)

(2) Use countervailing market buying power (monopsony) to counter local provider market power and resistance to change

(3) Impose direct regulation of prices or specific behaviors of competitors

In the remainder of my testimony, I will argue that all three are necessary to address specific market problems and achieve the salient goals of health system reform: cover all Americans and make our delivery system sustainable. Specifically, I will explore hospital, physician, and insurance markets to illustrate how each policy approach can be useful in improving health care markets.

HOSPITAL MARKETS

Impact of Competition on Medicare Efficiency

Let me be clear: most hospitals and the people who work in them do not have time to worry about the economic optimality[9] of market-wide performance. In many ways, they are doing the best they can by their patients given our inefficient system and its perverse incentives. Some leaders and organizations do amazingly well. By and large, however, we are getting the results we should expect from the rules and incentives our policies have created.

Hospital markets are heterogeneous. In general, they illustrate both the promise and problems in health service markets. The March 2009 MedPAC report to Congress helps illustrate how price, efficiency, quality, and competition are linked. The report finds that 72 percent of hospitals lose money on Medicare. Some infer from this that Medicare underpays hospitals. Thus, the solution must be for Medicare to adjust its prices upward. This is not, however, how MedPAC interprets the full set of data at their disposal.

Instead, MedPAC characterizes hospitals by the competitiveness of the marketplace in which they operate.[10] According to MedPAC, a hospital is in a "high-pressure" market if their non-

[9] To be perfectly optimal, the market must have distributed all goods and services in a way that maximize everyone's happiness. In a non-optimal situation, even just one person's happiness could be increased by a different distribution of goods.

[10] They do not judge competitiveness like antitrust authorities (e.g., using Herfindahl-Hirshman index scores), but rather they adopt a more performance-based standard.

Medicare operating margin[11] is 1 percent or less and if their net worth would grow by 1 percent or less if their Medicare margin were zero. These hospitals depend on Medicare for growth and financial success. By contrast, a market is "low pressure" if hospitals have non-Medicare margins of at least 5 percent and if their net worth would grow by more than 1 percent if their Medicare margin were zero. These hospitals lose money on Medicare and depend on private payers for financial strength. "Medium pressure" hospitals are those whose margins and net worth paths fall in between.

Table 2. Median hospital operating margins in markets arrayed by competitive pressure

	High pressure	**Medium pressure**	**Low pressure**
Medicare margin	4.2%	-3.8%	-11.7%
Non-Medicare margin	-2.4%	4.5%	13.5%
Share of all hospitals	28%	14%	58%
Share of large teaching hospitals	53%	18%	29%
Share of all discharges	27%	37%	36%

Source: MedPAC March 2009 Report to Congress, table 2A-7, p. 61.

Hospitals with negative Medicare margins compensate for Medicare shortfalls by charging other payers more to achieve very large non-Medicare margins. This is possible because of their local market power vis-à-vis private payers, commercial insurers, and self-insured employers alike.

In the most competitive markets, however, non-Medicare margins are negative. As a result of competition in these markets, hospitals cannot compensate for negative Medicare margins with large, positive non-Medicare margins. Therefore, their positive operating margins are solely a result of their relative efficiency in serving Medicare patients. Thus, they are highly motivated to become efficient enough to make money off Medicare payments.

These data show that competitive pressure leads hospitals to be more efficient. The 28 percent of hospitals in high pressure markets find that Medicare payments are more than enough to cover the costs of delivering care to Medicare beneficiaries. This is proof, to MedPAC and to me, that Medicare payments are adequate. We need new tools, however, to engender inefficient hospitals in non-competitive markets to improve.

[11] The non-Medicare margin includes private, Medicaid, and uninsured patients.

Range of Efficiency in Medicare

The range of efficiency (or inefficiency) in Medicare is considerable. In March 2009, MedPAC also examined median Medicare margins for those hospitals with Medicare margins less than -10 percent and those hospitals with positive Medicare margins. The median Medicare margin among those hospitals with a Medicare margin less than -10 percent was -20 percent. For those hospitals with a positive Medicare margin, the median Medicare margin was +7.6 percent.

Table 3. Medicare margins by hospital category

Category of Hospital	**Median Medicare Margin of Category**	**Average Overall Margin of Category**
Medicare margins less than -10%	-20%	4.6%
Positive Medicare margins	7.6%	3.4%

Source: MedPAC March 2009 Report to Congress

Thus, the *median* efficiency differential for the same[12] patients is 27.6 percent. The complete range of the efficiency distribution across hospitals must be much larger.

In general, the stunning fact is total margins (including all patients) are highest for the least efficient hospital group. For those hospitals with Medicare margins below -10 percent, the average overall margin is 4.6 percent. Hospitals with positive Medicare margins have overall margins of 3.4 percent. Private market pricing power of inefficient hospitals must be considerable. This pricing power has a larger effect on their bottom line than efforts at cost cutting by hospitals in more competitive markets.

Solutions

Before I discuss specific solutions below, it is important to identify three potential approaches that will fall short of comprehensively addressing the underlying problems driving inefficient hospital markets:

- **Increased anti-trust regulation alone is not enough.** Some local payers have lamented the relative absence of antitrust enforcement in hospital mergers.[13] Since the FTC and Thomas Greaney are also testifying today, I will merely note that in many cases the underlying source of local market power for hospitals (and sometimes for single specialty or large multi-specialty physician groups) cannot be remedied effectively with traditional antitrust tools such as stopping a merger or a divestiture order. This is because the hospital (or physician group) is likely to either be a *de facto* monopoly (natural or not) or have an outsized quality reputation, a form of product differentiation that is impossible or difficult to calibrate and divest.

[12] The "same" patients means that they are case-mix adjusted Medicare patients.

[13] Antitrust authorities tried and largely failed to win for the wrong reasons in the 1990s; Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs* 23, no. 2 (March/April 2004): 8-21.

Quality reputation and actual quality are not necessarily the same. The last step in MedPac's analysis of these different hospitals examined and compared performance quality by efficiency class. Predictably, they found that the most efficient hospitals *also* consistently produced higher quality patient outcomes.[14] [15] Patient satisfaction, however, was statistically indistinguishable between efficiency groups. Therefore, people on average do not know (or care) about true quality differentials. This is what makes quality reputation so difficult to change by antitrust or any other traditional means.

- **Simply paying providers less will not solve the inefficiencies driving health care cost growth.** The solution is not just about paying hospitals and providers less. It is about changing the incentives of health service delivery so that we move from a volume-based to a value-based system. If we did nothing but just pay hospitals less, hospitals in low and medium pressure markets would raise private payer rates even more. We must have a system-wide solution to the three problems of prices higher than cost, sub-optimal quality, and inefficient cost structures, or we will have no solution at all.

- **Market forces alone cannot solve the problem.** In much of the country, there are insufficient market forces to drive prices to the efficient cost level without policy intervention.[16] This does not mean there is no role for market forces, but we must be realistic about their potential and limits. Smarter Medicare payment policy, coupled with information and teaching tools, more transparency, and evidence-based regulatory changes can actually make latent market forces far more effective than they have been heretofore.

The only buyer with enough market clout to challenge hospitals or physician groups with considerable local market power is Medicare. **Therefore, Medicare payment reform is the key to optimizing hospital market competition**. A growing chorus is calling for significant restructuring of the Medicare payment structure.[17]

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[14] The patient outcomes were measured by risk adjusted mortality for a variety of conditions.

[15] This is one more bit of evidence supporting the conclusion that we can lower costs while improving quality nationwide.

[16] This was the conclusion of a team of researchers from the Center for Studying Health System Change five years ago. Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley, "Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning," *Health Affairs* 23, no. 2 (March/April 2004): 8-21.

[17] Health CEOs for Health Reform, the Bi-Partisan Policy Center, noted scholars like Robert Berenson and Larry Casalino, David Cutler and Judy Feder, Elliott Fisher, Mark McClellan, and John Bertko, MEDPAC itself (more gently), the Center for Payment Reform, and very recently the New York Times Editorial Page all support it. The Obama White House and OMB Director Peter Orzag are also generally supportive, judging by their proposals in the President's Budget and beyond and by continuing policy statements linking health reform with economic sustainability and fiscal balance which will clearly require Medicare cost trajectories to be brought under control. Early health reform legislation and proposals in the Congress also include some elements that would move toward serious payment reform in the Medicare program, but many commentators are hoping you will all be emboldened by our arguments and logic, and in particular by the credibility of the health system stakeholders who are willing to embrace this approach, so that you will go even further in the final legislation that is sent to the President's desk to sign this fall.

The overall strategy of fundamental payment reform in Medicare is complex. I will summarize key elements here since Medicare payment reform is not under the direct jurisdiction of this committee. Payment reform is, however, highly relevant to discussions of competitive performance in health care markets.[18]

A few observations at the outset:

- **Getting prices to efficient cost levels quickly will be difficult.** Therefore, we should focus first on achieving optimal levels of quantity and quality, while we try to bring costs down to their efficient levels over time.

- **The current Medicare payment structure drives inefficiency.** Separate payment for 8,000 Current Procedural Terminology (CPT) codes and 745 diagnosis related groups (DRGs) is not likely to facilitate optimal quantity or quality.

- **Some organizations and communities actually do provide something close to optimal quantities and optimal cost levels today.** Examples include well-integrated systems like the Billings Clinic, Geisinger Health System, Denver Health, Intermountain Health Care, Kaiser Permanente in Northern California and Colorado, Mayo, Marshfield Clinic, Virginia Mason Medical Center and Group Heatlh Cooperative (both in Seattle), and collaborative communities without integrated systems, like Grand Junction, Colorado.

Combining these observations leads me to the following conclusions.

- **Fee-for-service payment methods are unsustainable.** Medicare should announce that it will lead the transition away from fee-for-service payment within a specified time frame. Medicare payment should move toward more bundled payment structures that are adjusted for patient acuity and tied to efficient quantities and cost

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See for examples: Health CEOs for Health Reform, "Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers," *New America Foundation*, June 12, 2009. For more information, visit: http://www.newamerica.net/hc4hr; Howard Baker, Tom Dashcle, and Bob Dole, "Crossing Our Lines: Working Together to Transform the U.S. Health System," *Bipartisan Policy Center*, June 17, 2009;Len M. Nichols and Robert Berenson, eds., *Making Medicare Sustainable,* (Washington, D.C.: New America Foundation, 2009);Melinda Beeuwkes Buntin and David M. Cutler, "The Two Trillion Dollar Solution: Saving Money by Modernizing the Health Care System," *Center for American Progress*, June 24, 2009; Ellen-Marie Whelan and Judy Feder, "Payment Reform to Improve Health Care: Ways to Move Forward," *Center for American Progress*, June 24, 2009;Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner, "Fostering Accountable Health Care: Moving Forward In Medicare," *Health Affairs* 28, no.2 (March/April 2009): w219-w231;Medicare Payment Advisory Committee, "Report to the Congress: Reforming the Delivery System," June 2008;Center for Payment Reform, "Principles," http://www.centerforpaymentreform.org/Principles.html, Accessed July 2009;"Financing Health Care Reform," *New York Times*, July 6, 2009;Senate Finance Committee, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs," *Description of Policy Options*, April 29, 2009; House Committees on Ways and Means, Energy and Commerce, and Education and Labor, "Key Features of the Tri-Committee Health Reform Draft Proposal in the U.S. House of Representatives," June 9, 2009.

[18] For more elaboration, read: Health CEOs for Health Reform, " Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers," *New America Foundation*, June 12, 2009; Len M. Nichols and Robert Berenson, eds., *Making Medicare Sustainable,* (Washington, D.C.: New America Foundation, 2009).

structures.[19] This announcement will also be catalytic in moving the broader health system toward more value-based payment incentives.

- **We must give providers the tools they need to succeed.** Moving away from fee-for-service payment will be welcomed by many if it includes a commitment to coordinate the production and dissemination of best practice knowledge across private and public sectors through a program similar in scope to the Cooperative Extension Service in agriculture. In addition, this will require public investments in electronic medical records, decision support tools, best practice research, and interoperability standards.

- **We must reduce the barriers to high quality and efficient practice styles wherever they exist.** Evidence based regulation is just as essential to our health system's future as evidence based medicine. We must consolidate and streamline the monitoring and oversight of providers into distinct but complete quality, financial, and educational dimensions. Malpractice reform will protect clinicians who utilize agreed upon best practice protocols.

- **Clinicians must be able to share in the savings from high-quality, efficient care.** Existing antitrust laws, anti-kickback statutes, anti-bribing laws, and other laws and regulations often make it difficult for clinicians and hospitals to share in the savings realized when costs and utilization are reduced—sometimes known as "gainsharing." In order to move toward more bundled payment models, we must develop statutory and "safe harbor" solutions so that clinicians and hospitals can negotiate and share in resource savings when quality and patient care standards are met. Antitrust and regulatory authorities may feel these rules are clear and optimal already. Many clinicians and hospitals, in my experience, do not agree.

- **Medicare Advantage plans should bid competitively.** We must stop overpaying Medicare Advantage plans by formula. The Medicare Advantage plan should move toward a competitive bidding payment structure that also rewards high-quality care and patient satisfaction.

- **Medicaid must also be held to quality and efficiency standards.** Once Medicaid payment rates are increased (as they must be), providers and managed care plans should be expected and required to meet the same quality standards as they do for private and Medicare enrollees. Our goal should be nothing less than complete parity and equity across insured and ethnic groups.

Innovations in Medicare payment structures should spread to the private sector. Yet, provider market power outweighs payer power in most markets today. As a result, even if

[19] Bundled payment means combining the payments to hospitals and physicians – and a sufficient amount to purchase appropriate drugs, devices, and ancillary tests along the way – into one patient acuity-adjusted amount that will then be shared.

Medicare moves to value-based payment rules there is a real danger that hospitals could simply "charge" their way out of efforts to drive efficiency.

All payer rate setting does come to mind. Savvy analysts have recently recommended this tool be added back into the policy arsenal.[20] It is a logical solution to the problem of local provider market power. However, it would require a far more elaborate regulatory apparatus than we have today. It would also tilt the playing field against providers and toward private insurers at a time when we really need providers to help usher in a value-based not volume-based health system. We might also benefit from innovation in private payer incentive contracts. These innovations could be foreclosed by a rapid push to all payer rate setting. It is hard to know which problem to tackle first, but perhaps a good rule of thumb is to not adopt the experiment that could end all experimentation.

Another potential solution to poor private market performance because of local market power is making Medicare bundling software, incentive forms, data reporting, shared savings contracts (with providers), and bundled price levels completely transparent and available to all. This would allow private insurers to quickly adopt them, piggybacking on Medicare's processes. Medicare could provide a bonus payment to providers who agreed to use similar bundling and incentive contracts with all or a critical mass of private insurers. This would likely improve the quality and efficiency of care delivery throughout the health care system, including for Medicare beneficiaries themselves.

PHYSICIANS

The top two problems with physician market performance at the current time are:

(1) Too little payment for care coordination, evaluation, and management services. This results in the undersupply of these services and presents a serious threat to the long-term viability of primary care physician practices[21]

(2) Distorted prices from physician-owned capital equipment and facilities, which lead to too much diagnostic testing, technical procedures, and excess system costs

Flaws in Relative Physician Payment

As a result of flaws in the way Medicare and private payers pay physicians, we pay too much for some things and not enough for others. These distorted prices are "stuck," and do not adjust.

The Medicare physician pricing rule, resource based relative value scale (RBRVS), determines the time cost of each procedure in the 8000 CPT code manual and "values" a physician's time in proportion to the length of their training. By definition, this favors specialists over primary care. This technique is essentially an application of the labor theory of value. As

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[20] Stuart H. Altman, "Financing Comprehensive Health Care Reform," *Testimony Before the U.S. Senate Committee on Finance*, May 12, 2009.

[21] Thomas Bodenheimer, "Primary Care – Will it Survive?" *New England Journal of Medicine* 355, no. 1 (August 31, 2006): 861-864.

such, it tries to build a market value by valuing only supply side inputs, without taking into account the value to patients and payers.

Adjustments to the RBRVS have been made repeatedly over the years. Yet, the all-physician committee that recommends updates is heavily dominated by specialists. All changes to the fee schedule must be budget neutral for the program. Payments to specialists would need to be cut in order to raise the fees of primary care providers. The Center for Payment Reform is leading an effort to get this RBRVS update committee (RUC) process changed to be more representative of all physicians and of payer interests.[22] More importantly, this effort is seeking to reassess the RBRVS to account for the value of services from the perspective of patients and payers.

Most private payers effectively use the RBRVS as the basis for their fee schedule's *relative* payments to physicians, as the Medicare program's analytic work is like a public good which others can use for free. Private payers do use a different multiplier or "conversion factor" to translate the RVS per CPT code into dollar prices. Most often they pay more than Medicare, but not always.[23] This wholesale adoption of RBRVS by private payers has had the unintended effect of making the powerful force of inertia oppose making adjustments to pay primary care physicians more.

Why more private insurers do not deviate from the RBRVS on their own is unclear. This could be a result of simple economics. Because most payers effectively follow RBRVS, insurers do not have to pay more and go to the trouble of adjusting the RBRVS schedule because they can attract the primary care physicians they need by paying the lower rates. Yet, we face single digit percentages of new doctors going into primary care. This is a truly unsatisfactory result and one we must change to build the 21st Century health system we want and need.

No single private insurer has a large enough market share to reverse the underpayment of primary care physicians caused by the RBRVS. One insurer paying more than "market" rates cannot deliver enough market share to enable primary care physicians to raise their reservation price (i.e., refuse to accept patients from all insurers that have not raised payment rates). Therefore, the first payer would end up just increasing its costs relative to its competitors with no salient effect. That just will not happen. Once again, fundamental payment reform within Medicare must be part of the solution. Medical home models[24] are promising. But perhaps the most promising development are bundled payments that span

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[22] Peter V. Lee, "Health Care Reform: Creating a Sustainable Path to High Quality Health Care for All Americans," *Testimony before the U.S. House of Representatives Committee on Ways and Means*, June 24, 2009; Peter V. Lee, "Payment Reform: Getting the Payments Right Means Getting the Process Fixed," *Pacific Business Group on Health*, June 12, 2009.
[23] Paul Ginsburg, "Comparing the Traditional Medicare Program to Private Insurance," *Testimony before the U.S. Senate Committee on Finance*, May 12, 1999.
[24] American College of Physicians, "Patient-Centered Medical Home," Accessed July 2009: http://www.acponline.org/running_practice/pcmh/; American Academy of Family Physicians, "Patient-Centered Medical Home," Accessed July 2009: http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html; Patient-Centered Primary Care Collaborative, "Joint Principles of the Patient-Centered Medical Home," February 2007.

the ambulatory,[25] acute, post-acute, drug, and ancillary costs of treating specific patients combined with shared savings models to encourage collaboration, coordination, efficiency, and quality care.

For shared savings, bundled payment, and some pay-for-performance payment models to work in settings outside a completely integrated delivery system, guidance and exemptions from some antitrust enforcement impulses may be necessary. I expect Thomas Greaney or the Federal Trade Commission (FTC) to have more insight. But I do want to make clear that revisiting antitrust prohibitions on collaborative[26] price incentive negotiations is warranted. I would recommend a task force jointly chaired by the Attorney General, the Chairman of the FTC, and the Secretary of HHS be formed as soon as possible. This should not wait for comprehensive health reform legislation to pass. We must pursue this type of payment reform regardless of potential coverage reforms.

Physician-owned Capital Equipment and Facilities

The second big physician market problem is one wherein some physicians' entrepreneurial impulses, combined with incentives partially created by past attempts to prevent self-referral, leads to growth in use and total cost that is not improving patient outcomes. This phenomenon has been masterfully described by Atul Gawande in his recent *New Yorker* article.[27] Currently, physicians can maximize income by investing in equipment and even facilities like specialty hospitals or labs rather than focus on delivering high quality evidence based care as efficiently as possible. This illustrates that payment reform must be considered broadly. Facility fee distortions to returns on investment, assumptions about percent time used, and proper depreciation schedules of physician-owned diagnostic equipment must all be on the table.

One option could be to consider allowing physicians who have overinvested in imaging equipment to have a one time immediate complete depreciation allowance and then find other uses for the machines elsewhere. These currently overused machines are kind of like toxic assets. We must get rid of them – or move them to more productive locations – before we can achieve the efficiencies we need.

INSURANCE MARKETS

Another witness is focusing on insurers so I will address two problems I think are most important about insurance market competition very briefly.

Exclusion of sick from risk pools. This must be solved through insurance market reforms, specifically requiring all insurers to sell to everyone (guaranteed issue) and prohibiting health status rating (guaranteed renewal, modified or pure community rating). To make insurance markets both more efficient and fairer, everyone must be required to

[25] Primary and specialist
[26] multi-insurer and multi-provider
[27] Atul Gawande, "Annals of Medicine: The Cost Conundrum," *New Yorker*, June 1, 2009.

purchase or obtain coverage.[28] This set of reforms will force insurers to compete based on price, value, and customer satisfaction rather than marketing and underwriting.

Many insurance markets lack adequate competition, especially in the small group market. The consolidation of the insurance industry is well-documented.[29] Therefore, I will focus on Arkansas. I grew up in Arkansas and had the opportunity to study the Little Rock market professionally while Vice President of the Center for Studying Health System Change from 2001-2004. The most recent data available show that Blue Cross Blue Shield of Arkansas has a market share of 75 percent in total. Its closest competitor, United, has a market share of 6 percent.[30] United's position has deteriorated since 2003 when I studied the Little Rock market.[31]

Competition in the Arkansas Small Group Market

How does Blue Cross Blue Shield of Arkansas maintain their dominance? During the Center for Studying Health System Change study in 2003, we were told by many respondents in Little Rock that Blue Cross Blue Shield of Arkansas reimbursed physicians at very high levels, substantially more than Medicare rates. This level of payment made physicians reluctant to contract with other plans such as United, Cigna, or Aetna who reimburse at lower rates. If physicians insist on "market" or "Blue Cross Blue Shield" payment levels, it makes it very difficult for other insurers to enter or grow in the market.

There is nothing illegal about this. In fact, at first glance premiums in Arkansas do not look unreasonably high. Premiums in Arkansas are about 21 percent lower than the national average.[32] Of course, this reflects the fact that median household income in Arkansas is 21 percent below the national average as well.[33]

Yet, the average deductible in Arkansas in the small group market – the market where competition is lacking in so many states – is 23 percent of the premium.[34] This compares with 17 percent nationwide. In other words, Arkansans are buying less-generous-than-average policies.

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[28] Len M. Nichols, Reforming the Health Care Delivery System," *U.S. Senate Committee on Finance*, April 21, 2009; Len M. Nichols, "Addressing Insurance Market Reform in National Health Reform," *U.S. Senate Committee on Health, Education, Labor, and Pension*, March 24, 2009.

[29] John E. Dicken, "Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market," *Government Accountability Office*, February 27, 2009.

[30] Ben Furnas and Rebecca Buckwalter-Poza, "Health Care Competition: Insurance Market Domination Leads to Fewer Choices," *Center for American Progress*, June 2009; American Medical Association, "2007 Update: Competition in Health Insurance, A Comprehensive Study of US Markets: 2007 Update," http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.

[31] Aaron Katz, Joy Grossma, Robert Hurley, Jessica May, Len M. Nichols, and Bradley Strunk, "Little Rock Providers Vie for Revenues, as High Health Care Costs Continue," *Community Report* 3, Center for Studying Health System Change, July 2005.

[32] Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey: Insurance Component," 2006.

[33] Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, U.S. Census Bureau, Current Population Reports, P60-235, (U.S. Government Printing Office: Washington, DC, 2008).

[34] Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey: Insurance Component," 2006.

Another indicator of poor insurance market performance in Arkansas is the fact that only 29 percent of small employers with fewer than 50 workers offer health insurance in Arkansas. This is compared to 43 percent nationwide. Finally, Blue Cross Blue Shield of Arkansas reports that their overall "loss ratio" is about 85 percent, which means they charge an average load of 15 percent across all their business.[35] In other words, 15 percent of premiums collected by Blue Cross Blue Shield of Arkansas are not used to pay for patient care.

Firms with fewer than 50 workers represent just 14 percent of the insurance market. Sixty percent of the market is made up of firms with more than 1000 workers[36] who pay administrative loads between roughly 7 and 10 percent. Therefore, we must infer the average load in the small group market in Arkansas, as it is in most states, is considerably higher than 20 percent. In short, workers and small firms in Arkansas are paying very high loads for policies that are less generous than the already parsimonious national averages for small firms.

This is not to condemn Blue Cross Blue Shield of Arkansas--they are doing what our laws and incentives allow and encourage them to do. They are earning a healthy surplus (high load) off most sales, but why would they not, given their opportunities?

Public Health Insurance Plan

This scenario explains why so many people support the introduction of a competing public health insurance plan in addition to the insurance market reforms discussed earlier.[37] Insurance markets like Arkansas' are the indisputable reason competition will be well-served by a public health insurance plan competing on a level playing field with private plans.

Imagine year one of a new health insurance market (or exchange) without a public health insurance plan. Currently, dominant insurers do not want competition or the insurance reforms that will reduce their "loads" or margins. In the absence of a credible competitor that will compete on a level playing field and bid actuarially fairly, I worry that an unhappy but unchallenged dominant insurer will bid very high and blame the high bid on "excessive regulation."

However, if the dominant insurer knows that an actuarially fair bid is forthcoming from a public health insurance plan with the network capacity necessary to actually take substantial market share away from the dominant insurer, then I predict the insurer will be much more likely to bid competitively and low. In effect, the existence of a public health insurance plan

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[35] Quick Health Insurance Group, Inc., "Blue Cross Blue Shield of Arkansas," http://quickhealthinsurance.com/bluecrossblueshieldarkansas.htm ,accessed July 14, 2009.
[36] Agency for Healthcare Research and Quality, "Medical Expenditure Panel Survey: Insurance Component," 2006.
[37] Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Health Plan," *New America Foundation*, March 2009; Linda Blumberg and John Holahan, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform," *Urban Institute*, 2008; Jacob Hacker, "The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage," *Institute for American's Future*, December 2008.

could "keep insurers honest" in the absence of another way to engender competition in particular marketplaces.

Administrative Costs

The McKinsey Global Institute estimated that in 2006, the United States spent $650 billion more on health care than we should have, given our demographics and wealth. Of this $650 billion, $91 billion or almost 15 percent is excess spending on administrative activities.[38] There are more than 1,100 insurers in the United States. The complexity of so many insurers requiring slightly different forms and information is considerable and results in very large costs for providers and patients.

Some commentators report that non-clinical personnel are the fastest growing category of hospital employees. Credible aggregate estimates approximate that 21 percent of hospital costs and 27 percent of physician office costs are spent on administration, half of that on billing and insurance related costs alone.[39] So as we work to change payment rules and incentives to engender better performance in health service markets, we should remember there is a lot of money to be saved in administration as well. Addressing these administrative burdens would boost clinician morale instantaneously.

A task force convened by the Secretary of Health and Human Services that includes payer and provider representatives should be given a deadline of six months to report on concrete ways to streamline administration, save money, and improve the efficiency and quality of data transmission. United Health Group recently released a working paper which concluded that known administrative processes could save as much as $332 billion over 10 years, half of which would accrue to providers, another 20 percent of which would accrue to federal and state governments. Some regulations and standards may be necessary to capture these savings, but the United paper would suggest the solutions are known.

CONCLUSION

I hope the ideas and opinions in this testimony are useful to you as you consider how to make health markets perform better. I do recommend relying primarily on Medicare payment (and insurance market) reform as the lynchpin of any comprehensive effort. However, in each case the intent and designed effect is to use information and realigned incentives to improve the chances all Americans will soon be getting high-quality care consistently, and paying prices closer to the efficient cost level. I would be glad to answer any questions you or your staff may have at any time.

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[38] McKinsey Global Institute, "Accounting for the Cost of U.S. Health Care: A New Look at Why American Spend More," November 2008.

[39] J.G. Kahn, et al., "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals," *Health Affairs* 24, no. 6 (2005): 1629-1639.