

August 18, 2014

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
United States Senate

The Honorable Charles Grassley  
United States Senate

Dear Chairman Wyden and Senator Grassley:

The undersigned organizations and companies, representing employers, insurers, researchers, patients, consumers and providers, are pleased to respond to your letter of

U.S. health spending will total roughly \$40 trillion over the next decade.<sup>1</sup> Of that staggering sum, about one-quarter<sup>2</sup>—and perhaps more than one-half<sup>3</sup>—will go toward services that are clinically unnecessary and, indeed, often dangerous.<sup>4</sup> Meanwhile, prices for common tests and procedures typically are 3-5 times higher in the U.S. than in other developed countries,<sup>5</sup> generally without yielding better outcomes.<sup>6</sup> This very low customer value (reflecting high prices and wasteful prescribing) has collateral effects on the macro economy, public finances and household living standards. By one widely used measure, health costs for the typical family of four rose from about 16 percent of the median family income in 2001 to 33 percent in 2012.<sup>7</sup> The growing diversion of employee compensation into health benefits, meanwhile, has contributed to the decline in real (cash) wages and rising income inequality.<sup>8</sup>

The Center for Medicare and Medicaid Services (CMS) projects that annual national health expenditures (NHE) will grow by an additional 2.7 percent of GDP during 2013 to 2022. We note that NHE grew by 1.9 percent of GDP during 2003-2012, a period that saw the rapid erosion of affordability. Taming this trend is among our greatest national priorities.

Converging developments may soon allow the much more vigorous monitoring and management of the factors that drive costs. After decades of languishing at the back of the pack in terms of IT adoption, the health sector is investing heavily in a new infrastructure of secure health records and communication systems. Clinical routines are changing to accommodate both the input and

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<sup>1</sup> CMS Office of the Actuary, *National Health Expenditure Projections 2012-2022*, November 20, 2013, and authors' calculations.

<sup>2</sup> Institute of Medicine, "[Better Care at Lower Cost: The Path to Continuously Learning Health Care in America](#)," published on-line, September 2012.

<sup>3</sup> Kristen Bronner, "[Supply Sensitive Care](#)," *Dartmouth Health Atlas of Health Care, Center for the Clinical Evaluative Sciences*, January 17, 2007.

<sup>4</sup> Shannon Brownlee, "[Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer](#)," Bloomsbury, 2008.

<sup>5</sup> International Federation of Health Plans, [2012 Comparative Price Report—Variation in Medical and Hospital Prices by Country](#) April 2013.

<sup>6</sup> Institute of Medicine, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, January 2013.

<sup>7</sup> In 2001, the Milliman Medical Index (MMI), a comprehensive measure of annual health spending by the typical family of four, was \$8,414, while the [median income](#) was \$51,407. In 2012, the MMI was \$20,728, while median income was \$62,241.

<sup>8</sup> Sylvester Schieber and Steven Nyce, "[Treating Our Ills and Killing Our Prospects](#)," *Council for Affordable Health Coverage*, June 2011.

uses of data. Advances in big-data analytics are dramatically expanding our capacity to process data in ways that generate actionable, real-time insights with respect to both the efficacy of cures and efficiency of care delivery. Finally, the rapid-fire adoption in the private sector of consumer-directed and value-based health plan designs is fueling demand for reliable measures of provider cost and quality. Participation in health exchanges, likewise, is increasing consumer demand for more data on health plans.

While these developments could greatly strengthen the demand side of health markets, realizing this potential will require the broader use of data to generate meaningful and accurate provider-specific performance measures. Today such measures are rudimentary and imprecise, in part, because much of the efficiency, quality and safety data needed to manage care and facilitate comparison-shopping is not available for commercial use. In addition, quality metrics under the Medicare and Medicaid programs are insufficient to address the challenges of excessive volume and intensity.

## 1. The Role of Data in Health Care Markets

Putting more and better data into the hands of health plans and consumers can lead to innovation that mitigates high prices and wasteful care. For example, by tracking the practice patterns of individual physicians, health plans can identify and reward high value providers through network inclusion and quality ratings. By providing enrollees and their primary care physicians with comparison-shopping tools, plans can direct consumers toward the highest-value providers within their networks. Finally, by providing physician practices, clinics and hospitals with detailed feedback with respect to practice and referral patterns of individual practitioners, plans can help hospitals and practice administrators to better manage costs. Notably, these same metrics also can be used to generate consumer-facing measures for health plan networks, such as average network quality scores by specialty.

These beneficial market effects fall into four categories:

- a. Provider comparison shopping tools can help the “silent majority” of consumers to seek out better value and stimulate competition in concentrated provide markets.** By insuring healthy consumers from high provider charges, health plans historically have fostered a consumer preference for convenience over cost. Such a preference localizes health markets (narrowing their geographical footprint), and thus enhances providers’ pricing power. For example, the Federal Trade Commission found that a 2000 merger of hospitals located 2.5 miles apart in Berkeley and Oakland, CA had allowed the smaller of the two hospitals to raise its prices by up to 44.2 percent, despite the presence of 17 hospitals within a 20-mile radius.<sup>9</sup> Weak price sensitivity also leads to extreme price variation.<sup>10 11</sup> Thus, for example, in 2013 the cost of a colonoscopy in New York varied

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<sup>9</sup> Steven Tenn, “The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction,” Federal Trade Commission Working Paper No. 293 (November 2008): 20-26.

<sup>10</sup>Paul B. Ginsburg, “[Wide Variation in Hospital and Physician Payment Rates—Evidence of Provider Market Power](#),” Research Brief No. 16 *Center for Studying Health System Change* (November 2010): 5-6.

<sup>11</sup> Office of Attorney General Martha Coakley, [Examination of Health Care Cost Trends and Cost Drivers](#), March 16 2010: 3-4, 17-40.

eleven fold—from a low of \$740 to a high of \$8,400.<sup>12</sup> The widespread adoption of health plan designs that expose consumers to price variation up to their out-of-pocket limits has broadened providers’ geographical footprint by incentivizing consumers to travel for non-emergent, schedulable tests and procedures. Because provider prices are negotiated confidentially with plans, consumers require plan-specific in-network comparison-shopping tools with both cost and quality metrics.

- b. Data will enable health plans to better manage the care of the chronically ill.** Health spending is highly concentrated, with 20 percent of the population accounting for 81 percent of spending and 5 percent of accounting for roughly half of spending.<sup>13</sup> The most costly patients are neither price sensitive (having exceeded their out-of-pocket limits) nor mobile. Many are disinclined or unable to comparison shop. But the use of data in other ways can still deliver better value for these patients. Sophisticated data analytics that track the performance of individual physician specialists, who prescribe care for patients with the most complex needs, can help both providers and plans to identify and manage waste.
- c. The measurement of individual provider performance can facilitate collaboration by insurers, employers, physician practices, hospitals and other providers in managing practice and referral patterns.** Within hospitals, the performance of individual physicians and other clinicians varies. For example, some physicians may have higher rates of surgical complications or prescribe unnecessary tests or procedures more frequently. Feedback from health plans can help hospital or practice administrators to identify and manage their staff’s strengths and weaknesses. Primary care clinicians participating in medical homes or ACO payment systems, likewise, have financial interests in the efficiency of specialists and facilities to whom they refer patients.
- d. The availability of data can facilitate market entry by insurers.** Insurance is essentially a retail product, with transparent, capitated prices, whose underlying costs are amenable to efficiency gains. Various studies indicate that best-value medical practices (i.e. practices that minimize waste without sacrificing quality) could generate several trillions of dollars in consumer and taxpayer savings over the next decade.<sup>14</sup> These very large potential economies—which require data to achieve—give insurers a strong business case for entering one another’s markets. The early experience from public health exchanges indicates that the plans that are most adept at managing costs stand to gain significant market share.<sup>15</sup> Finally, providing consumers with information on health plans—their networks, formularies and other features—can strengthen insurers’ business case for cost management.

## 2. Recommendations

You requested input with respect to which data sources should be more widely available, in what form, and for what purposes; and how legislative reforms might reduce fragmentation and

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<sup>12</sup> New York Times Editorial Board, “[The Weird World of Colonoscopy Costs](#)” (June 8, 2013).

<sup>13</sup> Kaiser Family Foundation, Kaiser [Fast Facts](#). Published on-line.

<sup>14</sup> Donald Berwick and Andrew Hackbarth, “[Eliminating Waste in US Health Care](#),” JAMA 307, no. 14 (April 11, 2012): 1531-6. Up to 49 percent of care is waste—at a projected cost of \$20 trillion during 2013-2022.

<sup>15</sup> Kaiser Family Foundation, “[Kaiser Health Tracking Poll: February 2014](#)”. Published online.

improve the accessibility of data and otherwise minimize barriers to its wider use. Data often serves a dual purpose, benefitting both the advancement of clinical science and the efficient operation of health care markets. Because affordability is itself a powerful determinant of population health, we believe cost management should be a core goal of federal health data policy.

To this end, we recommend that the federal government:

- a. Expand the availability and permissible uses of data collected pursuant to federally funded programs, including Medicare, Medicaid, CHIP, Tricare, the Veterans Administration (VA), the Federal Employee Health Benefits Program, and the Indian Health Service.** Together these programs account for more than half of all health services purchased in the U.S. and, as such, are essential to the completeness of health data sets. For example, the ability to combine public data with data collected by private health plans will allow more complete tracking of individual patient outcomes and provider performance. In furtherance of this goal, subject to strict patient privacy requirements, the federal government should:
  - i. Provide data from all federally funded health programs.** The Qualified Entity program currently permits the release of only Medicare Part A, B and D data. QE reforms passed last year by the House would expand data sharing to the Medicaid and CHIP programs, but not Tricare, FEHB and VA data. Completeness requires a uniform federal policy toward data transparency, while recognizing disclosure of some proprietary pricing may discourage discounting or price concessions in some markets.
  - ii. Provide timely, detailed claims data.** Such data includes line item detail on specific services by specific providers for specific (though de-identified) patients. To be relevant to operational needs, data should be as current as possible.
  - iii. Provide federally supported quality and safety data from registries and Medicare performance measures.** The federal government funds, both directly and indirectly, data collection on a range of patient safety and quality metrics, including medical society registries and provider-level data on readmissions and hospital-acquired conditions. Most physicians and hospitals that serve Medicare and Medicaid patients also serve the privately insured population, making federal quality and safety measures equally relevant to non-beneficiaries. Publicly insured patients also would benefit from insights gleaned by combining public and private data. Federal health data policy must expressly embrace the principle that no consumer should unknowingly patronize an unsafe provider.
  - iv. Provide data to commercial, state governmental, research organizations, nonprofit and public entities for the express purpose of managing costs and analyzing the impact of payment and other policies on costs and market competition.** Current rules permit the sharing of public data for the express purpose of improving quality, but not efficiency. Yet affordability is itself a powerful barrier to improvements in population health. Even amid the much-discussed “slowdown” in health costs, private premiums have continued to grow more than twice as fast as

household incomes. Arresting this growth should be a primary, not a tertiary, focus of federal health data policy. Improvements in clinical science alone will not bring down medical costs.

- v. **Develop uniform standards for the sharing of public data.** Non-uniform agency policies are a legacy of a now-abandoned 1979 federal court injunction, which held that the publication of public claims data could violate physician privacy. Little data was shared during this highly restrictive period, which saw data sharing policies defined by a confusion of federal and state agency-specific rules, each reflecting different mixes of stakeholder input. The lifting of the injunction in 2013 opened the way for broader sharing, while the growing power of data analytics to generate actionable findings is raising the potential benefits of such sharing. As the potential benefits of data sharing increase, so too do the opportunity costs of non-uniformity.
  - vi. **Align federal data policy with permissible uses for private data.** Commercial uses of health data with respect to privately insured populations are governed by HIPAA and other federal privacy laws. When federal and state agencies impose stricter standards on the use of publicly collected data, the effect is to reduce the uses, and hence the value, of both public and private data. To maximize the value of data, we recommend that federal policy strive toward the least burdensome standards necessary to protect patient privacy.
  - vii. **Charge users of federal data less.** Once large public data sets have been created, the marginal cost of providing that data to each additional user is relatively low. To facilitate the dissemination and use of public data, the federal government should charge no more than this marginal cost.
- b. **Support the sharing of private data.** Private health plans, which cover roughly 190 million Americans, hold extensive data, but frequently no single carrier or plan has enough data to generate actionable findings in highly localized health markets. The growing potential of data analytics as a tool for controlling costs has created a growing business case for the voluntary combining of commercial data. Yet antitrust rules actively discourage data sharing by commercial interests, particularly among potential competitors in the insurance industry. To accommodate antitrust restrictions, plans have formed voluntary multi-payer claims databases, such as the Health Care Cost Institute and the California Healthcare Performance Information System. Meanwhile, in highly concentrated insurance markets, carriers may have fewer incentives to share proprietary claims data with potential competitors as well as with self-insured employer (ERISA) plans, for which they serve as third-party administrators. In part to overcome this resistance, thirty-one states have formed, or are considering forming compulsory all-payer claims databases. To support private data sharing, the federal government should:
- i. **Relax antitrust restrictions on data sharing and transparency.** Current anti-trust policy has failed to embrace data sharing and price transparency tools that could help contain volume and intensity. We are not advocating a requirement for public disclosure of all negotiated prices, because this may discourage discounting or price concessions in some markets. But we believe data sharing and price transparency pose far fewer risks to consumers, and hold the prospect of greater benefits, than

currently envisioned. We note that relaxing antitrust restrictions on the private sharing of data would mirror ACO policy, which subordinates antitrust policy to efficiency goals. Finally, antitrust rules may also presume that price transparency would lead to less competition among insurers. The opposite is true: competition among insurers would be more robust, and health plan costs would be lower, if more insurers had the analytic tools for eliminating waste.

- ii. **Facilitate agreements among multi-payer and all-payer claims databases (APCD) with respect to the organization, reporting and sharing of data.** The reporting requirements and formats for APCDs vary widely and can differ significantly with those used in multi-payer databases. We believe that, with the right leadership, consensus on the goals, core data elements and reporting standards associated with private data sharing lies well within reach. Multi-payer and all-payer claims databases also have varying protocols and practices for sharing de-identified claims data with third parties for purposes of public reporting, quality improvement, and research and analysis. One way to facilitate greater agreement and consistency would be for the federal government to commission a standing working group whose role would be to convene and forge consensus among the various parties with respect to shared goals and best practices related to data collection, standardization, and reporting, and the sharing and use of data in key areas that are in the public interest. Such a commission might also define best practices with respect to the obligations of carriers serving as third-party administrators of self-insured ERISA plans to share data with the plan sponsors; and best practices for making data available to research organizations and others to monitor and analyze the impact of payment programs, provider consolidation, anti-trust policies and other factors on costs and market competition.
  - iii. **Ensure private data that is shared publicly is not used to institute price controls.** We are concerned that recent attention on prices may lead to calls for price controls on private products or payers. We support more private competition, not less.
- c. **Improve quality and efficiency measures to better identify waste.** Today, quality measurement at the institution and medical group levels combined with robust provider feedback has yielded improvement. But the current measure sets used for the Patient Quality Reporting System, Meaningful Use, and Accountable Care Organizations are misaligned and focus more on process than outcomes, creating excessive burdens on providers and only limited value for taxpayers. Among several commonly used measurement sets (NCQA, HEDIS, NQF Endorsed Measures, ACO measures, and the AMA PCPI measures) fewer than ten percent address overuse or appropriate use while many are underuse measures. Reforms designed to highlight outcomes, overuse, and total cost of care could yield significant savings. Furthermore, to ensure these measures can more accurately reflect performance at the individual clinician level, it will be critical to address challenges related to insufficient number of comparable cases, socioeconomic variations, and data reliability. Congress should direct the secretary to prioritize the measures, place a high priority on developing measures of overuse or misuse, and weight clinical and patient reported outcomes measures more heavily than process measures (but include all three) in federal incentive programs.

- d. Facilitate comparison-shopping by providing certain information with respect to providers and insurers directly to the public.** The great preponderance of health expenditures go toward care for patients with complex, individualized needs. Hospital charge masters, meanwhile, have up to 30,000 items. This complexity makes the business of medicine ill-suited to organization on a retail model. Nevertheless, some medical services, such as knee replacements, colonoscopies and vaccinations, are relatively standard and thus amenable to retail price comparisons. Meanwhile, an estimated 51 million Americans are uninsured and, hence, must shop for care without the benefit of in-network comparison-shopping tools. Finally, health insurance itself is a retail product that consumers can compare and purchase on the individual policy market. While the public health exchanges established under the ACA are designed to facilitate such comparison-shopping, many currently provide little information beyond price. To support consumer selectivity, the federal government should:
- i. Require hospitals, testing centers and ambulatory clinics to post on the Internet the average amounts collected from both the insured and uninsured for common tests and procedures.** Most providers do not provide prices publicly, and when they do, those prices reflect “charges”—list prices—that often exceed actual amounts collected by several fold. Often this means the uninsured, who tend to have low incomes, pay the highest prices. To address this problem, Senators Coburn and McCaskill have introduced legislation to require hospitals to disclose the average amounts collected, respectively, from privately insured and uninsured patients for the 200 most common services. We believe this approach can help to reduce price variation and price discrimination and lead to more provider-consumer price negotiation. For those with insurance, we believe the insurer may be in the best position to inform the consumer what their cost sharing obligations may be.
  - ii. Require plans offered on the ACA health exchanges to disclose relevant consumer information in addition to price.** Such information should include, for example, current provider networks, prescription drug formularies and whether the plans are Health Savings Account qualified.
- e. Provide consumers with relief from anticompetitive contracting.** While data is critical to the development of comparison-shopping tools, the use of such tools is constrained by anticompetitive clauses embedded in price contracts between providers and insurers. The terms of such contracts are confidential—which limits authoritative research on their prevalence and market effects. In 2009, however, the Massachusetts Attorney General subpoenaed price contracts and subsequently documented a range of questionable practices such as “anti-steering,” “anti-tiering,” “guaranteed inclusion” and “product participation parity” clauses.<sup>16</sup> For example, anti-steering clauses prevent plans from using shopping tools or value based insurance designs to steer policyholders to less expensive providers. In its 2011 ACO guidelines, FTC identifies several such practices, but merely advises providers seeking to combine clinical efforts “to avoid” them prior to

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<sup>16</sup> Attorney General Martha Coakley, “[Examination of Health Cost Trends and Drivers, Report for Annual Public Hearing](#)” (March 16, 2010): 40-41. The Coakley report provides rare examples of such restrictive language. See also: Paul B. Ginsburg, “[Shopping for Price in Medical Care](#),” *Health Affairs*, Web Exclusive, vol. 26, no. 2 (February 6, 2007), p. w213. The Coakley report provides rare examples of such restrictive language.

merging (notably, FTC’s enforcement powers to not extend beyond approving or disapproving mergers).<sup>17</sup> The State of California has outlawed “gag clauses” that forbid health plans from listing negotiated prices in consumer-facing comparison-shopping tools.<sup>18</sup> The government should forbid contracting practices whose primary purpose is to suppress price-sensitivity or to suppress competition among health plans.

### 3. Conclusion

While the price of health coverage in the US is excessive by many measures, its underlying costs are amenable to management with more and better data. Data analytics can both advance our common understanding of clinical science and permit the development of precise, timely measures of provider performance. Such performance measures are particularly important for specialists, who manage patients with the most complex and expensive needs. Federal data policy currently inhibits data sharing—and, by so doing, may be harming public health. These opportunity costs are rising in tandem with the growing power of analytics and the growing collateral effects of health cost growth on the economy, public budgets and households.

We thank you again for your leadership on data policy and look forward to working with you and your staffs toward its improvement.

Sincerely,

Blue Shield of California  
Catalyst for Payment Reform  
Council for Affordable Health Coverage  
National Coalition on Health Care  
Pacific Business Group on Health

cc: Senator Orrin Hatch  
Ranking Member  
Committee on Finance

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<sup>17</sup> Department of Justice and Federal Trade Commission, “[Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program](#),” (October 28, 2011): 10-11.

<sup>18</sup> California State Assembly, [analysis of SB 1196](#) (Ed Hernandez) - As Amended: April 10, 2012