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On behalf of the American Benefits Council and the Pacific Business Group on Health

Thank you for the opportunity to speak on behalf of the American Benefits Council and the Pacific Business Group on Health, which include many of the nation's largest employer purchasers of health care.

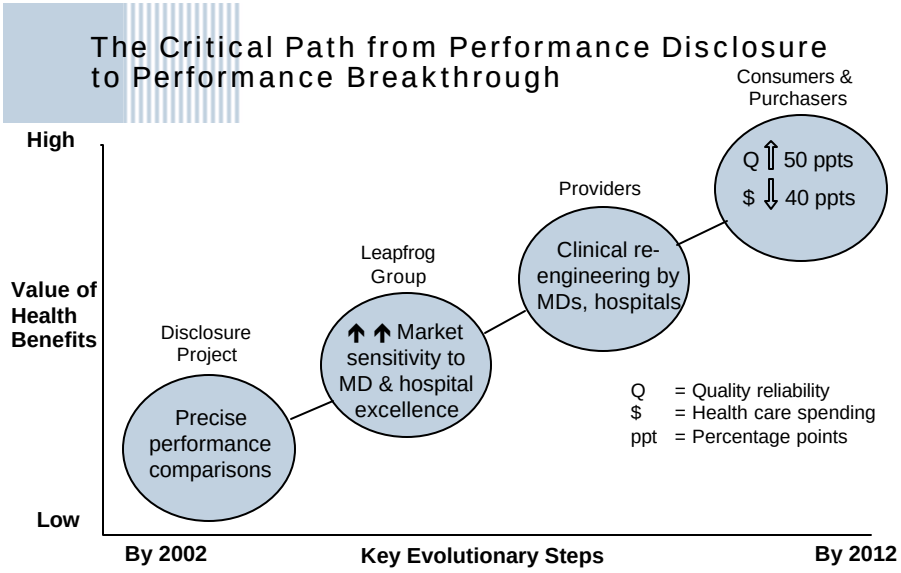
The Market is Failing to Assure Excellence by Hospitals and Physicians

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

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

Employers and Consumer Groups are Promoting Performance Measurement and Reward

To accelerate these two foundations of a market solution to weak health care industry performance, large American employers launched two linked "pro-competitive" initiatives: the Consumer and Purchaser Disclosure Project ("the Disclosure Project"); and the Leapfrog Group. A vision for how these initiatives could trigger breakthroughs in the value of health care to consumers and purchasers is illustrated in the following figure:



The Disclosure Project is an informal partnership of *large employers* such as 3M, Ford, GM and Motorola, *employer groups* such as California's Pacific Business Group on Health, Wisconsin's Alliance, and the American Benefits Council, and *consumer advocacy organizations* with a commitment to health care performance accountability, such as AARP, the AFL-CIO, and the National Partnership for Women and Families. The Disclosure Project's goal is that "by January 1, 2007, Americans will be able to select hospitals, physicians, integrated delivery systems and treatments based on public reporting of nationally standardized performance measures for clinical quality, patient experience, equity and efficiency."

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

purchasers of continued performance-blind selection of hospitals, doctors and treatments have become intolerable.

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

Intensified Competition Faces Challenges

Our vision of intensified market competition catalyzing provider performance breakthrough faces multiple challenges, which are summarized in the attached recent article on evolution in American employer health benefit purchasing strategies from *The New England Journal of Medicine.* Among these challenges are doctors or hospitals, commonly in the form of *aggregated* doctor and/or hospital organizations, which may, and sometimes do, use market dominance in their service areas to impede competition based on disclosure and reward of their comparative performance. I will herein refer to such providers, whether individual or in provider organizations, as "market-dominant providers." Market dominant providers have contributed to extreme irrationalities in the commercial health insurance supply chain. In some California cities, market dominant hospitals are commanding more than twice the average payment for the same treatment as non-dominant providers, with no evidence of quality distinction or other sound rationale. Note that market dominance by hospitals and medical specialists is intensified by two related characteristics inherent to health care markets: (1) 85% of the spending is by the 25% of consumers who suffer from major illnesses; (2) significant illness dampens the willingness of such consumers to travel farther or switch to an unfamiliar doctor or hospital.

The FTC Can Help Promote Competition

Many large employers are supportive of doctor or hospital aggregation when it is used to create sufficient scale to mobilize the capital and/or management talent necessary to attain performance excellence. However, we strongly encourage the FTC to consider how its efforts might assure adherence by both aggregated and individual market-dominant providers to *pro-competitive rules of the road.* The following are eight such rules based on my work with employers and insurers across all U.S. regions:

1. Assure Performance-Based Tiering

Aggregated provider organizations should not restrain insurers from classifying their individual providers into performance tiers on which to base consumer out-of-pocket costs or inclusion in insurance plan offerings. This is because performance may vary widely among individual providers within aggregated provider organizations. Obscuring these performance differences within multi-provider performance averages prevents the market's recognition and reward of individual provider excellence.

2. Assure Service Line-Based Tiering

Similarly, market-dominant providers, both individual and aggregated, should not restrain insurers from varying consumer out-of-pocket costs or insurance plan offerings based on an individual provider's performance within specific service lines ("service line based tiering"). Scientific evidence is clear that hospitals and physicians that excel in one service line, such as cardiac surgery, may perform poorly on obstetrics or other service lines. Quality cannot be optimized if market-dominant providers insist on "all-or-none" insurer contracts that require that their poorly performing service lines receive the same level of market preference as do the services lines in which they excel.

3. Assure UPINs on Every Provider Bill

To enable detection of individual provider excellence, aggregated provider organizations should routinely provide on every bill the Medicare unique provider I.D. number (UPIN) of the individual physician or hospital providing the service. Without such information, insurers cannot assess individual provider performance for services in which individual performance matters, such as surgery.

4. Assure Disaggregated Price Negotiations

Aggregated provider organizations should not restrain individual member providers from independently negotiating their prices with insurers; nor should they restrain individual providers from independently responding to performance reporting requests from insurers when data needed for performance measurement extends beyond billing data.

5. Assure Consumer Access to Disaggregated Performance Scores

When an aggregated provider organization exercises de facto control over an insurer by providing a majority of the insurer's services, the provider organization should disclose to the public the same individual provider performance measures as do other providers who do not control an insurer. This will allow consumers who use provider-controlled insurers to recognize and preferentially select higher performing individual providers in all health insurance plans.

6. Assure Reasonableness of Comparative Prices

Where providers, individual or aggregated, dominate a service area, their unit prices, as well as their efficiency with respect to the total health benefit costs incurred under their care, should be held to a reasonableness test, based on comparisons with other providers who do not dominate their markets. Higher prices directly attributable to efficiently delivered distinction in quality, teaching, research or uninsured care should be considered reasonable.

7. Assure Customer Definition and Access to Performance Ratings

Market-dominant providers, both individual and aggregated, should not restrain insurers' freedom to define and disseminate provider performance measures. It should be up to the customer of a service, or the customer's intermediaries, to judge the value of the service, not the producer.

8. Assure Consistency of Performance Measures

To minimize consumer confusion, insurers in the same market should not be restrained from collaborating and adopting common performance measures for providers and treatment options, including measures intended for performance-based compensation of providers. We understand and accept that insurers should be prohibited from collaboration with each other when negotiating compensation agreements with providers.

Robust Competition is Essential to Healing Health Care

America's large employers do not seek to unwind all of the many hospital mergers and physician aggregations permitted over the last twenty years. However, market-dominant providers should not restrain the performance comparisons and performance contingencies needed to enable the market's invisible hand.

It is time to emancipate all health care stakeholders from the irony of offering world class biomedicine via pre-industrial health care delivery systems.

Relying on regulation and professionalism to assure excellence has proved insufficient. Despite the knowledge asymmetries and psychological uniqueness of health care, many employers, consumer organizations, and insurers are ready to foster a more discerning market. Consumer research published by the Voluntary Hospital Association indicates that over 85% of Americans are prepared to select their physicians and hospitals based on credible performance comparisons, if such comparisons were available. Market competition can heal our health care delivery systems, if we assure such competition is robust.