October 22, 2013

The Honorable Dave Camp
Chairman, Committee on
Ways and Means
U.S. House of Representatives
1101 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, Committee on
Ways and Means
U.S. House of Representatives
1101 Longworth House Office Building
Washington, DC 20515

Dear Congressmen Camp and Levin:

Recent years have seen the emergence of a powerful expert consensus that opaque, uncompetitive medical markets are making health coverage less affordable for the average family. The undersigned companies and organizations, representing health plans, employers and consumers, are writing to urge the Committee's leadership in passing legislation this year as part of the Medicare Sustainable Growth Rate (SGR) formula reform bill that will help Americans to make better-informed choices about the price and quality of the services offered in private markets. Transparency reform should focus on following three areas:

1. The further release and use of federal and state claims and patient de-identified clinical data to power consumer tools;
2. Consumer facing reforms that empower patients with price and quality information; and
3. Reforms that enable smart choices among service providers.

We believe that the first step in making markets work for consumers is to put better price and quality information into the hands of those who are paying the bills. Quality information is important because, without it, consumers may mistakenly assume that higher cost services equate to higher quality services, when often the opposite is true.

To this end, we recommend the following approaches.

1. Expand the availability and allowed uses of Medicare claims and registry data.

The Center for Medicare and Medicaid Services (CMS) is sitting on a trove of records that, when combined with comparable information collected by health plans, will give insurers, employers and researchers valuable insights into the practice and billing patterns of individual physicians, group practices, hospitals, post-acute care providers and others. Modern data analytics—the ability to glean granular truths from diverse, large data sets—holds the promise of faster, more efficacious and more accurate diagnoses and treatments. In the world of large data, the whole is greater than the sum of the parts. For example, when private sector data alone is used, the sample size may be too small to permit reliable conclusions.

Accordingly, we urge the Committee to clarify that CMS data should be more widely available for government, nonprofit and commercial research. Currently, Medicare claims data is restricted to only a handful of nonprofit Qualified Entities (QE), who, in turn, face tight

restrictions on their ability to share the processed results with consumers and health plans. We believe QE designation should also be available to those commercial and nonprofit research interests who can demonstrate competency and integrity in protecting patient privacy.

In addition to expanding the number and kinds of entities who can access Medicare claims data, the Committee should broaden the use of this data to support consumer decision-making and provider performance incentives. QEs currently may only provide specified public reports to Medicare physicians and suppliers rather than health plans and consumers. In this respect, we note that the QE program, established under the Affordable Care Act, is already out of date. In 2010, the prevailing common law held that the dissemination of Medicare provider claims data violated physician privacy. Earlier this year the courts rejected this logic, opening the way for a statutory revision of QE. Reforms adopted by the Energy and Commerce Committee in its bipartisan bill to update SGR (HR 2810) represent a positive step in this direction.

We also urge the Committee to make registry data more widely available for qualified entities, to inform the choices of consumers. Dr. Martin Makary, Director of Surgical Quality and Safety at Johns Hopkins Hospital, has identified more than 150 national clinical registries that track patient outcomes. One-quarter are federally funded, yet only three make their outcomes available to the public. This information is helping to improve the quality of care under Medicare, but it is equally relevant to the health and safety of privately insured consumers. Qualified Entities already must meet strict requirements for the protection of personal health information in their work with Medicare claims data. Expanding their access to registry data would enable them to furnish a fuller picture of quality of care to consumers, purchasers and the providers themselves.

Finally, Medicare claims and quality data should be available with a minimal time lag. When matched with contemporaneous private records, timely data can identify safety and efficiency problems more quickly. More timely data sharing will also aid in the detection and deterrence of fraud and abuse, saving taxpayers and private consumers many billions of dollars in the process. For example, a provider who bills 80 percent of his time to both Medicare and private plans would merit immediate investigation.

The principle of making taxpayer-financed information freely available to the larger public is embodied in HR 2843, the *Medicare Data Access for Transparency and Accountability Act*, sponsored by Representatives Jim Sensenbrenner and Elijah Cummings. This bipartisan bill would require CMS to create a searchable online Medicare claims database, while providing safeguards to assure the confidentiality of personal health information. It remains that records presented only in this format would not be amenable to data analytics; nor would HR 2843 require the provision of CMS safety and quality information. HR 2843 nevertheless represents a promising approach, one that we urge the Committee to adopt and improve upon this year.

2. *Support the sharing of private sector data.*

Maximizing the benefits from data analytics also requires the wider sharing of private claims and quality data from the private sector, provided that patient information is de-identified. Comprehensiveness allows all payers to draw more accurate, actionable conclusions about the

efficiency, quality and integrity of care delivery at the individual provider level. The Committee can facilitate these benefits by creating an institutional framework for consensus building with respect to the goals, models and rules for private price and quality data sharing.

Voluntary private sector initiatives include the Health Care Cost Institute, a non-profit repository on commercial claims data, and the California Healthcare Performance Information System, a state-level compendium of insurers and employers. In addition, thirty states have created or are contemplating all payer claims databases (APCDs), which require the reporting of private sector claims and other records to state agencies. Together these efforts are helping to create a national health data infrastructure on provider cost and performance. Yet their lack of coordination works against this goal. Common reporting standards, for example, would reduce compliance burdens for health plans while helping to ensure that the outputs are actionable.

We believe that, with the right leadership, consensus on goals, core data elements and reporting standards associated with private data sharing lies well within reach. One way to facilitate such concord would be for the federal government to commission a standing working group to convene, and forge consensus among the various parties with respect to shared goals and best practices related to data collection, standardization and reporting.

3. *Strengthen consumers' rights to comparison shop.*

We urge the Committee to adopt protections designed to allow consumers to comparison shop on health plan or vendor websites. Some dominant hospitals and physician groups use "gag clauses" to forbid health plans from sharing quality information and negotiated prices with enrollees directly or via third parties. Nevertheless, a large and growing percentage of privately insured Americans now depend on medical price and quality information to make crucial financial decisions. For example, in 2012, negotiated prices for cataract surgery ranged from $2,418 to $8,143, according to the International Federation of Health Plans. Price transparency can make a big difference for American families.

Value based insurance designs (VBID), which used tiered copayments to direct volume toward high-value providers, and account-based health plans (ABHP), which pair high deductibles with health savings accounts, are the fastest growing segment of the employer-sponsored plan market. According to some estimates, as many as half of insured workers will participate in ABHPs by 2020, up from 30 percent this year and 15 percent in 2010. The 2013 Kaiser Family Foundation/Health Research Educational Trust survey finds that 23 percent of firms' benefits included a tiered or high-performance network in their largest health plan option, up from 16 percent in 2010.

The potential savings from competition will never be realized if dominant providers are able to use their market power to keep price and quality information secret from consumers. Some states, such as California, have taken concrete steps to end such abuses[1]. While we support such state initiatives, the challenge of runaway medical inflation is national in scope and merits a national solution.

[1] See, for example, California Senate Bill S. 1196.

Finally, we note that even after implementation of the ACA, roughly ten percent of Americans will remain uninsured, according to the Congressional Budget Office. This population also needs tools to assess what they can expect to pay based on procedures across facilities and offices. The Committee should consider reforms that require hospitals to notify the public of the average rates paid by uninsured patients over the preceding two years for the 50 most common inpatient and outpatient procedures.

In conclusion, although price and quality transparency is not a cure all for America's health woes, it would constitute a positive first step. We applaud the Committee's attention to the market factors behind America's health cost crisis and stand ready to work with you and your colleagues in passing meaningful transparency reforms this year.

Thank you for considering our comments.

Sincerely,

Council for Affordable Health Coverage

National Coalition on Health Care

AARP
The Boeing Company
Caterpillar Inc.
Community Catalyst
Corporate Health Care Coalition
Health Care Cost Institute
National Association of Health Underwriters
National Retail Federation
Midwest Business Group on Health
UPS

Blue Shield of California
Castlight Health
Communicating for America
Compass Healthcare Advisors
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HR Policy Committee
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