NATIONAL COALITION ON HEALTH CARE

# HEALTH COSTS AND THE AMERICAN FAMILY:
## A Report Card on the 113th Congress

Despite the dazzling achievements of modern medicine in reducing morbidity and mortality, remarkable levels of waste and inefficiency have fueled unnecessary increases in health care spending without producing corresponding improvements in health, health care outcomes, or wellbeing. The result has been an enormous squeeze on the budgets of American families and businesses.

And while the partisan battle over the Affordable Care Act (ACA) has dominated the headlines, stakeholders, congressional staff, and Members of Congress have also been working to advance viable, bipartisan solutions that can provide some relief from rising costs while simultaneously driving improvements in health care delivery.

The National Coalition on Health Care (NCHC) offers this report card on the outcome of those efforts in the 113th Congress. **Based on our analysis, the 113th Congress has thus far failed to make the grade on controlling health care costs.**

We confine this report card solely to what the 113th Congress has accomplished. We recognize that promising efforts to curb costs abound among private sector providers and plans, and that state governments and executive agencies are working to carry out the laws passed in previous Congresses. However, if we are to fairly assess this Congress' performance, we can grade only on its own contribution to health care affordability.

To further ensure a fair grade, we focused solely on the three subjects which represented the best opportunities for bipartisan legislation during this Congress: physician payment modernization, health care transparency, and reforms to strengthen Medicare.[1]

In each of these subjects, bipartisan Congressional champions, their staff, and diverse stakeholder organizations earned As for effort. Most impressively, their dedication led to the introduction and debate of a bipartisan, bicameral SGR reform bill. This bill has the potential to migrate physician payment away from volume-based fee-for-service and toward value-oriented payment models, a movement consistent with calls from lawmakers and health care advocates from across the political spectrum.[2]

However, when it comes to translating smart policy and bipartisan consensus into law, the 113th Congress has yet to pass the test

| HEALTH COSTS AND THE AMERICAN FAMILY: A Report Card on the 113th Congress | FINAL GRADE |
|---|---|
| Modernizing Physician Payment and SGR Repeal | Incomplete |
| Price and Quality Transparency | F |
| Strengthening Medicare | D+ |

1 Although this document analyzes and discusses a range of specific policy proposals and legislation, some members of NCHC do not, or cannot, take positions either on specific legislation, strategies, or on any policies outside their respective mission areas.

2 See Mazzolini, C. (2013, Nov 25). 259 Congressional Representatives Call for SGR Reform. *Medical Economics*. Retrieved from http://medicaleconomics.modernmedicine.com/medical-economics/news/259-congressional-representatives-call-sgr-reform; Center for American Progress. (2012, Nov). The Senior Protection Plan: $385 billion in health care savings without harming beneficiaries. Retrieved from http://cdn.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf; and U.S. Chamber of Commerce. (2013, Jun). Health Care Solutions from the America's Business Community: The Path Forward for US Health Reform. Retrieved from https://www.uschamber.com/sites/default/files/documents/files/USCCHealthCareSolutionsCouncilReport_0.pdf

## Why Care About Health Care Costs: The Impact on American Families and Businesses

Recent journal articles and news reports have focused on signs of progress in curbing health costs. Individual health care providers, employers,[3] communities,[4] and even government programs[5] have demonstrated that it is possible to deliver better care at a lower cost. The American health system has even experienced an overall slowdown in the *rate of growth* of overall health care spending.[6]

Unfortunately, this progress has not been enough: the slowdown is not expected to persist and the level of health spending in the United States remains higher than any other country in the world.

Moreover, the squeeze on the American family is only getting tighter; families face rising monthly premiums, higher out-of-pocket costs, and a tax burden driven by the increasing cost of public programs as well as the tax exclusions and deductions related to health care. The total impact of these costs has wiped out most or all of the gains in real family income between 1999 and 2009.[7] And since 2009, health care costs have continued to climb, albeit at a slower rate. Amidst an otherwise slow economic recovery, persistent increases are eroding families' earnings. The impact on business is hardly encouraging either. Over the last decade, employers have seen their contribution to family coverage climb from $7,289 to $12,011.

For a family trying to make ends meet or a business trying to make payroll, the recent signs of progress have brought little comfort. Nor should they.

While this kind of cost growth might be understandable if Americans were getting their money's worth, that does not appear to be the case. Experts have estimated that waste, inefficiency and outright fraud consume 1/3 of the nation's health care spending.[8] When applied to the CMS Actuary's projected total health spending in the United States in 2014, that estimate amounts to slightly more than a trillion dollars or $3,211.12 for every man, woman and child in the United States. For a four-person household, the impact is $12,844.50. That's a per-household expense equal to a year's worth of mortgage payments on a modest home, cost of a new car, or a year and a half of in-state tuition at the average public college.

## Political Context: Hope for Progress?

As this Congress convened in January 2013, the prospects for constructive health care policy-making appeared bleak. Since at least the 1990s, conservatives and progressives had been locked in an extended battle over their firmly-held visions for health care's future. Since the initial debate over the ACA in 2009-2010, little bipartisan progress had been made on health care.

However, signs soon appeared of a thawing in the cold war between the political parties in Congress. Though still locked in a struggle over the ACA, members of both parties began devoting time and energy to the hard work of legislating in the areas where they could find agreement. In the months that followed, those efforts bore fruit, producing detailed, sometimes ambitious, legislative proposals that garnered support across party lines. We examine Congress' progress in these policy areas below.

## Modernizing Physician Payment and Repealing the Sustainable Growth Rate:

### The Issue:

Health care experts have long noted that Medicare's provider payment policies, particularly the fee-for-service (FFS) approaches used in reimbursing physicians and other providers, promote volume of services over the value or outcomes of those services.

In an effort to curb these trends in spending, particularly in physician services, Congress enacted the Medicare Sustainable Growth Rate (SGR) in 1997. Through a complicated formula, the SGR established a maximum rate of growth in physician fees and required cuts to those fees should Medicare spending

3 Robinson, JC & Brown, TT. (2013, Aug). Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery. *Health Affairs*. 32(8): 1392-1397. Retrieved from http://content.healthaffairs.org/content/32/8/1392.abstract

4 Gawande, A. (2010, Aug 2). Letting Go: What should medicine do when it can't you're your life? *The New Yorker*. Retrieved from http://www.newyorker.com/magazine/2010/08/02/letting-go-2

5 Urdapilleta, O.; Weinberg, D; Pederson, S; Kim, G; Cannon-Jones, S; Woodward, J. (2013, May 31). Evaluation of the Medicare Acu -te Care Episode (ACE) Demonstration. Center for Medicare and Medicaid Services. Retrieved from http://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf

6 Elmendorf, DW. (2013, Sep 19). Comment on "Is This Time Different? The Slowdown in Healthcare Spending" Presentation. Congressional Budget Office. Retrieved from http://cbo.gov/sites/default/files/cbofiles/attachments/44595-Presentation.pdf

7 Auerbach, DI & Kellerman, AL. (2011, Sep). A Decade of Health Care Cost Growth has Wiped Outh Real Income Gains for an Average US Family. *Health Affairs*. 30(9): 1630-1636. Retrieved from http://content.healthaffairs.org/content/30/9/1630.abstract.

8 Institutes of Medicine. (2011, Feb 24). The Healthcare Imperative: Lowering Costs and Improving Outcomes – Workshop Series Summary.

exceed that rate.

However, these fee cuts were bluntly and poorly designed, applying across the board to all participating health professionals. As a result, Congress has temporarily delayed the implementation of these cuts through a series of "doc fixes" every year with only one exception. Yet because the underlying law establishing the SGR remains on the books, Congress must act whenever each fix expires to avoid massive, SGR-mandated cuts to physician payment and the disruption of care that these cuts would precipitate. This repeated scramble to patch the SGR has distracted policymakers, physician organizations, and other stakeholders from the need for a broader overhaul of today's fee-for-service system and its incentives for volume over value.

### What Stakeholders Did:

- A repeal of the SGR has long been at the top of the agenda for physician organizations. But recently, the leading voices of physicians, including the American Medical Association (AMA), specialist societies, and primary care groups, have acknowledged the need to also change the underlying incentives of Medicare's FFS system. The time was ripe for a deal that advanced new payment models emphasizing value while permanently repealing the SGR. On October 15, 2012, the AMA, 48 state medical societies, and 61 specialty, medical education and other groups showed extraordinary leadership by embracing such an approach in a letter submitted to the relevant committees in Congress.[9]

- Traditionally, fights over health care provider reimbursement raise little concern among those not directly involved. But by spring 2013, a broad range of stakeholders had recognized SGR repeal could be a vehicle for advancing other much-needed reforms to the health system. On April 26, NCHC sent a letter to the key congressional committees urging them to couple a permanent SGR repeal with broader payment overhaul. Signatories included not only physician groups, but also leading consumer, disease advocacy, pension fund, health plan, quality measurement, hospital, and post-acute provider organizations.

### What Congressional Champions Did:

- After lengthy consultations with other policymakers and stakeholders, the Chairmen and Ranking Members of the House Energy and Commerce Committee and its Subcommittee on Health jointly introduced legislation to repeal the SGR permanently and put in place a new value-based physician payment system. Building on this show of bipartisan cooperation, the bill was unanimously approved by the full committee in early August.

- In December, the Senate Finance Committee and the House Ways and Means Committee marked up and passed similar versions of SGR repeal legislation. Their respective bills had been developed in close coordination and each passed committee with overwhelming bipartisan support.

- In early 2014, the three committees launched a remarkable, bipartisan process that concluded with agreement on consensus bill. On February 11, 2014, the bipartisan leadership of the committees introduced the *SGR Repeal and Medicare Physician Payment Modernization Act* (H.R. 4015/S. 2000) in the House and Senate. This remarkable bipartisan, bicameral consensus signified the furthest that Congress has come toward physician payment reform since the establishment of the SGR in 1997.

### The Results:

- Following introduction of this consensus bill, the leadership and members of the full House and Senate had fifty-three calendar days between February 6 and March 31 to address the biggest outstanding issue: whether to offset the budgetary cost of SGR repeal and how to do so.

- The bipartisan, bicameral cooperation displayed by the committees unfortunately did not extend to the rest of Congress or its leadership. The House approved the legislation only after combining it with a delay of the ACA's individual mandate, ensuring its defeat in the Senate. And for the Senate's part, neither the House bill nor a Democratic alternative—which offset SGR repeal with unspent war funds—received floor consideration.

- Ultimately, rather than pursue permanent repeal, House and Senate leadership negotiated and pushed through a temporary fix, H.R. 4302, over the vehement objections of the medical community. This bill temporarily delayed SGR cuts for yet another year, funded by a few small-scale but important payment reforms. Committee leaders from both sides of the aisle have subsequently called for further consideration of permanent reform legislation during the upcoming "lame duck" session.

**Final Grade for Modernizing Physician Payment and SGR Repeal:**

**INCOMPLETE***

**As with any academic subject, this grade of incomplete will become an F unless action is taken by end of this term.*

9 Letter from Medical Societies to Chairman Max Baucus and Senator Orrin Hatch. (2012, Oct 15). Retrieved from http://www.amda.com/publications/sgr-transition-principles-sign-on-letter.pdf

## Price and Quality Transparency:

### The Issue:

America's health system relies heavily on markets to deliver health care goods and services, yet those markets too often lack the basic information and transparency needed for effective competition.

Individual consumers are too often uninformed of either the price or quality of the services they might receive, with a higher percentage of consumers comparison-shopping for their auto mechanic than their doctor.[10] And consumers are not the only ones suffering from the absence of accessible, transparent information in health care. With incomplete or inadequate information on providers' performance, health plans and employers face challenges forming networks or rewarding performance. At the same time, providers lack sufficient information on their performance relative to peers, which is critical to quality improvement.

As the 113th Congress began in January 2013, there were encouraging signs for advancing legislation is this space. The private sector was beginning to recognize that transparency could be meaningful to individual health care consumers, provided that price was paired with quality information. And throughout the duration of this Congress, federal regulators took steps toward increased transparency, with public disclosure of providers' quality performance and Medicare payments to providers.

### What Stakeholders Did:

- Health plans, rather than waiting on policy change, were investing in comparison shopping tools and providing them to their customers. Separate vendors were helping self-insured employer plans furnish similar tools to their employees. Together, these market dynamics meant that personalized estimates of an individual's out-of-pocket costs and provider-specific quality information were increasingly available to consumers.

- NCHC partnered with the center-right Council for Affordable Health Coverage (CAHC) and formed a new working group. The purpose of the group was to assemble stakeholders behind policies that would support plans' and employers' efforts to promote consumer comparison shopping providers' efforts at quality improvement. Health plans like Aetna, business representatives like the Pacific Business Group on Health, major employers like Boeing, and consumer groups like AARP and U.S. PIRG all joined this new group

- After *Time* magazine published Steven Brill's March 2013 expose, "Bitter Pill: Why Medical Bills Are Killing Us," a national spotlight came to rest on the enormous variation in hospital charges and the frequent irrelevance of those charges to the actual price of services. Suddenly, health care's lack of cost and quality transparency was at the center of a national debate.

### What Congressional Champions Did:

- Within a few days of Steven Brill's article, the bipartisan trio of Representative Mike Burgess(R-TX), Representative Gene Green (D-TX), and Representative John Carter (R-TX) re-introduced a transparency bill from 2009. The latest version of their bill, the *Health Care Price Transparency Promotion Act* (H.R. 1326), calls for public posting of charges for hospital care in every state participating in Medicaid, and for grant consumers the right to know their expected out-of-pocket costs prior to treatment.

- In the months that followed, Republicans and Democrats from both chambers of Congress pushed for greater value through data transparency by expanding and reforming Medicare's Qualified Entity program. Under current law, the program provides certain non-profit groups (Qualified Entities or QEs) with access to Medicare claims data—a treasure trove of information on treatment patterns and provider performance. Unfortunately, current program regulations severely restrict that data's usefulness in care improvement and consumer transparency efforts. To allow for more effective use of the data, would-be reformers of the program argued that QEs should be allowed to sell in-depth analyses of claims data to providers, plans, and employers, with proper protections to prevent misuse of personal health information. Providers could then use that information to drive clinical performance and value, and plans and employers could better provide the information consumers need to choose the best providers or care.

- With support from the transparency working group assembled by NCHC and CAHC, QE reform was included in both the House and Senate SGR reform bills. Additionally, Representatives Paul Ryan (R-WI) and Ron Kind (D-WI) as well as Senators John Thune (R-SD) and Tammy Baldwin (D-WI) introduced stand-alone legislation in their respective chambers.

10 Lynch, W. (2012, Mar 8). Presentation to the NCHC Policy Committee Meeting on Harnessing Consumer Engagement. Retrieved from http://altarum.org/about/news-and-events/health-care-consumerism-roundtable

### The Results:

- Despite repeated congressional hearings, Congress has enacted no legislation related to provider price transparency. Neither the *Health Care Price Transparency Promotion Act* nor the several other provider transparency bills have been enacted.

- As noted above, the originally bipartisan push for SGR reform legislation collapsed. This made the enactment of QE reform unlikely before the 2014 elections. Despite bipartisan support and backing from industry and consumer groups, the stand-alone versions of the QE legislation have yet to pass either Congressional chamber.

**Final Grade for Price and Quality Transparency:**

**F**

## Strengthening Medicare

### The Issue:

Medicare is the largest payer in the United States, accounting for approximately ¼ of United States health spending. Additionally, private payers base their payment policies on those of Medicare. If health care is to become more affordable for all American families and businesses, change must start with Medicare.

Fortunately, experts have put their finger on a huge opportunity to strengthen Medicare and the rest of the health system. From region to region and provider to provider, data shows a substantial amount of variation in the number of services provided, without a clear relationship to care quality or outcomes.[11] Though fraud and abuse certainly help drive this variation, most analysts point to payment rules which allow providers to reap financial windfalls from delivering more care, without necessarily delivering better care, as the source of the problem. In traditional FFS Medicare, variation is highest in post-acute care but observed throughout the range of the program's providers.[12]

If this unwarranted variation and the resulting waste are to be addressed, changing Medicare's provider payment policies is crucial. Efforts are already underway to implement value-based and alternative payment models. In Medicare FFS, the first results from the Medicare Shared Savings Program's Accountable Care Organizations (ACOs) indicate modest savings.[13] The Acute Care Episode Demonstration produced real savings and quality improvements.[14] In the Medicare Advantage program, where many of the most promising innovations were pioneered, plans are making gains in quality and are increasingly partnering with ACOs as well.

Yet most analysts agree that further reform is needed, even though polarized debate over the ACA and recent Medicare premium support proposals have led many to doubt the prospects for progress.

### What Stakeholders Did:

- By mid-2013, those larger debates remained far from resolved but experts from right, left, and center had begun to agree on some of the incremental steps needed to curb unnecessary costs in Medicare. This new consensus embraced the notion that coordinated, effective anti-fraud efforts and more widespread use of episodic bundling and other payment reforms could help drive down the wide variation in the cost of post-acute care.

- Another key point of agreement was the need for stronger action to coordinate care for beneficiaries enrolled in Medicare FFS. A bipartisan panel of experts at the Brookings Institution and a team of former congressional leaders under the auspices of the Bipartisan Policy Center each made a new, improved form of ACO the centerpiece of their respective proposals. Beneficiaries would be able to actively enroll in these 2nd generation ACOs, and the ACOs would have the flexibility to adjust cost-sharing to guide beneficiaries toward utilizing higher-value care and higher-quality providers. Around the same time these plans were being developed, Emory University Professor Ken Thorpe, a former Clinton Administration official, and Avik Roy, a former spokesman for the Romney campaign, were advancing their own separate proposals to improve value in Medicare FFS. Though independently developed, the strikingly similar plans from Thorpe and Roy both called for groups of providers or plans to coordinate and bolster care for Medicare FFS enrollees. Though the details

11 Medicare Payment Advisory Commission. (2011, Jan 31). *Report to Congress: Regional Variation on Medicare Service Use*. Retrieved from http://medpac.gov/documents/Jan11_RegionalVariation_report.pdf

12 Medicare Payment Advisory Commission. (2011, Jan 31). *Report to Congress: Regional Variation on Medicare Service Use*. Retrieved from http://medpac.gov/documents/Jan11_RegionalVariation_report.pdf

13 Centers for Medicare and Medicaid Services. (2014, Sep 16) Medicare ACOs continue to succeed in improving care, lowering cost growth. Fact sheet. Retrieved from http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html

14 Urdapilleta, O., Weinberg, D., Pederson, S., Kim, G., Cannon-Jones, S., Woodward, J. (2013, May 31). Evaluation of the Medicare Acute Care Episode (ACE) Demonstration. Center for Medicare and Medicaid Services. Retrieved from http://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf

of these proposals remained a matter of significant debate among thought leaders and stakeholders, the direction was clear: policymakers needed to act boldly to improve integration and accountability for beneficiaries enrolled in traditional Medicare FFS.

### What Congressional Champions Did:

- With Medicare facing improper payment rates of 10.1% in FFS and 9.5% in Medicare Advantage, the *Preventing and Reducing Improper Medicare and Medicaid Expenditures (PRIME) Act* (S. 1123/H.R. 2305) was introduced in Congress by Senator Tom Carper (D-DE) and Senator Tom Coburn (R-OK), and by Representative Peter Roskam (R-IL) and Representative John Carney (D-DE). This bill aimed to protect beneficiaries and the program's finances by combating identity theft and cracking down on improper billing.

- The leadership of the House Ways and Means and Senate Finance Committees jointly introduced the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act* (S. 2553/H.R. 4994). As a first step toward broader payment reform, this legislation called for the alignment of patient assessment and quality measures across the various types of Medicare providers offering post-acute services. Another bipartisan initiative, the *Comprehensive Care Payment Innovation Act* (H.R. 3796), introduced by Representative Diane Black (R-TN) and Representative Richard Neal (D-MA), would open up cost-saving bundled payment programs to post-acute and hospital providers across the country.

- In January 2014, another bipartisan, bicameral foursome of lawmakers, Senator Ron Wyden (D-OR), Senator Johnny Isakson (R-GA), Representative Erik Paulsen (R-MN), and Representative Peter Welch (D-VT), introduced an ambitious new bill, the *Better Care, Lower Cost Act* (S. 1932/H.R. 3890). The bill would allow FFS beneficiaries facing two or more chronic diseases to sign up for new Medicare Better Care programs, offered by groups of providers or plans. Additionally, in another example of bipartisan leadership, Representative Diane Black (R-TN) and Representative Peter Welch (D-VT) introduced a package of reforms, *The ACO Improvement Act* (H.R. 5558), designed to expand the impact of the existing ACO programs.

### The Results:

- Significant portions of the *PRIME Act* were added to the Senate Finance Committee's bill to repeal the SGR and overhaul physician payment, and to a discussion draft of anti-fraud legislation released in August 2014 by the House Ways and Means Committee. However, these provisions were absent from the SGR repeal legislation passed by the House, H.R. 4015, and the Ways and Means Committee's work on a broader anti-fraud bill, which includes provisions of the *PRIME Act*, has yet to lead to the introduction of legislation.

- In a rare instance of bipartisan legislative achievement, the *IMPACT Act* passed both the House and Senate by voice votes in September 2014. Yet despite this small success, there is little hope for broader post-acute reform legislation this Congress. The *Comprehensive Care Innovation Act* has not yet received a hearing in Committee, let alone made it to the floor of the House.

- Congressional committees passed up the opportunity to further improve care coordination in FFS Medicare by not holding a markup on either 2nd generation ACO proposal or the approach embodied in the *Better Care, Lower Cost Act*. The *ACO Improvement Act*, although substantively promising, was introduced in the last week of Congressional session prior to the 2014 elections, making enactment during this Congress unlikely.

- The otherwise disappointing SGR patch bill, H.R. 4302, did represent progress in one respect: the cost of the patch was offset, in part, by cost-saving reforms to Medicare payment policies. The specific reforms included a new value-based purchasing program for Skilled Nursing Facilities, reevaluation of physician fee schedule payment codes, and new appropriate use criteria discouraging the overuse of certain diagnostic tests. While the overall budgetary impact of these incremental reforms may be limited, Congress' decision to embrace bipartisan payment reforms rather than blunt cuts to providers or beneficiaries sets an important precedent for future offset conversations.

**Final Grade for Strengthening Medicare:**

**D+**

## The Term Ahead:

Rising health care costs have clearly tested this Congress's ability to put aside differences and govern. Thus far, the 113th Congress has yet to pass the test.

But in the coming lame duck session, the 113th Congress has one last chance to go back and change those disappointing grades for the better. They should not squander it.

In January, a new term will begin and the 535 members of the new, 114th Congress will take their seats in the Capitol. For the upcoming term, the usual partisan blame game on health costs simply will not make the grade.

The consumer, provider, payer, and employer groups represented by NCHC will be working on an aggressive agenda in coming weeks. This agenda will encompass the topics discussed above as well as new areas for potential common ground, such as more robust patient and family engagement in their health and health care decision-making. Next year, NCHC will be on Capitol Hill demanding results, not more rhetoric, because with health care costs climbing month in and month out, America's families cannot afford another two years of failure.