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AM, FRIDAY SEPTEMBER 9, 2011****



Business Health Care Group

Driving Meaningful Change

Written Testimony

Of

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of

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Before the

U.S. House of Representatives

Ways and Means Committee

Health Subcommittee

Hearing on Health Care Industry Consolidation

September 9, 2011

Background

Good morning and thank you, Mr. Chairman and Members of the Committee, for the invitation to speak to you today. My name is Dianne Kiehl and I am appearing here representing the Business Health Care Group of Southeastern Wisconsin, a progressive and actively engaged employer-based health care purchasing coalition operating in Milwaukee, Wisconsin where I have served as the executive director since 2004.

I have spent 41 years in the health care field, with the first 14 spent providing patient care as a registered nurse and clinical lab technologist. For the past 27 years I have worked in a variety of leadership positions assisting the employer community in managing health care costs, including 12 years as a business owner. I also serve on the boards of directors of five organizations, Wisconsin Collaborative for Healthcare Quality, Wisconsin Health Information Organization, Wisconsin Health Information Exchange, Greater Milwaukee Business Foundation on Health and WISHIN, Wisconsin's State-Designated Entity for Health Information Exchange (HIE). WISHIN is responsible for developing HIE capability throughout the state. In addition, I serve on numerous steering committees related to payment reform and other health industry related activities.

I am here today to share with you my own and the organization I represent's experience and perspective on the health care industry's consolidation in our region – specifically, southeast Wisconsin which includes the greater Milwaukee metropolitan area.

When I started my career in health care; and for a good many years after that, health care was available based on community need. For example, this meant, if you had a serious neurological need you went to one facility, cardiac surgery, you went to one of three facilities, and neonatal care was only provided at one of two facilities. This kept costly infrastructure to a minimum. In essence, we had a virtual “center of excellence” model of care delivery for high cost ticket items.

Today, with the vertical integration of health care providers, most systems provide virtually every service regardless of actual community need. The emphasis is now on keeping the patient in its integrated delivery system which is intended to protect revenue stream and support the quality of care. This has resulted in an incredible expansion of cardiac, neonatal, orthopedic and cancer units/facilities in our market, including three specialty hospitals; one dedicated to cardiac and two to orthopedic care, and all partially owned by hospital systems.

With the exception of a very few, services are duplicated at every health care system in our region, resulting in increased and unnecessary infrastructure. As health care purchasers, when we question the duplication of services within a system, frequently the answer is that the community wanted it, but does the community know the price tag?

At a time of rampant provider consolidation in our region, consider the following facts:

- In a study by the Greater Milwaukee Business Foundation on Health – using the most recent data available – average southeastern Wisconsin hospital commercial payments have increased approximately 24 percent from 2003 through 2007. Total Medical CPI

during this same time period for our market was 12.8 percent, so hospital costs escalated at a faster rate.

- Wisconsin's health insurance rates have increased faster than the national average. According to Citizen Action of Wisconsin's 2010 Wisconsin Health Insurance Cost Rankings, national employer-based single health insurance premiums have increased 120 percent this decade – in Wisconsin, they have increased 179 percent. These rankings show that all Wisconsin regions and metro areas have suffered health insurance cost inflation above the national average.
- According to a 2004 Government Accountability Office report, health care spending in Milwaukee was about 27 percent higher than the average across all of the Metropolitan Statistical Areas studied in the analysis. A quote from the same report suggests provider consolidation may be a possible reason for higher costs, "We have found some evidence to support the stakeholders' assertion that hospitals and physicians had more leverage than insurers in negotiating prices."

When faced with escalating health care costs, employers have several choices, none of them appealing. They can choose to pass the costs on to their employees in the form of higher premium contributions or higher deductibles. They can limit wage increases. They can try to get by with fewer employees. They can make the decision to no longer offer health insurance benefits. Or they can choose to relocate their operations to a location with more reasonable health care costs.

Business Health Care Group Background

I will provide you with more detail on our experience with provider consolidation in our region later in my testimony. However, I would like to take a few moments to give you some information on the group I represent as well as some important health care cost and quality initiatives that have been organized in our state and have played an integral role in our efforts. The Business Health Care Group of Southeastern Wisconsin or as we refer to it, the BHCG, grew out of the frustration felt by several CEOs of large Milwaukee-based employers concerning health care costs in southeast Wisconsin as compared to their other locations, particularly other areas in the Midwest.

A study commissioned by the Greater Milwaukee Business Foundation on Health found that in 2003, health care costs in southeast Wisconsin were 39 percent above the Midwest average. In 2003 the cost of health benefits for employees in the state rose 14.8 percent to \$6,940 per employee which was 20 percent higher than the national average for workers in businesses with 500 or more employees. The CEOs realized that something needed to be done if our area was going to maintain jobs in our market.

The CEOs also understood that no one employer was large enough to influence the health care market. It would take a number of large employers, speaking with one voice, walking in unison with a common strategy, to impact the costs of health care in southeast Wisconsin and actually move the market. Ultimately, 11 corporations with headquarters in southeast Wisconsin and two other existing coalitions founded the BHCG as a member owned Limited Liability Corporation in 2003 to explore alternatives to contain health care costs in the region. They soon established a goal to get costs at or below the Midwest average within five years.

Our current goal is to enable southeast Wisconsin to become a premier community for health care, recognized for its ability to provide low cost, high quality health care services and promote employee well-being. BHCG member companies are committed, in collaboration with employees and health care providers, to maintain our cost status of being at or below the Midwest average and to achieve ongoing medical cost trend rate at or below the rate of general inflation.

Several tenets were established early on that, to this day, serve us well in advancing our mission. We push for accountability from all stakeholders – this includes health care providers, employers, employees/consumers and our sole health plan administrator. Consumers need to be held accountable for becoming more engaged in their own health and to use information to make more informed decisions. Health care providers need to be held accountable for outcomes, efficiency and to reduce variation in care thereby mitigating cost trend. Employers need to be engaged in coalitions, provide a healthy environment and their total health benefit offerings need to be based on best practices. The administrator needs to meet the needs of the local markets, have the ability to support engaged employers, assist in removing barriers to reforming the market and perform their core activities efficiently and effectively.

One key component to our success is our network strategy which promotes competition through re-contracting with all significant providers at the same time every three years. We also strive to enter into provider contracts with fixed prices as opposed to arrangements with a percentage off charges. Since we have excess infrastructure in our market, our member companies support a narrow network approach which further provides the impetus for the providers to compete in order to be included in the network. Only members of the BHCG can use the exclusive network offered by our sole administrator.

The BHCG is committed to the education of both employers and their employees as a basic principle of our strategy. We believe employees must be motivated through plan design and educated to become better consumers of health care. We develop tools for our employer

members to help make their employees better purchasers of the health care they consume. Our health plan administrator provides online pricing (to the extent allowed under their contracts) and quality information to allow them to make better decisions. The BHCG developed consumer videos focused on key consumer accountabilities that are available to our members. We provide educational forums and support projects that promote best practices for employers to utilize in managing their health care dollars and benefit programs effectively.

We continue to have the active engagement of the CEOs of some of our largest members, providing guidance and direction for our organization. This is a key to keeping the provider community engaged with our group. We meet with the provider community on a regular basis through a provider action plan process established by our group to promote provider accountability and to support increased communication between the provider and business communities.

Our success would have not been possible without a committed employer community who partnered with an administrator that was willing to allow the employer community to drive marketplace change.

Business Health Care Group Successes

Presently, the Business Health Care Group service area includes 11 counties in southeast Wisconsin. Our membership includes over 1,200 employers of all sizes, with over 110,000 employees and their dependents using the network offered by our administrator. In 2006 when we first launched our health plan option, it included 14 employers and 67,000 employees and dependents enrolled in the health plan. Our group includes both fully insured, through our sole administrator, and self-funded member companies.

I am pleased to be able to report that for 2009 – the most recent year that data is available – Business Health Care Group member health care costs were 6 percent below the Midwest average and 13 percent below the average for southeast Wisconsin. Measured another way, we have been able to limit the average annual increase in health care costs for our self-funded employers to 1.4 percent for the past five years.

This is some remarkable success, but it would not have been possible without an enormous amount of hard work from our employer members. To sustain a coalition of diverse employers requires countless hours from membership in the form of serving on numerous committees and work groups. This work on the part of member representatives is in addition to their jobs they perform for their employer. Our employer members have also provided financial support in the form of both start up money and ongoing membership fees.

Strategic Partners

The Business Health Care Group is a formidable force in the community, but other organizations have contributed to the results in our market. In Wisconsin we are privileged to have a number of organizations that work in collaboration to tackle the challenges of improving health care quality and reducing costs. Three organizations deserve special mention. The first is the Wisconsin Collaborative for Healthcare Quality, or WCHQ, a voluntary consortium of provider organizations committed to improving health care quality in the state of Wisconsin.

WCHQ is active in developing and guiding the collection and analysis of health care performance measures. They publicly report performance data and identify and share best practices among their provider members. A recent research project funded by The Commonwealth on WCHQ data showed the following: transparency drives improvement, what gets measured and reported publicly improves faster and provider groups that belong to WCHQ perform at a higher rate than those that do not participate. Better quality removes unnecessary costs. For example, if diabetics are managed according to best practices standards, the potential for complications decrease and dollars are saved.

The second organization is the Wisconsin Health Information Organization (WHIO). WHIO is a voluntary, not for profit public-private partnership with a multi-stakeholder board which includes payers, providers, business and the state government. WHIO has developed a statewide data mart of health care information which can be used to produce comparative analytics on provider performance and evaluate population health. Providers and others use this information to improve value in health care by focusing on quality and resource utilization. All the major payers and the Medicaid data are included in the data mart. However, at this time, the Medicare data set – which is critical to complete the data mart – is missing.

The third organization is the Wisconsin Health Information Exchange (WHIE). In its fourth year of operation, WHIE is a nonprofit organization whose mission is to improve the quality, safety, efficiency and accessibility of health care through the secure delivery of timely, accurate electronic health information to authorized users across institutional boundaries. WHIE's initial initiative involved linking emergency departments to a database that allowed emergency department personnel access to a patient's emergency department visit and treatment history. When medical information is shared in this way, substantial money can be saved by reducing duplicate tests, procedures and unnecessary inpatient admissions. In addition, the patient experience and quality of care is improved. WHIE is one of the nation's leading efforts to improve health care through regional electronic information exchange. The BHC Group provides reimbursement to WHIE for paid emergency room visits for which the linked data was used.

A recently released study shows this saves money.

As a result of the efforts of our provider community, these organizations and many others, Wisconsin consistently ranks in the top ten states in terms of health care quality according to the Agency for Healthcare Research and Quality.

Provider Consolidation in Southeast Wisconsin

Southeast Wisconsin has seen extensive provider consolidation in the past twenty years, starting with hospitals merging and acquiring one another. At one time we had 26 independent general hospitals in the metropolitan Milwaukee area in six counties. The bulk of the hospital consolidation took place in the early to mid 1990s. Presently all the hospitals remaining in the area have been consolidated into six health care systems which include 21 hospitals. Nine new hospitals have been built, four of them in just the past two years.

In roughly the past five years, hospital health care systems have begun buying up independent primary care physician practices. In the past three years there has been an uptick in health care systems buying multi-specialty clinics and specialty groups. This is due to the systems currently having a significant number of primary care physicians employed through practices they purchased. They can now control where the primary care physician refers which puts undue pressure on specialists to sell their practices in order to maintain their referral stream.

These consolidations have occurred for a number of reasons. Providers realize that increased market share, especially in specific geographic markets, improves their access to commercial insured versus government funded programs and offers them greater contractual leverage. When health systems purchase independent practices, they can automatically move reimbursement levels to those of the acquiring larger group or system. Based on a third party analysis of physician fees in our market, doctors employed in consolidated systems have fees that are on average 56 percent higher than those of independent doctors. In addition, the more consolidated a community becomes, the less chance of any one provider group or system being excluded from any one network or plan.

The increasing complexity of health care administration and regulations placed upon independent physicians makes overtures on the part of health care systems to purchase them sound appealing. Physicians can sell their practices for lucrative sums and avoid the day-to-day administrative headaches of running a practice.

Providers are also preparing for all the expectations that are included in health care reform. Health care systems believe consolidation is the simplest way to provide coordinated or

integrated care. Integrated care should be the goal, but consolidation is technically not necessary to achieve this goal. It is possible to integrate care through technology, operational processes and collaboration.

A Purchaser Perspective on the Effects of Consolidation

Decreased competition, increased cost

The obvious concerns surrounding consolidation are decreased consumer choice and competition, greater leverage and a physician community that is now locked into a specific system. Not so long ago, doctors had admitting privileges at multiple hospitals. Now those same doctors are employed in practices owned by health care systems and those physicians can only admit to their employers' facilities. This fact is in direct opposition to the contention that consumer directed choice is a key component of the solution to our health care crisis. Since our member companies do business in a heavily consolidated market, we must now hold the provider community accountable to deliver the results promised through integrated care. In addition, we need to escalate the efforts to engage consumers to be a force in the health care market.

In our market, consolidation caused two systems to build three hospitals that opened in the last two years to capture new geographic market share. This was primarily based not on lack of access to services, but to keep patients within their care systems to support their idea of integrated care. This has resulted in four hospitals sharing the market that two used to share, resulting in excess capacity. There was considerable cost incurred that will need to be covered by the promise of integrated care.

We do have examples in our market where costly services are being consolidated within a system and not replicated at each of their facilities. We also have an example where a system is trying to work with their community independent physicians to function as an ACO. I never thought I would see the day where physicians are participating in work groups with employers to come up with solutions but we believe our provider community understands that the "gravy days" for health care are over and they are prepared to work with us to deliver the results we need. But all of this will not end the arms race for market share.

The quality question

Health care systems also maintain that consolidation gives them more control over quality. However, even though we are glad we live in a state that consistently ranks in the top ten states for health care quality, one has to look at what that really means.

For example, chances are good that some of you or your loved ones are diabetics. If you are, you most likely know that good glycemic control is critical to successfully managing your condition. According to the Wisconsin Collaborative for Healthcare Quality's 2009 to 2010 data, southeastern Wisconsin health care systems ranged from a low of 59 percent to a high of 76 percent compliance with the standard of providing diabetic patients with two A1c tests per year which is best practice. Good glycemic control for people with diabetes is cost-effective and improves the quality of life, yet good A1c control for the patients in this same group ranged from a low of 55.7 percent to a high of 65.3 percent. Clearly there is much more work to be done to improve these statistics in our area despite the hoped for effects of integrated care as a result of provider consolidation.

The negotiating table

Health care is a local issue, yet many of our employers are multi-region, multi-state employers who find it tough, if not impossible to equitably offer uniform health plans and influence health care value for all their employees. We represent diverse employers with diverse interests, cultures and market pressures, unlike providers who have the advantage of selling services that are largely necessities and geographically locked. Our member companies have to compete globally and for the most part, our health care providers only have to compete locally. Consolidation creates provider leverage for specific contractual provisions that limit the ability of what employers can do such as shifting care based on price and quality, often referred to as tiering.

Provider clout at the negotiating table as a result of consolidation has a deleterious effect on transparency of cost and quality information available to payers and consumers. Provider systems, given their size, are adept at pushing for contract language that severely restricts information to assist consumers in making wise purchasing decisions.

Health care administrators are also not without fault when it comes to restrictions placed on transparency. Administrators treat provider pricing as a core competency when it should not be. We need to hold the provider accountable for their prices, not the administrator. Administrators use their contract pricing to differentiate themselves in the market. If differential pricing disappears, they will need to redefine their value proposition.

To allow transparency to truly work for consumers and payers, providers must be forced to make public their fees. The entity that should be selling their rates to the consumer is the provider, not the administrator. Providers and administrators are making it virtually impossible for consumers to have access to pricing in order to make wise purchasing decisions. We believe this is an extremely important issue for the government to understand. Additionally, the plan I enroll in should not affect what I pay for a certain service at a certain provider.

Going Forward – What Needs to Happen?

It is obvious that we need to provide care efficiently in a patient-centered model where patients get care at the right time, right place and by the right provider. Integrated care is the goal, but it does not require consolidation.

Providers and the health care administrator and insurance community need to take responsibility for the lack of transparency of provider prices. What other services or commodities do you purchase where you don't know the price until after the fact? The BHCG believes full transparency of price and quality is essential to a patient-centered model.

From our perspective, ACOs will further limit consumer choice by locking in market share. Under the current law, new payment mechanisms will be incorporated in which ACOs will be taking some financial risk so they will want to control physicians, which in turn, gives them control over revenue, processes, care delivery and priorities. Will they also provide financial incentives to physicians that support patient-centered care? Not every provider system does everything well, we need to make sure consumers have the choice to use the best provider for their situation.

I believe the Accountable Care Organization concept that promotes patient-centered care is a good one. But in reality, its presence in the current health care reform law has only provided more fuel to the fire for physicians to sell their practices to hospitals and hospital systems to lock up market share, especially the commercial market share. Fear of the unknown is driving defensive behavior. Physicians prefer not to give up their autonomy but see no choice.

In summary, the considerable health care industry consolidation has made our efforts and those of many other similar organizations an absolute necessity if employers are to maintain some control over the cost of their health care benefits. We expect more consolidation to occur in our region, ratcheting up our concerns as well as our efforts. Even though we have seen some improvement, it is not enough to bring trend to a tolerable level.

We will need to see dramatic improvements in quality and significant adoption of best practices and patient-centered care – all key elements called for in the reform of health care in this country. Provider-driven business practices need to be kept in check and balance by a very engaged employer community. Cost and quality information needs to be accessible to consumers and used to drive improvement and competition in this new world.

Mr. Chairman, I would like to thank you and the committee for your time and the opportunity to share my testimony on this very important topic. It is indeed an honor to share my thoughts and experiences with such esteemed company. I look forward to your questions and comments at this time.