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August 11, 2014

The Honorable Ron Wyden  
Chairman, Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Charles Grassley  
Member, Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Wyden and Senator Grassley:

Thank you for the opportunity to provide comments in response to your June 12, 2014 request for public input on enhancing the availability and utility of health care data. The [Pacific Business Group on Health](#) (PBGH) is a non-profit organization that leverages the strength of its 60 member companies—who collectively spend \$40 billion a year purchasing health care services—to drive improvements in quality and affordability across the U.S. health system.

Increasing the availability and utility of health care data has long been a cornerstone of PBGH's efforts to improve value for our members and their 10 million employees. At the federal level, we continue to actively engage in improving the health care quality measurement and data reporting enterprise through our co-leadership of the [Consumer-Purchaser Alliance](#), a diverse group of consumer, employer, and labor groups. Much of the Alliance's work now centers on advancing public reporting of provider performance and patient outcome data to support consumer choice and promote payment reform.

At the state level, PBGH collaborates with the [California Healthcare Performance Information System](#) (CHPI), an aggregated health care claims database covering more than 12 million patients enrolled in three large private health plans, and Medicare. When fully operational, CHPI will allow insurance carriers to identify and develop high-performing networks, encourage consumers to make more informed health care choices, and foster accountability among doctors and hospitals. CHPI is certified as a "Qualified Entity" by the federal government and began receiving Medicare data in 2013.

We also work closely with our members to provide employees with the direct, personalized information they need to better assess the quality and cost of health insurance, doctors, hospitals, and treatments. Our Health Plan Chooser product now allows two million employees to select coverage based on individualized measures of affordability, anticipated medical and medication needs, and doctors in network. This and other sophisticated consumer decision-aids clearly rely on data—data on costs, provider performance, wellness services, and managing disease, to name a few.

Similarly, many of the innovative payment reform and benefit design strategies that PBGH supports simply do not work without meaningful information on the price and quality of health care services. Our reference pricing initiative, travel surgery network, and outpatient care program all require accurate, timely, and comprehensive data. Unfortunately, this type of information is often hard to come by—either because it does not exist, it is difficult to convey, or health care providers and plans are reluctant to release it.

We are, however, making progress. The continued proliferation of health information technology in the clinical setting is generating data to help providers deliver more effective care and engage in quality improvement efforts. Consumers and purchasers continue to push for better quality indicators that enable

patients to better understand a doctor or hospital's record on important metrics like patient-reported outcomes, coordination of care, and affordability. And many public and private efforts to place more data in hands of consumers are beginning to bear fruit.

Ultimately, our members believe that greater transparency of price and quality information will improve the functioning of health care markets, facilitate value-based decision-making by individuals and employers, and lead to better and more affordable care across the U.S. health system. PBGH appreciates the opportunity to provide input into this committee's work on improving the usefulness of health care information and fully supports its efforts to increase transparency throughout the U.S. health system.

We offer the following comments in response to your specific questions:

**1. What data sources should be made more broadly available?**

PBGH is committed to comprehensive efforts that advance the transparency of price and quality information for all of those with a stake in the performance of the US health system—patients, providers, employers, insurance carriers, and policy officials. Most immediately, Congress has direct authority over the dissemination of health care data related to public payers and should seek the eventual release of payment and quality information (including registry data) from all federally funded health programs.

Within the Medicare Qualified Entity (QE) program, Congress has authorized organizations like PBGH to receive claims data from Medicare Parts A, B, and D. QE reforms passed last year by the House—but not yet signed into law—would expand data sharing to the Medicare Advantage, Medicaid, and CHIP programs. A complete federal commitment to transparency would also include information from TRICARE, the Veterans Administration, and the Federal Employees Health Benefit Program.

More broadly, PBGH is supportive of Congress' efforts to expand the QE program to allow organizations more flexibility in sharing data, generating analyses, and supporting sustainable business models. While PBGH was pleased to see important reforms to the QE program incorporated into the Sustainable Growth Rate reform bill introduced earlier in the year, we are especially supportive of Sen. Baldwin and Sen. Thune's Quality Data, Quality Care Act (S. 1758), which includes a more expansive list of users entitled to the data and analyses produced by QEs.

Outside of the QE program, PBGH applauded the release of several large Medicare data sets for widespread use this spring. In April, the Administration provided the public with Medicare physician billing records for 2012, followed by charge information for more than 3,000 U.S. hospitals, including the 100 most-common Medicare inpatient procedures and the 30 most-common outpatient procedures. In addition to the pricing data, CMS also unveiled several new interactive tools to help users process and understand the new information.

While the public release of this type of Medicare data is a very positive development, further work is needed for stakeholders to begin to truly understand the performance of hospitals and doctors participating in the program. Congress should encourage the Administration to produce and release information that would allow analysts to, among other things, risk-adjust claims for patient severity

and standardize data for geographic differences in cost. Linking provider claims to electronic registry data and meaningful quality measures like patient-reported outcomes (PROs) are further steps that will improve the usefulness of future data releases.

Patient-Reported Outcomes are a key missing ingredient in the nation's effort to develop a truly patient-centered health care system. PROs are what matter most to patients and therefore should be used for provider accountability as well as information for consumer choice. PROs have been in use for a long time in academic research, in clinical trials<sup>1</sup>, and, more recently, for performance measurement, feedback, and public reporting. We strongly recommend that Congress provide support for the rapid development and use of better performance measures, including patient-reported outcomes, patient experience of care, care coordination, appropriateness of care, and total resource use. Finally, we also note the need for more data on patient populations' social and behavioral determinants of health.

On the commercial side, PBGH was pleased to see three of the nation's largest health insurance companies—Aetna, Humana and UnitedHealthcare—announce their intention to develop and provide consumers free access to an online tool that will offer information about the price and quality of health care services. An independent, not-for-profit group called the Health Care Cost Institute (HCCI) will create and administer the information portal, which is expected to be available in early 2015. The plan expands the mission of the institute, set up in 2011 to make data on private insurers' costs available to researchers, to begin providing cost and quality information to the general public.

This is clearly a step in the right direction. However, the new initiative is a more constrained release of data than recent Medicare efforts—private insurers continue to argue that their data is proprietary and “commercially sensitive,” and thus limit how the public can use it. Instead of providing a comprehensive list of prices paid to individual physicians and hospitals for specific services, it will offer consumers an approximate price” for health services in their communities, based on aggregated data. Although this will provide customers with better information about prices, including how much they'll have to pay out of pocket, ultimately we need to make sure actual negotiated prices are available to the public.

Congress can further improve the availability of price information in the private sector by passing legislation requiring the disclosure of actual amounts paid to providers, rather than “charges” or list prices that often bear little resemblance to what patients or their insurance companies ultimately pay. To that end, Sen. Coburn and Sen. McCaskill recently introduced the CLEAR Cost Information Act of 2013, which would require hospitals to disclose the actual amounts collected from uninsured and insured patients over the preceding two years for the 50 most common procedures. The measure is currently pending before this committee.

## **2. How, in what form, and for what purposes should this data be conveyed?**

Given that information on the price and quality of health care services is needed by so many different constituencies—and will be used in so many different ways—a multi-pronged and comprehensive strategy is needed regarding future public releases of health care data. At minimum, the broad release of Medicare claims information needs to be accompanied by rudimentary tools that allow the general public to understand resource use and billing patterns among individual providers in different

geographic areas. Further linking this information to meaningful quality measures like patient-reported outcomes and safety will allow consumers to begin to understand the value offered by different providers.

PBGH's comprehensive research and work developing sophisticated decision aids has shown that patients want total cost-of-care and quality information presented in an easy-to-understand, searchable format. While it is important for researchers and policymakers to track the cost of a discrete service, what consumers and purchasers really want to know is the total cost of care for a whole treatment episode, including their out-of-pocket costs. Patients diagnosed with a specific condition, seeing a specific doctor, for a specific treatment should know what their out-of-pocket cost will be before receiving services.

Congress should examine ways to ensure that public and private health plan enrollees have this type of information. The Federal Employees Health Benefits Program and several private plans have begun presenting patients with both quality information and cost calculators—this is a positive development, but these tools need to be further refined and expanded. All consumers—not just those who happen to work for a specific employer or buy coverage from a particular health plan—need to know plan- and provider-specific, bundled out-of-pocket costs for treatments and services.

Congress should also explore opportunities to leverage the QE program to convey data in a useable format to a variety of stakeholders. QEs have the technical expertise needed to interpret and communicate sophisticated quality information and manage data privacy concerns, particularly as claims data is linked to provider quality data and patient registry information. Allowing QEs to convey data and analyses to a more expansive list of users, as provided under Sen. Baldwin and Sen. Thune's bill, is consistent with this approach.

**3. What reforms would help reduce the unnecessary fragmentation of health care data? What reforms would improve the accessibility and usability of health care data for consumers, payers, and providers?**

PBGH is an enthusiastic supporter of efforts to spread the use of health information technology among health care providers and create interoperable networks that allow the secure exchange of patient data among clinical settings. To that end, we are deeply troubled by the Administration's recent proposal to further postpone implementation of the Meaningful Use incentive program, as any delay in building a robust electronic health information exchange will compromise efforts to address the fragmented health care delivery system that consumers and purchasers face today.

PBGH also encourages the development of multi- and all-payer claims databases that can inform employers' decisions about provider networks and empower consumers with information about the cost of treatments and services among various hospitals and doctors. While these databases are statewide initiatives, federal support for harmonization of data collection standards among states would encourage their proliferation by minimizing the reporting burden for multi-state payers.

**4. What barriers stand in the way of stakeholders using existing data sources more effectively and what reforms should be made to overcome these barriers?**

Several obstacles are preventing stakeholders from fully utilizing existing data on health care prices and quality. First, meaningful information on price and quality is often difficult to capture, and adjusting for the clinical complexity of individual cases is challenging. Electronic systems and networks to share data may be underdeveloped. Certain groups may resist efforts to measure their performance. And some organizations may have concerns about releasing prices derived from confidential negotiations and may be legally prohibited in some cases from disclosing such information. Despite these challenges, greater use and transparency of price and quality information is both possible and urgently needed.

In summary, several federal-level policies will increase the amount of information available to all of those with a stake in the affordability and performance of the U.S. health system. These include:

- Ensuring health plan enrollees (starting with those in the exchanges, and FEHBP) have both quality information and cost calculators that include plan- and provider-specific, bundled out-of-pocket costs.
- Supporting aggregated multi-payer databases that pool claims data, including actual paid amounts, while protecting patient privacy. Harmonization of data collection standards across states would minimize the reporting burden for multi-state payers.
- Removing barriers to the disclosure of provider quality measures and cost information in health plan contracts.
- Clarifying that self-insured employers have a right to access and use their own claims data.
- Developing meaningful provider performance measures, including price information, for high priority conditions.
- Removing the limitations on the use of Medicare data by Qualified Entities and other entities with claims expertise.

Thank you again for the opportunity to provide input regarding this important topic. We look forward to working with the Committee on these and other matters.

Sincerely,



Bill Kramer  
Executive Director, National Health Policy  
Pacific Business Group on Health

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<sup>i</sup> Deshpande PR, Rajan S, Sudeepthi BL, Abdul Nazir CP (2011) Patient-reported outcomes: A new era in clinical research. Perspectives in Clinical Research, October 2011