U.S. PIRG
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U.S PIRG COST CONTAINMENT REPORT CARD:
On the Senate Finance Committee Bill as Amended

The Finance Committee health reform bill scores a solid B for its all-around cost containment provisions. While Senator Max Baucus' (D-MT) original health care plan only received a B-, the committee process added new cost-saving measures to the bill, bringing the grade up to a B. Only the lack of a strong, cost-saving public option and insurer efficiency standards prevent the bill from getting an A.

Overall grade: B

Detail	Current Grade	Original Grade of Baucus Proposal
Fixing Skewed Payment Incentives	A	A-
Studying What Works Best	B+	B+
Increasing Competition in the Insurance Market	C-	D+
Taming High Administrative Costs	C+	C+

Grading Methodology

To arrive at its grades, the health policy experts at the **U.S. Public Interest Research Group** evaluated the bill to determine if it delivers **what Americans want and need most from health reform**: lower health care costs.

The grades are based on how well the bill addresses key causes of skyrocketing health care costs: uncompetitive insurance markets, high administrative costs, skewed incentives that discourage high-quality, cost-effective care, and the lack of unbiased research about which drugs or treatments work better.

Grade Explanations

Fixing Skewed Incentives: A

America's cost and quality problems start with the payment system that Medicare and many private health insurance companies use. Under this system, known as "fee-for service," health care providers receive payment for each visit with a patient, each test ordered, and each procedure performed. Payment is based solely on the quantity and complexity of care that the patient receives, regardless of how effective that care actually is or how well it is delivered. This payment structure penalizes those providers or hospitals who focus on disease prevention and treatment protocols which identify medical problems before they become acute.

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It also fails to encourage coordination of care between providers. At the same time, fee-for-service rewards hospitals and doctors who rely on a higher complexity and quantity of tests and treatments, with no connection to quality of care, or patient satisfaction or outcomes.

Worse, the minutiae of Medicare payment policy are set directly by Congress. Over the years, well-heeled industry lobbies have used their clout and powerful friends to stop most real payment reforms to the fee-for-service system.

The initial Finance Bill's aggressive payment reforms, including value-based purchasing, bundled payments and physician feedback programs would reward quality, well-coordinated care that delivers results rather than paying solely based on the number of tests and procedures. In mark-up, the Finance Committee added still more reforms: measures to pay doctors based on the value of care they deliver to patients and pilot programs that start the transition away from fee-for service medicine and towards salaries for doctors.

The proposed Medicare Commission would generally insulate policy decisions about payment and pharmaceutical and insurer subsidies within Medicare from special interest politics, thereby preserving Medicare for present and future beneficiaries. This otherwise strong provision was weakened somewhat by a deal that excludes hospital payments from the Commission's jurisdiction.

Taken as a whole, the amendment process has pulled this grade up to an A.

Studying What Works Best: B+

Our current health care system fails to give health care providers and patients the information needed to determine the best course of treatment. Only half of medical interventions are supported by adequate evidence of clinical effectiveness.[1] For certain diseases which have an established, evidence-based treatment, studies show that patients receive the recommended care only 54% of the time.[2] Even when evidence exists and an established course of treatment is available, clinical guidelines can fail to account for differing effects of the same treatment on different populations, such as children or minorities. These gaps lead to the waste of precious health care dollars on care that is unnecessary and doesn't work, They also undermine a family doctor's or other care giving professional's ability to give American families the care on which they depend.

[1] Consumers Union, Powerpoint Presentation to the Bipartisan Policy Center. April 2008. Downloaded from http://www.bipartisanpolicy.org/ht/d/sp/i/5479/pid/5479

[2] McGlynn, E.A., et al, "The Quality of Health Care Delivered in the United States," The New England. Receiving Poor-Quality Health Care? The New England Journal of Medicine, 2006:354(11): 1147-1156.

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The bill establishes a permanent home and funding stream for **comparative effectiveness research**, ensuring that doctors can rely on the best science in helping patients make their care decisions, not the latest propaganda from an industry sales representative. While a strong start, the Finance bill is weaker than the House bill's alternative language, which gets an A for applying more protective conflict of interest requirements to board members overseeing the research studies.

No markup amendments strengthened or weakened these proposals, so its grade remains unchanged at B+.

Increasing Competition in the Insurance Market: C-

A recent American Medical Association survey found that 94% of insurance marketplaces met the federal Department of Justice definition of “highly concentrated.” That means that consumers in these markets were not getting the affordability and quality that a functioning, competitive market can provide. When the dominant insurers in the market increase prices or skimp on coverage, consumers have few places to go for a better deal.

The best remedy to this problem is to offer to consumers the choice of a public, government-sponsored health insurance plan alongside private plans. The negotiating power of a large, nationwide plan would allow the public plan to leverage significant savings. Further, it would employ the cost-saving, quality-improving policies discussed in the rest of this report card. By offering a low cost alternative to private insurance, private insurers would have to innovate to bring their own costs down and so compete with the public plan.

The only way to earn an A in this category is to include this public option, which the Finance Bill does not. However, states would have the option to develop an alternative health reform plan, potentially including their own, state-level public options, provided they contained cost, extended coverage, and did not add to the federal deficit.

This improvement is enough to pull the grade up to a C- for choice and competition.

Taming High Administrative Costs: C+

The health care system is far behind virtually every other American industry in integrating productivity-enhancing information technology systems. Electronic storage and sharing of clinical, administrative and financial health information not can only streamline administration – they also can assist doctors in providing better care.

In our fractured, Balkanized health care system, however, administrative inefficiencies abound. In addition to paper records and a lack of modern information technology, doctors are required to use an array of different forms, codes, and billing procedures e. These systems are different

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for each insurer, and often reliant on paper records. As a result, some doctors can spend up to 45 minutes on paperwork for every hour of care they provide.

To make matters worse, insurers in many states are not required to devote any fixed portion of the premium dollars consumers pay to medical care. As a result, insurers have less incentive to rein in unnecessarily large spending on inefficient administrative practices and untold layers of red tape.

The Finance Committee bill takes steps toward addressing these unnecessary costs, mandating simplified, less expensive electronic transactions between providers and insurers. These new programs mesh well with the health information technology programs passed earlier this year in the American Recovery and Reinvestment Act.

However, the Senate Finance committee failed to approve insurer efficiency standards requiring premium dollars to be spent on care not administrative overhead and executive compensation, despite the fact that the other four Congressional committees writing health care bills have included this important consumer protection.

The amended bill earns a C+ on taming administrative costs.