



HOW TO GET LOWER-COST, HIGHER QUALITY HEALTH CARE IN SOUTHWESTERN PENNSYLVANIA

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This report is based in part on a series of articles which appeared during 2011 and 2012 in the Regional Insights column of the *Pittsburgh Post-Gazette*.

Executive Summary

- The major cause of high and growing health care costs in the Pittsburgh Region and other parts of the country is the high prices charged by large health systems. (See page 3 for more detail.)
- Prices for the same hospital procedures vary by 100% or more between hospitals in the Pittsburgh Region, and the higher-priced hospitals do not have higher quality. (See pages 3-4 and 14-15 for more detail.)
- There is no incentive for patients to use lower-cost hospitals for expensive procedures. Highmark does not offer the kind of tiered network product that employers in other regions are using to control costs. (See pages 4-5 for more detail.)
- Current healthcare payment systems penalize doctors and hospitals for reducing costs and improving quality. There are better ways to pay for health care, but no health plans in the Pittsburgh Region pay this way, and no health systems in the Pittsburgh Region are offering to be paid differently. (See pages 5-6 for more detail.)
- In addition to prices that are higher than necessary, health care costs are high in the Pittsburgh Region because of the over-utilization of hospital services here. The Pittsburgh Region has some of the highest rates of hospitalization, surgery, and emergency room usage of any major region in the country. (See pages 6-7 for more detail.)
- The high utilization of healthcare services is not just because the Pittsburgh Region has an older or sicker population. Even after controlling for age and illness, utilization is higher in the Pittsburgh Region than other major regions for both seniors and working-age adults. (See pages 6-7 and 9-10 for more detail.)
- The overuse problem is concentrated in hospitals. The Pittsburgh Region has more hospital beds and more hospital employees than other major regions of the country (see pages 8-9 for more detail.) In contrast, the Pittsburgh Region under-invests in primary care, which can help to keep patients well and reduce hospitalizations (see page 8 for more detail.)
- Reducing hospital costs doesn't necessarily mean layoffs. The Pittsburgh Region spends more on hospital equipment and facilities, and less on hospital workers, than other parts of the country. (See page 11 for more detail.) Lower-cost healthcare will require more jobs in primary care offices and home care. (See pages 11-12 for more detail.)
- There is relatively little data to determine whether Pittsburgh Region hospitals are providing high-quality care. U.S. News and World Report hospital rankings are based primarily on opinion, not fact, and they give higher rankings to hospitals in the region that have lower quality on objective measures. There is much less information about the quality of hospital care in the Pittsburgh Region than people in other regions have. The limited data available suggest that most hospitals in the region provide equivalent quality care, and some smaller hospitals deliver better care than UPMC. (See pages 12-13 more detail.)
- Hospitals provide extremely large discounts to health plans, so if a hospital refuses to contract with a health plan, it could mean that employers or patients could pay 2-4 times as much for care if that hospital is the only place that offers a particular procedure. The best way to prevent this problem is to require hospitals to charge the same amount to everyone. (See pages 14-16 for more detail.)
- Increasing competition among health insurance plans in the Pittsburgh Region could increase premiums rather than reduce them. The biggest impact on costs will come from having more competition among hospitals, not health plans. (See pages 16-18 for more detail.)

I. Creating the Right Kind of Competition in Healthcare

The prospect of a “divorce” between the Pittsburgh Region’s largest health insurer (Highmark) and largest hospital system (UPMC) has caused concern for many residents of the region. Will they have to switch doctors or change insurance? Many community leaders have called on Highmark and UPMC to settle their differences and return to business as usual.

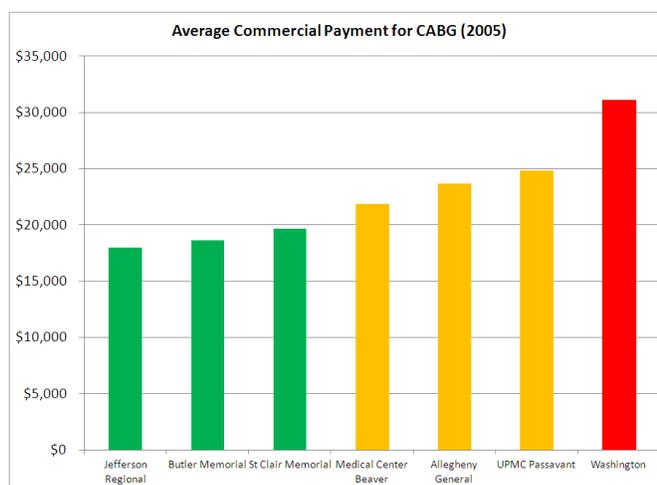
However, business “as usual” isn’t good enough anymore. The high cost of healthcare is hurting businesses and families, both nationally and in southwestern Pennsylvania. There are ways to make health insurance more affordable without denying patients the care they need.

Contrary to popular belief, the reason health insurance costs are increasing is not lack of competition among health plans. There is growing evidence nationally that a major cause of high costs is high prices charged by large health systems. For example, last year, an investigation by the Massachusetts Attorney General found that some of the larger hospitals and physician groups in that state charged twice as much or more than others for the same services. The higher-priced facilities did not provide higher quality of care, nor were they paid more because they treated more complex patients or had teaching programs. The only explanation was that big hospitals and physician groups had the power to demand and receive higher prices. Moreover, the report found that “price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts.”

High prices are not just a problem in Massachusetts. The Health Insurance Commissioner in Rhode Island found that large health systems in that state were being paid 50% more than smaller hospitals for the same procedures. The Medicare Payment Advisory Commission (MedPAC) issued a report in 2011 which showed that in many regions of the country, some hospitals and physician groups are paid twice as much or more than others.

In the Pittsburgh Region, the amount that hospitals are paid by health plans is a closely guarded secret, but several years ago, the Pennsylvania Health Care Cost Containment Council (PHC4) revealed what hospitals are actually paid by commercial health plans. While some hospitals in southwestern Pennsylvania were paid an average of \$18,000 to perform heart bypass surgery, others were paid as much as \$35,000 for the same procedure. Similarly, payments for heart valve surgery ranged from a low of \$24,000 to a high of \$54,000. Moreover, the lowest priced hospitals (Jefferson Regional, Butler Memorial, and St. Clair Hospitals) actually had lower mortality and readmission rates (i.e., better quality) than the highest-priced hospitals (UPMC, Mercy, and Washington Hospitals).

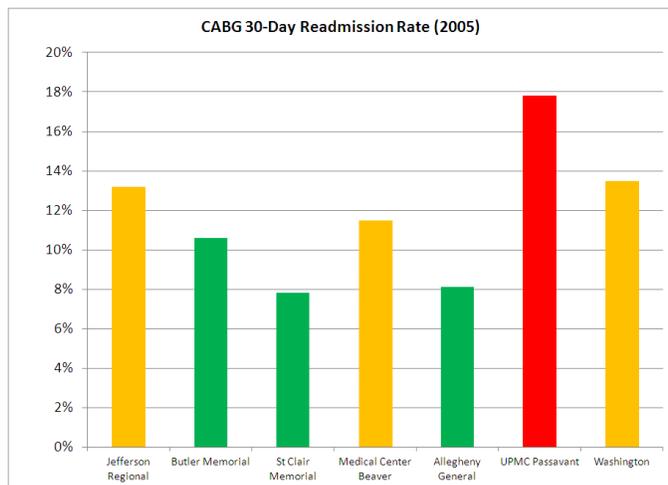
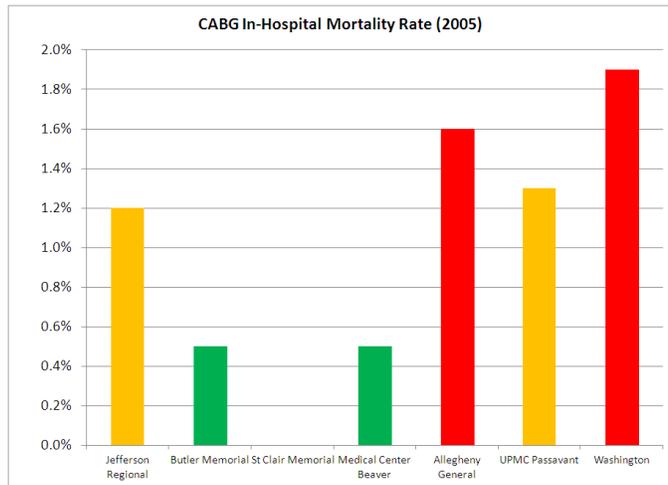
What all of this means is that the Pittsburgh Region could be spending 30%-50% less on hospital care than it is today, without sacrificing quality, if the highest price hospitals would reduce their costs. And since hospital care represents 40% of typical commercial insurance costs, cost



reductions there could make health insurance policies 10-20% cheaper than they are today – saving thousands of dollars per year on a typical family health insurance plan.

Tougher negotiations between health plans and hospitals aren't the answer. Each side just tries to get bigger to gain more leverage, and patients and businesses are the losers. The answer isn't getting more or different health insurance companies, either. (See Section VII.)

The problem is the *type* of health plans insurance companies offer. Under most health insurance plans, hospitals don't have much incentive to reduce their costs, because it doesn't matter to patients how much the hospital charges. For example, suppose you need knee surgery and you have a choice of two high-quality hospitals; Hospital #1 charges \$15,000 and Hospital #2 charges \$30,000. If you were paying on your own, you'd likely choose Hospital #1. But under a typical health insurance policy, you would only be responsible for a 10% co-insurance payment up to an overall annual \$1,500 limit on out-of-pocket expense. So it would cost you \$1,500 to get your knee replaced at Hospital #1 and \$1,500 to have it done at Hospital #2 – exactly the same amount. It would be no different under a high-deductible plan, because the cost of the surgery is well above most deductibles.



On the surface, this sounds like a pretty good deal – go wherever you want without regard to cost. The health insurance company, not you, would pay the \$15,000 difference if you choose Hospital #2. However, the insurance company has to charge you or your employer a higher premium for the privilege of choosing more expensive hospitals without regard to cost. The more members of your health plan who choose higher-cost hospitals, the faster your premiums will increase. Even if you're healthy and you don't need a hospital at all, you're paying to give everyone else the freedom to choose without regard to cost. It would be as if your neighbor decided to buy a Ferrari instead of a Ford, and you had to help them pay for it.

Other regions have different kinds of health plans that give patients more responsibility for choosing hospitals and doctors based on cost as well as quality. For example, Blue Cross Blue Shield of Massachusetts now offers a health plan where members pay less if they choose lower-cost hospitals. Employers in Maine and Minnesota have created tiered network plans where employees pay a lower premium if they choose to get their care from lower-cost health systems.

Not surprisingly, the biggest resistance to these types of health plans comes from large, high-priced health systems. In some regions, non-profit hospitals have refused to contract with a health insurance company at all if it offers such a health plan. That's not only anti-competitive behavior, but counter to the mission of a charitable institution.

So instead of going back to the old system where cost doesn't matter or creating "narrow network" health plans that limit patient choice, Pittsburgh's health insurance companies and health systems should be creating health plans that give patients full choice of which doctors and hospitals to use and better information about the cost and quality of care that they provide, but also give them greater responsibility for deciding whether a higher-priced provider is worth the extra cost. That would encourage health providers to compete on both cost and quality, resulting in better and more affordable healthcare for the entire region.

II. Paying for Value in Health Care, Not Volume

The single biggest barrier to improving health, reducing hospitalizations, and improving outcomes is the way doctors and hospitals are paid for healthcare services today:

- Physicians, hospitals, and other healthcare providers are paid based on how *many* services they deliver, not on the quality of those services or their effectiveness in improving a patient's health. Under today's payment systems, doctors lose money if their patients stay healthy.
- Physicians and hospitals make more money if their patients get infections or are readmitted after discharge. Under today's payment systems, reducing infections, complications, and readmissions can actually make it harder for a hospital to balance its budget.
- Many valuable preventive care and care coordination services are not paid for adequately (or at all), which can result in unnecessary illnesses and treatments. Today, health plans pay any time someone needs to be hospitalized, but don't pay for many things that will help people avoid the need for hospital care.
- Primary care physicians – the doctors that can help patients stay well and out of the hospital – are paid far less than any of the specialists who treat illnesses after they've occurred.

Fortunately, there are better ways to pay for health care (you can learn more about them at www.paymentreform.org). Two major types of payment reforms are being used in other parts of the country:

1. ***Episode-of-Care Payment***, i.e., paying a single price for all of the services needed by a patient when they enter the hospital. In effect, the hospital and doctors are providing a "limited warranty" on their services, the way every other industry does. For example, the Geisinger Health System in Central Pennsylvania now offers "ProvenCare," a 90-day warranty on heart surgery, orthopedic surgery, maternity care, and other services, and it has dramatically improved the quality and efficiency of its services as a result. No hospital or health system in the Pittsburgh Region offers anything similar.
2. ***Comprehensive Care Payment*** (sometimes called "global payment"), i.e., paying a single price for all of the care that a patient with a specific healthcare condition needs during the course of a year, with bonuses/penalties based on the quality of care that's delivered. This rewards doctors for keeping their patients well and out of the hospital, rather than penalizing them as today's payment systems do. Blue Cross Blue Shield of Massachusetts is paying a growing

number of healthcare providers this way as part of its “Alternative Quality Contract.” No health plan in the Pittsburgh Region does anything similar.

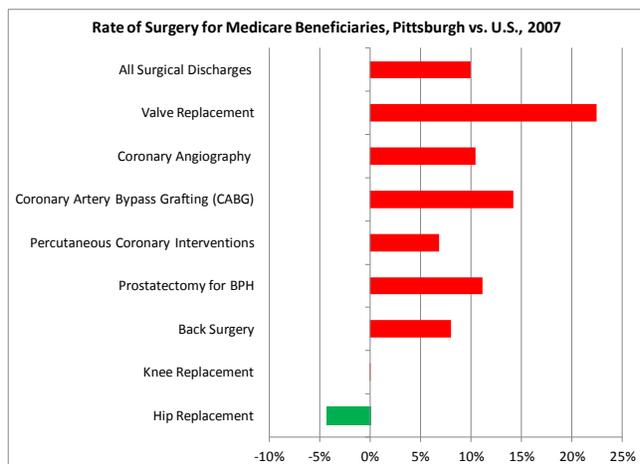
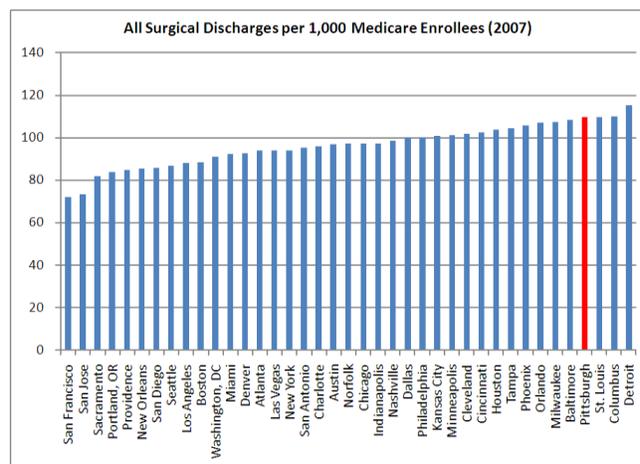
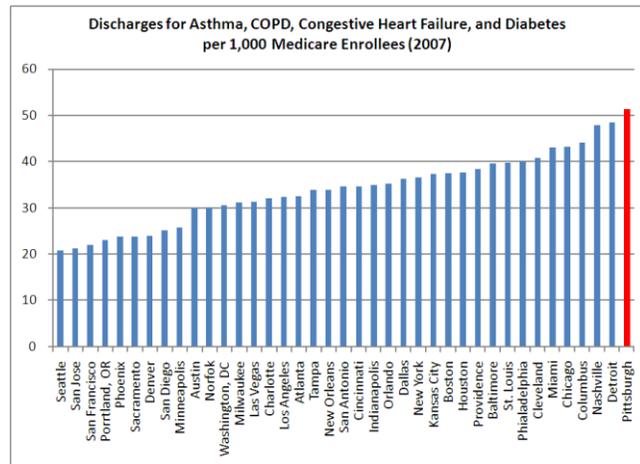
III. Less Health Care Could Be Better for Us

High prices for healthcare services are a major cause of high health insurance costs both in Pittsburgh and other regions. But healthcare costs in the Pittsburgh Region are also high because people here are hospitalized more often than in any major region in the country.

The most comprehensive national information about utilization of healthcare services comes from Medicare data on senior citizens. In 2007 (the most recent data available), the Dartmouth Atlas of Health Care reported that Medicare beneficiaries in the Pittsburgh Region who had chronic diseases such as asthma, diabetes, emphysema, and heart failure were hospitalized at the highest rate among the 40 major regions in the country. Chronic disease patients here are hospitalized 50% more often than the national average.

Medicare beneficiaries in the Pittsburgh Region also underwent surgery at the fourth highest rate among the top 40 regions – 10% more often than the national average. Pittsburgh seniors had 23% more heart valve replacements, 14% more heart bypass operations, and 8% more back surgeries than seniors in the rest of the country.

This dramatically higher amount of hospital care is not due to people being older or sicker in Pittsburgh than in other regions (see Section IV), and it’s unlikely that Pittsburgh seniors have both weaker hearts and more bad backs than seniors in the rest of the country. In fact, when Dartmouth Atlas researchers adjusted for differences in age, sex, race, and Medicare payment rates across regions, Pittsburgh ranked #1 in the



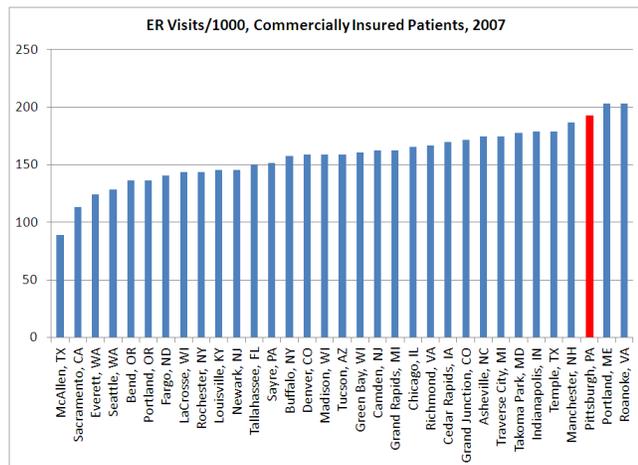
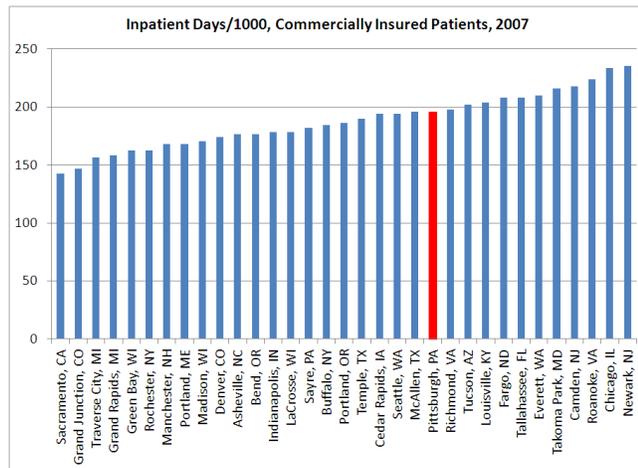
nation in Medicare spending for hospitals and skilled nursing facilities in 2008.

Younger people are also going to the hospital more often here than in other regions. A 2010 study by the actuarial firm Milliman found that for commercially-insured individuals, the Pittsburgh Region had 6% more hospital admissions and 26% more emergency room visits than the national average. Pittsburgh had one of the highest rates of emergency room utilization among 33 regions they analyzed.

High rates of hospitalizations, surgeries, and emergency room use are not only expensive, they're signs that the region's healthcare systems aren't functioning efficiently or effectively:

- Many of the chronic disease patients who are being hospitalized today could stay healthier and avoid the need for hospitalization through better primary care and patient support services. A great place to start is by reducing readmissions – Pennsylvania Health Care Cost Containment Council data show that 23% of the chronic disease patients in Pittsburgh who are hospitalized end up back in the hospital in less than a month. These high readmission rates can be significantly reduced; for example, projects organized by the Pittsburgh Regional Health Initiative at UPMC St. Margaret and at Premier Medical Associates showed that improving care for chronic disease patients can reduce readmission rates by 40% or more.
- Although it's great that Pittsburghers have access to excellent surgeons and hospitals when they need them, national studies have shown that many types of major surgery, such as heart surgery, back surgery, and Cesarean sections, are being performed on many patients who don't really need them. For example, a review in 2011 found 200 cases of unnecessary coronary stent implants at Excelsa Health in Greensburg. Studies have shown that when physicians take time to review all the options with patients, the patients choose surgery far less frequently.

It would be one thing if Pittsburgh residents were healthier as a result of all of this hospital care, but they're not. Pittsburgh had the 11th highest death rate for Medicare recipients among the top 40 regions, and nearly one out of every 50 people hospitalized in the Pittsburgh Region gets an



infection during their hospital stay. National studies have shown that regions with high rates of hospital utilization tend to have worse outcomes for patients.

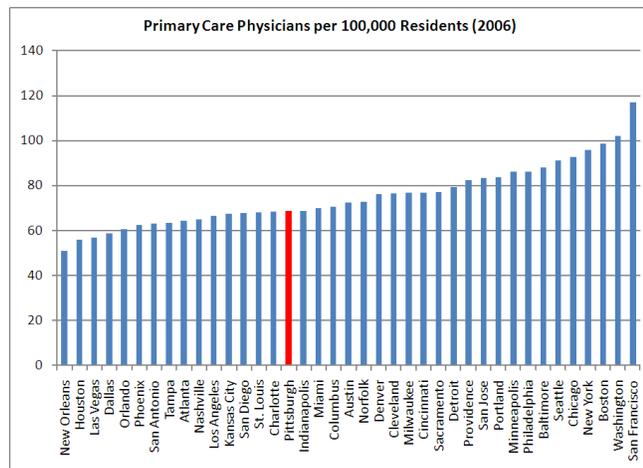
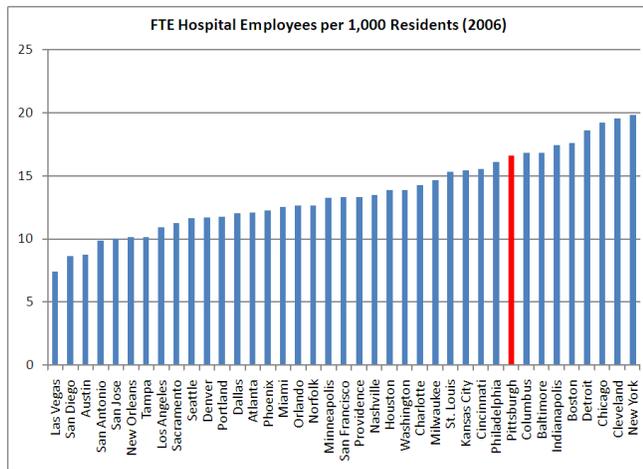
Pittsburgh’s overuse problem primarily occurs in hospitals, not in the rest of the healthcare system. In fact, the region ranks below the national average in spending on physician services for both Medicare beneficiaries and commercially-insured patients. Although Pittsburgh has 12% more hospital beds and 19% more hospital employees per capita than the national average, it has 5% fewer primary care physicians and 3% fewer specialists.

What this means is that in order to reduce health insurance costs, the region is going to need to stop spending so much on hospitals and invest more in primary care and wellness initiatives.

How can that be done? First, physicians need to take the leadership to reinvent the way healthcare is provided so their patients can stay well and stay out of the hospital, rather than forcing health plans and Medicare to cut fees (which underpays physicians and hospitals for needed care) or to create bureaucratic prior authorization systems (which can delay or deny needed care), or allowing hospitals try and put each other out of business in order to keep filling their own beds. Only physicians, who know their patients and what they really need, can ensure costs are reduced in ways that are actually better for patients.

Second, health plans need to change the way they pay for health care. Today, doctors and hospitals get paid more when patients are hospitalized more often, rather than being rewarded for keeping patients well. There are better ways to pay for health care that give physicians greater flexibility over the care their patients receive as well as greater accountability for outcomes and costs, but unfortunately, the health plans in the region have not yet implemented them. (See Section II.)

Would reducing the overuse of hospital care hurt the region’s economy? Spending less money on the expensive drugs and medical devices used in hospitals and spending more on primary care could actually boost the local economy by keeping more of the healthcare dollars inside the region, making the workforce healthier and more productive, putting more dollars into



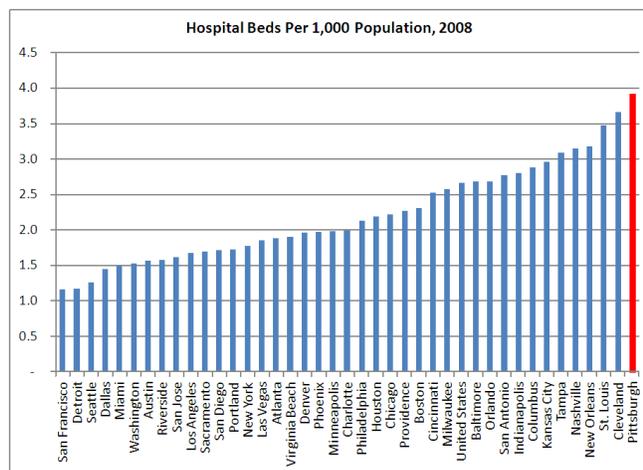
workers’ wallets that they can spend locally, and encouraging new businesses and residents to locate here.

Clearly, creating a higher-quality, lower-cost healthcare system should be one of the region’s highest economic development priorities.

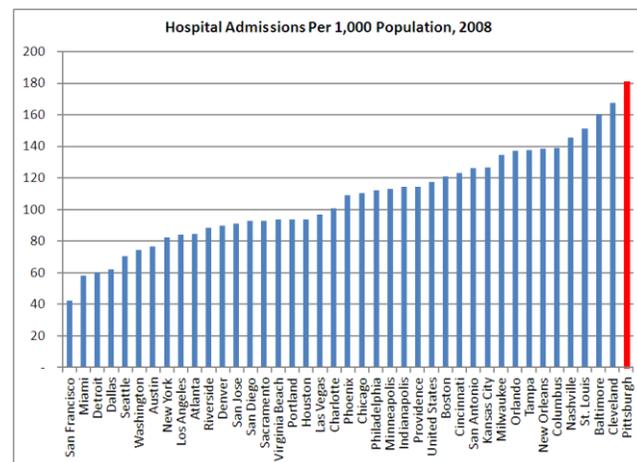
IV. Reducing Hospital Costs Can Benefit the Region’s Economy

The biggest driver of healthcare cost increases is hospital care. Over one-third of the growth in national healthcare spending over the past decade has been caused by higher spending on hospital care, far more than spending on either physician services or pharmaceuticals. Any long-term solution to healthcare costs will require significant reductions in the growth in spending on hospitals.

Nowhere is this more true than in Pittsburgh. According to American Hospital Association data, Southwestern Pennsylvania has more hospital beds relative to the size of its population than any of the forty largest metropolitan regions in the country. “More” is actually an understatement – the Pittsburgh Region has 50% more hospital beds per capita than the U.S. average, and three times as many beds per capita as Dallas, Detroit, or Seattle.



Not only does Pittsburgh have more hospital beds, it fills them with patients more often than other regions. In 2008, the Pittsburgh Region had the highest rate of hospital admissions per capita among the top 40 regions in the country. Pittsburgh also had the fourth highest rate of emergency room visits and the second highest rate of surgeries per capita of any major region in the country.



The high rate of hospitalization here is not because we have an older population. In fact, if you just compare hospitalization rates among Medicare beneficiaries, you find that the seniors living in Pittsburgh are hospitalized much more often than in other regions. (See Section III.)

One reason that hospitalization rates could be higher among Medicare beneficiaries than other regions is that seniors are sicker here than other regions. Medicare data suggest that may be true, but:

- There are other regions that have Medicare populations as sick or sicker than Pittsburgh, but spend less to take care of them than Pittsburgh does;
- The measure of “sickness” is determined by the health system, not by an independent evaluation of a senior’s health. Studies have shown that if a senior moves from a region that has low utilization of health care to a region with high utilization (such as Pittsburgh), the seniors will suddenly be classified as sicker.

HRR	Average HCC Score Expressed as a Ratio to the National Average	Ratio to Pittsburgh	Actual Per Capita Costs	Standardized Per Capita Costs	Ratio to Pittsburgh	Standardized Risk-Adjusted Per Capita Costs ^a	Ratio to Pittsburgh
NY - Bronx	1.21	9%	\$14,035	\$9,578	-3%	\$6,599	-16%
NY - Manhattan	1.22	10%	\$13,505	\$9,465	-4%	\$6,825	-13%
NJ - Newark	1.16	4%	\$11,694	\$9,144	-7%	\$6,958	-12%
CA - Los Angeles	1.13	2%	\$11,909	\$9,687	-2%	\$7,156	-9%
NY - East Long Island	1.14	2%	\$11,738	\$9,025	-9%	\$7,234	-8%
PA - Philadelphia	1.12	0%	\$10,740	\$9,279	-6%	\$7,414	-6%
PA - Johnstown	1.14	3%	\$9,471	\$9,694	-2%	\$7,464	-5%
PA - Wilkes-Barre	1.11	0%	\$9,290	\$9,325	-6%	\$7,490	-5%
NJ - Camden	1.11	0%	\$10,454	\$9,049	-8%	\$7,491	-5%
PA - Pittsburgh	1.11	0%	\$9,654	\$9,882	0%	\$7,890	0%
MI - Dearborn	1.19	7%	\$11,431	\$10,226	3%	\$7,956	1%
MI - Detroit	1.22	10%	\$12,016	\$10,693	8%	\$7,988	1%
MI - Royal Oak	1.12	1%	\$11,102	\$10,066	2%	\$8,138	3%
FL - Hudson	1.15	4%	\$10,077	\$10,183	3%	\$8,177	4%
TX - Harlingen	1.22	10%	\$12,881	\$12,252	24%	\$8,294	5%
FL - Fort Lauderdale	1.12	0%	\$11,353	\$10,559	7%	\$8,672	10%
TX - McAllen	1.25	12%	\$14,835	\$14,095	43%	\$9,286	18%
FL - Miami	1.31	18%	\$17,953	\$15,813	60%	\$9,911	26%

(It’s important to recognize that the amount Medicare pays hospitals in the Pittsburgh Region for procedures is much lower than in many other regions because of the low cost of living in the region, so spending looks lower in the Pittsburgh Region than in other regions simply because of the lower payment amounts. The “standardized per capita costs” column in the table above adjusts for these price differentials, so that spending can be compared on an apples-to-apples basis.)

But haven’t hospitals been one of the major contributors to the region’s economic growth? Won’t cutting hospital spending mean fewer jobs and higher unemployment?

While it’s true that over the past decade, more jobs have been created in *healthcare* than any other sector of Pittsburgh’s economy except for professional and business services, those jobs haven’t been created in *hospitals*. Despite significantly higher spending on hospitals, there are fewer people working in hospitals here today than twenty years ago. All of the healthcare job growth in Pittsburgh over the past two decades has been in ambulatory care services, particularly physicians’ offices.

Hospital spending hasn’t gone up because of higher wages for hospital workers, either. In fact, hospitals in Pittsburgh pay their employees less than hospitals in any other major region. In 2008, average compensation for hospital staff here was 25% below the national average. For example, registered nurses in Pittsburgh had lower average salaries than nurses in 36 of the top 40 regions in the country.

What’s been driving the growth in hospital spending is that hospitals have been building more facilities, buying expensive equipment, and using expensive medical devices and drugs. This is particularly true in Pittsburgh. In 2008, more than 55% of hospital spending here went to non-personnel costs, compared to a national average of less than 49%.

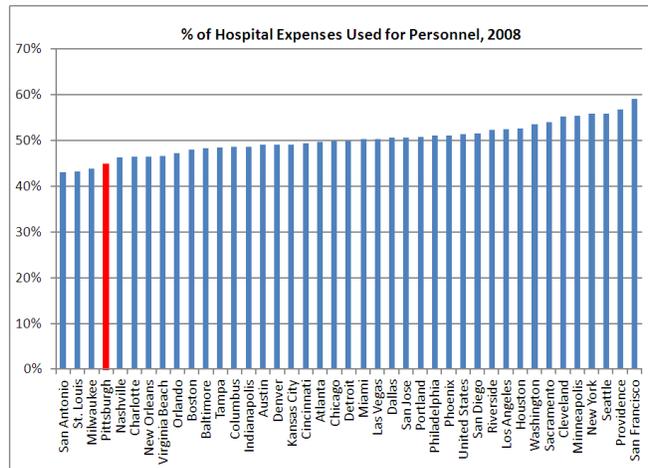
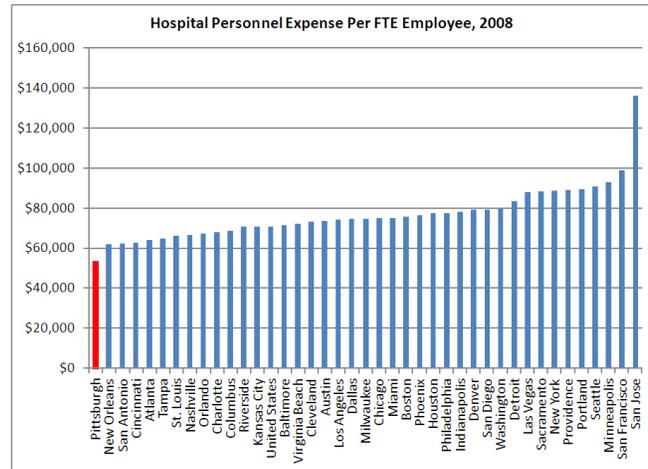
This means that hospital spending in Pittsburgh could be reduced significantly without cutting hospital jobs at all and without harming patients. Hospitals in other parts of the country have found ways to significantly reduce their costs through more efficient scheduling of procedures,

better methods of purchasing equipment and medical devices, and eliminating unnecessary expenses. Many of the techniques for doing this were pioneered here in Pittsburgh by the Pittsburgh Regional Health Initiative. Hospital employees could help reduce costs and actually improve the quality of care for patients by learning these techniques and using them more systematically.

Today, however, hospitals are rewarded for the types of equipment they have and how many procedures they do, not for their quality or efficiency. Employers in Pittsburgh need to demand that health insurance plans give patients incentives to choose more efficient hospitals, as employers and health plans in other regions are doing. (See Section II.)

The biggest opportunity to reduce spending on hospitals, though, is by helping people avoid the need for hospital care in the first place. One reason there are more hospital admissions here is that people in other regions are getting better preventive care and care management than Pittsburghers are. For example, thousands of hospital admissions for chronic diseases could be prevented by making fairly simple, low-cost improvements in the region’s primary care services.

If healthcare systems do a better job of keeping people well so they don’t need to be hospitalized as often, the region will need fewer hospital beds and fewer hospital employees. But that doesn’t necessarily mean unemployment for healthcare workers, because helping people stay out of the hospital will require more jobs in primary care, home health agencies, and other ambulatory care services. The healthcare careers of the future will increasingly be in primary care and home care, not in hospitals.



Having fewer hospital beds doesn't necessarily mean the region should have fewer hospitals, either. In fact, to ensure hospital care is delivered as efficiently as possible, patients need to have a choice of hospital systems and to make that choice based on both the cost and quality of hospital services. (See Sections V and VII.)

The bottom line is that reducing spending on hospital care can actually boost the region's economy, not harm it. Lower health insurance costs will give families more money to spend, make businesses more competitive, and create more jobs for everyone. And if regional leaders want to attract more businesses and families to Pittsburgh, one of the best ways to do that is to offer lower-cost, higher-quality healthcare than other regions.

V. Better Data Would Help Us Get Better Hospital Care

Depending on how the battle between Highmark and UPMC is resolved, Pittsburghers may have to choose a health insurance plan based on which physicians and hospitals it covers. People in the midst of treatment are understandably frightened about being forced to change doctors or hospitals. But for most people, the challenge will be to decide where they will get the best care for health problems they may develop in the future.

UPMC touts the fact that it's the only Pittsburgh hospital on the U.S. News and World Report "honor roll" of best hospitals in the country. The West Penn Allegheny Health System (WPAHS) promotes the fact that it's the only health system designated as a top national performer by Thomson Reuters, and notes that Allegheny General Hospital (AGH) is also recognized by U.S. News and World Report as one of the country's best hospitals.

Should you use either of these rankings to choose a hospital? Ideally, what you'd like to know is whether a hospital will improve your health rather than worsen it, e.g., how likely you are to die, be injured, or be infected during your hospital stay, or to be readmitted because of complications you experience after discharge. You'd also like to know if the hospital staff will treat you respectfully, respond promptly when you need help, and make sure you're not in pain.

The U.S. News and World Report "Best Hospitals" list only looks at two outcome measures (patient survival and safety), and gives them relatively low weight. Only 32.5% of a hospital's score is based on how often patients survive, and a mere 5% is based on patient injury rates. Another 30% is based on "structural measures" like whether the hospital has the latest technology and how many nurses it has. The remaining 32.5% is based on an opinion poll: 200 randomly selected doctors around the country in each specialty are asked to pick the top 5-10 hospitals for "inpatient care for the most complex or difficult conditions [in that specialty]." Patients' ratings of their experience don't count at all.

Let's look at the rankings for cardiac care, since heart problems are the most common reason people are hospitalized. The most recent "Best Hospitals" report shows that AGH performs better than UPMC on patient safety, and that both hospitals performed the same on patient survival. ("UPMC" here means only Presbyterian/Shadyside Hospitals; the other UPMC hospitals are ranked separately and have lower scores.) But UPMC was ranked higher (#20) than AGH (#44) because 5.2% of the cardiologists surveyed listed UPMC as one of the best U.S. hospitals for cardiac care, whereas only 1% put AGH on their list. For U.S. News, that small difference in the opinion poll outweighed the better patient safety scores at AGH. (The #1 hospital was the

Cleveland Clinic, which had better patient survival rates than either UPMC or AGH and was chosen as a top hospital by 75% of the physicians surveyed.)

If you're thinking about a knee or hip replacement, both UPMC Presbyterian/Shadyside and AGH are on the "Best Hospitals" list for orthopedic care. Here, AGH outperformed UPMC on both patient survival and patient safety, but AGH was again ranked lower overall because a smaller percentage of the 200 physicians surveyed nationally picked AGH as a best hospital. The same was true for cancer care, diabetes/endocrinology, gynecology, and other specialties.

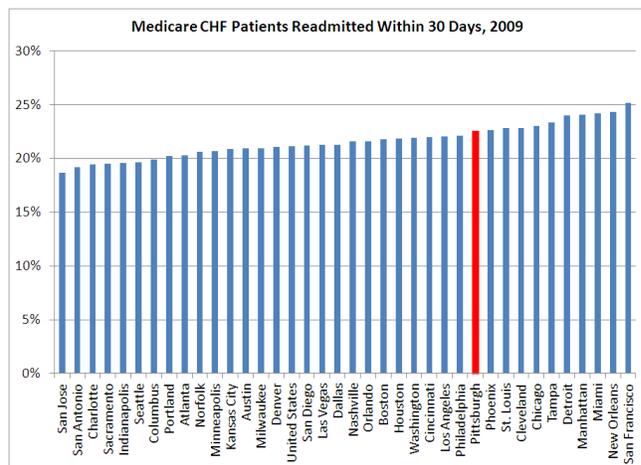
The bottom line is that for the most common types of conditions, the limited objective data in the U.S. News rankings give a slight edge to the quality of care at AGH, but also show that neither AGH nor UPMC has outcomes as good as many other hospitals in the country.

Thomson Reuters ranks hospitals based only on objective data, not opinion polls, and uses a broader range of measures of outcomes, care process quality, patient experience, and cost of care. (The patient survival measures used by U.S. News are actually generated by Thomson Reuters.) None of the hospitals in the region made Thomson Reuters' list of "100 Top Hospitals" in 2011, but AGH made the list of "50 Top Cardiovascular Hospitals," and WPAHS was ranked in the top 20% on the list of "Top Health Systems." However, since Thomson Reuters doesn't make the underlying data public, you can't easily find out why any hospital did or didn't make the lists, so they're not of much value for patients who want to choose a hospital.

A number of quality measures (including many of those used by Thomson Reuters) are publicly available for each of the hospitals in the region on the U.S. Department of Health and Human Services' Hospital Compare website (www.hospitalcompare.hhs.gov). However, the outcome measures are based only on patients admitted for a heart attack, heart failure, or pneumonia. Although some hospitals in the region have better outcomes than others, most of the differences aren't big enough to be statistically significant. Once again, though, there are hospitals in other parts of the country with significantly better outcomes than any hospital here.

In sum, the limited data available indicate that you can get good quality care for the most common types of health conditions at both UPMC hospitals and non-UPMC hospitals, but that all hospitals here could deliver much better care than they do today.

Pittsburghers shouldn't be satisfied with anything less than the best possible healthcare, but today, they don't have enough data to know whether they're getting it. People living in places like Iowa, Minnesota, and Wisconsin can access far more data on the quality of hospital care in their communities than Pittsburghers can. They can find out how often patients get blood clots and infections after different kinds of surgery in each of their local hospitals, how often mothers and babies are injured during labor and delivery, and a host of other measures of quality.



The reason is their hospitals have made a commitment to measure and publicly report on their performance. And because they publicly report and compare their performance, they are also working hard to improve the quality of care they deliver.

Few people would buy a car without first looking at ratings of the car's quality and safety. How can Pittsburghers choose a hospital without similar information? And how can hospitals improve if they don't know how well they're performing?

Pittsburghers should demand that their hospitals publicly report data on the quality of care in a common format, along with the prices of that care. That would enable them to make informed choices about which hospitals to use, and it would encourage hospitals not just to be good, but to be the best in the nation.

VI. Price Discrimination in Health Care

Imagine going to the grocery store and being told that the price you'd pay for food would depend significantly on whether you had a job and where you worked. If you worked for one company, you'd get milk and bread at a price close to what the store paid the wholesaler. If you worked for a different company, you would have to pay 20% or 30% more. If you didn't have a job at all, you'd have to pay three or four times as much. Same milk and bread, same store, but a different price for different customers.

Bizarre, right? Yes, but that's exactly the way things work in the health care system. What hospitals "charge" is double, triple, or quadruple what it actually costs them to perform the procedure. But the only people expected to pay those full charges are those who don't have insurance. In most cases, those are the people who can least afford to pay.

If you have insurance, your health plan typically pays only a percentage of the published charge amount, but the discount may be bigger or smaller depending on which health plan you have. Same procedure, same hospital, but a different price depending on where you work.

How big of a discount do hospitals give health plans? That's a closely guarded secret, but on average in Pennsylvania, hospitals are only paid about one-fourth of what they charge. If you have insurance and you've had a procedure performed, you'll see the discount on your "Explanation of Benefits" (EOB) form, where it lists both the amount that was charged and the "allowed amount," i.e., the discounted price paid by your health plan.

The difference between what is charged and what is actually paid by those with insurance varies dramatically from hospital to hospital. Several years ago, the Pennsylvania Health Care Cost Containment Council issued a report showing the published charges and the actual payments that hospitals received for heart bypass surgery. In some hospitals, such as Butler Memorial, Excelsior Westmoreland, Jefferson Regional, and the Medical Center of Beaver, patients without insurance were charged about twice as much as those with insurance. At other hospitals, such as Allegheny General, St. Clair, and Washington Hospital, the charges were about 2.5 to 3 times as much as what insurance plans paid. But at a couple of hospitals -- UPMC Passavant and Presbyterian/Shadyside -- the charges were quadruple what the hospitals were actually paid by insurers. However, even though the UPMC hospitals gave bigger "discounts" than the other hospitals, the average amounts they were actually paid were still higher because their charges were

so much higher than the other hospitals; i.e., regardless of whether you had insurance or not, the cost of treatment was higher at those hospitals than at most of the others.

If you have health insurance, does any of this matter to you? After all, most people with insurance just pay a copayment or coinsurance regardless of where they go; the rest of the payment is up to your health plan and the hospital to work out.

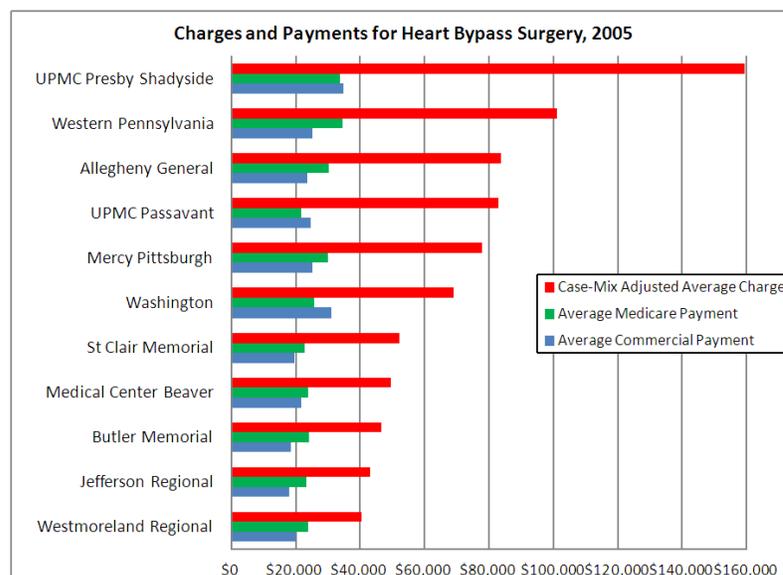
It will start to matter if you find that your preferred doctor or hospital is no longer in the “network” of your health plan. When you go to an “out of network” hospital, you can face having to pay those full hospital charges with no discount, just as if you had no insurance at all.

In most cases, a hospital will want to be “in network,” because otherwise, most patients couldn’t afford to go there. However, a big, expensive hospital might decide to stay out of a health plan’s network and try to force patients to switch to a health plan that has less negotiating clout so the hospital could get paid higher prices. If a new health plan tells you it has the biggest, most expensive hospitals in its network, there’s a good chance that the plan is paying a lot more for hospital care than if it only included hospitals that offered high-quality care at more reasonable prices. And even if that health plan offers you a low premium now, it might be forced to raise it in the future in order to have enough money to pay those higher prices.

There’s one case, though, where a hospital can’t charge more if it is “out of network.” When a senior citizen with a Medicare Advantage insurance plan goes to a hospital that’s not in the plan’s contracted network, the hospital is required by federal law to accept standard Medicare fees for treating that patient, and those fees are generally significantly *lower* than what the hospital would be paid if it had a contract with the Medicare Advantage plan.

So it’s not surprising to find that a hospital would *want* to be “in network” for an insurance company’s Medicare Advantage plans (since that would give it higher payments for treating seniors), yet *refuse* to be in network for the same insurance company’s commercial health plans (so that it wouldn’t have to give big discounts for treating younger individuals). This is exactly what has happened in the Pittsburgh Region. UPMC has refused to contract with Highmark for commercially insured patients, but UPMC has willingly contracted with Highmark for its Medicare Advantage members, and UPMC was upset when Highmark refused to provide in-network access for its Medicare Advantage members to UPMC’s new hospital.

Not surprisingly, there is growing evidence that this bizarre system of price discrimination and secret discounts is actually making health care less affordable. Both health plans and hospitals



try to get bigger and bigger in order to “win” in price negotiations, and it’s the patients and local businesses who are the biggest losers.

Is there a better way? One approach would be to have the government regulate prices, so that hospitals can’t charge someone more based on what type of insurance they have. Maryland does that, and their analyses show their hospital costs are lower than in many other states. However, regulating prices also removes the incentive for hospitals to find innovative ways to deliver care more cost-effectively.

A better approach would be to let hospitals charge whatever they want, but require them to charge everyone the same amount regardless of what kind of insurance they have, and to make their prices public. Instead of being restricted to a narrow network, patients could go wherever they wished for care, but if they chose to go to a higher-priced hospital, they’d have to pay more to do so. That would create pressure on the high priced hospitals to either lower their costs or lose patients to the more affordable high-quality hospitals in town.

Employers and health plans in other parts of the country are doing just this. Rather than restricting where their employees can get care, they’re charging them less for their health insurance if they choose hospitals that deliver high-quality care at a lower cost, or they’re giving the employees a fixed amount of money for a procedure – an amount they know is adequate to get good quality care at reasonably-priced hospitals – and then letting the patient choose which hospital offers the best combination of quality and cost. (See Section I.)

Just like sunshine and fresh air can be good for your health, bringing health care prices out in the open and creating a fresh approach to competition could give the region better quality, more affordable health care.

VII. Do We Need More Competition from Health Plans or Hospitals?

In a typical economic market, the more sellers of a particular product or service there are, the lower prices will be, because the sellers will compete on price in order to attract customers. This has led many people to believe that the way to get lower health insurance premiums is to have more health insurance companies competing to sell insurance in the region.

However, it’s not quite as simple as that, because health insurance companies are not only sellers of insurance, they’re also the buyers of healthcare services. They negotiate with hospitals and physicians to set the prices paid for the services individuals and employers receive when they buy a health insurance policy. The more that health plans have to pay for hospital care, the more a health insurance plan will cost. And simple economic theory tells us that, all else being equal, bigger health insurance plans have more clout to negotiate lower prices for healthcare services than smaller plans do.

Most people experience this every day in retail. Consumers don’t buy goods directly from manufacturers; they buy them from retail stores. Does having more retail stores result in higher or lower prices for consumers? Big retailers like Walmart or Target can usually buy products from manufacturers for a lower price than smaller retail stores can, and so they can sell the products to consumers for less. If there were only one big retailer, consumers would probably see higher prices, because the monopoly retailer could keep the price discounts for itself in the form of higher

profits. But conversely, if there were only small retailers, prices for consumers would probably also be higher, because those retailers couldn't negotiate large price discounts from manufacturers.

What consumers pay depends not just on the number and size of retailers, but on how much competition there is among manufacturers of the product. For example, if there were only one company that manufactured televisions, it wouldn't matter how many TV retailers there were or how big they were, because a monopoly television manufacturer could set the price as high as it wanted, and both the retailer and consumer would have to pay more to get a TV.

Just like retailers, health insurance companies sit in between the producers of healthcare services –hospitals and physicians – and the ultimate consumers of those services, i.e., patients. The more health plans there are, the smaller each of them will be, and that means they'll have to pay higher prices to health providers, particularly big hospital systems. It also likely means the health plans will have higher administrative costs as a percentage of healthcare costs, since smaller health plans will have fewer economies of scale. Both of those things will push insurance premiums up. The only thing that competition among the health plans will reduce is their profits.

On balance, having more health plans will be more likely to increase premiums than to reduce them. Under the federal Affordable Care Act, health plans can only retain 15-20% of their premium revenues for administrative costs and profits; the remaining 80-85% must be spent on health care services and quality improvement activities. Even if greater competition among health plans resulted in, say, a 25% reduction in their administrative costs and profits, that would reduce premiums by at most 5% (i.e., 25% of the maximum 20% of premium that can be spent on non-medical expenses), whereas if bigger health plans could negotiate a 10% larger discount on the prices paid to healthcare providers, that could reduce premiums by 8% or more (10% of the minimum 80% of premium that's devoted to medical expenses).

In fact, research indicates that having more health plans increases the prices paid for healthcare. For example, a 2010 study by Carnegie Mellon Professor Martin Gaynor and colleagues found that having five health insurers in a region instead of four would increase hospital prices by 7%, and a 2011 study by University of Southern California Professor Glenn Melnick and his colleagues found that hospital prices in markets with more health plan competition were 13% higher than in markets with a small number of large health plans.

It's important to note that what counts is not the total size of the health insurance company, but how many people it insures in the local region, i.e., its local market share. When large national insurance companies enter a market, they may offer lower premiums than existing health plans, but it's probably not because they're getting lower prices from hospitals; it's more likely that they're just setting their prices below their costs in order to build their business, and paying for those discounts by charging higher premiums in other regions.

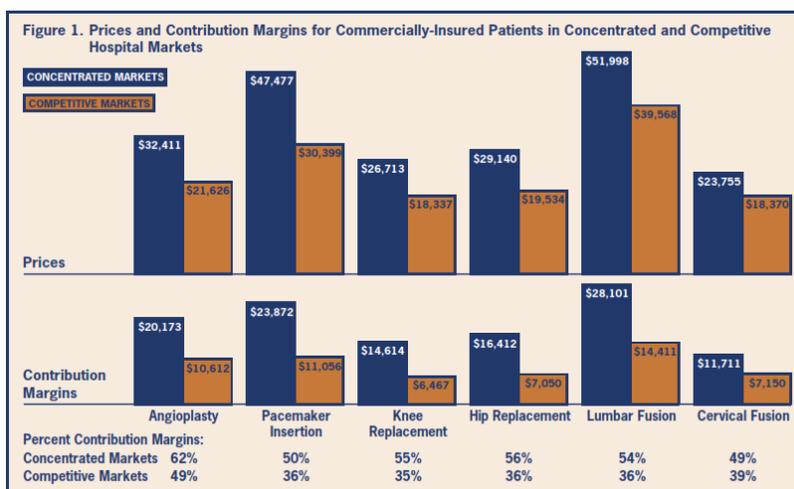
Unfortunately, although having bigger health plans can help businesses and consumers pay lower prices for healthcare services, it can also unintentionally encourage the creation of large, monopoly health systems. Since big health plans can demand bigger price discounts from smaller hospitals and physician practices than from large systems, small providers may be forced to either go out of business or merge with the large systems. This is a problem because of the growing evidence nationally that high healthcare costs are being caused by the high prices demanded by large, consolidated health systems. For example, research by University of California Professor James Robinson found that in markets where there were fewer hospital systems, prices were 13%-25% higher for a range of cardiac and orthopedic procedures.

The solution to high healthcare costs isn't to change the number or size of health plans. The solution is to completely change the way health care is paid for:

- Hospital systems should be expected to compete on both cost and quality. Instead of secretly negotiating prices with health plans, they should make both their prices and quality measures public, charge the same price to all patients regardless of the type of insurance they have, and offer warranties on their care. For example, the Geisinger Health System in Central Pennsylvania now offers cardiac surgery, maternity care, and a number of other procedures for a single, total price, and they don't charge extra when errors or complications occur. (See Section II.)

- Patients need to take responsibility for comparing hospitals on both their cost and quality, and to pay more if they choose expensive hospitals when other hospitals offer high quality care at a lower cost. For example, Massachusetts Blue Cross Blue Shield is asking patients to pay higher copays when they choose higher-cost hospitals.

What the Pittsburgh Region needs from health plans is for them to implement new payment systems and benefit designs that support effective competition by providers and more value-based choice by patients. Instead of trying to get more health plans in the region, employers should be choosing the health plans that will support a rapid transition to higher-quality, lower cost healthcare.



“More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits, James C. Robinson, National Institute for Healthcare Management, November 2011

About the Author

Harold D. Miller is the Executive Director of the Center for Healthcare Quality and Payment Reform and the President and CEO of the Network for Regional Healthcare Improvement. Miller has been working at both the regional and national levels on initiatives to improve the quality of healthcare services and to change the fundamental structure of healthcare payment systems in order to support improved value. Miller also serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University's Heinz School of Public Policy and Management.

Miller organized the Network for Regional Healthcare Improvement's national Summits on Healthcare Payment Reform in 2007 and 2008. His report *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform* which was prepared for the 2007 Summit was published by the Commonwealth Fund in September, 2007, and his summary of the recommendations from the 2008 Payment Reform Summit, *From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs*, was published in November 2008 by NRHI and the Robert Wood Johnson Foundation. His paper "From Volume to Value: Better Ways to Pay for Healthcare" appeared in the September 2009 issue of *Health Affairs*. He also authored the Center for Healthcare Quality and Payment Reform's reports *How to Create Accountable Care Organizations* and *Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care*, the Massachusetts Hospital Association's report *Creating Accountable Care Organizations in Massachusetts*, and the American Medical Association's report *Pathways for Physician Success Under Healthcare Payment and Delivery Reforms*. He is a frequent speaker at national and state programs on healthcare reform.

Miller's work with the Pittsburgh Regional Health Initiative (PRHI) demonstrating the significant financial penalties that hospitals can face if they reduce hospital-acquired infections was featured in *Modern Healthcare* magazine in December, 2007. He designed and led a multi-year PRHI initiative that significantly reduced preventable hospital admissions and readmissions through improved care for chronic disease patients. In 2007 and early 2008, he served as the Facilitator for the Minnesota Health Care Transformation Task Force, which prepared the recommendations that led to passage of Minnesota's path-breaking healthcare reform legislation in May, 2008. He is currently working in a number of states and regions to help design and implement payment and delivery system reforms.

Miller previously served as the President of the Allegheny Conference on Community Development and the Executive Director of the Pennsylvania Economy League of Southwestern Pennsylvania. He also served for 10 years as the Director of the Southwestern Pennsylvania Growth Alliance, a ten-county public-private partnership dedicated to promoting the economic development needs of the region with state and federal officials. Prior to joining the Allegheny Conference, Miller served as Associate Dean of the H. John Heinz III School of Public Policy and Management at Carnegie Mellon University, and as Director of the Governor's Office of Policy Development for the Commonwealth of Pennsylvania.

Miller serves on the Board of Directors of the National Quality Forum, and he represents the Network for Regional Healthcare Improvement on the National Priorities Partnership.