Testimony of

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Mr. Chairman, Ranking Democratic Member Baucus, and distinguished Members of the Finance Committee, my name is Bruce Bradley. I am director of Health Plan Strategy and Public Policy for General Motors and it is a pleasure to be before you today to discuss private sector approaches to purchasing the delivery of high quality, efficient health care. This is an issue that has been a focus of my professional career including nearly two decades of managing health plans and community-based health maintenance organizations, as well as my responsibility for developing and implementing value-based health care purchasing over the past twelve years at GTE and General Motors.

I am particularly proud of General Motor's commitment to improve health care by focusing on value oriented purchasing with an emphasis on accountability for high quality care and positive medical outcomes. We believe our work not only benefits our employees, retirees and our stockholders, but also makes a contribution to improving the overall health care system by encouraging health care delivery changes that benefit other patients, purchasers and communities as well.

Not surprisingly, we strongly believe that quality and performance based strategies by other purchasers, such as the Medicare program, can and will improve the health care system for all consumers and payers of health care. With this in mind, we support the Employer's Coalition on Medicare and bipartisan efforts to modernize and improve health care delivery within the Medicare program, including – but not limited to -- the eventual enactment of a meaningful and universal Medicare prescription drug benefit within the broader context of reform. We therefore greatly appreciate the opportunity to share GM's experience driving quality improvement and health care delivery reforms that could potentially be applied to Medicare on behalf of the program's beneficiaries and the taxpayers who support it.

GM Experience

At General Motors, we provide health care coverage for over 1.2 million employees, retirees and their dependents at an annual expense of over $4.5 billion. We are self-insured and provide numerous plan choices for our beneficiaries. We offer traditional indemnity plans and contract with over 160 HMOs and PPOs. GM spends over $1.5 billion a year on prescription drugs alone. We manage this drug benefit quite aggressively and I will detail some of these efforts in short order. However, we are also very committed to competitively oriented management of all our health care plans and all the services they provide.

We believe that there is significant clinical and administrative waste in our nation's health care delivery system that contributes to not only excessive expenditures, but far more important, substandard care. One cannot come to any other conclusion when studies find that billions of dollars are wasted in unnecessary and inappropriate health care diagnostics and interventions, that hundreds of thousands of lives are put at risk and countless unnecessary and expensive hospitalizations ensue as a result of medication errors, and that nearly 100,000 Americans a year die as a result of preventable medical

errors just in hospitals. These figures really strike home when you recognize that they could translate to the deaths of one to two GM beneficiaries a day. This is unacceptable to us and should be intolerable for all public and private plans.

GM's Value-Based Purchasing Approach. Recognizing the quality and cost problems within the health care system and how they negatively affect us, GM has made a company-wide commitment to improving health care and utilizing the best of value-oriented principles of health care delivery to improve the care our employees and retirees receive. To effectively do this it is necessary to develop and implement performance expectations, measures of success and failure, and real incentives for change. At GM, we have done all three.

First, we chose four major expectations or goals for health care delivery: (1) high quality care, including positive medical outcomes, (2) patient satisfaction, (3) effective and responsive health plan and provider service delivery, and (4) value and cost effectiveness. All four goals are critically important, as we believe they contribute to a healthier and productive workforce and health care at a more affordable cost. At a time when health care costs per employee in this nation far more than double that of our worldwide competitors, we have no choice. More importantly, though, it is the prudent management course of action to take.

Second, we have developed scorekeeping methods that help us measure the performance of our health care suppliers to determine if we are achieving our goals. For example, we require the use and reporting of structural and process measures, which determine if plans and providers have instituted proven methods that result in better patient outcomes. Examples include frequent blood testing, eye exams and foot exams for diabetics, use of computers to enter prescription drug orders in the hospital, and Intensive Care Unit staffing. We also survey our members to determine satisfaction rates with their encounters with their plan and providers. Finally, of course, we evaluate the costs to determine the plans and providers that most consistently produce value for our multi-billion dollar investment on behalf our employees, retirees and their families.

Third, and perhaps most important, we use our measures in a very competitive fashion. The scores that our plans, and indirectly the providers they contract with, receive are used as an explicit tool to improve care OR lose business. More specifically, we provide incentives for beneficiaries to move to higher quality plans as well as to drive quality improvement in the plans. We do so through offering lower premium contributions for higher quality health plans, coupled with a report card providing information about each plan.

Our members vote with their feet and the best plans and providers significantly improve their market share. For example, over the past six years, enrollment in our "benchmark" or best HMOs have increased by 217 percent while enrollment in our poorest performing HMOs have declined by 63 percent. This is the result of beneficiaries moving to those organized health delivery systems that improved their performance and produced higher quality health care. Also we have dropped a number of poor performing plans. The CEOs of several of our newly designated benchmark HMOs have told us that their improvement was directly influenced by GM's benchmarking strategy. In fact, from 1998

through 2002, our plans have produced a 40 percent increase in their quality assessment scores.

As a consequence of our health care management techniques, our GM employees, retirees and families are receiving better, more cost-effective care. Our plans, which largely provide very similar benefit packages, are actually competing on the basis of quality and cost – not on the basis of who can attract the healthiest beneficiary. Good plans are rewarded and plans performing less well are given incentives to improve. While we have used our purchasing leverage to drop poor performing plans, our actual goal is to use our techniques to improve the quality of all plans and providers.

Mr. Chairman, I am pleased to report that a number of our plans and providers have made dramatic improvements. For example, our largest organized health delivery plan, designated a "benchmark" this year, has made dramatic improvements in its diabetes care performance measures resulting in reduced probability of hospitalization, blindness and foot amputation of its diabetic members. Notably, after reviewing our statistics on the performance of all of our plans for all the health care they provide, we have found an explicit and positive statistically significant correlation between plan performance and cost-effectiveness.

GM's Management of Prescription Drug Costs. Mr. Chairman, I would be remiss if I did not share with the Committee some of the benefit design, administrative and competitive techniques we use to manage our $1.5 billion prescription drug benefit. GM has a full time doctorate level clinical pharmacist on its health care initiatives management team. Her role is to lead the management of our drug benefits, focusing on quality and appropriate use, through both GM programs and a Pharmacy Benefit Manager or PBM. To ensure we benefit as much as possible from the drug managing techniques the PBM utilizes, we provide performance awards that provide incentives for successes at assuring appropriate utilization, increasing the use of quality generic drug products, and reducing cost growth.

In our efforts to improve the appropriate use of pharmaceuticals, we have drug benefit designs with multi-tier co-payments to encourage the use of the most therapeutically and cost-effective medications. We utilize prescription drug counseling/drug utilization review (DUR) programs to help ensure our enrollees avoid excessive and inappropriate use of medications that can lead to drug interactions that can have severe health and cost consequences. We also use physician-based therapeutic interchange programs that encourage physicians to prescribe medications that are both therapeutically and cost effective. And, as I have mentioned, we continue to encourage plans to contract with hospitals that utilize computer-based prescribing tools to ensure proper medication use.

The GM Quality Purchasing Experience and Implications for Federal Purchasers

Mr. Chairman, there are a wide range of interventions we and our health plans use that we believe could improve Medicare's ability to purchase higher quality, more cost-effective health care. Likewise, I believe that private purchasers would generally benefit if Medicare were empowered to be a more competitive purchaser of health care. We

have noted that when Medicare and FEHBP do institute positive changes that make the delivery system more efficient, all purchasers – including us – indirectly benefit as well. We are aware of many excellent Medicare demonstration projects and encourage continued and widespread implementation of those that add value by improving quality and efficiency for its beneficiaries.

The quality orientation approach GM now uses is something that we believe could be applied to Medicare fee-for-service and managed care contracts as well. In recent years, CMS, and formerly HCFA, has started to effectively push for and implement quality measures. We have found our joint collaborations to be extremely fruitful. For example, Medicare is actively participating in a number of public and private sector performance measurement initiatives, most notably the National Quality Forum. They have begun to use a series of hospital quality performance measures, which combined with private sector use will have a real impact on quality improvement. Medicare has also participated in several of GM's community initiatives to improve quality.

Applications of GM lessons learned for Medicare. There is no question, however, that Medicare could use its purchasing leverage even more aggressively to produce more value out of the health system. There is no reason that managed care plans participating in the Medicare program could not be subject to greater accountability for their quality performance similar to what I have previously described. Likewise, contracts with private carriers and intermediaries administering the traditional Medicare fee-for-service program could also be required to be held similarly accountable. And CMS should certainly be given even more authority to drop contracts from those plans, whether they are insurers administering the fee-for-service program or managed care plans bearing insurance risk, that are not performing.

Having said this, few people know more than us that unassailable quality and cost-effectiveness measuring tools have yet to be fully developed. Moreover, the risk-adjustor to fairly evaluate differential patient mix by different plans and providers will -- for the foreseeable future -- be subject to some level of dispute. As such, in the more politically sensitive world of Medicare, it might well be more difficult and controversial for Medicare to implement these approaches than it has been for us. It would be our hope, however, that the Congress and the Administration could cite the ever improving valued-based purchasing techniques that GM and other innovative large private purchasers are using and developing as the very rationale for moving ahead in this arena.

Just as we believe that a modernized Medicare program should be empowered to promote a much greater emphasis on quality and value, we share the Congress' belief that it is long past time for the program to be updated and include a well-managed and meaningful outpatient prescription drug benefit. We believe that the management and benefit design tools we use to ensure appropriate prescription drug utilization can and should be utilized by Medicare and we would be happy to provide any assistance we can in this regard.

Conclusion

As I am confident you and most Members of this Committee in both parties well recognize, we simply cannot allow less than perfect quality improvement measures and sometimes politically difficult to implement purchasing improvements to be an excuse for not taking steps now to improve Medicare and all health care in this nation. If GM and our competitors took that course of action in the 1980s, American car manufacturers would not have benefited from the quality improvements we now have in our marketplace today. While many of the steps we took were similarly extremely difficult at the beginning, we simply would not be as competitive as we are today.

Mr. Chairman, at GM we strongly believe the quality of care our employees, retirees and their families are receiving has improved substantially and costs are perhaps lower than they would otherwise be. However, the one indisputable fact we have learned in our experience in managing health care is that no purchaser – private or public -- has a monopoly on wisdom. We all could do a better job at assuring quality, affordable health care for our enrollees.

We benefit from learning from each other's successes and failures. While private purchasers can generally implement innovations more rapidly, we rarely have the type of positive impact on overall health care delivery that public purchasers do when they implement and improve on what we have done. We look forward to continuing our collaboration with you and others in the Federal government to ensure that all health care consumers and purchasers and taxpayers alike receive the value they deserve from their extraordinary financial investment in our nation's health system. I hope my comments prove helpful in your ongoing efforts to modernize and strengthen the Medicare program. I would be happy to answer any questions you may have.