

Testimony for Senate Committee on
Health, Education, Labor and Pensions Hearing

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**Lowering Health Care Costs:
Creating Functional Markets and Purchasing Value for Patients**

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Written Testimony

Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee, thank you for the opportunity to share the experiences of large purchasers of health care in seeking to reduce health care costs and improve quality. It is an honor to have been invited to participate in today's discussion.

My name is Elizabeth Mitchell. I am the President and CEO of the Pacific Business Group on Health, a coalition of large public and private purchasers of health care. We thank you for your leadership and for your consideration of our comments.

The most important points I want to make today are:

- We have strong evidence that cost-effective delivery of high-quality care is possible and should be expected.
- Although we prefer market solutions to the problem of high costs, many parts of the health care market are fundamentally broken. Government action is needed to ensure healthy competition among providers, health plans, suppliers and manufacturers in the health care sector. And in some cases, the only solution is price regulation.
- In addition to the key elements of the Committee's draft legislation – most of which we support – we encourage the Committee to incorporate stronger steps to contain out-of-control drug prices and to add a component to increase investment in primary care.

It may seem surprising that an organization representing some of the largest private sector employers in the world would be seeking policy intervention into the market. And it is. My members are committed to private sector market-driven solutions. But in much of US healthcare, the market is broken. A functional market does not regularly drive families in to bankruptcy; it does not depend on Go-Fund-Me campaigns for treatment costs; it does not absorb a decade of US wage growth. A functional market does not require the world's largest employers to absorb annual cost increases of 4-20% with no corresponding increase in quality or outcomes. Imagine any other industry in which prices increase steadily with no visibility and

no accountability for quality or value. The dysfunction is so profound that we are seeking your support to make a market-based solution -- a functional market in US healthcare -- possible.

PBGH members collectively spend over \$100 billion annually purchasing healthcare on behalf of their employees. Collectively that means buying healthcare for over 15 million Americans. And our members are deeply committed to the health and well-being of their employees and buying the healthcare services that promote optimal health. But even the largest private purchasers of healthcare in the world cannot overcome the industry consolidation, opacity, anti-competitive practices and egregious pricing in US healthcare. If large employers can't buy affordable high-quality care on behalf of their employees, it is almost a cruel joke that we would expect that of small businesses, municipalities, or families.

We do and will pay for high value care. We have stellar examples of bold innovations driven by our employer members to buy high quality care. The Employers Centers of Excellence Network (ECEN) – managed by PBGH on behalf of our members -- has shown significant improvements in health outcomes and costs.¹ ECEN sets high quality standards, vets and selects the best providers and facilities in the country for specific procedures, and encourages employees to use these Centers of Excellence (CoEs) for needed care. The ECEN program results demonstrate that it is possible to save money by reducing unnecessary services, while improving outcomes and patient experience. Even when factoring in travel expenses and waived co-pays, negotiated bundled payments for surgical procedures performed by CoEs cost considerably less, on average, than what members currently pay for these services. The cost equation improves even further, since these high-quality procedures produce quality outcomes that can mitigate costly revisions and infections. Much of the cost reduction comes from avoiding unnecessary procedures, with top-performing surgeons using evidence-based medicine to determine surgical appropriateness. Think about this. This is just a glimpse in to the unnecessary services being delivered in this country by providers and facilities that are paid only if they administer treatment -- and the more treatment, the more they are paid. Furthermore, the ECEN program convenes all participating hospitals and their surgeons annually to compare best practices across the network, and 98 percent of patients recommend the ECEN program. The good news is that through this program we are also starting to demonstrate the ultimate win-win-win in healthcare: better outcomes, much better patient experience at significantly lower costs. Better care can and does cost less. It is my position that if everyone had access to the performance information to choose the best care -- and the resources and wherewithal to hold the system accountable -- we could move the entire market. This is what we should all be working towards.

Unfortunately, we also have alarming examples of system failures. Just this past Friday I was meeting with one of my large employer members who is committed to offering high quality affordable care to his many employees across the country. He shared the story of one employee who had recently had a kidney transplant and was on a critical medication. This

¹ Slotkin, Jonathan R., MD, et al. "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees", Harvard Business Review, June 8, 2017. Accessed online 10/9/17 at <https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees>.

employer has paid approximately \$138,000 every two weeks (\$3 million during the last 12 months) on one patient for this drug and its administration at the provider's office. Because this employer has a Specialty Pharmacy, the plan is now able to source this drug directly from the manufacturer for \$26,092 each two weeks and, at the patient's request, have a nurse provide infusions in the patient's home. They also agreed to waive all patient cost share if she agreed to change the place of service for exactly the same medication. It was a "Win-Win" for the patient and plan. The drug is still expensive, but it is a savings of over \$200,000 per month. In another example this same employer had a pediatric patient receiving medication administration from a hospital in California at a cost of \$750,000 annually. The employer searched the local market for alternatives and, with the agreement of the family, changed the treatment location to another California hospital. That same medication for that same patient at a different hospital cost only \$250,000 per year. You might say that is an example of the market working. The buyer figured out a smart way to obtain a better price. But this situation is rare and depends on transparent information and market leverage that very few have. Imagine a small employer, or an employer without transparent pricing information – or an individual patient – trying to achieve this kind of savings. It simply is not possible in the US healthcare market. The market needs to work for everyone. We believe that many of the proposals in this bill would begin to enable a more rational, functional – and fair -- market.

Recommendations for Policy Action

Our policy recommendations build on the testimony submitted by David Lansky, PBGH's former President & CEO, to the Senate HELP Committee in July 2018, as well as the letter we sent on March 1, 2019, in response to the Committee's request for information, and our June 5 comments on the Committee's discussion draft of the Lower Health Care Costs Act of 2019. These recommendations are based on the principles and key levers that can drive change and improvement in our health care system that we described in the earlier testimony and follow-up letters.

In particular, we applaud the Committee's recognition of the importance of a healthy, functioning marketplace to drive lower costs and improved quality. We believe the following are essential for a healthy competitive marketplace:

- **Full and transparent information** regarding provider performance on cost, quality outcomes and patient experience.
- **Competitive marketplaces** among providers, health plans, suppliers, etc., including regulation and enforcement as needed to prevent anti-competitive behaviors.

Comments on Specific Elements of the Discussion Draft

In addition to the consumer protections in the draft bill, PBGH endorses the intent to **hold down overall health costs**. In nearly all cases, large employers are seeking market-based solutions to the nation's increasing health care costs, but we believe that **public policy interventions are needed when markets fail**. This has clearly happened in the case of certain

facility-based physician services and ambulance services. In a recent paper on surprise billing by my colleague Benedic Ippolito from the American Enterprise Institute, this market failure occurs when “consumers cannot feasibly avoid providers who deliberately chose to be out-of-network” – for instance, in emergency situations. “Similarly, even for elective admissions to the hospital, it is typically not possible to choose many ancillary providers.”² In these situations, it is difficult for even the most innovative purchasers to achieve high quality and affordable care and coverage for their employees. In the specific case of surprise bills, policy makers must take steps to protect consumers and hold down the overall costs of care.

REDUCING THE PRICES OF PRESCRIPTION DRUGS

The cost of drugs is an increasingly serious problem for employers and their employees. Growth in drug spending is expected to exceed the growth in total health care spending in future years, driven largely by increases in prices for specialty drugs.³ As I described earlier, large employers are struggling with this cost burden, and they often are in a weak position to negotiate prices with drug manufacturers and pharmacy benefit managers (PBMs). They recognize that public policy changes are needed to address the fundamental problems driving high drug prices, and they support policies that would improve transparency and increase healthy market competition.

We appreciate the Committee’s intent to address the problem of high drug costs, and several of the elements in the draft legislation would be helpful. In aggregate, however, we do not believe that these steps would go far enough to rein in drug costs. Specifically:

- We support the reforms of the “Purple Book” and “Orange Book”, which would increase the transparency of patent information and enable manufacturers of generic drugs and biosimilars to develop competing alternatives to expensive brand-name drugs.
- We also support elements of the draft bill that would reduce the blocking of generic drugs.
- We strongly support the elements of the draft bill that would require transparent reporting from pharmacy benefit managers (PBMs) to plan sponsors. The lack of transparency makes it impossible for most employers to even know prices, rebates and other pricing complexities, much less negotiate for lower prices. We also support the

² Benedic N. Ippolito and David A. Hyman, “Solving Surprise Medical Billing”. American Enterprise Institute (AEI) Economic Perspectives, March 2019. Accessed online at <http://www.aei.org/publication/solving-surprise-medical-billing/> on June 15, 2019.

³ Kaiser Family Foundation analysis of National Health Expenditure (NHE) Historical (1960-2016) and Projected (2017-2026) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/?_sf_s=recent+trends#item-growth-prescription-spending-slowed-2016-increasing-rapidly-2014-2015_2016 (accessed 7/14/18).

proposed prohibition on the use of “spread pricing” by PBMs, and the requirement for PBMs to pass-through 100% of rebates or discounts to the plan sponsor. These steps will help to align the PBMs’ business models with the needs of consumers and purchasers, thereby leading to lower drug costs.

- We understand that the Committee will be considering additional legislation to address the serious problem of high drug costs, and we strongly encourage Congress to take more **substantive steps to reduce the cost burden on consumers and purchasers**. Specifically, we support legislation that would increase transparency and provide advance notice and justification for significant price increases, reduce the barriers to generic drug development, reduce the barriers to development and use of biosimilars, and prohibit abuse of the patent system to extend exclusivity for brand-name drugs.

IMPROVING TRANSPARENCY IN HEALTH CARE

Transparent information on cost and quality is a necessary element of healthy functioning markets. We cannot choose and pay for high value care if we do not know what it is. The recent RAND study on commercial pricing quantified an average 240% difference in charges for private payers compared to Medicare raising important questions for purchasers. Although transparency by itself will not fix the problem of high health care costs, it provides an essential foundation. Sadly, the people who receive and pay for health care do not have the information they need to make critical health care decisions.

- Patients want to know what outcomes they can expect from care, and whether and how outcomes vary across providers. We are strong advocates for the adoption of patient reported outcome measures across all markets.
- Transparent information needs to fully reflect the costs that the employee will ultimately face, taking into account such complexities as their own employer’s benefit design, the formulary deployed by their Pharmacy Benefit Manager, the possibility of out-of-network charges, and the aggregation of costs across a complex episode of care. In short, consumers and purchasers want to see meaningful price transparency that reflects total cost of care and the complexities of our payment and cost-sharing systems.
- We support the elements of the draft bill that would establish programs to improve maternal health care quality and reduce maternal mortality and severe morbidity. We encourage the Committee to go further, however, by **requiring standardized public reporting of maternal and infant mortality by all providers nationwide**.

In our experience, data access has been a major barrier to transparent information and the proposed creation of an all payer claims database may enable more meaningful cost transparency across markets.

- We support the elements of the draft bill that would establish a non-governmental not-for-profit organization to create an **all-payers claims database**. PBGH has extensive experience with the design and use of these types of databases. We have

provided technical assistance and recommendations to Committee staff on this proposal, and we can provide additional detailed guidance and feedback as needed. In the design of this program, it is essential that users of the information – especially physicians and patients – have a key role in governance.

- We support the key elements of the draft bill that would enable data sharing and require commercial health insurers to make information available to patients through application programming interfaces, while protecting individual patient privacy.

In addition to improving claims data access, we believe that Congress needs to take further action to improve health care information that is needed by patients and purchasers. Specifically, we encourage Congress to **require outcomes-oriented quality measures for priority conditions, including maternal and infant care**. The Centers for Medicare and Medicaid Services (CMS) has taken tentative steps towards reducing the burden of quality measurement by increasing the use of outcomes measures, but such efforts must be dramatically increased and accelerated. The federal government can act quickly in three ways:

- Develop the national infrastructure for measurement of outcomes across all major conditions
- Simplify the quality reporting requirements under Medicare to emphasize standardized outcome measures for each condition
- Require the adoption and publication of outcomes data for all federal payment programs.

COMPETITIVE MARKETS

There is growing recognition that our health care system has a serious problem that needs to be addressed – the effect of market consolidation on prices. We know the following:

- Market power has enabled providers, drug companies and others to raise prices, and it is largely the result of market concentration. According to a recent paper, “Hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals.”⁴ A recent Kaiser Health News article commented specifically on the problem of high hospital prices in California.⁵
- Market concentration has been growing in recent years. Most hospital markets are already highly concentrated, and hospitals have also been buying up physician

⁴ Zack Cooper, Stuart V. Craig, Martin Gaynor, John Van Reenen, “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured”. NBER Working Paper No. 21815. Issues in December 2015, Revised in May 2018. <http://www.nber.org/papers/w21815>

⁵ Chad Terhune, “As Hospital Chains Grow, So Do Their Prices for Care”, Kaiser Health News, June 13, 2016. <https://khn.org/news/as-hospital-chains-grow-so-do-their-prices-for-care/>

practices. The trends in consolidation are documented in a recent *Health Affairs* article.⁶

Most employers believe that the best way to improve value (improved quality and patient experience, at lower cost) is through market forces, i.e., healthy competition among providers. Unfortunately, real competition no longer exists in many markets. In these situations, we believe that government action is needed to ensure that competition works in a way that benefits consumers and purchasers. Anti-trust enforcement is one policy lever, but its effectiveness is limited, especially in addressing markets that are already concentrated. Other actions to address anti-competitive practices are needed.

We are encouraged that the Committee has recognized this problem and proposed policy changes to address it. Specifically,

- We strongly support the elements of the draft bill that would **remove gag clauses** on the sharing of price and quality information by providers.
- We strongly support the elements of the draft bill that would **ban anti-competitive contracting practices** by providers, including anti-tiering, “all-or-nothing” and similar clauses that are used to gain market power and raise prices.

We encourage Congress to consider additional steps that would address the problem of market concentration and high prices. Among the potential policy steps, the following appear to be the most promising and feasible.

- Site-neutral payments
- Transparency and standardized provider performance reporting, as described above.
- Promotion of entry of new competitors and reduction of barriers to entry

In addition, we encourage Congress to **enable Medicare beneficiaries to identify and seek care from high performing centers**. In recent years, centers of excellence (CoEs) have become a common feature of commercial insurance and private purchaser medical care networks. Nearly 90% of large employers expect to use such centers to improve quality of care and predictability of cost for their employees.⁷ Commercial CoE programs have primarily been used for common elective procedures and certain medical conditions with high costs and variability in quality and price, including hip and knee replacements, spine care, heart surgery, bariatric surgery, and some oncology services.⁸ As I described above, we have demonstrated that a CoE programs can generate superior quality outcomes, reduce costs for patients and employers, and improve patient experience.

⁶ Brent Fulton, “Health Care Market Concentration Trends in the United States: Evidence and Policy Responses”. *Health Affairs* 36, no.9 (2017):1530-1538. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556>

⁷ National Business Group on Health, *Large Employers' 2018 Health Care Strategy and Plan Design Survey*. <https://www.businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=334>

⁸ The NBGH survey cited above reports 77% of employers using (47%) or considering COE for orthopedics; 77% for bariatric; 62% for cardiac; 56% for cancer.

We believe that a well-designed CoE program within traditional Medicare would offer:

- Better health outcomes than typically achieved by most fee-for-service providers
- Lower beneficiary expenses through reduced cost-sharing
- Program cost savings through more appropriate and higher quality care
- System-wide quality and affordability improvements due to provider competition.

By setting a high bar and stimulating healthy competition among providers, a CoE program would be a catalyst for change that would eventually “lift all boats” by improving quality and affordability system-wide.

ENDING SURPRISE MEDICAL BILLS

- We strongly support the protection of patients from out-of-network deductibles in emergencies and from other surprise bills and balance billing. We strongly recommend, however that the definition of services in these sections be **expanded to include ground and air ambulance services**. Surprise medical bills for these services can amount to hundreds or even thousands of dollars in medical costs that consumers are unprepared to pay. We are pleased that the Committee has acknowledged this as a problem, but the transparency requirements for ambulance services in the draft bill are simply inadequate to protect consumers and purchasers from unaffordable and unpredictable ambulance costs. We understand that states are limited in addressing this problem due to federal jurisdictional authority; it is up to Congress to fix this problem directly

With regard to the three payment options presented in the draft bill, we offer the following comments:

- **PBGH supports Option 3 – Benchmark for Payment.** We strongly recommend setting payments based on the **average payment to specialty physicians, e.g., 125% of Medicare payment rates**. A second-best solution would be the use of payments based on median contracted payment rates in each geographic area, although we are concerned the resulting benchmarks under that method would reflect prices that are already too high.
- **Option 2 – Independent Dispute Resolution.** We believe that an arbitration process would not achieve the aims of the bill to adequately protect consumers, payers and purchasers from high costs. In fact, it would add significant administrative costs and burden to physicians and health plans, the last thing we need in our already administratively complex health care system. Furthermore, we are concerned that the arbitration process would be opaque, and the outcomes would be uncertain.
- **Option 1 – In-network Guarantee.** We appreciate the Committee’s attempts to develop a creative approach to this problem, but we are skeptical that this would produce the needed cost reductions. While some economists have assumed that without the ability for emergency physicians and other facility-based providers to

stay out-of-network, they will have less bargaining leverage, and therefore prices will be lower. Based on the real-world experiences of PBGH members, however, we are not confident that this would happen, especially in markets in which dominant hospitals and physician groups have strong market power. We anticipate that the physicians would negotiate with the hospitals or health plans to maintain the current high prices, thereby locking in the current unaffordable costs to consumers and employers. This would likely be a serious problem for small rural hospitals that are often in a weak bargaining position with local physician specialty groups.

Additional Policy Recommendation: **Primary Care**

The U.S. health care system needs to dramatically increase investment and support for primary care – the foundation of good health for all Americans. This includes integrated behavioral health because behavioral healthcare is primary care. The evidence is clear; we know that the decisions made in primary care practices have outsize influence on downstream medical care. A Stanford University study published last year showed that high value primary care for a commercially insured population can lead to spending that is 28% lower than average value primary care⁹. The savings are clustered in four areas: unnecessary surgical and other specialty procedures (41%), low value prescribing (26%), avoidable hospitalizations and ED visits (17%), and unnecessary testing (8%). The high value primary care practices did see their patients more often, resulting in higher spending on office visits, but only by 2%.

Rebalancing spending away from specialists and the hospital setting and towards primary care in the community is important. Employers encourage their employees and dependents to affiliate with effective primary care practices, but we are concerned that the national imbalance between primary and specialty care can only be corrected with strong signals from the Medicare program. We are encouraged by the recent announcement by the Centers for Medicare and Medicaid Innovation (CMMI) to launch pilot programs for advanced primary care models.

In addition, we believe Medicare should **authorize payment models and increase payment rates for advanced primary care** models that achieve high quality outcomes and reduce total cost of care. The Medicare Payment Advisory Committee (MedPAC) and other experts have observed that certain procedures and specialty services are overpriced, based on the relative value units (RVUs) used to calculate payment rates to physicians. It appears that the Centers for Medicare and Medicaid Services (CMS) has relied too heavily on recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC), resulting in underpayment for critical primary care services. Congress and CMS should consider structural and process changes to correct this imbalance.

Summary

⁹ Melora Simon et al, “Exploring Attributes of High-Value Primary Care”, Ann Fam Med 2017;15:529-534. <https://doi.org/10.1370/afm.2153>.

PBGH members are deeply concerned about high health care costs and inconsistent quality. We strongly support public policies that will enable health care markets to function effectively, which will make health care more affordable and improve the quality of care. We believe steps must be taken to end surprise medical bills, reduce drug prices, improve transparency and prohibit anti-competitive practices. Meaningful, accessible information about prices and health outcomes could provide the foundation for real competition between providers, and allow patients and employers to make informed decisions about where to seek care. We look forward to constructive competition between provider organizations based on common, transparent definitions of episodes of care or full accountability for populations, so that providers are motivated to continuously seek better ways to use technology, workforce, and expensive care resources to achieve superior health outcomes. Implementation of these and other policies will take time and require significant changes by important stakeholders. Yet the vitality of our economy, the solvency of our nation's treasury, and the welfare of all Americans depend upon our efforts.

Thank you for your leadership in driving improved value in our health care system, and we look forward to working with you and other stakeholders to make the improvements that we all need.