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REDUCING HEALTH CARE COSTS: IMPROVING AFFORDABILITY THROUGH INNOVATION

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING REDUCING HEALTH CARE COSTS, FOCUSING ON IMPROVING AFFORDABILITY THROUGH INNOVATION

NOVEMBER 28, 2018

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C O N T E N T S

STATEMENTS

WEDNESDAY, NOVEMBER 28, 2018

REDUCING HEALTH CARE COSTS: IMPROVING AFFORDABILITY THROUGH INNOVATION

Wednesday, November 28, 2018

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Cassidy, Young, Murkowski, Murray, Casey, Bennet, Baldwin, Hassan, and Smith.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order. Senator Murray and I will each have an opening statement, then I will introduce the witnesses. Then we will hear from the witnesses and Senators, and we will have 5 minutes to ask questions.

Senator Murray has asked me to go ahead and begin, because she has a conflict and will be here in about 15 minutes. I will ask her to preside for about 10 minutes at 10:00 a.m. when I have to leave to go introduce a judge before the Judiciary Committee.

I mentioned to the witnesses a little earlier that we greatly appreciate their coming. We sometimes find we do as much good by putting the spotlight on issues as we do by passing laws, and this is an example of putting the spotlight.

International Paper, a 120-year-old company headquartered in Memphis, has, since 2004, used a variety of tools to manage the cost of healthcare for their 33,000 employees. One tool International Paper uses is encouraging employees to use, at no cost, Best Doctors, an independent company that International Paper works with.

For example, when an International Paper employee's doctor recommends a hip replacement, the employee can call and ask for a second opinion from Best Doctors. Best Doctors reaches out to get the necessary medical records from the employee's doctor, sends the records to medical professionals who review the case, and then either reaffirm the hip replacement or recommend a different course of treatment, such as physical therapy.

The use of this voluntary program saved International Paper over a half million dollars in 2017 by preventing unnecessary treatment.

In June, this Committee launched a series of hearings on the rising cost of healthcare, an issue that is at the front of Americans' mind. According to a Gallup Poll released days before the mid-term elections, 80 percent of registered voters rated healthcare as extremely or very important to their vote, a higher percentage than any other issue polled, including the economy, immigration, and taxes.

At our first four hearings last year, we looked first at how much healthcare costs in America. Second, how to reduce what we spend on unnecessary healthcare tests, services, procedures, and prescription drugs, and how to increase preventive care. Third, how to reduce administrative burdens imposed by the Federal Government. And fourth, how to make information on the cost and quality of care more easily available.

We heard some startling testimonies from people who are supposed to know what they are talking about. For example, one witness, Mr. James, from the Academy of Medicine, estimated that as much as half of the money we spend on healthcare is unnecessary. And fraud, waste, and abuse, which we often talk about, is only a part of that. Most of the other witnesses that day agreed with him.

Secretary Azar has been passionate about giving patients more information on their care, as a way to reduce healthcare costs. For example, the Centers for Medicare and Medicaid Services is beginning to require hospitals to post the amount it charges, or they charge, for services online and to keep that information up to date.

While there may be a role for Government to play, at today's hearing, our fifth in this series of hearings, we will examine ways private companies, doctors, and states are taking innovative steps to disrupt the healthcare system and reduce healthcare costs.

Employers are the largest purchasers of health insurance in the country. One hundred eighty-one million Americans, or nearly 60 percent of the insured population, get their insurance on the job.

We heard at a previous hearing how employers have incredible purchasing power when buying healthcare for their employees and are motivated more than ever to take advantage of that purchasing power. One way employers do that is through wellness programs, which encourage employees to lead healthy lives.

There is a consensus, and we have heard it in the testimony here, that wellness—lifestyle changes, such as eating healthier and quitting smoking—can prevent serious illness and reduce healthcare costs. And it is hard to think of a better way to make a bigger impact on the health of millions of Americans than to connect that consensus about wellness to the health insurance that 181 million people get on the job.

Another way to reduce the cost of healthcare is to give employees access to additional resources, such as what International Paper is doing with the Best Doctors program. And a third way is for employers to band together, like our witness The Alliance, a regional organization of employers that is cultivating traditional insurance to negotiate better deals on laboratory testing, such as CT scans, MRIs, surgeries, including knee and hip replacements, and other healthcare for employees.

These are a few examples of employers harnessing their power to affect how much they and their employees pay for healthcare.

Private healthcare companies also have the ability to reduce healthcare costs. For example, HCA Healthcare, another witness here today, has 178 hospitals and 119 freestanding surgery centers located in 20 U.S. States and the United Kingdom. HCA has implemented new techniques to reduce the spread of MRSA, a drug-resistant bacterial infection in intensive care units. These new techniques have reduced cases of MRSA by 37 percent in HCA hospitals and have been so effective that the World Health Organization and the Centers for Disease Control and Prevention have added them to best practices.

According the HCA, this reduction in MRSA saves $170,000 for every 1,000 patients. These savings are shared among hospital insurers and patients. Dr. Perlin, our witness from HCA Healthcare, has been on the frontlines of this and other innovations, showing what a smart doctor can do when given the resources to impact an entire system, such as one as large as HCA.

Today, we will hear more stories like these about how the private sector is working to address America's high healthcare costs and hearing what Washington needs to do to get out of the way of private sector innovation. Going forward, I plan to take what we have learned from our hearings and ask leading healthcare policy experts, including economists, doctors, nurses, patients, hospital administrators, state regulators, legislators, governors, employers, insurers, and healthcare innovators, for specific ideas on how the Federal Government can reduce the cost of healthcare.

Senator Murray.

[Laughter.]

The CHAIRMAN. Your timing is always excellent.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Mr. Chairman, I apologize. As you know, we had to move the hearing up. So I apologize for being a few minutes late. Jammed morning.

Welcome to everyone. And thank you, Mr. Chairman. Thank you to all of our witnesses for joining us as we continue a series of hearings focused on high healthcare costs.

There is really no question that this is an urgent problem. I have heard from families all over Washington State struggling to afford the care they need, and I know my colleagues have heard from families in their own states as well. And we all heard from voters across the Nation this month, as they soundly rejected the Republican approach of sabotage as healthcare policy.

The will of the people could not be clearer. It seems they are very tired of President Trump's broken promises and backward steps and blatant gimmicks, and they are tired of the divisive repeal attempts, and they want real solutions to make sure quality healthcare is accessible and affordable.

They want to know that breaking a bone is not going to break the bank. That a high fever will not come with a high cost. That filling a prescription will not mean emptying their savings account. And people want to know that when a loved one is fighting a life-or-death illness, they can focus on getting healthy, not getting out of debt.

That is why they want Congress to come together in a bipartisan way and work together on plans to bring down healthcare costs. Today's hearing is a great opportunity to do that as we explore how innovation can help address this challenge.

One part of the equation is innovation driven by employers. So I am really excited to hear from King County Executive Dow Constantine, who is with us from my home State of Washington, about how they have been tackling this. With 15,000 employees, King County is Washington State's 13th-largest employer. In order to help drive down healthcare costs, the county has partnered with their local healthcare system and other employers, developed a wellness initiative, and focused on shifting to value-based care purchasing, but the county is also taking unique and innovative steps to keep employees informed of these efforts and approach them as partners in making healthcare more affordable.

Their success shows cost-saving innovation must be joined by education and engagement so people understand how they can benefit from new programs and initiatives. So I look forward to hearing from you, Executive Constantine, and thank you for being here.

Another critical part of the equation is provider-driven innovation, which is why I am glad Dr. Perlin is here today to share his insights. Dr. Perlin has led projects to improve quality at the Veterans Health Administration and in the private sector. So I know he will also have valuable lessons to share today.

As we focus on this topic, we should not forget that Congress created the Center for Medicare and Medicaid Innovation. It is a laboratory for trying out new ways to deliver healthcare to help public programs and the private sector innovate together.

Now unfortunately, instead of supporting this lab of innovation, President Trump has been working to undermine it. He proposed rescinding part of its budget in his failed rescissions proposal, but luckily, as we know, Congress came together to reject that. Or when he delayed and even canceled sensible demonstration projects meant to encourage providers to keep costs down and deliver the best results for patients.

Recently, he also warped the 1332 waivers. It is a tool Congress intended to help states innovate, so they encourage states to sabotage healthcare protections instead. It seems like the only innovative thing about President Trump's healthcare strategy has been as sabotage. He has, as we know, slashed investments, shortened enrollment windows, expanded junk plans, and undermined protections for people with preexisting conditions.

When Congress, including many of us in this room here today, got close to passing a common sense solution to repair some of the damage and bring prices down, that was sabotaged as well.

But Mr. Chairman, I am really hopeful that we can revive discussions in the new Congress and find a way past the ideological standoffs of the past. It is long past time this came to an end, and voters have made it clear that they agree.

We saw in the mid-terms exactly what we saw before Trump Care went down in flames. People standing up. They make their voices heard. They send a strong message that the Republican strategy of standing aside and giving President Trump free rein to undermine healthcare is taking us in the wrong direction, which is

why I am very glad we are sitting down here today to look for bipartisan solutions that will bring down costs for patients, families, businesses, and Government.

I hope Republicans got the message, ready to turn over a new leaf with us and agree that repeal is off the table, and finally agree we should be holding President Trump accountable for sabotage and, importantly, working to repair it. And I do hope we can all get back to the negotiating table to hammer out a plan for problems we were sent here to solve. Democrats are here. We are ready.

We have some promising ideas where we hope we can find some common ground. Ideas to repair the damage that has been done to drive up prices with sabotage. Ideas to address the surprise balance billing, so patients are not caught off guard by unexpected and unaffordable price tags for out-of-network care. Ideas to lower skyrocketing prescription drug costs, so families do not have to wonder whether they can afford the medicine they need. And ideas to give families facing a health scare, a bit more peace of mind by making sure that everyone in the country can afford to be healthy.

I am looking forward to all of our witnesses' ideas on this today, and I am hopeful that we can join together, taking what we hear today and working to find common ground and pass common sense solutions.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

I look forward to working with Senator Murray, as this Committee often does, in a bipartisan way on big, complex issues, and we usually get results. And we can revisit the so-called Alexander-Murray proposal, if you would like, but I would—without provoking a debate about it, I would say that we had an agreement that—last year that would have reduced rates in individual insurance by up to 40 percent over 3 years, according to the Oliver Wyman firm. And it included 3 years of re-insurance, 3 years of cost-sharing subsidies, and more flexibility for states without changing the essential health benefits.

From my vantage point, the only reason it did not succeed was that Democrats would not vote for the Hyde Amendment to apply to it, regulating a compromise that affects how Federal funds are spent for abortion, even though they voted for it 100 times in other parts of the same bill. So I regretted that did not work, and maybe we can find a way to make it work in the new session. We certainly will try on the issue of healthcare costs, which are the larger issue, because if we are spending—as much as half of our funding of healthcare spending is unnecessary, why, we have a responsibility to do what we can about that.

The first witness we will hear from is Dr. Lee Gross, who is president of Docs 4 Patient Care Foundation, a nonprofit of practicing physicians focused on advancing healthcare freedom and empowering patients.

Additionally, Dr. Gross is the co-founder of Epiphany Health Direct Primary Care—Direct Primary Care Practice, offering preventive healthcare services through a low-cost membership program in North Port, Florida.

Next, we will hear from Ms. Cheryl DeMars. And Senator Baldwin, would you like to introduce Ms. DeMars?

Senator BALDWIN. Mr. Chairman, I would. I am honored to introduce today Cheryl DeMars, president and CEO of The Alliance in Madison, Wisconsin.

Cheryl joins us to share The Alliance's award-winning work, providing efficient and high-value care to its members as a nonprofit employer-owned cooperative.

Cheryl DeMars has significant industry experience in cost and quality measurement, bundled payments, and transparency. She holds leadership positions in the Wisconsin Collaborative for Healthcare Quality, the University of Wisconsin Population Health Institute, and is the vice chair of the Wisconsin Health Information Organization.

In 2009, Cheryl DeMars was appointed to Wisconsin's Wired for Health Board, which helped oversee the implementation of the HITECH Act and the successful launch of a statewide health information exchange.

Cheryl, welcome to the HELP Committee, and thank you for joining us today to share The Alliance, the story of The Alliance and your expertise in this area.

The CHAIRMAN. Senator Murray.

Senator MURRAY. Well, thank you, Mr. Chairman.

I am always glad to welcome my fellow Washingtonians, and I am particularly pleased to introduce our next witness, King County Executive Dow Constantine.

In King County, Executive Constantine is responsible for over 15,000 employees who work to provide essential government services to over 2 million people, covering public transportation, waste water treatment, human services, public health, and a lot more.

In addition to overseeing the state's largest county, Executive Constantine has also worked to overhaul how it provides healthcare for its employees. As a result of these innovative efforts, King County has saved $46 million, implemented a new wellness program, and been recognized with a Harvard Innovations in American Government Award.

Executive Constantine, I am very glad you could join us here today. I know it is a long flight. So thank you for coming out here. Looking forward to your testimony.

The CHAIRMAN. Thank you, Senator Murray.

Finally, we will hear from Dr. Jonathan Perlin. He is president of Clinical Services and chief medical officer of Nashville-based HCA Healthcare, a healthcare service provider with 178 hospitals in 20 states and the United Kingdom. He is a member of the Medicare Payment Advisory Commission, the Congressional Budget Office Panel of Health Advisers, and the National Academy of Medicine.

Prior to joining HCA, Dr. Perlin served as Under Secretary for Health in the U.S. Department of Veterans Affairs and currently serves as Chair of the Secretary of Veterans Affairs Special Medical Advisory Group.

Welcome again to our witnesses. Dr. Gross, let us begin with you.

STATEMENT OF LEE S. GROSS, M.D., PRESIDENT, PATIENT CARE FOUNDATION AND FOUNDER, EPIPHANY HEALTH DIRECT PRIMARY CARE, NORTH PORT, FL

Dr. GROSS. Good morning. Thank you, Chairman Alexander, Ranking Member Murray, and distinguished Members of the Committee.

I greatly appreciate you holding a series of hearings on a very important topic, which is actually reducing healthcare costs because that is really not a topic that we have been discussing—we have been discussing coverage, but the underlying problem of healthcare cost has been a true problem, and I am excited to actually share some of our experience.

I am a practicing physician, family medicine in southwest Florida. I have been practicing since 2002. And starting in 2009, it became obvious that things were really starting to sort of deteriorate in the private practice of medicine, and we had an actual epiphany, the name of our company is Epiphany Health. And the epiphany was, why are we using insurance to pay for primary care?

Why are we inserting so many obstacles between a primary care doctor and the patient? Why are—you do not insure gasoline for your car. You do not insure the lightbulbs for your home. Yet we are using an insurance vehicle to insure the most basic aspects of medical care delivery, which is primary care services.

If you are taking all of healthcare, you are going to put it in a box and you are going to call that box health insurance, and you have to charge one price for that entire box. And you are going to put affordable primary care, but very expensive end-of-life care, long hospitalization, rehab stay, so forth, that, actually when you bundle it together, blocks access to affordable primary care. But when you split out the primary care portion of it, it actually becomes quite affordable.

We ended up doing in 2010 was creating a program which has since become known nationally as "direct primary care." There are now 1,000 practices nationwide, but essentially, it is a membership-based primary care program.

We charge $60 a month for adults, $25 a month for one child, and $10 a month for each additional child. And after that, we do not charge anything for services we provide in our office. No copays, no deductibles. We do not charge for any procedures we do. EKGs, cortisone injections, halter monitors, spirometry, that is all included at no additional cost.

We are insurance-free practice. So our patients that have good insurance, bad insurance, no insurance are all treated absolutely equal. Past medical history, chronic medical conditions, we can manage the diabetes in our office, asthma, hypertension. I can remove minor skin cancers for no additional costs.

Part of our program is we tried to figure out what a primary care doctor needs to do his or her job effectively outside of a traditional third-party payer system, and so we reached out to independent labs, independent imaging centers. It almost took like a Priceline.com approach and said, "If you have a CAT scan machine that you own that is not running 24 hours a day, and we sent a patient, as a cash-paying patient, what could sell that unused scan for?"

We approached the labs and said, "If you did not have to chase down insurance claims, if you did not have to worry about how the bill was coded, if you did not have to worry about what test was ordered and why it was ordered, if we collected the money up front and you send us one bill for all of our patients, what could you sell us the labs for?"

What you find is that we actually end up purchasing our services wholesale. So we can get a CAT scan for $175. We can get an MRI for $225. Routine laboratory for monitoring a diabetic patient is about $40. And so, what we are seeing now is that patients are actually coming to our practice not only from all over the State of Florida, but they are coming to our practice from out of the State of Florida. They are coming across the country. We are even having patients coming to us from out of the country for affordable medical care.

We have recently seen an inbound case of medical tourism into the United States, through our practice, for affordable surgical services because we have negotiated cash-bundled-price surgeries in an inpatient facility in a rural hospital in Florida.

We are very happy that the Committee is interested in exploring direct primary care. Again, there are now about 1,000 practices nationwide that are practicing in this model. This is a growing model. Most of that growth has occurred literally with the past few years.

We believe that this is a way for most people to get access to the care that they need. And if surrounded by a catastrophic major medical plan, the combination of affordable access with no co-pays, no deductibles, for the routine care, for the routine chronic disease management, if you then bundle that with an affordable major medical wrap-around option for the unpredictable, let us make the predictable affordable for everybody. Let us make routine care affordable for everybody, regardless of insurance status. If we can provide that level of care to most people, then we can find ways to afford and pay for the unexpected.

I am excited to share our experiences with you. We, again, have been doing this since 2010. I can tell you that our prices have not increased since we started our practice for anybody that joined. So we have not seen the cost inflation that you have seen in traditional insurance plans.

The services that I have negotiated for labs, for imaging services, are almost exactly the same today as they were nearly 10 years ago. We have not seen the skyrocketing cost of healthcare in our practice that you have seen in most other areas. And so, we are happy to work with you and see how we can expand this model.

Thank you.

[The prepared statement of Dr. Gross follows:]

PREPARED STATEMENT OF LEE S. GROSS

Chairman Alexander, Ranking Member Murray, and distinguished Members of the HELP Committee, I am Dr. Lee Gross, and I am a full-time practicing family physician from Southwest Florida. I appreciate this opportunity to testify how an emerging primary care practice model can use free-market principles to help simplify health care delivery, reduce the cost of care, lower barriers to access, reduce physician burnout and restore the patient as the central focus of our health care system. Direct Primary Care (DPC) physicians are strongly committed to working to fix our broken health care system to reduce complexity, improve value and pa-

tient health, and improve health care access regardless of a patient's pre-existing conditions or socioeconomic status.

Personal Background

I grew up in a rural community outside of Cleveland, Ohio. After college, I spent three years coordinating clinical trials for the Cleveland Clinic Foundation's cardiology program prior to attending medical school at Cleveland's Case Western Reserve University. Despite my extensive background in cardiology, the primary care field of family medicine that allowed me to care for the entire patient called to me during my training. I went on to complete a family medicine residency at University Hospitals of Cleveland, where I became a chief resident.

At the time of completing my residency, the Cleveland health care market was undergoing a major transformation with nonprofits University Hospitals (UH) and Cleveland Clinic Foundation (CCF) both in frenzied growth modes, acquiring medical practices and expanding their footprint across the entire regional landscape including my rural hometown. A graduating physician that wanted to stay in the Cleveland market had essentially 3 options: work for CCF; work for UH; or don't work. Not interested in the large corporate model of health care delivery, I left Cleveland and relocated with my family to Southwest Florida, where I have remained in private practice since 2002.

Having a primary care career in private practice has been a matter of survival of the fittest. My solo practice rapidly grew and within a few years, I was ready to bring on a partner, Dr. William Crouch. My practice was an early adopter of electronic health records (EHR), starting in 2003, because it made sense and helped us improve efficiency and workflow. As the government got into EHR regulation and certification, Washington regulations were now the driver of the EHR development, not the user experience. Our once affordable and helpful technology platform rapidly became an extremely costly, clunky and inefficient billing tool—a required burden that no longer had the ability to capture the nuances of the patient encounter.

As a Florida-based practice, we were very heavy in Medicare patients in our practice. Over the years, we seemed to play a continuous game of "whack-a-mole" with Medicare as CMS would change regulations that limited what services we could provide to our patients and cut off sources of practice revenue. Every time Congress used the phrase "stamping out fraud and abuse", came another several hundred pages of paperwork that we were required to complete and more staff were required to complete them.

The SGR payment adjustments became a constant source of fear, as half of our accounts receivables would often be uncertain due to Washington brinksmanship. We were a small business that had no way to keep our fiscal house in order because we had less and less control over what we spent our money on and no idea what our projected payments might be from Medicare. The SGR ordeal forced us to open a personal line of credit to make sure we could meet payroll the next time Washington froze Medicare claims processing. With Medicare patients comprising more than half our patients at the time, we were eventually forced to make the difficult decision to stop accepting new Medicare patients into the practice to minimize our exposure to the uncertainty.

Private practice consultants offered universal advice—see more patients. The 30-minute office visit for the complex patient became 15 minutes, then 7 minutes. Twenty-five patient visits per day became the new normal. Providing care to our patients in the hospital was no longer financially viable, as we needed to be in the office seeing more and more patients.

Through all of the complex regulatory changes in health care, two people have been forgotten—the patient and the doctor. We have created a "system" of primary care delivery that is so complex, it would make Rube Goldberg proud. We have become a reactive delivery care model of "sick care" that only seems to work for the hospitals, pharmaceutical industry and 3rd party payers. It is driving even further consolidation by hospitals. It is reducing the physician workforce by forcing physicians to choose early retirement or leaving the profession entirely. It is leading to physician burnout and an epidemic of physician suicide.

It is in this context that we had our "epiphany" in 2009.

Our Epiphany

Epiphany is a strange name for a medical company, but my partner, Dr. Crouch, and I had an epiphany. We were in the rat race of independent practice primary care, where you are trying to funnel the patients through as fast as possible, keep-

ing office visits to seven minutes, fighting with insurance companies to get procedures and medications approved. It ended up feeling like we were treating the chart and the computer and the insurance company but not providing good medical care. We decided there had to be a better way to do this.

It was about that time when a patient made a staggering suggestion.

He owned an air-conditioning business, and all 10 of his employees were patients of our primary care practice. And his insurance rates continued to climb sky high.

He said, "Why am I paying my insurance company to pay you? Why don't I just hire you directly to take care of my employees? I'll take out a catastrophic insurance policy on them and, even if they hit their deductible every year and I have to pay it, I'd still come out ahead and so would they." That was our epiphany, and the impetus for naming our practice *Epiphany Health.*

Why are we insuring primary care?

Why are we using an extremely expensive, extremely inefficient and incredibly impersonal insurance vehicle to finance the most basic aspect of health care delivery?

Why are we inserting so many barriers, financial or otherwise, between the doctor and the patient?

Our epiphany was that we are using health insurance wrong. We don't expect our homeowner's insurance to pay for blown light bulbs or routine maintenance. Imagine how complex and expensive it would be to purchase gasoline if we used our auto insurance to pay for fuel. This is what we expect from our health insurance, yet we are surprised that it is expensive, inefficient and impersonal. Our epiphany was that we should work towards making routine care affordable for everyone in a predictable, price transparent manner, without needing insurance. Let health insurance be true insurance—a hedge against an unexpected catastrophic loss. Out of that epiphany, we created what was to become one of the nation's pioneer **Direct Primary Care (DPC)** practices, Epiphany Health.

How It Works

We ended up creating a membership based primary care program for our patients ages 5 and up. Instead of charging fee-for-service for things we do in our office, we charge a flat monthly membership fee, and then we don't charge for anything that we do. That fee is $60 per month for adults, $25 for one child and $10 for each additional child. A family of four pays just $155 per month. Beyond that, we don't charge for anything we do in the office. No copays. No deductibles. We don't bill anything to any insurance company. It includes all necessary in-office testing and procedures such as EKG, holter monitors, strep testing, urine tests, blood thinner monitoring, minor surgical procedures, joint injections, abscess draining and more. The payment is made by automated electronic funds transfer, eliminating expensive labor-intensive invoicing and collections.

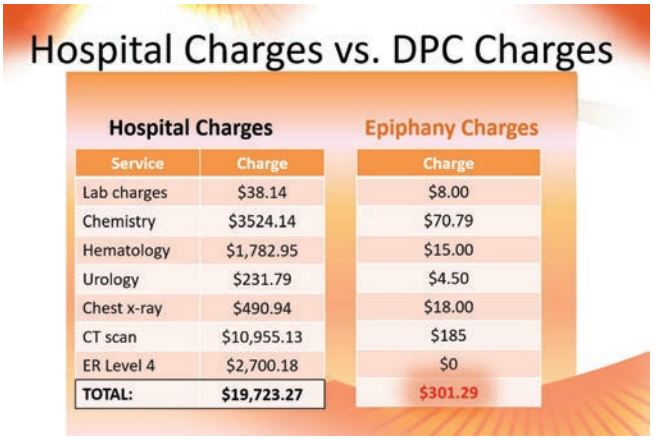
It is like Netflix for health care. After you pay your membership, you don't have to pay for each episode of care. Patients consume what they need at no extra cost, including unlimited email, text, phone calls or technology visits. Our practice finances were stabilized by a steady revenue stream that no longer required converting every patient contact into an office visit in order to get paid.

We determined what services outside our office a primary care doctor needed to do his or her job, without relying on a 3rd party to finance it. We needed access to affordable labs, imaging services, physical therapy, specialty care, pharmaceuticals, and durable medical supplies. Our office supplies were already relatively inexpensive. Mostly, in primary care we are just selling time. Managed correctly, that can be affordable.

We reached out to other practitioners and almost took a *Priceline.com* approach. I said, "If you have a CT scan machine, and it's not running all day long, and I could send a cash-paying patient to fill an open slot, payable at the time of service, what would you sell us your CT scan for?" With the labs, I said, "if we send you 500 patients, instead of billing the patients individually or their insurance companies—where you'd have to track them down for their co-payments or deductibles and wait 6 months to get paid—what if I collected from the patient when I gave them the order and you sent me one bill and I paid it, what could you sell me your services for?" We ended up buying labs and imaging wholesale, and the prices we got were ridiculously low—pennies on the dollar. We had eliminated their largest expense—labor costs and time for the purpose of collecting money.

As a result, Epiphany patients pay $175 for a CT scan. If that procedure were performed in an emergency room, it could be billed at $10,000. With Epiphany, an MRI costs $225. An x-ray costs $25. Physical therapy costs $35 per session, which is less than most people pay with commercial health insurance, where the co-pay is about $50. Routine bloodwork costs our patients $45. One of our first patients with rheumatoid arthritis was quoted $1,800 for blood work. Using our pricing, her blood tests were purchased for under $100. The savings from one blood test alone nearly paid for 2 ‡ years of her membership in our program.

As an example of the potential savings, I offer the following. In the figure below, I show the actual billed charges for a patient that went to the ER for abdominal pain. The total itemized bill came to just under $20,000. We have the ability to see patients urgently, because our schedules are not overly packed with patients. Actually, patients can often see us faster than they might be seen in the ER. Because we know the patients, we might eliminate the need for many of the ordered tests. Even so, we can also arrange for stat labs and imaging. Our actual cost for a patient without insurance for the exact same tests that the hospital billed $20,000 for is $301.29.



Of course, everyone knows that those services don't actually cost $20K, but most don't know that they can cost as little as $300. If the patient had no insurance or was with a self-funded health plan, they would have to negotiate the billed charges, maybe getting a 30—50 percent reduction payable over many years. If the patient had insurance, there would be a network discount applied, maybe discounted to $5,000. Often that $5,000 would be out-of-pocket due to deductibles.

What happens to that $15,000 "savings" for having insurance? In many cases, a percentage of that savings goes to the PPO for negotiating the discount. While one might think that a health plan is incentivized to find the best prices, they are often incentivized to find the highest charges with the biggest negotiated discount. In the end, it is the patient that bears the financial burden, especially those without insurance. In this example, the insured patient may pay $5,000 for $300 worth of medical care and pay a hefty insurance premium for that privilege. In either case, whether $5,000 or $20,000, the hospital is equally likely to not get paid and often both insured and uninsured patients declare bankruptcy. Timely and effective primary care access through DPC has great potential to reduce this financial impact.

DPC doctors have the ability to manage a myriad of chronic medical conditions such as diabetes, hypertension, heart disease or asthma. As long as it can be done within our four walls, there's no additional charge. Everything outside of our office, we offer complete price transparency. Most people nowadays have high-deductible health plans, and we are asking them to be cost-conscious consumers while shopping in a supermarket that has no prices on it. We put prices on everything. We even have negotiated transparent bundled surgical prices for inpatient and outpatient surgeries in 2 local hospitals. As physicians, we take a Hippocratic Oath to do no harm. That oath should include doing no financial harm. This allows us to

include cost and value in the conversation about the risks, benefits and alternatives of the patient's personal health care treatment approach.

In the 3rd party payment system of high volume care, primary care physicians are relegated to data entry clerks and referral agents. In this context, we do not adequately use the physician's skills. In a DPC model, because we don't have to bring the patient in for everything, it frees up our office time for more complex cases. Instead of 7 minute visits, a doctor may have 30—60 minutes to manage a complex illness. That allows family physicians to use the full-scope of their 22,000 hours of clinical training, rather than referring out patients simply due to lack of time. It also allows the practice to hire employees to provide patient care rather than paying employees to chase insurance requirements.

Doing primary care better prevents unnecessary downstream utilization, unnecessary referrals, unneeded consultations / tests / hospitalization / procedures / surgeries. Not through rationing, but through better care delivery and dedicating the right amount of resources to the right patient as determined by the doctor and the patient—not an arbitrary third party. Unfortunately, commercial 3rd party payers are financially disincentivized from reducing downstream utilization and spending because their profits are tied by the Medical Loss Ratio (MLR) to a percentage of that spending. They must grow spending to grow profits.

Although Epiphany's clients include small businesses, the patients who really benefit are those who slipped through the cracks of the Affordable Care Act. We are capturing those people who go to insurance exchanges, and they see the price tags and know they want it, but can't afford it, even if they may get penalized. We are even getting referrals from the Affordable Care Act navigators; they're sending patients in our direction. We often receive referrals of new patients from the charity clinics, health departments and emergency rooms. We have become the safety net's safety net for chronic disease management.

Epiphany has remained one of the last independently owned and operated primary care practices in the region—one of the few that haven't been bought out by large corporations. Despite the "skyrocketing cost of health care", our prices remain lower today than they were on the day we launched in 2010. Additionally, our negotiated prices for medical services outside our practice have largely remain unchanged over the same time period. In fact, many have come down through increased volume and competition.

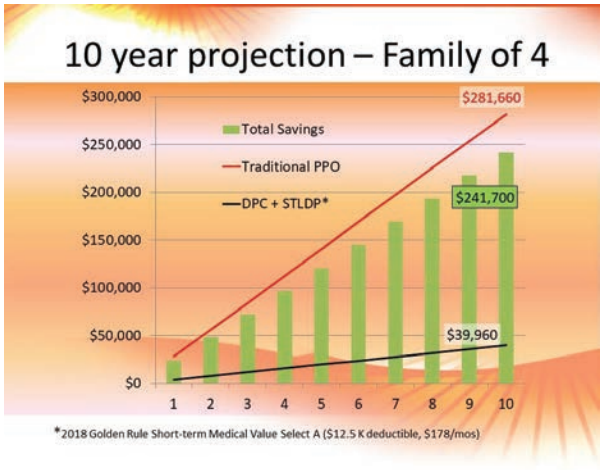
Patients without insurance sometimes drive hours to our practice. We see patients in our Southwest Florida practice from Miami, Orlando, and Naples. We have some that travel from out of state. They drive past nonprofit tertiary care facilities because they can afford what we are offering. One of our patients came to us from the Caribbean island of Antigua for treatment of thyroid cancer. Her thyroid surgery would have cost her $100,000 without insurance in the islands. We cured her once-in-a-lifetime catastrophic event for just over $10,000, including surgery, staging, specialty consultation, imaging, medications and 6 months of medical care.

The majority of our patients do have insurance, and we encourage all of our patients to have coverage. However, most plans today have high deductibles to meet or large copays. While the ACA allows patients with pre-existing conditions to get coverage, our practice population is evidence that coverage is not health care. The high deductibles often keep patients from accessing the care they need to prevent those chronic conditions from becoming more severe out of fear for what it may cost them. Even a patient with a subsidized bronze plan may have a $7,000 out-of-pocket financial exposure. Those patients seek out our practice to care for their chronic medical conditions, because the cost is predictable and transparent. Complex problems are no longer needing to be cared for in a short office visit because of fear of another $50 copay or the uncertainty of an unmet deductible. In fact, patients frequently pay much less for care outside our office using our negotiated prices than they would if they used their insurance. Patients commonly share that their responsibility for tests or surgery with insurance is twice the cost of our pricing without insurance.

What are we insuring if using that insurance doubles the out-of-pocket cost to the patient on top of the insurance premiums?

According to the *Milliman Medical Index,* in 2018, the cost of health care for a typical American family of four covered by an average employer-sponsored preferred provider organization (PPO) plan is $28,166. Of that, the employee contribution is $12,378 per year, with $4,704 being for out-of-pocket costs paid when using health care services. Using these numbers, an employer sponsored PPO for a family of 4 will cost $281,660 over 10 years (see figure below). A membership in Epiphany Health Direct Primary Care plus an underwritten short-term limited duration plan

would cost $39,960 over 10 years (assuming it were allowed to be renewed that long). The net difference is a $241,700 10-year potential savings for one family. To put that potential savings into perspective, the *average total household debt* in the US is under $135,000 for all age brackets, including a home mortgage. The potential savings is also 10-times what the same family of 4 is likely to take home from the recently passed *tax cuts.*



If the family became extremely ill and hit their deductible and maximum out of pocket every year for 10-years, it would still cost less than the PPO plan. The difference being that the PPO is loaded with built-in pre-paid benefits and no potential savings for services that are not needed or wanted. It is for this reason why our patients continually ask us how they can get affordable major medical plans to wrap around DPC. Of course, it is the fear of the $20,000 ER bill above that drives people to pay for an insurance product that may otherwise make no financial sense. And that patient from Antigua—her once in a lifetime catastrophic thyroid cancer was cured for less than the cost of one year of premium payments.

Using our program, we make routine and predictable care affordable. We also make unpredictable expenses affordable, even those once felt to be impossible to afford without insurance. We can't do anything for catastrophic illness, other than try to prevent it through good primary care and prevention. We are hopeful that Congress will pass legislation that will improve access to catastrophic only coverage. In the interim, we welcome the Administration's recent rule change expanding access to short-term medical plans. While far from perfect, they are an option that can bundle with a DPC membership to provide an affordable combination of access to routine care/chronic disease management plus coverage for catastrophic illness.

A National Movement

As it turns out, many practices around the country were having a similar epiphany at the same time. There were likely under a dozen practices developing a similar approach, now collectively referred to as **Direct Primary Care.** Practices in the state of Washington, Nevada, Virginia, North Carolina, Kansas, Pennsylvania and others began popping up and making waves. Some did not survive, while others thrive. Where there were likely less than a dozen DPC practices in 2010, there are estimated to be nearly 1,000 true DPC practices today. Most of that growth has been in the last 4 years, with an 800 percent growth in the number of DPC practices since 2014. Many of these practices can be found by going to *www.dpcfrontier.com/mapper.* These practices are now serving patients of all socioeconomic groups in rural, urban, suburban and inner-city settings in nearly every state. Some practices even include prenatal care and baby delivery in the membership.

DPC is frequently confused with "concierge medicine", which is often considered care for the affluent. DPC was born out of the concierge movement. While some may use the terms DPC and concierge interchangeably, DPC practices generally offer lower price points that most can afford. Much like airbags first appeared on luxury

cars, they are now standard safety features on even the most affordable vehicles. The national average membership fee for a DPC practice is approximately $70. Concierge practices also often still bill 3rd parties on a fee-for-service basis in addition to the membership fee, where a DPC practice usually does not charge extra beyond the membership.

DPC is frequently accused of skimming the "worried well" and healthy from the system, while leaving the sick patients for insurers and the government to care for. As it turns out, DPC practices tend to attract the opposite. Patients that are healthy have little interest in paying a recurring monthly fee for a service that they will rarely use. DPC practices tend to attract those with chronic diseases that are finding it difficult to navigate within our broken health care system, often bringing with them problems that have been neglected for many years.

Because of the efficiency of the DPC practice delivery model, it is no wonder that businesses are seeking to work with DPC practices to keep their employees healthy, especially those with self-funded health plans. As our "epiphany" employer realized, DPC is an affordable vehicle for small business owners to provide employee access to medical care, even if they cannot afford health insurance coverage.

I presently serve as the President of Docs 4 Patient Care Foundation. D4PCF is a national leader in educating physicians on how to set up a DPC practice. Our grant-supported national conference curriculum has helped train hundreds of physicians from across the nation at little to no cost for the physician attendee. We maintain a large video library of free content for those interested in learning more at *www.d4pcfoundation.org.* Our third annual DPC Nuts and Bolts conference, *November 1—3 in Orlando,* is on track to attract well over 300 attendees.

DPC doctors are a special breed of small business owners with an entrepreneurial spirit and huge heart. Unlike most competitive businesses, DPC practices are always willing to step up and help each other and help others. This was true in the case of Hurricane relief, where DPC docs started an effort that sent tens of millions of dollars in private medical supply donations to doctors in need, delivering medical supplies and medicines to damaged clinics in Texas, Puerto Rico and elsewhere. It was also true when several DPC practices in the Mid-Atlantic joined forces to pay off *$1.4 million in patient accumulated medical debt.*

Regulatory Relief

There have been several hurdles along the way for the DPC movement. Some of those hurdles remain. Simply put, the best way for Congress to support the DPC movement in restoring the health care system is to let it happen and not try to force it or stop it. The movement is transforming the health care landscape in many good ways. It is a non-partisan movement, supported by all but those that continue to do well in our current broken system.

Some have argued that physicians that enter directly into a contract with a patient for a defined package of medical services should be regulated as risk bearing entities and treated as insurance companies. Twenty-five states have seen differently and passed legislation defining a direct contractual relationship between a doctor and a patient as being exempt from regulation as an insurance product. These relationships are already heavily regulated by state boards of medicine and also fall under the regulation of standard contract law. To date, no state has legislated a contrary position.

While there is presently a pilot program for DPC currently under consideration by Center for Medicare and Medicaid Innovation (CMMI), many members of the DPC community have expressed concerns during the recent RFI. To be clear, many Medicare beneficiaries are already members in DPC practices and Medicare is enjoying those savings. However, in order for a doctor to legally contract with a Medicare patient outside of the traditional fee-for-service structure, the doctor must opt-out of Medicare entirely. That greatly limits moonlighting opportunities which can be critical to the success of a physician starting a practice in this model. The DPC movement would be helped tremendously if CMS and Congress were to adopt rules and regulations that allow doctors to develop DPC practices without having to opt out of Medicare.

Many DPC practices dispense wholesale medications direct to their patients, resulting in tremendous savings and improved compliance. In the example provided below, courtesy of Plum Health DPC in Detroit, a patient could easily save hundreds of dollars every month just through direct dispensing of generic medications. These savings alone often easily cover the DPC membership cost. While most states allow direct dispensing of medications by physicians, some states restrict the prac-

tice. Congress could improve affordability and access to medications by structuring incentives for states to allow physician direct dispensing of wholesale medications.

Which Pharmacies Have the **Best Rx Prices**?

To find out, Consumer Reports' secret shoppers called more than 150 drugstores across the U.S.—representing dozens of chain pharmacies, supermarket drugstores, and independent pharmacies—to compare prices for five commonly prescribed generic drugs. They included the diabetes drug pioglitazone (generic Actos, 30 mg); the painkiller celecoxib (generic Celebrex, 200 mg); the antidepressant duloxetine (generic Cymbalta, 20 mg); the cholesterol medication atorvastatin (generic Lipitor, 20 mg); and clopidogrel (generic Plavix, 75 mg), a blood thinner. The chart shows average discounted retail prices that pharmacies quoted for a one-month supply.

Plum Health DPC	$4.30	$6.47	$7.04	$2.09	$4.28	$24.18
RETAILER	**Pioglitazone** *Actos*	**Celecoxib** *Celebrex*	**Duloxetine** *Cymbalta*	**Atorvastatin** *Lipitor*	**Clopidogrel** *Plavix*	**TOTAL PRICE**
HealthWarehouse.com	$12	$22	$13	$10	$10	$66
Costco [1]	$16	$26	$35	$13	$16	$105
Independents [2]	$19 $10–$40	$34 $11–$295	$31 $20–$267	$15 $8–$187	$15 $8–$260	$107 $69–$1,381
Sam's Club [1]	$20	$38	$31	$20	$45	$153
Walmart	$132	$203	$123	$30	$30	$518
Kmart	$160	$185	$120	$35	$35	$535
Grocery Stores [3]	$113 $10–$349	$189 $48–$250	$170 $13–$223	$32 $11–$71	$36 $7–$224	$565 $69–$1,117
Walgreens	$167	$204	$251	$65	$65	$752
Rite Aid	$255	$194	$170	$128	$119	$866
CVS/Target	$270	$187	$195	$135	$141	$928

Direct Primary Care was included in Sec 1301(a)(3) of the Affordable Care Act as an acceptable minimum essential coverage that can be sold on the Exchanges when paired with appropriate wrap-around coverage. In 2014, Ranking Member Murray and colleagues sought clarification in *a letter to then IRS Commissioner Koskinen* about use of HSA dollars to pay for DPC memberships in support of a pioneer DPC practice in Washington state. *Commissioner Koskinen's response letter* established the IRS position that DPC was a health plan, contradictory to the ACA rules, not only disqualifying use of HSA dollars to pay for DPC memberships, but disqualifying DPC member patients from contributing to their HSA whatsoever. This single obstacle has served to greatly slow the uptake of DPC, particularly among the majority of Americans with an employer sponsored health plan. As a result, DPC is the only physician service in the country that is ineligible to accept HSA dollars for payment.

The U.S. House of Representatives recently passed *H.R. 6199.* Section 3 of that bill pertains to HSA use with DPC memberships. While we appreciate the importance of resolving this big issue, the language in the bill has some considerable flaws that make it less helpful, perhaps even harmful for the DPC movement at large. The original bill language introduced in Ways and Means contained a reference to a definition of primary care that was so narrow, likely less than one-third of primary care practices would meet the definition. Most importantly, the language would have unintentionally prevented DPC practices from including routine services such as women's wellness care in their memberships. Fortunately, that restrictive language was removed before passage by the House. However, after passage, Treasury felt that the change was a drafting error and advised reinserting the troublesome primary care definition reference.

Unfortunately, the bill fixes the wrong section of the Internal Revenue Code (IRC). The bill makes DPC an eligible *health plan* to use HSA dollars under IRC 223(d), instead of making it an eligible *health care expense* under IRC 213(d). By designating DPC as a health plan, it sets up conflict with the 25 states that have legislation declaring DPC is NOT a health plan. It also creates potential regulatory conflict in the remainder of states that do not have such legislative DPC clarification. It would be helpful if HR6199 or similar legislation was consistent with most opinion that DPC is not health insurance.

Despite DPC being the shining beacon for price transparency in American health care, the bill imposes the first-ever legislative cap on physician charges and potentially blocks DPC practices from accepting HSA dollars if they dispense medications. While we greatly hope to see this bill move forward in the US Senate, I welcome the opportunity to work with lawmakers to help make it a better bill, resolving the issues stated above.

Conclusion

Thank you for the opportunity to testify about the transformative potential of Direct Primary Care. This rapidly growing care delivery model has the ability to properly align the incentives of the doctor, patient and health care system in general. It eliminates third party intrusion into the private patient decisions and is a much needed change in providing critical access to all patients, regardless of insurance status or pre-existing conditions. I look forward to your questions and look forward to a continuing dialogue on regulatory and legislative changes to expand the positive impact and growth of Direct Primary Care.

[SUMMARY STATEMENT OF LEE S. GROSS]

In his testimony, Dr. Lee Gross highlights the challenges with government regulations, Medicare and commercial insurances that are driving the consolidation of independent medical practices and interfering with the physicians' practice of medicine. Over-burdensome insurance requirements, government regulations and heavy-handed policies are driving up costs of medical care. They are contributing to physicians' burnout, early retirement, or leaving the practice of medicine entirely. The third-party payment system is driving a wedge between the doctor and the patient, driving up costs and creating a critical access to care issue in the US.

After years in private practice in Florida, Dr. Gross and his colleagues had an "epiphany" about an affordable health care solution, free of insurance and government interference in the doctor-patient relationship. They asked a simple question, "Why are we using insurance to pay for primary care?" In 2010, they launched Epiphany Health, a pioneer Direct Primary Care (DPC) practice. Now, a DPC revolution is sweeping across the nation, providing access to health care for those who have been neglected by the system for decades.

The doctors contract directly with their patients for care, outside of the typical 3rd party payer arrangement, on a fixed monthly basis. This membership-based approach eliminates the need to use insurance to pay for primary care services. Adult Epiphany DPC memberships start at $60 per month and children cost as little as $10 per month. Beyond that, all necessary office visits, technology visits, in-office testing and procedures are included. There are no exclusions or increased prices based upon pre-existing conditions. The elimination of fee-for-service in this model dispenses with copays or deductibles, and removes barriers to access.

Direct Primary Care practices are providing care to patients of every socioeconomic background without regard to pre-existing conditions. They serve rural, urban, suburban, inner-city and critical access patient populations. The removal of barriers to access allows more effective management of chronic conditions. DPC doctors are treating these conditions at a cost that most can afford. Untreated, it would otherwise result in more serious morbidity and an economic burden on both the patient and society. Bundled with a high-deductible health plan, DPC provides a combination of affordable care for the routine and coverage for the catastrophic.

DPC doctors negotiate price transparent arrangements and make group purchases on behalf of their patients, passing through the savings without retail markup. This allows them to give patients wholesale buying power for labs, imaging, medications, surgical care and much more. Savings are frequently as much as 95 percent compared to standard charges.

DPC doctors harness the power of complete price transparency to allow real time incorporation of cost into the conversation about treatment options. That allows doctors to add "doing no financial harm" to their Hippocratic Oath. This price transparency allows market forces to take hold in communities, causing local practices to compete on price and quality as perceived and determined by the person receiving and paying for those services—the patient. As a result, Epiphany Health has seen almost zero inflation in the cost of health care services since their 2010 inception.

This testimony outlines examples of cost savings and how those can be extrapolated to the national health care economy. It offers suggestions for regulatory and legislative actions that could support the DPC movement, thereby increasing uptake and improved patient access to affordable medical care.

The CHAIRMAN. Thank you, Dr. Gross.

I am sure there will be lots of questions about that.

Ms. DeMars, welcome.

STATEMENT OF CHERYL DEMARS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE ALLIANCE, MADISON, WI

Ms. DEMARS. Thank you, Chairman Alexander, Ranking Member Murray, and Members of the Committee, for the opportunity to speak with you today.

I would like to share three approaches that Alliance members are using to control healthcare costs. The first is pooling our purchasing power to contract directly with providers. The Alliance was founded for this purpose.

We are not jumbo employers. Our average size is about 400 employers, but together, we spend $787 million every year on healthcare. I have four of our members here with me today—Wendy Culver from Mead & Hunt, Annette Mikula from Rock County, Brad Olm from Gordon Flesch, and Vikki Brueggeman from Zimbrick.

We contract directly with hospitals and clinics, creating a network of providers that gives our employees access to the doctors and hospitals they want to see at rates that are competitive in our market. We negotiate terms that are important to us, such as the right to share prices with our employees and to protect them from balance billing.

Our goal is to buy healthcare based on value, balancing quality and appropriateness with price. And since we know that no one health system is the best at everything, we include many providers to create competition on cost and quality.

We work to build partnerships with the hospitals and clinicians in our communities because we know that improving healthcare value is a team sport. We each have a role to play to create a healthcare system that costs less, delivers better results and better health for people, and is more rewarding in a humane environment in which to both deliver and receive care.

The second approach we employ is investing in high-value primary care. We know that primary care has the potential to make a significant positive impact on the health of our employees and on our total healthcare costs. Optimal high-value primary care delivers appropriate preventive care and helps people manage chronic conditions like diabetes when they occur. However, studies have shown that such evidenced-based care is only delivered about 55 percent of the time.

To address this gap, some employers are establishing their own primary care clinics. These clinics provide convenient patient-centered care. One such example is Flambeau, Inc., in Baraboo, Wisconsin.

Prior to opening their onsite clinic in 2012, Flambeau spent $7,900 per employee per year on healthcare and prescription costs. In 2017, 5 years later, after opening their onsite clinic, they spent $7,950, an increase of less than 0.5 percent. What is more, Flambeau's onsite clinic has had a positive impact on employee health. The clinic staff have identified hundreds of undiagnosed conditions, performed hundreds of preventive exams on employees who would not normally get them, and increased medication adherence for chronic conditions by dispensing maintenance medications.

The third approach is to move market share to high-value providers. One of the surest and fastest ways to improve the value of

healthcare is simply to use providers who deliver good care at a lower price. That is why we developed the QualityPath program. QualityPath encourages employees to use high-value providers for shoppable procedures and tests like hip and knee replacements, CTs, and MRIs.

Hospitals and doctors have to apply for the program and must prove the quality and appropriateness of their care based on national quality measures. They must also adopt practices that reduce unnecessary care and agree to a lower bundled price backed by a warranty. Employers encourage their employees to use these providers by reducing or eliminating their out-of-pocket costs. Since its inception 3 years ago, QualityPath has saved more than $1.5 million for our members.

We appreciate the opportunity to offer suggestions for Federal policy reforms, and my written testimony includes several suggestions that we believe would be beneficial.

Briefly, these include requiring Medicare to do more to make meaningful cost and quality information more readily available and to persist in its value-based purchasing policies. We need CMS to keep their foot on the gas. Also consider changes to the rules for health savings accounts to allow them to be used with value-based benefit designs and free access to worksite clinics. Repealing the Cadillac Tax, which penalizes employers for taking some of the steps I have described here today. And finally, clarifying wellness rules, so employers know the parameters as they design new approaches to improve employee health.

Thank you again for this opportunity, and I would be happy to respond to questions.

[The prepared statement of Ms. DeMars follows:]

PREPARED STATEMENT OF CHERYL DEMARS

Thank you Chairman Alexander, Ranking Member Murray and distinguished Members of the Senate Health, Education, Labor and Pensions Committee for the opportunity to speak with you today.

I am Cheryl DeMars, President and CEO of The Alliance. We are a not-for-profit health care purchasing cooperative owned by 240 self-funded employers that provide health benefits to more than 85,000 employees and their family members in Wisconsin, Illinois and Iowa. Our mission is to move health care forward by controlling costs, improving quality and engaging individuals in their health.

We appreciate this Committee's recognition that the cost of health care is a critical issue for our country. This is certainly true for our member employers and their employees. And while I will share examples of some of the successful strategies we are using, I also want to emphasize that reining in health care costs requires different actions from all health care stakeholders. Health care providers, insurers, purchasers/employers, consumers/patients and the government must make changes to co-create the type of health care system that this country deserves; one that costs less, delivers better results and better health for people, and is a more rewarding and humane environment in which to both deliver and receive care.

I would like to share three approaches we use to impact health care costs: (1) pooling our purchasing power to contract directly with providers, (2) investing in high value primary care and (3) moving market share to high value providers. Each of these strategies is enabled by having information with which to measure and compare cost and quality and then using that information to realign financial incentives to support required behavior change—topics this Committee has already heard about in previous hearings.

Pooling Purchasing Power to Contract Directly with Providers

The Alliance was founded for the purpose of uniting employers to contract directly with hospitals and doctors. We are not jumbo employers. We range in size from 60

to 8,700 employees, with an average of about 400 employees. But together we spend $780 million on health care every year.

We contract directly with hospitals and clinics, creating a network of providers that gives our employees access to the doctors and hospitals they want to see at rates that are competitive in our market. We negotiate terms that are important to us, such as the right to share prices with our employees and to protect them from balance billing. We build partnerships with the hospitals and clinicians in our communities, because we know that improving health care value is a team sport.

Our goal is to buy health care based on value — balancing quality and appropriateness with cost. Since we know that no single delivery system is the best at everything, our network includes many delivery systems and an increasing number of unique and innovative providers that specialize in bundled, high value care, such as NOVO Health and Twin Cities Orthopedics. These ambulatory surgery centers have developed business relationships with all of the providers needed to deliver care for these procedures, eliminating the "surprise billing" that can occur when a component of care is delivered by an out-of-network provider without the patient's knowledge.

Direct contracting has its limitations, however. Employers need to acquire expertise in health care billing and reimbursement in order to negotiate effectively with providers. Even then, cost shifting is rampant. While the rates we have negotiated are competitive in our region, they are still many times the Medicare rate. And we are not closing the gap between the prices we pay and the cost of health care in other countries with whom our members compete in their core business operations. Just managing the rate of health care cost increases is not enough. We need to spend less.

Consolidation among health care providers creates additional challenges. Health care systems that ostensibly become "too big to exclude" increase their bargaining power, which drives up the unit cost of health care, as many studies have shown. [1] [2] [3] And as decision-making, governance and dollars shift to corporate health care headquarters located elsewhere, we see less awareness of and concern for the needs of local employers and communities.

Investing in High Value Primary Care

We believe in the potential for primary care to make a significant positive impact on the health of our employees and on our total health care costs. Optimal, high value primary care delivers appropriate preventive care, accurately diagnoses and efficiently treats acute conditions, and helps people manage chronic conditions such as diabetes, when they occur. Studies have shown that such evidence-based care is delivered only about 55 percent of the time. [4]

To address this gap, some employers are establishing their own primary care clinics. One such example is provided by Flambeau, Inc., in Baraboo, Wis. In 2012, the year before Flambeau opened their onsite clinic, they spent $7,901 per employee per year on medical care and prescriptions. In 2017, five years after establishing their onsite clinic, they spent $7,950, an increase of only 0.6 percent.

In addition to stabilizing the cost of health care outside of the clinic, Flambeau's onsite clinic staff has identified hundreds of undiagnosed conditions, performed hundreds of preventive exams on employees who wouldn't normally get them and increased medication adherence for chronic conditions by dispensing maintenance medications, all of which improves health, increases productivity and decreases ab-

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[1] 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. Issued in December 2015, Revised in May 2018.*http://www.nber.org/papers/w21815*

[2] 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/*

[3] 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*

[4] Elizabeth A. McGlynn, "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, (June 26, 2003). *https://www.nejm.org/toc/nejm/348/26?query=article—issue—link*

[5] Sunita Desai, "Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees," Health Affairs 36, no. 8 (2017).*https://doi.org/10.1377/hlthaff.2016.1636*

[6] Nicole Ketelaar, "Public release of performance data in changing the behaviour of healthcare consumers, professionals, or organizations." Cochrane Database Syst. Rev., Nov. 9, 2011. *https://www.ncbi.nlm.nih.gov/pubmed/22071813*

senteeism. Two years ago, they added chiropractic care and low-cost massages, taking the employee appreciation of the onsite clinic to new heights.

Colony Brands provides free onsite clinic services to employees and dependents covered by its self-funded health plan in Monroe, Wis., and Clinton, Iowa. Working in partnership with a local health system, Colony's onsite clinic focuses on prevention and health coaching based on the results of the annual health risk assessment. The clinics serve 2,200 employees as well as 3,000 temporary employees. The Clinton clinic is staffed by a nurse practitioner and a certified medical assistant, while the Monroe location has two physician assistants, two certified medical assistants, an exercise counselor, a registered dietitian, and a pharmacotherapist who is available as needed. Patient satisfaction has remained at 99 percent or above throughout its six-year history with total cost savings of $4,290,000. But what can't be measured is the long-term impact, in dollars and in lives, of Colony's focus on preventive services and disease management for conditions like diabetes and high blood pressure.

Brakebush Brothers, Inc., Westfield, Wis., credits its onsite clinic for helping keep per-member costs for 2018 below its per-member costs for 2014, when the company began self-funding its health benefit plan. Employees can use the Brakebush Center for Health to access free primary and urgent medical care, have lab work done, fill common prescriptions, have physical therapy and rehabilitation, or get personal training, health coaching, hypnotism, chaplaincy care, or financial and legal services. This wide range of services responds to the full needs of an employee seeking health care. For example, an employee may schedule an appointment with a physical therapist to address knee pain. If the therapy resolves the issue, the physical therapist may refer the employee for personal training to build knee strength. But if therapy doesn't help, then the employee can be referred to a physician assistant, who may suggest the employee get a free MRI by using a provider who is part of Brakebush's Centers of Excellence. If the MRI indicates more care is needed, the employee can see the orthopedic surgeon who visits the Center for Health once a month. If the employee needs surgery, he or she will be referred to the Centers of Excellence program to get quality care and reduce out-of-pocket costs. Following surgery, the employee would return to the Center for Health for rehabilitation care. If the employee is suffering emotionally from coping with pain and recovery, they might also be referred to a chaplain, health coach or hypnotist.

Employer-based primary care clinics are also able to use data on cost and quality to refer patients to high value facilities and clinicians when appropriate. They are not obligated to refer only to a specific set of providers, as is typically the case for primary care clinicians who are employed by health systems.

Because many of our employers are too small for a workplace clinic to be a viable option, we are pursuing "shared-site" clinics as a collaborative effort among employers who are in close proximity to one another.

Finally, while onsite and shared-site clinics show promise to deliver better results at lower total cost, this "parallel universe" does little to improve the health care system in a community. For this reason, we are also developing new models to pay for primary care within the current system. Payments that are based on patient health status and the total cost of care, as opposed to traditional fee for service models, could be effective in building needed capabilities in primary care.

Moving Market Share to High Value Providers

One of the surest and fastest ways to improve the value of health care is to simply use providers who deliver good care at a lower cost. This strategy depends on the availability of information with which to compare cost and quality, which is often lacking. It also assumes that consumers will respond to information by choosing high value care. Our experience reinforces what published studies[5][6] have shown: simply sharing information with consumers is insufficient to drive change.

QualityPath®

The Alliance is overcoming these barriers through our QualityPath® program. QualityPath encourages employees to use high value providers for "shop-able" sur-

[5] Sunita Desai, "Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees And Retirees," Health Affairs 36, no. 8 (2017).*https://doi.org/10.1377/hlthaff.2016.1636*

[6] Nicole Ketelaar, "Public release of performance data in changing the behaviour of healthcare consumers, professionals, or organizations." Cochrane Database Syst. Rev., Nov. 9, 2011. *https://www.ncbi.nlm.nih.gov/pubmed/22071813*

geries and tests, like knee and hip replacements, CTs and MRIs. QualityPath is a voluntary program whose promise is better outcomes and lower costs for employees and employers and increased market share for providers.

Hospitals and doctors that want to participate must share physician-specific outcomes on national quality measures, and must meet or exceed national standards. They must also adopt practices that reduce unnecessary care and agree to lower-priced bundled payments backed by a warranty on their care. Employers share their savings by providing incentives that lower or eliminate the out-of-pocket cost for employees when they choose a QualityPath provider for an eligible service.

More than 50 employers who provide health benefits to 27,000 employees and their family members are enrolled in QualityPath today. Since its inception three years ago, QualityPath has saved more than $1.5 million on total hip replacements and knee replacements in an inpatient setting, as well as outpatient CT and MRI scans. Employers save an average of $12,000 per surgery, while savings on scans average 20 percent. We are in the process of expanding the program to add colonoscopies.

As is our intent, QualityPath's impact extends beyond the care received by members of The Alliance. To meet eligibility requirements for QualityPath, hospitals and physicians must demonstrate that their standard of care for all patients meets the requirements of the program. This includes patient-centered and cost-saving measures to ensure care is appropriate to begin with and ultimately what the patient wants, once informed of their choices.

Incentives to use low cost providers

While information to assess and compare quality may be generally lacking, because our employer-driven contracting standards require transparency, Alliance members can know the cost. And it varies tremendously. For outpatient services such as imaging or laboratory services, contrary to Medicare, we routinely experience a five-fold to seven-fold variation in price for the same service among in-network providers and a three-fold to four-fold variation in price within metropolitan regions for the same service. For instance a simple MRI of the lower leg can cost anywhere from $950 to $4,750 within 25 miles of Madison.

This wild variation is not unique to our market and our organization, but is observed across the U.S. and the commercial insurance marketplace. 1A[7] Alliance members believe that directing care based on cost and quality is the gold standard. However, for care that is largely commodity-based, when quality information is not available or is withheld, it would be irresponsible to ignore differences in costs. We don't believe doing so serves consumers either, given that 40 percent of American households have $400 or less in cash on hand. 1A[8]

In these cases, some Alliance members are using plan design or other financial incentives to encourage the use of lower cost providers. For example, Colony Brands in Monroe, Wis., developed its Smart Choice program to offer financial incentives for employees to use freestanding MRI facilities, which offer savings of thousands of dollars on a single MRI scan when compared to a hospital setting. Employees get $250 for choosing to use a designated freestanding facility instead of a hospital for an MRI scan.

Recommended Federal Policy Reforms

We appreciate the invitation to share our perspective on federal legislative and administrative policy reforms that would stimulate innovation with respect to employer sponsored health coverage, leading to lower health care costs and a healthier workforce and population. We concur with the recommendations shared with this Committee at its hearing on July 17, 2018, by Mr. David Lansky, President and CEO of The Pacific Business Group on Health. In addition, The Alliance has identified five priority policy areas for your consideration.

1. Make timely information on health care cost and quality more available so that employers and their employees can understand and use the information.

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[7] 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. Issued in December 2015, Revised in May 2018.*http://www.nber.org/papers/w21815.*

[8] Report on the Economic Well-Being of U.S. Households in 2017, Board of Governors of the Federal Reserve System, May 2018, p. 2. *https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-us—households-201805.pdf*

2. Repeal the Cadillac Tax.
3. Enable employers to offer HSAs in addition to value-based benefit design components, such as free access to onsite clinics, and co-pay and deductible waivers for high value care.
4. Clarify wellness rules.
5. Maintain momentum of value-based payment policies.

1. Make timely information on health care cost and quality more available.

Employers, consumers and health care providers all need increased transparency of information on cost and quality. When information is more widely available, and easier to understand and use, it drives healthy competition as providers see how they compare to their peers or to national standards. It is fundamental to employer purchasing decisions that are based on value—quality, as well as cost. It enables employees to choose health care services, providers and settings that are safe, high quality and affordable for themselves and their families.

While many self-funded employers can access information about the services their own employees receive, information to measure and compare all of the care that a particular hospital or physician provides is spotty, at best. Some states mandate health care data reporting by providers while others do not. Different reporting programs may use different measures or methodologies, making it difficult to compare one provider to another. Where voluntary reporting mechanisms exist, participation by providers is incomplete.

In Wisconsin, we have experienced both the successes and limitations of voluntary, private-public transparency partnerships. The *Wisconsin Collaborative for Healthcare Quality* (WCHQ) is a provider-led, multi-stakeholder measurement, public reporting and practice transformation initiative. WCHQ has been successful in measuring and reporting important measures of ambulatory care since its inception in 2003. Not only does WCHQ provide an important source of publicly reported, comparable performance information, but public reporting has served as a catalyst to spur improvement as well. Yet more than 30 percent of ambulatory care providers have chosen not to participate in WCHQ, making it difficult to get a comprehensive picture.

Wisconsin also led the way in creating a voluntary all-payer claims data organization known as the *Wisconsin Health Information Organization* (WHIO). WHIO was founded in 2005 and today captures at least one claim on nearly 76 percent of the state's population. Through WHIO's data mart, we are able to see wide variation in health care performance and resource use that occurs even in a state that consistently ranks in the top five for overall health care quality. Yet, being a voluntary organization presents challenges as some payers refuse to participate and concerns over disclosing contracted amounts have thus far thwarted efforts to create a true measure of the total cost of care.

Voluntary measurement and reporting initiatives such as these are an important start to providing the information needed to create better value health care. However, these Wisconsin-based resources do not shed light on the cost or quality of health care in Illinois or Iowa. Those states do not have similar initiatives in place. Having to take a state-by-state approach to transparency is cumbersome and unwieldy for employers. It can be confusing and frustrating for patients who live in and receive care in areas with less information available.

We need a national framework that establishes at least some minimum threshold of information that is publicly available across all regions of the country. There are promising steps being made toward this end and we urge that these be strengthened and continued:

- The Medicare Qualified Entity Program has increased access to Medicare data, but there are gaps, as not every state has a Qualified Entity that is able to receive and share the data.
- The recent CMS guidance to hospitals requiring that they publish their standard charges online will stimulate conversation; however, consumers need to know what their out of pocket costs will be.
- The Patients Right to Know Drug Prices Act of 2018 that prohibits the "gag clauses" used in contracts to prevent pharmacies from telling consumers if their prescription drugs are cheaper if they pay out of pocket versus through their insurance plans.
- Senator Cassidy's bipartisan Health Care Price Transparency Initiative, which is working to incorporate real world experience and evidence-based policies with the aim of improving price transparency and lowering costs.

2. Repeal the Cadillac Tax

Employers are the largest sponsors of health care coverage for Americans. And the biggest threat to employer sponsored health insurance is the Cadillac Tax. Ironically, many of the steps employers are taking to reduce their health care costs, such as workplace clinics and wellness programs, will be penalized by the Cadillac Tax.

While the recently approved delay of Cadillac Tax implementation is welcome, most businesses have a benefits-planning window of 18 to 24 months. Without a full and permanent repeal of the tax, employers will be faced with taking steps now to manage this risk by reducing benefits or passing increases on to their employees.

3. Enable employers to offer HSAs in addition to value-based benefit design components, such as free access to onsite clinics, and co-pay and deductible waivers for high value care.

By incorporating Health Savings Accounts (HSAs) into benefit plan designs, employers encourage their employees to plan and save for their future health care needs. HSAs have become an important tool to promote employee engagement and health care consumerism.

At the same time, the restrictions associated with HSAs inadvertently undermine some of the important innovations previously described. For instance, Alliance members with HSA plans are prohibited from waiving co-pays and deductibles for the QualityPath program. They also must charge the fair market value of services received in their workplace clinic, when they would prefer to make these services available to their employees at no cost. We ask that Congress direct the Department of Health and Human Services (DHHS) and the Internal Revenue Service (IRS) to explore increasing the caps on HSAs and expanding the flexibility of HSA dollars.

4. Clarify Wellness Rules

The Affordable Care Act changed ERISA rules to enable employers to incentivize employees to participate in voluntary "health-contingent" wellness programs. Employers were allowed to create incentives valued at "up to 30 percent of the cost of the employee health coverage." Use of financial incentives has increased participation in programs and has helped employees make positive lifestyle changes. Janet Mezera cited the support she received from her Alliance-member employer, Miniature Precision Components in Walworth, Wis., as a key factor in changing her eating habits and making fitness part of her life. With help from Miniature Precision Components' wellness program as well as its onsite medical clinic, Ms. Mezera made changes that got her blood sugar under control, reduced her cholesterol levels and relieved her knee pain so she could stop using a handicapped parking space. Her transformation was recognized when she received the Wisconsin Wellness Council's 2016 Light of Wellness Award in the Healthy Behaviors Category. Miniature Precision Components' benefit plan includes a wellness incentive that rewards employees for healthy behaviors. The company offers wellness programs that are accessible to all employees regardless of location or working hours as well as onsite primary care clinics at five facilities.

Unfortunately, last year a federal court struck down these EEOC rules, citing that 30 percent was too great an incentive to be considered voluntary. The court remanded the EEOC to rewrite wellness program rules to meet a voluntary threshold, but the court's order did not define "voluntary". Current EEOC rules will expire at the end of 2018, yet to date, the EEOC has not issued new rules. Without clear guidance, employers risk running afoul of the EEOC. To avoid this risk, some employers are pulling back from the use of meaningful and effective incentives to encourage good health habits.

We ask Congress to direct the EEOC to adopt new wellness program rules so that employers can move forward with programs that offer meaningful incentives to employees who proactively make healthy lifestyle decisions.

5. Maintain momentum of value-based payment policies

The most significant step Congress can take to drive better value health care is continued reform of its payment policies to create incentives for better care at lower cost. Because the federal government is the largest purchaser of health care, any efforts by DHHS and CMS to redesign how health care is paid for will influence a "new normal" for all consumers. Medicare accounts for 30 percent of hospital revenue in Wisconsin and 41 percent of revenue in Illinois. A change in Medicare payment policy gets immediate attention from the provider community and can crowd out payment and delivery reform efforts at the regional level. Therefore, it is important for CMS to consider how its payment policies will impact the cost and delivery of care for all patients, not just Medicare recipients.

While CMS has continued with some payment innovations adopted by the prior administration, including the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative, in other cases the agency has slowed down payment reform initiatives, narrowed their scope and reduced their targets.[9] Market-based health care transformation requires public-private sector alignment and persistent use of strategies that are showing promise.

We urge Congress and DHHS to stay the course and continue to pursue aggressive payment reforms even as providers and other health plan sponsors object and raise concerns. While these concerns should be considered and worked through, reducing cost in health care means reducing revenue for some in the health care system. Businesses, their employees and the government itself as a health care purchaser simply cannot continue to shoulder year after year health care cost increases that outpace inflation. Reforms are needed. They will not be easy, they will often be unpopular with health care providers, drug companies and some plan sponsors, but they are essential.

Thank you for this opportunity to share the perspectives of our member companies with this Committee. I would be pleased to provide additional information on any of the points I have raised, and I look forward to sharing more about The Alliance's innovative work.

[SUMMARY STATEMENT OF CHERYL DEMARS]

Employer Innovations that Reduce Health Care Costs

The Alliance is a not-for-profit health care purchasing cooperative owned by 240 self-funded employers that provide health benefits to more than 85,000 employees and their family members in Wisconsin, Illinois and Iowa. Member employers range in size from 60 to 8,700 employees, with an average of about 400 employees. The cost of health care is a critical issue for these employers and their employees.

We are using three approaches to impact health care costs.

1. Pooling our purchasing power to contract directly with providers enables us to create a network of providers that gives our employees access to the doctors and hospitals they want to see at rates that are competitive in our market. Our goal is to buy health care based on value—balancing quality and appropriateness with cost. We build partnerships with the hospitals and clinicians in our communities, because we know that improving health care value is a team sport. Provider consolidation is a threat to this strategy.

2. Investing in high-value primary care—primary care has the potential to improve health and lower costs, but our current delivery system often falls short of this promise. To close this gap, some employers are creating workplace-based primary care clinics with great success. The Alliance is pursuing "shared-site" clinics to help smaller employers enjoy these same benefits. We are also developing new payment models to encourage high-value primary care within the delivery system.

3. Moving market share to high value providers improves value by using providers who deliver good care at a lower cost. The Alliance *QualityPath*® program has used this strategy to save more than $1.5 million in three years on total hip replacements, knee replacements, and CT and MRI scans. Hospitals and doctors apply for the program and must prove the quality and appropriateness of their care on national quality measures. They must also adopt practices that reduce unnecessary care and agree to a lower bundled price backed by a warranty. Employers encourage their employees to use these providers by reducing or eliminating their out-of-pocket costs.

To support these strategies and other employer efforts, The Alliance asks the Senate HELP Committee to consider five priority policy issues:

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[9] Cunningham, Paige Winfield, "The Health 202: Trump administration pulls back from key Medicare goals." The Washington Post, Feb. 20, 2018. *https://www.washingtonpost.com/news/powerpost/paloma/the-health—202/2018/02/20/the-health-202-trump-administration-pulls-back-from-key-medicare—goals/5a8737f430fb047655a067d4/?noredirect=on&utm—term=.af6046f5927c*

1. Make timely information on health care cost and quality more available so that employers and their employees can understand and use the information.

2. Repeal the Cadillac Tax.

3. Enable employers to offer HSAs in addition to value-based benefit design components, such as free access to onsite clinics, and co-pay and deductible waivers for high value care.

4. Clarify wellness rules.

5. Maintain momentum of value-based payment policies.

We urge Congress and the Department of Health and Human Services (DHHS) to continue to pursue aggressive reforms that make it easier for Alliance member employers, and their employees and families, to understand the full picture of health care cost and quality, provide high-value primary care in convenient settings and adopt value-based benefit designs and payment strategies.

The CHAIRMAN. Thank you, Ms. DeMars.

Mr. Constantine, welcome.

STATEMENT OF DOW CONSTANTINE, EXECUTIVE OF KING COUNTY, SEATTLE, WA

Mr. CONSTANTINE. Thank you, Chairman Alexander, Ranking Member Murray, Members of the Committee. Thank you for the opportunity to speak with you today.

I am Dow Constantine. I am the elected executive of Martin Luther King County, which you would know better as the Greater Seattle Area. King County delivers vital regional services—including housing, transit, criminal justice, public health—for nearly 2.25 million people.

King County reduced healthcare costs and also worked upstream to prevent those costs in the first place through our work as the public health provider and our early childhood initiative, which we dubbed "Best Starts for Kids."

My written testimony provides more detail of our unique vantage point as both a purchaser of healthcare for our 15,000 workers and their dependents and a provider of public health services.

Our story illustrates that to succeed in moving forward with a more affordable, high-quality, and prevention-oriented health system, you need partnerships. Patients and providers. Management and employees. Employers and health plan administrators. And partnerships between the public health system and healthcare delivery systems.

Managing the rising costs of employee healthcare is an ongoing challenge. Last year, King County spent over $235 million on employee healthcare. In the early part of the century, as employers around the nation faced skyrocketing healthcare costs, King County responded with two key actions.

First, we convened the region's purchasers' health plans and providers and jointly tackled cost and quality problems. We founded what is now known as the Washington Health Alliance, whose vital work to increase transparency this Committee heard about in a hearing, I believe, last month.

Second, we approached our labor partners—and this was critical—the folks with whom we negotiate benefits, and together, we sat down and designed high-quality, lower-cost health plans with a local HMO that is about a third cheaper than our traditional

plan. And we also put in place a wellness initiative, as Senator Murray mentioned. It was called Healthy Incentives, and participating employees received lower out-of-cost—lower out-of-pocket costs.

Over a 5-year period, we did save about $46 million, and our approach did earn us—and we are quite proud of this—a 2013 Harvard Innovations in Government Award. That alone, though it hangs on my wall in my office even today, was not enough. So, by tracking data, we realized that most of the savings that we could yield from this first set of efforts had plateaued, and we wanted to do more. So we sharpened our focus on achieving value rather than volume and building off lessons from private sector leaders like Boeing.

This year, we added a new value-based plan choice for employees, Accountable Health Networks. Enrollment in value-based plans—that is the HMO that I described earlier and in our Accountable Health Networks—has grown from 21 percent of our employees in 2011 to 37 percent today, and we have a goal of reaching three quarters of our total employees being enrolled in those value-based plans within the next 5 years.

Our new approach focuses on building an overall culture of health. Going beyond the typical calls to eat less and exercise more. Most important, we have taken a public health approach to employee healthcare by tailoring efforts to our diverse workforce.

For example, nearly 5,000 transit employees work at King County. And as it turns out, compared to our other county workers, this group, our bus drivers, in large part, were much less likely to have had a recent dental checkup. Nearly one out of three had not visited a dentist in over a year.

We worked with the transit union and with our dental carrier to design a 6-month pilot in which we are reducing cost sharing, going out to the bus bases where folks are working, offering scheduling help, and taking other steps to help our workers find a dentist that is right for them. This will help avoid not just cavities, but future costs for us and our employees.

As we look ahead, I would like to highlight three areas where Congress' attention would help foster continued innovation to manage healthcare costs, very briefly.

First, the Federal Government should continue to use its significant purchasing power to accelerate strategies that pay for value over volume and increase transparency and help all payers better align their efforts, focusing on the pharmaceutical industry in particular.

Second, I urge you to increase investments in prevention, both public health and behavioral health. Ben Franklin was right when observed that an ounce of prevention represented the best value proposition.

Finally, we ask that you work to protect the gains in coverage, care, and prevention of the ACA. Over time, access to a healthier workforce can help employers—big employers like King County and others across the region—better fulfill their missions and strengthen our competitive edge.

I thank you so much for having this hearing today on this very serious topic, and I look forward to your questions.

[The prepared statement of Mr. Constantine follows:]

PREPARED STATEMENT OF DOW CONSTANTINE

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to testify before you regarding innovation and the affordability of health care. It is an honor to be invited to participate in today's discussion.

My name is Dow Constantine. I currently serve as the nonpartisan King County Executive in the state of Washington, an office I have held since November 2009. I previously served as a member of the state Legislature, and of the Metropolitan King County Council.

King County is home to 2.2 million residents, and the County employs a workforce of approximately 15,000 employees to provide our region with such services as parks, public transit, corrections, courts and legal services, human services, elections, wastewater treatment, property tax services, records, and public health, among others. We are also the local government for our unincorporated communities, providing animal control, land use regulation, police protection, and roads services. Approximately 80 percent of our employees are represented by labor unions.

Commitment to a culture of health

King County has long recognized that good health is a fundamental underpinning of our region's prosperity. We contribute to better community and individual health through many roles: we serve as the local public health jurisdiction, responsible for promoting and protecting the health of our residents; we lead the community mental health and substance abuse systems; and we address social determinants of health through our innovative work in such areas as housing, early childhood, transportation, economic development, and the promotion of equity and social justice. As the thirteenth largest employer in the state, King County's other key role in health is the support we provide to advance the physical, mental, social, and financial health of our workforce. We purchase health care services for employees and their families, foster a safe working environment, provide workplace health and wellness programs, take action to reduce harmful levels of work and life stress, and actively address racial, ethnic, and gender inequities.

One of the greatest challenges we face as an employer is the high and rising cost of health care: we currently spend about $235 million per year. The high costs of health care not only take away from other investments we could make in our workforce in the form of wages and other benefits, it impedes our ability to invest in other regional priorities. Like most employers, King County continually seeks to balance the provision of a competitive benefits package to attract and retain employees, with the need to manage rising costs and get the most value from every tax dollar. These conditions have led us to become champions of Triple Aim [1] approaches—both for our own employees and for the region as a whole—through which we strive to improve the patient experience of care, improve the health of the population, and reduce per capita health care costs.

My testimony today shares highlights of how the County's innovative work and partnerships have evolved over the past 15 years and what we have learned, and calls attention to how Congress could best help us continue to innovate and be part of the solution to our national health care crisis.

Early innovations and their results

In the early 2000s, health care costs were rising at three times the Consumer Price Index, threatening to double the cost of the County's self-insured medical plan in less than seven years. Recognizing the complexity of the problem, King County knew that it had little ability to influence the situation by itself. The County convened and founded the Puget Sound Health Alliance in 2004, a purchaser-led coalition which would go on to win national recognition for its work publicly rating the quality of regional health care providers, advocating for the alignment of payment systems that reward quality over volume, and increasing transparency. The Puget Sound Health Alliance later expanded its work statewide and is now known as the Washington Health Alliance.

[1] The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts *(www.ihi.org)*.

A second area of focus during this time was the work that occurred between King County and the labor unions that represent a majority of our workforce. The financial crisis we faced might have taken the expected adversarial route of "who's going to get stuck with this bill"—but that was not the case. Instead, we saw it as a shared challenge, one that led us to roll up our sleeves, learn together, and design a set of strategies to curb costs without significant shifting of costs to employees or making substantial reductions in benefits. And in 2005, King County reached a historic agreement with labor unions to overhaul the medical plan design. Instead of charging premiums, the County offered lower out-of-pocket expenses for employees' participation in wellness activities under a program known as Healthy Incentives. Participants received a substantial reduction in out-of-pocket expenses for taking a health risk assessment and even lower for participating in an action plan targeting behavior-related health risks. The incentive was never tied to outcomes, only to participation.

In addition, the County built cost differentials into the benefit plan designs to motivate employees to choose higher quality healthcare. Member out-of-pocket expenses were set considerably lower for the Group Health Cooperative HMO plan (now Kaiser Permanente) than for the Preferred Provider Organization (PPO) plan. As a result, membership in the HMO grew by more than 8 percentage points. Group Health's care system not only cost less, it had the highest quality ratings in public reports from the Puget Sound Health Alliance measuring area providers' adherence to evidence-based medical practices.

Taken together, these changes led to an estimated $46 million in avoided costs from 2007 to 2011.

- $6.5 million from employees electing to shift to higher quality, lower cost health care plan
- $14.6 million from improved health (projected savings from employees' healthier lifestyles, include a reduction in smoking rate from 11 percent to 6 percent, and significant weight loss)[2]
- $24.7 million from benefit plan design changes (increased employee cost sharing in the PPO plan, and lower utilization of services that accompanied that)

In 2013, King County received an Innovations in American Government award for Healthy Incentives from Harvard University's Kennedy School of Government.

Expansion of value-based purchasing in employee health care

Through the federal Centers for Medicare and Medicaid Innovation (CMMI), Washington State was granted a State Innovation Model Award in 2015 to help accelerate health transformation, including payment and delivery system reform. Under the Healthier Washington initiative, their work involves testing several payment redesign strategies, including offering an accountable care health plan for the state's public employees. Early on, they shared their lessons and tools openly with King County, encouraging us and other purchasers, both public and private, to adopt a similar value-based payment model.

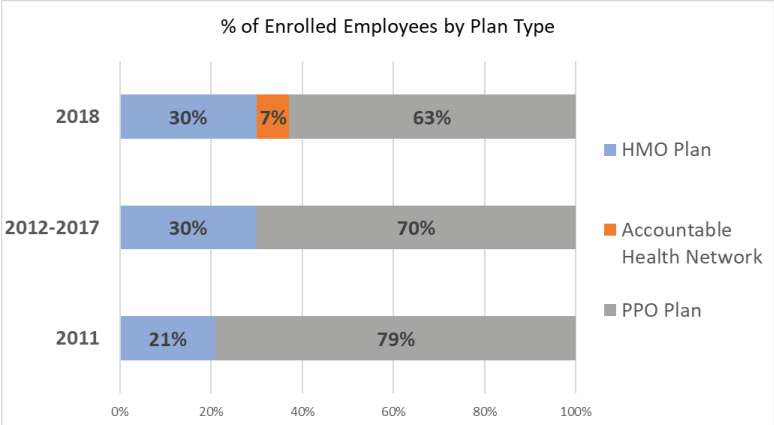
King County took up this call to action, a natural next step that built upon our previous efforts. While enrollment in the high value Kaiser Permanente HMO plan was remaining steady at 30 percent over the years, we needed new tools that would better engage members of the PPO plan. With labor partners, we articulated a vision for what we hoped to achieve through adding accountable health networks, and learned the details of how our dollars would play a role in rewarding these integrated care systems for meeting certain quality, patient experience, and financial targets. Accountable Health Networks had become available as a product through our PPO third-party administrator, Regence BlueShield, and we rolled it out to employees in 2018. To encourage employees to consider the Accountable Health Networks, we invested heavily in communications to explain the new option and help them understand all their choices. As an incentive to consider the new plan, a portion of the deductible was waived for the first year.

Enrollment into the Accountable Health Networks exceeded our expectations, with 7 percent of employees electing it in 2018—about 1,800 covered lives. This brings to 37 percent the employees now enrolled in a value-based plan (that is, either Kai-

[2] Scoggins, JF, Sakumoto, KN, Schaefer, KS, Bascom, BB, Robinson, DJ, Whalen, CL. Short-term and Long-term Weight Management Results of a Large Employer-sponsored Wellness Program. JOEM. 2011, 53(11) 1215—1220

ser Permanente or the Accountable Health Network), and we have a target for 2019 to move this to 44 percent.

The Accountable Health Network is lower cost both for the County and for our employees compared to the traditional PPO. Over a two-year period, a 10 percent enrollment shift into the accountable health plan is expected to yield about a half million dollars in savings. Most important, we are contributing to the needed infrastructure and clinical process changes that will help provider systems reach their goals to deliver more efficient, effective, and prevention-oriented care over time.



Looking ahead, our long-range goal is for 80 percent of our health care payments to be linked to quality and value within the next five years. Strategies we intend to explore in the years ahead include incorporating the use of Centers of Excellence and bundled payments, increasing the availability and use of telehealth services, and focusing more on intensively on driving improved access to and the quality of mental health services. Network and plan design strategies that will help reduce the use of unnecessary and low-value care are other key areas of interest, especially in light of recent information regarding the extent of waste here in Washington. [3]

Modernizing the workplace health promotion and well-being strategy

Over 2017—2018, we also evolved the Healthy Incentives program, removing the 10-year-old incentive structure that linked participation to one's out-of-pocket costs in their health plan. Our commitment to continuous improvement led us to recognize that the approach was no longer producing optimal value either in terms of avoided costs, or for our employees in terms of supporting their overall well-being. We were increasingly mindful that a segment of our employees—especially those in lower socioeconomic groups—were facing barriers to participation and thus paying more for their health care than other employees.

We are now shifting to a more inclusive approach to how we invest in our employees, widening our lens to embrace the important ways that our larger practices as an organization—such as how work is organized, our leave policies, support for financial literacy, our equity and social justice efforts—contribute to a culture that affects health and well-being. Emerging work from the Robert Wood Johnson Foundation and Global Reporting Initiative has begun to more clearly document the positive, proven health and business outcomes associated with specific business practices, and the value of building a culture of health for business. [4]

As we modernize our approach to workplace health programs and policies, we are also taking a lesson from the public health playbook. While the King County region on average enjoys good health, there are significant differences by place, race, and income. In King County, life expectancy varies greatly by neighborhood, with gaps

[3] First Do No Harm: Calculating Health Care Waste in Washington State. Washington Health Alliance. February 2018.*www.wacommunitycheckup.org*

[4] A Culture of Health for Business Stakeholder Consultation Draft. August 2018. Accessed 9–9-2018. www.globalreporting.org/cultureofhealthforbusiness

of more than 10 years between neighborhoods with the highest and lowest life expectancies.[5] An understanding of the extent of these disparities led public health partners to foster a much more tailored approach to working with communities to support them in their health improvement goals.

Similarly, we find that health concerns and opportunities vary greatly across subgroups of our employees. In a recent study regarding the health of low socioeconomic status employees, researchers found that many employers are reluctant to discuss anything related to employee socioeconomic status, income, or education, including how employees in different job roles might experience different barriers. They noted that "at a time when companies are investing increasing amounts in workplace health promotion, company reluctance to consider differences between groups of employees is counterproductive for their efforts to improve employee health."[6]

King County, by contrast, is leaning in to better understand and respond to these differences. An example of one way we're being more responsive to the diversity of our workforce is the creation of a workplace health improvement fund to which employee teams may apply for modest funds for projects to strengthen health, safety, and well-being in their worksites. One of the hallmarks of successful workplace health promotion is the extent to which employees are involved in its development, and have a stake in its design and direction.[7] Another example is the work underway with our transit employees. We realized that, compared to other County workers, this group was much less likely to have had a recent dental check-up—nearly 1 out of 3 had not visited a dentist in the past year—a situation which can lead to more costly problems down the road. So we worked with the transit union ATU 587 and our dental carrier, Delta Dental, to co-design a six-month pilot in which we are reducing cost sharing, offering scheduling help at bus bases, and taking other steps to help workers find a dentist that's right for them. *See Attachment A for an example of a poster we posted at bus bases.*

Finally, we are taking steps to increase the extent to which our employees are active participants in their own care and able to understand how health coverage works. We want our employees to be better shoppers of health care, to establish a primary care provider relationship, to feel confident in talking with their care team, to be an active participant in decisions that affect them, and to avoid low value and unnecessary care.

In the near term, we anticipate returns on this investment will manifest as more engaged employees, reduced stress, greater productivity and retention, and more regular engagement in preventive and primary care services. Will it impact health care costs and outcomes? Taking the long view, we would expect that this more comprehensive, tailored, and upstream focus will, over time, yield benefits in health improvement and contribute to a reduction in health care cost growth in concert with larger community efforts to improve health.

Driving greater value in the care for low-income residents and those in the Medicaid program

In addition to reforming how we pay for employee health services, King County is also driving pay-for-value innovations in systems of care that serve low-income and vulnerable residents of King County.

For example, King County is an active partner with the state of Washington in the Medicaid Transformation project, a five-year agreement between the state and federal government under a Section 1115 waiver through which the state will receive up to $1.5 billion to restructure, improve, and enhance the Medicaid program. Early on, King County convened local stakeholders and helped lay what is now a strong, collaborative foundation for Medicaid Transformation to occur in our region, through the *HealthierHere* regional partnership.

With local tax revenues, too, we are challenging ourselves to move to new value-based payment models. One such recent innovation is the creation of a "Pay for Suc-

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[5] King County Community Health Needs Assessment 2018/2019. Retrieved 9–9-2018 from Public Health—Seattle & King County, Community Health Indicators. www.kingcounty.gov/health/indicators

[6] Parrish, Amanda T., MA; Hammerback, Kristen, MA; Hannon, Peggy A., PhD, MPH; Mason, Caitlin, PhD; Wilkie, Michelle N., BA; Harris, Jeffrey R., MD, MPH, MBA. Supporting the Health of Low Socioeconomic Status Employees: Qualitative Perspectives From Employees and Large Companies. Journal of Occupational and Environmental Medicine: July 2018—Volume 60, p. 577–583.

[7] Workplace Health Model, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Accessed 9-9-2018 *https://www.cdc.gov/workplacehealthpromotion*

cess" model that will allocate $1.4 million a year in incentive payments to mental and substance use treatment agencies that provide outpatient treatment on demand for people in need. King County partnered with the Ballmer Group and Third Sector Capital Partners to design the innovative contracting arrangement and a rigorous evaluation; the pilot stemmed from a 2016 recommendation of the regional Heroin and Prescription Opiate Addiction Task Force to develop treatment on demand capacity.

Across King County's lines of business, we are innovating to make health care more affordable and sustainable. We're using every available lever—how we purchase health care for employees, how we engage in Medicaid payment reform, and how we purchase services for low-income residents—to accelerate this.

Lessons learned

Our involvement in health system transformation over the past 15 years has shed light on three factors that have been most critical to supporting innovation.

1. Work in coalition and align efforts. We have seen the benefits of working in coalition at every step of our journey. As an active member of Washington State's Healthier Washington initiative, we come to the table with a wide range of public and private entities– insurers, employers, health departments, health systems, and others—to learn from each other, find common ground, align our efforts, and commit to actions that are mutually reinforcing. For example, when King County negotiates contracts with health plans, we align with the state's common measure set, a practice which helps avoid unnecessary increases in administrative burden. Similarly, our coalition approach to working with labor unions on benefit design has remained thoughtful and fruitful over the years. In monthly committee meetings, we monitor actuarial reports together, review quality data from the Washington Health Alliance, and co-design workplace health promotion activities, all informed by a commitment to achieving the Triple Aim.

2. Commit to continual improvement. King County embraces Lean to help us solve problems. We respect the people who do the work as the sources of continuous improvement, and we strive to eliminate waste and deliver better value for the residents and communities of King County. We apply these principles as a purchaser of health care, working actively to understand the products we are buying, pushing for greater transparency, and working to eliminate waste. We also apply this in workplace health promotion efforts. Last year, we reached out to and heard from over 2,000 employees in the process of designing the next generation of our well-being strategy. They had a lot to say about what would better support their well-being, and they're among the most important experts we should be listening to.

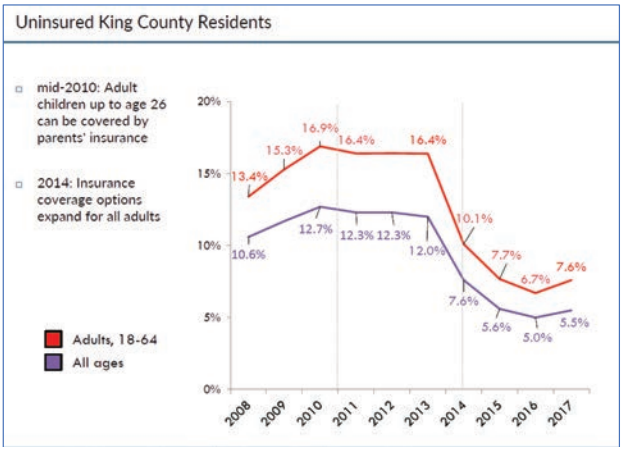
3. Work both downstream and upstream. Much of the current dialogue on ways to address health costs focuses on the health care system itself, such as its degree of waste, the variation in prices and quality, and ways to improve care for those with costly, complex conditions. Innovations in these areas are certainly critical, and King County has been among those working to change incentives and practices for the better. But even as we do that work, we are mindful that much of our spending is still for the treatment of physical, mental health, and substance use conditions that are largely preventable. Until collectively we pay even more attention to what's happening upstream, we won't be able to truly impact downstream health care costs over the long term. King County is an active innovator in upstream efforts, investing in everything from early childhood supports through the Best Starts for Kids initiative, to mental health promotion and substance abuse prevention, to public health programs, to workplace health promotion. The evidence of cost effectiveness is strong and growing. Yet at a time when more than 17 percent of the U.S. Gross Domestic Product is spent on health care, only 3 percent of the government's health budget is spent on public health measures. [8]

[8] For the Public's Health: Investing in a Healthier Future. Institute of Medicine. April 2012.

How Congress can help accelerate innovation

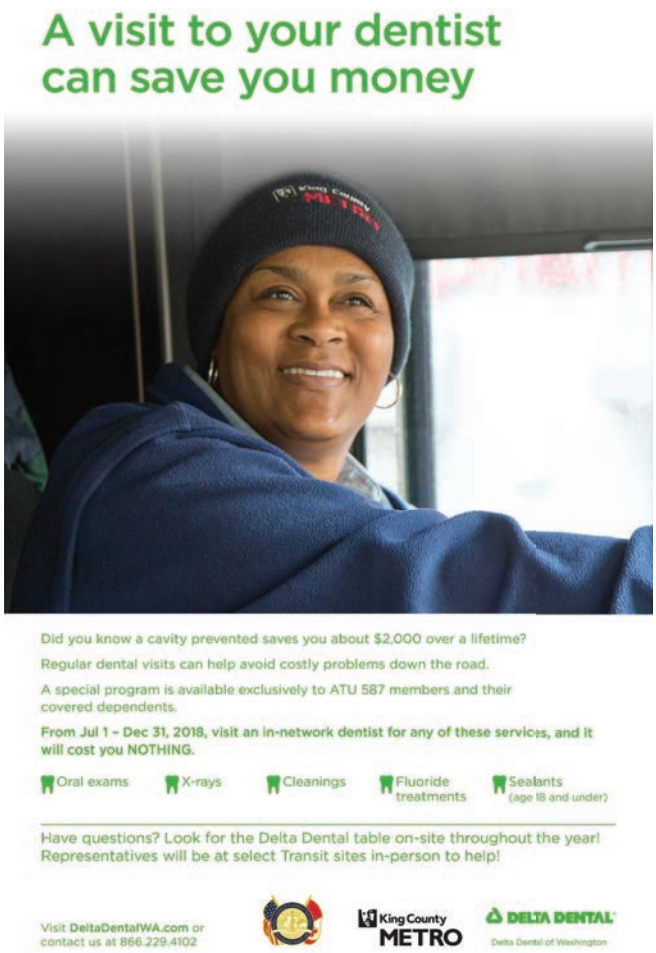
We recommend three areas of attention from Congress that will be helpful in reducing the growth of health care costs, and enabling continued innovation and engagement at the local level from entities such as King County.

- **First, lead the way in value-based payment, increased transparency, and efforts to reduce waste in health care.** Purchasing power is greatest at the federal and state levels, and action here is critical to accelerate strategies that pay for value, such as accountable care organizations and bundled payments—and to help assure that payers across Medicare, Medicaid, and the employer-based system are well aligned. We have experienced firsthand the way that federal investments in the Centers for Medicare and Medicaid Innovation and its partnership with states has spread to King County, allowing us to more easily align our efforts with others. Looking ahead, Congress should provide leadership to tackle one of the thorniest problems we face—the spiraling costs of specialty drugs and continued lack of true transparency in the pharmaceutical industry.
- **Second, support a robust prevention and public health system at the local, state, and federal levels.** Public health systems work upstream to promote health and prevent disease, addressing the root causes of poor health and health inequities. It's a great value buy, with evidence that it offers a positive return on investment.[9] As value-based purchasing in health care begins to create stronger incentives to keep people healthy, there will be new opportunities and needs for greater partnerships between public health systems and clinical care systems. The underfunded prevention and public health system needs a deeper investment in order to play these and other critical roles that stand to help bend the cost curve over time.
- **Third, protect the gains in coverage, care, prevention, and innovations that the Affordable Care Act has ushered in.** Here in King County, the uninsured rate dropped from 12 percent to 5.5 percent since new insurance options became available. Over time, access to a healthier workforce can help employers like King County and others across the region better fulfill their missions and strengthen their competitive edge.



[9] McCullough JM . "The Return on Investment of Public Health System Spending," AcademyHealth. June 2018.

Attachment A: Poster placed in bus bases to highlight dental coverage benefits for transit employees.



[SUMMARY STATEMENT OF DOW CONSTANTINE]

Background

King County delivers vital regional governmental services including human services, transit, elections, wastewater treatment, public health, and criminal justice for nearly 2.2 million people. King County is the most populous county in Washington State and with 15,000 employees, it is the state's thirteenth largest employer.

Summary of key points

Our story illustrates that to succeed in moving toward a more affordable, high quality, and prevention-oriented health system, you need partnerships—between patients and providers, between management and employees, between employers and health plan administrators, and between the public health and the health care delivery systems.

Together with labor partners, King County designed a high quality, lower cost health plan with a local HMO that is about one third cheaper than the traditional PPO plan. Many employees chose the HMO plan because it was substantially cheaper and offered high quality care. A wellness initiative was created where participation further rewarded employees with lower-out-of-pocket costs. Over a five year period, King County saved $46 million; this approach earned the 2013 Harvard Innovations in American Government award.

When gains from this early work ceased, King County renewed its work to pay for value instead of volume, building off lessons learned from private sector leaders like Boeing, as well as other governmental agencies.

This year King County added a new value-based plan choice for employees—accountable health networks. As a result, enrollment in value-based plans has grown from 21 percent of employees in 2011, to 37 percent today. King County also overhauled its wellness program, disconnecting participation from what employees pay for their coverage. The new approach focuses on building an overall culture of health, going far beyond the typical calls to exercise more and eat better. Most important, King County takes a public health approach to employee healthcare by tailoring efforts to better respect and respond to the diversity of its workforce.

How Congress can help improve affordability through innovation

1. Continue to use your significant purchasing power to accelerate strategies that pay for value over volume, increase transparency, and help all payers better align efforts.
2. Increase investments in upstream public health and behavioral health strategies.
3. Protect the gains in coverage, care, and prevention the Affordable Care Act ushered in.

Senator MURRAY. [Presiding] Thank you.
Dr. Perlin.

STATEMENT OF JONATHAN B. PERLIN, M.D., PH.D., M.S.H.A., M.A.C.P., PRESIDENT, CLINICAL SERVICES AND CHIEF MEDICAL OFFICER, HCA HEALTHCARE, NASHVILLE, TN

Dr. PERLIN. Good morning. Let me also thank the Committee and staff for the privilege of being here to testify this morning and just might take a personal privilege of thanking both Chairman Alexander and Ranking Member Murray for their statesman-like leadership in helping us move forward in healthcare.

I am particularly appreciative of the Chairman's extraordinary leadership and representation of Tennessee and will ever be indebted to Senator Murray for her championship of veterans, VA, and so I will mention our work together. So thank you for that.

I am Dr. Jon Perlin and have the privilege of serving now as president of Clinical Services and chief medical officer of Nashville,

Tennessee-based HCA Healthcare. With nearly 2,000 sites of care, around about 250,000 colleagues, we include 84,000 nurses, 30,000 allied health professionals, and approximately 45,000 affiliated physicians. Together, we have the privilege of providing care through more than 30 million patient encounters every year.

I am delighted to be here with you today to discuss how innovation can help improve the value of healthcare. At HCA, we believe in math, science, and evidence.

First, the math. Value is often defined as outcomes divided by cost, outcomes specifically in areas of quality and safety. So value improves when quality and safety increase, or costs drop, or both occur. And we offer three examples of innovation in HCA that not only improves patient outcomes and saves lives, but through publication and sharing of our innovations also improves value around the nation and around the world.

Between the 1970s and early 2000s, in the first example, medical intervention shortened the length of pregnancy by about 10 days. Concerns about elective pre-term delivery at less than 39 weeks led HCA to partner with the March of Dimes to study this issue.

In over just 90 days, 27 HCA hospitals examined 18,000 deliveries. In using admission to the newborn intensive care unit as a proxy for potentially avoidable complications like respiratory distress, we found that the risk for complications was 4 times greater at 37 versus 39 weeks and over twice as great at 38 versus 39 weeks.

Having created this evidence, we felt obliged to use it. Through a series of studies, we defined a now industry-standard 39-week hard stop, which sanctions obstetricians for elective pre-39-week delivery. This became the basis of CMS' Strong Start for Healthy Mothers and Newborns program. And this fundamental change in practice is estimated to have saved Medicaid over $1 billion annually and countless babies and families from cost and distress. Good quality is always more efficient.

In the second example that Chairman Alexander mentioned, we addressed the epidemic of avoidable hospital-acquired infections, infections that affect almost 5 percent of hospitalized patients and claim 80,000 lives annually. About one quarter of these infections are from forms of staph bacteria, including the highly drug-resistant MRSA. Colleagues at AHRQ, CDC, and Harvard asked if we could the HCA hospital platform to define which among three competing best practices was truly best in preventing these infections.

In 18 months across 43 hospitals, enrolling 75,000 patients, we discovered that an antiseptic sponge bath and antibiotic nose drops reduced potentially fatal bloodstream infections by 44 percent and MRSA infections specifically by 37 percent. And a follow-on study done outside of HCA demonstrated that for every thousand patients treated this way, U.S. healthcare saved $171,000. Again, safety is more efficient.

This HELP Committee held a hearing in conjunction with World Sepsis Day in September of 2013. You inspired us to do better for patients with this condition, in which overwhelming infection turns the body's immune system against itself. Sepsis is the 11th leading cause of death in the country, 9th in American hospitals and 3rd

among all intensive care units. For every hour of delayed diagnosis, mortality increases by 4 to 7 percent. Time is life.

Using data science to examine the big data product of interoperable health information, we now have algorithms to do what no clinician can do—monitor labs and other data 24/7, 365, for every patient in 164 HCA hospitals. The system identifies patients with sepsis more accurately than the best clinicians and excludes patients without sepsis twice as accurately.

While we have not yet done a formal financial assessment of how less care and shorter hospitalization generates lower cost, we can tell you this. We are saving lives through this big data and predecessor strategy. In fact, to date, these improvements have saved over 5,500 lives for patients who would have tragically succumb to sepsis.

Let me close by briefly mentioning an exciting recently announced initiative. HCA joined with a number of other major healthcare organizations collectively representing about 500 hospitals to found Civica Rx, a new, not-for-profit generic drug company that addresses shortages and high prices of life-saving medications.

Civica Rx has identified 14 important generic drugs that it will produce and in many instances really lower prices for generic drugs for hospitals to a fraction of their current costs. This can save patients and healthcare systems hundreds of millions of dollars every year, and we believe that this initiative will result in more predictable supplies of essential generic medications, helping ensure patient needs come first in the generic drug marketplace.

HCA is leading additional initiatives in infection prevention, timely identification of cancer patients, automating human labor with artificial intelligence tools, and sorting laboratory tests more carefully, to provide better care at lower cost.

I look forward to discussing those activities with you, and we thank you again for the privilege of testifying today and for your leadership in fostering improvement in healthcare value through innovation.

Thank you.

[The prepared statement of Dr. Perlin follows:]

PREPARED STATEMENT OF JONATHAN B. PERLIN

Chairman Alexander, Ranking Member Murray and Members of the Committee, I am Dr. Jonathan Perlin, and I have the privilege of serving as the President of Clinical Services and Chief Medical Officer of Nashville, TN-based HCA Healthcare. Our organization includes 179 hospitals, 135 ambulatory surgical centers, 121 urgent care centers, and more than 1,200 additional sites of service. Our ranks number almost 250,000 colleagues, including 84,000 nurses, 30,000 allied health professionals and approximately 43,000 affiliated physicians. Together, we have the privilege of providing care through more than 30 million patient encounters every year.

I am delighted to be here with you today to discuss how innovation can help improve the value of healthcare. At HCA, we believe in math, science and evidence. First the math: Value is often defined as quality and safety divided by cost. Value improves whenever quality and safety increase, costs drop, or both occur.

As for the science and evidence, safety and quality are always most efficient. Every breach of safety (like an avoidable infection) or negative variation in quality (like ordering the wrong test) is not only hurtful to the patient, but inefficient. This relationship is so obvious in manufacturing. If rework is required, flaws in the manufacturing process not only erode quality, they erode efficiency and drive avoidable cost.

Good management means looking for opportunities to improve value where the science provides evidence of a known best practice. Innovation means using science to discover best practices when the answer is not known. Let's look at three examples of innovation in HCA that are not only changing practice for our patients, but through publication and sharing our innovations, are improving value for patients around the nation and the world.

Between the 1970's and the early 2000's, medical interventions shortened the length of pregnancy by about 10 days. Babies are pretty robust, so no hospital, let alone an individual obstetrician, appreciated differences in outcomes between 37, 38 or full-term, 39-week pregnancy. That said, there were some concerns that maybe there really was a difference.

Because HCA has the privilege of delivering over 200,000 babies a year, the March of Dimes asked to partner with us to study the issue. Over 90 days, at 27 HCA hospitals, we looked at 18,000 deliveries. Using admission to the Newborn Intensive Care Unit as a proxy for potentially avoidable complications (such as respiratory distress), we found that the risk for complications was four times greater at 37 versus 39 weeks and over twice as great at 38 than 39 weeks.

Having created this evidence, we felt the obligation to use it. In a series of following studies, we defined the now industry-standard, 39-week "hard stop," which sanctions obstetricians for elective, pre-term delivery. This, in turn, became the basis of the CMS "Strong Start for Healthy Mothers and Newborns" program. This fundamental change in practice is estimated to save the Medicaid program over a billion dollars annually. Good quality is more efficient.

Let's turn our attention to the United States epidemic of avoidable hospital-acquired infections. This epidemic affects almost five percent of hospitalized patients or over two million people annually. 80,000 patients pay the ultimate price, and that toll is more than the annual mortality of breast cancer, car accidents and HIV combined. By the way, about one quarter of these infections are due to forms of the staph bacteria, including the highly drug-resistant "methicillin resistant staph aureus," known as MRSA.

After demonstrating how our initial approach reduced such infections in HCA to one third lower than expected, colleagues at AHRQ, CDC and Harvard asked if we could again use the HCA platform of hospitals to find out which among three competing "best practices" was truly best. In 18 months, across 43 hospitals, we enrolled nearly 75,000 patients and discovered that the practice of an antiseptic sponge bath with antibiotic nose drops reduced potentially fatal MRSA infections by 37 percent and all bloodstream infections by 44 percent. A follow-on study demonstrated that for every 1,000 patients treated this way, the health system saved $170,000. Safety is more efficient.

Let me offer one final clinical example—improving care for patients with sepsis. This committee held a hearing in conjunction with World Sepsis Day, September 2013. You inspired us to do better for patients with this condition in which overwhelming infection turns the body's immune system against itself. Sepsis is the 11th leading cause of death in the country, 9th in hospitals, and 3rd among all intensive care units. Unfortunately, for every hour of delay in diagnosis, mortality increases by an additional four to seven percent. Time is life.

Using data science to examine the "big data" product of meaningful use, we now have algorithms that monitor every patient in every hospital that's been part of HCA for more than a year. This system identifies patients with sepsis as accurately as the best clinicians and excludes patients without sepsis twice as accurately. It gives new clinicians a support system that can make them as good as the best clinicians, and it does what no clinician can do; it monitors all the relevant labs and other data 24x7x365. While we haven't yet done a formal financial assessment of how less care and shorter hospitalizations generate lower costs, what we can tell you is that this algorithmic system and its predecessor strategy have saved more than 5,500 lives.

Science provides the evidence that innovation is a central tool for higher quality and safety at lower cost. In turn, it underpins the math that we join with you in seeking for higher-value healthcare.

Let me close by briefly mentioning an exciting, recently announced initiative that HCA is a part of: HCA joined with a number of other major health care organizations, that collectively represent about 500 U.S. hospitals, to found Civica Rx—a new, not-for-profit generic drug company that will help patients by addressing shortages and high prices of life-saving medications. Civica Rx has identified 14 important generic drugs as its initial focus, which it will either directly produce or subcontract to reputable manufacturers. In many instances, prices for generic drugs

used in hospitals can be reduced to a fraction of their current costs. This can save patients, and the healthcare systems that care for them, hundreds of millions of dollars each year. We believe this initiative will result in lower costs and more predictable supplies of essential generic medications, helping ensure that patient needs come first in the generic drug marketplace.

HCA Healthcare is leading additional initiatives in infection prevention, timely identification of cancer patients, automating human labor with artificial intelligence tools, and stewarding laboratory tests more carefully that result in better care at lower cost. I look forward to discussing those with the Committee.

Thank you for both the privilege of testifying today and for your leadership in fostering improvement in healthcare value through innovation.

[SUMMARY STATEMENT OF JONATHAN B. PERLIN]

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Having created this evidence, we felt the obligation to use it. Through a series of studies, we defined the now industry-standard 39-week "hard stop," which sanctions obstetricians for elective, pre-39 week delivery. This became the basis of the CMS "Strong Start for Healthy Mothers and Newborns" program. This fundamental change in practice is estimated to save Medicaid over a billion dollars annually and countless babies and families from cost and distress. Good quality is more efficient.

The epidemic of avoidable hospital-acquired infections affects almost five percent of hospitalized patients, and claims 80,000 lives annually. About one quarter of these infections are due to forms of staph bacteria, including the highly drug-resistant "MRSA."

Colleagues at AHRQ, CDC and Harvard asked if we could use HCA hospitals to find which among three competing "best practices" was truly best in combating these infections. In 18 months, across 43 hospitals, we enrolled nearly 75,000 patients and discovered that an antiseptic sponge bath with antibiotic nose drops reduced potentially fatal MRSA infections by 37 percent and all bloodstream infections by 44 percent. A follow-on study demonstrated that for every 1,000 patients treated this way, U.S. healthcare saved $170,000. Safety is more efficient.

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Using data science to examine the "big data" product of interoperable health information, we now have algorithms that do what no clinician can: Monitor labs and other data 24x7x365 for every patient in 164 HCA hospitals. This system identifies patients with sepsis as accurately as best clinicians and excludes patients without sepsis twice as accurately. While we haven't yet done a formal financial assessment of how less care and shorter hospitalizations generate lower costs, we can tell you this algorithmic system and its predecessor strategy have saved more than 5,500 lives.

HCA Healthcare is leading additional initiatives in infection prevention, timely identification of cancer patients, automating human labor with artificial intelligence tools, stewarding laboratory tests more carefully and joining with other health systems in the Civica Rx initiative to less expensively produce life-saving generic medications that are in short supply. These efforts result in better care at lower cost.

The CHAIRMAN. [Presiding] Thank you, Dr. Perlin.

We will now go to a round of 5-minute questions by Senators. We have a briefing—a classified briefing—at 11:00 a.m., which many of us hope to go to, but I think we have time for everyone to ask questions.

We will begin with Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Thank you for your comments, your testimony this morning and for your leadership in various fronts around the country.

Some very good suggestions. I think there is some general applicability throughout all of this. As my colleagues know, my lens in this Committee really tends to focus on access to care in rural areas. And so, I would like to just present to each of you what you have shared with us is good, but is it workable in a place that is highly rural, where there is very little competition, where access to an MRI is not possible in your community and perhaps not even in your region? And so, the effort to gain access to many of the things that others might just take for granted are limited.

I know, Dr. Gross, you are in Florida. Ms. DeMars, you are kind of all over the country. We have got Tennessee and King County. You have got two or three times more people in King County than we have in our entire state.

Can you share with me how what you have learned can also be applicable in high-cost, very low-population areas where we simply do not have competition, or is it an entirely different model? We have had hearings in this Committee that are more specific to rural healthcare, but share with me what we can learn from you as applied to rural access.

Dr. GROSS. Mr. Chairman? So, although I am in southwest Florida, we are about 45 minutes from a critical access rural hospital. And that is actually the area that we partnered with to get bundled surgical pricing. And what that has been able to do is for us to drive elective surgical volume into this critical access hospital that would have normally left this region.

They are actually starting to see inbound—so even a 10 percent increase in margin for a hospital like this is actually huge. I mean, it is the difference between staying open and closing of certain wards.

But we have restructured—worked with them to restructure their health benefits programs so that they are actually—if their employees sign up for our program, not only did they see a 20 percent reduction in their premiums, but they will actually lower—eliminate out-of-pocket costs. And what we are seeing is—restructuring, we actually saved that program about $800,000. We are projected to save that program about $800,000 in the first year.

Now if you could transition that savings to the county, the school board, the local prison employees, that has the ability to save that local community millions of dollars in annual costs that can go towards higher wages, can go towards new school facilities, or whatever. But instead of spending the money and wasting the money on unnecessary healthcare services, to provide healthcare better, with a solid foundation in primary care, is a way for the rural practices to actually save money.

Using our approach, we have actually found a way. Because it is an under-served community. You cannot get fee-for-service prac-

tices to survive in this environment, but our membership requires a lower barrier to survive in this model. So we actually are not only going to succeed out there, we are going to thrive out there.

Senator MURKOWSKI. Others?

Dr. PERLIN. Thank you, Senator Murkowski, for a great question.

One of the areas that we think applies greatly to intensely rural areas and critical access hospitals, the use of telehealth services. HCA has over 200 telehealth programs, and we have been able to stabilize essential critical access hospitals by providing telehealth support.

For example, a stroke patient who does not need transfer can stay there and be managed—managed with some guidance, but a patient who really needs some intervention is the one that, when conditions are possible, can be airlifted out. And of course, we appreciate your support of our Alaska Regional Hospital, and these are the sorts of programs that we think really innovation can help to improve healthcare and value.

Senator MURKOWSKI. Good, thank you.

Ms. DEMARS. Senator Murkowski, the addition I would make is that it is in rural areas I think even more important for the buy side of the market, the purchasers, to get together and be able to speak with one voice with the providers that are in that market about what is important to them.

An example that I can think of from our region is a relatively rural county that did not have urgent care services. The purchasers, the employers in that market, approached the local hospital to discuss the availability, making available an urgent care center, and they worked together to establish that capacity in that community.

Senator MURKOWSKI. Good, thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Murray.

Senator MURRAY. Thank you very much, and thank you to all of our panel. It is really good testimony this morning. Appreciate you all being here.

Executive Constantine, let me start with you. Thank you for explaining the series of steps that King County has taken over the last decade to control costs. I was especially interested in the work you have done to engage employees in these efforts, both the design and the cost containment programs.

You testified you view your workers as the source of continuous improvement, and you have to employ multiple strategies to engage workers in a variety of roles, like the transit workers you mentioned, who can be the hardest to reach. Tell us a little bit more about how King County engages workers themselves and maybe what lessons that your experience can teach other employers.

Mr. CONSTANTINE. When I came to office, we were in the depths of the recession, and there was a lot of pressure to cut costs and balance the budget. And we were confronted with this choice between either balancing the budget on the backs of the employees, including a struggle over who was going to be handed the inflated healthcare bill, or working with our employees to take on those cost drivers. And we chose to do that.

We sat down with our employees. We had to build trust around our intentions to really work with them to do that, and we succeeded. Our employees understood that the system we were all using was not either delivering the best health outcomes nor was it efficient from a cost perspective. And so, they worked with us to create a set of incentives and a plan in our local HMO that would provide better service for the workers at less cost to them, as well as to the taxpayer.

The beginning of that has led to further advances where we were able to have that trust with our employees, where this is not a zero-sum game, as between the employer and the employee, but there is this external challenge that we have to face together. And it has been very successful, and we have had the opportunity to keep building on that. And now as we move toward our Accountable Health Network, we are using that same trust we built with our employees to create new options for them, high-value, lower-cost options that are delivering objectively better results.

One of the additional things, Senator, that we learned is that we cannot treat all employees equally, just as we cannot treat a very diverse public equally. In our public health work, we recognize that subpopulations will have different challenges and different outcomes. We are taking that same public health approach and applying it to our employees and understanding that we have to approach bus drivers differently than we approach those who work in a white-collar desk job if we are going to have everyone have better health outcomes.

Senator MURRAY. That has worked fairly well for you?

Mr. CONSTANTINE. It is working well, and of course, it is a continuous improvement process, one in which we are engaging all of our employees and the unions that represent them as our strong partner.

Senator MURRAY. I think that is a really strong point that your workers need to be involved in it. Otherwise, they will feel you are doing something bad to them.

Mr. CONSTANTINE. That is exactly correct.

Senator MURRAY. Good. Dr. Perlin, as we have heard from all of our witnesses today, and also in our previous hearings, the high cost of care hurts patients across our healthcare system. Along with other hospital organizations, HCA recently helped found Civica Rx. You mentioned it in your testimony. It is, as I understand it, a not-for-profit drug company that manufactures generic drugs so that hospitals can avoid drug shortages and overpaying for older drugs when manufacturers spike their costs.

But one fact that was very clear to me in all of our hearings is that all stakeholders, all of them, need to play a role in bringing costs down. So I am very interested in Civica Rx and want to ask you how you are now going to use the savings that have been generated by that to improve affordability and quality?

Dr. PERLIN. Well, Ranking Member Murray, thank you very much for the question about Civica Rx. It is really an effort of a number of different partners in healthcare, as you mentioned. It is not only the healthcare providers, but three foundations that are joining as well.

While it was a great question to ask how those savings may be used, I can mention this, is that when I looked back on the data about the cost inflation on hospital costs for the past few years, 2015, 38 percent of the cost increases of hospital care was directly attributable to the increase in the cost of pharmaceuticals. So this is one of the areas where I think by getting control over the cost of pharmaceuticals, we get better handle on the cost of healthcare overall.

All that said, as you might imagine, there is some substantial work to be done in starting up a new entity to produce drugs that have the appropriate FDA regulatory approvals, whether they are directly manufactured or subcontracted. And so, we look forward to actually getting from concept to production and——

Senator MURRAY. What is the timeline on that?

Dr. PERLIN. I am not sure exactly what the timeline is. I can find out when the first drug should be available, in written comment after the hearing.

Senator MURRAY. Okay, thank you. And I would love to hear that. I think it is a really interesting concept.

Dr. PERLIN. Thank you.

Senator MURRAY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Dr. Gross, let me make sure I understand this. So if I am in your area, for $60 a month for an adult, $25 for one child, $10 for each additional child, I can get your coverage. So that sounds like a family—the annual cost might be a $1,000, $1,200 a year, something like that.

Let me focus in on exactly what you get for that. Let me compare it. I visited a Federally Qualified Community Health Center in Lewis County, Tennessee, pretty impressive place. The doctors there told me that about—they could handle about 90 percent of what walked in the door. You know, they are not open at night, but they are open 7:00 in the morning to 7:00 or 8:00 at night. It is clean. They got a couple of doctors, nurses.

The other 10 percent, they then refer to a hospital that is not too far away. I suspect most of the bills are paid by insurance—Medicare, Medicaid, and private insurance—and there would be some co-pay there. I do not know whether it would add up to $1,000 or $1,200 a year. But how do the services you provide compare with the primary care that someone might get at a Federally Qualified Community Health Center like the one in Lewis County, if you can make that comparison?

Dr. GROSS. Yes, so thank you for the question. While I cannot specifically compare the care to the Federally Qualified——

The CHAIRMAN. Well, let me ask it this way. Of the people who walk in the door, can you take care half of their problems, roughly, 80 percent of their problems, 90 percent?

Dr. GROSS. I would estimate about 90 percent of our patients do not require outside referrals, but the other interesting thing we are able to do is because we are not working within an insurance system, we do not have to bring patients into the office for the purposes of charging. So we can do things over email, technology visits, texting your physician, and so you can avoid unnecessary emergency room visits. It allows us to spend time with the right patient

in the right venue at the right time. So we can spend more time with the patient that is sick because we can handle simple things through——

The CHAIRMAN. But so, I am in your area, and I come to you, and you could say to me that, "Probably we can help you with 80 or 90 percent of the problems that you are—the healthcare families your problem has. And when we cannot, we will then refer you to some place." Now, does that—do the surgeries that you talk about buying, is that part of the $60, or is that an additional charge that is paid for by the patient or by their insurance?

Dr. GROSS. So any procedure that is done in our office is included, no extra charge. So removal of a skin cancer we can do. Drainage of an abscess we can do. There is no extra charge.

If I refer it out, then we negotiate that bundle. So a colonoscopy is $1,100 cash price. And the interesting thing about the colonoscopy is it bundles the pathology. So everyone sort of knows how you have to code the colonoscopy, and if it is not coded properly, your free colonoscopy could end up being $3,000 because—if they found a polyp.

That is not the case. Our pathology is bundled. So the price going into the procedure is the price going out of the procedure. There are no surprise bills. It is all predictable expenses.

The CHAIRMAN. What are the Federal regulations or laws that interfere with the expansion of practices like yours, if any?

Dr. GROSS. I think one of the biggest challenges is that drug primary care memberships have not been classified as—with the IRS as a 213(d), qualifying medical expense.

The CHAIRMAN. What does that mean?

Dr. GROSS. That means that you can use it for health savings accounts, health reimbursement accounts. They are tax deductible. You are able to pay with pre-tax dollars. So direct primary care memberships are the only medical expense in the country that you cannot use for a health savings account.

The CHAIRMAN. So you would like to—your recommendation would be that people be able to use their health savings account funds in order to pay the $60 a month?

Dr. GROSS. That is correct. That is sort of the point of a high-deductible health plan is that you can afford access to the routine care, and then you have your health plan as your safety net. So the direct primary care bundles well with an HSA, but when you prohibit the HSA use with a high-deductible health plan, it sort of defeats the purpose of the high-deductible health plan.

The CHAIRMAN. Would you provide us in writing after the hearing, any—please, any suggestions you have for changes in laws or regulations, such as that one, that would make it possible for there to be more primary care service centers like yours?

Dr. GROSS. Absolutely. And thanks for the question.

The CHAIRMAN. Dr. Perlin, you have got a lot of experience—and I have just a little time left. But sometimes technology helps, sometimes it does not. It seems to overburden doctors, hospitals and cost lots of money. We have found that with electronic healthcare records. What can you tell us about how we should approach technology and making it an asset rather than a burden for our healthcare system?

Dr. PERLIN. Well, thanks for that question and thanks for your championship. Through entities like Center for Medical Interoperability, located in Tennessee, we are realizing the opportunities with data liquidity. What we mean by that is that rather than the EHR being both beginning and the end of health information, it is a piece of it. And once you have that health information, we can really use the tools of data science and artificial intelligence to improve healthcare, make it more efficient.

Quick example. We have developed a product called Cancer Patient ID. It is being commercialized as Patient Insights, wherein it actually reads the reports from biopsies for patients who are having a biopsy to rule out lung or prostate or colon cancer.

Instead of taking cancer navigators spending 75, 85 percent of their time reading reports and not working with patients, they now spend 75 to 85 percent of their time working with patients, incredible change in workflow. And it is all because of the data liquidity and the opportunity to really use these new data science, artificial intelligence tools. That is a huge efficiency in terms of improving the value of healthcare.

The CHAIRMAN. Thank you, Dr. Perlin.

Senator Jones is not here.

Senator Smith.

Senator SMITH. Pardon me. Thank you very much, Chair Alexander and Ranking Member Murray, for this hearing.

Thank you to Senator Baldwin for ceding her time so that I can go to one of the other committees I have to go to.

Thanks so much to all of you for being here. These—I found these hearings on cost control to be very, very valuable and interesting, and I think it reminds us all to focus on our common interest in solving problems that expand access and lower cost, and as you were saying so well, improve the value of the healthcare that Americans are able to get.

I would like to hone in an issue that I am very—am focused on having to do with mental health. You know, nearly one in five Americans suffer from challenges related to mental health, and this, of course, leads to high healthcare costs, and there are significant challenges around access to mental health services as well. And this is particularly true, given that many people with behavioral health problems wind up in emergency rooms and clinics where there is not the staffing that people need.

The Certified Community Behavioral Health Clinic program is helping to drive the integration of primary care and behavioral health. And in my state, these clinics have—this program has allowed us to help fill vacancies in Minnesota clinics and are making a big difference in including—excuse me, in improving access to care and helping people. And also lowering healthcare costs.

I would like to—I am interesting in working to reauthorize this program in Congress. But today, I would like to hear from all of you. Maybe I will start with Mr. Constantine. Give us your insights in how we can help better provide incentives for health systems to integrate mental health and primary care.

Mr. CONSTANTINE. Well, and thank you, Senator, for your question.

In Washington State, we are taking on the integration of primary care and mental health, or behavioral health generally, in earnest, and King County is right at the center of that. We worked with a whole network of providers in order to come up with a system that was seamless and that allowed that transition to happen in a way that is helpful to patients.

Our real—one of our main concerns is the degree to which we are spending money reacting to little problems that have been allowed to blossom into crises.

Senator SMITH. Exactly.

Mr. CONSTANTINE. 17 percent of the gross domestic product is spent on healthcare. Only 3 percent of Government health spending is on prevention. And we know that there is an enormous amount of value just in terms of cost saved, but also in terms of lives that are redeemed by getting to these challenges early.

I believe that we have had some challenges in our region, because of the unusually high cost of living, in retaining professionals in behavioral health clinics. And we started to take that on with the assistance of the Ballmer Group, who helped provide us some pay-for-performance assistance that is building that treatment on demand capacity, but both making sure that there is adequate funding to keep professionals in this and that this integration is hastened so that we—because we understand that there is a strong connection between physical and mental health, it would be tremendously helpful to us at the local level.

Senator SMITH. Of course, I sit in the seat that was held by Paul Wellstone, who was such an advocate for mental health parity and worked along with Senator Domenici from New Mexico to really expand this. And I am concerned that we have not fulfilled the promise of mental health parity.

Would anybody like to comment on that and just make a comment on how that ties to our core goal of improving value for healthcare?

Ms. DEMARS. Well, I would just like echo your concerns about the dire need for integrating behavioral healthcare into traditional healthcare. We see from the employer side, the cost of untreated mental healthcare and behavioral health conditions not only in terms of increased healthcare costs, but also workplace productivity and employee well-being. And it is something that I think is critical to solve.

In Wisconsin, we are working, as employers and other purchasers with plans, to raise awareness of the need for integration of behavioral healthcare into medical care and thinking about ways that we can support that integration by paying differently while, at the same time, working to destigmatize behavioral health conditions.

Senator SMITH. Right, right. Well, I so appreciate your comments on this, and Mr. Chair and Ranking Member Murray, I look forward to continuing to work on this. I was very—just close by saying there was an interesting article in the Minneapolis Star Tribune talking about a very innovative strategy to get health behavioral therapists into preschools and early learning to address—to the point of being, needing to get upstream—addressing this challenge right when those little kids are exhibiting the first symptoms

of challenge. And it is working. So I think we need to work more on this.

Thank you very much.

The CHAIRMAN. Thank you, Senator Smith.

Senator Cassidy.

Senator CASSIDY. Mr. Chairman, first I would like to submit for the record, a written testimony from Ochsner Health System—and I am sorry, I have a script to read on this—that acknowledges the innovative work that they have done in improving patient care and outcomes, reducing costs. And some of that work includes developing a digital health program for the management of chronic disease, highlighted by both Apple and Microsoft.

I ask unanimous consent that this statement be submitted.

The CHAIRMAN. So ordered.

[The information referred to follows:]

[STATEMENT OF OCHSNER HEALTH SYSTEM]

Ochsner Health System (Ochsner) appreciates the opportunity to submit comments for the record for the Senate Health, Education, Labor & Pensions Committee hearing titled, "Reducing Health Care Costs: Improving Affordability Through Innovation". We commend you, Chairman Alexander and Ranking Member Murray for convening this hearing and exploring ways in which innovation can be deployed to help improve patient care and outcomes, enhance value in the provision of health care, and reduce costs. We stand ready to work with you and your colleagues on the Committee and serve as a resource on these and other health care delivery system issues. We would like to take this opportunity to highlight a selection of our advanced and national award—winning programs in digital medicine, discuss how we are using artificial intelligence and predictive analytics, and present a number of our other innovations in hospital care and use of telemedicine. These and other initiatives have resulted in significant improvements in the care and management of patients with chronic disease; accelerated diagnoses and treatment for patients with acute and deteriorating medical conditions; and, provided vital and real-time health information and continuous engagement with individual patients in hospital, home, and community based settings.

Overview of Ochsner Health System

Ochsner, founded more than 75 years ago by five physicians in New Orleans, is one of the nation's leading health systems. Ochsner is Louisiana's largest not-for-profit health system and one of the largest independent academic health systems in the United States. Ranked as a top hospital in Louisiana by U.S. News, Ochsner also boasts national number one rankings by Carechex for organ transplant and liver transplant. A top 100 hospital by Truven Health Analytics 2017 and Becker's Great Hospitals in America 2016, we provide a comprehensive range of inpatient, outpatient, and in-home services through our network of more than 30 owned, managed or affiliated hospitals and more than 110 total sites of care, including its health centers and urgent care clinics, which are located throughout Louisiana and areas of Mississippi.

Our clinical care team offer expertise in more than 90 medical specialties and subspecialties, and includes approximately 3,600 affiliated physicians, with 1,300 employed Ochsner physicians and 20,000 employees, making us the largest private employer in Louisiana. In 2017, at Ochsner we saw more than 730,000 patients and through the Ochsner Health Network (see attached map) we treated more than 1 million patients and saved our partners more than $60 million.

Ochsner serves as a major referral center and treats patients from across Louisiana, every state in the nation, and more than 60 countries. We are proud to provide a wide array of nationally-ranked and specialized clinical services to treat some of the most challenging and complex medical conditions, including: organ transplantation; oncology; neurosciences; cardiovascular care; high risk obstetrics/in-vitro surgery; pediatric specialty care; and, programs focused on chronic diseases.

From a broad perspective, Ochsner has developed the type of integrated delivery system that many policymakers envision featuring a comprehensive range of clinical services, coordinated systems of care, a sophisticated electronic health record (EHR),

and the geographic reach, scale, and clinical capability necessary to manage and improve the health of a large patient population. Further, Ochsner is a major academic medical center with nearly 300 full-time residents and fellows participating in 28 ACGME accredited graduate medical education programs and four additional specialty programs; a global medical school partnership with The University of Queensland School of Medicine in Brisbane, Australia; and, programs of biomedical research. We currently have more than 700 active clinical trials, offer training and education to health professionals through our Ochsner Clinical Simulation and Patient Safety Center, and deliver clinical education to more than 575 allied health students each year through our Allied Health program.

We are proud that for six years Ochsner has been actively engaged in the Medicare Shared Savings Program through its Accountable Care Organization (ACO) and has successfully transitioned to the Track 1+ ACO Program with approximately 25,000 attributed beneficiaries. In addition, Ochsner provides care for another 35,000 Medicare Advantage enrollees through a capitated, global payment mechanism that has fostered the acceleration of clinical innovation and the deployment of digital medicine technologies that are a key focus of the subcommittee hearing. In all, we have approximately 230,000 patients in value-based contracts and maintain a strong commitment to continuing to innovate so we can improve outcomes and reduce costs for the individuals, families, and communities we serve.

Improving Health Through Innovation: Health Innovations by Ochsner

In 2015, Ochsner formed its own innovation lab, known as innovation Ochsner (i O), whose mission is to reimagine and revolutionize the delivery and experience of healthcare and dramatically improve health outcomes using technology, data and new thinking. Through iO, Ochsner has been a pioneer in developing solutions in the areas of digital health, advanced analytics and artificial intelligence (AI), and precision medicine. We are proud that our investment and focus in this area has resulted in a number of ground-breaking innovations, which are measurably advancing the quadruple aim of healthcare: improve the patient experience of care, improve the health of populations, reduce the per capita cost of health care, and improve the work life of the provider of care.

Overview of Digital Medicine Programs for the Care and Management of Chronic Disease

Ochsner has developed advanced digital medicine programs that immediately feed patient—generated data into its electronic health record (EHR), and was the first health system in the nation to integrate its Epic EHR system with the Apple Healthkit, which is an IOS app that acts as a health dashboard by capturing health and activity data from other apps and wearable devices. [1] These data provide physicians and the care team a more complete view of a remote patient's health status and allows and empowers providers to offer proactive, holistic care and recommendations, from medication management to lifestyle factors, leading to better health outcomes, lower costs, and higher levels of patient engagement, satisfaction, and convenience.

Using the integrated data and health dashboard, Ochsner has developed and implemented programs targeted to support patients with congestive heart failure, diabetes, hypertension and cancer, as well as expectant mothers, to help them stay connected to their care teams between their in-person visits to their physicians. These programs can be expanded and adapted to treat asthma, arthritis, chronic obstructive pulmonary di—sease, high cholesterol and many other conditions. Chronic disease accounts for 75 percent of deaths and 86 percent of healthcare costs in the United States, so innovative models of care like Ochsner Digital Medicine that dramatically improve health outcomes are critical in our quest to save and change more lives.

A New Care Model for the Most Prevalent Chronic Disease: Hypertension Digital Medicine Program

The Hypertension Digital Medicine program is a new way to care for high blood pressure, the most prevalent chronic disease in the United States (and indeed the world), where half of all patients —still suffer from uncontrolled blood pressure. In

[1] A profile of Ochsner's Hypertension Digital Medicine digital medicine program can be found on the Apple healthcare website under the heading "Continue Patient Care at Home"*https://www.apple.com/healthcare/*.

contrast to traditional models of care, which are based on episodic data points and physician visits, our Hypertension Digital Medicine program offers a continuous care model, where patients send in regular data and are remotely monitored by a dedicated care team who provides proactive, preventative interventions. Patients enrolled in the program take their blood pressure weekly using a wireless, at-home blood pressure cuff. The results are transmitted to their care team, who is able to see the trends in each patient's blood pressure measurements. This is an innovative approach that allows more frequent data and a more meaningful feedback loop between patients and the care team, instead of relying on only a handful of readings each year during in-office visits. Using this real-time information and trend data, we can provide their patients timely and tailored feedback, such as medication adjustments, healthy eating tips, and exercise goals. Patients and doctors receive monthly reports to track progress.

The early results of the program have been encouraging where more than 71 percent of patients who were previously out of control achieved control within 90 days of entering the program compared to 31 percent of patients following the traditional care model. [2] For patients, lower blood pressure

Ochsner Health System Written Testimony for the Hearing Record Submitted to the Senate Health, Education, Labor & Pensions Committee "Reducing Health Care Costs: Improving Affordability Through Innovation" November 2018 means a lower likelihood of heart attack, stroke, and kidney failure. In turn, these changes in patient risk factors for numerous chronic diseases will reduce costs and improve patient quality of life.

Apple has featured Ochsner' s Digital Medicine program as a model for leveraging technology and data to improve health outcomes and patient engagement. [3] Likewise, the HHS Office of the National Coordinator has recognized the program as a model for patient engagement it its Patient Engagement Playbook. Harvard Medical School and Harvard Business School have also recognized this innovative program through their Health Acceleration Challenge.

0 Bar: A "Genius Bar" Providing Physician Approved and Prescribed Apps and Devices to Patients

Ochsner has also launched a novel service to introduce patients and consumers to personalized health technology -the O Bar. A national model for promoting patient engagement in technology to improve outcomes, the O Bar makes it easy for patients and the communities we serve to learn about, test and obtain healthcare-related apps and connected devices, with the help of an Ochsner—staffed expert. Now with five locations in Jefferson Parish, New Orleans, Baton Rouge, Covington and Westwego, the O Bar offers a curated selection of apps focused on wellness, nutrition, fitness, diabetes, women' s health, smoking cessation and more, as well as state-of-the art medical devices including Bluetooth blood glucose monitors, wireless blood pressure monitors, activity trackers, and wireless scales. Ochsner physicians tailor and prescribe apps and devices for their patients and 0 Bar staff can help patients by downloading and demonstrating the use of apps and devices, and ensure that patients can easily access and use these digital health tools. [4]

Optimal Hospital—Innovation in Hospital Care

Ochsner has introduced new technology, science and work flows to improve the hospital experience for patients through its Optimal Hospital initiative. The program includes several elements. Patients are given wireless vital sign monitors to allow for continuous data collection that is entered automatically into the electronic health record, while still allowing for patient mobility. Patients are offered mobile tablets through which the patient can access information about their attending physician and care team, educational resources, the schedule of the day, test results, and medication information, all of which assists in helping patients feel supported and less overwhelmed while in the hospital. Physicians also have mobile access to devices and apps through which they can see patient test results, which can assist them in communicating with and caring for their patients throughout the day and

[2] Milani RV, et al., Am J Medicine 2017;130:14–20.

[3] A video describing the program is featured on the Apple healthcare website under the heading "Continue Patient Care at Home" and can be found at *https://www.apple.com/healthcare/*.

[4] The O Bar has been featured on CNBC; the report can be viewed at *https://www.cnbc.com/2015/06/09/take-this—app-and-ill-call-you-in-the-morning.html.*

in different locations within the medical center. The program has been well-received by patients and has improved efficiency and flow of information to physicians. [5]

Use of Advanced Analytics to Predict and Improve Hospital Patient Care: 2018 Microsoft Health Innovation Award for Artificial Intelligence and Machine Learning

Ochsner has deployed the use of artificial intelligence and machine learning for acutely ill hospital patients using an iO-developed algorithm with more than one billion clinical data points, creating a deep recurrent neural network. This approach can predict health status deterioration of patients who are in the hospital but not yet in the ICU at a 98 percent accuracy rate. Using this tool, Ochsner's rapid response team of clinical providers is notified in real-time when patients exceed a certain risk threshold and thus can intervene proactively to address and possibly prevent adverse events, and provide better outcomes. Ochsner is one of the first health systems in the country to use this type of technology to improve patient care, and early results have been exceptional. During the 90-day pilot, cardiac arrests and other adverse events outside of the ICU were reduced by 44 percent. These complex machine learning algorithms are powered by Epic machine learning and Microsoft Azure cloud platforms. [6]

Telehealth and Telestroke Network

Ochsner has developed an extensive telehealth and telestroke network, which serves more than 40 rural hospitals located throughout Louisiana and Mississippi. Unfortunately, these areas face a significant shortage of neurologists, psychiatrists, and other physician specialists, leaving too many communities without access to the specialty care their residents need and deserve. Ochsner' s telestroke program provides 24 hour -7 days per week coverage by vascular neurologists who—through telemedicine are immediately available to emergency room physicians in rural hospitals to help them quickly diagnose and treat patients presenting with symptoms of a possible stroke. A key indicator for stroke outcome is prompt and accurate diagnosis a delay in treatment can have catastrophic results. The program has been instrumental in successfully treating thousands of patients across the region in a timely manner and offering an important source of clinical support and expertise for rural hospitals and their medical staffs.

Conclusion

Thank you for your leadership in holding a hearing to identify innovative practices in health care. We are eager to be a resource to you and your staff. We appreciate this opportunity to provide these examples and highlights of how Ochsner has developed and designed numerous clinical innovation initiatives and deployed digital technology to serve our patients, improve outcomes, enhance the patient experience, and reduce costs. We welcome an opportunity to present to you additional examples and details regarding how Ochsner is leading efforts to develop and deploy innovative practices and technology in the 21st century delivery of health care. Please call on us if we can be of assistance on this or other issues under the Committee's jurisdiction.

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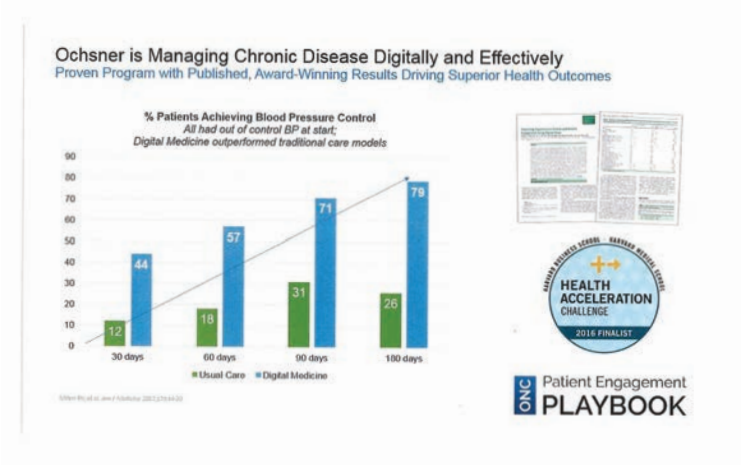
[5] The Apple healthcare website also features a video describing aspects of the Optimal Hospital initiative and can be found under the heading "Apple in the Hospital" and can be found at *https://www.apple.com/healthcare/*.

[6] A video explaining this program can be accessed at *https://www.voutube.com/watch?v=ONgWbDALGAE&feature=youtu.be.*


Statewide Ochsner Partners
CHRISTUS Health
Glenwood
REGIONAL MEDICAL CENTER
CHRISTUS Health
CHRISTUS Health
St. Tammany
SMH
Lafayette General Health
Ochsner
Health System
TGMC
Financially Integrated
Affiliated
Population by Metropolitan Area
1,000,000 to 9,999,999
100,000 to 999,999
10,000 to 99,999
1,000 to 9,999
TEXAS
LOUISIANA
MISSISSIPPI
ALABAMA
ARKANSAS


Ochsner Health System Locations
OMC-BR
OMC-K
OMC
OMC-NS
OMC-WB
Baptist
St. Anne
LEGEND
OHS Clinics
OHS Hospitals



Senator CASSIDY. Next, Mr. Chairman, you just set me up with your conversation with Dr. Gross. Because I now know that you are going to cosponsor our bill——

[Laughter.]

Senator CASSIDY.——that Senator Cantwell, Senator Carper, and I are working on, bipartisan, obviously, on direct primary care. Relatively simple change to the tax code to make these sort of arrangements that Dr. Gross spoke about so that the IRS will see that the DPC would be eligible to be paid for through a health savings account. Again, we have this—Cantwell, Cassidy, and Carper are doing this, and we would love to have all of you onboard as well.

Dr. Gross, my—I am a physician, and my observation is that when you align the incentives of the patient and the physician, both in terms of her health, as well as the financial incentives, is when you get the best outcomes. It sounds like that is what you are doing. Because if you are getting a colonoscopy, all-in with anesthesia, facility fee, pathology for $1,100, that is probably a Medicare rate. But I suspect you are sending them to the provider that

gives the greatest satisfaction, not the person who your wife or you play bridge with, and so—because otherwise, you lose your patient. You want them to be satisfied.

I point that out because we have had conversations—medicine is so complicated. How do you enable or equip the patient to make the right decision when, again, it requires a medical school education to fully fathom? But I gather your model aligns those incentives, again, working for her physical health as well as her pocketbook health. Is that a fair summary?

Dr. GROSS. No, I think it is absolutely a fair summary. You know, so what this program allows us to do is enter value into the conversation. Because if you do not know what things cost, then you cannot have the conversation. Because we believe—we take an oath to do no harm, and that should also include financial——

Senator CASSIDY. I have only got a few minutes. Let me interrupt. I am guessing that if an outpatient imaging procedure is required, and she is paying cash for it because her deductible is 6K or her HSA has paid for it, I suspect that you can get her the best price, cash price for that procedure?

Dr. GROSS. In many cases, the cash price is half the price of what would come out of pocket with an insurance.

Senator CASSIDY. But she would not know that, but you do. Correct?

Dr. GROSS. That is correct.

Senator CASSIDY. By the way, I will say, as practicing—well, I am kind of a practicing physician – it is rare for the physician to know actually what it is going to cost because, frankly, it is difficult. And yet, in your practice, it is mandatory in order for you to give guidance. So, again, hats off.

Dr. GROSS. Thank you.

Senator CASSIDY. Ms. DeMars, thank you for kind of engaging on the price transparency issue. That is something I care about, and I appreciate that. What on the Federal level could be done to aid the issue of price transparency, if you will?

Ms. DEMARS. You know what, that is a tricky question, and I would say that for starters, the Federal Government, as a purchaser itself providing health benefits to its employees, can be doing more to make price transparency available to those employees.

Senator CASSIDY. So if you are saying through the Federal Employees Health Benefit Program or through Medicare, mandating price transparency for the beneficiaries of those programs?

Ms. DEMARS. Yes.

Senator CASSIDY. You know, that makes sense to me because, obviously, if a hospital system buys a physician's practice and begins to bill Medicare through hospital outpatient department rates, as opposed to a freestanding rate, the beneficiary's co-pay goes up dramatically.

Ms. DEMARS. Yes.

Senator CASSIDY. She does not know it?

Ms. DEMARS. Correct.

Senator CASSIDY. She does not realize there has been a sale of a practice?

Ms. DEMARS. The co-pay would not necessarily go up, but—yes. I am sorry. Yes, you are right. The co-pay would go up.

Senator CASSIDY. Yes. So now, also I think you are operating in a state in which there has been efforts to address surprise medical billing?

Ms. DEMARS. We do that ourselves through our co-op.

Senator CASSIDY. How do you do that? If somebody goes to an out-of-network physician, even if they are an in-network hospital, how do you manage that?

Ms. DEMARS. Well, on the front end, we take a lot of steps to ensure that all of the ancillary providers that patient might see going into that building are in our network.

Senator CASSIDY. But if there is only one ER group, do you get an assurance from the hospital CEO that ER group with be in network?

Ms. DEMARS. We address that, yes, on the front end. In cases where there are ancillary providers that are not part of our network or where the hospital may sell off a service to an outside group like dialysis, we take steps to bring that provider in network, but not at any price, or negotiate on a one-off basis that patient's bill.

Senator CASSIDY. Well, I am out of time, but I would be interested, since dialysis providers tend to be a monopoly, how you happen to do that? But anyway, I——

The CHAIRMAN. Thank you, Senator Cassidy. We may have time to come back for a second round.

On your bill, I am very interested in that, look forward to talking with you about it. It would have to be—it would be a Finance Committee bill. But fortunately, you are on the Finance Committee. Senator Murray might—she can speak for herself—she might have an interest in it. So let us talk about that, what the score might be and what we could do to help move that along.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

Wisconsin has a tradition of pioneering efforts to contain costs and increase the quality of care, and I am so glad to have you, Ms. DeMars, here to share some of those Wisconsin successes.

One unique effort in our state is our state's all-payer claims database, the Wisconsin Health Information Organization that we know as WHIO. It helps increase transparency surrounding health costs and quality for subscribers that include physicians who can access claims data to help them compare costs and outcomes.

In 2015, Congress enacted my bipartisan Quality Data, Quality Healthcare Act to expand access to Medicare claims data by modernizing the Qualified Entity Program. This helped unlock Medicare's data for those who can use it best, and it empowered doctors to make better decisions that will improve patient care and reduce costs.

In your testimony, you shared WHIO's story in providing access to claims data as a qualified entity. Can you describe how healthcare decision-makers are utilizing this cost information and any barriers that remain in the QE program that prevent employers, providers, and insurers from unlocking the full potential of claims data to improve care quality and outcomes?

Ms. DEMARS. Thank you, Senator Baldwin.

You are exactly right that I think the first step to meaningful transparency is having claims data available, having that pool of data available from which to do measurement and compare performance. And WHIO, as you described, is a great example of a model that is working. Not perfect, but the data that it provides has been useful to The Alliance and many other payers, as well as providers, in helping to understand a baseline and then track over time things like resource use and even some measures of quality.

It is a strong underlying foundation that can be made better with greater participation by all payers, the access and availability of Medicare data, and also having that same resource available in all states. We have this in Wisconsin. We do not have this in Illinois. We do not have this in Iowa.

Many of our employers cross multiple states, have employees in multiple states, and so the usefulness of information on a state-by-state basis, nice if everyone is in Wisconsin. Difficult if you are trying to share information across a broader population or compare what is happening in Wisconsin with what is happening elsewhere.

Senator BALDWIN. Making sense of healthcare costs can be really confusing and overwhelming for patients. And they may deal with high prices at the pharmacy counter or variations in the price, say, of an MRI from one hospital to the next, without knowing what they are getting for the money expended.

I am really proud of The Alliance's work to empower patients with information that they can understand through the QualityPath initiative. It helps patients choose providers who deliver more efficient and high-quality care. Why is it important to give patients the information that they can and know how to use and specifically information about both costs as well as quality of care? And any other comments you might want to make about consumer-patient utilization of this information and how to expand that.

Ms. DEMARS. Yes, that is a great question. I think, for starters, most consumers do not understand the wide variation in costs. Nor do they believe, necessarily, or understand that there is differences in quality or that those two are not correlated. And so, I think it is critical for, first, education to occur, so that people understand that an MRI can cost $4,800 or $650 and that the quality of that care does not differ. So giving people that guidance is critically important.

What we have found is that it is not enough just to make information available to people. We need to provide them with greater support. For us, that often comes in the way of their employers, helping them understand and use information by providing incentives in benefit plan designs or through other means, through workplace-based programs, to be aware of information and then use it effectively. We are also interested in finding ways to partner with providers because we understand that once their primary care provider makes a referral, it is sometimes difficult then to change if you find that there is a low-cost or high-quality provider that you have not been referred to.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Hassan.

Senator HASSAN. Well, thank you, Mr. Chair and to Ranking Member Murray, for convening this hearing.

Thank you to all of our witnesses today for really important and meaningful testimony, and I want to start my questions with following up where Senator Cassidy was on surprise medical bills.

I have a bill as well, which is actually in HELP Committee, and my senior Senator from New Hampshire has another bill on this issue dealing with the individual market and the uninsured. So I think there is a lot of bipartisan interest here. It is something we hear about from our constituents all the time.

Studies have shown that nearly one in five emergency room visits involves care from providers who are out of network. And non-emergency situations often result in surprise medical bills as well. These situations are not the patient's fault, obviously. You do not know who is even reading your X-ray, for example. And it is fundamentally unfair to hold patients accountable for bills that they have no control over.

That is one of the reasons I introduced the No More Surprise Medical Bills Act of 2018, and my bill focuses on the parts of the large employer market that states cannot regulate. And it would stop surprise medical bills, and it would establish an independent dispute resolution process based on "baseball style" or final offer arbitration models to incentivize reasonable payments and resolve payment disputes between plans and providers without putting patients in the middle.

I know that we have work going on both sides of the aisle on this, but Executive Constantine, I wanted to start with you on this. How are you and your partners in King County working together to come up with innovative solutions to protect patients from surprise bills and hold down healthcare costs?

Mr. CONSTANTINE. Thank you, Senator.

King County works with our healthcare plans and employees to increase transparency, as we have talked about this morning, in cost delivery so that our employees can make informed decisions about their healthcare needs. But surprise billing is an area where patients have made an educated choice. They have made a responsible choice to opt for an in-network provider, only to find out after the fact that, for whatever reason, the provider changed.

As health plans work to more tightly coordinate care and manage costs, as with the new plan that I described for King County, this is only going to be a greater challenge. And unfortunately, there is not that much we can do, either as an employer or as a government, to protect our workers from this challenge. There has been legislation, the Washington State legislature tried to do what sounds very much like your bill. And I think it is absolutely critical that we stop surprise billing by holding the patient harmless and requiring those who are in a better position to understand who is to pay for what, who is covered and who is not, to take the responsibility.

I am not an expert on which dispute resolution process should be used, but I do think that this is something that needs to happen at the national level and not just on a state-by-state basis. I strongly support the intent of your bill. Everyone agrees, consumers should not be caught in the middle of these billing disputes. And

as an employer, I feel a particular responsibility to our employee family to make sure that they are not getting stuck with a large, unexpected medical bill.

Senator HASSAN. Yes, I talked to one of my constituents, literally went in for a cut on his finger to the emergency room. There was no other option. It was a Saturday night. So he needed to go to the emergency room to get it taken care of.

It was an in-network hospital. He ended up with a bill for $3,500. And he was able to negotiate it down to $1,200, all for really a cleaning off of the finger, and I do not even think stitches were involved. So I would appreciate continuing to work with all of you on that.

Ms. DeMars, I appreciated your testimony about all the work that you all try to do to make sure that your patients are not getting hit with these surprise bills, but I did want to move on to one more topic, which is one that Senator Baldwin was talking about. New Hampshire also has an all-claims database, and actually, I will give a shout-out to my state. We were the first ones in the country to do it.

We have been a leader in a lot of work related to promoting better value in healthcare. And we have for state employees something called Vitals SmartShopper Program. It offers financial incentives to employees to choose low-cost, quality options for their care. But I think to a point you were making, Ms. DeMars, and I just want to quickly get anybody else on the panel who wants to speak to it, for us, the critical thing has been to help patients understand that just because care is low cost—lower cost does not mean it is lower quality.

How do we really help patients understand, and how can we have transparency in outcomes as well as cost? So I will start with anybody who wants to answer that.

Go ahead, Ms. DeMars.

Ms. DEMARS. Happy to jump in. Yes, it is an education process. And I think that being able to show employees data in ways that are digestible, easy to understand and use, about cost and quality and how those two things are not correlated—high cost does not mean high quality—has been impactful.

I also think that as consumers increasingly have high-deductible health plans, that is making a difference. People—we have people's attention when they are paying the first $5,000 of their care. And we have found a willingness to take a look at and respond to information. Even more powerful if there is quality information to accompany the cost information.

Senator HASSAN. Well, I thank you. And I see I am over, Mr. Chair. I will invite the other witnesses to comment in writing as a follow up. Thank you so much.

The CHAIRMAN. Thank you, Senator Hassan.

We have a classified briefing at 11:00 a.m., but we have a little time for other questions.

Senator Murray, do you have any other comments or questions?

Senator MURRAY. Mr. Chairman, I just want to thank the panel. This has been really a good panel, and I appreciate all of your input.

I do have additional questions I will submit for the record. I know Dr. Cassidy wants to ask some, and as you said, we have a hearing, but I just want to—really appreciate everybody. Mr. Chairman, look forward to working with you on it.

The CHAIRMAN. Thank you, Senator Murray, and thanks for this, working with us together on this hearing.

Dr. Gross, I just have one question. Do you ever go to employers and say, "Why don't you buy our services for your employees?"

Dr. GROSS. Yes, and we have also had employers come to us as well.

The CHAIRMAN. Does that happen often?

Dr. GROSS. It does. Mostly with the small employers, the small employer market. This is a hospital that we just incorporated into their benefits plan as a—I think it was 400 plan, life plan. It is a self-funded plan, and again, we are going to see some extraordinary savings while expanding their coverage.

The CHAIRMAN. So if I could—if I employ 20 people, I might come to you and say, "I will pay you $1,000 or $1,200 per employee per year, and I will take the responsibly for providing a catastrophic insurance for big things."

Dr. GROSS. Right. And so that was actually part of our original epiphany was we had a company with 10 employees that came to us and said, "My insurance premiums are skyrocketing, and all my employees already see you. Why do I not just hire you to take care of my employees, and I will just take out a major medical plan?"

If you look at the cost of the standard PPO plan now under the Milliman Index, it was about $29,000 for a family of 4 per year, as opposed to a direct primary care plus a major medical plan. The 10-year savings over that, that is about $250,000 for a family of 4. That is a huge savings for an employer of 10 employees, potentially of saying there is that potential savings if the employee does not hit that mark. But even if that employee hit that $10,000 or $12,000 deductible every year, they would probably still come out about $100,000 ahead just by using the insurance as insurance and having a safety net.

The CHAIRMAN. More than 90 percent of Americans have some form of health insurance. Do you know what percent of your customers have health insurance?

Dr. GROSS. Mine is probably closer to 50 percent.

The CHAIRMAN. But 50 percent doing—still they pay the $60 a month?

Dr. GROSS. Same price, yes.

The CHAIRMAN. Dr. Cassidy.

Senator CASSIDY. We are out of time, and so I'd like to first submit into the record a letter from the AAFP, the American Academy of Family Physicians in support of the bill that we spoke of earlier.

The CHAIRMAN. So ordered.

[The information referred to follows:]

AMERICAN ACADEMY OF
FAMILY PHYSICIANS.

Hon. LAMAR ALEXANDER, *Chairman,*
Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

Hon. PATTY MURRAY, *Ranking Member,*
Committee on Health, Education, Labor, and Pensions,
428 Dirksen Senate Office Building,
Washington, DC.

DEAR CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write to share the organization's views on health care innovation in response to the Committee's hearing, "Reducing Health Care Costs Through Innovation." AAFP appreciates the opportunity to highlight primary care innovations including Advanced Primary Care, broader systems to address Social Determinants of Health, Direct Primary Care, and Independence at Home.

The benefits of primary care access are well-understood. U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health. The impact of better ratios holds true even after controlling for socio-demographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).

Advanced Primary Care

Advanced primary care activities and demonstrations are new delivery models focused on patient needs where primary care serves as a robust foundation for maximizing value in health care delivery. An investment in advanced primary care has been shown to spur better health outcomes and lower costs. In its sentinel research report, the Patient-Centered Primary Care Collaborative's 2018 indicates that new primary care delivery models, namely patient-centered medical homes (PCMH), played an integral role in the success of some accountable care organizations. Utilizing both the 2014 Medicare Shared Savings Program (MSSP) data set and the National Committee for Quality Assurance (NCQA) PCMH data set, the study documented that Medicare ACOs emphasizing broad adoption of the PCMH model had a higher likelihood of producing important savings, earned higher quality scores, and showed positive patient outcomes. On average, the programs with the higher number of PCMH primary care practices produced savings at 1.2 percent as compared to .6 percent for those with no advanced primary care practices.

In addition, ACOs with a strong emphasis on the PCMH model were associated with higher pneumococcal vaccination and depression screening scores. They also demonstrated better tobacco screening and cessation rates, and higher diabetic and coronary artery disease composite scores. The PCPCC study provides valuable information about the important synergies associated with advance primary care delivery and ACOs, but more research is needed to understand how to generate greater savings and evaluate programs' longitudinal health outcomes.

Social Determinants of Health

There are numerous exciting advances associated with health care delivery that better address the critical role that social determinants of health (SDOH) play in overall health care delivery improvements. A 2018 Health Affairs report suggests that community financing programs targeted at addressing SDOH are improving health outcomes, reducing health disparities, and reducing cost. Family physicians play an important role in identifying and addressing the social determinants of health for individuals and families, incorporating this information in the biopsychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care.

To support that mission, the AAFP established its Center for Diversity and Health Equity to provide opportunities to become a more thoughtful and visible leader in addressing SDOH. The AAFP has developed a new SDOH screening tool as part of an initiative called the EveryONE Project, and actively promotes this tool to our 131,400 members. The Academy also offers family physicians use of the

AAFP's nationwide Neighborhood Navigator referral network, which connects patients to food, housing and other resources to address SDOH based on their individual needs. AAFP also conducted a 2017 survey that found that nearly 60 percent of family physician respondents currently screen patients for SDOH and 52 percent follow up on identified needs by referring patients to community-based social services. As with other innovations, systems designed to address SDOH merit federal review to understand and promote best practices, identify opportunities for public-private partnerships, and bring promising programs to scale.

Direct Primary Care

The Direct Primary Care (DPC) innovation model is a practice and payment model where patients pay their physician or practice directly in the form of periodic payments for a defined set of primary care services. DPC practices typically charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services.

The DPC practice framework includes any practice model structured around direct contracting with patients/consumers for monthly or annual fees. For primary care services, DPC can replace the traditional system of third party insurance coverage. Typically, these periodic payments provide patients enhanced services over traditional fee-for-service medicine. Such services may include real time access to their personal physician via advanced communication technology, extended visits, home-based medical visits, and highly personalized, coordinated, and comprehensive care administration.

The AAFP supports the physician and patient choice to, respectively, provide and receive healthcare in any ethical healthcare delivery system model, including the DPC practice-setting. The Academy has supported the Primary Care Enhancement Act of 2017 (S. 1358), introduced by Senators Bill Cassidy and Maria Cantwell, to allow HSA enrollees to contract for services from a DPC practice and pay for it through the Health Savings Account structure. It is our hope that DPC is included in statutory health innovations as a high quality, patient-centered option.

Independence at Home

The AAFP also supports the Independence at Home program, a demonstration that provides high-quality primary care for Medicare patients with severe chronic illnesses and disabilities. We are pleased the Bipartisan Budget Act of 2018, passed by Congress and signed by the President on February 9, 2018, extended the Independence at Home demonstration for two years. The program is based on 20 years' worth of data showing that home-base primary care is an effective way to deliver care for seriously ill patients and to produce savings. Research shows that the demonstration program produced high quality care for seniors with chronic diseases and met their complex needs. We urge the Committee to examine this program as its health care review process continues.

We appreciate the opportunity to share innovative health care programs. Please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or *sclay@aafp.org* with any questions or concerns.

Sincerely,

MICHAEL L. MUNGER,
MD, FAAFP,
Board Chair.

Senator CASSIDY. Mr. Constantine, Dr. Perlin, you had talked about—in the written testimony of Mr. Gross, the issue of price transparency. This is what it costs in the hospital, this is what it costs—this is what it costs in his clinic. And we discussed price transparency, but I think there has been resistance from hospital systems regarding price transparency.

Now we only have about 5 minutes, and I just asked you the theory of life.

[Laughter.]

Senator CASSIDY. So I will ask you to submit in writing, because I really think it kind of goes to the crux of it, why should there

not be price transparency of what an all-in colonoscopy costs at a hospital? We understand burn patients are a different category, but—or a multiple trauma patient—that is what insurance is for.

But it does seem as if the—I bought your cardiology practice, you are now coming here to see the cardiologist. There should be some transparency there.

Again, we are out of time. So if you would submit that for the record, I would appreciate that.

Thank you.

The CHAIRMAN. Thank you, Senator Cassidy.

Well, thanks to the four of you for coming. This has been very helpful, and as we learn and listen, my hope is that we have plenty of ideological and political differences, and you can see them on display with a Committee this big, but we also usually find a way to identify those things on which we agree. And we certainly ought to be able to find ways to deal with the problem if it is true, and it appears to be true that as much as 50 percent of the money Americans spend on healthcare is spent unnecessarily.

Some of those ideas may be big. Some of them may be small. And Senator Murray and I and the Members of the Committee will work together over the next couple of years to see what we can do about that.

Your testimony has been very helpful. If you have things you wish you had said but did not, we will read what you write us, and we look forward to staying in touch with you.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time, if they would like.

The CHAIRMAN. The HELP Committee will meet again tomorrow, November 29, for an Executive Session.

Thank you for being here today.

The Committee will stand adjourned.

[Whereupon, at 10:54 a.m., the hearing was adjourned.]

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