S. HRG. 116–556

LOWER HEALTH CARE COSTS ACT

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE LOWER HEALTH CARE COSTS ACT

JUNE 18, 2019

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C O N T E N T S

STATEMENTS

TUESDAY, JUNE 18, 2019

LOWER HEALTH CARE COSTS ACT

Tuesday, June 18, 2019

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

The Committee met, pursuant to notice, at 9:34 a.m., in room 430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Collins, Cassidy, Murkowski, Romney, Braun, Murray, Casey, Baldwin, Murphy, Kaine, Hassan, Smith, and Rosen.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Committee on Health, Education, Labor, and Pensions will come to order.

Senator Murray has an important meeting right now, and she has asked me to proceed with the hearing because we have six excellent witnesses and we want to make sure that we hear from each of you, and then we want the Senators to have a chance to ask questions of each of you. So Patty should arrive about 10 o'clock. When she comes, we will interrupt and let her make her opening statement, and then we'll resume the hearing.

Good morning, Senator Murphy.

Nearly a year ago, Dr. Brent James from the National Academies testified before our Senate Health Committee with a startling statistic: up to one-half of what the American people spend on health care may be unnecessary.

Let me repeat that: up to half of the $3.5 trillion the United States collectively spent on health care in 2017 was unnecessary, according to Dr. James, and many of the other witnesses at our hearings agreed with that.

That is $1.8 trillion, three times as much as we spend on all of our national defense, 60 times as much as we spend on Pell grants for college students, and about 550 times as much as we spend on national parks.

A recent Gallup poll found that the cost of health care was the biggest financial problem facing American families.

Like every American family, both Democrat and Republican United States Senators are concerned about the cost of health care. Health care has become a tax on family budgets and on businesses, and on Federal and State governments. Warren Buffett has called it "a tapeworm on the American economy."

Over the last 2 years, this Committee has held 16 hearings on a wide range of topics related to reducing the cost of health care;

specifically, how do we reduce what the American people pay out of their own pockets for health care. These included hearings on the cost of prescription drugs, on the 340B drug discount program, on primary care, and the importance of vaccines.

Last December, I sent a letter to experts at the American Enterprise Institute and the Brookings Institution, and to doctors, economists, Governors, insurers, employers, and other health care innovators, asking for specific steps the Congress could take to lower the cost of health care. We received over 400 recommendations, some as many as 50 pages long.

In May, Senator Murray and I released for discussion the Lower Health Care Costs Act of 2019, a package of nearly three dozen proposals from 16 Republican Senators and 14 Democratic Senators, that is designed to reduce what Americans pay out of their own pockets for health care.

Since then, we've received over 400 additional comments on the legislation, and today's hearing was scheduled to hear your feedback on this legislation that will reduce what Americans pay out of their own pockets for health care.

First, it ends surprise billing.

Second, the legislation creates more transparency. There are seven bipartisan proposals in the bill that will eliminate gag clauses and anti-competitive terms in insurance contracts, designate a non-profit entity to unlock insurance claims for employers, ban Pharmacy Benefit Managers from charging more for a drug than the PBM paid for the drug, and require patients to be given more information on the cost and quality of their care. You can't lower your health care costs until you know what your health care costs actually are.

Third, it increases prescription drug competition. There are nine bipartisan proposals within this legislation to bring more lower-cost generic and biosimilar drugs to patients. That is about 90 percent of all the drugs that are prescribed.

Here are a few of the ways this legislation will lower health care costs.

Ensure that patients don't receive a surprise medical bill, which is when you receive a $300 bill, or even a $3,000 bill 2 months after your surgery because one of your doctors was outside of your insurance network.

Many Senators, including Senator Cassidy, Senator Hassan, Senators Murkowski and Enzi, and many others are interested in ending surprise billing.

It lowers the cost of prescription drugs by helping biosimilar companies speed drug development through a transparent, modernized, and searchable patent data base. Senators Collins, Kaine, Braun, Hawley, Murkowski, Paul, Portman, Shaheen, and Stabenow worked on this provision.

Improves the Food and Drug Administration's drug patent data base by keeping it more up to date to help generic drug companies speed drug development, a proposal offered by Senator Cassidy and Senator Durbin.

I'm mentioning these Senators names on purpose because I want it to be clear how much work has been done by Democratic as well as Republican Senators together on the provisions in this bill.

Prevents the abuse of citizens petitions that can be used to unnecessarily delay drug approvals; Senators Gardner, Shaheen, Cassidy, Bennett, Cramer, and Braun.

Clarifies that the makers of brand biological products, such as insulin, are not gaming the system to delay new, lower-cost biosimilars from coming on the market; Senators Smith, Cassidy, and Cramer.

Eliminates a loophole that allows drug companies to get exclusivity just by making small tweaks to an old drug, a proposal from Senators Roberts, Cassidy, and Smith.

Bans gag clauses that prevent employers and patients from knowing the price and quality of health care services. This proposal from Senators Cassidy and Bennet would allow an employer to know, for example, that a knee replacement might cost $15,000 in one hospital and $35,000 at another.

Requires health care facilities to provide a summary of services when a patient is discharged from a hospital to make it easier to track bills, and requires hospitals to send all bills within 30 business days to prevent unexpected bills many months after care. That is from Senator Enzi and Senator Casey.

Requires doctors and insurers to provide patients with price quotes on their expected out-of-pocket costs for care so patients are able to shop around, a proposal from a number of Senators, including Cassidy, Young, Murkowski, Ernst, Kennedy, Sullivan, Cramer, Kennedy, Braun, Hassan, Carper, Bennet, Brown, Cardin, Casey, Whitehouse, and Rosen.

Increases vaccination rates and prevents disease outbreaks through two proposals by Senators Roberts and Peters, and there are more proposals.

For example, banning anti-competitive terms in health insurance contracts that prevent patients from seeing other, lower-cost, higher-quality providers. The Wall Street Journal identified dozens of cases where anti-competitive terms in contracts between health insurers and hospital systems increase premiums and reduce patient choice.

Banning Pharmacy Benefit Managers, or PBMs, from charging employers, health insurance plans, and patients more for a drug than the PBM paid to acquire the drug, which is known as 'spread pricing.'

Eliminating a loophole allowing the first generic drug to submit an application to the FDA that can block other generic drugs from being approved.

Provisions to help Americans stay healthy by preventing obesity, and improving care for expectant and new moms and their babies.

Provisions to make it as easy to get your personal medical records as it is to book an airplane flight.

Provisions to incentivize health care organizations to use the best cybersecurity practices to protect your health information privacy.

Other Senators may have additional ideas that we hope to be able to vote on at a markup later this month.

For example, Senator Murphy and Senator Cassidy are working to improve access to mental health care, building on their work in this Committee last year that became a part of the SUPPORT Act.

I am optimistic we can get agreement to include something on that in this bill as well.

Other committees in the Senate are also working on their own packages of legislation to lower the cost of health care.

Since January, Senator Murray and I have been working in parallel with Senator Grassley and Senator Wyden, who head the Finance Committee. They are working on their own bipartisan bill, which they plan to markup this summer.

The Senate Judiciary Committee is working on some bipartisan bills to address high drug costs and has held a hearing on consolidation in health care.

The House of Representatives Energy and Commerce, Ways and Means, and Judiciary Committees, have all reported out bipartisan bills to lower the cost of prescription drugs.

Secretary Azar and the Department of Health and Human Services have been extremely helpful in reviewing and providing technical advice in a timely way on various proposals to reduce health care costs.

The President has called for ending surprise billing and reducing the cost of prescription drugs.

The Administration has also taken steps to increase transparency so families and employers can better understand their health care costs.

For the last decade, Congress has been locked in an argument about the individual health insurance market, where 6 percent of Americans get their health insurance.

Especially for Americans without subsidies, the cost of health insurance remains way too expensive. I am sure that the debate about how to fix that will continue. But that is not this discussion. This is a different discussion.

We will never have lower-cost health insurance until we have lower-cost health care, which is why our Lower Health Care Costs Act of 2019 takes steps that will actually bring down the cost of health care that Americans pay out of their own pockets.

This bill will lead to doctors, hospitals, insurance companies, and employers providing Americans a better experience and a better outcome at a lower cost.

I want to thank Senator Murray and her staff. She is not here at the moment, but her staff is, led by Evan Schatz and Nick Bath, and my staff, led by David Cleary and Grace Graham, who have worked together to find about three dozen proposals that Democrats and Republicans agree on to reduce health care costs.

This is not unusual for our Committee, because we have found a way to provide solutions to difficult problems that Members of both Republican and Democratic caucuses can support. We did that with fixing No Child Left Behind, we did it with the 21st Century Cures Act, we did it with user fee funding for the Food and Drug Administration, and most recently, in the midst of all the fireworks over Justice Kavanaugh, we had 72 Senators of both parties working together to produce the legislation that dealt with the opioid crisis.

Our goal for this legislation, the Lower Health Care Cost Act of 2019, is to be one more example of that sort of cooperation, because

the American people expect us to work together to provide ways to reduce what they pay for health care out of their own pockets.

Now, as I mentioned earlier, we will proceed with the witness testimony. I'll introduce the witnesses now. When Senator Murray comes, we'll ask her to make her opening statement. Then we'll proceed with the witnesses, and then we'll go to questions from the Senators.

I'm pleased to welcome the six witnesses.

Sean Cavanaugh is the first. He serves as Chief Administrative Officer at Aledade. It's a startup founded in 2014. It works to develop and strengthen accountable care organizations in order to reduce health care costs and improve care. He joined Aledade in 2017 during the same year he served as an advisor for Parent Ping, an innovative Boston-based health technology company, as well as Omada Health. Prior to 2017, he was Deputy Administrator and Director of the Center for Medicare at the U.S. Centers for Medicare and Medicaid Services. He now sits on the Board of Directors for the Center for Medicare Advocacy. He is a graduate of the University of Pennsylvania, received his Master's in Public Health from Johns Hopkins.

Dr. Ben Ippolito is an Economic Policy Research Fellow at the American Enterprise Institute. He focuses on health economics and health policy. A lot of his recent work pertains to price regulation, specifically surprise medical billing. He graduated from Emory before receiving his Master's and Ph.D. in Economics at University of Wisconsin-Madison.

Tom Nickels is Executive Vice President of Government Relations and Public Policy of the American Hospital Association, representing approximately 43,000 individuals, and serves nearly 5,000 hospitals, health care systems, and health care providers. Mr. Nickels has been with the American Hospital Association since 1994. He was Director of the American College of Emergency Physicians Washington office before that.

Senator Collins, would you like to introduce Ms. Mitchell.

Senator COLLINS. I would. Thank you, Mr. Chairman.

Mr. Chairman, I know I speak on behalf of all the Members of the Committee in welcoming you back and saying it's great to see you looking so well.

The CHAIRMAN. Thank you.

Senator COLLINS. I very much appreciate the opportunity to introduce Elizabeth Mitchell. Although she is testifying in her role as the President and CEO of the Pacific Business Group on Health, I wanted the Committee to know that she is a native Mainer who we hope is only temporarily living on the West Coast.

Before her work took her across the country, Ms. Mitchell led a multitude of health care organizations in the State of Maine, including serving as CEO of the Maine Health Management Coalition and the Network for Regional Health Care Improvement in Portland. In those roles she was a powerful catalyst for health care transparency and quality improvement. She also served in the Maine State Legislature.

Although Ms. Mitchell and I are in different political parties, I can tell you that I've always found her work to be insightful, practical, and non-partisan. Given her extensive efforts to improve

health care transparency and quality, I was pleased to recommend Ms. Mitchell for the Federal Physician Focused Payment Model Technical Advisory Committee, one of the longest committee names possible, PTAC, where she served as Vice Chair. I very much look forward to hearing Elizabeth's testimony this morning from an employer perspective.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

Welcome, Ms. Mitchell.

Mr. Frederick Isasi is Executive Director of Families USA, a nonprofit consumer health advocacy organization that promotes a high-quality, affordable, and patient and community-centered health system. He was once Health Division Director at the bipartisan National Governors Association Center for Best Practices. In addition to his work with the Governors, he served as Vice President for Health Policy at the Advisory Board Commission and as Senior Legislative Council on both the Finance Committee in the Senate, and the Pension Committee for our friend, former Senator Jeff Bingaman.

Welcome.

Our final witness is Marilyn Bartlett, Special Projects Coordinator for the State of Montana's Commissioner of Securities and Insurance. She is recognized as a leader in health care cost reforms and legislative initiatives, as well as improving benefit plan cost effectiveness. Before working for the Montana Commissioner, she served as Health Care and Benefits Division Administrator for Montana and managed health care for 33,000 individuals, distributed $200 million in annual benefits. She is credited with negotiating down the state's health care plan costs and increasing health care price transparency in Montana.

Thanks to all of you for coming.

Mr. Cavanaugh, let's begin with you. Welcome.

STATEMENT OF SEAN CAVANAUGH, CHIEF ADMINISTRATIVE OFFICER, ALEDADE, WASHINGTON, DC

Mr. CAVANAUGH. Thank you, Mr. Chairman.

I'm Sean Cavanaugh, Chief Administrative Officer at Aledade. We partner with independent physicians in 24 States to succeed in value-based payment models, such as ACOs.

Mr. Chairman, you mentioned Dr. James' testimony where he talked about the enormous amount of waste in our health care system. I think we all face a fundamental decision of how we're going to get rid of that waste, and it really boils down to a choice of two approaches. One is competition, and the other is regulation.

I personally have a background in regulation. I am, one might say, the ultimate regulator. You mentioned I worked at CMS. At CMS, I published regulations all year long, centrally administering prices. In a previous career I worked at the Maryland Hospital Rate Setting Commission, where I set all payer hospital rates in Maryland.

I am here to tell you, whenever possible, we should rely on competition, not regulation. So I applaud the approach this Committee has taken to try to ensure competition works wherever possible.

At Aledade, we believe maintaining a robust, independent physician sector is essential to supporting competition and high-value care. Unfortunately, this approach is at risk as hospitals have aggressively been purchasing physician practices, and hospital consolidation is a growing impediment to competition and high-value care.

Over half the markets in this country are considered highly consolidated by objective standards of hospital consolidation. And we know when hospitals merge, prices increase and quality stagnates. Hospitals have argued that consolidation will lead to greater efficiencies and more coordinated care, but the evidence doesn't bear this out.

Gag clauses, anti-tiering, and all-or-nothing clauses are all prime examples of excess market power, enabling anti-competitive behavior. These practices run counter to the movement to value-based care.

Aledade strongly supports the provisions of Title 3 that should restore some competition to these overly consolidated markets.

Other provisions of the legislation address other market failures and deserve support. Surprise billing in particular occurs because of a market failure. Patients don't have the time or the information necessary to shop to avoid these bills. We applaud this Committee's willingness to take on this issue and your willingness to consider multiple solutions and put patients interests first.

For many years, studies of the American health care system have relied solely on Medicare claims data. This is problematic. Medicare is very different than the private insurance sector, and the patients are very different as well. Many anti-competitive behaviors have been exposed by studies using multi-payer claims data bases such as the one administered by the Health Care Cost Institute.

I applaud your restrictions on PBM spread pricing. PBMs should be competing on the basis of providing high-value formularies to health plans and should generate the revenue that way, not by taking advantage of asymmetries in information between drug manufacturers and health plans and employers.

Finally, while I support time limits on provider billing—I think that's very patient-centric—I do worry. We work with quite a few small practices and rural practices, and we wonder whether some of them might struggle with a 30-day limit. So I ask the Committee to consider whether small rural practices should have longer timeframes.

Finally, I want to mention a couple of other things this Committee hasn't done but should consider in future legislation, eliminating facility fees for services that can be provided in a physician's office. These fees are unnecessary and have helped fuel hospital consolidation.

Anything you can do to support physicians in independent practices—loan repayment programs, even for those who work in private practices—would be great.

We encourage the Committee to reform restrictive CON rules, which often give hospitals monopoly powers.

We encourage you to reinvigorate antitrust enforcement generally and specifically grant the FTC the ability to review potentially anti-competitive behavior by hospitals.

Finally, our personal story at Aledade, we believe hospitals should be required to share patient-centric data. There is literature that shows when a patient is discharged from a hospital and sees a primary care physician shortly thereafter, they do better. They have fewer comorbidities, fewer readmissions. At Aledade, that's one of our big strategies, how our doctors visit the patient after discharge. We go to local hospitals and say we will bear the cost of the interface, we will bear the cost of setting up you alerting us when these patients are discharged. Most hospitals comply because they realize it's good for their patients, but there is a subset of hospitals that refuse to share these data for competitive reasons. We think hospitals ought to be compelled to share these data, especially when we're bearing the costs.

CMS has proposed a rule in this regard, and we're supportive of that, but anything that fosters patient-centric data-sharing is good for their health and safety and the Committee should support.

Thank you for your time, Mr. Chairman.

[The prepared statement of Mr. Cavanaugh follows:]

PREPARED STATEMENT OF SEAN CAVANAUGH

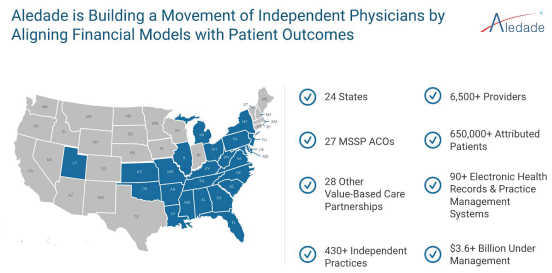
Chairman Alexander, Ranking Member Murray and Members of the Committee, thank you for inviting me to discuss the Lower Health Care Costs Act.

My name is Sean Cavanaugh, Chief Administrative and Performance Officer for Aledade, a health care company that partners with independent primary care physicians to help them transition to and thrive under value-based payment models. Previously, I served at the Centers for Medicare and Medicaid Services (CMS) for 6 years, as the Deputy Director of the Center for Medicare and Medicaid Innovation (CMMI) and then as Director of the Center for Medicare. In those capacities, I supported the movement toward value-based payment and service delivery models in Medicare and Medicaid, and I'm proud to continue that work in the private sector.

Aledade was founded in 2014 to help independent physicians thrive in value-based programs. We bring together independent primary care practices who are committed to value-based care, join the Medicare Shared Savings Program, and negotiate similar accountable care organization (ACO) arrangements with commercial payers. We provide population health workflow tools and integrated data analytics, and we transform how our practices deliver care.

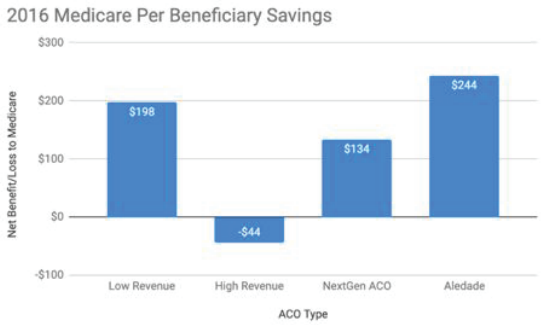
Aledade has grown rapidly and continues to do so. This year, Aledade is partnering with over 430 independent physician practices, Rural Health Centers and federally Qualified Health Centers. Organized into 27 ACOs across 24 States, these physicians are accountable for nearly 650,000 people; this includes 350,000 beneficiaries through the Medicare Shared Savings Program, and almost 300,000 people (Figure 1) through ACO arrangements with Medicare Advantage plans, commercial insurers and other payers. More than half of our primary care providers are in practices with fewer than ten clinicians.

Figure 1. Summary of Aledade's Footprint.



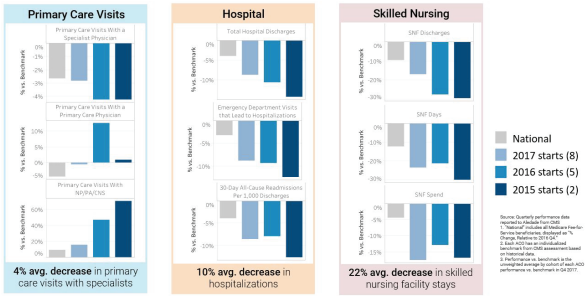
Aledade is producing meaningful results. In 2017, our ACOs saved Medicare over $40 million. But we are not alone in succeeding in the Medicare Shared Savings Program. Our analysis of CMS data shows that physician-sponsored ACOs are generating outstanding results (Figure 2). CMS data indicate that "low revenue" ACOs (i.e., largely physician-led) generated nearly $200 in savings per beneficiary in 2016, or $499 million, in total, to Medicare. By comparison, "high revenue" ACOs (i.e., largely hospital-led) generated a net loss to Medicare. The Next Generation ACO model also produced positive results. On average, Aledade ACOs outperformed both Next Generation ACOs and other physician-led ACOs.

Figure 2. 2016 MSSP ACO Performance



These savings were generated through real improvements in the care received by Medicare beneficiaries. We have empowered our practices to deliver more primary care and reduce unnecessary hospitalizations and post-acute care stays, and our results improve the longer our practices work with us (Figure 2).

Figure 2. Summary of Aledade's Results.



We are committed to outcome-based approaches to improve the value of health care. We are committed to using technology, data, practice transformation expertise and, most important, the relationship between a person and their primary care physician (PCP).

We are pleased to see the Committee's attention to lowering health care costs and believe that increasing provider competition is central to doing so. My testimony focuses on the encouraging pro-competitive provisions included in the Lower Health Care Costs Act. I have also offer several additional ideas for the Committee to consider as it continues to assess next steps.

Competition

As a Nation, we need to make a fundamental decision about how to drive more efficiency and higher quality in our health care system. In simple terms, this choice is between a competitive approach and a regulatory approach. I have extensive experience as a regulator: I set all-payer prices for Maryland hospitals and established provider and health plan payment rates at CMS, which guide over $600 billion in spending a year. But, we should rely on regulation only when market competition isn't feasible, or when it has failed. To give markets a chance to work, we have to establish an environment that fosters competition. Unfortunately, our current health care system has a number of market failures, including payer and provider consolidation, and our laws permit practices that undermine competition.

It is well known that hospital consolidation is a growing impediment to a high-value health care system. Evidence continues to show that when hospitals merge prices increase and quality stagnates.[1] And this makes sense: concentration increases the local bargaining power of large health systems, which allows them to demand higher prices for services in the commercial market. And without alternative providers to generate competition, there is little incentive to provide higher quality care.[2] Further, we see the most aggressive actors exert their market dominance with anti-competitive contracting practices that entrench their position in the market. Hospitals have argued that consolidation will lead to greater efficiencies and more coordinated care, but the evidence shows the opposite is true.

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[1] Vogt. W.B., & Town, R. (2006). How Has Hospital Consolidation Affected the Price and Quality of Hospital Care, Robert Wood Johnson Foundation. Research Synthesis Report No. 9. *http://www.rwjf.org/content/dam/farm/reports/issue—briefs/2006/rwjf12056/subassets/rwjf12056—1;* Ginsburg, P.B. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power.; Gaynor, M., & Town, R. (2012). The Impact of Hospital Consolidation—Update. Robert Wood Johnson Foundation. Policy Brief No. 9. *http://www.rwjf.org/content/dam/farm/reports/issue—briefs/2012/rwjf73261;* White et al. Inpatient Hospital Prices Drive Spending Variation for Episodes of Care for Privately Insured Patients. Cooper et al. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured; New York State Health Foundation, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement.

[2] Gaynor, M., Ho, K., & Town, R.J. (2015). The Industrial Organization of Health-Care Markets. Journal of Economic Literature. 53(2), 235–284. *http://dx.doi.org/10.1257/jel.53.2.235;* Vogt, W. B., & Town, R. How has hospital consolidation affected the price and quality of hospital care?; Gaynor, M., & Town, R. (2012). The impact of hospital consolidation—Update.

I applaud this Committee for confronting some of the current contracting abuses and market failures—and for trying to chart a path toward true competition. Gag clauses, anti-tiering, anti-steering, as well as all-or-nothing clauses, are prime examples of excess market power enabling anti-competitive behavior. By banning gag clauses, Congress can prohibit dominant providers from concealing the price and quality of the care delivered by health systems; this is information about the people's health care, and patients and their representatives, such as employers, ought to know it. A similar abuse arises when health systems demand that insurance companies do not "tier," or rank, their providers based on the cost and quality of the care that patients receive. Anti-steering clauses prohibit health plans from encouraging patients to receive care with higher value providers. And finally, "all or nothing" clauses are coercive to health plans; they state that "if you're going to contract with any providers of our system, you must contract with all of them." This allows a monopoly in one area to diminish competition in a completely different market.

Together, these practices are anti-competitive and hurt patients. They stand in direct opposition to the movement to value-based care, asserting that cost and quality don't matter if dominance in the market is great enough.

There is one objection to these provisions that I'd like to address, both as a former regulator and in working closely with rural health care providers today. Some have claimed that banning these market distorting practices could limit the power of health systems to negotiate higher rates that support some rural hospitals. In response, I would first question how prevalent this dependence is. Second, where these rural hospitals do struggle, the solution to inadequate funding is not to promote anti-competitive behavior and opaque cross-subsidies. If rural hospitals need greater support, direct subsidies would be a more efficient and transparent mechanism.

I also note that there are new models being tested that focus on rural health care, including important ones in Pennsylvania and Maryland, under the auspices of the CMS Innovation Center. Both of these models seek to ensure access to care in rural communities while still promoting high value care. Neither model relies on anti-competitive behavior.

In addition, there are other ideas to promote rural health while advancing value-based care competition. One such idea would fix what is known as the Rural Glitch, which is a quirk in Medicare ACO policy that systematically disadvantages rural providers who participate in ACOs. Such policy remedies come at a much lower cost because they directly address the rural issues. We urge Congress to press ahead with such proposals and consider incorporating them in your legislation.

There are additional elements of this legislation that would address other market failures and deserve support.

Surprise billing. Surprise billing involves taking advantage of vulnerable patients who are not in a position to make an informed alternative choice. A functioning market would never permit surprise billing because *it would drive away business from those who engage in the practice.* The fact that we have this problem is proof of a market failure that requires corrective action by Congress. We applaud this Committee's willingness to take on this issue and to consider multiple solutions.

All-payer claims data base. For many years, studies of the American health care system relied on Medicare claims data, which was the only available national data base. But we know that Medicare beneficiaries are very different from the privately insured population and that the two markets often behave very differently. Many of the anti-competitive practices that this legislation seeks to correct were exposed by studies using multi-payer claims data bases, such as the one administered by the Health Care Cost Institute. We need to support and nurture these types of data bases to understand market dynamics.

Restrictions on PBM spread-pricing..Markets do not work when important information is kept from customers, including health plans and employers. PBMs should be competing on the basis of providing high-value formularies to health plans and should generate revenue on that basis, not by arbitraging asymmetries in information between drug manufacturers and health plans and employers. Again, if the market for PBM services were highly competitive, PBMs would not be able to withhold information from their customers. In light of this market failure, it's appropriate for Congress to take action.

Claims submission time limit. We are supportive of time-dependent requirements on billing. This is directionally the right step, it promotes transparency, and it is patient-centric. One cautionary note: we worry that this could impose a burden on small physician practices. Many of our solo practitioners who work around the clock

seeing patients may struggle to submit a bill within 30 days . So I urge you to consider exemptions or longer timeframes for small practices in legislation like this.

Additional Recommendations to Improve Competition

This legislation takes steps to address the most egregious contracting practices that result from consolidation, but there is much more to be done to make our provider markets more competitive. Some of the ideas highlighted here are drawn from the work of Dr. Farzad Mostashari (CEO of Aledade), Dr. Martin Gaynor and Dr. Paul Ginsburg, writing with the support of the Brookings Institution. [3]

- Site-neutral payments. Facility fees paid to hospital outpatient departments for services that can be provided in physician offices helps hospitals acquire independent practices and reduce competition in their markets. Congress passed legislation in 2015 to put an end to extra Medicare payments to new hospital sites but "grandfathering" allowed sites acquired before 2017 to continue billing and receiving "facility fees.". In recent rulemaking, the CMS has attempted to apply site-neutral payments to a limited number of so-called "excepted" sites, and for a limited number of services. That rule change is being challenged in court, and we encourage a legislative remedy that achieves full site neutrality.
- Improve access to capital for independent practices. Independent physician practices, especially PCPs, appear to perform better in value-based models, but their financial status is often weak. Congress could expand loan repayment programs to providers who serve in rural areas, even if they work at private practices. Congress could also focus on Small Business Association loans targeted at rural private practices.
- Reform Certificate of Need (CON) rules. When a state strictly limits the number of hospitals that can receive a CON for a particular service, it is often granting monopoly power for that service in those markets with no corresponding mechanism to control costs or improve quality. Congress could establish Federal grants for states that commit to pro-competitive policies, such as repealing or reforming CON laws.
- Reinvigorate antitrust enforcement. The FTC, which can oversee mergers of nonprofit hospitals, does not have the ability to review other potentially anti-competitive behavior by hospitals. While this legislation would outlaw many of the contracting abuses that FTC would potentially monitor, we believe that the agency should be better equipped moving forward.
- Require patient-centric data sharing. Medical and economic literature demonstrate that patients have fewer readmissions and other adverse outcomes when they see their PCP after discharge from the hospital. Aledade practices avoid one hospital readmission for every eight transitional care visits they provide. But independent physicians can provide this care only when they receive timely notification of the patient discharge. Aledade has encountered resistance from some hospitals in providing these data—even when we bear the cost of the interfacing and there is no technological barrier. CMS recently published rules requiring hospitals to share admission, discharge and transfer data. We applaud this move as it will greatly increase patient safety. That the rules are needed at all is proof that maintaining a competitive environment requires vigilance.

I am very supportive of this legislation and commend the Committee for its bipartisan work. Thank you for the opportunity to share Aledade's experiences with you, and I look forward to continuing to engage with Members of the Committee as you consider this legislation.

[SUMMARY STATEMENT OF SEAN CAVANAUGH]

My name is Sean Cavanaugh, Chief Administrative Officer for Aledade, a health care company that partners with independent primary care physicians to help them succeed in value-based care, particularly accountable care organization (ACOs). We provide population health workflow tools and integrated data analytics, and we

[3] Gaynor, M; Mostashari, F; Ginsburg P (2017) Making Health Care Markets Work: Competition Policy for Health Care. Brookings Institution.*https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/*

transform how our practices deliver care. Our mission is to sustain independent primary care and offer community providers an alternative to hospital consolidation. We are pleased to see the Committee's attention to lowering health care costs by promoting competition.

To address rising health care costs, we should work to create a more competitive market before resorting to more regulatory approaches. Unfortunately, our current health-care system is rife with market failures, including payer and provider consolidation, and our laws permit practices that undermine competition. Evidence continues to show that when hospitals merge prices increase and quality stagnates. I applaud the Committee for confronting anti-competitive practices and for charting a path toward true competition. Gag clauses, anti-tiering, anti-steering, as well as all-or-nothing clauses, are prime examples of excess market power enabling anti-competitive behavior. These practices stand in opposition to the movement to value-based care.

I also commend the Committee for supporting the creation of an all-payer claims data base. For many years, studies of the American health care system relied solely on Medicare claims data. Many of the anti-competitive practices that this legislation seeks to correct were exposed by studies using multi-payer claims data bases, such as the one administered by the Health Care Cost Institute. We similarly support action on PBM practices, in which consolidation has led to pricing opacity that increases costs. Finally, we support time limits on billing because it promotes transparency, and it is patient-centric, but we urge the Committee to consider exemptions or longer time requirements for small practices that may struggle, in earnest, to meet such deadlines.

The Committee could take additional steps to support competition by creating site neutral payments for services that can be provided in a physician's office, improving access to capital for small practices to enable physician independence, strengthening the FTC, and encouraging states to remove anti-competitive regulation, such as Certificate of Need (CON) laws.

Thank you for this opportunity to testify today.

The CHAIRMAN. Thank you, Mr. Cavanaugh, for your testimony. Dr. Ippolito, welcome.

STATEMENT OF BENEDIC N. IPPOLITO, RESEARCH FELLOW, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. IPPOLITO. Thank you very much. Chairman Alexander, Ranking Member Murray when she arrives, and Members of the Committee, thank you for the opportunity to appear before you today to discuss the Lower Health Care Costs Act.

My name is Benedic Ippolito, and I am an economist and research fellow at the American Enterprise Institute.

I first want to applaud the Committee on this evidence-based and constructive proposal. Together, the provisions in this bill will meaningfully increase competition and transparency in health care markets. If enacted, this legislation would lower insurance premiums and drug prices for consumers, and it would ensure patients are no longer exposed to surprise medical bills.

By lowering costs, this bill would also improve access to health care. It's a laudable proposal and one of the most impressive bipartisan health policy bills in recent years.

Now, much of my written testimony is going to echo recommendations submitted to the Senate HELP Committee by health policy experts at AEI and the Brookings Institution earlier this year. In my remarks this morning, I'm going to focus on two provisions of the Lower Health Care Costs Act: namely, establishing a transparency organization to lower health care costs, and ending surprise medical bills.

First, the provision establishing a non-governmental entity that would assemble and analyze data from commercial insurers would meaningfully improve our understanding of the private health care market, and I'm very much going to echo the previous comments by saying that the Federal Government already regulates many parts of the private health care market, yet much of our understanding of health care has traditionally come from public payers like Medicare. As it was previously noted, this represents a substantial problem.

Ensuring a vibrant and competitive private market requires that policymakers are not flying blind. Assembling data on the private market in this manner would improve research and, in turn, improve policymaking.

Second, I'd like to discuss surprise medical billing, a feature of the health care system that has received considerable recent attention. All three proposals included in the draft legislation represent serious attempts to resolve this issue.

With that said, adopting an in-network guarantee is the best option. It represents a straightforward and market-oriented way to stop surprise medical bills before they ever occur rather than adjudicating them after the fact.

By tasking hospitals with ensuring that physicians are in-network for insured patients, market actors would need to bargain over prices themselves rather than having those prices set by arbitration. Physicians at in-network hospitals would have two choices: either they could come to an agreement with the insurer, as many already do; or they could choose to be paid by the hospital if they prefer. This would force the small number of bad actors to stop surprise billing patients and impose little additional burdens on the majority of providers who do not engage in this behavior.

This approach has received support from a wide array of health policy experts, including those at the Brookings Institution, the Center for Budget and Policy Priorities, Georgetown Law, Yale University, and my colleague Jim Capretta at AEI. As scholars at Brookings note, the in-network guarantee is the only option that would fully address the market failure that gives rise to surprise bills, and as economists at Yale further emphasize, the resulting payments would be generated by market forces.

I agree with these assessments, and I really think this is a point worth emphasizing. With an in-network guarantee, there are no more surprise bills to adjudicate after the fact. We need not rely on an arbiter to tell us which of either the provider or the insurer is being more reasonable. The bills simply do not happen, and we task market actors with figuring out what an appropriate market price is.

Now, an alternative option would have disputes over out-of-network bills be adjudicated by an arbiter. While I understand the appeal of this process, I think in practice arbitration effectively represents an inferior version of setting a simple benchmark. The arbiter ultimately must decide what a reasonable price for a service is, just like a price setter would.

Moreover, the process is less transparent. It includes unnecessary expenses. It can be unpredictable. It takes the resolution out of the hands of market actors, and it does not stop surprise bills

from occurring in the first place. An arbitration scheme is not the best option for resolving surprise medical billing.

Now, while some pieces are yet to be finalized, I do want to be very clear on one thing. This bill represents a very impressive bipartisan effort to meaningfully lower health care costs for Americans. I applaud your efforts, and I genuinely thank you for the opportunity to be here today, and I look forward to your questions.

[The prepared statement of Mr. Ippolito follows:]

PREPARED STATEMENT OF BENEDIC N. IPPOLITO

Chairman Alexander, Ranking Member Murray, and Members of the Committee. Thank you for the opportunity to appear before you today to discuss the Lower Health Care Costs Act.

I want to applaud the Committee on this evidence-based and bipartisan effort. Together, the provisions in this bill would meaningfully increase competition and transparency in health care markets. If enacted, this legislation would lower insurance premiums and drug prices for consumers, and would ensure patients are no longer exposed to surprise medical bills. By lowering costs, this bill would also improve access to health care.

In this testimony, I discuss a few of the specific provisions—some of which echo those submitted to the Senate HELP Committee by health policy experts at the American Enterprise Institute and the Brookings Institution at the request of Chairman Alexander.[1] Specifically, I focus on two titles of the proposed bill: ending surprise medical billing and increasing transparency in health care.

Ending Surprise Medical Bills

Surprise medical bills occur when patients are unexpectedly treated by health care providers who do not accept their insurance, but whom they could not reasonably avoid. When patients are treated by these out-of-network providers, they can be billed at "list prices," which are typically many times higher than what any insurer would pay. Surprise medical bills are one of the most pernicious features of the modern health care market.

Unfortunately, these bills are not rare. An estimated 20 percent of emergency department visits, 50 percent ambulance rides, and even one-in-ten scheduled stays at in-network hospitals, where patients have the opportunity to do their due diligence, result in a bill from an out-of-network provider.[2] These rates are fairly constant across employer-sponsored plans and those purchased on the individual market.[3] It is important to note that these bills are also not random. Physicians that are least likely to be actively chosen by patients, like anesthesiologists and emergency physicians, set their list prices highest. Doing so increases the size of resulting surprise bills and is suggestive that physicians are behaving strategically.[4]

It is not only those consumers who receive surprise bills that are affected by this phenomenon. Because some health care providers can implicitly threaten to engage in this kind of behavior, they will only agree to join insurance networks if in-network payments are very generous. Because of this, the physicians with the greatest ability to surprise bill also receive the highest in-network payment rates. Figure 1 presents data on average contracted payment rates for selected specialties relative to Medicare payment rates (these data were originally presented in Adler et al., 2019). For example, anesthesiologists and emergency physicians receive average in-

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[1] "Cost-reducing health policies: A response to Chairman Alexander of the Senate Committee on Health, Education, Labor, and Pensions." Henry Aaron, Joseph Antos, Loren Adler, James Capretta, Matthew Fiedler, Paul Ginsburg, Benedic Ippolito, and Alice Rivlin. May 1, 2019. *https://www.aei.org/wp—content/uploads/2019/03/cost—reducing—health—care—recommendations—antos—capretta—ippolito.pdf*

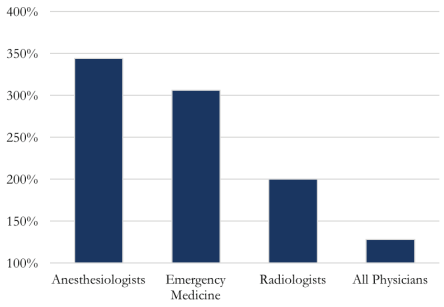
[2] Cooper, Zack and Fiona Scott Morton. 2016. "Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise." New England Journal of Medicine. 2016; 375:1915–1918. *https://www.nejm.org/doi/full/10.1056/NEJMp1608571;* Garmon, Christopher and Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." Health Affairs. 36(1). *https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.*

[3] Garmon and Chartock, 2017.

[4] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. February 2019. *https://www.brookings.edu/wp-content/uploads/2019/02/Adler—et-al—State-Approaches-to-Mitigating—Surprise-Billing–2019.pdf*

network payments that are over 300 percent of Medicare reimbursement. Among all physicians, however, average payments are under 130 percent of Medicare rates. As a result, the lucrative outside option to surprise bill patients means that all commercially insured patients are left paying higher premiums.

Figure 1: Average Contracted Payment Relative to Medicare Rates



Note: Anesthesiologist comparison based on relative mean conversion factors in 2018. Emergency physician comparison based on relative mean payment rates for CPT code 99285 in 2012. For radiologists, 200% represents mean commercial payment for CT Head/Brain scans relative to the Medicare rate (CPT code 70450). All physicians comparison based on data from commercial PPO claims for one large national insurer. Source: Stead and Merrick 2018; Trish, Ginsburg, Gascue, and Joyce 2017; MedPAC 2017

The very unpredictability which defines surprise bills is the same feature that makes it hard for markets to correct this behavior. If patients cannot reliably avoid providers who engage in such practices, they cannot send market signals to end it. Because of this market failure, targeted legislative intervention is well merited. I commend the Committee for including multiple options to address this in the Lower Health Care Costs Act.

The Wisdom of the In-Network Guarantee

While all three proposals represent serious attempts to resolve this issue, adopting an in-network guarantee is the best option. It represents a straightforward and market-oriented way to stop surprise bills from occurring in the first place, rather than adjudicating them after the fact. By tasking hospitals with ensuring that physicians are in network for insured patients, market actors would need to bargain over prices themselves, rather than having those prices set by arbitration or regulation. Physicians at in-network hospitals would have two choices: come to an agreement with the insurer, or chose to be paid by the hospital. This would force the small number of bad actors to stop surprise billing patients and impose few additional burdens on the majority of providers who do not engage in this behavior.

This option (or very similar options) has received support from a wide array of health policy experts, including those at the Brookings Institution,[5] the Center for Budget and Policy Priorities,[6] Georgetown Law,[7] Yale University,[8] and my colleague James Capretta at AEI.[9] Scholars at Brookings, who have studied surprise billing extensively, emphasized that the in-network guarantee is "the only option

[5] Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. February 2019.

[6] Straw, Tara."Lawmakers can prevent surprise medical bills, lower health costs." Center on Budget and Policy Priorities. June 11, 2019.

[7] Ippolito, Benedic and David Hyman. "Solving surprise medical billing." AEI Economic Perspectives. 2019.

[8] Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "Surprise! Out-of-network billing for emergency care in the United States." No. w23623. National Bureau of Economic Research, 2017.

[9] Capretta, James. "Congress should force the medical industrial complex to end surprise bills" RealClearPolicy. May 17, 2019.

that would fully address the market failure that gives rise to surprise bills."[10] They go on to note that under this solution "payment for these services would be negotiated among the insurer, hospital, and clinician. This would then resemble a more typical market negotiation, rather than today's situation where certain clinicians can leverage the threat of surprise billing patients to secure higher contracted payment rates." [11] Scholars at Yale further emphasize that the resulting payments would be "generated by market forces."[12]

Similarly, my AEI colleague, James Capretta, argues that, "if a patient goes through the trouble of ensuring the hospital and main physician (such as a surgeon) are in-network, then the entire care process should be treated as an in-network episode. That means the insurers, working with the hospitals and physicians, should be required to build networks that prevent this kind of surprise billing from ever occurring."[13] I agree with these assessments. This is the best way for Congress to restore normal order to this market.

As the Committee moves forward, I would suggest that they consider two possible improvements to this proposal. (Note: the following two paragraphs are largely taken from Adler, Fiedler, and Ippolito, 2019.)[14]

Providers and insurers could seek to skirt these requirements by setting up creative arrangements in which a facility was notionally out of network, but the facility tacitly agreed to accept a rate similar to the one it would have accepted in network and the insurer agreed to apply cost-sharing terms similar to in-network cost-sharing terms. The Senate HELP discussion draft includes some language that appears to be aimed at foreclosing this possibility, but it would be also worth considering additional safeguards. For example, a facility could be "deemed" in-network for the purposes of these provisions if it treated a large enough fraction of an insurer's enrollees in a given geographic area.

Notably, the network matching requirements in the current Senate HELP discussion draft appears to apply more broadly to all out-of-network services at an in-network facility, not just out—of-network services delivered by emergency and ancillary clinicians. In revising the draft, consideration should be given to narrowing the requirement to exclude other categories of clinicians in cases where they meet notice and consent standards.

I want to address a few concerns that have been raised regarding this proposal. First, some suggest that this approach will transfer too much bargaining power to insurers. Under a worst-case scenario, a dominant insurer could use their leverage to drive down rates for affected physicians so far that they would be unwilling to work. This is a concern that appears to particularly resonate in rural states where ensuring the supply of providers can be more challenging. In practice, however, I believe this is unlikely to be a problem. In order to stay open, hospitals need to ensure adequate staffing. Even under a scenario with a dominant insurer, hospitals can ensure this in two ways. One option is to "top up" the payment rates to anesthesiologists, and similarly affected physicians, to ensure they are willing to work. A more likely option is to demand that insurers guarantee reasonable market rates to these doctors as part of their broader negotiations with insurers. That is, hospitals can leverage access to their entire facility to ensure that payments to physicians remain at acceptable levels.

To the extent that rural states remain concerned about the supply of health care providers, there are a number of other steps they can take. Chief among them is ensuring that a state's scope of practice laws support a robust supply of providers. For example, CMS requires anesthesia services to be provided by an anesthesiologist (i.e. a MD), or nurse anesthetist—but only if the nurse anesthetist is supervised by an anesthesiologist.[15] However, CMS allows states to opt out of this and permits nurse anesthetists to practice independently if the Governor (in consultation with the state medical board) submits a letter to CMS opting out. Opting out provides states with a way to make sure the supply of qualified providers remains robust. And number of states with substantial rural areas have done just that—these include Alaska, North Dakota, New Hampshire, Montana, Idaho, Nebraska, Kansas,

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[10] Adler, Loren, Matthew Fiedler, Paul Ginsburg, and Christen Linke Young. "Comments on the Lower Health Care Costs Act of 2019." USC-Brookings Schaeffer Initiative for Health Policy. June 5, 2019.

[11] Ibid.

[12] Cooper et al., 2017

[13] Capretta, James. "Congress should force the medical industrial complex to end surprise bills" RealClearPolicy. May 17, 2019.

[14] Adler, Loren, Matthew Fiedler, and Benedic Ippolito. "Network matching: An attractive solution to surprise billing." Health Affairs Blog. May 23, 2019.

[15] 42 CFR § 482.52

and Iowa. Taking steps like these can further ensure a healthy number of providers even in rural states.

Second, some have argued that this represents an untested reform. While it is true that no state has implemented this exact proposal to resolve surprise billing, it is not the case that this type of contracting arrangement is untested. The vast majority of physicians or other health care professionals already secure payment from hospitals or insurers. Moreover, data from a large, national health insurer shows that most hospitals already effectively require that physician and hospital networks align. Indeed, most hospitals have surprise billing rates that are below 2 percent. [16]

Finally, I acknowledge that intervening in the contracting practices of private firms and workers should not be entered into lightly. Any such regulation must be motivated by clear evidence of a market failure and be a case where contracting reforms can restore market forces to the situation. In this case, I believe the evidence is sufficiently compelling that this type of intervention is well supported.

Concerns with Independent Dispute Resolution

A separate option would have Congress solve this issue by having disputes over out-of-network billing be adjudicated by an arbiter. Both the insurer and provider would submit final offers to an arbiter, who would then choose which is "more reasonable." The appeal of this option is understandable—in theory, arbiters could have flexibility to tailor resolutions to specific cases. In practice, however, arbitration effectively represents an inferior version of rate setting. The arbiter must decide what a "reasonable" price for a service is, just like any price fixer. Moreover, this process is not transparent, is unnecessarily expensive, can be unpredictable, carries the greatest risk of unintended consequence, and takes the resolution out of the hands of market actors. I believe that arbitration is not the best solution to surprise medical billing.

Some may argue, however, that this process is not opaque or uncertain since the independent dispute resolution gives some guidance to the arbiter on what to consider when adjudicating cases. If the goal is to reduce unpredictability or variability in the outcome of arbitration, however, setting a transparent benchmark payment at this same rate is a preferable option since it eliminates those concerns and costs nothing to implement.

I am not alone in my concerns about arbitration. Researchers at Yale who studied the effects of the arbitration system in New York note, "it is extremely unlikely that a regulated price of this sort will match the market price for any given transaction." [17] My colleague, James Capretta, has also warned that this approach is "likely to lead to an ever-expanding role for government rate-setting." [18] If Congress must put limits on payment rates, it should do so in the most transparent and restricted way possible.

Opportunities to go further

I encourage the Committee to consider further reforms surrounding ambulance transportation. Roughly half of all ground ambulance rides and nearly 70 percent of air ambulance rides are out of network. [19] By its very nature, emergency transportation is an area where patients generally have limited scope for choice, making it hard for markets to solve this issue. Among other possible reforms, the Committee may consider whether Federal pre-emption of state regulation of air ambulances is worth revisiting.

Improving Transparency in Health Care

I further applaud the Committee for its efforts to improve the competitiveness and transparency of health care markets. If markets are to tame health care costs, they need the data and opportunity to do just that. The provisions in this section of the bill are a bold step toward that goal.

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[16] Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "Surprise! Out-of-network billing for emergency care in the United States." No. w23623. National Bureau of Economic Research, 2017.

[17] Ibid.

[18] Capretta, James. "Congress should force the medical industrial complex to end surprise bills" RealClearPolicy. May 17, 2019.

[19] U.S. Government Accountability Office. March 2019. *https://www.gao.gov/assets/700/697684.pdf*

Pro-competitive contracting reforms

Dominant health care providers make use of a number of contracting strategies to reduce potential competition. These include gag clauses, which prohibit enrollees, plan sponsors, or referring providers from seeing data on cost and quality of providers. These provisions can also prevent plan sponsors from accessing de-identified claims data for plan administration and quality improvement purposes.

I agree that denying information in this manner is anti-competitive behavior. Without information on costs and quality of services, market forces have no way of disciplining costs of the health care system. Congress is well justified in banning this type of contract. Doing so will increase transparency and introduce more downward pressure on health care costs.

The Lower Health Care Costs Act would further restrict contracting by disallowing "anti—tiering" and "anti-steering" clauses which prevent plans from incentivizing patients to see providers with lower costs or higher quality. In cases where dominant providers engage in this behavior, they can solidify their market dominance and inflate costs over time. I would, however, suggest that the Committee consider adding some caveats to this provision. In a provider market that is very competitive, these clauses are not necessarily unduly anticompetitive. If insurers can simply exclude providers who demand these kinds of clauses in their contracts, and instead direct patient volume to other providers, they would be naturally disincentivized by the market. Thus, the Committee could consider applying such bans to markets that are deemed "sufficiently consolidated" (for example, if the Herfindahl-Hirschman Index, or another measure of concentration, is sufficiently high). The same considerations should apply to proposed bans on "all-or-nothing" or "most-favored-nation" contracting clauses.

Some will argue these proposed reforms would force consumers to choose narrower networks or otherwise limit choice. For example, the American Hospital Association argues that "banning so-called 'all or nothing' clauses could lead to even more narrow networks with fewer provider choices for patients."[20] I believe this framing is misleading. Under the status quo, dominant providers can effectively force consumers to have very broad and costly plans, without any other option. Insurance plans do not reflect patient preferences, but those of the large provider. The contracting provisions in this draft would give insurers, and ultimately consumers, more choice over the kind of plan they want. If providers are confident that consumers only want the kinds of plans that result from this anti-competitive contracting behavior, then they have no reason to worry. Consumers will presumably continue to choose those very plans. If, however, consumers prefer lower cost plans, they would now have more options to choose them.

Establishing a transparency organization

I applaud the Committee's efforts to further increase transparency by designating a nongovernmental, nonprofit entity which will use de-identified health care claims data from self-insured plans, Medicare, and participating states to help patients, providers, academic researchers, and plan sponsors better understand the cost and quality of care, and facilitate state-led initiatives to lower the cost of care. Assembling and disseminating this kind of information is crucial for addressing the long-term health care cost growth.

In 2009, Atul Gawande famously profiled the town of McAllen, Texas in the New Yorker.[21] Data from Medicare had shown that the unassuming city in the south of Texas held an inauspicious title: It was one of the most expensive health care markets in the country. In 2006, Medicare spent $15,000 per enrollee there. The national average was just half of that. McAllen was the example of health care markets gone horribly awry, and if we failed to act, "McAllen won't be an outlier. It will be our future." Little did Gawande know at the time, but that might have been a good thing.

In the mid–2000's, data on the commercial market was extremely rare, so researchers had to rely on data from public insurers, like Medicare. Unfortunately, this led to gross mischaracterizations about U.S. health care. Only later did we learn that health care spending by commercial insurers in that same McAllen, Texas was actually pretty unremarkable. Data on private insurers from the Health

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[20] Nickels, Tom. "AHA statement on Senate HELP Committee draft legislation on health care costs." American Hospital Association. May 23, 2019. *https://www.aha.org/press-releases/2019–05–23-aha-statement-Senate-help-committee-draft—legislation-health-care-costs*

[21] Gawande, Atul. "The cost conundrum: What a Texas town can teach us about health care." The New Yorker. May 25, 2009. *https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum*

Care Cost Institute shows that McAllen's commercial price level is near the national average and its use of health care is actually meaningfully lower than normal in the commercial market.[22] In other words, Medicare data only told part of the story.

The Federal Government is tasked with regulating parts of the private market, yet much of our understanding of health care has traditionally come only from public insurers like Medicare. Ensuring a vibrant and competitive private market requires that policymakers are not flying blind. Accurate data is an important element of ensuring this is not the case.

Joint Ventures

The bill would further task the Government Accountability Office with producing a report which describes what is known about profit-and revenue-sharing relationships in the commercial health care markets. This information is important for helping researchers and policymakers better understand the nature of market dynamics in health care markets. I believe this report could be useful for future efforts to make sure health care markets retain competitive forces where possible.

[SUMMARY STATEMENT OF BENEDIC N. IPPOLITO]

In my testimony, I discuss a number of the specific provisions—some of which echo those submitted to the Senate HELP Committee by health policy experts at the American Enterprise Institute and the Brookings Institution at the request of Chairman Alexander.

First, I commend the Committee for addressing surprise medical billing so constructively. I believe that adopting an in-network guarantee is the best option for resolving surprise medical billing. This approach has received support from a wide array of health policy experts, including those at the Brookings Institution,1 the Center for Budget and Policy Priorities,2 Georgetown Law,3 Yale University,4 and my colleague James Capretta at AEI.5 I agree with scholars at Brookings who note that this is "the only option that would fully address the market failure that gives rise to surprise bills."6 While well intentioned, arbitration is not the best solution to this problem and carries the largest chance of unintended consequences.

Second, establishing a nongovernmental entity to increase our understanding of the private health care market represents a major opportunity to improve health care in the future. Third, I applaud a number of pro-competitive contracting reforms but suggest that the Committee consider targeting some to only those cases where provider markets are sufficiently concentrated. Fourth, tasking the GAO with producing a report describing what is known about profit-and revenue-sharing relationships in commercial health care markets strikes me as a smart step forward for ensuring competitiveness of markets.

I thank you for the opportunity to engage on this ambitious and substantive proposed bill.

1 Adler, Loren, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. February 2019. 2 Straw, Tara."Lawmakers can prevent surprise medical bills, lower health costs." Center on Budget and Policy Priorities. June 11, 2019. 3 Ippolito, Benedic and David Hyman. "Solving surprise medical billing." AEI Economic Perspectives. 2019.

4 Cooper, Zack, Fiona Scott Morton, and Nathan Shekita. "Surprise! Out-of-network billing for emergency care in the United States." No. w23623. National Bureau of Economic Research, 2017. 5 Capretta, James. "Congress should force the medical industrial complex to end surprise bills" RealClearPolicy. May 17, 2019. 6 Adler, Loren, Matthew Fiedler, Paul Ginsburg, and Christen Linke Young. "Comments on the Lower Health Care Costs Act of 2019." USC-Brookings Schaeffer Initiative for Health Policy. June 5, 2019.

The CHAIRMAN. Thank you, Dr. Ippolito.

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[22] "Healthy Marketplace Index." Health Care Cost Institute. *https://www.healthcostinstitute.org/research/hmi/hmi—interactive—HMI-Price-and-Use*

Senator Murray has asked that we continue with the witness statements, and then she'll make her statement at the end of Ms. Bartlett's comments.

Mr. Nickels, welcome.

STATEMENT OF TOM NICKELS, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. NICKELS. Thank you, Mr. Chairman. I appreciate the opportunity to be here today. My name is Tom Nickels. I am the Executive Vice President for American Hospital Association, here to represent our 5,000-member hospitals.

The Committee has identified several important areas where we can make the health care system work better and cost less for patients. On each of these, we stand ready to work with you.

On surprise medical billing, the bottom line is we must protect patients from surprise medical bills, and the AHA supports a Federal legislative solution to do so. Protecting patients means limiting their cost-sharing to an in-network amount, as the draft legislation does, and keep them out of any subsequent negotiation between providers and the health plan. Once the patient is protected, providers and payers should be allowed to determine fair and appropriate reimbursement.

The Committee put forward in its discussion draft three further options to address surprise billing. The in-network guarantee or network matching approach would require facility-based practitioners to contract with every plan for which a facility has a contract. This approach interferes with the fundamental relationship between hospitals and their physician partners and severely limits practitioners ability to negotiate terms with insurers. It's going to be particularly hard for rural areas, who are already challenged, to recruit practitioners. We believe health plans should not be absolved of their core function of establishing provider networks and negotiating rates with providers.

The second option is the independent dispute resolution process with the balance of bills paid at the median contracted rate. While the AHA believes that hospitals and payers should negotiate reimbursement for out-of-network claims without government involvement, there may be a role for a dispute resolution process, not for hospital services but certainly for physician claims. We encourage the Committee to look at the features of S. 1531, with some modifications, as an option for determining out-of-network reimbursement for physicians. This proposal allows a market-based, flexible, and efficient negotiation to take place.

However, while much of the structure of the process outlined in S. 1531 is positive, we do believe that an automatic payment prior to initiating the dispute resolution undermines a provider's opportunity to negotiate fair reimbursement.

The baseball style of arbitration, similar to what New York State and many other states have implemented, and which does not include hospitals, appears to be an efficient process that places the responsibility to initiate the request with the provider or health plan, not the patient. Studies have shown a 34 percent reduction in out-of-network billing. Decisions have been largely split between

providers and payers, and there's not been a noticeable inflationary impact on premium costs.

The third option is to establish a benchmark rate. We oppose a national rate for out-of-network services such as a median contracted in-network rate, even if geographically adjusted, as it would not be able to capture the many factors that specific health plans and providers consider.

We are also concerned that setting a reimbursement standard in law will serve as a disincentive for insurers to maintain adequate provider networks.

We also share the Committee's goal of increasing transparency in the health care system. However, we have serious concerns with a couple of the policies proposed. For example, discussion draft would prevent providers from declining unfair tiering and/or steering restrictions imposed by insurers. We believe these and other provisions in the transparency section would infringe on provider and health plan contracting in ways that could limit our Members ability to pursue new care delivery models and value-based purchasing arrangements designed to improve quality and coordination of care while reducing costs.

Put another way, commercial insurers cannot be allowed to have it both ways; that is, enjoy the savings from providers shouldering financial risk under a value-based care arrangement while simultaneously encouraging those same patients to go elsewhere for care. Likewise, it would be unfair, particularly to rural hospitals, to allow commercial insurers to cherry-pick which hospital in the system they contract with. We strongly urge the Committee to remove those provisions.

I want to thank the Committee for looking for ways to improve the health and well-being of all Americans by making investment in public health priorities, like vaccinations and public health data systems. We especially appreciate the Committee's look at maternal health. As hospitals work to improve outcomes, we are redoubling our efforts to improve the health of mothers and babies, and reaching out to community partners to aid in this effort.

I also want to thank you for your efforts to reduce drug prices. Runaway drug prices mean that many of our patients simply cannot afford their medications for conditions that cannot be managed.

We support the drug pricing provisions in the bill. Each seeks to increase competition.

We also in our testimony identify additional actions the Committee may consider, such as further increasing transparency in pricing through the FAIR Act.

Mr. Chairman, we have an opportunity to help patients with their health care costs and affordability. We look forward to working with you and the Committee on those efforts. Thank you very much.

[The prepared statement of Mr. Nickels follows:]

PREPARED STATEMENT OF TOM NICKELS

Chairman Alexander, Ranking Member Murray and Members of the Committee, my name is Tom Nickels. I am executive vice president of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals and health systems, along with our clinician partners, I appreciate the opportunity to testify today.

We appreciate the Committee's interest in addressing the important issue of health care costs, and recently provided feedback on the Lower Health Care Costs Act of 2019. The cost of health care in America affects all stakeholders, including patients and their families, employers, policymakers and care providers. We all play a role in making care and coverage more affordable. Hospitals and health systems understand the importance of this issue and have been addressing it directly by taking steps to redesign care and implement operational efficiencies.

The Committee has focused its efforts around surprise medical bills, prescription drug prices, health care transparency, public health and health information technology. I address the provisions contained in the Lower Health Care Costs Act, as well as suggest some potential additions to the package, below.

Surprise Medical Bills

No patient should be surprised by a medical bill. Hospitals and health systems are deeply concerned about the effect unanticipated medical bills can have on our patients. These bills can cause patients financial and emotional stress and undermine trust and confidence in their caregivers. Protecting patients from surprise medical bills is a top priority for the AHA and our members.

The AHA supports a Federal-level solution to protect all patients from surprise medical bills, including individuals who receive health care coverage through plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) and those who live in states that have not yet enacted comprehensive protections.

Our preferred solution is simple: Patients should not be balance billed for emergency services, or for services obtained in any in-network facility when the patient could reasonably have assumed that the providers caring for them were in-network with their health plan. In these situations, patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Once the patient is protected, hospitals and health systems should be permitted to work with health plans on appropriate reimbursement. We strongly oppose the imposition of arbitrary rates on providers, along with untested proposals such as bundling payments or "network matching," which would significantly increase complexity in the system and may, ultimately, be unworkable. We encourage the Committee to use this opportunity to help simplify the health care system rather than add more complexity.

Notice and Disclosure Prior to Post-stabilization Out-of-Network Service.

The committee's discussion draft would require that hospitals, prior to the provision of any out-of-network post-stabilization service, provide the patient with: notice of out-of-network services with the option to affirmatively consent to them; a list of in-network hospitals or practitioners with the option for referral; and the estimated amount such provider would charge for out-of-network services. Hospitals and health systems recognize the importance of patients receiving care from in-network providers; therefore, most hospitals have some form of notice-and-disclosure protocols in place. In addition, many states have laws to require notification of network status, including requiring of estimates of fees for potential out-of-network care. While providing the patient such network status information is important, it is not in and of itself a solution to surprise medical bills. In addition, the provision, as written, should be revised to be a shared responsibility between the providers and the patient's insurer. For example, the out-of-network hospital is not going to have access to information on in-network alternatives, which should be the responsibility of the insurer to provide. We encourage the Committee to focus on fully protecting patients by prohibiting surprise bills and expanding notice-and-disclosure requirements to insurers as part of the solution.

Addressing Payment Disputes.

The committee's discussion draft outlines three options to resolve payment disputes between providers and health plans: an in-network guarantee; an independent dispute resolution process; and a benchmark rate.

Option 1 would require that in-network facilities guarantee to patients and health plans that every practitioner caring for the patient in the facility is considered in-network. Some have described this approach as "network matching," where the facility-based practitioner would be required to contract with every plan for which the facility has a contract.

The AHA opposes this option because it interferes with the fundamental relationship between hospitals and their physician partners and severely limits practitioners' ability to negotiate contract terms with insurers. Providers consider a number of factors besides reimbursement when determining whether to contract with a payer, including whether the payer is a fair business partner in terms of administrative burden and processes. In addition, providers and health plans should be able to develop networks that meet consumers' needs, and neither party should be compelled to enter into a contract based on the decision of a third party. It is also important to note that this proposal represents a prescriptive, national application of an unproven approach that will certainly have negative unintended consequences. In addition, it could result in significant economic harm to rural hospitals and communities.

In *Option 2,* an independent dispute resolution process would be established for payment disputes above $750. Plans, facilities and/or practitioners would submit their best offer to the arbiter consistent with "baseball-style" arbitration. The arbiter could take into consideration information that would include the median in-network rate for services in the geographic area. The arbiter's decision would be binding and the losing party would pay the arbitration costs. Balance bills valued at $750 or less would be paid at the median contracted rate for that service in the geographic area.

The AHA believes that hospitals and payers should be left to negotiate reimbursement for out-of-network claims without government interference; however, there may be a role for an alternative dispute resolution process for physician claims. Several states have passed laws to establish such a process to mediate out-of-network claims between physicians and health insurers. Prominent among these processes is "baseball-style" arbitration, and New York is one such state that frequently is referenced as having a successful process. One study noted that the New York law reduced out-of-network billing by 34 percent.[1] A more recent study found that, "as of October 2018, IDR [New York's independent dispute resolution entity] decisions have been roughly evenly split between providers and payers, with 618 disputes decided in favor of the health plan and 561 decided in favor of the provider... Additionally, insurers and physicians appear to be making 'a real concerted effort' to work out their payment disputes before filing with IDR." The study also noted that, while it may be too soon to know if the arbitration process leads to higher out-of-network prices, there had not yet been an inflationary impact on insurers' annual premium rates.[2]

For arbitration to work within the context of a Federal solution to surprise medical billing, it would need to be designed effectively and accommodate existing state programs. In our comments to the Committee, we identify several features that are important to include, such as ensuring that patients are removed entirely from the process.

In addition, the AHA appreciates the work done by the Senate Bipartisan Working Group in S. 1531 that has developed such a model. We encourage the Committee to look at the features of S. 1531, with some modifications, as an option for determining out-of-network reimbursement for physicians. That proposal allows a market-based, flexible and efficient negotiation to take place. However, while much of the structure of the process outlined in S. 1531 is positive, we do believe that an automatic payment prior to initiating the dispute resolution undermines a provider's opportunity to negotiate fair reimbursement.

In Option 3, the health plan would pay the out-of-network practitioner and/or the facility based on the median contracted rate for services in the geographic area. We urge Committee Members to reject a legislative proposal like Option 3 that would have the government dictate rates between two private entities. Health plans and hospitals have a longstanding history of resolving out-of-network emergency service claims, and this process should not be disrupted. We are particularly concerned that any attempt at setting a reimbursement standard in law will have significant consequences, including by disincentivizing insurers to maintain adequate provider networks. Growth in the use of no-network, reference-based pricing models in the com-

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[1] Surprise! Out-of-Network Billing for Emergency Care in the United States; Zack Cooper, Fiona Scott Morton, and Nathan Shekita; NBER Working Paper No. 23623 July 2017, Revised January 2018.

[2] New York's 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study; Corlette, S. and Hoppe, O.; Georgetown University Health Policy Institute—Center on Health Insurance Reforms; May 2019 *https://georgetown.app.box.com/s/6onkj1jaiy3f1618iy7j0 gpzdoew2zu9*

mercial market suggests this already is a growing strategy, and one that would accelerate if the insurer could simply point to a government-dictated rate or methodology. In addition, this proposal does not allow for future adjustments short of another act of Congress.

Also, this approach could be particularly devastating to rural hospitals, which already are operating with thin margins, as it would put further downward pressure on their financial resources, and make it even more difficult to attract and compensate an adequate health care workforce. Medicare and Medicaid made up 56 percent of rural hospitals' net revenue in 2017 and, as these programs already pay less than the cost of care, further reduction on the commercial side will increase the already heavy financial burden rural hospitals are facing. More than 40 percent of rural hospitals have negative total operating margins and 107 rural hospitals have closed since 2010, including 10 this year alone.

Air Ambulance Billing.

The committee's discussion draft begins to address concerns regarding out-of-network billing for air ambulances; however, the draft only addresses issues regarding price transparency and does not prohibit balance billing by these providers. The AHA believes Congress has a real opportunity to put forward a Federal solution to address growing concerns over surprise billing for air ambulance services. **We encourage Congress to address air ambulance service issues while developing legislative solutions related to surprise medical billing.** More specifically, we ask that the Congress extend similar consumer protections from out-of—network billing to air ambulance services and include air ambulance services in network adequacy requirements.

Reducing the Prices of Prescription Drugs

The AHA applauds the Committee's continued work to lower the price of prescription drugs for both patients and the providers who care for them, and supports the drug pricing proposals included in the Lower Health Care Costs Act. Each of the proposals in the legislation seek to increase competition and protect access through appropriate market-based solutions.

Specifically, we support the inclusion of provisions aimed at restoring clarity and transparency to both the Purple and Orange Books. Abuse of patent and exclusivity law remains a significant barrier to lowering drug prices, and the Committee's proposals to restore transparency related to patent and exclusivity periods for biological products and small molecule drugs is a critical component of removing those impediments. We thank the Committee for its inclusion of several proposals focused on fostering increased competition, as well as ensuring patient access to affordable medicines on which they rely. In addition, we support the Committee's plan to facilitate the increased utilization of biosimilar products, when appropriate, by requiring that the U.S. Food and Drug Administration (FDA) establish educational tools for both biosimilar and interchangeable products. We also support the Committee's recognition of a longstanding issue concerning the drug approval process—abuse of the 5-year New Chemical Entity (NCE) exclusivity. This proposal would rightfully establish a process to properly apply the NCE designation, granting exclusivity to only the most novel drugs that are developed.

However, we suggest the Committee consider additional ways to increase transparency and keep drug prices in check. In particular, we support the Fair Accountability and Innovative Research (FAIR) Act, which would require drug manufacturers to disclose and provide information related to planned price increases. Specifically, this bill would increase transparency around the price of certain drugs by requiring, for the first time, a justification for the price hike, as well as research and development costs, marketing and advertising costs and the net profits attributed to the drug. Hospitals, as well as other stakeholders, already provide a significant amount of similar publicly available data, and it is time to hold drug manufacturers to that same standard.

Hospitals are required by law to submit cost reports in order to receive Medicare payment. Hospitals must send expenditures, charges and other financial information to Medicare to qualify for reimbursement. Specifically, the cost report is a series of forms that collect descriptive (ownership status, type of facility, etc.), financial, cost, charge, wage index and statistical data. Hospitals already submit information similar to what would be asked of pharmaceutical companies through the FAIR Act. Specifically, research expenses are described on line 191 ("Research") of Worksheet A ("Balance of Expenses"). Advertising and marketing expenses are included in "Other Nonreimbursable Expenses" on line 194 of Worksheet A. Cost report data

are public and contained in the Healthcare Cost Report Information System (HCRIS) via the Centers for Medicare & Medicaid Services' website in raw format. There are a number of private vendors that repackage and sell cost report data; however, it is common for analysts to work directly with the raw data.

In addition, non-profit hospitals, must also file Form 990 with the Internal Revenue Service. Among other data, the Form 990 collects information on both advertising and research expenses. Advertising and promotion expenses are described on line 12 of Part IX. Fundraising expenses are also described in several places in the 990: direct expenses of fundraising events are reported in Part VIII, line 8b of the 990; indirect expenses of fundraising events, including advertising expenses, are reported in Part IX, column (D). Descriptions of research activities, including associated expenses and revenues, are included in Part III ("Statement of Program Service Accomplishment").

Increased transparency into drug pricing, such as what is already provided by hospitals, could be used to hold drug manufacturers accountable for fairly pricing products, help calculate the value of a drug, and will play a foundational role in supporting future policymaking.

As the Committee continues its work to lower drug prices for both patients and the providers who care for them, we urge you to consider additional proposals that would be effective. Specifically, we recommend the Committee examine responses to pay-for-delay and ever-greening tactics employed by drug manufacturers, which, contrary to congressional intent, are used to extend FDA exclusivity and force potential competitors out of the market. We also ask the Committee to consider incorporating existing legislation that would align payment with the most commonly used dosages for drugs. Far too often, hospitals have no choice but to purchase too much of a drug because of manufacturer packaging sizes, resulting in increased waste at a high cost to patients. Further, as the health care delivery system transitions toward more value-based payment models, we urge the Committee to pursue comparative effectiveness testing aimed at demonstrating the value of new drugs relative to other, more affordable options, as well as to consider the implementation of potential risk-sharing models based on patient outcomes.

Improving Transparency in Health Care

The AHA supports increased consumer access to health care pricing information. However, we have serious concerns with some of the policies proposed.

Provider/Health Plan Contract Requirements. The discussion draft includes a number of new requirements that would severely impede provider and health plan contracting. **We do not support these policies because they would unnecessarily increase costs, discourage commercial health insurers from pursing value-based care arrangements with providers and/or put consumers at risk of being subject to practices that would limit their access to care.** In addition, for some integrated delivery systems, some of the provisions would be wholly unworkable and result in their dissolution, jeopardizing patient access to high-quality, integrated coverage and care delivery.

The provisions in Section 301 are perplexing; hospitals support providing consumers with tools to understand the extent of their coverage and payment obligations, so it is not clear what the actual issues are that the discussion draft seeks to address. With respect to HIPAA requirements, the underlying legislation and rules provide a consistent and largely workable framework for commercial health insurers or any other legitimate business associate to obtain the information needed to process claims and provide consumers with the services they require. Again, it is not clear what the actual issues are that the discussion draft seeks to address and how it would benefit consumers.

Conversely, a number of the provisions in Section 302 would not benefit consumers and would harm hospitals and hospital systems, including those with integrated health plans. For example, preventing providers from declining unfair tiering and/or steering restrictions imposed by insurers would undermine the basis for value-based care. Put another way, commercial insurers cannot be allowed to have it both ways—that is, enjoy the savings from providers shouldering financial risk under a value-based care arrangement while simultaneously encouraging those same patients to go elsewhere for care.

Likewise, it would be unfair, particularly to rural and urban hospitals, to allow commercial insurers to cherry-pick which hospitals in the system they contract with. There are enormous economic efficiencies and quality benefits associated with contracting with commercial insurers as a system. For example, to promote efficiency

and maintain quality, many systems do not duplicate services at every site of care within the system. That means, excluding one or more of those sites would, at best, limit access to care. Moreover, allowing commercial insurers to decline to include system hospitals that serve vulnerable communities, particularly in rural areas, which is the most likely scenario, would put those already vulnerable communities at even greater risk by limiting access to care.

It is incumbent on those who support legislation in the area of private contracting to provide data, rather than mere anecdotes, to justify such intrusion by the government before the Committee adopts such significant change.

We also are deeply concerned about the provisions in Section 309 that would prohibit health plans from contracting with providers unless the provider agreed to provide enrollees their estimated cost-sharing amount at the time of scheduling or within 48 hours of a request. The AHA supports policies that encourage the continued development of out-of-pocket estimates, when appropriate, and many of our members are already undertaking these endeavors. However, restrictions on provider-health plan contracts are not the right approach, especially in light of significant movement in this area by the field.

The AHA agrees that patients should have access to an estimate of their out-of-pocket costs. However, there are a number of challenges to providing accurate and reliable out-of-pocket cost estimates, not least of which is the inherent uncertainty that exists within health care. While there are treatments that generally follow a common course and are agnostic to patient characteristics, there are many others for which the services needed can change over the course of care, depending on how a particular patient responds to a treatment and the evolution of their disease or injury. For those services for which estimates can be generated, hospitals and health systems have typically relied on financial assistance staff to help patients navigate their insurance benefits and develop out-of-pocket cost estimates. While providers are working to develop the ability to provide these estimates in other ways, such as through their websites and other online applications, there is still much work that must be done directly with patients and insurers if complications or questions arise. Therefore, it is not always possible to provide estimates within 48 hours.

Finally, providers must work with payers to obtain all of the information necessary to generate an estimate. For example, providers need to know a patient's current eligibility, as well as their specific cost-sharing obligation and where they are within their deductibles. While electronic transaction standards already exist to share this information, we hear from our members that health plans often do not comply fully with these requests. We, therefore, appreciate that Section 501 of the discussion draft would require health plans to provide providers with this information.

All Payer Claims Data base. The discussion draft would establish a national all-payer claims data base (APCD) and provide grants to states to encourage implementation of their own APCDs. These data bases are intended to promote transparency by requiring insurers to submit claims data, which are made available to researchers and policymakers for use in analysis. They also are intended to enable hospitals, health care providers and communities to benchmark their performance against that of others.

The AHA recognizes the potential of APCDs to drive quality improvements and cost-containment, as well as helping to identify and track issues within the health care system. However, to guarantee the integrity of the data and insights that they yield, great care must be taken to protect the privacy and security of the data, that data released be presented in its full context, and that relevant stakeholders be involved in the governance process.

Should the Committee move forward with this effort, we recommend that the privacy and security requirements for receiving, storing and transmitting data be strengthened by: requiring privacy and security training for staff and authorized users, including Federal agency users; and requiring the APCD contractor in the required annual report to describe the privacy and security standards around receiving, accessing, storing and transmitting data, as well as any privacy or security incidents that have occurred. We would also ask that the data released by the APCD be put in context, as claims data are highly complex and do not always present a full picture of the care and services offered by providers. In order to draw meaningful conclusions from these data, it is important to understand what is and is not included in the data. This means having a clear understanding of any limitations or gaps in the data, as well as understanding what other factors not represented in the data may impact the findings of analyses. Finally, we request that the gov-

ernance body developed to oversee the APCDs include dedicated seats for health care providers who could play a valuable role in translating the experience of providing care, what occurs in a clinical setting and what is not captured in administrative claims data.

Provider Network Transparency. Section 304 of the discussion draft would require that health plans establish processes to ensure patients have the most current information on their health care provider's network status. The AHA believes that up-to-date provider directories play an important role in holding health plans accountable for adequate networks. The primary responsibility for ensuring provider directories are accurate is with health plans, and the AHA is pleased that the discussion draft recognizes this dynamic. However, we are concerned that the discussion draft does not hold health plans truly accountable for errors in the provider directory. In fact, the discussion draft holds providers responsible for refunding patients when an error occurs, even though the health plan controls the accuracy of the directory. In addition, providers could be subject to civil monetary penalties for violations except for one safe harbor that would allow the provider to rescind the bill within 30 days of billing. This safe harbor time window could be too restrictive, however, in the event that the patient does not raise an issue with the bill within the allotted timeframe. **The committee should hold health plans accountable for the accuracy of provider directories rather than rely on the patient and the provider to figure out when mistakes are made.** That accountability should extend to civil monetary penalties for plan errors as well.

Billing Requirements. Section 305 of the discussion draft would require providers to give patients a list of the services rendered during a health care visit at the time of discharge and bill the patient within 30 business days of the visit. It also would require providers to allow patients at least 30 days to pay their bills. Though AHA supports the goal of timely patient billing, we have a number of recommended changes to the proposed policy to address underlying issues. **Most critically, the AHA recommends basing the 30-day timeframe for sending timely bills on the date the health plan adjudicates a claim and sends remittance information to the provider, rather than on the date of discharge.** In order for a patient bill to be accurate and reflect the true out-of-pocket cost, the health plan needs to process the claim. Requiring providers to send bills prior to the completion of this process would mean that some patients would inevitably receive statements with inaccurate balances, causing further confusion and directly contradicting the purpose of this legislation.

We also recommend updating "upon discharge" in (a)(1) to "after discharge" and adding "as requested" to this requirement. Often, a full list of services received is not available at discharge because departments wait until after a patient is discharged to submit final charges. Requiring patients to wait until all charges are submitted could delay discharge and unnecessarily increase their length of stay. In addition, this information may not be of interest to every patient. Itemized bills can be provided upon request but should not be mandated for every patient.

Finally, the AHA recommends clarifying that a good faith attempt is in compliance with this policy. We are concerned that, without clarification, an attempt to comply with this policy could still render our members out of compliance if there is no proof of receipt or if a bill is returned due to a wrong address. One member has reported that between 4 and 6 percent of insured patient bills are returned due to a bad address.

Improving Public Health

The AHA supports the provisions of the discussion draft that make important investments in public health priorities like maternal health, vaccinations and public health data systems.

Maternal health is a top priority for the AHA and our member hospitals and health systems as we seek to eliminate maternal mortality and reduce severe morbidity. The causes of maternal mortality and morbidity are complex, including a lack of consistent access to comprehensive care and persistent racial disparities in health and health care. As hospitals work to improve health outcomes, we are redoubling our efforts to improve maternal health across the continuum of care and reaching out to community partners to aid in that important effort.

The AHA supported legislation enacted last year, the Preventing Maternal Deaths Act, which provides funding to develop maternal mortality review committees. The Lower Health Care Costs Act builds on this initiative by funding programs that develop and disseminate best practices to improve maternal outcomes and support state perinatal quality collaboratives. Improving maternal outcomes also requires

better coordination of services for mothers across the continuum of care, so we are pleased that the legislation establishes programs that promote the delivery of integrated health care services to pregnant and postpartum women.

We commend the Committee on Section 407 of the bill, which would authorize Title VII training grants to address discrimination and implicit bias. We encourage the Committee to also specify training in the areas of cultural and linguistic competence in order to reduce health disparities and require the Secretary to work with professional medical societies to develop recommendations for continuing medical education programs, as many currently practicing medical professionals may have not received training in implicit bias or cultural competency.

In addition, the AHA is pleased that the legislation would bolster efforts to address vaccine-preventable illnesses by authorizing a national educational campaign to increase the awareness of and combat misinformation about vaccinations. We also applaud the provisions that would fund much needed modernization of public health data systems used by the Centers for Disease Control and Prevention and state and local health departments.

Improving the Exchange of Health Information

Requirement to Provide Health Claims, Network and Cost Information. The draft bill requires commercial health plans in the group and individual markets to make certain information easily available, including historic claims, encounter and payment data, network information and individualized out-of-pocket estimates for common procedures and all prescription drugs. As noted in our comments on Improving Transparency in Health Care, this information is critically important for patients as they make decisions about their health and health care. However, it has not always been easily accessible, or even reliably accurate. We applaud the Committee's attention to transparency in regard to a patient's out-of-pocket costs and its recognition that health plans are key players in this effort.

While we are supportive of this policy overall, we are concerned about the privacy and security of a patient's health information when entered into a third-party application—a key tenant of this proposal. We encourage the Committee to extend HIPAA protections to third-party apps that access patient data via these APIs, ultimately promoting the safety and security of this data, regardless of where it resides.

Recognition of Security Practices. **The AHA is pleased the draft legislation would incentivize strong cybersecurity practices by encouraging the Department of Health and Human Services to consider entities' adoption of recognized cybersecurity practices when conducting audits or administering fines related to the HIPAA Security Rule.** Hospitals and health systems understand it is our responsibility to protect patient information and, more importantly, their safety against cyber threats. Despite complying with HIPAA rules and implementing best practices, hospitals and health systems will continue to be the targets of sophisticated cyberattacks, and some attacks will inevitably succeed. The AHA believes that victims of attacks should be given support and resources, and enforcement efforts should rightly focus on investigating and prosecuting the attackers.

Conclusion

We thank you for the opportunity to share the hospital and health system field's suggestions and concerns as they relate to the Lower Health Care Costs Act of 2019. We appreciate that the issues of health care costs and affordability are a priority for the HELP Committee, as they are for our patients and members. We look forward to working on legislative solutions that address the issues raised in the Committee's legislative proposal, while preventing unintended negative consequences on the health care system.

[SUMMARY STATEMENT OF TOM NICKELS]

Tom Nickels, executive vice president, will be appearing on behalf of the American Hospital Association (AHA). The organization represents nearly 5,000 hospitals and health systems, along with their clinician partners. The AHA testimony focuses on feedback on the Committee on Health, Education, Labor and Pension's Lower Health Care Costs Act of 2019. We appreciate the opportunity to provide these comments and support the Committee's efforts to examine the cost of health care in America.

Regarding surprise medical bills, the AHA supports a solution to protect patients and remove them from the middle of any reimbursement disputes. The preferred solution: patients should not be balance billed for emergency services, or for services obtained in any in-network facility when the patient could reasonably have assumed that the providers caring for them were in-network with their health plan. In these situations, patient cost-sharing obligations should be based on an in-network amount. Once the patient is protected, we believe Congress should allow providers and payers to determine fair and appropriate reimbursement. We strongly oppose the imposition of arbitrary rates on providers, along with untested proposals such as network matching. However, an arbitration system for physician services without a benchmark rate could be appropriate. We encourage the Committee to use this opportunity to help simplify the health care system rather than add more complexity.

The AHA expresses serious concerns about several proposals that would allow the government to intrude into private commercial contracts between providers and insurers, which could undermine value-based purchasing arrangements aimed directly at improving the quality of care while reducing costs. We have particular concerns about the impact on rural communities. We strongly urge the Committee to remove these provisions.

The AHA appreciates the Committee's efforts to invest in public health, including modernizing the public health data system and improving maternal health outcomes. We also support provisions aimed at increasing competition in the prescription drug market and ensuring patient access to these drugs and make suggestions for other provisions for the Committee to consider, such as the Fair Accountability and Innovative Research (FAIR) Act. We appreciate the Committee's focus on the importance of ensuring the privacy and security of patient health information and are pleased the draft legislation would incentivize strong cybersecurity practices.

The CHAIRMAN. Thank you, Mr. Nickels.

Ms. Mitchell, welcome.

STATEMENT OF ELIZABETH MITCHELL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CA

Ms. MITCHELL. Thank you, Senator Alexander, Senator Murray, Senator Collins—my heart is still in Maine—and Members of the Committee. Thank you for this opportunity.

I am President and CEO of the Pacific Business Group on Health. We are a non-profit coalition of large public and private purchasers seeking to achieve higher quality and more affordable care on behalf of our employees. It is an honor to be here. This is the right discussion to be having. Thank you for your bipartisan leadership.

PBGH members collectively spend over $100 billion annually, purchasing health care on behalf of their employees, collectively for over 15 million Americans. Our members are deeply committed to the health and well-being of their employees and buying health care services that promote optimal health.

But even the largest private purchasers of health care in the world cannot overcome the current industry consolidation, opacity, anticompetitive practices, and egregious pricing in U.S. health care. It may seem somewhat surprising that an organization representing large private-sector companies would seek policy intervention into the market, and it is surprising. My members are committed to private-sector, market-driven solutions, but in much of U.S. health care the market is simply broken.

A functional market does not regularly drive families into bankruptcy, it does not depend on Go Fund Me campaigns for treatment costs, and it does not absorb a decade of U.S. wage growth.

If the world's largest and most sophisticated companies are challenged by high-quality and affordable care, it is simply unfair to expect that of small businesses or families. The dysfunction is so profound that we are seeking your support to make a functional market in the U.S. health care system possible, and we believe that this bill goes a long way to achieving that.

There are several important points but three that I want to highlight. There is strong evidence that cost-effective delivery, high-quality care is possible, and it should be expected. Although we prefer market solutions to the problem of high cost, government action is needed. We also support your efforts to control drug pricing, and we would urge you to go even further and to include provisions that support primary care and mental health.

Most importantly, we want to say that it is possible, and we have bold innovations driven by our employer members, most notably Walmart's recent pilot with Centers of Excellence for specialty services. This is a program, the Employer Center of Excellence Network, designed by Walmart, administered by PBGH and our TPA, for hip and knee replacements and surgeries. We set high-quality standards, vet and select the best facilities in the country, and support employees to use these.

I provided for your reference a recent Harvard Business Review article on the results of the program, but it is important to highlight that patients who participated reported 98 percent satisfaction and better patient-reported outcomes. Readmission and complication rates were markedly lower. The program results demonstrate that it is possible to save money by reducing unnecessary services and improving outcomes and patient experience, while highlighting that the practices this bill seeks to address are barriers to widespread adoption of this model.

Additionally, we strongly support the elements that would remove gag clauses on the sharing of price and quality information by providers. It's hard to imagine that providers are barred from sharing information about quality and cost with patients. We strongly support the elements of the bill that would ban anti-competitive contracting practices, including anti-tiering, all-or-nothing, and similar clauses that are used to gain market power and raise prices regardless of quality or variable performance. We urge Congress to enable Medicare beneficiaries to identify and seek care from high-performing centers in a similar program.

We also strongly support the protection of patients from out-of-network deductibles, surprise billing, and we support Option 3, a benchmark for payment. We strongly recommend setting payments based on average payments to specialty physicians; i.e., 125 percent of Medicare rates. While it may be unusual to have us ask for price setting, we believe that this fairly captures the costs. We also think this is the most straightforward, efficient, and transparent approach to regulating these prices.

A second-best solution would be the use of payments based on median contracted payment rates, although we are concerned that the resulting benchmarks under this method would reflect prices that are already too high.

We strongly also recommend that the definition of services in surprise billing be expanded to include ground and air ambulance

services. We are pleased that you have acknowledged that this is a problem, and we understand that states are limited in addressing this problem due to Federal jurisdictional authority, and it is up to Congress to fix this directly.

We strongly support all of the transparency initiatives, including the establishment of an all pair claims data base, but would urge you to consider complete data access, including pricing in allowed amounts, for the greatest utility of this data base. We would ask that physicians and patients have key roles in the governance of such a data base, and that these data sets are mutually accessible and coordinated with regional State data bases.

We look forward to additional questions and discussion of most of the provisions in this bill.

Particularly and finally, we strongly support everything included in the bill that would address drug pricing and would ask you to actually go further. We also strongly support the elements that would require transparent reporting from pharmacy benefit managers to plan sponsors. The lack of transparency makes it impossible for most employers to even know prices, rebates, and other pricing complexities, much less negotiate lower prices.

Thank you.

[The prepared statement of Ms. Mitchell follows:]

PREPARED STATEMENT OF ELIZABETH MITCHELL

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

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

The most important points I want to make today are:

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

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

PBGH members collectively spend over $100 billion annually purchasing healthcare on behalf of their employees. Collectively that means buying healthcare for over 15 million Americans. And our members are deeply committed to the health and well-being of their employees and buying the healthcare services that promote optimal health. But even the largest private purchasers of healthcare in the world

cannot overcome the industry consolidation, opacity, anti-competitive practices and egregious pricing in US healthcare. If large employers can't buy affordable high-quality care on behalf of their employees, it is almost a cruel joke that we would expect that of small businesses, municipalities, or families.

We do and will pay for high value care. We have stellar examples of bold innovations driven by our employer members to buy high quality care. The Employers Centers of Excellence Network (ECEN)—managed by PBGH on behalf of our members—has shown significant improvements in health outcomes and costs.[1] ECEN sets high quality standards, vets and selects the best providers and facilities in the country for specific procedures, and encourages employees to use these Centers of Excellence (CoEs) for needed care. The ECEN program results demonstrate that it is possible to save money by reducing unnecessary services, while improving outcomes and patient experience.

Even when factoring in travel expenses and waived co-pays, negotiated bundled payments for surgical procedures performed by CoEs cost considerably less, on average, than what members currently pay for these services. The cost equation improves even further, since these high-quality procedures produce quality outcomes that can mitigate costly revisions and infections. Much of the cost reduction comes from avoiding unnecessary procedures, with top-performing surgeons using evidence-based medicine to determine surgical appropriateness. Think about this. This is just a glimpse in to the unnecessary services being delivered in this country by providers and facilities that are paid only if they administer treatment—and the more treatment, the more they are paid.

Furthermore, the ECEN program convenes all participating hospitals and their surgeons annually to compare best practices across the network, and 98 percent of patients recommend the ECEN program. The good news is that through this program we are also starting to demonstrate the ultimate win-win-win in healthcare: better outcomes, much better patient experience at significantly lower costs. Better care can and does cost less. It is my position that if everyone had access to the performance information to choose the best care—and the resources and wherewithal to hold the system accountable—we could move the entire market. This is what we should all be working towards.

Unfortunately, we also have alarming examples of system failures. Just this part Friday I was meeting with one of my large employer members who is committed to offering high quality affordable care to his many employees across the country. He shared the story of one employee who had recently had a kidney transplant and was on a critical medication. This employer has paid approximately $138,000 every 2 weeks ($3 million during the last 12 months) on one patient for this drug and its administration at the provider's office. Because this employer has a Specialty Pharmacy, the plan is now able to source this drug directly from the manufacturer for $26,092 each 2 weeks and, at the patient's request, have a nurse provide infusions in the patient's home. They also agreed to waive all patient cost share if she agreed to change the place of service for exactly the same medication. It was a "Win-Win" for the patient and plan. The drug is still expensive, but it is a savings of over $200,000 per month. In another example this same employer had a pediatric patient receiving medication administration from a hospital in California at a cost of $750,000 annually. The employer searched the local market for alternatives and, with the agreement of the family, changed the treatment location to another California hospital. That same medication for that same patient at a different hospital cost only $250,000 per year. You might say that is an example of the market working. The buyer figured out a smart way to obtain a better price. But this situation is rare and depends on transparent information and market leverage that very few have. Imagine a small employer, or an employer without transparent pricing information—or an individual patient—trying to achieve this kind of savings. It simply is not possible in the US healthcare market. The market needs to work for everyone. We believe that many of the proposals in this bill would begin to enable a more rational, functional—and fair—market.

Recommendations for Policy Action

Our policy recommendations build on the testimony submitted by David Lansky, PBGH's former President & CEO, to the Senate HELP Committee in July 2018, as

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

well as the letter we sent on March 1, 2019, in response to the Committee's request for information, and our June 5 comments on the Committee's discussion draft of the Lower Health Care Costs Act of 2019. These recommendations are based on the principles and key levers that can drive change and improvement in our health care system that we described in the earlier testimony and follow-up letters.

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

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

Comments on Specific Elements of the Discussion Draft

In addition to the consumer protections in the draft bill, PBGH endorses the intent to hold down overall health costs. In nearly all cases, large employers are seeking market-based solutions to the Nation's increasing health care costs, but we believe that public policy interventions are needed when markets fail. This has clearly happened in the case of certain facility-based physician services and ambulance services. In a recent paper on surprise billing by my colleague Benedic Ippolito from the American Enterprise Institute, this market failure occurs when "consumers cannot feasibly avoid providers who deliberately chose to be out-of-network"—for instance, in emergency situations. "Similarly, even for elective admissions to the hospital, it is typically not possible to choose many ancillary providers." [2] In these situations, it is difficult for even the most innovative purchasers to achieve high quality and affordable care and coverage for their employees. In the specific case of surprise bills, policymakers must take steps to protect consumers and hold down the overall costs of care.

Reducing the Prices of Prescription Drugs

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

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

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

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

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

the use of "spread pricing" by PBMs, and the requirement for PBMs to pass-through 100 percent of rebates or discounts to the plan sponsor. These steps will help to align the PBMs' business models with the needs of consumers and purchasers, thereby leading to lower drug costs.

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

Improving Transparency in Health Care

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

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

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

- We support the elements of the draft bill that would establish a non-governmental not-for-profit organization to create an all-payers claims data base. PBGH has extensive experience with the design and use of these types of data bases. We have provided technical assistance and recommendations to Committee staff on this proposal, and we can provide additional detailed guidance and feedback as needed. In the design of this program, it is essential that users of the information—especially physicians and patients—have a key role in governance.
- We support the key elements of the draft bill that would enable data sharing and require commercial health insurers to make information available to patients through application programming interfaces, while protecting individual patient privacy.

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

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

Competitive Markets

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

- Market power has enabled providers, drug companies and others to raise prices, and it is largely the result of market concentration. According to a recent paper, "Hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals."[4] A recent Kaiser Health News article commented specifically on the problem of high hospital prices in California.[5]
- Market concentration has been growing in recent years. Most hospital markets are already highly concentrated, and hospitals have also been buying up physician practices. The trends in consolidation are documented in a recent Health Affairs article.[6]

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

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

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

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

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

In addition, we encourage Congress to enable Medicare beneficiaries to identify and seek care from high performing centers. In recent years, centers of excellence (CoEs) have become a common feature of commercial insurance and private purchaser medical care networks. Nearly 90 percent of large employers expect to use such centers to improve quality of care and predictability of cost for their employees.[7] Commercial CoE programs have primarily been used for common elective pro-

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

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

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

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

cedures and certain medical conditions with high costs and variability in quality and price, including hip and knee replacements, spine care, heart surgery, bariatric surgery, and some oncology services.[8] As I described above, we have demonstrated that a CoE programs can generate superior quality outcomes, reduce costs for patients and employers, and improve patient experience.

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

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

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

Ending Surprise Medical Bills

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

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

- **PBGH supports Option 3—Benchmark for Payment.** We strongly recommend setting payments based on the average payment to specialty physicians, e.g., 125 percent of Medicare payment rates. A second-best solution would be the use of payments based on median contracted payment rates in each geographic area, although we are concerned the resulting benchmarks under that method would reflect prices that are already too high.
- Option 2—Independent Dispute Resolution. We believe that an arbitration process would not achieve the aims of the bill to adequately protect consumers, payers and purchasers from high costs. In fact, it would add significant administrative costs and burden to physicians and health plans, the last thing we need in our already administratively complex health care system. Furthermore, we are concerned that the arbitration process would be opaque, and the outcomes would be uncertain.
- Option 1—In-network Guarantee. We appreciate the Committee's attempts to develop a creative approach to this problem, but we are skeptical that this would produce the needed cost reductions. While some economists have assumed that without the ability for emergency physicians and other facility-based providers to stay out-of-network, they will have less bargaining leverage, and therefore prices will be lower. Based on the real-world experiences of PBGH members, however, we are not confident that this would happen, especially in markets in which dominant hospitals and physician groups have strong market power. We anticipate that the physicians would negotiate with the hospitals or health plans to maintain the current high prices, thereby locking in the current unaffordable costs to consumers and employers. This would likely be a serious problem for small rural hospitals that are often in a weak bargaining position with local physician specialty groups.

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

Additional Policy Recommendation: **Primary Care** The U.S. health care system needs to dramatically increase investment and support for primary care—the foundation of good health for all Americans. This includes integrated behavioral health because behavioral healthcare is primary care. The evidence is clear; we know that the decisions made in primary care practices have outsize influence on downstream medical care. A Stanford University study published last year showed that high value primary care for a commercially insured population can lead to spending that is 28 percent lower than average value primary care [9]. The savings are clustered in four areas: unnecessary surgical and other specialty procedures (41 percent), low value prescribing (26 percent), avoidable hospitalizations and ED visits (17 percent), and unnecessary testing (8 percent). The high value primary care practices did see their patients more often, resulting in higher spending on office visits, but only by 2 percent.

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

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

Summary

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

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

[SUMMARY STATEMENT OF ELIZABETH MITCHELL]

The Pacific Business Group on Health (PBGH) is a coalition of large public and private purchasers of health care. Although we prefer market solutions to the problem of high costs, we know that many parts of the health care market are fundamentally broken. Government action is needed to ensure healthy competition, and in some cases, the only solution may be price regulation. With regard to specific elements of the Committee's discussion draft:

- Surprise Medical Billing. We strongly support the protection of patients from out-of-network deductibles in emergencies and from other surprise bills. We strongly recommend, however that the definition of services be

[9] Melora Simon et al, "Exploring Attributes of High-Value Primary Care", Ann Fam Med 2017;15:529–534. *https://doi.org/10.1370/afm.2153.*

expanded to include ground and air ambulance services. We also recommend setting payments based on the average payment to specialty physicians, e.g., 125 percent of Medicare payment rates.

- Reducing the Prices of Prescription Drugs. We strongly support the elements of the draft bill that would require transparent reporting from pharmacy benefit managers (PBMs) to plan sponsors, prohibit the use of spread pricing by PBMs, and require PBMs to pass-through 100 percent of rebates to the plan sponsor. In aggregate, however, we do not believe that these steps would go far enough to rein in drug costs. Specifically, we support legislation that would increase transparency and provide advance notice and justification for significant price increases, reduce the barriers to generic drug and biosimilars development, and prohibit abuse of the patent system to extend exclusivity for brand-name drugs.
- Improving Transparency in Health Care. We strongly support the elements of the draft bill that would improve transparency of costs and quality outcomes, including provisions to establish a non-governmental not-for-profit organization to create an all-payers claims database. In addition, we encourage Congress to require outcomes-oriented quality measures for priority conditions, including maternal and infant care.
- We strongly support the elements of the draft bill that would remove gag clauses on the sharing of price and quality information by providers, as well as the elements that would ban anti-competitive contracting practices by providers. We encourage Congress to consider additional steps to address the problem of provider concentration, including site-neutral payments and the promotion of entry of new competitors and reduction of barriers to entry. In addition, we encourage Congress to enable Medicare beneficiaries to identify and seek care from high performing providers and facilities.
- In addition to these elements of the Committee's discussion draft, The U.S. health care system needs to dramatically increase investment and support for primary care. We believe Medicare should authorize payment models and increase payment rates for advanced primary care models that achieve high quality outcomes and reduce total cost of care.

The CHAIRMAN. Thank you, Ms. Mitchell.

Mr. Isasi, welcome.

STATEMENT OF FREDERICK ISASI, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, DC

Mr. ISASI. Thank you very much, Chairman Alexander, Senator Murray, and Members of the HELP Committee. I am Frederick Isasi, Executive Director of Families USA. For nearly 40 years we have served as one of the leading national voices for health care consumers, both here in

Washington, DC. and on the State level. Our mission is to allow every individual to live to their greatest potential by ensuring that the best health and health care are equally accessible and affordable to all, and thank you for the opportunity to testify.

The cost and quality of American health care is a profound economic and public health problem, and an utterly bipartisan issue. Almost half of the public cannot see a doctor when they need to because of cost. About a third say that they had trouble paying for basic necessities because of health care costs. And nearly two-thirds of the public believe that we as a nation do not get good value from the U.S. health care system. And analyses of the health care system support the public's perception.

Despite spending two or three times more than other wealthy nations on health care, we live shorter lives than those in other wealthy nations. The U.S. health care system is more likely to fail

its people, and even our moms and our babies are dying at higher rates.

As a Nation, we can do better for families, and it's well past time that the health care system change.

Families across the country who face ever-increasing health care costs often are forced to make untenable decisions: pay a medical bill, or buy groceries to feed the family; pay the electric bill to keep the heat on, or buy a child's asthma medication. At its worst, out of control health care costs and lack of high quality can be truly devastating.

I'd like to talk to you about Deborah, from the Chairman's home State of Tennessee, a remarkable woman who shared her story with Families USA story bank. Deborah worked hard. She went to college. She studied. She graduated, and she for many, many years worked in a successful career as a microbiologist for the State of Tennessee.

Then in 2012, after going to the hospital for a routine hip replacement, Deborah received a hospital-acquired infection. This created a multi-year cycle of infection and illness that resulted in her losing her job and losing almost everything she had worked for.

Following the surgery, an infection spread from Deborah's hips to her vertebrae and discs, and by 2016 she was at risk for full spinal collapse. She had 10 back surgeries, and at times she was placed in a drug-induced coma. Today, Deborah is bedridden and in extreme pain.

Since her first surgery, Deborah has moved from employer coverage to the Tennessee Health Insurance Marketplace, and now Medicare. Despite this coverage, paying for her care has taken all of her savings. Deborah told us, 'I had about $2 million in surgeries, plus a bunch of other expenses, including an intravenous antibiotic that cost about $850 a day. Before this, I had a brand new house, I had a brand new car. The car was repossessed, and I almost went into foreclosure.

Deborah was in the hospital when, and I quote, 'the repo papers came. I planned my life 20 years ago, and I didn't expect this to happen. It hit me so hard, and it took everything. This isn't what I thought would happen to me.

Any of us, any of us could be Deborah. Any of us could be building our lives, saving, contributing to society, and then because of poor health care quality and out of control costs, all that we have worked for can be taken from us.

It is time for our nation to take a long, hard look at our health care system. The system should work for families to ensure the best health possible, not threaten our economic independence and vitality.

Families USA strongly supports the Lower Health Care Costs Act. It's an important step in the right direction, and we've provided written comments with specific recommendations about the legislation.

Before I conclude, I was hoping to briefly focus on the legislation's prohibition on surprise medical bills. Your legislation would end this practice and the profound financial insecurity it creates. The most critical aspect of the legislation would ban charging patients out-of-network rates while receiving in-network care. This is

most critical. The legislation also would establish a mechanism to ensure that providers can't charge outrageous amounts of money for these categories of out-of-network services. Recent studies have shown that as providers consolidation has reached all-time highs, providers are leveraging the lack of competition to charge ever-escalating prices. These prices are a central reason why health insurance premiums for all of us continue to escalate so quickly. We strongly support and encourage the Committee to maintain these provisions in the legislation that not only prohibit out-of-network surprise bills but also the outrageous sums being charged for these services.

The work you do in this Committee is absolutely vital to the health and well-being of every single person in this country. We hope the work will continue and the legislation will be enacted this year.

Thank you again for the opportunity to testify, and I look forward to responding to any questions.

[The prepared statement of Mr. Isasi follows:]

PREPARED STATEMENT OF FREDERICK ISASI

Chairman Alexander, Senator Murray, and Members of the Committee on Health, Education, Labor, and Pensions. I am Frederick Isasi, Executive Director of Families USA. For nearly 40 years, we have served as one of the leading national voices for health care consumers both in Washington, DC. and on the state level. Our mission is to allow every individual to live to their greatest potential by ensuring that the best health and health care are equally accessible and affordable to all. As a former aide to Sen. Jeff Bingaman, a long-time Member of this Committee, it is my honor to have the opportunity to speak with you today.

The Larger Context of Health Care Costs for Families

The cost of American health care is a profound economic and public health problem: 44 percent of the public report not seeing a doctor when they need to because the costs are too high; 30 percent say the cost of medical care interferes with basic needs like food, housing, and heat; and nearly two-thirds believe that, as a country, we do not get good value from the U.S. health care system.[1] As a Nation, we can do better for America's families, and it's well past time for the health care system to change.

Over the last 40 years, health care spending in the United States has increased six-fold, from $1,797 per person in 1970 to $10,739 in 2017 (using constant 2017 dollars).[2] During that same period of time, the U.S. more than doubled the percentage of its gross domestic product (GDP) on total health care spending from 6.9 percent of its GDP in 1970 to spending nearly 18 percent of its GDP on health care in 2017.[3]

This increase in national health care spending has outpaced the growth of the U.S. economy, with per capita national health expenditures growing faster than inflation from 1980 to 2008 and again from 2014 to 2015.[4] And, U.S. health care costs are high not only by historical standards, but also compared to other industrialized nations. Among industrialized countries, the United States ranks highest for the amount spent on health care but lowest on fundamental health outcome indicators. For example, a recent study in The Journal of the American Medical Association found that, although U.S. per capita spending on medical care is nearly twice that of 10 of the highest-income countries, the United States has the lowest life expect-

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[1] NORC at the University of Chicago and West Health Institute, Americans' Views of Healthcare Costs, Coverage, and Policy, March 2018 *http://www.norc.org/PDFs/WHI—20Healthcare—20Costs—20Coverage—20and—20Policy/ WHI—20Healthcare—20 Costs—20Coverage—20and—20Policy—20Issue—20Brief.pdf.*

[2] Rabah Kamal and Cynthia Cox, "How Has U.S. Spending on Healthcare Changed Over Time?" Peterson-Kaiser Health System Tracker, December 10, 2018, *https://www.healthsystemtracker.org/ chart-collection/u-s-spending-healthcare-changed-time/ itemhealth-spending-growth-has-outpaced-growth-of-the-u-seconomy—2017.*

[3] ibid.

[4] ibid.

ancy and the highest infant mortality and maternal mortality rates.[5] Our country also ranks near the bottom of the list of wealthy nations in terms of access, equity, outcomes, and administrative efficiency.[6]

High and rising health care costs are a critical problem for national and state governments, and affect the economic vitality of middle-class and working families. Over the last 40 years, these families have experienced stagnating wages and income. From 1973 to 2013, hourly wages rose 9 percent in real terms, while workers' productivity increased 74 percent. In comparison, from 1948 to 1973, wage growth kept pace with workers' productivity: Wages and productivity increased 91 percent and 96 percent, respectively.[7] Stagnation in wage growth is particularly evident in trends in annual pay increases for middle-and lower-income Americans. Since 1979, annual increases for the top 1 percent of America's earners increased by a startling 138 percent, while the bottom 90 percent saw their wages increase by only 15 percent.[8] While there are many contributors to this half-century long trend of lower wages, there is evidence that the rapid growth in U.S. health care costs has created sustained downward pressure on wages and incomes.[9, 10]

Between 1999 and 2016, the total cost of a family employer-sponsored health insurance plan rose from $5,791 to $18,142 in real 2016 dollars.[11] Thus, the high cost of health care also is a critical problem for employers. As wages remain relatively flat and health care costs increase, a growing number of families struggle to afford health insurance deductibles and cost-sharing. These people are commonly referred to as the "underinsured." Currently, 45 percent of U.S. adults were underinsured—an estimated 87 million people. Distressingly, this is more than triple the rate of underinsurance in 2003.[12]

Families across the country who face high and rising health care costs often are forced to make untenable decisions: pay a medical bill or buy groceries to feed the family; pay the electric bill to keep the heat on or buy a child's asthma medication; seek treatment for a substance use disorder or postpone treatment because an employer doesn't offer health insurance. These tradeoffs have a direct impact on individuals' and families' ability to live healthy lives.

To illustrate the myriad ways our health care system is failing so many people, allow me to take a moment to tell you the story of Debra, from Tennessee, a brave woman who shared her story with Families USA's story bank program:

> *For many years, Debra had a successful career as a microbiologist for the State of Tennessee. A hip replacement in 2012 kicked off a multiyear cycle of infection and illness that resulted in her leaving her job and losing almost everything she had worked for. Following the surgery, an infection spread from Debra's hips to her vertebrae and disks, and, by 2016, she was at risk of a full spinal collapse. She's had 10 back surgeries and, at times, has been in a drug-induced coma. Today, Debra is bedridden.*
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> *Since her first surgery, Debra has cycled from employer-sponsored coverage to COBRA coverage, a plan through the Tennessee marketplace, and Medicare. Paying for her care has taken all her savings. "I had about $2 million*

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[5] Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," JAMA 319, no. 10 (2018): 1024, *https://jamanetwork.com/journals/jama/article-abstract/2674671.*

[6] Eric C. Schneider, Dana O. Sarnak, David Squires, Arnav Shah, and Michelle M. Doty, "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," The Commonwealth Fund, July 2017, *http://interactives.commonwealthfund.org/2017/july/mirror-mirror/*

[7] Lawrence Mishel, Elise Gould, and Josh Bivens, "Wage Stagnation in Nine Charts," Economic Policy Institute, January 6, 2015, *https:// www.epi.org/publication/charting-wage-stagnation/.*

[8] ibid.

[9] Josh Bivens, "The Unfinished Business of Health Reform: Reining in Market Power to Restrain Costs Without Sacrificing Quality or Access," Economic Policy Institute, October 10, 2018, *https://www.epi.org/publication/ health-care-report/.*

[10] Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," Journal of Labor Economics 24, no. 3 (2006): 609–634, *https://sites.hks.harvard.edu/fs/achandr/JLE—LaborMktEffectsRisingHealthInsurancePremiums—2006.pdf*

[11] Gary Claxton, Matthew Rae, Michelle Long, Anthony Damico, Heidi Whitmore, and Gregory Foster, "Health Benefits in 2017: Stable Coverage, Workers Faced Considerable Variation in Costs," Health Affairs 36, no. 10 (October 2017): 1838–47, *https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0919.*

[12] Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty, "Health Insurance Coverage Eight Years After the ACA," The Commonwealth Fund, February 7, 2019, *http://www.commonwealthfund.org/ publications/issue-briefs/2019/feb/health-insurance-coverageeight-years-after-aca.*

in surgery, plus a bunch of other expenses"—including an intravenous antibiotic that cost about $850 per day. "Before this, I had a brand new house. I had a new car. The car was repossessed, and I almost went into foreclosure," Debra says. She was in the hospital "when the repo papers came. I planned my life 20 years ago, and I didn't expect this to happen. It hit me so hard, and it took everything. I worked for over 30 years, and this isn't what I thought would happen to me."

Any of us could be Debra. Any of us could be building our lives, saving, contributing to society and then, because of poor quality and out-of-control costs, all that we have worked for could be taken from us. It is time for our Nation to take a long hard look at our health care system. The system should work for families to ensure the best health possible, not threaten their economic independence and vitality.

The Public Across the Political Spectrum Want and Need You to Act

A recent survey found that 60 percent of Americans believe the government should be responsible for ensuring that all Americans have health care coverage. [13] Furthermore, almost 80 percent of Americans believe the government should help to ensure that everyone has access to affordable, quality health care. [14]

Despite the public's overwhelming support for universal and affordable access to health care, the interest of families and health care consumers is often absent in the decisions made by policymakers, particularly with respect to complicated and detailed health care payment and delivery system policies. Public policy research has found that well-organized groups representing specific business interests have substantial influence on U.S. policy, while consumers have little or no independent influence. [15] And, within this dynamic, the health care industry often has the unique ability to command the attention of policymakers—indeed, health care stakeholders spend more money lobbying Congress and the administration than any other industry. [16]

Consider, for example, the market failures and lack of competition that fuels "surprise" medical bills from out-of-network providers and ever-rising drug prices. Or, examine the way in which health care prices are established in the Medicare Physician Fee Schedule—the model for how most physician services are reimbursed by the Medicare program and most typically used as the foundation by which prices are established in Medicaid and even in commercial insurance. Prices are determined by physician specialty societies that have a vested interest in maximizing prices to generate their income rather than what is in the best interests of their patients. Meanwhile, primary care physicians who are on the front lines in providing cost-effective, patient-centered, community-based health care are paid among the lowest prices compared to other physicians. [17]

Other anti-consumer distortions permeate much further into our health care system. For example, the system fails to address the fundamental needs of consumers when patients and health care providers lack access to timely, effective, and interoperable health care data. These data are the foundation for consumers to make informed decisions about their care. Data are critical for society to understand who provides high-quality and high-value care, for policymakers to establish evidence-based legislative and regulatory initiatives, and for innovators to be rewarded for improving the Nation's health and health care systems.

It is for these reasons that just last month, Families USA launched a new national coalition called Consumers First: The Alliance to Make the Health System Work for Everyone. Consumer's First is dedicated to uprooting the fundamental eco-

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[13] Donna Rosato, "Feeling Squeezed: Healthcare Is Top Concern in CR's New Consumer Voices Survey," Consumer Reports, May 18, 2017, *https://www.consumerreports.org/healthcare/healthcaretop-concern-in-consumer-reports-new-consumer-voices-survey/*.

[14] Jocelyn Kiley, "Most Continue to Say Ensuring Health Care Coverage Is Government's Responsibility," Fact Tank (blog), Pew Research Center, October 3, 2018, *https://www.pewresearch.org/ fact-tank/2018/10/03/most-continue-to-say-ensuring-health-carecoverage-is-governments-responsibility/*.

[15] Martin Gilens and Benjamin I. Page, "Testing Theories of American Politics: Elites, Interest Groups, and Average Citizens," Perspectives on Politics 12, no. 3 (September 2014): 564–581, *https://www.cambridge.org/core/ journals/perspectives-on-politics/article/testing-theories-of-american-politics-elites-interest-groupsand-average-citizens/62327F513959D0A304D4893B382B992B*

[16] Center for Responsive Politics, Ranked Sectors, 2019, *https://www.opensecrets.org/lobby/top.php'indexType=c&showYear=2019*.

[17] Leslie Kane, "Medscape Physician Compensation Report 2018," Medscape, April 11, 2018, *http://www.medscape.com/slideshow/2018-compensation-overview–6009667*

nomic distortions in the Nation's health care system to ensure that the best health and health care are accessible and affordable for every person across the country.

Consumers First is operated by a steering committee comprised of leading national health policy organizations that are working to ensure that the U.S. health care system provides affordable, high-quality care for America's families, children, seniors, and adults. These include organizations represent consumers, employers, organized labor, primary care providers, and children.[1] In its Call to Action, Consumers First identified six policy areas ripe for immediate action to benefit consumers. Namely:

- Economic Distortions in Prescription Drug Pricing;
- Distortions created by provider payment systems, including Medicare;
- Increased Health Care Industry Consolidation;
- Federal tax policy of nonprofit health care institutions and insurance plans;
- Flawed workforce policy; and
- Inadequate access to data and lack of transparency.[18]

We are delighted that the HELP Committee is seeking, in bipartisan fashion, to address several of the issues identified by Consumers First.

The Lower Health Care Costs Act

First, I want to state clearly: Families USA strongly supports the Lower Health Care Costs Act discussion draft circulated by this Committee. We applaud the Committee for working in a bipartisan fashion to develop legislation that has the potential to be meaningful and enacted this year. We have a number of recommendations to improve this legislation, summarized below, and transmitted in full to the Committee in our attached comment letter dated June 5, 2019, but we are very pleased that the Committee is taking real action to improve health care for millions of struggling families across the country. **We encourage you to continue to work diligently to finalize this legislation this year.**

Below, I have provided a summary of our comments on each of the five titles included in the *Lower Health Care Costs Act*. **In addition, we've attached our more detailed comment letter as an appendix.**

Title I: Ending Surprise Medical Bills

Surprise out-of-network bills are a clear example of how distorted economic incentives in the health care sector are overwhelming the interests of patients. They are the result of a systemic problem in our health care system that places families directly in the middle of a tug-of-war between health care providers and insurers over the price of services.[19]

The rate negotiated between providers and insurers for services is at the center of their business models. Larger hospital systems have significant leverage, allowing them to command top dollar for in-network rates. Insurers are often forced to pay their high charges for in-network status, or insurers may simply walk away from the negotiation.[20] On the other hand, when hospitals are smaller, insurers hold the leverage. Those hospitals must choose between accepting lower negotiated rates than they desire, or walking away from the negotiation and providing care out-of-network.[21] In general, compared to in-network providers, out-of-network providers

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[1] The Steering Committee of Consumers First consists of: Families USA; American Academy of Family Physicians; American Benefits Council; American Federation of State, County and Municipal Employees; American Federation of Teachers; First Focus Campaign for Children; Pacific Business Group on Health.

[18] Frederick Isasi, Robert Berenson, and Sophia Tripoli. "Consumers First, Our Call to Action." Families USA, 2019, *https://familiesusa.org/sites/default/files/product—documents/Consumers-First—Our-Call-to-Action—Report—Final.pdf*

[19] Loren Adler, Matthew Fiedler, Paul B. Ginsburg, Mark Hall, Erin Trish, Christen Linke Young, and Erin L. Duffy. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. 2019, *https://www.brookings.edu/wp-content/uploads/2019/02/Adler—et-al—State-Approaches-to-Mitigating-Surprise-Billing–2019.pdf.*

[20] Robert Berenson, Robert, Paul Ginsburg, Jon Christianson, and Tracy Yee. "The Growing Power Of Some Providers To Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed." Health Affairs. 2017, *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0920.*

[21] Commonwealth of Massachusetts Health Policy Commission. "Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System." Commonwealth of Massachusetts. 2016, *https://www.mass.gov/files/documents/2016/07/xf/community-hospitals-at-a-crossroads.pdf.*

charge nearly three times as much for care.[22] These prices are not disclosed to patients in advance. This leaves families with balance bills that average over $600, but can exceed $20,000, despite the fact they are being provided within in-network facilities.[23] Providers and payers should not be permitted to walk-away from negotiations for services that are occurring in relation to other in-network services and simply leave families to bear the financial burden.

Surprise Billing Action is Needed Now

Among the many valuable provisions included in the Lower Health Care Costs Act, a prohibition on surprise billing is probably the most significant and badly needed today. The statistics are staggering: One-in-five emergency department visits results in a surprise medical bill.[24] More than one-in-five lab claims (22.1 percent) incurred at in-network hospitals are billed as out-of-network.[25]

Behind each of these statistics, however, is the story of a real person who has been harmed by a surprise bill. Allow me to highlight the experience of Nicole, from Colorado.

> *Nicole woke up in the middle of the night with intense stomach pain. After first visiting a freestanding ER, she was told she needed an emergency appendectomy, and she went to the local hospital. She did her due diligence to confirm repeatedly that the hospital and its providers accepted her insurance. However, months later, she received a surprise bill from the surgeon for $4,727. While the hospital was in-network, the surgeon was an independent, out-of-network provider.*
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> *Nicole explained the situation to the insurer, but they continued to demand payment. She declined to pay the bill, and within 2 years, a credit agency representing the surgeon took her to court, and won the full amount, including interest. As a result, a lien was placed on her home, and the collection agency garnished her wages by 25 percent each month. This came right as she was pregnant and about to go on maternity leave.*

The disagreement over the payment rate between providers and insurers has dominated the debate on surprise billing on Capitol Hill this year. The irony is that for decades, it has been families who have been harmed by surprise bills when powerful industries cannot agree on a payment rate. Now, the same powerful industries are fighting over this legislation and families' voices are once again overshadowed.

Whatever reimbursement methodology you choose, it is critical to millions of people like Nicole across the country that you enact legislation this year. Every day that goes by, families across the country are receiving devastating surprise bills that threaten to send them to medical bankruptcy. Families USA has been fighting surprise medical bills for three decades and we have never been this close to stopping one of the most egregious business practices harming consumers. You have come this far—please do not fail your constituents now.

Lower Health Care Costs Act's Protections against Surprise Bills

Your legislation, as drafted, provides strong consumer protections by ensuring no one will pay more toward their care than their in-network cost-sharing (including copayments, coinsurance, or deductibles) in a surprise billing situation regarding emergency services (regardless of the state in which the patient resides), non-emergency services at in network facilities, and out-of-network services after an enrollee has been stabilized. We support the clear indication that cost-sharing amounts count toward the in network out-of-pocket maximum and deductible. Finally, we support the clear specification that referrals for diagnostic services are included in these protections.

In addition to recommending a few clarifying changes as reflected in our attached comment letter, I would note one particular change to ensure the best possible consumer protections across the country. Namely, **we urge the Committee to clarify**

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[22] Cooper, Zack and Fiona Scott Morton. "Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise" New England Journal of Medicine. 2017, *https://www.nejm.org/doi/full/10.1056/NEJMp1608571.*

[23] ibid.

[24] Ibid.

[25] Kennedy, Kevin, Bill Johnson, and Jean Fuglesten Biniek. "Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016." Health Care Cost Institute. 2019, *https://www.healthcostinstitute.org/blog/entry/oon-physician-bills-at-in-network-hospital*

that Federal law applies to surprise bill situation unless, in the judgment of the Secretary, state law is equally or more robust. For state law to take precedent, it must have as robust consumer protections and payment cost-controls as the Federal law. This will prevent the potential for state laws to undermine Federal law on surprise billing and therefore leave consumers unprotected and vulnerable to premium increases. Additionally, even if states have their own surprise billing laws, Federal law should apply to any health plans that states cannot fully regulate, such as self-insured, ERISA-regulated plans.

Payment Mechanism Options

Your legislation contemplates three different options for establishing a mechanism for settling out-of-network bills between plans and providers.

Overall, we are very concerned about any out-of-network payment mechanism that would serve to further inflate costs, which would then be passed onto consumers in the form of higher insurance premiums. Due to its ability to hold down costs, and therefore protect consumers from premium inflation, and its administrative simplicity, **Families USA supports your third option—a benchmark payment rate based on median in-network contracted rates.** Conversely, we strongly oppose basing benchmark rates on billed charges due to its inflationary effects.

While we believe Option 3 is the strongest of the three alternatives you propose, we believe both an in-network guarantee (Option 1) and independent dispute resolution (IDR) (Option 2) also hold promise and represent improvements upon the status quo.

The in-network guarantee could provide a significant degree of simplicity and clarity for consumers who would know that any provider or service they access in an in-network facility (such as diagnostic imaging or laboratories) would be considered in-network. However, we recognize that the in-network guarantee model marks a dramatic shift from the health care system as it operates currently, and thus could present substantial implementation challenges.

IDR is not likely to contain costs as significantly as a benchmark mechanism and creates additional administrative burdens. However, if implemented properly, it would lower costs in surprise bill situations relative to the status quo. We are pleased that the dispute resolution entity would be an unbiased entity, tied neither to insurers nor providers, and will consider the median in-network rate. However, we recommend explicitly requiring that if pursued, an IDR entity may not consider billed charges in its deliberations. Billed charges are often wildly inflated above the cost of care and what the provider has agreed to in-network negotiations. As a result, considering billed charges would drive up health care costs and therefore premiums for consumers.

Surprise Bills for Air Ambulances

Air ambulances are a vital link in our Country's trauma care system, saving thousands of lives every year. However, Air ambulance services are particularly likely to lead to surprise medical bills. Nearly seven out of ten of air ambulance patient transports that people often require in life-or-death situations are out-of-network, and balance bills from these air ambulance providers are rarely below $10,000.[26]

Congressional intervention is needed to address this problem, as states are preempted from fully solving this pressing issue. Whether in this bill or future legislation, Federal protections should hold consumers harmless from paying more than in-network cost-sharing for air ambulance transport when they have no option for in-network airlift. Additionally, Federal preemptions that prohibit state regulation of air ambulance rates and networks should be eliminated. In the meantime, greater transparency of air ambulance costs, as proposed in this draft legislation, is beneficial.

Title II: Reducing the Prices of Prescription Drugs

In 2015, the United States spent $457 billion on prescription drugs—which accounted for nearly 17 percent of overall personal health care services.[27] The benefits

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[26] U.S. Government Accountability Office. "Air Ambulance: Available Data Show Privately Insured Patients are at Financial Risk." GAO. 2019. *https://www.gao.gov/assets/700/697684.pdf.*

[27] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, "Observations in Trends in Prescription Drug Spending," March 8, 2016, *https://aspe.hhs.gov/ system/files/pdf/187586/Drugspending.pdf*

of pharmaceutical drug therapies are substantial, but these benefits often come with significant financial costs to patients and to payers, and their prices are not always justified. For example, between 2012 and 2016, people with diabetes saw the price of insulin—a 100 year-old drug—double from $344 to $666 per prescription.[28] It is hard to understand how a drug so old can cost so much, until one looks at the financial practices of drug companies: On average they spend less than a quarter of their revenue on innovation[29] and nine out of 10 of the largest drug companies spend more on marketing than creating new drugs.[30] What's more, drug companies spent $172 million on lobbying in 2018—more than any other industry.[31]

While most other Federal reimbursement for health care is based on a set of standards, the government has no ability to establish a rational price for drugs in the Medicare program. For drugs without sufficient competition, it is clear that some prices are wildly inflated and those prices are not associated with production costs, efficacy, value, or need.[32]

Families USA supports the measures included in the legislation that lay a foundation of Federal reforms on prescription drug costs. In particular, the bill includes several measures to bring generics to market faster, providing lower cost alternatives to costly, monopolistic brand-name drugs. In particular, we support provisions like Section 201 and 202 that will provide greater transparency on patents for biologics, including on exclusivity periods and when they expire, so that generic manufacturers have the timely and accurate information they need to bring competition to market.

We also support sections 203, 204, and 205, which include important measures to prevent gaming that can delay the availability of generics. We recommend that the Committee supplement these provisions, whether in this legislative package or elsewhere, with the CREATES Act and legislation to completely ban so-called "Pay for Delay" practices, which would also make important progress in bringing generic drugs to market faster.

The bill would also be improved by facilitating greater transparency in how prescription drug prices are set. S. 1391, the FAIR Drug Pricing Act, sponsored by Sen. Tammy Baldwin, would require drug manufacturers to justify price increases of more than 10 percent in a single year or 25 percent over three consecutive years. We would also support a requirement that drug companies justify launch prices over a specified amount. One option would be mandated justification on launch prices that exceed the threshold in Medicare to qualify as a specialty drug, currently $670 per month ($8,040 annually).

While we support the prescription drug provisions in the Lower Health Care Costs Act, they will not significantly reduce the escalating cost of drugs without overarching reforms that will directly lower list prices. Some of these provisions may fall outside of the Committee's jurisdiction. **We urge the Committee to work with Senate leadership and ensure that policies that allow for government oversight of drug pricing be enacted this year. In particular, we urge the Senate to consider legislation to allow the Federal Government to directly negotiate the price it pays for prescription drugs in Medicare Part D.** S. 377, the *Medicare Negotiation and Competitive Licensing Act,* sponsored by Sen. Sherrod Brown, is one such example.

Title III: Improving Transparency in Health Care

Meaningful improvements in all of the areas included in your legislation—including prescription drug prices, surprise billing, and improved public health—all require better access to and flow of health care data. Today, health care costs and

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[28] Amanda Frost and John Hargraves, "Price of Insulin Prescription Doubled Between 2012 and 2016," HealthyBytes (blog), Health Care Cost Institute, November 29, 2017, *https://www.healthcostinstitute.org/blog/entry/price-of-insulinprescription-doubled-between–2012-and–2016*

[29] Florko, Nicholas. "A new study sparks a war of words over the drug industry's commitment to research." STAT News. May 14, 2019. *https://www.statnews.com/2019/05/14/war-of-words-over-pharma-commitment-toresearch/*.

[30] Richard Anderson, "Pharmaceutical Industry Gets High on Fat Profits," BBC News, 2014 *https://www.bbc.com/news/business–28212223*

[31] Center for Responsive Politics, Pharmaceutical Manufacturing: Lobbying, 2018. *https://www.opensecrets.org/ industries/lobbying.php'cycle=2018&ind=H4300.*

[32] Henry Waxman, Bill Corr, Kristi Martin, and Sophia Duong, "Getting to the Root of High Prescription Drug Prices," The Commonwealth Fund, July 10, 2017, *https://www.commonwealthfund.org/publications/issue-briefs/2017/jul/getting-root-high-prescription-drug-prices*

measures of quality and effectiveness are often inaccessible and nearly impossible to share. [33]

Consumers face many barriers to being informed purchasers of health care when they do not have access to price and quality information in the health care system. We also believe that it is critical to ensure that health care providers, payers, researchers and policymakers have access to underlying cost and quality data in order to make informed and effective health care payment and delivery system policies.

Banning Gag Clauses

Families USA supports Section 301 of the legislation, removing barriers to obtaining accurate and complete health care price and quality information including banning gag clauses included in executed contracts between insurance plan issuers and providers or provider networks. Increasing the transparency of such information will not only enable consumers to be more informed purchasers of health care but it would also unveil fundamental information that policymakers, researchers and other stakeholders need in order to identify health care markets with the highest prices and then build policy that encourage competition.

National All-Payer Claims Data base

Further, we strongly support Section 302 of the bill, which would establish a national all-payer claims data base (APCD) that receives and utilizes health care cost and quality information to generate reports available to the public and to researchers.

Your legislation could be meaningfully strengthened by making the following additions to the bill text:

- **Require that price and quality data be collected and accessible through the APCD in manner that allows for research and analysis**. Some in industry argue that the collection and dissemination of price data could result in increased prices because industry negotiators will drive toward the highest prices being paid. While this is a valid concern, with simple protections price information can be collected and provided to researchers and governments to study health care cost and value without unveiling prices to industry negotiators.
- Specify the categories of claims data that the APCD will utilize to include: medical and clinical, prescription drug, dental, behavioral health, and available social services data.
- Establish a mechanism in statute or direct the Secretary to establish a mechanism through rulemaking that will require health plans, hospitals, health care providers to share claims data with this new entity.
- Direct the Secretary to establish national interoperability standards to facilitate data sharing between health care industry entities and with state APCDs.
- Require that the establishment of a board of directors or other governance structure over the APCD equal representation of consumer groups in its composition.
- Require in statute that the Advisory Committee include at least 12 percent representation by consumer health care organizations and at least 12 percent representation by consumer groups whose missions are to reduce racial/ethnic health disparities.

Provider Directories

Inaccurate provider directories cause consumers to struggle to obtain needed medical care and to pay high out-of-network costs for care due to no fault of their own. Studies have found that for some specialties, directory information is accurate less than half of the time. [34] We applaud the HELP Committee for including this issue in the *Lower Health Care Costs Act.* Our attached comment letter includes more de-

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[33] Kamal and Cox. Op. Cit.

[34] Claire McAndrew. "Improving the Accuracy of Health Insurance Plans' Provider Directories." Families USA. 2015. *https://familiesusa.org/sites/default/files/product—documents/ACA—Provider—20Directory—20Issue—20Brief—web.pdf.*

tailed recommendations on how to ensure directory accuracy requirements are sufficient, but I would like to highlight two specific recommendations for your attention:

First, we recommend clarifying the legislation to ensure that providers would be prohibited from balance billing consumers in instances when consumers received inaccurate information about their network status. Providers should be required to provide notice about their network status at least 7 days before delivering care. If a patient does not provide advanced consent to receiving out-of-network care at least 7 days before a service, a provider should be prohibited from balance billing.

Second, all provider directories should be required to include a prominent notice of consumers' rights to pay no more than in-network cost-sharing if they receive out-of-network care due to a provider directory inaccuracy, and how to contact the health plan if they believe they relied on inaccurate information. Without such a notice, consumers are unlikely to know of their rights as proposed in this draft legislation.

Title IV: Improving Public Health

Families USA strongly supports the HELP Committee's attention to critical public health problems that our Nation currently faces. Maintaining a robust and effective public health infrastructure is essential to ensure that America's families have access to the health and health care they deserve. From the importance of vaccinations, to addressing the high rates of maternal mortality, to addressing the impact of discrimination on health in our health care system, we support efforts that enable our public health infrastructure to respond quickly and effectively to emerging public health challenges.

Achieving health equity is central to becoming a nation where the best health and health care are equally accessible to all. Throughout our history, people of color have been systematically denied a fair opportunity to be as healthy and productive as possible and reach their full potential. Consequently, these communities continue to struggle with deep and persistent health inequities. In addition to facing disproportionate barriers to high-quality, affordable health care, communities of color, and other underserved communities, also face significantly higher health risks, and markedly lower opportunities to improve their health. As a result, these communities are more likely to suffer from a myriad of serious health conditions, like diabetes, asthma, and many cancers, among others. This drives higher rates of poor health status and premature death, even among infants.

In our attached comment letter, Families USA identified a number of improvements to this title to help ensure that policies to improve public health are culturally tailored, evidence informed, and address social determinants of health. One of the central challenges in improving health care equity in the United States is the relative paucity of data that is stratified by race, ethnicity, gender, sexual orientation, and disability status. To improve data stratification, we recommend that Section 405, which would provide data system modernization grants to public health departments, include community-based organizations as grant recipients; and require that the grants include building capacity to collect and report data by race, ethnicity, gender, sexual orientation, and disability status.

Title V: Improving the Exchange of Health Information

Today, health care data are often inaccessible and nearly impossible to share.[35] The flow of well-managed and protected health care data should be viewed as central to improving health care quality and driving down costs across the system. Because health care data are not considered for their impact of the public good, they have been used to drive the business interests of some companies, instead of being used to drive better value across the system.[36]

For those who suffer from poor-quality care and unnecessarily high costs in our health care system, this dynamic must change. Access to interoperable and transparent data enables employers, purchasers, providers, and other actors to encourage the use of higher value care. Hence, it is vital that data be made more broadly available and interoperable across the payment and delivery system.

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[35] Miriam Reisman, "EHRs: The Challenge of Making Electronic Data Usable and Interoperable," P&T 42, no. 9 (September 2017): 572–75, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5565131/*.

[36] ibid.

Among several additional comments Families USA made in its attached comment letter (including comments on to improve patient privacy), I would like to highlight two recommended improvements to Section 501.

First, we recommend the legislation be updated to be made consistent with a recent Centers for Medicare & Medicaid Services (CMS) proposed rule regarding application programming interfaces (APIs): To be consistent with the CMS proposed rule, we recommend including language that requires payers (including dental plans) to include the following data sets price and cost data:

- Adjudicated claims (including cost);
- Encounters with capitated providers;
- Provider remittances;
- Enrollee cost-sharing;
- Clinical data, including laboratory results (where available);
- Provider directory data;
- Drug benefit data including pharmacy directory and formulary data; and
- Dental claims data.

Second, while we support requiring payers to provide data to consumers through APIs, we have serious concerns about the oversight over third-party apps to ensure that consumers' privacy is protected. With the rapid proliferation of health technology innovations over the last decade, it is critical that third-party apps and any other entities that may be involved with consumer health data are subject to the highest standards of protection and security for consumer health data.

We recommend the bill text stipulate that HIPAA be used as a framework for a comprehensive privacy structure for third party apps and any new entities that would create, store or transfer health care data.

More Action is Needed

The Reducing Lower Health Care Costs Act is an ambitious piece of legislation—particularly so as a bipartisan bill in these most contentious of times. You deserve commendation for your leadership. That being said, with our health care system so rife with economic distortions, misaligned incentives, and bloated prices, **the bill should best be thought of as a down payment on future reforms**. Once this legislation is passed into law, we look forward to working with you on continuing to address the many ways in which the needs of children and families are not being met by our current health care system. Among the policies we believe Congress must take up are:

- Legislation to directly lower prescription drug prices, including by allowing the Federal Government to leverage its power to negotiate through the Medicare program.
- Legislation to establish a national health care workforce strategy, including funding for the national health workforce commission
- Changes to graduate medical education policy
- Better oversight of non-profit hospitals to ensure they are meeting the needs of their local communities
- Further efforts to improve data interoperability and transparency, including through a federally mandated interoperability standard.

Once again, thank you for the opportunity to testify before this Committee, and for your leadership on these vital issues for America's families.

[SUMMARY STATEMENT OF FREDERICK ISASI]

The cost of American health care is a profound economic and public health problem: A recent survey conducted by NORC at the University of Chicago found that 44 percent of the public report not seeing a doctor when they need to because the costs are too high; 30 percent say the cost of medical care interferes with basic needs like food, housing, and heat; and nearly two-thirds believe that, as a country, we do not get good value from the U.S. health care system.

Families USA strongly supports the Lower Health Care Costs Act discussion draft circulated by this Committee. We encourage you to continue to work diligently to finalize this legislation this year.

- Title I: Surprise Medical Bills—Among the provisions included in the discussion drat, a prohibition on surprise billing is probably the most significant and badly needed.
- Among the three reimbursement options contemplated in the draft, Families USA recommends Option 3—a benchmark payment rate. We believe the other two options are less effective, but if structured correctly, would represent an improvement on the status quo for consumers.
- We recommend the HELP Committee address air ambulance surprise billing, either within this legislation or in future legislation.
- Title II—Reducing the Price of Prescription Drugs: Families USA supports the policies in the discussion draft, but recommend the Committee go further by mandating improved transparency requirements; passing the CREATES Act; and passing legislation to ban so called "pay-for-delay" agreements between brand and generic manufacturers. To ensure truly meaningful reductions in drug prices, the Senate must should pass legislation to allow Medicare to directly negotiate the price of Part D drugs.
- Title III—Improving Transparency in Health Care: Families USA supports the provisions in Title III. We make specific recommendations on how to improve several sections, including strengthening the all-payer claims data base, and clarifying that consumers given false information in provider directories are not subject to balance bills.
- Title IV—Improving Public Health: We support the provisions in Title IV. We make specific recommendations on how to ensure public health improvements also improve health care equity.
- Title V—Improving the Exchange of Health Information: We support the provisions in Title V. We make specific recommendations on how to improve application programming interfaces to ensure patient privacy and align with current administration rulemaking.

The CHAIRMAN. Thank you very much.
Ms. Bartlett, welcome.

STATEMENT OF MARILYN BARTLETT, SPECIAL PROJECTS COORDINATOR FOR THE COMMISSIONER OF SECURITIES AND INSURANCE, OFFICE OF THE MONTANA STATE AUDITOR, HELENA, MT

Ms. BARTLETT. Chairman Alexander, Senator Murray, distinguished Members of the Committee, I am honored to speak today about my success in lowering health care costs for Montanans. When I was appointed Administrator at the Montana State Employee Health Plan, reserves were projected to be at minus-$9 million in less than 3 years. Instead, the reforms that we implemented resulted in a reserve balance of $112 million to the positive in that timeframe.

I then joined Montana Insurance Commissioner Matt Rosendale's office to research and draft legislation aimed at lowering prescription drug costs. The Montana State Plans Prescription Drug Benefit was provided through a purchasing cooperative with seven different contracts. I researched the contracts; I researched the data files. I found spread pricing, limited data access, arbitrary changes to pharmacy reimbursements, and limited rebate pass-through, so I terminated these agreements and we contracted with Navitus, a PBM that offers a transparent full pass-through model with audit ability.

When CVS refused to accept our level of reimbursement, I kicked them out of the network and immediately saved $1.6 million for Montanans. In just the first year on our new program, we saved

$7.4 million, 23 percent. Now, that might not sound like a lot to some of you from much larger states than Montana, but in the U.S. the privately insured market has $140 billion in pharmacy spend. A 23 percent reduction could generate $32 billion in savings.

As proposed, your bill addresses spread pricing and rebate pass-through to generate health care savings. The bill also addresses compensation disclosure for brokers and consultants. The current system is flawed. The broker/consultant acts as the buyer's agent but most often is paid by the seller through confidential agreements. My colleagues found up to 17 undisclosed revenue streams for brokers, consultants, TPAs, associations, and others costs within employer plans.

I needed consultant expertise to help us make the change that had to take place in the Montana plan. I contracted with Alliant, who had my back the whole time, and the contract only allows for direct compensation to them from the plan.

Compensation disclosure for brokers and consultants is a good step. However, I recommend that the Committee strongly consider extending these requirements to all third parties that provide products or services to a plan.

The bill includes traditional transparency provisions intended to put downward pressure on costs by increasing competition. In my experience, I found that these transparency efforts are only effective in reducing total costs if you also pay attention to the prices. The prices must be fair.

As I delved into our claims data, I found extraordinary variations in prices charged by similar hospitals for identical procedures. The Rand 2.0 study confirmed this level of variation across the United States. Hospitals develop a secret chargemaster for the prices that you cannot see, so they set prices by the chargemaster. The insurance company or the TPA comes in and negotiates a secret discount off of that chargemaster. When I delved into our information, it was very plain to see that we had no control.

I contracted with Allegiance Benefit Management Plans as our TPA. Together we negotiated reimbursement rates as a multiple of Medicare and contracted with all Montana hospitals, including our 48 rural critical access hospitals. Medicare pricing is a common publicly available reference, and we paid a multiple of it. We are now paying a transparent and a fair price, and this change on its own saved millions of dollars for our health plan and for Montanans.

Hospital payments consume 40 to 50 percent of a plan's resources, so I urge the Committee to consider provisions to force hospitals to justify their prices, not just disclose them.

I am an accountant; I follow the money. I saved Montana State Employee Plan millions of dollars while not raising employee or employer contributions over a 5-year period. I did this by analyzing data, demanding transparency and fair pricing, finding the right partners, and taking the money out of the system and getting it back to the taxpayers and the members. It was my fiduciary duty to do so.

The bill before you demands better business practices from the health care industry, and I thank you for that.

[The prepared statement of Ms. Bartlett follows:]

PREPARED STATEMENT OF MARILYN BARTLETT

Chairman Alexander, Ranking Member Murray, distinguished Members of the Senate Health, Education, Labor, and Pensions Committee.

I am honored to speak to you today about my success in lowering health care costs for Montanans. As Administrator of the Montana State Employee Group Health Plan, I turned the Plan from pending bankruptcy to a large surplus in less than 3 years. I then joined Montana Insurance Commissioner Matt Rosendale's office, researching and drafting legislation and regulations specifically aimed at lowering the cost of prescription drugs for Montanans. Many of the concepts I implemented and policy we developed are found in the Lower Health Care Cost Act of 2019 (LHCCA).

Prescription Drug Costs

Sections 301, 302, and 306 of the LHCCA, are critical components of the reforms required to lower prescription drug costs. I particularly praise the emphasis on contracting practices in Section 302, and the prohibition on spread pricing and restrictions on prescription drug rebating in Section 306.

When I assumed the position of Plan Administrator in late 2014, I found that the prescription drug benefit was provided through a purchasing cooperative and governed by 7 separate contracts. Through contract and data analysis, we found the model capped rebates at $22/per script; included spread pricing; duplicated services; and restricted data access. I canceled these contracts and contracted with Navitus, a PBM that offered a transparent, full pass-through model, that eliminated spread pricing and guaranteed the Plan received all rebates. The PBM's only compensation was the contracted administrative fee paid by the Plan. The contract requires full audit access, allowing the Plan to properly exercise its fiduciary responsibility over employee and taxpayer funds.

In just the first year under the new PBM contract, we saved $7.4 million. This may sound like a small number to many of you, but the savings of 23 percent is huge. According to CMS, US pharmacy drug spending in the privately insured market is $140 billion; a 23 percent reduction could generate $32.2 billion savings for American employers and consumers.

Though many employers are afraid of disruption and have been convinced they cannot take on the big players in the system, when CVS would not accept the stated level of reimbursement, I kicked them out of the pharmacy network, and immediately saved Montanans $1.6 million/year. The provisions of sections 301, 302, and 306 of your bill take on these nefarious contracting schemes we find in health care and will assist employers in their negotiating power with vendors and middlemen.

Broker and Consultant Compensation

Section 308 of the LHCCA addresses disclosure of compensation for brokers and consultants of health care products and services and is a big step in the right direction.

As a new Plan Administrator, I was initially unaware of the sheer volume of products and services brokers, consultants, carriers, third-party administrators (TPA), product vendors and others are constantly pitching and marketing to health care purchasers and payors.

The Plan had 4 separate wellness products, which were not coordinated nor designed to work together. Brokers and vendors had promised their product(s) would lower costs, but the services weren't integrated and Plan costs were certainly not decreasing. It was just product applied upon product without digging into the root cost problems.

The Plan was under contract with a large broker/consulting firm, and the contract was vague regarding potential compensation from third parties. The firm agreed to complete an analysis of our prescription drug benefit for an additional $25,000, and their review concluded the existing contracts were good and costs were appropriate. Since my analysis showed the opposite, I terminated that broker/consultant contract.

I then contracted with Alliant, a mid-sized firm with extensive experience in reference-based pricing, pharmacy contracting, data analytics, and public entity health plans. The contract prohibits the consultant from receiving commissions, discounts, rebates, or other kickbacks from third party vendors related to the Plan's consideration, contracting, or performance.

The current system is flawed, as the broker or consultant is acting as the buyer's agent yet is paid by the seller. My colleagues found up to 17 undisclosed revenue streams in one employer health plan, adding hidden costs to health care.

Section 308's requirements for disclosure of compensation for brokers and consultants is a very good first step. However, I recommend that the Committee strongly consider including disclosure of compensation to all third parties that provide a product or service to a plan.

Pricing

Sections 303, 305, 307, and 309 of the LHCCA are traditional "transparency" provisions that are intended to put downward pressure on costs by increasing visibility on them. In my experience, I found that transparency efforts are only effective in reducing health care costs if the prices are fair.

As I delved into claims paid by the State Plan, I found extraordinary variations in prices charged by similarly situated hospitals for identical procedures. The Rand 2.0 study confirmed this level of variation exists across the US.

Hospitals develop a "charge master" for the prices they bill, which can be changed at any time and is not accessible by the Plan. A carrier or TPA will negotiate a discount off the charge master price, which is proprietary and confidential. So, employer plans are required to pay an arbitrary charge reduced by a secretly negotiated discount, which can change at any time without their knowledge.

I decided we would adopt a new strategy that would disrupt the standard model: Our Plan would set reimbursement for Montana hospitals and providers based on Medicare rates for the price reference.

Medicare offered the following that is absent in the current charge-less-discount model:

- Common reference to overcome variation in charge masters and differences in billing practices
- Largest healthcare payer in the world
- Prices and methods are empirically based and transparent
- Medicare prices intended to be fair
- Uses quality measures/value-based payment

The TPA under contract could not support our new reimbursement strategy. I terminated that contract. We then contracted with Allegiance Benefit Plan Management as our TPA, and successfully implemented contracts with all hospitals in Montana for reimbursement as a multiple of Medicare, with no balance billing to members. We are now paying a transparent and a fair price for services. This change, on its own, contributed millions in savings to the Plan.

The Lower Health Care Costs Act does not directly address the issue of arbitrary hospital pricing, yet hospital pricing typically consumes 40–50 percent of a Plan's resources. I understand the skepticism around using Medicare pricing as a reference. However, researching the MEDPAC reports and related methodology showed me it is the best source at this time to determine an appropriate cost of services. I believe using this reference for reimbursement will force hospitals to analyze their costs, adjust pricing accordingly, and move to a transparent, open network economic model, promoting competition and lower prices.

Sections 303, 305, 307, and 309 of the LHCCA add additional administrative costs to health care and will only be effective in reducing health care costs if intense scrutiny of the opaque cost/pricing systems occurs and provisions are added to promote fair pricing. I strongly recommend that the Committee prioritize efforts to force hospitals to justify their prices, not simply disclose them.

Conclusion

In December 2014, actuarial projections showed Montana's Plan reserves would be at minus $9 million in 2017 if we didn't make significant changes. I disrupted the reimbursement systems for health benefits, and we increased the Plan reserves to positive $112 million in December 2017. By summer 2017, the Plan had higher reserves than the Montana General Fund and was in a position to lend funds to the State.

I am an accountant. I follow the money. I saved Montana's state health plan from bankruptcy by reading contracts, analyzing claims data, demanding transparency from hospitals and middlemen, and then negotiating better deals. It was my fiduciary duty to do so.

Currently, in my role as Special Projects Coordinator for the Montana Insurance Commissioner, I helped draft and pass legislation modeled off my success at the Montana State Health Plan, which when enacted WILL lower the cost of health care.

Attached is a listing of detailed LHCCA recommendations submitted to the HELP Committee staff from the Office of Montana Commissioner of Securities and Insurance staff.

The LHCCA demands better business practices from the healthcare industry. If Congress passes this bill, American consumers are certain to see reductions in healthcare costs, especially in the pharmaceutical arena.

[SUMMARY STATEMENT OF MARILYN BARTLETT]

As Administrator of the Montana State Employee Group Health Plan, I faced a projected Plan reserve of minus $9 million. I successfully increased the Plan reserves to positive $112 million in less than 3 years. I then joined Montana Insurance Commissioner Matt Rosendale's office, researching and drafting legislation and regulations specifically aimed at lowering the cost of prescription drugs for Montanans. Many of the concepts I implemented and policies we developed are found in the Lower Health Care Cost Act of 2019 (LHCCA).

Prescription Drug Costs. Sections 301, 302, and 306 of the LHCCA, are critical components of the reforms required to lower prescription drug costs. When I assumed the position of Plan Administrator in late 2014, the prescription drug benefit was provided through a purchasing cooperative and governed by 7 separate contracts, which included spread pricing, limited data access, and partial rebate pass-through. I canceled these agreements and contracted with Navitus, a PBM that offered a transparent, full pass-through model, that eliminated spread pricing, guaranteed the Plan received 100 percent of the rebates, and provided full data access.

In just the first year under the new PBM contract, we saved $7.4 million, or 23 percent of the annual Plan spend.

Broker and Consultant Compensation. Section 308 of the LHCCA addresses disclosure of compensation for brokers and consultants of health care products and services and is a big step in the right direction.

The Plan had an existing contract with a large broker/consulting firm, which was vague on compensation terms with third-party vendors, and I canceled that contract. I then contracted with Alliant, prohibiting receipt of commissions, discounts, rebates, or other kickbacks from third party vendors related to the Plan.

Section 308's requirements for disclosure of compensation for brokers and consultants is a very good first step. However, I recommend that the Committee strongly consider including disclosure of compensation to all third parties that provide a product or service to a plan.

Pricing. Sections 303, 305, 307, and 309 of the LHCCA are traditional "transparency" provisions that are intended to put downward pressure on costs by increasing visibility on them. In my experience, I have found transparency efforts are only effective in reducing health care costs if the prices are fair.

To set fair reimbursements to Montana hospitals, we contracted with Allegiance Benefit Plan Management to adopt a new strategy. We set reimbursement levels using a multiple of Medicare pricing. We are now paying a transparent and a fair price for services.

The LHCCA does not directly address the issue of arbitrary hospital pricing, yet hospital reimbursements typically consume 40–50 percent of a plan's resources. This initial step will move hospital reimbursements toward transparent, open networks, promoting competition and lower prices.

Sections 303, 305, 307, and 309 of the LHCCA will only be successful in reducing health care costs if the provisions include provisions for fair pricing. I strongly recommend that the Committee consider provisions to force hospitals to justify their prices, not simply disclose them.

The LHCCA demands better business practices from the healthcare industry. If Congress passes this bill, American consumers and employers are certain to see reductions in healthcare costs, especially in the pharmaceutical arena.

The CHAIRMAN. Thank you, Ms. Bartlett. And thanks to all the witnesses.

We will now go to Senator Murray's opening statement, and then we'll have questions from the Senators to the witnesses.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much, Mr. Chairman. And thank you to all of our witnesses today for your excellent testimony.

I too have heard from families across my home State of Washington who are really struggling to afford health care, and I've been absolutely clear from the start, Democrats are at the table, we are eager to work with Republicans to bring costs down for health care for all.

The bill that we're talking about today is an important step in the right direction. It is also proof that when Republicans and Democrats join at the table and put partisanship aside, and put our families first, we can find common ground and help the people who are looking to us for relief on health care.

People like Stacy. She's a woman from Seattle. She wrote to my office about how she got an unexpected ER bill for over $1,000 after she had a bike accident because, while the hospital she visited was in network, one of the doctors who treated her was not. And Stacy also shared with me how her mother has struggled with high health care costs too, because after her mother was diagnosed with Type I diabetes, she was forced to move in with Stacy to afford her insulin.

Families like Stacy's, and there are so many of them, are really looking to us for help. So I'm really glad that our legislation works to address surprise billings so patients like Stacy will no longer get caught off guard by exorbitant charges for out-of-network care through no fault of their own.

I especially want to thank Senators Hassan, Bennet, Carper, Cassidy, Young, and Murkowski for their work on this issue.

This bill also works to open the doors for a cheaper generic insulin which could bring down costs for patients like Stacy's mom, and it would make it harder for drug companies to game the system and put up roadblocks to competition from cheaper generic drugs.

I want to thank Senators Kaine, Shaheen, Smith, Casey, Cassidy, Collins, Enzi, Roberts, and many others for working together on many of the ideas in this bill. And those are just a few of the many common steps we were able to come together on.

Thanks to the work of Senators Peters and Duckworth and Roberts, this bill includes a strong response to the threat of vaccine hesitancy and supports efforts to counter misinformation and increase vaccination rates in communities that are at risk of outbreaks.

It includes investments in public health data systems pushed for by Senators Kaine, King, and Isakson, to better protect families against public health threats, and would ensure that state, local, and tribal health departments have important guidance on obesity prevention efforts thanks to Senators Jones and Scott.

It also includes proposals from Senators Schatz, Kaine, and Murkowski to help expand the Echo Telemedicine model which we heard about in our hearings on the opioid crisis so it can be used

to bring care to even more people in more places and help address even more health care needs.

It includes proposals to update electronic health records, to make health data more accessible for providers and patients alike, and it would take a much-needed step to respond to our Country's maternal mortality crisis, including supporting investments in care for pregnant women and providing implicit bias training to help address the fact that women of color in particular are dying at unacceptably high rates.

Overall, this bill offers a lot of good bipartisan steps. So, Mr. Chairman, I hope we can continue to improve it in the coming days by continuing to work on proposals such as Senator Baldwin, Braun, Smith, and Murkowski's important drug price transparency bill.

But I do want to just say, to be clear, if we're really going to bring down costs across the board and help families who are struggling, this is no place to stop on this bill; far from it, because even as this bill offers families important relief on many issues, the Administration's policies are undermining health care for tens of millions of people across the country. They have rejected Democrats efforts to defend protections for people with preexisting conditions coverage for people nationwide from a partisan lawsuit that is now moving through our courts. President Trump has allowed insurance companies to go back to selling junk plans that leave people with preexisting conditions vulnerable, and refused to take significant action to curb drug prices despite campaign promises. And he has slashed investments in helping people navigate the health care system and get the plans that are right for them.

To put a finer point on it, when your car is totaled, you can't fix the windshield and expect to start driving.

We have a lot of work ahead to do, and I am really glad that we are here together on this legislation, and I'm going to keep making it clear it needs to be a first step, not a last one. Democrats understand that. I know families do, as well. We have a lot of critical work ahead of us beyond this.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Before you came, I said much the same thing. Health care is a big topic, and there are a number of areas on which we disagree and which we will continue to debate. But one thing we've been able to do—and I thank Senator Murray and the Committee Members for this, and the staffs—is identify nearly three dozen provisions, about 16 from Republicans, 14 from Democrats, and we have a few more that we're working on such as the Cassidy-Murphy provision on health care, and another that Senator Murphy mentioned. All of these are aimed at reducing the cost of health care paid for out of your own pocket.

These are first steps. I agree with her on that. There are other issues that we need to work on, but we've been able in this Committee, in fixing No Child Left Behind, the 21st Century CURES, opioids, other major issues, to identify the things we agree on and move ahead in meaningful ways.

I thank her for working in that way, and I complimented both staffs before she came.

Now, I only have 5 minutes, just like each Senator does, so I hope we can have an efficient back and forth because I've got two or three questions I'd like to ask.

Mr. Cavanaugh, being at CMS, you've seen the health care in a broad sense. This legislation basically seems to me to do three things: end surprise billing, No. 1; a whole series of provisions aimed at transparency, increasing transparency, based on the theory that you can't reduce the cost until you know the cost; and the third thing is to—and you mentioned this yourself as a former regulator—we've got nine provisions to try to increase competition for generic and biosimilar drugs, which are 90 percent of all the drugs prescribed.

If you look at those three areas—surprise billing, transparency, increasing competition—do you see those as meaningful steps, and which ones would have the most impact on reducing the cost of what people pay out of their own pocket for health care.

Mr. CAVANAUGH. Sure. I actually don't see them as that different. I feel like surprise billing is addressing a failure of the market where the consumer is not in a position to be an informed consumer making choices. They're in distress. They're going somewhere without full information. Transparency, again, transparency is what makes markets work so that people know what they're doing. So these are all, to me, pro-competitive policies, and that's why I applaud the Committee.

If I had to quantify the magnitude, I think the Title 3, the ones that are specifically labeled pro-competition about certain hospital negotiating tactics, I think that will have the most direct and immediate, but I think they're all rowing in the same direction.

The CHAIRMAN. Thank you.

Mr. Nickels, let me ask you this. Transparency is a big theme here we've talked a lot about. On the 340B program, hospitals put on their websites where the money goes. 340B is a law that says drug discounts should go to help low-income people. Why shouldn't hospitals be required to report that same information to HRSA. Is there any problem with that transparency in your view?

Mr. NICKELS. Mr. Chairman, we're all for transparency. We have a voluntary initiative among our members. Our 340B members, all 1,100 of them, have complied by putting out that information.

The CHAIRMAN. Well, then why don't you just take that information and give it to HRSA so we can——

Mr. NICKELS. Well, I think our plan is—by the end of this summer we will have all that information. We want to give people time. It can be complicated, but we do intend on providing to HRSA the names of the folks who have signed up and access to that data.

The CHAIRMAN. Well, from my point of view—I mean, the community health centers have to do that. They have to let us know how the money is spent. My own view is that if we're going to talk about transparency, and the law says the money is to be spent for low-income folks, that we at least ought to see how it's spent. That doesn't mean we're going to tell you how to spend it. At least we would know how it's spent.

Mr. Ippolito, let me go back to surprise billing for a minute. A lot of Senators have worked on that. You spent some time on it. It seems to me that if the problem is out-of-network doctors, that

the solution is to have in-network doctors. That seemed to me to be the simplest solution to the problem, and it also saves the most money. All three of the proposals we put out take the patient out of it. In other words, there are no more surprise bills. So the question is how do we reduce health care costs the most?

The other two provisions are the benchmark type provision, which the House seemed to prefer, and then arbitration. You talked about it some in your testimony, but isn't arbitration really a sort of benchmark? I don't see much difference between the two. And what are the problems with arbitration, as opposed to the House benchmark proposal, or the one that I instinctively like the best, which is make everybody in-network.

Mr. IPPOLITO. The short answer to your question is there's not much difference in practice between an arbitration system and a benchmark system, and the reason is basically that if you think about what the arbiter is doing, they have to make the same decision that the person choosing to benchmark is going to have to make. They've got two offers in front of them; they've got to choose which one is more reasonable. Well, the only way you can do that, as far as I'm aware, is you have to know what the reasonable number is, which one is closer. So when I look at that just in terms of practice, I think it's very, very similar.

Now, there are some differences between those two options. It tends to be a little less transparent, it tends to be a little more expensive, and then over the long term I think a number of experts have worried that it might be a little bit less predictable about how it's going to evolve over time. I know some will disagree with me on that point.

But generally speaking, the answer is they're quite similar at their core.

The CHAIRMAN. Your preference, No. 1, is the in-network guarantee; No. 2, the benchmark—well, you tell me what your preference is.

Mr. IPPOLITO. Yes. So, my ordering is the ordering you were just going down. I like the in-network matching specifically because it's the way that we solve this problem in every other market. When you go get your car replaced, you don't have to worry about an unexpected bill from the person who repainted the bumper, and it's not because we have an arbitration system to litigate bumper bills. It's because we go with all-in pricing in most markets. That's how we solve this issue. So to me, that seems the most natural approach.

The CHAIRMAN. My time is up. Thank you very much.

Senator Murray.

Senator MURRAY. Thank you, Mr. Chairman.

Mr. Nickels, Senator Alexander asked you about the 340B program, which requires pharmaceutical companies to provide discounts on crucial outpatient drugs for providers that serve low-income, high-need patients. In other words, 340B is one of the most effective programs at managing high drug costs that we currently have, and there aren't any taxpayer funds involved in providing those discounts; correct?

Mr. NICKELS. That is correct. It's drug company funds.

Senator MURRAY. Drug company funds. So I just wanted to be clear. We can all debate the best way to oversee this program, but we're not talking about wasting taxpayer dollars.

Mr. NICKELS. Correct.

Senator MURRAY. Mr. Nickels, hospitals do a lot of reporting as part of their participation in Medicare. As part of their Medicare cost reports, do hospitals report on labor costs, physical plant expenses, marketing costs, and other things?

Mr. NICKELS. Yes, all of the above.

Senator MURRAY. They do. But Medicare doesn't pay hospitals for some of those costs, like marketing?

Mr. NICKELS. Yes. Some of those are unallowable costs, but we still report them.

Senator MURRAY. But you still report them.

Mr. NICKELS. Yes.

Senator MURRAY. Mr. Isasi, Families USA supported the establishment of a minimum medical loss ratio for health plans. Does the MLR require plans to report on their administrative costs, like marketing and executive compensation?

Mr. ISASI. It absolutely does.

Senator MURRAY. It does. So, Mr. Isasi, Senators Baldwin, Braun, Smith, and Murkowski do have a bill requiring drug companies to report on those types of costs when they make price increases over 10 percent. Do you think that is helpful information?

Mr. ISASI. We think it's critically important, and it's important to remember that these drugs are life and death to a lot of people. This information should be available to the public and policymakers.

Senator MURRAY. You would support that approach?

Mr. ISASI. One hundred percent.

Senator MURRAY. Okay.

Mr. ISASI. We also would encourage an examination of launch price, as well as increases.

Senator MURRAY. Okay.

Ms. Mitchell, many states, including my home State of Washington, have passed legislation to end surprise medical bills. Your organization works with large employers to bring down the cost of health care. Why is it important to your members for the Federal Government to act?

Ms. MITCHELL. Well, we have multi-State employers, and it's often variation across states that really increases the challenge for them. So we need Federal legislation in this area.

Senator MURRAY. One of the issues that we are debating is what is the appropriate rate for an insurer to pay providers for a surprise bill. What impact do you think the proposals that we have in our discussion draft will have on enrollee premiums and access to care?

Ms. MITCHELL. Well, our experience in California is that it has no effect on premiums. We actually believe that we can achieve very fair pricing at 125 percent of Medicare. Evidence shows that 25 percent of hospitals are actually succeeding under Medicare rates. We think that there are significant opportunities for business practice improvement and increased efficiency among hospitals, but we believe that is a fair rate and could be sustained.

Senator MURRAY. Okay, thank you.

Mr. Nickels, the bill that we're talking about here today addresses a number of public health issues that are critical to conversations regarding health care costs. One issue of increasing concern that I've heard so much about is the rise in maternal mortality rates. We, I believe, have to do more to help reduce those preventable deaths, and many of these deaths occur not during childbirth itself but during the weeks and months before or after childbirth.

Can you tell us how hospitals are working with community partners to help make sure women have the information and the health care they need to avoid unnecessary illness or death associated with pregnancy?

Mr. NICKELS. Yes, thank you. You're absolutely correct. Two-thirds of the maternal deaths do not occur during childbirth in a hospital. It's before and after, as you know. And we are working with community partners. We're part of a coalition that has been led by ACOG for many years to try to address that better. And what your bill does is it provides more funding, more focus.

The Senate took action last year, Senator Capito's bill. There is legislation in the House by Representative Kelly that we support, and I think we need to do as much to solve this problem—and we ought to have a deadline where we really solve this problem nationally.

Senator MURRAY. Okay. Thank you very much. I appreciate that.

Mr. Nickels, on one other topic, over 1,000 cases of measles have been reported in the U.S. in 2019, the greatest number in nearly three decades. More than 80 of those were in my home State of Washington. Those outbreaks put families and communities at risk and put an unnecessary strain on our health care and public health care system. I was overwhelmed by what I saw in Clark County, where we saw the majority of these and the cost that it took to the public health officials, the community itself, all of the reporting, looking for people. So I'm really glad that the bill we're talking about that's in front of us includes provisions to combat misinformation and increase vaccination rates.

How can health care facilities and providers and public health professionals work together to increase what we call 'vaccine confidence'?

Mr. NICKELS. Yes. Again, we are very supportive of the provisions in your bill with the Chairman, and I think you go a long way in that direction. We hear from our members increasingly about the measles outbreak and what it's doing to the communities, and what it's doing to their facilities. But we all need to work together, and you put your finger on it, it's the misinformation that's out there that's causing this problem that has to be fixed.

Senator MURRAY. Okay, thank you.

My time is up. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Ms. Mitchell, you've dedicated a substantial portion of your career toward promoting more transparency in health care pricing, as well as higher quality. And as a result, today the State of Maine is one of the best states where you have all-payer claims data base.

I've joined Senators Rick Scott and Cory Gardner in introducing a bill that would create a consumer-friendly data base for prescription drug prices.

In your written testimony, you talked about two powerful examples of an employer who was over-paying for prescription drugs. One was a kidney patient where the employer cost was $138,000 every 2 weeks. It now looks like it's going to go down to $26,000. The other was a pediatric patient. The cost for the employer was $750,000. And now, using a different hospital, that cost may be only a third of that amount.

What led to those success stories? Was it greater transparency? Was someone negotiating for the employer? What produced those kinds of results?

Ms. MITCHELL. Thank you, Senator Collins. I think those are important examples of both the problems in the system and also the opportunities to fix them.

These cases could not have been addressed without transparent pricing information, and only these very large employers can have access to that information oftentimes. We believe that with greater transparency more actors, more employers, more insurers, would identify solutions like this.

I wanted to point out that, particularly in the case of the pediatric patient, those annual costs of $750,000 were brought down to $250,000 a year, the same drugs, and they were administered at home at the request of the family. So this was a win-win for the employer and for the patient. We believe that transparency would enable more success stories like that.

Senator COLLINS. Thank you.

Mr. Nickels, some of the rural hospitals in Maine are worried about increased transparency because their prices, because of the smaller patient population that they're serving, tend to be higher than their urban counterparts. Now, those rural hospitals are really important to communities and allow people to live where they can get care.

How do we balance the need to maintain a rural infrastructure for health care and the need to lower prices, which is imperative?

Mr. NICKELS. You're absolutely right, and I think we need to be very mindful of the impact of any of these policies on rural America and the unintended consequences that these policies can have. For example, rate setting, which has been discussed here a little bit, because rural hospitals—yes, their costs are higher, their margins are smaller, they have a more difficult time getting staff—physicians, nurses, et cetera. We can't have a national rate imposed on them that will be basically a race to the bottom. So whatever we do here, ending surprise bills, I think everybody agrees on that, and the provisions in the bill do that. But there are other provisions in the bill like rate setting that worry us a lot, particularly the impact on rurals.

Senator COLLINS. Ms. Mitchell, let me return to you for my final question. Biologics are one of the categories of drugs that are most expensive. The Aging Committee, which I Chair, has had a number of hearings on this issue, and what we found is that the brand-name manufacturer often puts up patent thickets that prevent biosimilars from coming to the market. By contrast, the biosimilar

uptake in Europe is much more prevalent than in the United States. In fact, the former FDA Commission, Scott Gottlieb, has estimated that if all the biosimilars that have been approved by FDA actually made it to market in a timely fashion, that American consumers would save more than $4.5 billion.

Do you have any thoughts and do you support the provisions in our bill that attempt to prevent the gaming of the patent system to delay the advent of biosimilars to the marketplace?

Ms. MITCHELL. Absolutely. We strongly support any of the changes that will enable increased access to biosimilars, and anything that prevents—we believe there needs to be strong action on drug pricing, and we strongly support your provisions.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Hassan.

Senator HASSAN. Well, thank you, Mr. Chairman and Ranking Member Murray, for your work to address rising health care costs. I also want to give a special thank-you to your staffs. These are complex issues, lots of stakeholders, and therefore lots of incoming for your staffs, and they've been just terrific.

Americans have called on Congress to act, and I applaud Members of this Committee and both sides of the aisle for taking these calls seriously. I'm particularly encouraged by the momentum behind our work to end the absurd practice of surprise medical bills. People get health insurance precisely so they won't be surprised by health care bills, so it is completely unacceptable that people do everything that they're supposed to do to ensure that their care is in their insurance network, and then still end up with large unexpected bills from an out-of-network provider.

As has been mentioned, I've been working with Senator Cassidy, Murkowski, and others to address this issue in a bipartisan way. We've worked for over a year now on this issue and received incorporated feedback from many of you on this panel, and I'm very grateful for your testimony. This hearing is an important step forward as we work to protect consumers and end surprise medical billing.

Mr. Cavanaugh, I'd like to start with a question to you. My colleagues and I in our bipartisan working group agree that patients must be removed from surprise billing disputes. But it has become clear that there's no benchmark payment rate that plans and providers can agree would be an appropriate one-size-fits-all approach.

During your time at CMS, you experienced firsthand how difficult it is to set uniform payment rates that work well throughout the country. Can you briefly touch on why that work was so challenging?

Mr. CAVANAUGH. Sure. Thank you, Senator. Again, if you think about Medicare Advantage, which is an analogy, in Medicare Advantage, if you go out of network, there are limits on balanced billing, and there's a set rate that the provider will be paid because it's a highly regulated system. But that's built on an enormous infrastructure of the Medicare fee-for-service program that takes thousands of employees in Baltimore working every day. So there's an infrastructure that's been refined over time. It's not perfect, but it's built on something.

If you were to go the benchmark route, we support all three approaches because you're protecting the consumer.

Senator HASSAN. Understood.

Mr. CAVANAUGH. We don't have a preference for that after that. But I do think, and the legislation tries to anticipate, you will run into as you try to—a benchmark rate is essentially rate setting of a sort, and you will run into unanticipated consequences, and someone is going to need to figure out how to adjudicate all those situations and make sure—because you're not building on the Medicare fee schedule, which has a whole agency administering it. You're starting from scratch.

Senator HASSAN. Briefly, is it fair to say that even when you do establish a benchmark, a rate, it's hard to maintain that as an applicable rate across the country for all providers?

Mr. CAVANAUGH. I think what you're getting at is I do think there are some unanticipated consequences from this that, if you decide to go that way, we will all learn it will take more work than any of us can anticipate, but it is one of the approaches.

Senator HASSAN. Yes, thank you.

Mr. Nickels, we've heard a lot of disagreement throughout this process on how to best create a payment resolution that works for all parties. So, yes or no, based on your experience, do you believe that there is a benchmark rate that you and your colleagues in the provider and payer community could agree to which Congress could then legislate into Federal law and apply across the country?

Mr. NICKELS. We do not.

Senator HASSAN. Given the lack of consensus around what a correct benchmark payment rate would look like, it seems unwise to me for Congress to legislate an inflexible benchmark, especially when we know that if we get it wrong, it would take another act of Congress to undo it.

Do you believe an independent dispute resolution framework, similar to what's already in place or in law in 12 States, would be workable for hospitals, providers, and payers? And why or why not?

Mr. NICKELS. Okay. I believe, as I mentioned, of the three options in the bill, that is the most preferable option. We would prefer to continue negotiating with our insurance colleagues for bills, and we would like to do that. I think particularly for physicians, particularly for the rural physicians, going back to Senator Collins' question, a dispute resolution system, much like in New York State, which has proved effective, efficient, et cetera, would be the best option that is in the bill.

Senator HASSAN. Thank you very much.

I yield the remainder of my time.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Cassidy.

Senator CASSIDY. Dr. Ippolito, how are you? I like much of your testimony.

By the way, Ms. Bartlett, I just read an article about you, and I just said be still my heart.

[Laughter.]

Senator CASSIDY. It is Montana, you know. If I wasn't married to my wife, and I don't know your status——

[Laughter.]

Senator CASSIDY. Dr. Ippolito, two stories. My daughter got kicked off of Alice in Wonderland in Central Park, and we took her to the emergency room, and she's bleeding from her forehead, and the ER said we don't have a plastic guy, go to his office. So I went to his office. I got a bill for $3,000 for glue the guy put in it took him 5 seconds to place.

I was at a tennis match here in D.C., and all of a sudden I get this black spot. I call an ophthalmologist friend of mine. He says you're having a retinal tear, go to the ER right away. I go to the ER. They say you don't need an ER. We're going to hook you up with the ophthalmologist, and go see him tomorrow morning, both emergencies. In that case, I think I got a bill for $1,500, both out of network.

Does network matching help me in either of those situations in which I was not seen in a hospital but rather referred to the physician's office?

Mr. IPPOLITO. Yes, that's a very good question. It's a very good clarifying question. The in-network guarantee would take care of a very large portion of the surprise bills, but they are the ones that occur at your in-network facility.

Senator CASSIDY. On the other hand, what Ms. Hassan was speaking of, I do gather that under the proposal that she and I have, I would have been cared for in both situations in which there would have been an in-network price, and so there would have been an out-of-network dispute, but I wouldn't have paid $3,000 for 20 seconds worth of glue, or $1,500, probably worth it because I got my retina back in place—but nonetheless, it was out of network.

I want to say there is a superiority. I think we're naive if we don't think there would be more migration out of the in-network hospital into a setting not covered by an in-network rate if we were to put restrictions on that which a physician could bill. I mean, we would be naive to otherwise think so.

Mr. IPPOLITO. I would clarify one point. The first is that both an arbitration and a benchmark system would have covered you in that case that you're talking about.

Senator CASSIDY. Arbitration and benchmark would, but not an in-network.

Mr. IPPOLITO. That's exactly right. So in-network would in theory need to be paired with something else.

Senator CASSIDY. The other thing I want to say about benchmark is that this is a ratio of—Ms. Moody, would you hold that up, please?

Ms. Moody calls herself Vanna White.

[Laughter.]

Senator CASSIDY. If you see dark blue has the highest rates of care, dark brown has the lowest rates. It's easier to get doctors in Florida than it is to get doctors in Alaska, so therefore you must pay doctors in Alaska more; market forces, if you will. Dr. Cavanaugh would like that. I suspect even in Florida there is great variation. If you're in Miami, you probably get more docs willing to get work, and if you're in a rural area fewer. But I will make the point, as Ms. Hassan did, that they have a benchmark would require a complexity that would reflect both different states as well

as different areas within a state, and I do think that's a complexity there.

Mr. IPPOLITO. I think it's an important point, and I think it's the reason why the benchmark and the arbitration options that are included in the bill that we're talking about are based on the average in-network rate in the area.

Senator CASSIDY. I'm not sure that our benchmark actually is, but we can look——

Mr. IPPOLITO. We'll be happy to circle back.

Senator CASSIDY. The other thing I want to dispute, if you will, is that you had mentioned in your testimony that—I should also raise this. I also want to make the point that the purple are states which, as laboratories of democracy, have put in arbitration models, and the orange—Tennessee orange, for our Chair—are states which have the benchmark, but no State has a network matching. So empirically, I want to just say that there is a prejudice among our states for—and I see Washington State either has UW purple of LSU purple, I'm not sure what that is.

Mr. IPPOLITO. I would clarify one thing just in the sense that the data do indicate that most hospitals do not produce out-of-network bills for in-network patients, which really, I think, if we were mapping that, would suggest that in all 50 States——

Senator CASSIDY. I accept that. In fact, I think that's a superiority of the dispute resolution. But I have limited time, so I want to make one more point. In your testimony you suggested that the dispute resolution be more expensive, but I will point out that CBO scores the savings of the Hassan-Cassidy proposal at $17 billion, and the network matching is only $9 billion. So it might be expensive, but it's less expensive than network matching.

I'll probably hang for a second round, if there is, but I will now yield back.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Smith.

Senator SMITH. Thank you, Chair Alexander. It's great to have you back. And thank you, Ranking Member Murray. I think there's been some really good work done on this bill, and I'm grateful for all of you for being here today to testify and answer some of our questions.

I believe that the number-one thing that I hear about from Minnesotans across the board is their worries about rising health care costs, and often they hone down right away to the rising cost of prescription drugs. So I'm really glad that the proposal that we have before us includes some good drug pricing provisions, and I'm glad that the bipartisan bill that I worked on with Senator Cassidy, the Protecting Biosimilars Act, is included, which would help more low-cost biosimilars into the market, like insulin. And also the proposal, the bill that I worked on with Senator Roberts, the Ensuring Innovation Act, which would prevent the ability of drug companies to make minor tweaks in their formularies and then extend their exclusivity, which again I think is an anticompetitive strategy that benefits the drug companies and not consumers.

Mr. Isasi, I know that your organization has done a lot of work on the issue of how to lower the cost of prescription drugs. I have first a general question. What is your feedback on the proposals

that we have in this bill, and is there anything more that you think—what else do you think we should be doing?

Mr. ISASI. Well, we very much support the proposals in the bill which are primarily aimed at transparency. We think that's very important. But it is not nearly far enough. We strongly support your bill around patent abuses and first filers. We also strongly support the notion that price is the problem, and we should not get confused, and we need to address drug pricing. We need the government to get in there, and a majority of Americans, including a majority of Republicans, want the government in there to help fight for fair prices.

Senator SMITH. Right, exactly. And I think several of you made the point that increased transparency is useful, but that is not the only thing that is going to address lowering drug pricing. Thank you. I appreciate you mentioning the bill that I have. I think it was the very first bill I introduced when I came to the Senate, which essentially cracks down on—what it says is it would allow subsequent generic—it's a little technical, but subsequent generic drug filers to share market exclusivity with first filers if they win that litigation, so that they don't have the—it actually does something about the exclusivity in a way that they think is meaningful to the drug companies.

Mr. ISASI. Right. As you say, it will allow us to refocus the drug industry on innovation and not reward smart lawyers.

Senator SMITH. Exactly. Not that we have anything against smart lawyers.

[Laughter.]

Senator SMITH. However——

[Laughter.]

Senator SMITH. I want to go to another issue that I think is really important. It's important to Minnesota. This is something that Senator Braun and I have been working on. It has to do with the all-payer claims data base. Ms. Bartlett, it sounds to me that in Montana you've done a lot of work with this. This all-claims data base has been incredibly useful in Minnesota to help us get a handle on what's happening with drug products like insulin, how much Minnesotans are paying on average, and how those prices have risen over time. It has given our Department of Health a very, very important tool for addressing some of these issues. I think one of you said how important it is to look at this information on a regional level.

The bill that we have before us does work to advance the work of all-claims, all-payer claims data bases, but I've heard some concerns from the Minnesota Department of Health and others about how this actually would work in real time and what it might do or not do to help states get the information that they need.

I'm going to ask Mr. Ippolito this. You know that some of my—a little bit about the concerns that the Minnesota Department of Health has had with this. How do you respond to the concerns that they have raised, specifically that the legislation before us as drafted might not provide states with timely access to data that they need, as well as the Federal Government, from self-insured plans?

Mr. IPPOLITO. Well, there are multiple approaches of achieving effectively the same goal when we think about all-payer claims

data bases. As I understand the bill—and I could, of course, be misreading, but I understand it as an effort to try and create a Federal all-payer claims data base for those ERISA-regulated plans but also allow State ones to coexist and, in fact, combine their data with the Federal data set.

Now, the one catch is that I do believe they have to share their data with the Federal Government. So to the extent that that's a sticking point, I'm certainly amenable to rethinking the exact structure. But I do think at a baseline they can coexist, at least in theory.

Senator SMITH. Thank you. Well, maybe, as I am about to run out of time, Senator Braun may have some questions about this as well. But I am very eager to resolve this issue so that some of the great work that Ms. Bartlett was talking about can proceed at the State level, as well as at the Federal level.

Great. Thank you. I'm out of time.

Senator MURRAY. [presiding] Thank you. The Chairman has left for a committee. He'll be back in just a few minutes, and in his absence I will continue.

Senator Braun.

Senator BRAUN. Thank you, Ranking Member Murray.

I wish we did have more than 5 minutes. This is such an important topic. And I think, as you can understand, 14 proposals from the other side of the aisle, 16 from our side, this is a big deal.

I am approaching this as recently a CEO of a company that brought health care issues into the C suite 10 years ago. It needs to be there, not probably in HR, if we're ever going to fix it.

I want to give you a little bit of history on what I did. I was not a member of a group as large as Ms. Mitchell's. I wish I had been, but I was simply frustrated as a Main Street entrepreneur that every year it was the same issue, premiums kept rising. I'd get this smirk of 'You're lucky it's only going up 5 to 10 percent a year.

I want to let the industry know, as well as the American public, that we are with you there, that it is a crisis, and I would challenge the industry. We shouldn't need 14 proposals from one side of the aisle, 16 from this side, to be fixing what's 18 percent of our GDP. If it was any other part of our GDP, competition and transparency would have gotten rid of the whole mess through the process that works elsewhere when you've got it.

Through that frustration, here's what worked for us, and I'm seeing some of it being incorporated in these ideas that we're talking about.

I figured out back then—and we haven't talked much about the consumer, the user, the employee, completely atrophied in terms of being involved in the market because it's been so paternalistic. When the insurance companies basically said, hey, part of this is the fact that the people that use it never ask how much does it cost, they don't want to be involved in it, I think that's important.

I devised a plan that did force skin in the game, gave all the tools you could give, including health savings accounts, and basically emphasized wellness, not remediation, did everything and the kitchen sink, basically cut costs out of the gate by 50 percent, and for my employees covering preexisting conditions, and no caps on coverage, which we need to do as conservatives and Republicans,

part of Obamacare. That just wasn't going to work due to its structure. We need to get with it.

I've not had a premium increase now into the 10th year because I've got my employees engaged. Every time they enter the health care system, they at least see how much does it cost and look at their alternatives, despite the industry not doing much to accommodate it.

It can be done. We're running out of time. Employers are getting frustrated. Most aren't as passionate as I am, or maybe the group in California, and there's a clear alternative on the other side. I give this as a warning to the industry. You ought to be fixing it yourselves, not having us here having to nudge you with legislation that wouldn't occur in any other sector of our economy.

My question is going to be directed—first of all, excellent slate of witnesses. Maybe there's another round and we can get more in. I always stay here until the last person is standing. This will be for Ms. Mitchell.

In your group, which looks like it's got a lot of large employers, I'm sure a lot of what I said kind of resonates. What have you done to look at the other end of the equation? Consumers drive most markets with full transparency and the desire to get the best choice of quality and price. Do you think the consumer, the employee has atrophied to where if we do make it more transparent and we get the industry to ever get out of its doldrums, will we have employees, consumers, patients be willing to have some skin in the game and help the system out as well?

Ms. MITCHELL. Absolutely, and I think patients and families absolutely have skin in the game, the health of their families. But they are in a completely untenable, unfair situation. They have no information. We're talking about providers not even being allowed to share information with them, the providers that they trust, and we ask them to be responsible consumers with no ability to do so, no cost information, no relative quality information.

Our members—and you would always be welcome as an honorary member. Our members are trying any innovative approach they can to actually work with their employees to address their concerns. So we absolutely believe transparency is necessary and that we will have active involvement of patients.

Senator BRAUN. So what I did is devised a plan with dollar one, you do have skin in the game, but then capped costs to where you could never go broke because you had a bad accident or got sick, and it did work, and I've had it 10 years. I'd love to share those details with you.

But I think you're saying the same thing that I am. We all, for families, along with education, it's the most important thing out there. And ironically, that's the other thing going up faster than health care costs.

The industry needs to really take this as a warning and a challenge. We're going to get some stuff across the finish line here. It's only nipping at the flanks. It's not going to happen unless we go to the other plan, which is Medicare for all. That's basically what all other countries have done. We're at a moment in time when we can keep the best of what we've got, but it's got to reform itself, or else that will be the only alternative.

Industry, wake up.

Thank you.

Senator MURRAY. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you.

I am certainly encouraged by the Committee's effort to address health costs and critical issues like surprise billing, but I am very frustrated that we have not begun to hold drug companies accountable for jacking up prices of existing medications.

In the past 5 years, prices of brand-name drugs have increased at 10 times the rate of inflation, putting life-saving treatments out of reach for far too many families. Meanwhile, drug company CEOs are seeing bigger paychecks. Reports show that the median drug company CEO pay increased by 39 percent in 2018, with some of the highest paid executives making $20 to $50 million per year.

That is why I worked with colleagues on both sides of the aisle, including Senators Braun, Murkowski, and Smith, on the Fair Drug Pricing Act, to require basic transparency of drug companies when they increase prices of existing drugs.

I really urge the Committee to add our bipartisan bill to the Lower Health Care Costs measure that we will vote on in the near future.

Drug companies spent $172 million in lobbying last year. They work hard to defend and often distract from their price increases, often by citing industry-sponsored statistics that show large investments in developing new cures. But we have numerous studies showing the opposite. One recent study found that nearly 80 percent of every dollar spent by big drug companies goes to something other than research and development, things like marketing or stock buy-backs.

The market is clearly broken, and taxpayers deserve to know what we are getting for our money.

Mr. Isasi, why do we need to include the Fair Drug Pricing Act in this package to ensure systematic transparency for drug price increases? And why is it important for companies to report specific metrics, things like research and development expenditures, marketing and advertising expenditures, and other items?

Mr. ISASI. Thank you very much for the question. We strongly support the legislation that you have worked so hard on. We believe it's very important.

As you point out, this industry is currently broken. We are incentivizing smart legal tactics and not innovation, and these drugs are life-saving. So at the very least, these companies should be able to justify, like insurance plans do, like hospitals do, why they're charging what they're charging and what the increases are for.

Senator BALDWIN. Thank you.

To be clear, this bipartisan bill simply asks companies to report more information on their pricing decisions to taxpayers. Innovative companies who invest significant resources in research and development should have the opportunity to demonstrate the value of their investment to the public, and this bill would do nothing to prevent a manufacturer from increasing prices.

Ms. Mitchell and Mr. Isasi, can you discuss how more data on drug pricing decisions and expenditures will help policymakers, researchers, and other policy stakeholders make better health care decisions?

Mr. ISASI. This information is critically important. What we know is, for example, that most of the drug pipeline has dried up. They have converted to generic drugs, right? So these drugs you're talking about that have these huge price spikes are the ones that have the least amount of competition. They're not necessarily the most effective drugs. So we should have transparent information about exactly why the price is going up, and we would think even further why the launch price existed, if this is a real innovation that's adding to American families. But without that information, what's happening right now is that drug companies are making more and more money not because they're saving lives, not because they're curing illness, but because they simply are exploiting a distorted market.

Ms. MITCHELL. I would simply agree. The problem is the pricing, and everything we're talking about—rebates—that's just obscuring the actual issue here, which is the pricing. Our members are trying to offer discounts. They're basing those on estimates because they can't get insight into the actual price of the drug. So we absolutely need transparency, but it's just the starting point.

Senator BALDWIN. Thank you.

My time has expired.

Senator MURRAY. Senator Romney.

Senator ROMNEY. Thank you, Ranking Member Murray. I appreciate the members of the panel coming together to inform us on this most critical issue for the American family.

I very much sympathize with the comments made by Senator Baldwin. Prescription drugs I think is an area of important focus for this Committee and an area where an opportunity is apparent for us to help the American consumer.

One of the things that Senator Braun and I have worked on as a measure to help in this regard is to assure that individuals who are responsible for co-insurance for prescription drugs, that co-insurance rate is based upon the net price, not the retail price of the drug. So when rebates or the like have been provided, that the consumer has the advantage of that feature and hope that becomes part of the final bill.

But most of the discussion today has focused on different points of view with regards to surprise billing, and so I want for a moment to focus on that area.

Mr. Cavanaugh, you indicated that one of the challenges with benchmarking is that you have a huge network of people that are responsible for setting Medicare rates, but something of that nature doesn't exist if we were to put in place a benchmark system. On the other hand, Ms. Mitchell indicated that she would set the benchmark based upon the Medicare rates. So would that not remove the complication that you're concerned about, which is to simply set a benchmark rate and do it based upon either 1.25 times the Medicare rate or 1.5 times, or equal to, but basically use that as the benchmark figure? Would that remove that complexity you were concerned about?

Mr. CAVANAUGH. Sure. Thank you, Senator. The only point I was trying to make is in Medicare Advantage there is a benchmark rate that operates this way, but it's publicly known, like I can go online and tell you today what the benchmark rate is in every community for every service. This legislation, one of the options would create a new benchmark rate with a different methodology, and someone is going to have to go and build that and figure out what those rates are. I didn't mean to make any bigger point than that.

Senator ROMNEY. Yes, thank you.

Ms. Mitchell, do you have any comment on that?

Ms. MITCHELL. Again, we think that this is the most straightforward, efficient, and transparent way to come up with fair rates, and the evidence supports the rate.

Senator ROMNEY. Would anyone want to comment on the advantage or disadvantage of using that system, which is if you could use a benchmark, using the Medicare benchmark and keying off of that, as opposed to an arbitration process? I'm concerned just at first blush that with an arbitration process it's going to be highly complex, with after-the-fact negotiations going on and differences in different communities and arbitrators that may or may not be familiar with the specific circumstances. Wouldn't it just be a lot easier to tie into the Medicare rate, one way or the other?

But if people have differing views—Mr. Nickels, please.

Mr. NICKELS. Thank you, Senator. Yes, I would have a different view. So I think our concern is, first of all, it's well documented, and Congress' own advisory board, MedPac, says that Medicare does not pay the costs for hospitals that are fair, and to base anything on Medicare rates I think is a mistake.

Second, there is no difference between that and Medicare for all, which was just described earlier, which we have real concerns about.

The third thing I would say is one of our concerns about setting a rate is if it's out there, what we want is for negotiation to occur between providers and insurers. If there's a default rate, why won't the insurer just always go to the default rate? There won't be a negotiation. They won't have broad networks, which they need. And again, I think we're coming back to the same thing as Medicare for all.

Mr. IPPOLITO. I'd like to follow-up, if I can, Senator.

Senator ROMNEY. Please.

Mr. IPPOLITO. To be clear, again, when we are going through an arbitration process, we're using a benchmark. You've got to decide who wins and who loses. So ultimately we're doing the same thing. So I would push back and simply say that if you think Medicare is too low, and that's completely fine with me, then it doesn't mean you can't use Medicare, at least in concept. You could say Medicare times 2, Medicare times 3, whatever number you think is appropriate. The one advantage that has is it isolates it from being gamed by the market actors; that is, trying to engage in these kinds of shenanigans, to be in or out of network, to affect the benchmark rate that is a function of that. So that's the one advantage.

Senator ROMNEY. Ms. Mitchell.

Ms. MITCHELL. Thank you. I concur.

I would also point out that actually 25 percent of U.S. hospitals manage their costs well enough that they are successful under Medicare rates, and we're not talking yet about costs. The recent report by Rand shows that hospitals bill commercial payers and employers an average of 240 percent of Medicare, so what is the actual cost to provide that care, and how do we agree on a common standard. We believe that 125 percent is fair.

Senator ROMNEY. Thank you very much, Mr. Chairman.

The CHAIRMAN. [presiding] Thank you, Senator Romney.

Senator Casey.

Senator CASEY. Mr. Chairman, thanks very much. I want to thank you and the Ranking Member for the work you've done on these issues, and the panel for being here.

We're doing a lot of hearings today, so I've been in and out. But, Mr. Chairman, I wanted to raise something that I know you're aware of and we're trying to get done, and this is the reform in the FDA's authority to regulate over-the-counter drugs. All of us, I think, have an interest in making sure that any prescription drug is safe and effective according to the most up-to-date information available. This is bipartisan legislation that Senator Isakson and I have worked on for many years now, at least several years, and we're hoping we can get it done.

Mr. Chairman, I just wanted, for the record, to ask you to commit to pushing ahead and finding a way to pass this legislation, the so-called over-the-counter monograph reform legislation.

The CHAIRMAN. You know that I think it's very important and would like to find a way to pass it, so thank you for the question.

Senator CASEY. I appreciate that, and I'm glad that's on the record—not that it was essential, but we're grateful for that work and trying to move it forward.

I wanted to move to a question about some developments that have played out over the last several years now, but something even more alarming that just arose in the last couple of weeks. We know that this Committee is engaged in a process to try to bring down the cost of health care, as well as the cost of prescription drugs. While that's happening, two things I think are undermining those kinds of efforts.

One is what can only be described as sabotage by the Administration, sabotaging the health care system with regard to what happens on the exchanges, as well as with regard to Medicaid itself. I won't dwell on that today, but we do know that from data just released earlier this year, 7 million fewer people have health care. There's a good article that describes this data that Gallup found. Here's the name of the article, dated January 23d, 2019, by Sarah Kliff and the publication Vox: 'Under Trump, the Number of Uninsured Americans Has Gone Up by 7 Million. That's the title of the article.

This problem is now compounded by what the Administration is undertaking with regard to the official poverty measure. We know that if this proposal is adopted and the official poverty measure is tied to so-called chain CPI—and I'm reading from a letter that I drafted, co-signed by 42 Senators—'Because chained CPI shows slower inflation over time, fewer Americans would fall below the poverty line in the future.

Here's what it affects. Health and Human Services bases its annual poverty guidelines on the official poverty measure thresholds. That will affect Medicaid, the Children's Health Insurance Program, the Maternal and Child Health Block Grant, the Community Services Block Grant, Head Start, the School Breakfast Program, on and on and on.

This is the letter that we sent to the Administration to reconsider this proposal. I ask all of that—and I want to direct this question to Mr. Isasi to ask what your view is on that in terms of those two what I would call undermining forces with regard to what we're trying to do here with regard to lowering health care costs.

Mr. ISASI. Well, first and foremost, Families USA is incredibly proud of the work of this Committee in a bipartisan fashion to build legislation that will address health care costs. But we have to be very clear: what American families want is to be able to be healthy, and if they get sick, get care and not go bankrupt. So efforts to undermine the ability of families to get real, meaningful coverage is the opposite of that goal. So we're very deeply concerned. We've seen hundreds of thousands of people lose coverage, as you point out. In particular, I think one of the most troubling things that we care deeply about is the fact that we've seen over 300,000 children lose coverage. That's totally unacceptable.

In terms of chained CPI, we're very concerned about this. Another half-million Americans will lose coverage because of this, and access to the other programs you're describing. Over half of those will be children.

I think this Committee is focused on the notion that families want financial security and to know that their health care costs aren't going to bankrupt them, and we should all be pulling in that same direction. So we're deeply concerned about this.

Senator CASEY. Thank you very much.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Casey.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Thank you. I apologize. I wasn't here to hear your testimony. I've had an opportunity to read it and appreciate the perspectives that you all lend to this very important discussion.

My colleagues here on the Committee know that every time I ask a question when it comes to health care, it's always through the lens of what is the impact on our rural areas and areas in my State that are beyond rural. So I look at all of this through the perspective of one who says we don't want anticompetitive provisions, but if I only have one hospital, if I only have one clinic, if I only have one provider, how does all this work?

I'm going to start with you, Mr. Cavanaugh. You spoke to the potential impacts of the transparency and the anticompetitive provisions on rural health providers. When we are looking at the various proposals that we have in front of us as ways to reduce the cost, I'm curious to know whether your review has included situations where you have a community with both a single hospital, a single prominent insurer. Who has the most negotiating power there?

How do you determine an in-network rate in an area where you don't have in-network providers?

When we talk about similar geographic area, in a lot of my communities, in 80 percent of the communities in the state, we're not connected by any kind of a road, so how do we define this?

You have looked at this through the regulator's perspective and one who is looking at the broader market as a whole now. Do you think it is possible for us at the national level to adopt a standard payment methodology that can account for this wide discrepancy and differences?

Mr. CAVANAUGH. Thank you for the question. Let me preface it by saying two things. One, in the context of surprise billing, all three approaches are equal in that first and foremost they protect the consumer. Alidade represents independent physicians in the community. They're not the ones involved in surprise billing, so I applaud that. The first order of business is to protect the consumer, and they all do that.

After that, you are really, as you accurately point out—then it's just a dispute between insurers and providers. It becomes particularly problematic where either the provider community is consolidated, and we are equally concerned when the insurer community is consolidated. So some of the approaches I think are stronger in a competitive market, meaning the approach to use in-network guarantee, makes a lot of sense when you've got multiple providers and multiple insurers hashing it out. It might become more difficult in a rural community where it's just one provider, one——

Senator MURKOWSKI. But again, I worry that we try to do one-size-fits-all because that's most convenient for us back in Washington, DC. We want some kind of a standard. But I remain concerned that in certain places it's not possible.

Let me turn to you, Dr. Ippolito. In your written testimony you provide a couple of different options when you say, 'In order to stay open, hospitals need to ensure adequate staffing two ways. One option is to top up the payment rates, an anesthesiologist, to ensure they're willing to work. A more likely option is demand that insurers guarantee reasonable market rates to doctors.

When you say 'In order to stay open, hospitals need to ensure adequate staffing, last week in Tennessee the 107th rural hospital in the country closed since 2010. We're going the wrong way here in terms of encouraging our rural hospitals to keep their doors open. How do you line up your statement there with adequate staffing?

Mr. IPPOLITO. Well, I think there's a basic economic challenge that faces rural hospitals that don't face urban hospitals, and I think it's a challenge that exists outside of a surprise billing-specific scenario that we were talking about.

Senator MURKOWSKI. Fair enough. But when we're talking about surprise billing, how does this keep the doors open?

Mr. IPPOLITO. Maybe I should caveat that comment by saying conditional on this being a sufficiently robust area that a hospital can stay open, then I don't think that any of the particular solutions that we're talking about for surprise billing are going to be fundamentally problematic.

However, if there is a concern over a higher-level decline in the profitability, or even just the ability to exist of rural hospitals, then I certainly hear the concern. I think the solution to that is probably not found in anything related to surprise billing but something a little more directly aimed at those rural hospitals.

Senator MURKOWSKI. Mr. Chairman, my time has expired. I've got a lot more questions, and I'll stick around here to listen to others, but thank you.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Rosen.

Senator ROSEN. Welcome back, Mr. Chairman, and thank you to you and Senator Murray for working together on this important package.

For all of you being here today, I'm going to give a special shoutout to Ms. Bartlett, who is a University of Nevada graduate. Yes, thank you, thank you. I really appreciate that.

I want to add to Senator Murkowski's rural concerns. What I really want to do is focus on Section 404 of the bill today, which authorizes grants to expand the use of telemedicine to increase access to specialty services in underserved areas. At home in Nevada, I hear over and over again that preserving access to quality health care is one of the top issues, and everywhere in Nevada, like Alaska, is underserved. So this is critical to us.

It is currently drafted—and anybody here can chime in—that the funds that are authorized can be used for telemedicine equipment, training, and program evaluation. So I have kind of a two-part question. What else do you think is effective to get a telemedicine program up and running? And what do you think the minimum time span would be reasonable for a telemedicine program, especially once we get some templates done?

Would anybody like—yes, please.

Mr. ISASI. The point you're making is incredibly important. I spend a lot of time working on rural health care issues, and as you point out, what we need in rural America are true disruptions that allow for health care to be delivered in high-quality settings that aren't the old business model of a hospital with four walls that is very expensive. So this is a really good example.

As the Chairman mentioned, Project Echo is a phenomenal example of a program that allows for—in this case, it started in New Mexico, for folks in very rural, frontier communities in New Mexico to get better health care than they were getting in the hepatitis clinic in Albuquerque, because it does a few things. It trains the providers in those communities to an evidence-based standard of care. It creates a learning community. And then third, it allows providers who have really challenging patients to talk to each other and learn. So those are all critical elements.

I think that, as you point out, something like Project Echo around this country is an incredible example of how we can get high-quality health care to rural America.

Senator ROSEN. Do you think creating templates that we can export around the country would be a good working model?

Mr. ISASI. Absolutely, and there are other examples. Mississippi is another. There are wonderful telemedicine advances happening in Mississippi as well.

Ms. MITCHELL. If I may, Senator Collins graciously shared that I am from Maine. Much of Maine is also frontier, and I worked closely with many rural hospitals in the state. We are very sensitive to the pressures on those hospitals. They are very real. And we hear hospital and physician executives saying they have to charge inflated prices to subsidize the care that we aren't appropriately paying for, like maternity care or primary care. So I agree that we need to look at direct ways to subsidize that care, and we need to be thinking about rural patients instead of just rural hospitals.

I also was extremely encouraged in my time on the Physician-Focused Payment Model Technical Advisory Committee. There were innovative proposals, like hospital at home, that were supported by physicians, new ways to deliver care to rural patients that needed hospital-level treatment.

Telemedicine, hospital at home, these innovations are absolutely essential to bringing care to those communities.

Senator ROSEN. These are great things. So how can we consolidate or find in a common place these kinds of templates that other places across America can see the challenges they have maybe in a particular disease area that they want to improve upon? How do you suggest that we can get these good examples and export them to other communities across the country?

Mr. CAVANAUGH. Thank you, Senator. Fortunately, this Congress has answered that question by creating the Innovation Center at CMS, and there are a number of demonstrations now underway specific to rural hospitals. One is in Pennsylvania, and the other—in Maryland it's a global budget for all hospitals, but it really started with global budgets for rural hospitals, the notion being don't make these rural hospitals dependent on inpatient admissions. Free up those funds so they can do all those things Mr. Isasi and Ms. Mitchell mentioned, and that should be the platform. These are publicly funded. There will be public evaluations. There will be disseminations of the learnings. I think you're right, we need to get these lessons and these models out to the rest of the country.

Senator ROSEN. In what ways can we here, through this bill or others, help you potentiate what's happening across this country and export that? What do you need from us?

Mr. CAVANAUGH. I think the Innovation Center has all the tools, thanks to this Congress. I think you can continue to support them. But, as always, put pressure on them, go faster, go better, and be more public.

Mr. ISASI. I would say one thing we can't lose sight of, though, is that—and it's exciting because for all of us, those of us who don't live in rural America, these innovations are going to be available to us.

Senator ROSEN. Right.

Mr. ISASI. I mean, this is about need creating really interesting disruptions. But scope of practice is something that we all have to get a handle on. I think Senator Murkowski's State has been a real leader in thinking about new ways for a service to be provided by new kinds of providers. I think scope of practice is critically important.

Senator Murray was very involved in creating a National Workforce Commission. That commission needs to be funded. We need to understand the dollars flowing into workforce and what our communities actually need, because right now we have total misalignment between the Federal dollars flowing through Medicare toward workforce and the needs of our communities.

Senator ROSEN. Thank you. I think my time has expired, but thank you.

The CHAIRMAN. Thank you, Senator Rosen.

Senator Kaine.

Senator KAINE. Thank you, Mr. Chair, and welcome back. Glad we're having this hearing, and appreciate the work of the Chair and Ranking in getting our package in a good place where hopefully we can move forward with it.

Since the discussion just recently happened about rural hospitals, I just want to follow-up Senator Murkowski and look at it a slightly different way.

Mr. Nickels, your testimony, since 2010, 107 rural hospitals have closed, 10 this year, one last night in Tennessee, I was not aware of that and I'm sorry to hear it. We've had two hospitals close in Virginia, one in Patrick County, one in Lee County. There have been really heartbreaking stories about the effect of rural hospital closures. I read one recently in the New York Times dealing with a hospital in southeastern Kansas, where I grew up; another Washington Post article dealing with closure of a hospital in Oklahoma.

There's a solution, not a magic one-item solution, but there is a solution for many of these communities. Ninety-three of the 107 hospitals that have closed in rural America since 2010 are in states that have not accepted Medicaid expansion. The two hospitals in Virginia that closed, Virginia has now accepted Medicaid expansion, but the two hospitals that closed, closed years before the State accepted Medicaid expansion, and they said to our legislature if you accept Medicaid expansion, we can keep the hospital open.

Now that Virginia has done Medicaid expansion, at least one of the hospitals is exploring can they reopen. It's a lot harder to reopen a hospital than keep it open. But nevertheless, there is a possibility.

But when we have these discussions about rural health, that is a statistically very significant bit of data, 93 of 107 hospitals that have closed since 2010 in this country have closed in states that did not embrace Medicaid expansion.

Now, I know hospitals don't like Medicaid reimbursement rates, and they like Medicare reimbursement rates a little better but not much. But the difference between a Medicaid reimbursement rate and charity care for which you're not compensated is a very significant factor in the bottom line of a hospital.

I'm going to have you speak to this, Mr. Nickels, but I just want to say there are some things we can do in this bill, and we should. There are some things State legislatures have been able to do since the Supreme Court rendered the ruling about it being a State option on Medicaid expansion. And when I read articles and people are decrying that their community is losing a health care resource and people are losing access to care that they've had in the community for their entire life, and they have it within their capacity not

to solve every financial woe on a balance sheet but to dramatically affect whether the hospital can stay open or not, and yet they are choosing to not embrace Medicaid, they are basically consigning their rural hospitals to a situation where it is very likely that they will continue to close.

I hope one message that we might deliver from this Committee, from Congress, and I certainly am glad that my State eventually got this message, is that there's no glory in being the last one, the caboose, you know? When Medicaid passed in 1965, it was an option, not a mandate. It's interesting that the last State to embrace Medicaid in 1982, Arizona, it was 17 years after the majority of states before they finally embraced Medicaid. When the Affordable Care Act passed and there was now a Medicaid expansion option, where did Arizona fit? They were one of the first in, with two Republican houses, with a Republican Governor, because what they realized is what did they get by being the caboose on Medicaid? What did they get by waiting for 17 years? What they got was worse health care for hundreds of thousands of people over 17 years. They weren't going to be the caboose the second time.

We've now had 35 States that have done the expansion. Don't compete to be the caboose. If you want your rural hospitals to have a fighting chance of staying alive, there are other things that have to happen too, but Medicaid expansion will keep these pillars of rural health care from closing in many, many instances.

Mr. Nickels, you wanted to comment on this.

Mr. NICKELS. Yes, I totally agree there. I mean, there's a crisis in rural America, there's a crisis with rural hospitals, and there's no question from our members, the ones who are feeling it the most are in non-expansion states. Our members work in those states to try to convince the legislatures, and they have been successful in some, and Virginia was one of them. They take the lead in trying to get Medicaid expansion. But there's no question when you look at the issue that is probably the number-one concern. That doesn't mean things like broadband aren't important. That doesn't mean the telemedicine provision in this bill isn't important, but there's a lot that has to be done.

My example, and Sean uses an excellent one, there are rural models out there that we should be experimenting with. But the important thing is that people need to have coverage.

Senator KAINE. Thank you.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Kaine.

We have completed our round of questioning, and we have a vote at noon. I think Senator Murkowski and Senator Braun may have a question they want to ask.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I don't know whether the issue has come up previously in the round of questioning, but when we look at some of the surprises that come, and Alaska is a very high-cost state, I mentioned 80 percent of our communities are not connected by roads, so how do we get to the hospital? We fly. It's air ambulance, it's Medivac, and it is not unusual for a Medivac to be between $50,000 and

$100,000. Some Alaskans have—more and more are seeking insurance.

I want to ask this question to you, Ms. Bartlett. You're from Montana?

Ms. BARTLETT. That's correct.

Senator MURKOWSKI. Okay. So you've got big open space out there, former State plan administrator. Have you made any progress within your State to address air ambulance costs within the health plans there? I know that this is not part of what we're dealing with, but again, as we're talking about those cost drivers, I'm trying to understand if there are some areas where we've seen some headway.

Ms. BARTLETT. Thank you, Senator Murkowski. Within the State employee health plan, we set reimbursement at 250 percent of Medicare, and that's what we paid whether you were in-network or out-of-network. At the same time, I served on an interim committee to deal with this issue, and the result of that committee was legislation that did pass in Montana that requires initial payment to either be the normal in-network payment that would be paid, the billed amount, or a negotiated amount, because that allows for the member to be held harmless. At that point, the member is definitely held harmless.

Then if the other party, whether it be the air ambulance or the insurance company, believes that it's not a fair amount, then it goes to arbitration, and the arbitration oversight is the commissioner of insurance.

Senator MURKOWSKI. That's been working well within Montana?

Ms. BARTLETT. It absolutely is working well. Within the State health plan, we immediately saw all of the out-of-network air ambulance come in-network except for one, and that particular air ambulance service has closed a couple of their areas, but they were not in rural places. So we have not had lost care at all.

Senator MURKOWSKI. Thank you for that.

Mr. Nickels, I wanted to just extend the question that I directed to Mr. Cavanaugh earlier about the differences within regions, the variations in rural markets. A benchmark payment rate based on average negotiated rates for a region, in my view, appears to be the most simple and the most predictable framework. But do you believe that a benchmark rate based on negotiated rates within a region adequately accounts for those variations that we see within the rural markets, and can you speak more broadly to the impact of such a model where you have few providers and few insurers?

Mr. NICKELS. Yes. As you know, we do not support that sort of an approach, and we do believe that—and I addressed this to Senator Collins and Senator Cassidy when they were here. If you set a national rate, it will not acknowledge local conditions, it will not acknowledge a place like Alaska. We fear the harm it will do most, and Senator Collins mentioned this, is to rural America, where prices are higher, margins are smaller, and the danger of something going wrong here is far greater than it is elsewhere.

There are some untested ideas being discussed here, and we need to make sure that whatever we do does no harm to rural America. That's why we think get the patient out of the middle of this. We all agree with that. I don't think there's any disagreement whatso-

ever. We think that the approaches that the Committee has talked about, that arbitration is the best one. Anything with a benchmark rate, however it's described, however it's defined, will create, I think, a significant problem for rural America.

Mr. IPPOLITO. I would like to clarify——

Senator MURKOWSKI. Mr. Ippolito.

Mr. IPPOLITO [continuing]. one thing very quickly, if I could. The arbitration system and benchmark system included in the HELP bill, both reference the local in-network rate as the benchmark rate. So when we think about an arbitration system and we think about a benchmark rate, they're both based—at least the guidance to an arbiter would be based on the same thing that the benchmark would be, which is a local rate. So I do think that's worth emphasizing.

Senator MURKOWSKI. I'm going to ask Mr. Nickels and then Ms. Bartlett very quickly to—it sounds like a rebuttal.

[Laughter.]

Mr. NICKELS. Well, a question that I answered earlier from Senator Hassan, that's why we don't like that rate that's in the bill as it relates to having a benchmark. We think there should be no benchmark. It should be arbitration and negotiation between two parties, and one of them will win, one of them will lose, there will not be a benchmark. That's why we think that that's the better approach. That's in the Cassidy and Hassan bill, and your bill.

Ms. BARTLETT. Senator Murkowski, if I may add one thing, within Montana this legislation was passed in the 2017 session, and there have been no cases go to arbitration.

Senator MURKOWSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Let me go to the Democrat. Senator Murray, do you have any questions?

Senator MURRAY. No, Mr. Chairman. I just want to thank all of our witnesses for being here and for all of your help and input.

Mr. Chairman, thank you for working so diligently on this.

The CHAIRMAN. Thank you.

Senator Kaine.

Senator Braun.

Senator BRAUN. I'll make it very quick, one for Mr. Nickels and one for Ms. Mitchell.

David Ricks, Chairman of the Board of Eli Lilly, just came out publicly that he wants to get rid of PBM rebates, wants them to go directly to the pharmacy and the individual. I applaud him for sticking his neck out as a major individual in the health care industry.

American Hospital Association, my local hospital embraced—I think they called it CareLight or something, but it was still the chargemaster being published in its inscrutable form where you couldn't understand it.

Would the American Hospital Association be willing to publish in understandable form chargemasters across all hospitals? And in talking to a lot of people who really know what makes the current system not work, would you be willing to expose third-party arrangements between providers and health insurance companies? So many people have told me if that ever happened, it would break

the system and you'd cascade into transparency and competition. I know that's a load, but give me your quick comment on it, please.

Mr. NICKELS. I hope I can remember all that.

Senator BRAUN. Chargemaster first.

Mr. NICKELS. Chargemaster I know is a daunting experience. We have worked with CMS to publicize more and more of the chargemaster, but I agree with you, I don't think that's data that people need. I mean, something that gives people prices, to the degree that we can do it, to the degree that we can make that simple enough for people to understand, I think that's the way that we should go, and we would definitely support that.

Senator BRAUN. It's mandatory that you find out how to do it.

Now, what about the third-party agreements between providers and insurance companies? You blew the whole system with opaqueness. Go ahead.

Mr. NICKELS. That we would disagree with.

Senator BRAUN. I figured you would.

Mr. NICKELS. I'm certainly predictable. We've raised concerns. I know the Administration has discussed that. The ability for two parties to have private contractual negotiations is important, and I think even the Federal Trade Commission, which has never been the biggest——

Senator BRAUN. In a robust competitive market, I'd agree with you. In a broken system like yours, you ought to get with it.

Ms. Mitchell, what do you think? You've been wrestling with this kind of stuff. Do you see the industry, especially hospitals, 30 percent of the health care bill, kind of resisting right there in terms of what they think, do you think there's any chance that the industry will start coming around to where we don't have to legislate them into action?

Ms. MITCHELL. Well, one can hope. I would say that if the secret negotiations between providers and plans worked, we would not be sitting here. I think everyone in America deserves insight and information about their medical care, the quality of the outcomes, and the cost. We are all in this together. We all have skin in the game. We need a system that is responsive to the American people, that requires and presumes transparency and accountability.

Senator BRAUN. Agree 100 percent. Thank you.

The CHAIRMAN. One question, Ms. Mitchell, then we'll wrap up. The bill that Senator Murray and I proposed requires pharmacy benefit managers to give employers information on the rebates in the system so employers understand what they're paying for. So if a pharmacy benefit manager negotiated a $400 discount and, let's say, a $600 insulin price, the employer would know that instead of $600, the price is $200. How will we know that the employer will pass that $400 discount on to the patient who has diabetes?

Ms. MITCHELL. I think it's an important question, and many of our members are doing this now. They are offering and extending the rebates to their employees. But as I said earlier, they don't have the actual cost and price information, so they are using the estimates. The problems with spread pricing and rebates off wildly inflated prices make this more complex and convoluted. So they are looking for ways to decrease these costs for their employees, and transparent, clear pricing is part of that.

The CHAIRMAN. Thank you very much.

I want to thank our six witnesses. I want to thank the Senators, especially Senator Murray and our staffs. This is the way the U.S. Senate is supposed to work. We've taken an area where there's plenty of room for lots of contentious discussion, and we have it here in the area of health care, and we've said, all right, at least we can see if we can identify some ways to reduce health care costs that people pay for out of their own pockets.

We've talked about surprise medical billing. We've talked about transparency. There are a number of provisions in the bill that you have said increase transparency, and there are a number of provisions in the bill that increase competition for biosimilars and generic drugs, which are 90 percent of prescriptions.

As Senator Murray said, those are steps in the right direction. I hope that our Committee can move ahead next week to vote on this. We call it marking it up, giving it to Senator McConnell, Senator Schumer, and say let's put it on the floor and let's turn it into a law.

We appreciate the thorough process this has been through, 16 hearings, hundreds of comments from people who are affected. We still have a few things we need to work out, but we end up with about three dozen proposals from about an equal number of Democrats and Republicans, and we're on a good track, doing what the American people expect us to do.

The hearing record will remain open for 5 days. Members may submit additional information for the record within that time if they would like.

Thank you for being here.

I had the wrong glasses on. Within 10 days.

[Laughter.]

The CHAIRMAN. The Committee will stand adjourned.

APPENDIX MATERIAL

Section 301	Removing gag clauses on price and quality information

We support the provisions to ensure the group health plan or group health insurer receive their plan information for price and quality. We offer the following comments:

- (a)(1)(B) Per HIPAA regulations, personal health information (PHI) access under HIPAA depends upon the "need to know". Limiting claims and encounter data to "de-identified" data will not provide a plan administrator or a group health insurer with the data needed for population management, disease management, fraud prevention, medical and pharmacy adherence, and other plan management needs that require the member/enrollee's identification. We recommend deleting **"de-identified"**, and letting the provisions of HIPAA, GENA, and ADA govern.
- (a)(1)(B) (i – iii) potentially limits the types of information provided, with the use of "such as" or "including". Claims and encounter data files include many fields that are required for plan management, including allowed amount, plan paid amount, member paid amount, date of service, provider name and location, diagnosis codes, item description (medical devices); CPT codes, etc. If pharmacy claims are included, the Plan would also want to know NDC number, quantity, days' supply, etc. WE recommend either deleting lines 15-19, or only state (i) financial information: (ii) provider information;(iii) service codes; and (iv) **other claim detail** required to manage the group health plan or group health insurance.

Section 302	Banning Anticompetitive terms in facility and insurance contracts that limit access to higher quality and lower cost care

- We support the prohibition in this section of anti-competitive contract restrictions. However, Montana has also seen instances of these contract provisions forced on providers BY health plans (Most Favored Nation in particular). Health plans may require that a provider offers no more favorable discounts/billed rates to other plans for instance. **Therefore, we recommend prohibiting these contract terms in general, rather than just the clauses that require a health plan to comply.**

- Additionally**, we believe it is imperative to incorporate prohibitions on anti-competitive health plan steering practices into this bill to coincide with removing these contract barriers**. For example, we would like to see a focus on conflicts of interest and kickback incentives for network steering in health plans. We are particularly concerned with health plans steering members to facility/practitioner options that provide the health plan a financial benefit that is hidden from the consumer, regardless of cost or quality.

- We also are concerned about anti-competitive steering occurring in the pharmaceutical space, where insurers are vertically integrating with PBMs and Pharmacy Chains and stand to gain a direct financial benefit from network member volume. Un-regulated steering in vertically integrated space like the pharmaceutical industry could lead to further monopolization, forcing out small independent pharmacies from the market. Montana has seen this play out in the context of PBM's steering members towards mail-order pharmacies they own and away from small, independent pharmacies. **We recommend that the committee develop restrictions on anti-competitive steering practices to coincide with prohibition on anti-competitive contract provisions.**

Section 303	Transparency Organization to Lower American's Health Care Costs

- Transparency, alone, does not reduce the cost of health care. Any data must be actionable:
  - (b)(1)(A) improves transparency by using **deidentified** health care data. For the information to be public, we agree it needs to be **deidentified.** However, to inform patients about the cost and quality of their care or assist providers/hospitals with their patient care requires identified information. Aggregate information is already available through the Medicare Cost Reports to compare facilities now.
- Other provisions of this act allow consumers to use their in-network influence to reduce costs.
- The data base requirements will result in insurers and plans incurring significant additional costs to compile and submit the required data. The costs will be passed on to consumers through increased premiums.
- Would it be a better use of taxpayer dollars to utilize targeted audits and subsequent investigations that could yield returns for the consumer, rather than an expensive data base?
- The provision would require significant tax dollars and a significantly long time frame to fully implement a solution that would prove value to the health care purchasers. Please consider utilizing the Federal dollars to assist states in developing their own all payer claims database solutions. Results will be less costly, completed sooner and relevant to specific populations and medical services available.

Section 305	Timely Bills for Patients

- Section 305 ensures the patient receives a bill timely. What about the plan, the TPA or the health insurer? Many times, these entities receive a bill from a hospital several months after the procedure or service. Could the provision include timely bills to these parties also?

Section 306	Health Plan oversight of PBM services

- Reports to Group Plan Sponsors (b)(1) (B) is limited to each **covered** drug dispensed during the reporting period. Non-formulary drugs are also dispensed, so we recommend removing the word **covered**, and simply say each drug in this specific section.
  - (i) identifies the drug information required for reporting. We understand just referencing "National Drug Code", should the numbering structure change. However, PBMs have been known to cut off the last 1 or 2 digits that determine the package size. They may be repackaging drugs to create their own custom NDC (usually for mail order) which gives them the power to set their own AWP. Recommend requiring **11-digit NDC.**
  - (ii) "dosage units" is not common terminology in the industry and is probably used here to capture non-pill drugs. The more common unit of measure is "days' supply". Recommend using **days' supply** to remove confusion and be consistent with industry terms.
  - (ix) this is a good clause to identify amounts paid to third parties. However, it may create a loophole that limits its application to any party who "referred" the business. A third party could change the name of the compensation to "education" or other term, rather than "refer". We recommend changing the wording to: "….brokers, consultants, advisors, or any other individual or firm receiving compensation from the pharmacy benefit manager."
- (b)(1)(C) recommendations:

- Section provides specifics for reporting high dollar spend for the Plan. For larger plans, this list would include low cost drugs that have high volume, and this probably isn't the intent. But using an aggregate cost of $1,000 will quickly expand the list. Recommend stating cost more than **$1,000 for a 30-day supply**.

- (c) addresses Spread Pricing recommendations:
  - Section (1) currently reads that the group health plan, health insurance issuer, or PBM may not charge more to the group health plan or the health insurance issuer and amount that exceeds the actual price paid by the group health plan or health insurance issuer to the pharmacy. In practice, the PBM pays the pharmacy directly, and we recommend adding clarification by striking the words "by the group health plan or health insurance issuer" on lines 15 and 16. This edit would bring the change you are looking for as the group health plan, health insurance issuer or enrollee would not pay an amount that exceeds *the actual price paid to the pharmacy* for the drug.
  - Section (2) for consistency, we recommend changing the title to **pharmacy** benefits manager, rather than the current reference of **prescription** benefits manager.
  - Section (2)(B) appears to match the Medicaid rule. To the private market, the reporting and compliance costs will be significant and ultimately passed on to the consumer via fees, and not be lowering healthcare costs. Most of the transactions will default to (A), the wholesale acquisition cost. A retroactive comparison will not be costly as the claims file can be analyzed.
- (d) Full rebate pass-through to Plan.
  - Consider including a provision for 100% pass through to the health insurance issuer on individual policies, with further requirement that the benefit be passed on to the individual enrollee. SB 71 (Montana legislation) included the following provision:
    All compensation remitted by or on behalf of a manufacturer, labeler, repackager, or wholesale distributor that is directly or indirectly related to a health benefit plan must be remitted to and retained by the health benefit plan and used to lower health benefit plan premiums or member out of pocket requirements.
  - Consider requiring drug rebates or any other consideration paid by manufacturers be paid directly to the health plan. This would eliminate the financial incentive for the PBMs, and the manufacturers already track the rebate amounts by plan.
- (f) definition for "wholesale acquisition cost" references the Social Security Act stated below. Do you need to include the wholesale acquisition cost on the **date of dispensing**?

  (*B) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data*.

Section 308	Disclosure of direct and indirect compensation for brokers and consultants – employer-sponsored health plans and individual market.

- Page 112, beginning line 13, (AA). Defining Brokerage Services. Definition identifies specific selection of services (i.e. insurance products, recordkeeping services, ……). Recommendation to broaden the definition, as a loophole may be found by a creative producer to craft a role or service not listed in this section. Consider adding an all-encompassing phrase at the end of this section, such as "…third party administration services, or **any other product/service related to the "covered plan"**

- Page 113, beginning line 6 (BB). Defining Consulting services. Same comment as previous. Consider adding an all-encompassing phrase at the end of this section.
- Page 116, beginning with line 16 (iii). This section addresses required disclosures to the responsible plan fiduciary. The entire section addresses disclosures for **prospective** arrangements, so the plan is aware of direct and indirect compensation before signing a contract. The plan fiduciary also has the responsibility to know actual services and amounts that were paid. Recommendation:
    - Add past tense to each section, such as changing "to be provide" to "**provided and to be provided**"
    - Since this section is focused on prospective, add a **separate section** for required reporting of actual services and compensation received.

TRANSFORMING HEALTH CARE

Half of Americans get their health insurance through work, costing companies nearly $700 billion a year. Yet quality is all over the map. Can employers find a better way?

by Lisa Woods, Jonathan R. Slotkin, MD, and M. Ruth Coleman

CAMI O'BRIEN

HOW EMPLOYERS ARE FIXING HEALTH CARE

WALMART HAS EMBRACED A NEW APPROACH TO IMPROVE THE QUALITY OF CARE AND LOWER COSTS. THE RESULTS HAVE BEEN DRAMATIC.

BY LISA WOODS, JONATHAN R. SLOTKIN, MD, AND M. RUTH COLEMAN

A 56-year-old man who works at Walmart — we'll call him Bill — had been suffering from mild neck pain for years. Recently the pain had worsened, and his wife noticed a subtle tremor in his hands. An MRI showed some narrowing of the spinal column along with disc degeneration. A local surgeon explained that Bill's best option was spine surgery.

Bill had two choices. He could have the surgery at his community hospital and absorb deductibles and co-pays. Or he could enter Walmart's travel surgery program and fly with his wife to a top spine center in another state, all costs covered. Bill opted for the travel plan.

Two weeks later the couple headed to Danville, Pennsylvania, for an evaluation at Geisinger Medical Center. The team there immediately noticed Bill's tremor and some shuffling as he walked. They suspected the problem wasn't his neck. A neurologist saw him that day and confirmed the team's suspicions: Bill had Parkinson's disease.

The team conferred with Bill's local doctors to map out a plan of care. The next morning Bill and his wife flew home, and he began treatment, which was covered under Walmart's standard plan. He paid exactly zero for a correct diagnosis and avoided potentially dangerous surgery that wouldn't have helped — and Walmart saved about $30,000 by averting the

THE AUTHORS
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For the past 29 years **Lisa Woods** has worked in a variety of benefits roles at Walmart. Today she's in charge of the design and strategy of U.S. benefits, including the Centers of Excellence program created in coordination with teams at Health Design Plus, Geisinger, and other providers. "When you start a project like COEs, you feel like the innovative scientist behind the curtain," she says. Now that meaningful data on outcomes is available, Woods wants to open up about what Walmart has learned. "It doesn't mean we have all the answers, but we want to share and teach," she notes. "Our goal is to create positive changes in the health care space. It's become a mission. It's that important."

Jonathan R. Slotkin, a neurosurgeon, directs spine surgery at Geisinger Neuroscience Institute and is the associate chief medical informatics officer at Geisinger Health. This means he not only operates on patients but also focuses on digital transformation, the reengineering of care delivery, and the design of novel methods of health care payment. According to Slotkin, Geisinger's partnership with Walmart and Health Design Plus shows that providers don't have to be stuck in a fee-for-service system — and that providers, employers, and third-party entities don't need to be at odds. "Geisinger focuses on innovating with the patient at the center," he says. "Walmart's health care transformation is likewise centered on its associates and customers. There is a perfect cultural marriage between what Geisinger and Walmart are trying to do. The alignment is truly there."

A nurse, **Ruth Coleman** founded Health Design Plus in 1988. Her experience has shown that building direct contracts between companies and providers is a great way to achieve quality patient care. She calls the 30-year growth of this approach remarkable. "I'm a child of the sixties," she says. "That's why I started HDP — taking care of patients the right way is the best way to get good outcomes while reducing employer costs." As for the potential of partnerships like the one HDP has with Walmart and Geisinger, Coleman doesn't mince words: "This could revolutionize health care."

unnecessary procedure. Bill's symptoms have dramatically improved, and he's returned with new energy to his hobbies and work.

. . .

For competitive companies, providing quality coverage is good business. It helps attract and retain employees (good health plans are a sought-after benefit), and workers who receive good, affordable care are more satisfied and productive. But that coverage is expensive, and costs are rising. Employer spending on health care services increased by 44% per enrollee from 2007 to 2016, reaching an annual amount of nearly $700 billion in 2017 — roughly what the Pentagon spends on defense. Walmart alone spends billions of dollars a year on health care for its associates (as the company refers to its employees).

Much is at stake: Various actors in the health care ecosystem, some large insurers and providers among them, benefit from an arrangement that layers on administrative costs and rewards volume, not value. Yet business as usual is unsustainable for those absorbing the costs and experiencing the uneven quality of care. Pioneering employers and providers are in a position to upend the status quo and change expectations about what affordable, quality care can and should be. What follows is an account of our experience with one important effort, among several being tried, to find a better way.

Walmart and other innovative companies, including Lowe's, McKesson, GE, and Boeing, are disrupting how employers pay for care by taking insurers out of the equation and contracting directly with leading health systems. Working closely with providers such as Geisinger, the Mayo Clinic, Johns Hopkins, and Virginia Mason, and with the help of specialized consultants, they are crafting bundled payment arrangements that cover the cost of an employee's care for certain episodes from start to finish — all the procedures, devices, tests, drugs, and services needed for, say, a knee replacement or a back surgery. They're also, in most instances, picking up the tab for any necessary travel, lodging, and meals for the employee and a caregiver, thus democratizing destination care programs that have historically been reserved as an executive perk. Bill is one of many notable successes of Walmart's six-year-old Centers of Excellence program, which covers several common surgeries, cancer evaluations (to confirm the diagnosis and treatment), and, through the integration of an earlier initiative, organ transplants.

COE programs are at the vanguard of U.S. companies' efforts to control health care costs while providing employees with superior care, and results have been dramatic. Working with teams at our respective organizations, we have played key roles in crafting Walmart's initiatives with Geisinger and other clinical partners: Lisa as the senior director of strategy and design for U.S. benefits at Walmart, Jonathan as the director of spine surgery at Geisinger's Neuroscience Institute, and Ruth as the founder of the third-party administrator Health Design Plus. As we'll show, the resulting bundled care programs have saved the company and its associates tens of millions of dollars and produced better outcomes than conventional care has. To the best of our knowledge, the data we provide below is the most thorough and transparent on employer-purchased care ever published. Drawing on this experience and that of other companies and providers, we offer guidance that many employers, even midsize companies, can apply.

WHAT'S DRIVING COMPANIES

Employers provide the lion's share of health care coverage in the United States. They insure 49% of Americans, while government entities (principally Medicare and Medicaid) cover another 35%. (The remaining population is self-insured or uninsured.) Walmart itself, the largest private employer in the world, provides coverage to more than 1.1 million U.S. associates and their families under its self-funded plan.

Expense isn't the only problem employers face. Like other health care purchasers, companies struggle with tremendous variation in cost and quality from one provider to the next. Walmart associates live in every state, and costs for the same service can vary by more than 50% from region to region and sometimes even within a community — and they often have little relation to quality. At the extreme end, costs vary more than tenfold; a 2011-2012 survey, for example, found that hip replacements ranged from $11,100 to almost $126,000 nationwide.

Such variation makes it hard for companies to accurately budget their health care expenses. And although employers shoulder much of the growing cost, employees are absorbing a large and increasing burden too. Nationally, workers' out-of-pocket expenses (beyond premiums) have increased in parallel with employers' costs; according to the Health Care Cost Institute, they topped $5,600 per person, on average, in 2017.

At the same time Walmart, like most other employers, has had limited control over the quality of care workers get, given the wide variation in outcomes for common procedures among different providers. This isn't a new problem. Nearly 30 years ago Walmart founder Sam Walton was taped at a meeting of his senior leadership, excoriating the health care industry for gouging payers like Walmart and, by extension, their employees, himself included. Walton challenged his team to do something about it. "These people are skinnin' us alive," he said. "Not just here in Bentonville but everywhere else, too....They're charging us five and six times what they ought to charge us....So we need to work on a program where we've got hospitals and doctors...saving our customers money and our employees money. We haven't even started to do that. And if we don't get it done this year, I'm gonna get real upset. I mean real upset."

That impassioned speech is still talked about as a defining moment for the company — the point where Walmart turned its formidable procurement capabilities to the challenge of buying affordable, quality health care. The company didn't get it done that year, of course, but it did start on a decades-long project. There's a direct line from Walton's 1991 call to arms to Walmart's Centers of Excellence program today.

Companies have long used traditional measures, such as increasing employees' share of expenses and limiting their access to specialists, with mixed success, and to workers' frustration. Only recently have growing numbers taken a more active role in the development of their health plans, applying their purchasing power and procurement smarts to do an end run around insurers and negotiate directly with providers. According to a Willis Towers Watson survey, although just 6% of employers had such relationships in 2017, 22% said they either planned to contract directly or would consider doing so by 2019.

These relationships can take many forms, and they use a variety of payment schemes, including payment of a set amount per enrollee over a defined period (so-called person-year arrangements); shared-risk contracts, such as an accountable care organization (ACO) model, which commonly reward hitting quality and cost targets, penalize missing them, and split any savings or additional expense between payer and provider; and bundled payments — the single-price, soup-to-nuts coverage Walmart has negotiated with providers for specific, defined episodes of care.

WALMART'S ACO INITIATIVES

Accountable care organizations, or ACOs, are clinically integrated collaborations among doctors, hospitals, and other providers. They seek to decrease costs and improve outcomes through careful coordination aimed at eliminating duplication and errors, by applying best practices to reduce unwarranted variation, and by emphasizing preventive care. They often involve shared-risk contracts, which pay a set amount per enrollee for a specified period of time. These contracts may also reward good performance on clinical and cost goals and penalize falling short.

Beginning in 2016 Walmart has added accountable care plans, or ACPs, to the medical benefits associates can choose from. It currently has 11 ACOs in select markets, including Mercy, in Missouri, Oklahoma, and Arkansas; Memorial Hermann Health System, in Houston; and Ochsner Health System, in the New Orleans area. Some of these are also Walmart Centers of Excellence providers. ACPs cover many medical services with a co-pay ($35 for primary care and behavioral health, $75 for specialist and urgent care) and no deductible. Members choose an ACO provider for all routine primary care. They are covered for out-of-network medical emergencies but pay the full cost of any nonurgent out-of-network care. ACP members also have access to Walmart's Centers of Excellence program.

Walmart has developed not just bundled coverage but also ACO arrangements with selected providers. In each case the driving principle has been to secure the highest-quality care at the best price. Bundles, as we've seen, are well suited to travel surgery programs; ACOs work well for broader coverage, including primary care for associates in a local market — say, the community within a 45-minute drive of a given provider.

In this article we'll focus on how the travel surgery program works and the results it has obtained so far.

GETTING STARTED

All employers are trying to control health care costs, but a single-minded focus on cost containment would be shortsighted. From the start Walmart, like the providers it partners with, has explicitly pursued health care *value* — lowered costs coupled with

better outcomes. It would do little good to secure bargain-priced care if that didn't help people resume their lives and return to work.

Walmart had traditionally used various insurance carriers to manage its health benefits, but those companies were huge and often had limited ability to innovate and to negotiate on Walmart's behalf for high-value deals. In 2012, building on its experience with a long-term relationship with the Mayo Clinic for organ transplants, the company set out to develop similar arrangements with other providers for an expanded set of conditions. Early in the discussions its benefits plan leadership zeroed in on the procedures with the greatest opportunity for improvement: common and expensive surgeries (those costing more than $20,000, on average) with high variation in cost and clinical outcomes across providers. Heart and spine surgeries meet those criteria. What's more, they're risky procedures that, done poorly, can have a devastating impact on a patient's health and well-being; in the case of spine surgeries, evidence suggests that a large number aren't even necessary. Walmart launched its heart and spine surgery programs in 2013. It went live with joint replacements (hip and knee) in 2014, certain cancer evaluations in 2015, and bariatric, or weight loss, surgery in 2016.

The benefits team knew that crafting and administering these complex contracts and running the travel program's ongoing operations would require specialized expertise — a third-party administrator. TPAs provide care management, claims administration, and benefits structuring, generally at a fee of 2% to 4% of the cost of the total plan management, depending on their exact role. Although they offer full benefits administration, they generally don't take on insurance risk, and they are small and flexible enough to craft customized programs for single employers.

Health Design Plus, or HDP — a TPA founded in 1988 by coauthor Ruth Coleman — was instrumental in developing and managing Walmart's program, including its bundled care contracts.

SELECTING PROVIDERS

Companies that rely on traditional insurance generally view doctors' offices and hospitals as mere vendors of care. It's different with the COE providers Walmart associates use. Walmart and the HDP team sought true partners — providers that would share the company's vision for the program, take a team approach to care, and include patients and their families in decisions.

The process started with a review of health benefits data to identify providers that had delivered significant amounts of high-quality service to Walmart associates. Publicly available information on the quality of care from these and other providers was also evaluated. On the basis of this analysis, Walmart reached out to potential hospital partners. Medical centers in targeted regions throughout the country were selected according to the distribution and needs of associates. The company focused on integrated systems, in which care is closely coordinated across constituent provider organizations and clinicians. The assumption (which has largely been borne out) was that the hospitals in such systems would be better aligned than others, would resonate more fully with Walmart's health care mission, and would be better equipped to take on bundled rate contracts. Providers participate in bundled pricing much more readily now than in 2012, but many health systems had to be eliminated from consideration because they were unwilling or unable to commit to the model.

THE VALUE TO PROVIDERS

As one of the physicians leading Geisinger's destination care program, I'm sometimes asked by other health care providers why a health system would enter into an agreement with employers in which it is paid less for services than it would be in a conventional fee-for-service arrangement. The answer, in short, is that clinicians, patients, and the business itself can benefit. (For more information, see "What Makes Geisinger's Destination Care Program Tick," on page 23.)

On the clinical side, the exercise of creating and running efficient, high-touch, multidisciplinary bundled-care programs leads to process improvements that diffuse to clinicians and patients throughout the organization and to patients outside of the programs — an important "halo effect." What's more, frequent scheduled collaborations (including an annual in-person summit) with the other health systems providing care to participating employers encourages valuable sharing of outcomes data and best practices, improving everyone's performance. The data clearly shows that patients win too.

On the business side, travel care contracts with employers, particularly big ones like Walmart, bring in new patients, usually from far beyond a system's local population. These patients represent true business growth. In addition, direct partnerships with employers generally establish stable, set payments for services, in contrast to Medicare and conventional fee-for-service arrangements, where reimbursements can shift — often downward. Finally, participating in these programs can increase a system's visibility to other employers, helping attract new business.

For more on the impact of these programs on systems such as Geisinger, see the HBR.org article "Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees."

— Jonathan R. Slotkin, MD

We've found that good integration and a willingness to build bundles are necessary but not sufficient. Becoming a COE provider can suddenly increase patient volume. Some providers have assumed that the main challenge would be ensuring adequate surgical capacity. In fact it has to do with the support team — having enough nurse practitioners, navigators, and other staff

members to manage patients throughout the process. We've had to pause referrals to some medical centers so that they could better prepare for an influx of patients.

Success with bundled contracts turns out to be a good indicator of the capabilities and character of a hospital and its providers; it shows that a provider is motivated and able to integrate the work of a diverse clinical team around a patient's needs, align incentives to improve value, and track outcomes to inform continued improvement. Walmart and HDP found that providers with those capabilities were more likely than others to meet key selection criteria, including:

- strong quality indicators, such as low complication rates, good performance on patient safety metrics, and systems for measuring quality, including at the individual physician level
- evidence-based, integrated care delivery
- patient-centered, collaborative, team-based decision making
- a willingness to construct competitive bundled prices

Although bundled pricing is critical to the program, we intentionally put it last on our list. Walmart decided that no center would be selected if the first three criteria weren't met, no matter how attractive the price.

BUILDING BUNDLES

By defining and pricing all the elements in an episode of care, prospective bundles (which are defined in advance and paid for soon after the end of each episode of care) cap costs and can improve quality. They should appeal to employers for those reasons alone. But they have other advantages, too. They encourage integrated care, reduce incentives to perform unnecessary care, and make it easier for employers to accurately predict their health care costs. And once the initial employer-provider negotiation is concluded, price discussions are largely off the table. This lets all involved focus on what's best for the patient.

As mentioned, employers rarely have the in-house expertise to negotiate bundled care contracts, and Walmart enlisted the help of Health Design Plus. In developing a bundle for, say, hip replacements, HDP identifies the procedure's standard billable components (which include imaging, tests, devices, and pre- and postsurgical inpatient care) and negotiates a total price with the provider. The negotiated rates typically average 10% to 15% less than prices paid under conventional insurance and traditional fee-for-service reimbursement. In some cases a bundle may cost slightly more than FFS, because it provides higher-quality care; unit cost reduction is far from the biggest driver of the COE program's financial success. High-quality, ethical providers have lower complication rates and provide less unnecessary care.

The transparency of the process means that all parties know precisely what is being bought and paid for. In the spine surgery bundled care program that Geisinger and other centers provide for Walmart associates, for instance, all episode-related inpatient care is included, but postdischarge skilled nursing and rehabilitation isn't. Bundles might include a second visit, depending on the type of care (weight loss surgery always involves two visits, for example). And although providers engage with associates far in advance of travel, the bundled payment starts when a patient arrives at the hospital and typically ends upon discharge for the trip home.

Being clear about the arrangement from the start prevents disputes later on about what's covered and what's not — the bane of providers when dealing with insurers. Of course, it's impossible to predict every contingency, so contracts need some flexibility. Patients might require unanticipated tests or have unforeseen complications, such as a previously undiagnosed cancer or a fall after arrival but before care. Provisions in the contracts address surprise costs and assure fair compensation for the provider (without shifting those surprise costs to the patient) — a feature that reinforces the sense that the employer and the provider are partners in patients' care, not adversaries jockeying to minimize their own costs. All procedures include a warranty: If a patient has complications and needs to return for further treatment within 30 days, the provider does not receive additional compensation for that care.

When managing bundled arrangements for employers, HDP oversees the entire process, from initial employee referral to discharge home and payment of claims. Although the provider ultimately decides what care is needed, if there are anticipated or actual charges outside the bundle, HDP approves payment on a case-by-case basis. Because the COEs are so carefully vetted and are regarded as team members, conflicts about charges are rare. The various clinical sites, along with HDP and Walmart, have frequent calls; during them, clinical feedback from the sites is occasionally used to expand (and more rarely to remove) covered services.

A known risk of bundled payment strategies is that they can create incentives for providers to perform more episodes of care. This can be mitigated in various ways, including having strict treatment criteria defined by the provider organization and selecting only providers with a track record of sound clinical decision making and integrity.

THE PROGRAM IN ACTION

Most Walmart health care benefits are covered by traditional self-funded plans managed by a major

carrier, but associates are encouraged through incentives and various communications to use the COE program for the surgeries we've described. Promotions across the company intranet, open enrollment materials, testimonial videos, benefits portals, and other channels tout the program's upsides: access to superior providers; all travel, lodging, and meals covered for the associate and a caregiver companion (except in the case of weight loss surgery); and (with a few other exceptions) no co-payments, coinsurance, or deductibles.

Associates who are eligible for the program can choose not to use it — but at a cost. Beginning in 2017, those opting for spine surgery outside of the COE network (to avoid travel, for example) had to pick up half the total cost; the amount climbed to 100% in 2019. The same applies to associates who want surgery even though the COE concludes it's not needed. In 2018 Walmart instituted a 50% co-pay for non-COE joint replacements. (These charges are always waived for emergent and urgent conditions.) The co-pays have driven a dramatic increase in utilization: After Walmart introduced the one for joint replacements, the number of patients choosing to have their surgery at a COE site increased by 113%.

Associates typically start to engage with the program when they are clearly on a path to surgery. The first step is to connect with HDP. A customer service team there conducts an initial triage; if the associate meets the basic criteria for the program, she is put in touch with a dedicated nurse-management team. Continuity of care is critical for good outcomes, so associates are accepted into the program only if a local physician — usually a primary care doctor — has agreed to provide follow-up care after the patient's return. The nursing team educates the associate about the process, evaluates her self-reported clinical status and symptoms, and, if she meets more-detailed program criteria, refers her to the appropriate provider. Program coordinators and specialist physicians at the COE take over at this point. They review the patient's records to determine whether surgery or a medical evaluation visit (in the cases of spine and bariatric surgeries) is appropriate; if so, the provider submits a plan of care to HDP and schedules a surgery or a nonoperative visit.

HDP handles all logistical and financial arrangements and communicates the details with the associate and her caregiver. The caregiver is much more than a companion; he or she must be an able adult who can meet specific support requirements and assist the patient after leaving the hospital and with travel home. HDP verifies that the caregiver has agreed to this role before the associate receives final approval.

Unless they choose to drive themselves, the associate and her caregiver board a flight a day or two before the surgery. They are picked up by a hired sedan at the airport in the provider's city and brought to a hotel experienced in hosting postsurgical patients. The next day they make a short trip to the hospital, where they connect with the navigators and nurse coordinators who will shepherd them throughout their stay. The associate also meets the treatment team for a medical evaluation; barring the unexpected, the surgery is performed the following day. Inpatient stays vary according to procedure and patient status but are generally a few days. The associate is discharged to the hotel, and after the medical team issues an all-clear, she and her caregiver are driven to the airport for their flight home.

The medical team communicates with the associate's local physician about her experience, clinical status, and follow-up care, and the COE provider remains available as needed. Most centers check in frequently with the patient and her local doctor to track her recovery. Payments now revert to the associate's standard benefits. A dedicated HDP nurse relays her status and care needs to a nurse at her insurance carrier, who arranges any additional care related to the episode in the rare cases when that's needed.

More than 5,000 associates have participated in Walmart's travel program, and the overwhelming majority give it high marks. Despite the disruption inherent in travel, HDP surveys find that more than 95% of patients are "satisfied" or "very satisfied" with the care and the overall experience. One associate said, "This has been the best medical experience of my life. This is the most important benefit of working at Walmart." The company and its COE clinical sites have received scores of similar, unsolicited testimonials.

Of course, some patients have been less thrilled; complaints from the small percentage who are "dissatisfied" tend to center on the decision not to move forward with surgery. In most cases these patients have been told by their local doctor that surgery can heal them; learning otherwise can be frustrating and disappointing. In other cases COE surgery isn't an option because of health issues such as obesity and tobacco use. Although we work with these patients on necessary lifestyle changes, the experience of being denied surgery and advised to lose weight or quit smoking doesn't always sit well.

Other challenges range from the merely inconvenient — travel patients have missed pre-op appointments because they were sightseeing — to the serious: One year we had to divert patients from several locations because of hurricanes and wildfires. Preparing

for the unexpected is a less obvious but critical part of running the program.

POSITIVE OUTCOMES

The happiness most participants report with their COE experience stems in part from its concierge aspect. But good outcomes and affordability also boost satisfaction. Patients receiving their care at the centers do better, on average, than other patients on a host of clinical measures — and recall that in most cases they pay nothing. We'll look now at data for three of the travel programs in turn. (Unless otherwise specified, the statistics given for them represent averages.)

1. SPINE SURGERY

Almost half of the Walmart associates who had spine surgery or a medical evaluation without surgery from 2015 to 2018 did so at a COE site. That group, totaling 2,300 patients, was divided equally between men and women, and most were 50 to 64 years old.

One reason for the good outcomes is the fact that, as we've discussed, the program heads off unnecessary or inappropriate surgeries in favor of more-effective, less dangerous, and less expensive treatments. It prevented more than half of the surgeries recommended by non-COE providers.

More Than Half of COE Spine Patients Avoided Surgery

Source: Walmart, Geisinger, and Health Design Plus ©HBR

Among associates who did undergo surgery, those at COE sites spent 14% less time in the hospital than those who went outside the program...

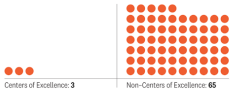
COE Spine Patients Had Shorter Hospital Stays

Source: Walmart, Geisinger, and Health Design Plus ©HBR

...and their likelihood of readmission was 95% lower.

COE Spine Patients Had Lower Hospital Readmission Rates

Rate of readmission per 1,000 patients



Source: Walmart, Geisinger, and Health Design Plus ©HBR

Because of the relatively good health status of COE patients postsurgery, only 0.6% of them had to be discharged to a skilled nursing facility for monitoring and rehabilitation, compared with 4.9% of patients receiving surgery outside of the program.

Few COE Spine Patients Required Postsurgical Care in a Skilled Nursing Facility

Rate of discharge to these facilities per 1,000 patients

Source: Walmart, Geisinger, and Health Design Plus ©HBR

Patients at COE sites returned to work sooner than non-COE patients, shaving 20% off their time away.

COE Spine Patients Returned to Work Sooner

Source: Walmart, Geisinger, and Health Design Plus ©HBR

The cost to Walmart for surgery at a COE site is about $2,400 (8%) higher than that at a non-COE site, but as we've just seen, the payoffs are considerable: earlier discharge, lower readmission rates, far less

utilization of skilled nursing facilities, and faster return to work. And the slightly higher cost per case is more than offset by the hundreds of surgeries that are appropriately avoided and by improved outcomes.

Walmart's Per-Patient Cost for Spine Surgery Was Higher at COEs Than at Non-COEs

But the company saved money overall because of surgeries that were avoided and better outcomes.

Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

2. JOINT REPLACEMENT SURGERY

Eighteen percent of the Walmart associates who had joint replacement surgery from 2015 to 2018 had it at a COE site. Roughly two-thirds of these 1,836 patients were women, and most were 50 to 64 years old.

Here, too, COE specialists headed off unnecessary procedures, having determined that many patients would not benefit more from surgery than from more-conservative treatments, such as physical therapy, or had health reasons that rendered surgery inadvisable.

One-Fifth of COE Joint Replacement Patients Avoided Surgery

Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

Among the associates who had surgery, those at COE sites spent 32% less time in the hospital than those who went outside the program.

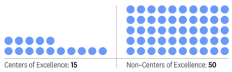
COE Joint Replacement Patients Had Shorter Hospital Stays

Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

Because COE patients experienced fewer postsurgical complications, they were 70% less likely than non-COE patients to be readmitted.

COE Joint Replacement Patients Had Lower Hospital Readmission Rates

Rate of readmission per 1,000 patients

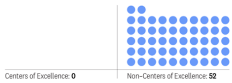


Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

Given their relatively good health status postsurgery, none of the COE patients needed a skilled nursing facility after discharge, compared with more than 5% of the patients treated outside the program.

Zero COE Joint Replacement Patients Required Postsurgical Care in a Skilled Nursing Facility

Rate of discharge to these facilities per 1,000 patients



Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

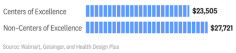
And because they were discharged sooner and recovered more quickly, the COE patients returned to work a week and a half sooner than their non-COE counterparts.

COE Joint Replacement Patients Returned to Work Sooner

Source: Walmart, Geisinger, and Health Design Plus ⓒ HBR

Walmart's cost per case is about 15% less at COE sites than at non-COE hospitals, and the savings from avoiding inappropriate surgeries and from better outcomes are great.

Walmart's Per-Patient Cost for Joint Replacement Was Lower at COEs Than at Non-COEs



Source: Walmart, Geisinger, and Health Design Plus ©HBR

3. BARIATRIC SURGERY

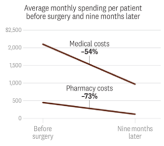
As we've discussed, obesity can cause or exacerbate medical problems such as diabetes and high blood pressure. It can be expensive for employers and employees alike: Medical and pharmaceutical costs can exceed $10,000 per member per month. Bariatric surgery — which reduces the size of the stomach, routes food past it, or limits the amount that can be eaten — can help people lose weight and keep it off. Walmart covers 75% of the procedure's cost; patients pay the rest, along with their travel expenses. The surgery is offered only through the travel program, so we lack data comparing it with non-COE care. Still, early results are promising.

To date more than 300 associates have had the surgery. Three-quarters were women; the average age was 46. Before surgery the group's average body mass index was just over 50. (For reference, a 5'4" woman with a BMI of 50 would weigh 291 pounds; a 5'9" man with a BMI of 50 would weigh 338 pounds.) Six months after surgery the women had lost an average of 39 pounds, the men 45.

It's too soon to know definitively whether this weight loss reduces absenteeism or so-called presenteeism (working while sick), but preliminary data suggests so. We do know that it dramatically cuts pharmacy and medical costs. Those decreases reflect the profound impact of the surgery on patients' health: Complications of obesity drop sharply, as does the need for medication.

Sources of savings. To understand exactly how the COE programs save money, HDP has analyzed direct cost reductions, the effects of care quality and decreased complications on cost, and the impact of avoided costs, including surgeries recommended outside the COE program but not performed along with reductions in hospital readmissions, additional operations, and the use of skilled nursing facilities. For the 2017 benefits year we estimate that Walmart, Lowe's, and McKesson together saved

Costs Dropped After COE Bariatric Patients Had Surgery



Source: Walmart, Geisinger, and Health Design Plus ©HBR

$19.4 million through their spine and joint surgery programs (Walmart associates made up a majority of those patients). About one-third of the savings resulted from direct cost reductions; the rest came from the avoidance of unnecessary care and a decrease in complications.

WHAT'S NEXT FOR WALMART — AND FOR U.S. HEALTH CARE

We've focused here on Walmart, but a growing number of other companies have launched or are developing similar value-based, direct-to-provider programs, sometimes sharing models, partners, and resources, in conjunction with HDP or one of the several other capable TPAs operating nationally.

In tandem with the rise of these programs is the emergence of business coalitions that help employers connect with superior providers and advocate for value-based contracts. To that end Walmart has partnered with HDP and the Pacific Business Group on Health, a San Francisco–based not-for-profit employer-advocacy organization, to create the Employers Centers of Excellence Network, or ECEN. The state of Washington, through its Health Care Authority, has selected two hospital systems to cover hip and knee replacements and spine care for its employees, with clinical standards and bundled pricing informed in part by the Bree Collaborative. Dozens of purchaser coalitions exist in the United States, providing a smorgasbord of resources and services; nearly 40 can be found within the National Alliance of Healthcare Purchaser Coalitions, which serves 12,000 purchasers. What they broadly have in common is a focus on helping employers use their clout to improve the value of care for their employees. These employers' combined scale (NAHPC members alone cover 45 million Americans) strongly suggests that companies will become an increasingly powerful force in the transformation of U.S. health

care — and providers and commercial insurers should pay heed.

All this may look very complex — and when first approached, it is. We advise employers and providers contemplating direct employer-purchased care not to wait while they assess the feasibility, clinical benefits, and return on investment; we, and coalitions such as ECEN, have already done that work. As legacy insurance companies assume less and less insurance risk (while often operating at a notable surplus), it makes sense for health care purchasers and providers to connect directly, and many validated approaches for doing so exist. The right providers and an experienced third-party administrator can lift the burden from the employer. Although there will be demanding work up front, once programs are established the work becomes less complex, and even more of the burden is borne by the TPA and the providers. The return in both dollars and employee wellness and satisfaction is high.

Walmart CEO Doug McMillon has publicly stated that health care now represents one of the company's two most significant areas of innovation focus (digital transformation is the other). So, what does the future hold? Walmart's COE program ensures that associates get high-quality care; however, it is not realistic to think that employers can ask employees to travel for all types of care, or that travel is always the best approach. By design Walmart's program has focused on acute episodic surgical care. General medical and chronic conditions such as diabetes, high blood pressure, and heart disease are more common and, in aggregate, more costly in both dollars and employee health and well-being. Care for them is often best done by the top providers in patients' own communities. Walmart's ultimate goal is to bring a COE-level experience to the communities where its associates live, offering convenience, quality, and transparent, fair pricing. This will also allow the company to measure and continuously improve the impact of its programs on health.

Employers will shoulder a substantial portion of the cost of U.S. health care for the foreseeable future. Until recently they've had few options but to shift some of the growing cost to employees and fight for rate decreases. Those tactics have not stemmed rising costs and have done little to address quality. But as we and others have found, higher-quality care is reliably the most cost-efficient. The success of Walmart and other employers in improving health care value through direct partnerships can be a model for others, helping them address the cost-and-quality dilemma and drive change nationally. We urge other companies to act on Sam Walton's call to arms. ■

A BRIEF (AND INCOMPLETE) HISTORY OF VALUE-BASED PURCHASING BY EMPLOYERS

1997 Walmart contracts directly with the Mayo Clinic as its exclusive provider for organ transplant surgeries.

2010 Lowe's begins a program with the Cleveland Clinic to provide eligible full-time employees and their covered dependents with enhanced benefits coverage for qualifying cardiac procedures.

2010 Lowe's engages Health Design Plus to assist in designing and managing a Centers of Excellence program for heart surgery.

2013 Walmart launches COE cardiac and spine surgery programs at five hospitals and health systems.

2013 Intel and Presbyterian Healthcare Services debut Connected Care, an initiative with novel risk-sharing arrangements and a value-centered payment structure that includes bonuses for hitting certain quality and financial targets.

2014 Walmart launches COE hip and knee replacement programs.

2015 Boeing starts offering employees access to narrow-network local care delivery initiatives in several cities. This direct employer-purchasing arrangement has provided more than 15,000 employees with benefits, including low or no co-pays, same-day appointments, and access to expanded digital-health tools.

2015 Walmart launches a COE cancer evaluations program.

2016 Walmart launches a COE bariatric surgery program.

2018 Dallas Area Rapid Transit launches an accountable care organization offering with the Baylor Scott & White Quality Alliance. It emphasizes preventive care, measurable outcomes, and the involvement of providers with a population health-management perspective.

INSIDE EMPLOYERS' NEW HEALTH CARE PLAYBOOK

Organizations big and small are contracting directly with providers for bundled care and other services. Here's how to get started.

by Jonathan R. Slotkin, MD, Nancy Jester, Lisa Woods, and M. Ruth Coleman

Last year, U.S. employers spent nearly $700 billion on employee health care services, and costs keep rising. To try to control these costs and to improve the quality of care, an increasing number of companies are cutting out commercial insurers and striking deals directly with health care providers. That can help rein in costs by eliminating the margins skimmed off by insurers and, when done well, can dramatically improve quality.

Companies including Walmart, GE, Boeing, and Lowe's have all pursued these arrangements, partnering with carefully vetted providers to design programs for their associates. The programs, such as bundled surgical care that covers start-to-finish costs, have saved the companies millions of dollars and allow employees to get back to their lives and work faster. (See "How Employers Are Fixing Health Care," on page 3.)

Not every company has Walmart's scale, resources, and clout, but smaller firms too can make direct-to-provider arrangements work. The key is to know what you're looking for and how to partner effectively. Here we'll describe two broad approaches:

- a *centers of excellence* (COE) strategy, in which employers often tap into a purchaser coalition that helps them identify best-in-class providers and create bundled-care contracts for a defined episode of care
- an *accountable care organization* (ACO) strategy, in which an employer works with a provider to craft coverage that may pay a set amount per associate for a given period and that usually links reimbursement to the provider's performance on quality and cost metrics

As you move forward, you'll benefit from working with a third-party administrator (TPA) that has expertise in crafting and managing innovative employer-based, and especially self-funded, benefit plans. Most such plans today, in fact, are managed by TPAs. In addition to facilitating the initial contract and managing the ongoing relationship with a provider, the TPA often serves as the principle point of contact and navigator for employees as they connect with the selected provider.

It's important to choose the right TPA at the outset. Ask these questions to gauge a prospective partner's capabilities:

- *What is your process for identifying qualified providers?* Look for expertise in finding value-driven providers who have experience in direct, at-risk contracts with employers.
- *Do you evaluate the quality of physicians as well as the overall provider system?* The correct answer is "yes."
- *Do you have experience in managing both the contracting process with providers and the ongoing administration of direct-to-provider*

programs, including paying bundled claims and other types of at-risk pricing? Require "yes" answers and ask for specifics.

- *Do you have existing agreements with providers in the geographic areas we're targeting that excel in the medical services we're seeking? Can we access those providers?* Seek a TPA that answers "yes" to both.
- *How do you assist employee-patients as they seek out and engage with a selected provider?* Find a TPA that holds employees' hands throughout the process.

Whichever model you pursue — COE or ACO — remember that engaging in a direct-to-provider relationship is a strategic decision and that senior leadership needs to be on board every step of the way.

What follows is a guide for evaluating that decision, with advice on how to start and who to partner with. Obviously, the process is complex — it can take six months to a year to identify and contract with a single provider — but these are the essential steps.

STEP 1: GATHER DATA AND SET GOALS

Start by clearly defining the management goals for your medical benefit plan. Presumably you want to cut costs while maintaining or improving quality. (In our experience, higher-quality care is always cost-efficient in the long run, even if some elements are more expensive.) And you want a plan that will satisfy current employees and help attract new ones.

Bear in mind that COE and ACO strategies involve narrow networks of only your selected health care providers. Consider how important having many provider options is for employee recruitment and retention (surveying your workforce can help you find out). If employees feel that the selected approach limits their choices too much, you may save money but pay a price in terms of employee satisfaction.

If you do pursue a direct contract, you'll want to get a clear picture of what you're spending on health care, which will help you evaluate alternatives. You'll also want to understand where your current benefit plan costs may be out of line. Find out how your total cost per employee compares with the industry average. If your company is spread across multiple locations, knowing your costs at each one will help you prioritize, focusing on the highest-cost areas first.

Next, figure out which medical conditions are costing you the most money. Grouping annual costs by major diagnostic categories will reveal where your employees' highest health care costs lie, and suggest the type of direct-to-provider approach that might be best. High-cost categories often include cardiac disease, orthopedics, cancer, digestive disease, and neurology. If these are the sources of the greatest expense in your employee plan, a COE program that provides bundled care for defined surgeries may be the best option, as these categories often require surgical management. If your costs accrue more in managing general or chronic conditions, such as diabetes, an ACO strategy may be the better bet. Some employers, including Walmart, are using both approaches.

STEP 2: CONSIDER SIZE AND GEOGRAPHY

The next considerations are employer size and geography. A company's size affects the resources it can bring to bear and its attractiveness to providers; its location can inform which type of model it uses.

Employer size. Most premium-based plans that provide full coverage for employees don't offer direct-to-provider arrangements, which is why direct relationships typically require self-funding. Self-funding, however, can be financially risky. Because bigger employers are better able to take on this risk, by virtue of their size, many of them use self-funding because of the added control over employees' coverage it affords. Research shows that while just 20% of companies with 50 to 199 workers are self-funded, that number increases to 50% for those with 200 to 999 employees and to 91% for those with 5,000 or more. Thus bigger employers are more able than smaller ones to engage in direct relationships and craft innovative programs.

Bear in mind that a company's leverage in its negotiations with providers depends partly on how many patients the employer does or would send their way. Therefore, companies must determine whether they have enough employees in a location to support a cost-effective and mutually beneficial arrangement.

In addition, these programs are generally managed by a TPA as a "carve-out" to standard benefit plans — meaning employees still have their standard plan, but the care of certain conditions is handled outside of that plan — which makes managing the standard plan more complicated. Smaller employers may have a harder time getting conventional carriers to cooperate with such approaches in self-funded arrangements.

That said, self-funding and the direct relationships it can support are within the reach of many smaller and midsize firms. A few tested strategies can help. Regional coalitions are emerging that facilitate direct-to-provider employer programs within their communities. They support or directly purchase the best medical services on behalf of their members, and negotiate competitive bundled or other at-risk pricing that rewards providers based on value. The aggregate size of a group of employers, coupled with the psychological impact of employers banding together, can

provide leverage in negotiations with providers. Often, these coalitions also offer administrative support that simplifies the management task for individual employers.

There are dozens of purchaser coalitions in the U.S. — 40 of them within National Alliance of Healthcare Purchaser Coalitions — and they provide a smorgasbord of resources and services. What they broadly have in common is a focus on helping employers use their clout to improve the value of the care their employees receive. (For more detail, see again our article on page 3.)

Additionally, smaller employers can benefit from the work already done by TPAs that have developed programs for larger employers. Generally, these administrators design contracts in a way that simplifies the process of bringing on additional employers. For example, Health Design Plus, the TPA founded by one of us (Ruth), creates direct contracts with centers of excellence in such a way that even smaller employers can join these initiatives and tap the programs' benefits. In one case, a midsize employer reached out to Geisinger Health System to explore such an arrangement; building on the contractual groundwork laid by Walmart and Health Design Plus, this group is now in the late stages of designing its own contract with Geisinger.

As an emerging model, alternative TPAs have entered this market to provide options for employers that have 100 to 2,500 employees. The best of them are independent TPAs that underwrite their clients, process and pay claims, and take risk. They often provide digital tools that go beyond legacy companies' basic portals, streamlining members' experience. Promising examples include Apostrophe Health, which focuses exclusively on direct-to-provider plans, and WellNet Healthcare, which expects to be offering such plans beginning in the second quarter of 2019.

Geography. A company that is concentrated in one area may benefit particularly from an ACO model, while one with more distributed operations may do better with a COE approach — although some concentrated employers use a COE model. ACO contracts are almost always with local providers within a relatively small region (30 to 45 minutes' driving time), as the ACO providers generally cover all care for members — in this case, a company's employees and their dependents. COE arrangements that offer travel-care programs can span much larger geographies; some big employers have just one COE provider covering employees living in several states. Geisinger, for example, provides spine surgery for Walmart associates from Pennsylvania, Ohio, New York, and 12 other states, and weight-loss surgery for associates from Maine, North Carolina, Georgia, and 15 other states. While employers need to figure employees' travel costs into these programs, they can expect that COE providers will be willing to negotiate a competitive price since these programs expand the providers' patient pool.

STEP 3: CHOOSE PROVIDERS

Now you can begin selecting providers. Start by evaluating publicly available cost and quality data (good resources include the Leapfrog Group, CareChex, and the Centers for Medicare & Medicaid Services' Hospital Compare). That analysis can quickly narrow your choices.

Also consider choosing providers that employees already use — assuming they meet quality criteria. This has two potential benefits: (1) Many employees may be able to stay with their current provider, reducing disruption and increasing acceptance, and (2) it can improve the employers' negotiating leverage because the providers will want to keep the company's employees as patients.

After identifying a provider for consideration, an initial discussion with the provider group's management at the highest levels is essential — ideally with a CEO, president, chief strategy officer, CFO, or chief of service (generally a lead physician). Buy-in at this level is important, as direct relationships can be disruptive for providers that don't have a lot of experience with them. The necessary internal change that the provider organization must make to deliver on these contracts can benefit from the "air cover" provided by senior leadership.

To gauge the provider's ability and willingness to partner with you, start with the questions below. Involving a TPA experienced with this type of contract can make this step easier.

- Are you interested in partnering in a direct, employer-to-provider relationship — either as a COE partner for acute episodic bundled care (such as surgery) or in an ACO arrangement that includes the management of chronic conditions such as diabetes?
- Do you have the structure and capacity to accept patients in these types of value-based, at-risk arrangements?
- Have you previously accepted bundled pricing or other forms of financial risk in health care contracts? (This could include taking a fixed price or agreeing to meet financial targets per patient during a specified period.)
- Do you have systems in place to provide data on cost and quality, including on safety and outcomes at the individual physician level?
- Do you have the people and systems in place to provide value-based

care, such as program-specific nurse navigators and the ability to engage patients in decisions about their health and treatment and outcomes that matter to them (things like quality-of-life measures as opposed to strictly clinical indicators)?

In our experience, it's not unusual for fewer than half of providers contacted at this initial stage to answer "yes" to these fundamental questions. Equivocation or an outright "no" on any of them should be reason to reconsider or even disqualify a provider.

If both sides are encouraged by the opening discussion, typically they'll sign a nondisclosure agreement (NDA), which allows the free flow of information. Employers may share data on the number of employees in a given area and their demographics, the number of providers they expect to engage with, and the specific services they're seeking; providers must share data on costs and quality. An NDA also provides the first indication of a provider's approach to partnerships. It should be a worrisome sign if a provider struggles to finalize the language in the NDA or seems hesitant about sharing information after signing it. Transparency on cost and quality is a critical part of an effective direct relationship.

The next step is pivotal. The employer-TPA team has a call that includes the provider's lead physician and his or her team to better understand their approach to patient management, and to cover the program's goals and the employer's expectations in greater detail. This is the time to get a clearer sense of the organization's culture and its ability to create and run a COE program, by delving deeper into and beyond the questions above. If all goes well, the provider completes a request for proposal from the employer that covers granular quality information, program process and support, financial stability, ownership and structure, potential conflicts of interest, bundled price, and other information.

Before you make a final decision, we strongly suggest that representatives from your company (typically including a benefits manager) and the TPA do an in-person visit. This will let them validate how the provider handles and measures safety and quality, get a closer look at the provider's approach to problem solving and partnerships, and further gauge the culture, including how staff — from the front desk to clinical leaders — interact with each other and with patients and families. We recommend the representatives physically walk the paths patients will take during their time at a hospital and — without management present — interview the staff involved in direct patient care.

If the provider passes these tests, it's time to craft the contract that will formalize the relationship. These contracts set roles, expectations, and requirements and are very different from those in typical managed-care agreements. As such, completing the agreement before making a final commitment to send patients is critical to ensuring that everyone is aligned with the program's mission and goals.

FINAL STEPS

In your new collaboration with a provider, it's a good idea to launch a pilot program addressing one type of care (say, cardiac surgery or diabetes management). That said, before you move forward with a pilot program, we recommend discussing program expansion opportunities with the provider, because real value is created as multiple programs scale up. Development should be managed in stages, with new programs offered one or two at a time and design changes integrated as operations are optimized.

Finally, remember that the success of these programs depends on whether employees and leadership embrace them. To choose these plans over traditional ones, employees need strong incentives, such as ready access to same-day appointments, free travel, or — if the program is a carve-out — reduced or zero deductibles and co-insurance. And leadership expects to see a clear return on investment and improving performance over time. Direct-to-provider relationships have an impressive track record to date, as illustrated in "How Employers Are Fixing Health Care," on page 3. Doing them well will encourage employees to buy in as well as boost credibility with leadership — both of which are necessary for the program to expand and flourish. ■

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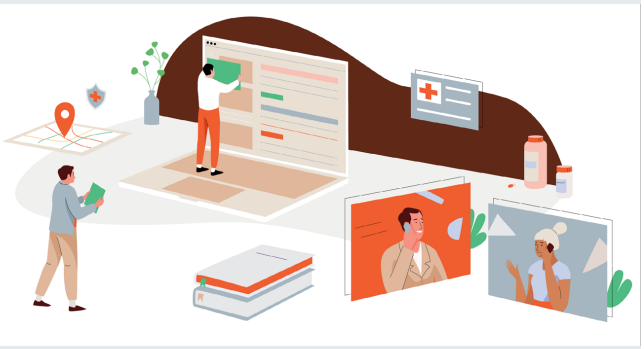


WHY DO EMPLOYERS PROVIDE HEALTH CARE IN THE FIRST PLACE?

A historical perspective

by Melissa Thomasson

In 2017, Americans spent $3.5 trillion on health care — a level nearly equal to the economic output of Germany, and twice as much as other wealthy countries spend per person, on average. Not only is this a problem for the people seeking care; it's also a problem for the companies they work for. Currently, about half of Americans are insured through an employer, and in recent years companies have borne the financial brunt of rising costs. Frustrated, many employers have shifted the burden to workers, with average annual deductibles rising by more than 50% since 2013.

This isn't sustainable for anyone. So it's no wonder that firms like Amazon, Berkshire Hathaway, and JPMorgan Chase, as well as Walmart, have embarked on efforts to re-envision health care for their employees. Warren Buffett has even gone so far as to argue that health care costs hamper economic competitiveness more than taxes do.

How did the United States end up with such an expensive system? Unlike countries that have either government-provided health care or government-sponsored insurance, the U.S. system involves the interplay of employers, insurance companies, health care providers, consumers, and government. In order to understand the cost conundrum of America's health care system today, you have to understand where the system began — and how increasing costs and technological advances have created new pressures and incentives over time.

EARLY 1900S: THE FIRST HEALTH INSURANCE PLANS TAKE SHAPE

In the 19th and early 20th centuries, medical care was largely ineffective. Many hospitals were charity institutions that functioned as shelters for people who could not be cared for at home, rather than places for people with acute injuries and illnesses to be treated. Physicians usually ministered to paying patients at home, since hospitals could be breeding grounds for infection. Because the care these doctors provided was basic, families did not face unexpectedly high health care costs and did not need the financial protection offered by health insurance; the average annual per capita spending on health care was about $5 in 1900, the equivalent of $150 today.

In some European countries, health insurance developed earlier than in the U.S., but not because of the high cost of medical care. In 1883, German chancellor Otto von Bismarck enacted a health insurance system to stem socialist sentiment as he cemented German unification. The German system enabled workers to see a physician if they were sick, but, even more important, provided what we would today consider disability insurance: giving workers money if illness or injury prevented them from being on the job. In Britain, the 1911 National Insurance Act provided a sickness benefit and free medical treatment to British workers. Versions of these disability insurance

programs, referred to as "sickness insurance," also began forming in the U.S. around the same time, organized largely by trade unions and fraternal societies. While there was an early attempt during the Progressive Era to pass compulsory insurance at the state level, it never gained traction, and it died completely when anti-European sentiment rose during World War I.

In the first decades of the 20th century, medical treatment shifted out of the home; reforms in medical education led physicians to train and practice in hospitals, which housed state-of-the-art antiseptic surgical suites and new technologies such as x-rays. As more people sought treatment in hospitals, health care costs began to rise. By 1929, average annual medical costs per person were $108, equal to about $1,550 today. A stay in the hospital became out of reach for middle-class families.

Existing fire and casualty insurance companies were reluctant to offer medical coverage, because they viewed health as uninsurable and feared that people who might be more likely to need medical care would be the only ones buying insurance. This problem — known as adverse selection — was a big problem for insurance markets in the 1920s and 1930s (and still is one today). For insurance to be effective and affordable, both healthy people and people more likely to become ill must take part.

And that's why employers started playing an outsize role.

1930S: ENTER HOSPITAL PAYMENT PLANS

Employment-based insurance developed in the U.S. primarily because offering insurance to groups of workers mitigates adverse selection. Ironically, it was not insurance companies that figured this out. Rather, the problem was solved in 1929 when Justin Ford Kimball, an administrator at Baylor University Hospital, devised a means to alleviate the financial pressure the hospital faced from unpaid hospital bills. During his time as the superintendent of Dallas schools, Kimball had developed a sickness benefit program for teachers. In his new role at Baylor, he developed a simple plan based on insurance principles to help people pay their hospital bills, and recruited Dallas teachers to test his theory. Under Kimball's plan, Baylor would provide each teacher with 21 days of hospital care for a prepaid annual fee of $6. By selling health insurance to a group of employed teachers who were healthy enough to work, the plan ensured that the risk pool would not be overwhelmed by people who were likely to be sick.

Word of the Baylor plan's success spread rapidly, and at a crucial time for hospitals. As the nation sunk into the Great Depression, hospital occupancy rates plummeted to as low as 50%. Desperate for revenue, numerous hospitals began to form their own prepayment plans. Eventually, the American Hospital Association (AHA) developed a logo for these plans to use, and the "Blue Cross" plans were born.

In addition to stemming adverse selection, Blue Cross also helped control costs by limiting so-called moral hazard, which occurs when having insurance coverage causes people to increase their use of health care services. Blue Cross initially covered only hospital bills and paid hospitals a set rate for a finite number of covered days, preventing patients from overusing the system. Blue Shield, which separately provided coverage for physicians' charges, turned to a different method: paying a fixed dollar amount of a bill, with patients paying the difference. (This practice, called "balance billing," may sound familiar. While it is rare today for consumers who see in-network providers, it can result in high bills for consumers who venture out of network, or who go to a hospital that is in network but are treated by an out-of-network physician.)

Commercial insurance companies, which had initially been reluctant to offer health insurance, witnessed the success of the Blues in conquering adverse selection and moral hazard and soon began to compete with the Blue Cross plans by offering insurance to employee groups. By 1940, roughly 9% of Americans had insurance coverage for hospital expenses.

WORLD WAR II: THE RISE OF MODERN HEALTH CARE BENEFITS

In the 1940s, a series of events ensured the expansion of the health insurance market and its employment-based nature. The tremendous mobilization of troops and resources during World War II led to a huge decline in unemployment, which fell to a low of 1.2% by 1944. In 1943, President Franklin D. Roosevelt signed Executive Order 9328, which limited the ability of firms to raise wages to attract increasingly scarce labor. The offering of health insurance, however, was exempted from this ruling. As a result, firms began to offer health benefit packages to secure workers. Unions also negotiated for health insurance on behalf of workers — a right that was assured in 1948 and 1949 when courts ruled in favor of steelworkers in two similar cases regarding health care coverage, one of which was later affirmed by the U.S. Supreme Court. These rulings, during a time when union membership rates were at their highest, played a key role in expanding employer-provided health insurance and other benefits.

The tax treatment of employer-sponsored health insurance also fostered the rapid growth of coverage. Employers were permitted to deduct

health insurance contributions from their taxes as a cost of doing business, just like wages. But unlike wages, employer contributions to employee health insurance premiums were (and still are) considered exempt from employees' taxable income, a ruling codified in the 1954 Internal Revenue Code. The tax treatment of health insurance led more Americans to be covered, and the coverage became more generous. In 1952, just before these changes in the tax code occurred, 47% of households had group health insurance. By 1957, nearly 66% of households had employment-based coverage.

1946-1965: HEALTH CARE COSTS RISE

In the years following World War II, when the economy was strong, hospitals began placing an emphasis on expansion. In 1946, the Hill-Burton Act was passed, pumping billions of dollars into the construction of new hospitals. These facilities featured improved laboratories, operating suites, and equipment. With the advent of medical miracles like penicillin during the war, hospitals and physicians were eager to provide care, and Americans were just as eager to consume it.

But even as health insurance became more generous and more expensive, consumers were still insulated from health care costs, due to the reimbursement systems developed by Blue Cross and Blue Shield.

1960-1990S: AFTER THE INTRODUCTION OF MEDICARE, COSTS RISE AGAIN

Unfortunately, the health insurance system didn't change in response to increased expenses; in fact, a task force set up in 1963 by the AHA and the Blue Cross Association affirmed the use of a "cost-plus" reimbursement system, where hospitals were reimbursed for the cost of treating patients. Hospitals thus had carte blanche to charge patients at will, passing the bill along to insurers and employers.

The passage of Medicare in 1965 added even more fuel to the fire. To ensure physician participation in the program, Medicare reimbursed physicians based on a calculation of the "customary, prevailing and reasonable" fees within any given geographic area. With the program underwriting whatever fees doctors charged, the rate of increase in fees doubled. The rise in provider reimbursement costs combined with more patients obtaining health insurance for the first time proved to be expensive. Within four years of its implementation, Medicare resulted in a 37% increase in real health expenditures, with about half of that rise coming from the entry of new hospitals into the market and the other half coming from expansion of services. Between 1970 and 1980, health care spending increased at an average annual rate of 12%, leading overall expenditures to more than double.

In an attempt to stem medical cost inflation, Medicare switched from its cost-based reimbursement system to a system of fixed prospective payment in 1983. Under the new system, which most commercial insurance companies began following as well, Medicare reimbursed hospitals according to a predetermined fee schedule based on diagnosis. Under this system, a hospital's revenue was a function of patient admissions, and incentives for volume-based care took priority.

Moreover, evidence suggests that as insurance expanded the market for health care, it generated incentives for increased development of technology. While some of this new technology represented a significant improvement over current treatments, other innovations, such as proton-beam therapy for prostate cancer, did not improve outcomes compared to existing procedures, while costing the system substantially more.

By 1990, Medicare payment reforms had only somewhat slowed the rate of growth in health care spending, with the average annual growth rate falling from 12.1% in the 1970s to 9.9% in the 1980s. At this point, 61.3% of Americans had private health insurance. Employers were starting to feel the pinch of rising health insurance costs, and they began to seek ways to ease them.

Their primary method was managed care. Numerous types of these arrangements flourished, ranging from true health maintenance organizations (HMOs), which integrated finance and delivery of care, to looser networks of preferred provider organizations, in which providers agreed to utilization review and discounted their fees. But without any meaningful changes in the U.S. health care system, costs for insurers and employers remained high. And the coming consolidation in the health care sector didn't help matters.

2000 TO TODAY: CONSOLIDATION AND MORE CONSOLIDATION

Over the past 20 or so years, consolidation among both providers and insurers has reduced competition in health care. In 2016, 90% of metropolitan areas were considered highly concentrated for hospitals, with 65% concentrated for specialist physicians and 39% concentrated for primary care physicians. A recent report by the American Medical Association reports that 69% of markets have high insurance company concentration.

Less competition in markets causes prices to rise. One recent study shows that prices at monopoly hospitals are 12% higher than in markets with more competitors. Numerous regulatory barriers to competition exist in the pharmaceutical market, too, providing

very little pricing transparency for both physicians and patients. Instead of negotiating directly with drug companies, insurance plans rely on pharmaceutical benefit managers (PBMs) to act as their intermediaries. PBMs negotiate drug prices and rebates with manufacturers on behalf of the insurance plans and create a covered list of drugs behind the scenes. This lack of transparency makes it difficult, if not impossible, for consumers to compare prices. In addition, increasing consolidation among PBMs has led to higher prices for prescription drugs over time.

As a result of these trends, employers have shifted costs to employees; one common example is the implementation of high-deductible insurance plans, which increase consumers' out-of-pocket costs. High costs can hurt employees in other ways, too: there's evidence that as employer-provided health costs rise, employers are constrained in their ability to increase wages.

. . .

The history of health insurance in the United States is a lesson in good intentions with unforeseen consequences — along with an inability or unwillingness to act when the consequences become clear. The combination of government-provided and private health insurance, including the Affordable Care Act and Medicaid, now covers 90% of the population, but as long as health care providers lack competition and profit from volume-based care, it's unlikely that costs can be constrained. And when it comes to employer-based plans, costs are becoming untenable — and increasingly are shouldered by employees. ■

About the author: ***Melissa Thomasson*** is the Julian Lange Professor of Economics in the Farmer School of Business at Miami University and a research associate at the National Bureau of Economic Research. Her work focuses on the economic history of health care and health insurance. Follow her on Twitter @thomassonecon.

TWO SURGERIES, TWO OUTCOMES

What Walmart's health care program looks like from the patient's perspective

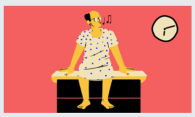
by Harvard Business Review Staff

Two fictional Walmart associates, Sean and Carla, have struggled with back pain for years. Both associates (as the company refers to its employees) recently had MRIs that came back abnormal. Sean opts to go to a surgeon affiliated with a local health system, using his traditional insurance coverage. Carla chooses Walmart's Centers of Excellence (COE) program for spine surgeries.

A COE program circumvents traditional insurance companies, connecting employers directly to health care providers. With the help of a third-party administrator (TPA), the two groups negotiate a bundled payment that entirely covers the cost of care — all the procedures, devices, tests, drugs, and services a person will need. The program also picks up the cost of travel, lodging, and meals for both the associate and a caregiver. For more information on COEs, see "How Employers Are Fixing Health Care," on page 3.

One of the best ways to understand the differences between traditional insurance and the COE program is to compare Sean's and Carla's experiences from start to finish. All the data included on the timeline is based on Walmart associate averages from 2018, and each patient's journey is representative of what associates experience with that health care option.

STEP 1: SCHEDULING SURGERY



PATIENT ONE

Sean sees a surgeon. A date for surgery is set.

PATIENT TWO

Carla contacts her traditional insurance carrier, where a health care adviser connects her with a TPA. The TPA team handles her intake, and a nurse gathers her relevant health history.

Next, a hospital that is part of Walmart's COE program is selected based on Carla's location.

A team at the hospital, comprising coordinators, doctors, nurses, and administrators, collects and reviews her MRI images and medical records. Carla is connected to the nurse navigator who will guide her through the care process.

STEP 2: HEADING TO THE HOSPITAL

PATIENT ONE

Sean wakes up early and his brother drives him to the hospital.

PATIENT TWO

Carla and her sister, who serves as her caregiver, **fly to an airport** near the hospital, where they are picked up by a **sedan service**. (There are eight spine centers in the U.S., so air travel is common for Walmart associates seeking treatment.) Carla then meets with her spine care specialists — surgeons, rehabilitation medicine physicians, psychologists, and an internist — along with her nurse navigator.

Doctors determine that spine surgery is the best option for Carla. This isn't always the case; **54%** of her colleagues who are referred to a COE for spine surgery don't need it due to better treatment options — or because surgery wouldn't fix their problem. Carla's surgery is scheduled for the next day.

KEVIN WHITE

STEP 3: SURGERY

PATIENT ONE

Sean has surgery. He stays in the hospital for **2.9 days**, the average for associates using traditional insurance.

PATIENT TWO

Carla has surgery. She stays in the hospital for **2.5 days**, the average for associates using the COE program. Half a day in a hospital can cost anywhere from $1,000 to $5,000, based on national averages.

STEP 4: RECOVERY

PATIENT ONE

Sean is discharged from the hospital. His brother picks him up and he recovers at home. He's lucky — **4.9%** of associates who have non-COE spine surgery are discharged to a skilled nursing facility because they require additional rehabilitation.

PATIENT TWO

Carla is transferred to a local **hotel** with her sister. A nurse navigator stays in close contact with them during their stay. They are given a benefits card, paid for by Walmart, that allows them a daily stipend for meals and other expenses.

After postoperative visits with her surgeon, Carla is cleared to travel. (A mere **0.6%** of Walmart associates who use the COE for spine surgery are discharged to a skilled nursing facility for rehab.) She and her sister are driven to the airport by a **sedan service** and **fly home**.

The nurse navigator reaches out to Carla's primary care physician to communicate about the surgery, share a summary report, and confirm Carla's first follow-up appointment. The nurse navigator checks in regularly in case there are unexpected complications. (Patients who need to return to the COE for additional care do so at no charge.)

STEP 5: RETURNING TO WORK

PATIENT ONE

Sean returns to work after **90 days**. In total, Sean pays **50%** of his spine surgery costs, which for Walmart associates average around **$15,000**. As of January 2019, however, the surgery would cost him **100%**, or around **$30,000**; Walmart has changed its health benefits to encourage associates to use the COE program.

PATIENT TWO

Carla returns to work after **75 days**. To help Walmart and the COE program assess her experiences and recovery, she completes surveys three, 12, and 24 months after surgery.

In total, and including travel, Carla's surgery costs her **$0**. The cost for Walmart is **a little over $30,000** — more than Sean's and Walmart's payments combined in his case. But the COE is an overall cost saver for the company and its associates, because so many unnecessary surgeries are avoided and outcomes are better at program sites. ■

WHAT MAKES GEISINGER'S DESTINATION CARE PROGRAM TICK

A Q&A with interim CEO Dr. Jaewon Ryu

by Gardiner Morse

Before he arrived at Geisinger in 2016, Jaewon Ryu, an emergency medicine doctor with a law degree, held a raft of leadership roles in health care, insurance, and government, including at Kaiser Permanente, Humana, and the Centers for Medicare and Medicaid Services. He joined the Pennsylvania-based health system as an executive vice president and chief medical officer, and this December became interim president and chief executive officer when its former CEO David Feinberg headed to Google to lead its health care strategy.

Geisinger is huge — it has 13 hospital campuses, two research centers, a medical school, and a commercial health plan — and is famously innovative. Its best-practice approaches have been widely adopted, and it is spearheading one of the largest DNA-based precision-health projects in the world. So it's little surprise that Geisinger is a pioneer in another area, so-called centers of excellence (COE) destination-care programs. In these arrangements, employers such as Walmart, Lowe's, and McKesson fly employees to selected COEs for complex care — with remarkable results. (See "How Employers Are Fixing Health Care," on page 3.)

HBR's Gardiner Morse spoke with Dr. Ryu about the benefits and challenges for providers of embarking on COE programs, and their implications for both employers and insurers. Following are edited excerpts of their conversation.

Why is Geisinger engaging in these arrangements with employers to fly their employees in for care?

Partly it's about growth. Being a destination-care provider for employers like Walmart allows us to reach a patient population that isn't already getting its care within Geisinger and is beyond our backyard. So it's a good way for us to expand the scope and reach of what we're doing.

But it also aligns really well with how we deliver care. We're big believers in developing best-practice protocols and then designing workflows to deliver them. We have developed care protocols for many clinical scenarios, including areas like cardiac surgery, spine surgery, chronic obstructive pulmonary disease, diabetes management, and many others, and they yield the best combination of quality and patient experience. It's a program that began years ago, and we've been refining the protocols and adding new ones ever since. It's a chassis, if you will, that these new centers-of-excellence programs can easily build on. We have the resources, culture, and processes already in place to develop,

say, a joint-replacement bundle with an employer. And doing that reinforces our culture and processes. There's a positive feedback loop.

Where does the destination-care program fit in that feedback loop, reinforcing how people work?
We've seen that sometimes after you go live with a protocol you can get what we call "beach erosion," where over time people can become less diligent or deliberate about making sure everyone follows the protocol. Being one of the centers of excellence for employers in programs like these helps prevent that erosion because it's yet another area where the protocols are applied. It keeps us on top of our game, as employers are paying close attention to how we perform. So the program reinforces their consistent use.

What would you say to other providers who maybe don't have smooth-running protocols like Geisinger's about the risks of these types of programs?
That's the ultimate question for any system that wants to embark on this journey. For us, it made sense because it was already ingrained as our approach to care, so there weren't the same start-up costs and culture-change challenges that you might see in an organization that didn't already have the culture and protocols in place. Also, we like reimbursement models like bundles where we're taking risk, because we tend to do better with those in driving overall value than we do under an episodic, per-widget model. But that's part of the calculus for any provider. Do you have the culture and operational programs and processes in place to succeed with this kind of model?

There's a huge opportunity for a provider that doesn't yet have these capabilities fully in place to pursue direct arrangements with employers as a way to jump-start the shift. Delivering value is the direction that health care is going — whether to patients, employer groups, the payers you're partnering with, or the government. Building the chassis I've been talking about positions any health system better for what's coming in the future, and what is in many ways already here. In time, every system is going to need to have this capability, and this kind of program is a way to get started.

I'm assuming doing programs like these reflects well on a provider?
Well, it can help the provider tell the story about the value they're offering. For instance, we work hard at making sure that we're not doing unnecessary procedures, so we find that a significant number of patients referred to us for a surgical procedure actually don't need it after all. We take a lot of pride in that because it shows that we're focused first and foremost on determining what is the best care rather than on how many procedures we can do. Data from Walmart shows that more than half of their employees referred to centers-of-excellence programs like ours for spine surgery end up not needing it. It can be more work to convince a patient that they don't need a procedure, but doing that results in the best care.

Let's talk about the challenges. This can't be easy.
That's right. Make no mistake — even if you have the chassis in place there's still a lot of work you need to do on the culture to go live with a program like this. We were lucky — we had a running start, if you will. But even so, it's not something you turn on overnight. We've been on this journey for more than a decade. It takes constant work and vigilance. For instance, even when you recruit physicians you need to make sure they are brought along into our organizational approach and don't introduce unwarranted variation into how we approach care.

It also requires constant attention to make sure your protocols are up-to-date and to assure that everyone's aligned with them. It turns out that if you follow evidence-based best practices reliably, great things happen for patients. So you need physician leadership that is committed to pursuing these protocols and tracking performance, and updating them as the science changes.

What's an example?
Well, the conventional wisdom that many doctors were taught in medical school was that patients should have nothing by mouth in the hours preceding surgery, and should be eased back on a clear liquid diet after surgery. So essentially you'd starve them before and starve them after surgery.

But so-called enhanced-recovery-after-surgery, or ERAS, protocols showed that patients do better if you give them enriched-nutrient shakes before and after. Complication rates go down, length of stay goes down, and they're up and mobile more quickly. It runs counter to the traditional teaching and so it makes some physicians uncomfortable, but we incorporated this into our own protocols and it's how we do many elective procedures now. It's easier to launch an approach like this systematically when your culture embraces the need to continuously seek better ways to do things and to do them more consistently.

Making sure everyone is on board and aligned must require real transparency about performance. How does that work at Geisinger?
We're firm believers in transparency. Data is probably more visible here than you'd see at just about any other health system.

Let me give you a snapshot of what that transparency looks like. A few years ago, we launched a primary care redesign program that focuses on closing gaps in care. If you're due for your mammogram or a colonoscopy, how often are we making sure that you get those preventive services? We track this at the level of individual providers. If you walk into any one of our primary care sites today, there would be a whiteboard where the whole team huddles every morning and the name of every provider in that clinic is listed on it. It has information about their appointment availability and also a score for how they're doing on closing care gaps, including any missed opportunities they might have had. Nurses are also listed there, with information about how effectively each is setting up patients for those care-gap actions. It's taken some work to get us to this point, and admittedly the transparency can be uncomfortable at first. But it helps us reinforce and support each other in driving for the best outcomes. And I think we could do even more.

How do you manage the discomfort that this transparency must cause? If a doctor isn't performing well, and it's visible to the team, that must create tension all around.
Well, partly there's a socialization that makes it acceptable. Transparency is part of our culture, but it does take a little time to get used to it. We really try not to do this in an embarrassing or "gotcha" kind of way. There's a lot of preprocessing and vetting with the clinical leaders and the teams around what we're going to measure and how we will track it, so people are more aware of the process and reasons for it. We try to do it in a very objective way — we're asking, "What can we do to learn from each other and improve the overall game?" We look at data such as the rate at which patients within a given primary care panel are landing in the emergency room or how often our emergency medicine physicians are ordering CT scans for nonserious head trauma, and look for outlier behavior. Sometimes the outlier behavior is justified. But shame on us if we're not asking why there are outliers.

Of course, from time to time you have differences of opinion about the accuracy of the data or to whom they're attributed. And if there's any question about their applicability at the level of individual providers we'll focus instead on the team. So we might identify teams that are behaving differently than others. That might be a good thing, or it might indicate a need for change — but let's have that discussion. I think that's the key: The data isn't the be all and end all, but it can serve to start the discussion, and framing it that way helps get acceptance.

Let's move on to the bigger picture. What kind of impact do you think programs like yours, where employers contract directly for care, will have at a national level?
I think programs like these are going to grow because they address the cost and quality problems employers are struggling with. But destination care for defined episodes like spine surgery is only a piece of where I think the industry is migrating. The broader approach that I expect we'll see a lot more of is employers directly partnering with providers for the totality of care for their employees — taking care of the whole person, and the whole employee population. In other words, an employer contracting directly with a provider in a prepaid model to take care of a population. We're already seeing some movement in this direction.

There will be some tension between employers seeking high-value care in these types of programs and consumers' desire for choice. You may get better value when an entity like Geisinger partners directly with an employer like Walmart, but, to get that, employers need to direct their employees to a smaller network of providers selected based on performance. If an employer wants to preserve employees' ability to have a phone book of providers to choose from, there's going to be a trade-off between employee choice and better value, since a lot of providers may not be as focused on quality and value in the ways we're talking about here.

How are commercial insurers responding to all this? I'd think they'd see it as a threat — but there's probably an opportunity in this for them too.
I think that's right. On the surface, it looks like a threat because it disintermediates them from the role they currently play in the relationship between employers and health care providers. But the opportunity for them is that insurers are good at identifying and contracting with quality provider networks. And they're good at pricing. Those capabilities will be very important as the industry moves this way. Even if the traditional role of the commercial insurer changes, employers still need to rely on someone to identify high-value providers and negotiate prices and develop contracts. Currently, third-party administrators do this, but it's a space commercial insurers are well positioned to move into.

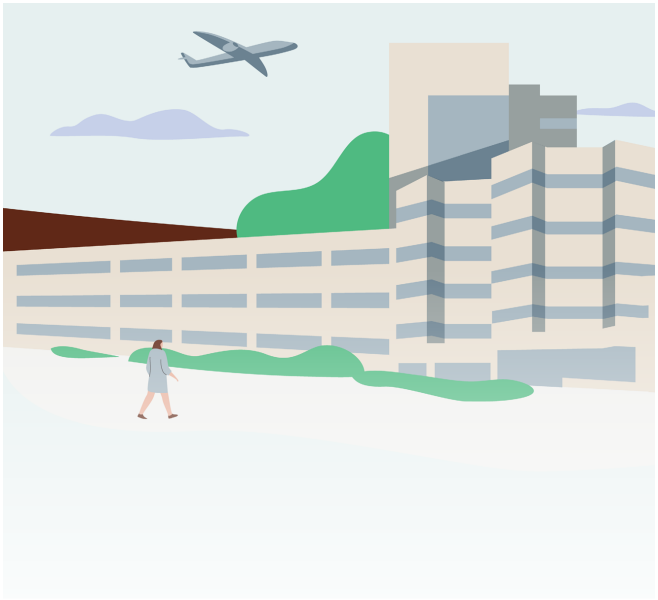
What do you think the employer's role should be in moving employees toward higher-value networks?
I think they should be encouraging that shift, and some like Walmart are, for instance, by giving employees a broad choice of providers but telling them they'll need to pick up more of the cost if they choose a provider that's

not a Walmart center of excellence. A challenge is that employees' and even employers' perception of quality and value aren't always aligned with reality. Sometimes people equate fancy facilities with great quality, and of course those things aren't always correlated. But employers need to be looking at providers' data and driving people toward the best ones.

What's next for Geisinger?
We're looking to expand the centers-of-excellence, destination-care model to make it available to other employers as well. There's a scattering of local employers that are potentially interested in going down this path. That's the beauty of how the model was built. It can be adapted to serve local markets, and we get the opportunity to deliver care in the way we think is best, and we grow. The employer and employee/patient get value. I think that's a nice win-win-win.

Any final words of advice for employers?
Employers have an important role to play in getting better value out of their health care dollars. They have a tremendous opportunity to reward providers that deliver value. The more employers seek out and contract directly with the best providers, the more traction these types of programs will get — and everyone benefits. ■

About the author: ***Gardiner Morse*** is a senior editor at Harvard Business Review.

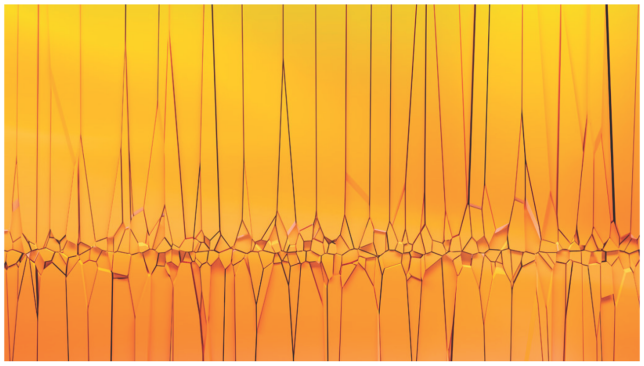


LEADERSHIP & MANAGING PEOPLE

Why GE, Boeing, Lowe's, and Walmart Are Directly Buying Health Care for Employees

by Jonathan R. Slotkin, MD, Olivia A. Ross, M. Ruth Coleman, and Jaewon Ryu, MD

JUNE 08, 2017



While Medicare has led the development of bundles in the U.S., large employers are now directly purchasing bundled care for their employees through selected providers. It is little surprise that direct employer-purchasing of bundled care is a burgeoning area of healthcare payment innovation. Purchasers of healthcare services encounter widely disparate charges across different healthcare delivery systems for equivalent surgical procedures, varying by up to 40%. Boeing and General Electric have been among the leaders in adopting bundles, in part to address these disparities. Other companies including Lowe's, Walmart, McKesson and JetBlue Airways have recently partnered with the Pacific Business Group on Health (PBGH) and Health Design Plus (HDP) to launch the Employers Centers of Excellence Network (ECEN) which helps employers identify quality providers and negotiate bundled payments. PBGH is a non-profit, employer-led organization that represents public and employer healthcare purchasers, including numerous Fortune 100 companies. HDP is a third-party administrator with expertise in the development and management of travel surgery programs, providing strategic and operational management of this program.

ECEN began first with total joint replacement, then added spinal surgery, and recently has begun providing bariatric (weight loss) surgery at selected centers. ECEN provides employees of participating companies with 100% coverage for all travel and medical expenses at carefully selected healthcare systems; patients pay no out-of-pocket costs. Participating employers benefit from the quality assurance of the ECEN's rigorous center selection process and the financial savings from paying competitive, pre-set rates for bundled care negotiated between participating hospitals and HDP.

Geisinger Health System began partnering with Walmart around cardiac surgery in 2012, and joined ECEN for spinal surgery in 2015. Three key questions employers and providers commonly ask about arrangements like these are: "What is the process to be selected as a site?" "What does a healthcare system look like that earns one of these contracts?" and "Does the program actually lead to improved value care delivery?"

leads to an extensive review of the system's quality, outcomes, and patient satisfaction data.

After an assessment phone call that includes PBGH, HDP, as well as physicians and administrators from the health system under consideration, an extensive request for proposal is sent for completion. Candidate centers must provide information including detailed clinical protocols, surgical-patient selection criteria, clinical registry participation (more on that below), information on multidisciplinary shared decision-making, as well as institutional and physician-level performance metrics. These metrics include length of stay, return to surgery, infection rates, and procedure-specific outcomes such as joint dislocation after hip replacement and nerve covering tears occurring during spinal surgery.

For centers remaining in consideration after these initial steps, PBGH and HDP perform an in-depth site visit utilizing a patient tracer methodology. The patient experience is reviewed from arrival at the airport, throughout the care cycle, and to departing for home. A successful visit moves the process along to negotiation and contracting.

Negotiated prospective bundled rates cover all services rendered during the episode of care including facility fees, professional fees, ancillary care, implants, and durable medical equipment; the bundles created significantly exceed the services typically included in standard fee for service (FFS) care for the same procedures. These charges usually average 10% to 15% less than what would traditionally be paid in standard fee-for-service arrangements. HDP and the hospital systems negotiate the final terms of the contract, including provisions for outlier situations (such as catastrophic or unrelated complications), and ad hoc additional services occasionally needed (such as pain injections or nerve testing studies).

Why would a health system want to enter into a relationship that potentially decreases profits relative to the system's similar activities? This reservation has been a significant reason some hospitals have disengaged discussions with ECEN, while certain other systems presented

beyond the program. For example, the ECEN spine program requires that all patients be evaluated by pain psychology, internal medicine, physiatry, and spinal surgery providers; At Geisinger, this "idealized" care — which is not routine for patients at any hospital — has become the aspirational model for the creation of the system's integrated practice units.

What does a healthcare system look like that earns one of these contracts?

In 2012 when Geisinger Health System was finalizing a destination-care agreement for cardiac surgery, the leadership team determined that we were not ready to pursue similar initiatives in spinal surgery; the necessary care-delivery systems were not yet sufficiently in place in that clinical area. Why was cardiac surgery ready and spinal surgery not? In 2006 Geisinger embarked on a broad care delivery reengineering initiative around cardiac surgery called ProvenCare. This process-improvement methodology includes workflow redesign, error proofing, best-practice implementation, cost bundling, financial risk sharing, and outcomes measurement. The elements of ProvenCare bear a notable resemblance to current payment innovations such as certain Medicare bundles and employer-purchased bundles. Implementing and expanding these prescient efforts created routine operational processes and a contagious mindset: that quality improvement is part of everyday work, and that we keep score.

In late 2012 Geisinger initiated ProvenCare Lumbar Spine. This work, which spanned most of a year, engaged all parties to agree on best practices and to minimize unwarranted variation in care delivery. The electronic health record was used to "hardwire" the agreed-upon elements through the consistent use of checklists, forcing functions, and dashboards to follow system and individual provider performance. The very act of providers agreeing on best practices itself brought significant value in improving our care and creating a shared vision. Striving to measure our outcomes on every patient was a critical component.

Having systems to measure specialty-specific patient reported outcomes (PROs) provided an

Specialty-specific registries are not a new concept (the Society of Thoracic Surgeons National Database was formed in 1989) but some medical specialties have been slow to adopt this approach, and many healthcare institutions do not have the necessary infrastructure or human capital to participate. We have found that participation in neurosurgery's prospective clinical registry, the Quality Outcomes Database (QOD), mobilizes our providers and creates a culture where we continuously examine how our activities will impact our patients' outcomes. Registry participation is labor intensive and worth it.

Support from the highest levels of an organization's leadership provides "air cover" for building the necessary systems and cultural change necessary for this high-touch style of care. One hospital's contracting team believed it could not improve upon its offer of bundled rate charges 50% higher than those seen at already participating centers. Six months later the system's CEO approached ECEN to reopen discussions matching the other centers' pricing – only to find that the hospital could no longer be accommodated. Administrative leaders experienced with their hospital's operational network are needed when the necessary new care pathways and processes are disruptive. Business development, contracting, and finance personnel are also required. Dedicated nurse navigators and program coordinators greatly assist with the logistical complexity encountered and the concierge-type approach needed for destination care. Frequent thank you letters from satisfied patients in this program often highlight the importance of our nurse and program coordinator.

Does the program actually lead to improved value care delivery?

Programs of this type are not worth the investment if they do not increase value for patients, purchasers, and hospitals by improving patient outcomes and satisfaction and decreasing costs. Since 2014, 5,355 people have inquired about participating with the ECEN program, and 3,450 were referred to a center for clinical evaluation. 1,700 patients have undergone joint replacement surgery. While nearly all of the 450 spine patients who presented to one of the participating centers had been

16% of patients recommended for total joint replacement by a home provider were recommended not to have surgery by COE centers. Avoiding unnecessary surgery is a significant driver of the program's long-term benefits.

The program has led to lower patient out-of-pocket costs and excellent patient satisfaction scores. The average Lowe's associate who has joint replacement surgery performed by one of the ECEN centers personally saves approximately $3,300 in copayments and other fees as compared to those patients who get the same care under traditional insurance. In an analysis of 12 month's experience, 100% of Lowe's ECEN joint surgery patients reported that they would refer co-workers or family to the program for a similar surgery. Data from The Boeing Company's experience has shown similarly high employee satisfaction.

Twelve-months claims data comparing Lowe's associates who have surgery with local providers under traditional insurance as compared to those who have surgery as part of ECEN demonstrated striking findings. 9.1% of patients having joint surgery with local providers needed discharge to a skilled nursing facility after surgery, compared to 0% of those getting care with ECEN. 5.9 % of those having lumbar spine surgery with local providers needed skilled nursing care after surgery, while 0% of ECEN patients needed that care. In addition, standard health plan participants had a 6.6% chance of being readmitted to the hospital within 30 days after joint surgery as compared to just 0.4% of ECEN patients. Savings from avoiding unnecessary surgery alone was estimated at $1.3 million. For the highest volume spine procedures, 52% of patients recommended for surgery by home providers are found by our COE providers to not be appropriate surgical candidates. More than 90% of those patients heed that recommendation and do not go on to have surgery at home through traditional insurance. Early estimates around the newer ECEN spine program have indicated savings of an additional $1 million to $2 million per year.

Employer purchased bundled payment innovations continue to expand. Prepared healthcare systems are pursuing these relationships, while others caught behind feel trepidation. Rigorous

limited resources back home, was the program really a success?"). Health Transformation Alliance is developing a scaled concept of delivering bundled, high-quality care in the metropolitan areas where patients live, while attempting to underpin the effort with robust analytics. There is a growing need for healthcare delivery systems prepared to participate in these initiatives. Given the value to patients, providers, and care purchasers, systems would be well served to recognize the value of capitalizing on these opportunities.

We are grateful to Eric Foster of Lowe's Companies, Inc. for valuable support and data for this article.

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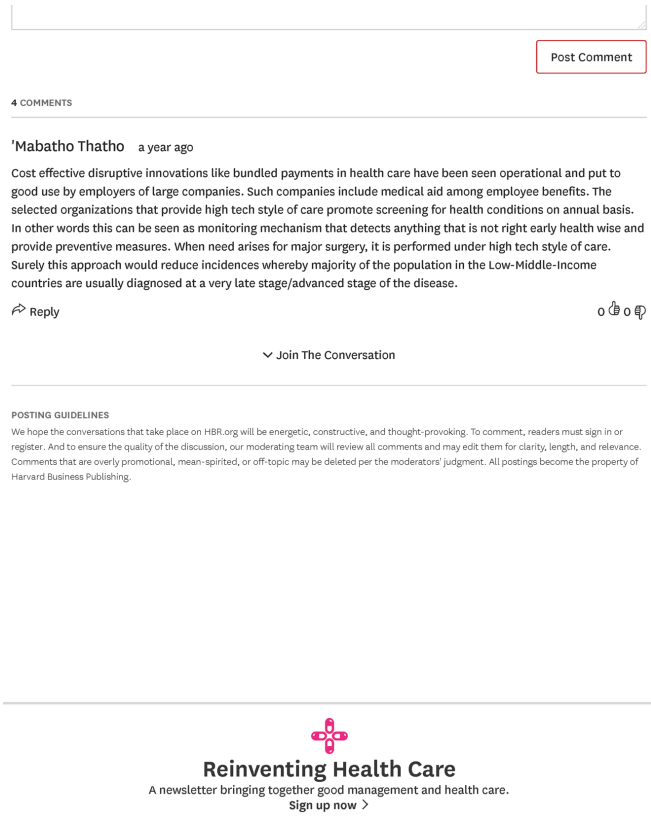

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4 COMMENTS

'Mabatho Thatho a year ago

Cost effective disruptive innovations like bundled payments in health care have been seen operational and put to good use by employers of large companies. Such companies include medical aid among employee benefits. The selected organizations that provide high tech style of care promote screening for health conditions on annual basis. In other words this can be seen as monitoring mechanism that detects anything that is not right early health wise and provide preventive measures. When need arises for major surgery, it is performed under high tech style of care. Surely this approach would reduce incidences whereby majority of the population in the Low-Middle-Income countries are usually diagnosed at a very late stage/advanced stage of the disease.

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FAMILIES USA,
June 5, 2019.

Hon. LAMAR ALEXANDER, Chairman
Hon. PATTY MURRAY, Ranking Member
U.S. Committee on Health, Education, Labor, and Pensions
Washington, DC.

CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY:

Families USA, a leading national voice for health care consumers, is dedicated to the achievement of high-quality, affordable health care and improved health for all. We write to comment on the U.S. Senate Health, Education, Labor and Pension (HELP) Committee's May 23 bipartisan discussion draft, the Lower Health Care Costs Act of 2019.

For decades, America's families have been in need of lower cost and higher quality health care. The cost of American health care is a profound economic and public health problem: 44 percent of the public report not seeing a doctor when they need to because the costs are too high; 30 percent say the cost of medical care interferes with basic needs like food, housing, and heat; and nearly two-thirds believe that, as a country, we do not get good value from the U.S. health care system.36 As a Nation, we can do better for America's families, and it is well past time for the health care system to change. Families USA commends the Senate HELP Committee on the release of the Lower Health Care Costs Act, and appreciate the Committee's attention to rising consumer health care costs.

Below are our specific comments on the draft legislation, by title. Recommended changes to the legislation are bolded in the text below. Recommendations for specific legislative text are in red.

Title 1—Ending Surprise Medical Bills

Families USA strongly supports the HELP Committee's attention to the critical consumer problem of surprise medical bills. Consumers face surprise medical bills when they receive out-of-network medical care due to no fault of their own. Whether due to an emergency visit at an out-of-network facility or unexpected care from an out-of-network provider in an in-network facility, surprise bills can be hundreds or even thousands of dollars and are all too common.36

Families USA believes that a Federal legislative solution is needed to address the problem of surprise medical bills. Consumers in every state experience this unfair problem. Even in states that have passed laws to address surprise medical bills, many consumers remain without sufficient protection, as state laws cannot fully protect consumers in self-insured plans that are regulated by the Employee Retirement Income Security Act (ERISA).36

We urge the Senate HELP Committee and the full Senate to pass legislation on surprise medical bills swiftly to protect consumers from this harmful problem while holding down health care costs overall.

Our specific comments on Title I of the legislation follow. Our comments first apply to options 1, 2, and 3 in the draft legislation overall, and we then provide comments regarding the pros and cons of the various options.

Section 102: Protection against Surprise Bills

We strongly support that the bill clearly protects consumers from paying any more toward their care than their in-network cost-sharing (including copayments, coinsurance, or deductibles) in a surprise billing situation regarding emergency services (regardless of the state in which the patient resides), non-emergency services at in-network facilities, and out-of-network services after an enrollee has been stabilized. We also support the clear indication that cost-sharing amounts count toward the in-network out-of-pocket maximum and deductible. Finally, we support the clear specification that referrals for diagnostic services are included in these protections.

Families USA strongly supports that this draft legislation applies to self-insured, ERISA-regulated plans. We read the draft legislation to apply to grandfathered plans, but the language appears ambiguous. We urge the Committee to clarify that the legislation does apply to grandfathered plans.

Regarding enrollees who are admitted to hospitals after receiving emergency services or who are in labor, we recommend the bill be strengthened as follows:

- Insert missing language on page 6, line 16 as follows: Clarify that enrollees cannot be balanced billed unless the "enrollee, once stable and in a condition safe for transport..." We believe it is critical that legislation does not put enrollees in a situation to choose between experiencing out-of-network balance billing or transit for which they are not medically ready.
- Indicate that enrollees cannot be forced to choose between balance billing and transferring to another facility unless in-network medical transport is available, or the enrollee can safely be transported by non-medical transportation. Consumers should not be set up to experience surprise ambulance bills under surprise bill legislation.
- In addition to requiring paper and electronic notification, require hospitals to provide verbal notice of enrollees' options.

We recommend the bill clarify whether the Secretary or the states serve as the primary line of enforcement for the law. If states are to enforce the law, they may

require resources and training from Federal agencies. If Federal agencies are to enforce the law, they may require additional resources for oversight and enforcement capacity.

Regarding the maintenance of state surprise billing protections, we are concerned about the potential for state laws to undermine Federal law on surprise billing and therefore leave consumers unprotected and vulnerable to premium increases. Families USA recommends permitting states to apply their own surprise bill laws, if state law is equally or more robust than Federal law, in terms of both consumer protections and a payment rate between insurers and providers that holds costs down. Specifically, we urge the Committee to clarify that Federal law applies unless, in the judgment of the Secretary:

- State law requires insurers to pay out-of-network providers a lower amount in surprise bill situations, or
- State law implements a baseball style arbitration system that forbids the consideration of billed charges.

Even if states have their own surprise billing laws, Federal law should apply to any health plans that states cannot fully regulate, such as self-insured, ERISA-regulated plans.

Section 103: In-Network Guarantee (Option 1)

A guarantee that all providers delivering care in a facility are in the same insurance network as the facility itself could greatly simplify the health care system for consumers. No longer would consumers have to worry about navigating complicated provider directories or about provider directories inaccurately indicating that providers and facilities are in the same networks. Similarly, if both the facility and provider were in the consumer's insurance network, surprise bills would be cut down dramatically for consumers.

However, the in-network guarantee model for addressing surprise bills marks a dramatic shift from the health care system as it operates currently, meaning it could also face some implementation challenges that would need to be addressed to prevent difficulties for consumers. For example, if insurers cannot contract with a health care facility unless the facility guarantees that all practitioners are in the facility's network, will there be facilities that cannot contract with insurers at all in rural areas where hospitals face great challenges attracting providers, even under current rules?

We strongly support that in this section, laboratories and diagnostic services that are referred by the health care practitioners are included in the requirements. However, it is possible that some laboratory and diagnostic providers may contract with some, but not all, of the same insurers as a referring facility. It should be appropriate for a facility to refer a patient to such a lab or diagnostic provider as long as the provider accepts the particular patient's insurance. Under the bill as written, it appears that facilities may only refer to labs or diagnostic providers who accept all insurance plans that the facility accepts. This may result in consolidation and too much market power to insurers, so we urge the Committee to modify the language to reflect alignment with a patient's insurance plan, not all insurers that a facility and providers accept.

Additionally, we believe an addition is required to this section to provide information on how a referring practitioner and facility obtain information regarding which laboratories and diagnostic providers are in-network for patients, as well as who is responsible if a lab or diagnostic provider to which a patient is referred does ultimately balance bill a patient.

We strongly support the use of the median in-network contracted rate to reimburse providers of out-of-network emergency services.

Section 103: Independent Dispute Resolution (Option 2)

Although we believe that a benchmark payment rate is an ideal way to resolve payment in surprise billing situations, as if set appropriately it is most likely to deter premium increases while minimizing administrative burden, independent dispute resolution (IDR) can also present an improvement upon the status quo. We support that the proposed independent dispute resolution process will still apply a benchmark payment rate in a large share of cases. Additionally, we are glad that the dispute resolution entity will be an unbiased entity, tied to neither insurers nor providers, and will consider the median contracted rate.

However, we recommend explicitly requiring that the IDR entity may not consider billed charges in its deliberations. Billed charges are often wildly inflated above the cost of care and what the provider has agreed to in network negotiations. As a result, considering billed charges would drive up health care costs and therefore the premiums that consumers pay.

Section 103: Benchmark for Payment (Option 3)

Due to its ability to hold down costs, and therefore protect consumers from premium inflation, and its administrative simplicity, a benchmark for payment is Families USA's recommended approach for resolving payment between insurers and providers in surprise billing situations. We support setting payments based on median in-network contracted rates. Conversely, we strongly oppose basing benchmark rates on billed charges due to its inflationary effects.

Section 106: Air Ambulance

Surprise bills for air ambulance are typically over $35,000. As air ambulance rides are usually out of network, consumers often have no ability to protect themselves from balance bills when in need of air lift.36 congressional intervention is needed to address this problem, as states are preempted from fully solving this pressing issue.

Whether in this bill or future legislation, Federal protections should hold consumers harmless from paying more than in-network cost-sharing for air ambulance transport when they have no option for in-network airlift. Additionally, Federal preemptions that prohibit state regulation of air ambulance rates and networks should be eliminated. In the meantime, greater transparency of air ambulance costs, as proposed in this draft legislation, is beneficial.

Title II—Reducing the Prices of Prescription Drugs

High and rising prices of prescription drugs impact families' access to the medicines they need and even impact their ability to afford other health services and basic necessities. Voters across the country are therefore eager for Congress to enact reforms that will rein in egregious drug costs that strain family budgets.36

Families USA supports the measures included in the legislation that lay a foundation of Federal reforms on prescription drug costs. While we support the prescription drug provisions in the Lower Health Care Costs Act, we cannot significantly reduce the escalating cost of drugs without overarching reforms that will directly lower list prices. Prescription drug reforms must directly target these prices, which drive high costs throughout the drug supply chain and health care system and keep needed medicines out of reach for families.

This bill includes many measures to bring generics to market faster, providing lower cost alternatives to costly, monopolistic brand-name drugs. Specifically, we support provisions like Section 201 and 202 that will provide greater transparency on patents for biologics, including on exclusivity periods and when they are expired, so that generic manufacturers have the timely and accurate information they need to come to market. We also support sections 203, 204, and 205, which include important measures to prevent gaming that can delay the availability of generics. We recommend that the Committee supplement these provisions, whether in this legislative package or elsewhere, with the CREATES Act and legislation to completely ban so-called "Pay for Delay" practices, which would also make important progress in bringing generic drugs to market faster.

We urge the HELP Committee and Congress to advance legislation to directly lower prescription drug prices, including by allowing the Federal Government to leverage its power to negotiate through the Medicare program. For more on this issue, please see Reining in High Prescription Drug Prices: What Families Need from Congress, by the Coalition for Fair Drug Prices, chaired by Families USA.

Title III—Improving Transparency in Health Care

Families USA strongly supports the HELP Committee's attention to the critical problem of transparency of cost and quality information in the health care system. Consumers face many barriers to being informed purchasers of health care when they do not have access to price and quality information in the health care system. We also believe that it is critical to ensure that health care providers, payers, researchers and policymakers have access to underlying cost and quality data in order to make informed and effective health care payment and delivery system policies.

While we support efforts to increase transparency of cost and quality data across the health care system, Families USA believes that transparency alone will not meaningfully bring down the costs of health care.

Section 301: Increasing Transparency by Removing Gag Clauses on Price and Quality Information

Families USA supports legislation that removes barriers to obtaining accurate and complete health care price and quality information including gag clauses included in executed contracts between insurance plan issuers and providers or provider networks. We believe that increasing the transparency of such information will not only enable consumers to be more informed purchasers of health care but it would also unveil fundamental information that policymakers, researchers and other stakeholders need in order to identify health care markets with the highest prices and then build policy that encourage competition.

Section 303: Designation of a Nongovernmental Nonprofit Transparency Organization to Lower Americans' Health Care Costs.

Families USA supports the designation of a nonprofit, nongovernmental transparency organization to support the establishment and maintenance of a data base that receives and utilizes health care cost and quality information to generate reports available to the public. The legislation could be strengthened significantly by making the following additions to the bill text:

- Specify the categories of claims data that the nongovernmental nonprofit organization will utilize to include: medical and clinical, prescription drug, dental, behavioral health, and available social services data.
- Require that price and quality data be accessible through the nongovernmental nonprofit transparency organization.
- Establish a mechanism in statute or direct the Secretary to establish a mechanism through rulemaking that will require health plans, hospitals, health care providers to share claims data with this new entity.
- Direct the Secretary to establish national interoperability standards to facilitate data sharing between health care industry entities and with state all-payer claims data bases.
- Require that the establishment of a board of directors or other governance structure over the entity includes equal representation of consumer groups in its composition.
- Require in statute that the Advisory Committee include at least one consumer health care organization, and at least one consumer group whose mission is to reduce racial/ethnic health disparities.

Section 304: Protecting Patients and Improving the Accuracy of Provider Directory Information

Inaccurate provider directories cause consumers to struggle to obtain needed medical care and to pay high out-of-network costs for care due to no fault of their own. Studies have found that for some specialties, directory information is accurate less than half of the time.

Families USA believes that congressional action is needed to guarantee that accurate, comprehensive and easily accessible information on in-network providers and facilities is available to consumers. We applaud the HELP Committee for including this issue in the Lower Health Care Costs Act. Below we outline specific recommendations for this section of the draft legislation.

Regarding the information that consumers must be able to receive on in-network providers, we recommend consumers have the ability to obtain information over the phone at their request, in addition to online. This is important for consumers who do not have Internet access or who have disabilities that may make online information challenging to receive. Additionally, we recommend that plans be required to make information on provider network status available to consumers in their preferred language.

We strongly support that plans may not charge consumers more for services than in-network cost-sharing if enrollees can demonstrate that they relied on inaccurate information in a provider directory. To ensure this section comprehensively protects patients, we recommend two additional requirements:

- Providers should be prohibited from balancing billing consumers in instances when consumers had inaccurate information about their network status. Providers should be required to provide notice about their network status at least 7 days before delivering care. If a patient does not provide advanced consent to receiving out-of-network care at least 7 days before a service, a provider should be prohibited from balance billing.
- All provider directories should be required to include a prominent notice of consumers' rights to pay no more than in-network cost-sharing if they receive out-of-network care due to a provider directory inaccuracy, and how to contact the health plan if they believe they relied on inaccurate information. Without such a notice, consumers are unlikely to know of their rights as proposed in this draft legislation.

We support requirements that plans verify and update their provider directories. However, we believe that the particular verification and update standards in the draft legislation are not strong enough to make a meaningful impact for consumers and are not in line with other common laws and regulations on provider directory accuracy. We urge modifying this section as follows:

- Require health plans to verify and update their provider directories at least monthly. This requirement was in place for Federal Marketplace plans until 2017 when CMS removed it and other related provider directory and network adequacy requirements and deferred them to states.36 We strongly support Congress instituting Federal requirements, as not all states have requirements in place. However, a monthly update and verification requirement or more stringent requirements are in place in states like California and Georgia, as well as the District of Columbia.36
- Add additional specificity on steps required to verify and update a provider directory: Most health plans already indicate they update their provider directories even more frequently than every month. Problems arise when they are only updating directories based on information they directly receive from providers, and not doing any audits of whether old information has been remaining in the directories untouched for months or even years. Provider directory updates require active processes from insurers in order to be effective. Therefore, we recommend that the legislation require the following to ensure updates and verification are meaningful:
- Require each health plan to place a prominent link and phone number on the directory where consumers can report inaccurate information. Require each health plan to investigate reports, and if applicable, remove inaccurate information within 1 month.
- Replace the requirement that plans remove providers from the online directory if providers have not verified information within 6 months with a requirement that plans proactively contact any providers who have not filed claims within the past 2 months to verify their network status. If network status cannot be verified, plans should remove the providers from the directory within 1 month of the attempt to contact the provider.
- Require an annual audit of the plan directory: At least annually, health plans should be required to do a comprehensive audit of their provider directories, contacting all providers listed and verifying their network status. Any providers who do not respond in within 2 months should be removed from the directory.

We support states enacting their own provider directory laws, if those laws are more robust than Federal law. However, we recommend clarifying that Federal law will preempt state law if state law does not provide standards that are at least as robust as those outlined in Federal law.

Section 305: Timely Bills for Patients

Families USA supports requiring health care facilities and practitioners to provide to patients a list of services rendered during the visit to that facility or practitioner prior to discharge, and that all bills are sent to patients within 30 business days. We recommend adding a requirement that the list of services provided upon discharge indicate whether each service was provided in-network or out-of-network.

Section 306: Health Plan Oversight of Pharmacy Benefit Manager Services

Pharmacy Benefit Manager (PBM) practices can contribute to the problem of high and rising drug costs that are ultimately due to large underlying drug prices set by manufacturers. We appreciate the HELP Committee's attention to PBM practices.

We strongly support providing plan sponsors clear and user-friendly information about covered drugs and utilization mechanisms for those drugs. For the requirement that group plans receive this information, we recommend adding a requirement that the information be made available to plan enrollees as well, in a reader-friendly format. This requirement should apply to individual market enrollees as well.

We support providing employers with price information about covered drugs, as well as information about the rebates that PBMs receive for those drugs. However, we are concerned about the information on employees' prescriptions that this section makes available to employers, without providing clear indications of what the information will be used for and with very limited privacy protections. We are concerned that providing employers with information about which drugs employees are prescribed, and how many employees are prescribed them, along with information as specific as prescription fills, will leave employees vulnerable to identification by their employer and potentially discrimination. Instead of providing employee prescription information to employers, we urge the Committee to instead require insurers to provide in comprehensive rate review reporting on how much they spend on drugs and how much they receive in rebates, as well as the share of rebates that are passed on to consumers, in addition to providing price and rebate information to employers.

Families USA strongly supports protecting enrollees from paying more for a drug than the actual price paid by the issuer to the pharmacy for the drug and from upcharges on drugs dispensed by pharmacies wholly owned by the issuer or PBM.

Section 308: Disclosure of Direct and Indirect Compensation for Brokers and Consultants to Employer-Sponsored Health Plans and Enrollees in Plans on the Individual Market

Greater transparency about broker compensation can help consumers and employers understand the role that compensation may have in how brokers provide information about health coverage. Families USA supports providing additional information about direct and indirect compensation that brokers receive for connecting consumers and employers to health care. We recommend that the legislation clarify that this section applies to web-based brokers and to the sale of short-term plans, association health plans, and other non-ACA complaint arrangements that may be sold by brokers.

Title IV—Improving Public Health

Families USA strongly supports the HELP Committee's attention to critical public health problems that our Nation currently faces. Maintaining a robust and effective public health infrastructure is essential to ensure that America's families have access to the health and health care they deserve. From the importance of vaccinations, to addressing the high rates of maternal mortality, to addressing the impact of discrimination on health in our health care system, we support efforts that enable our public health infrastructure to respond quickly and effectively to emerging public health challenges.

Section 401: Public Awareness Campaign on the Importance of Vaccinations

Families USA supports the development and implementation of a public awareness campaign on the importance of vaccinations. As this Committee knows well, vaccinations are a foundational component of an effective public health infrastructure for any nation to keep its citizens healthy, safe and secure. The scientific and evidence-base is clear: vaccinations greatly reduce disease, disability, death and inequity around the world, and are safe. At a time when our Nation is struggling to combat certain disease outbreaks directly resulting from lower vaccination rates in certain communities, the need for a robust public awareness campaign about the importance, safety and efficacy of vaccinations is critically important. In addition to the efforts detailed in this bill focused on at-risk populations, we also recommend that public awareness campaigns include a broad national campaign to help educate the public at large about the importance of vaccinations in protecting public health and safety, and to help maintain current vaccinations rates at the population level.

Section 403: Guide on Evidence-Based Strategies for State Health Department Obesity Prevention Programs

The obesity epidemic is a critical public health priority and an important health equity and child health issue. We applaud efforts to develop solutions for this public health challenge. However, we have several concerns about how the legislation is currently drafted. Given the disparate impact of obesity on communities of color, and the rapid growth of obesity rates in children, we would like this legislation to strengthen its focus on these populations, understanding the need for culturally tailored strategies to maximize effectiveness. Moreover, given that there are many social determinants of health that contribute to obesity, and the role of family and community in preventing obesity, we suggest that there be more input from and coordination with representatives and experts from affected communities and expertise in community engagement.

To that end, it is vital that the guide include strategies tailored to the specific populations most at need. Given the changing demographics of the Nation, ensuring that the strategies that are developed and implemented are effective in communities of color must be a high priority. No single approach will work to combat the obesity epidemic.

Further, the guide should include strategies based on evidence-informed practices, mixed method research, and community based participatory research. Evidence based medicine is the gold standard to which we all should aspire. However, we have concerns that the exclusive focus on evidence-based strategies that focus heavily on randomized control trials, while ideal, is incompatible with the current state of the evidence base in relation to addressing the health needs of women, children, and racial and ethnic minority groups. For example, Blacks and Latinos make up only 6 percent of all participants in federally funded health research even though they comprise nearly one-third of our population.

Our current evidence base does not accurately reflect which treatments work well among different racial and ethnic groups. Instead, our clinical guidelines and policies have been informed by research that only studies the average efficacy and safety of individual medications, medical devices, and treatments. While important efforts are underway to diversify participation in clinical and health systems research, the bulk of the data available is generated from non-heterogeneous studies where women, children, and racial and ethnic minorities are largely underrepresented. Therefore, in order to capture emerging evidence generated from these groups, which are badly needed given the disparate impact of obesity they face, and the need for culturally tailored strategies, we must widen the findings included in the guide to encompass evidence-informed strategies.

Finally, the strategies promoted by the guide should encompass a broader definition of interdisciplinary coordination that includes additional roles. Interdisciplinary coordination between relevant public health officials specializing in fields such as nutrition, physical activity, epidemiology, communications, and policy implementation is critical. We recommend that the list be expanded to include community health workers, and navigators.

To ensure guide includes evidence-informed strategies; culturally tailored strategies based on evidence-generated from populations that are representative of those communities; and acknowledge the importance of different intervention strategies for adults and children, we recommend the following legislative language changes:

- Amend subsection a(1) A. (page 133) to read:

"describe an integrated program structures for implementing interventions proven to be effective in preventing, controlling, and reducing obesity that include culturally tailored interventions for specific racial and ethnic groups that bear a disproportionate burden of obesity as well as specific to children; and that take into account community needs and challenges

Amend subsection a (1) B (ii) to read:

(I) the application of evidence-based and evidence informed practices to prevent, control, and reduce obesity rates

Section 404: Expanding Capacity for Health Outcomes

We support the development of award grants to expand the use of technology-enabled collaborative learning and capacity building models to increase access to health care services. Health is driven predominantly by the factors that influence health such as socioeconomic status, stable housing, employment, food security, exposure to trauma and violence and other factors. These factors are referred to as

the social determinants of health. As Congress establishes support to use new technology innovations to increase access to health care services, it is critical to include specific reference to those services not typically defined under the medical system, which are predominantly responsible for driving health outcomes. Those services include a wide range of social and human services including but not limited to housing support, nutritional assistance programs, employment services, community-based programs, child care services. In addition to the health care services outlined in Sec.404(6)(b)(18–23), we recommend that the bill text specifically include reference to social services and the social determinants of health.

Section 405: Public Health Data System Modernization Grants

Families USA strongly supports efforts to help public health departments to modernize public health data systems including enhancing interoperability of current public health data systems incorporating certified health information technology. The ability to safely and security collect, store and transfer public health data is critical to ensure the health care system is meeting the needs of the 21st century. Local health departments often lack the resources needed to invest in new technology to support a robust public health data system. Similarly, community-based organizations which are often the bedrock of the health care system and infrastructure at the community level often lack the capitol needed to make investments into health information technology and data systems.

We also believe it is critical to collect and disseminate data that is disaggregated to clearly identify variations in treatment responses that are often overlooked when only analyzing aggregated data. Disaggregating data will enable improved tailored treatment interventions that promote high-quality health care for all.

We recommend that the HELP Committee make the following changes to the bill text:

- Include community-based organizations as grant recipients to modernize their health care data systems.
- Require in statute or mandate the Secretary to establish national interoperability standards that include public health data systems and the data systems for community-based organizations to ensure these various data systems can effectively communicate with the broader health care system.
- Require in statute that the public health data modernization grants include building the capacity to collect and report data by race, ethnicity, gender, sexual orientation, and disability status.

Section 406: Innovation for Maternal Health

We support the efforts to address the high rates of maternal mortality in the United States and to improve maternal health. The wealthiest nation in the world can do better to ensure the health and well-being of our mothers. Importantly, racial and ethnic minorities have significantly worse maternal and infant health outcomes even when compared to their white counterparts of the same socioeconomic status. Black women are twice as likely to suffer from severe maternal morbidity or experience infant mortality when compared to non-Hispanic whites. We recommend adding language to prioritize activity that is culturally tailored to the racial and ethnic groups that are disproportionately affected by poor maternal and infant health outcomes.

Additionally, we want to ensure that new programs to improve maternal health outcomes address the importance of oral health. Oral health coverage and oral health care are critical to supporting a woman's overall health and the health of her pregnancy. Untreated oral disease has been shown to be linked with various pregnancy complications, like preeclampsia, preterm birth, and low birth weight infants. Research has also established that a woman's oral health status during pregnancy is a good predictor of her future child's risk for developing oral disease. We recommend specifically including oral health in the establishment of best practices or implementation of programs to improve maternal health outcomes both during pregnancy and postpartum.

Section 408: Study on Training to Reduce and Prevent Discrimination

We applaud the efforts to conduct a study on training to reduce and prevent discrimination in the health care system. Establishing training that reduces and prevents discrimination and mitigates implicit bias is a key strategy for reducing

health inequities. This type of training should be implemented throughout the provision of all health care services since racial discrimination is at the root cause of health inequities. We recommend including this type of training throughout the provision of all health care services. It is critical that everyone who is involved with delivering health care services takes part in these trainings since care coordination is a necessity in delivering equitable care. We also recommend including a clear definition of health professional training programs.

Title V—Improving the Exchange of Health Information

Families USA strongly supports the HELP Committee's attention to improving the exchange of health information. We believe that to ensure good health and high-quality health care, consumers, providers, policymakers, insurers and payers must be equipped with the tools to address the factors that influence health. Those factors extend beyond the medical system, where we know that only 10 percent of a person's health is influenced by clinical care. While 60 percent of factors that influence health are based on social and environmental factors. The health care data system should be equipped to be interoperable across the factors that influence health. Families USA believes that we must modernize our health care data system to meet the needs of consumers, health care providers, payers, researchers and policymakers in the 21st century and beyond. As the health care data system is modernized, Families USA believes that it is critical to ensure that the privacy of consumers is protected and preserved, and that public trust and confidence in health information technology and health information exchanges is held to the highest standard.

Section 501: Requirement to Provide Health Claims, network and Cost Information

We support efforts to require payers to share certain data with patients through application programming interfaces (API). A robust data system incorporating APIs will enable consumers to access health care data from multiple health care providers including hospitals, providing them with a comprehensive view of their health and health care. Historical claims, provider encounter and payment data for each enrollee is an important step. A recent Centers for Medicare & Medicaid Services (CMS) proposed rule, if finalized in its current form, would require payers to make the following data sets available through APIs:

- Adjudicated claims (including cost);
- Encounters with capitated providers;
- Provider remittances;
- Enrollee cost-sharing;
- Clinical data, including laboratory results (where available);
- Provider directory data;
- Drug benefit data including pharmacy directory and formulary data.

While this list of data sets are comprehensive, it does not include specific cost and pricing information. Congress is keenly aware of the high and rising costs of health care in the United States. These uncontrolled costs threaten the affordability of care for families, seniors and children, and create unsustainable budget pressures on the Federal Government and state governments. As the largest single payer, Medicare rates are often used as a standard upon which private payers and providers negotiate prices without transparency and oversight by the public. Payment rates in private insurance are often substantially more than what Medicare pays for services. Further, we know that payment rates not only vary by payer but also that there is considerable variation in payment rates across geographic areas and within health care markets.

There are several actions Congress could take to address price distortions which fall outside the scope of this bill. Within the scope of this bill, however, Congress could mandate substantially improved price transparency. Requiring payers to include price and cost data through APIs would be a groundbreaking development that would not only enable consumers to be more informed purchasers of health care but would also unveil critical information that policymakers, researchers and other stakeholders need to inform better payment policies. To be consistent with the CMS proposed rule, we recommend including language that requires payers (including dental plans) to include the following data sets price and cost data:

- Adjudicated claims (including cost);
- Encounters with capitated providers;
- Provider remittances;

- Enrollee cost-sharing;
- Clinical data, including laboratory results (where available);
- Provider directory data;
- Drug benefit data including pharmacy directory and formulary data
- Dental claims data

While we support requiring payers to provide data to consumers through APIs, we have serious concerns about the oversight over third-party apps to ensure that consumers privacy is protected and preserved, and that public trust and confidence in health information technology and health information exchanges are not eroded. Third-party apps are notorious for their lackluster effectiveness in protecting and securing consumer data. With the rapid proliferation of health technology innovations over the last decade, it is critical that third-party apps and any other entities that may be involved with consumer health data are subject to the highest standards of protection and security for consumer health data. We recommend the bill text stipulate that HIPAA be used as a framework for a comprehensive privacy structure for third party apps and any new entities that would create, store or transfer health care data.

Strengthening the regulatory framework for the health technology innovations of today, and the future, must clearly define who governs and controls health data; who has access to it; which entities are responsible for protecting and securing the data; and the extent to which these data and data systems will be interoperable with the health data systems within the health care system. Federal laws and regulations have not kept pace with rapid innovations in health technology. The existing health data regulatory infrastructure already contains significant gaps in the privacy and protection of patient-generated and personally identifiable data. Decisions about whether or not these data are subject to HIPAA's privacy and security protections is dependent on the role of a covered entity in creating or storing the data for a particular patient. The emergence of new health technology innovations will continue to challenge the existing regulatory framework. We recommend including language mandating the Secretary be responsible for strengthening the regulatory framework and infrastructure needed to operate an efficient, effective, interoperable health care data system that protects and secures consumers health data and maintains the highest level of public trust in health care data systems and information exchanges for the 21st century and beyond.

We further recommend mandating the Secretary to develop national interoperability standards for which all payers are required to participate.

Conclusion

Thank you for the opportunity to comment on this discussion draft of the Lower Health Care Costs Act of 2019. We greatly appreciate the Committee's efforts to increase access to affordable, high-quality health care for everyone. We commend you for your leadership, and we look forward to working with the Committee again on this important issue.

Sincerely,

SHAWN GREMMINGER,
Senior Director of Federal Relations.

[Whereupon, at 11:51 a.m., the hearing was adjourned.]

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