COMMISSIONER OF SECURITIES & INSURANCE

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OFFICE OF THE
MONTANA STATE AUDITOR

Written Testimony of Marilyn Bartlett, June 18, 2019

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 cancelled 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% is huge. According to CMS, US pharmacy drug spending in the privately insured market is $140 billion; a 23% 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.

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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% 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.

Respectfully,

Marilyn Bartlett