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

July 17, 2018

**Reducing Health Care Costs:**
**Eliminating Excess Health Care Spending and Improving Quality and Value for Patients**

David Lansky, Ph.D.
President and CEO
Pacific Business Group on Health
San Francisco, California

Written Testimony

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

My name is David Lansky. I am the President and CEO of the Pacific Business Group on Health, a coalition of large public and private purchasers of health care. Together our members spend $100 billion each year to sponsor health care coverage for about 12 million Americans. They expect – reasonably – that this enormous investment will assure that their employees and their families receive high quality, appropriate and effective care that enables the workforce to be healthy and productive. Unfortunately, the data needed to judge whether services are being delivered efficiently and whether optimal health outcomes are achieved are not available. As a result, neither consumers nor purchasers can identify and reward high quality care, and health care providers and suppliers are given little incentive to compete or continuously improve their performance. We believe that the techniques of value purchasing could drive the evolution of a more efficient and effective health system, but that these approaches will not be fully effective until we have meaningful transparency of cost and outcomes data. Government action will be needed first to create that information infrastructure and second to use federal purchasing power to drive value-based competition.

**Employers' Understanding of the Problem**

Our members share the commitment of Congress and the Administration to address the cost of health care, in part by accelerating the shift to value-based health care based on meaningful, transparent outcomes and pricing information. Because private employers and their employees pay for about half of US health care, and public programs pay for half, it is imperative that policymakers collaborate with public and private purchasers to deploy value

based purchasing strategies that convey consistent signals to the health care industry. The most important points I want to make today are:

- Cost-effective delivery of high quality care is possible and should be expected and rewarded.
- The successful methods for supporting high-performing health care are known.
- Public and private purchasers must be aligned in deploying these methods in order to send consistent signals to the healthcare industry.

**Effective Employer Strategies to Reduce Costs**

Employers and public agencies responsible for assuring that effective medical care is provided to their population have worked aggressively to improve the quality of care while stabilizing or reducing spending. While each of these four approaches have been successful, they can only be brought to scale, and achieve deep impact on the health care economy as a whole, if supported by both public and private purchasing programs.

- Procurement and payment change: We share the general view that fee-for-service and fragmentary payment systems have encouraged practices that work against patient-centered, coordinated, effective, and efficient care. Our members have begun migrating to models that create rewards for doctors and hospitals based on achieving good patient outcomes while taking responsibility for the efficient use of resources. These models fall into several categories, including bundled payments, direct primary care, and population-based models such as Accountable Care Organizations. Many of our members, as very large purchasers, have found that they can achieve more effective payment and delivery arrangements by working directly with provider organizations rather than through large insurance carriers. The direct contracting approach allows purchasers to evaluate and identify organizations who can demonstrate a track record of excellent and cost-effective care, and to enter into financial arrangements where the plan sponsor, the patient, and the provider organization share the benefit of cost-effective care. Good examples include our efforts to shift payment for maternity care to longitudinal bundles or blended case rates in California, and the work of Intel and Boeing to contract directly with provider organizations in Seattle, Albuquerque, Charleston, Southern California and St. Louis. In the case of maternity bundles, we are observing savings of 20% compared to traditional payment; our centers of excellence bundles achieve total cost of care savings of 10-15%; the population based contracts between large employers and ACOs have generated significant savings compared to market trends. These experiences lead us to encourage CMS, CMMI and Congress to continue the early efforts in value-based payment exemplified by the Comprehensive Joint Replacement, Oncology Care Model, and Comprehensive Primary Care programs. CMMI should be supported in its efforts to design and test payment and improvement models that drive greater value.
- Consumer incentives. Employers use several techniques to encourage their employees and family members to use health care services appropriately. In our Employers Centers

of Excellence Network (ECEN) program, employees of Walmart and Lowes stores, for example, face zero cost-sharing if they choose to go to a carefully selected, high quality hospital for surgery. About 25% of qualifying patients choose to use these high performing centers. Employees covered by Safeway stores and CalPERS face financial disincentives meant to discourage use of low-value providers: if they choose the high cost provider, they must pay the full cost of care above a market-set reference price. CalPERS found that 21% of employees switched to a lower cost hospital when the reference price approach was introduced.[1] Purchasers believe there is an appropriate balance of roles between the employer and the patient: the employer has the expertise to identify high performing programs and offer modest incentives for their use, and the patient should have the information and incentives to make the right decision for themselves. We believe that similar principles could apply to many public programs.

- Transparency and Performance Information. Most PBGH members have provided cost and quality transparency information to their employees, particularly in programs that include high deductible health plans. There remain significant concerns about the usefulness of these tools and the level of consumer engagement, however. To be valuable, such information needs to fully reflect the cost 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. The commonly available tools do not capture all of this information. Patients also want to know what outcomes they can expect from care, and whether outcomes vary across providers. We are strong advocates for the adoption of patient reported outcome measures across full markets. To demonstrate the value of this approach, PBGH led the creation of the California Joint Replacement Registry (now part of the American Joint Replacement Registry), which captured patients' pain, functioning and health status following knee and hip surgery for 41 hospitals. PBGH is now collaborating with the International Consortium of Health Outcomes Measurement to implement standard outcome measures in the United States, with an initial focus on oncology outcome measures throughout Michigan. In short, purchasers want to see meaningful price transparency that reflects total cost of care and the complexities of our payment and cost-sharing systems, and they want to see widespread availability of meaningful outcome measures.
- Implementation of care improvement models: For many years, purchasers subscribed to the "managed competition" model, which held that the purchaser's role was to hold the health plan or provider system accountable for outcomes and total cost of care for a population, and then allow providers to compete for business against those standard metrics. Most of the contracting approaches described above reflect that approach: it is not the employer's business to tell the providers how to deliver care. But this view has changed in recent years. Many of our members now engage quite vigorously with

[1] James C. Robinson and Timothy T. Brown. Increases In Consumer Cost Sharing Redirect Patient Volumes And

their provider partners to ensure conformity to evidence based guidelines, or even to offer training and improvement support to the providers. For both large health systems and small physician practices, we have learned that the expertise to analyze data, identify opportunities for improvement, and bring in the necessary training and collaboration resources are often lacking. As a result, individual employers like Intel and multi-employer collaboratives are now more prescriptive about improvement priorities, methods, and measures. PBGH operates the California Quality Collaborative for this purpose, and has led implementation of a CMMI-sponsored practice transformation initiative for 5,000 physicians in California; our colleagues at the Health Transformation Alliance have recommended specific diabetes and orthopedics protocols to their contracted providers; in our centers of excellence network, we convene all participating hospitals and their surgeons annually to compare best practices across the network. Our recognition that purchasers need to engage actively with their provider partners to ensure that best clinical practices are adopted has a corollary in federal programs. It will be important to tie together the federal investments in payment reform, quality metrics, and improvement support if we want to see significant transformation in quality, efficiency and accountability.

In addition, I will mention purchasers' increasing interest in encouraging federal programs to observe and adopt best practices from successful private sector efforts. Employers and public purchasers have learned that they are too fragmented and lack the scale to compel changes in the nation's approach to health care payment or measurement. They share a vision of a health system in which providers compete for our business by succeeding at providing high quality care while making efficient use of resources. But the continuing prevalence of volume-based payments coupled with a chaotic and burdensome measurement environment, as well as the persistence of a regulatory regime originally designed to manage a traditional medical indemnity system makes it impossible to achieve meaningful competition and the likely price discipline that could result. For that reason, employers are enthusiastic about aligning strategies with large state and federal health care purchasers. PBGH supports a significant public policy effort, which includes programs to bring employers to Washington to share lessons learned about emergent purchasing strategies, a collaborative effort between employers, consumer and patient organizations to respond to proposed innovation models and rulemaking, and active participation on advisory bodies at the Congressional Budget Office, National Quality Forum and similar programs.

**Purchasers' Recommendations for Policy Action**

We encourage your attention to three main policy approaches that provide significant opportunities to reduce costs and improve quality: transparency of health outcomes, strengthening the ACO and bundled payment programs, and encouraging centers of excellence in Medicare. Employers also encourage Congress to consider several additional measures to accelerate the shift to value, addressing primary care, high drug costs, and competitive markets.

1. Require outcomes-oriented quality measures for priority conditions: CMS has taken tentative steps towards reducing the burden of quality measurement by increasing the use of outcomes measures, but such efforts must be dramatically increased and accelerated. The federal government can act quickly in three ways:
    a. Develop the national infrastructure for measurement of outcomes across all major conditions
    b. Simplify the quality reporting requirements under MACRA to emphasize standardized outcome measures for each condition
    c. Require the adoption and publication of outcomes data for all federal payment programs.
2. Strengthen the ACO and bundled payment programs to increase provider risk for total cost of care: Although accountable care organizations (ACOs) were initially introduced in the Medicare program, large employers have aggressively promoted advanced ACO models. For example, the Boeing Company is contracting directly with accountable care organizations through its "Preferred Partnership" program. Launched in 2015, Boeing offers direct employer-to-ACO contracts to more than 60,000 employees and their families in California[2], Missouri, South Carolina, and Washington.[3] All of these arrangements feature two-sided financial risk with shared savings for reduced costs and improved quality and downside risk if total costs exceed the targeted trend. Additionally, Boeing negotiates performance standards for a priority set of metrics, including clinical quality, member experience and access to care. Furthermore, Boeing expects the ACOs to offer an intensive outpatient care (IOCP) program to manage the care for medically complex patients. The experience from ACOs led by large employers provides lessons that can be applied to Medicare ACOs:
    a. Patients should be given the opportunity to actively enroll in ACOs, rather than being passively "attributed" to health systems.
    b. The most successful ACO models include "two-sided risk" – that is, they give providers the opportunity to share in savings if costs go down, as well as the risk of having to cover costs if total costs go up
    c. ACOs should be held accountable to a robust, standardized and publicly-reported set of outcomes-oriented quality measures that enable consumers to make an informed choice when choosing to enroll.
3. Enable Medicare beneficiaries to identify and seek care from high performing centers: In recent years, centers of excellence (CoE) have become a common feature of commercial insurance and private purchaser medical care networks. Nearly 90% of large employers expect to use such centers to improve quality of care and predictability of cost for their employees.[4] Commercial CoE programs have primarily been used for

---

[2] *Boeing and MemorialCare Partner on Boeing's First California Customized Health Plan Option Offering Better Benefits and Lower Costs for Boeing Employees and Their Families.* Press Release, June 21, 2016. https://www.memorialcare.org/about/pressroom/news/boeing-and-memorialcare-partner-boeing-first-california-customized-health-plan.

[3] M. Stempniak, *Will Boeing Change Health Care?* (Hospitals & Health Networks magazine, December 10, 2015) https://www.hhnmag.com/articles/6709-will-boeing-change-health-care.

[4] National Business Group on Health, *Large Employers' 2018 Health Care Strategy and Plan Design Survey.*

common elective procedures and certain medical conditions with high costs and variability in quality and price, including hip and knee replacements, spine care, heart surgery, bariatric surgery, and some oncology services.[5]

The Employers Centers of Excellence Network (ECEN) – managed by PBGH on behalf of our members -- has shown significant improvements in health outcomes and costs.[6] 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. Furthermore, 98 percent of patients recommend the ECEN program.

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

- Better health outcomes than typically achieved by FFS 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.

Furthermore, the procedures and conditions that are most commonly included in CoEs – orthopedics, cardiac care, cancer care, and diabetes -- are among those that affect many Medicare beneficiaries and constitute a large proportion of Medicare spending.

For a CoE program to be introduced in Medicare, however, several regulatory, administrative, and political obstacles need to be addressed. To address these issues, CMMI should consider development of a voluntary CoE pilot with an appropriate evaluation design to determine the benefits of CoEs for Medicare beneficiaries. A CoE pilot would enable CMMI to test bundled payment models as part of a comprehensive quality improvement program rather than a standalone test of a new provider payment model. Furthermore, the voluntary nature of a CoE pilot (for providers as well as beneficiaries) would address CMMI's concerns about "mandatory" bundled payment models. The use of benefit design under Medicare to reward patients who choose high-performing providers would set an important precedent and be a disruptive force in the

---

https://www.businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=334

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

[6] 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.

health care system. 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.

These three policy initiatives would send a profound signal to health care providers, suppliers, and payers. They should be designed in close alignment with state and private purchasers. Employers also encourage Congress to consider several additional measures to accelerate the shift to value, addressing primary care, high drug costs, and market consolidation.

4. Primary Care

The decisions made in primary care practices have outsize influence on downstream medical care. A Stanford University study published last year showed that high value primary care for a commercially insured population can lead to spending that is 28% lower than average value primary care. The savings are clustered in four areas: unnecessary surgical and other specialty procedures (41%), low value prescribing (26%), avoidable hospitalizations and ED visits (17%), and unnecessary testing (8%). The high value primary care practices did see their patients more often, resulting in higher spending on office visits, but only by 2%. Rebalancing spending away from specialists and the hospital setting and towards primary care in the community is important. Employers encourage their employees and dependents to affiliate with effective primary care practices, but we are concerned that the national imbalance between primary and specialty care can only be corrected with strong signals from the Medicare program. Three policy changes would significantly strengthen the primary care foundation of our health care system:

1. Develop and implement alternative payment models that support advanced primary care delivery. For example, the American Academy of Family Physicians (AAFP) has proposed a payment model for comprehensive care management and coordination, including payments for services not traditionally covered by Medicare (e.g., non-face-to-face services), with financial accountability for quality outcomes and total cost of care.
2. 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.
3. Promote the uptake of direct primary care (DPC), which would allow patients to use their HSA dollars to pay the fixed fees charged by DPC practices. Several bill under consideration in Congress, including S. 1358 – Primary Care Enhancement Act, would address this need.

5. Drug Costs

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.[7]

Large employers are struggling with this cost burden, and they 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, increase healthy market competition, and make use of value-based payment models.

One serious problem that employers are trying to address is the distortion introduced by rebates. Rebates distort the market by encouraging drug companies to increase list prices to allow for higher rebates for PBM/PDPs. Because patient cost sharing is typically calculated based on the list price, a higher list price causes patient cost sharing to increase. Because drugs with higher list prices generate higher rebates for PBMs, they are likely to include them on the formularies in a favorable tier. One example of this waste is having a branded, expensive drug on the formulary when there are cheaper generics available. Rebates may also provide an incentive for the PBM to favor less clinically effective branded drugs over competitors with lower rebates. Finally, the rebates encourage more drug use because the rebates are based on volume. We can see these inefficiencies by looking at the existing formularies and seeing that nearly all PBM/PDPs include branded drugs on their formularies when generics are available. We estimate that a "waste free" formulary – based on clinical evidence and rigorous benefit/cost analysis -- would reduce drug spending by between 8% and 15% with no adverse effects on patient outcomes. Large employers are beginning to develop and test the use of a "waste-free" formulary, and the lessons from these initiatives will be relevant to Medicare drug pricing policy.

A second approach to address the problem is being initiated by large employers: inclusion of drug costs in accountable care arrangements. Instead of financing drug benefits separately from other health care services, these arrangements integrate drug cost management into the comprehensive quality and cost management of health care. Specifically, this means that the health systems and provider groups accept responsibility and accountability for the total cost of care – including drugs – as well as quality outcomes. The provider systems are in a better position to evaluate the benefits of drugs and make the appropriate decisions regarding drug treatment vs. other treatments. This puts the accountability for clinical and cost decisions in the right place, and it is more likely to result in lower overall costs and improved quality. Applying this approach in Medicare is challenging due to the separation of Part D from Parts A and B, but we encourage CMS to experiment with integrated payment arrangements, which

[7] 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).

may point the way for legislative changes to integrate drugs with other health benefits under Medicare.

6. Competitive Markets

In addition to these four specific areas, there is a systemic 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."8 A recent Kaiser Health News article commented specifically on the problem of high hospital prices in California.9
- 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.[10]

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, but real competition no longer exists in many markets. Government action may be 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. Several recent articles and reports describe potential policy solutions.[11] [12] [13] [14] Among the potential policy steps, the following appear to be the most promising and feasible.

- Site-neutral payments

[8] 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

[9] 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/

[10] 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

[11] Thomas L. Greaney, "Coping With Concentration", Health Affairs 36, no.9 (2017):1564-1571. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0558

[12] National Academy of Social Insurance, "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets", April 2015. https://www.nasi.org/sites/default/files/research/Addressing_Pricing_Power_in_Health_Care_Markets.pdf

[13] Leemore S. Dafny and Thomas H. Lee, MD., "Health Care Needs Real Competition", Harvard Business Review, December 2016, pp. 76-87. https://hbr.org/2016/12/health-care-needs-real-competition

[14] Martin Gaynor, Farzad Mostashari, and Paul Ginsburg, "Making health care markets work: Competition policy for health care. Brookings Institution, April 13, 2017. https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/

- Transparency and standardized provider performance reporting
- Promotion of entry of new competitors/reduction of barriers to entry
- Prohibition of anti-competitive practices, e.g., anti-tiering, anti-steering, and gag clauses.

**Summary**

Pacific Business Group on Health represents over 60 large health care purchasers who collectively spend close to $100 billion each year to provide health coverage for about 12 million Americans. Our members – large employers and public agencies - are deeply concerned about the growth in health care costs. Purchasers believe that aggressive implementation of value based purchasing approaches by both public and private sectors could lead to reduced health care spending and improved quality. 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.

The Congress and federal agencies need to provide leadership to this process, by accelerating adoption of the necessary standards, infrastructure, and purchasing models. Key actions include:

1. Develop the national infrastructure for measurement of outcomes across all major conditions
2. Simplify the quality reporting requirements under MACRA to emphasize standardized outcome measures for each condition
3. Require the adoption and publication of outcomes data for all federal payment programs
4. Strengthen the ACO and bundled payment programs to increase provider risk for total cost of care
5. Enable Medicare beneficiaries to identify and seek care from high performing centers

The Medicare, state Medicaid and employee programs, and private purchasers must act in concert to convey a consistent expectation to providers and suppliers. Together, they can deploy a portfolio of high-leverage tools that can reduce health care spending while also assuring that more Americans receive high quality care. Implementation of these and other methods will take time and inflict some pain on important stakeholders. Yet the vitality of our economy, the solvency of our treasury, and the welfare of all Americans depend upon our aligned efforts.