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Health, Education, Labor and Pensions Hearing:
Reducing Health Care Costs: Improving Affordability through Innovation

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Employer Innovations that Reduce Health Care Costs

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Written Testimony

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

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

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

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

Pooling Purchasing Power to Contract Directly with Providers

The Alliance was founded for the purpose of uniting employers to contract directly with hospitals and doctors. We are not jumbo employers. We range in size from 60 to 8,700 employees, with an average of about 400 employees. But together we spend $780 million on health care every year.

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

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

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

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

Investing in High Value Primary Care

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

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

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

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

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

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

In addition to stabilizing the cost of health care outside of the clinic, Flambeau's onsite clinic staff has identified hundreds of undiagnosed conditions, performed hundreds of preventive exams on employees who wouldn't normally get them and increased medication adherence for chronic conditions by dispensing maintenance medications, all of which improves health, increases productivity and decreases absenteeism. Two years ago, they added chiropractic care and low-cost massages, taking the employee appreciation of the onsite clinic to new heights.

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

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

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

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

Finally, while onsite and shared-site clinics show promise to deliver better results at lower total cost, this "parallel universe" does little to improve the health care system in a community. For this reason, we are also developing new models to pay for primary care within the current system. Payments that are based

on patient health status and the total cost of care, as opposed to traditional fee for service models, could be effective in building needed capabilities in primary care.

Moving Market Share to High Value Providers

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

QualityPath®

The Alliance is overcoming these barriers through our *QualityPath®* program. *QualityPath* encourages employees to use high value providers for "shop-able" surgeries and tests, like knee and hip replacements, CTs and MRIs. *QualityPath* is a voluntary program whose promise is better outcomes and lower costs for employees and employers and increased market share for providers.

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

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

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

Incentives to use low cost providers

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

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

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

service. For instance a simple MRI of the lower leg can cost anywhere from $950 to $4,750 within 25 miles of Madison.

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

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

Recommended Federal Policy Reforms

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

1. Make timely information on health care cost and quality more available so that employers and their employees can understand and use the information.
2. Repeal the Cadillac Tax.
3. Enable employers to offer HSAs in addition to value-based benefit design components, such as free access to onsite clinics, and co-pay and deductible waivers for high value care.
4. Clarify wellness rules.
5. Maintain momentum of value-based payment policies.

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

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

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

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

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

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

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

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

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

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

2. Repeal the Cadillac Tax

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

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

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

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

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

4. Clarify Wellness Rules

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

Unfortunately, last year a federal court struck down these EEOC rules, citing that 30% was too great an incentive to be considered voluntary. The court remanded the EEOC to rewrite wellness program rules to meet a voluntary threshold, but the court's order did not define "voluntary". Current EEOC rules will

expire at the end of 2018, yet to date, the EEOC has not issued new rules. Without clear guidance, employers risk running afoul of the EEOC. To avoid this risk, some employers are pulling back from the use of meaningful and effective incentives to encourage good health habits.

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

5. Maintain momentum of value-based payment policies

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

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

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

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

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