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THE AMERICAN BENEFITS COUNCIL'S WRITTEN STATEMENT FOR THE RECORD:

U.S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS HEARING ON HOW TO REDUCE HEALTH CARE COSTS

The American Benefits Council ("the Council") applauds the Senate Committee on Health, Education, Labor and Pensions for holding a hearing focusing on how to reduce health care costs. Frustrated by paying for the volume of health services delivered rather than the value received, and by the uncoordinated and fragmented care their workers receive, employers are taking meaningful action to reduce health care cost and improve quality. This is the message of **Leading the Way: Employer Innovations in Health Coverage**, a recent report from the Council and Mercer.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

According to the U.S. Census Bureau, more than 178 million Americans currently have employer-sponsored health coverage – over half of all Americans. On average, employers pay 82 percent of the cost of coverage. In fact, when we compared the total amount employers paid for group health insurance in 2016 ($691.3 billion) to the value of the tax expenditure that same year ($155.3 billion), we found that employees received $4.45 worth of benefits for every $1 of forgone tax revenue. In other words, for every $1 of tax expenditure employers spent $4.45 to finance health benefits.

To provide this value to working families and taxpayers, employers turn to innovation by both design and necessity. Employers play a critical role in the health

care system, leveraging purchasing power, market efficiencies and plan design innovations to provide comprehensive health coverage at a fraction of the cost to government compared to federal programs. Despite employers playing such a significant role in the health care market, policy debates have too often ignored them. Some policymakers subscribe to the myth that employers don't feel the need to manage their own health care spending. That they don't seek more cost-efficient health plans. That they don't work to ensure quality of care. That they don't innovate. To the contrary, employers are working diligently to slow cost growth while still ensuring employees and their families have access to high-quality care. Indeed, they are at the forefront of improving America's health care system through innovative strategies and value-based solutions.

Today's hearing is intended to provide direction on how to reduce health care costs and gain a better understanding of the cost of health care in America. Employers know well the challenge of reducing health care costs. Their efforts and their successes shed light on the drivers of health care costs and can help lead the way toward lower prices and better quality in the nation's health care system. In partnership with Mercer, the Council has composed a playbook of some of employers' most innovative strategies that demonstrates employers' commitment to leading the way.

As detailed in Leading the Way, employers have pioneered strategies that directly address the biggest cost drivers in the US health care system: the relatively small number of high-cost claims that drive such a large percentage of spending, increasing unit prices resulting from marketplace consolidation, misplaced incentives, waste, inefficiency, uneven quality of care and lack of transparency. The IDEA Institute (Innovations in Design, Employers in Action), a new website hosted by the Council, includes these and other stories, and will be continually updated.

Many of these employer innovations have met with startling success and — if scaled and encouraged — have the potential to fundamentally improve the health care system as a whole. The ability to achieve large-scale improvements to our health care system exponentially increases when private sector employers are working hand in glove with policy makers and public payers (like Medicare, Medicaid, State Employee Health Plans, Office of Personnel Management/FEHBP and the exchanges) to implement these innovations. We hope that your focus on reducing health care costs will help lead the way to larger-scale success.

We recognize that a key piece of solving the health care cost and quality puzzle remains a lack of price and quality transparency. As such, the Council's long-term strategic plan, published in 2014, "2020 Vision: Flexibility and the Future of Employee Benefits" included this recommendation:

> *Support greater quality and price transparency in the health care system. Meaningful information on price and quality is often hard to capture and adjusting for the clinical complexity of individual cases is difficult. Despite these challenges, greater transparency of*

quality and price information is important and urgently needed. Employees should have quality and cost calculators and other tools that provide enrollees with specific data about the quality and total out-of-pocket costs of certain services. Public policy should not impede employers' access to information needed to design and operate their plans and to help employees use these tools.

Unfortunately, many transparency tools don't enable patients to view specific quality information at the provider level and prices tend to be estimates. Change is needed in the way that data is aggregated and utilized to better inform health care decision-making. Collecting the relevant data is no doubt important, but perhaps even more important is ensuring that data is presented to consumers in meaningful and actionable ways.

Health care transparency, while a key component of reducing health care costs, is a means to an end, not an end in and of itself. Simply having participants know the cost and potential benefits will not necessarily drive behavior change. Only when the system incentivizes behavioral change will the transformation to higher-value health care at lower costs take hold.

The following is a brief summary of the paper and a set of policy recommendations designed to support ongoing employer innovation.

CHANGING THE WAY PROVIDERS ARE PAID TO ACHIEVE LOWER COST, BETTER VALUE

Intel contracted with health systems in key markets to create accountable care organizations in which payment reflects performance on cost, quality and patient experience measures. With an emphasis on care coordination, **the Connected Care program is achieving higher member satisfaction, lower cost trend and overall lower spending per member.**

ARLP is combating opaque pricing and inconsistent care by partnering with facilities that have proven track records in performing services for contracted prices. For example, **an outpatient facility will perform a knee replacement for $27,000, whereas a local hospital might charge $87,000.** ARLP pays members' travel expenses.

The Alliance (a not-for-profit employer-owned cooperative) steers members to centers of excellence and high-performance networks by offering an optional richer benefit and a patient experience manager to assist with the process. Providers meet quality criteria and are reimbursed using prospective payment bundles. **Savings have been significant — on average, $12,000 for a joint replacement surgery and 20% for imaging.**

FINDING THE RIGHT SITE FOR CARE

The National Rural Electric Cooperative Association stepped up management of high-cost specialty medications to prevent waste and improve the patient experience by moving all specialty drugs under the pharmacy benefit. Patients are connected with a specialty pharmacy team to improve adherence and ensure medications are dispensed in the most cost-effective setting — sometimes the patient's home. **The program saved $1.3 million in 2016.**

A brokerage provides employees and family members with free 24/7 access to onsite or near-site clinics offering primary care services and generic drug dispensing. The clinic accepts a fixed per member per month payment averaging less than $100 as payment in full. **The reduction in emergency room and urgent care utilization has produced significant savings** — from 10%–30% in actual health care spend.

SUPPORTING EMPLOYEES IN NAVIGATING THE HEALTH SYSTEM

Princeton University implemented an expert medical opinion (EMO) program when it learned that few employees sought second opinions, even when facing major surgery. Now over 20% of patients using the EMO program receive a different diagnosis, and two-thirds receive another treatment option to consider. One way this saves money: **The number of back, hip and knee surgeries has dropped for two years in a row.**

Walgreens shifted the burden of finding quality, cost-effective providers from plan members to care coordinators within the health plan. These coordinators discuss options and costs with members, who can earn cash incentives to choose lower-cost providers. The health plan is incentivized as well, with a percentage of savings relative to market trend. **The program expected to save 4% of total medical claims.**

Boeing is removing barriers to behavioral health care. Through an innovative program in several of Boeing's accountable care organizations, primary care doctors can consult directly with a psychiatrist's office during a patient's office visit — **a collaborative care model that produces better outcomes.** A new program will provide members with same-day telephone or video access to a psychiatrist or doctoral psychologist for free.

IMPROVING EMPLOYEE HEALTH WITH TARGETED PROGRAMS

A tech company found that users of infertility services incurred far higher maternity and newborn claims. By carving out infertility services to a specialty program, **the rate of multiple births from IVF has dropped to less than 3%, whereas the national**

average is 22%. The cost for a multiple birth averages about $145,000, compared to about $17,000 for a single birth. User satisfaction is very high.

A Fortune 50 retailer used two targeted programs to provide the right support to members with diabetes and those identified as prediabetic. With strong engagement in the programs, **growth in claims related to diabetes, which had risen 20% in the two years prior to program implementation, slowed to just 5%.**

BorgWarner takes a holistic approach to wellness, with an array of programs including health assessments, coaching, clinical programs and access to a health advocate as members' first point of contact. **The company's medical claims are 5% lower than the health plan's book of business, which translates to savings of $3.8 million per year.**

HOW POLICYMAKERS CAN HELP

Below are suggestions about ways to make it easier for employers to continue providing affordable, quality coverage to over half the country and drive innovation that improves the health care system as a whole.

1. **Modernize health savings accounts (HSAs)** by:
    - Updating the definition of "prevention" to include management of chronic conditions.
    - Allowing employers to provide care at onsite and near-site medical clinics at low or no cost to employees enrolled in HSA-eligible high-deductible health plans.
    - Allowing employers to use lower cost-sharing to incentivize employees enrolled in HSAs to use centers of excellence, telemedicine and expert medical opinion programs

2. **Protect the longstanding tax treatment of employer-provided health coverage** by fully repealing the so-called "Cadillac Tax" on employer-provided health coverage and rejecting new proposals to tax employees' health benefits.

3. **Support greater quality and price transparency in the healthcare system**, starting by adopting uniform quality measures for public and private healthcare purchasers, such as the measures defined by the Integrated Healthcare Association and the Pacific Business Group on Health pertaining to commercial accountable care associations.

4. **Repeal the Affordable Care Act (ACA) employer mandate penalty.** The employer mandate was intended to enable individuals to meet their legal obligation to have an established level of coverage — a legal obligation that no longer exists now that the

individual mandate penalties have been repealed. The vast majority of large employers offered coverage to their employees before the ACA was enacted and would continue to do so in the absence of an employer mandate.

5. **Preserve ERISA's uniform standard for plan administration.** Innovation in employer-sponsored health coverage thrives in an environment of regulatory certainty. This is due in large part to Congress' wisdom more than 40 years ago, when it enacted the Employee Retirement Income Security Act (ERISA) to include a provision that ensures ERISA plans are free from most state and local regulation. Otherwise, employers would be forced to comply with a patchwork of different state and local regulations, resulting in overwhelming administrative burden.

Thank you for your consideration of our comments. Please let me know how the Council can further assist in your efforts.

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