



AMERICAN BENEFITS COUNCIL

March 23, 2018

The Honorable Bill Cassidy, M.D.
United States Senate
Washington, DC 20510

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

The Honorable Todd Young
United States Senate
Washington, DC 20510

The Honorable Michael Bennet
United States Senate
Washington, DC 20510

The Honorable Thomas R. Carper
United States Senate
Washington, DC 20510

The Honorable Claire McCaskill
United States Senate
Washington, DC 20510

RE: Health Care Price and Information Transparency

Dear Senators:

The American Benefits Council (“the Council”) applauds the bipartisan effort you are launching to increase health care transparency to empower patients, improve quality, and lower costs. We agree that greater price and information transparency is a critical and necessary component to achieving these goals – and we strongly view transparency as a means to achieving these goals rather than transparency *being* the goal.

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 health and retirement plans that cover more than 100 million Americans.

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, [*A 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.

Your letter notes the importance of “real world experience and evidence-based policies from health care stakeholders and experts.” Employers are at the forefront of improving health care quality and controlling cost by implementing various value-based payment reforms. To help shape your effort, the Council is pleased to share this experience and the priorities, opportunities and challenges identified by employers in reaching these goals.

Employers cover more than 178 million Americans – over half of all Americans -- and 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. This more than 4:1 return on investment is a tremendous bargain for U.S. taxpayers.

For decades, employers have been working to increase health care quality and price transparency. Indeed, a number of employers have successfully increased quality and transparency through innovative strategies. – we summarize a handful of these successes below. The ability to achieve large-scale success, however, exponentially increases when private sector employers are working hand in glove with public payers (like Medicare, Medicaid, State Employee Health Plans, Office of Personnel Management/FEHBP and the exchanges) to implement similar policies measured in standardized ways. Too often, a single entity tries to go it alone, which makes success much more difficult to attain. We appreciate your efforts and understand the complexity of the task. We hope that your initiative will bring us closer to the large-scale success that has been elusive thus far, and look forward to helping in any way we can.

EMPLOYER INNOVATIONS IN HEALTH COVERAGE

As detailed in our recent report developed with Mercer, [*Leading the Way: Employer Innovations in Health Coverage*](#), 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.

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. Many of these experiments have met with startling success and — if scaled and encouraged — have the potential to fundamentally improve health care for all Americans.

Rising health care costs, as well as the threat of the looming 40 percent “Cadillac Tax” on health plans, have forced many employers to increase their deductibles and other cost sharing as part of a strategy to implement a glide path to avoid triggering the tax in the future. This increase in employee out-of-pocket costs has, in turn, increased the demand and necessity for useful transparency tools that help patients and employees know the cost of a service or bundle of services before receiving them.

Health care consumerism aims to put economic purchasing power and decision-making in the hands of plan participants, thereby enabling patients to become wholly involved in their health care decisions. Health care cost transparency is a critical element in consumer-based designs, because consumers can't make cost-conscious decisions without being able to shop intelligently for procedures and providers.

Employers are increasingly offering tools to deliver price and quality information about specific health care providers or service to employees. Employees often access tools online, telephonically or via mobile applications. Two notable examples of employer innovation in driving informed consumerism through increased transparency are described below.

ARLP Established Direct Contracts to Improve Quality and Manage Cost

THE ISSUE:

ARLP, a diversified coal producer and marketer, was facing increasing costs and was concerned about a lack of transparency and poor outcomes from health care providers. The company had implemented primary care interventions, but wasn't seeing continued cost reductions.

THE SOLUTION:

The first step in trying to manage cost trend was to understand the price of the various procedures in the claims data. The company began by moving to a third-party administrator that agreed to provide price-per-procedure codes, instead of averaging out claim costs for similar procedures. This allowed ARLP to drill down and identify major cost drivers. What it found was stunning: 4% of its members were driving 50% of its claim costs. This explained why primary care interventions hadn't helped to bring down costs — the top cost drivers were patients with intensive health issues being handled by multiple specialists and hospitals. The patients were often critically, chronically ill with low disease knowledge and limited therapy management and coping skills.

ARLP then sought partnerships with facilities that were willing to disclose prices before interventions and work with the plan and its population for better health outcomes. One such partnership was with a facility that had proven outcomes for knee replacement surgery. A more sensible solution, both from a financial and a patient-care perspective, was to pay for a member to travel 300 miles to get a knee replacement at an outpatient surgical center that performs the operation routinely for a contracted price, rather than send that patient to a nearby hospital.

THE RESULTS:

As it turns out, convenience can be costly. ARLP's direct contractors for full knee replacements charged less than \$27,000, whereas other facilities charged more than \$87,000. ARLP Direct Contract facilities have demonstrated better outcomes for the participant, better prices for the plan and lower rates of complications. With the implementation of this program, ARLP has seen negative cost trend growth.

AT&T's Full Commitment to Making Consumerism Work

THE ISSUE:

AT&T believes the consumer can best defend against the high cost of health care — but only if they have the proper tools and support. An early adopter of high-deductible, consumer-driven health plans, the company soon discovered by examining claims and plan selections in tandem that many employees were not choosing the plan that made the most sense for them, from both a cost and coverage perspective. Employees needed more help in navigating the health care system to find high-quality, cost-effective providers.

THE SOLUTION:

AT&T implemented an integrated benefits platform, "Your Health Matters," to give employees access to decision-making tools and other health benefits resources in one place. The platform evolved since implementation to integrate a cost-comparison tool and a second-opinion program. All of AT&T's health plans are HSA-eligible, and three levels are offered: Gold, Silver and Bronze. However, ongoing analyses showed that some employees remained over-insured. On the new platform, employees' actual claims experience was imported into the decision-making tools to help employees pick the right plan, based on their past health care use.

Employees also completed a questionnaire to establish their risk tolerance and the results produced a score for each plan, ranking them in order of "best match" for the employee and their health care needs. To encourage appropriate migration into lower-cost plans, AT&T matched employees' HSA contributions for the Bronze plan, up to \$500 for individuals and \$1,000 for family coverage.

THE RESULTS:

Employees have more choice and more financial responsibility — and more support. The new decision-making support tool, along with the HSA matching contribution, resulted in a 30% increase in enrollment in the Bronze plan in the first year. In the upcoming plan year, when the match will be doubled for the Bronze plan and a new match added for the Silver plan, AT&T expects a similar increase in Bronze plan enrollment and a 20% increase in Silver plan enrollment. Though the program was initially designed to be cost-neutral, AT&T's medical trend has dropped below the national trend.

For many organizations, the first step in trying to determine the approach to take to address their population's health issues is delving into their data. One Council member has used its data analysis service to:

- Examine the efficacy of high-deductible health plans (quantified cost-avoidance over the past three years)
- Develop scorecards by location for high use of ER versus urgent care, low use of generics and communication of preventive benefits.
- Study outcomes of employees who have had biometric screenings that revealed high blood pressure.

Unfortunately, success stories in this regard are the exception rather than the rule as 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

THE QUEST FOR UNIFORM, STANDARDIZED QUALITY MEASURES

Meaningful and uniform quality measures are at the foundation of value-based purchasing decisions. Adopting uniform quality measures, such as the measures defined by the Integrated Health care Association and the Pacific Business Group on

Health pertaining to commercial accountable care associations (ACOs), are a critical first step in untangling the health care cost and quality puzzle. As more large employers implement innovative payment reforms, like direct contracting or creating an accountable care organization, it would be incredibly helpful – if not vital - to have a uniform set of standardized quality measures. This helps achieve two policy goals:

First, standardized quality measures make it easier for providers participating in new payment programs to have one uniform set of measures on which to report. Some physicians have lamented being required to measure blood pressure three different ways for three different Medicare programs (measured one way for ACOs, another way for patient centered medical homes, and yet another way for certain bundled payment programs). Providers are already being pulled in many different directions and are pressed for time, policymakers could ease the workload while at the same time improving quality by implementing a standardized measure set.

In addition, standardized quality measures make it easier for patients and employers to identify high performing providers. If every program and provider necessitates its own set of measures, it quickly becomes impossible to compare providers. A uniform measure set -- at a minimum uniform across all Medicare payment programs and demonstrations – would help lay a strong foundation to achieving more meaningful payment reforms.

Uniformity in quality measures is essential. However, uniformity alone will not empower consumers to make smart health care decisions. Such measures must be meaningful to import value-based decisions into our health care system.

DATA COLLECTION

Many states have either created or are considering creating all-payer claims databases (APCDs). Early versions attempted to require large, self-insured plan sponsors to submit their data. In *Gobeille v. Liberty Mutual Insurance Company*, the U.S. Supreme Court struck down a Vermont law requiring all health plans (including self-insured plans) to file informational reports (including claims data) for the state's all-payer claims database, finding that the state law was preempted by ERISA. However, Vermont still may seek to revise its law to restore the requirement and additional states have adopted or are considering all-payer claims databases, many of which have conflicting and overlapping reporting requirements with respect to the content and format of data reporting.

While data clearly holds the key to more meaningful transparency tools, requiring large employers to comply with 50 state APCDs and the varying requirements each might impose is inefficient and would wrap employers in reams of red tape. This also raises important questions about data security. As such, the Council filed an amicus brief with the U.S. Supreme Court describing the importance of ERISA preemption as it applies to self-funded employers, arguing that the Vermont law and similar state programs undercut ERISA's objectives by subjecting self-insured plans to a morass of

state reporting requirements that Congress neither intended nor allowed in enacting ERISA.

To be effective tools across the county, data systems need resources to partner with private-sector innovators in the development of solutions for consumers and employers and develop operations that align with the business needs of price and quality transparency.

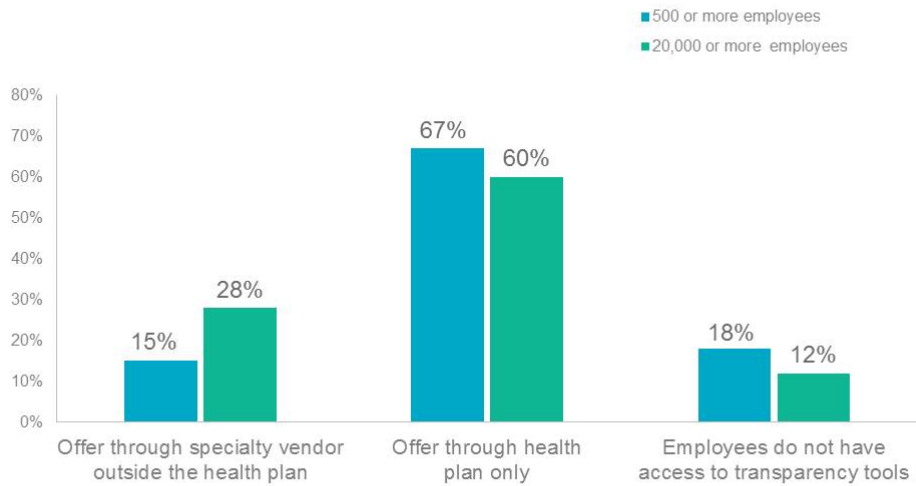
Your letter poses the question of how can our health care system better utilize big data, including information from the Medicare, Medicaid and other public health programs to drive better quality outcomes at lower costs. Medicare and Medicaid have a plethora of data on providers with whom private payers also contract. Employers and employees could benefit from access to this information to help make informed decisions about their health care strategies and options. As long as data from government programs could be extrapolated to be relevant to employer-specific populations, access to such information could help fill in a big piece of the puzzle.

USEFULNESS OF THE DATA

Clearly it is critical to collect the relevant data, but perhaps more importantly it is critical to ensure the data is presented to employees in a meaningful and actionable way.

According to Mercer's 2017 National Survey of Employer-Sponsored Health Plans, over 80 percent of employers with 500 or more employees offer a transparency tool either through their health plan or another specialty vendor. In organizations with more than 5,000 employees that offer transparency tools, only one in five employees are utilizing them to compare provider prices and/or quality. For those consumers that have tried to access this data, the experience has been frustrating at best. The available data often fails to provide the specificity or relevance needed to make an informed decision as important as one about health care for you or a family member. This really drives home the point that merely creating transparency tools is not the goal – the goal is to utilize transparency tools to empower patients, improve quality, and decrease costs. We aren't there yet, but how can we get there? At a minimum, large, self-funded employers should be able to easily access their own data – which has been difficult for many of our members. The next step is to translate this into a tool that is useful for employees and educate them about its availability.

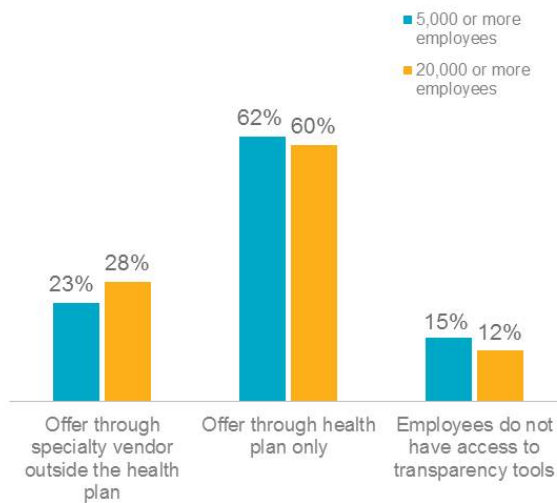
OFFER A TRANSPARENCY TOOL FOR COMPARING HEALTH PROVIDER PRICE AND/OR QUALITY



MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

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MOST EMPLOYERS CONTINUE TO OFFER CARRIER-BASED TOOLS FOR COMPARING HEALTH PROVIDER PRICE AND/OR QUALITY



	Employers with 5,000+ employees	Employers with 20,000+ employees
Average utilization rate of transparency tools	21%	30%
Offer incentives to use	11%	13%

MERCER NATIONAL SURVEY SUPPLEMENT FOR EMPLOYERS WITH 5,000 OR MORE EMPLOYEES / NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 37

REMOVING BARRIERS TO INNOVATION

We appreciate you asking about current regulatory barriers that should be eliminated to make it less burdensome and more cost-efficient for stakeholders to provide high-quality care to patients.

Health savings accounts (HSAs) have been used to help make health coverage more affordable, encourage a wiser consumption of health services and allow pre-tax spending on a wide range of qualified medical expenses. However, dated laws and regulations make it difficult for employers to include innovative reforms in HSA-eligible High-Deductible Health Plan (HDHPs). The Council urges Congress and the executive branch to update HSAs to better align this increasingly popular plan design with innovative delivery system reforms, such as:

- Updating the definition of prevention to help Americans with chronic conditions.
- Making it easier for employers to offer on-site and near-site health clinics.
- Encouraging employees to utilize Centers of Excellence programs.
- Removing barriers to telemedicine and second opinion services.

CONCLUSION

We need to look at health care transparency as a means to an end, not as 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.

Thank you for your consideration of our comments. Please let us know how we can further assist you in your efforts.

Sincerely,

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