September 21, 2015

Mr. Bill Lindsay
Chair
Colorado Commission on Affordable Health Care
7351 E. Lowry Boulevard
Denver, CO 80230

Dear Mr. Lindsay:

On behalf of America's Health Insurance Plans (AHIP) and the Colorado Association of Health Plans (CAHP), we are pleased to respond to the Colorado Commission on Affordable Health Care's seven questions regarding the costs of health care and other relevant issues. We appreciate the opportunity to provide you with our perspectives and we look forward to working with the Commission to enhance the affordability of quality health care in Colorado.

Please note that the responses to the questions and the links to additional information provided below speak to both the broad topic of the costs of health care as well as the more specific topic of the cost of health insurance. *Because the cost of health insurance is directly tied to the underlying costs of health care we urge the Commission to view both as inextricably linked.*

1. What do you think are the fundamental cost drivers and why?

Higher Unit Prices. As a result of ever-rising health care prices, consumers are spending more on health care even though they are using fewer services. Hospitals are increasing their charges for services. According to a study published in the journal *Health Affairs,* some US hospitals charge more than 10 times what Medicare pays for the same service in the same area. Also, doctors are charging more for services, especially when their practices are purchased by hospitals, a fact reinforced by a recent *The New York Times Upshot* blog: "When Hospitals Buy Doctors' Offices, and Patient Fees Soar." As more hospitals gobble up doctors' offices, the blog says, patients see the price for services jump – such as $189 for an ultrasound to $453 for the same service from the same physician post-consolidation. Especially dramatic has been the growth in spending on prescription drugs, while the number of units used has remained fairly steady. This results from price increases that are a most important driver of spending growth, as illustrated by this chart. More about high priced drugs below.

High Priced Prescription Drugs. A recent report by Avalere looked at a handful of drugs currently in the pipeline and predicted the future of pharmaceutical pricing. The report

estimates a cost to the federal government of a combined amount of roughly $50 billion in the next decade - for just 10 drugs. The cost will be equally staggering to private health insurers. Additionally, there is no transparency of pharmaceutical pricing by pharmaceutical manufacturers, even though, according to an IMS Institute for Healthcare Informatics estimate, overall spending on prescription drugs grew by 13.1 percent in 2014 to $373.9 billion – the largest year-over-year increase since 2001.

While new five-to-six digit "breakthrough" drugs (such as Sovaldi's $1,000-per-pill Hepatitis C medication) have gotten the most media attention, there have also been large price increases in medications that have been prescribed for decades, including insulin and drugs used to treat multiple sclerosis. In fact, a *study* published in the May 26, 2015 *Neurology: The Official Journal of the American Academy of Neurology* found that drugs for multiple sclerosis, which cost $8,000 to $11,000 a year in the 1990s, now sell for about $60,000 a year. *USA Today* interviewed Vinay Prasad, MD, chief fellow of oncology at the National Cancer Institute, who studied whether increased costs of medications create better outcomes. "Our ultimate consensus was that there is no rational basis for drug prices," said Prasad, whose study was published in *JAMA Oncology* in April. "It's not based on how novel they are or how well they work. It's based on what the market will bear."

Prevalence of Chronic Conditions. The prevalence of chronic conditions continues to increase. Many Americans are now managing multiple chronic conditions, including diabetes and heart disease. Managing the risk factors for these conditions can also have a significant cost impact. It has been estimated that the annual costs of obesity-related illness are $190.2 billion, nearly 21 percent of annual medical spending in this country. In addition, childhood obesity alone represents $14 billion in direct medical costs. And among the Baby Boomers, some two-thirds of traditional Medicare enrollees have multiple chronic conditions, representing more than 40 percent of the $324 billion spent on traditional Medicare.

Provider Consolidation. As discussed in a Data Brief from AHIP's Center for Policy and Research, a growing number of studies have suggested that provider consolidation may be motivated less by aiming to achieve operational efficiencies and more by the removal of competitive rivals and increasing market power. In a Health Affairs study conducted in 2014, one standard deviation increase in a standard measure used by economists to measure market competition, resulted in a four percent increase in hospital prices and more than a six percent increase in total hospital expenditures incurred by payers, despite a negligible change in the volume of patients admitted to the hospital.

Another study, detailed in the *Journal of the American Medical Association*, examined the cost implications of hospitals acquiring physician practices and medical groups. After controlling for various county and hospital characteristics, such as physician supply, hospital profit status, size, etc., researchers found that local hospital ownership and multihospital

health system ownership of provider groups resulted in per-patient expenditures that were 10 to 20 percent higher than patients seen at independently owned groups. That translates into an extra $1,200 to $1,700 per patient per year.

Restriction on Health Plan Benefit Design. When health insurers are restricted from offering a full range of provider networks (both broad and smaller high-value networks) and other benefit designs that help make coverage more affordable, employers and consumers are denied the value propositions and affordable coverage that they seek. A recent McKinsey report showed that health plans with smaller high-value provider networks have premiums that are 15 to 23 percent lower than those associated with broader networks. Moreover, 70 percent of the lowest-priced plans for 2015 had such high-value networks. It is clear that network design can be a large determinant of premium prices.

Waste in the Health Care System. Please see the response to Question 5 below.

Out-of-Network (OON) Provider Fees. Health plans develop provider networks to offer affordable health insurance products to consumers and employers who want access to a range of health care providers who deliver high-quality care. In Colorado, when a patient goes to an in-network facility (hospital, surgical center, etc.) and sees an out-of-network physician, that physician can charge insurers whatever he or she chooses to charge and, according to Colorado law, the insurer must pay the full amount. These amounts are often far in excess of the usual and customary rate for the same service. It is not unusual for carriers to receive bills that are anywhere from double to more than five times the average Medicare fee for the same service. This practice has contributed to the high cost of health care for both insurers and patients, who are liable for their coinsurance and deductibles and have not taken the high cost of a non-participating provider into account when calculating what their hospital visit will cost them.

2. **What are the barriers to reducing costs?**

- **Regulatory and statutory barriers.** The following are examples of regulatory and statutory barriers to reducing costs:

  Disincentives for "Young Invincibles" To Purchase Insurance Coverage. An affordable market for consumers requires broad participation in the health system, particularly among the young and healthy. But currently, the tax penalty for not purchasing coverage is less costly than purchasing coverage. Many individuals may choose to forgo coverage altogether as a result.

  Pharmaceutical Pricing Power. Pharmaceutical pricing power is a significant barrier to cost reduction. Policy makers must advance policies that promote innovation and foster

competition, including those that allow a pathway forward for biosimilars. This is discussed in greater detail in the answer to Question 7.

Limits on Cost Sharing for Specialty Drugs. Colorado has imposed limits on cost-sharing on specialty drugs. Such restrictions continue to give drug companies a free pass to continue to raise prices while hiding the true costs of prescriptions from consumers. But consumers and employers pay in the form of higher premiums and fewer insurance plan options.

- **Provider-specific barriers.** The following are examples of barriers to reducing costs that stem from provider behavior:

Higher Unit Prices. Providers have incentives to bring in additional income which can be achieved by either increasing the volume of services they provide or by increasing the charge for each service. The ability of a provider to increase the volume of services he or she is providing is limited due to that provider's time and availability, so the remaining option is to increase the fee charged for each service in order to bring in additional income.

Unnecessary Services. In "What is Driving US Health Care Spending?," the Bipartisan Policy Center notes that "reimbursement under a [Fee-for-Service] model generates a strong incentive for a high volume of tests, procedures, inpatient stays and outpatient visits, including those that have questionable potential to improve health." This can have a dramatic impact on health care costs, as noted by Laurence Baker, PhD, Chief of Health Services Research at Stanford University. He observed that there are "many difficult-to-ignore indications that suggest the 'overuse' of medical care." That overuse comes in the form of unnecessary, ineffective, or unwanted care. He estimates that such care represents between 10 and 30 percent of spending.

Out-of-Network Providers. When doctors or hospitals choose not to participate in health plan networks, the fees those providers charge can be extremely costly to the consumer and insurers. And, as mentioned above, Colorado law creates a disincentive for OON providers to contract with health plans because it allows the providers to charge any amount they want if they remain out-of network providers while working at in-network facilities.

Provider Consolidation. As noted above, when provider consolidation increases, so do the fees that those providers charge health plans. In Colorado, only three hospital systems control the majority of the market. Additionally, once a physician's practice is consolidated by a hospital, that physician can charge a facility fee in addition to the professional fee. This significantly increases the cost of services.

Non-Contracted Business Models. Colorado has recently seen an influx of independent free standing emergency rooms (FSERs). By stating that they are providing emergency care, FSERs do not have to contract with insurers, but can charge insurers a large "facility fee," and are guaranteed payment due to federal and state emergency care regulations. Yet, FSERs typically do not have the resources to provide the same emergency care that a hospital emergency department can provide. So, FSERs are transferring patients who need serious emergency care to acute care hospital emergency rooms. When this happens, costs are increased because the carrier and patient will now be paying two facilities for essentially the same services.

3. **Can you list up to three things that you are doing to address costs that are unique?**

The health insurance industry is working to address cost through both member engagement and provider engagement, uniquely addressing cost issues. Further detail on each is provided below.

Transitioning to a Value-Based Payment Model. Carriers are working to transition the payment model away from fee-for-service to a quality-based one to ensure that employers and consumers get more value out of the money they are spending on care. If patients are receiving more quality and bundled care, costs will inevitably decrease and there will be fewer duplicative visits and tests for the same issue. Specifically, plans have played critical roles in these initiatives by providing tools and data to support population-based care, providing programs and staff to better coordinate care, and structuring provider contracts to reward high-quality performance and reductions in practice variation and cost. In Colorado, carriers have worked with their contracted primary care providers to create a better payment model, and a large majority of these PCPs have embraced value-based and risk-sharing models to improve patients' quality of care while also decreasing unnecessary costs. Not all providers are equally ready to make the transition into new payment arrangements, so health plans have adjusted their arrangements to meet the abilities and needs of their provider partners and their respective patient populations to move toward changed payment models.

Managing Chronic Care. Related to payment model reform efforts, as mentioned above, health plans have also developed programs to support enrollees who are managing their chronic conditions. This effort is more fully discussed here.

Increasing Price Transparency. Health insurers have taken important steps to promote price transparency, including developing tools to help consumers choose providers and services that deliver cost-effective care. A large proportion of commercial insurers make cost-estimate tools available to their members. While the level of functionality of transparency tools and products varies, there are several elements that appear to be common among insurance companies. These include information on in-network physicians and hospitals, price information on basic procedures and tests, cost/quality comparison across

multiple providers, and the total cost of care and consumers' share of costs. Such transparency tools are fully discussed in this Issue Brief.

4. Is there any supporting data that demonstrates a reduction in cost?

Below we provide supporting data demonstrating a reduction in cost relating to two principle areas – the scope of provider networks and the use of alternative payment models.

Use of Alternative Payment Models. There is an array of data that suggests that alternative payment models, rather than the long-standing fee-for-service model, can reduce costs. For example, the AHIP Issue Brief Transforming Care Delivery highlights early research results with regard to the following alternative payment models:

- Patient Center Medical Home (PCMH), where physicians have decreased the rate of high-tech radiology use by 6.3 percent, decreased emergency room visits by 6.6 percent, and shown a 7.0 percent lower rate of adult ambulatory care sensitive ER visits over non PCMH participating physicians.
- Accountable Care Organization, where there have been decreases in inpatient days per 1000 (15 percent), decreases in inpatient readmissions (14 percent) and savings of $15.5 million in health care costs over a one year period and have been seen across several plans.
- Bundled/Episode-Based Payment, where preliminary results showed one Acute Care Episode pilot achieving a 10 percent reduction in cost for the average hip/knee replacement episode.

Scope of Provider Networks. Allowing carriers to offer a broad range of networks has supporting data indicating a reduction in cost. According to a recent McKinsey report, health plans that use high value networks have premiums that are 15 percent to 23 percent lower than those with broader networks. Moreover, 70 percent of the lowest-priced plans in 2015 offered high value networks.

5. Where do you see waste in the system?

In a December 2012 Health Policy Brief, *Health Affairs* estimated that a third or more of all health care expenditures may be wasteful. *Health Affairs* also summarized a 2012 study by former CMS Administrator Donald Berwick and RAND Corporation analyst Andrew Hackbarth that pointed to six categories of waste that represented 18 to 37 percent of all health care spending in 2011. They were (1) failures of care delivery (such as poor execution or a lack of widespread adoption of best practices) and (2) overtreatment (including extra testing stemming from incentives in fee-for-service medicine, defensive medicine, and intensive care at the end of a person's life). They also pointed to (3) administrative complexity (including a lack of standardization of forms and procedures); (4) overpriced

services; and (5) fraud and abuse (not only scams and improper medical billing, but also the cost of regulation to counter wrongdoing).

One of the largest sources of waste in our health care system is (6) failures of care coordination. A common example of this is that primary care physicians often refer patients to specialists when the condition could be treated effectively by the primary care physician. Another example is when a patient is referred to a specialist, the test results from the referring physician are not transferred to the specialist in time for the appointment so the specialist orders the test again. Also, the Centers for Medicare and Medicaid Services (CMS) has acknowledged and addressed this issue, noting that quality over quantity is a wiser way to spend dollars and improve care, with its Bundled Payments for Care Improvement initiative.

6. What are the principle barriers to transparency?

Cost-benefit concerns. There are concerns about the costs associated with creating an infrastructure to generate, analyze, and provide information that is understandable and actionable by consumers.

Duplicative or inconsistent health-related data. There are also concerns with inefficiencies sometimes created by duplicative or inconsistent health-related data. Such concerns are strikingly apparent in the National Institute of Medicine (IOM) report, "V*ital Signs: Core Metrics for Health and Health Care Progress."* The description of the project on the IOM website noted that, "[t]housands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system." As a result, the IOM convened stakeholders to identify "core measures" that will yield the clearest understanding and focus on better health and well-being for Americans." Among those 15 core measures are personal spending burden, population spending burden, obesity, addictive behavior, and care access. The IOM announced these core measures earlier this year, however it will likely take years before they are fully integrated into quality measurement and reporting.

It is important to distinguish "barriers to transparency" from "limitations on transparency initiatives" that are guided by sound public policy. The Federal Trade Commission (FTC), the US Department of Justice (DOJ), and academic researchers have recognized that in certain situations, "transparency" can lead to reduced competition and harm to consumers. This is particularly the case when transparency initiatives result in the broad dissemination of non-public pricing information. The FTC and DOJ have emphasized that through approaches such as aggregation, the important policy goals behind these transparency initiatives can be achieved without the harm to competition.

7. What would you change to make things better related to cost?

We believe policymakers and regulators can meet the goals of affordability and patient access by making changes to the following cost-drivers:

Provider Consolidation. Provider consolidation must be scrutinized closely to ensure that such consolidation does not impede competition that provides downward pressure on costs.

Provider Networks. Amending the current Colorado law that allows non-participating providers in in-network facilities to be paid for full billed charges would create a great incentive to contract and would save costs. Additionally, Colorado could decrease costs by establishing restrictions around entities such as free standing emergency rooms that increase health care costs.

Transparency. Greater transparency from providers and hospitals regarding their participation in networks is important. In addition, Colorado would benefit from greater transparency regarding pharmaceutical prices. That transparency could include information about the amount spent on research and development, manufacture and distribution, and advertising; the profit derived from sales; the amount of financial assistance associated with the drug; and other factors contributing to the prices that are charged.

Relating to the high price of drugs, in addition to enhanced transparency noted above, the following changes would help lower costs:

- Encouraging alternative payment and incentive structures – such as coverage with evidence developments – for new drugs and technologies.
- Shortening the exclusivity period for biologics to promote greater price competition and earlier access to lower-cost specialty drugs or biosimilars.
- Prohibiting abuse of the patent process by drug companies.
- Removing barriers at the state level that restrict the use of biosimilars.
- Expanding agencies' authority to consider research on treatment effectiveness.
- Encouraging competition and innovation.
- Promoting transparency on prescription drug research, development, and pricing.
- Reforming Medicaid drug manufacturer rebates to promote competition.
- Adopting a "least costly alternative" standard for certain drugs covered under Medicare Part B.

We acknowledge that while the Colorado Commission on Affordable Health Care might not be able to influence all of these factors, the Commission could contact the Colorado Congressional Delegation to make them aware of concerns regarding the high costs of

prescription drugs. In addition, the State could align with other states and interested parties to reach out to federal agencies with these concerns.

Thank you again for the opportunity to provide input regarding these seven questions. Providing health care that is not only affordable but also effective and of value to the consumer is a priority for the health insurance industry. We appreciate the chance to further this objective. If you have any questions about our answers, or would like to see additional information or materials regarding any issue area, please do not hesitate to contact us.

Sincerely,

Dianne Bricker
Regional Director – State Affairs
America's Health Insurance Plans

Charlie Sheffield
Executive Director
Colorado Association of Health Plans

America's Health Insurance Plans -- AHIP

AHIP is the national trade association representing the health insurance industry. AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid. AHIP members offer a broad range of health insurance products in the commercial marketplace and have also demonstrated a strong commitment to participation in public programs throughout the country.

Colorado Association of Health Plans -- CAHP

CAHP is the Colorado state trade association representing the health insurance industry and providing health care coverage for over 3 million Colorado residents. CAHP has been rated among the best in the country, serving a range of groups including Medicare beneficiaries, Medicaid recipients, participants in employer-sponsored plans, and individuals purchasing non-group coverage. All health plan types, including for-profit and non-profit organizations, are represented. Private, commercial, and government programs are presented by CAHP.