



COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR

March 1, 2019

Senator Lamar Alexander
Chairman, Senate Committee on Health, Education, Labor and Pensions
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Alexander,

Thank you for your letter requesting recommendations to address the nation's rising health care costs. We appreciate your recognition that we need to get to the root of what really drives health insurance costs: the rising costs of health care. To put it simply, insurance is expensive because the health care it pays for is expensive. The rising costs are staggering – national health expenditures in the U.S. grew to \$3.5 trillion in 2017, and private health insurance accounted for over a third of those costs.¹ Without action, rising health care costs will saddle our nation's economy with a tremendous financial burden – national health spending is projected to grow at an average rate of 5.5 percent per year for 2017-26 and to reach \$5.7 trillion by 2026, outpacing the rate of health care cost increases for the past decade.² The costs are being felt by the hardest working Americans: in 2018, employees paid an annual average premium of almost \$7,000 for single coverage and nearly \$20,000 for family coverage.³ Action to stem the tide is not only warranted – it is our duty as public servants to cultivate a more affordable and sustainable health care market for our fellow citizens.

Health care costs should be affordable, understandable, and reliable. Achieving these aims requires a two-fold approach: first, we must tackle the underlying costs of health care delivery to allow for more affordable health care coverage, and second, we must work to ensure patients can rely on predictable health care costs and avoid unexpected health care costs when possible.

I. Reducing the underlying costs of health care delivery

¹ Centers for Medicare & Medicaid Services, National Health Expenditure Data, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

²Centers for Medicare & Medicaid Services, National Health Expenditure Data, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

³Kaiser Family foundation, 2018 Employer Health Benefits Survey, October 3, 2018, <https://www.kff.org/report-section/2018-employer-health-benefits-survey-summary-of-findings/>

Comprehensive Coverage

Congress should work to retain the comprehensive coverage currently provided by the Affordable Care Act (ACA), so consumers will be able to maintain their health rather than postpone care until conditions require sudden, intense, and expensive medical intervention. Further, the comprehensive care provided by the ACA works to treat the whole person by providing physical and mental health care, which can be more cost efficient in diagnosing and treating patients.

The coverage and cost protections of the ACA's preventive services provisions are important to retain so that individuals continue to seek preventive care at no cost to them. This will avoid the need to address and treat conditions when they are first presented as a more serious disease, which will subsequently bend the health care cost curve downward. The federal Health and Human Services Assistant Secretary for Planning and Evaluation estimates that in just the first year that the ACA went into effect, approximately 137 million people nationwide received preventive services at no cost to them. Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating conditions. The preventive coverage requirement also removes cost barriers, as costs would otherwise prevent some individuals from obtaining preventive services. Enabling individuals' access to routine preventive care allows them to live a life of higher quality by potentially avoiding catastrophic and expensive complications.

The ACA also built upon the Mental Health Parity and Addiction Equity Act to expand coverage of mental health and substance use disorder benefits and federal parity protections in three distinct ways: (1) by including mental health and substance use disorder benefits in the Essential Health Benefits; (2) by applying federal parity protections to mental health and substance use disorder benefits in the individual and small group markets; and (3) by providing more Americans with access to quality health care that includes coverage for mental health and substance use disorder services. Such an increase in access to mental health services breaks down silos that previously existed between mental and physical health and enables our health care system to treat patients more efficiently, harnessing the potential to lower the costs of health care in our country.

Congress should look to preserve coverage that provides true value to consumers by including comprehensive access to care facilitated by the ACA and avoid the proliferation of health care coverage that falls short of such benefits. For example, short-term, limited-duration insurance has been billed as an affordable alternative to comprehensive ACA-compliant insurance, but it is severely lacking in benefits and coverage, which ultimately provides little to no value for consumers.⁴ Consumers may purchase short-term plans to experience an upfront savings in premiums, but the "affordability" of the plans will likely prove to be illusory: those who need

⁴ See Insurance Commissioner Jessica Altman's testimony before the House Energy and Commerce Committee's Subcommittee on Health: <https://www.insurance.pa.gov/Documents/Press%20and%20Communications/Testimonies%2c%20Remarks%2c%20Speeches/2019/Testimony-Altman-ACA%20Leg%20Hearing-021319.pdf>

health care will run up against exclusions and limitations on coverage that render any notion of “affordability” to actually be a trade-off for benefit coverage and provider access. Short-term plans increase the potential for consumer harm and market destabilization both immediately and over the long-term, as the ripple effects of the changes impact premium prices and market stability, that is, insurer commitment to participating in the individual market, and the availability of comprehensive coverage for millions of Americans. The federal government should ensure that products sold to individuals as comprehensive health insurance truly include the benefits contemplated by the ACA, particularly including consumer protections that ensure value and meaningful coverage for individuals who purchase the product.

Transparency

Our health care system is convoluted and opaque, so much so that consumers do not have the tools they need to make informed decisions. We must give consumers the information they need to make good health care decisions and we need to give it to them in a format that is understandable, accurate, and actionable. Taking steps to make information on cost, quality, and access more readily available and comprehensible is what will enable consumers to do this. In 2016, the Commonwealth took those steps by unveiling a new Health Innovation in Pennsylvania (HIP) Plan. Price and quality transparency were one of the three primary strategies outlined in the HIP plan, leading to work groups on shoppable care and primary care transparency work, both of which recommended the creation of an All Payer Claims Database (APCD).⁵ During the 2017-2018 legislative session, APCD legislation was introduced in Pennsylvania, but has yet to pass. As of early 2018, 18 states have enacted legislation, and 16 APCD’s are operational. Many more states are considering legislation.⁶

Some argue that consumers often do not use price transparency tools when they are provided, and not all care is “shoppable.” However, the encouragement and proliferation of understandable and cost-effective tools that allow patients to be informed consumers will prove even more necessary as our health insurance system puts more financial onus on the patient. Additionally, consumers should have the ability to shop for care in non-emergency situations, when the services are reasonably well defined, there are comparable alternatives to explore different provider and service location options, and there are adequate incentives and information to make shopping for care worthwhile and possible.

The federal government can take action to make claims collection tools more comprehensive. The U.S. Supreme Court ruled in *Gobeille*⁷ that self-funded plans governed by the Employee Retirement Income Security Act (ERISA) are not required to submit claims data to APCDs, thereby limiting states’ ability to provide a complete picture of the health care landscape.

⁵ Shoppable Care Work Group Report, September 2017, available at <https://www.health.pa.gov/topics/Documents/Health%20Innovation/Shoppable%20Care%20Report%20September%2019%202017.pdf>

Primary Care Transparency Workgroup, November 30, 2017, available at <https://www.health.pa.gov/topics/Documents/Health%20Innovation/Final%20Report%20Recommendations%20-%20Primary%20Care%20Transparency%20WG%2011%2030%202017.pdf>

⁶ Collecting Health Data: All-Payer Claims Databases, website visited Jan 11, 2019, available at <http://www.ncsl.org/research/health/collecting-health-data-all-payer-claims-database.aspx>

⁷ *Gobeille v. Liberty Mutual Insurance Company*, 136 S.Ct. 936 (2016).

The federal government can assist states in enhancing the comprehensiveness of claims data collection if the U.S. Secretary of Labor were to require ERISA plans to report claims data, thereby providing states with the ability to provide a more robust database for consumers.

Value-Based Payments

For decades, our health care system has been based on fee-for-service payments that incentivized over-utilization of health care. As a nation, we have begun the transformative shift away from these pay-for-volume structures to payments that encourage high quality, necessary care. Value focuses on the quality of care and the cost of care. Focusing on value-based payments might reverse the current course of health care costs by improving care and population health.

While many of these value-based payment investments have been made at the federal level through the Medicare program, states, insurance companies, hospitals and other health care providers have also made significant investments in payment reform efforts that are tailored to their health care ecosystems. These investments should be protected and expanded, so that we can continue on the path to creating the right incentives in our health care system and ultimately rein in health care costs.

We also encourage the federal government to identify value-based models that are mutually beneficial to states and the federal government with regard to services provided to individuals who are dually eligible for Medicare and Medicaid. The federal government could be of great assistance to this vulnerable population by identifying and promulgating quality measures for dual-eligible participants and supporting efforts to use these measures for value-based purchasing initiatives. Further, the federal government can provide more resources for the State Health Insurance Assistance Programs to address inquiries and the needs of dual eligible participants for both the Medicare and Medicaid programs. Finally, the federal government should reopen 1115A demonstration projects to allow for much broader integration and alignment between the Medicare and Medicaid programs.

We encourage the federal government to continue to incentivize providers to transition to value-based reimbursement programs, as the rest of the health care payer community is following the federal government's lead.

Prescription Drug Costs

The fastest rising cost in the health care system is the cost of prescription drugs, and slowing or reversing this trend will help control health care costs nationwide. National prescription drug spending increased 0.4% to \$333.4 billion in 2017⁸. However, even more troubling is that prescription drug prices are projected to continue to grow year over year for the foreseeable future, and they are growing at a rate faster than any other area of health care spending. In a nation with the highest health care costs in the world, where health care spending is expected to exceed 20% of GDP within the next decade, this trend cannot continue and must be moderated. In Pennsylvania, drug costs represent over 20% of the claims insurance companies pay on behalf of their enrollees, so driving down the cost of these drugs would have a significant impact on the cost of insurance

⁸ Centers for Medicare & Medicaid Services, National Health Expenditure Data, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

for consumers as well as on state and federal budgets through Medicare, Medicaid, CHIP and other health programs funded with public dollars.

Due to the interstate nature of pharmaceutical transactions, states are limited in their ability to tackle the issue of rising drug prices, with state solutions thus far mostly limited to addressing the need for transparency in pharmaceutical pricing and through measures implemented in government-controlled health care coverage programs. While transparency is a necessary component of controlling prescription drug costs, the federal government must take this issue on if we want to see these costs curbed and prescription drugs become more affordable for all. We are encouraged by the recent hearings held by the Senate Finance Committee and the House Oversight Committee to take an in-depth review of actions the federal government can take to truly slow the growth of prescription drug costs. We support Congress's review of the panoply of options contemplated at the hearings.

Fostering Competition

The health care market is experiencing a wave of consolidation in both the payer and provider aspects and the federal government can play a meaningful role in the review of the transactions. The consolidation is manifesting in various forms, including affiliations, risk bearing relationships, joint ventures and more formal mergers and acquisitions. The relationships between payers, providers and integrated systems that include both a payer and provider entity merit a closer review than traditional business transactions.

Increased competition among health care providers improves quality of care and decreases cost of health care. Typically, providers compete for inclusion in a health insurer's network by negotiating both reimbursement terms and contractual expectations, which may include, for example, participation in value-based reimbursement programs. Strong provider competition allows insurers the opportunity to negotiate lower reimbursement rates, which simultaneously lowers health insurance costs for consumers and employers. Research has indicated that a lack of local competition can increase costs by an estimated 12.5 percent, on average.⁹ But the increase going forward may be greater than 12.5 percent: a few years ago, a merger of six physician practices in Pennsylvania resulted in a price increase of up to 25 percent for different insurers.¹⁰ Additionally, when providers participate in value-based incentive programs, providers are motivated to improve the quality of their services in addition to simply using a modicum of quality as a tool to attract patients. Increased provider consolidation jeopardizes this dynamic and provides an unintended consequence of consumer harm through increased costs and decreased quality of care.¹¹

The federal government has played a key role in assessing mergers of major health insurers, as evidenced in the 2017 Department of Justice actions pertaining to the affiliations of Aetna and

⁹ Holly Lawrence, How to Lower Health Care Costs in America, February 27, 2018, <https://www.nextavenue.org/lower-health-care-costs-america/>

¹⁰Holly Lawrence, How to Lower Health Care Costs in America, February 27, 2018, <https://www.nextavenue.org/lower-health-care-costs-america/>

¹¹Edith Ramirez, J.D., Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality, December 11, 2014, <https://www.nejm.org/doi/full/10.1056/NEJMp1408009>

Humana as well as Anthem and Cigna. A study by the Harvard Business Review found that mergers of this kind rarely bring lower premium prices for the end consumer.¹² In fact, the resulting decrease in market competition is typically expected to bring higher premiums for the policyholders of the health insurers.

There is a larger role for the federal government to play in the increasingly more frequent vertical mergers in the health care delivery system. As a state, we have limits on our ability to review transactions that involve diverse entity types, including non-insurer and non-clinical entities like pharmacy benefit managers. Congress should work to ensure that the federal government is properly authorized and staffed to strategically and thoroughly review vertical mergers within the health care delivery system; the goal should be to permit transactions that will lower health care costs and improve the quality of care as well as to prevent transactions from proceeding that will only add layers of cost to the health care delivery system. While a more rigorous review of vertical transactions will require the dedication of resources, the federal government is appropriately situated and staffed with the best subject matter experts to thoughtfully review the transactions while prioritizing what is best for consumers and the health care market overall.

Emerging Technologies

Emerging technologies harness the potential to curb growing health care costs, and the federal government should work to encourage the proliferation of technologies in a safe, cost-effective manner for patients. Telemedicine is one such tool that can be utilized to improve quality of care and access to care for patients living in rural communities or with limited mobility. For example, a recent study in the *Journal of Informatics in Health and Biomedicine* explored the impact of health information technology to underserved adults with diabetes. Diabetes can be managed successfully through lifestyle changes and self-management education and these strategies can be communicated to patients through telemedicine. The study found that patients who interacted with health care professionals using telemedicine as opposed to telephone interventions alone held patients to a higher level of accountability, kept them engaged in their care, and has the potential to improve outcomes and reduce costs.¹³ Diabetes is the seventh leading cause of death in the United States and impacts 29.1 million people. The medical expenditures of diabetics are approximately 2.3 times higher than expected costs of non-diabetic patients, and the total estimated cost of diagnosed diabetes in 2017 was \$327 billion.¹⁴ Telemedicine use in treating diabetes is one example of how technology can help bend the cost curve. Utilizing telemedicine as a strategy to manage other chronic diseases has the possibility of making a significant difference in reducing health care costs and improving outcomes.

¹² Leemore Dafny, *The Risks of Health Insurance Company Mergers*, September 24, 2015, <https://hbr.org/2015/09/the-risks-of-health-insurance-company-mergers>

¹³ Elizabeth M Heitkemper, Lena Mamykina, Jasmine Travers, Arlene Smaldone; Do health information technology self-management interventions improve glycemic control in medically underserved adults with diabetes? A systematic review and meta-analysis, *Journal of the American Medical Informatics Association*, Volume 24, Issue 5, 1 September 2017, Pages 1024–1035, <https://doi.org/10.1093/jamia/ocx025>

¹⁴ Centers for Disease Control and Prevention, *Calculate What Diabetes Costs Your Business*, <https://www.cdc.gov/diabetes/diabetesatwork/plan/costs.html>

The federal government plays an important role in encouraging the proliferation of certain technologies. For example, in programs like Medicare, the Children’s Health Insurance Program (CHIP), Medicaid, Tricare and the Veterans Health Administration, the federal government, as the primary payer, can be a leader by incorporating evidence-based technology into programs’ covered services, and set an example for the private sector to do the same. While there are barriers that will need to be addressed for health care professionals and patients to gain access to telemedicine technology, including cost, reimbursement, bandwidth, security, and privacy, the federal government should be an active convener and participant in efforts to overcome these barriers.

Scope of Practice

Scope of practice laws, which govern the parameters of clinicians’ roles in health care delivery, may have anticompetitive ramifications, and lawmakers can improve healthcare productivity, lower costs, and reduce administrative burdens if advanced-practice registered nurses and physician assistants didn't face such barriers.¹⁵ Changes to scope of practice laws for nurses and physician assistants especially are tied to more cost-effective and productive care. Additionally, changes to scope of practice laws may also allow physician assistants and nurses to get into the field more quickly, helping to address provider shortages in certain geographies.

Currently, scope of practice laws provide a patchwork of regulatory oversight across the country. The federal government has the opportunity to provide consistency by reviewing the value of supervisory agreements, collaborative practice agreements and protocols, provider to physician ratio requirements, and prescribing authorizations to explore how scope of practice laws can evolve to improve efficiencies in the health care delivery system and help control health care costs.

II. Reducing consumers’ unanticipated costs

Surprise Balance Billing

Surprise balance billing happens when an individual seeks medical care from providers and facilities they believe are in their health insurance plan’s network, but unknowingly receives a service(s) from an out-of-network provider. At some later point, the consumer receives a surprise bill from the out-of-network provider, for which, depending on their insurance plan’s out-of-network benefit, they will be responsible for paying a large portion, if not all, of the cost. These bills unexpectedly drive up consumers’ out-of-pocket health care costs, creating greater cost strain on the health care system as a whole. These unexpected and sometimes financially significant bills are troubling and can be unaffordable for a consumer who may have done everything right when choosing to receive care in-network but unknowingly receives services from an out-of-network physician; and the consumer is then subsequently billed directly for the difference between the insurer’s reimbursement and the cost of the services.

¹⁵ E. Kathleen Adams and Sara Markowitz, *Improving Efficiency in the Health-Care System: Removing Anticompetitive Barriers for Advance Practice Registered Nurses and Physician Assistants*, June 2018, http://www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf

Consumers receive surprise balance bills much more frequently than one would think. According to a Kaiser Family Foundation (KFF) analysis¹⁶ that was published in February 2018, nearly one in five inpatient admissions includes a claim from an out-of-network provider. Almost 18 percent of inpatient admissions by enrollees in large employer health plans – typically governed under ERISA – include at least one claim from an out-of-network provider. In the same analysis, KFF noted that patients using in-network facilities still face claims from out-of-network providers, particularly for inpatient admissions. In fact, the percentage of inpatient admissions with a claim from an out-of-network provider remains significant (15.4%) even when enrollees use in-network facilities.

The Commonwealth's Insurance Department and Department of Health receive many complaints regarding surprise balance bills that compel intervention by the agencies to assist a consumer. A recent consumer complaint involved a consumer who carefully researched her obstetrician provider and delivery site. When she delivered, there were complications with the newborn which required services from a neo-natal specialist and the neo-natal intensive care unit. The insurance company denied the claims as out-of-network, even though she was an inpatient at a network facility. The consumer was billed \$83,452.98. Thankfully, that consumer sought assistance, but many do not, and suffer the economic consequence.

The primary goal for any proposed solution to this issue should be to protect consumers from receiving these unexpected bills, while minimizing the burden on the stakeholders involved in these complicated situations. Some states, including Pennsylvania, are currently exploring a legislative fix to solve this problem for their residents and a number of states have already taken action, but due to jurisdictional limitations, legislation at the state level has a limited impact. We encourage the Senate to continue its bipartisan effort to establish a path to resolution for consumers when they receive unexpected balance bills, as action by Congress would expand the scope of a resolution to include self-funded plans governed by ERISA, providing a more comprehensive solution to this issue.

Facility Fees

Finally, the Commonwealth has received numerous consumer complaints regarding facility fees charged in conjunction with the provision of outpatient healthcare services. This issue arises when hospitals purchase providers of outpatient services, such as physician practices, and convert them from independent freestanding offices to hospital outpatient departments. Following this conversion, a facility fee may be added to the amount charged for the outpatient services. A facility fee is intended to compensate the hospital or health system for the administrative and operational expenses of the hospital or health system.

A 2015 study found that from 2007-2013, the share of spending on physicians whose practices are owned by hospitals increased from 16.9 percent to 26.5 percent, an indication that the proportion of hospital-owned physician practices is growing; it is estimated that these acquisitions led to price increases of nearly 14 percent at these hospital-owned practices, in part

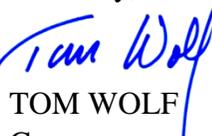
¹⁶ <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start>

due to facility fees.¹⁷ The growth of facility fees in outpatient settings also may lead to higher out-of-pocket spending among consumers. Among Medicare beneficiaries, one report concluded that facility fees led to an estimated \$400 million more in out-of-pocket spending for outpatient office visits in 2015.¹⁸ Additionally, if consumers are not aware that their physician is part of a practice that has been acquired by a hospital, the consumer may face a surprise bill due to a facility fee.

The federal government is best situated to take action to address facility fees through regulatory and legislative action, as states are limited in their authority over such an issue. A more consistent and far reaching approach regarding how providers assess facility fees is best accomplished through a federal approach. We encourage the federal government to investigate the issue thoroughly and stand ready to serve as a resource in this endeavor as needed.

We share the vital goals of providing quality, affordable health insurance coverage while stemming the unsustainable growth of health care costs, and I hope that you find my feedback to be constructive in this regard. States play a critical role in ensuring consumers have access to health insurance and security in knowing they will be protected from catastrophic health care costs, but we can't do it alone. I am committed to working with you as we continue to strive for these goals and would welcome any additional opportunities to discuss how we improve our health care system for all Americans.

If you have additional questions, please reach out to Andrew Sharp, Deputy Secretary of Intergovernmental Affairs, at any time. He can be reached by email at andsharp@pa.gov or by phone at 717-319-1227. Thank you again for your interest in our feedback and the feedback of all states. I look forward to further discussions.

Sincerely,

TOM WOLF
Governor

cc:

The Honorable Bob Casey, Jr.
The Honorable Pat Toomey

¹⁷ Capps, C., Dranove, D., and Ody, C. (2015), "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending" available at <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf>.

¹⁸ Medicare Payment Advisory Commission (2017), "Report to the Congress: Medicare Payment Policy," available at http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0.