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"LOWERING COSTS AND INCREASING ACCESS TO HEALTH CARE WITH EMPLOYER-DRIVEN INNOVATION"

Thursday, January 11, 2024

ABOUT CALIFORNIA SCHOOLS VEBA

Chairman Good, Ranking Member DeSaulnier, and distinguished members of the Subcommittee, thank you for the opportunity to appear before you today. My name is Laura Josh, and I am the General Manager of the California Schools VEBA ("VEBA").

A VEBA – or a voluntary employees' beneficiary association – is a tax-exempt trust established by employers or employee groups to provide benefits – including health care – to their members. The California Schools VEBA was founded in 1993 through the combined efforts of school superintendents and representatives of both the California Teachers Association and the California School Employees Association to combat rising health care costs in Southern California. Since then, VEBA has grown to more than 70 participating employers – including school districts, municipalities, and public sector employers – with more than 150,000 members and is the fourth largest purchaser of health care in the state of California.

VEBA strives to leverage its collective purchasing power to keep health care premiums low and ensure access to comprehensive benefits designed to keep employees physically and mentally healthy. Governed by a joint labor-management Board of Directors and organized as a 501c(9) non-profit health care trust, all funds are spent in service of member benefits and health improvement, and the board has a legal obligation to do what's right for the members that they serve. VEBA has developed a stellar reputation for doing just that – delivering high-value care, providing health resources that are effective, affordable, and of the highest quality and value.

VEBA renewals have consistently outperformed the national market while eschewing traditional cost containment strategies like cost shifting to employees, limited optionality and high-deductible health plans (HDHPs). We firmly believe in offering a variety of plan designs and expansive provider networks, ensuring low out-of-pocket costs and shielding members from price increases, while providing a comprehensive suite of well-being and wraparound programs. Instead of shifting costs to employees to reduce care consumption and increasing barriers to access, VEBA has reigned in costs through innovative, patient-focused care and quality programs. For example, our first-of-its-kind direct contracting program leads to stable premiums while delivering on our high-quality commitments to our members. While California school districts that are not members of VEBA typically see annual premium increases of 12-14%, VEBA members historically average around just 4-5%.[1]

VEBA not only has a reputation for delivering high-value care, but there is strong buy-in from members that collectively agree we can make a difference in the health care delivery system. The tools VEBA leverages have not only saved member employers millions but our philosophy of personalized population health results in better care and improved well-being of the individual employees who have become their own health advocates. We hope our learnings can inform other employers and push the system to adopt higher-quality, lower-cost and more patient-centric health care.

[1] Comparison completed by Tall Pine Consulting LLC, 2020.

VEBA VALUE

HIGHER-QUALITY COVERAGE FOR LOWER COSTS

The cost of health care in the US and per person spending continues to increase despite a focus on cost containment across the health care ecosystem. Rising spending is driven primarily by an increase in prices – not a marked increase in utilization – and this change has resulted in increased premium costs and an increased percentage of income Americans are spending on health care.[2] In 2023, the average annual premium for employer-sponsored health insurance was $8,435 for single coverage and $23,968 for family coverage, each increasing 7% over the last year.[3]

To address rising health care costs, many employers have adopted cost containment strategies such as high-deductible health plans, cost-centric narrow-network plan designs and programs targeting high-cost diseases and treatments in an effort to limit health care consumption and reduce high-cost claims. Large plans in California aim to leverage their volume and market power to negotiate greater discounts and encourage employees to switch between insurers to obtain better rates. But bigger isn't always better and these large plans have not proved to be a better solution to rising costs.

While VEBA has meaningful localized volume within Southern California, we cannot, and do not, rely on volume alone to achieve our goal of driving down costs. We also firmly believe in limiting cost-sharing for employees and continuing to offer performance-based networks and innovative well-being and prevention programs to our members. This has driven VEBA to pursue innovative cost containment strategies that have helped to stabilize premiums while delivering on our promises to members and staying true to our guiding principles.

At the core of these principles are measures that strengthen the provider-patient relationship, efforts to improve the quality of care members receive and a personalized patient-centered approach that addresses the whole person and their unique circumstances. In pursuing these goals, VEBA stands out from its peers in prioritizing plans that feature enhanced access and quality, instead of being driven primarily by costs, and offers a variety of thoughtful plan options targeted to different populations and life circumstances.

For VEBA, this has resulted in a 94% satisfaction rating in a recent member survey, which is significantly higher than the 81% average reported nationally.[3] This high-member satisfaction gives us the opportunity to think about the long-term cost drivers of health care in a more creative and personalized manner.

[2] Health Care Cost Institute, "Health Care Cost and Utilization Report (HCCUR)."
[3] KFF, "Survey of Consumer Experience with Health Insurance."

INNOVATING TO LOWER OUT-OF-POCKET COSTS FOR WORKING FAMILIES

Ensuring access to comprehensive benefits designed to keep employees healthy and happy is a core value of VEBA's plan design. To ensure access to care for lower- and working-income employees, VEBA eschewed national deductible and cost-sharing trends, retaining low out-of-pocket costs across plan designs and shielding members from price increases. Instead of shifting costs to employees to reduce care consumption, which increases barriers to access, VEBA endeavored to rein in costs through innovative patient-focused care and quality programs.

According to the Kaiser Family Foundation, the average deductible has increased 10% over the last five years and 53% over the last 10 years. Workers at small employers (under 200 workers) on average face much larger deductibles than workers at larger firms ($2,434 vs. $1,478). These increases were driven by the rising cost of health care, resulting primarily from increased prices – not utilization – forcing many plans to shift costs onto their employees. While premiums are paid by all members, co-pays and deductibles are borne by those who need to use health care services. More than half (58%) of employers say their workers have at least a moderate level of concern about the affordability of their plan's cost-sharing requirements. The average general annual deductible for single coverage is $2,944 for HDHP/Health Reimbursement Accounts (HRAs) and $2,518 for Health Savings Account (HSA)-qualified HDHPs.[4]

We believe that health care coverage is useless if it is too costly for individual members and their families to access care. VEBA has made significant efforts to minimize employee cost-sharing, which is reflected by the majority of our members being enrolled in plans with zero-dollar deductibles and $10 primary care co-pays. This unconventional and innovative approach, which we provide more details on below, has resulted in tens of thousands of dollars in savings for individual members requiring health care services when compared with other health plan options over the same time period. Over a 10-year period, a typical family enrolled in any VEBA plan would save $30,000 on average compared with a family enrolled in the average employer plan and $80,000 compared to a family enrolled in Covered California without cost-sharing assistance (see table below). For public sector employees, these cost savings are significant.

The chart below compares the 2020 cost-sharing requirements in VEBA's Performance HMO Plan, the average silver plan in Covered California (the most popular by enrollment), the average California employer plan, and the CalPERS Basic Choice PPO.

[4] Kaiser Family Foundation, "2023 Employer Health Benefits Survey," October 18, 2023.

	VEBA Performance HMO Plan B Network 1	Average Silver plan (covers 70% average annual cost) offered by Covered California	Average California employer Plan	CalPERS Basic Choice PPO
Deductible	$0 / $0 deductible (individual/ family)	$4,000/$8,000 deductible (individual/family)	$1,402/ $2,706 (individual/family PPO) $2,457/ $4,834 (individual/ family HDHP)	$500/$1,000 (individual/ family)
Primary	$10 primary care copay	$40 primary care copay	Data not available	$20 office visit co-pay for each service provided
Emergency	$100 copay (waived if admitted)	$400 copay for emergency room visits	Data not available	$50 emergency room deductible; 20% for other emergency services
Out-of-pocket max	$3,000/$6,000 (individual/family)	$7,800/$15,600 (individual/family)	Data not available	$3,000/$6,000 (individual/family)
Mental health	$20 copay for mental health services (no charge if inpatient)	Data not available	Data not available	$35 for specialist visits; 20% if hospital

Source: Tall Pine Consulting LLC analysis, 2020; Covered California, "Health Insurance Companies and Plan Rates for 2020; California Health Care Foundation, "2019 Edition – California Employer Health Benefits," August 29, 2019;" CalPERS, "2019 Health Benefit Summary."

HOLDING THE LINE ON DRUG PRICING

The cost of prescription drugs is one of the largest challenges facing both employers and their workers. In 2021, retail prescription drugs accounted for 8.9% of US health spending but a larger share of private health plan spending. Retail prescription drugs account for 16.1% of fully insured private health plan premiums after accounting for rebates.[5] This is driven primarily by the rising prices of specialty and brand-name drugs, as the price of many generics have remained flat or decreased.

Over the past several years, VEBA came in below the national pharmaceutical trend while making changes to plan design focused on improving health and incentivizing smart consumption. Between 2017-2020, VEBA managed pharmaceutical spending to a trend of 1.8% year over year, well below the national average of 7-8% for large employer groups.[6] [7]

For VEBA, managing pharmaceutical costs doesn't mean looking first to limit access to new or high-cost drugs, it means helping patients afford their maintenance drugs so they can manage

[5] Peterson KFF Health System Tracker, "What are the recent and forecasted trends in prescription drug spending?" September 15, 2023.
[6] NBGH, "2020 Large Employers Health Care Strategy and Plan Design Survey," 2020; Mercer analysis.
[7] VEBA estimates by Tall Pine Consulting LLC.

chronic conditions like diabetes, adopting best practices to reduce the incidence of abuse, and incentivizing lower-cost options. Recent initiatives include:

- Launching a diabetes management program that provides free, unlimited test strips to participants that can save members about up to $400 annually;
- Waiving member co-pays for more than 100 specialty medications that cost, on average, $2,500 per month;
- Adopting prescribing best practices to reduce the incidence of opioid misuse and addiction; and
- Incentivizing use of biosimilars and generic drugs while protecting patients who demonstrate medical need for a brand or specialty drug.

We are also working with our providers on a way forward to address complex obesity, developing a program that includes comprehensive lifestyle changes and cognitive behavioral therapy, as well as the option of GLP1 coverage. VEBA is constantly innovating to address the ever-changing clinical, pharmaceutical, operational, and cost environment inherent in our complex system to the benefit of our members.

PROVIDING MORE CHOICE AND BETTER ACCESS

In order to meet our members' diverse needs, VEBA has prioritized cultivating relationships with a broad network of providers to ensure enhanced access and favorable pricing. VEBA's provider relationships include major hospitals and specialty programs in the region, enabling us to meet the diverse needs of the VEBA community. In addition to effective cost management, members have said they value the stability of their networks.

VEBA currently offers more than 30 different HMO and PPO plans through UnitedHealthcare, Cigna, SIMNSA, and Kaiser Permanente, as well as our new VEBA Direct Plan (see more below). In comparison, CalPERS currently offers just 5 basic PPO plans and 11 basic HMO plans for active members. Nationally, only 12% of large employers offer more than 2 plan designs.[8] We have found that our members appreciate and value these diverse plan options and are better able to select the plan that best suits their unique health and financial needs.

We are constantly innovating across our plan designs and supporting new technologies. In addition to our performance network and direct contracting efforts (more below), we are also testing a new PPO platform for out-of-state dependents that allows real-time adjustment of the cost to members to drive toward higher-value providers before they receive care. This enables true consumerism that ties upfront co-pays to cost and quality, delivering savings to our members and lower out-of-pocket costs and higher quality for patients.

[8] Tall Pines Consulting LLC analysis; CalPERS, "2020 Health Benefit Summary"; Covered California, "Health Insurance."

VEBA INNOVATION

QUALITY AND HEALTH INCENTIVES

Performance Network

VEBA is focused not only on offering high-quality care but on actively helping members to navigate their health benefits and own their health care decisions. For example, in 2010, VEBA developed a "performance network" aimed at incentivizing members to select higher-quality, lower-cost providers. By analyzing cost and quality data from both public sources and our proprietary database of millions of physician encounters, VEBA created a stratified health care provider network categorized into three tiers: 1) providers who deliver high-quality care for a reasonable cost; 2) providers who did not meet either the cost or the quality threshold; and 3) providers who delivered average to good care but at prices 180% or more of the county average.

A fourth, hidden tier included providers excluded from the network because their quality was deemed unacceptable at any price. To nudge members to the top tier of providers, VEBA used financial incentives – choosing a provider in the top tier resulted in lower out-of-pocket costs, both at the time of service and in premiums. This design allowed VEBA to preserve choice for members who may, for example, want to remain with a provider not in the top tier, while successfully migrating 96% of the population to tier one, high-value providers. The results were outstanding. The first year of savings amounted to around $50 million (approximately 10% of premiums) and was achieved with a member satisfaction rate of 94%.

The structure of the program also allowed VEBA to offer over 90% of its membership improved benefits, which has allowed VEBA to save members and employers hundreds of millions of dollars. The significance of the savings was recognized by the Regional Taxpayers Association of San Diego. Due to the significant success of the model, VEBA was able to enter discussions with higher-cost and/or lower-quality facilities, most of whom agreed to reduce costs and/or improve their quality to achieve better tier placement in the future.

Direct Contracting

VEBA's Performance Network served as the proof of concept for our recent direct contracting initiative, as it showed significant savings, improved outcomes, and satisfaction. However, we were still significantly constrained as our innovation needed to be accommodated by contracts established by our partner health plans, to which we were not a participating signatory. This significantly limited how much influence VEBA had over contract details related to our specific programs and goals. Direct contracting is now serving as a tool for VEBA to remove the middleman and directly partner with providers on innovative primary care and prevention in ways not currently contemplated by existing health plans, often due to their shortsighted outlook in managing health.

We did not come to this easily, however. Currently, self-funded employer plans and union trusts in California are unable to directly enter into risk-based contracts with provider groups. Instead, today, any direct contracts are required by state law to operate on a fee-for-service basis, which leads to misalignment of incentives, overutilization, and ultimately higher costs. In an effort to realign incentives and deliver better outcomes for our members, VEBA began exploring a legislative fix in 2017-2018 to enable the use of risk-bearing contracts, and we were ultimately successful in advancing a solution in 2020. The state bill (AB1124) created a four-year pilot

program to allow an approved applicant to contract directly with a provider group(s) in such a risk-bearing contract, with an independent review agency monitoring the pilot to gauge the cost savings, patient impact, and care delivery over time.[9] VEBA was selected to build the first pilot program in California.

Establishing the direct contracting program required an extensive application with the Department of Managed Health Care (DMHC) and took more than eight months from submission to conditional approval. While we encountered several challenges along the way, such as finding an administrator for the program, given that most Third Party Administrators (TPAs) operate on leased networks from the carriers on a fee-for-service basis, we are excited to have gone live with membership effective January 1, 2024 and hope to secure an extension in an upcoming legislative session.

The competitive network consists of several large, integrated systems, including Sharp Rees-Stealy, Sharp Community Medical Group, University of California San Diego, and Rady Children's Hospital, with 15 participating employers representing approximately 2,500 members and 4,500 total members. Our annual budget for the program is around $34 million, which generated a 2% savings (roughly $700,000) for the pilot population in the first year. This is based on conservative pricing estimates and is expected to compound over the ensuing years.

The contracts in the network delegated risk to the medical groups for portions of the care to effectively align the incentives of both VEBA and the participating medical groups to lower costs through healthier membership. In addition, the carve-outs for the plans were negotiated to mitigate risk at reasonable reimbursement rates.

VEBA is hopeful that this pilot proves the cost savings and quality-driving power of risk-based arrangements such as this. We look forward to a more permanent solution and support removing barriers to allow for greater participation in risk-based contracts.

A PARTNER IN IMPROVING HEALTH

Personalized Population Health

VEBA's mission to reduce costs by better addressing the whole health of its members reflects a belief that far too many health care dollars are spent responding to crises while far too few are invested in proactive health management. With this in mind, VEBA opened our first VEBA Resource Center (VRC) in 2019, providing a personalized approach to well-being. The VRC is different from on-site medical centers provided by other employers and embraces a much bigger goal: addressing the whole health of our members through a personalized population health approach, the by-product of which is avoiding costly acute health episodes in the future.

At the VRC, members receive personal guidance from a trained nurse Care Navigator who leads them in designing customized plans for physical, social and emotional health. The VRC looks at each member as an individual with a unique past and set of experiences that could be contributing to present health issues and works with those members to customize a plan that improves their habits and lifestyle and identifies risk factors to help avoid higher-cost health care emergencies. Each individual care plan varies but can include a mix of fitness, nutrition, mindfulness, holistic pain management, and stress reduction.

[9] California Senate Floor Analysis of AB 1124.

The VRC also includes access to individual and group counseling and encourages other healthy activities by providing access to cooking demonstrations, group fitness classes and other activities that focus on whole member health. VEBA members' no-cost access to the VRC includes supportive services that remove barriers to care and make achieving individual plan goals easier, such as free childcare services, transportation support, and telemedicine.

By all accounts, the VRC has been a huge success, with so much member interest that VEBA launched a second location and is opening two new locations in 2024. As we measure long-term longitudinal health outcomes in the population, initial anecdotal evidence has shown member successes ranging from weight loss and improved nutrition to avoided suicides and mitigation of abusive relationships.

Robust Mental Health Support and Care Integration

VEBA has rolled out several initiatives to build on its model of personalized population health and to fill critical gaps in care, namely, inadequate access to mental health care and a lack of integrated solutions. VEBA offers robust mental health benefits including through the holistic VRC, Employee Assistance Program (EAP) and one-on-one care navigation, where members receive access to confidential in-person, virtual, and telephonic emotional, physical and whole person health support. VEBA also works with our school system members and across the community to reduce stigma and encourage access to comprehensive behavioral health and wellness supports, as well as trauma-informed care. For example, VEBA is engaged in anti-stigma and education campaigns to encourage uptake and access to mental health benefits, including their "How the Strong Rise" campaign and recent partnership with The Honor Foundation to create an Emmy-award winning documentary, "Breaking the Stigma," featuring a VEBA team member and veteran. VEBA has also piloted various programs aimed at ensuring trauma-informed care, seamless transitions, and warm handoffs from trusted primary care providers to mental health care resources and other supportive services.

The vital importance of behavioral health integration and its potential impact on health outcomes and costs can be witnessed through our VEBA member stories. Two chronically ill patients in one of our plans both experienced failed suicide attempts due to the pain and suffering of their illnesses. These million-dollar claims could have potentially been mitigated – along with the suffering of our VEBA family – with earlier and integrated mental health interventions. The importance of behavioral health integration with primary care and chronic disease management cannot be stressed enough. That is why VEBA is exploring behavioral health screening interventions for members with chronic disease diagnoses while ensuring adequate mental health support as they navigate their disease.

VEBA believes that mental health care is a critical component to health care that can have wide-reaching effects on overall health, but knows that many Americans struggle to successfully navigate and meaningfully access the mental health care system. While the California Department of Managed Health Care requires no more than a 10-day wait for mental health services, many Californians report waits of more than two months to access mental health care providers.[13] According to a California Health Care Foundation survey, more than half (53%) of Californians trying to make a mental health appointment reported waiting longer than they thought reasonable to get one, and 49% of Californians who tried to make an appointment for mental health care said it was difficult for them to find a mental health care provider who took

their insurance.[10] VEBA is working to change that. Our focus is on enhancing access to high-quality, culturally sensitive mental health care services while achieving cost reductions for VEBA members and their families.

Other Wraparound Benefits

In addition to our robust benefits and other offerings mentioned above, VEBA offers a suite of other wraparound services to ensure members are engaged and empowered advocates for their own well-being. For example, VEBA has long offered a second opinion service, which provides free consultation with medical experts for member employees or dependents who have questions about their health. Through this service, VEBA discovered that up to 45% of patients seeking a second opinion for a serious diagnosis are misdiagnosed, and that 79% require a change in their treatment plan. After utilizing the service, our members frequently shift to newer, less invasive and higher-value treatments. The impact of this shift in treatment is profound for the individual undergoing treatment, as well as for the cost implications for the plan.

POLICY PRIORITIES

VEBA's unique structure, member-centric perspective, and innovative thinking has empowered us to address some of health care's most serious problems while making care affordable for Southern California's teachers, custodians, cafeteria workers, and other public servants. If we are to meaningfully address the $4.5 trillion elephant in the room – otherwise known as US annual health care spending, along with issues surrounding access, quality, chronic disease, and culturally appropriate care – innovators like VEBA must continue to keep pushing the system towards patient-centered, value-based care and prove that when done right, members will find better outcomes, higher levels of satisfaction, and through it all – lower costs. We must remove barriers to high-value care innovation and empower other employers – including small and mid-size employers – to join in. We truly believe that a rising tide lifts all boats; we want to move the whole system forward together.

1. **Remove barriers to employer participation in value-based programs, such as high-performance networks and direct contracting, and incentivize adoption across the health care ecosystem.**

   Direct contracting is a cost containment tool that small and midsize employers can leverage to improve care delivery, quality and cost for employees. Independent, impartial research conducted by the U.C. Berkeley School of Public Health and the Integrated Healthcare Association consistently shows that the solution to rising health care costs is to increase the percentage of health care that is delivered through clinically integrated providers that share the financial risk with health plans, government, and employer payers. To date, this kind of health care financing and delivery model has been used in the fully-insured, employer-sponsored HMO, Medicare Advantage, and Medi-Cal Managed Care market segments.[11]

   We strongly encourage Congress to eliminate federal and state barriers that limit or discourage direct contracting across the employer market. As discussed above, VEBA worked for years to advance legislation in California just to get a pilot to allow us to enter into a

[10] CHCF, "The 2023 CHCF California Health Policy Survey," February 2023.
[11] California Senate Floor Analysis of AB 1124.

direct contract arrangement with well-known hospital systems with the goal of reducing costs and giving our members access to high-quality in-network care. Smaller employers cannot move forward with such innovation if Congress does not act to remove barriers. We encourage the committee to pass legislation that would encourage employers to enter into risk-based arrangements, including direct contracting arrangements, through the creation of a grant program and educational efforts to support this vital shift in the way we pay for and deliver health care.

VEBA also supports passing legislation that bans anticompetitive terms in facility and insurance contracts that restrict access to higher-quality, lower-cost care (e.g. the provision contained within Section 302 of the Lower Health Care Costs Act in the 116th Congress). Currently, "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans restrict plans from creating innovative, high-value programs such as VEBA's high performance network. This change would allow more employers to do what VEBA has been so successful in doing – offering tiered provider networks and incentives for enrollees to use lower-cost and higher-quality providers. In our experience – and confirmed by the CBO's estimates – this reduces costs for the plan and for the system overall.

Similarly, VEBA supports other efforts aimed at increasing adoption of value-based care arrangements, including in Medicare, as a large-scale purchaser of health care, ideally with both up- and downside-risk. As the largest payer of health care, Medicare's adoption of value-based care arrangements can positively impact the entire health care ecosystem.

2. **Increase transparency into health care claims and encounter data, along with information on costs and quality for health care providers.**

In order for programs such as our performance network to work, health care purchasers need data that includes meaningful cost and quality metrics for providers, health systems, PBMs, and other service providers. VEBA was fortunate to have access to quality and cost data from California's Office of the Patient Advocate, which was critical to the development of our tiers. However, access to such data is unique and should be universally accessible. We believe that having even greater transparency could triple our savings in years to come, decreasing costs and increasing efficiencies while also driving beneficial outcomes for our members and beyond. VEBA strongly encourages provider-level quality data and creating flexibility to exclude providers from in-network status, where there is evidence of a pattern of consistently poor care outcomes.

Additionally, our analysis indicates that at least 25% of health care claims may be fraudulent, excessive, miscoded, or indicate an abuse of the system, with hundreds of millions of dollars in fraudulent claims going unchallenged every year. We are actively working with California stakeholders to create access to meaningful data, including representation on the All Payer Claims Database project, which is encouraging ERISA plans to self-report data. Access to cost and utilization data, along with actual claim payments and contract allowance amounts for hospitals and ambulatory surgical centers, will empower public agency employers and public employee-related trusts, such as VEBA, to access the data necessary to improve health care for employees and reduce costs. A change such as this will help ensure we are using taxpayer funds cost-effectively and efficiently through more informed negotiation and better plan design.

VEBA spends over $1 billion a year in health care; we want to know every word and every dollar in our contracts, which are getting increasingly complex through carve-outs and

various financing mechanisms. To be good stewards and fiduciaries of our members' care, we must have this transparency.

Finally, we also support many of the transparency policies contained within the "Lower Costs, More Transparency Act" (H.R. 5378) passed out of the House on December 11, 2023 and commend the committee for its leadership. This includes codifying federal price transparency rules and adding new price transparency measures for imaging services providers, ambulatory surgical centers and clinical diagnostic laboratories (Sections 101-105), as well as provisions to ensure that health plan fiduciaries are not contractually restricted from receiving cost or quality of care information about their plan (Section 401) and language aimed at increasing transparency into hospital outpatient billing practices and correcting Medicare payment discrepancies that increase both patient and Medicare spending and perversely incentivize hospital consolidation (Sections 203-204).

While VEBA believes Section 203, which would align Medicare payments for physician-administered drugs in off-campus HOPDs and free-standing physician offices, serves as an important first step toward protecting patients from paying hospital-level prices for non-hospital level care, we support more expansive language included in the SITE Act (S. 1869) that would remove exceptions for site-neutral payments included in the 2015 Bipartisan Budget Act. Similarly, we strongly support policies that require pharmacy benefit manager (PBM) reporting to plan sponsors around the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, aggregate rebate data and other fees (Section 106), but support extending the spread pricing prohibitions (currently just for Medicaid) into the commercial market (Section 202). Additional insight into these contracts and elimination of opaque practices and terms is necessary for us to fully understand our health care spending and drive additional value for our members.

3. **Bolster access to and payment for mental health care through tele-mental health, care integration and workforce solutions.**

As a key underlying driver of health care costs, mental health treatment must be prioritized. VEBA supports policies to relax telehealth rules for behavioral and mental health providers to provide more timely access to patients in need and create more meaningful metrics related to the inclusion of and access to behavioral health and mental health professionals.

We believe that enhanced access to tele-mental health is an important way to increase access amid workforce shortages and bring care to people as soon as they are willing or able to access it, in addition to addressing other barriers like child care, concerns of privacy, time and other constraints. We support legislation that enables providers to work across state lines and for patients to receive services in their home, as well as making permanent the flexibility for HSA-eligible plans to offer telehealth pre-deductible (H.R. 1843 / S. 1001). We also support investments in broadband and telehealth infrastructure to ensure equitable access to mental health care.

VEBA also supports advancing legislation and continued funding of programs across all payers and communities that address the critical integration of primary care and mental health, as well as payment models and quality metrics that incentivize and support individual providers in participating. We applaud our California Department of Health Care Services (DHCS) for launching a first-in-the-nation statewide effort to screen patients for Adverse Childhood Experiences (ACEs) and setting a bold goal of reducing ACEs and toxic

stress by half in one generation and encourage other states to follow suit.[12] Similarly, we support legislation that would increase access to chronic disease management services, such Chronic Disease Flexible Coverage Act (H.R. 3800 / S. 3224), given the frequent co-morbidities with mental health conditions, along with funding for programs that encourage primary and behavioral health integration.

We also support legislation aimed at incentivizing the growth of the mental and behavioral health care workforce. About 37% of Americans currently live in areas where there is a shortage of mental health providers, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), and by 2025 the US will be short about 31,000 full-time equivalent mental health practitioners.[13] We need targeted solutions aimed at ensuring adequate access to care.

4. Give employers the flexibility to design programs to address chronic conditions and improve health outcomes.

VEBA has seen firsthand the power of targeted solutions to address chronic conditions and improve health outcomes. As discussed above, VEBA looks at each member as an individual with a unique past and set of experiences that could be contributing to present health issues and works with those members to customize a plan that improves their habits and lifestyle. This may include supportive services that remove barriers to care, providing support and encouragement without judgement. We believe employers should have the flexibility to address the needs of their members and design programs that lead to better outcomes, including addressing social drivers of health. For example, VEBA is hoping to launch a Food is Medicine initiative that enables members to access nutritious food in their local communities at no or low-cost to them with the confidence it will directly improve health outcomes.

This is why VEBA supports the Chronic Disease Flexible Coverage Act (H.R. 3800 / S. 3224), which allows greater flexibility to offer pre-deductible coverage for chronic disease prevention (even though we do not offer high-deductible health plans); the Telehealth Expansion Act (H.R. 1843 / S. 1001); legislation that allows employers to provide more robust services, like care at onsite medical clinics pre-deductible without charging cost-sharing (these provisions are included in H.R. 5688); and other similar efforts to bolster access to robust chronic disease management, resources and support

5. Ease federal and state restrictions on pooling, with appropriate protections, for small employer groups to bring the VEBA value to other employers.

VEBA is now the fourth-largest purchaser of health care in the state of California, aggregating more than 70 participating public employers and over 150,000 members – including four of the top ten largest school districts in California. We use our market power to directly negotiate with medical groups and hospital centers, exerting greater influence as a group with the collective power to impact change and deliver higher-value care. Enabling employer pooling through VEBAs, Association Health Plans (AHPs), and other mechanisms – ensuring appropriate guardrails – saves taxpayers money and can significantly reduce

[12] DHCS, "Trauma Screenings and Trauma-Informed Care Provider Trainings."

[13] National Council for Mental Wellbeing, "New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society," April 25, 2023.

costs for employers so they can focus on their core business. In VEBA's case, this means improving retention of teachers and custodians while directing critical and limited resources to furthering student education.

Over the years, numerous employers have asked if they can have access to the California Schools VEBA. Unfortunately, the California state limits on AHPs and the current VEBA rules prohibit us from either starting a new pool or expanding access to many employers. We support easing federal and state restrictions with appropriate protections for small employer groups so they can join a large risk pool such as VEBA's, protecting them from rate rebound and enabling them to deliver higher-quality, lower-cost care to their members.

VEBA is also concerned about state laws that prohibit the development of high-quality association or employment-based health plans. VEBA believes that with updated safeguards, these could provide meaningful market options for small and mid-size employers to bring the benefits of pooling to a smaller market, like VEBA does for educators and civil servants.

Thank you again for the opportunity to testify in favor of expanding access to direct contracting with providers, improving cost and quality transparency, and for your work to encourage innovation, like our direct contracting options, in the employer-provided health care market.