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Chairman Roe, Ranking Member Polis, and members of this subcommittee: Thank you for the opportunity to participate in today's hearing about initiatives to support and sustain a healthy workforce. My name is Sabrina Corlette. I am a research professor at Georgetown University's Center on Health Insurance Reforms. However, the views I share here today are my own and do not represent those of the university, its faculty or staff.

Most Americans under 65 receive their health coverage through their employer – over 150 million people. Employment-based health insurance, or "ESI" has been the foundation of our health care system for several generations. Among workers, it consistently rates as one of the most popular benefits, second only to paid leave.

In my testimony today I would like to make 2 primary points: (1) The foundation of ESI remains strong, but affordability continues to be a challenge for employers and employees alike; and (2) To improve affordability, an all-stakeholder effort that includes employers is needed to actively engage in local delivery system and payment reforms.

Our system of employer-sponsored insurance remains strong, but affordability is a challenge

In spite of early fears, the Affordable Care Act (ACA) has not caused employers to drop coverage for their workers, nor has it resulted in reductions in employment. On the contrary, the employment-to-population ratio in 2015 was higher than expected.[1] Companies are not shifting full-time workers to part-time status.[2] And coverage trends for ESI have remained stable under the ACA.[3]

What is clear is that employers are benefiting from the significant slowdown in the growth of health care prices, compared to the pre-ACA growth rate. And there is some evidence that these savings are being passed on to workers, as the growth in workers' premium contributions has slowed, and the average contribution is significantly lower than it would have been if cost growth had continued at pre-ACA levels.[4]

Even with these promising trends, affordability remains a huge challenge for too many families. While the growth in workers' share of premiums has slowed, it is still growing – worker contributions to health plan premiums grew an estimated 83 percent between 2005 and 2015.[5]

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[1] Garret B, Kaestner R, Claims That the ACA Would be a Job Killer are Not Substantiated by Research, February 3, 2016. Available at: http://healthaffairs.org/blog/2016/02/03/claims-that-the-aca-would-be-a-job-killer-are-not-substantiated-by-research/.

[2] Moriya AS, Selden TM, Simon KI, Little Change Seen In Part-Time Employment as a Result of the Affordable Care Act, *Health Affairs*, January 2016, vol. 35, no. 1, 119-123.

[3] Kaiser Family Foundation, 2015 Employer Health Benefits Survey, September 22, 2015. Available at: http://kff.org/health-costs/report/2015-employer-health-benefits-survey/. *See also* Blavin F, Shartzer A, Long SK, Holahan J, Employer-Sponsored Insurance Continues to Remain Stable under the ACA: Findings from June 2013 through March 2015, June 3, 2015. Available at: http://hrms.urban.org/briefs/Employer-Sponsored-Insurance-Continues-to-Remain-Stable-under-the-ACA.html.

[4] Jason Furman, The Economic Benefits of the Affordable Care Act, April 2, 2015. Available at https://www.whitehouse.gov/blog/2015/04/02/economic-benefits-affordable-care-act.

[5] Kaiser Family Foundation, 2015 Survey of Employer-Sponsored Health Benefits.

Many think of ESI as the "gold standard" of coverage, but nearly one quarter of people with ESI report problems paying medical bills.[6] For many, the problem is high and rising deductibles. People in high deductible plans are twice as likely to report problems paying medical expenses as those in low deductible plans. Yet deductibles are steadily increasing. The average deductible for covered workers in 2015 was $1,077, up 67 percent from 2010, and up 255 percent from 2006.[7] We are also seeing a trend away from flat dollar copayments to coinsurance, where enrollees are required to pay a percentage of the cost of the service. Coinsurance not only makes it difficult for consumers to understand what their bottom line out-of-pocket costs will be, but for high cost specialty drugs and hospital stays, charges can run to thousands of dollars. Thanks to the ACA, families with these high medical costs get some financial protection, through an annual cap on out-of-pocket costs. But for many middle-class families these amounts pose a considerable financial burden.

Employers are also reducing their support for dependent coverage. In a recent Kaiser Family Foundation survey, 10 percent of employers report that they have eliminated coverage for spouses and domestic partners, and 49 percent report that they are considering doing so within the next five years.[8]

The bottom line? Employers AND employees are struggling under the burden of high health care costs. Tackling affordability requires an all-stakeholder effort, and employers have a particularly important role to play.

Reducing health care costs while protecting consumers

Cost shifting to workers is not happening by accident. While premium cost increases have moderated since the ACA, they are still rising at a faster clip than the overall rate of economic growth.

In response, many employers, both on their own and in concert with other local purchasers, are engaged in innovative, on-the ground efforts to push back against high and rising health care prices, while not sacrificing the quality of care provided to their employees. Many of these efforts, although in early stages, are showing promise in achieving efficiencies and have demonstrated improvements on key quality metrics.

Using Market Clout to Change the Delivery System

Some of our nation's largest employers are using their market clout to keep costs in check. Intel is a good example. After trying a number of different approaches to curb its rising health care costs, including higher deductibles and workplace wellness programs, the company realized a few years ago that while these efforts helped shift costs to employees, they didn't address the root cause of the

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[6] Hamel L, Norton M, Pollitz K et al, The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey, January 2016. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf.

[7] Kaiser Family Foundation, 2015 Survey of Employer-Sponsored Health Benefits.

[8] Ibid.

problem: the ever-higher prices associated with the care its employees were receiving. So it partnered with a major local health system to see if they could improve quality *and* reduce waste in the system. Over five years, Intel's Healthcare Marketplace Collaborative reduced the costs associated with treating three high cost chronic conditions between 24 and 49 percent. At the same time, it was able to demonstrate high levels of patient satisfaction with their care.[9]

Other large companies, such as American Express, Macy's, and Verizon, have formed alliances to share data on provider costs and health outcomes, and potentially use their combined market clout to "target the supply chain" and get better deals from providers.[10] Smaller employers can achieve similar results through multi-payer efforts that are emerging all over the country, such as the one sponsored by the Maine Health Management Coalition, which works with its employer members to change how care is paid for.[11] By joining forces with other local businesses, unions, and health plans, there is evidence that employers can lead the way to a lower-cost, more efficient, more patient-centered health care system.

ACA-Sparked Initiatives to Shift from Volume to Value

The ACA has spurred activity in payment and delivery system reform across the public and private sectors, building momentum to improve health care value. The ACA created the Center for Medicare and Medicaid Innovation (CMMI) to design, launch, and test new payment models to shift our health care system away from fee-for-service, or volume-based, payment, to value-based payment. For example, a multi-payer initiative in Arkansas is leveraging partnerships with Medicare, Medicaid, state employees and Walmart to expand primary care medical homes and improve care coordination for people with chronic conditions.[12] While the evidence on these new models is still mixed, they provide new opportunities for employers to partner with major government purchasers to pressure providers to reduce inefficiencies and improve quality.

Workplace wellness

For many employers, workplace wellness programs are intuitively appealing. A majority of large employers offer at least some form of wellness program. And that's great. Most of us spend most of our waking hours at work, and there is much that employers are doing to ensure that our working environment supports health. These include laudable efforts to improve nutritional offerings in cafeterias and vending machines, opportunities to participate in lunchtime walking clubs, yoga classes, and stress reduction sessions, and redesigning our office space to encourage employees to get up and move around.

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[9] McDonald, PA, Mecklenburg RS, Martin LA, The Employer-Led Health Care Revolution, *Harvard Business Review*, July-August 2015. Available at: https://hbr.org/2015/07/the-employer-led-health-care-revolution.
[10] Louise Radnofsky, Companies Form New Alliance to Target Health-Care Costs, *Wall Street Journal*, February 4, 2016. Available at: http://www.wsj.com/articles/companies-form-health-insurance-alliance-1454633281.
[11] How Employers Can Improve Value and Quality in Health Care, Robert Wood Johnson Foundation and Aligning Forces for Quality, January 2013. Available at: https://www.pcpcc.org/sites/default/files/resources/rwjf403361.pdf.
[12] Stremikis, K, All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform, Milbank Memorial Fund and Pacific Business Group on Health, 2015. Available at: http://www.pbgh.org/storage/documents/Milbank_-_PBGH_Report_FINAL_2_17_15.pdf.

Fewer employers – an estimated 30 percent - tie an employee's achievement of a particular health outcome to health insurance premiums or cost-sharing. That may be because there is very little evidence that doing so will result in either improved health, increased productivity, or lower health care costs.[13] To the contrary, there is strong evidence that, with many conditions, such as obesity, tobacco use, and high cholesterol, financial incentives do little to change behaviors. What they do instead, unfortunately, is raise the barriers for these individuals to access the health care services and support they need to achieve better health outcomes. A smoker won't be able to access cessation counseling if he can't afford the premiums to maintain health coverage. These programs also hit the hardest the people who can afford it the least, as many of the targeted health conditions have greater prevalence among lower-income populations.

There is also disturbing evidence that some wellness programs place employees' privacy at risk. Workplace wellness vendors can and do harvest vast amounts of personal health information from employees. Some require employees to allow access to medical records and claims data in order to participate, and many also require completion of a health risk assessment (HRA) and/or physical exam. Although federal law restricts the information that wellness vendors can share with employers, nothing restricts what these companies can share with business partners for marketing purposes.[14] Yet many employees feel tremendous pressure to participate in these wellness programs, especially when up to 30 percent of the cost of a family premium is at stake (which could mean $5,263 or more each year).

Benefit Design Changes: Tiering, VBID, and Reference Pricing

Just as with workplace wellness programs, many new payment and delivery system reforms sound promising on the surface, but may ultimately be more about cost-shifting than actually improving health outcomes. For example, many insurers and employers have touted network tiering as a way to encourage consumers to seek care from higher quality, lower-cost providers. However, there is limited evidence to suggest that providers in the lower-cost tiers are actually selected with quality taken into account. Their "preferred" status is often just a function of price. At the same time, there is a large body of evidence telling us that consumers often don't understand how to use their insurance plans. When networks are subdivided into three or four tiers, it can be incredibly difficult for consumers to assess what their bottom line costs might be.

Similarly, another trendy concept – reference pricing – needs to be carefully considered in terms of its impact on consumers. It works only if consumers have easy-to-understand and use information about who the lower-cost providers are, if they are reasonably accessible, and if there is sufficient time for the patient to make an informed decision. Yet referring providers are notoriously reluctant to discuss costs

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[13] RAND, Workplace Wellness Programs Study. Available at: https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf; *see also* Patel MS, Asch DA, Troxel AB et al, Premium-Based Financial Incentives Did Not Promote Workplace Weight Loss in a 2013-2015 Study, *Health Affairs*, January 2016, vol. 35 no. 1, 71-79.

[14] Pollitz K, Rae M, Workplace Wellness Programs Characteristics and Requirements, Kaiser Family Foundation, January 2016. Available at: http://kff.org/private-insurance/issue-brief/workplace-wellness-programs-characteristics-and-requirements/.

with patients, and very few do. Most don't even know their patients' source of coverage when referring them for a test or service.

Another effort – value-based insurance design – is also great in concept, but difficult to execute. Reducing or eliminating cost-sharing for high value services and drugs helps reduce financial barriers to needed care, but hasn't been shown to reduce costs. Raising cost-sharing for low-value services and drugs *might* reduce costs, but few employers want to be in the business of deciding which drugs and services are low value.

Targeting the real culprit (and it's not consumers)

A fundamental challenge for employers and their workers today is the cost of health care. But many proposed reforms don't get at the primary cost drivers: providers and suppliers, many of whom use local market clout to demand reimbursement disproportionate to the actual value they deliver. With increasing consolidation among provider systems and payers, this problem is only likely to get worse. Ultimately, it may fall to employers – in partnership with other major purchasers, including Medicare and Medicaid – to drive the reforms that will ultimately reduce costs and achieve better health outcomes.

Thank you Mr. Chairman and Members of the Committee for the opportunity to testify today. I look forward to the discussion.

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