

March 1, 2019

The Honorable Lamar Alexander
Chairman, Senate Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander,

Thank you for the opportunity to provide recommendations to help address rising healthcare costs. As you know, more than 181 million Americans—well over half the population—receive healthcare coverage through an employer. Employers play a critical role in the US health care system, leveraging purchasing power and plan design innovations to provide that coverage in ways that strive to control costs while improving the quality of care. Still, high healthcare costs remain the source of many our challenges, and we applaud your commitment to addressing these issues and are ready to work with you in this effort.

Mercer is a business unit of Marsh & McLennan Companies (MMC), a US-based leading professional services firm with a global network of more than 65,000 experts in risk, strategy, and people. In addition to Mercer, the businesses of MMC, include Marsh, Guy Carpenter and Oliver Wyman, and we employ 25,000 colleagues in the US. Together, we collaborate with our clients to navigate the increasingly complex healthcare marketplace in order to: (i) help individuals, families and employees stay healthy and productive, (ii) enable innovation and (iii) lower their costs.

Before sharing our views on specific issues, it is important to note again that US employers are working hard to control costs—health benefit costs rose by a moderate 3.6% in 2018 and are expected to rise by about 4% again in 2019. That is faster growth than in 2017, however, costs are still outpacing inflation and workers' earnings growth. Smaller employers especially are having a tougher time controlling costs: firms with 10-499 employees were hit with an average increase of 5.4%, while midsize and large employers held cost growth to 3.2%. Prescription drugs—specialty drugs in particular—remain a top cost driver for all employers.¹

¹ Mercer, National Survey of Employer-Sponsored Health Plans, 2018, <https://www.mercer.us/what-we-do/health-and-benefits/strategy-and-transformation/mercerc-national-survey-benefit-trends.html>

Our research shows that the steps an employer takes—or doesn't take—to manage costs over time has a significant impact on their health plan cost and cost growth. There is no one silver bullet, but rather a matter of doing a lot of different things right. We believe this approach also applies to crafting sound policy, and we are grateful for the opportunity to share our views and recommendations on the following issues.

Pursue drug pricing reforms

Specialty drugs continue to make an enormous impact on people's lives by improving health outcomes or shortening treatment durations for some of the most threatening diseases, such as diabetes, multiple sclerosis, viral hepatitis and cancer. But while some of these medicines bring life-changing results to some plan members, their price points are also viewed as unsustainable by employers and patients.

Prescription drug cost is rising faster than overall medical cost, driven by the cost for specialty drugs. Although the specialty drug trend has cooled slightly since 2017 (15.4%), it remained in the double digits in 2018 (11.9%), and continues to be a top priority for employer plan sponsors.²

The most common cost-management approach, used by about half of all large and midsized employers is simply to steer employees to a specialty pharmacy to fill prescriptions for specialty medications. Specialty pharmacies offer services above and beyond those typically offered at the retail level as part of their standard of care. Ideally, this translates into improved care with measurable, positive clinical outcomes. Applying pay-for-value strategies may have more potential for cost savings. By carving out specialty drug management, employers can address the misalignment of incentives by separating distribution and management, and gain greater flexibility in formulary, clinical and plan design features.

Employer Case Study: NRECA Implemented a Carve-Out for Specialty Drugs

For the National Rural Electric Cooperative Association (NRECA), specialty drugs represented 35% of the \$100 million total pharmacy spend. NRECA stepped up management of high-cost specialty medications to prevent waste and improve the patient experience by moving all specialty drugs under the pharmacy benefit. Patients are connected with a specialty pharmacy team to improve adherence and ensure medications are dispensed in the most cost-effective setting—sometimes the patient's home. The program saved \$1.3 million in 2016.³

² Mercer, National Survey of Employer-Sponsored Health Plans, 2018

³ This employer case study first appeared in *Leading the Way: Employer Innovations in Health Coverage*, a report co-authored by Mercer and the American Benefits Council that profiles 15 companies that are implementing cutting edge strategies to manage healthcare costs, drive better quality and personalize the experience for their plan members. <https://www.mercer.us/content/dam/mercer/attachments/north-america/us/Health/us-2018-health-innovation-whitepaper.pdf>

One area of great interest to us is where specialty drugs are administered. Approximately 40% of specialty drug spend flows through the medical plan as opposed to the drug plan. When drugs run through the medical plan we tend to see the same drug with the same dosage being administered at a much higher cost with no additional value. Nonpartisan research shows that, on average, hospitals mark up drugs by approximately 487% over their acquisition cost and in the outpatient hospital setting the mark-up over acquisition cost averages 252%.⁴ Unfortunately, many employers aren't aware of these drug markups due to the current state of medical reporting. We estimate 3-8% of specialty drug savings can be achieved through the aggressive management of where drugs are administered. Through specialty drug programs like NRECA's and other employer-led initiatives we're seeing results but there's opportunity for increased employer participation in site of care strategies.

Despite employers' ability to implement cost savings strategies, we recognize that the current pharmacy management system is significantly flawed on multiple levels and there is material room for improvement. One key issue is that the providers of products and services (pharmaceutical companies, pharmacy benefit managers (PBMs), health insurers) do not have incentives that align with payers (employers, individuals and government programs). As with any for-profit business, many providers focus on greater consumption of goods and services; payers are more interested in cost control and rewarding value (i.e. outcomes) rather than simply volume. Realignment of these incentives so that all stakeholders are focused on purchasing for value and to control cost will take time. Initial steps should focus on mechanisms to gradually move away from those aspects of our current rebate system that result in high drug prices. Rebate reform should be coupled with increased transparency for private payers and flexibility for public payers. These changes would then set the stage for a pharmacy model aligned with a pay-for-value approach.

We have structured our suggestions⁵ beginning with shorter term reforms that form the foundation and structure for midterm and longer term reform. While movement away from the current misaligned system is critical, we believe it should be done in a phased fashion to achieve better results under the new model.

- **Reforms in the rebate system are needed to get to a value-based model, but any changes must occur across both the public and private sector.** Eliminating the federal law's anti-kickback safe harbor which allows drug rebates in federally funded programs won't necessarily change PBM contracting or practices with private sector plan sponsors. Instead consider incenting stakeholders to drop their rebate practices. But recognize that rebate elimination or restriction is likely to produce other consequences—such as higher

⁴ The Moran Company, *Hospital Charges and Reimbursement for Drugs: Analysis of Markups Relative to Acquisition Cost*, October 2017, http://www.themorancompany.com/wp-content/uploads/2017/10/Hospital-Charges-Report-2017_FINAL.pdf

⁵ Mercer Response to Request for Information on HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs, July 16, 2018, <https://select.mercer.com/blurb/360334/>.

premiums and/or cost-sharing—since many private sector plan sponsors now use rebates to help defray overall plan costs. Given these dynamics, Mercer suggests looking at ways to move away from a rebate-driven structure over a specified transition period. In the short term, focus on mechanisms to increase pricing transparency in the private sector.

- ***Incentives should be created to increase transparency and flexibility.*** Private sector plan sponsors do not know the actual acquisition costs associated with the pharmaceutical products used by members on their plan. Current contracts with health insurers and PBMs include only aggregate guarantees on key financial terms. The employer does not get access to individual drug level data. Those sponsors, thus, are unable to negotiate effectively—causing concern by some employers that they may not be able to meet their ERISA fiduciary responsibility. Consider ways to incent drug manufacturers, PBMs and health insurers to disclose price and rebate information to employers like they now provide to public program sponsors. Specifically, Mercer suggests that reporting under both PBM and insurer arrangements be required to use National Drug Codes (NDCs) so the plan can view each drug’s adjudicated price. Additionally, other components like administration costs, rebate offset, and any other financial components would be included.
- ***Mercer strongly supports a pharmacy model aligned with a pay-for-value approach.*** This model would shift the focus for all stakeholders (pharmaceutical companies, PBMs and payers) to health improvement and trend control for complex and high-cost drugs, especially during their exclusivity period, because of their impact on overall health care spending. With a value-based model, PBMs or insurers might receive a pre-negotiated fixed fee for the pharmacy services they provide. The plan sponsor would pay the actual acquisition cost for pharmaceuticals, eliminating the “spread” on rebates or product cost, plus the pre-negotiated fixed fee with the PBM/insurer. PBMs and insurers could enter into a “gain sharing” agreement with the plan sponsor, retaining a portion of savings if they demonstrate cost control and value-based management, thus aligning incentives. In the case of pharmaceutical manufacturers, the focus for high-cost new and emerging drugs and therapies would move away from providing a consumption-based drug rebate to reimbursing payers if drug therapies do not achieve identified clinical improvements. Creation of new metrics and ways of accommodating their measurement will be necessary in transforming the industry to a value-based structure.
- ***Any approach taken must ensure it does not result in cost shifting and that it includes mechanisms to increase competition across the pharmacy landscape.*** In many cases initiatives in the public sector (particularly regarding cost control) result in cost shifting to the private sector. The impact of this cost shift means that private sector patients pay much more for the same product or service. For example, based on our experience and analyses, it is not unusual for an employer to pay Average Sales Price (ASP) + 150% to 200% for an infused specialty medication when the same medication in the same venue costs a Medicare patient ASP + 6%. Public policies should be favored which support a pharmacy landscape vibrant with healthy competition. Mercer suggests legislative and

regulatory changes designed to champion competition—such as prioritizing approvals of drugs with insufficient competition and preventing use of safety protocols which delay generic competition—and consider means to rein in year-over-year price increases above inflation for long-approved drugs.

While we appreciate the Administration’s recent proposed rule to address rebates involving prescription drugs,⁶ we don’t think it goes far enough since it only applies to federal programs, not private insurance. The proposal could trigger major cost shifting to the private sector. In assessing reforms that would alter the pharmacy landscape, the Administration must proceed cautiously to ensure changes include mechanisms to increase competition and do not result in cost shifting.

Support consumerism strategies with greater HSA flexibility

Health Savings Accounts (HSAs) put individuals in charge of their own health dollars and can lead to more responsible use of health resources. Consumer-directed health plans, where HSAs are coupled with high-deductible health plans (HDHPs), have been shown to have a real impact on consumer behavior, decreasing total healthcare spending about 5 percent in each of the three years after a plan is introduced.⁷

Adding well-designed transparency tools and consumer education helps ensure that members are equipped to make better healthcare decisions. HSAs have been gaining in popularity in recent years, and more than half of large employers (53 percent) now offer an HSA-eligible plan to their employees.⁸ This trend is likely to continue as more mid-size employers follow large employers’ lead. Still, only about a third of employees, on average, elect an HSA-eligible plan when one is offered as a medical plan choice.

Some best practice efforts to promote quality, cost efficiency and better health outcomes are hamstrung by the current HSA regulations. As our healthcare system transitions from one that rewards volume to one that rewards value, it would be helpful if HSAs were also afforded more flexibility to transition. Current rules make it difficult for consumers to get the right care at the right time in the right setting. HSAs might be more attractive if eligibility rules were modernized to allow alternative, cost-effective care delivery, such as onsite medical clinics and telemedicine, and if funds could be used for more pre-deductible coverage for people with chronic conditions. With proper policy and regulatory support, the HSA could be a key vehicle for improving costs across Medicaid, Medicare, individual market, and employer populations.

⁶ 42 CFR 1001

⁷ Do “Consumer-Directed Health Plans Bend the Cost Curve Over Time?” National Bureau of Economic Research, <http://www.nber.org/papers/w21031>.

⁸ Mercer, National Survey of Employer-Sponsored Health Plans, 2018

Policies that would make HSAs more useful include:

- Creating an HSA eligible High Deductible Health Plan (HDHP) safe harbor allowing plans the option of covering drugs and services used to treat chronic conditions on a pre-deductible basis;
- Allowing employers to provide care at on-site medical clinics or via telemedicine providers on a pre-deductible basis to employees and eligible dependents enrolled in HSA-eligible HDHPs;
- Increasing the annual HSA contribution limits to align with high-deductible health plan out-of-pocket maximums; and
- Allowing greater flexibility for the use of HSAs in retirement

Improve price, quality transparency

As consumers are given financial incentives to consider cost in their healthcare decisions, they must have the information they need to do so. But for many consumers that have tried to access cost and quality data, the experience has been frustrating at best. In many instances, they can't view specific quality information at the provider level and prices tend to be estimates. The data available today while directionally helpful doesn't satisfy the consumer need for specific data that helps them make important decisions. They expect the same type of price and quality data that's available when they buy consumer goods.

Although the majority of employers are offering transparency tools, many are finding it difficult to improve those tools because it's becoming increasingly difficult to obtain their self-funded plan data from health insurers/third-party administrators. When data is available, employers are accessing and using data-driven tools in ways that enable valuable actions and better decisions in areas such as population health management, physician decision support, research, cost, and quality improvements. We support efforts that will standardize data formats and exchange protocols such as FHIR (Fast Healthcare Interoperability Resources) which supports consumers access to and ownership of their electronic medical records. Only through the transparent sharing of data can employers maximize the impact of the programs, clinical interventions, networks, and partners within their specific benefits ecosystems, and to measure objectively their impact. ***Mandating data sharing requirements may be helpful.***

In the case of quality data, the challenge is that some data are collected on a voluntary basis. The Leap Frog Group conducts a hospital survey that measures quality and safety. Historically, only about 50% of hospitals have responded to this voluntary survey. ***Requiring a response from hospitals and providers to a survey that collects quality and safety measures like this would be useful.***

Another challenge is the lack of, or difficulty in obtaining, real-time data, on provider price and quality. As an industry, we know that access to things like deductible accumulators and account balances for HSA plans are available in real time. We should demand similar immediacy with pricing and quality information. We engage with many third-party vendors who are working feverishly to compile robust databases of information that will allow them to develop solutions to steer members to high quality providers. But all of these vendors struggle with access to data so they can build solutions that will assist consumers in making real time decisions about their care. These vendors are making great strides but the dated and limited data sets are hampering their ability to innovate faster and better.

In general, Congress can help by enacting legislation that boosts price and quality transparency in healthcare and requires hospitals and health insurers to provide healthcare cost information to patients and beneficiaries before the point of care.

Provide clear, uniform rules for wellness programs

Workplace wellness isn't just a benefits strategy—it's a workforce and business strategy. Employee well-being is associated with lower turnover,⁹ lower healthcare costs¹⁰ and higher profitability.¹¹ More than 80% of large employers (those with 500 or more employees) provide well-being programs to their employees. A growing percentage is purchasing optional well-being services through their health plan or contracts with a specialty vendor for these services. Employee engagement is key to the success of a wellness program, and many employers provide financial incentives for employees to participate and pursue health behavior change.

But employers offering wellness programs with health screenings—such as employee or spousal health risk assessments or biometric screenings, which are often the gateway to other wellness programs—now face the same uncertainty that existed before 2017: Just how much of a financial incentive, if any, is too much and would cause the program to be deemed involuntary and impermissible under the Americans with Disabilities Act (ADA) or Genetic Information Nondiscrimination Act (GINA)? The Equal Employment Opportunity Commission (EEOC) is not expected to issue new guidelines before vacancies in its leadership are filled. In the meantime, EEOC field offices can take enforcement action if they believe an employer has a noncompliant wellness program.

⁹ Umland, Beth, *The Surprisingly Strong Connection Between Well-being and Turnover*, April 10, 2018, <https://www.mercer.us/our-thinking/healthcare/the-surprisingly-strong-connection-between-well-being-and-turnover.html>.

¹⁰ Mercer, *National Survey of Employer-Sponsored Health Plans*, 2018

¹¹ Grossmeier, Jessica et al. "Linking Workplace Health Promotion Best Practices and Organizational Financial Performance: Tracking Market Performance of Companies with Highest Scores on the HERO Scorecard." *Journal of Occupational and Environmental Medicine* 58, no. 1 (2016): 16–23.

Wellness programs linked to a group health plan must also comply with long-standing HIPAA rules, which have financial incentive limits and other requirements—such as reasonable design, disclosure and confidentiality provisions—for programs contingent on health-related factors, activities or outcomes. The DOL has been especially active in enforcing these rules, particularly the reasonable alternative standard and notice requirements that are meant to protect participants from discrimination based on a health factor. The agency has brought complaints against employers for failure to offer a reasonable alternative to a premium surcharge for participants who use tobacco or don't meet certain biometric targets. Careful compliance with HIPAA's wellness program requirements is essential for employers looking to avoid DOL scrutiny.

We encourage lawmakers and regulators to address current compliance uncertainties and ensure that a consistent and supportive federal policy is aligned across multiple agencies and Congress.

Repeal the “Cadillac” tax, reject proposals to tax health care benefits

The Affordable Care Act (ACA) will impose a 40% tax on employer-sponsored coverage that exceeds certain thresholds. For millions of Americans who enjoy health insurance coverage through an employer, the threat of this tax has already resulted in reduced coverage and increased out-of-pocket costs. As you know, Congress has twice delayed the tax by two years, so the original effective date of 2018 has been pushed to 2022.

Employers' ability to alter benefit design to stay below the tax thresholds is constrained by the ACA's benefit mandates, out-of-pocket limits and prohibitions on lifetime and annual dollar limits. Additionally, increasing the threshold limits based on the new chained CPI-U index will help ensure that those limits lag far behind the cost of medical inflation. Historically, medical costs have increased at a much faster rate than general inflation, so the tax is expected to be imposed on many more plans each year.

This tax will hurt Americans in a very inconsistent and inequitable way because, contrary to its nickname, the tax does not simply tax generous health plans. It also affects ordinary plans that are expensive simply because they cover people with higher-than-average health costs, such as women, older and disabled workers, families with catastrophic health events and those who live in more costly areas.

Some policymakers in Congress have suggested replacing the Cadillac tax with a cap on the employee tax exclusion for employer—provided coverage. These proposals would tax health benefits provided by employers, meaning higher income and payroll taxes for millions of working Americans. These proposals are subject to many of the same flaws as the Cadillac tax, disproportionately affecting employer plans in high-cost locations or with older workers, to name just two factors that affect health plan cost.

Repeal the “Cadillac Tax” on employer-provided health coverage and reject new proposals to tax employer-provided healthcare benefits.

Conclusion

Mercer shares the same goals as you and lawmakers on both sides of the aisle: meaningful long-term reductions in health care costs and a thriving employer-sponsored system. We believe that these outcomes are possible through the engagement of key stakeholders and bipartisan cooperation.

Your call for recommendations helps accomplish these goals, and we again thank you for soliciting our feedback. Mercer is eager to assist you and the Committee—through data and information sharing, policy and technical discussions and analyses, and in whatever other ways would be helpful—in your ongoing efforts to lower costs and strengthen the US healthcare system.

Sincerely,



Tracy Watts

Senior Partner, National Healthcare Reform Leader