March 23, 2018

Submitted electronically to transparency@cassidy.senate.gov

Re: Stakeholder request for information on pricing/financial transparency in healthcare

Dear Senators Cassidy, Bennet, Grassley, Carper, Young, and McCaskill:

Thank you for your bipartisan effort to increase transparency in healthcare. The West Health Institute has long been an advocate of empowering healthcare consumers through increased transparency. The following is a description of our organization and responses to questions that we feel could be useful to you as you consider legislative action on healthcare transparency.

Solely funded by philanthropists Gary and Mary West, the nonprofit and nonpartisan **Gary and Mary West Health Institute** is an applied medical research organization and part of West Health, which includes the **Gary and Mary West Foundation** in San Diego, and the **Gary and Mary West Health Policy Center** in Washington, D.C. These organizations work together toward a shared mission dedicated to enabling seniors to **successfully age** in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.

We thank you for the opportunity to submit these comments and hope they are helpful to you as you tackle our shared goal of increasing pricing transparency in healthcare. Should you have any questions or require additional information, please feel free to contact me at talash@westhealth.org.

Sincerely,

Tim Lash
Chief Strategy Officer
West Health Institute

West Health Institute Responses to Pricing Transparency Questions in Healthcare

What information is currently available to consumers on prices, out-of-pocket costs, and quality? What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system? What role should cash price play in greater price transparency? How should this be defined?

Hardly any information is currently available to consumers on prices, out-of-pocket costs, and quality. Through our extensive work with low-income, older adults, we have learned that the most useful information to provide is the amount of out-of-pocket expenses the consumer will owe for a given medical service or product. List prices, charges, or network prices are not actionable reference points for the average consumer.

It is difficult to comment on the usefulness of the "cash price," as that term is not currently defined in a common or consistent way. It may be defined as the price for an uninsured individual or the price for an insured individual who chooses to pay out-of-pocket for a certain service or product – and these two price points may be different.

What are the pros and cons of different state approaches? What is the best quality and price information to collect for consumers and businesses?

The approaches taken by Colorado, Kentucky, Virginia, and Maryland that were cited in the stakeholder request are useful; however, these initiatives do not increase transparency at the consumer level. For example, a patient in Maryland may have access to pricing information for the most common treatments in all hospitals, with detailed information such as the average charges per case and per day. Yet, this information will not tell the patient how much she will owe for one of these treatments, given the varying cost-sharing requirements of different insurers. As noted above, more transparency is positive; however, if we want to leverage transparency to drive a reduction in spending, we must find a way to publicize out-of-pocket cost information at the consumer level.

Who should be responsible for sharing pricing information and who should share the information with consumers?

The answer depends on the segment of the healthcare market. Prescription drugs provide a useful example, as it is one of the least transparent, most complex, and most counterintuitive markets in our system. As a result, our prescription drug supply chain suffers from misaligned and, in some cases, perverse incentives, in large part due to a morass of middlemen who add no meaningful value for patients. For example, pharmacy benefit managers (PBMs) administer prescription drug plans for payers, including government payers such as Medicare Part D. PBMs have several administrative functions, but also negotiate price concessions with drug manufacturers and pharmacies, as well as design formularies to control drug utilization by beneficiaries. There are no requirements for transparency in any of these functions, nor are there requirements imposed by Medicare to pass through the negotiated savings to beneficiaries. In the commercial world, there may be pass-through or other contractual

requirements, but patients, businesses, and payers have often alleged in litigation that these requirements have not been honored.[1]

A recent editorial in *The Times Reporter* highlighted the specific issues resulting from the lack of PBM transparency in the context of Ohio's Medicaid program.[2] CVS has 80% of the PBM business in the state and decides how much it will bill the insurer for a drug, as well how much it will pay the pharmacy for that same drug. Given that those two price points are known only to CVS, it should come as no surprise that Ohio policymakers, consumer groups, pharmacies, and other stakeholders have expressed concern about the potentially significant difference between the two price points, and the fact that CVS has no obligation to disclose what that difference is. It is unthinkable that billions of taxpayer dollars annually are entrusted to for-profit, non-transparent entities that have no obligation to report to the public—and all Americans—how the money is being spent. It is a simple matter of good governance to change this paradigm.

We believe it is the responsibility of the PBMs to disclose taxpayer money involved within the various pricing arrangements and pass through savings to patients—a responsibility they are consistently shirking. In response to public outcry and political pressure, UnitedHealthcare recently announced it would start sharing some of the rebates it obtains from manufacturers with its customers.[3] While this announcement is laudable, older, low-income Americans have been burdened by high out-of-pocket costs for pharmaceuticals for years. What has taken so long? Why aren't other PBMs following suit? Why won't PBMs disclose financial data to indicate what percentage of the savings are being passed through?

While the for-profit middlemen may be the only ones holding all of the information, we do not believe they are in the best position to provide it, as they benefit from the current lack of transparency and would likely game the information they provide. Instead, the West Health Institute supports leveraging the power of the government to negotiate prices in Medicare Part D. The current system is mind-bogglingly complex and only benefits the middlemen. Out-of-pocket costs for consumers are high and continue to grow rapidly, while rebates and other price concessions are increasing at a significant rate, from $67 billion in 2013 to $106 billion in 2015.[4] Empowering the government to negotiate prices in Part D would eliminate complexity, increase transparency, and greatly improve accountability to the taxpayer.

[1] http://www.pbmwatch.com/pbm-litigation-overview.html.
[2] http://www.timesreporter.com/opinion/20180318/editorial-medicaid-drug-prices-shouldnt-be-secret.
[3] https://www.nytimes.com/2018/03/06/health/unitedhealth-drug-prices.html.
[4] https://www.fiercepharma.com/pharma/new-numbers-support-pharma-s-rebuke-complex-distribution-system.

How do we ensure that in making information available we do not place unnecessary or additional burdens on healthcare stakeholders?

The healthcare industry, as it exists today, has been able to avoid innovation for far too long, in part, by decrying potential new "burdens" as a reason for not wanting to change. We should be careful not to overburden the system, however, the West Health Institute believes that financial transparency should be a basic requirement for participation in public health programs utilizing taxpayer dollars. Simply alleging that compliance would be complicated is not a sufficient reason to avoid change.

What current regulatory barriers exist within the healthcare system that should be eliminated to make it less burdensome and more cost-efficient for stakeholders to provide high-quality care to patients?

As noted above, the West Health Institute believes that repealing the non-interference clause in Part D would result in increased access to pharmaceuticals for seniors, which will improve health outcomes.

How can our healthcare system better utilize big data, including information from the Medicare, Medicaid, and other public health programs, to drive better quality outcomes at lower costs?

We must be more comfortable contracting for value in public health programs, and using program-wide outcomes data to do so. An example of an arrangement in the private world to replicate in public programs is the deal struck between drug maker Amgen and Harvard Pilgrim Health Care: if the product does not work, Amgen will provide a refund to the health services company.[5] This kind of arrangement would work very well in disease areas that have many treatment options (the Amgen example is a cardiovascular product), and they exist for most consumer products we buy today. We should replicate this arrangement, whenever possible, to ensure we are getting value for each taxpayer dollar we spend on pharmaceuticals, procedures, and other medical services, and we can use big data to ensure adherence.

What other common sense policies should be considered to empower patients and lower healthcare costs?

The West Health Institute is focused on enabling older adults to age in place, with dignity, high quality of life, and independence. Aging at home is what seniors prefer and it is significantly

[5] https://www.fiercepharma.com/pharma/amgen-inks-repatha-refund-arrangement-harvard-pilgrim.

cheaper than institutional care. In 2014, for the first time in Medicaid's history, more than half of program funding for long-term care was spent on home and community-based services. Although this is encouraging, any cuts to Medicaid have the perverse effect of cutting funding for less expensive home-based care, while maintaining funding for the more expensive, institutional setting. This is because home and community-based services are optional for states to cover, while the nursing home benefit is mandatory. Any reform of Medicaid should acknowledge this imbalance and seek to correct it.