To the Members of the National Committee on Vital and Health Statistics:

My name is Jessica Brooks and I am the CEO and executive director of the Pittsburgh Business Group on Health (PBGH), an employer-led, non-profit coalition of insurance purchasers and healthcare advocates in southwestern Pennsylvania, representing more than 90 organizations, including private and public employers, government and academia – and two million lives.

Moreover, I am equally pleased to represent PBGH employer members as a representative on the Health Innovation in Pennsylvania (HIP) Price and Quality Transparency Work Group as well as the All-Payer Claims Database Subcommittee, which is helping to determine how Pennsylvania continues to move toward the all-payer claims model.

On behalf of the employer-members of PBGH, I am pleased to share their business concerns which are driving their desire to make claims data available in an actionable manner so they can make informed decisions about the cost and quality of the health care they are buying for their employees, as well as serve as more effective fiduciaries of their employee benefit plans. Our mission, as a business coalition, is to improve the delivery, cost and quality of health care and employee benefits in our region. In order to do so, we believe that an employer-led data strategy is the key to address change and transparency in health care.

As I discuss our efforts, I will cover three important areas: One… why we embarked on the effort to create a regional claims data strategy… Two… what we expect to achieve (including the barriers we are encountering)… and Three, what our position is regarding All-Payer Claims Databases.

First, our reasons for embarking on a regional claims data strategy. Employer access to their own information regarding payments, providers, and other aspects of administering a health benefit plan, which is held by Third Party Administrators, is vital to Plan Sponsors to exercise their fiduciary duty, established by ERISA and substantial case law, to ensure that the plan is being run in the best interests of the plan's members. Having access to such information would allow employers to review their costs, the quality of healthcare being delivered, and identify areas of improvement in terms of both lowering and controlling costs and increasing the quality of care available to the plan's members.

Further, past efforts to address change and transparency in health care historically have been made by single employers acting individually and often working across disparate silos of information with the proverbial left hand not knowing what the right hand is doing.

The lack of a concerted and concentrated effort to truly optimize data results in inefficiencies, which in turn leads to fragmented decision-making and buyer's remorse as the costs of healthcare continue to rise for both the employer and employee, and the quality of the care provided continues to be confusing and misunderstood.

PBGH employer members have not leveraged their collective buying power or influence because they have lacked transparency and insightful benchmark data, which would allow them to drive lower costs, improve health, and target benefits programs that more specifically meet employees' needs.

As such, PBGH recently contracted with a national data analytics partner, Innovu, to aggregate raw member data and develop regional performance benchmarks to measure access to high quality and affordable health care in the region. This brings us to point two, what we expect to achieve and the barriers to adoption.

Employers intend to use this information in two ways: (1) to set performance expectations of cost and quality with the providers and health plans in the region; and, (2) to inform each employer of how to improve their own benefit offerings to their employees.

Along with being part of the collective voice for southwestern Pennsylvania and achieving true insight into the issues driving costs, quality and population health, PBGH and its employer members also receive detailed insights to improve and understand not only specific health and benefit plans, but how those plans stack up to others in terms of costs, design, performance thresholds, predictive analytics, provider profiles, risk stratification, and other analytic parameters, both nationally and regionally.

Additionally, employers can use such information for renewals and new services, advance plan design and benefit program management with current regional benchmarks and trends, enhance leverage with vendors by having comparative data, and prevent loss of claims data if vendors are changed.

We also acknowledge, though, that the integration of several other elements are needed to overcome obstacles.

Alignment of interest among employers and organizations to manage and deliver benefits

Collaboration across employers, providers, health plans, and advisors to jointly discuss best practices and actionable priorities based on factual data

The key to this regional data strategy is accessing the raw member claims data. Unfortunately, access to the employer's own data has been blocked by the TPA's and health plan ASO's contracted by self-insured employers. Third Party Administrators use Non-Disclosure Agreements/Confidentiality Agreements/ Business Associate Agreements and other similar documents to restrict the usage of employer data by the employer and its designated agent and other third party service providers. Such restrictions of employer information usage include, but are not limited to, prohibiting the following: data aggregation, the creation of transparency tools using employer information, and other tools or solutions that could lower the costs of healthcare for plan members.

There are also technical challenges to a claims based database, which is why selecting the right analytic partner/or tool is imperative. Some technical challenges include data errors, data integration, member matching, and establishing timely electronic feeds. Collecting any of the requisite data to build a meaningful claims-based database presents its own challenges. When the data is collected, it is rarely delivered in sequence. As such, the ETL process to populate the database must account for delayed, unordered data to be loaded in for any given time period at any given point. Security-maintaining compliance with Federal and State law require strict adherence and enforcement of rigorous security policies. These policies must include robust encryption standards for data in transit as well as at rest, access control based on Principle of Least Privilege, authorization based on at least two factors, and auditing of all activity.

A comprehensive assessment of our health care landscape can only be achieved by leveraging the collective power of employers' and their health care data. Analyzing both the cost of care and the quality of the care received are powerful tools to drive change. The PBGH regional data strategy helps address claims data access and analytics, while simultaneously providing an opportunity for CEOs, CFOs, and other executive leadership to give their companies a voice in how the regional health care landscape will be built for the future.

Given the context of the actions the PBGH and its employer members are already taking steps to leverage a regional claims data strategy, so now I would like to share my thoughts on point 3, the role of an All-Payer Claims Database.

As the healthcare landscape evolves by way of alternative payment models and delivery system models, the

position purchasers are taking is also evolving. Employers in particular demand to be a leader in healthcare, because, frankly they have no choice- if they expect to be able to afford to continue staying in the healthcare space. As the customers they want to understand what they are buying, what they are getting for it, and what their options are, as well as their role in making it better. APCD's facilitate the opportunity for the supply side and the demand side to meet and determine the best next steps to achieve sustainable, best in class changes in the way care is accessed, delivered, paid for, and enhanced.

As the number of ACOs and PCMHs grow, and payment reform models are being forged, we need an APCD that will provide the oversight and measurement to:

- Deliver a greater level of transparency for consumers about quality, cost and relative value.

  The lack of transparency creates barriers to improved coordination and outcomes for the payers and providers that are essential in serving patients. It also inherently disadvantages employers from being able to practice accountability due to the restrictions placed on accessing their own data. Their ability to truly measure performance is not possible without the actionable insight that is achieved by harnessing their data.

- Evaluate the comparative effectiveness of ACOs and PCMHs for high-cost patients and assist with the implementation of two-sided risk for providers to be exposed to adverse performance.

  It is time for to get to the point where care is transparent and high value care is constantly improving through collaboration and incentives. Success for an ACO is being able to improve the quality of care and lower the cost of that care enough to share in the savings. Evaluating how organizations are changing patient care is essential to determining the key work processes and metrics to implement across the continuum of care.

- Drive the adoption of policies and programmatic changes through the use of actionable data that yield cost containment and quality improvement.

  The APCD has the potential to help identify the source for escalating health care spend and drive adoption of the policies that enlist the full scope of the issue to support change. A prime example is the APM efforts which calls for a credible source, like an APCD, for measuring value in ways that allow us to assess the impact of treatments, outcomes, and data-driven policy interventions.

This is an opportunity for us to collectively leverage our resources to address the issues plaguing healthcare today such as the cost of healthcare tripling since 2001 for the average family. Amongst PBGH membership in-network deductibles increased 43% since 2015, out of pocket maximums reaching $16,636. Nearly 70% of employers offer high deductible plan offerings that are shifting the cost to the employees and their families, accounting for approximately 20% of the consumers spending. Yet, the cost shift doesn't address the root cause of mediocre quality of care and outcomes, high utilization and unaffordability.

Poor access to medical records, duplicate testing, gaps in communication (patient to physician, physician to patient, physician to physician), rushed and fragmented health care are affecting patients from receiving the right care at the right time. Resulting in thirty-five percent of Americans having difficulty paying their medical bills, and nearly two-thirds of all bankruptcies being linked to inability to pay medical bills due to being uninsured or underinsured.

We are on the brink of a harsh reality even with our rural and independent hospitals as they experience a market in which it is becoming increasingly hard to survive when the larger systems are eagerly seeking market expansion and eliminating competition.

For these reasons, the cost for healthcare is becoming even more unsustainable and directly impacts the future of our health care investment.

Collectively, we can all benefit from an APCD that affords us the opportunity to oppose these challenges by evaluating these health care expenditures, identifying effective outcomes and quality measures, addressing variability in cost and regional variations in care, recognizing high performing areas and best practices to spearhead value-based improvement, compare costs, quality measures and benefits among and across providers to make more informed choices.
I wish to wrap up with a few lessons, which I've learned in working on both the regional and state level. Several things have become abundantly clear during our efforts to drive the regional claims data strategy with Innovu:

> The collection, aggregation and use of cost and quality data cannot be left up to health plans or to providers… rather, self-insured employers should have the loudest voice in the matter and a guaranteed right to their claims data. They should also not be burdened with push back from their contracted TPA's and ASO's. Our members feel that in order for businesses and their employees to benefit from transparency regarding cost, access and quality, there must be unfettered and expedient access to critical benefits claims data.

As we continue our journey with the regional claims data strategy, we expect a number of benefits to emerge, including:

- Transparency of the data across stakeholders will create a level-playing field for discussion and opportunities to leverage trusted data across the health care system
- Frequent monitoring and tracking regarding the impact of changes within the regional data set will improve the effectiveness of the health care supply chain – targeting the improvement of health care delivery and cost reduction
- Based on the prioritized programs, the creation of a data-driven measurement strategy that easily measures the progress of each program and outcomes
- Comparability of best practices across other regional initiatives to assess impact

Any tool that allows companies to put their data to work for their employees – giving them actionable insights they need to understand and improve the ability to influence true change in health care – is a good thing and one our employer members are fully embracing.

Thank you for your time.

Sincerely,

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