CITY OF OAKLAND

AGENDA REPORT

To: Chair Schaaf and Members of the Finance & Management Committee
From: Council President Patricia Kernighan
Date: August 27, 2014
Re: Health Care Task Force Report

RECOMMENDATION

I recommend acceptance of this Health Care Task Force Report and accompanying resolution:

RESOLUTION STATING THE INTENT OF THE CITY COUNCIL OF THE CITY OF OAKLAND TO SUPPORT THE GOALS OF THE CITY OF OAKLAND/EMPLOYEE UNION HEALTH CARE TASK FORCE, WHICH SEEKS TO REDUCE HEALTH COSTS WHILE IMPROVING QUALITY BY ESTABLISHING TRANSPARENCY AND HOLDING HEALTH PLANS AND PROVIDERS ACCOUNTABLE FOR DELIVERING SAFE, EFFECTIVE, AND FAIRLY PRICED HEALTH CARE SERVICES TO OAKLAND EMPLOYEES, RESIDENTS, AND TAXPAYERS

EXECUTIVE SUMMARY

This report provides background information regarding the collaborative effort of the Health Care Task Force and seeks City Council action. Specifically, the City Council is encouraged to pass the accompanying resolution that is designed to combine efforts of the City and its unions to reduce the cost of health care.

OUTCOME

The Health Care Task Force wants the City Council to direct the City's lobbyist at the State legislature to seek and pass bills designed to reduce the cost of health care, including establishing a health information database that would generate under strong public oversight reliable quality and cost information on California hospitals, physician groups, and delivery systems.

BACKGROUND/LEGISLATIVE HISTORY

In the United States we spend 30 percent more on health care costs than any other country.[1] Since 1960 the cost of health care has increased dramatically from 2.4 percent of GDP to 16.2

[1] Organization for Economic Development, Health Data 2009, June 2009

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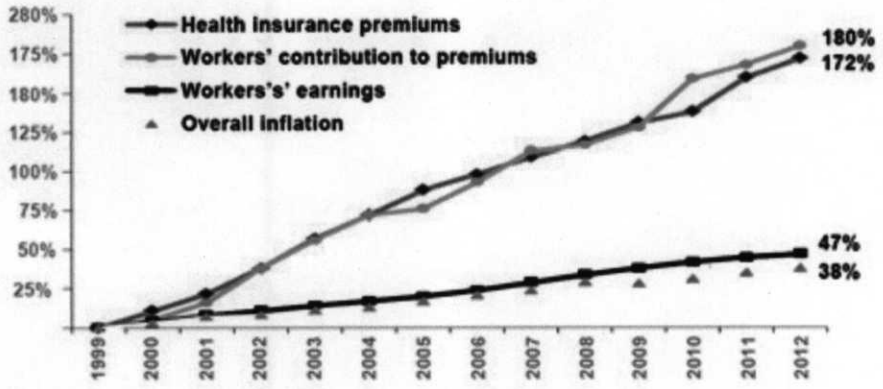
percent of GDP in 2008. By 2008, this huge increase in health care costs had left about 45 million Americans uninsured for medical care. Public agencies were not immune from these increases. The City of Oakland currently pays approximately $51 million toward medical care for its employees and retirees. This amounts to approximately 6 percent of the City's expenditures (or 9 percent of the General Purpose Fund.)

For much of the last decade the annual increase in medical care cost was approximately 9 percent, most of the cost being directed toward hospital care, physicians, and clinical services (National Health Expenditures, 2010, *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html*). For 2015, the increase in Kaiser premiums (the most popular and usually the least expensive option) is approximately 3 percent, which followed a hefty 11 percent increase last year. As a result, some California public agencies have sought to mitigate the fiscal impact of these large increases by shifting some of the costs to employees. This and other cost cutting measures have resulted in lower take-home pay for some public employees. The chart below shows the adverse effect nationally of soaring premiums on workers' wages between 1999 and 2012. California is no different, with premiums increasing 185 percent since 2002.

Cumulative changes in U.S. insurance premiums and workers' earnings, 1999–2012



Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 1999–2012*

While the Health Care Task Force is intended to avoid employees having to bear any increase in the cost of health care, the members of the Health Care Task Force agree that this joint effort does not preclude either the City of Oakland from proposing that employees make additional health care contributions or unions from proposing improved benefits. Further, the Health Care Task Force is united in the belief that collective effort to improve transparency and accountability with other public agencies coupled with the implementation of the related additional measures can reduce health benefits costs or at the very least slow their rate of increase.

For example, joint efforts by the City of San Francisco and public employee unions - including a public hearing, a joint labor-management presentation on industry cost drivers, two resolutions unanimously enacted by Supervisors on the public's need for quality and cost information, and significant media attention on these issues - resulted in a historic 2 percent reduction in Kaiser's 2015 premium and a zero percent increase in the 2016 premium. These efforts, combined with earlier City efforts to improve care access, and the integration and coordination through formation of Accountable Care Organizations led to millions of dollars of savings for the City of San Francisco and its employees.

CalPERS has also achieved cost-savings by encouraging vendors to develop integrated delivery systems. The Accountable Care Organization pilot in the Sacramento region, for example, achieved millions in savings by reducing avoidable events and improving efficiencies. Additionally, CalPERS has implemented "reference pricing." Reference pricing is essentially a "cap" on the amount that CalPERS pays for certain procedures, thus encouraging providers to price the procedures under or close to the cap. What is lacking, however, is a monitoring and accountability framework to identify and further reduce preventable utilization or to determine if providers are compensating for lost revenues in one service line by raising prices in other lines of service.

During the last round of negotiations, some of the City's unions proactively proposed that the City form a joint management-labor committee to consider ways in which to achieve the mutual goal of reducing health care costs. While the parties did not have this goal enshrined in any of the labor agreements, the idea was embraced by both sides and resulted in the formation of the Health Care Task Force. The Task Force is comprised of representatives from each of the City's bargaining groups and management representatives from several City departments.

ANALYSIS

The Health Care Task Force's goal is to reduce health care costs for all City workers, residents, and taxpayers by establishing quality and cost transparency and holding plans and providers accountable. Experts widely agree that escalating insurance and health care costs are the result of: excessively high prices, especially where patients lack choice; unsafe or ineffective care leading to preventable events; inefficiently delivered care; high administrative costs; and fraud. The Institute of Medicine - established as an arm of the National Academy of Science - calls these problems "waste" and says they account for 30 percent of national health care spending.[2] Waste explains why the U.S. vastly outspends every other industrialized country on earth while Americans receive fewer health care services in aggregate and have lower life expectancy and poorer health outcomes.[3]

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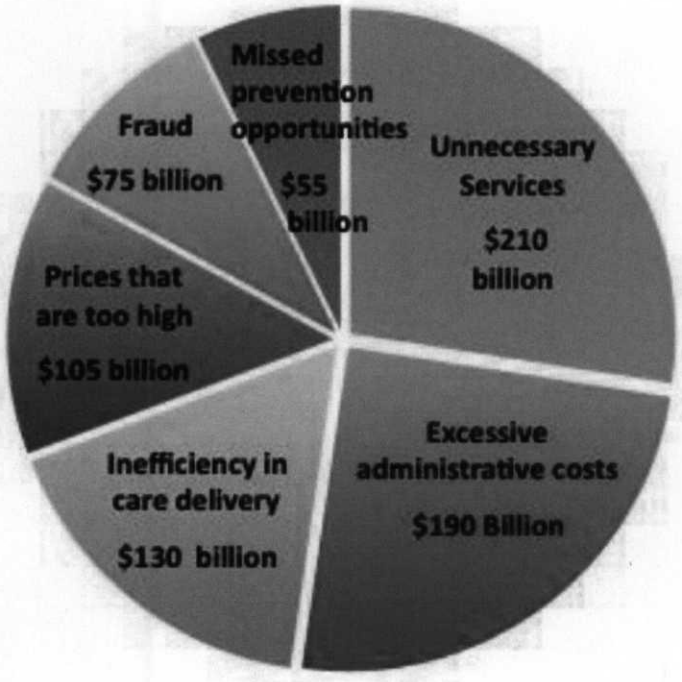
[2] Institute of Medicine, The Cost of Health Care: How Does It Compare? See http://resources.iom.edu/widgets/vsrt/health care - waste.html.

[3] Organization for Economic Cooperation and Development, *Health at a Glance 2012, OECD Indicators,* http://dx.doi.org/10.1787/health_glance-2012-en.

Institute of Medicine: $765 billion out of $2.6 trillion spent on U.S. health care in 2009 is "waste."



Under current trends, family health insurance and out of pocket costs are predicted to equal 50 percent of median household income by 2018.[4]

Currently, the City cannot determine the percentage of health care dollars wasted on prices that are too high or on preventable events. The Task Force therefore agreed that transparency is essential for accountability.[5] Further the taskforce has agreed to the following:

- Joint advocacy of policy and purchasing solutions to the high cost of health care
- Reporting of patient treatment outcomes and average costs by provider for common conditions and procedure, including frequency and costs of preventable adverse events (e.g., errors, infections, avoidable hospitalizations)
- Contracts that hold plans and providers accountable for better care and results at lower costs
- Outreach to other local governments for coordinated action to establish transparency, reduce waste, and improve quality and value
- Utilization of providers and systems that offer demonstrably higher quality and value

As part of this effort, the Task Force will seek to continue the following:

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[4] RA Young and JE Devoe, "Who Will Have Health Insurance in the Future: An Updated Projection," Annals of Family Medicine, Vol 10, No 2, March/April 2012.

[5] Robert Wood Johnson Foundation, Does publicly reporting performance help improve health care quality? Issue brief, July 2011; Marty Makary, M.D., Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care, Bloombury Press, New York, 2012.

1. Foster member, policymaker, and public awareness via hearings, briefings, media outreach, and other means that high prices and ineffective health care are major drivers of premium costs.

2. Engage public employers and unions in the San Francisco Bay Area to encourage CalPERS and other public and private payers to accelerate efforts to reduce costs by improving quality, safety, efficiency, and value.

3. Win state legislation to establish transparency, ensure accountability for public health care dollars, and address the pricing power of dominant plans and providers.

4. Identify other strategies that could be employed to contain health care costs while improving the quality for members and stakeholders.

PUBLIC OUTREACH/INTEREST

This report did not require any additional public outreach other than the required posting on the City's website.

COORDINATION

The Mayor's Office, Office of the Council President, Budget Office, the City Attorney's Office, Human Resources Management, Employee Relations and all City bargaining units were consulted in the preparation of this report.

COST SUMMARY/IMPLICATIONS

If this collaborative effort is successful, Staff anticipates a reduction in health care costs for the City and its employees.

SUSTAINABLE OPPORTUNITIES

Economic: Potential reduction in City expenditures related to health benefits.

Environmental: There are no environmental impacts associated with this report.

Social Equity: There are no social equity impacts associated with this report.

For questions regarding this report, please contact Anil Comelo, Human Resources Management Director at (510) 238-6450 or Sally Covington, SEIU L1021 Health Care Benefits and Policy Advisor at (510) 710-0176.

Respectfully submitted,

Patricia Kernighan, Council President
District 2 Councilmember

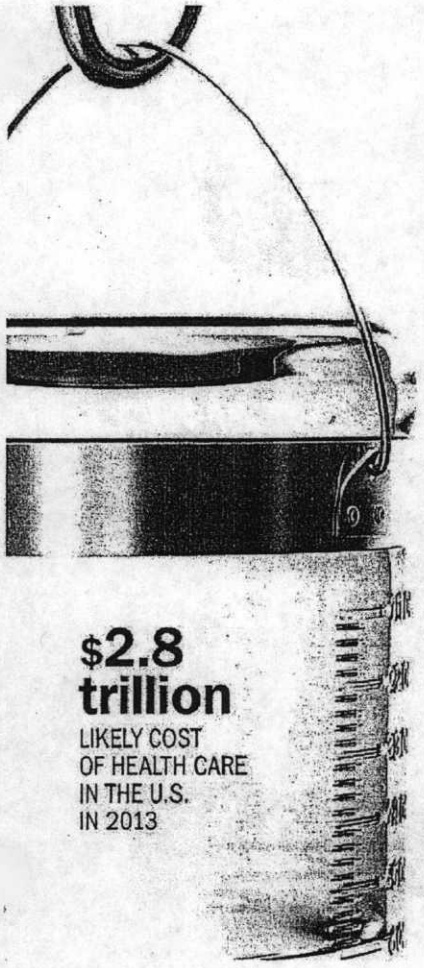
Prepared by: Anil Comelo, Human Resource Management Director
Sally Covington, Health Care Benefits and Policy Advisor, SEIU L1021

Attachments: ***A – What Makes Health Care So Expensive?***
B – Health Care Costs: Continuing to Rise at Unsustainable Rate
C – Briefing Paper on Health Care Cost Drivers

HEALTH CARE

What Makes Health Care So Expensive?

Andrea Ford, Heather Jones, Claire Manibog and Lon Tweeten



$2.8 trillion
LIKELY COST OF HEALTH CARE IN THE U.S. IN 2013

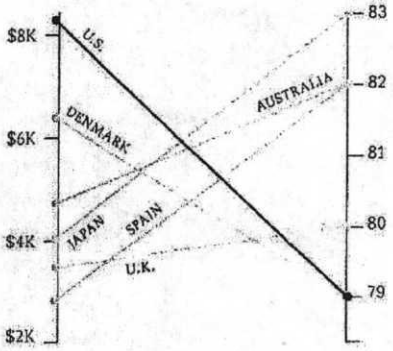
1

The Mess We're In

The U.S.'s uniquely high health care spending, which has been rising disproportionately to the economy, is not reflected in outcomes

Annual health care spending
per person in U.S. dollars, 2010

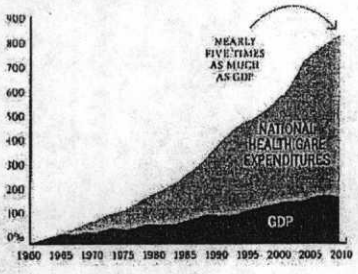
Life expectancy
at birth, in years



Infant mortality is relatively high

NO. **50**
U.S. RANK IN THE WORLD, NINE SPOTS BELOW CUBA, 2012

Health spending has maintained a steep climb
Percentage growth since 1960



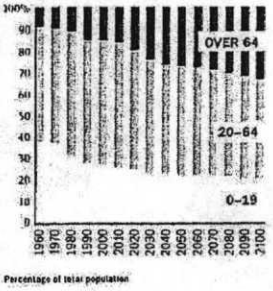
Adjusted for inflation and population growth

Health care is a major factor in personal finance

69% of those who've experienced medically related bankruptcy were insured at the time of their filing

62% of bankruptcies are related to illness or medical bills

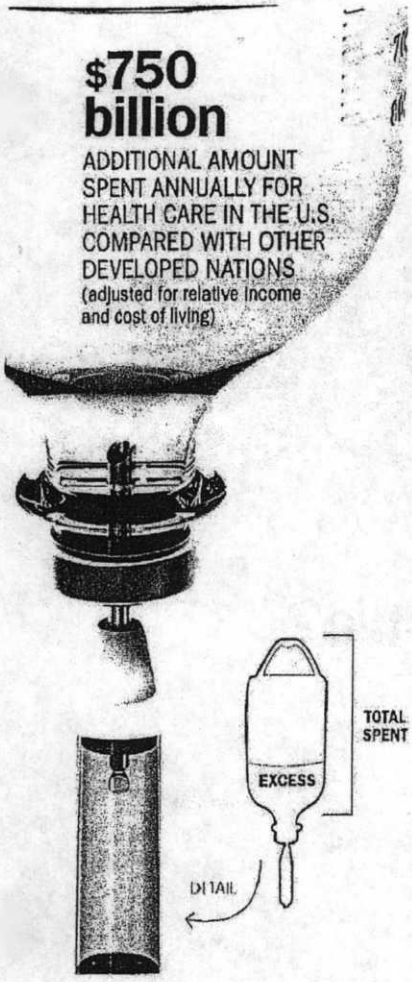
The aging U.S. population will require more care



Percentage of total population

2

What Makes Health Care So Expensive



$750 billion

ADDITIONAL AMOUNT SPENT ANNUALLY FOR HEALTH CARE IN THE U.S. COMPARED WITH OTHER DEVELOPED NATIONS (adjusted for relative income and cost of living)

Average drug prices are sky-high

THE PRICE OF ...

One Lipitor pill in the U.S.

is the same as that of three in **Argentina**

One Plavix pill in the U.S.

is the same as that of four in **Spain**

One Nexium pill in the U.S.

is the same as that of eight in **France**

Procedure costs are higher in the U.S. than in most other countries

	CT SCAN (HEAD)	APPENDECTOMY	CORONARY BYPASS
ARGENTINA	$78	$1,030	$9,319
AUSTRALIA	$254	$4,926	$38,891
CANADA	$122	$5,606	$40,954
CHILE	$184	$5,509	$20,505
FRANCE	$141	$3,164	$16,140
GERMANY	$272	$3,093	$16,578
INDIA	$43	$254	$4,525
SPAIN	$123	$2,615	$17,908
SWITZERLAND	$319	$5,840	$25,486
U.S.	$510	$13,003	$67,583

Average cost, 2011

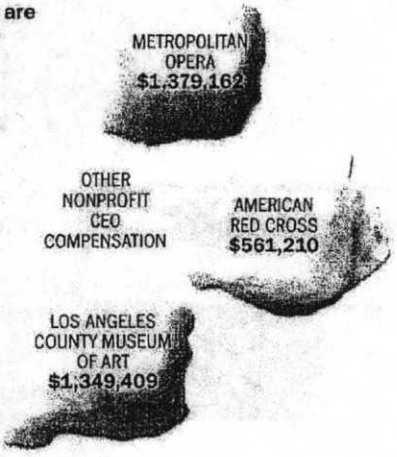
Nonprofit hospitals are making big bucks ...

Top 10 largest nonprofit hospitals*

HOSPITAL NAME	OPERATING PROFIT	CEO COMPENSATION
University of Pittsburgh Medical Center Presbyterian	$769,700,054	$5,975,462
Cleveland Clinic	$572,298,875	$2,564,214
Barnes-Jewish Hospital, St. Louis	$489,696,091	$2,335,882
New York–Presbyterian/Weill Cornell Medical Center	$383,477,548	$4,356,039
Indiana University Health Methodist Hospital, Indianapolis	$360,836,468	$2,080,779
Florida Hospital Orlando	$352,017,588	$2,925,356
Orlando Regional Medical Center	$250,843,745	$2,244,110
Montefiore Medical Center–Moses Division Hospital, Bronx, N.Y.	$196,868,926	$4,065,194
Methodist University Hospital, Memphis	$151,910,728	$2,180,962
Norton Hospital, Louisville, Ky.	$118,101,911	$2,206,401

*Hospital size by number of beds. Most recent available profits and salaries. Operating profit is defined as excess of revenue over expenses, plus the amount listed on tax returns for depreciation of assets. In some cases, salaries refer to those of the president or CEO of the parent health system

... and hospital leaders are receiving big pay



Includes all salaries, bonuses, deferred compensation and other payments, most recent available

The industry spends heavily on lobbying Congress

Total, 1998–2012

$5.36 billion

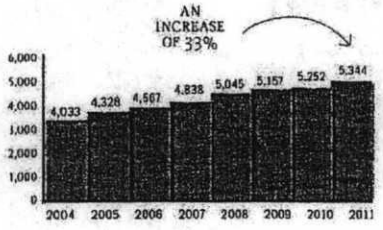
Lobbying by the pharmaceutical and health-care-products industries and organizations representing doctors, hospitals, nursing homes, health services and HMOs

$1.53 billion

Amount spent on lobbying by defense interests in the same period

More outpatient care allows for more procedures

Number of ambulatory surgery centers



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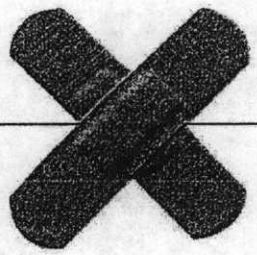
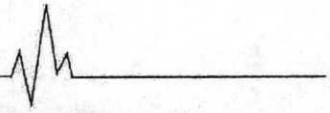


What We Can Do About It

Drawing on previous studies, ***Steven Brill*** *has estimated potential savings in the nation's health care system. Americans' bills tell us we don't have anything approaching a free market. The changes Brill suggests would allow the U.S. to provide better care at lower costs without substituting the kind of government-provider system typical in comparison countries*



Sources, these pages: World Bank; *CIA World Factbook*; McKinsey & Co.; *American Journal of Medicine*; U.N. Population Division; International Federation of Health Plans; *Becker Hospital Review*; IRS; Center for Responsive Politics; Centers for Medicare and Medicaid Services; Kaiser Family Foundation

Sources, other pages: Center for Responsive Politics; Kaiser Family Foundation; Commonwealth Fund; *Journal of Family Practice*; Employee Benefit Research Institute; McKinsey & Co.; ADP Research Institute

GRAPHIC BY ANDREA FORD, HEATHER JONES, CLAIRE MANIBOG AND LON TWEETEN

PHOTOS: GETTY IMAGES (29); CORBIS (2)

POTENTIAL SAVINGS	**$94 billion**	**$84 billion**	**$74 billion**	**$50 billion**	**$30 billion**	**$28 billion**
SOLUTION	Control prescription-drug prices, which make up 10% of U.S. health care costs. Studies show that drug prices in the U.S. are, on average, 50% higher than in other developed nations	Recapture 75% of profits from hospitals, whose expenses are about a third of health care costs, by taxing them and regulating their prices or ensuring real competition and transparency and the end of the chargemaster	Cut 5% from hospital and physician costs by reducing the overordering of tests and other procedures—sometimes used only to prevent medical-malpractice lawsuits	Spending on outpatient clinics and labs owned by doctors could be cut by a third by regulating fees or taxing profits	Use transparency, price controls and whatever else it takes—the Affordable Care Act included a 2.3% tax on medical devices—to bring the overall gross profit margins of medical-device makers like Medtronic down to 50%	Allow and fund comparative-effectiveness evaluations in decisions to prescribe drugs, tests and medical devices

What You Need to Know

Health Care Costs: Continuing to Rise at Unsustainable Rate

To make healthcare coverage more affordable, the nation must address the soaring cost of medical care that continues to increase at an unsustainable rate. There needs to be a much greater focus on the main drivers of medical cost growth: soaring prices for medical services, new costly prescription drugs and medical technologies, unhealthy lifestyles, and an outdated fee-for-service system that pays for volume rather than value.

Higher health care spending is a result of higher health care prices.

- According to an annual report by Milliman, the typical family of four saw an **increase in healthcare costs by $1,319, a 7.3% increase** between 2010-2011.

- A recent study by the Health Care Cost Institute examining health care costs between 2010 and 2011 found that **"Rising prices – not rising utilization – was the primary driver of spending growth... Price increases were driven by changes in fees, not intensity of services."**
  - According to the report, "Spending growth for outpatient facilities outstripped all other major health service categories. Prices grew fastest for outpatient care—double the rate of inflation."

- An issue brief from the National Institute for Health Care Management, Understanding U.S. Health Care Spending, found that **"rising prices per unit of service have played a larger role than rising utilization rates as a determinant of recent expenditure growth."**

- In 2010, Massachusetts Attorney General Martha Coakley released an updated report, Examination of Health Care Cost Trends and Cost Drivers, which found that **"price increases, not increases in utilization, caused most of the increases in health care costs during the past few years in Massachusetts."**

Provider consolidation drives up prices.

- James Robinson, a professor of health economics at UC Berkeley, says **"hospitals in concentrated markets were able to charge higher prices to commercial insurers** than otherwise-similar hospitals in competitive markets..."

- Paul Ginsburg and Robert Berenson, in an article in the February 2010 edition of *Health Affairs*, stated that **"providers' growing market power to negotiate higher payment rates** from private insurers is the **'elephant in the room'** that is rarely mentioned."

Other examples of higher health care costs:

- Express Scripts' Drug Trend Report, an annual look at prescription drug price and utilization trends, found that "overall drug inflation climbed 5.4%," "record inflation

of branded drugs at 9.4% exceeded generic inflation by a wide margin," and "specialty drug trend was 17.4% in 2010, fueled by unit cost growth of 11.5%."

- A study from Commonwealth Fund compared health care spending, supply, utilization, prices, and quality in 13 industrialized countries. The United States' median spending of nearly $8,000 per person in 2009 far surpassed the median of all other countries ($3,000 per person). The study concludes that "higher spending is largely due to higher prices and perhaps because of more readily accessible technology and greater rates of obesity."

- The International Federation of Health Plans, a global insurance trade association of more than 100 insurers in 25 countries, conducted a survey of its members on the prices of 23 medical services and products in different countries. In nearly all cases (22 of 23), Americans were paying higher prices than residents of other developed countries.

Rising medical costs are driving up premiums for employees with self-funded and fully-insured coverage.

- A Kaiser Family Foundation survey on employer health benefits found that "annual premiums for employer-sponsored family health coverage increased to $15,073 this year, up 9 percent from last year."

- One overlooked aspect of the Kaiser report is that this survey includes data on both fully-insured and self-funded employer plans. According to the new survey, 60 percent of covered workers are in partially or completely self-funded plans in 2011 – a trend that has been increasing for many years. **The fact that premiums are increasing for both fully-insured and self-funded employer plans is further evidence that these increases are being driven by rising claims costs.**

Health plans are leading the way in delivery system reform and deploying the next generation of medical management tools to promote a high-value health care system.

Additional Resources on Health Care Costs:

- **Health Care Cost Institute: 2011 Health Care Cost and Utilization Report**
- **National Institute for Healthcare Management: Understanding U.S. Healthcare Spending**
- **National Health Expenditure Data**
- **NEHI: Waste and Inefficiency in Health Care**
- **Milliman Medical Index 2011**

COMMUNITY CAMPAIGNS
for Quality Care

http://communitycampaigns.org // Office: 510.879-7415

Briefing Paper on Health Cost Drivers

Until health costs are stabilized, California state and local governments face destructive options, such as reducing health benefits and access to care or increasing beneficiary contributions. The most significant driver of costs is medical inflation. California premiums have risen 185 percent since 2002, more than five times the state's overall inflation rate. California's HMO premiums have been higher than the nation's since 2010 and average monthly premiums for single coverage in California were $572, compared to $490 nationally.[1]

Slowing medical inflation by even one percent would significantly reduce the growing pressure on public budgets. A recent report by the San Francisco Controller found that a one percent reduction in medical inflation would reduce the City's unfunded retiree health care liability by $400 million. Bending the curve is crucial for controlling costs without eroding benefits.

With medical inflation a key determinant of future health benefit costs, attention must focus on what drives it and what public agencies and policymakers can do about it. Broad agreement exists that:

- **High provider prices are a major cost driver.** The increase in unit prices in the U.S. is the "single biggest driver of health spending increases."[2] Compared to 10 other countries, private U.S. insurers in 2012 were charged up to 26 times more for common procedures, drugs, and hospital and physician visits.[3] Even though we use less health care than other OECD nations, we outspend them by wide margin. Higher prices explain why.[4]

- **Potentially Avoidable Complications (PACS) are common and costly.** The Institute of Medicine estimates that 30% of U.S. healthcare spending is wasted on unsafe and ineffective care.[5] PACs -- errors, avoidable hospitalizations, infections -- account for up to 56% of total cost of care for chronic conditions and up to 24% of total costs for procedures.[6] Based on an analysis of CalPERS' PPO claims, CalPERS likely spent an estimated $1.5 out of $7 billion on PACs in 2013 without knowing which providers were responsible.[7]

- **Supply drives demand.** Wide variations in health care utilization and costs in Medicare have far more to do with the supply of health care resources than with demand, or differences in population health. In short, more hospital beds, more admissions; more CT scanners, more scans; more hospital beds, more admissions; and more specialists, more procedures. When supply rather than medical need or science governs utilization, patients suffer and costs will be uncontrollable.[8]

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[1] California Health Care Foundation and the National Opinion Research Center, University of Chicago, *California Employer Health Benefits Survey: Workers Feel the Pinch*, January 2014, available at: http://chcf.org.

[2] Robert Murray and Suzanne F. Delbanco, *Provider Market Power in the U.S. Health care Industry: Assessing its Impact and Looking Ahead*, Catalyst for Payment Reform, available at: http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf.

[3] International Federation of Health Plans, *2012 Comparative Price Report: Variation in Medical and Hospital Prices by Country*, available at http://www.ifhp.com/documents/2012iFHPPriceReportFINALMarch25.pdf.

[4] Organization for Economic Cooperation and Development, *Health at a Glance 2011, OECD Indicators*, available at http://oecd.org. Anderson GF, Reinhardt, UE, Hussey, PS, and Varduhl, P, "It's the Prices, Stupid: Why the United States is so Different From Other Countries," *Health Affairs*, Volume 22, Number 3, May/June, 2003.

[5] Institute of Medicine, *To Err Is Human: Building a Safer Health* System, November 1999, and *Crossing the Quality Chasm: A New Health System for the Twenty-First Century,"* 2001, National Academy Press (Washington, D.C.).

[6] For more on PAC rates within "episodes of care," see Health Care Incentives Improvement Institute (http://hci3.org).

[7] Covington S and Moore T, *How Frequent and Costly are Potentially Avoidable Complications Among CalPERS' PPO Health Plan Members?* Community Campaigns for Quality Care, May 2012.

[8] See Center for the Evaluative Clinical Sciences, *Supply-sensitive Care, A Dartmouth Atlas Topic Brief*, available at: http://www.dartmouthatlas.org/downloads/reports/supply_sensitive.pdf. For more on utilization and cost variations in the Medicare program in general, see The Dartmouth Atlas at http://www.dartmouthatlas.org.

- **Fee for service medicine is inherently inflationary.** Fee for service reimbursement pays providers for each service they deliver -- office visits, tests, procedures – providing a strong incentive to order more services whether or not unwarranted. Research indicates that overuse is a major problem in our health care system.[9] Fee for service payments systems also providers who re-engineer patient care and safety, thus preventing adverse events. Health care is the only industry where mistakes of omission and commission are a major revenue source. For these reasons, the National Commission on Physician Payment Reform has joined a growing number of national review bodies calling for fundamental changes in provider reimbursement.[10]

- **Performance transparency and payment reform are essential for accountability and cost control.** Transparency is the necessary foundation for a transformed and affordable health care system in California, yet our state recently received a "F" grade in state transparency laws.[11] Research has shown that providers accelerate efforts to improve when their performance is publicly reported[12] and that replacing fee for service medicine with bundled payments has far greater potential to reduce health spending while improving quality than other prominent approaches, including hospital rate regulation, disease management, health information technology, medical homes, retail clinics, scope of practice changes, and benefit design changes.[13]

- **Health care, like politics, is local.** It is possible to lower health spending while maintaining or improving quality of care, as a growing number of U.S. communities have demonstrated. While local efforts have not yet changed national trends, they have changed trends at the community level. The local character of health care is why national experts are calling for development of regional data collection and multi-payer collaboration to identify and reward high quality providers and systems. The Commonwealth Fund, for example, has recently proposed 50 to 100 "health improvement communities" that would embrace payment and delivery system reforms at the community level to dramatically improve outcomes while lowering overall costs.[14]

- **Whether or not health costs are stabilized and less destructive to public and household budgets will largely depend on local actions taken by local purchasers.** The federal government acting alone cannot establish quality and cost transparency or change the current incentive structure in ways that strengthen prevention and primary care, reward effective care, eliminate harm, and cut waste. And commercial health plans will not voluntarily support health *system* transformation unless they financially benefit from it. In order to make cost-stabilizing performance improvements system-wide, public purchaser leadership is necessary.[15]

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[9] See National Priorities Partnership, *National Priority: Overuse – Eliminate overuse while ensuring the delivery of appropriate care*, http://www.qualityforum.org/setting_priorities/npp/national_priorities_partnership.aspx.

[10] National Commission on Physician Payment Reform, *Our Nation Cannot Control Runaway Medical Spending Without Fundamentally Changing How Physicians Are Paid*, March 2013, available at: http://www.dartmouthatlas.org/downloads/reports/supply_sensitive.pdf.

[11] Catalyst for Payment Reform and Health Care Incentives Improvement Institute, *Report Care on State Price Transparency Laws*, March 12014, available at: www.catalyzepaymentreform.org/images/documents/2014Report.pdf.

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