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(CalPERS)

Testimony Before the Senate Special Committee on Aging:
“Modernizing Health Care: How Shoppable Services Improve Outcomes and
Lower Costs”
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Introduction:

Chairman Scott, Ranking Member Gillibrand, and Members of the Committee, thank you for inviting me to testify on behalf of the California Public Employees' Retirement System (CalPERS) and discuss how shoppable services can help control health care costs. I will be using our reference pricing program and other aligned purchasing innovations as case examples.

My name is Don Moulds and I serve as the Chief Health Director for CalPERS. With more than 1.5 million members, CalPERS is the largest commercial health benefits purchaser in California and the second largest commercial purchaser in the nation after the federal government. We contract with numerous large health insurance companies to provide our members with a variety of health plan offerings that include health maintenance, preferred provider, and exclusive provider organization (HMO, PPO, and EPO) plans, as well as Medicare Supplemental and Medicare Advantage (MA) plans. In 2024, we spent over \$12.4 billion purchasing health benefits for active and retired members and their families on behalf of the State of California (including the California State University) and nearly 1,200 public agencies and schools.

In my testimony, I will outline successes and lessons learned from CalPERS' two reference pricing programs: our hip and knee replacement reference pricing program and our Ambulatory Surgery Center Reference Pricing program. I will also describe a new program we instituted last year to incentivize our members to use independent laboratories for shoppable lab services rather than higher cost hospital-based labs. Finally, I will touch on our experience with a price transparency tool.

As I share our experiences, I wish to underscore that there is no "one size fits all" solution for rising health care costs. The cost-driving challenges are multifaceted. So too must be the solutions. We've learned that initially encouraging ideas can have underwhelming results or unintended consequences and that purchasers must be ever vigilant in monitoring and evaluating interventions to ensure they produce the outcomes we are seeking. Having said that, CalPERS considers consumer-oriented incentives, such as reference pricing, to be an integral part of our value-based purchasing model. At the end of my testimony, I will discuss other mechanisms that CalPERS utilizes to provide superior health care services at the greatest value for our members.

About CalPERS:

For more than nine decades, CalPERS has provided retirement and health security for state, school, and public agency members serving more than 2 million members as the nation's largest defined-benefit public pension fund.

As part of our role in administering health benefits for members and their families, CalPERS is committed to ensuring access to equitable, high-quality, affordable health care.

To promote competition and keep premiums affordable, CalPERS regularly commissions competition studies. For example, based on results from the 2021 study, CalPERS implemented health plan service expansions and introduced lower-cost HMO plans. These efforts increase competition within the CalPERS insurance marketplace and put downward price pressure on the premiums, positively impacting CalPERS members and employers.^{1,2}

To control rising health care costs, CalPERS works to align financial incentives with the health plans and Pharmacy Benefit Manager (PBM) we contract with, aiming to mitigate cost trend increases. In June 2024, CalPERS awarded new five-year contracts for its self-funded PPO plans to Blue Shield of California (BSC) and to Included Health, which serves as the population health management vendors. The contracts are designed to promote savings and improve quality by establishing financial incentives and clinical performance guarantees. BSC and Included Health have committed \$464 million at-risk over the term of the contract if they do not meet the program's goals for controlling medical cost trends and improving quality. The contracts set the initial medical trend cost target at 5.5% in 2025, decreasing annually to 3% by 2029. If CalPERS' medical cost trend is lower than the target, BSC and Included Health stand to share in the savings.

In July, CalPERS announced a new five-year pharmacy benefits contract with CVS Caremark (CVS) designed to address rising costs of prescriptions while ensuring access to safe and effective medications for members. Under the agreement, CVS has committed \$250 million at-risk over the term of the contract for controlling drug costs and improving health outcomes. Similar to our HMO and recent PPO contracts, the new PBM contract builds on CalPERS' broader efforts to align health care affordability with quality and equity. By aligning pharmacy benefits with our overall health care goals, CalPERS aims to create a model that can serve as a blueprint for purchasers across the nation.

Reference Based Pricing

CalPERS mitigates medical trend increases through cost and quality conscious strategies, including leveraging curated hospital networks for better pricing, implementing value-based purchasing and integrated health models, fostering competition, and flex-funding. One contributor to increased health care costs is significant price variation for the same service. For example, lab services tend to vary greatly in price, despite no quality difference. Additionally, the prices for procedures provided in hospital outpatient departments are typically higher than those charged in freestanding centers due to the hospitals' higher costs and stronger bargaining position with insurers. In fact, Medicare reimburses hospital-based outpatient procedures at rates substantially

¹ See CalPERS, Pension & Health Benefits Committee Agenda Item 7a, *available at* https://www.calpers.ca.gov/docs/board-agendas/202103/pension/item-7a_a.pdf

² See CalPERS, Competition Study & 2022 New Plans, Area Expansion, and Benefit Changes, *available at* https://www.calpers.ca.gov/docs/board-agendas/202103/pension/item-7a-attach-2_a.pdf

higher than those it pays freestanding ambulatory facilities.³ As such, employers and insurers have started to utilize programs encouraging employees and enrollees to select the most cost-effective setting, including reference pricing models, which CalPERS has had success with. In a reference pricing model, the payor sets a maximum price for a specific health care service. Patients still have the option to receive that service at a facility of their choice, but they are responsible for charges above the reference price. This process helps contain costs while maintaining access to quality care by encouraging members to choose a pre-arranged high-quality, lower-cost provider for certain medical services. Patients who require hospital outpatient services due to specific clinical needs or limited local options are not subject to cost-sharing initiatives.

CalPERS Experience #1: *Hip and Knee Reference Pricing*:

In January 2011, CalPERS and Anthem Blue Cross of California (Anthem), our prior third-party administrator for our PPO plans, implemented a reference pricing program for high-cost elective procedures with minimal quality difference among facilities. CalPERS initially aimed to control inpatient hospital orthopedic surgery costs for total hip and total knee replacements. The program involved 46 hospital inpatient facilities statewide that accepted a reference price of \$30,000 and met quality and volume standards. Members who used the designated reference price facilities were responsible for their standard coinsurance payments. However, members who chose a non-designated facility were responsible for any charges above the \$30,000 reference price. Medical exceptions were granted for non-routine procedures, and travel benefits were available for members living over 50 miles from a designated facility. A significant level of effort was devoted to both implementation and member education.

Results: The reference pricing program successfully increased the proportion of members who used designated facilities from about 50% to 64% within two years. Notably, non-reference pricing facilities lowered their charges to match the CalPERS \$30,000 reference price. In turn, price variation for hip and knee replacements decreased dramatically. The average price at preferred facilities dropped from \$35,000 to \$25,500, while the non-reference pricing facilities reduced their prices from \$43,000 to \$27,000.

A study by University of California Berkeley health economists found that CalPERS' reference pricing program saved \$5.5 million in its first two years, with the average price per procedure declining by 26% or about \$9,000.⁴ Initially, the program sought to create savings through consumer decisions, but market changes and hospital pricing had the biggest impact. We learned anecdotally that non-reference pricing facilities were lowering prices to draw CalPERS members.

³ See Robinson, James C., Timothy T. Brown and Christopher Whaley. "Reference-Based Benefit Design Changes Consumer Choices and Employers' Payments for Ambulatory Surgery." *Health Affairs* 2015 34:3, 415-422
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1198>

⁴ See Robinson, James C., and Timothy T. Brown. "Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery." at *Health Affairs* 32.8 (2013): 1392-1397.
<https://doi.org/10.1377/hlthaff.2013.0188>

Berkeley economists concluded that 14% of the savings arose from more individuals selecting reference-based pricing facilities, while 86% were due to cost reduction. Our analysis showed that the program continued to generate approximately \$4 million in annual savings through 2020, with participating facilities expanding from 46 to 72. Additionally, members who utilized reference pricing facilities had lower rates of complications and infections with similar follow-up admission rates. Patient experience was also shown to be better at the reference pricing facilities.

In terms of our overall health care spend, savings from reference pricing have been relatively modest, but the model has nonetheless offered valuable insights and lessons that may inform future strategies and potentially yield further savings.

- More member outreach could have been beneficial, such as phone calls or letters to members who had been referred to a procedure that could have been done at an ASC or a pop-up in the price transparency tool when members searched for a reference pricing procedure.
- Our reference price has applied only to the facility portion of the procedure and excluded professional fees and other related costs. Adopting a bundled payment approach alongside reference pricing could be beneficial.
- CalPERS has used a single statewide price that is easily communicated to members, despite significant price variation by region, with Northern California historically much more expensive than Southern California. Cost savings could be improved with regional pricing, but it might be more difficult to explain to our members.

CalPERS Experience #2: *Ambulatory Surgery Center Reference Pricing*

In 2012, CalPERS and Anthem introduced a second reference pricing program for Colonoscopy, Cataract and Arthroscopy services. Under this program, procedures not performed at an Ambulatory Surgery Center (ASC) have a set reference price. Similar to the hip and knee replacement procedures, we identified large price variations for colonoscopy, cataract, and arthroscopy services. The variation mainly depended on the location of care, specifically whether procedures were provided by Hospital Outpatient Facilities vs. ASCs. We noticed a substantial increase in routine non-screening colonoscopies at ASCs, climbing from 70% to over 90%. In contrast, Anthem's broader business had around 75% of these procedures at ASCs.

Results: The University of California, Berkeley's evaluation of this program showed total savings of \$5 million each year and realized average reductions of 21%. Specifically, cataract surgeries resulted in \$1.3 million in savings (20% reduction), colonoscopies saved \$7 million (28% reduction), and arthroscopies contributed \$2.3 million (17% reduction) across a two-year

timeframe.^{5,6} As a result, in 2018, CalPERS extended its ASC reference pricing program to 12 additional procedures, including endoscopic and laparoscopic procedures.

CalPERS Experience #3: Member Incentive Lab Program:

In 2024, CalPERS implemented a member incentive program for labs due to high price variation with no quality difference. National research shows that lab services in hospitals (e.g., large health systems) cost roughly 3.7 times more than those at independent labs.⁷ Our data indicates the markup may be even higher, especially compared with California's two largest independent lab providers.

Our program offers no cost sharing for preferred independent labs in California, but non-preferred labs require standard coinsurance. In contrast to the other reference pricing programs, the lab incentive program provides financial incentives for our members to choose the lower-cost option without imposing additional costs for those who opt out.

While we are still evaluating this program, preliminary results indicate it increased preferred lab use by 4% and saved members \$2.4 million in its first year. As a result, we are expanding outreach to improve awareness of the program and encourage more use of the preferred lab sites.

CalPERS Experience #4: Price transparency tool

To aid price shopping, CalPERS provided a price transparency tool for PPO members in 2014 that allowed members to use an app to search for location, price, and quality of services. The tool was created to empower members to shop for services based on both price and quality, fostering greater member engagement. When paired with reference pricing, the goal was to create a more informed and engaged member.

Results: Ultimately, the price transparency tool fell short of delivering expected overall cost savings. Members saved on imaging costs, but spending in other 'shoppable' categories and reference pricing procedures showed no decrease.

We found that few of our members used the tool, especially for price shopping. Even though 24% of CalPERS households registered to use the tool, only 12% used it to search prices, and just 4% maintained usage (3 or more times, at least 90 days apart). Our experience is consistent with other research in this area.⁸ A small fraction of people sign up for these tools, and among those who sign

⁵ See Robinson, James C., Timothy T. Brown and Christopher Whaley. "Reference-Based Benefit Design Changes Consumer Choices and Employers' Payments for Ambulatory Surgery." *Health Affairs* 2015 34:3, 415-422
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1198>

⁶ See Robinson, James C, Timothy T. Brown and Christopher Whaley. "Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications." *JAMA Internal Medicine* 2015;175;(11):1783-1789.
<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/243473>

⁷ See Chang, Jessica, Katie Martin, Yuvraj Pathak and Marissa Myers. "Price Markups for Clinical Labs: Employer-based Insurance Pays Hospital Outpatient Departments 3X Than Physician Offices and Independent Labs for Identical Tests." *Health Care Cost Institute*, https://healthcostinstitute.org/images/pdfs/HCCI%20Lab%20Brief_103124.pdf

⁸ Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA*. 2016;315(17):1874–1881.
[doi:10.1001/jama.2016.4288](https://doi.org/10.1001/jama.2016.4288)

up, few use the tool before seeking care. Furthermore, when they do use the tool to search prices, for most services, users do not choose a lower cost provider.

As such, CalPERS stopped offering the tool after 2.5 years due to the added cost of the tool. We found that there are a limited range of services that are truly ‘shoppable’ and that our benefits with low cost sharing diminished the relevance of price shopping for most services. While members express an interest in quality and pricing, their decisions frequently hinge on the referrals they receive from healthcare providers.⁹ Additionally, rural communities lacked sufficient options to facilitate a meaningful comparison.

Limitations on Reference Based Pricing:

Reference based pricing has shown promise, but it is not a panacea. Research suggests that if implemented as broadly as possible, it saves about 5 percent of total cost of care.¹⁰ Considering that CalPERS spends approximately \$2.3 billion each year (or \$6.4 million per day) on the affected PPO population, the savings are quite modest.

Overall savings are limited by the small number of procedures where reference pricing makes sense. While reference pricing is well suited for non-emergent elective procedures with significant price differences, many healthcare services are not “shoppable.”

Our experience has shown that while price referencing programs can work, to truly manage rising health care costs, other issues need to be addressed, including:

- **Competition:** CalPERS has found that insufficient competition results in higher prices. Since 2010, competition among hospitals and providers in California has lessened, notably in rural regions.^{11,12} As of 2018, 52% of specialists and 42% of primary care physicians were in health system-owned practices.¹³ In markets with fewer hospitals, consolidation led to a 12% increase in premiums, a 9% rise in specialist fees, and a 5% rise in primary care costs from 2013 to 2016.¹⁴

To address abuses in this space, Congress could pass laws to stop anti-competitive practices in contracts between providers and health plans. Specifically, we support the passage of the Healthy Competition for Better Care Act (S. 1451), which encourages a more open market, fosters competition, drives innovation, improves quality, and reduces costs.

⁹ Semigran, H., Gourevitch, R., Sinaiko, A., Cowling, D., & Mehrotra, A. (2018). Patients' views on price shopping and price transparency.. The American journal of managed care, 23(6), e186e192-ee192. Available at: <https://pubmed.ncbi.nlm.nih.gov/28817296/>

¹⁰ White, Chapin, and Megan Eguchi. Reference Pricing: A Small Piece of Health Care Price and Quality Puzzle. National Institute for Health Care Reform. Available at: https://nihcr.org/wp-content/uploads/2016/07/Research_Brief_No_18.pdf

¹¹ See California Health Care Foundation (CHCF), The Sky's the Limit: Health Care Prices and Market Consolidation in California, available at <https://www.chcf.org/wp-content/uploads/2019/09/SkysLimitPricesMarketConsolidation.pdf>

¹² See California Health Care Foundation (CHCF), Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California, available at <https://www.chcf.org/publication/markets-monopolies-health-care-consolidation-california/>

¹³ Ibid.

¹⁴ See Health Affairs, Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices, available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472>

- **Transparency:** We see transparency as vital in developing shoppable services but emphasize that it should be user-friendly for all stakeholders. CalPERS maintains a comprehensive claims data warehouse to track health care costs and outcomes, allowing us to identify cost drivers and innovate in areas like reference pricing. Other payers may lack this long-term data, making federal standards for hospital transparency crucial. We commend the Administration's efforts to ensure comprehensive and precise reporting of hospital price data.
- **Innovation:** Beyond reference pricing, CalPERS continuously explores innovative approaches to reduce costs and improve quality. For example, CalPERS, in alignment with other large public purchaser partners in California, adopted a subset of quality and outcome measures and tied significant financial accountability to high-performance on these measures for our health plans. These measures, known as the Quality Alignment Measure Set (QAMS), and the financial incentives tied to them, aim to improve care for clinically important conditions for which there are major opportunities for improvement and evidence-based measures in current use. The QAMS consists of five measures, all of which are nationally endorsed, evidence-based NCQA HEDIS measures: Childhood Immunizations, Controlling High Blood Pressure, Comprehensive Diabetes Care – Poor Control (HgbA1c >9 percent), Colorectal Cancer Screening, Maternity Care (reflecting a combined score for Timeliness of Prenatal Care and Postpartum Care).

Conclusion

Thank you, again, for inviting me to participate in today's hearing. CalPERS' application of Reference Pricing models demonstrates modest but notable savings in shoppable services. However, truly curbing rising health care costs requires a thoughtful, multi-faceted approach. CalPERS is uniquely positioned to assist the Committee as it develops policy and I welcome your questions on how we manage health care costs.