Hello everyone. My name is Dr. Vikas Saini. I'm president of the Lown Institute, a national healthcare think tank based in the Boston area.

I've got over 30 years of experience in the clinical practice of cardiology at both the Brigham and Women's Hospital and in the community setting of Cape Cod. I also founded and led a large primary care physician network on the South shore and Cape and have done research and teaching in the Harvard system.

At the Lown Institute, we focus on achieving higher value care in the US, defined as getting better results at lower cost. I'm here to voice my enthusiastic support for bill S.750. Based on a decade of work looking at the optimal design of health care delivery systems, I believe this proposal represents a real leap forward.

It is no secret that Massachusetts, and the US as a whole, face a cost and affordability crisis. Policy decisions taken long ago purported to address this by increasing payments from the pocket of the patient. They have had predictable consequences: massive financial hardships for patients, with the worst outcome being debt. It's time to change course. The lack of co-pays and deductibles in S.750 is a welcome shift that promises to reduce medical debt in the Commonwealth.

S.750 will also improve the efficiency of health care. It's not well understood that too often, medical decision making is driven by the pressure of time and unfamiliarity with the patient. For patients, a trip to the emergency room is perfectly rational when there is no alternative, and hospitalizations that are of borderline necessity can often occur when there is no PCP to manage things on the outside. This drives up costs. When the clinician and patient know each other well, tremendous efficiency is achieved. This is a paradox – unlike in factories, in health care, the more time that is spent with the patient, the more efficient care can become. Continuous, relationship-based care is also critical for avoiding overdiagnosis or overtreatment.

In short, S.750 is a key part of cost containment. The evidence for this is substantial.

In my prior role as one of the founders and executives at New England Quality Care, a primary care physician network, I have seen with my own eyes the savings that robust primary care can achieve.

We also know from international comparisons that countries that invest more of the premium dollar on primary care have less overall costs.

Evidence from studies in the VA system confirms that primary care visits are associated with lower total cost especially among high-risk patients. In one analysis, each primary care visit was associated with a cost reduction of $721.2 -- and over a full year having a PCP was associated with $3274 lower costs from reduced outpatient, inpatient, and total costs.

In California an analysis of commercial insurance found that investment in primary care was associated with better quality, better patient experience, fewer hospital visits, fewer ER visits, and lower total costs. The analysis further suggested that if the lowest brackets of spending (4.9%) on primary care matched the highest bracket (11.4%), 25,000 hospitalizations, 90,000 ER visits and $2.4 billion, or roughly 2% of total health care spending, would have been avoided in a single year.

We need to move away from our dependence on urgent and emergency care and pass this legislation to rebalance the system. If adopted, S.750 would propel Massachusetts towards a health care system that is affordable, effective, and just, and would catapult the Commonwealth into the vanguard of national leadership on health policy.

Thank you for your attention.

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