COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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Senator Lamar Alexander
Chairman, Senate HELP Committee
428 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Patty Murray
Ranking Member, Senate HELP Committee
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

Thank you for the opportunity to comment on bipartisan discussion draft legislation entitled the *Lower Health Care Costs Act of 2019.* The Council for Affordable Health Coverage (CAHC) is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations. As a result, these comments reflect the positions of CAHC, but may not necessarily reflect the individual views of all members.

CAHC supports efforts to lower health costs through reforms that will increase competition by improving access, fostering and expanding informed consumer choice, promoting value, and empowering consumers. The draft *Lower Health Care Costs Act* is a good step and we outline several changes below to improve the proposal. We look forward to working with you on these issues.

Title I – Ending Surprise Billing

The current situation of third-party payment allows health care providers to not participate in the network even when providing services in in-network facilities. This has allowed surprise billing so profound that government intervention to reset the rules of the road is essential. We believe a national approach is needed to comprehensively address the issue and to prevent specialists from state shopping.

CAHC supports the language in Sections 101 and 102 that protect consumers from surprise bills, only apply in-network cost sharing and count the cost sharing against deductible and maximum payment limits. Consumers should not be responsible for surprise medical bills.

- CAHC supports the in-network matching proposal (Subtitle A, Option 1) as the best way to lower costs and address the market failures that foster surprise billing. Under this proposal, we assume in-house provider rates are reduced toward average billing rates hospitals themselves negotiate with health plans, which we estimate are about 190 percent of Medicare rates. Under the bill and absent an agreement between insurer and provider within 30 days, out-of-network emergency services reimbursement would be set at the median in-network rate. Using the in-network median rate would cause some payments to come down a little, because the median is probably lower than the mean due to high outliers. While an improvement over current practice, we are concerned using the median will be used to drive up the in-network price. This is inflationary and will increase costs over time and could lock in price advantages for some insurers over others. We have the same concerns for Subtitle C-Option 3.

- We suggest setting a maximum reference price as percentage above Medicare rates (we believe 150 percent is reasonable considering a surprise bill should be a rare occurrence) for provider reimbursement in out-of-network situations. Medicare rates are often used as a benchmark in private negotiated rates, so this formulation would not be unusual or difficult for private plans and providers to administer. We would

gradually lower the reference price over time to approximately 125 percent of Medicare rates. Setting the rate as a differential between in-network and out-of-network creates incentives to join networks and resolve issues without the need for a reference benchmark. As a result, we estimate savings of about $9 billion over 10 years.

We caution against using other approaches to address surprise billing as they can add to administrative complexity or increase costs. Specifically, we are concerned that:

- An independent dispute resolution structure (Subtitle B, Option 2) should be rejected because it has the potential to be very expensive to administer, opaque, and prone to provider capture. The instructions to the arbitrator essentially function as rate or price setting. IDRs would set rates considering a number of factors, including the median contracted rate, which would lock in current high rates and tend to keep costs greater than otherwise. While initial data seems to indicate some cost savings are available, we believe the data is not yet sufficient to warrant moving forward with an IDR approach. When the state of New York implemented such a system, the percent of out-of-network emergency department services decreased but the number of non-emergency surprise bills sent to dispute resolution increased by a whopping 212% in the first two years. Because the bill sets the level for IDR review at $750, and the average emergency room visit cost $1,389 in 2017, up 176% over the decade[1], we are concerned that claims sent to dispute resolution would swamp the system.

- Capping rates "shall not pay more than" vs. setting them "shall pay" is an important distinction. CAHC supports a "not pay more than" approach to ensure payments may be lower than the limit.

Title II – Reducing the Costs of Prescription Drugs

CAHC supports commonsense efforts to advance reforms that will promote affordability through lower costs for prescription drugs.

- **CAHC supports timely access to generics and Section 203.** The citizen petition process has been frequently used to attempt to delay the approval of generic drug applications. While FDA has stated that these petitions have rarely delayed specific generic drug approvals, the petitions have created resource burdens on the drug review process. The citizen petition process is a worthy tool when used appropriately but we support a more efficient approach to reviewing these petitions that allow FDA to deny those submitted with a primary purpose of delaying a generic drug approval and thereby allowing the agency to focus more resources on scientific reviews.

- **CAHC supports Section 205 because it prevents first-to-file generic drug applicants from blocking entrance of subsequent generic drugs to the market beyond the 180-day exclusivity period granted by FDA.** Currently, the 180-day exclusivity period is triggered only when the first-to-file applicant is granted final marketing authorization, and sponsors have taken advantage of this by parking their applications by intentionally delaying final approval and thereby preventing the 180-day clock to trigger. Downstream applications that are eligible for approval wind up delayed because of the first-to-file applicant's eligibility for exclusivity. We know that first-to-file applicants sometimes make "pay-for-delay" agreements with brand sponsors, further delaying generic entry. We support the Committee's proposal to trigger the 180-

[1] HCCI, "10 Years of Emergency Room Spending for the Commercially Insured"; Presentation to Academy Health Annual Meeting, June 2019. https://www.healthcostinstitute.org/images/pdfs/ARM2019_ER_Posterv2.pdf Importantly, the $1,400 figure is just the cost of entry for emergency care; it does not include extra charges such as blood tests, IVs, drugs or other treatments. Available here:

day exclusivity clock for the first to file applicant when a subsequent applicant receives tentative approval for their product if the first to file has not received final approval within 30 months of their submission.

Title III – Improving Transparency in Health Cate

Consumers have become more familiar with online comparison shopping and are increasingly comfortable using digital health tools to inform choices of doctors, plans, and drugs. This new willingness of consumers to comparison shop will create needed price competition across much wider geographic areas than historically have been the case. To empower consumers and other payers, we recommend the following:

- **CAHC supports the prohibition on "gag clauses" in Section 301. Congress should prohibit "gag clauses," in which dominant providers forbid insurers from including their prices in online comparison websites for policyholders.** At a minimum, such prohibitions should be a standard condition of merger approvals.

- **CAHC supports the prohibitions on anti-competitive agreements in section 302.** Congress should ban anti-competitive arrangements that limit competition and decrease consumer welfare, such as anti-tiering, anti-steering, most-favored-nation, and other contract clauses where taxpayers have a vested interest in lower costs (either through spending or tax subsidies).

- **CAHC supports modifications to Section 303, which would designate a new national non-profit transparency organization. This section is duplicative of the current Qualified Entity Program (42 CFR 401).** Current federal and state efforts are not effectively leveraging the latest technology and available data to achieve these goals. For example, the Qualified Entity (QE) program, first enacted in 2010, allows QEs to access and use Medicare claims data. Additional reforms authorized in MACRA permit QEs to combine Medicare data with private sector data and to sell analyses and, in some cases, data for a range of non-public uses. The law constrains the data, however, to provider performance feedback or to provide health insurance. Congress should expand the QE program to allow use of already disclosed claims data to be repurposed to create tools – apps and on-line web tools – that consumers can use to shop for health services based on price, quality and safety. Doing so will create a more market-oriented health system.

- **CAHC supports Section 304 that would provide up to date provider directory information, but with an appropriate implementation period.** Plan information on provider networks, formulary and total cost of care, should be reflected in online tools. Consumers, who are mobile and price sensitive, need comparison shopping tools capable of showing, for example, the often-inverse correlation between quality and cost.

- **CAHC supports Section 305 that requires consumers to receive timely bills for services.**

- **CAHC has concerns about Section 306 (Section 2729D of the PHSA) and believes the section will have the unintended effect of reducing competition and raising prescription drug costs.** Plan sponsors should have flexibility to contract for their prescription drug benefits in the manner they choose. Whether it be a union plan, large self-insured plan, or health insurer, each already has a variety of choices in a competitive marketplace to get the right organization to administer their prescription drug benefits that meets their and their plan enrollees' unique needs. Unless the terms of those agreements limit competition, those agreements should be left to the private parties—as it is with other private contractual relationships—with specific financial terms, data disclosure, etc. left for them to develop, negotiate, and agree. The

impact of Section 306 is to limit choices that employers are currently voluntarily making and reduce competition. We are concerned this will raise costs. We urge you to eliminate Section 306 from the bill.

- **We support the intent of Section 309 Tools but encourage the committee to modify the language to support the adoption of Real-Time Benefit Tools.** Prescribers should be equipped with tools to see a patient's formulary options while the patient is still in the office. Real-Time Benefit Tools can accomplish this, providing valuable information to providers on lower-cost drug options that may be available to patients. These tools are in use today and should be required in taxpayer subsidized programs including for ACA plans. Standards and tools are not yet ready to display medical service costs at the point of care but are being worked on. We believe a three-year window is appropriate for adoption of service costs given the state of technology and encourage its inclusion in the legislation.

Title IV – Improving Public Health

- **CAHC supports Sections 401 and 402 because it will increase awareness of vaccines for the prevention and control of diseases and provide the necessary resources to stem the spread of misinformation about vaccine safety and efficacy.** Vaccines protect individuals from dangerous diseases such as measles, smallpox, and polio, and prevent the spread of these diseases within communities. A resurgence of diseases that are easily prevented by vaccines will undoubtedly take a tremendous and unnecessary toll on the healthcare system.

Title V – Improving the Exchange of Health Information

While CAHC supports plans making actionable information available to individuals and others to improve health care efficiency, transparency and quality, we believe Section 501 should be removed until issues such as privacy and security can be addressed. We believe plans may require more time to make information available in a format that can be shared via API without special effort. Technology is constantly evolving and the technology used to store beneficiary data five years ago is vastly different than today. Given the amount of data payers hold, we urge the Committee to take this into consideration when finalizing a timeline for this requirement. In addition, requiring this information to be made available at no charge to third parties, facilities and practitioners and their business associates at no charge precludes the development of a market for value-added services. We encourage the Committee to consider that the goals and considerations in publicly funded programs such as Medicare and Medicaid are different than those in commercial health plans.

The Committee proposal creates a system where HIPAA covered entities, such as payers, are required to provide patient information directly to the patient or direct the information based on patient requests. The draft legislation envisions a system where patients are able to manage their health information through the use of third-party applications. While CAHC supports this, we also recognize that third-party applications often will not have a business associate agreement with payers and may not be covered under existing HIPAA liability provisions. This is a significant issue that the Committee should address prior to moving forward with the API approach.

The Committee should create clear legal bounds for when actors cease to be liable for EHI breaches and for maintaining the security of certain transactions. Under the bill, payers are required to provide significant amounts of EHI, which they invested heavily in protecting, to third-party developed software that may have little or no experience in managing patient data of this kind. The Committee should clarify where security begins and liability ends. This will require a fundamental rethinking – and legislative rewrite – of HIPAA's privacy configuration and new rules that consider new technologies and new digital tools. Because this framework is premature, we suggest tabling Section 501 until hearings and a full airing of the needs and solutions can occur.

Conclusion

The stakes involved in promoting more competitive markets are considerable. Dartmouth Health Atlas estimates that 30 percent of health spending—more than $1 trillion in 2019—is "waste." A reduction of this magnitude would raise worker incomes while substantially eliminating federal budget imbalances. Strengthening the business case for productivity may be the single most important object of cost containment.

CAHC appreciates your careful consideration of our comments. We stand ready to serve as a resource to you and your staff on the issues related to improving affordability, transparency, and empowerment for all patients.

Sincerely,

Joel C. White
President