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

Dear Chairman Alexander:

Thank you for the opportunity to share our thoughts on the steps Congress should take to lower health costs, incentivize care that improves health outcomes, and enhance patients' ability to access their health information in order to make informed decisions. 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.

Our message is simple: we encourage you to enact policies that hold total spending growth to less than wage growth so that health coverage will become more affordable for all Americans. While some of the ideas outlined in this letter are easy to do, others will require difficult, and politically unpopular choices. But the return could be, effectively, a pay raise for working families of about $10,000 per year.

Overview: The Challenge of Rising Health Costs

The U.S. health sector will take in more than $50 trillion over the next decade alone.[1] At least one-quarter [2]—and perhaps more than one-half [3]— of that staggering sum will go toward services that are clinically unnecessary and sometimes dangerous.[4] Meanwhile, highly concentrated health markets produce prices for common tests and procedures that are 3-5 times higher than in other developed countries,[5] generally without yielding better outcomes.[6] Commercial spending growth in each year from 2012 to 2017 was almost entirely due to price increases, itself a reflection of weak competition.[7] Consumers have more information on the price and quality of their televisions and smart phones than they do their doctors and hospitals.

Rising health costs have collateral effects on the macro economy, public finances and household living standards. Health costs for working families, who receive coverage through employers, have grown dramatically faster than pay. The two trends are connected: rising premiums soak up raises that otherwise would boost living standards. The growing diversion of employee compensation into health benefits has contributed to the decline in the median household (cash) incomes and rising income inequality. Since 2010, the medical cost trend has grown by

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[1] National Health Expenditure Projections, 2018–27: Economic And Demographic Trends Drive Spending And Enrollment Growth, Andrea M. Sisko, Sean P. Keehan, John A. Poisal, Gigi A. Cuckler, Sheila D. Smith, Andrew J. Madison, Kathryn E. Rennie, and James C. Hardesty, Health Affairs (February 20, 2019).
[2] Institute of Medicine, "Better Care at Lower Cost: The Path to Continuously Learning Health Care in America," published on-line, September 2012.
[3] Kristen Bronner,"Supply Sensitive Care," *Dartmouth Health Atlas of Health Care, Center for the Clinical Evaluative Sciences*, January 17, 2007.
[4] Shannon Brownlee, "*Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer*," Bloomsbury, 2008; and James, Brent, Testimony to Senate HELP Committee, 2018.
[5] International Federation of Health Plans, *2012 Comparative Price Report—Variation in Medical and Hospital Prices by Country* April 2013.
[6] Institute of Medicine, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, January 2013.
[7] Health Care Cost Institute "2017 Health Care Cost and Utilization Report"

73 percent, about four times faster than the average wage and five times faster than the Consumer Price Index. Because costs (total, out-of-pocket, premiums, etc.) are rising faster than wages, health coverage is becoming less and less affordable. If current trends persist, the typical working family will spend more than 40 percent of its income on health care by 2030. In 2019, this medical cost trend is, once again, expected to rise 6 percent, with health costs for a working family of four averaging almost $30,000.

Behind the rise in health costs has been relentless inflation at the point of care. America spends about seventy percent more, as a share of GDP, on health care than the rich country average, yet has some of the lowest life expectancies across practically every socioeconomic group at practically every age. Life expectancy in the U.S. has declined in each of the past two years, and stems in part from an epidemic of chronic diseases, including opioid abuse.

CAHC supports efforts to address these problems through reforms that will increase competition by improving access, fostering and expanding informed consumer choice, promoting value, and empowering consumers. Congress and the Administration should work aggressively to expand and enhance competition and consumer choice while reducing statutory and regulatory burdens. Perhaps most importantly, decision makers should heed the threat posed by rising health costs and act this year to tame medical inflation.

I. Enact a Data Framework to Address the Cost Crisis

Converging developments may soon allow the much more vigorous monitoring and management of the factors that drive costs. After decades of languishing at the back of the pack in terms of IT adoption, the health sector is investing heavily in a new infrastructure of secure health records and communication systems. Clinical routines are changing to accommodate both the input and uses of data. Advances in big-data analytics are dramatically expanding our capacity to process data in ways that generate actionable, real-time insights with respect to both the efficacy of cures and efficiency of care delivery. Finally, the tripling of the number of commercial enrollees with high deductible health plans, from 8 percent in 2008 to 29 percent in 2018, is fueling demand for reliable measures of provider cost and quality. Participation in health exchanges, likewise, is increasing consumer demand for more data on health plans.

While these developments could greatly strengthen the demand side of health markets, realizing this potential will require the broader use of data to generate meaningful and accurate provider-specific performance measures. Today such measures are rudimentary and imprecise, in part, because much of the efficiency, quality and safety data needed to manage care and facilitate comparison-shopping is not available for commercial use. In addition, quality metrics under the Medicare and Medicaid programs are insufficient to address the challenges of excessive volume and intensity.

Putting more and better data into the hands of health plans and consumers can lead to innovation that mitigates high prices and wasteful care. For example, by tracking the practice patterns of individual physicians, health plans can identify and reward high value providers through network inclusion and quality ratings. By providing enrollees and their primary care physicians with comparison-shopping tools, plans can direct consumers toward the highest-value providers within their networks. Finally, by providing physician practices, clinics and hospitals with detailed feedback with respect to practice and referral patterns of individual practitioners, plans can help hospitals and practice administrators to better manage costs. Notably, these same metrics also can be used to generate consumer-facing measures for health plan networks, such as average network quality scores by specialty.

Taxpayers fund public health programs and the cost and clinical data they produce. These rich sets of data include valuable information on costs, utilization, outcomes, and other measures that could be used to glean insight into

both long standing and emerging problems. Unfortunately, this data too often is not being shared in ways that benefit society. We encourage Congress to enact a data framework to help address the cost crisis, that would include the following:

- **Expand the availability of taxpayer-financed claims, quality and safety data to provider organizations, quality improvement groups, health plans, productivity vendors and other competent parties, for the express purpose of managing utilization and treatment costs.**

- **Congress should reset the quality framework to better identify waste and low value care.** Today, quality measurement at the institution and medical group levels combined with robust provider feedback has yielded improvement. But the current measure sets used for the Patient Quality Reporting System, Meaningful Use, and Accountable Care Organizations are misaligned and focus more on processes than outcomes, creating excessive burdens on providers and only limited value for taxpayers. Among several commonly used measurement sets (NCQA, HEDIS, NQF Endorsed Measures, ACO measures, and the AMA PCPI measures), fewer than ten percent address overuse or appropriate use and instead focus on measures of underuse. Reforms designed to highlight outcomes, overuse, and total cost of care could yield significant savings. Furthermore, to ensure these measures can more accurately reflect performance at the individual clinician level, it will be critical to address challenges related to insufficient number of comparable cases, socioeconomic variations, and data reliability. Congress should direct the Secretary to prioritize measures, placing a high priority on developing measures of overuse or misuse, and weight clinical and patient reported outcomes measures more heavily than process measures (but include all three) in federal incentive programs. More measures should be used in quality reporting and pay for performance programs to drive and reward appropriate utilization of services.

- **Medicaid data should be standardized across states and reported to the federal government, and made available publicly for research and cost containment purposes.**

- **Expand the availability and permissible uses of data collected pursuant to federally funded programs, including Medicare, Medicaid, CHIP, Tricare, the Veterans Administration (VA), the Federal Employee Health Benefits Program, and the Indian Health Service.** Together these programs account for more than half of all health services purchased in the U.S. and, as such, are essential to the completeness of health data sets. For example, the ability to combine public data with data collected by private health plans will allow more complete tracking of individual patient outcomes and provider performance. In furtherance of this goal, subject to strict patient privacy requirements, the federal government should:

    - **Provide data from all federally funded health programs.** The Qualified Entity program currently permits the release of only Medicare Part A, B and D data, and Medicaid and CHIP data, but not TRICARE, FEHB and VA data. Completeness requires a uniform federal policy toward data transparency, while recognizing disclosure of some proprietary pricing may discourage discounting or price concessions in some markets.

    - **Provide timely, detailed claims data.** Such data includes line item detail on specific services by specific providers for specific (though de-identified) patients. To be relevant to operational needs, data should be as current as possible.

    - **Provide federally supported quality and safety data from registries and Medicare performance measures.** The federal government funds, both directly and indirectly, data collection on a range of patient safety and quality metrics, including medical society registries and provider-level data on readmissions and hospital-acquired conditions. Most physicians and hospitals that serve

Medicare and Medicaid patients also serve the privately insured population, making federal quality and safety measures equally relevant to non-beneficiaries. Publicly insured patients also would benefit from insights gleaned by combining public and private data. Federal health data policy must expressly embrace the principle that no consumer should unknowingly patronize an unsafe provider.

- **Provide data to commercial, state governmental, research organizations, nonprofit and public entities for the express purpose of managing costs and analyzing the impact of payment and other policies on costs and market competition.** Current rules permit the sharing of public data for the express purpose of improving quality, but not efficiency. Yet affordability is itself a powerful barrier to improvements in population health. Even amid the much-discussed "slowdown" in health costs, private premiums have continued to grow more than twice as fast as household incomes. Arresting this growth should be a primary, not a tertiary, focus of federal health data policy. Improvements in clinical science alone will not bring down medical costs.

- **Align federal data policy with permissible uses for private data.** Commercial uses of health data with respect to privately insured populations are governed by HIPAA and other federal privacy laws. When federal and state agencies impose stricter standards on the use of publicly collected data, the effect is to reduce the uses, and hence the value, of both public and private data. To maximize the value of data, we recommend that federal policy strive toward the least burdensome standards necessary to protect patient privacy, including a national, electronic authorization framework.

- **Charge users of federal data less.** Once large public data sets have been created, the marginal cost of providing that data to each additional user is relatively low. To facilitate the dissemination and use of public data, the federal government should charge no more than this marginal cost.

- **Support the sharing of private data.** Private health plans, which cover roughly 197 million Americans, hold extensive data, but frequently no single carrier or plan has enough data to generate actionable findings in highly localized health markets. The growing potential of data analytics as a tool for controlling costs has created a growing business case for the voluntary combining of commercial data. Yet antitrust rules actively discourage data sharing by commercial interests, particularly among potential competitors in the insurance industry. To accommodate antitrust restrictions, plans have formed voluntary multi-payer claims databases, such as the Health Care Cost Institute and the California Healthcare Performance Information System. Meanwhile, in highly concentrated insurance markets, carriers may have fewer incentives to share proprietary claims data with potential competitors as well as with self-insured employer (ERISA) plans, for which they serve as third-party administrators. In part to overcome this resistance, thirty-one states have formed, or are considering forming compulsory all-payer claims databases. To support private data sharing, the federal government should:

  - **Relax antitrust restrictions on data sharing and transparency.** Current anti-trust policy has failed to embrace data sharing and price transparency tools that could help contain volume and intensity. We are not advocating a requirement for public disclosure of all negotiated prices, because this may discourage discounting or price concessions in some markets. But we believe data sharing and price transparency pose far fewer risks to consumers, and hold the prospect of greater benefits, than currently envisioned. We note that relaxing antitrust restrictions on the private sharing of data would mirror ACO policy, which subordinates antitrust policy to efficiency goals. Finally, antitrust rules may also presume that price transparency would lead to less competition among insurers. The opposite is true: competition among insurers would be more

robust, and health plan costs would be lower, if more insurers had the analytic tools for eliminating waste.

While the price of health coverage in the US is excessive by many measures, its underlying costs are amenable to management with more and better data. Data analytics can both advance our common understanding of clinical science and permit the development and timely use of precise measures of provider performance. Such performance measures are particularly important for specialists, who manage patients with the most complex and expensive needs. Federal data policy currently inhibits data sharing—and, by so doing, may be harming public health. These opportunity costs are rising in tandem with the growing power of analytics and the growing collateral effects of health cost growth on the economy, public budgets and households.

II. Pay for Safe, High Value Care

In 2019, health care spending will total $4.0 trillion—equal to 18.3 percent of the economy (38 percent more than the total output of California). Over the next 10 years, national health expenditures (NHE) are on track to top $50 trillion. The Center for Medicare and Medicaid Services (CMS) projects that health spending will grow 63 percent during 2018 to 2026, compared to GDP growth of 49 percent. In this projection, NHE's share of the economy will expand from 18.0 percent of GDP to 19.7 percent of GDP.[8] The health sector's largest component is hospital care, followed closely by physician and clinical services, and finally prescription drugs. All major components of the medical industry are expected to grow faster than GDP – with their shares remaining relatively stable.

To maximally impact affordability, we encourage you to focus policy changes in areas where costs are the greatest or where they are growing the fastest by more rapidly transitioning to payment for value. Because you tend to get more of what you pay for, we encourage Congress to pay more for high value care (high quality, low cost), and less for low value care.

Reward Outcomes

Health care is undergoing a monumental shift as payers move to aggressively reward value defined by lower costs and better outcomes. Bundled payments, accountable care organizations, evidence-based medicine, and VBID have become key tools in a system-wide movement away from traditional volume-based, fee-for-service payment models. In such value-based systems, payment for a service or treatment is linked to real medical outcomes, rewarding lower cost and higher quality – not quantity. Current law has inhibited this move in the prescription drug space, however. Because care value (patient outcome, efficiency, etc.) is not effectively measured, federal payment programs reimburse the same regardless of outcome, and taxpayers subsidize – and get more of - low value care.

Key reforms must be made to enable this shift toward value-based reimbursement. Ultimately, this kind of approach will more effectively encourage resources to be allocated to treatments that provide the most benefit at the lowest cost to consumers and society, enabling consumers and governments alike to make the most of their available resources.

- **Measure low value care.** Private calculators are available to measure low value care based on both cost and clinical outcome. Congress should require HHS to develop or contract for an analytical tool to quantify and report on potentially unnecessary services so that high value care can be rewarded, while payment for low value care is limited or terminated. The tool would analyze claims, billing and clinical data to

[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

identify and flag potentially wasteful services. Such calculators are already used in the private sector, and identify unnecessary or harmful care with precision.

- **Reform pricing models that inhibit value-based arrangements.** Manufacturers and payers are reluctant to enter into value-based arrangements, in part, because of the challenge of squaring such innovative approaches with the inflexible complexities of rebate liabilities under Medicaid's "best price" reporting requirements. Additionally, other drug reporting programs also hinge reimbursement on sales prices, which compounds the chilling effect on value-based systems by setting artificial pricing floors. The result is that many innovative, lower cost arrangements simply are not pursued. We recommend that clear exceptions to Medicaid best price and Average Manufacturer Price reporting be established for value-based arrangements, coupled with clear guidance to reduce current ambiguity about how to capture value-based pricing for reporting purposes.

- **Reform Anti-Kickback and Stark restrictions.** The Anti-Kickback and Stark laws are intended to prevent fraudulent and abusive practices by prohibiting arrangements where organizations, individuals, and physicians could receive inappropriate payments for referring a product or service that would be paid for by federal health programs. Although the laws have historically been effective in capturing true misconduct, their broad and relatively inflexible approach has also had the unintended consequence of hampering the adoption of innovative arrangements and patient engagement efforts that can truly benefit consumers and the health care system. This is especially relevant to value-based and care coordination arrangements, which should be allowed safe harbors from both laws to allow for greater care coordination and payment. Combined with the changes to Medicaid Best Price, we project up to $36 billion in annual savings to the U.S. healthcare system from adoption of these approaches, and $2.8 billion in federal budgetary savings over the ten-year budget window.

- **Enable medication synchronization programs** to assist patients in filling their multiple prescriptions. P4HA estimates incentivizing medication synchronization programs in federal health programs will save up to $42 billion in annual healthcare costs.

- **Reform Medication Therapy Management** programs in Medicare Part D to target resources to at risk beneficiaries based on data driven insights from EHRs.

- **Real Time Benefit Tools** allow prescribers to see a patient's formulary options while the patient is still in the office. It promotes primary medication adherence and lowers costs (by up to $18 billion, according to West Health). It should be required in the Medicare Part C and D programs in the same manner as e-prescribing. RTBTs should be added to certification requirements used in EHR programs (CEHRT)

- **Leverage health IT** to assist in (1) the identification of non-adherent behavior; and (2) improving non-adherence through various tools that can help via reminders, health coaching, etc. There have been many research articles done on the effects of various electronic tools to help improve adherence. These electronic tools should be allowed in federal programs as a tool to lower costs.

Lift the Threat of Surprise Billing

Surprise medical billing is a problem that arises when patients receive services from providers (physicians, hospitals outpatient facilities, laboratories, etc.) that they reasonably assumed would be in-network, but are actually out-of-network, or when patients have no real choice over the network status of their providers (such as in emergency care situations). CAHC supports holding the consumer harmless for surprise medical bills, requiring

them only to pay copayments and deductibles calculated from in-network rates. For provider reimbursement in such out-of-network situations, we recommend a maximum reference price as percentage above Medicare rates (we believe 150 percent is reasonable considering a surprise bill should be a rare occurrence). 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.

III. Inject Competition Into the Marketplace

The relaxation of antitrust guidelines in 1992, 1994, 1996 and 2011—and court rulings based on now-disproven behavioral theories—has facilitated the rapid consolidation in local health services markets. PwC estimates that this year 93 percent of metropolitan statistical areas will be highly concentrated,[9] up from 90 percent in 2016. As in other industries, a central motive for consolidation is pricing power. The prices charged to private patients are determined through annual negotiations between insurers and myriad providers in thousands of local markets. Insurers' ability to hold down prices depends on their ability to exclude high-cost providers when forming networks. Market concentration turns this process on its head, giving high-cost providers the ability to exclude low paying insurers.

For example, analysis of rate filings for 2017 show that the largest contributors to premium increases are costs for hospital outpatient services, followed by taxes and hospital inpatient services. This data highlights a steady shift away from physician services toward outpatient hospital costs. This is largely due to the increasing acquisition of physician groups by hospitals. Many of these consolidating provider systems are creating their own health plans, which further deteriorates the competitive process that keeps provider rates in check.

In the final rule establishing Medicare ACOs, the Federal Trade Commission identified several suspect practices that strengthen provider bargaining power at the expense of health plans and consumers. Consistent with this policy, Congress should nullify and prohibit contractual provisions preventing or discouraging competition. Contracts that prevent private payers from directing or incentivizing patients to choose certain providers, through "anti-steering," "anti-tiering," "guaranteed inclusion," "most-favored-nation," or similar contractual clauses would be prohibited. Horizontal consolidation across markets allows hospital systems to us their dominance in one market to boost prices in others. This, too, should be prohibited.

- **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 in programs (such as the ACA and ERISA) where taxpayers have a vested interest in lower costs (either through spending or tax subsidies).

- **Congress should provide the Department of Justice and the FTC additional resources to better promote competitive markets.**

- **DOJ and FTC should systematically review local markets** and seek to improve competition in markets that are not competitive. DOJ and FTC should not rely on a prospective approach but should seek to expand competition and consumer welfare in markets that today are highly concentrated.

- **States should set upper payment limits in areas where competition is non-existent.** Medicare already allows private insurers to pay CMS-administered rates under the fast-growing Medicare Advantage program. Medicare prices are transparent and adjusted to reflect geographic and other trends. Creating a

[9] Ingrid Stiver, "One inflator of medical cost trend in 2019: Provider megamergers," PwC Health REesearch Institute. November 20, 2018

similar upper payment limit (set at a percentage above Medicare rates) for state employee plans and all private health plans would be straightforward and affect all local markets more or less equally. Such limits could be phased in over several years rather than implemented all at once. Montana has already implemented such a system for their state employee plan, saving taxpayers there $17 million in 2016 and 2017, and a projected $15 million in 2018 without cutting employee benefits to raising premiums.[10]

- **Promote strategic alliances.** While market consolidation can lead to increased costs through an imbalance in power, greater alliance and care coordination can improve patient outcomes and increase value and inefficiency without creating market imbalances and inhibiting competition. Strategic alliances formally bring together separate, independent parties in pursuit of a common goal. These approaches, such as shared savings models, risk sharing arrangements, bundled payments and medical homes should be encouraged.

- **Examine Provider Licensing and Scope of Practice Rules.** For example**,** telemedicine services for appropriate provider types (such as behavioral health) should count in meeting network adequacy requirements. Such a policy could improve patient access, promote provider competition and lower prices while lowering costs.[11]

IV. Deliver Meaningful Market Transparency

Eighty-three percent of health spending is consumed by the 20 percent of the population that is most seriously ill and injured.[12] Insurers and health care providers spread these costs onto the healthier 80 percent via premiums and prices. Historically, insurance has inured relatively healthy consumers from high provider charges, thereby fostering a preference for convenience over cost. Such a preference localizes health markets and enhances provider pricing power. For example, in a 2008 study examining a 2000 merger of hospitals located 2.5 miles apart in Berkeley and Oakland, California, FTC found that the merger had allowed the smaller of the two hospitals to raise its prices by 28.4 percent to 44.2 percent (for different insurers). This was despite the presence of 17 hospitals within a 20-mile radius.[13] Enhanced pricing power is reflected in sometimes extreme price variation for routine tests and procedures. [14, 15]

More recently, however, large deductibles on exchange plans, the increased adoption of HSA eligible high deductible health plans - which expose consumers to price variation up to the deductible limit - and Value-based Insurance Design (VBID) plans has broadened the geographical "footprint" of markets for non-emergent, schedulable tests and procedures. Recent research has found that consumers with deductibles greater than $2,501 (much less than the average second lowest cost silver plan deductible) were more likely to shop for coverage or switch doctors than consumers with a lower or no deductible. But consumers have less information on the price and quality of health care providers than they do on televisions or smart phones. Most providers do not provide prices publicly, and if they do, the prices typically reflect "charges"—list prices—that often exceed actual amounts collected by several fold. In addition, prices within local markets can vary by as much as 700 percent. For example, MRIs are largely a commodity, but their price varies greatly.

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[10] https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care

[11] Telemedicine: Decreasing Barriers and Increasing Access to Healthcare, Healthcare Value Hub, November 2017

[12] Kaiser Family Foundation, Kaiser Fast Facts, published on-line: http://facts.kff.org/chart.aspx?ch=1344

[13] Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," Federal Trade Commission Working Paper No. 293 (November 2008): 20-26.

[14] Paul B. Ginsburg, Wide Variation in Hospital and Physician Payment Rates—Evidence of Provider Market Power," Research Brief No. 16 *Center for Studying Health System Change* (November 2010): 5-6.

[15] Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers*, March 16 2010: 3-4, 17-40.

Separately, consumers have become more familiar with online comparison shopping. In many metropolitan areas, the 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 mobile consumers, we recommend the following:

- **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.

- **HHS should finalize rules to prohibit information blocking and to promote interoperability.** It is also important to establish standards to support comprehensive patient electronic data portability, including tests to assess vendor compliance with data access requests. Patients should be able to take their entire EHR with them (not just a summary) when changing physicians or seeing subspecialists and other providers.

- **Better data is a prerequisite for better comparative information tools.** Commercial entities, including insurers and data analytics firms, should have greater access to both public claims and private quality data for the purposes of managing care and constructing effective cost calculators and online comparison-shopping tools for consumers that disclose provider prices, quality and safety reports. Plan information on provider networks, formulary and total cost of care, should be reflected in on line 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. Effective comparison-shopping tools must consider such complexities as risk-weighting and efficiency, which requires sophisticated data analytics.

- **Strengthen the plan and enrollment data made available for the ACA's health insurance exchanges.** HHS should regularly release enrollment data by health plan, carrier, county, and state, just as it does for Medicare Advantage and Part D.

V. End the Public Exchange Monopoly

Health exchanges are a fundamentally sound idea. They reflect the proposition that informed consumers can stimulate system-wide improvements in the cost and quality of health care as they have in other realms. The exchanges are designed to facilitate online comparison shopping for health insurance plans by providing a transparent review of complicated price and coverage details. CAHC has conducted an annual survey[16] to assess the e-commerce competency of the public exchanges created after the enactment of the ACA. The subjects of our study include the 12 exchanges run by individual states and the District of Columbia, as well as the federal health exchange, Healthcare.gov, which provides services in 38 states.

Our independent review offers an unbiased look at all of the exchanges — monopolies serving captive markets within their respective states. In some cases, state-run exchanges may be subject to chronically weak legislative oversight and the structural flaws inherent in monopolies are well-documented: Monopolies are notoriously insensitive to customer needs and can be laggards in innovation. Total reliance on public exchanges and enrollment efforts have proven to be insufficient to offer consumers consistently functioning sites that both inform and ease the plan selection process. Despite the more than $5 billion spent to establish and maintain

[16] https://www.cahc.net/newsroom/2018/10/29/new-report-highlights-shortcomings-on-healthcaregov-state-based-exchanges-ahead-of-open-enrollment-season

public exchanges, most have been operating below the state of the art in consumer accessibility and decision-support tools even though these tools are often found in the private sector.

To promote choice and to lower costs, HHS should contract out most functions of healthcare.gov and encourage states – via 1332 waivers and other mechanisms – to expand channels for enrollment, including through private exchanges and web sites. Ideally, healthcare.gov should become a federal data hub, where private exchanges would query the database to determine enrollment and APTC eligibility. Private web brokers, direct enrollment and exchanges would then facilitate enrollment into plans. HHS should not compete with private entities who are better equipped and suited to compete in eCommerce enrollment.

Recommendations:

- Over the next three years, transition to a privately-operated exchange model and eliminate funding for activates unrelated to the federal data hub in the HealthCare.gov program;

- Transition an increasing number of APTC eligible enrollees into privately operated exchanges, starting with at least 10 percent in the enhanced direct enrollment pathway in 2019;

- Congress should enable all beneficiaries to use their premium tax credits off the public exchanges, to also be used in the privately-operated exchange model when fully implemented; and

- Reduce or eliminate the 3.5 percent premium tax that funds public exchange monopolies.

VI. Offer Better Choices

Plan choice and competition have declined under the ACA. Estimates indicate that more than one-third of consumers have just one issuer option on exchanges. The ACA has significantly limited the types of plans available to consumers by restricting plan design and limiting subsidies to plans sold on public exchange markets. Some states have further reduced choices by disallowing any plan design variation and/or prohibiting the sale of plans outside public exchanges.

Overly restricting plan design flexibility and choice limits the pool of consumers who may want to purchase coverage. It also hinders efforts to negotiate provider payment rates to lower costs for consumers. CBO has estimated that the essential health benefits (EHB), actuarial value (AV), and guaranteed issue requirements, alone, drive up costs by 27 to 30 percent. Both premiums and out-of-pocket costs are on the rise, and the ACA has tied consumers' hands in their ability to utilize tax-preferred health accounts to cover these costs.

- **Encourage Value Based Insurance Designs.** Congress should encourage plan designs that that target and improve care for patients with high-cost conditions such as diabetes, mental health, and other illnesses.[17] Because the exchange population has been shown to have greater medical needs than the general population, specialized plans can help insurers keep enrollees with higher cost conditions healthier, which can lower costs and premiums in a unified risk pool. Current non-discrimination rules may make it difficult for plans to offer such coverage, however. As states consider standard benefit designs, the standards should allow for the "clinically nuanced" cost-sharing associated with these models.

[17] Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality, Healthcare Value Hub, July 2016

- **Encourage creativity in network design.** Networks have grown increasingly narrow as a way to contain costs. This is particularly true in areas where there is an imbalance in market share between insurers and providers. Rural areas are particularly impacted as these areas contain fewer providers, making it difficult to both meet network adequacy standards and to negotiate competitive rates. This results in higher premiums and fewer options for everyone, but particularly for rural consumers. Over the last several years, state and federal regulators have held insurers to quantitative network design standards (such as time and distance). HealthCare.gov has even begun rating plans based on network breadth alone. Congress should inform consumers about network quality as well as breadth.

- **Flexible Benefit Designs.** The statutory definition of the essential health benefits (EHB) is narrow, but regulations have significantly increased mandates and restricted benefit design by, among other methods, including all state benefit requirements imposed prior to enactment of the ACA in the EHB. These restrictions have limited the types of plans available to consumers and increased costs. A narrower definition of the EHB requirements would lower costs.

- **Improve and expand the use of consumer-driven health products.** Congress created these products, like HSAs and FSAs, partly to generate more awareness and control in health consumption while maintaining access to care. The ACA limited ways that consumer-driven health products can be used, which can drive up costs for consumers. The following changes will improve competition by giving consumers greater control over their health care:

    - The ACA prohibits individuals from using any remaining premium tax credit for the purchase of qualified health plans to be placed into an HSA. This creates powerful disincentives for consumers to choose lower-cost plans and place any left-over credit into an account for later use. Consumers should be allowed to use any remaining subsidy credits for HSA contributions.

    - The ACA prohibited the use of HSAs, FSAs, Archer Medical Savings Accounts, and Health Reimbursement Arrangements to purchase or be reimbursed for the purchase of over-the-counter (OTC) medications without a prescription. There are many lower-cost alternatives to prescription drugs available OTC, but the law requires patients who would like to use these tax-preferred mechanisms to either go to their physician for a prescription (where the visit would have to be reimbursed) for the OTC drug or get a prescription for a similar drug covered by insurance. Either scenario drives up costs for the insurer and the patient. Patients should be allowed to use consumer-driven health products for OTC medications.

    - More flexibility should be given to the types of plans eligible for HSAs to meet more diverse consumer needs. Anyone facing a chronic condition will likely use all or most of their HSA funds annually with little or no funds to roll over to cover large medical expenses that may be incurred later. CAHC supports broader use of HSAs by individuals facing chronic conditions. Allowing HSA-eligible plans to provide first-dollar coverage for targeted treatments and preventive services that are clinically proven to improve health outcomes and prevent chronic disease progression would maintain appropriate access to necessary care. For example, such a plan could provide a diabetic patient with pre-deductible access to test strips, insulin, and diabetic eye exams. Reforming these rules to allow insurers to provide more incentives for cost-effective care prior to the deductible could increase the value of benefits for many enrollees while also potentially reducing costs.

    - Cost-sharing generates more awareness of health consumption, which can positively influence consumer behavior. To maintain access to care, lower-income individuals should have access to

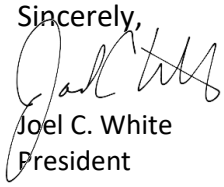
assistance to cover these obligations. Converting cost-sharing assistance subsidies into account-based plan deposits, putting health funds directly in the hands of consumers, would empower consumers to make better decisions, generate competition and promote good stewardship.

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
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