National Business Group on Health®

20 F Street, NW, Suite 200
Washington, D.C. 20001
202.558.3000 • Fax 202.628.9244
www.businessgrouphealth.org

Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

March 1, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510-6300

Dear Chairman Alexander:

The National Business Group on Health (NBGH), whose members include 437 of the nation's largest employers, is grateful for the opportunity to respond to your request for specific recommendations for Congress and the Administration to slow rising health care costs, improve health outcomes and increase access to information to make informed decisions about health care. The nation's employers provide stable health benefits that more than 181 million Americans value and rely upon—the largest source of health coverage in the country. In addition, according to HHS data as you point out, in 2016, employers and employees paid over half the $3.3 trillion we spent on health care in that year.

Along with the government, taxpayers and families, employers have a vested interest in improving the efficiency and effectiveness of health care delivery. As you noted, employers are more motivated than ever to leverage their purchasing power to transform health care delivery. According to NBGH's 2019 Large Employers' Health Care Strategy and Plan Design Survey, almost half, 49% of respondents are taking an activist role in driving delivery system change[1]. Employer plans continue to be a leading force in driving innovations in health care delivery transformation, lower cost alternative sources of care, quality improvement, consumer engagement, employee well-being, and new tools to help patients navigate among health care options and providers for needed care.

In addition to these innovations driven by employer plans, below are some specific recommendations for Congress and the Administration that can reduce growth in health care spending, improve health outcomes, and increase access to usable, actionable information to make health care decisions:

Repeal the Excise Tax on Employer Plans

The Business Group strongly supports the bipartisan bill (H.R.748) that would eliminate the 40 percent tax on the value of health benefits above a government-determined amount

[1] 2019 Large Employers' Health Care Strategy and Plan Design Survey, National Business Group on Health

imposed by the Patient Protection and Affordable Care Act (ACA), commonly referred to as the "Cadillac Tax." A companion bill is likely to be introduced in the Senate soon. Any tax that raises the cost of health benefits will harm the more than 181 million Americans who rely on and value employer-sponsored health coverage.

According to our survey data, absent plan changes, 73% of companies who responded will have at least one plan that triggers the tax in 2022 and 94% will in 2026. In a few short years, if the tax is not repealed, **it will affect nearly 100% of employer plans** since the *tax is indexed to general inflation, not medical inflation, which is consistently much higher*. To control health care costs, Congress would have more success focusing on supply-side drivers of medical inflation and unnecessary costs including eliminating FFS in Medicare, ridding Medicare of perverse payment incentives (e.g. supporting site neutral payments), and supporting policies that increase competition and promote sustainable pricing for prescription drugs (detailed below), rather than taxing this source of valued coverage and of health care innovations.

End Surprise Billing

Surprise medical bills from out-of-network anesthesiologists, pathologists, emergency room physicians and radiologists impose unanticipated significant bills on patients. In most instances, the patient is seeking treatment at an in-network facility when these out-of-network facility-based physicians perform ancillary services. While many employers protect employees and their families from balance billing in these situations and assist patients faced with a surprise bill, the underlying problems persist, and undermine employer and patient efforts to seek better health care value and lower costs.

We urge Congress to consider the following principles in crafting legislation to protect patients from surprise medical bills *without undermining access to high-quality, value-based health care networks*.

- End Surprise Billing

  Any effort must begin with eliminating balance billing by emergency providers, out-of-network (OON) providers at in-network facilities, and providers who consistently produce surprise bills under the current system.

- Promote Better Quality and Lower Cost for Consumers

  Health plan networks promote better quality and lower costs for consumers. Federal legislation to address surprise billing should not incentivize providers to continue to reject network participation. Solutions to surprise billing should serve to lower, not increase, premiums and costs for consumers. We are concerned that mandated arbitration would not only raise costs and undermine network participation, it would also be an inefficient and ineffective method of addressing surprise billing.

- Require Transparency

Patients and consumers have a right to be adequately informed of potential health care charges and to authorize any non-emergency treatment for which they will be billed by an OON facility-based physician at an in-network hospital. Facility-based physicians should disclose price and quality data so patients can make informed choices about treatment.

- Preserve Administrative Simplicity for Employer Plans

Employer plans value the ability to provide uniform health and retirement benefits to employees and retirees across the country. ERISA provides the framework that allows employers and employees to benefit from reduced costs that come from uniformity in plan design and administration without the burdens of a patchwork of state and local laws. We are concerned about any legislative change that affects uniformity in plan offerings for our employees and their families. Federal legislation should not require employers to comply with state laws that govern the offering of health coverage to employees. Self-insured plans must not be subject to state laws relating to surprise OON billing, including with respect to state mandatory binding arbitration or payment requirements.

- Protect Value-Based Payment Arrangements and Network Participation

Any legislation should be crafted in a way that ensures that value-based payment arrangements, which depend on provider participation in networks, are not hindered through unintended consequences of the law. These programs and benefit designs help reduce costs and improve patient outcomes.

- The Role of Health Care Facilities

Since facility-based providers are the most common source of surprise bills, these providers are not generally selected by patients but rather have contracts with in-network facilities, and the value and financial protections afforded by in-network facility status are diminished when these providers remain out-of-network, NBGH believes that hospitals and other facilities must play a key role in solving the issue.

Support HSA-Qualified Health Plan Improvements

The Business Group strongly supports legislation of the 115th Congress (H.R. 5138, the Bipartisan HSA Improvement Act) that would make many important health savings account (HSA) and HSA-qualified plan improvements and increase their value to employees and their families. Given that over 21 million Americans are covered by these plans, the following changes would help reduce current future health costs by assuring that patients receive needed care earlier, focus on maintaining their health, and remove obstacles to lower cost, more convenient sources of care. For example, the bill would:

- Permit plans to cover medications and services to manage chronic conditions before the deductible;

- Allow plans to cover primary, preventive, and chronic care management services in employee or retail clinic before the deductible;
- Clarify that plans can cover use of telehealth, second opinion, and similar services before the deductible;
- Incentivize wellness activities by allowing employees and other plan participants to use HSA dollars for exercise, fitness, and similar activities up to a specific dollar limit.

Advance Policies to Promote More Affordable, Financially Sustainable Prescription Drug Pricing

While many of the recommendations below are directed toward various agencies in the Administration, several of them require Congressional action. All of these policy recommendations are highlighted in the National Business Group on Health's Issue Brief on Policy Recommendations to Promote Sustainable, Affordable Pricing for Specialty Pharmaceuticals

- Remove Uncertainties Surrounding Risk-based and Value-Oriented Contracting and Implement Indication Specific Pricing and Reference Pricing in Public Programs
    - Consider exemptions for value-based contracts from Medicaid best price requirements and clarify how drug makers and payers can conceive of value-based contracts without triggering broader Medicaid best price program implications.
    - Allow for variable pricing, where the price better reflects the evidence for benefit.
    - Evaluate the usefulness and application of the existing developed value frameworks and their potential to impact drug pricing in public programs, as well as their overall utility to the health care system.
    - Directly link reimbursement and improved patient outcomes.
    - Consider how drug makers and payers can enter into other types of innovative VBP arrangements, such as indication-specific pricing.
    - Implement reference pricing policies supported by clinical evidence consistently across public programs, where possible.

- Limit Reach of Medicare Part D Protected Classes

    - Following the MedPAC's recommendations, the Congress and CMS should limit legislative and regulatory restrictions on formulary design within protected classes by modifying the Medicare Part D rules to remove those protected classes where enough generic competition exists, a change that would give private plans more freedom to control their formularies and negotiate for expanded manufacturer rebates.

  - Specifically, CMS should resubmit its proposal to remove antidepressants, antipsychotics, and immunosuppressants for transplant rejection from the list of protected classes because, in these classes, price reductions have been more closely linked with the availability of generics than to their status as "protected" and stand firm against industry-funded campaigns that seek to undermine the agency's data-driven proposal to increase competitive pricing.
  - At a minimum, policy makers should evaluate the potential anticompetitive influence of protected classes on the commercial market, and specifically, evaluate the limitations imposed on private payers' ability to negotiate competitive prices for drugs in the protected classes due to market spillover.

- Eliminate Perverse Payment Incentives Under Medicare Part B

  - Eliminate financial incentives for prescribing more expensive medicines, in more expensive settings.
  - Establish direct links between reimbursement and improved patient outcomes.
  - Encourage manufacturers to assume some financial risk for use of high-priced drugs.

- Encourage the Uptake of Biosimilars

  - Consider the utility of having an "interchangeability" distinction and potential alignment with the European biosimilars model, which has no such distinction.
  - Work with stakeholders to disseminate provider and patient education to firmly establish the safety and efficacy of biosimilar drugs to their reference products, recognizing that key successes to the uptake of biosimilar medicines in other countries was predicated on the creation of trust and confidence among all the stakeholders involved, such as prescribers, pharmacists, and patients.
  - Maintain payer autonomy to implement utilization management tools for specialty pharmaceuticals, including tools that pertain to biosimilar products.

- Reform Permissive Patent and Exclusivity Protocols

  - Reduce the market exclusivity period for biologics from 12 years to 7 years.
  - Eliminate or limit additive patent extensions and exclusivity periods that serve only to extend monopoly power, especially where there is limited, or no additional company investment or patient value produced.
  - Develop sound policy that would discourage patent abuses such as "evergreening" and "product hopping." These policies may include

financial penalties, loss of exclusivity periods and/or reduced patent terms for other products.
- Refine the biosimilars patent dance to effectively incentivize the use of the section 351(l) patent dispute resolution provisions.

Continue to Encourage and Promote Transparency

HHS should continue to support efforts to establish core measure sets of quality outcome metrics as well as measures of cost and efficiency – these allow consumers to make meaningful comparisons. The most valuable information is relevant, actionable, and in a user-friendly format, and increasingly accessible through mobile devices.

- CMS should continue to participate in and encourage efforts to balance the necessity to streamline data collection and reporting requirements for providers with the ability to provide meaningful measures of quality and price to patients and payers.
- CMS should continue to release to the public and make broadly available for analysis Medicare physician claims and hospital payment data as well as information on quality.
- Require outpatient facilities and physician offices to disclose whether they are billing as providers or as facilities and require them to disclose the differential prices (facility fees) prior to patients' receipt of services and preferably at the time they schedule appointments.
- Similarly, CMS should make publicly available transparency information on prescription drugs provided in the hospital outpatient and inpatient settings for Medicare patients.
- Specifically, with respect to making these data broadly available, CMS should broaden the category of "qualified entities" that can access and analyze Medicare claims data to include payers such as self-funded employers and their data warehouse partners.
- If employer plan claims data are required to be collected for all-payer databases, rules for ERISA plans should be standardized through the federal Department of Labor and centralized so that plans deal with one entity and one set of requirements nationwide, with particular attention to simplicity and minimizing the administrative burden on plans, and permitting employer plans access to aggregate data for their own analyses.
- We support the work and efforts by the Patient-Centered Outcomes Research Institute to provide evidence-based, independent data on clinical comparative effectives of treatment alternatives. It has and continues to provide valuable information. However, given the broad societal benefits, we do believe that funding should come from general revenues and the Medicare program rather than a renewal of an assessment on employer plans.

Accelerate Payment Reform and Delivery Reform in Medicare and Medicaid

- We strongly support the work of the Center for Medicare and Medicaid Innovation (CMMI) and encourage wider adoption of proven innovations to improve outcomes and reduce costs. We believe that Medicare Advantage innovations, including the recent ability to provide non-health services to enable beneficiaries to stay in their communities and reduce hospital admissions; the total cost of care model; direct contracting model for primary care; comprehensive primary care plus; the pioneer ACO and advanced ACO models; and diabetes prevention program are some examples of success or that hold promise.
- More generally, we strongly believe that models that include global budgets for the total cost of care with an emphasis on population health are likely to be more successful at improving outcomes and reducing overall costs.

The National Business Group on Health, representing 437, primarily large, employers (including 70 of the Fortune 100) who voluntarily provide valued health benefits and other health programs to over 55 million American employees, retirees, and their families, looks forward to working with you on our shared goals for health care: lower costs, improved access, and higher quality. Please contact Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail or if we can provide additional information as the Committee considers this legislation further.

Sincerely,

Brian J. Marcotte
President and CEO