



March 1, 2019

Senator Lamar Alexander
455 Dirksen Office Building
Washington, DC 20510

Dear Chairman Alexander:

On behalf of the National Coalition on Health Care (NCHC), we appreciate the opportunity to provide options and recommendations to address America's rising health care costs. NCHC is the largest, most broadly representative nonpartisan alliance of organizations focused on improving American health care. We encourage the Senate Committee on Health, Education, Labor and Pensions (HELP) to take a comprehensive approach to lower costs to produce a more affordable and effective health care system.

We applaud the 2018 bipartisan hearings you and Ranking Member Murray held to examine the growing costs of health care. At the National Coalition, we embarked on a year-long comprehensive examination of the drivers of health care costs. We convened experts and stakeholders at summits in seven major cities to review data and trends, and identify options to make health care more affordable and lower the growth rate of the total cost of care. We heard from some of the same experts and stakeholders as you heard from in your hearings. Many of the options we consider are consistent with those made by witnesses in your hearings. Our findings are detailed here in a full report, Strategies for Improving the Affordability of High-Quality Health Care and Coverage.

Summary of Findings

We summarize our findings below, followed by a table of options and recommendations for your consideration. Our fact-finding process identified six major drivers of health care costs:

- 1. Chronic illness rooted in non-medical determinants of health, attributable both to individual behaviors and certain policy choices that underinvest in prevention and discourage investments in the amelioration of these non-medical determinants;
2. Poorly coordinated, inefficient care delivery, driven by fee-for-service reimbursement and misaligned incentives that fail to reward providers, plans and states that manage to deliver better results;

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Table with 5 columns: Chairman, Board of Directors, and three columns of staff members with their titles and affiliations.

3. **Misuse of provider market power**, which arises when providers in increasingly concentrated markets engage in anti-competitive behaviors to drive up prices;
4. **Barriers to transparency and competition in pharmaceuticals** that produce unsustainable launch prices in new biologic and specialty drugs, frequent price increases for brand name drugs, and price spikes in low-volume generic drugs;
5. **Insurance and reimbursement rules that promote cherry picking of healthier patient populations** and undermine stability of ACA marketplaces, as well as flaws in Medicare's risk adjustment and post-acute care payment policies; and
6. **Cost barriers to high-value care that result from increasing deductibles** and, especially, from the increasing prevalence of High-Deductible Health Plans (HDHPs) linked with Health Savings Accounts (HSAs).

We offer policy options designed to address the identified six cost drivers, improve health outcomes, and increase the ability of patients and purchasers to access information to make informed decisions:

### Social Determinants of Health

To address the non-medical (i.e. environmental, social, and behavioral) determinants of health, policymakers should consider:

- A permanent, bipartisan funding mechanism for prevention and population health initiatives similar to that which supports federal medical research at the National Institutes of Health (NIH);
- A policy framework that supports and encourages individual behavior change, through intensive lifestyle interventions for cardiovascular and endocrine conditions, broader access to evidence-based treatment for substance use, and more aggressive tobacco control;
- Investment in the health of the next generation through prevention of childhood obesity, tobacco use and substance abuse, testing and scaling of interventions to reduce exposure to Adverse Childhood Experiences, assuring access evidence-based services in Medicaid and the Children's Health Insurance Program; and
- Removal of policy barriers to upstream investments by health care entities, by promoting population-based provider payment, removing compliance and regulatory barriers to upstream interventions and avoiding restrictions on Medicaid's ability to deploy non-clinical interventions.

### Value-Based and Population-Based Approaches

Policymakers need to accelerate the adoption of value-based payment and population-based payment both in traditional Medicare and other public programs and commercial markets. Toward that end, federal policy can:

- Provide increased incentives for delivery innovation by evolving successful payment reform strategies including global payment, health maintenance organizations (HMOs), and integrated care options for dually-eligible Medicare-Medicaid beneficiaries;
- Strengthen infrastructure for value-based transformation, by improving alignment of performance measures across payers and strengthening the primary care workforce.

To implement these policy options, the Senate Committee on HELP should coordinate and complement its work with efforts undertaken by the Senate Finance Committee by encouraging value-based and population-based payment adoption in employer-sponsored ERISA plans and ACA marketplaces.

#### Curb Misuse of Market Power in Provider Markets

Options identified by our fact-find process that pertain to the HELP Committee include using its grant making authority to encourage states and institutions to educate more primary care providers and allow them to contribute to the fullest extent on care teams. In addition, the Committee could condition eligibility for certain grants based on whether the state has reformed barriers that may inhibit competition, such as “certificate of need” laws, and to adopt policies such as the interstate physician licensure compact.

The Committee should accelerate the adoption of All-Payer Claims Databases (APCDs) through a grant program that would improve their capacity to track cost trends and inform purchasers and stakeholders. The Committee should address the growing problem of “surprise” medical bills, particularly for consumers covered by ERISA plans that cannot be regulated at the state level. Patients should be protected from balance billing, and dispute resolution mechanisms should result in reasonable rates that don’t diverge significantly from in-network rates.

#### Bring Down Barriers to Transparency, Competition and Value in Prescription Drugs

The HELP Committee should promote transparency regarding the value of new drugs compared to existing therapies. Key steps include allowing the Patient Centered Outcomes Research Institute (PCORI) to consider comparative cost effectiveness, liberalizing manufacturers’ ability to share cost information with payers in advance of launch, and authorizing public access to registry information. The Committee should act to curtail gaming endemic to the drug approval process, by cracking down on abuses of patents, Risk Evaluation and Mitigation Strategies (REMS) procedures, and orphan drug programs. Strengthening competition from biosimilars is also particularly important.

#### Curb Cherry-Picking and Risk Selection

To stabilize individual insurance markets, the HELP Committee should authorize federal funding for reinsurance while being careful not to encourage over pricing of services and episodes to qualify for reinsurance payments. The Committee should require that CMS reach a settlement with plans on risk adjustment payments. In addition, the Committee should restore the rules on short-term limited duration

plans, restore grants for outreach and enrollment in ACA marketplaces, and consider mechanisms for auto-enrollment.

Align Cost-Sharing with Value

High deductibles are the reality of insurance today, and they erect cost barriers that discourage appropriate utilization of high-value primary care and therapeutics. In the ACA marketplaces, the Committee should promote value-based, standardized insurance designs (VBID), and consumer choice architecture that facilitates the understanding of tradeoffs in plan design. The ACA marketplaces should support the availability of Health Maintenance Organization (HMO) plan options that use co-pays and low deductibles rather than co-insurance.

Table of Options and Recommendations

In the table below, we list the biggest cost drivers that were identified by our fact-finding process, and recommendations and options that came out of our regional listening sessions, and that are generally in the HELP Committee’s jurisdiction.

Major Cost Driver	Options and Recommendations
Chronic illness rooted in non-medical determinants of health	<ul style="list-style-type: none"> <li>● Fund AHRQ and CDC to evaluate impact of various non-health interventions on outcomes such as incidence of chronic disease</li> <li>● Authorize expert entity similar to the US Preventive Services Task Force (USPSTF) to evaluate the impact of non-medical interventions on health outcomes</li> <li>● Invest in high-value non-health interventions, such as Meals on Wheels and Head Start</li> <li>● Fund FQHCs to integrate behavioral health services and primary care</li> <li>● Study the evidence for community health workers (CHWs) to support prevention and management of chronic disease</li> <li>● Look broadly across HELP Committee’s jurisdiction at interventions such as early childhood education, paid leave, and minimum wage on health outcomes</li> </ul>
Poorly coordinated, inefficient care delivery	<ul style="list-style-type: none"> <li>● Expand reforms, led by Medicare, to move from fee-for-service payment to value and population-based payment to other programs and markets</li> <li>● Support employer-sponsored ERISA plans in risk-sharing arrangements</li> <li>● Encourage individual and SHOP marketplaces to be “active purchasers” similar to California and leading employers, such as Wal-Mart</li> </ul>

	<ul style="list-style-type: none"> <li>● Encourage ERISA plans to join “all-payer” payment models to drive value and lower administrative costs, and minimize cost-shifting among payers</li> <li>● Strengthen the primary care workforce by expanding Teaching Health Center Graduate Medical Education program and incentives for primary care providers</li> <li>● Provide grants to states to enact the interstate physician licensure compact to promote mobility, address shortages, and facilitate telehealth access</li> </ul>
<p>Misuse of provider market power</p>	<ul style="list-style-type: none"> <li>● Provide grants to states to support All-Payer Claims Databases (APCDs) to assist stakeholders in examining cost trends and evaluating payment models</li> <li>● Provide incentives to ERISA plans to participate in APCDs, to standardize definitions across APCDs, and ensure public reporting of data</li> <li>● Require APCDs to measure and track the share of spending devoted to primary care; similarly, require Medical Loss Ratio (MLR) reporting by cost category, including primary care</li> <li>● Address “surprise” billing by out-of-network providers by requiring use of transparent reference prices while protecting patients from balance billing (see Senator Hassan’s bill)</li> <li>● Use APCDs to identify inefficient and high-cost sites of care</li> <li>● Use grants and loan forgiveness programs to encourage states to license “mid-level” providers</li> <li>● Ensure state Certificate of Need (CON) laws are not inhibiting competition</li> <li>● Authorize grants for states to deploy community health workers (CHWs) in evidence-based roles</li> <li>● Examine network adequacy rules in ACA marketplaces to ensure they do not exacerbate provider market power</li> </ul>
<p>Barriers to transparency and competition in pharmaceutical pricing</p>	<ul style="list-style-type: none"> <li>● Invest in comparative effectiveness research to promote competition based on value for pharmaceuticals</li> <li>● Use binding arbitration to address excessive launch prices of new therapies</li> <li>● Use tax credits instead of extended exclusivity to incentivize the development of orphan drugs</li> <li>● Enact the CREATES Act to promote greater availability and speed to market of generic drugs</li> </ul>

	<ul style="list-style-type: none"> <li>● Promote access to biosimilars</li> <li>● Continue to fund NIH at levels that support advances medical and scientific knowledge through basic research</li> <li>● Curb anti-competitive pay-for-delay deals that delay generic competition</li> </ul>
Insurance pooling mechanisms and rules that shift risks and costs	<ul style="list-style-type: none"> <li>● Limit short-term duration plans in individual markets to terms of 3 months or fewer</li> <li>● Develop accurate re-insurance and risk adjustment mechanisms that don't reward high prices or inflated costs</li> <li>● Retain restrictions on use of Advanced Premium Tax Credits (APTCs) to marketplaces where essential health benefits (EHBs) are required and other consumer protections are enforced</li> </ul>
Cost barriers to high-value benefits and care	<ul style="list-style-type: none"> <li>● Avoid expanded tax or other subsidies for high-deductible plans that discourage enrollees from accessing high-value prevention and chronic disease treatments</li> <li>● Incorporate VBID options in marketplace plans and standard plan designs to facilitate consumer choice</li> <li>● In individual and SHOP marketplaces require that rebates and discounts be shared with consumers</li> <li>● Encourage participation of HMOs in public and private health plan offerings</li> </ul>

We thank you for your consideration of NCHC's comments. Should you have any questions, please do not hesitate to contact me at [jrother@nchc.org](mailto:jrother@nchc.org) or 202-638-7151.

Sincerely,



John Rother, President & CEO