Congress of the United States
House of Representatives
Washington, DC 20515-3605

January 10, 2022

To All Interested Parties:

We, the Healthy Future Task Force Affordability subcommittee members, write today requesting information on design considerations for legislation to make healthcare more affordable. In 2019, our nation's health expenditures reached $3.8 trillion, almost a fifth of our economy.[1] In 2020, health expenditures grew 9.7 percent to $4.1 trillion.[2] While the explosive growth of last year reflects the impact of the COVID pandemic, longer-term growth trends make it imperative Congress and health care stakeholders work together to make changes or else our national healthcare spending will almost double and reach $6.2 trillion in seven years.

We believe bold steps are necessary to lower health care costs for America's workers, protect our seniors' promised benefits, and provide for the uninsured, vulnerable and at-risk communities. To drive down the true cost of care for families, rather than simply increase government subsidies for the health care sector, we request information on legislation that would increase price transparency, lower barriers to competition, and empower consumers to have more choice in their healthcare providers.

In light of these goals, please respond to the following questions on the google form at https://forms.gle/VLKJH5KzS25UL8SdA by February 4, 2022.

Sincerely,

Kevin Hern
Member of Congress

Rick Allen
Member of Congress

Victoria Spartz
Member of Congress

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet
[2] https://www.cms.gov/files/document/highlights.pdf

Please respond to the following questions:

I. Improving Healthcare for America's Workers and Small Business Owners

1. On June 19, 2018, the Department of Labor finalized the Association Health Plan (AHP) rule[3], which allows small businesses, including the self-employed, to band together by geography or industry to obtain healthcare coverage as a single large employer. In addition, this Congress Rep. Walberg, Republican Leader Foxx, Rep. Allen, and Rep. Burgess introduced H.R. 4547, the Association Health Plans Act to codify association health plans.
    a. Have geographic based AHPs been successful in creating additional insurance options for small businesses?
    b. Should Congress expand upon the Trump Administration rule to increase the number of entities eligible to form AHPs, such as by expanding the "commonality of interest" necessary to form an AHP?
    c. What are the key features needed to allow small businesses to successfully band together to leverage their size to lower costs? What barriers currently exist?
2. The centerpiece of small business health insurance relief in the Affordable Care Act (ACA) was the Small Business Health Insurance Tax Credit. Proponents of the ACA claimed the credit would assist millions of small businesses in offering affordable coverage to their employees. CBO estimated that the credit would peak at $6 billion in utilization. Yet, the promises of this benefit never came to fruition. Despite the affordability crisis growing worse after ACA passage, data on the credit from the Internal Revenue Service shows that utilization peaked at around $555 million in its early implementation before steadily declining to just $30 million in the last year data is currently available from Treasury.
    a. What are the primary factors contributing to the low utilization of the Small Business Health Insurance Tax Credit?
    b. What kind of credit design would help incentive small businesses to offer or maintain coverage given the availability of highly subsidized coverage on the individual market? Who would benefit from an improved small business tax credit, and would increasing government spending on this type of credit result in savings to other government programs?
3. On June 20, 2019, the Trump Administration finalized the Individual Coverage Health Reimbursement Arrangement (ICHRA) rule[4], which allows employers to make tax-advantaged, defined contributions for employees to purchase their own health insurance or pay for medical expenses. ICHRAs became available to employers January 1, 2020.
    a. How can Congress build on the Trump administration's health reimbursement arrangement rule?
    b. What barriers are employers having to participating in ICHRAs?

[3] https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans

[4] https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans

II. Promoting Employer Programs to Lower Costs and Improve Care

1. Many large employers are participating in innovative initiatives to lower costs and improve care such as direct contracting, high performance networks, and centers for excellence; however, midsize and smaller employers often face barriers such as establishing "critical mass" to utilizing these programs[5]. The goal of the following questions is to 1) identify barriers that exist for employers which prevent them from entering these programs, and 2) work towards achieving policy solutions to help employers of all sizes and in all geographic regions provide health care at a lower cost and higher value to their employees.
    a. In what ways can the federal government help midsize and smaller employers enter the programs listed above?
    b. What barriers exist that prevent smaller companies from banding together to enter these types of programs?
    c. Are there any state or federal regulations that disincentivize employers, payors, or providers from entering into these programs?
    d. What data barriers exist that prevent employers from entering these types of programs?
        i. What legislative solutions could Congress offer to help address these barriers?
    e. What innovative tools, like medical decision support tools, can employers offer to help employees navigate the healthcare system and improve convenience?
2. Entities who participate or are planning to participate in programs such as direct contracting, high performance networks, and centers for excellence must determine how to measure value and health care outcomes. For those who participate in these types of private value-based programs please answer the following questions:
    a. How is "value" defined?
    b. How are outcomes measured?
    c. What data is available to understand baseline expenditures, utilization, and population health?
        i. How is this data sourced?
    d. How are providers targeted for network inclusion? What criteria will be used to evaluate performance and where will you source this data?
    e. When applicable, how will an employer group operationalize the contract management, including:
        i. Contract negotiation and management
        ii. Claims payment
        iii. Issue resolution
        iv. Outcomes tracking
        v. Case management/Utilization management
    f. When recruiting providers, how is participation incentivized?
    g. For entities who participate in direct contracting
        i. If the operational aspect of contract management is outsourced, how is confidentiality of terms maintained?
        ii. Is the program regional or national?

[5] https://healthpolicy.duke.edu/sites/default/files/2021-09/Pathway%20for%20Coordinated%2C%20Affordable%20Employer-Sponsored%20Health%20Care..pdf.

iii. Does it include all services or select high value specialties (oncology, orthopedics, etc.)?
iv. Does the direct contract exist in addition to standard health plan benefits (*for example, will the patient liability be less if the direct network is used, while offering the patient the option of a wider PPO option via standard coverage*)?
v. Has virtual care enhanced these programs? How so?
vi. Please give an example of the successes and challenges of the program. Please share any additional information about these programs you believe the Healthy Future Task Force should know.

III. Increasing Transparency and Marketplace Innovation

1. Hospitals in the United States typically have more than 20,000 items in their chargemaster files, making it very difficult for patients to compare the price of individual services across hospitals. On November 27, 2019, the Department of Health and Human Services finalized price transparency requirements that make hospitals publish a list of user-friendly, standard charges for certain items and services online.[6]
    a. Earlier this year a report found that the majority of the nation's biggest hospitals were noncompliant with the Department's chargemaster price transparency requirements.[7] Additionally, many hospitals that are in compliance still make it difficult for consumers to access the price information by blocking information from displaying on search engines and providing the information in a non-useable format. What uniform standards should Congress consider to ensure user-friendly, accessible chargemaster data for patients?
    b. In addition to having user-friendly, accessible chargemaster prices it is critical patients have access to accurate information. Oftentimes, chargemaster prices are vastly greater than actual payments for those services. To what extent do distorted chargemaster prices affect negotiated payment rates? To what extent do Medicare outlier payments influence hospital chargemaster prices?
    c. What quality measurements should hospitals incorporate on their consumer price transparency tools?
2. In the following series of questions we compare, contrast and inquire about the strengths and weaknesses of price transparency tools run by states, health plans and consumer groups.
    a. As of 2012, there were 62 state-based, consumer-oriented price comparison websites.[8] Almost half of these tools were funded by state governments. What are the strengths and weaknesses of state-run price transparency tools? Which state tools are the best models?
    b. On average, 9.9 percent of enrollees access price transparency tools their health insurance plan offers. What factors contribute to low utilization of price transparency tools run by health plans?

[6] https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and
[7] https://www.healthaffairs.org/do/10.1377/hblog20210311.899634/full/
[8] https://jamanetwork.com/journals/jama/fullarticle/1697957

c. On November 12, 2020, the Trump Administration finalized the transparency in coverage rule to require group health plans and health insurance issuers to disclose cost sharing information upon request to patients.[9] What policies should Congress consider to build on this rule? Where can Congress improve the requirements set forth in the rule?
d. Less than ten percent of existing price transparency tools provide price estimates based on patient insurance status or specific health plan. At the end of 2019, Congress passed a law to ensure both service and plan specific advanced, true and honest estimates for patients. Implementation of that provision is delayed because stakeholders told the Administration they don't have the technology to do it, despite use of technology to conduct prior authorizations and after-the-fact explanation of benefits.
    i. What standards must the Administration issue to ensure this critical patient benefit can be implemented as soon as possible?
    ii. How can Congress build on this landmark provision in future legislation to further improve patients' access to pricing information in advance of receiving health care services?

3. Before the Affordable Care Act passed, states set the rules for what private health insurance needed to cover in that state, controlled who could and couldn't offer health insurance, reviewed and set rules for rates, and handled consumer complaints. Now, the federal government is involved in all of these activities.
    a. Are there ways to return some of this power to states that would increase affordability while protecting those with pre-existing conditions?
    b. How can 1332 waiver authority be improved to help address affordability?
    c. Would removing the firewall between 1332 and 1115 waivers allow for state innovation to improve affordability?

IV. Increasing Competition and Identifying Anti- Competitive Consolidation

1. On November 21, 2018, the Trump administration issued a final rule reducing reimbursement rates for clinic visits at hospital-owned outpatient provider departments by 40%, matching the rates paid for clinic visits in physician offices. CMS estimates that this final rule could save Medicare about $760 million annually.[10] Despite legal challenges, the Biden administration is upholding the rule.
    a. How can Congress build on the Trump Administration's site neutral payments rule?
2. Hospital consolidation leads to higher prices with no measurable improvement in quality. In 2016, 90 percent of Metropolitan Statistical Areas (MSAs) were highly concentrated for hospitals, 65 percent for specialist physicians, 39 percent for primary care physicians, and 57 percent for insurers.[11] As of 2020, the top 10 health systems controlled 24% of market share and their revenue grew at twice the rate of the rest of the market.[12] Prices for services provided by acquired physicians increase by an average of 14%.[13]

[9] https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage
[10] https://www.govinfo.gov/content/pkg/FR-2018-11-21/pdf/2018-24243.pdf
[11] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0556
[12] https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html
[13] https://pubmed.ncbi.nlm.nih.gov/29727744/

a. Vertical consolidation is a financial arrangement that occurs when a hospital acquires a physician practice and/or hires physicians to work as salaried employees. According to a 2015 Government Accountability Office (GAO) study, the number of vertically consolidated hospitals increased from 1,400 to 1,700, while the number of vertically consolidated physicians nearly doubled from 96,000 to 182,000. The consolidation occurred across all regions and hospitals sizes, leading to higher Medicare charges.[14] What role should the Federal Trade Commission (FTC) play in preventing and addressing consolidation in the hospital sector?
b. What quantifiable metrics and data should be used to identify market concentration in the healthcare sector?

3. Since its establishment in 1992, the 340B program's mission has been to help stretch scare federal resources. But as the number of providers increased substantially to roughly 2,500 active hospitals and over 26,000 contract pharmacy sites in 2020, allowing for increased profiting from the program while prices of drugs for patients actually purchasing these drugs increase, we must consider areas that merit reform and modernization in order to deliver on targeted drug and services affordability. The 2019 Government Accountability Office (GAO) report and a 2018 House Energy & Commerce Committee report found issues within the program, including high rates of fraud and abuse in the program like duplicate discounts and diversion, and raised the need for reforms. As Congress considers next steps for the program, please provide responses to the following areas of interest:
    a. Program Eligibility:
        i. Are there other recommended measures for program eligibility, other than Disproportionate Share Hospital?
        ii. Should there be separate eligibility standards for child sites?
        iii. How should eligibility for child sites be considered, if the child site becomes a child site after being acquired by a covered entity?
    b. Transparency:
        i. In order to shed light on utilization and true cost savings, while also balancing overburdensome reporting, what are appropriate types of information that should be submitted by covered entities to give both patients and taxpayers a better understanding and confidence that the program's mission is being met?
    c. Program Integrity:
        i. If an independent audit was required for some covered entities, what should the audit assess and evaluate, aside from the Health Resources and Service Administration's authorities?
        ii. What data and measures should be included in a contract pharmacy audits?
        iii. Are there other audit and reform policies that could be taken to reduce rates of duplicate discounts and reforms among eligible entities?
    d. Are there any unique issues that have developed since the start of the COVID-19 pandemic that would merit additional considerations?

[14] https://www.gao.gov/products/gao-16-189