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OF THE
UNITED STATES OF AMERICA

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

The Honorable Patty Murray
Ranking Member
Senate Committee on Health,
Education, Labor and Pensions
Washington, DC 20510

Dear Senator Alexander and Senator Murray:

The U.S. Chamber of Commerce applauds your efforts to tackle the difficult challenges that persist in America's health care system, including:

- Surprise and sometimes exorbitant out-of-network medical bills;
- Inhibited access to affordable prescription drugs and generic products;
- Impediments to transparency on cost and quality information;
- Public health challenges; and
- Access to health information.

The five titles of the discussion draft language of the "Lower Health Care Costs Act" ("LHCCA") would explore opportunities to advance solutions to each of these problems by reducing costs and improving access to health information.

The bipartisan discussion draft marks the first time comprehensive and targeted health care legislation has been considered in nearly a decade. This legislation is a tremendous step forward and the Chamber supports efforts in Title IV to improve public health. While there are laudable goals intended with many of the provisions in Titles I, III and IV, the Chamber has some concerns with several components of these Titles in particular in the draft bill that we hope you will address.

Title I: Ending Surprise Medical Bills

As stated in our letter sent to six Senators on March 5, 2019 in response to a request for information, the Chamber strongly supports efforts to protect patients from surprise bills while providing certainty for payers and employers. Equally important, any solution should preserve and encourage market-based negotiations.

General View

Patients typically do everything they can to seek and receive treatment from in-network providers and are generally able to discern which facilities are in-network. A far more challenging situation occurs when patients are seeking treatment at in-network facilities but

receive out-of-network ancillary services, often from a facility-based physician not of the patient's choosing. As such, the Chamber supports a hybrid of the proposed options in the discussion draft. We encourage the Committee to adopt:

- A variation of the solution outlined in Option 2 (Independent Dispute Resolution) when surprise out-of-network facility medical bills occur; and

- A variation of the solution outlined in Option 3 (Benchmark for Payment) to address the more common scenario when an individual receives ancillary services from an out-of-network facility-based physician.

Specific Position

The most common scenarios that give rise to surprise medical bills occur because of the way many facility-based physicians (most typically **E**mergency room physicians, **R**adiologists, **A**nesthesiologists, and **P**athologists or "ERAP") interface with patients. With these providers, there is virtually no way for an individual patient to choose which facility-based physician provides their treatment.

As a result, when patients receive these ancillary services from an out-of-network facility-based physician, they are faced with a surprise medical bill after the fact. Even more frustrating for patients, these ERAP doctors oftentimes provide ancillary services behind the scenes, such as reading x-rays, images, or lab tests and providing feedback to the treating physician. They may not even meet with or see the patient in-person, leading to further befuddlement when patients receive an out-of-network surprise bill. We suggest Option 3 be modified as follows:

- For surprise bills, the health plan will pay the facility-based practitioner based on the median contracted rate for services in that geographic area.
- The median contracted rate that is paid to an out-of-network facility-based practitioner may be brought before an arbiter if there are concerns about whether the correct rate was applied.

For the far less common instance when a patient receives a surprise medical bill from a facility, the Chamber supports a variation of Option 2:

- For bills that are $5,000 or less, the health plan will pay the facility based on the median contracted rate for services in that geographic area.

- For surprise bills greater than $5,000, either the payer or the facility can elect to initiate an independent dispute resolution process using a third party arbiter certified by the Secretary of Health and Human Services in consultation with the Secretary of Labor. The payer and facility will submit a best final offer, and the arbiter will be supplied with information to review the offer, including the median in-network rate for services in that geographic area. The arbiter will make a final, binding decision on the best offer and the loser will pay for the cost of arbitration.

We believe that this approach would appropriately balance the goals of protecting patients, providing certainty to payers, reflecting the market-based rates and encouraging private entities to enter into contracts.

Title III: Improving Transparency in Health Care

The Chamber supports the goal of improving access to health care cost and quality information that is appropriate and actionable for consumers and plan sponsors. However, the health care market and the provision of services by the various industries are inherently different from other private sector markets.

General View

The challenge of balancing the benefits of providing transparency information to consumers against the sensitivity of rates in competitive privately negotiated contractual agreements between health sector industries is significant. We believe that consumers and plan sponsors would benefit from having more information about cost-sharing obligations associated with different services, settings and providers.

Specific Position

Efforts to move to a more value-based system hinge on the ability to incentivize quality outcomes and encourage the use of higher quality providers. The Chamber supports the banning anti-competitive and anti-steering terms in contracts in Section 302.

The Chamber has significant concerns about including any negotiated contractual rates in a central database as proposed in Section 303 and the effect this would have on rates, and eventually on premiums. Public release of negotiated rates does not inform what the patient will pay for a service and could increase costs by discouraging competition among healthcare providers by facilitating price collusion and undermine the effectiveness of health plan contracting.

We also support Section 304's efforts to protect patients and improve the accuracy of provider directory information and encourage the Committee to consider which entity would absorb or pay the difference in an instance when a patient goes to an out-of-network provider that he/she believes to be in-network based on incorrect information. We believe that in instances where this is the result following provider conduct, act or omission, the provider should absorb the difference in reimbursement; however, if the act or omission is the fault of the insurer, the insurer/plan sponsor should pay the provider the out-of-network reimbursement amount.

The Chamber recommends that the Committee omit Section 305. Despite altruistic goals, we believe that this section would impose untenable timing requirements when in many instances additional services may be provided following discharge – such as pathology or laboratory work.

Just as the Chamber opposed the Administration's proposal to require 100% of rebates to be passed on to beneficiaries at the point of sale, we also oppose Section 306's requirement that 100% of the rebates or discounts be passed on to the plan sponsor. We support allowing contractual agreements to determine when and to whom rebates are allocated.

Finally, the Chamber believes that the commercial insurance market is already providing and in fact driving efforts to provide information to consumers about out-of-pocket costs. We

recommend that the Committee refrain from imposing additional requirements on providers and insurers.

Title V: Improving the Exchange of Health Information

As the Chamber articulated in the June 3, 2019 comment letter to CMS on the Interoperability Rule, we support efforts to advance interoperability and improve patient access to health information. However, as we did with CMS in the public program arena, we encourage the Committee to take a more measured approach in the commercial insurance area with regard to the All Payer Claims Database ("APCD") proposal in Title V.

General Views

We are concerned about the expansive scope of Title V's proposals and some of the very problematic components within, including:

- The disclosure of private contract terms and negotiated reimbursement rates;
- The questionable ability to ensure patient information is protected and secure when it is given to/managed by third parties who are not covered entities under Health Insurance Portability and Accountability Act ("HIPAA"); and
- The unrealistic timeframe, which suggests that these requirements would affect plans beginning in 2020.

Additionally, continuous monitoring ("CM") is defined as the ongoing awareness of cybersecurity, vulnerabilities, and threats to support organizational risk management decisions. Public and private organizations increasingly believe that CM is an important part of their cybersecurity efforts, which, in turn, are built on a sound security framework.

The information generated through CM is typically provided to organizations' risk management officials in a timely manner through data management and automated reporting tools. CM can enhance a dedicated, mature process for building the necessary trustworthiness into information systems that support industry and government missions.

Specific Position

Instead of creating a national APCD, the Chamber encourages the Committee to consider alternatives that would meet the same objectives without the substantial risks involved in centralizing claims data for millions of beneficiaries. The Committee should consider alternatives such as:

- Amending ERISA to require that all issuers and third-party administrators ("TPAs") serving self-funded employers make data available to employers directly, using distributed data approaches to collect data for defined research purposes, and
- Investing in state APCDs

These alternatives would be less costly, quicker to implement and more effective at safeguarding the privacy and security of sensitive claims data.

We strongly support greater consumer transparency, but urge the Committee not to require the disclosure of negotiated rate information. We support efforts to empower consumers with greater access to information to help them make the best choices for their care and to evaluate the

quality of providers. Consumer access to meaningful, actionable and credible information on providers and services is critical to better healthcare decision-making. However, we strongly believe information provided to consumers should be within the context of providing consumers with tools to make better decisions with their own health benefits.

With regard to continuous monitoring, the Chamber urges the Committee to adopt the following language on page 161, beginning at line 1, of section 502. The text in blue is proposed text.

(b) ADDITIONAL CONSIDERATION.—

(1) In General.—At the voluntary election of the entity or business associate, the Secretary may provide further consideration to an entity or business associate that can adequately demonstrate that such recognized security practices were in place, as determined by the Secretary.

(2) Adoption of Automated Continuous Monitoring Tools.—Such voluntary consideration shall include a whether an entity or business associate can adequately demonstrate the adoption of automated continuous monitoring tools as a component of an entity or business associate's security practices.

Conclusion

The Chamber commends you and the Committee for your bipartisan and comprehensive efforts to address the challenges that remain in America's health care system. Despite positive intentions, portions of the draft are likely to have negative unintended consequences if implemented. We look forward to continuing to work with the Committee to explore how to effectively advance meaningful and beneficial policy changes.

Sincerely,

Neil L. Bradley

cc: Members of the Senate Committee on Health, Education, Labor and Pensions