U.S. Chamber of Commerce

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April 26, 2023

The Honorable Cathy McMorris Rodgers
Chair
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Dear Chair McMorris Rodgers and Ranking Member Pallone:

The U.S. Chamber of Commerce appreciates the opportunity to submit comments for the record regarding today's hearing on "Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care." As the follow-up to the bipartisan hearing that the Subcommittee held on March 28, 2023, this bipartisan hearing is focused on exploring ways to improve price transparency and competition within the health care system to reduce costs for patients. These priorities are indeed laudable, and the Chamber supports efforts to ensure every American has equitable access to useful information on the cost and quality of health care services as well as equitable access to health care treatments and cures. The business community is concerned about the approach many of the recently enacted bills and proposed legislation would pursue, and we believe they will in fact subvert the intended goal.

Congress and federal agencies have enacted or implemented many laws and regulations over the past decade to advance these priorities, several of which are the focus of today's hearing. These include the Inflation Reduction Act and codifying the Transparency in Coverage regulation. While additional legislative proposals under review at this hearing also intend to provide transparency and lower costs, the Chamber has concerns about the likely results which will run counter to efforts to improve access and lower costs. In particular, the Chamber opposes efforts to prohibit private sector contractual provisions widely used and leveraged by the employer-sponsored insurance system. In addition, the Chamber continues to oppose efforts to repeal a ban on physician-owned hospitals. While well intended, the Chamber expressed when many of these laws, regulations, and current legislative proposals were introduced and reiterates those concern now.

The Inflation Reduction Act: Government Price Controls Will Impede Access

Last month the Chamber released its *2023 Patient Access Report (Phase One)* ("the report"). As GIPC President and CEO David Hirschmann explained in a letter to HHS Secretary Becerra, the report confirms what in truth policymakers already know: marketplace competition and effective intellectual property protections enhance patient access to the latest medicines.[1] In contrast, the Chamber's research shows that market-restrictive policies like price controls can deter future innovation, inhibit patient access, and limit patient choice.

[1] Ltr from David Hirschmann, President and CEO, Global Innovation Policy Center, to Secretary Xavier Becerra, March 22, 2023.

We know that the cost of prescription medicines is a top priority for this Administration. As indicated above, we also support efforts to help ensure every American has equitable access to life-saving medicines, including COVID-19 vaccines and life-saving therapeutics.

Unfortunately, this Administration has accepted the false, failed premise that government intervention and price setting is the most effective way to provide patients with access to life-saving innovations. This approach is embodied in the drug pricing provisions of the IRA and in the President's Budget Proposal. While the Administration claims to promote access by controlling prices through so-called "negotiation," the reality is that innovators are forced to comply with the government's arbitrary price controls or face crippling penalties.

To describe the IRA as disastrous for American innovation would be an understatement. First, these proposals send a signal to America's life-science companies that there is no support for the development of further innovations and cures. According to Nick Shipley, Chief Advocacy Officer for the Biotechnology Innovation Organization, the price controls would "further destabilize Medicare, slow critical investment in future research and development, stall drug innovation, and ultimately harm patients." Anecdotally, the IRA's anticipated harms have already been revealed through the numerous life-science innovators who have officially ended product development programs, citing new price controls. For example, Eli Lilly CEO Officer Dave Ricks said the company had already dropped a blood cancer drug from its pipeline because they "couldn't make the math work . . . [i]n light of the Inflation Reduction Act, this program no longer met our threshold for continued investment."[2] Similarly, Novartis warned that the new law could discourage research in its most promising areas of research: RNA and radioligands.[3] Finally, Alnylam has stopped the development of a treatment for a rare eye disease due to the need "to evaluate impact of the Inflation Reduction Act." [4]

These are but a few examples of the type of innovative, life-saving products whose realization is threatened by the IRA's price controls. In addition, our report cautions that the IRA's drug pricing penalties will cause additional harm to patients by forcing them to forfeit early and extensive access to the best life-saving medications. The report's methodology demonstrates that in other OECD countries which have implemented price controls, patients see fewer overall biopharmaceutical product launches, including biologics and oncology products, and have delayed access to medicine.[5] For example, prior to the enactment of the IRA's price controls, out of 104 new oncology products released globally, 80% were launched in the U.S., while only 58% were launched in Europe. Similarly, in several benchmark countries, patients can wait up to several hundred days to receive access to life-saving treatments, with patients waiting an average of 133 days in Germany and up to 500 days in Spain.

Surely this outcome—less innovative medicines and longer wait times—is not what any policymaker or advocate wants. Government intervention in price setting undermines the innovation ecosystem that has empowered the U.S. to become one of the most innovative countries in the world.

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[2] Joe Grogan, *The Inflation Reduction Act Is Already Killing Potential Cures*, The Wall Street Journal, November 3, 2022.
[3] Ludwig Burger, *Novartis warns U.S. plan to curb drug prices could hit key research*, Reuters, January 20, 2023.
[4] Grogan, *supra* note 1.
[5] The report found that fewer overall biopharmaceutical product launched in Canada, Japan, South Korea, Australia, and European Union member states than in the United States over the past 20 years.

Decision-makers must consider the implications of price controls on patients before proceeding with implementation of the IRA's disastrous pricing framework.

Codifying Transparency Regulations

The Chamber continues to have several specific concerns with the Transparency in Coverage Rule and the Hospital Price Transparency Rule as initially shared with the Trump Administration when the rules were initially proposed in 2020.[6,7] First, more meaningful and consumer-specific private sector tools are already available. Second, the Chamber disputes the claim that negotiated rates will be useful to consumers and that all items and services are shoppable. Third, as several analyses from the Federal Trade Commission, Department of Justice and the Congressional Budget Office on similar proposals have demonstrated, publishing negotiated rates will have the perverse and unintended effect of increasing rates and driving up both private sector and federal spending. Codifying these requirements in statute will further hamper innovation in developing actionable and personalized tools for consumers and is not warranted given the lack of value experienced to date from these transparency requirements.

I. Consumer-Specific Tools Exist

First, regulating the public disclosure of negotiated-rates on all items and services will jeopardize the ability of companies to continue to provide and develop those valued consumer-specific tools. Instead, companies should have flexibility to be innovative and cater consumer tools to the needs of those consumers based on feedback received from those using the tools – the consumers. Companies spend significant resources to understand the needs of their customers and are best equipped to develop tools specific to those needs.

Many carriers and third-party administrators ("carriers/TPAs") already provide member consumers with individualized out-of-pocket estimated costs on shoppable services. Currently, these transparency tools are driven by the market demand for information on beneficiaries' out-of-pocket exposure while reflecting where an individual/family is with respect to satisfying any out-of-pocket costs including his/her/its deductible/deductibles. These tools are continuously evolving and serve as a way for carriers/TPAs to continue to innovate and improve the information available to member consumers. The cost tools include many of the following features:

- The cost tools provide real-time, personalized out-of-pocket estimates for the most common medical, non-emergency, in-network health care services - including those that may offer the biggest opportunity to save on health care expenses and are likely to cause member consumers to comparison shop.

[6] Transparency in Coverage Comments.pdf
[7] https://www.uschamber.com/assets/archived/images/comments_hospitaloutpatientprospectivepaymentsystem_hhs.pdf

- Some carriers/TPAs provide tools that give enrollees an estimate of the average in-network versus out-of-network cost of an episode of care, or overall average cost for certain diseases and conditions, for approximately 200 types of office visits, diagnostic tests and vaccines, surgical and scope procedures, dental services, and treatments for diseases and conditions.

- Carriers/TPAs offer enrollees the ability to review and compare cost ranges for medical procedures among participating facilities: inpatient, outpatient, and other facilities (e.g., free-standing radiology centers). Carriers/TPAs regularly provide the following individualized information: all costs from admission to discharge, facility-specific information—not regional averages—for common medical procedures (e.g., maternity care, MRIs, CT scans, colonoscopies, and mammograms). Displayed costs are broken down into managing physician charges and ancillary charges, as well as cost ranges.

- The cost tools allow enrollees to calculate personal financial responsibility by searching services such as physician office visits and the most common elective inpatient, outpatient, and imaging services by facility. All costs are displayed at the episodic level (i.e., all costs rendered for a normal, uncomplicated procedure), including everything from admission through discharge. These costs are the contracted allowed amounts and are shown in a narrow range from minimum, to likely, to maximum costs. The likely 4 amount is displayed as equaling the employer share (if the member is part of a self-insured plan) and the out-of-pocket amount. This "out-of-pocket amount" is further broken out by co-pay, coinsurance, and so forth, with each line item containing greater context to educate the member consumer on what these amounts mean and how each amount is calculated. Enrollees are also presented with alternative treatment options depending on the procedure of interest and the available options.

II. Consumers Don't Pay Negotiated Rates

Second, negotiated rates will not be useful to consumers and will instead lead to greater consumer confusion and will jeopardize the ability of companies to negotiate lower prices for their customers. Individual consumers are interested in their specific out-of-pocket expenses and exposure for a given episode of care. For an individual to accurately know what his/her out-of-pocket costs will be, it is necessary to also know that individual's standing in terms of satisfying his/her deductible. Publicly posting negotiated rates for myriad services and items will not inform a consumer of his/her specific, expected out-of-pocket costs.

- Consumers are not going to be paying these negotiated rates. It is far more useful and appropriate to help a covered beneficiary assess out-of-pocket costs for receiving a service from various providers and to further quantify that cost exposure given the specific beneficiary's deductible standing than for a consumer to see the various negotiated rates from carriers with whom they are not insured.

- In order for the consumer to even find the correct negotiated rate, he/she/they will have to know what particular service(s) will be performed and/or all item(s) provided. In addition, the

consumer also would have to know the corresponding code(s) of the service(s) and/or item(s) (as well as any billing modifiers that may apply to multiple codes billed on the same date of service). This is not information that consumers will have, be able to obtain, or know how to use.

- In looking at the negotiated rate for a particular service or item, consumers are likely to find that the amount listed for that service or item does not reflect the costs associated with their entire treatment (i.e., their episode of care). In many cases, there will be ancillary services provided as well and the consumer may (in error) simply try to ascertain the cost of the primary service.

- The consumer may also find that their costs are higher than those associated with the payer-specific negotiated rate due to comorbidities and complications.

- The negotiated rate information does not inform consumers about any quality measures associated with a particular provider.

Beyond being simply unhelpful, this information is likely to confuse consumers and leave them frustrated when the negotiated rate they identify prior to treatment varies tremendously from what is charged afterwards. Until episodes of care become standardized for pricing comparison, negotiated rates on specific billing codes do not provide meaningful information to consumers.

III. Publishing Rates Will Increase Spending

Posting publicly the negotiated rates will lead to anti-competitive behavior that will ultimately increase rates and, in turn, premiums.

- The Federal Trade Commission along with the Organization for Economic Cooperation and Development have produced analyses of comparable proposals, both of which indicate that CMS' Proposed Rule is likely to result in higher prices to consumers.[8] Higher-priced hospitals will use the competitively sensitive rate information to increase rates to the highest price the market will bear, while lower-priced providers will use the competitively sensitive rate information to raise rates so as to match the prices charged by the higher-priced providers.
- The Federal Trade Commission and the Department of Justice, the two agencies tasked with regulating anti-competitive behavior and potential antitrust violations, have stated clearly

[8] Letter from Marina Lao, Deborah Feinstein, & Francine Lafontaine, Federal Trade Commission, to Joe Hoppe & Melissa Hortman, Minnesota House of Representatives 7 (June 29, 2015), available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf and "There have been instances where government mandated increases in price transparency seemed to have produced higher rather than lower prices, probably because they facilitated anti-competitive co-ordination among sellers." Organisation for Economic Co-operation and Development [OECD], Price Transparency, at 9, OECD Doc. DAFFE/CLP (2001)22 (Sep. 11, 2001). See U.S. examples id. at 32-33.

that where markets are concentrated and subject to exclusive behavior, greater price transparency leads to less competition. [9] This Proposed Rule will create such behavior.

Further, the overall cost and details of the negotiated rates are confidential, proprietary, and constitute confidential trade secrets. Any required public disclosure of that proprietary pricing between payers and providers would be contrary to long-established prohibitions on the forced disclosure of trade secrets. The cost and details of a health plan's negotiated rates constitute confidential trade secrets protected from disclosure under the Defend Trade Secrets Act, as well as property interests protected under the Fifth Amendment to the U.S. Constitution. Third, as several analyses from the Federal Trade Commission, Department of Justice and the Congressional Budget Office on similar proposals have demonstrated, publishing negotiated rates will have the perverse and unintended effect of increasing rates and driving up both private sector and federal spending. This is the precise opposite outcome of that intended, and codifying these requirements would only inhibit further improvements in personalizing tools and information for consumers.

Legislative Proposals Will Not Lower Costs

We Oppose Legislation to Prohibit Risk Mitigation Pricing

Risk mitigation pricing (also referred to as spread pricing) provides employers a definitive price for prescription drug benefit payments to pharmacies, and transfers the risks associated with daily fluctuations in drug prices onto the Pharmacy Benefit Manager (PBM). This ability to include spread pricing as part of a contractual agreement is highly valued by many employers and plan sponsors and incentivizes these PBMs to push pharmacies to reduce their acquisition costs. This is a contracting term that employers demand, bringing much-needed pricing predictability. The Chamber opposes proposals that would eliminate and prohibit the ability of entities to include such a provision in private contracts.

We Oppose Legislation to Expand Physician-Owned Hospitals

The Chamber has long been concerned about the significant problems stemming from physicians self-referring patients to hospitals in which they have an ownership interest. As articulated in letters dating back to 2007 and 2008, the Chamber continues to remain concerned about the increased utilization and costs associated with physician self-referral. For these reasons, the Chamber continues to oppose efforts to unwind current protections in the law.

Unbridled and spiraling health care costs is one of the most important challenges facing our health care system today. One legal protection that currently helps combat unnecessary cost

[9] See, e.g., FTC and Department of Justice, Antitrust Guidelines for Collaborations Among Competitors 15 (2000), available at https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-doj-issue-antitrust-guidelines-collaborations-amongcompetitors/ftcdojguidelines.pdf; FTC and Department of Justice, Statements of Antitrust Enforcement Policy, Statement 6 (1996), available at https://www.ftc.gov/sites/default/files/attachments/competitionpolicyguidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pd

increases is a safeguard against certain self-referral practices. When the most profitable patient cases are referred to hospitals where physicians have a financial interest, “cherry-picking” occurs. While this referral practice increases profits for these physician-owned hospitals, such cherry-picking also has the negative impact of leaving the more complicated and poorly reimbursed cases to be treated by neighboring community hospitals. Studies by the Medicare Payment Advisory Commission (MedPAC), Government Accountability Office (GAO), and the HHS Office of Inspector General (OIG) have documented the dangers of self-referral. These data have driven Congress to take action to prevent these practices and limit the harm that results, under both Republican and Democratic leadership. If the most recent protection enacted as part of the ACA is reversed, increased and unnecessary utilization of medical services will inflate premium costs to employers, raise the overall cost of health care for all Americans, and diminish access to quality medical care for communities.

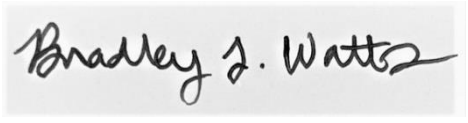
Balancing entrepreneurial spirit and sound public policy is no easy feat, but Congress achieved the right balance when it prohibited self-referral prospectively while grandfathering arrangements in place prior to December 31, 2010. Congress also provided for a safety valve, allowing for growth if facilities can demonstrate a need in the community. This alternative affords proper exceptions when expansion is appropriate and necessary.

The Chamber urges Congress to not take a step backward on this policy which has historically enjoyed strong bipartisan support dating back over a decade. The Chamber supports the current self-referral law and opposes any effort to unwind or weaken it.

Conclusion

We appreciate the goal of improving transparency and efforts to provide additional information to consumers on cost and quality. However, the Chamber believes that the Inflation Reduction Act is the most recent legislative example of the harm that can be enacted when efforts to impose government control into health care. Artificially holding down costs, broadly publishing private contractual arrangements, or prohibiting private contractual terms widely used and preferred will not advance the goal of greater information and access.

Sincerely,



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cc: Members of the House Energy and Commerce Committee