

February 4, 2022

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Submitted via email and Google Form: <https://forms.gle/VLKJH5KzS25UL8SdA>

Dear Healthy Future Task Force Affordability Subcommittee Members,

Thank you for this opportunity to provide input on behalf of members of The ERISA Industry Committee (ERIC) regarding your request for information on policy solutions to make health care more affordable for workers and their families. ERIC is the only national association advocating exclusively for large employer plan sponsors that provide health, retirement, paid leave, and other benefits to their nationwide workforces. With member companies that are leaders in every economic sector, ERIC advocates on the federal, state, and local levels for policies that promote quality, affordable health benefits for employees, their families, and retirees.

Americans engage with ERIC member companies many times a day, such as when they drive a car or fill it with gas, use a cell phone or a computer, watch TV, dine out or at home, enjoy a beverage, fly on an airplane, visit a bank or hotel, benefit from our national defense, receive or send a package, go shopping, or use cosmetics.

Below, we will highlight the topline policy proposals ERIC urges you to consider in upcoming legislation. Many of these policies address questions outlined in the RFI. Our ardent belief is that employers can be an important partner in this effort, helping to forge solutions that result in improved health care access, affordability, quality, transparency, and safety for all Americans.

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

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Most of our ERIC member companies do not use ICHRA's and find them too complicated and expensive for employees to utilize. Many member companies found that the amount the employer must deposit into the ICHRA in order to comply with the Affordable Care Act's (ACA) shared responsibility requirements, would be unaffordable to the employer, while eliminating a worker's eligibility for tax credits to obtain Exchange coverage. Because of this, some member companies find that their employees are better off without ICHRA contributions.

In order for ICHRAs to be more widely used and attractive to both employers and employees, ERIC recommends that the subcommittee write legislation that would:

- 1. Reduce the negative impact on individual's eligibility for tax credits if they have employer contributions in an ICHRA;**
- 2. Streamline ICHRA requirements for employers by simplifying ACA rules, allowing the employer to contribute the same amount to an employee's ICHRA as the employer would otherwise pay in premiums for a self-funded plan; and**
- 3. Deem an employer who provides ICHRA funds matching an amount that would have provided affordable coverage in a self-funded plan, to be in compliance with the shared responsibility employer mandate.**

II. Promoting Employer Programs to Lower Costs and Improve Care

Direct Contracting

Many large employers are participating in innovative initiatives to lower costs and improve care, such as direct contracting, high-performance networks, and centers of excellence. ERIC member companies support the goal to increasingly transition to paying for value and outcomes rather than for the volume of services, promoting high-quality care while reducing unnecessary or duplicative services through the alignment of financial incentives. Member companies across industries have set up and invested in innovative, accountable care organization (ACO) arrangements with integrated hospital systems that focus on delivering coordinated, high-quality, and intensive primary care. These arrangements are located throughout various regions and require provider partners to accept up and down-side risk, and to meet financial, meaningful quality and patient satisfaction metrics. These arrangements can prove fairly difficult for small and medium-sized employers that lack sufficient employee volume to effectively negotiate with health systems exercising significant market power. Those smaller employers will need avenues by which they can combine beneficiary populations to achieve the value and significant change in the health of their employees from controlling blood pressure to managing diabetes that can arise from payment reforms.

Some member companies invested in direct primary care arrangements in areas where the health care market is not conducive to certain preferred provider partnerships like ACOs. In this model, member companies directly contract with health care providers that focus on population health and disease prevention. Some direct contracting programs have been in place since 2008 and continue to thrive in improving patient outcomes and lowering health care costs. States have also taken interest in direct contracting, such as Washington State, which established its program in 2009 but has since ended it. **ERIC urges the subcommittee to establish policies that encourage states to implement their own direct contracting programs, starting with state and local government employees, and gradually expanding to include Medicare and Medicaid beneficiaries, and then (at the option of plan sponsors) private plan beneficiaries as well.**

Patient Safety

Preventable medical errors are one of the leading causes of death in the United States, and patient safety is another area where Congress can make targeted, bipartisan reforms to produce significant improvement in our health care system. Many organizations have worked to reduce adverse events for over two decades since the Institute of Medicine report, *To Err is Human*, was published in 1999. More can be done so that current technology can be applied to the health care system and lower adverse and avoidable events in the future. **Employers encourage Congress to improve patient safety by:**

- 1. Creating an independent National Patient Safety Board to empower health systems with big data, study patient safety incidents, and provide recommendations to improve processes;**
- 2. Align Medicare patient safety standards with the private sector, by updating the current “no-pay list” policy to instead mirror the Leapfrog Group’s hospital safety metrics and “Never Events” policy; and**
- 3. Require the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) to collect and publish physician quality metrics and safety information from all providers and hospital systems, and to collect data from providers and facilities that currently do not report quality or safety information.**

Centers of Excellence & Demonstration Projects

ERIC member companies also offer centers of excellence programs through which employees can receive care for certain conditions at high-quality sites of care. The member companies often cover all procedures and travel costs (including for a companion), which encourages participation, but still saves significant money by improving quality of care and outcomes. ERIC member companies find value in offering this benefit to their employees, knowing that they are safe receiving care at a trusted facility. These centers of excellence raise quality throughout the health system by encouraging competition based on quality. **We request that Congress require the Medicare program to implement centers of excellence – either gradually starting with demonstration programs, or immediately based on already available data – so that Medicare beneficiaries can have access to improved specialized care. Medicare must publish all relevant data on quality and outcomes for the public. Further, participation in these centers of excellence should be open to other payers beyond CMS.**

While ERIC believes that improvements to the Medicare program will benefit all patients (due to systemic improvements that will take place throughout the health care system), employers are also seeking a more direct partnership with CMS in efforts to improve quality, reduce costs, and reform the payment system. Specifically, employers have watched with interest as the CMS Innovation Center (CMMI) tests various payment and service delivery models that aim to achieve better care for patients, smarter spending, and healthier communities. **ERIC encourages Congress to require CMMI to design and implement demonstration projects in a way that allows other payers, including large employers, to be active and full participants.** We define “participate” as actively setting up and abiding by the requirements of the demonstration and taking part in providing the required data, such that private plan beneficiaries can experience the same health care improvements that a participating Medicare beneficiary would experience, and private payers can utilize the findings and outcomes data to better hone our benefits design, network-building, and vendor management.

III. Increasing Transparency and Marketplace Innovation

Telehealth

Telehealth has proven to be a valuable tool during the COVID-19 pandemic. Researchers found that there was a 154 percent increase in telehealth visits from March 2019 to March 2020.¹ As time continued, patients have seen and experienced the value of shorter wait times to see a provider, the convenience to be seen at a location of their choice, and lowered risk of being exposed to infections and illnesses or needing to travel. More needs to be done on telehealth policy, such as offering a standalone telehealth benefit for anyone not enrolled in the employer's full medical plan and making telehealth visits more affordable for patients with high-deductible health plans (HDHPs). We will provide more detail on our telehealth policy recommendations in the Modernization subcommittee RFI.

Consumerism and Improvements to HDHPs

While ERIC member companies offer an array of different plan options for employees, many have focused efforts on consumer-driven plan options, often an HDHP paired with a Health Savings Account (HSA). We believe that momentum toward consumerism has faltered because Congress has not made meaningful improvements to these plans in nearly 20 years, and best practices for improving health and promoting value in plan design are no longer sufficiently reflected in the rules for HDHPs. During this time, employers have learned they would like to offer preventative care services before an employee reaches their deductible. Receiving these services before hitting the deductible will be more affordable, lower waste in the health care system, and improve patients' health outcomes. As such, employers request Congress to make targeted reforms to HDHPs and HSAs, including:

Telehealth for HDHP Beneficiaries. HDHPs still operate under the philosophy that drove the 2003 rules in the wake of the *Medicare Modernization Act* (P.L. 108-173), which seek to encourage patients' "skin in the game" by barring them from coverage of most needed and high-value medical services until they have satisfied a deductible. Employers would like to offer free or low-cost telehealth visits to their employees as it offers preventative care that can help avoid costly care later on. Due to these inhibitive Internal Revenue Service (IRS) rules, employees must first reach their deductible. Continuing to prohibit preventative care utilization before the deductible is met can cost more for employers and employees in addressing employee's health needs. Under the *CARES Act*, employees with an HDHP were able to have 1st-dollar of telehealth visits until December 31, 2021. **The provision has since expired, and we encourage Congress to pass the *Primary and Virtual Care Affordability Act* (H.R. 5541) to allow 1st-dollar coverage of telehealth and primary care visits so patients can have better health outcomes.**

¹ Koonin LM, Hoots B, Tsang CA, et al. Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1595–1599. DOI: <http://dx.doi.org/10.15585/mmwr.mm6943a3>

Chronic Disease Management. Employers follow the U.S. Preventive Services Task Force’s recommendations that were put into Treasury guidance, allowing the list of preventative care benefits to be expanded. The expansion included insulin and other glucose-lowering agents for those with diabetes, blood pressure monitors for those with hypertension, and more. However, chronic disease management is still not accessible with 1st-dollar coverage. **Congress should codify IRS guidance that allows for chronic disease management to be considered “preventative” for purposes of 1st-dollar coverage in a HDHP and pass the “Chronic Disease Management Act of 2021” (H.R. 3563 – S. 1424).**

Worksite Health Centers. Worksite health centers have proven to be the first point of access for many patients’ health care needs, but for approximately half of the workforce who have a high-deductible health plan (HDHP) paired with a Health Savings Account (HSA), they must be charged the “fair market” rate for their health care services if they have not yet reached their deductible. This is especially problematic given that patients enrolled in other types of health plans (such as a PPO) are usually offered free or heavily discounted rates at worksite health centers. The high cost of market value services proves prohibitive for patients that may need immediate help managing their depression or anxiety, and are unable to see a mental health counselor, psychiatrist, or other mental health provider due to an overload of appointments. **We encourage Congress to allow those with HSAs to access worksite clinics under the same cost structure as those not in a qualified HDHP, without first being required to meet their annual deductible.**

Fairness for Veterans, Working Seniors, and Native Americans. Currently, working seniors who have enrolled in Medicare, veterans who have access to TRICARE or the Veterans Health system, and Native Americans eligible for care at the Indian Health Service are deemed ineligible to contribute to HSAs. As a result, employers who contribute money to employees’ HSAs as a way of shielding them from part of the costs of paying their deductible, are legally required to discriminate against these individuals. The result is that these individuals are less likely than other plan beneficiaries to obtain needed care – including mental and behavioral health. **ERIC encourages Congress to develop legislation to correct this inequity so that Veterans, seniors, and Native Americans can utilize HSAs.**

Direct Primary Care. The subcommittee should also include ways for Congress to promote primary care and integrate behavioral health into that setting. Primary care is shown to improve health care outcomes and reduce disparities.² It can serve as the “first interaction” in addressing health care conditions and focuses on complete well-being, not just physical health, but behavioral health as well. Direct primary care does just this and takes the “whole person” approach, but there are currently barriers in place for those with high deductible health plans paired with a HSA to receive such valuable care. **Congress should pass the *Primary Care Enhancement Act* (H.R. 4301 and S. 128) to allow employers to pay for the cost of the direct primary care arrangements for all employees or for patients participating in a direct contracting arrangement to contribute and use their health savings account (HSA) to pay for their direct primary care arrangement.** Passing the legislation would help patients better address their mental and behavioral health and their chronic conditions, as well as to use their HSA funds appropriately.

² Shi L. (2012). The impact of primary care: a focused review. *Scientifica*, 2012, 432892.
<https://doi.org/10.6064/2012/432892>

HSA Administrative Issues. Due to HSA and HDHP policy not being addressed by Congress for so long, a number of “quirks” in the tax code have arisen, making it hard for patients to save for medical expenses, or to access their own money. These scenarios show where HSA legislation did not keep up with the creation of the ACA. Some of these include:

- Some married couples are on two different benefit plans, one with an HSA with HDHP, and the other with a Flexible Savings Account (FSA). In this case, the spousal FSA should not disqualify HSA contributions;
- The current tax code does not allow “adult children,” who are on their parents’ HDHP, to access HSA funds for their medical care. It likewise does not allow domestic partners to do so either;
- Funds from other consumer-driven account types like FSAs and Health Reimbursement Accounts should have a streamlined and simple method to do a one-time conversion into an HSA; and
- HSA funds should be permitted to be used for physical activities and exercise to promote health and weight loss.

Health Information Technology

Many of the other elements of value-driven care that employers support are dependent upon on the effective use of interoperable electronic medical records (EHRs) to promote coordinated care, eliminate duplicative tests, and drive other efficiencies. *The 21st Century Cures Act of 2016* prevented EHR vendors from information blocking between systems, but not enough progress has been made in the last six years.

ERIC recommends that the subcommittee draft legislation that requires EHR vendors to improve the transfer of data (data exchange) from one system to another and initiate penalties one year after enactment. EHR vendors have had enough time to comply and must be held accountable. Additionally, Congress should revisit and strengthen CMS’ “meaningful use” incentives, to ensure that EHRs are indeed interoperable, are aligned and owned by the patient (a patient should have one, single, unified record), and are not effectively paper records on a computer screen.

Transparency

ERIC member companies believe transparency is integral both to reduce health care costs and improve the quality of care. We continue to cope with health care costs that rise at an unsustainable rate and believe that disruption is critical to change this dynamic. We believe specific changes in statute, and to the current regulatory regime, could significantly strengthen transparency in the health care system, thus giving rise to better care for patients, more competition, greater value, and improved quality and safety.

Employers advocated for the critical health care transparency provisions that were included in the *Lower Health Care Costs Act*, some of which were enacted as part of the *Consolidated Appropriations Act of 2020 (CAA)*. We also strongly supported the Hospital Transparency Rule, as well as the Transparency in Coverage Rule. As such, we appreciate the issuance of [Frequently Asked Questions](#) from the Departments of Labor, Treasury, and Health and Human Services (HHS) (the Departments) in 2021 that provided more detail on implementation of some of these new policies. Large employers welcomed the delay of enforcement of the requirement that we publish machine-readable files, update our price comparison tools, and report pharmacy benefits and drug costs to the Departments. The additional implementation time can only help our member companies prepare to make their covered items and services transparent for health care consumers who will make informed, cost-conscious health care decisions – and we remain 100 percent committed to complying with the rules, and making the health care system transparent.

The data required by the CAA can also help provide the insights our member companies need to offer employees and their families access to high-quality providers while improving health outcomes and lowering costs. **Employers urge Congress to ensure the Transparency in Coverage Rule is completely implemented, including requirements related to prescription drug cost transparency. Congress should also consider passing the Health Care PRICE Transparency Act (S. 1524 – H.R. 3029) to codify the transparency rules.** Experience has shown that competition and information are critical to a functioning marketplace for any product, and health care is no exception. Many large employers directly engage with transparent providers and systems, or use price transparency tools to foster competition, and to inform patients who have increasing skin in the game due to the adoption of consumer-directed health plans. In fact, with half of the U.S. workforce now in high-deductible health plans, this legislation is more important than ever. Employers are major innovators in health care, and transparency will accelerate our ability to improve benefits and coverage, increase affordability for patients, and drive efficiencies, quality, and value in the system.

Transparency in Coverage. ERIC appreciates the Transparency in Coverage Rules and the delay by the agencies in implementation. ERIC member companies are currently working on publishing machine-readable files for in-network rates and out-of-network allowed amounts and billed charges for plan years beginning on or after January 1, 2022, by July 1, 2022, and meeting the other reporting requirement deadlines.

Because the proposed regulations require plan sponsors to disclose the plan's negotiated in-network rates and "allowed amounts," some plan sponsors fear that this information may continue to be withheld. In addition, while we hope information like the negotiated in-network rates and "allowed amounts" would be readily shared with the plan sponsor (as required under the proposed regulations), we are concerned that plan sponsors may not always be able to access this information from the carriers and/or medical providers in a timely manner.

In most cases, employers contract with vendors to gather the necessary data (usually from a combination of vendors to the employer's benefit plan, such as insurance companies, pharmacy benefit managers, behavioral health specialty vendors, and the like). And often the employer must rely on third parties both to provide and to promulgate this data. **ERIC requests that the subcommittee craft legislation to permit an employer who has contracted with vendors to comply with the Rule, to rely on those vendors (and hold them liable), and direct the agencies to set a common data standard reporting under the Rule.** This would reduce the administrative burden for employers and allow for better use of the data to compare prices between plans, facilities, networks, and procedures.

Additionally, while we have addressed many of our points on direct contracting in the last section, transparency in coverage challenges exist for employers with these programs. **ERIC requests that Congress apply data standards for the Transparency in Coverage Rules so that contracting entities can provide the needed information to employers.**

Additionally, Congress should align requirements around the new consumer-facing tools employers must create, and the new advance explanation of benefits (EOB) requirement contained in the CAA. ERIC believes the advance EOB requirement is duplicative, and should be stricken. Beneficiaries will have access to the same information, in a customized, personalized manner, via the tools required under the Transparency in Coverage Rule. The CAA requirement only adds layers of red tape and unnecessary costs that will ultimately be paid by beneficiaries, in the form of higher health insurance premiums.

Hospital Transparency. We appreciate the development and implementation of the Hospital Transparency Rule, but we request that Congress codify the rule, and strengthen enforcement by the Departments to require more data standardization. ERIC has encouraged employers to utilize hospital pricing data to foster competition and hold our vendors (such as insurance companies) accountable. But too often, employers still find barriers in accessing the information, or when they do get the pricing information, the lack of standardized reporting makes it very difficult to make "apples to apples" comparisons between various hospitals. Some employers have signed agreements with data companies to aggregate the hospital data that is currently made available online, and are beginning to use this data to improve provider networks and improve value for patients. ERIC also applauds the Biden Administration for increasing noncompliance penalties (in the face of flagrant violation of the rules by a large percentage of hospitals). Congress should condition any funding for further provider relief on full compliance with the Hospital Transparency Rule.

Pharmacy Benefits and Prescription Drug Costs Reporting

ERIC appreciated the Departments for delaying the requirement to report the most frequently dispensed prescription drugs covered, their costs, premiums, and drug rebates as required under Section 204 of Title II of Division BB of the *No Surprises Act* transparency requirements in the CAA until December 27, 2022.

We are also pleased that the Departments allow employers to assign third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to satisfy the reporting obligations under this interim final rule (IFR). However, the plan sponsors must now rely on these third parties to comply with the Departments' rule where they have limited means (other than contractual) to ensure compliance. All plan sponsors have little or no way of verifying compliance or accessing reported data, yet they are ultimately held responsible for the accuracy and completion of the reporting. Self-funded plan sponsors lack the means to aggregate and report their information if a TPA or PBM does not report for them.

We urge Congress to issue the following recommendations to the Departments to best address compliance challenges facing plan sponsors with ERISA plans:

- 1. Revise the IFR to confirm that CAA Section 204 "Reporting on pharmacy benefits and drug costs" data is subject to Section 202 "Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market";**
- 2. Impose reasonable cooperation requirements for PBMs, TPAs, and insurers regarding the reporting obligation;**
- 3. Provide good faith compliance relief for plan sponsors relying on PBMs, TPAs, and insurers to submit their data; and**
- 4. Update the RxDC module in the Health Insurance Oversight System to send a confirmation notice to plan sponsors when a report is successfully submitted.**

Gag Clauses

Section 201 of the CAA, which aims to increase transparency by removing "[gag clauses](#)" on price and quality information, still needs clarity so that providers, health plans, and plan sponsors can fully benefit from the legislation and Congress' intent. While Section 201 allows enrollees, plan sponsors, or referring providers to see cost and quality data, it also extends to contracts between providers and group health plans. Currently, some plans and providers prevent plan sponsors from accessing de-identified claims data that could be shared under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements with third parties for plan administration and quality improvement purposes. Because no guidance has been published delineating what exactly a gag clause is, and what data a vendor may NOT withhold from a plan sponsor, gag clauses are still ubiquitous, even despite the CAA provision being a year past its intended effective date.

We urge Congress to require the agencies to issue additional guidance clarifying the following:

1. **Effective date and when gag clauses must be removed;**
2. **Prohibition of non-disclosure agreements (NDAs) between health plans and third parties; and**
3. **Appropriateness to include language to remove gag clauses in current Administrative Service Only (ASO) contracts.**

Pricing information should be made available immediately to the plan sponsor and their third party for their use in transparency tools or benchmarking solutions and plan administration.

All Payers Claims Database (APCD). The CAA also required the Department of Labor (DOL) to develop a common reporting framework for self-insured employers to voluntarily share data with state APCDs. While we applaud the effort DOL has undertaken, we do not believe any significant number of self-insured employers will go through the trouble of reporting to the various state databases. **Instead, we renew our call for creation of a federal APCD,** which could then share self-insured employer plan data with state APCDs. This would increase price transparency, and greatly improve the ability of state authorities to promote value and control costs in state health care programs.

1332 State Innovation Waivers

The business community recognizes the importance of a stable individual insurance market and supports state efforts to increase flexibility, lower costs, and ensure that state residents can obtain affordable health insurance. However, 1332 waivers were not intended to disrupt the stable and affordable health insurance offered through employer-sponsored plans. **The subcommittee should clarify through legislation that states that implement 1332 waivers cannot make changes that affect ERISA plans, whether it be plan coverage mandates, changes to the shared responsibility affordability threshold, or reinsurance programs that would transfer money from patients in employer plans into a state health Exchange. Congress should also clarify that Section 1332 of the ACA requires due process for regulated entities, by abiding by the original waiver process through which entities would have an opportunity for notice and comment via action in a state legislature, and then with the federal agencies, before a waiver could be implemented.**

IV. Increasing Competition and Identifying Anti-Competitive Consolidation

Large employers and businesses of all sizes have been concerned for decades about health system consolidation and limited access to certain provider groups. Certain private equity firms have acquired physician practices during the pandemic and then taken those providers out-of-network due to much of the country's elective health care services being canceled or indefinitely postponed during the majority of 2020.³ We are still concerned that market-consolidation will continue to drive up costs for patients, workers, and employers.

³ Bruch J, Gondi S, Song Z. COVID-19 and Private Equity Investment in Health Care Delivery. JAMA Health Forum. 2021;2(3):e210182. doi:10.1001/jamahealthforum.2021.0182 <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2777170>

Fairness in Contracting

One result of increasing market consolidation is that provider systems are using market power to demand unethical and deeply unfair contractual terms, which reduce the quality and safety of care while increasing costs for patients. **We encourage Congress to promote competition and reduce network consolidation by introducing House companion language to the “Healthy Competition for Better Care Act” (S. 3139) introduced by Senators Tammy Baldwin (D-WI) and Mike Braun (R-IN).** The legislation would allow:

- Discounts or incentives for enrollees who choose high-quality and low-cost providers;
- Insurers and employers to contract with hospitals and providers for their patients, without requirements to enter into additional contracts with other affiliated providers or hospitals;
- Health insurance issuers to negotiate their own rates with other providers who are not a party to the contract of the provider involved; and
- Hospitals and issuers to freely negotiate prices, without requirements to pay higher amounts for items or services than other issuers have agreed to.

Empower the Federal Trade Commission (FTC)

Congress should also consider additional authority and funding for the FTC to improve oversight of potential hospital market consolidation. The FTC has done significant work in recent hospital mergers, but has a poor record of preventing market consolidation. This is often attributed to a lack of sufficient funding for legal and research staff, to a lack of cohesive agency-wide mission to protect market competition, and to a lack of statutory authority needed to win the cases the agency brings. Employers believe that all of these problems can and should be addressed by Congress.

Mergers in the health care market are often approved based on vague promises of “efficiencies” leading to savings and care improvements for patients. However, employers and their plan beneficiaries have rarely seen any of these efficiencies actualized, and instead witness higher prices for the same products, procedures, and services, due to a lack of competition. This problem has been recognized both by the Administration and by relevant Congressional committees, and now is the time to take action.

Timely and Honest Medical Bills

ERIC calls on Congress to implement guardrails to protect patients from unethical medical billing practices. The COVID pandemic has seen vast consolidation in health care markets, including mass purchase of provider practices by hospital systems. These purchases are often immediately followed by price inflation, including the addition of facility fees, as if the service was provided at the hospital, even though the care took place at a doctor’s office. This wasteful spending does not benefit the patient, and serves only to enrich entrenched medical interests. **Congress should require that facilities bill using the appropriate forms, and unique site identifiers, so that inappropriate facility fees cannot be charged for visits to doctors’ offices or other offsite care. Further, Congress should support transitioning to site-neutral payments, to further reduce the incentive for hospitals to buy (and physicians to sell) practices purely to increase billable charges.**

Congress should also direct the Government Accountability Office (GAO) to investigate billing by medical providers, to determine whether fraudulent billing is common. ERIC member companies have reported a significant increase in “up-coding,” wherein providers bill for more difficult or lucrative services or procedures, as well as instances of providers who are more junior, yet bill at higher rates by subsuming their charges under the auspices of a more senior provider (which would have severe consequences in the legal profession). Based on the findings of GAO, Congress should consider legislation to further discourage these harmful and inappropriate billing practices to protect patients from high health care costs.

Patients also need to receive timely hospital bills for their health care services. *The Lower Health Care Costs Act* originally included text that would require hospitals to issue patient bills within 30 days. After pressure from hospitals, the requirement gradually grew to 45 days, 60 days, and eventually the provision was stripped out and not included in the CAA. Timely bills are a key step in preventing surprise billing, which Congress aimed to end starting in 2022. **We encourage the subcommittee to reintroduce this policy requiring hospitals to issue medical bills to patients within 30 days of a patient’s discharge.** Patients should no longer fear receiving medical bills months and years after they actually obtained services, making these bills impossible to plan and budget for. Further, timely billing will eliminate perverse incentives in the medical billing system, which encourage providers to “find” additional charges for past patients when quarterly earnings goals (etc.) are not met. This provision has been scored and vetted by Committees in both the House and Senate, and should be passed promptly.

Bipartisan Action Needed on Prescription Drug Competition

House Republicans should consider cracking down on gaming of the Food and Drug Administration (FDA) rules, which continue to have an ill effect on the availability of and competition among prescription drugs. Many of the current problems in the prescription drug market are a result of failure by various parties to live by the “rules of the road” established by the 1984 *Drug Price Competition and Patent Term Restoration Act* (Public Law 98-417), usually referred to as the *Hatch Waxman Act*. The law laid out a compromise wherein innovator companies are rewarded with market monopolies, for a limited duration of time, and then must face competition from generic products. Various strategies are now used to delay or escape entirely from that competition, and the result has been unconscionable prices and costs to plan sponsors and patients. ERIC supports policies to increase competition and address market failures, including:

- Ending “evergreening” and other gaming of the drug patent system (such as “product hopping”, “patent thickets,” etc.);
- Stopping abuse of FDA “citizen petitions”;
- Preventing the “blocking” of generic competition (and other forms of patent trolling);
- Eliminating so-called “rebate traps” and couponing strategies;
- Enacting other policies to promote affordable and a competitive market for biosimilars;

- Protecting medical management (including step therapy, “try first,” and other policies) to ensure value for all plan enrollees;
- Addressing issues related to so-called "international free-riding" wherein Americans pay vastly higher drug costs than other wealthy, industrialized nations;
- Eradicating sovereign immunity schemes;
- Reform the PBM industry, by imposing full transparency for drug costs, requiring that rebates and discounts be passed through to the plan sponsor, limiting so-called “spread pricing” (including at PBM-owned retail, mail-order, and specialty pharmacies), requiring transparency of secret agreements between PBMs and drug manufacturers, and considering ERISA fiduciary liability for vendors to plans in the same way employers are considered fiduciaries. This language can be found in Section 306 of the *Lower Health Care Costs Act* and should be updated;
- Create reciprocity or a massively shortened FDA approval process for biosimilar products already approved in other industrialized nations and markets;
- Allow certain medications to be “reimported” or purchased from overseas pharmacies that are registered with and regulated by the FDA; and
- Investigate and address false or misleading prescription drug information, discourage anti-competitive behaviors, and increase progress to get products to market.

Preventing Abuse by Kidney Dialysis Monopolies

Employers have reported to Congress on more than one occasion that the extreme amount of consolidation in the kidney dialysis industry has led to unconscionable price gouging of patients. In some instances, for the same dialysis session which would cost the Medicare program about \$400, a patient with a private sector insurance plan could be billed \$4,000 – ten times as much. To make matters worse, the dialysis companies have admitted to funding so-called “charities” that works to steer patients off of public programs (which pay the dialysis programs less), and on to private insurance, where the patient and employer can be gouged without government regulation.

CMS has noted this problem in Exchange plans, as premiums for enrollees with government-paid ACA subsidies have shot up due to these abuses by dialysis companies. However, CMS’ attempt to issue a rule to crack down on this behavior was stymied by a lobbying blitz and lawsuits. **ERIC urges Congress to direct CMS to complete this rulemaking, and to ensure that private sector plans are protected the same way as ACA plans will be protected, from abusive steering of beneficiaries by dialysis companies and their fake charity fronts.**

Additionally, Congress should consider a number of other policies to address the dialysis monopolies, including to:

- 1. Ensure that any beneficiary steered from a public program to private insurance, can only be billed at public program rates;**
- 2. Ensure that employers are only be billed at Medicare rates during the so-called “coordination period”, while a beneficiary remains on an employer-sponsored plan;**
- 3. Hold dialysis companies to a medical loss ratio the same as insurance companies, requiring that at least 80 percent of their revenues are spent directly on patient care;**
- 4. Ban dialysis providers from balance billing patients;**
- 5. Deem out-of-network dialysis providers to be in-network for billing purposes, as providers are in the Medicare Advantage program; and**
- 6. Explore a universal rate for dialysis sessions, consulting with GAO and the National Academy of Medicine, to determine a fair rate that would be paid by both Medicare and the private sector.**

Conclusion

Thank you for the opportunity to share our views with the Task Force. The ERISA Industry Committee and our member companies are committed to working with you to meaningfully make health care more affordable for workers, their families, and retirees. We are confident that our policy recommendations can provide meaningful changes to our health care system. We look forward to working with the subcommittee to further help in policy development and enact legislation.



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