ERIC
The ERISA Industry Committee
Driven By and For Large Employers
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The Honorable Lamar Alexander
Chairman
U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP)
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP)
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray,

On behalf of The ERISA Industry Committee (ERIC), thank you for the opportunity to provide comments on the "*Lower Health Care Costs Act of 2019*," legislation to address the nation's surprise medical billing crisis, reduce the cost of prescription drugs, ensure transparency in health care, improve public health, and advance the exchange of health information. This proposal is not only timely – it is sorely needed, to address a number of significant problems currently plaguing the health care system. We applaud the Committee's effort, and urge swift advancement of the legislation. These comments will be focused on Titles I, II, and III.

ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation policies at the federal, state, and local levels. ERIC's large employer member companies operate in every industry sector, employing workers in every state in the nation and sponsoring comprehensive health benefits for employees, their families, and often retirees as well. ERIC and its member companies are committed to advancing policy that will lower costs and improve the quality of health care, and offer the following comments on the HELP Committee's discussion draft:

I. Ending Surprise Medical Bills

ERIC strongly supports the efforts of the Committee to address the surprise medical billing crisis **without raising health care costs**. Congress has the opportunity this year to end surprise billing, provide certainty to patients and payors, and put a stop to the problematic behaviors and strategies in the health system that have created the current situation. This will require tough decisions that inevitably will be challenged by parts of the health industry. ERIC recommends the following:

- Consistent with our testimony before the House Ways and Means Committee, ERIC supports in-network matching (*Option 1*) to eradicate the vast majority of surprise medical bills before they ever happen:

"*If a patient goes to an in-network facility, every provider they see should be required to accept in-network rates as payment in full.*"

This approach has been praised by the Brookings Institution and the American Enterprise Institute, the Manhattan Institute, and many others.

This in-network matching rate guarantee would ensure that providers are paid fairly, based on privately-contracted rates agreed to between similarly situated providers, facilities, and insurers. At the same time,

it would eliminate any and all confusion, as well as any and all gaming of the system – **including that done by outsourced medical and emergency room staffing firms**. A patient who goes in-network would be 100 percent protected, and based on where they chose to practice, providers would have a consistent and certain understanding of reimbursement expectations.

In the case of out-of-network emergency care, **including emergency medical transportation**, the Committee should provide certainty to patients and providers by banning balance billing, and designating a reasonable benchmark. The most straightforward benchmark would be based on a percentage of Medicare, just as most private insurance reimbursement amounts are based on a percentage of Medicare. ERIC suggests considering 125 percent of Medicare. We have provided comments on the House Energy and Commerce Committee's proposal here, which may be useful.

If the Committee chooses not to use a Medicare-based reference, a variation on the median in-network rate in a given market is an appropriate option to consider (*Option 3*). But the benchmark must not serve to legitimize or encourage the current strategy of some provider groups to eschew networks. Networks are critically important to ensure patients have access to high quality, affordable health care. There should remain a financial incentive for most providers to choose networks – and thus, the benchmark rate for out-of-network care should not exceed median or average amounts paid to in-network providers. We strongly dispute contentions that designating a benchmark is price-setting. Rather, it would create a needed backstop to get parties to the table, encourage network agreements, and eliminate the uncertainty for plan sponsors who may now be forced to pay.

- **No arbitration – stop the surprise bills before they happen.** ERIC opposes mandatory binding arbitration, mediation, or any other quasi-judicial resolution of surprise medical bills, for several reasons:

- These "solutions" do not end surprise billing – they merely change who is subject to paying the surprise bill. As such, binding arbitration enshrines the current strategy of certain medical providers to eschew networks and generate surprise bills;
- They raise costs, requiring payments to arbitrators, lawyers, or other representatives to the parties, facilities, and in "*baseball style"* arbitration, mandate that sometimes the plan or plan sponsor must pay excessive "billed charges" that no competent fiduciary would ever agree to pay. These costs will be passed on directly to patients, **creating surprise bills for everyone**; and
- In order to avoid out-of-control costs, binding arbitration would still require a benchmark payment rate. As such, it does not actually shield Congress from making a decision about backstop payments – instead, it merely obfuscates this decision, adding in layers of non-transparent administrative costs and incinerating resources that would be better spent on the provision of care.

As such, ERIC urges the Committee to stand strong and resist demands by provider groups to replace a reasonable benchmark with any kind of mandatory arbitration or mediation.

- **Ensure that emergency medical transportation is not left out.** The current draft's air ambulance provisions are insufficient to protect patients.

While protecting patients at the hospital is a laudable goal, it is imperative that Congress ensure the patient is not already made financially destitute by the ride there. Transparency is a step in the right direction, but will not necessarily change the behavior of providers.

Emergency medical transportation that is out of network, should be treated exactly the same way out-of-network emergency room care would be treated. These services should be reimbursed based on a benchmark tied either to Medicare rates, or to comparable in-network rates in that or a similar geography.

Ambulance or air ambulance providers' participation in the Medicare program should be conditioned upon their agreement to abide by reasonable billing practices – thus eliminating any Congressional jurisdictional concerns that may arise. If that is not feasible, insurers and group health plans should be prohibited from contracting with or directing payments to any ambulance or air ambulance provider that does not abide by said practices. **This does not and should not require a referral to the Commerce Committee**.

II. Reducing the Prices of Prescription Drugs

ERIC strongly supports all of the provisions included in Title II. ERIC has officially endorsed the following bills (which span multiple Committees of jurisdiction, and some of which are included in this package), and urges inclusion of as many as possible in a final package:

1. S. 658, "***ADAPT Act***" (Sen. Braun): This bill would create an expedited FDA approval pathway for medications already approved in other developed countries such as the EU, Japan, Israel, etc. This could spur more competition in U.S. markets, thus reducing costs.

2. S. 61, "***Safe and Affordable Drugs from Canada Act***" (Sens. Grassley, Klobuchar, Shaheen, Baldwin, Wyden, Leahy, Brown, King, Hassan, Merkley, Whitehouse, and Collins): This bill would allow limited importation of approved drugs from approved Canadian pharmacies, with protections to shore up supply chain security. Plan sponsors should be permitted to reimburse participants who take advantage of this option.

3. S. 64, "***Preserve Access to Affordable Generics and Biosimilars Act***" (Sens. Klobuchar, Grassley, Leahy, Ernst, Cramer, and Durbin): This bill would limit so-called "pay-for-delay" agreements to increase generic competition. ERIC endorsed this concept in our "Roadmap" letter to HELP (our original submission to this committee), and a successful compromise was recently reached by Republicans and Democrats, which paved the way for the legislation to advance through the House Energy and Commerce Committee.

4. S. 474, "***Stopping the Pharmaceutical Industry from Keeping Drugs Expensive (SPIKE)***" (Sens. Wyden, Cardin, Carper, Coons, Duckworth, Klobuchar, Menendez, Stabenow, Tester, Gillibrand, and Cortez Masto): This bill requires drug manufacturers to publicly explain when prices increase 10 percent or $10,000 over one year, 25 percent or $25,000 over three years, or those with a launch price of more than $26,000. ERIC has previously called for more transparency regarding drug cost increases, even if "name and shame" legislation is only a partial solution. A compromise version of the bill was included in a package that was **unanimously approved** by the House Ways and Means Committee.

5. S. 476, "***Creating Transparency to Have Drug Rebates Unlocked (C-THRU)***" (Sens. Wyden, Brown, Carper, Tester, and Coons): This bill would require PBMs to report aggregate rebate amounts to CMS, and CMS would post the info. It would also ensure that Medicare beneficiaries' cost-sharing was based on negotiated, not list, prices. ERIC member companies often express interest in more transparency, and a compromise was struck in the House Ways and Means Committee that drastically narrowed the scope, and addressed many concerns about the legislation – in fact, the PBM trade group PCMA released a statement saying they "appreciate the Committee's work."

6. S. 340, "***Creating and Restoring Equal Access to Equivalent Samples (CREATES)***" (32 Senate sponsors): This bill would prevent the gaming of patient safety protocols to thwart generic competition.

7. H.R. 938, "***Bringing Low-cost Options and Competition while Keeping Incentives for New Generics (BLOCKING)***": This bill prevents gaming ("parking") of generic drug applications in a way that thwarts generic competition with branded drugs. ERIC has called for an end to patent shenanigans, and BLOCKING would end at least one of the currently practiced tricks used to prevent competition.

8. H.R. 1520, "***Purple Book Continuity***," and H.R. 1503, "***Orange Book Transparency***": These bills would codify, clarify, and improve FDA responsibilities to publish information that helps generic companies know the current exclusivity landscape, thus empowering them to more efficiently navigate the requirements to get generics to market. These bills have passed the House and are awaiting Senate action.

9. H.R. 2113, "***Prescription Drug STAR Act***": This bill was passed unanimously in the House Ways and Means Committee, and includes several of the bills described above. It also includes additional provisions designed to improve transparency.

10. S. 440, "**PACED Act**," (Sen. Cotton, Ernst, and Toomey): This bill would affirmatively ban sovereign immunity schemes that some drug manufacturers have attempted to use to avoid patent challenges.

We are additionally supportive of legislation that would:

- Clear the way for greater use of value-based purchasing agreements for medications;
- Eliminate so-called "rebate traps";
- Ban abusive use of coupons and third-party payment schemes to steer beneficiaries to branded or other expensive treatment options;
- Ensure that plans and plan sponsors have access to meaningful comparative effectiveness data on various pharmaceutical products; and
- Incentivize the use by medical providers of point-of-prescribing and real-time benefits tools they can use to guide patients to affordable treatments.

ERIC commends the Committee for the decision **not to include** S. 1348, the "***Prescription Drug Rebates Reform Act of 2019,***" (Sens. Romney, Braun, and Blackburn). ERIC and its member companies strongly believe that this legislation is counterproductive, and would **harm the health care system and the affordability of health coverage for most Americans**. Specifically, we believe that:

- This legislation **is still in a developmental stage**. It is an initial idea that has not been fully vetted with stakeholders, most importantly, plan sponsors who can share the troubling, real-world effects of the legislation as currently drafted.
- This legislation is **extraneous in the context of the larger package**. If other provisions of the *Lower Health Care Costs Act* are enacted, the mandate contained in this bill is ineffective and unnecessary.
- This legislation **does not lower health care costs**. Instead, it simply requires all beneficiaries to pay more in order to subsidize the relatively small subset of plan participants who choose to fill expensive branded prescriptions that give rise to rebates.
- This legislation **keeps drug costs high**, by hampering the ability of plan sponsors to steer patients to the most efficient, effective, affordable treatments. It rewards pharmaceutical companies that

maintain high prices, by increasing the likelihood that beneficiaries will choose their products over more affordable alternatives.

Additionally, we urge the Committee to include in the final package the "***Chronic Disease Management Act***" (S. 2410, 115th – Senators Thune, Carper, and Grassley). This legislation would allow plans and plan sponsors to provide first-dollar coverage within a high-deductible health plan (HDHP) of medications and other services to manage chronic conditions. This simple, straightforward step would give plans the option to provide free or subsidized insulin for diabetics, inhalers for asthmatics, and other treatments that prevent those with chronic conditions from experiencing catastrophic episodes that often give rise to much more serious health issues. **This bill is in the Senate Finance Committee's jurisdiction, but the Finance Committee may markup drug cost legislation focused solely on public programs. In the** *Chronic Disease Management Act***, the Senate has an opportunity to advance a measure that could measurably lower health care costs and help millions of patients.** We urge the Senate to take action on this critical provision.

III. Improving Transparency in Health Care

ERIC appreciates the Committee's work on ensuring that beneficiaries, plans, and plan sponsors have access to a more transparent and equitable health care system. We offer the following comments on sections of Title III:

Sec. 301 (Gag Clauses): ERIC supports provisions to ensure that patients and plan sponsors (as well as service providers such as wellness and disease management programs) cannot be denied access to quality and cost data. It is our understanding that there could also be additional payments made pursuant to bonus agreements, sometimes on a quarterly or year-end basis – and those payments should be included in this section. The Committee appropriately included language to ensure that privacy is protected.

Sec. 302 (Truth in Contracting): ERIC supports provisions to eliminate abusive contracting strategies undertaken by health systems and providers. Specifically:

- "Anti-tiering" and "anti-steering" clauses are disruptive to value-driven plan design, as well as to centers of excellence programs. These clauses ultimately harm patients, and the legislation rightly bans them. Plan sponsors should have and maintain the ability to steer patients to higher quality, lower cost providers.
- "All-or-nothing" clauses lead to abuse that is greatly compounded under the current environment of consolidation in the health care provider community. These clauses force plans to include dangerous, low-performing, and excessively expensive providers and facilities in what should otherwise be value-driven networks. Ultimately, this raises costs for patients, threatens worse health outcomes, and props up problematic providers and facilities – eliminating what would otherwise be incentives for improvement. These clauses should be banned.
- "Most-favored-nation" clauses have the potential to raise costs for consumers without regard to any value provided. This is especially destructive for multi-state and nationwide plans and plan sponsors, who have populations that are spread out, rather than highly concentrated. These clauses should not be permitted.
- Unconsented contractual obligation clauses should also be banned. ERIC member companies have fallen victim to certain unscrupulous provider systems that abuse leverage over third party administrators (TPAs) to attempt to bind ERISA plans under terms they have not agreed to. ERIC supports legislation that has been proposed on the state level to ban these practices, and we commend the Committee for proposing a nationwide ban on these clauses.

Sec. 303 (All-Payer Claims Database): ERIC supports the creation of a national APCD to fill data gaps for states, empower plan sponsors with data, and ensure that ERISA plans are not subject to state efforts to implement claims data reporting regimes.

ERIC has endorsed the creation of a national APCD that aggregates large employer claims data, as well as state-level and fully-insured data, and Medicare data, giving employers and researchers the opportunity to get a **comprehensive** view of health care markets and trends. We believe this section of the legislation strikes the right balance in respecting states' rights to create their own databases, ensuring states get access to the multitude of data they currently do not have access to, and protecting the ability of ERISA plans to operate on a national, uniform level. Critically, this section should put to rest any continuing attempts by states to impose reporting requirements on ERISA plans. While we believe the U.S. Supreme Court's *Gobeille* decision makes clear that ERISA plans are not subject to these state efforts, we acknowledge that states can make use of self-insured claims data – just as self-insured plans can make use of a comprehensive database that includes fully-insured data and public employee/public plan data. As such, ERIC supports this federal solution.

We encourage the Committee to consider expanding the scope of possible hosts for the APCD to include public-private partnerships. While it is critical that users have access to the APCD without being subject to user fees and other impediments, we believe that more options for where to house the APCD are likely to result in expanded possibilities – and may the best competitor prevail.

Additionally, we support proposals to expand the scope of authorized users to ensure that health information technology companies can access the APCD. To reach its maximum potential, the APCD should be queried in creative and novel ways. Allowing more parties to participate in this process is likely to increase the utility of the resource. As such, we urge the Committee to include academic and private sector researchers and innovators as potential database users.

Sec. 304 (Provider Directories): ERIC supports requirements that provider directories be updated in real-time and maintained as efficiently as possible. ERIC member companies engaged in an extremely wide variety of businesses are able to provide consumers with up-to-the-minute information about inventory, services, relationships, and much more. We support efforts to bring health insurance network information likewise up to speed. It may take time for TPAs to implement these systems, and the Committee should allow a 12-month implementation period before enforcement takes place.

In the case of a patient who reasonably relies on a provider directory that is not up to date, we support holding the patient responsible only for what the in-network cost would be. However, the plan sponsor should similarly be held harmless if the data (provided and maintained by a TPA) is inaccurate.

Sec. 305 (Timely Bills): ERIC supports prompt reporting to patients of services rendered, limiting billing to within 30 days of services, and giving patients 30 days to pay said bills. As laid out earlier, ERIC member companies provide similarly prompt information to customers in a variety of situations, and a 21st Century health system should be able to similarly meet patient needs.

Sec. 306 (Pharmacy Benefit Manager Services): ERIC supports ensuring transparency in PBM services and contracting. We offer the following specific comments:

- ERIC supports robust reporting requirements for group health plan vendors. Group health plans should know exactly how much they are paying, when, for what, to whom, and why. This reporting should be non-controversial, and while the private sector is already moving in this direction, the *Lower Health Care Cost Act* can serve to speed the already inevitable transition. This section should also prevent drug manufacturers from entering into any agreements that

include clauses that prevent disclosure of data to plan sponsors. Additionally, some of the reporting included in this section is static throughout a plan year, and need not be included on a quarterly basis.
    - As outlined above, ERIC is concerned about manufacturer copay assistance coupons, cards, and the like. However, PBMs may not have sufficient access to this information to fulfill the obligations laid out in this section. Instead, drug manufacturers should be required to provide this reporting to plan sponsors.

- ERIC member companies are aware of a hearing in the Senate Finance Committee in April 2019, in which most major PBMs appeared to support elimination of spread pricing. Indeed, as stated above, plan sponsors should know exactly how much they are paying for prescription drugs, with no subterfuge or obfuscation. However, there may potentially be plan sponsors who are interested in risk-sharing agreements with a PBM (which, arguably, a spread pricing contract could be considered). In those cases, spread pricing should be permitted, provided 100 percent transparency that ensures the plan sponsor knows exactly how much is spent, how much is remitted to various parts of the supply chain (including the PBM), and can clearly compare how this amount varies from what payments directly to the pharmacy would have cost. But these agreements need to be completely discretionary on the part of plan sponsors, fully transparent, and paired with ongoing reporting and consent obligations.

  ERIC member companies believe that this policy should be uniformly applied to all PBMs and similar vendors, without singling out any specific company. Provisions necessary to ensure compliance should be balanced with consistency for all stakeholders. Changes may be necessary to this section to ensure no single company is placed at an unfair competitive advantage, maintain the ability of PBMs and plan sponsors to create competitive and value-driven pharmacy networks, and maximize the savings potential of specialty pharmacy and mail-order pharmacy contracts.

- ERIC notes that in a hearing held by the HELP Committee in October 2017, Chairman Alexander questioned the need for rebates – representatives across the supply chain all agreed that changes were in order. It is the position of ERIC member companies that all remuneration from a pharmaceutical company to a group health plan's vendors, including a PBM, that could be construed as pursuant to said group health plan, should in fact be the property of the group health plan. As such, we support the requirement that a PBM pass on 100 percent of rebates, discounts, or other payments from manufacturers. Plan sponsors should be free to share these payments with a PBM or other vendor; however, these funds must first be passed to the plan sponsor, and then returned to a PBM only with direct consent, approval, and knowledge of the plan sponsor – including knowledge of and specific agreement to all amounts, sums, and payments.

ERIC notes that some plan sponsors may wish to maintain their PBM contracts exactly as they are today. This should be an option. Nothing in this legislation should necessarily limit or reduce compensation to PBMs or other plan vendors. However, it is appropriate to apply transparency requirements, to ensure plan sponsors know exactly what they are paying under any such agreement, as this affects the cost of health coverage for hundreds of millions of Americans covered by group health plans.

While ERIC supports reforms to ensure transparency in the relationship among plans, plan sponsors, and vendors in the prescription drug space, we urge the Committee to keep in mind: **regulating PBMs will not make prescription drugs affordable.** Ultimately, drugs' list prices are set by manufacturers, and while changes to the supply chain can help bring clarity and eliminate certain excess costs, reforms must be made to the drug approval system, the patent system must be modernized, and the government must move aggressively to eliminate so-called "shenanigans" that hamper choice and competition. This is a critical opportunity to truly address the high and unsustainably-increasing costs of prescription drugs.

Sec. 307 (Joint Ventures): ERIC supports increased Congressional oversight of profit-sharing agreements in the health care system, especially those between a facility that may be participating in health insurance networks, and a medical staffing firm that has adopted an out-of-network billing strategy. While we are supportive of banning some of these arrangements as illegal kickbacks, adoption of the "In-Network Guarantee" proposed in Title I may eliminate this problem for most ERIC plan beneficiaries.

Sec. 308 (Brokers and Consultants): ERIC member companies have not provided sufficient feedback on this section to weigh in at this time.

Sec. 309 (Patient Costs): ERIC supports transparency for patients on expected costs related to medical services. Most ERIC member companies provide transparency tools, plan documents, and other materials that should meet these requirements. We believe that providers, in coordination with our TPAs, can also provide this information to patients. Indeed, access to this information should help patients to better navigate the health care system.

Conclusion

ERIC appreciates the opportunity to weigh in on these important issues, and looks forward to working with the Committee to advance comprehensive legislation to lower health care costs, encourage transparency, end the surprise medical billing crisis, and make significant improvements to the health care system. If you have questions concerning our comments, or if we can be of further assistance, please contact us at (202) 789-1400.

Sincerely,

James Gelfand
Senior Vice President, Health Policy