THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

Sunday, October 15

Committee on the Budget
U.S. House of Representatives
Washington, D.C. 20515

Submitted via email: hbcr.heatlh@mail.house.gov

Dear Members of the Health Care Task Force:

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 improve health outcomes while reducing health care spending. 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. ERIC member companies offer benefits to tens of millions of employees and their families, located in every state, city, and Congressional district.

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 highlight the topline policy proposals ERIC urges you to consider in upcoming legislation. Many of these policies address questions one and four outlined in the Request for Information (RFI). Employers can and should be important partners in this effort, helping to forge solutions that result in improved health care access, affordability, quality, transparency, and safety for all Americans. ERIC looks forward to working with you on the following policy proposals identified by our member companies as key to this shared goal.

I. Regulatory, Statutory, or Implementation Barriers That Could Be Addressed to Reduce Health Care Spending

A. HDHP/HSA Modernization

ERIC member companies offer an array of different plan options for employees, including High Deductible Health Plans (HDHPs) paired with Health Savings Account (HSAs). 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 also uncovered the need for a number of administrative fixes, which may include, for example, allowing adult children, who are on their parents' HDHP, to access HSA funds for their medical care, or covering more preventative care services before an employee reaches their deductible.

ERIC appreciates the work by the Ways and Means Committee to advance several HDHP/HSA modernization policies, including the recent markup of the "*Bipartisan HSA Improvement Act of 2023"* (H.R. 5688) and the "*HSA Modernization Act of 2023"* (H.R. 5687). These bills make several key improvements to HSAs including many that would significantly help persons with HDHPs mitigate their out-of-pocket financial costs when seeking commonplace, routine healthcare, such as:

- Allowing HDHPs and HSAs to be paired with direct primary care arrangements, and allowing the costs of these arrangements to be paid with HSA dollars;

- Allowing employers or plans to offer free or subsidized care to HDHP beneficiaries at on-site or near-site health clinics, without jeopardizing beneficiaries' HSA contribution eligibility;

- Ensuring that an individual can still have an HSA even if his or her spouse has a flexible spending arrangement (FSA); and

- Enabling one-time terminations and conversions from FSAs and health reimbursement arrangements (HRAs) into HSAs.

While an important step forward, more changes are needed to better serve patients, Veterans, and their families who want to access affordable primary care and other health services utilizing their HSA dollars. As such, we ask that the Task Force consider the following additions to the language that the Ways and Means Committee advanced regarding worksite health clinics and Veterans' access to HSAs:

- **Worksite Health Clinics**. Worksite health clinics have proven to be the first point of access for many patients' health care needs, but for approximately half of the workforce who have an HDHP paired with an HSA, they must be charged the "fair market" rate for 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.

  During the 117th Congress, members of the Committee on Ways and Means introduced bipartisan legislation ("*Employee Access to Worksite Health Services Act"* (H.R. 7487)) that would expand the list of qualified items and services at worksite health clinics to include primary care items and services and mental and behavioral health services – all critical services that some worksite health clinics are currently performing. These listed services, however, were not included in the bill's introduction this Congress. The high out-of-pocket costs required by the market value of these 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 expand the list of qualified items and services to include primary care and mental health and 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 first 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 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 they are less likely than other plan beneficiaries to obtain needed care – including mental and behavioral health. While language related to Veterans was included in the "*HSA Modernization Act of 2023"* (H.R. 5687), language should be included to protect those eligible for health programs administered by the Department of Defense (DoD), such as TRICARE or TRICARE for Life. ERIC encourages Congress to correct this inequity so that Veterans and members of the armed services with HSAs have equal access to and are not disqualified from health programs through their employers.

Additionally, we recommended the Task Force support and Congress enact the following policies to further drive HDHP/HSA modernization and accessibility for beneficiaries:

- **Direct Primary Care.** Primary care is shown to improve health care outcomes and reduce disparities.[1] 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 has a "whole person" approach, but barriers remain for someone with an HDHP paired with an HSA to receive such care.

  Congress should pass the "*Primary Care Enhancement Act"* (H.R. 4301 and S. 128) to allow employees participating in direct primary care arrangements to contribute to HSAs and allow patients to use their HSAs to pay for their direct primary care arrangements. This would help patients better address their mental and behavioral health needs as well as their chronic conditions and use their HSA funds appropriately. ERIC appreciates the House Ways and Means Committee including the legislation in the "*Bipartisan HSA Improvement Act"* (H.R. 5688) and urges Congress to advance the legislation.

- **Telehealth for HDHP Beneficiaries**. Employers would like to offer free or low-cost telehealth visits to their employees. Telehealth can be used for preventative care that can help avoid costly care later, costs that employers are under ever-growing pressure to contain as they continue to rise year after year. Due to 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 health needs. Currently, employees with an HDHP may have 1st-dollar coverage of telehealth visits through the end of December 2024 under a temporary extension provided by Congress.

[1] U.S. Department of Health and Human Services. Access to Primary Care. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

This policy should be made permanent. The Employee Benefits Research Institute (EBRI) found that 96 percent of employers adopted pre-deductible coverage for telehealth services because of Congress' bipartisan work.[2] ERIC strongly encourages Congress to make this policy permanent by passing the "*Telehealth Expansion Act of 2023"* to ensure that individuals with HDHP/HSAs can continue to access virtual care services on a pre-deductible, permanent basis beyond 2024. Many patients will have experienced this benefit for several years, and discontinuing the policy will put patients' access to medical care and potentially their health at risk, leading to higher medical costs.

- **Chronic Disease Management.** Employers follow the U.S. Preventive Services Task Force's recommendations under the U.S. Department of the Treasury guidance, allowing the list of preventative care benefits to be expanded. The expansion includes insulin and other glucose-lowering agents for those with diabetes, blood pressure monitors for those with hypertension, and more. However, much chronic disease management is still not accessible with 1st-dollar coverage. Congress should pass the "*Chronic Disease Flexible Coverage Act*" (H.R. 3800) allowing for 1st-dollar coverage and codifying the guidance.

- **Infectious Disease Treatment.** During the COVID-19 pandemic, employers were reminded how imperative it is to contain and control outbreaks before they spread throughout a workforce. Numerous supply chain issues, and significant economic disruption, could be attributed to the spread of COVID variants through a given workforce. Congress should update HDHP rules to ensure that employers and insurers can pay for treatments for infectious disease prior to an individual meeting their deductible, in order to remove barriers to stopping outbreaks and keeping pandemic and other infectious diseases under control.

- **Physical Fitness and Wearable Technologies.** Employers strive to promote participation in employee wellness programs. Many offer a wearable device to employees free of charge, to improve health outcomes and connect health data to electronic medical records. ERIC supports the "*PHIT Act of 2023*" (H.R. 1582, S. 786), which would broadly allow a medical care tax deduction for the employee for up to $1,000 of qualified sports and fitness expenses per year and allow HSA funds to be used to promote physical activity. ERIC encourages Congress to consider legislation that allows employers to supply employees with wearable or other medical devices as part of a wellness program or health plan, without imputing income to the employee, or jeopardizing the employee's ability to contribute to an HSA. These changes will enable more participation in wellness programs and have the potential to significantly improve patient health outcomes for the entire health care system, leading to lower health care costs. They would also provide for more complete medical records for providers in designing and monitoring plans of care.

  Wearables in the Medicare program should also be covered to ensure uniformity in the markets. Many aspects of private insurance follow the lead of Medicare, including reimbursement codes and definitions of care. Currently, Medicare Advantage plans may choose to buy and give wearable devices to enrollees.

[2] Fronstin, Paul. Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans. EBRI. October 14, 2021 https://www.ebri.org/docs/default-source/pbriefs/ebri_ib_542_hsaemployersur-14oct21.pdf?sfvrsn=73563b2f_6

Congress should allow the provision of wearable medical devices to be covered through the core medical benefit of both traditional Medicare and Medicare Advantage plans.

B. Digital Health

Digital health, such as telehealth or telemedicine, provides individuals with greater access to care as well as the opportunity for greater engagement in managing their health care. It can help improve the treatment and prevention of chronic conditions and empower individuals with information they need to advocate for health care services.

1. Telehealth

ERIC member companies are pioneers in offering robust telehealth benefits. Telehealth enables individuals to obtain the care they need, when and where they need it, affordably and conveniently. Telehealth visits are generally less expensive than in-person visits and significantly less expensive than urgent care or emergency room visits. Telehealth visits allow individuals who may not have a primary care provider and are experiencing medical symptoms an affordable alternative to an otherwise unnecessary emergency room visit. Access to telehealth benefits saves individuals significant money and reduces the cost to the plan, which ultimately lowers health insurance premiums.

Telehealth benefits reduce the need to leave home or work and risk infection at a physician's office, provides a solution for individuals with limited mobility or access to transportation, and has the potential to address provider shortages, especially related to mental health, and improve choice, competition, and reduce costs in health care.

ERIC's member companies continue to lead the way in rolling out telehealth improvements – held back only by various federal and state government barriers. This includes overly restrictive provider licensing, unnecessary barriers, such as banning store-and-forward communications, or specific technology requirements. Additionally, ERIC member companies are interested in offering telehealth to certain sectors of their workforce who currently cannot be offered these services.

These impediments to provider licensing seriously impact telehealth coverage offered to employees from state to state. For example, primary care is largely available to employees in every state, but offering behavioral health and mental health services to patients in each state is a challenge because there are not enough licensed providers in many states. Everyone's telehealth care access is limited based on state rules and what can be covered through the medical plan or Employee Assistance Program (EAP).

Additionally, we encourage Congress to pass the "*Telehealth Benefit Expansion for Workers Act of 2023"* (H.R. 824). This bill would allow employers to offer standalone telehealth benefits to millions of individuals who are not enrolled on the employer's full medical plan, such as part-time workers, interns, seasonal workers, persons on a waiting period, and others, by removing barriers currently presented under current law, such as the *Affordable Care Act* (ACA).

2. Interoperability of Health Records and FDA Approvals

Changes are also needed to end data blocking to promote coordination of care and encourage unification of electronic medical records, which will drive innovation, leading to advancements in health care management and patient-centered care. Furthermore, the U.S. Food and Drug Administration (FDA) approval processes should not serve as a bottleneck to innovation for new technologies like wearable medical technologies and mobile applications but should foster an environment for it to be widely used. ERIC recommends that Congress direct the FDA to minimize barriers to entry for mobile application developers and wearable medical device manufacturers to spur innovation in this area.

C. Transparency and Accountability Reforms

Transparency is integral both to reduce health care costs and improve the quality of care. 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.

Experience has shown that competition and information are critical to a functioning marketplace for any product, and health care is no exception. Employers are major innovators in health care, and transparency will accelerate our member companies' ability to improve benefits and coverage, increase affordability for patients, and drive efficiency, quality, and value in the system.

ERIC appreciates the efforts which Congress, and both the previous and current administration, have undertaken to create more transparency across differing health care industries. This includes the Hospital Transparency Rule, the Transparency in Coverage Rule, and numerous provisions under the *Consolidated Appropriations Act of 2021* (CAA). ERIC along with other employer organizations are generally supportive of the House transparency bill, the "*Lower Costs, More Transparency Act*" (H.R. 5378). This legislation is particularly important as it incorporates several critical bipartisan provisions that were adopted by the Education and the Workforce Committee that address ongoing issues self-insured ERISA plan sponsors face as they continue to be denied access to their own data by their service providers and third parties acting on their behalf while facing fiduciary liability and attestation requirements under the law per the CAA.

1. Health Plan Transparency

With regards to health plan transparency, ERIC supports codification of the Transparency in Coverage Rules with important modifications such as requiring the use of application programming interface (API) technology, increasing the frequency of the reports, aligning requirements and consolidating the new consumer-facing tools employers must create, and folding the new advance explanation of benefits (AEOB) requirement under the CAA into these consumer tools (unless adapted into the framework of existing requirements, the new AEOB 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 (and takes steps in the wrong direction, requiring the provision of paper and snail mail communications, and the use of call centers, rather than newer electronic delivery technologies).

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 all payers claims databases (APCDs). While we applaud the effort DOL has undertaken, self-insured employers are unlikely to 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.

2. Hospital Transparency

Despite current hospital reporting requirements, complete, updated, and accurate hospital pricing data remains out of reach. This data holds the promise to foster competition and hold vendors (such as insurance companies) accountable. But too often, employers find barriers in accessing the information, or when they do get 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 is supportive of the codification of the Hospital Transparency Rule in the "*Lower Cost, More Transparency Act"*, although the number of reportable services should be greatly expanded. Publicly available health care service prices will promote competition, value, and quality, and will reduce health care spending for patients and taxpayers.

Additionally, hospital safety data should be collected and posted online in a uniform manner by the Centers for Disease Control and Prevention (CDC). This data should pertain to specific hospitals and sites of care, not large health systems with multiple sites, and should be made fully available for patients, plan sponsors, and other entities that want to use safety information to inform plan design, make network decisions, or make informed decisions about their own care or that of a loved one.

3. PBM Reform

Strong PBM reforms, which restore accountability and competition to the market, are critical for the nation's private and public employers who provide health benefits to 178 million working Americans and their families. While PBM transparency is an important component, as is transparency across the health care system, to mitigate the ever-growing costs of health care employers and employees face each year, mere reporting/sharing of information is not enough. The PBM transparency provision of the "*Lower Cost, More Transparency Act"* is unlikely to move the dial in terms of true impact on negating the anti-competitive private market practices PBMs have been engaging in to drive profits. ERIC strongly supports the Senate Health Education, Labor and Pensions (HELP) Committee's legislation, the "*Pharmacy Benefit Manager Reform Act*" (S. 1339) and urges the House to reconcile their legislation with this bill and adopt the strongest and best provisions from both.

There are misaligned incentives and spread pricing models not addressed in the House legislation that will leave unaddressed high prescription drug costs. ERIC members support banning the practice of spread pricing, requiring that rebates be passed through to employer-sponsored plans, and fully extending ERISA's fiduciary duty applicability to PBMs and third parties when acting on behalf of plan sponsors.
As the primary customers of PBMs, we urge Congress to include these reforms so that workers, families, and retirees can experience lower health care costs.

D. Addressing Provider Consolidation

Health care provider market consolidation continues to rise, including mass purchase of provider practices by hospital systems. With such widescale consolidation comes great market power to demand higher prices. To that end, ERIC members are seeing the impact of this through enhanced pressures regarding provider contracting, as well as varying payment rates across sites of care for the same service performed by a provider.

Because Congress has failed for many years to address provider consolidation, and administrative agencies charged with policing monopolies and unfair trade practices have failed to effectively engage, health care markets are spiraling out of control. There is no conservative case for a *laissez-faire* approach to such egregious market failures; immediate intervention is needed to preserve free markets in health care, or something akin to "Medicare for All" is likely to become a greater threat as markets continue to deteriorate and prices continue to challenge patients' access to care.

1. Fairness in Contracting

Health care providers 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 the Task Force to support and Congress to enact the "*Healthy Competition for Better Care Act*" (H.R. 3120 and S. 1451). The legislation would promote competition and reduce network consolidation by allowing:

- 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 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.

2. Timely and Honest Medical Bills

Provider consolidation has also given rise to unethical medical billing practices. The Task Force should support, and Congress should enact legislation that will stop hospitals from reclassifying a doctor's office they own as a hospital setting in order to charge more money ("*Facilitating Accountability in Reimbursement (FAIR) Act"* (H.R. 3417) and "*Site-based Invoicing and Transparency Enhancement (SITE) Act"* (S. 1869)). Further, the Task Force 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.

E. Bipartisan Action Needed on Prescription Drug Competition

The Task Force should consider taking action to address the 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 abide by the standards 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:

- Enacting policies to promote an affordable and competitive market for biosimilars, including eliminating barriers to substitution such as the "interchangeability" designation;
- 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);
- 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;
- Preventing unconscionable markup of prescription drug costs at hospitals, and ending abuse in the 340(b) drug program;
- Allowing certain medication to be reimported or purchased from overseas pharmacies that are registered with and regulated by the FDA; and
- Investigating and addressing false or misleading information, discouraging anti-competitive behaviors, and increasing progress to get products to market.

F. Innovation in 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.

1. Creation of a National Patient Safety Board

Patient safety reportable events have not decreased since 1999. Most policies related to reducing preventable medical errors have been focused on the actions of frontline workers, but the reliance on individuals is part of why efforts to sustain, spread, or standardize progress have been unsuccessful. Other industries have seen dramatic improvements in safety. The aviation industry has had a stellar safety record thanks to the work of the Commercial Aviation Safety Team (CAST) and the National Transportation Safety Board (NTSB), which together have been improving and promoting transportation safety in the United States for more than 25 years.

A proposed independent federal board housed within the Department of Health and Human Services, titled the National Patient Safety Board (NPSB), would model the efforts of CAST and NTSB within health care. The NPSB, with its nonpunitive, multidisciplinary Research and Development Team, would complement existing agencies in monitoring and anticipating patient safety events with modern tools such as machine learning, predictive analytics, machine learning, and artificial intelligence. It would provide expertise to study the causes of errors and create recommendations and solutions to prevent future harm. By serving as a central repository for these patient safety solutions, NPSB will leverage existing systems to bring key learnings into practice. The NPSB would guarantee a data-driven, scalable approach to preventing and reducing patient safety events in health care settings. ERIC urges Congress to advance legislation to establish the NPSB and appropriate the necessary funding to save patient lives.

2. Serious Reportable Events or "Never Events"

The National Quality Forum (NQF) created a set of serious, preventable, and harmful clinical events that occur throughout different clinical settings so that health professionals could assess, measure, and report performance. This list includes events such as wrong-site surgeries, malfunctioning devices, medication errors, and more. These events happen to patients in employer-sponsored health plans and those in government programs such as Medicare but are handled quite differently depending on a patient's insurance. Currently, for patients with employer-sponsored insurance who experience one of these "never events," the plan will not compensate providers or permit providers to bill the patient or the plan for services related to the serious reportable event. Medicare refuses to pay a higher diagnostic-related group for the error, but the hospital still gets paid in full under the *Deficit Reduction Act's* "No-Pay List". ERIC encourages Congress to improve patient safety by aligning Medicare patient safety standards with the private sector, by updating the current "no-pay list" policy to instead cover all NQF serious reportable events, and to mirror the Leapfrog Group's hospital safety metrics and "Never Events" policy.[3]

II. Examples of Evidence-Based, Cost-Effective Preventive Health Measures or Interventions that Can Reduce Long Term Health Costs

A. 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

[3] The Leapfrog Group. Never Events. https://www.leapfroggroup.org/influencing/never-events

support the goal to increasingly transition to paying for value and outcomes rather than for the volume of services and 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 difficult for small and medium-sized employers that lack sufficient employee volume to effectively negotiate with health systems exercising significant market power. 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, which established its program in 2009 but has since ended it. Data related to Washington's program is not publicly available, but the Society of Actuaries commissioned a report to evaluate direct contracting care delivery and cost savings.[4]

ERIC urges the Task Force 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.

B. 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. They 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. The centers of excellence encourage competition based on quality thereby increasing quality throughout the health system. We urge the Task Force to support requiring Medicare to implement centers of excellence – either gradually starting with demonstration programs, or immediately based on already available data – so beneficiaries can have access to improved specialized care.
Medicare could be required to 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 Centers for Medicare and Medicaid Services (CMS) beneficiaries.

[4] Busch, Fritz, Dustin Grzeskowiak, and Erik Huth. "Direct Primary Care: Evaluating a New Model of Delivery and Financing" May 2020. https://www.dpcare.org/actuaries-report

While ERIC believes that improvements to Medicare will ultimately benefit all patients, its member companies also seek 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 the Task Force support requiring CMMI to design and implement demonstration projects in a way that allows other payers, including large employers, to be active and full participants. Employers would be interested in partnering with CMMI on a number of different initiatives, including experimenting with comprehensive medication management to improve quality of care and reduce costs.[5]

Conclusion

Thank you for the opportunity to share our views with the Task Force. ERIC 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 produce significant positive changes to our health care system. We look forward to working with the Task Force to further help in policy development and enact legislation.

[5] GTMRx Institute. Comprehensive Medication Management (CMM): The Value-Based Solution to Managing Medication Therapy Problems in Accountable Care Organizations (ACOs) and Risk-Bearing Entities. https://gtmr.org/resources/comprehensive-medication-management-cmm-the-value-based-solution-to-managing-medication-therapy-problems-in-accountable-care-organizations-acos-and-risk-bearing-entities/