USC-Brookings Schaeffer Initiative for Health Policy
Economic Studies, Brookings Institution
1775 Massachusetts Avenue NW
Washington, DC 20036

June 5, 2019

Re: Request for Comments on the Lower Health Care Costs Act of 2019

Dear Chairman Alexander and Ranking Member Murray:

Thank you for the opportunity to comment on the Lower Health Care Costs Act of 2019. We are encouraged to see bipartisan legislation that takes the challenge of reducing health care spending seriously. We commend the Committee for producing a discussion draft that would take important steps toward meeting that challenge.

Our comments focus on three aspects of the discussion draft that we believe have particular potential: the proposals to address surprise billing, reforms to prevent anti-competitive behavior in health care markets, and the proposal to create a nationwide health care cost transparency organization. The proposals in the discussion draft are a strong starting point, and our comments discuss both the strengths of the Committee's proposals and potential areas for improvement.

In addition, we note that while the proposals in this discussion draft would be important steps forward, they are only the beginning of the reforms needed to ensure that the United States health care system consistently delivers efficient, high-quality care. As this process moves forward, policymakers should consider other reforms with the potential to reduce health care spending that have attracted support from experts in both parties in the past, such as expanding the use of site-neutral payments in Medicare, reforming the catastrophic phase of the Medicare Part D drug benefit, reforming the tax treatment of employer-sponsored health benefits, and expanding the resources available for anti-trust enforcement.

Surprise Billing

All three proposals in the discussion draft would represent an important step forward that would meaningfully protect patients. However, they would address the market failure that currently leads to surprise billing with differing degrees of success. We discuss their relative merits and offer a number of specific comments on the different proposals.

Overall Assessment of the Three Proposals

The only option that would fully address the market failure that gives rise to surprise billing is the "in-network guarantee" or "network matching" approach, which two of us wrote about in more detail in a blog for *Health Affairs* that was jointly authored with Benedic Ippolito of the American Enterprise Institute.[1] (Much of what follows is lightly adapted from that blog.) The other two approaches would be improvements over the status quo, but would likely partially lock in the excessive payment rates for the categories of services for which surprise bills are common today and therefore do less to reduce health care spending.

The in-network guarantee would eliminate the possibility of surprise billing at in-network facilities by requiring facility-based emergency, ancillary, and similar clinicians to contract with all the same health plans as the facility as a condition of practicing at that facility and securing payment from the insurer. These clinicians already contract with and have a financial relationship with the facility at which they practice, and the facility is responsible for the flow of patients they treat, so it is natural to require concordant network contracting decisions. Moreover, many hospitals already effectively require this of their emergency and ancillary physicians.[2] With the network matching provision in place, payment for these services would be negotiated among the insurer, hospital, and clinician. This would then resemble a more typical market negotiation, rather than today's situation where certain clinicians can leverage the threat of surprise billing patients to secure higher contracted payment rates.[3]

Some have suggested that this approach shifts too much leverage to insurers, who would know that these facility-based clinicians have to agree to contract terms in order to practice. However, we believe this would not be a significant problem in practice because the hospital (or other facility) needs to arrange for adequate payment to its clinicians in order to ensure adequate staffing. Thus, if insurers attempted to use this leverage to pay emergency and ancillary clinicians very low rates, the hospital would step in to insist that health plans offer reasonable rates as a condition of their contract with the hospital – or provide additional direct compensation to these clinicians and recover those costs from the payer as part of the negotiated facility rate.

It is difficult to predict the eventual clinician payment rates that would emerge with the current market failure removed, but they would likely be notably lower on average than today's contracted rates, which appear to be well above the levels that would prevail in a better-functioning market.

---

[1] Adler, Loren, Matthew Fiedler, Benedic Ippolito. 2019. "Network Matching: An Attractive Solution to Surprise Billing." *Health Affairs* Blog. https://www.healthaffairs.org/do/10.1377/hblog20190523.737937/full/.

[2] Indeed, using data from one large insurer, a paper from Zack Cooper, Fiona Scott Morton, and Nathan Shekita finds that 50 percent of hospitals have out-of-network billing rates in the emergency department below 2 percent, whereas 15 percent of hospitals have out-of-network billing rates of more than 80 percent. See Cooper, Zack, Fiona Scott Morton, Nathan Shekita. 2019. "Surprise! Out-of-Network Billing for Emergency Care in the United States." *NBER* Working Paper 23623. https://www.nber.org/papers/w23623.pdf.

[3] Adler, Loren, et al. 2019. "State Approaches to Mitigating Surprise Out-of-Network Billing." USC-Brookings Schaeffer Initiative for Health Policy. https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/

The magnitude of reductions faced by different providers will vary significantly and should be directly commensurate to how much different providers are currently benefitting from the explicit or implicit threat of surprise billing patients. Therefore, in addition to protecting patients from large unexpected bills, the in-network guarantee approach should generate the largest premium savings for people enrolled in private insurance coverage among the three options, which would also generate federal budgetary savings by reducing the cost of the tax exclusion for employer-provided health insurance and the Affordable Care Act's premium tax credit.

The other two options, which we have termed forms of "billing regulation," would require insurers to make a minimum payment for out-of-network services delivered at in-network facilities and prohibit providers from balance billing patients above that amount. One option specifies that minimum payment directly while the other leaves that determination to an outside arbitration process if the insurer and provider are unable to come to an agreement.

In principle, these approaches can lead to outcomes that are very similar to those under a network matching approach—if the rate is set an appropriate level. In practice, however, because the two discussion draft options set the payment standard or guidance to arbitrators at median in-network contracted rates, this approach largely locks in today's inflated payment rates for these services, thereby forgoing much of the opportunity for surprise billing reform to reduce health care spending. Arbitration proposals have the same basic shortcomings, plus the arbitration process adds an additional layer of uncertainty and administrative cost.

Payment Standard and Arbitration Approaches Lock in Today's Excessive Payment Rates

Today, emergency physicians and ancillary clinicians benefit from the ability to bill patients out-of-network not only when they actually collect high out-of-network bills, but also because they can use the threat of surprise billing to obtain greater *in-network* payment rates. Basing an out-of-network payment standard (or guidance to arbiters) on today's in-network rates will lock in these unnecessarily high prices. Emergency physicians and anesthesiologists appear to obtain in-network payment rates more than 3 times what Medicare pays for the same services.[4,5] This contrasts starkly with payment rates for non-emergency and ancillary specialists: one study found that employer-sponsored insurance payments for office visits provided by specialists averaged about 117 percent of Medicare;[6] and a Medicare Payment Advisory Commission (MedPAC) analysis of commercial PPO claims from one large national insurer found that contracted payment rates nationwide for all physicians averaged 128 percent of Medicare rates.[7]

---

[4] Ibid.
[5] Stead, Stanley W., Sharon K. Merrick. 2018. "ASA Survey Results for Commercial Fees Paid for Anesthesia Services— 2018." *ASA Monitor* 10 2018, Vol. 82, 72-79. http://monitor.pubs.asahq.org/article.aspx?articleid=2705479.
[6] Biener, Adam I., Thomas M. Selden. 2017. "Public and Private Payments for Physician Office Visits." *Health Affairs*. Vol 36 No. 12. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0749.
[7] MedPAC. March 2017. "Report to the Congress: Medicare Payment Policy." http://medpac.gov/docs/defaultsource/reports/mar17_entirereport.pdf.

To fully ameliorate the consequences of the current market failure, the minimum insurer payment should reflect the normal market rate that would be negotiated in the absence of the ability to surprise bill patients. One way to achieve that goal would be to set a minimum payment equal to the same multiple of Medicare payment rates that other specialists in the same geographic region receive in their contracts with insurers. Patients do choose these other specialists, so payment rates in these specialties are likely to more closely resemble normal market rates. For instance, if specialists other than emergency and ancillary physicians in a geographic area were paid, on average, 130 percent of the relevant Medicare rate, then the minimum insurer payment to emergency and ancillary physicians would be 130 percent of the Medicare rate for their services.

We note that setting the minimum payment too high misses an opportunity to reduce health care spending and, thereby, reduce patients' premiums and out-of-pocket costs. On the other hand, there is little risk in setting the payment standard too low. If the rate is set too low, facilities will ensure adequate staffing in these specialties by either demanding insurers pay in-network rates that exceed the payment standard or, alternatively, by directly supplementing these specialists' compensation and negotiating higher facility payment rates to fund this supplemental compensation.

Method for Calculating Median Contracted Rates Could Have Unintended Consequences

The discussion draft approaches rely on median contracted rate calculated separately for each plan in each geographic area. It appears to assume that those rates would be updated over time. This approach could create two unintended consequences.

First, this approach would create incentives for insurers to terminate contracts with physicians who they are currently paying more than the median and create incentives for physicians to terminate contracts with insurers who are currently paying them less than the median. These types of strategic contract terminations could cause the median contracted rate to evolve in unpredictable and unintended ways. Contract terminations could also be disruptive for patients and providers (although the bill's patient protections would mitigate many of the consequences for patients). These problematic incentives could be avoided by calculating the median contracted rate using data from a period before the legislation took effect and then trending that rate forward for future years. For example, an insurer could be directed to calculate the ratio of its median rate to the Medicare rate for each set of services in a prior year and apply that same ratio to the Medicare rate to compute the minimum payment in future years.

Second, using insurer-specific rates could lock in an unlevel playing field across insurers. Some insurers are paying high rates today, perhaps because they placed a particularly high value on limiting how often their enrollees were balance billed, while others are paying lower rates. Basing payment rates in this legislation on those issuer-specific rates could lock in these differences across insurers, potentially putting some insurers at a competitive disadvantage going forward. This problem could be addressed by establishing a common payment standard for all services delivered in a given geographic area or nationally. Suitable payment rates could be calculated by the Secretary using data from existing commercial claims databases; alternatively, insurance plans

meeting certain size criteria could be compelled to provide the Secretary with de-identified summary information on their payment rates.

Ambulances

Whichever option is chosen, strong consideration should be given to extending the law's protections to out-of-network ambulance services (both ground and air), beyond the transparency provisions included in the discussion draft. Ambulances, both ground and air, represent a significant source of surprise out-of-network bills.[8,9] Addressing air ambulances is particularly critical because states are unable to regulate their practices, and there is no way for a functioning market to develop on its own. Ground ambulances, at least, are often regulated by local governments. However, this is insufficient to fully address the problems in this market, and a federal solution would be appropriate. For these services, one of the billing regulation approaches is necessary because there is no in-network facility that patients are actively choosing, as in the case of elective health care procedures, so the network matching approach is not applicable.

Competition

We praise the Committee for including significant proposals to reduce health care spending by fostering greater competition. The Committee's proposals fall in two main categories. One involves increased transparency, enabling not only consumers, but also health plans and providers to make more accurate and more efficient comparisons on the basis of costs and quality. A second category is prohibitions on activities by providers that have market leverage designed to use that leverage to increase their advantage with competitors or achieve higher prices.

The draft bans "gag" clauses in contracts between providers and health plans that block consumers, plan sponsors or referring providers from seeing cost or quality data on providers. It would also ban clauses that prohibit plan sponsors from accessing de-identified claims data that could be shared with third parties for plan administration and quality improvement purposes. These are critical building blocks for a health care system that serves consumers better through transparency. Since gag clauses often are motivated by attempts to block competition, we recommended granting the Federal Trade Commission the authority to enforce this this ban.

Another provision in the draft focuses on prohibitions of contracting approaches that allow large providers or insurers to increase their leverage by interfering with competition. It would prohibit anti-steering and anti-tiering clauses in contracts between providers and health plans. Such clauses prevent health plans from directing or using incentives for enrollees to use providers that are competitors and allow providers that are important to include in networks to use that status to

[8] Garmon, Christopher, Benjamin Chartock. 2017. "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills." *Health Affairs*. Vol 36. No. 1. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970.
[9] U.S. Government Accountability Office (GAO). March 2019. "Air Ambulance: Available Data Show Privately-Insured Patients are at Financial Risk." Report to Congressional Committees. GAO 19-282. https://www.gao.gov/assets/700/697684.pdf.

further increase prices. Additionally, the bill would ban "most favored nation" contracts, where providers agree not to accept payment rates lower than those from the contracting health plan from other plans. Such contracts can entrench a dominant health plan's advantage over competing health plans and discourage entry into the market by other health plans. These three provisions address the core concerns of many economists who have written about fostering a more competitive health care system, and we commend the Committee for their inclusion.

We do note that these reforms are included within the Public Health Service Act. As a result, they are structured so that payers (insurers and group health plans) are prohibited from entering into contracts with providers that have certain anti-competitive features, but no separate prohibition is applied to providers. We believe an approach like this could effectively prevent much of the conduct that the legislation aims to address, but it does have two shortcomings.

First, because the obligation falls only on payers, it may not be successful in discouraging provider conduct in instances where there is ambiguity about the applicability of the statutory prohibition. Because providers face no penalties under the law and the federal government may be reluctant to pursue enforcement actions payers in instances where the provider was the party insisting on the anti-competitive contract provision, providers may retain some leverage to demand anti-competitive contractual provisions in these ambiguous cases. Second, the enforcement mechanisms of the Public Health Service Act may not provide the full range of remedies that policymakers want to make available. Therefore, to address both of these issues it may be appropriate to explore other enforcement frameworks outside of the Public Health Service Act.

Non-Profit Health Care Transparency Organization

We are enthusiastic about the proposal in the discussion draft to create a non-profit organization that would maintain a database of health care claims submitted by self-insured group health plans, Medicare, and insured health plans operating in participating states. Identifying strategies to reduce health care costs and improve health care quality often requires reliable, claims-level data on current health care price and utilization patterns. But existing data sources cover relatively narrow slices of the health care system, and many are proprietary and expensive to access. The Committee's proposal would offer researchers, policymakers, and others a much broader and more accessible window on the health care system than is currently available, thereby bolstering efforts to improve it.

The Committee's proposal would also bolster state all-payer claims databases (APCDs) by allowing APCDs to access data for self-insured group health plans via the non-profit entity. The proposal would thus address the problems state APCDs face under the Supreme Court's 2016 decision in *Gobeille v. Liberty Mutual Insurance Co.*, which barred states from requiring self-insured group health plans to report to APCDs. Notably, the Committee's approach to addressing the problems created by *Gobeille* has some advantages relative to approaches that would allow states to collect data directly from self-insured plans. The Committee's approach would ensure that comparable data are collected from self-insured plans in different parts of the country and, by

requiring reporting to only one repository, would likely impose lower administrative costs on the entities (typically insurers) that submit data on behalf of self-insured plans.

While the Committee's proposal would be an important step forward, there are two important ways in which the Committee could improve this proposal, each of which we discuss in turn.

Refine the De-Identification Requirements

The draft appropriately aims to ensure that the benefits of this database do not come at the cost of patients' privacy. To that end, the Committee directs that any data held by the non-profit be de-identified "in accordance with" 45 CFR 164.514(a), which implements the provisions of the Health Insurance Portability and Accountability Act (HIPAA). Unfortunately, precisely what would be permitted under these standards is somewhat unclear, and some interpretations of these rules could, likely contrary to the Committee's intent, make it impossible to conduct many analyses with significant potential to improve care. Alternative approaches could allow analyses like these to go forward while ensuring protections for patients' privacy.

In particular, some interpretations of the HIPAA de-identification standards could require the removal of data fields that are important for analytic purposes. For example, some interpretations could require the removal of: geographic identifiers below the 3-digit-zipcode level (which would, for example, prevent comparisons of urban and rural areas or patients from poorer and richer neighborhoods); the dates on which patients receive care (which prevents analyses where understanding the sequence in which care was delivered is important); and fine-grained information on patient age (which is, for example, important when studying neonatal and pediatric care). Some interpretations would also make it impossible to use the data to follow a patient over time, which is also often important.

The draft aims to mitigate these problems by specifying that the de-identification process should be conducted in way that retains "the ability to link data longitudinally for the purposes of research on cost and quality, and the ability to complete risk adjustment and geographic analysis." But this language does not address all of ways in which certain interpretations of the HIPAA standards could frustrate the Committee's goal of creating a database that can support a wide range of analyses with the potential to improve care.

One relatively straightforward solution to these problems would be to reference the HIPAA definition of a "limited data set" at 45 CFR 164.514(e), rather than the HIPAA definition of a "de-identified" data set. This approach would still require removal of all direct individual identifiers (e.g., names, social security numbers, and similar identifiers) from the database, but would preserve greater flexibility to retain other fields that are important for analytic purposes. This approach would not change the requirement that database users abide by strict privacy and security standards, so strong privacy protections would remain. Notably, the federal government allows researchers and others to access Medicare claims data under standards that are more permissive than this, without damaging patient privacy.

Another, likely less effective, approach would be to retain the reference to 45 CFR 164.514(a), but to expand the language in subsection (d)(1)(C)(i) that enumerates the types of analyses that the de-identified database must still be suitable for. Particularly important, that language could be expanded to include "the ability to analyze the sequence in which services are delivered" and "the ability to conduct research on how the cost and quality of care varies with patient age." The phrase "in accordance with" could also be changed to "using standards similar to those described at," to clarify that the HIPAA de-identification standards can and should be adapted to meet the legislation's objectives.

Ensure Data Access for Policymakers

To realize the database's full potential, it would be important for state and federal policymakers to be able to use these data (subject to privacy and security safeguards) to inform policy decisions, but the existing draft is unclear about the circumstances under which this would be possible. The draft explicitly specifies procedures by which the Congressional Budget Office, the Government Accountability Office, the Medicare Payment Advisory Commission, and the Medicaid and CHIP Payment Advisory Commission could access these data. For other policymakers, however, it merely says that these data "shall…be available to…policymakers…subject to subsection (e)," but subsection (e) does not specify procedures intended to apply to policymakers. This ambiguity could be addressed by simply adding policymakers to list of types of authorized users encompassed by paragraph (e)(2).

Thank you again for the opportunity to comment. Of course, if we can provide any additional information, we would be happy to do so.

Sincerely,

Loren Adler
Matthew Fiedler
Paul B. Ginsburg
Christen Linke Young