

Smarter Health Care Coalition

March 1, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor, and
Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor, and
Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The Smarter Health Care Coalition (Coalition) appreciates the opportunity to respond to your recent letter seeking specific recommendations to address rising health care costs in the United States and steps that Congress and the Trump Administration should take to address this important issue. In doing so, we urge you to consider policy solutions that increase access to high-value health care services and medications consistent with the principles of value-based insurance design (V-BID).

The Coalition represents a broad-based, diverse group of health care stakeholders, including consumer groups, health plans, life science companies, employers, provider organizations, and academic centers. The Coalition is squarely focused on achieving “smarter health care” by removing barriers to clinically-nuanced health care services and medications. Our goal is to better align health care spending with value, improve the patient experience, and lower health care costs by supporting innovative benefit design that encourages the use of high-value care, and discourages the use of low-value care.

Overall, we offer the following recommendations consistent with the principles of V-BID to address rising health care costs in the U.S.:

- 1) **Increase Access to High-Value Care for Chronically Ill Patients with Health Savings Account (HSA)-qualified high deductible health plans (HDHPs).** Ensure that chronically ill individuals in HSA-HDHPs are not prohibited from having pre-deductible access to critical services and drugs to help manage their chronic conditions.
- 2) **Extend the flexibilities available under the Medicare Advantage (MA) V-BID Demonstration permanently to MA plans.** Enact legislation encouraging the Centers for Medicare and Medicaid Services (CMS) to issue regulations extending recent flexibilities made available under the MA V-BID Demonstration (e.g., telehealth network requirements, rewards and

incentives flexibilities, etc.) more broadly to MA plans, including MA Part D plans (MA-PD), so that MA and MA-PD plans may offer clinically nuanced plan designs that benefit patients with chronic conditions.

- 3) **Address Wasteful Spending by Disincentivizing Low-Value Care.** Pursue efforts to reduce spending on unnecessary, duplicative, and/or potentially harmful health care services by incentivizing high-value care and disincentivizing low-value care.

INCREASE ACCESS TO HIGH-VALUE CARE FOR CHRONICALLY ILL PATIENTS WITH HSA-QUALIFIED HDHPS

The Coalition strongly urges the Administration to promulgate regulations or Congress to pass legislation to allow high deductible health plans (HDHPs) coupled with Health Savings Accounts (HSAs) to offer chronic care services and drugs to patients on a pre-deductible basis by expanding the current preventive care safe harbor (section 223(c)(2)(C) of the Internal Revenue Code).¹ Doing so could remove cost barriers for millions of chronically ill Americans to access critical health care services to help manage their illnesses.

Congress created HSAs in 2003 with the provision that these accounts would only be available to those enrolled in qualifying HDHPs. The tax advantages of HSAs and lower HDHP premiums have driven rapid uptake among employers. Studies show the percentage of employers offering HDHPs grew by 20 percent between 2005 and 2017, and the percentage of employees covered by HDHPs over the same period grew by 24 percent.² Additionally, the Kaiser Family Foundation's 2017 Employer Health Benefits Survey shows average annual deductibles increased 89 percent between 2010 and 2017.

Guided by the Internal Revenue Service (IRS) safe harbor under section 223(c)(2)(C) of the Internal Revenue Code, HSA-eligible HDHPs may provide coverage of some preventive services prior to satisfaction of the deductible, including, for example, mandatory coverage of US Preventive Services Task Force (USPSTF) recommended services and vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

HSA-HDHPs are currently prohibited from offering services and medications to manage an individual's chronic conditions on a pre-deductible basis, creating financial and access barriers to care for chronically ill patients such as those with diabetes, asthma, mental health disorders, and opioid addiction. While primary prevention (e.g., USPSTF services and immunizations) is important, the Centers for Disease Control and Prevention estimates 90 percent of the nation's \$3.3 trillion in annual health expenditures are for people with chronic and mental health conditions. Without appropriate management, these conditions can often lead to adverse effects on quality of life and can cause preventable, premature death.

¹ <https://www.irs.gov/pub/irs-drop/n-13-57.pdf>

² Kaiser Family Foundation, 2017 Employer Health Benefits Survey, September 2017, available at, <https://www.kff.org/report-section/ehbs-2017-section-8-high-deductible-health-plans-with-savings-option/>.

Employers and health plans offering HSA-HDHPs should be permitted the option and flexibility to make chronic disease preventive services and drugs available on a pre-deductible basis to chronically ill individuals. This will help increase access to necessary services, encourage adherence to treatment and/or medication care plans, and, in certain clinical circumstances, reduce total health care spending. The Coalition urges policymakers to modernize what qualifies as ‘preventive care’ under the statutory safe harbor to enhance access to these potentially life altering services and drugs.

Recommendation: The Coalition commissioned a legal analysis stating the Administration has the legal authority to define preventive care to include chronic disease prevention, and we urge you to encourage the Administration to utilize this authority and make it possible for employers and health plans to decrease out-of-pocket spending for millions of Americans with HSA HDHPs. If the Administration does not act, we strongly urge you to include the provisions of the *Chronic Disease Management Act of 2018* (H.R. 4978 / S. 2410) in any package that is considered by the Committee to address rising health care costs. This bipartisan, bicameral legislation allows HSA-HDHPs to cover health care services and medications that manage chronic conditions on a pre-deductible basis with greater employer and plan flexibility, consistent with the principles of V-BID. Doing so will benefit patients, employers, and payers alike, including improved health, enhanced workplace productivity, and the avoidance of unnecessary emergency care visits and hospitalizations and will ensure a more rational and sustainable health care system.

EXTEND THE FLEXIBILITIES AVAILABLE UNDER THE MA V-BID DEMONSTRATION PERMANENTLY TO MEDICARE ADVANTAGE PLANS

Last year, CMS increased the flexibility in MA uniformity requirements and supplemental benefits by allowing MA plans the ability to reduce cost-sharing amounts for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for MA enrollees that may meet specific medical criteria. Under this flexibility, MA plans have the ability to tailor the cost-sharing and benefits to their enrollees based on “objective and measurable” medical criteria. CMS further expanded these flexibilities this year, allowing MA plans to offer non-primarily health related benefits based on individual needs of their members. The Coalition strongly supports and commends the agency for these flexibilities that would allow MA plans to apply V-BID principles to the cost-sharing and other benefits offered to their enrollees. However, there are still limitations within MA that could be informed by the MA V-BID Demonstration. For example, the uniformity requirements afford flexibility only to Part C and not Part D. The Coalition strongly supports extending the uniformity flexibility to Part D. Additionally, the Center for Medicare and Medicaid Innovation (CMMI) introduced new flexibilities for telehealth network requirements, rewards and incentives maximums, tailoring care based on socioeconomic status, etc. under the MA V-BID Demonstration that are not available in traditional MA plans.

Recommendation: The Coalition encourages you to enact legislation encouraging CMS to issue regulations extending recent flexibilities made available under the MA V-BID Demonstration (e.g., telehealth network requirements, rewards and incentives flexibilities, etc.) more broadly to MA

plans, including MA-PDs. Broader adoption of V-BID Demonstration flexibilities in MA will help ensure that patients continue to have more accessible and affordable options for prescription drugs. Such legislation should ensure the current uniformity flexibility afforded to Medicare Part C also extends to Part D.

ADDRESS WASTEFUL SPENDING BY AVOIDING LOW-VALUE CARE

Studies estimate the U.S. spends hundreds of billions of dollars on low-value medical care, defined as services and drugs that provide little to no clinical benefit.³ Low-value care also exposes patients to harm, imposes high and unnecessary out-of-pocket costs, and can lead to lost productivity. In addition, low-value care crowds out the ability of our health care system to pay for the things that actually improve our health or maintain our well-being, such as chronic disease management or precision medicine.

For example, several physician organizations have concluded that there is a preponderance of evidence that many pre-operative tests are wasteful.⁴ Most patients undergoing low-risk surgery do not need laboratory tests such as complete blood counts, basic or comprehensive metabolic panels, or coagulation studies. Prior to non-cardiac surgery, low-risk patients also do not need baseline diagnostic cardiac testing, such as stress tests. Other professional societies advise against needless pulmonary function testing and routine chest x-rays – a source of unnecessary radiation – before surgery. Incidental findings from unnecessary pre-surgical testing can lead to downstream risks, avoidable costs, and unnecessary delay of evidence-based care. Often, these tests provide no information that will change the course of treatment or surgery. Extrapolating data from a study in Virginia, an estimated 19.2 million unneeded pre-surgery tests and imaging services were performed in 2014 across the country. These services accounted for about \$9.5 billion in avoidable spending.⁵

In addition to unnecessary pre-operative testing, the U.S. federal government continues to pay for unnecessary screenings that cost the taxpayers millions of dollars in upfront costs. For example, in 2014 the Medicare program paid upwards of \$79 million for prostate-specific antigen (PSA) screenings for men over 75.⁶ The USPSTF, designed to assess available evidence regarding the value of primary preventive services, ranks PSA screenings for men over 70 as a D-rated service.⁷ A “D-rated” services means that there is significant clinical evidence to suggest that the harms of the service significantly outweigh the benefits.⁸ The Medicare Payment Advisory Committee (MedPAC) released a list of 31 low-value care services covered by Medicare, which accounted for up to \$6.5 billion in estimated wasteful spending – between 34 and 72

³ <https://www.nap.edu/read/12750/chapter/5>

⁴ Choosing Wisely

⁵ <http://vbidhealth.com/low-value-care-top-five-services.php>

⁶ http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0

⁷ <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1>

⁸ <https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions#drec2>

percent of Medicare fee-for-service beneficiaries received at least one low-value service in 2014. Included in that list are PSA screenings and pre-operative testing, among others.

The dollar estimates represented above do not take into consideration the downstream, cascading effects of incidental findings as a result of unnecessary testing or the subsequent medical costs due to iatrogenic harm associated with low-value care. PSA screenings for example often lead to unnecessary, invasive biopsies or prostatectomies that come with their own host of risks and costs. The dollar estimates also do not include out-of-pocket costs, which can be very high and the result of care that was not needed in the first place.

Recommendation: The Secretary of Health and Human Services is already empowered to act to address low-value preventive services. The Affordable Care Act (ACA) included a provision that would allow the Secretary to not pay for USPSTF D-rated preventive services (Sec. 4105(a)).⁹ However, HHS has yet to act on this section of the ACA. Doing so would encourage evidence-based medicine, reducing harm to Medicare patients, and freeing federal dollars for medical care that is clinically proven and effective. Congress should urge the Secretary to utilize this existing authority. Additionally, Congress could commission a GAO study on low-value preventive care and the extent to which the Secretary could use existing authorities to stop paying for care that unequivocally does more harm than good, including a thorough study of the cost savings potential of expanding the scope of the Secretary's authority to address low-value care.

Mr. Chairman and Ranking Member Murray, thank you for your attention to the important matter of addressing rising health care costs in the United States. We encourage you to advance the recommendations above to ensure that we constrain health care costs while ensuring the best care for patients.

Sincerely,

Andrew MacPherson, Co-Director Ray Quintero, Co-Director Katy Spangler, Co-Director

⁹ <https://www.hhs.gov/sites/default/files/iv-prevention-of-chronic-disease.pdf>