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The Alliance to Make the Health Care
System Work for Everyone

Consumers First 2021 Legislative Agenda: Policy Solutions to Drive Value into the U.S. Health Care System in the 117th Congress

The 117th U.S. Congress presents an important opportunity to address inefficiencies, inequities, and market failures in the U.S. health care system that drive high-cost and low-quality care. Each of these underlying problems was compounded by the COVID-19 pandemic. *Consumers First*, an alliance that brings together diverse organizations representing the interests of families and children, working people, employers, and primary care providers to improve the fundamental economic incentives and design of our health care system, urges Congress to enact the following key policy reforms that will drive value into the U.S. health care system in 2021 and beyond.

5 Key Policy Reforms

1. **Drive** down costs for consumers, working people, and employers by addressing consolidated health care markets.
2. **Lower** prescription drug costs for our nation's families.
3. **Improve** price and quality transparency in the health care system.
4. **Establish** national data-sharing and interoperability standards to reduce waste and improve health care quality.
5. **Develop** and implement a national health workforce strategy.



THE PROBLEM

The COVID-19 Public Health Crisis Compounded the Existing U.S. Health Care Cost Crisis and Other Fundamental Failures within Our Health System

The COVID-19 pandemic sent shockwaves throughout the country, resulting in hundreds of thousands of deaths and millions of people falling ill. It further unveiled the harsh realities of existing disparities in health and health care in the United States, where Black, Latinx, and Indigenous communities experience significantly higher rates of infection and death.¹ Further, it triggered the worst economic crisis since the Great Depression, with millions of people losing their jobs and health insurance. All told, the pandemic created enormous new challenges for our health system and exacerbated long-standing problems that threaten the security of our health, the financial sustainability of certain sectors in the health care system, and the economic livelihood of our nation's families, workers, and employers.

Health care providers and health care organizations of all sizes worked to respond quickly, modifying facilities and operations and prioritizing the delivery of critical services to provide safe, effective care for people with COVID-19. Health care workers met the challenge of the pandemic even when adequate protective gear was not available to them. At the same time, many provider organizations — especially

those reliant on fee-for-service payment models — experienced dramatic and persistent revenue shortfalls as a result of the severe disruptions caused by the pandemic. These shortfalls threatened the collapse of entire sectors of our health care system.

Primary care practices experienced declines of up to 50% in service volume, putting nearly 30% of these practices at risk of going out of business,² thereby jeopardizing access to primary care at a time when families needed it more than ever. Pediatricians experienced precipitous drops in patients served since the start of the pandemic, resulting in vaccination declines of 22% in Medicaid patients under age 2 between March and April 2020.^{3,4} While Congress and the administration created programs to provide direct financial assistance to providers, many — especially those serving disadvantaged and rural communities — still experienced substantial harm from the pandemic. Yet at the same time, other sectors of our health care system, including many private insurers and some large hospital systems, pulled in windfall profits due to changes in utilization and financial support from the federal government.

This systemwide failure was not an unforeseeable problem. Long before the pandemic struck, the U.S. health care system was already in serious trouble. Prior to COVID-19, national expenditures on health care were rising at a staggering rate.

Yet for all that spending, the U.S. health care system produces the highest infant mortality and maternal mortality rates and the lowest life expectancy compared with other industrialized nations.

This systemwide failure was not an unforeseeable problem. Long before the pandemic struck, the U.S. health care system was already in serious trouble. Prior to COVID-19, national expenditures on health care were rising at a staggering rate. In 2015, for the first time, the federal government spent more on health care — \$936 billion — than on any other public benefit program, including Social Security.⁵ By 2019, U.S. national health care expenditures reached \$3.8 trillion.⁶ With costs growing at excessive rates, the U.S. now spends nearly twice the share of its total economy on health care as the average Organisation for Economic Co-operation and Development (OECD) country.⁷

Yet for all that spending, the U.S. health care system produces the highest infant mortality and maternal mortality rates and the lowest life expectancy compared with other industrialized nations.⁸ Additionally, 60% of the U.S. population has at least one chronic condition,⁹ which has been identified as a significant risk factor for complications for people infected with COVID-19. And there continue to be millions of people who live with the burden of poor health, who cannot access the right care at the right time, who receive low-quality care,¹⁰ and who disproportionately face systemic inequities, including communities of color, those with low incomes, those with disabilities, and people living in distressed neighborhoods.¹¹

Health care costs have been rising faster than workers' wages and inflation, making it more difficult for families to access and afford health care:

- » From 2019-2020, average family health insurance premiums increased 4%, but workers' wages only increased 3.4%, and inflation increased 2.1%.¹²
- » The total cost of an employer-sponsored health insurance plan for one family grew from \$5,791 in 1999¹³ to \$21,342 in 2020.¹⁴
- » Fully 44% of people in the U.S. report that they did not see a doctor when they needed to because of high health care costs, and one-third of people report that the cost of medical care interferes with their ability to secure basic needs like food and stable housing.¹⁵

THE SOLUTION

We simply cannot afford to continue at this rate. To address the U.S. health care cost and quality crisis, and to safeguard our health care system from any future public health crisis, Consumers First urges Congress to consider reforms in five key policy areas focused on driving value into health care payment and delivery.

1. Drive Down Costs for Consumers, Working People, and Employers by Addressing Consolidated Health Care Markets

High and increasing health care prices are making health care unaffordable for America's families, workers, and employers. Too often, health care prices and costs vary significantly between providers and are unrelated to the quality of care or health outcomes to the detriment of health care consumers.¹⁶ A recent example from the current public health emergency unveiled that list prices for COVID-19 diagnostic tests — the price charged to uninsured individuals and employer plans for out-of-network treatment — ranged from \$20 to \$850 per test at major hospitals across the U.S.¹⁷ Further, it is well established that hospital prices range from 150% to more than 400% of Medicare rates.¹⁸ These high and variable health care prices are the result of growing consolidation across and within health care markets among hospitals, insurers, and other health care organizations that battle for relative market power and control over health care markets to set prices, limit provider networks, or prevent health care data from being shared.¹⁹ Consolidation undermines the ability of competitive health care markets to function and is a primary source of the profound market failure that is driving our nation's health care cost crisis. Addressing the impact of consolidation on health care prices is a fundamental step to control health care costs, improve the value of health care,

and bring down health care costs for our nation's families, working people, and employers.

Congress should:

- » Prohibit gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers, and that prevent plan sponsors from accessing de-identified claims data that could be shared, under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes. *Prohibiting gag clauses has strong bipartisan support as passed by the Senate Health, Education, Labor and Pensions (HELP) Committee in 2019 in Section 301 of S. 1895.*
- » Mandate site-neutral payments requiring Medicare and Medicaid to pay the same rates across hospital outpatient departments (on and off campus), ambulatory surgery centers, freestanding and nonfreestanding emergency departments, and off-campus physician offices while protecting access to care in underserved rural and urban communities.
- » Prohibit anti-competitive terms in provider and insurer contracts that limit access to higher-quality, lower-cost care. *Banning*

*anti-competitive contracting has strong bipartisan support as passed by the Senate, Health, Education, Labor and Pensions (HELP) Committee in 2019 in Section 302 of S. 1895**

2. Lower Prescription Drug Costs for Our Nation's Families

In 2015, the United States spent \$457 billion on prescription drugs, which accounted for nearly 17% of overall personal health care services.²⁰ The benefits of pharmaceutical drug therapies are substantial, but these benefits often come with significant financial costs to patients and to payers. High and rising prices of prescription drugs impact consumers' access to the medicines they need and their ability to afford other health services and basic necessities.²¹ Fundamental to reducing the escalating cost of prescription drugs is implementing reforms that will lower list prices, increase transparency, and promote competition. Prescription drug reforms must directly target these prices, which drive high costs throughout the drug supply chain and health care system, preventing access to needed medication for families.

Congress should:

- » Restructure the Medicare Part D benefit to significantly lower the out-of-pocket maximum that beneficiaries will pay, and reduce federal reinsurance payments for catastrophic coverage. *Restructuring the Medicare Part D benefit has strong bipartisan support as passed by the House of Representatives in Section*

301 of H.R. 3 and as introduced in the Senate in Section 121 of S. 2543, both in 2019.

- » Limit price increases for Part D drugs and for single-source drugs in Medicare Part B to the Consumer Price Index for All Urban Consumers (CPI-U). Manufacturers that raise prices on single-source Part B drugs and brand-name Part D drugs above the rate of inflation must be required to rebate the difference to Medicare. *Establishing a Consumer Price Index for All Urban Consumers (CPI-U) to prevent price increases above the rate of inflation has strong bipartisan support as passed by the House of Representatives in Sections 201 and 1860D-14B of H.R. 3 and as introduced in the Senate in Section 209 of S. 2543, both in 2019.*
 - » If an inflation rebate mechanism is enacted, such as described above, protections should be included to prohibit drug companies from cost-shifting to employment-based group health and individual insurance plans.
- » Require drug manufacturers to report to the secretary of the Department of Health and Human Services (HHS) information and supporting documentation to justify price increases for drugs and biological products. Require the secretary to publicly post those price justifications. *Requiring drug manufacturers to report justification for price increases as well as requiring the secretary to publicly post said*

* Provisions from Section 302 of S.1895 include: preventing "anti-tiering" and "anti-steering" clauses in contracts between providers and health plans that restrict the plan from directing or incentivizing patients to use specific providers and facilities with higher-quality and lower prices, preventing "all-or-nothing" clauses in contracts between providers and health plans that require health insurance plans to contract with all providers in a particular system or none of them, preventing "most-favored-nation" clauses in contracts between providers and health plans that protect an insurance company's dominant position in a market by requiring insurance companies be given the most favorable pricing of any health plan in the market; and prohibiting obligations on plan sponsors to agree to contract terms that the sponsor is not party to and cannot review, which could conceal anti-competitive contracting terms.

justifications have strong bipartisan support as passed by the House of Representatives in Sections 1150C and 1150D of H.R. 3 and as introduced in the Senate in Section 1128L in S. 2543, both in 2019.

3. Improve Price and Quality Transparency in the Health Care System

The lack of national, real-time information on health care data — including utilization and payment — has been a major hindrance to our pandemic response, including our ability to understand and effectively care for people of color and others most impacted by the pandemic. Moreover, it poses a significant barrier to the successful integration of high-value care into the broader health care system. Establishing a national transparency organization is an essential infrastructure need to improve the quality of care provided throughout the U.S. health care system. The collection and availability of comprehensive health data would allow consumers, policymakers, and experts to have access to health care information, including cost data, to inform consumer decisions and allow for more robust understanding of the quality and value of health care services in order to reduce health care costs and improve the quality of care. Such data should be collected and made available in a manner that protects confidentiality and privacy, as is the standard of practice in other industries.

Congress should:

- » Establish a national all-payer claims database to lower Americans' health care costs. Require both public and private payers to report health care utilization and claims data to the national APCD according to federally established standards across the following categories: medical and clinical, prescription

drug, dental, behavioral health, available social services data, as well as prices charged for health care services related to COVID-19. Data would be required to be collected and reported across all data categories stratified by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age, and disability status. The collection and reporting of stratified data by these categories is an essential first step in being able to build payment incentives to reduce health disparities and improve health outcomes for historically underserved people and communities. *Establishing a national all-payer claims database has strong bipartisan support as passed by the Senate Health, Education, Labor and Pensions (HELP) Committee in 2019 in Section 303 of S. 1895.*

- » Require the disclosure of negotiated rates between payers and each specific provider. Ensure that any pricing information is paired with quality information to achieve meaningful transparency of cost and quality for consumers, researchers, and purchasers. Require the secretary of HHS to do the following:
 - » Pilot full public price transparency for all services in several health care markets and conduct longitudinal studies on the impact of the policy on negotiated prices.
 - » Make hospital- and plan-specific negotiated prices for all services available to plan sponsors and researchers in the large-group market.
 - » Provide negotiated prices for all services to individuals, plan sponsors, and researchers in the small-group and individuals markets.

- › Provide information to the public on negotiated prices, within reasonable limits (e.g., providing statistical information including the range and distribution of privately negotiated rates between providers and health plans).
- » Require the secretary of HHS to establish harmonized reporting of performance measures by health care providers across all payers, including a core set of disparity reduction measures. The secretary would lead a multistakeholder process to build consensus and then publish the harmonized set of measures by 2022.

4. Establish National Data-Sharing and Interoperability Standards to Reduce Waste and Improve Health Care Quality

National data-sharing and interoperability standards are essential for reducing waste and inefficiencies in the health care system by enabling the real-time coordination of health care services across health care providers and organizations, which will drive needed improvements in the quality and value of health care services. A national transparency system that enables health care data to flow and be interoperable would support health workers to effectively test, trace, and quarantine those exposed to infectious disease. It would specifically enable

health care providers on the front lines of the COVID-19 response to provide better coordinated, more effective care to their patients.

Congress should:

- » Building on the Interoperability and Patient Access final rule[†] enacted in 2020, require all payers, health care providers, and public health agencies to participate in mandatory exchange of accurate, real-time data across the following categories: medical and clinical, prescription drug, dental, behavioral health, and available social services data. Provide funding to states to support participation by public health agencies.
- » Building on the 21st Century Cures Act final rule enacted in 2020,[‡] mandate the expansion of interoperability standards to support the exchange of data between health care providers, health systems, payers, public health agencies, and social service agencies across the following categories of data: medical and clinical, prescription drug, dental, behavioral health, and available social services data. Ensure that those systems have the ability to effectively allow the information to be used in real time to provide high-quality, coordinated health care to consumers. Provide funding to states to support public agencies in implementing this expansion.

[†] On March 9, 2020, the Centers for Medicare & Medicaid Services finalized the Interoperability and Patient Access final rule (85 FR 22979), which requires payer-to-payer exchange of certain patient clinical data at the patient's request and requires hospitals, including psychiatric hospitals, and critical access hospitals to send electronic patient event notifications of a patient's admission, discharge, and transfer to other health care providers or facilities.

[‡] On March 9, 2020, the Office of the National Coordinator finalized the 21st Century Cures Act final rule, which implements new health information technology interoperability standards to enhance patients' access to their electronic health records information. The rule also prevents data blocking by imposing civil monetary penalties of up to \$1 million per violation.

5. Develop and Implement a National Health Workforce Strategy

Ensuring an adequate workforce is critical to achieving a high-value health care system that meets the needs of the people it serves, including ensuring access to health care services. However, the current supply, makeup, and distribution of the U.S. health workforce is not adequate to meet the needs of our nation’s families, children, and seniors.²² Primary care, behavioral health, and oral health represent the areas with the most significant shortages nationwide.^{23,24} In addition, the COVID-19 emergency has led to disproportionate rates of deaths and infection in Black and Latinx communities, reinforcing the underlying disparities in the U.S. health care system that drive worse health outcomes for Black, Indigenous, and other people of color. Building an adequate health workforce that can meet the needs of all communities is a critical strategy to improve health equity and reduce disparities. Many researchers predict significant shortages of physicians and other health care workers that will grow over time,^{25,26,27} and the need to address the distribution of physicians and other providers by specialty, care setting, and care location to ensure the right providers are in communities where they are most needed.^{28,29} The United States needs a national health workforce strategy and lead entity that is responsible for driving improvements to the nation’s health workforce to ensure it is equipped with the tools and resources needed to provide high-quality, affordable health care to the American people.

Congress should:

- » Restructure the graduate medical education (GME) system to focus specifically on training the primary care workforce and underrepresented physician and nonphysician clinician specialties,[§] as well as allied health professionals,[¶] to include community-based workforce training, to emphasize workforce training for underserved geographic areas, and to ensure safety net hospitals can train critical specialties to meet the needs of underserved populations.
- » Establish and fund a National Health Workforce Committee that:
 - › Makes recommendations to Congress about key policy changes needed to operationalize a national health workforce that meets the needs of our nation’s families in the 21st century and beyond. The committee would make recommendations to Congress based on analyzing trends in the national health workforce, including appropriate supply to meet national demand; making assessments of current and future health workforce needs; and ensuring we build a culturally and linguistically diverse workforce that is centered on health equity.
 - › Collaborates with the secretary of HHS to publish, implement, and update, on an annual basis, a systematic workforce development plan that includes education, training, and

[§] Nonphysician clinicians include registered nurses, nurse practitioners, nurse-midwives, and physician assistants.

[¶] Allied health professions are defined as those health professions that are distinct from medicine and nursing. Allied health professionals include non-nurse, nonphysician health care providers, including audiologists, speech language pathologists, physical therapists, occupational therapists, diagnostic medical personnel, imaging specialists, nutritionists, emergency medical personnel, dental hygienists, mental health counselors, and family therapists. See “What Is Allied Health?” The Association of Schools Advancing Health Professions, accessed November 24, 2020 <https://www.asahp.org/what-is>.

payment for primary care providers, physician and nonphysician clinicians, behavioral health providers including those with lived experience, allied health professionals, oral health providers, public health workers and community providers, including sustainable financing to support public health and community health workers. In addition, the workforce development plan should ensure we build a culturally and linguistically diverse workforce that is centered on health equity. The committee should also study and make recommendations about health workforce needs for value-based care models, including alternative payment models and workforce needs regarding virtual care and telehealth.

- » Reauthorize and expand the Teaching Health Center Graduate Medical Education (THCGME) program in a targeted way to address the physician shortage facing communities across the country, as designed in the [Training the Next Generation of Primary Care Doctors Act \(H.R. 2815, S. 1191 in 2019\)](#). In addition, pass legislation that expands the use of GME funding to nonphysician providers and new physician specialties, such as palliative care.

By enacting these policy recommendations, the 117th Congress has the opportunity to realign the economic incentives and design of health care payment and delivery to ensure the system delivers the health and high-value care that all people across the nation need and deserve. *Consumers First* stands ready to work with policymakers to achieve that goal.

Endnotes

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CONSUMERS FIRST

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