AMERICAN BENEFITS COUNCIL

March 1, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The American Benefits Council ("the Council") appreciates your request for specific recommendations to help address America's rising health care costs. The Council is a public policy organization whose members include over 220 of the world's largest corporations, as ranked by Fortune and Forbes. Collectively, the Council's members either sponsor directly or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

In one prominent election night poll, when voters were asked if they had to prioritize which of the following health care reforms is most important at this time, 55 percent of respondents chose "reducing health care costs," 23 percent chose "covering more people," and 23 percent chose "covering more of the health services people need."[1] In other words, voters identified health care costs as the most urgent health care reform issue policymakers should address.

According to recently reported National Health Expenditures data, Americans spent an estimated $3.6 trillion on health care in 2018, and health costs are expected to comprise 19.4 percent of the country's gross domestic product in 2027.[2] The 2018 Medicare Trustees Report predicted the Medicare trust fund will be depleted in 2026 –

[1] http://www.fightthe40.com/AlliancetoFightThe40/assets/File/Alliance/LUNTZPOLLrelease11072018.pdf

[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05499

seven years from now.[3] The 2017 Medicare Trustees Report had predicted the fund would be depleted in 2029; meaning the trust fund lost three years of viability in just one year. This is an unsustainable path that will ultimately lead to serious economic consequences.

The American people want lower health care costs and the dismal federal budget numbers demonstrate something must be done to constrain health care costs, both for America's businesses, which provide coverage to over 181 million Americans, as well as for federal health care programs. Nearly all stakeholders in the health care system understand this daunting challenge and we applaud your committee for taking on the task of researching and hopefully advancing proposals to decrease the cost of health care in our country.

Through a series of hearings begun last Congress, you have sought a better understanding of the drivers of health care costs and turned to various stakeholders to seek solutions. We commend you for looking to private-sector innovations to improve affordability. Employers are at the forefront of initiatives to lower health care costs and improve quality through various value-based strategies. This is the message of *Leading the Way: Employer Innovations in Health Coverage,*[4] a report from the Council and Mercer showing how employer providers of health coverage are succeeding at lowering costs and improving quality through innovation. It is also a vital component of *American Benefits Legacy: The Unique Value of Employer Sponsorship,*[5] a recent report by the Council that details the important contribution employer-sponsored benefits make to the health and financial security of American workers, their families and the economy.

Below, the Council offers insight on the root causes of rising health coverage costs and some practical and realistic solutions for addressing the problems at their core. The Council is pleased to share the priorities, opportunities and challenges identified by employers in reaching our shared goal of reducing health care costs.

DEFINING THE PROBLEM

According to U.S. Census data, employers provide health coverage to more than 181 million Americans.[6] According to the Kaiser Family Foundation Employer Health Benefits Survey, average annual premiums for employer-sponsored health insurance in

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2018.pdf

[4] https://www.americanbenefitscouncil.org/pub/16e9bbe3-9b27-d7aa-ec7c-e9f86419c786

[5] https://www.americanbenefitscouncil.org/legacy

[6] https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

2018 were $6,896 for single coverage and $19,616 for family coverage,[7] a five percent increase over 2017. An informal survey of Council members demonstrates two primary reasons health care costs continue to increase for large employer plan sponsors.

The first reason is increases in the cost per unit of service, a result of increases in the prices of specific services and shifts toward the use of higher-priced services.

The testimony of Niall Brennan, president and CEO of the Health Care Cost Institute, before your committee last summer summarized the problem well. "Utilization is not driving spending growth … working Americans are using the same or lower quantities of health care but are paying more for it every year," Brennan said. His testimony went on to call out hospital spending specifically, which comprises the greatest percentage of health care spending. "Despite a cumulative 12.9 percent reduction in hospital admissions per 1,000 people, hospital spending rose by 8.3 percent [between 2012 and 2016] – meaning that price increases and service intensity played an important role in increasing hospital spending during a period of declining hospital utilization."[8] Based on reviews of their plan data, Council members are reaching the same conclusion, which bears repeating: **health care utilization is not driving spending growth, *price* is driving spending growth**. Specifically, one large national employer and Council member found:

- 57 percent of modifiable* health care trend is due to price (unit cost) escalation.
- 43 percent of modifiable* health care trend is due to health risks, the growth in illness/disease and the severity of those conditions.

* Modifiable trend removes the drivers such as family size growth from the equation as employers expect people to have growing families.

This data highlights **the second key reason costs continue to rise: a small minority of the population drives a large share of health care spending**.

According to the Agency for Healthcare Research and Quality, in 2014, the top one percent of persons ranked by their health care expenditures accounted for 22.8 percent of total health care expenditures, while the top five percent of the population accounted for 50.4 percent of total expenditures.[9] According to the Centers for Disease Control and Prevention (CDC), 90 percent of the nation's $3.3 trillion in annual health care expenditures in 2016 were for people with chronic physical and mental health conditions.[10]

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[7] https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/

[8] https://www.help.senate.gov/imo/media/doc/Brennan1.pdf

[9] https://meps.ahrq.gov/data_files/publications/st497/stat497.pdf

[10] https://www.cdc.gov/chronicdisease/about/costs/index.htm#ref1

America's employers have pioneered strategies that directly address these top cost drivers in the U.S. health care system. Many of these experiments have met with resounding success and — if scaled and encouraged — have the potential to fundamentally improve health care for all Americans. Even so, **over the years, policymakers have erected barriers limiting the actions employers can take to control costs, improve quality and manage their populations.** Employers' innovative efforts have been hamstrung by an underlying health care system – dominated by the Medicare program – that continues to misalign incentives and reward providers that pursue high *volumes* of services rather than high *value.*

Fundamental market failures also challenge employers. Congress and the executive branch have begun to chip away at this decades-old roadblock by incentivizing alternative payment models, but more work remains to be done. Below are detailed recommendations about ways to make it easier for employers to continue providing affordable, quality coverage to over half the country and drive innovation that improves the health care system as a whole.

RECOMMENDED POLICY SOLUTIONS

Increasing Access to Data

Most employers that have had success decreasing the rate of health care spending have started by taking deep dives into their data. They do this to better understand how much they are spending for various services delivered in different settings and, ultimately, to steer their enrollees to higher-value providers operating in higher-value settings. Thus increased access to data will enable natural and healthy market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes. Specific recommendations include:

1. **As a way to increase plan sponsor access to plan claims data, policymakers should consider requiring third party administrators (TPAs) and other service providers to disclose to self-funded employers full and complete data, including, for example: financial fields, such as allowed amount; unencrypted provider information; and service codes.** This disclosure requirement should be crafted such that it does not increase liability for plan sponsors.

2. **Policymakers should incentivize disclosing greater *upfront* information to consumers from providers about the service to be received and the pricing.** Issuance to the consumer of a *good-faith* notice based on the proposed services would provide the consumer better knowledge of whether their providers (all providers in the continuum of care) are in-network and whether a balance bill will occur, as well as their estimated financial obligation.

3. **Regulators should consider using existing authority to increase transparency.** In 2014, the U.S. Department of Labor (DOL) ERISA Advisory Council recommended applying ERISA Section 408(b)(2) to health and welfare plans. Under this potential approach, service providers to an ERISA plan, including pharmacy benefit managers (PBMs), would disclose to employers at time of contracting the fees and compensation (both direct and indirect) the service provider would earn as a result of providing services to the plan. This would help ensure the service providers only receive reasonable compensation for the goods and services provided to the ERISA plan. If the DOL pursues this regulatory approach, this disclosure requirement should be crafted such that it does not increase liability for plan sponsors.

4. **Encourage DOL to revise its frequently asked question (FAQ) guidance regarding Schedule C reporting ("back-end disclosure") of PBM compensation to require a PBM's "discount and rebate revenue" to be reported as indirect compensation.** In 2010, DOL issued FAQs regarding Schedule C Reporting of PBM Compensation. FAQ 26 confirms that compensation received by a PBM *directly* from an ERISA plan is reportable on Schedule C as "direct compensation." However, FAQ 27 provides that "discount and rebate revenue" paid to PBMs by drug manufacturers need not be reported on a plan's Schedule C as indirect compensation pending further guidance. Requiring at least Schedule C reporting by PBMs to plan sponsors of this "discount and rebate revenue" would provide more complete information to plan sponsors to ensure that PBMs receive no more than reasonable compensation for services rendered to the plan. This disclosure requirement should be crafted such that it does not trigger additional liability for plan sponsors.

5. **Increase access to the Centers for Medicare and Medicaid Services (CMS) data, by allowing CMS Qualified Entities access to Medicare Advantage data and Medicaid data.** The CMS Qualified Entity (QE) Program enables certain organizations to receive Medicare claims data under Parts A, B, and D for use in evaluating provider performance. Organizations approved as QEs are required to use the Medicare data to produce and publicly disseminate CMS-approved reports on provider performance. These public reports can be used by employers and service providers to inform network design and track trends in health care spending. Expanding the data available will make these reports even more useful.

6. **CMS (or another entity) should publish hospital "charge master data," which lists the prices hospitals charge for thousands of services, alongside the amount Medicare reimburses for each service and publicly report egregious outliers.** This would increase transparency and create incentives for hospitals that charge many times what Medicare pays for services to reduce their rates.

7. **Policymakers should consider facilitating a national all-payer claims database (APCD)**. We strongly recommend that policymakers prevent the administrative burden associated with conflicting state requirements that arise from any mandates for reporting to 50 state APCDs.[11] Congress could consider the creation of a single nationwide repository using existing authority or providing federal funding for a pilot program for a non-governmental (or quasi-governmental) entity or entities to serve as a national all-payer claims database.

Identifying and Using Uniform Quality Measures

Meaningful and uniform quality measures are a foundation of value-based purchasing decisions. As more large employers implement innovative payment reforms, like direct contracting or accountable care organizations, a uniform set of standardized quality measures is critical. Specifically, a uniform measure set -- at a minimum uniform across all Medicare payment programs and demonstrations – would help lay a strong foundation to achieving more meaningful payment reforms. **Policymakers should support and promote the work of the Core Quality Measures Collaborative.**[12]

Taking the "Surprise" Out of "Surprise" Billing and Addressing Out-of-Network Providers

Policymakers are hard at work identifying solutions to the problem of "surprise" medical bills sent to patients from out-of-network (OON) providers. **Any legislation should adequately address the problem of surprise billing without raising premiums for consumers or undermining the value of health plan networks.** To protect consumers and families, policymakers should prohibit balance billing patients for emergency services provided by an OON provider or for non-emergency treatment by an OON provider at an in-network facility.

Health plan networks promote better quality and lower cost for consumers. Federal legislation to address surprise billing should not incentivize providers to reject network participation by offering them reimbursement rates higher than in-network rates or higher than existing applicable Affordable Care Act (ACA) requirements. Shifting the burden of balance billing from the patient to the plan or employer will result in higher

[11] In *Gobeille v. Liberty Mutual Insurance Company*, the U.S. Supreme Court struck down a Vermont law as applied to ERISA plans that required plans to file informational reports (including claims data) to the state's all-payer claims database, finding that the state law interfered with uniform plan administration and thus was preempted by ERISA.

[12] https://www.qualityforum.org/cqmc/

premiums and increased costs for all consumers. As we wrote in a comprehensive February 22 letter[13] to a bipartisan group of six senators focused on this issue, a federal solution to "surprise" billing should serve to lower, not increase, premiums and costs and improve quality of care for consumers.

Lessening Incentives for Provider Consolidation via Site-Neutral Payment Reform

Congress should be vigilant of the impact that provider consolidation has on health care prices and encourage policies that foster competition, which benefits consumers and plan sponsors. **One way to decrease incentives that are leading to increased consolidation is for Medicare to expand implementation of site-neutral payment reform.** In support of this effort, the Council is a member of the Alliance for Site Neutral Payment Reform,[14] which is advocating for this goal.

The need for site neutral payment reforms is evident. Payment policies supporting higher reimbursement in the hospital outpatient department (HOPD) setting have resulted in increased costs to patients, employers and taxpayers. Patients and the Medicare program pay more when the same services are delivered in the HOPD instead of independent physician practices for a wide variety of services such as chemotherapy: $281 vs. $136,[15] cardiac imaging: $2,078 vs. $655 and colonoscopy: $1,383 vs. $625.[16] The increased cost to both patients and Medicare is substantial. Over a three-year period, Medicare paid an additional $2.7 billion on services and patients spent $411 million more in out-of-pocket costs when services were delivered in a hospital-owned setting.[17]

Congress recognized the negative consequences these unsubstantiated payment disparities have on patients, taxpayers and businesses by directing CMS to institute site-neutral payments for newly acquired and newly built off-campus provider-based HOPDs. However, these reforms represent only a small step in the right direction. The majority of existing provider-based off-campus facilities and those that were mid-build were "grandfathered" and able to continue billing Medicare at the much higher rate for the same services. These exempted facilities still have a strong incentive to purchase physician practices and move them into existing HOPDs.

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[13] https://www.americanbenefitscouncil.org/pub/?id=e871c8dc-de6a-7740-f4ad-29fdad23f074

[14] http://www.siteneutral.org/

[15] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018 (CMS-1676-P)

[16] Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services, The National Institute for Health Care Reform (NIHCR): Published online June 2014

[17] Avalere, PAI: Implications of Hospital Employment of Physicians on Medicare & Beneficiaries, November 2017.

The issue of site-neutral payment reforms has long had bipartisan support from policymakers, health care economists, regulators and MedPAC. **In terms of savings, a recent projection from the Congressional Budget Office suggests site-neutral payments for outpatient services have the potential to save $13.9 billion over 10 years.**

Modernizing Health Savings Account Rules and Regulations

For over a decade, the Council has been advocating for changes to the Health Savings Account (HSA) rules to give plan sponsors more flexibility. Using the benefit design to waive out-of-pocket cost is an effective incentive to encourage consumers to use high-quality, cost-effective providers. HSAs have been used to help make health coverage more affordable, encourage a wiser consumption of health services and allow pre-tax spending on a wide range of qualified medical expenses. However, outdated laws and regulations make it difficult for employers to include innovative reforms in HSA-eligible HDHPs. Congress and the executive branch should implement several policies to update HSAs to better align this increasingly popular plan design with innovative, value-driven delivery system reforms. Some recommendations include:

1. **Update the definition of prevention to help Americans with chronic conditions**. Current law allows qualified HDHPs to offer certain preventive services on a pre-deductible basis. Internal Revenue Service guidance narrowly defines "prevention" to include only primary prevention, and while this is important, primary prevention is a small component of total health care spending. By contrast, the CDC estimates about 90 percent of our health care spending goes toward care for patients suffering from chronic physical and mental health conditions.[18]

   If IRS were to update its guidance to allow chronic disease prevention to be covered on a pre-deductible basis, it would give employers and health plans the ability to prevent more effectively the progression of chronic disease, leading to overall decreased health care spending and a better quality of life for employees. For example, some employers ensure enrollees with diabetes have access to insulin, test strips, annual eye exams and hemoglobin A1c testing without imposing cost-sharing. These designs increase patient compliance which improves quality of life and productivity while also decreasing long-term health care spending. Unfortunately, IRS guidance prohibits employees enrolled in HSA-eligible HDHPs from receiving these high-value services on a pre-deductible basis. IRS should update its guidance to allow chronic disease prevention to be offered on a pre-deductible basis. And if it does not, Congress should pass legislation to allow this policy.

[18] https://www.cdc.gov/chronicdisease/about/costs/index.htm#ref1

2. **Encourage employees to use Centers of Excellence programs.** Many employers offer or plan to offer Centers of Excellence (COE) programs that incentivize employees to receive care from providers that attain high marks for the quality of care delivered and with whom employers are able to negotiate reasonable rates that keep costs in check. In many instances, employers will waive copays or deductibles entirely if the employee receives care from the COE. Unfortunately, waiving the deductible if the employee is enrolled in an HSA-eligible HDHP would disqualify any contributions made to the HSA, making the employee liable for taxes and fees on any contributions made. This imposes a barrier to these popular and valuable programs, and therefore it should be eliminated by Congress or the executive branch.

3. **Make it easier for employers to offer on-site and near-site health clinics.** Currently, employees enrolled in HSA-eligible HDHPs who receive medical care at on-site or near-site medical clinics must pay for services received at the on-site clinic if they have not met their deductible. This creates an unnecessary barrier to care and subjects employers to unnecessary red tape by forcing them to calculate fair market value and collect cost-sharing. **Employers should be allowed to provide care at on-site and near-site medical clinics at low or no cost to employees and dependents enrolled in HSA-eligible HDHPs.**

4. **Remove barriers to telemedicine and second-opinion services.** Employers increasingly offer telemedicine and second-opinion services to their employees as one more avenue for increasing access and quality. Second-opinion services are a helpful tool for ensuring employees have the right diagnosis and the best treatment plan based on their personalized medical information. Currently, for employees enrolled in HSA-eligible HDHPs, these services cannot be offered outside the group health plan or they could disqualify the employee from making HSA contributions. If the services are offered as part of the group health plan, employers must charge employees to access the service if the employee has not met his or her deductible. Many employers would prefer to offer these services without imposing cost sharing as a way to encourage this high-value venue for receiving care and ensuring a correct diagnosis and treatment plan. This barrier should be removed by Congress or the executive branch.

5. **Ensuring Medicare and Tricare enrollees are able to contribute to HSAs.** Congress should permit employees age 65 and over to contribute to an HSA. Currently, active employees are only allowed to contribute to an HSA if they are not enrolled in Medicare. Employees should be allowed to continue to contribute to their HSAs until they retire, even though they are automatically enrolled in Medicare Part A at age 65. Similarly, U.S. Armed Forces military personnel, military retirees, and their dependents participating in Tricare should be able to contribute to an HSA.

These are a handful of policy suggestions pertaining to Health Savings Accounts. A full list can be found in the Council's *Magnifying a 2020 Vision: A Closer Look at Selected Approaches to Strengthen Employer-Sponsored Benefits.*[19]

Addressing Low-Value, Harmful Care

The Council is a member of the Smarter Health Care Coalition,[20] which shares the concern raised by witnesses before your committee that 30 percent of health care spending in the U.S. could be considered unnecessary. Low-value medical care, defined as services and drugs that provide little to no clinical benefit,[21] 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, prior to non-cardiac surgery, low-risk patients 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.[22]

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.[23] The US Preventive Services Task Force (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.[24] A "D-rated" service means that there is significant clinical

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[19] https://www.americanbenefitscouncil.org/pub/?id=0aa9316e-fe6c-021c-8bcf-9ea59a717811

[20] http://www.smarterhc.org/

[21] https://www.nap.edu/read/12750/chapter/5

[22] http://vbidhealth.com/low-value-care-top-five-services.php

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

[24] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1

evidence to suggest that the harms of the service significantly outweigh the benefits.[25] **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. Included in that list are PSA screenings and pre-operative testing, among others.**

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 HHS Secretary to not cover USPSTF D-rated preventive services (Sec. 4105(a)).[26] However, HHS has yet to act on this authority. Doing so would encourage evidence-based medicine, and reduce harm to Medicare patients, freeing federal dollars for medical care that is clinically proven and effective. Given such an authority exists, **Congress should encourage HHS to use existing authorities to stop paying for care that unequivocally does more harm than good. Congress should consider expanding the scope of the HHS Secretary's authority to address other unnecessary and potentially harmful low-value care.**

Protecting the Favorable Tax-Treatment of Employer-Sponsored Health Benefits

When Americans obtain their health care coverage through an employer, the cost of that coverage is "excluded" from an employee's taxable income. This favorable tax treatment has given rise to America's enormously successful employer-sponsored health system, in which employers typically pay, on average, 70 percent of the cost of coverage.

According to *The American Benefits Legacy: the Unique Value of Employer Sponsorship*,[27] when the total amount employers paid for group health insurance in 2016 ($691.3 billion) is compared to the value of the tax expenditure that same year ($155.3 billion), we can calculate that employees received $4.45 worth of benefits for every dollar of forgone tax revenue – a more than four-to-one "return on investment."

Employer-provided health insurance is popular, high-quality coverage that leads to better health outcomes and more satisfied and productive employees. It also is currently one of the most effective means of mitigating the impact of high health costs on working Americans and their families. Taxing these benefits would undermine the core of Americans' health coverage system, which is why **the Council recommends fully and immediately repealing the 40 percent "Cadillac Tax" on employer-provided**

[25] https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions#drec2

[26] https://www.hhs.gov/sites/default/files/iv-prevention-of-chronic-disease.pdf

[27] https://www.americanbenefitscouncil.org/legacy

health coverage. The Council also urges you to reject proposals to tax employee benefits.

CONCLUSION

Employers are on the front lines of implementing innovative strategies to improve health care quality and decrease costs, and they have a vested interest in securing the health and well-being of their workers. America's businesses recognize that helping employees thrive has a measurable impact on virtually every aspect of their business. When commitment to employees is coupled with their drive for innovation, employers are the key to lowering health care costs and increasing quality for working families and the health care system as whole. Even so, over the years, policymakers often have erected barriers limiting the success employers can achieve to control costs and improve quality. Reducing health care costs entails removing these barriers, restoring a competitive marketplace and realigning incentives to promote high-value care.

The Council represents a broad array of employers from numerous industries who provide their employees with group health coverage. In that role, the Council notes that the overarching goal of your effort to lower health care costs is to reduce expenses for all purchasers of health services, including private-sector employers, patients, or public payers like the federal government. Therefore, efforts to reduce costs in public programs should not – intentionally or inadvertently – come at the expense of the more than 181 million Americans who receive coverage though employer-sponsored group health plans.

The Council commends you for taking on the task of addressing America's rising health care costs. Thank you for the opportunity to inform your work. We look forward to continuing our dialogue with the committee as you blaze a bold path to tackle these challenges and create a more efficient and effective health care marketplace. Please do not hesitate to reach out with any specific questions.

Sincerely,

Ilyse Schuman
Senior Vice President, Health Policy