



AMERICAN BENEFITS COUNCIL

June 5, 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

RE: Lower Health Care Cost Act

Dear Chairman Alexander and Ranking Member Murray,

The American Benefits Council (“the Council”) appreciates the opportunity to provide comments in connection with the Lower Health Care Cost Act discussion draft (the “Draft Act”) released by the Committee on Health, Education, Labor and Pensions (“the committee”) on May 23, 2019.

The Council is a Washington D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial well-being of their workers, retirees and families. Council members include over 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

The Council applauds the efforts of the committee to lower health care costs for American workers and their families. The committee’s Draft Act represents an important step in combatting these rising costs. We understand the complexity of this challenge, and support the committee’s approach to addressing the root causes of rising health care costs.

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,¹ 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*,² 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.

Employers cover more than 181 million Americans – over half of all Americans -- and on average, employers pay 82 percent of the cost of coverage. In fact, when we compared the total amount employers paid for group health insurance in 2016 (\$691.3 billion) to the value of the tax expenditure that same year (\$155.3 billion), we found that employees received \$4.45 worth of benefits for every \$1 of forgone tax revenue. In other words, for every \$1 of tax expenditure employers spent \$4.45 to finance health benefits. This more than 4:1 return on investment is a tremendous bargain for U.S. taxpayers.

Unfortunately, rising health care costs, as well as the threat of the looming 40% “Cadillac Tax” on health plans, have forced many employers to increase their deductibles and other cost sharing as part of a strategy to implement a glide path to avoid triggering the tax in the future. Thus, fully repealing the “Cadillac Tax” is one of the most effective means of bringing relief to working families struggling with the high cost of health care.

Employers play a critical role in the health care system, leveraging purchasing power, market efficiencies and plan design innovations to provide comprehensive health coverage at a fraction of the cost compared to federal programs. The Council shared with the committee in its March 1, 2019, letter the lessons learned from innovative employers striving to decrease health care costs and improve quality. To help shape your effort, the Council identified opportunities and challenges identified by employers in reaching these goals and offered solutions for addressing the problem of rising health care costs at its core. Among these challenges to employer innovation are misaligned incentives that reward providers that pursue high *volumes* of services rather than high *value*, a lack of transparency, market consolidation and fundamental market failures that stifle competition and patient choice. We offered 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.

We are pleased to see that a number of the recommendations aimed at improving price transparency across the health care delivery system, facilitating the use of

¹ <https://www.americanbenefitscouncil.org/pub/16e9bbe3-9b27-d7aa-ec7c-e9f86419c786>

²

<https://www.americanbenefitscouncil.org/pub/?id=b949f447%2Df1ca%2D4dd0%2D817a%2Da7e96d8e3bfc>

value-based insurance designs and addressing surprise billing are reflected in the Draft Act. In addition to the comments below, we invite the committee to review our May 1, 2019, letter,³ as well as the Council's proposed changes to the Draft Act as set forth on the attached "redline" of the Draft Act.⁴

'SURPRISE' MEDICAL BILLING

The Council supports protecting patients from surprise medical billing, but urges the committee to *reject* independent dispute resolution (Option No. 2) as the means of resolving surprise billing.

Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. We view the effort to protect patients from surprise balance bills within the broader context of the effort to lower health care costs. As such, we urge you to develop legislation addressing surprise balance billing that protects these patients without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employer providers of health coverage. The committee seeks feedback on three different options for resolving surprise medical bills: (1) in-network guarantee, (2) arbitration or (3) a benchmark for payment based on median contracted rate. Providing feedback on this critical point requires examining the drivers of surprise medical billing: a lack of meaningful patient choice in choosing certain providers and the resulting market distortion.

A lack of meaningful patient choice between providers who participate in a plan's network and those who do not is the key component of surprise balance billing. In the case of emergency services provided at out-of-network facilities and air ambulance services, the patient simply needs the most expeditious stabilizing care. Even when patients seek care at an in-network hospital from in-network providers, patients generally lack a role in choosing ancillary (but necessary) physicians like an anesthesiologist, radiologist, or pathologist. On the day of surgery, is the patient really going to question the network status of the anesthesiologist?

A study published in JAMA comparing physician charge-to-Medicare payment ratios across specialties, sheds light on the drivers of surprise billing. "Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status."⁵ For example,

³ <https://www.americanbenefitscouncil.org/pub/?id=432EE9DE-D448-3701-9BC9-2AECC50B16F5>

⁴ <https://www.americanbenefitscouncil.org/pub/C2F258F7-1866-DAAC-99FB-F8BE9F4285D0>

⁵ <https://jamanetwork.com/journals/jama/fullarticle/2598253>

anesthesiologists were changing rates more than five times as high as the Medicare rate. The ability of such specialties to set billing rates in this environment serves as a powerful incentive to remain out of network, which, in turn, generates surprise balance bills.

A recent report by the USC-Brookings Schaeffer Initiative for Health Policy drew a similar conclusion about why surprise out-of-network bills happen, stating that:

For most physicians in most geographic areas, it is not possible to maintain a practice without entering some insurer networks because few patients are willing to bear the higher costs associated with seeing an out-of-network physician. However, for some types of physicians, that basic dynamic does not apply. For ED physicians, patient volume is driven by patients' choice of hospital and is unlikely to be affected by whether the physician is in-network or not; hospitalists and neonatologists face a similar dynamic.⁶

The related costs and burdens on American families can lead to financial distress, adverse credit results, loss of retirement savings, and in some cases, personal bankruptcy. Clearly, this constitutes a market failure that limits the benefit of networks in controlling costs for patients and plans and necessitates legislative intervention.

Health plan networks play a critical role in employer efforts to lower the cost and improve the quality of health care for employees and their families – they are the best tool employers have to drive better health care value. One Council member company with 130,000 covered lives estimates that without networks, premiums would increase by approximately \$8,000 – a 45% increase. Legislation addressing surprise balance billing must protect patients without undermining access to high-quality, high-value networks and raising costs for consumers.

To this end, the Council supports the use of the benchmark payment methodology included in Option No. 3 of the Draft Act. Option No. 3 is the most likely to ensure the intended results of the committee without imposing significant administrative and transactional costs on all stakeholders, payers and providers alike. The market-based benchmark approach seeks to address the underlying root of the problem. Prohibiting balance billing and establishing a benchmark payment rate based on the median contracted rate for the service in the geographic area would remove the incentive for certain providers of emergency services and those practicing at in-network facilities to remain out of network. In so doing, the legislation would both protect patients from surprise bills and be non-inflationary for all consumers.

⁶ https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

With respect to Option No. 3, however, the Council recommends the committee consider the use of a Medicare-based reference price to establish the benchmark rather than the use of the median contracted rate. The use of a Medicare rate as the benchmark will guarantee clarity for both plans and providers, and could go further in reducing health care costs more quickly.

The Council is also supportive of Option No. 1, with certain modifications. In general, the concept of an in-network guarantee is consistent with the goal of eliminating surprise balance billing in non-emergency situations. When a plan contracts with a facility, it stands to reason that ancillary but essential services performed at the facility would be included in the network. However, as a practical matter, Council members are concerned that the use of the in-network guarantee could materially disrupt the ability of plans and issuers to negotiate with potential network providers, as some out-of-network professional providers could choose to be “holdouts” or otherwise refuse to enter into network agreements unless paid above-market or otherwise usurious amounts – thus making facility contracting impossible, and potentially resulting in the facility leaving the network. One possible way to address this issue would be for the Draft Act to be amended to include a provision that would deem certain facilities as an in-network provider (*e.g.*, such as those with a specified share of the payer’s claims for similar services).

Additionally, regardless of the approach taken, our members believe that the federal agencies should have sufficient authority to provide ongoing guidance and regulations to prevent facilities and providers from seeking to circumvent the rule. For example, federal agencies should have the flexibility to address situations where an out-of-network professional provider agrees with the in-network facility to refer the patient to an out-of-network facility, eliminating application of the rule. Similarly, the implementing rules should be drafted to address efforts to game the median contracted rate, for instance by using a geographic location other than the site of care should be prohibited.

The Council strongly opposes Option No. 2 as set forth in the Draft Act. Option No. 2 would impose an independent dispute resolution (IDR) requirement in certain surprise balance billing situations. The Council believes that the use of a mandatory IDR process would continue to impose on plans and issuers – as well as providers – significant administrative inefficiencies, unnecessary costs, and unpredictable outcomes. For large companies with nationwide operations, a binding arbitration model would be administratively complex, costly and time-consuming. “Baseball-style” arbitration would create incentives for providers to remain out-of-network and increase rates in an effort to increase the final reimbursement they receive.

As the committee strives to bring greater transparency to health care costs, arbitration is a step in the wrong direction. However artfully the legislation is crafted, arbitration brings unpredictability and the individual bias of the arbitrator into the

equation. Congress needs to fix the problem of surprise medical billing at its root and in a uniform manner, not add more cost, risk and opaqueness to it.

Additionally, the IDR provision as currently drafted applies to all claims in excess of \$750. The Council has material concerns that this threshold is far too low given the cost of arbitration and recommends that the threshold amount be increased materially.

As currently drafted, the Draft Act's amendments to Title XXVII of the Public Health Service Act (PHSA) clearly apply to insured group and individual health insurance coverage. Due to the role of ERISA in regulating self-funded group health plans, it is unclear whether these proposals directly apply to self-funded group health plans. As a result, the Draft Act should also include an amendment to Section 715 of ERISA specifying that all of Part A of Title XXVII of the PHSA apply to self-funded group health plans, not just those that were adopted as part of the Affordable Care Act, as currently referenced in Section 715(a) of ERISA.

Further to this point, in order to avoid significant discrepancies between self-funded and insured payments, the Council recommends that the Draft Act be amended to clarify that under the PHSA a state standard that is more protective may continue to apply, and that the federal rule would apply to insured group health plans in states where no rule had been adopted or where the state's rule is not as protective as the federal rule. Of course, self-funded group health plans, consistent with ERISA's long-standing preemptive effect, should remain exempt from application of state laws governing surprise balance billing in all events.

The Council also notes that the regulation of surprise balance billing, transparency, and non-competitive contract terms is focused largely on group health plans and health insurance issuers through Title XXVII of the PHSA. However, at least in one instance, the Draft Act specifically regulates provider billing practices directly through proposed Section 399v-7 of the PHSA. The committee should consider using a similar statutory construction to limit (1) the amount that out-of-network providers can bill group health plans and health insurance issuers under this authority and (2) the types of contract terms to which providers can agree.

Finally, the Council strongly requests that the committee include emergency air and ground ambulance services within the ambit of the surprise balance billing protections and payment requirements of the Draft Act. These services, particularly in rural areas, are critical to addressing emergent situations, and patients should not be faced with the choice between enormous out-of-pocket costs and seeking life-saving care.

PRICE AND QUALITY TRANSPARENCY

The Council supports increased price transparency and access to data for employer plan sponsors.

A key piece of solving the health care cost and quality puzzle remains a lack of price and quality transparency. As such, the Council's long-term strategic plan published in 2014, *A 2020 Vision: Flexibility and the Future of Employee Benefits*, included this recommendation:

Support greater quality and price transparency in the health care system. Meaningful information on price and quality is often hard to capture and adjusting for the clinical complexity of individual cases is difficult. Despite these challenges, greater transparency of quality and price information is important and urgently needed. Employees should have quality and cost calculators and other tools that provide enrollees with specific data about the quality and total out-of-pocket costs of certain services. Public policy should not impede employers' access to information needed to design and operate their plans and to help employees use these tools.

Health care consumerism aims to put economic purchasing power and decision-making in the hands of plan participants, thereby enabling patients to become wholly involved in their health care decisions. Health care cost transparency is a critical element in consumer-based designs, because consumers cannot make cost-conscious decisions without being able to shop intelligently for procedures and providers.

Additionally, employers are increasingly offering tools to deliver price and quality information about specific health care providers or services to employees. Employees often access tools online, telephonically or via mobile applications. For many organizations, the first step in trying to determine the approach to address their population's health issues is to analyze their data. One Council member has used its data analysis service to:

- Examine the efficacy of high-deductible health plans (quantified cost- avoidance over the past three years).
- Develop scorecards by location for high use of emergency care versus urgent care, low use of generics and communication of preventive benefits.
- Study outcomes of employees who have had biometric screenings that revealed high blood pressure.

Unfortunately, success stories in this regard are the exception rather than the rule as many transparency tools do not enable patients to view specific quality information at the provider level and prices tend to be estimates. Additionally, many employers currently lack meaningful access to their plan data to allow them to make plan design changes intended to increase quality and patient outcomes while at the same time

reducing cost inefficiencies. And, even where such data is available, anti-competitive contract terms at the network provider level often stand as obstacles to employer flexibility in implementing these value-based plan designs.

Increased access to pricing data will enable market forces to work more effectively and efficiently, ultimately leading to better cost and quality outcomes. For example, many employers that have had success decreasing the rate of health care spending have done so by analyzing their plan data to better understand how much is being spent on specific health care services. This is particularly the case with health care services delivered in various clinical settings for which the plan can encourage enrollees to select higher-value providers operating in higher-value settings. Programs that are focused on value-based benefit design and value-based payment reform have the potential to transform our system by realigning incentives that keep participants healthier – while at the same time lowering costs. Increased price transparency and plan sponsor access to pricing data will help facilitate the development and expansion of such programs.

To this end, the Council supports the elimination of gag clauses in provider network agreements found in Section 301 of the Draft Act. These provisions will help facilitate plan design decisions and networking decisions as employers engage in efforts to provide high quality care as efficiently as possible. Plan sponsors increasingly face difficulties and variable costs in accessing claims data regarding their own plans through numerous techniques developed by third party administrators and providers. These blocking techniques are anti-competitive and tie the hands of employers who are trying to offer the highest-value benefits to their employees. Ensuring employers have access to their own plan data is an important priority of the Council. Employers want to ensure they can also use their data to inform creation of the most efficient and effective benefit designs that steer patients to the highest-value providers operating in the highest-value settings.

The Council also supports the efforts by the committee to address anti-competitive contract terms that disrupt market dynamics and raise the cost of health care services across the system. The Council believes that the contract provisions addressed in Section 302 of the Draft Act will, in the aggregate, increase competition and promote lower cost health care delivery. That said, because the requirements apply to the group health plan there are concerns that plan sponsors will face undue liability as a result of their fiduciary duties under ERISA unless they examine the minutiae of all provider contracting arrangements. The Council suggests that the committee consider including language in the Draft Act that will create a safe harbor for fiduciary liability and any applicable market reform penalties if the plan sponsor receives representations from service providers that they have met the requirements of the proposed provisions.

The Council is also aware of large hospital systems that attempt to leverage their significant market share in forcing plans and issuers to contract with all affiliated facilities. These types of contract provisions create unnecessary inefficiency and limit

plan sponsor's flexibility in plan design. The Council supports the Draft Act's provisions that address these issues by limiting the use of contract terms requiring contracting with all affiliated facilities.

The Council generally believes that access to claims and related data will assist all stakeholders in making more informed utilization and plan design decisions. Accordingly, the Council is generally supportive of the establishment of an all-payer claims database at the federal level. A properly crafted database that minimizes the burden on self-funded group health plans could be a helpful tool in employer efforts to drive lower- cost, higher-quality health care. We are concerned, however, that the Draft Act would create a self-funded group health plan-*only* payer claims database, since it would not impose like reporting requirements on the other significant payers in our health care delivery system. Thus, any resulting database would be inherently asymmetric and incomplete in its information, reducing its value for stakeholders and plans. Given the associated burdens with undertaking the necessary reporting, to the extent that the Draft Act retains this concept, it is important that the reporting obligations be applied more broadly to all relevant payers in the system.

With respect to the Draft Act's payer claims database provision, the Council notes that the provision appears largely redundant to the current requirements imposed on group health plans and health insurance issuers through Section 2715A of the PHSA and, by incorporation, Section 715 of ERISA. While the agencies have not fully implemented Section 2715A of the PHSA, the Council recommends that the construct proposed by the committee in the Draft Act replace the current requirements of, PHSA Section 2715A. This would ensure the most comprehensive set of reporting data and eliminate the potential that group health plans and health insurance issuers are subject to duplicative and administratively burdensome reporting requirements.

ACCESS TO HEALTH DATA

The Council supports health information exchange initiatives.

The Council supports changes to law that will facilitate the sharing of pricing and other information with health plan participants. The Council and its members believe that group health plans (and their administrators or insurers) should be required to provide data that can easily be utilized to render this information useful for participants. To this end, the Council believes that Section 501 is an important step in that direction. This is consistent with the approach recently taken by the Centers for Medicare and Medicaid Services in requiring health information exchange for Medicare Advantage Plans. The Council recommends that the committee consider changes to the Draft Act that would ensure the implementation and maintenance of open APIs (application programming interfaces) that allows third party applications to retrieve data, with the approval of the participant, to access the data, as opposed to any

requirement that the group health plan or health insurance issuer provide an application to participants.

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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 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,

A handwritten signature in black ink that reads "Ilyse Schuman". The signature is written in a cursive, flowing style.

Ilyse Schuman
Senior Vice President, Health Policy