AMERICAN BENEFITS COUNCIL

June 25, 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 Costs Act

Dear Chairman Alexander and Ranking Member Murray,

The American Benefits Council ("the Council") is writing to express our support for the Lower Health Care Costs Act (S. 1895). We urge the Committee on Health, Education, Labor and Pensions ("the committee") to approve this vitally important measure to lower health care costs for American workers and their families.

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.

Employers play a critical role in the health care system, covering more than 181 million Americans – over half of all Americans -- and on average, paying 82 percent of the cost of coverage. 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

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

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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.

In its March 1, 2019, letter to the committee, the Council shared the lessons learned from innovative employers striving to decrease health care costs and improve quality and offered solutions for addressing the problem of rising health care costs. Among the 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 policy recommendations to help employers continue providing affordable, quality coverage to over half the country and drive innovation that improves the health care system as a whole.

We commend the committee for incorporating several of the Council's recommendations in the Lower Health Care Costs Act. Notably, we are pleased that the legislation includes provisions aimed at improving price transparency across the health care delivery system, facilitating the use of value-based insurance designs and addressing surprise billing. A product of the committee's careful examination of health care costs, the legislation represents a significant step forward in fixing the problem of rising health care costs at its core. In so doing, the legislation can truly deliver on the promise of its title and help employers bring affordable, high value health care to America's working families.

'SURPRISE' MEDICAL BILLING

Employers are deeply concerned about the burden that unexpected medical bills from out-of-network providers place on employees and their families. We seek to protect patients from surprise bills without undermining access to high-quality, high-value networks or increasing health care costs for individuals and employer providers of health coverage. Indeed, 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 members of the committee to support Title I of the Lower Health Care Costs Act, and also seek a few modifications to further control cost and decrease premiums.**

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. As

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

noted in our letter dated June 5, 2019, 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."[3] For example, 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. Clearly, this constitutes a market failure that limits the benefit of networks in controlling costs for patients and plans and necessitates legislative intervention.

To this end, prohibiting balance billing and establishing a benchmark payment rate based on the median in-network 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.

However, to go further in reducing health care costs more quickly, the Council strongly recommends that the benchmark be set *at the lower of* the median in-network rate or 125% of the Medicare rate**.** Establishing the benchmark rate on basis of the median-in network rate alone could enshrine the inflated in-network rates that these specialists are able to garner by virtue of the fact that patients lack a meaningful role in their selection. A recent survey found that the in-network rates for anesthesiologists, for example, averaged nearly 350% of Medicare rates in 2018, far above the average contracted rate for all physicians of 128% of Medicare.[4]

The Council strongly opposes the use of independent dispute resolution (IDR) in surprise balance billing situations. The Council believes that the use of an IDR process would impose on plans and issuers – as well as providers – significant administrative inefficiencies, unnecessary costs and unpredictable outcomes. For large companies with nationwide operations, arbitration would be administratively complex, costly and time-consuming. 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.

Finally, the Council strongly supports the inclusion of emergency air and ground ambulance services within the ambit of the surprise balance billing protections and payment requirements. These services, particularly in rural areas, are critical to addressing emergency situations and patients should not be faced with the choice

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[3] https://jamanetwork.com/journals/jama/fullarticle/2598253

4 https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/

between enormous out-of-pocket costs and seeking life-saving care. We commend you for also ending surprise air ambulance bills in the legislation and recommend you add ground ambulance bills as well.

PRICE AND QUALITY TRANSPARENCY

The Council supports increased price transparency and access to data for employer plan sponsors. We applaud you for identifying the lack of price and quality transparency as a key piece of solving the health care cost and quality puzzle. 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. However, 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.

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.

ANTICOMPETITIVE CONTRACTING

To this end, the Council supports the elimination of gag clauses and anticompetitive terms in provider network agreements found in Sections 301 and 302 of the Lower Health Care Costs 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 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 and avoids redundant reporting requirements could be a helpful tool in employer efforts to drive lower- cost, higher-quality health care. On the contrary, a requirement that self-funded group health plans report data to 50 different state databases, even if in a purportedly uniform format, would impose a significant and undue burden.

FACILITATING THE USE OF VALUE-BASED DESIGNS

The Council also applauds the committee for addressing 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 Lower Health Care Costs Act will, in the aggregate, increase competition and promote lower cost health care delivery. Anti-competitive contract terms at the network provider level often stand as obstacles to employer flexibility in implementing value-based plan designs that reduce cost and increase quality. The Council is 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 and "anti-steering," "anti-tiering" and "most-favored-nation" contract provisions create unnecessary inefficiency and limit plan sponsor's flexibility in plan design. The Council supports the

provisions in the legislation that address these issues by restrict the use of such contract terms.

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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.

By helping to remove these barriers, restore a competitive marketplace and realign incentives, the Lower Health Care Costs Act is an important step forward in reducing health care costs in the U.S. We urge the committee to advance this legislation and for the full Senate to consider it. We look forward to continuing to work 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