PARTNERSHIP FOR
EMPLOYER-SPONSORED COVERAGE

STATEMENT FOR
U.S. SENATE HEALTH, EDUCATION, LABOR, & PENSIONS COMMITTEE
MARK-UP OF:
S. 1895, LOWER HEALTH CARE COSTS ACT
JUNE 26, 2019

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability. Employers have been on the leading edge of health delivery innovation and modeling for decades.

The Partnership for Employer-Sponsored Coverage applauds HELP Committee Chairman Alexander and Ranking Member Murray for their bipartisan efforts to address surprise medical billing and air ambulance service costs. As the Committee considers S. 1895, the Lower Health Care Costs Act, we would like to reiterate our support for protecting patients from surprise billing and enacting a minimum payment standard to resolve out-of-network claims disputes instead of an arbitration system and addressing the high cost of air ambulance services. Attached are our full comments on the draft legislation submitted to the Committee early this month.

June 5, 2019

The Honorable Lamar Alexander Chairman U.S. Senate HELP Committee 428 Dirksen Senate Office Building Washington, D.C. 20510	The Honorable Patty Murray Ranking Member U.S. Senate HELP Committee 428 Dirksen Senate Office Building Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

As members of the Partnership for Employer-Sponsored Coverage, we applaud you for your bipartisan work in developing the *Lower Health Care Costs Act of 2019* to address several cost-driver issues within our nation's health care system. We welcome the opportunity to provide you with feedback as you work toward formal introduction and Committee action on this legislation.

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. The employer-sponsored coverage system provides health coverage for over 181 million hardworking Americans and their families every day. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability.

As you know, benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. With self-insured coverage under the Employee Retirement Income Security Act (ERISA), employers tailor coverage to meet their workforce's specific needs across state lines, pay all health claims and bear the financial risk, and utilize a third-party administrator (insurance carrier) for daily plan management. Through the fully insured state-regulated insurance market, employers purchase a prescribed benefit insurance product sold in a state from an insurance carrier and do not bear the full financial risk of claims.

As you work to formally introduce the *Lower Health Care Costs Act of 2019*, we would like to provide you with the following comments for your consideration. The Partnership for Employer-Sponsored Coverage has been working alongside other stakeholders in the employer and plan coverage community on these important issues and our comments below reflect shared policy opinions.

Title 1: Ending Surprise Medical Bills

Protecting Patients from Surprise Medical Bills

First and foremost, we strongly agree that patients should be protected when put in a situation in which they lack a choice of providers. We support the draft proposal to prohibit balance billing for all emergency services. We also support prohibiting balance billing from providers that patients cannot reasonable choose in situations in which there was scheduled care with an in-network provider, but associated care was charged at an out-of-network rate.

Increasing Transparency for Consumers

If you are sick and need care, navigating the health care system can be especially mindboggling, frustrating and emotionally draining. We support requiring providers to give patients receiving scheduled care written and oral notice at the time of scheduling about the provider's network status and any potential charges for out-of-network care. Transparency of this information is critical to ensuring patients are better consumers of their health care and protected from surprise medical bills. While transparency is useful to an extent, it should not be a license to charge whatever the provider demands for payment, however capricious. For the consumer who agrees to use an in-network hospital, they expect that those involved in their care are part of the hospital network.

Benchmark for Payment

We believe the best option for resolving surprise medical bills is through a benchmark payment system. While we do believe that the draft legislation's proposal of a market-based median contracted rate for the geographic area in which the service was delivered is a step in the right direction, we are in support of establishing a federal cap for emergency services at an out-of-network facility at 125 percent of the Medicare rate for the service.

In-Network Guarantee

We support the proposition that all providers in an in-network facility must accept the in-network rate. This will greatly reduce potential consumer confusion as well as the incidence of surprise billing.

Independent Dispute Resolution

We oppose the utilization of an arbitration system to settle payment disputes. An arbitration system would be an administrative nightmare to self-insured employers who would have to directly contest claims in court as they are the plan sponsor. For smaller and mid-size employers who self-insure, the legal costs of arbitration could potentially be devastating. Additionally,

arbitration offers no incentive to providers to agree payment resolution outside arbitration they can try to win a higher judgement through arbitration.

Air Ambulance Billing

We agree with the draft proposal of requiring bills for air ambulance trips to delineate charges between travel expenses and medical services. Further, we are very concerned about the non-participatory status of many air and ground ambulance services. It is unfathomable to think that the travel to a hospital in an air or ground ambulance could impoverish a patient.

We believe legislation should prohibit the balance billing of patients for these emergency services and encourage in-network participation by air and ground ambulance providers. We also support applying provider price transparency requirements to air and ground ambulance companies. While we understand there are issues governing air ambulance services under the Federal Aviation Administration (FAA) that complicate the committees of health care jurisdiction from implementing robust policy, we call upon Congress to resolve these issues so patients are no longer subject to exorbitant charges.

Title III: Improving Transparency in Health Care

Removing Gag Clauses on Price and Quality Information

We agree that removing contractual gag clauses in the commercial market will be beneficial to increasing transparency. Current contractual limitations that are placed by third party administrators hinder an employer's ability to assess quality, utilization and cost of services. We also encourage you to recognize recent efforts by employers to collaborate together in organizations specifically striving toward lowering overall systematic costs and bending the cost curve for both plan sponsors and patients.

Banning Anti-Competitive Terms

For talent retention and recruitment reasons, employers are committed to providing robust provider networks that address all of their employees' health care needs. Employers have been at the forefront of developing and implementing high value provider networks at the lowest possible cost, including telehealth, on-site and near-site health centers, utilizing centers of excellence, direct contracting, provider transparency initiatives and wellness programs. Legislation should be crafted in a way that ensures these employer innovations and other value-based network initiatives are not hindered.

Designation of a Non-Governmental, Non-Profit Transparency Organization

As you know, current all-payer claims databases in individual states collect data from fully insured products regulated by the state and not from self-insured ERISA plans governed under

federal law. While there is understanding that transparency of claims costs and utilization of services through the establishment of all-payer claims databases can help with overall system reforms and plan designs, the administrative details of these databases could have potentially devastating effects on multi-state self-insured employers. We oppose any effort to preempt ERISA and require self-insured employers to adhere to individual-by-individual state claims databases.

We appreciate that the draft proposal includes a designated seat on the advisory committee for an employer and recognizes the importance of providing employers with the ability to utilize the database to lower health care cost. As you further develop this proposal of a federal all-payer claims database we recommend: 1) the system be established in the least administratively burdensome way, including having a single point-of-entry for uploading information; 2) the system be used for health promotion and cost-control activities and not for the litigation of plan benefits; and 3) the system not be just another costly federally-mandated reporting exercise for employers. We strongly encourage Congress to consider the utility of a database to employers and understand the tipping point of when the costs of compliance out way the benefits of such a system.

Improving Accuracy of Provider Directory Information

As you know, employer plan sponsors are already required to provide enrollees with benefits guides and materials and devote a lot of time and resources to produce this information in ways that are innovative and interactive such as through web portals and clickable .pdfs. The process of updating network directories involves many entities: the employer plan sponsor, third-party administrators and the providers themselves. Legislation should recognize that this process for employers is often costly and burdensome, and employers are at the mercy of third-party administrators and providers for precuring network information. Providers must also play a key role in keeping these directories current. As you continue to identify ways to improve transparency in the system, please call upon employers to provide you with real-world examples about the process of updating network directors and providing employees with communications.

Timely Bills for Patients

While we are broadly supportive of timely billing practices, we caution against implementing a prescriptive federal law that could lead to unintended consequences for patients and employer plan sponsors. We agree with the draft proposal that patients should be given a list of services received upon discharge. However, providing patients will a final bill within 30 business days of medical service may not be a realistic goal. The medical billing process goes through several steps, including through third-party administrators. Should a patient receive a bill that does not reflect final charges and co-pays, there could be confusion and possible cost sharing over payment by the patient.

Title V: Improving the Exchange of Health Information

Requirement to Provide Health Claims, Network and Cost Information

We support increased transparency of information to enable patients to be better consumers of their health care. As you know, there are numerous federal requirements placed on employer plan sponsors to provide their employees with information about their coverage and cost sharing, including the Summary of Benefits and Coverage. Provider price transparency and easy to understand information about co-payments and deductibles help enrollees better understand their benefits coverage. We urge caution when considering legislative proposals to over prescribe burdensome reporting requirements on employer plan sponsors when the information being required to report might not be beneficial to an enrollee.

Conclusion:

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage has the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a great stake in the development and implementation of health care policies, and we look forward to working with you and your colleagues in a bipartisan manner throughout 116th Congress.

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