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June 25, 2019

VIA ELECTRONIC MAIL

Lamar Alexander, Chairman
Patty Murray, Ranking Member
Senate Committee on Health, Education, Labor, and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Re: **Lower Health Care Costs Act of 2019**

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the Pacific Business Group on Health (PBGH) and other large, self-insured purchasers, I would like to express my appreciation to the Senate Health, Education, Labor, and Pensions (HELP) Committee for the opportunity to present testimony at the Committee's hearing on June 18. The Lower Health Care Costs Act of 2019 is potentially a significant step forward in national health policy, and I commend the Committee for taking on the difficult issue of health care costs. In particular, I would like to thank each of you for your leadership on these issues.

I applaud the changes that the Committee has made to the bill since the hearing, and I would like to offer the following comments on the current version of the bill:

TITLE I -- ENDING SURPRISE MEDICAL BILLS

- Sec. 105: Ending Surprise Air Ambulance Bills. We **strongly support the addition of air ambulances** to this section. We are concerned, however, that the revised bill does not address ground ambulances, and we recommend that ground ambulances be added to this section.
- Sec. 103: Surprise Billing – Benchmark for Payment. We are encouraged that the Committee leadership has indicated support for the use of a benchmark payment price. As I stated in my testimony, large employers nearly always seek market-based solutions to the problem of high health care costs, but we believe that public policy interventions are needed when markets fail. In the specific case of surprise bills, it is clear that a market solution will not

work, and thus policy makers must take steps to protect consumers and hold down the overall costs of care.

We continue to believe that a benchmark based on 125% of Medicare payment rates is the best option. The basis for our recommendation that the benchmark payment be set at 125% of Medicare is a MedPAC analysis of commercial claims data that showed that contracted payment rates for all physicians averaged 128% of Medicare payment rates. The MedPAC study is cited in a recent article from Adler et al, "State Approaches to Mitigating Surprise Out-of-Network Billing" (see bottom of p. 11 and footnote 33). We prefer this approach to the option of setting payments based on median contracted payment rates in each geographic area, since the resulting benchmarks will reflect prices that are already too high. **Ideally, the Committee would adopt a benchmark of the lower of the median in-network price or 125% of Medicare payment rates.** The median in-network rate, however, is a reasonable second-best option – certainly better than the use of arbitration or in-network matching. As I stated in my testimony on these two latter options:

- Option 2 – Independent Dispute Resolution. We are skeptical that this would result in lower prices. Furthermore, we are concerned that the arbitration process would be opaque, the outcomes would be uncertain, and the administrative costs would be very high.
- Option 1 – In-network Guarantee. We appreciate the Committee's attempts to develop a creative approach to this problem, but we are skeptical that this would produce the needed cost reductions. While some economists have assumed that without the ability for emergency physicians and other facility-based providers to stay out-of-network, they will have less bargaining leverage, and therefore prices will be lower. Based on the real-world experiences of PBGH members, however, we are not confident that this would happen, especially in markets in which dominant hospitals and physician groups have strong market power. We anticipate that the physicians will negotiate with the hospitals or health plans to maintain the current high prices, thereby locking in the current unaffordable costs to employers and consumers.

TITLE II – REDUCING THE PRICES OF PRESCRIPTION DRUGS

We understand that the Committee will be considering additional legislation to address the serious problem of high drug costs, and we strongly encourage Congress to take more **substantive steps to reduce the burden of high drug costs on consumers and purchasers**. Specifically, we support legislation that would increase transparency and provide advance notice and justification for significant price increases (e.g., the FAIR Drug Pricing Act), reduce the barriers to generic drug development (e.g., the CREATES Act), reduce the barriers to development and use of biosimilars, and prohibit abuse of the patent system to extend exclusivity for brand-name drugs.

TITLE III – IMPROVING TRANSPARENCY IN HEALTH CARE

It is essential that the prohibitions on anti-competitive behaviors be retained in the final bill. The experience of PBGH members in California has shown that these contracting practices have led to increased market power and higher prices from dominant health systems and provider groups. Based on our experience:

- We strongly support the key elements of Section 301, which would remove gag clauses on the sharing of price and quality information by providers.
- We strongly support the components of Section 302, which would ban anti-competitive contracting practices by providers, including anti-tiering, "all-or-nothing" and similar clauses that are used to gain market power and raise prices.
- We strongly support the key elements of Section 303, which would establish a non-governmental not-for-profit organization to create an all-payers claims database (APCD). We believe this can be designed in a way that protects patient privacy and allows state-level APCDs to exist within a federal structure.
- We strongly support the components of Section 306, which would require transparent reporting from PBMs to plan sponsors, prohibit the use of "spread pricing" by PBMs, and require PBMs to pass-through 100% of rebates or discounts to the plan sponsor.

TITLE IV – IMPROVING PUBLIC HEALTH

- We support the key elements of Section 406, which would establish programs to improve maternal health care quality and reduce maternal mortality and severe morbidity. We encourage the Committee to go further, however, by requiring standardized public reporting of maternal and infant mortality by all providers nationwide.
- Similarly, we support the components of Sections 409 and 410, which would establish perinatal quality collaboratives and programs to deliver integrated services for pregnant and post-partum women.

Thank you again for your leadership in driving improved value in our health care system, and we look forward to working with you and other stakeholders to finalize this important legislation.

Sincerely,

Elizabeth Mitchell
President & CEO