U.S. House of Representatives Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions
Hearing on "Reducing Health Care Costs for Working Americans and Their Families."
April 26, 2023

Sabrina Corlette – Questions for the Record

Rep. Lucy McBath (D-GA)

1) As a breast cancer survivor, I know firsthand how getting the right prescription drug at the right time can make a difference in life or death. Studies among cancer patients show that utilization management tactics like step therapy don't alter the treatment the patient ultimately gets, but it does delay the patient in accessing that treatment, reducing their chances of survival. That's why I was proud to sponsor H.R. 2630, the Safe Step Act, to ensure that plans offer an expedient step therapy exception process.
    a. How can employers, insurers, and pharmacy benefit managers work together to improve upon step therapy so that we can keep people alive and healthy while keeping costs down?

While step therapy can be an important tool for employer health plans to encourage the use of less expensive treatment options and keep pharmaceutical costs in check, it can pose significant administrative hassles for providers and patients and may not be clinically appropriate for certain conditions. For example, many cancers can be fast-moving and time lost getting to the right treatment can be a life or death matter. Plans should thus ensure that patients have access to exemptions from a step therapy protocol, for example (a) when for a particular patient the drug is likely to be ineffective or adversely affect the patient, (b) when the patient has already gone through a step therapy process (i.e., when in a prior plan), and the initial steps failed, and (c) when the patient is already stable on a medication that is working for them. Plans should also ensure that adjudications of such exemptions are made on a timely basis, with an expedited process for patients for whom time is of the essence.

Rep. Mark DeSaulnier (D-CA)

1) Unfortunately, the final language for two of the bills discussed at this hearing was not introduced with sufficient time for careful review of the text. Now that both bills have been introduced, please provide your assessment of each:
    a. The Association Health Plans Act (H.R. 2868): How does this bill change current law? What concerns do you have with this language? How would it impact costs for individuals enrolled in association health plans and the broader risk pool?

H.R. 2868 allows small employers to band together and buy health insurance though associations. The bill effectively codifies a regulation promulgated by the Trump administration

in 2018 that has been enjoined in federal court. The bill creates an uneven playing field between AHPs and the small-group insurance market. AHPs would be able to cherry pick employer groups with relatively young and healthy employees with lower rates, but employer groups with older or less-healthy workers would facer higher rates. Over time, this adverse selection will result in higher premiums for employers in the small-group market.

Unfortunately, this bill simply re-arranges the deck chairs on the Titanic, shifting costs from the healthy to the sick. It does absolutely nothing to address the underlying reasons for the affordability challenges facing employer-based insurance: namely, the high and rising prices charged by hospitals, drug manufacturers, and other health care providers.

b. The Self-Insurance Protection Act (H.R. 2813): How does this bill change current law? What are potential concerns with the language in this bill that would preempt state authority to regulate stop-loss insurance?

H.R. 2813 would encourage the expansion of self-funded employer-based insurance exempt from key Affordable Care Act (ACA) protections and preempt states' efforts to stabilize premiums for small employers. By exempting stop-loss insurance from the definition of health insurance under federal law, and preempting states' ability to regulate in this space, the bill will encourage the proliferation of level funded plans in the small-group market. This poses three significant risks. First, level-funded plans expose small employers to financial and fiduciary risks they may not be fully aware of when they sign up. The NAIC has documented several consumer protection concerns associated with level funded products, including excluded benefits, lasering of high-risk employees, deadlines that leave employers financially responsible for late-submitted claims, and termination clauses that give the stop-loss issuer just 30 days to end the contract, without cause.

Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, less-healthy workers in the ACA-compliant small-group market. This causes adverse selection, meaning that premium rates rise for employers who cannot pass the stop loss issuers' underwriting. For employer groups that can pass underwriting, if their claims experience worsens over time, the stop-loss issuer will then "dump" the employer group (see 30-day termination clause issue, above) into the ACA-regulated small-group market.

Third, the proposal will prevent states from trying to stabilize their small-group markets by regulating stop-loss insurance. Some states have prohibited the sale of stop-loss policies to employer groups below a certain size; others limit stop-loss policies with attachment points so low that the level-funded plans is, in effect, a fully insured group plan that should be subject to the same market rules that apply to similar products. State insurance regulators, not the federal government, are best positioned to identify and respond to problems in their insurance markets, and this bill would tie their hands.

In addition to posing the above risks, this bill does nothing to address the underlying reason why there is an affordability crisis for employer-based insurance: the prices that commercial insurers pay for provider services and prescription drugs.

2) Association health plans and multiple employer welfare arrangements have a long history of fraud and insolvencies. And I am deeply concerned that Republican proposals fail to learn this lesson. In the 1990s and 2000s, two separate reports by the Government Accountability Office found that insolvencies of these arrangements left thousands of people with hundreds of millions in unpaid medical bills.
    a. Could you talk a little about the history of fraud and insolvency with respect to association health plans?

For decades, AHPs have been used as a vehicle for selling fraudulent insurance coverage. Scams grew after Congress initially exempted AHPs from state regulation under ERISA in 1974. AHP operators would target small employers and self-employed people, collect premiums for non-existent health insurance, and then leave businesses and individuals with millions of dollars in unpaid medical bills. To escape regulatory oversight, AHP operators would set themselves up in one state with lax oversight and market policies to people in other states with more robust oversight, bypassing those states' consumer protections and benefit standards.

In 1982, Congress tried to clamp down on what had become widespread fraud by amending ERISA to allow states to regulate AHPs and MEWAs. Since then, many states have established governance, solvency and other standards for AHPs. However, fraud and insolvency among AHPs have remained a problem. For example, my Georgetown CHIR colleagues found that between 2000-2002, 144 AHP operators left over 200,000 policyholders with over $252 million in medical bills. In 2018, the U.S. Department of Labor reported that it has pursued 986 enforcement actions against MEWAs since 1985, but it admits that its "enforcement efforts often were too late to prevent or fully recover major financial losses." The agency also admits that it fails to adequately collect information about "unpaid claims or their financial impacts on patients and healthcare providers."

AHPs are also often financially unstable, and there are no federal financial standards to ensure that AHPs remain solvent, even though this proposal would significant expand the numbers of small employers and self-employed individuals who enroll. Indeed, as recently as May 2023, the Department of Labor announced a $54 million court judgment over a MEWA's unpaid claims. The Department found severe mismanagement and underfunding, leaving enrollees and providers with millions in unpaid claims.

    b. Do you think that the Trump Administration's Final Rule or other Republican proposals (including H.R. 2868) to expand AHPs sufficiently address these concerns?

No.

3) There is a growing, bipartisan recognition that we don't have enough information about costs in the health care system. In your testimony, you identify an important issue, which is the lack of transparency from companies that contract with employer-sponsored health plans to administer their benefits – such as pharmacy benefit managers (PBMs) and insurance companies that serve as third-party administrators (TPAs).
    a. What are some of the challenges that plan sponsors face when they try to get information from vendors like PBMs and TPAs? What impact does that have on health care costs?

My colleagues and I at Georgetown's Center on Health Insurance Reforms recently completed a survey of 50 state employee health plans, and we asked about their experiences working with third-party vendors such as TPAs. Although state employee plans often the largest commercial purchasers of insurance in their states, and thus should have considerable influence over the vendors who seek their business, these plans report frustration with their TPAs. Plan administrators observe that these entities often drag their feet or even actively resist cost containment initiatives and greater transparency. This is likely due to misaligned incentives and a lack of accountability for cost growth. Furthermore, although the CAA of 2021 should have improved the sharing of claims data with plan administrators, reports suggest that many TPAs continue to place limits on employer use of that data.

    b. In what ways did the No Surprises Act and Consolidated Appropriations Act, 2021 improve transparency and what are some of the next steps we should consider?

The NSA/CAA included important policies to improve transparency for employers who purchase health benefits. In particular, the law prohibits gag clauses in provider-payer contracts, and requires brokers and other vendors to disclose financial transactions over a specified threshold. However, more could be done to ensure compliance with the ban on gag clauses, and to incentivize TPAs to lift restrictions on claims and pricing data for plan administrators (with appropriate privacy and security safeguards of personally identifiable information). In addition, Congress should continue to push the Department of Labor to clarify that the CAA's vendor disclosure requirements include TPAs and PBMs.

Rep. Susan Wild (D-PA)

4) Hospitals and hospital outpatient departments (HOPDs) play a critical role in providing many communities- including my own- with reliable access to high-quality health care. What is your response to concerns that site-neutral payment policies could lead to hospital closures and reduce patients' ability to consistently access high-quality health care services, especially in rural communities?

Depending on the payer and the state where a patient seeks services, hospitals can charge more, and insurers will typically pay more, for the same service provided in a hospital setting, such as an HOPD, than in a clinician's office. Some payers, like Medicare, have limited payments for these charges to certain facilities, practice locations and/or services, and some states have similarly restricted hospitals' ability to bill these higher charges. Higher prices for HOPD-based care result in higher health care spending for services that can be safely provided in a clinician's office, which ultimately translates into higher costs for health care consumers, employers, insurers, and public payers. These higher payments are also one factor (among many) incentivizing hospitals to acquire clinician practices and driving greater consolidation in our health care system. Site-neutral payment, in general, would instead equalize payments for ambulatory services across settings – whether the setting is an independent physician's office, a clinic, an HOPD, an ambulatory surgical center, or another setting.

To the degree that rural hospitals and other hospitals depend on higher payments for ambulatory care, site-neutral payment proposals may appear to threaten their financial bottom-line and their ability to keep their doors open. Ambulatory care payments, however, are only one revenue stream for acute care hospitals. Further steps toward site-neutral payment may also require payers to revisit how hospitals' important fixed costs, such as costs related to maintaining helicopter pads, emergency departments, and ICU units, can be better reimbursed through payments for the care that draws upon these resources.