Mr. Joel White Responses to Questions for the Record
Subcommittee on Health, Employment, Labor, and Pensions Hearing on
"Reducing Health Care Costs for Working Americans and Their Families"
April 26, 2023

Chairwoman Virginia Foxx (R-NC)

1. *At the April 26 hearing, several Subcommittee members discussed the benefits of expanding the Medicare Inflation Reduction Act price controls to apply to employers. What are the costs and benefits of this approach?*

RESPONSE: Unions and employers hire PBMs to routinely negotiate price protection rebates for commercial payers that require manufacturers to refund some or all, increases in list price back to the payer. For example, research sponsored by the PBM trade association PCMA shows savings from the use of private sector management of drug prices between 20 to 30 percent. The group estimates this will result in $469 billion in savings for commercial payers over the next 10 years.[1]

Likewise, federal employees enjoy the benefits of lower prices through the private sector. The Federal Employee Health Benefits Program (FEHB) provides health insurance (and drug benefits) for 8.2 million federal employees, retirees, and their dependents by contracting with more than 200 health insurance plans and PBMs. FEHB relies entirely on the private sector to negotiate their prescription drug benefits.[2] FEHB has implemented a number of private sector tools to manage the overall costs of prescription drugs. The Biden Administration has stated these cost containment efforts have had a positive impact and should continue to be a part of any comprehensive drug management program for federal employees going forward. The Office of Personnel Management (OPM) repeatedly states and touts the "market-based competition system" as a key part of FEHB that has choices for its beneficiaries and costs that are low.

Conversely, the Inflation Reduction Act uses two primary mechanisms to control drug costs – price controls and inflation rebates (drug taxes). Unlike market based tools, price controls come with great costs.

Price controls lead to less access, long wait times, and rationing. Most European countries have drug price controls in the form of government "negotiations," which the IRA mimics, but these countries apply price controls to employees with disastrous effects. Of the 290 new medical substances that were launched worldwide between 2011 and 2018, the U.S. had access to 90 percent versus:

- France - 48%
- United Kingdom - 60%
- Japan – 50%
- Canada – 44%

In addition, European price controls delay access to new therapies by an average of 14 months. If applied to unions and employers in the U.S., the workforce will have dramatically less access to new and existing drugs. Lack of access and adherence to therapies increases health costs, leading to disease progression and increased mortality.

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[1] Pharmacy-Benefit-Managers-PBMs-Generating-Savings-for-Plan-Sponsors-and-Consumers-January-2023.pdf (pcmanet.org)
[2] Final Management Advisory Report: Federal Employees Health Benefits Program Prescription Drug Benefits Coverage (oversight.gov)

Additionally, price controls must be administered by the government and imposed on unions and employers. A government bureaucracy and law enforcement must be funded to enforce the controls. In a price control scheme, politicians and bureaucrats hold the power – competition shifts from making drugs that consumers want to political markets and their lobbyists who attempt to influence price-setting and coverage decisions. The result is government in everyone's medicine cabinet. Congress should seek to depoliticize medical decisions and give control to patients and their doctors, not government bureaucrats and politicians.

With regard to inflation rebates, the CBO has previously noted that inflation penalties in Part D and Part B "would reduce costs for prescription drug benefits offered by commercial insurance plans" even without extending them to commercial units.[3] This conclusion carried over into the CBO's final score of the IRA where the CBO recognized increased federal tax revenue from lower prescription drug costs in the commercial market, even though the Part B and D inflation penalties are confined to units dispensed within Medicare.[4]

In addition, the inflation rebate pricing metrics used for the Part B and Part D inflation penalties already capture commercial sales. The pricing metrics used for the Part B and D inflation rebates – the Average Sales Price (ASP) and Average Manufacturer Price (AMP), respectively – already capture prices paid by most commercial purchasers (e.g., large providers, group purchasing organizations, wholesalers, retail community pharmacies, etc.). Medicare already accounts for commercial price growth in the inflation penalties currently being assessed.

2. *At the April 26 hearing, several Subcommittee members discussed the benefits of applying caps on insulin costs in commercial markets. What would be the impact of this approach should Congress adopt it?*

RESPONSE: While this politically popular approach to addressing high consumer costs of insulin is appealing, the market for insulin changed faster than Congress could respond. The major manufacturers of insulin have already adopted price caps of $35 or less.

A statutory cap at $35 would lock in a higher cost than market competition might produce. Any mandated benefit will increase payer costs. This is why adding dental or vision care to Medicare costs money. When Congress mandates benefits or benefit design, it increases costs, which are typically paid by consumers in higher premiums. For example, the CBO found legislation that passed the House in 2022 to cap insulin out-of-pocket costs would increase costs and raise employer and union plan premiums.[5] Over the last decade, the cost of employer plans increased nearly 50 percent, twice as fast as wages, reducing the affordability of coverage. If a cap on insulin were adopted, premiums could increase, and wages could go down.

3. *One of the witnesses at the April 26 hearing made several claims about association health plans (AHPs), including the following:*

- *AHPs have a long history of fraudulent practices and solvency problems.*

[3] Expected effects on spending (cbo.gov)
[4] https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf
[5] H.R. 6833 (cbo.gov)

- *Insurers and associations vie for employers' business by offering low 'teaser' premium rates and using underwriting or other tactics to cherry-pick and enroll the healthiest employer groups in the market (something ACA[Affordable Care Act]-compliant plans are prohibited from doing).*
- *Some AHP sponsors argue that they achieve lower premiums because they are somehow exercising market clout. This is a fallacy. If they are not engaged in risk selection, then the primary way to reduce costs is to negotiate lower reimbursement rates with providers. It is highly improbable that AHPs are able to do this better than traditional insurers.*

What are your responses to these claims?

RESPONSE: Under the bill, teaser rates are not allowed, and plans must submit premiums that are actuarially sound. This claim is both false and misleading.

On the claim that these plans will have no substantive negotiating power, the claim is without basis. Current AHPs and those envisioned under the bill do and will achieve lower premiums for a variety of reasons, including:

- Workers from many employers and the self-employed form into a large group and increase the leverage these workers collectively have with respect to negotiations on insurance costs and healthcare provider reimbursement. According to the Department of Labor, such discounts may reflect a combination of (1) administrative efficiencies; (2) influence over providers' utilization decisions and practices; and (3) reduction of excess provider profits.[6] Mom-and-pops and individuals have little or no leverage currently. Scale gives them market clout.

- The legislation allows geographically based AHPs that would be In some markets, we expect entirely local AHPs, for example in a single industrial park. Not only will providers compete but the regional AHP may be able to hire its own doctor or physical therapist to treat its members.

- For self-funded AHPs, the association has access to medical claims data, allowing them to identify overpayments and providers who charge much higher rates for the same services.

- Under the bill, AHPs are not constrained by benefit mandates and can design services around member needs rather than the politically approved, expansive, and costly benefit packages under the Affordable Care Act.

- AHPs are not subject to the Marketplace User Fees paid by insurers distributing their health plans on government exchanges which are typically around 3 to 3.5% of premiums, an added cost to consumers.

According to research based on AHPs issued under the Trump Administration rule (which are different than what is envisioned in the legislation), maximum savings claims averaged 29 percent for self-funded AHPs and 23 percent for fully insured AHPs compared to a business' current non-AHP plan.[7]

Finally, with respect to the fraud claims, Congress and the Biden Administration have taken steps to protect the market. This claim is a throwback to the 1970s and 80s and is not relevant today. Under

[6] 2018-12992.pdf (govinfo.gov)
[7] Study: First Phase of New AHPs Reveal Promising Trends | Association Health Plans

current law and the bill, AHPs would be subject to regulation, oversight and enforcement rules by the Department of Labor, the states, or both.

In 1983, Congress amended ERISA to allow states to regulate certain arrangements to promote compliance with state solvency and other rules. Likewise, the Affordable Care Act imposed a number of new policies to tighten up the market. According to the Department of Labor the ACA…:

> *"established a multipronged approach to MEWA abuses. Improvements in reporting, together with stronger enforcement tools, are designed to reduce MEWA fraud and abuse. These include expanded reporting and required registration with the Department of Labor prior to operating in a State. The additional information provided will enhance the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor authority to issue a cease and desist order when a MEWA engages in fraudulent or other abusive conduct and issue a summary seizure order when a MEWA is in a financially hazardous condition."*

Some states already allow pooling arrangements within their state. AHPs remain subject to all federal and state laws otherwise applicable to such plans, and the provisions of H.R. 2868 are not intended to modify the application or interpretation of such laws to such plans. In particular, the rules continue to apply around who governs and controls the AHP, AHPs are required to operate the plan solely in the interests of participants and beneficiaries, and that amounts paid into the plan by participating employer members and their employees may never revert back to an employer member will protect against bad actors. The bill builds on this framework by requiring AHPs to be in existence for at least 2 years prior to establishing the benefit plan (no fly-by-night operations rule), does not condition membership in the group or coverage under the AHP on any health related factor, the AHP is not a health insurer, and has established a governing board with by-laws to manage and operate the plan, of which at least 75 percent of the board members shall be made up of employer members of the group or association participating in the plan These improvements will strengthen the existing rules governing AHPs to ensure that consumers are protected and that employers have a solid insurance option by protecting against fraud and insolvency.

Finally, the bill requires rates to be actuarially sound, which will ensure financial solvency.

4. *At the April 26 hearing, a witness testified that the Self-Insurance Protection Act would encourage the proliferation of level-funded plans in the small group market, posing two primary risks. The witness stated: First, many small employers are not sophisticated purchasers of health benefits and may not realize the financial risks and fiduciary duties they take on when they self-fund their plan…. Second, if small employers with younger, healthier employees shift to level-funded products in significant numbers, it will leave employers with older, sicker workers in the fully insured small group market. This causes adverse selection and, in the worst cases, an insurance "death spiral," in which premium rates rise for employers whose groups cannot pass the stop-loss issuers' underwriting. Those with young and healthy workers pay less (although they could have unexpected financial liability if an employee gets sick), while employers with older, less healthy workers pay more. As with AHPs, the legislation 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. What are your responses to these claims?*

RESPONSE: The Self-Insurance Protection Act does nothing to change the status quo, it simply clarifies the law to protect benefit plans that some state regulators would like to restrict or outlaw. Employers are switching to self-funded plans because the ACA market is unaffordable. SIPA protects the current right

for employers to choose this option for their employees in a small group market that is already in a death spiral across the country.

4. At the April 26 hearing, a witness testified that under H.R. 824, the *Telehealth Benefit Expansion for Workers Act of 2023*,

> [T]elehealth stand-alone plans would be available to all employees (and potentially dependents), even those eligible for group health benefits. And as excepted benefits, telehealth plans would be exempt from the rules that apply to employer group health plans, including MHPAEA [*Mental Health Parity and Addiction Equity Act*]. Doing so creates the risk that employers, particularly those with lower-income workers, will substitute a telehealth-only benefit for a comprehensive group health plan.5

a. Does anything in H.R. 824 exempt employers from their requirements to offer a 60 percent actuarial value plan or from their obligations under ACA Section 6055 (related to reporting of minimum essential coverage) or ACA Section 6066 (related to reporting of information about health coverage provided to full-time employees in order to administer the employer shared responsibility provisions of Section 4980H of the Internal Revenue Code)?

RESPONSE: No. H.R. 824 does not change any of the requirements under the ACA to provide minimum essential coverage. Employers will still provide major medical benefits or face the repercussions spelled out in the law.

b. If an employer fails to offer comprehensive qualified coverage, they are subject to penalties. Considering this, do you expect employers to drop qualified coverage in favor of standalone telehealth benefits?

RESPONSE: No. Employers will not view telehealth as an equivalent benefit to major medical coverage. Defining telehealth as an excepted benefit ensures that telehealth cannot be treated as a major medical plan and has specific rules that further protect consumers. The only employers who will drop major medical coverage are those who will drop coverage regardless of the availability of telehealth as an excepted benefit.

Adding a separate telehealth benefit as an excepted benefit will have a bigger positive impact on those with significant health conditions who struggle to find providers with expertise in their medical condition. Indeed, the first telehealth services were provided in a hospital setting to ensure those suffering from a stroke had access to a specialist.

Rep. Michelle Steel (R-CA)

1. *Telehealth has been a critical tool to ensure patients can continue to access quality, affordable health care from their providers and to address workforce shortages throughout the COVID-19 pandemic. Increased access to telehealth has benefited a range of patients in my district, including seniors, high-risk patients, and patients located in suburban areas. While Congress has taken many steps to extend access to telehealth beyond the PHE, including by extending the CARES Act flexibility I have championed allowing Americans with health savings accounts to*

access telehealth services without meeting their deductible through 2024, certain populations are at risk of losing access to this life-changing modality without further action. During the PHE, the Departments of Labor, HHS, and the Treasury allowed employers to offer coverage for telehealth and other remote care services to employees who were not otherwise eligible for any group health plan offered by their employer. The Telehealth Benefit Expansion for Workers Act of 2023 (H.R. 824) would make this policy permanent. The option for employers to offer standalone telehealth coverage to their employees was not included in the Consolidated Appropriations Act, 2023 and will therefore end on May 11, 2023.

a. *How do you anticipate this will impact access to care for such individuals who benefited from this policy?*

b. *Can you share examples of how employers have leveraged this policy throughout the pandemic and the impact it has had on their employees?*

RESPONSE: Losing access to remote care through added telehealth benefits will negatively impact patient groups. Patients who have certain rare medical conditions will lose access to specialists that have expertise in managing complicated conditions that may be impacted by comorbidities. Remote workers who live in rural areas will no longer be able to access providers through video calls, and instead be forced to drive more than an hour to receive care. Families with children who have more routine medical conditions lose the ability to manage their time through telehealth visits facing the inconvenience of an unnecessary face-to-face visit.

Rep. Susan Wild (D-PA)

1. *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?*

RESPONSE: Between 2022 and 2031, Medicare is expected to spend $5.1 trillion on hospital services. The two site neutral provisions (parity in Medicare payments for hospital outpatient department services furnished off-campus and requiring a separate identification number and attestation for off-campus outpatient departments of a provider) adopted by the House Energy and Commerce Committee saves $4.2 billion over ten years. These modest changes amount to less than 0.0008 percent of total Medicare hospital spending over that period. To suggest hospitals will lead to closures is absurd.

It is also difficult to understand any justification for the proliferation of the use of hospital "facility fees" in the context of a visit with a physician office or clinic. In a predatory practice, hospital systems establish a monopoly on access to certain specialty practices and then use that monopoly to charge an often hidden additional fee to ensure the patient can have access to that specialty provider.

Struggling rural and critical access hospitals are not the primary practitioners of this practice - it is done primarily by large hospital systems. There is no prohibition on the hospital system-based physician from charging more for their services. This underhanded revenue trick not only costs patients more but also encourages hospital systems to buy niche medical practices, limiting competition and extending monopolies.