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CENTER ON HEALTH INSURANCE REFORMS

WRITTEN RESPONSES TO QUESTIONS FOR THE RECORD FOR
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HEARING ON

"COMPETITION AND TRANSPARENCY: THE PATHWAY FORWARD FOR A STRONGER HEALTH CARE MARKET"

WEDNESDAY, JUNE 21, 2023

Rep. Rick Allen (R-GA)

1. *Ms. Monahan, the Transparency in Coverage rule requires insurers to provide a great deal of pricing information in machine-readable files. This has led to insurers posting massive data files that are impossible to comprehend, which completely defeats the purpose and intent of the legislation. What are ways the Transparency in Coverage reporting requirements could be improved or streamlined to make pricing data more accessible for employers and patients?*

There are several ways the Transparency in Coverage (TiC) reporting requirements can be improved or streamlined to make pricing data more accessible for employers and patients. Below are a set of recommendations developed by leading experts in the area, including my colleagues Sabrina Corlette and Karen Davenport of the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy:[1]

- Reduce data redundancy by:
    - Requiring the use of relational databases or file structures, to identify where there are the same (or very similar) negotiated rates or limiting the posted files to unique network arrangements and associated fee schedules, providing users with the ability to crosswalk to the employer identification numbers (EIN) to which the network arrangement applies
        - Alternatively, consider creating a file structure that allows insurers to post one rate for a service or provider if different plans (self-insured, large-group fully insured, individual, etc) share the same rate.
    - Requiring a flag in the in-network file to denote providers with 20 or more services performed in the last year (a similar threshold is required for the out-of-network files)
    - Reducing frequency of reporting from monthly to quarterly or even biannually. This has the advantage of both giving users more time to analyze the data and reducing the compliance burden on issuers
- Improve accessibility by:
    - Requiring a clear library index (or "augmented index file") and standardized labeling of files so that users can see what provider/service codes are in each file
    - Maintaining a repository of issuers in compliance with the rule and include links to their data sources; issuers not in compliance should also be publicly identified
    - Imposing a file size limit to ensure that files are not unreasonably large. While ultimately each plan or issuer would still need to publish the same volume of data, requiring them to post a greater number of smaller files will enable users with standard computing capacity to download and use the data

[1] Further information is available online at *Transparency in Coverage: Recommendations* for Improving Access to and Usability of Health Plan Price Data*, https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.

    - Requiring issuers to use the same file type across all users, to enable the use of a single, standard, and open-source code to access the information
- Improve usability by:
    - Requiring clearer and standardized labels (file names) on each file (i.e., standard labels for network type, the services included, service area, etc.)
    - Require standardized conventions for and inclusion of providers' National Provider Identifiers (NPIs)
- Improve data quality by:
    - Reviewing a random sampling of files to assess data quality during each posting period. Issuers with poor data quality should be required to take corrective action
    - Providing a public-facing portal and reporting template for users to submit potential violations of the TiC posting requirements and flag potential data quality problems
    - Convene and maintaining a standing group of technical experts to advise the Centers for Medicare & Medicaid Services (CMS) on ways to improve accessibility and data quality, with the goal of ensuring that the agency is continually striving to ensure that the published data meets the needs of researchers, regulators, and purchasers

Congress may also want to consider requiring the Department of Health and Human Services (HHS) to produce an annual report that leverages the newly available price data to provide legislators and other stakeholders with critical information about the drivers of health system costs.

Rep. Mark DeSaulnier (D-CA)

1. *The* Consolidated Appropriations Act, 2021 *prohibited contract provisions that prevent plan fiduciaries from accessing quality and cost information (so-called "gag clauses"). However, there are increasing reports that vendors such as third-party administrators are throwing up roadblocks that prevent access to this information.*
    a. *What barriers do plan fiduciaries face in accessing the data described in the CAA?*

Ongoing litigation and reports from stakeholders indicate that plan fiduciaries continue to face significant barriers in accessing the data described in the *Consolidated Appropriations Act, 2021* (CAA). These barriers include the continued existence of contract provisions that limit plan sponsors' access to claims data, months or years of delays after data is requested, and significant gaps in the data when it is finally shared.

For example, a recent *Bloomberg* article by John Tozzi reported that the company Kraft Heinz has alleged that it "requested its claims data in November 2021. What Aetna provided, more than a year later, left out hundreds of data fields, including information that would link a medical

claim to a specific payment in order for the company to see if it was billed correctly." [2] Another company, Owens-Minor, has alleged that a unit of Elevance "blocked the company's attempt to get its health plan data with 'a year-long trail of emails and other correspondence, littered with defendant's excuses, arbitrary conditions, and illusory promises.'"[3] Tozzi reports that an "Elevance representative said the insurer wouldn't release billing information that would allow Owens & Minor to compare how much providers charged versus how much was paid for the services, according to the complaint. Elevance said in a legal filing that its contracts with providers are confidential."[4] More generally, Karen van Caulil, chief executive officer of the Florida Alliance for Healthcare Value, explained to Tozzi that employers have faced a "nightmare of delays" getting data claims data from their health plans.[5]

b. What is your assessment of the effectiveness of the requirement that plans attest that their contracts do not contain these provisions?

Meaningful enforcement mechanisms are critical to ensuring compliance with the CAA's provisions. While attestation can play a role in enforcement, I have heard concerns from stakeholders regarding current federal guidance that allows third-party administrators (TPAs), pharmacy benefit managers (PBMs), and other service providers to attest to compliance with the gag clause prohibition on behalf of the plan.[6] Gag clauses generally serve the interests of service providers and, under current law, service providers do not necessarily face liability if gag clauses remain in their contracts. As service providers themselves have emphasized, the responsibility for compliance falls solely on the plan.[7] Thus, service providers have little incentive to closely scrutinize their contracts to ensure all gag clauses have been removed and also may take a narrow view of what constitutes a gag clause. At the same time, employers may be encouraged to rely on their service providers' attestations—including explicitly so by the brokers and consultants they hire—particularly if the employer lacks independent expertise to identify and successfully negotiate for the removal of any gag clauses. This effectively has the fox guarding the hen house. For many of the same reasons, the Purchaser Business Group on Health has

[2] John Tozzi, *Health Insurers Don't Want You to Know Where Your Money Is Going*, BLOOMBERG (Aug. 2, 2023), https://www.bloomberg.com/news/features/2023-08-02/what-health-insurance-companies-won-t-reveal-about-your-medical-bills.
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 57 (Feb. 23, 2023), https://www.cms.gov/files/document/aca-part-57.pdf.
[7] *See, e.g.*, Memorandum of Law in Support of Defendants' Motion to Dismiss Plaintiffs' Complaint at 25, Trs. of Int'l Union of Bricklayers & Allied Craftworkers Local 1 Conn. Health Fund v. Elevance, No. 3:22-cv-01541-VLB (D. Conn. Mar. 10, 2023) (arguing that the plan sponsors can seek to renegotiate their contracts to meet "*their* obligations" if they so desire, but the gag clause prohibition does not impose any duties on the third-party administrator (emphasis in original)).

explained that employers and purchasers may "have no other option but to consider submitting a false attestation or none at all."[8]

c. What would the implications be of treating data as a plan asset under ERISA?

My impression is that treating data as a plan asset under ERISA would generally be welcomed by employers who are struggling to get and use this data today. On top of the issues accessing their data described above, even when service providers like TPAs share data with plan sponsors they may impose significant limitations on how the plan sponsor may use that data. This includes language prohibiting plan sponsors from using claims data to negotiate deeper discounts for services or advance transparency of health care quality and costs. Presumably if data were treated as a plan asset, such limitations would not apply to a plan sponsor's use of plan data.

At the same time, treating data as a plan asset also raises significant privacy concerns, including the extent to which plan member's personal health information is protected from improper access or use. Experts in privacy law and potentially affected stakeholders should be consulted on these topics.

d. Would it be useful for the Department of Labor to issue guidance on situations in which plan data is considered a plan asset? Is legislation needed?

The Department of Labor (DOL) would be well-suited to research this issue further, including the potential privacy concerns I noted above. DOL can then provide recommendations on how best to move forward, including the most appropriate legal mechanism for implementing any reforms.

e. How would you recommend Congress improve this provision?

The gag clause provision can be significantly improved by strengthening compliance and enforcement, such as the provisions currently proposed in H.R. 4527, the *Health Data Access, Transparency, and Affordability Act*. Key reforms include ensuring responsible plan fiduciaries can audit plan data without their vendors imposing unreasonable restrictions, holding service providers liable for violations of the law, and voiding any unlawful gag clauses, including contract terms that unduly delay a plan fiduciary's access to plan data.

[8] Darren Fogarty, *What Employers Need to Know About Removing Gag Clauses from Health Care Contracts*, PURCHASER BUS. GRP. ON HEALTH (Aug. 1, 2023), https://www.pbgh.org/what-employers-need-to-know-about-removing-gag-clauses-from-health-care-contracts/.

2. *One issue that frequently comes up is whether service providers, including pharmacy benefit managers (PBMs) and third-party administrators (TPAs), have conflicts of interest when they administer group health plans. These companies often successfully argue that they are not acting as fiduciaries with respect to the health plans they contract with.*
    a. *Would identifying functions performed by entities like TPAs and PBMs in which they are acting as fiduciaries change their business practices?*
    b. *What are some considerations that we should weigh when looking at this issue?*
    c. *Would it be possible for the Department of Labor to issue guidance clarifying functions of TPAs and PBMs that are fiduciary in nature or is legislation needed?*

I offer a single response to the above questions. Service providers like PBMs and TPAs have been able to successfully argue to courts they do not function as fiduciaries under ERISA in many circumstances because they are not exercising any discretion when administering the plan and they do not exercise authority or control with respect to the management and disposition of plan assets.[9] For example, courts have distinguished the act of "determining the amount of plan assets to be paid," from "controlling the actual payment – i.e., the disposition – of those assets."[10] Additionally, these entities also argue and courts often accept that they are not fiduciaries when performing activities like negotiating formularies, networks, and reimbursement rates or even recovering and settling potential overpayments because they are acting without regard to an individual health plan but rather their broader books of business and independent interests.[11] Whether these conclusions are the best or only reading of existing law may be debated, but they are certainly common and are likely to continue to dominate court decisions absent legislative change.

Under this framework, simply naming TPAs and PBMs as fiduciaries in legislation may be inadequate. Plan sponsors are the archetypal fiduciary, but this does not mean they are acting as fiduciaries with respect to every activity they perform. For example, employers generally act as "settlors," rather than fiduciaries, when establishing a health plan and thus can exercise business judgment with respect to decisions like whether to offer coverage at all, what type of coverage to

[9] *See* 29 U.S.C. § 1002(21)(A) (defining fiduciaries); *Pegram v. Herdrich*, 530 U.S. 211 (2000) (discussing scope of fiduciary functions); *Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.*, 2022 U.S. Dist. LEXIS 58083, *26–27 (D. Mass. 2022) (discussing cases involving whether TPAs and PBMs are functional fiduciaries); *Report to the Honorable Thomas E. Perez, U.S. Sec'y of Lab: PBM Compensation and Fee Disclosure* 12–13, ADVISORY COUNCIL ON EMP. WELFARE & PENSION BENEFIT PLANS (Nov. 2014) (summarizing case law on fiduciary status of PBMs).

[10] *Mass. Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.*, 66 F.4th 326 (1st Cir. 2023).

[11] *See, e.g., id.* at 322–23.

offer and to which employees, how much to contribute financially to that coverage.[12] If only labeled in legislation as fiduciaries, TPAs and PBMs are likely to agree they are fiduciaries when conducting activities courts have traditionally held to be fiduciary functions, but maintain that they are still not fiduciaries when performing activities that courts have said do not constitute fiduciary functions under existing case law. Like employers, they could simply wear "two hats."[13]

Consistently extending ERISA's fiduciary duties to common TPA and PBM activities like negotiating prescription drug formularies and provider networks, and setting reimbursement rates thus will likely require more specific changes in the law. Part of this would involve identifying the broad functions that policymakers believe should come with fiduciary duties—that is, what are the functions where these entities should be acting "solely in the interest of the participants and beneficiaries," for the "exclusive purpose" of "providing benefits to participants and their beneficiaries"?[14] These may be functions that significantly affect the cost or availability of care and where, due to market failures, PBMs and TPAs currently lack adequate incentives to negotiate better deals for employer plans and/or derive significant profits at the expense of employer plans and their participants and members. But policymakers also will likely need to consider and specify in law how ERISA's fiduciary duties should apply when PBMs and TPAs are negotiating contracts and deals that apply across multiple plans with different terms, rather than one specific plan. This would represent a departure from current precedent.[15] These reforms collectively would likely affect many common PBM and TPA business practices where profits dominate decision-making, but I defer to other experts and stakeholders to advise on these impacts.

[12] *See* Dana Muir & Norman Stein, *Two Hats, One Head, No Heart: The Anatomy of the ERISA Settlor/Fiduciary Distinction*, 93 N.C. L. REV. 459, 478–84 (2015) (discussing the Supreme Court's settlor/fiduciary doctrine).
[13] *Id.* at 463.
[14] 29 U.S.C. § 1104(a)(1).
[15] *Peterson v. UnitedHealth Group, Inc.*, 913 F.3d 769, 776 (8th Cir. 2019) ("While administrators like United may happen to be fiduciaries of multiple plans, nevertheless 'each plan is a separate entity' and a fiduciary's duties run separately to each plan." (quoting *Standard Ins. Co. v. Saklad*, 127 F.3d 1179, 1181 (9th Cir. 1997)).

3. *The* Consolidated Appropriations Act, 2021 *amended ERISA to require that plan fiduciaries must be provided with detailed disclosures of direct and indirect compensation earned by service providers that contract with the plan. The statute specifically states that covered service providers include pharmacy benefit managers and third-party administrators, among many others.*
    a. *Why is this information necessary to ensure that compensation paid to vendors is reasonable?*

Employers, as plan sponsors, have a duty to ensure the compensation they pay service providers is reasonable for the services provided.[16] In 2007, DOL recognized that plan fiduciaries—whether for pension or health plans—cannot comply with their legal duties when they do not have access to relevant information, stating: "To meet these obligations, it is vital that fiduciaries have enough information to make informed assessments and decisions about the services, the costs and the providers."[17] DOL thus proposed regulations that would require service providers to disclose their compensation and conflicts of interest to pension and health plans.[18] The Department, however, finalized the proposal for pension plans only, explaining that commenters effectively argued that it should develop a comprehensive disclosure framework specific to health plans rather than applying the same standards to both pension and health plans.[19] This never occurred and disclosures were not specifically required for health plans until Congress intervened and established new rules under the CAA.

It is my understanding that action was not taken before the CAA was enacted because both federal officials and employers tended to assume that health plan service providers—or at least the benefits consultants charged with vetting other plan service providers—were looking out for employer plans' best interests without close inquiry. Unfortunately, it has become clear that the employer-sponsored insurance market is rife with excessive and wasteful spending to which employers have largely been in the dark. This includes hidden fees and overpayments to TPAs and PBMs,[20] and massive commissions for employer benefit consultants and brokers

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[16] 29 U.S.C. § §1104(a)(1), 1108(b)(2); U.S. DEP'T OF LABOR, INFORMATION LETTER 02-19-1998, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/02-19-1998.

[17] Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure, 72 Fed. Reg. 70,988, 70,995 (Dec. 13. 2007).

[18] *Id.* at 70,989.

[19] Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure, 75 Fed. Reg. 41,600, 41,603 (July 16, 2010).

[20] Bob Herman, *Fed up with Exorbitant Health Costs, Employers and Workers Are Taking Insurers to Court*, STAT NEWS (June 12, 2023), https://www.statnews.com/2023/06/12/employers-sue-health-insurers; Christine Monahan, *Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators*, CHIRBLOG (Mar. 24, 2023), https://chirblog.org/questionable-conduct-allegations-insurers-acting-third-party-administrators/; *Pharmacy Benefit Tactics Drive up Drug Prices, Limit Access, Contribute to Health Risks*, PURCHASER BUS. GRP. ON HEALTH (Dec. 2022),

recommending and arranging contracts on behalf of employers.[21] Critically, employers have relied on their benefit consultants and brokers to offer impartial advice, not appreciating that, as Bob Herman recently reported for *Stat News*, that "[s]ome consulting firms often are getting paid more—a lot more—by the PBMs and health insurance carriers that they are supposed to scrutinize than by companies they are supposed to be looking out for."[22] Absent disclosure requirements, for example, an employer may be unaware that their broker receives significantly more money from a TPA or PBM if the employer renews their contract and thus may not alert them to more cost effective alternatives they employer otherwise may have chosen.

b. To what extent are entities described in this provision currently providing fiduciaries with the disclosures needed to ensure the reasonableness of their contracts?

Herman's reporting raises questions about the extent of compliance and clarity of disclosures, particularly with respect to indirect compensation,[23] but I do not have more specific information to share in response to this question.

c. What improvements would you recommend that would strengthen the disclosures that vendors must provide?

One concern I have heard from stakeholders is that service providers will just include complex formulas or percentages that broadly describe how compensations would be calculated, without disclosing specific compensation amounts. I can also understand why some vendors may argue that this flexibility is necessary, particularly to the extent their contracts for direct and indirect compensation from third-parties take several variables into account. One approach to resolving these competing concerns may be to additionally require that vendors disclose the total amount of direct and indirect compensation they received after the plan year has ended. This could be included at the same time disclosures regarding anticipated compensation are made, along with an explanation of any changes in the terms of their compensation contracts to the extent such

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https://www.pbgh.org/wp-content/uploads/2022/12/Pharmacy-Benefit-Tactics-Drive-Up-Drug-Prices-Limit-Access-Contribute-to-Health-Risks.pdf; Erin E. Trish et al., *PBMs Are Inflating the Cost of Generic Drugs. They Must Be Reined in.*, STAT NEWS (June 30, 2022), https://www.statnews.com/2022/06/30/pbms-inflating-cost-generic-drugs/.

[21] Bob Herman, '*It's Beyond Unethical': Opaque Conflicts of Interest Permeate Prescription Drug Benefits*, Stat (June 20, 2023), https://www.statnews.com/2023/06/20/pbms-consulting-firms-investigation/; *EP379: How Much Money, Really, Are Employee Benefit Consultants and/or Brokers Making from Plan Sponsors? With AJ Loiacono*, RELENTLESS HEALTH VALUE (Sept. 15, 2022), https://relentlesshealthvalue.com/episode/ep379; Marshall Allen, *Behind the Scenes, Health Insurers Use Cash and Gifts to Sway Which Benefits Employers Choose*, PROPUBLICA (Feb. 20, 2019), https://www.propublica.org/article/health-insurance-brokers-cost-commissions-bonuses.

[22] Herman, *supra* note 21.

[23] *Id.*

changes are expected to meaningfully impact the amount of compensation to come in the following year.

To shed further light on these types of compensation streams, policymakers may want to consider adopting parallel provisions that require PBMs and TPAs to publicly disclose the direct and indirect compensation they pay to plan vendors like brokers and benefit consultants. Policymakers also may want to explore establishing whistleblower protections for workers of service providers that do not disclose or inadequately disclose direct or indirect compensation, so they can safely report these failures to either the client or DOL without fear of retribution.

4. *Health care costs in the United States are the highest in the world, accounting for more than one sixth of our gross domestic product. Individuals covered under private health plans, including employer-sponsored plans, are billed by providers at rates that are usually multiple times what Medicare, Medicaid, and other public programs pay for the same services.*
   a. *Why is it so difficult for employers to reduce how much they pay for health care?*

Employers face several barriers to reducing health care costs. Historically, employers' exposure to rising health care costs have been moderated by the federal tax exclusion for employer-paid health insurance premiums.[24] Employers also have been able to shift costs to their employees by increasing their premium contributions, reducing the generosity of benefits, or limiting wage increases to offset the rising cost of health care services.[25] A lack of transparency regarding health care prices and costs also has long limited employers' interest and ability to reduce how much they pay for health care. As my colleagues Sabrina Corlette and Maanasa Kona have written, "most employers have little to no access to data on the prices they are paying, the relationship of prices to the actual costs of delivering care, or whether or not the prices being charged are correlated with higher quality or better patient outcomes. This can lead to what the U.S. Congressional Budget Office calls a 'lack of sensitivity' to high prices."[26]

Even when motivated and armed with information about health care prices and costs—which is becoming increasingly available thanks to recent executive and congressional action although more can still be done—employers face significant barriers to reducing costs because of the lack

[24] *See, e.g.*, CONG. BUDGET OFF., REDUCE TAX SUBSIDIES FOR EMPLOYMENT-BASED HEALTH INSURANCE (2022), https://www.cbo.gov/budget-options/58627.
[25] *See* Maanasa Kona & Sabrina Corlette, *The Erosion of Employer-Sponsored Health Insurance and Potential Policy Responses*, CHIRBLOG (Dec. 5, 2022), https://chirblog.org/erosion-employer-sponsored-health-insurance-potential-policy-responses/.
[26] Sabrina Corlette & Maanasa Kona, *Can Employer-Sponsored Insurance Be Saved? A Review of Policy Options: Price Transparency*, CHIRBLOG (July 6, 2023), https://chirblog.org/can-employer-sponsored-insurance-be-saved-a-review-of-policy-options-price-transparency/ (linking to CONG. BUDGET OFF., POLICY APPROACHES TO REDUCE WHAT COMMERCIAL INSURERS PAY FOR HOSPITALS' AND PHYSICIANS' SERVICES (2022), https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf).

of competition and misaligned incentives in the health care marketplace. There is widespread agreement that the primary cause of rising health care costs is rising prices for health care, particularly hospital care, which has been driven by consolidation in health care provider markets.[27] And, while the insurance market is significantly consolidated itself, the major insurers that employers hire to act as TPAs often lack significant incentive to negotiate competitive reimbursement rates under the current system.[28] Individual employers and even groups of employers struggle to gain meaningful price concessions given these forces.[29]

b. How would payment reforms, such as improving hospital outpatient billing practices, help lower costs for consumers and for businesses?

Payment reforms, including regulating hospital outpatient billing practices, can help lower costs for consumers and for business, although the impact will vary depending on the nature of the reform. Specifically in the context of outpatient billing practices, the reform that would have the largest effect on total costs would be to prohibit hospitals from charging facility fees for outpatient services that can be safely and effectively delivered outside of a hospital setting and capping the remaining professional payment. The impact this would have would depend on where the payment level is set and the scope of services covered by the reform. For example, a payment level that is set based on the median for all rates an insurer pays for a given service in a geographic region will have much less of an effect than a payment level that is set at the median reimbursement rate an insurer pays independent practices for a given service in a geographic region. Similarly, a policy that is limited to prohibiting such fees in off-campus settings will have a much smaller effect than one that includes specified services delivered in on-campus settings as well.

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[27] *See* Maanasa Kona & Sabrina Corlette, *Can Employer-Sponsored Insurance Be Saved? A Review of Policy Options: Limiting Provider Consolidation and Anti-Competitive Behavior*, CHIRBLOG (Mar. 8, 2023), https://chirblog.org/can-employer-sponsored-insurance-saved-review-policy-options-limiting-provider-consolidation-anti-competitive-behavior/; Aaron Glickman & Janet Weiner, *Health Care Cost Driers and Options for Cost Control* 6, PENN LDI (Apr. 2020), https://ldi.upenn.edu/wp-content/uploads/2021/06/LDI-Issue-Brief-2020-Vol.-23-No.-4_12.pdf; Gerard F. Anderson et al., *It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt*, 38 HEALTH AFFS. 87 (Jan. 2019), https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

[28] *See, e.g.*, CONG. BUDGET OFF., *supra* note 26 at 11; *Inside Big Health Insurers' Side Hustle*, TRADEOFFS (Sept. 23, 2021), https://tradeoffs.org/2021/09/23/inside-big-health-insurers-side-hustle/; Bob Herman, *Seven Health Insurance CEOs Raked in a Record $283 Million Last Year*, STAT NEWS (May 12, 2022), https://www.statnews.com/2022/05/12/health-insurance-ceos-raked-in-record-pay-during-covid/; Sarah Kliff & Josh Katz, *Hospitals and Insurers Didn't Want You to See These Prices. Here's Why.*, N.Y. TIMES (Aug. 22, 2021), https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html.

[29] Corlette & Kona, *supra* note 25.

Restricting outpatient facility fee billing without a cap on payments would likely meaningfully reduce consumer out-of-pocket cost exposure and thus improve affordability for many consumers. Consumers are particularly affected by outpatient facility fee billing due to current trends in health insurance benefit design, including the growing size and prevalence of deductibles and separate cost-sharing obligations for hospital and physician charges. Nonetheless, hospitals with market power would likely be able to make up for lost revenue by increasing other charges. Thus, the effect on total spending and premiums would likely be small, particularly over the longer-term.

Bringing more transparency to health care billing, including requiring off-campus settings owned by or affiliated with hospitals to acquire and bill with unique provider identifiers, could generate savings either for consumers with respect to out-of-pocket costs or on total spending only to the extent private insurers leverage this information. The reform nonetheless has value even when private insurers lack the market power and/or incentive to rein in spending because it will provide valuable information to policymakers and regulators regarding the current scope and effects of outpatient facility fee billing and consolidation more broadly. Officials, in turn, can use this information to develop targeted policy reforms or more effectively enforce existing regulations.

For sources and further discussion of these issues, please see Linda Blumberg & Christine H. Monahan, *Facility Fees 101: What is all the Fuss About?*, Health Affairs (Aug. 4, 2023), https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss and Christine H. Monahan, Karen Davenport, and Rachel Swindle, *Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform*, Georgetown Center on Health Insurance Reforms & West Health (July 2023), https://georgetown.app.box.com/file/1259606468349?v=statefacilityfeereport.

For a discussion of other payment reform options, please see Linda J. Blumberg, Sabrina Corlette, & Jack Hoadley, *Can Employer-Sponsored Insurance Be Saved? A Review of Policy Options: Price Regulation*, CHIRblog, (Jan. 18, 2023), https://chirblog.org/can-esi-be-saved-review-of-policy-options-price-regulation/.

c. Is there an argument that under ERISA plan fiduciaries have an obligation to seek lower costs and, if so, how could this help reduce health care spending?

Yes, there is an argument that ERISA plan fiduciaries have an obligation to seek lower costs. One important fiduciary function is the choice of service providers—from brokers and benefit consultants, to TPAs and PBMs, to hospitals and physicians providing health care to participants.[30] Because service providers' receipt of plan assets in exchange for services presents

[30] *See, e.g., Whitfield v. Cohen*, 682 F. Supp. 188, 195 (S.D.N.Y. 1988) (choosing a service provider is a fiduciary act requiring the responsible fiduciary to prudently investigate the credentials of the service provider and its ability to serve the plan); *Perez v. Chimes D.C.,*

risks of conflicts, plans can contract with service providers only to the extent their services "are necessary for the establishment or operation of the plan" and they are paid "no more than reasonable compensation."[31] Fiduciaries also must monitor service providers, including regularly evaluating "whether to continue using the current service providers or look for replacements," reviewing their performance, and checking the fees they charge.[32]

There are strong arguments that existing spending by employer-sponsored plans is not reasonable and has been inadequately monitored by plan fiduciaries. This applies equally to excessive fees and other payments made to TPAs, PBMs, brokers, and benefit consultants who help set up and administer the plans, which I've discussed above, and to hospital reimbursement rates that often are far above levels that would enable hospitals to "break even."[33]

Nonetheless, determining what is reasonable presents challenges. It is not the case that fiduciaries simply must pick the lowest bidder when evaluating service providers, as DOL has advised that, "[t]he responsible plan fiduciary must engage in an objective process designed to elicit information necessary to assess the qualifications of the provider, the quality of services offered, and the reasonableness of the fees charged in light of the services provided."[34] What's more, as I previously described, individual employers face significant market barriers to securing lower costs. It remains to be determined what steps plan fiduciaries must take to ensure they are acting prudently and their spending is reasonable. How far they choose to go in an effort to avoid litigation, or how far courts or DOL demand they go if presented this question, will affect the extent of cost savings that may be secured. So too will actions by policymakers. For example, reforms that limit abusive outpatient billing and other anticompetitive practices could enable plan fiduciaries to negotiate better deals and thus move the bar on how much cost savings employers can reasonably achieve.

2016 U.S. Dist. LEXIS 126982, *13–29 (D. Md. Sept. 19, 2016) (same); *Solis v. Webb*, 931 F. Supp. 2d 936, 953 (N.D. Cal. 2012) ("Implicit within the duty to select and retain fiduciaries is a duty to monitor their performance."); U.S. DEP'T OF LAB., *supra* note 16 (discussing health care providers as service providers).

[31] 29 U.S.C. § 1108(b)(2)(A).

[32] ERISA Fiduciary Advisor, U.S. Dep't of Lab., https://webapps.dol.gov/elaws/ebsa/fiduciary/q4f.htm#:~:text=Monitoring%20a%20service%20provider,providers%20or%20look%20for%20replacements.

[33] *See* Christopher Whaley, *Prices Paid to Hospitals By Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*, RAND (2022), https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1100/RRA1144-1/RAND_RRA1144-1.pdf; *Understanding NASHP's Hospital Cost Tool: Commercial Breakeven*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Mar. 28, 2022), https://nashp.org/commercial-breakeven/

[34] U.S. DEP'T OF LAB., *supra* note 16.