COMMITTEE ON
EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

July 19, 2023

Gloria Sachdev
President and CEO
Employers' Forum of Indiana
3352 Walnut Creek Drive North
Carmel, IN 46032

Dear Dr. Sachdev:

Thank you again for testifying at the June 21 Subcommittee on Health, Employment, Labor, and Pensions hearing on "Competition and Transparency: The Pathway Forward for a Stronger Health Care Market."

Enclosed are additional questions submitted by a Subcommittee member following the hearing. Please provide written responses no later than August 9, 2023, for inclusion in the hearing record. Responses should be sent to Michael Davis of the Committee staff who can be contacted at Michael.Davis@mail.house.gov or (202) 225-7101.

We appreciate your contribution to the work of the Subcommittee.

Sincerely,

Bob Good
Chairman
Subcommittee on Health, Employment, Labor, and Pensions

Enclosure

Questions for the Record for
GLORIA SACHDEV

President and CEO, Employers' Forum of Indiana

Submitted August 9, 2023

Committee on Education and the Workforce Subcommittee on Health, Employment, Labor, and Pensions
"Competition and Transparency: The Pathway Forward for a Stronger Health Care Market"
Wednesday, June 21, 2023 at10:15 a.m.

Thank you for the opportunity to share additional thoughts on this important topic. The comments in this document represent my own views and not that of Employers' Forum of Indiana members or their organizations.

Questions for Rep. Mark DeSaulnier (D-CA)

1. The *Consolidated Appropriations Act, 2021* prohibited certain contract terms, known as gag clauses, that limit access to cost and quality data. Despite this prohibition, many employers report that they continue to face onerous requirements imposed by their third- party administrators (TPAs) and other service providers that prevent accessing data.

   a. **What are some of the barriers that prevent compliance with the CAA's gag clause requirements**?

      i. This recent article highlights several barriers: https://www.ibj.com/articles/lawsuits-show-emerging-rift-between-employers-health-insurers.
      ii. While some TPAs provide data requested, others outright refuse to give self-funded employers requested data. This has resulted in employers across the country beginning to take legal action.
      iii. Often the data requested is not provided in a timely manner, i.e. 12-18 months after it is requested.
      iv. An example discussed in the article above, which I have personally been involved with, is "Unite Here Health, a union plan that covers 200,000 service workers and their families, tried to compel its insurer Blue Cross Blue Shield of Illinois to share its claims data with Rand for a prominent study of hospital prices, but the insurer refused, according to Ivana Krajcinovic, a vice president of the union health plan. A spokesman for the insurer, Dave Van de Walle, said in an email that participation in the Rand survey "is voluntary, and BCBSIL has opted out." BCBSIL should not have the purview to "opt out" when their self-funded employer client is demanding that employers' claims should be sent to Rand Corp for participation in a national price transparency study…or for any other means the employer wishes to use their own data.

   b. **If a plan fiduciary wants to audit the data, do TPAs and other service providers choose who conducts the audit? Are the fees imposed reasonable?**

      i. Many of the largest employers can hire an auditor of their choosing without any

TPA/service provider fees added on.

ii. However, often TPAs and PBMs insist on having veto rights over plan sponsor-selected auditors or require them to choose from a list of "approved auditors". Fees vary, and it unclear to me if these fees are reasonable.

iii. The following TPA and PBM contract provisions are also common:
   a) Frequency of audit is restricted, i.e. once every 3 years
   b) Look back period is restricted, i.e. only 18 months of claims data can be audited
   c) Audit sample size is restricted, i.e. 250-300 claims, and the TPA must agree on how the claim sample is selected
   d) Limitation of time frame in which an audit can occur
   e) General reference to limitations per "audit guidelines and policies"
   f) Requiring pre-approval of auditor selection
   g) Requiring review of the draft audit report and meeting with the auditors before the information is presented to the plan.
   h) Requiring that results of any audit cannot be extrapolated across the entire population of claims.

c. What are your recommendations for improving this provision?

i. Clarify that employers OWN ALL aspects of their data (charges, prices paid, employer contribution, employee contribution, utilization, quality, etc.)

ii. The term "Service Providers" could be clarified to include TPAs, carriers, insurance companies, PBMs, brokers/benefit consultants, data warehouses, and any organization that has employer data. This is important as service providers may subcontract data warehouse services to a third party or a subsidiary they own in their vertical business.

iii. Prohibit any type of audit restriction and audit fees. Require that plan sponsor and employers have a duty to select an auditor of their choice as they are the ones held as the fiduciary.

iv. Require discloser of all service advisors' (define advisors as noted in #1) indirect compensation (i.e. vacations and pro football tickets) and direct financial compensation.

v. If service providers are unwilling to follow the law set forth in Consolidated Appropriations Act, 2021 Section 201, there must be meaningful repercussions to financially incentivize the service providers to comply. The penalties need to be strong enough to force compliance, and without requiring employer group health plans to use the courts to access their data. Small employers do not have the resources to take large service provider companies to court.

vi. As lawsuits are expensive and especially cost-prohibitive for small employers, require service providers to pay for all employers' legal expenses.

vii. Note a specific time frame, i.e. 14 business days, in which TPAs, PBMs and all other service providers must provide employer-requested data. Providing a response (which could be as simple as "we are working on it" is not a substitution for providing the requested data.

viii. Assure that the gag clause prohibition applies to ALL agreements, no matter what the agreements are titled.

ix. Develop a process for employers to report bad actors to the federal government to facilitate accountability.

x. Employers should be allowed to share any and all aspects of the data they own with any third party for analysis without an additional fee for sending an electronic file(s). Self-funded employers currently pay a negotiated administration fee to TPAs and PBMs and within this administration fee should be unlimited data requests. Exhorbitent hidden fees are unacceptable.

xi. An opportunity for clarification is the look back period for employer attestation. The rule currently goes back to 2020 and it is unclear if employers need to attest for a former vendor partner or just current vendor partners.

2. In your testimony you discuss the issue of who owns data that is generated in the course of administering an employer-sponsored group health plan. This information is very important and has the potential to be used for the benefit of the plan participants to lower costs and improve quality.

   a. **Do you agree that the data is not the property of the TPA or other service providers? If it does not belong to the TPA, should it be treated as a plan asset under ERISA?**

      i. Yes, I agree that the data is not the property of the TPA or other service providers. The plan owns the data. Employers may rely on partners to house the data, sort through the data, and keep the data secure, but it should be made clear that employers maintain ownership rights.
      ii. Self-insured plan sponsors own and manage substantial financial risk of their covered population. They also have a fiduciary requirement to pay reasonable costs, thus they need unfettered access to their own data to support evidence-based purchasing decisions.
      iii. I need additional information on how "plan asset" is defined in this context and subsequent implications.

   b. **Should the Department of Labor help plans determine when and how this data should be treated as a plan asset?**

      i. Yes, this may help. Creating a DOL FAQ that states all data used in determining dollar transactions from plan assets becomes a plan asset may be helpful. For an employer plan sponsor to ascertain if their TPA is engaging in spread pricing, not overpaying a provider bill, etc., employers must be able to have their independent auditor have access to the 837 electronic claim files which go from provider to TPA noting charges, AND the 835 electronic files which are from the TPA to the provider with details on adjustments and the amount to be paid.

   c. **Is legislation necessary to clarify this matter?**

      i. Yes, making it clear that there is one data owner, the plan sponsor, is critically important.

3. In 2020, the Departments of Health and Human Services, Labor, and the Treasury issued final rules under the ACA regarding Transparency in Coverage. These rules have been a step forward for both consumers, who now have access to cost-sharing information, and for researchers, employers, and policymakers, who now have access to detailed information regarding health care costs. But challenges remain, and I am curious to learn more about the employer perspective on this issue.

   a. **What has been the experience of employers in navigating the data? Has it been useful or does more work need to be done to ensure it is useable?**

      i. The information has the potential to be highly valuable to employers to help them align payment with the value of services provided and determine which TPA has negotiated the best rate per provider per procedure….and which providers are accepting the best payment rate per procedure.
      ii. Accessibility and usability for employers has been challenging because of the large size of MRF data files and the complexity in sorting out valuable information. Thus,

more work needs to be done here. For example, it is challenging to determine how to ascertain net hospital system payment because each health system has numerous NPIs and/or Tax ID numbers and these are not linked to a health system ID number.

b. **How can CMS include provider quality transparency as part of the data?**

i. All purchasers of healthcare want to know where the best quality at the best price is. CMS could simply require hospitals to add their hospital CMS Hospital Compare quality star ratings to the MRFs. This may also incentivize hospitals to review and improve their quality over time.

ii. Background: CMS publishes a valuable data file, Hospital Compare, which is a free, public-facing data file that is updated quarterly. CMS Hospital Compare's quality data is organized into five domains, namely mortality, safety of care, readmissions, patient experience, timely and effective care. These five domains then roll up into an Overall Hospital Compare Star Rating. Both the Overall Star Rating and Patient Survey Star Rating are posted on CMS's website. For both of these metrics, 5-stars represents hospitals with the best quality and 1-star represents hospitals with the worst quality.

iii. A new opportunity is for CMS to pursue reporting of hospital quality by how purchasers shop for care. People/employers do not shop for care by readmission rate, mortality, etc., although researchers and policy makers may find this of value. Rather, they shop by what healthcare service are needed, i.e. oncology care, cardiovascular care, GI services, imaging services, etc. CMS maintains a MDC Clinical Category data dictionary, so this data dictionary could be used to develop a new quality measure set by organizing CMS claims data by clinical category.

iv. In addition, CMS may wish to consider creating an incentive for commercial data to be analyzed alongside CMS claims data using the Clinical Category format. Large commercial data warehouses currently exist and could conduct such an analysis.

c. **If this Committee considers legislation to codify the regulation, what suggestions would you have for additional changes that should be made?**

i. I strongly suggest consideration be given to creating a Summary MRF for the everyday employer/consumer to use. While the larger MRFs have useful information, access is limited to organizations with huge data storage capability. Every employer, consumer, policy maker, and researcher should have access to a MRF subset without having to pay a third party vendor. This Summary MRF should be in MS Excel as most people have this program on their personal computers. Excel has a file size limit and thus a defined subset of procedures, i.e. 300-500 procedures will need to be considered. The Summary MRF could include the date of the last update, rate (reflected as a dollar amount) for the plan name, network type, funding type (fully insured versus self-insured), service description, service MS-DRG diagnostic code, service CPT billing code, provider name, provider NPI, and the Place of Service code.

ii. While having separate NPIs is helpful to know WHERE a particular service is provided, each NPI and Tax ID, as relevant, should be mapped to a health system ID number. An advantage of requiring a health system ID number to MRFs is that it permits monitoring of hospital mergers and acquisitions on a monthly basis, allows comparison of price and quality of for-profit providers versus non-profit providers, allows state and federal monitoring of prices provided off-campus versus on-campus hospital services for monitoring of site neutral payments, etc.

iii. Ownership of NPI's and Tax ID's of all providers should be available in a file to monitor for horizontal and vertical integration and how this impacts pricing. Multiple

ownership lines need to be made available as several organizations may co-own a provider.

d. **Should health plans be required to submit this information to HHS, DOL, and Treasury? How would this help facilitate establishment of a federal database and perhaps a national All-Payer Claims Database?**

i. I do not know which federal organization would be best to submit health plan data to, but do believe when a health plan posts their data on their own website, they should send a copy to be placed in a federal database. This level of transparency will allow easier access for employers, researchers, and policy makers to conduct wide and deep analysis longitudinally for purchasing and regulatory monitoring purposes.

4. Under ERISA, fiduciaries have important responsibilities with respect to the plan, including a duty to act prudently and solely in the interest of plan participants and beneficiaries. However, in many cases entities such as third-party administrators and pharmacy benefit managers argue that they are not fiduciaries and are not subject to these obligations.

a. **How would adhering to a fiduciary standard change the practices of third-party administrators and pharmacy benefit managers?**

i. Holding TPAs and PBMs to a fiduciary standard would be a game changer as they would then have to perform their responsibilities in the best interest of their plan client, ensuring only reasonable, appropriate plan costs were paid from plan assets. Thus, would enhance aligning employer/employee payment with the value of services provided.
ii. In numerous industries, a person/organization hired to provide a service is required to act as fiduciary to their client, i.e. attorneys, real estate agents, financial investment advisors, etc. These people/organizations can still make a profit while doing what is in the best interest of their client. It is not enough for service providers to disclose the compensation that they get from various vendors. They should also be required to provide advice that is in the best interest of their clients, not themselves.

b. **Would it be useful for federal policymakers – either through legislation or regulatory action – to specify which functions performed by third-party administrators, pharmacy benefit managers, and others entail fiduciary duties under ERISA?**

i. It may be helpful to outline functions in regulatory guidance.
ii. I hesitate recommending legislation as functions will likely change over time with greater transparency, improved technology, etc.

5. The *Consolidated Appropriations Act, 2021* amended Section 408(b)(2) of ERISA to provide that contracts or arrangements between plan fiduciaries and service providers must include disclosures of direct and indirect compensation earned by service providers. The statute specifically specifies that contracts for the design and implementation of pharmacy benefit management services and third-party administrative services are subject to this requirement.

a. **Is it your understanding that service providers such as third-party administrators and pharmacy benefit managers are providing these disclosures to employers?**

i. To my knowledge, it is variable. Some TPAs and PBMs are complying and are some are side-stepping by disclosing fees designated as “commissions” or “fees in exchange” for placing an employer on an account but are not including “book of business bonuses” paid to brokers/benefit consultants for meeting certain revenue goals at end-of-quarter or year-end.
ii. Clearly defining “indirect” would be helpful to include bonus trips and other non-cash perks in exchange for meeting referral targets.
iii. Some PBMs and TPAs are informing their clients that they will manage the required disclosures directly but are not sharing the submitted disclosures with the plan sponsors.

b. **If employers are not provided this information, how are they able to determine if the compensation their vendors are receiving is reasonable?**

i. If they are not provided with the disclosure information, they cannot determine reasonable compensation. Making it worse is that the undisclosed compensation by TPAs and PBMs is ultimately passed on to employers and working families, further increasing their healthcare expenditures.