**Statement for Hearing on**
**"Competition and Transparency: The Pathway Forward for a Stronger Health Care Market"**

**House Committee on Education and the Workforce**
**Subcommittee on Health, Employment, Labor, and Pensions**

**June 21, 2023**

Employer-provided coverage delivers affordable access to care, effective ways to improve health, and financial security. From comprehensive health insurance coverage and income protection to dental and vision benefits, Americans have real choices and real control in the care and protection they receive through work. Nearly 180 million people – about half the total U.S. population - are covered by employer-provided coverage and 89% of all American workers are employed by a company that offers health benefits.[1] As the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day, we are committed to market-based solutions that make employer-provided coverage better and more affordable and accessible for everyone.

Where there is robust competition – for example, when there are several local hospitals, or generic alternatives for prescription drugs – private negotiations work to make health care more affordable, spur innovations such as value-based agreements and integrated care models, and provide Americans with more choices for their care.

True competition requires transparency – so people can make better and more informed decisions as they seek and receive care. Health insurance providers offer price transparency tools that enable hardworking Americans to make health care decisions that deliver better health care at lower costs, and they are continually improving them.[2]

At the same time, Americans continue to see health care prices escalate year after year – a challenge that can be tied directly to health care markets where there is little to no competition. This calls for a comprehensive effort to spur the robust competition that is essential to providing Americans with more choices, better quality, and lower costs. AHIP commends the

[1] https://www.ahip.org/documents/CaW_EPC_Primer.pdf
[2] https://www.ahip.org/documents/202206-AHIP_IB_Price_Transparency.pdf

subcommittee for looking at ways to increase competition and transparency to create a more patient-friendly, and pocketbook-friendly, health care system for Americans, and offers the following solutions.

**Health Insurance Providers are Committed to Meaningful Price Transparency**

AHIP and our member health insurance providers fully support the goals of providing Americans with information about the cost and quality of health care services, so they can make better-informed, decisions that take into consideration cost and value of health care. We are fully committed to providing personalized, accurate information on enrollees' estimated out-of-pocket costs, all while protecting patients' personal privacy and the security of their personal health information.

Health insurance providers have demonstrated their commitment to price transparency by providing meaningful cost estimates through tools that help people shop for affordable services. Ahead of regulatory deadlines in June 2021, 94% of commercial health plans were providing patients with access to meaningful price transparency by offering cost estimates through Internet-based self-service cost calculator tools.[3]

These tools provide personalized estimates of an enrollee's out-pocket costs for services and procedures including elective outpatient surgery/procedures, inpatient surgical services, inpatient non-surgical services, physician services, outpatient laboratory services, radiology services, prenatal care, and delivery and postpartum care, based on the enrollee's benefits, deductible, out-of-pocket maximum and the plan's cost-sharing features. Moreover, many of these tools offer quality and other information that can be helpful in shopping for services.

Health insurance providers are fully committed to providing people with information about their out-of-pocket costs prior to seeking health care services through advanced explanations of benefits (AEOB), which allow them to request a precise estimate of their expected out-of-pocket costs before a scheduled service. An AEOB will provide personalized, accurate cost information based on the particular provider, at a specific site (e.g., hospital inpatient or physician's office), based on a set of tailored billing codes, and reflective of that individual enrollee's benefits. Thus, AEOBs have the potential to be the most valuable transparency tool for Americans.

*Recommendations*

1. The subcommittee should work with stakeholders to ensure that any new reporting requirements are not duplicative and include directions to the federal agencies to streamline reporting to reduce burden.
2. Policy solutions should ensure that health care information is personalized, accurate, and easy to understand – focusing on treatments and services for which people can actually shop and make choices about.

[3] https://www.ahip.org/documents/202206-AHIP_IB_Price_Transparency.pdf

**Strengthening Negotiating Power to Drive Down Prescription Drug Costs**

Everyone deserves access to affordable prescription drugs, but Americans are paying increasingly more for the medications they need. Drug manufacturers continue to raise prices every year without any improvement in a drug's efficacy while launching new drugs at ever higher prices and manipulating patent rules to block competition from generic medications. Yet these manufacturers provide no transparency to their manufacturing or research costs to demonstrate how they would justify their monopoly prices. We agree that transparency is critical to ensure drugs are priced at levels that reflect their innovation and value. Patients benefit from seeing honest drug prices that reflect the actual value medications provide, not the highest prices the market will bear.

Absent this transparency from drug manufacturers, patients need an advocate to negotiate lower drug prices. Pharmacy benefit managers (PBMs) negotiate drug prices on behalf of patients, leveraging competition for prescriptions and keeping prices down. These private entities are a powerful tool in securing savings for patients, promoting safety in the system, and providing an important check drug manufacturers' power. Pharmaceutical manufacturers sets the prices for their drugs, including frequent price increases not associated with a change in value or outcome of the drug. PBMs are an essential negotiator for lower drug costs and protect patients from out-of-control prices.

Health insurance providers remain committed to price transparency and have made additional strides to increase transparency for the people they serve. For instance, some are implementing innovative solutions like new copay plans capping out-of-pocket copays on prescription drugs, fully transparent price models, and enhanced disclosure practices.[4] Other initiatives include increasing the interoperability between systems so that PBMs can proactively and transparently share patient benefit information with prescribers to ensure continuity of care and show out-of-pocket costs for prescription medications.[5] Additionally, health insurance providers and PBMs report substantial amounts of data on health care and drug spending to the federal government through the Prescription Drug Data Collection (RxDC).

*Recommendations*

AHIP supports additional standardized reporting by PBMs to plan sponsors on the following, which would empower employers to compare benefit packages:

1. Gross spending on prescription drugs
2. Net spending on prescription drugs after manufacturer rebates
3. Total drug utilization
4. Fees and compensation paid to brokers and consultants

However, to increase the overall transparency around prescription drugs, AHIP recommends Congress look at policies that require drug manufacturers to publicly disclose pricing information to the public and justify price increases for their high-priced drugs.

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[4] https://newsroom.thecignagroup.com/express-scripts-further-advances-transparency-and-affordability

[5] https://payorsolutions.cvshealth.com/insights/strategic-initiative-to-create-greater-transparency-and-access

**Site-Neutral Payment Reforms Would Increase Affordability and Transparency**

Enacting site-neutral payments across outpatient sites of service can help drive improved affordability for everyone. Historically, Medicare has paid a higher amount for comparable services when performed in hospital outpatient departments versus physician offices. In addition to higher reimbursement rates, hospital-owned locations can charge a facility fee along with professional service fees for even low-complexity services that can be safely performed at physician offices for a lower cost. Patients should not pay more for the same service furnished with the same quality of care simply because a hospital owns their physician's office.

Payment differentials across sites of service create two problems for health care affordability. First, it results in increased costs to patients and their health insurance providers for individual services at the point of care. Second, the prospect of higher reimbursement rates paid to hospital-affiliated practices is seen as a contributing factor to consolidation, as hospitals have an economic incentive to purchase independent physician offices to receive higher rates at those locations.[6] Implementing site-neutral payments for outpatient care has the potential to drive savings across markets, drive affordability for consumers, and remove incentives to consolidate.

*Recommendations*

The subcommittee should work with other committees of jurisdiction on legislative solutions that permit comparable payment for comparable services encourage an efficient and competitive market that works for Americans, including:

1. Require separate national provider identifier enumeration for off-campus hospital outpatient departments to strengthen implementation of site neutral payment policies.
2. Remove the exception for grandfathered hospital-based locations such that these sites are subject to site neutral payments.
3. Prohibit the assessment of facility fees for outpatient care that can be safely performed at physician offices unless a special exception applies.
4. Narrow the definition of free-standing emergency departments to those that provide most services on an unscheduled basis and require patient disclosure notices.

**Conclusion**

Competition, transparency, and a strong ERISA market are essential to ensure that the nation's health care system focuses on patients and their access to affordable, comprehensive health insurance coverage. Therefore, attempts to weaken the ERISA preemption protections will jeopardize the robust employer-sponsored health plans millions of Americans rely on today and increase costs to employers across the country. We are committed to working with the subcommittee to prevent the degradation of these ERISA preemptions and continue strengthening the employer-sponsored health insurance market.

[6] https://www.gao.gov/assets/gao-16-189.pdf