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HEARING ON

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

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Good morning Chairman Good, Ranking Member DeSaulnier, and members of the Subcommittee on Health, Employment, Labor, and Pensions.

My name is Christine H. Monahan and I am an Assistant Research Professor at the Center on Health Insurance Reforms within Georgetown University's McCourt School of Public Policy. At the Center, we study private health insurance and health care markets.

I am honored to be invited to testify today regarding competition and transparency in our health care markets. In my testimony, I will briefly address the growth of consolidation across our provider and insurance markets, and the effects this is having on consumers and employers, the users of and ultimate payors for health care in the commercial market. I will then turn to opportunities for Congress to address consolidation and its harms, with a particular focus on measures that shed more light on different aspects of our health care system.

Please note that these views are my own. They do not necessarily reflect the views of the Center on Health Insurance Reforms, the McCourt School of Public Policy, or Georgetown University.

Consolidation in health care markets is growing, to the detriment of everyone who uses and pays for health care

Both horizontal and vertical consolidation are increasing across our health care system, and have been for years now. In health care provider markets, health systems have been allowed to merge with each other and further expand their reach by acquiring physician practices and other ambulatory care settings. Today, the majority of physicians, including those that help diagnose and treat everyday conditions like family doctors, are employed by hospitals and other corporate entities.[1]

These changes to ownership in our health care provider markets are driving up costs for consumers and employers. One cause behind this increase is that hospitals charge and insurers typically pay more for the same care when it is provided in a hospital setting, like a hospital outpatient department, than an independent practice. While this may be appropriate when the care being provided is more complex and the patient may need additional services only a hospital can safely provide, these higher payments currently extend even to the most routine, everyday services that can be safely and effectively provided outside of a hospital. As hospital acquisitions expand the scope and volume of services that are delivered in hospital-owned or -affiliated

[1] R. Shawn Martin, Exec. Vice President & Chief Exec. Off., Am. Acad. of Family Physicians, Statement to the U.S. Sen. Comm. on Finance 4 (June 8, 2023), https://www.finance.senate.gov/download/06082023-shawn; *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020* at 11, PHYSICIANS ADVOC. INST. (June 2021), https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3D%3D.
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settings, we end up paying much more than we previously were paying or need to be paying for ambulatory care.[2]

Another reason consolidation among health care providers increases costs is that large, conglomerate systems gain significant leverage in negotiations with commercial insurers. They become must-have-providers to any insurers seeking to build a provider network, and can extract greater reimbursement rates because of that status.[3] They can also impose anticompetitive contracting clauses on insurers, for example requiring insurers to contract with all the providers in their system under the same terms, regardless of factors like the cost or quality of care they may provide.[4]

Compounding these issues, we have a commercial insurance market dominated by just a handful of major insurers.[5] Often, insurance markets pit only two or three major insurers against each other, and these insurers frequently are following the same business models under which constraining health care prices and spending is not necessarily a priority.[6] As experts writing for the Urban Institute have summarized: "even dominant insurers do not need to achieve low prices, only the lowest rates among their competitors to establish favorable market conditions and prevent entry of would-be competitors."[7] Indeed, a dominant insurer may even engage in anti-competitive arrangements with the dominant health system to keep rates high.[8]

Some also point out that the Affordable Care Act's (ACA's) medical loss ratio requirements discourage insurers from containing costs because the amount of profits they can take home is

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[2] *See, e.g.*, Frederick Isasi et al., *Gaming the System: How Hospitals Are Driving up Health Care Costs by Abusing Site of Service* 5–7, FAMILIES USA (June 7, 2023), https://familiesusa.org/wp-content/uploads/2023/06/Gaming-the-System-How-Hospitals-Are-Driving-Up-Health-Care-Costs-by-Abusing-Site-of-Service.pdf; *Facility Fees and How They Affect Health Care Prices: Policy Explainer*, HEALTH CARE COST INST. (June 6, 2023), https://healthcostinstitute.org/all-hcci-reports/facility-fee-explainer; *Moving to Site Neutrality in Commercial Insurance Payments* 2–4, COMM. FOR A RESP. FED. BUDGET (Feb. 2023), https://www.crfb.org/sites/default/files/media/documents/Moving_to_Site_Neutrality_in_Commercial_Insurance_Payments_4.pdf; Aditi P. Sen et al., *Site-Based Payment Differentials for Ambulatory Services Among Individuals with Commercial Insurance*, Health Servs. Res. (Jan. 18, 2022), https://doi.org/10.1111/1475-6773.13935.

[3] *See, e.g.*, Katherine L. Gudiksen et al., *Mitigating the Price Impacts of Health Care Provider Consolidation* 3, MILBANK MEM'L FUND (Sept. 2021), https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf; Katherine L. Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets* at 22–23, 40–41, THE SOURCE (Sept. 2020), https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/09/Preventing-Anticompetitive-Contracting-Practices-in-Healthcare-Markets-FINAL.pdf; Robert Berenson et al., *Addressing Health Care Market Consolidation and High Prices* 3, URBAN INST. (Jan. 2020), https://www.urban.org/research/publication/addressing-health-care-market-consolidation-and-high-prices.

[4] *See, e.g.*, Gudiksen et al., MILBANK MEM'L FUND, *supra* note 3 at 3, 5–7; Gudiksen et al., THE SOURCE, *supra* note 3 at 22–23, 39–41.

[5] U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105672, PRIVATE HEALTH INSURANCE: MARKETS REMAINED CONCENTRATED THROUGH 2020, WITH INCREASES IN THE INDIVIDUAL AND SMALL GROUP MARKETS (Nov. 2022) https://www.gao.gov/assets/gao-23-105672.pdf.

[6] Marshall Allen, *Why Your Health Insurer Doesn't Care About Your Big Bills*, PROPUBLICA (May 25, 2018), https://www.propublica.org/article/why-your-health-insurer-does-not-care-about-your-big-bills.

[7] Berenson et al., *supra* note 3, at 2.

[8] Gudiksen et al., THE SOURCE, *supra* note 3, at 11–13.

capped to a percentage of spending.[9] However, the ACA's subsidy structure can incentivize cost containment when multiple insurers compete to be one of the two lowest cost plans in the individual marketplace, as these plans tend to get large percentages of enrollment.[10] On the other hand, the bulk of major insurers' commercial business comes from administrative-services-only (ASO) contracts with employers,[11] for which they may have little incentive to negotiate competitive rates due to their relative market power and information monopoly vis-à-vis most employers.[12] These perverse incentives are only worsening as the major insurers engage in vertical consolidation themselves, including ownership of all the major pharmacy benefit management (PBM) companies,[13] and growing acquisitions of health care provider practices and other suppliers of health care.[14]

The effects of all of this consolidation is the continued rise in the prices that consumers and employers pay for health care. This, in turn, translates to increased premiums and out-of-pocket costs for employees and individual market consumers, which many are ill-prepared to take on. A recent study by the Commonwealth Fund found that 29% of individuals with employer-sponsored insurance and 44% of those with individual market insurance were underinsured—meaning they have insurance, but that coverage does not adequately protect them from unaffordable out-of-pocket costs.[15]

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[9] *See, e.g.*, Robert Book, *How the Medical Loss Ratio Requirement Could Increase Health Insurance Premiums and Insurer Profits at Taxpayer Expense*, Am. Action Forum (Apr. 2013), https://www.americanactionforum.org/wp-content/uploads/files/research/MLR_Paper_Final.pdf.

[10] *See* Jane M. Zhu et al., *Association Between Number of Insurers and Premium Rates in the Affordable Care Act Marketplace*, 177 JAMA INTERNAL MED. 1684, 1686 (Nov. 2017); John Holahan et al., *Marketplace Competition and Premiums, 2019–2022* at 9, URBAN INST. (Apr. 12, 2022), http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces.

[11] *Inside Big Health Insurers' Side Hustle*, TRADEOFFS (Sept. 23, 2021), https://tradeoffs.org/2021/09/23/inside-big-health-insurers-side-hustle/; Cathy Schoen & Sara R. Collins, *The Big Five Health Insurers' Membership and Revenue Trends: Implications for Public Policy*, 36 HEALTH AFFS. 2185, 2188 (Dec. 2017).

[12] CONG. BUDGET OFF., POLICY APPROACHES TO REDUCE WHAT COMMERCIAL INSURERS PAY FOR HOSPITALS' AND PHYSICIANS' SERVICES 11 (2022), https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf; TRADEOFFS, *supra* note 11; 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.

[13] Adam J. Fein, *Insurers + PBMs + Specialty Pharmacies + Providers: Will Vertical Consolidation Disrupt Drug Channels in 2020?*, DRUG CHANNELS (Dec. 12, 2019), https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

[14] *See, e.g.*, Jakob Emerson, *Meet America's Largest Employer of Physicians: UnitedHealth Group*, BECKER'S HEALTHCARE (Feb. 16, 2023), https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html; Bob Herman, *Profits Swell When Insurers Are Also Your Doctors*, AXIOS (July 16, 2021), https://www.axios.com/2021/07/16/unitedhealth-optum-providers-intercompany-eliminations; Jack O'Brien, *Why Health Insurers Want to Merge with Retail Giants*, HEALTH LEADERS MEDIA (Apr. 16, 2018), https://www.healthleadersmedia.com/finance/why-health-insurers-want-merge-retail-giants.

[15] Sara Collins et al, *The State of U.S. Health Insurance in 2022*, COMMONWEALTH FUND (Sept. 29, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.

Reducing the harms of consolidation through greater transparency and further interventions

The American public recognizes that health care provider pricing for people with commercial insurance is too high, too variable, and makes little sense. For example, a recent poll shows that a majority of voters, across political affiliation, believe that hospital prices are unreasonable (80%) and that it is important for the current Congress to act to reduce hospital prices (89%).[16] Similarly, large proportions of voters support specific policy reforms currently on the table, including "[r]equiring hospitals to publicly disclose their prices (87%)" and "[l]imiting outpatient fees to the same price charged by doctors in the community (85%)."[17] And, by far, more voters fear that Congress won't do enough (74%) than that it will go too far (26%).[18]

Action by Congress to shed more light about the financial incentives driving the growth in health spending is an important component to making our health care markets work better and addressing the harms that derive from consolidation. It can empower employers and employer coalitions to negotiate better deals from their vendors and health care providers. It can also inform regulators, including state and federal insurance and antitrust agencies that are charged with overseeing our health care markets and enforcing existing protections. Critically, it can also help policymakers at the state and federal levels develop and monitor the effects of new reforms, and ensure that the steps we are taking are moving us towards a health care system that provides affordable, high quality care to all. To that end, I'd like to address two broad areas for action: (1) shedding more light on and rationalizing commercial payment practices, and (2) exposing and eliminating wasteful and inappropriate spending in employer-sponsored coverage.

(1) Moving towards more transparent and rational payment practices in commercial insurance

Health care claims are a valuable source of information for payers, regulators, and policymakers, in addition to the broader research community. But consolidation in provider markets has obscured information about who provides care where. This lack of clarity undermines the ability of payers to make informed payment decisions and hinders our collective ability to understand the extent and effects of consolidation and target appropriate policy and legal interventions.

When health care is provided in a hospital-based setting, both the physician or other health care practitioners providing care and the hospital or health system typically will submit claims to the patient's insurer. These claims are submitted on separate forms. Currently, neither the physician form nor the hospital form needs specify the actual location where care was provided. Although the forms include address lines, providers typically will list the address for where payment

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[16] *New Poll: Majority of Voters Support Aggressive Congressional Action to Lower Hospital Prices*, ARNOLD VENTURES (Mar. 23, 2023), https://www.arnoldventures.org/stories/new-poll-majority-of-voters-support-aggressive-congressional-action-to-lower-hospital-prices.

[17] *Id.*

[18] *Id.*

should be sent—which may be a billing office in a different state—rather than the care setting. Providers will also include a national provider identifier (NPI), a ten-digit, federally assigned identification number that providers use for administrative and financial transactions. But hospital claims often include the NPI for the hospital main campus or whatever entity in the system is assigned to collect payment, while the physician claim will include the individual physician's NPI (or that of whoever is responsible for billing in a group practice), even though they may practice out of several different locations. To those on the receiving end of these claims or who rely on public and private claims databases, the actual physical location of care is often a mystery. What's more, because of these and other discrepancies between the claim forms submitted by hospitals and physicians, it is challenging to reliably associate separate claims and know the total cost of care for a given outpatient service.

From dozens of interviews I and my team conducted this winter and spring, the absence of this information is an immense frustration to those in private and public spaces trying to understand and respond to hospital outpatient facility fee charges and other outcomes of vertical integration. For example, a growing number of states are seeking to prohibit hospital-controlled facilities from charging facility fees in certain types of settings, like off-campus facilities or physician offices. Outpatient facility fees can significantly and unexpectedly increase the amount patients pay in out-of-pocket costs for routine medical care, while also contributing to overall premium growth. But states may have difficulty enforcing facility fee prohibitions if insurers and regulators alike cannot tell the actual location care was provided. [19] I also worry that insurers not having this information will undermine the benefits of ongoing efforts at the state and federal level to prohibit anti-competitive clauses in contracts between providers and insurers. An insurer may, for example, want to pay lower prices to or simply not contract with certain practice locations owned by a health system that have poor quality ratings. But if they cannot tell what care was provided at which location, they may be unable to effectively implement such changes.

Fortunately, there are very simple, minimally burdensome reforms that Congress can take to improve billing transparency. Specifically, as states like Colorado[20] and Nebraska[21] have done, Congress can require that each separate physical location where care is provided obtain a unique NPI, and that providers, including hospitals and individual physicians and other professionals, list this unique NPI on all claims for care provided at that location. This would mean, for example, that every off-campus hospital outpatient department would have a unique NPI and claims would clearly convey when services are provided there.

This reform comes with another potential benefit: The NPI application form currently includes fields asking an applicant to provide the Legal Business Name (LBN) and Taxpayer Identification Name (TIN) of its parent organization on the application form. To ensure this information is consistently captured, Congress could specify that any application that does not

[19] *See* Christine H. Monahan et al., *Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform*, CTR. ON HEALTH INS. REFORMS (forthcoming summer 2023) (on file with witness).
[20] Colo. Rev. Stat. §§ 25-3-118(1); 25.5-4-420.
[21] Neb. L.B. 296 § 12 (2023).

include this information must be rejected. This information can, in turn, help the federal government, as well as private insurers, better track who owns each of these locations and monitor consolidation across the health care provider market.

From here, it will also be important to take additional steps to limit hospitals' and health systems' ability to charge outpatient facility fees and ultimately move towards site neutral payments for care that can be safely and effectively provided in independent practice settings. As I previously discussed, major insurers often lack the financial incentives and market leverage to take these actions on their own. Several states, from Indiana, to Maine, to Connecticut, are showing us ways to tackle these issues in the commercial sector. Their reforms provide important protections to consumers who can face substantial out-of-pocket exposure to outpatient facility fee charges and bring us closer to a more rationale payment system that hopefully will ultimately help drive down costs at the system level.[22]

(2) Exposing and eliminating inappropriate spending in the employer-sponsored insurance market through increased transparency

The employer-sponsored insurance market is rife with excessive and wasteful spending, from wildly disparate reimbursement rates, many of which are far above levels that would enable hospitals to "break even,"[23] to hidden fees and overpayments to third-party administrators (TPAs) and PBMs,[24] to massive commissions for employer benefit consultants and brokers recommending and arranging contracts on behalf of employers.[25] This occurs despite the fact that employers, as plan sponsors, have a legal duty under ERISA to act "solely in the interest of the participants and beneficiaries of the plan" when administering their employee benefit plans,[26] and ensure the compensation they pay service providers (including health care providers) is "reasonable."[27]

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[22] *See* Monahan et al., *supra* note 19.
[23] *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/
[24] 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), 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/.
[25] *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.
[26] 29 U.S.C. § 1104(a)(1).
[27] Information Letter 02-19-1998, U.S. Dep't of Labor, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/02-19-1998.

The incongruity between the expectations on employers as plan fiduciaries and the reality of spending under employer plans today is driven by several factors discussed above, including the market dominance of hospitals, health systems, and major insurers vis-à-vis individual employers. A lack of transparency into the health care system also significantly undermines employers' ability to investigate and meaningfully engage in negotiations over plan spending and the terms of their contracts. This factor, however, has begun to become less of a barrier than it once was, thanks to efforts by Congress and the Executive Branch to bring more transparency into our health care system. Since Congress passed the Consolidated Appropriations Act of 2021 (CAA) and the administrative federal price transparency rules went into effect, there has been an awakening by many in the employer community to the need to begin acting on the new information becoming available. At the same time, continued improvements to these efforts can still be made to better equip employers and others to make sure health care dollars are well spent.

(a) Codifying and strengthening federal price transparency rules

The first reforms to go into effect were the federal price transparency rules requiring various disclosures by hospitals and insurers and health plans. Implementation of these rules has been challenging, from court battles, to administrative delays, to outright noncompliance and obstruction by hospitals. And although insurers and health plans released their data more readily than many hospitals, the format and volume of their files were largely inaccessible to anyone without a supercomputer.[28] Work by private organizations—like the Employers Forum of Indiana's creation of the Sage Transparency tool—has helped harness some of available the price transparency data and combine it with other information to help employers make better decisions. Nonetheless more must be done to ensure all of the data covered by these rules is widely accessible and meaningful to the public.

Congress can take steps to fortify existing efforts, including codifying the price transparency rules and requiring greater standardization to enable plan-to-plan and provider-to-provider comparisons. Congress also needs to strengthen federal enforcement, such as by increasing the penalties for noncompliance and requiring the random auditing of data disclosures. Other changes that can make the information more useable would be to require insurers to make their data available in smaller files and provide an index or directory to help users navigate the information better, and to require that pricing and reimbursement data be posted as a percentage of Medicare rates in addition to flat dollar rates. Finally, Congress could require federal agencies to create a publicly available central repository for hospital and insurer price data combined with quality information, and report annually on this information so legislators and other stakeholders

[28] *See generally* Maanasa Kona & Sabrina Corlette, *Hospital and Insurer Price Transparency Rules Now in Effect but Compliance is Still Far Away*, HEALTH AFFS. (Sept. 12, 2022), https://www.healthaffairs.org/content/forefront/hospital-and-insurer-price-transparency-rules-now-effect-but-compliance-still-far-away; Julie Appleby, *Health Insurance Price Data: It's Out There, but It's Not for the Faint of Heart*, KAISER HEALTH NEWS (July 27, 2022), https://kffhealthnews.org/news/article/health-insurance-price-data-access/.

are kept informed regarding health care costs. For additional ideas for improving the Transparency in Coverage rules in particular, I would refer you to a set of recommendations to which some of my colleagues at CHIR contributed.[29]

(b) Revisiting the ban on gag clauses

Congress sought to shed further light on health care prices with the CAA's prohibition on gag clauses. This provision specifically prohibits employer health plans from entering into agreements with service providers that contain gag clauses restricting the plan's access to cost and quality information, including deidentified claims data.[30] Unfortunately, reports from the field suggest insurers acting as TPAs have continued to put up barriers to plan sponsors accessing this information.[31] One problem appears to be that the responsibility for compliance ultimately falls on plan sponsors, while control of the data remains with TPAs. Indeed, in recent litigation in which plan sponsors are seeking access to their claims data, their TPA, a major insurer, has argued 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 TPA.[32] Additionally, as this guidance has been implemented by federal agencies, employers can rely on TPAs to attest that their contracts comply. But it is in the TPA's interest to assert compliance even if they may still retain arguably problematic contract terms. The fox, in effect, is guarding the henhouse.

Congress should explore ways to ensure that its intent in prohibiting gag clauses and giving plan sponsors access to their claims data, subject to appropriate privacy protections for plan members, is manifested. This will better enable employers to monitor their TPAs and the provider reimbursement rates the TPAs negotiate.

(c) Clarifying and expanding service provider disclosure requirements

In the CAA, Congress further empowered employers to better monitor their service providers and health plan expenditures by requiring service providers to describe in writing all direct and indirect compensation they expect to receive in connection with their services.[33] In speaking with employers and experts working in this area, they expect many employers will be shocked to learn of the amounts their consultants are making in commissions and other forms of compensation. As one example, many stakeholders highlight a Florida school district that alleged in 2021 that a

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[29] *Transparency in Coverage: Recommendations* for Improving Access to and Usability of Health Plan Price Data, and Usability of Health Plan Price Data*, https://georgetown.app.box.com/s/1ezsggz1c7smsaexkr8rght15sokgusl.
[30] 29 U.S.C. § 1185m.
[31] Sabah Bhatnagar et al., *Improving and Strengthening Employer-Sponsored Insurance* 22–23, BIPARTISAN POL'Y CTR. (Oct. 2022), https://bipartisanpolicy.org/wp-content/uploads/2022/10/BPC-Improving-and-Strengthening-Employer-Sponsored-Insurance-Oct-2022.pdf.
[32] 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) (emphasis in original).
[33] 29 U.S.C. § 1108(b)(2)(B).

consultant it hired to help them select a TPA for their employee health plan secretly received more than $2 million in extra insurer commissions over eight years.[34]

As this Committee already is familiar, however, some service providers—including PBMs and TPAs—maintain that this requirement does not apply to them. In December 2022, Committee leadership sent a letter to the Department of Labor regarding this issue and encouraging the agency to issue guidance clarifying that the compensation disclosure requirements fully apply to PBMs and TPAs. Because the agency has yet to act on this recommendation, further clarification from Congress may be necessary and appropriate to ensure that the CAA is implemented to its fullest effect and intent.

Beyond this, it is worth exploring what additional information TPAs, PBMs, and other service providers should disclose to current and potential plan sponsors to ensure plan sponsors have adequate information to fulfill their fiduciary duties. In doing so, it is important to balance several considerations. Information must be sufficiently specific to be actionable. One concern is that many disclosures are in the form of formulas, percentages, and other metrics that do not necessarily convey the extent of compensation (and, thus, potential conflicts of interest). PBM and TPA contracts are immensely complex, and identifying the specific metrics that matter most may be challenging. What's more, PBMs and TPAs may adapt to any new disclosure requirements, shifting where and how they maximize revenue and profits to areas that remain secret. A flexible approach that focuses on articulating the goal of disclosures, such as better informing plan sponsors of how their plan assets are being spent and potential conflicts of interest among their service providers, may be more effective in the long term than an overly detailed law that focuses only on the problems we already know exist.

Alternatively, Congress and DOL may want to explore avenues to ensure TPAs and PBMs are fiduciaries when performing key functions for employer health plans. In identifying these functions, I again encourage you to think about the goals you are seeking to achieve. Where, for example, is it important that TPAs or PBMs act in the best interest of the members of the plans they are administering rather than their own business interests, and what would that look like? There are likely to be some answers that are obvious, like not charging hidden fees or retaining recovered overpayments, and others that may be desirable but prove trickier, such as negotiating reimbursement rates that would apply across multiple plans.

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[34] Amended Complaint ¶ 36, Sch. Bd. of Osceola Cnty., Fla. v. Gallagher Benefit Servs., No. 6:21-cv-01979-ACC-LRH (M.D. Fla. Dec. 30, 2021).