Testimony For the Record of

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For the

Subcommittee on Health, Employment, Labor, and Pensions

Hearing On

"Lowering Costs and Increasing Access to Health Care With Employer-Driven Innovation"

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The Honorable Bob Good
Chair, Subcommittee on Health, Employment, Labor, and Pensions
461 Cannon House Office Building
Washington, DC 20515

The Honorable Mark DeSaulnier
Ranking Member, Subcommittee on Health, Employment, Labor, and Pensions
503 Cannon House Office Building
Washington, DC 20510

Dear Chair Good and Ranking Member DeSaulnier:

I commend the work of your committee in seeking testimony, conducting hearings, and continuing to evaluate provisions of the Lower Cost More Transparency Act. I present this testimony based on my experience in administering a state employee health benefit plan and the knowledge I have gained through my work as a forensic accountant focused on "following the money" in healthcare.

I served as Controller for a Blue Cross Blue Shield company and a Chief Financial Officer for a regional Third Party Administrator (TPA). In these positions, I was responsible for the accounting and reporting of financial healthcare transactions, including medical and pharmacy claims reporting for self-funded health plans. This gave me the opportunity to see into the "black box" of health care flow of funds.

In late 2014, I took the helm of the State of Montana Employee Group Benefit Plan, moving the Plan from projected reserves of negative $9 million to positive $112 million in less than 3 years, a $121 million gain. State employees have not had a premium increase since then, and over $50 million was provided back to the State of Montana, from excess Plan reserves. How did we do this?

- We compared Plan claims payments to Medicare rates for the same services, finding hospitals charging the Plan 300% to 600% of the Medicare Rates. We negotiated contracts with Montana hospitals to pay a multiple of the Medicare rate, rather than pay a secret discount off an unknown charge rate, with no balance billing to members.
- We terminated our traditional PBM contract and moved to a transparent, pass-through model, and removed CVS from our network for not accepting our pricing demands.
- We invested in primary care through on-site health centers.
- We implemented our own data warehouse with a third-party cloud based system, so the plan would readily have its claims data.
- We held our claims paying account allowing us the ability reconcile funds drawn from the Plan to the actual payment to the provider. Most all group health plans do not have this option, as the TPA/carrier requires the plan to fund an account owned by the TPA/carrier, and the plan is not able to verify the actual payment made to the provider.

The experience of managing a group health plan has led to my efforts today – to advocate for self-funded employer health plans to have transparency into healthcare prices and the payments made to reimburse providers for member claims. I applaud the bipartisan work achieved in

drafting the Lower Cost More Transparency Act, and recommend it be strengthened by provisions set forth in S 3548 as noted below:

- Allow the self-funded group health plan the ability to define the terms of claims audits with their TPAs/carriers and PBMs. The group health plan, rather than the vendor, must determine the frequency of audits, audit scope, auditor selection, and audit sample size, including 100% claims audited.
- Require TPAs/carriers provide group health plans access to their claims and encounter information, supported by penalties for non-compliance. While the 2021 Consolidated Appropriations Act took steps to remove gag clauses from group health plan contracts, employers are still challenged in trying to access their plan data. For example, one Virginia employer, Owens & Minor, was forced to file a legal claim against Anthem, after 18 months of waiting for their data. Suit Against Anthem Exposes Conflict Over Health Claims Data (bloomberglaw.com)
- Require the group health plan have access to standard electronic transactions, utilized by providers and TPAs/carriers.
    - ASCX12N 837 (837 file) is a standardized electronic file containing the medical claim and billing information sent from the provider to the TPA/carrier. Access allows the group health plan to reconcile provider charges to the claims file provided by the TPA/carrier.
    - ASCX12N835 (835 file) is a standardized electronic file of the Electronic Remittance Advice (ERA) transmission containing the amount paid to the provider by the TPA/carrier. Access allows the group health plan to reconcile payments made by the plan to the actual amount paid to the provider, determining if "spread pricing" is in play.

  The U.S. Department of Labor filed a lawsuit against Blue Cross Blue Shield of Minnesota, alleging the insurer wrongly passed along a Minnesota state hospital tax to self-funded employer health plans it administers. The suit claims that between 2016-2020, Blue Cross collected more than $66 million from 370 plans to cover provider tax obligations without proper authority. If these plans had access to the 837 and 835 files, they could have identified these improper payments.

- Require TPAs/carriers provide transparency in alternative payment arrangements, which include "value based payments", shared savings, and other incentive programs. Group health plans often "fund" these programs through supplemental rates added to claims, administrative fee adjustments, and other non-transparent methods. The plan administrator doesn't know how much they are paying nor what they are paying for.

In addition to the above recommendations, I encourage you to continue your efforts to:

- Codify the TiC rule to cover all commercial plans, requiring machine readable files with negotiated out-of-network, in-network, and prescription drug pricing. This information allows a group health plan to have comparative pricing to ensure they have the best vendors and providers for their members.

- Enact into law the extension of price transparency requirements, in House passed and Senate pending legislation, to ambulatory surgical centers, imaging centers and labs allow consumers and group health plans to better compare pricing for these services.

Thank you for this opportunity to submit comments and provide information I have gained from "following the money" in healthcare. I am available to answer any questions or provide further information, as needed.

Regards,

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