Testimony to the House Committee on Education and the Workforce on behalf of the National Alliance of Healthcare Purchaser Coalitions

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Subcommittee on Health, Employment, Labor, and Pensions

ERISA'S 50th ANNIVERSARY: THE PATH TO HIGHER QUALITY, LOWER COST HEALTH CARE

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Chairman Good, Ranking Member DeSaulnier, and Members of the subcommittee: I am Russell DuBose, Vice President of Human Resources for Phifer Incorporated, a mid-sized manufacturing company in Tuscaloosa, Alabama. Phifer has roughly 1,200 employees and offers self-funded health coverage to approximately 2,700 individuals in Alabama, California, and Pennsylvania. I'm testifying today on behalf of the National Alliance of Healthcare Purchaser Coalitions. The National Alliance is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its more than 40 regional employer/purchaser coalition members represent private and public sector, nonprofit, and union organizations and more than 45 million Americans, spending more than $400 billion annually on healthcare. I'm proud to serve on the National Alliance's National Purchaser Leadership Council and as the Chair of the Alabama Employer Health Consortium, one of the National Alliance's member coalitions. The AEHC works to educate Alabama employers on their role as healthcare purchasers, improve the healthcare system in which we participate, and inform lawmakers of the policy support needed for us to purchase healthcare effectively.

I'm here today to provide the perspective of self-funded employers and purchasers regarding the foundational role the Employee Retirement Income Security Act of 1974 (ERISA) plays in enabling us to provide high quality, uniform health coverage to employees across the country. Phifer is typical of a mid-sized manufacturing company, with worksite across three states. Because of ERISA, we can provide uniform coverage for all our families. To help describe how ERISA's structure enables employers to provide coverage and access solutions that uniquely meet the needs of their employees and families, I'd like to tell you about how we've aggressively pursued better value for our families.

The Phifer Healthcare Journey

About Phifer and our Values

Phifer Incorporated, founded in 1952, is a private family-owned business with corporate headquarters and manufacturing facilities in Tuscaloosa, Alabama; manufacturing facilities in Fayette, Alabama; and distribution facilities in City of Industry, California. Phifer is a world leader in the manufacturing of aluminum, fiberglass and polyester screening, sun shading fabrics, outdoor fabrics, and precision engineered products. Phifer is the last remaining Made-in-the-U.S.A. screening manufacturer.

Phifer succeeds in the marketplace based on a commitment to serve customers by providing quality products, on-time delivery, and world-class service. **Our corporate motto is The Golden Rule, "Do unto others as we would have them do unto us" and helps us on the pathway to our ultimate goal – excellence.** Treating each other with respect and compassion is essential for the success of our employees, customers, suppliers, and community. Because of our principles and approach to business, our

company enjoys an employer of choice status in the community. We are known for providing our employees stability, great pay and benefits, and an inclusive and participative workplace culture. Our average employee tenure exceeds 17 years, the average employee age is 47 years old, and our annual turnover is less than 10%.

Our Journey to Value Begins

During the 1990s and 2000s, the cost for maintaining competitive wages and benefits was relatively stable. However, after 2010, we began to experience a significant rise in benefit cost, specifically healthcare. **By 2015, the healthcare cost glide path had changed, and we envisioned an untenable scenario in which benefit costs were going to become unaffordable to the plan and to plan members.** Being a company that uses Lean Six Sigma problem solving, we conducted a kaizen event in 2016 to better understand healthcare, its components, and cost. The kaizen event consisted of a cross-section of leaders within the company, our healthcare insurance broker, a representative from Blue Cross Blue Shield of Alabama, and a college professor. The kaizen helped us better understand the complexities of healthcare and how we were spending our resources. But we did not have a plan for what we should do, much less a roadmap.

In 2017, I read *CEO's Guide to Restoring the American Dream* by Dave Chase, the co-founder of Health Rosetta — an organization dedicated to restoring and transforming healthcare.[1] I realized that I had discovered our blueprint. From the kaizen event, we knew the healthcare components affecting our company, but they were jumbled and opaque. Dave's book included a case study in which Rosen Hotels – a midsize employer in Orlando, Florida – created a localized ecosystem intentionally designed to drive higher value. That approach resonated with me. Our next steps were to ensure we had the right partners and to conduct a second healthcare kaizen event focused on building our roadmap.

I have learned that having the right partners is paramount to long-term success. I have also learned that most of the healthcare spend, about 80%, is wasted on intermediaries that bleed the system of resources and provide very little value. My first task was to replace my brokers with like-minded people who believed in the Health Rosetta model. I selected Ann Blair Gribbin of Cobbs Allen to be our broker and advisor. With Ann Blair on board, we conducted our second healthcare kaizen event.

The intent of our kaizen event was clear: Our task was to build a solution that created equity and value by eliminating access barriers to affordable, high-quality care. We made a commitment to keep the event active until we had a fully developed road map and go-forward plan that met our desired end-state. The first step was to pull apart our legacy healthcare plan using many of the Lean Six Sigma kaizen tools and synthesize the pieces into a Health Rosetta type plan. With our deliberate approach we

[1] Health Rosetta, 2022: https://healthrosetta.org/ceoguide/

constructed and published a seven-year roadmap with detailed planning and resource requirements. Our long-term vision included:

- Developing a value-based advanced primary care experience
- Transparent data for analysis and insight
- Transparent pharmacy benefits
- Direct contracting with best-in-class providers
- Nurse navigation and patient advocacy
- Innovative muscular skeletal solutions: physical therapy, chiropractic, and orthotics
- Onsite independent pharmacy
- Onsite specialty weight loss program
- Results-based wellness programs
- Independent high-value, transparent third-party administrator and compliance management

PhiferCares is Born

Because 90% of our 2,800 plan members lived within 17 miles of our Tuscaloosa facility, our first project in the seven-year roadmap was to build and open an onsite value-based advanced primary care health center. We conducted a formal RFP and interviewed three finalists. Ultimately we decided to build and operate the health center ourselves. With our onsite health center also serving as a service provider for our occupational health needs, we decided to outsource our dedicated staff positions to the local hospital. After a nine-month construction project and buildout, we named our onsite health center the PhiferCares Clinic. It opened on February 1, 2019.

Our PhiferCares Clinic is a zero cost-share advanced primary care solution that all plan members are eligible to use. The PhiferCares Clinic is built on the seven elements of advanced primary care: Enhanced access; realigned payment model; behavioral health integration; optimized time with patients; referral management; population health management; and effective clinical oversight. In addition, through direct contracting, we offer zero cost-share referrals for imaging, and conduct onsite collection for labs. With our broad scope of services, we employ a medical doctor, three nurse practitioners, four registered nurses, and two medical record technicians who use the Athena Electronic Healthcare Records digital management solution. Through marketing and traditional word-of-mouth advertising, the PhiferCares Clinic enjoyed early success. Within our first six months, daily capacity averaged 88% and 58% of our eligible users were actively using the PhiferCares Clinic. Our year end healthcare spend analysis for 2019 showed a significant migration from PPO network healthcare providers to the PhiferCares Clinic, which resulted in cost savings.

The beginning of 2020 was a bright period for our healthcare journey. With a strong primary care initiative underway it was time to begin project work for our second

initiative: pharmacy benefits. Amid preparation work for our next kaizen event, we were hit by a tsunami in March 2020 — the COVID-19 pandemic. As a manufacturer and essential business, we did not close one day during the pandemic. Our PhiferCares Clinic served as the front-line of defense against the pandemic, offering support to our workforce and families. We purchased personal protective equipment, COVID-19 lab testing equipment, developed multiple protocols, and created more than 40 corporate policies to survive — and thrive. The PhiferCares Clinic endeared itself to plan members and became a trusted healthcare partner.

With our project work derailed for a year, we returned to the whiteboard and brought multiple projects to life in 2021. We began direct contracting with high-quality healthcare providers and hired a registered nurse to serve on the Phifer HR staff to guide plan members to high-quality providers. We conducted a kaizen event to develop the Phifer Wellness Program and onsite physical therapy program, contracted a data warehouse solution, and created data feeds from the carrier and PhiferCares Clinic. In late 2021, we completed pre-work with our new pharmacy benefit advisor, RxDNA, to launch an RFP with the purpose of identifying a transparent pharmacy benefits manager aligned with our beliefs and values.

In early 2022, with our Phifer Wellness Program and onsite physical therapy programs launched, we pivoted and focused on pharmacy benefits. Our 2021 year-end analysis showed that pharmacy costs were beginning to rise at a higher rate than our other lines of healthcare spend. We completed the RFP process and selected MedOne to serve as our new transparent pharmacy benefit manager (PBM). By summer, we added Huron's physician performance scoring algorithm to assist our navigation team in identifying the best specialty providers for referrals and potential direct contracts. We also developed a specialty weight loss team within the PhiferCares Clinic. Our physician became board certified in specialty weight- loss management and our nurse practitioners became certified nutritionists. Our analysis also indicated that with our local plan member population density, migrating from a clinic dispensary to a full-scale pharmacy would further improve access and adherence. In late 2022, we broke ground, building out our onsite pharmacy.

2023 was a challenging year as we battled healthcare inflation and experienced a high-cost cancer claim. Because of an increase in cancer cases, we pivoted our onsite Phifer healthcare RNs from navigation to patient advocacy. This meant our RNs would now begin attending oncology appointments with plan members. The purpose was to ensure that each plan member understood all their treatment options and that they were supported in all their needs. The PhiferCares Clinic closed the dispensary upon opening the PhiferCares Pharmacy, creating time and space for the clinic to share in navigation duties. The Phifer Wellness Program increased participation to over 700 enrollees and our wellness bonus payout exceeded $200,000. In analyzing our annual healthcare spend, accounting for the high-cost claimant, the plan remained net flat. This was the fourth year in a row that our net spend was relatively flat.

The Healthcare Dividend

One of the most important concepts developed by Dave Chase is the creation of a "health care dividend." This is the intentional repurposing of previously squandered dollars to something that is meaningful and purposeful. Phifer has fully embraced this concept, creating an annual dividend that uses the savings we have derived from our projects to create sustainable, year-over-year investments in our employees, families, and community.

- Our first year of savings from 2019 was repurposed to support our scholarship fund for employee dependents. **Since the dividend was created in 2020, we have provided hundreds of thousands of dollars in scholarships for more than 100 dependents. These students have gone on to attend college at Bevill State Community College, Shelton State Community College, and The University of Alabama.**
- Savings from 2020 were reinvested in a new summer enrichment experience for our employee children. This experience was designed to serve as a summer day camp for dependents ages 6-14 to stop the "summer slide" of learning loss. The students, divided into cohorts, experience four rotations each day: Academic learning lab, arts, crafts, and sports. **To date, more than 200 children have attended this enrichment experience.**
- Based on our year-end analysis in 2021, we identified pharmaceutical cost-sharing as a barrier to access for some families. We used our 2021 dividend to eliminate copayments in our plan design for the new onsite pharmacy. **To date, more than 1,700 patients have been spared cost-sharing burden at our onsite pharmacy.**
- In 2022, we created another healthcare dividend: Designing an onsite chiropractic and imaging center to focus on muscular skeletal conditions, our next rising concern.
- Looking forward, we believe we are on track to generate enough savings in 2024 **to offer childcare assistance to more than 250 plan members** beginning in 2025.

Our Future Trajectory

The Phifer healthcare journey is relatively young, yet we have already accomplished many of the goals outlined in our seven-year roadmap. Aligning ourselves with many great partners has allowed us to accelerate learning and growth. As a result, with our continuous improvement mindset, we are revisiting the whiteboard and making changes to improve our roadmap. We believe the next chapter will include largescale direct contracting and aligning ourselves with the best administrators available. We will make more improvements to our mental health plan, weight loss program, wellness programs, and conduct better analysis as transparency becomes the norm. We know that our plan is working. We are eliminating out-of-pocket costs for our plan members, our retirement readiness has improved by more than 20 points since we began this journey, and our

employees and families have more disposable income to invest or purchase goods or services that they need. We look forward to what is next in our continuous journey towards excellence.

What Happens if ERISA is Weakened

Phifer's success is exemplary, but not unique. Employers around the country are reshaping the broken healthcare system into a functioning, efficient solution for employees. Given the pressures of the current labor market, it is more important than ever for employers to offer best-in-class benefits. Employee retention is a natural incentive for employers to design health plans that provide excellent service and high patient satisfaction. Further, and perhaps most important, employers have an interest in both the cost and the result of services they purchase. They need a healthy, productive, satisfied workforce to produce the output that is the backbone of our economy. The incentive toward high-quality healthcare at reasonable costs is not shared by other actors in the healthcare ecosystem. For the self-insured market, neither hospitals nor insurance companies are ultimately responsible for the cost of care or health outcomes. In fact, insurers and hospitals both make more money as the cost of care increases.

All the programs and strategies Phifer has aggressively pursued would be put at risk if ERISA is weakened. In such a destructive scenario, self-funded, multi-state employers would find themselves having to juggle a patchwork of state requirements to continue providing coverage to workers and their families. The likely result would be the end of self-funded health plans as we know them. In its wake, I expect most employers would instead choose to purchase "off the shelf" fully insured health insurance projects offered by the dominant health plans in their areas. In my state, where Blue Cross and Blue Shield of Alabama control more than 90% of the insurance market,[2] we would have no choice but to contract with them to provide fully insured coverage. ***Our ability to offer on-site clinics, direct contracting with high-quality providers, patient navigation and advocacy, and future healthcare dividends would disappear.*** The result would be higher-cost, lower-quality care and the reinforcement of dominant incumbent health insurance companies.

Faced with this prospect, I believe many employers may choose to forego offering health coverage altogether, instead allowing their employees and families "go it alone" in the individual market. Indeed, a 2018 survey conducted by the HR Policy Association found that ***more than one-in-three (37%) employers would consider ending healthcare coverage if faced with an "erosion of ERISA such that self-insured plans become subject to substantially differing state taxes and fees."***[3]

[2] Kaiser Family Foundation, 2021: https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/

[3] HR Policy Association, 2018: https://www.hrpolicy.org/insight-and-research/health-care/erisa-preemption-and-state-laws/

Given regulatory flexibility and aligned incentives toward high quality, efficient care, employers like Phifer are driving toward better value in healthcare. If employers like mine are stifled with an onslaught of pent-up state level regulation in the absence of ERISA, this opportunity for employers to reshape the system will be lost.

The Need for Federal PBM Legislation

Some of the most significant threats to ERISA's preemption of state laws have come from states seeking to regulate PBMs in their state. The recent spate of state laws seeking to regulate PBMs is caused, in part, by the vacuum created by the lack of meaningful action on PBM abuses at the federal level. To ensure uniform standards and meaningfully change to the PBM industry across the country, we encourage the committee to examine the appropriate roles for both states and the federal government and advance federal legislation to ensure PBMs providing services to self-insured employers are subject to strong uniform standards, eliminating their ability to evade oversight and accountability. Your goal should not be to stop permissible state regulation of PBMs, such as a law in Arkansas that the Supreme Court found to be allowed under ERISA statute, but to ensure the federal government is setting strong standards of conduct across the country.

The National Alliance and its members strongly support the Lower Cost, More Transparency Act crafted by this committee and overwhelmingly passed by the House. It would provide badly needed transparency in both the PBM market and other areas of the health care system. We also believe it is imperative to make the PBM market more functional by banning the practice of "spread pricing" and requiring PBMs to pass all rebates onto plan sponsors.

It is past time for Congress to take meaningful action to hold PBMs accountable to their customers.

ERISA and Telehealth

The pandemic and its aftermath have demonstrated the value of telehealth for patients and accentuated the need for ERISA. Today, roughly half of Americans report working remotely at least one day per week.[4] Millions of those people work in states other than where their company office is located. The ability of self-insured employers to offer standard benefits across state lines – increasingly using telehealth as a critical access point – has never been higher.

In addition to providing meaningfully enhanced access to care for patients – particularly those in rural and underserved communities – it could help reduce healthcare costs for employers and purchasers by offering lower-cost points of access. Unfortunately, many hospitals offering telehealth to patients have taken to tacking on "facility fees" for

[4] National Bureau of Economic Research, 2023: https://www.nber.org/papers/w31193

telehealth services, entirely ignoring the fact that the patient never set foot on hospital premises. This egregious practice highlights the broader problem of unnecessary facility fees for outpatient services.

The National Alliance strongly supports federal legislation to:

- ***Mandate "site neutral" payment in Medicare, banning the use of facility fees in that program.***
- ***Ban facility fees for telehealth services in all markets, including for self-insured health plans covered by ERISA.***

One of the most significant barriers to adoption of telehealth solutions for self-funded employers is the continuation of outdated state licensing arrangements. Under current rules, providers must be licensed to practice in the state where the patient is receiving care. At Phifer, we have dealt with this problem by requiring our Alabama-located telehealth providers to be licensed in California – an arduous and costly process. While we were able to achieve this, the problem is significantly compounded for other employers that may have employees in dozens of states. We see three options to deal with licensure problems:

- **Licensure reciprocity and interstate licensure compacts:** Some states allow for licensure reciprocity allowing providers to offer telehealth services to people located in neighboring states. Other states have experimented with interstate licensure compacts, allowing providers to practice across states included in the compact.[5] While this may be a solution for employers located within a broader geographic region, these programs fail for employers with employees across many states and regions, or – like Phifer – where workforce is dispersed across distant states.
- **Federal licensure of telehealth providers:** The federal government could seek to provide its own licensure structure for telehealth providers that would supersede state licensure requirements.[6] We recognize that this solution would represent a significant implementation endeavor and would likely face political opposition.
- **Switching the site of care:** One innovative solution proposed by the Purchaser Business Group on Health (PBGH) – a member of the National Alliance – in testimony to the Energy and Commerce Committee in 2021, would allow state licensing boards to continue to license telehealth providers in their state while significantly boosting the availability of telehealth.[7] By simply switching the site of care from where the patient is sitting to where the provider is sitting, any

[5] Center for Connected Health Policy, 2024: https://www.cchpca.org/policy-101/?category=cross-state-licensing-compacts
[6] Sawalha, 2020: https://www.amjmed.com/article/S0002-9343(20)30418-6/fulltext
[7] Purchaser Business Group on Health, 2021: https://docs.house.gov/meetings/IF/IF14/20210302/111255/HHRG-117-IF14-Wstate-MitchellE-20210302.pdf

interested provider could offer telehealth to patients across the country so long as they are physically in the state of their licensure when they provide the care. This solution would continue to allow Phifer-affiliated telehealth providers in Alabama to provide care to all our families whether they are on-site at our locations in California or Pennsylvania, working remotely in another state, or travelling anywhere nationwide.

Understanding ERISA Fiduciary Requirements

Under ERISA, self-insured employers and purchasers are required to act as fiduciaries over their health plan assets.[8] Specifically, ERISA stipulates that plan fiduciaries *"shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries … for the exclusive purpose of providing benefits to participants and their beneficiaries; defraying reasonable expenses of administering the plan; (and act) with the care, skill, prudence, and diligence."* I take it as a great honor and solemn responsibility to Phifer's employees and their families to act as the named fiduciary overseeing our health plan.

Given the complexity of running an ERISA health and welfare plan, Phifer and most other self-insured employers rely heavily on health insurers and PBMs as contractors to operate the day-to-day functions of our health plan. We firmly believe that any vendor or company with which we contract that can exercise discretion over plan assets already serves as a co-fiduciary over our health plan. The Department of Labor makes this point clear: *"A person using discretion in administering and managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for the plan, not just a person's title."*[9] Every day, our contracted health insurer and PBM make decisions over plan assets without the direct day-to-day management of me or my colleagues at Phifer.

We would thus support federal legislation to make explicit what is abundantly clear to us: any entity exercising discretion over plan assets is a fiduciary to the plan and thus must always take action in the best interest of the health plan, not the best interest of the contractor or any other entity.

As the named fiduciary of the health plan, it is also critical that self-funded plan administrators can appropriately oversee the work of their contractors. To that end, they need access to significantly more information than is often available today. Recognizing the importance of de-identifying information in compliance with HIPAA and related privacy laws, this includes (but is not limited to):

[8] 29 U.S. Code § 1101

[9] Department of Labor, 2023: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf

- Unimpeded access to all negotiated price information down to the claims level
- Access to any quality information made to the contractor
- Disclosure of any direct or indirect renumeration between brokers, health plans, PBMs, and providers
- Contract terms between health insurers and providers

While the Consolidated Appropriations Act of 2021 (CAA) requires contracted health insurance carriers and PBMs to provide broad transparency to employer clients, even very large employers in the country continue to face challenges getting access to their own data. According the to the PBGH, which represents many of the largest employers in the country, "*When employers request full, de-identified access to their health care data under CAA § 201, service providers … routinely block employers from accessing complete and accurate data sets or erect barriers to them sharing that data."*[10]

Without full access to all information, self-funded insurers cannot reasonably act as prudent fiduciaries in their own right. Put simply, how can I – as the named fiduciary of our health plan – ensure that plan assets are being used solely in the interest of participants and beneficiaries and that expenses are reasonable if I do not have access to critical data and contracting terms? I cannot.

Conclusion

For 50 years, ERISA has provided a bedrock foundation for high quality health coverage for self-insured employers and purchasers. While ERISA has provided an absolutely critical regulatory structure, overall healthcare costs – across all markets and coverage programs – have risen from $544 billion in 1974 (in inflation-adjusted 2022 dollars) to roughly $4.5 trillion today.[11] Across the country, employers spend an average of nearly $25,000 per worker to provide family coverage.[12] It is an honor and privilege to help our working families thrive by providing equitable access to high-quality healthcare. But we desperately need help from federal policymakers to continue to be able to provide access to care that we can be proud of.

Thank you for allowing me to provide my perspective today and I look forward to your questions.

[10] Letter from the Purchaser Business Group on Health to House Committee on Education and the Workforce, March 15, 2024

[11] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/

[12] https://www.kff.org/report-section/ehbs-2023-summary-of-findings/