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Advancing Health in America

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The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515-6100

Re: Building and strengthening the Employee Retirement Income Security Act on its 50th anniversary

Dear Chairwoman Foxx:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes in response to the questions posed by the Committee on Education and Workforce. We appreciate your efforts to examine ways to build upon and strengthen the Employee Retirement Income Security Act (ERISA).

VERTICAL INTEGRATION AND CONSOLIDATION

Health insurers have gone through dramatic vertical consolidation since ERISA was signed into law. Over the last decade, the major corporate insurers have spent billions of dollars acquiring not only other plans, but also providers, pharmacy service companies, and health technology and claims adjudication systems. For example, UnitedHealth Group acquired dialysis provider DaVita Medical Group in 2019 for an estimated $4.3 billion and home health provider LHC Group in 2023 under its Optum subsidiary for an estimated $5.4 billion.[1] It is now the largest employer of physicians in

1 https://www.beckersasc.com/asc-transactions-and-valuation-issues/optum-deal-brings-2022-acquisition-spending-to-nearly-8b.html

the nation. Experts speculate that Elevance agreed to acquire infusion provider Paragon Healthcare for more than $1 billion earlier this year.[2]

While it is difficult for external parties to determine just how much of the health care sector is controlled by corporate insurers and their subsidiaries, there are troubling indicators of the breadth and depth of commercial insurer control over the industry. Between the main brand and its subsidiaries, UnitedHealth Group claims to serve 152 million Americans — nearly half of all Americans — and employ or contract with 10% of the nation's physicians.[3] The recent cyber-attack against UnitedHealth Group's subsidiary Change Healthcare illustrates the risks of this consolidation. When one company controls such a large component of the health care infrastructure, there are serious risks to public health.

From a competition perspective, the AHA is deeply concerned that vertical consolidation in the commercial insurance industry harms Americans and their communities by reducing overall access to services and providers and undercutting smaller providers that are seeking to provide services to communities who need them most. In the ERISA context, these kinds of mergers and acquisitions may result in prohibited transactions. For example, corporate insurers often serve as the third-party administrator for employers' self-funded health insurance plans, in which role they may function as a plan fiduciary under ERISA. To facilitate the health insurance plan, plan fiduciaries then engage in transactions with parties in interest, i.e., a provider group, pharmaceutical service provider and other companies to ostensibly provide those benefits more efficiently. When commercial insurers engage in the kinds of acquisitions outlined above, they — in their role as plan fiduciaries — may offer favorable rates or contract terms to providers or servicers owned by the plan itself or by its subsidiaries.

This harmful self-dealing creates significant issues for plan beneficiaries, including by reducing choice and access to care and delaying medically necessary care. For example, the insurer may direct patients to providers owned or operated by the plan and away from other providers, even if the patient might prefer or be closer to another option (called "patient steering"), or require beneficiaries to obtain medically necessary drugs from specialty pharmacies unrelated to, and far from the oversight of, their health care providers because of a favorable arrangement for the health insurer (called "white bagging").

The AHA also has concerns that self-dealing among vertically consolidated commercial insurers can be used to manipulate medical loss ratios (MLR) such that commercial insurers can keep a greater share of American's hard-earned premium payments.

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2 https://www.reuters.com/markets/deals/elevances-deal-buy-paragon-healthcare-valued-over-1-billion-axios-2024-01-04/
3 https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/ic23/Investor-Conference-2023-Book.pdf

340B DRUG PRICING PROGRAM

The 340B Drug Pricing Program was established by Congress in 1992 to mitigate the high cost of drugs — an issue that persists today and is of particular concern to employers and ERISA plans. The 340B program successfully helps hospitals support access to critical patient services such as behavioral health, medication therapy management, chemotherapy, and free or discounted drugs.

Ordinary access to 340B discounts does not constitute self-dealing or violate prohibited transaction provisions under ERISA. 340B hospitals earn savings by purchasing drugs at a discounted price. It is this price difference that dictates how much they save, not the reimbursement they receive from plans or other payers for prescribing 340B drugs.

However, there is a critical connection between drug pricing and anticompetitive conduct by large commercial insurers. As noted above, pharmacy steering is primarily a practice that plans and their pharmacy benefit managers (PBMs) engage in to pad their profits. The practice ensures patients receive drugs at pharmacies that are vertically integrated with the plans, their affiliated PBMs or their parent companies. For example, UnitedHealthcare, one of the nation's largest insurers also owns Optum Rx, Genoa Healthcare and Avella specialty pharmacy, where patients can be steered to receive their drugs thereby capturing any drug company rebates, any dispensing fees for providing the drug to the patient, and the patient's premium dollars and any copays or co-insurance.

HOSPITAL PRICE TRANSPRENCY

Hospitals and health systems are dedicated to improving price transparency for patients. As we have expressed previously to policymakers, however, the numerous and sometimes conflicting requirements have created an overwhelming landscape of pricing information that is challenging to utilize.

There are three primary federal price transparency policies, each at different stages of implementation and each with different reporting and format requirements: Hospital Price Transparency requirements, Transparency in Coverage requirements, and No Surprises Act good faith estimates and advanced explanation of benefits.

Under the Hospital Price Transparency requirements in effect since 2021, hospitals disclose a machine-readable file annually that includes chargemaster information, as well as negotiated and self-pay rates for all relevant items and services. Hospitals are also required to provide consumer-friendly information to patients on shoppable service prices, either through a spreadsheet or an online price estimator tool. CMS found that as of 2022, 70% of hospitals had complied with both federal requirements and over 80%

had complied with at least one.[4] A more recent report by Turquoise Health shows that 90.7% of hospitals have met the requirement to post a machine-readable file, and 83.1% have included a substantial amount of negotiated rates.

Due to the ongoing efforts of the hospital field, these numbers will continue to improve. However, utilization of the machine-readable files remains quite low, in large part because the complexity of the data can be challenging for those outside of the hospital finance field to understand. As a result, it may take some time before organizations, such as plan sponsors, can utilize the data. The recent changes CMS made to the requirements, including implementing a standardized format, may address some of these challenges. However, large scale changes such as these require time and financial resources to bring existing files into compliance and can further delay use as data consumers recalibrate their analysis to new data formats, layouts, variable changes, and other adjustments. **Therefore, we urge Congress to avoid making further statutory changes to the Hospital Price Transparency requirements at this time.**

The Transparency in Coverage requirements in effect since July 2022 are similar to the Hospital Price Transparency requirements but apply to insurers. Under these requirements, insurers must publish monthly machine-readable files inclusive of all negotiated rates and out-of-network allowed amounts. Insurers are also required to provide personalized out-of-pocket cost estimates for all covered services, in addition to other information, through a consumer-friendly online tool. CMS has required insurers to use a standard format for the machine-readable files since these requirements went into effect.

A concern remains though that there is a high potential for conflicting information between the insurer and hospital files, given different approaches to calculating negotiated rates. **To ensure a single source of reference for negotiated rates, we recommend Congress direct CMS to maintain the requirement that insurers post all negotiated rates with providers, while allowing hospitals to focus solely on posting chargemaster rates and cash prices.** In doing so, consumers, third party vendors, researchers and other interested parties would retain access to all negotiated rate information while reducing the risk of conflicting information.

The third set of price transparency requirements was established by the No Surprise Act, which includes a process for patients to receive estimates based on their unique health care treatments plans. For uninsured and self-pay patients, providers have been required to provide good faith estimates for scheduled care since January 2022. For insured patients, the No Surprises Act requires providers and health plans to work

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[4] https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential

together to develop these estimates. This process is technically complex, and industry stakeholders and CMS are developing the necessary technical specifications to effectively implement this provision. These estimates, much like the price estimator tools provided by hospitals and health plans noted above, provide resources for patients looking for information on their expected out-of-pocket costs prior to care. **To ensure patients can access the information they most need as they plan for their care, we urge Congress to allow price estimator tools to continue to be used to meet the hospital shoppable service requirements.**

Before the new information available through the price transparency policies can be used effectively by the public, including plan sponsors, more needs to be done to align and streamline the various policies. **We would therefore request that Congress refrain from advancing additional legislation that may further confuse or complicate providers' ability to provide meaningful price estimates and potentially add unnecessary costs to the health care system.**

CYBERSECURITY

The cybersecurity threats facing health care are serious and affect every entity in the sector. Recent events related to the attack on Change Healthcare make that pellucidly clear. With respect to the Health Insurance Portability and Accountability Act (HIPAA), all covered entities (including health plans governed by ERISA) have responsibilities to ensure the security of patient data that is described in the HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164).

The AHA believes that the current HIPAA rules generally offer an effective legal framework and any fundamental revisions would create more challenges than benefits. Congress should not make any major revisions to HIPAA nor should Congress introduce new privacy or cybersecurity principles directly into the ERISA statute as this would be unnecessarily confusing to the regulated community, which is already well-governed by HIPAA.

The AHA has long advocated that HIPAA's requirements be the uniform, nationwide standard for protecting the privacy and security of all patient information. Because the HIPAA framework is both effective and entrenched, Congress should enact full federal preemption for HIPAA, including for the ERISA-covered entities that are already subject to HIPAA.

OVERSIGHT OF ERISA-REGULATED INSURERS

Inappropriate Denials of Care

Certain commercial insurers are erecting unfair and unnecessary barriers to care. These barriers have a human cost, including improper use of utilization management programs, inappropriate denial of medically necessary covered services, overly

restrictive and opaque medical necessity criteria, unnecessary and unreasonable documentation requirements, and mid-contract changes to patients' coverage.

In fact, some commercial insurer policies and practices appear designed to simply create barriers to appropriate payment. They also contribute to clinician burnout and significantly drive-up administrative costs for the health care system. And the outcomes of these practices illustrate that much of this effort and cost is unnecessary. For example, among some insurers, most appealed prior authorization denials are ultimately overturned. Even if beneficiaries can ultimately receive the care they need, this appeal process comes with significant cost. Inappropriate payment delays and denials for appropriate care contribute to financial and emotional stress for enrollees, serious patient care delays, health care provider financial instability, and compounding fiscal challenges plaguing our health care system.

Further, there is mounting evidence that these unfair practices are growing. Government agencies, as well as courts and arbitrators, have also uncovered concerning findings with respect to certain commercial insurer conduct. We strongly support increased scrutiny of insurer conduct under ERISA-regulated plans, especially with respect to practices that may routinely or inappropriately deny claims for services that should be covered. We also encourage Congress to consider whether commercial insurers are adhering to their fiduciary duties set forth in the statute. Greater oversight is needed to protect patients and consumers from cases of insurer misconduct and to ensure appropriate access to health care services that employers have provided payment to cover.

Prompt Payment

In addition to challenges with inappropriate denials of care, hospitals and health systems are increasingly reporting significant financial impacts from insurers' failure to pay promptly. In fact, an AHA member survey found that 50% of hospitals and health systems reported having more than $100 million in unpaid claims that were more than six months old. Among the 772 hospitals surveyed, these delays amounted to more than $6.4 billion in delayed or denied claims that are more than six months old.

These delays also add unnecessary cost and burden to the health care system, as combatting inappropriate delays and denials cost valuable time and resources, including resources needed to comply with insurer requests for additional documentation, physician peer-to-peer consultations and onerous appeal processes — and these processes may still be subject to other types of insurer audits or post-pay reviews that recoup payment to start the process all over again.

Given these realities and the challenges health care providers face in securing prompt payment from insurers for covered services, it is troubling that there are no prompt payment requirements with which insurers must comply under ERISA-regulated health plans (except for limited provisions related to out-of-network claims subject to the No

Surprises Act). Claims procedure rules that apply to ERISA-regulated insurance products are consumer protection rules that only apply to claims for benefits and not payment to providers. Most fully-insured insurance plans regulated at the state level contain some type of requirements for prompt payment for services.

Accordingly, the AHA urges Congress to apply a federal prompt payment standard for ERISA-regulated insurance plans, either in the ERISA statute or separately, and to increase oversight and scrutiny of timely payments to health care providers for services delivered to enrollees under the contract.

MEDICAL LOSS RATIO REQUIREMENTS

The MLR measures the amount of premium dollars that go toward health care services and quality improvement activities and caps the amount that insurers can spend on administrative activities or profits. The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to paying for covered medical services and ensuring patient access to care, while also holding health plans accountable for how premium dollars are spent. The MLR is not a comprehensive solution to prevent health plans from prioritizing profits over patient care, and we recommend appropriate monitoring, enforcement and additional controls to help ensure that patients are receiving appropriate coverage for their premiums.

Impact of Limiting Medical Loss Ratio

The AHA does not believe limiting the MRL requirements will incentivize health plans to reduce spending for the benefit of patients. To the contrary, AHA believes that insurers will continue to enrich themselves even more in the absence an MLR standard. Congress created the MLR requirement to protect the value that consumers receive in exchange for their health insurance premiums. This oversight and regulation resulted from legitimate concerns that health plans were spending an inappropriate portion of patient premiums on administrative or self-serving expenses for their own financial enrichment, instead of paying for patients' medical care.

First implemented in 2011, the benefit of the MLR to patients was immediate, helping to control inappropriate or self-serving plan expenditures, revealing that plans, when left unchecked, spend premium dollars on expenses that do not benefit patient and consumers. Limiting or reducing MLR requirements runs the risk of compromising these advances in consumer protection and jeopardizing the progress we have made in ensuring that more health care dollars go toward beneficiaries' medical care.

MLR and Vertical Integration in the Health Care Market

The AHA is deeply concerned about the ways in which insurers' vertical integration practices enable plans to channel excessive health care dollars to their affiliated health care and data services providers at patients' expense. While the AHA supports

arrangements in which an integrated system's health plan pays affiliated clinicians an appropriate rate for patient care, it is problematic when a plan directs excessive dollars to its own affiliated vendors and service entities in ways that inappropriately increase health system costs or steers patients to affiliated providers to benefit the insurer financially when not in the best clinical or financial interest of the patient.

Although our concerns with vertical integration are broader than the implications in the MLR context, the AHA is concerned with how payments to affiliated vertically-owned entities (e.g., owned by the same parent company) can be used to effectively manipulate the MLR. For example, the three largest pharmacy benefit managers — CVS Caremark, Express Scripts and OptumRx — are owned by large national insurers that offer employer-sponsored coverage throughout the country. Pharmaceutical purchasing from PBMs is a prominent expense for these plans, and the dollars spent on such procurement are classified as qualified care expenses for MLR calculations. When insurers purchase these PBMs, directing these large sums to the PBMs is essentially the insurers paying themselves. This vertical integration then enables plans to manipulate their MLR calculations by counting these extraordinary dollars paid to themselves as qualified care expenses, rather than sending those dollars back to beneficiaries or otherwise directing them toward actual health care spending.

Further, plans administered by vertically integrated insurer-PBM conglomerates can implement coverage or benefit design restrictions on where their enrollees can access certain covered drug therapies or services. Unsurprisingly, PBMs have been a primary enabler of site-of-service restrictions on physician-administered specialty drugs, often sprung upon beneficiaries through mid-year plan changes. Forcing patients to switch service providers can negatively impact the patient clinically or financially, as well as limiting access to covered services and patient choice.

Ultimately, the use of vertical integration to circumvent the goals of the MLR requirements is concerning and potentially harmful for patients and consumers. We urge policymakers to pursue solutions to increase oversight of the MLR as it relates to vertically integrated insurer conglomerates and prevent inappropriate or excessive payments to aligned companies to ensure that the MLR continues to protect patients in the manner it was intended by Congress.

SPECIALTY DRUG COVERAGE

Specialty drugs, which now account for nearly 50% of total drug spending in the U.S. and approximately 80% of the drugs approved by the FDA in 2023, are an important driver of overall employer sponsored insurance (ESI) costs. This is largely because drug companies decide to introduce many of these drugs at sky-high prices and subsequently increase those prices further. In fact, a recent government report found that nearly 2,000 drugs experienced price increases faster than general inflation between 2022 and 2023. These high drug prices increase the costs hospitals and physicians incur to deliver patient care, and thereby drive-up overall ESI costs. The

AHA supports initiatives geared toward reducing costs and increasing patient access, including efforts to reduce the cost of specialty drugs.

CONCLUSION

Thank you again for your interest in strengthening ERISA. We look forward to working with you to support and advance these important issues.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs