



# Improving and Strengthening Employer-Sponsored Insurance

BIPARTISAN POLICY CENTER

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## HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Program develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, rural health, behavioral health, and digital health.

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## DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders, its funders, or its board of directors.

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# Glossary of Acronyms

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<b>ACA</b>	Patient Protection and Affordable Care Act
<b>APCD</b>	All-payer claims database
<b>CMMI</b>	Center for Medicare & Medicaid Innovation
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>DOJ</b>	U.S. Department of Justice
<b>EBSA</b>	Employee Benefits Security Administration
<b>ERISA</b>	Employee Retirement Income Security Act of 1974
<b>ESI</b>	Employer-sponsored insurance
<b>FDA</b>	U.S. Food and Drug Administration
<b>FTC</b>	Federal Trade Commission
<b>HDHP</b>	High-deductible health plan
<b>HHI</b>	Herfindahl-Hirschman Index
<b>HHS</b>	U.S. Department of Health and Human Services
<b>HMO</b>	Health Maintenance Organization
<b>HPN</b>	High performance network
<b>HSA</b>	Health Savings Account
<b>ICHRA</b>	Individual Coverage Health Reimbursement Arrangement
<b>MA</b>	Medicare Advantage
<b>NSA</b>	No Surprises Act
<b>PBM</b>	Pharmacy Benefit Manager
<b>PPO</b>	Preferred Provider Organization
<b>SEHP</b>	State Employee Health Plan
<b>TPA</b>	Third-party administrator

# Executive Summary

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Some 58.1% of non-elderly Americans (158 million people) receive health care benefits through their employers as of 2019, making employer-sponsored insurance (ESI) the nation's largest source of health coverage. ESI is the foundation for the nation's public-private health system, but rising health care costs continue to put pressure on employers seeking to offer the same level of benefits and to boost wages. Similarly, employees are seeing their health insurance premiums rise in the face of stagnant real wages. Even the largest private employers lack the resources or market power to prompt and sustain the systemwide changes needed to improve the value they receive for their health care spending. They must contend with U.S. health care costs that have been rising for decades, outstripping inflation, wage growth, and overall economic growth and, in turn, squeezing incomes. Despite ESI being the dominant source of coverage, in-depth policy discussion on how to improve the employer system is lacking. With the policy conversation focusing on Medicare, Medicaid, and the individual market, decision-makers are left wanting for ESI-dedicated proposals and analysis. Consequently, both employers and employees need solutions to improve ESI so it can remain in place for the foreseeable future.

Today, employers offer a spectrum of ESI plans: Some are generous, while others do not meet employee needs. Lower-income workers are less likely to get their health coverage through ESI, which raises equity concerns. Lower-income employees who receive health coverage via ESI are also more likely than their higher-income counterparts to skimp on medical care and prescriptions, have problems paying their medical bills, and visit an emergency room.

Nonetheless, ESI is a popular benefit with employees. Employers offer health care benefits to recruit and retain employees, and they see the value of maintaining those benefits, especially in the face of talent shortages and resignations. In June 2022 alone, 4.2 million people quit their jobs as part of the "Great Resignation" and, as of that month, nearly 11 million positions remained unfilled. Employees were two times likelier to switch careers and less likely to recommend their employer if they did not get the health coverage they needed. As a result, employers must balance the need to offer generous benefit packages to attract and retain skilled employees with the high and rising costs of providing health care benefits.

[Total health spending](#) has grown from 6.9% of the economy in 1970 to nearly 20% in 2020. In inflation-adjusted terms, per capita health [spending](#) rose from \$1,875 to \$12,531 over that same period. As a result, from 2009 to 2019, the growth in deductibles (162%) and premiums (54%) has far outpaced inflation (26%) and wage growth (20%). Nearly 30% of employees now face deductibles of at least \$2,000, which is prompting some employees to postpone or forgo the health care they need.

What is driving health care cost increases? Multiple studies have shown that [unit prices](#), or the prices for individual services and products, are the largest contributor to health care cost growth. Health care prices rose 16% from 2012 to 2016—four times as fast as inflation. Hospital spending represented the lion’s share of U.S. health spending (31% in 2020), and hospital prices are a critical driver of spending growth—rising 42% between 2007 and 2014. Numerous studies have found that hospital consolidation—which enables hospitals with more market power to charge more—to be a key driver of higher prices. Pharmaceutical prices are also a significant contributor to the growth in health care spending. On a per capita basis, Americans spent more than \$1,100 on prescription drugs in 2019. In 2018, retail prices for widely used brand name pharmaceuticals increased by 5.8%—more than double the rate of inflation over the same period.

As a result, the Biden administration and Congress must take steps to help constrain health care cost increases and give employers the payment and pricing tools they need to strengthen ESI. With such tools, employers and other stakeholders can create a high value ESI system that improves health outcomes and constrains costs.

Policymakers have made no major changes to the health care system, including ESI, since the Affordable Care Act of 2010. Costs, however, continue to rise, increasing the financial burdens on employers and employees alike. Although policymakers on both the left and right promote policies that would ultimately end the nation’s reliance on ESI as a primary source of insurance coverage, such shifts would likely result in considerable disruption and currently do not have widespread political support. For policymakers across the political spectrum, strategies intended to strengthen ESI may thus be considered a reasonable way to address cost challenges.

Policymakers and other stakeholders should take steps in four areas. First, they should increase transparency in the health care system. Information about prices for products and services is readily available in most markets, but health care is a notable exception. A Congressional Budget Office (CBO) report on policy approaches to reduce what commercial insurers pay for hospital and physician services found that employers lack expertise needed to navigate a complex medical system and often outsource network design, price negotiation, and claims processing to consultants and other third parties. A lack of information about prices can also drive this outsourcing, thereby making employers somewhat price insensitive.<sup>1</sup> More transparency could make employers better-informed purchasers. It also could lower prices, shape policy decisions, and make the delivery of health care more efficient. However, efforts to increase transparency for consumers have not done much to lower health care costs, nor have they generally incentivized consumers to compare prices and shop for better health care. Additionally, price transparency efforts do not require reporting on quality of care—an important factor when comparing

health care providers and services. As such, greater transparency that includes both price and quality information will have its largest impact if policymakers, regulators, and health plans use it to enact policies to combat cost growth.

Second, policymakers and other stakeholders should empower employers to help lower costs by giving them payment and pricing tools that would help create a higher value ESI system that prioritizes employee health outcomes. To constrain prices and improve quality, policymakers should, through legislation and regulation, enable employers to design better provider networks.

Third, policymakers and other stakeholders should address problems in the private health care market. Negotiations between providers and payers shape market prices. Prices are also shaped by geography, the demand for services, the market power of providers and payers, and other factors. Employers often do not possess enough market power to negotiate lower prices due to the consolidation of health care providers. Provider consolidation continues to accelerate, with nearly 67% of hospital markets now considered highly or very highly concentrated. Consolidation often drives health care price increases, according to a large body of evidence. BPC has proposed policies to equalize market power dynamics to foster a more competitive employer-sponsored health insurance system.

Finally, policymakers should consider other legislative and regulatory steps to make health insurance more affordable. While more than 70% of workers, on average, accept employer-sponsored health care when it is offered, the figure is only 63% among firms that employ larger shares of lower-wage workers, such as part-time and temporary workers. Employees at firms with more low-wage workers pay higher premiums as a share of their incomes than employees at firms with fewer low-wage workers. These figures suggest that ESI remains less affordable, and as a result perhaps less desirable, for lower-wage employees. The administration could consider providing guidance on and make improvements to alternatives to traditional group health plans that allow employers to offer more affordable coverage to their employees.

## **BPC'S RECOMMENDATIONS**

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### **Section I: Increase Transparency in the Health Care System**

- Congress should establish a federal all-payer claims database (APCD) to promote a comprehensive understanding of the health care payment and delivery system and the underlying drivers of cost growth.
- Congress should require the U.S. Department of Health and Human Services' (HHS) secretary to establish a centralized data repository to host payer and provider pricing data and penalize entities that refuse to comply with existing transparency laws.

- Congress should consider creating a federal, publicly available database or clearinghouse to track health care ownership and require private equity firms to report health care provider purchases where concentration is high.

## **Section II: Empower Employers with Payment and Pricing Tools**

- The U.S. Department of Labor should leverage existing authorities to boost accountability for third-party administrators (TPAs) and other vendors, and issue guidance on what qualifies as a fiduciary function.
- The U.S. Departments of Labor, Treasury, and Health and Human Services should issue guidance to clarify the so-called gag clause ban and that plan data are a plan asset.
- Congress should require HHS to nationally designate Centers of Excellence.
- Congress should urge the administration to fulfill implementation of the No Surprises Act by urging the Advisory Committee on Ground Ambulance and Patient Billing to finalize committee membership and host its first meeting.
- Congress could consider options for encouraging ESI use of high performance network (HPN) health plans to motivate employers to offer and employees to choose high performance health coverage options.

## **Section III: Address Market Power Dynamics**

- Congress should prohibit anti-competitive contract language (such as anti-tiering, anti-steering, and all-or-nothing clauses) in insurer contracts with providers.
- The Department of Labor and the Center for Medicare & Medicaid Innovation Center (CMMI) should develop a standard model provider-payer contract to pilot at the state level, Medicare Advantage plans, and ACA qualified health plans.
- Congress should strengthen federal enforcement agencies' ability to identify and review potentially problematic transactions in the health care industry to avoid high concentration in markets and potentially reduce health care prices.
- To lower hospital prices in noncompetitive markets, Congress should permit hospitals in markets with a Herfindahl-Hirschman Index (HHI) score above 4,000 to enter into negotiations with the Federal Trade Commission (FTC) to bring the HHI score under 4,000, unless market consolidation was the result of a regulatory exception to the U.S. Department of Justice (DOJ) guidelines related to hospital mergers. Hospitals that do not enter negotiations with the FTC would be prohibited from charging private insurers more than the maximum rate paid by a private insurer to a hospital for a service based on the average Medicare Advantage (MA) rate for that service in the market. Alternatively, they would be prohibited from charging more than the average private insurance rate in a competitive market, whichever is lower.



- The Departments of Labor and HHS should issue guidance to encourage ESI plans to use reference-based pricing models.
- CMMI should design a multi-payer coalition demonstration with employers and public-sector payers to develop high performance networks and provide grant funding to state employee plans or agencies to coordinate coalitions.
- Congress should prohibit settlements between biologic and biosimilar manufacturers that postpone the market entry of lower cost biosimilars.
- The U.S. Food and Drug Administration (FDA) should issue guidance to promote regulatory clarity in the biosimilar marketplace, including establishing clearer standards for interchangeability of biologic products.

#### **Section IV: Provide Other Options for Health Insurance Affordability**

- To increase health care affordability and expand health care coverage options, Congress should adjust the ESI affordability firewall to align with the ACA marketplaces' percentage cap for contributions to health insurance premiums.
- To allow employers to utilize alternatives to traditional group health insurance, the Departments of Labor, HHS, and Treasury could provide guidance on and make improvements to alternatives to traditional group health insurance programs like Individual Coverage Health Reimbursement Arrangement (ICHRA) and State Employee Health Plan (SEHP) buy-ins.

# Introduction

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Employers play a vital role in funding and supporting the U.S. health care system. As of 2019, 58.1%<sup>i</sup> of non-elderly Americans—158 million in total—received health care benefits through their employers, making it the United States’ largest source of health coverage today.<sup>2,3</sup> These employers include small, medium, and large companies, although larger ones are more likely to offer health benefits: About half of small firms offer ESI, while nearly all companies with 1,000 workers or more do so.<sup>4</sup> Intended to serve as a recruitment and retention tool, ESI has been a popular employee benefit.<sup>5</sup> Nonetheless, ESI is quickly becoming financially untenable for both employers and employees, due to rising health care costs. These increases make it difficult for employers to maintain benefits, constraining real wages and increasing financial barriers to critical health care services for employees and their families.

To make matters worse, the reverberating impact of the COVID-19 pandemic is placing added financial pressures on the health care delivery system.<sup>6</sup> Staff shortages, as well as an over-burdened and in some cases shrinking workforce, are contributing to systemwide stress and labor cost increases that are being passed onto payers and, ultimately, to employer-sponsored plans.<sup>7</sup>

Family premiums for ESI have increased 54% and deductibles 162% since 2009. This rise is outpacing both inflation and wage growth, which have increased 26% and 20%, respectively, over the same time frame.<sup>8</sup> A recent [analysis](#) from Aon estimated that ESI premiums could grow 6.5% in 2023.<sup>9</sup> Nearly 30% of employees now face deductibles of \$2,000 or more—almost four times the percentage of employees who faced such deductibles in 2009.<sup>10</sup>

Despite significant bipartisan concern and the long-standing nature of these issues, stakeholders and policymakers have not made meaningful progress on slowing the growth. Even as of the early 1990s, personal health care spending was growing at twice the rate of disposable income, and excess medical pricing was a problem.<sup>11</sup>

Congress has made few legislative changes to health care—and ESI, specifically—as sweeping as the now 12-year-old ACA. Although the private sector has deployed innovative models, policy solutions are necessary to correct for market dynamics that are outside the control of employers and other payers. Individual employers—even larger ones with geographically dispersed staff—have very little leverage to influence provider or insurer behavior.<sup>12</sup> As such, federal strategies to address health system cost drivers and offer employers payment and pricing tools are critical to improving and strengthening the

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i 54% of all Americans have employment-based insurance, according to the [U.S. Census Bureau](#).

nation's ESI system. With these tools at their disposal, employers and other stakeholders have the potential to create a higher value ESI system that improves outcomes and constrains health care cost growth.

### ***A Brief History of ESI***

ESI's beginnings can be traced to the late 1920s, but the growth of private health insurance tied to employment did not take off until the 1940s and 1950s. This growth happened as a result of World War II, when businesses were unable to offer competitive wages and turned to benefits to attract workers.<sup>13,14</sup> Congress further spurred the evolution of ESI in 1954 when it made employer contributions to health insurance permanently tax free. Employer-sponsored insurance coverage was nearly universal by the mid-1960s.<sup>15</sup>

Today, employers offer health coverage primarily in three ways—self-funded, level-funded, and fully insured plans. Under self-funded health plans, which are governed by the federal Employee Retirement Income Security Act of 1974 (ERISA), employers assume the risk for the cost of health care coverage; 64% of workers utilize these plans.<sup>16</sup> These employers often hire insurers as third-party administrators (TPAs) to manage and administer benefits. The rest of employers offer coverage either through level-funded or fully insured plans, where employers purchase coverage from a state-regulated insurance company that assumes partial or all risk, respectively, on behalf of employees.

The type of benefits that employers offer has evolved in recent years, often driven by efforts to reduce costs. Early on, most employer coverage took the form of indemnity insurance, where the employee was responsible for a percentage of service costs. But as the cost of health care continually increased, employers turned to managed care, adopting health plans such as health maintenance organizations and preferred provider organizations, which limited provider networks.

Managed care plans, where insurers contract with health care providers to provide care for their members, emerged in the 1970s and 1980s. Although a growing number of employers started to offer health maintenance organizations (HMOs) in the 1970s, 1980s, and 1990s, they remained less popular than preferred provider organizations (PPOs) because they offered little opportunity for employees to use providers out of the prescribed network. PPOs, to the contrary, offer a fairly unfettered choice of providers, and enrollees' cost-sharing for in-network provider services was lower than for out-of-network services. Indeed, employers pulled back from more restrictive health plans after a backlash from workers, who wanted more flexibility in choice of providers.

In the 2000s, more and more employers began turning to high deductible health plans (HDHPs) under the belief that participants would be more cost-conscious due to higher deductibles.<sup>17</sup> Specifically, these plans have lower monthly premium payments but place a higher burden of payment

on consumers who use services before insurance kicks in.<sup>18</sup> Worryingly, while HDHPs lower the cost of care for employers, evidence has shown that consumers are more likely to simply delay or forgo needed care—especially preventive care—and that this is not a consequence of price-consciousness.<sup>19,20</sup> In 2021, self-pay after insurance accounts were the leading source of bad debt for hospitals, likely due to high HDHPs—ultimately driven by high provider prices.<sup>21</sup> One [analysis](#) found that 12% of privately insured adults with high deductibles carried medical debt, compared with 15% of uninsured individuals and 9% of Medicare beneficiaries.<sup>22</sup>

HDHPs are often accompanied by Health Savings Accounts (HSAs), which allow employees to pay for pre-deductible health care services and other cost-sharing charges, tax free. Some, but not all, employers might contribute to employees' HSAs as part of their health benefits package, and HSA usage has increased alongside the growth in HDHPs.<sup>23</sup> Furthermore, the percentage of workers enrolled in HDHPs has steadily risen—17% from 2011 to 2021—and the plans are prevalent today, with 28% of covered workers enrolled in them.<sup>24,25</sup> This growth rate has flatlined in recent years: 25% of smaller firms (less than 200 workers) offered HDHPs in 2020, compared with 20% in 2021. Similarly, 66% of large firms (more than 1,000 workers) offered HDHPs in 2021, compared with 67% in 2020.<sup>26</sup> As of 2022, the IRS defines HDHPs as those with a deductible of at least \$1,400 for an individual and \$2,800 for a family.<sup>27</sup> However, average deductibles in HDHPs are often over those thresholds – above \$2,300 for individuals and above \$4,500 for families.<sup>28</sup>

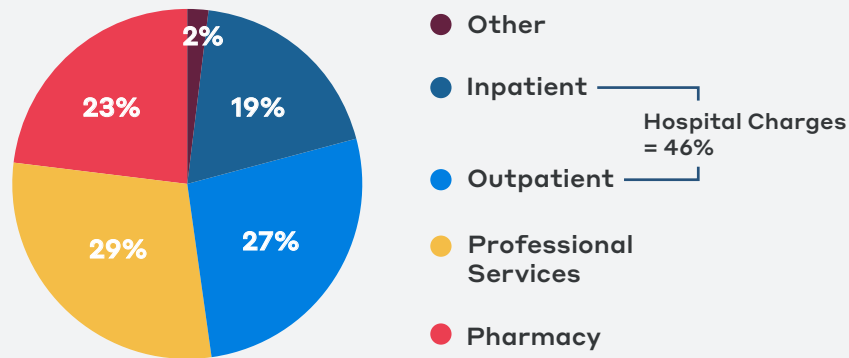
### ***ESI Today***

Employer-paid premiums are exempt from federal income and payroll taxes. This tax exclusion, which is unlikely to be rescinded, is projected to cost the federal government \$316 billion in 2022 alone (approximately \$2,000 per person enrolled in ESI).<sup>29</sup> Moreover, experts and economists argue that this tax exclusion, like other employee benefits, is regressive because higher-income workers accrue a disproportionate share of the benefits.<sup>30</sup>

Cost drivers today are largely unchanged from what they were a few decades ago, and hospital spending is the primary contributor: In 2020, hospital services represented 31% of total U.S. health spending. Spending on physicians/clinics and prescription drugs accounted for 20% and 8%, respectively.<sup>31</sup> Although the growth in hospital spending has slowed in recent decades, it continues to increase and has averaged a 4.6% increase annually between 2010 and 2020.<sup>32,33</sup> Hospital costs account for nearly half of plan sponsor health care spending, while pharmacy benefits represent 23% of plan sponsor spending (Figure 1).

### Figure 1: Group Health Plan Expenditures

Hospital costs contributed 46% of plan sponsor health care spending in 2022.



Source: 2022 Milliman Medical Index, May 2022

Source: [National Alliance of Healthcare Purchaser Coalitions, Beyond Hospital Transparency Getting to a Fair Price](#)

Beyond that, between 2012 and 2016, health care prices overall grew 16%—four times the rate of overall inflation.<sup>34</sup> Multiple studies have shown that unit prices, or the prices for individual services and products, are the largest contributor to health care cost growth.<sup>35</sup> Again, hospital prices are a critical driver of this growth, rising 42% between 2007 and 2014. Hospital consolidation remains a contributor to high prices, according to numerous studies, including a Medicare Payment Advisory Commission’s March 2020 report to Congress.<sup>36,37</sup>

Pharmaceutical prices are the second-largest contributor to health care spending growth. On a per capita basis, Americans spent more than \$1,100 on prescription drugs in 2019.<sup>38</sup> In 2018, retail prices for widely used brand-name pharmaceuticals increased by 5.8%—more than double the inflation rate over the same period.<sup>39</sup> Pharmacy Benefit Managers (PBMs) contract with health plans to administer pharmacy benefits and often develop prescription drug formularies by acting as intermediaries between plans and pharmaceutical manufacturers. PBMs receive rebates and discounts from pharmaceutical companies in exchange for formulary placement. Multiple studies have found that rebate payments lowered governmental costs and contributed to lower copays for plan enrollees.<sup>40</sup> However, there is evidence to the contrary—some studies suggest that PBMs could be raising prices for consumers because their revenue is based on a percentage of the drug’s list price—potentially incentivizing them to prioritize higher cost drugs.<sup>41</sup>

The [Inflation Reduction Act of 2022 \(P.L. 117-169\)](#), signed into law in August 2022, contains several provisions on drug prices in the Medicare program. The law allows the federal government to negotiate drug prices for some medications covered under Medicare, requires drug companies to pay rebates to

Medicare if drug prices rise faster than inflation, and caps insulin cost sharing for Medicare beneficiaries, among other changes. Although these changes apply to the Medicare program, they could affect employer costs as well.

Today, employers across the nation offer a spectrum of ESI plans, some of which are generous and others of which are costly yet still do not adequately meet the needs of employees. Studies indicate that ESI remains popular among employees.<sup>42</sup> Employers continue to offer health care benefits as a recruitment and retention tool and recognize the value in maintaining those benefits in the wake of talent shortages and resignations.<sup>43</sup> According to the [Bureau of Labor Statistics](#), in June 2022, 4.2 million people quit their jobs and nearly 11 million positions remain unfilled.<sup>44,45</sup> According to one survey, employees were twice as likely to switch careers and were less likely to recommend their employer to friends if they had not received adequate health care coverage.<sup>46</sup> However, despite its popularity, ESI can be inequitable. Lower-income workers are less likely to benefit from ESI and generally face greater affordability concerns—potentially leading to delays in needed care. Nearly 22% of health plan enrollees with incomes below \$50,000 reported that they had difficulty paying medical bills (compared with 12% across all income levels).<sup>47,48</sup>

Employers must balance attracting new employees by offering generous benefit packages while dealing with the high and rising costs associated with providing health care. The challenge, then, is to find ways to improve ESI so employers can offer more affordable, comprehensive coverage without shifting more costs to their employees through higher deductibles.

Recent U.S. Supreme Court decisions might also have broad ramifications for ESI benefits moving forward. After the Supreme Court overturned *Roe v. Wade* with its *Dobbs v. Jackson Women's Health Organization* decision, some employers began guaranteeing travel-related benefits to their employees, including reimbursement for travel expenses associated with abortion services.<sup>49</sup> Others might move to limit or enhance pregnancy-related service coverage in response to the ruling.

In another decision (*Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc.*), the Supreme Court ruled that a group health plan in Ohio did not violate federal law by limiting access to dialysis providers.<sup>50</sup> Although the ruling could enable payers to limit access to dialysis treatment, this type of plan design is rare in the employer market.

Finally, the Supreme Court's ruling to restrict the Environmental Protection Agency's ability to regulate carbon emissions (*West Virginia v. Environmental Protection Agency*) could jeopardize federal regulations for other sectors, including health. Health care organizations that fall under the purview of HHS are questioning whether other regulations could be subject to judicial review. Many of these organizations rely on federal payment predictability to make financial plans—contributing to nervousness about the ruling's fallout for health care.<sup>51</sup>

Under this continually evolving framework, BPC aims to understand the drivers of increasing costs and make recommendations for policy changes to help employers and employees best address them using payment and pricing tools.



## Recommendations

### SECTION I: INCREASE TRANSPARENCY IN THE HEALTH CARE SYSTEM

Pricing and quality information for products and services is readily available in most markets, but health care is a notable exception. Greater transparency in the health care system has the potential to make employers better-informed purchasers, to lower prices, to inform policy, and to produce more efficient outcomes. Evidence, however, shows that transparency efforts on the consumer front have not had a significant impact on costs and generally do not incentivize consumers to compare prices and shop.<sup>52</sup> Likewise, provider quality information is lacking and should be strengthened. As such, transparency efforts will have the largest impact if policymakers, regulators, and employers use them to enact informed policies to combat cost growth and improve quality of care.

*To promote a comprehensive understanding of the health care payment and delivery system and the underlying drivers of cost growth:*

- **Congress should establish a federal all-payer claims database (APCD).**

An APCD is a database of medical, pharmacy, and other health care claims from both public and private payers. APCDs—which states originally developed and continue to operate through independent agencies, commissions/committees or nonprofit organizations, or within state departments of health or state Medicaid agencies—document health care cost, usage, access, delivery, and performance over



time.<sup>53</sup> A broad range of stakeholders—including many consumers, employers, researchers, and policymakers—promote APCDs as a useful tool in controlling health care costs because they increase transparency in health care spending.

Furthermore, APCDs are an increasingly valuable means for policymakers, researchers, and decision-makers to measure the value of health care and the variation in health care prices. Based on BPC's conversations with expert stakeholders, states are utilizing APCDs to help set cost targets, as well as to understand issues in and changes to access to and quality of care. Legislators can also use APCDs to inform policymaking.<sup>54</sup>

However, APCDs vary widely by state in terms of the standard data elements, availability to researchers, price, and comprehensiveness. Currently, 24 states operate APCDs—some mandatory and some voluntary—and each with its own data collection and submission protocols.<sup>55,56</sup> A handful of additional states have APCDs in development.

Although federal policymakers can continue to promote the standardizing of health care data collection for APCDs among states, there is also value in leveraging the work being done by states and developing a federal all-payer health care claims database in which participation is mandatory. Moreover, states do not have the authority to require ERISA self-funded plans—accounting for 64% of covered workers nationwide—to submit claims data, due to the Supreme Court's 2015 decision on *Gobeille v. Liberty Mutual*. The Department of Labor, on the other hand, already has the authority to require the submission of such data for a federal APCD.<sup>57</sup>

In fact, the creation of a federal APCD would provide actionable information on national health care utilization and price data at a volume currently unachievable on a state-by-state basis. It would allow for an integrated look at data nationally and geographically. Congress should thus consider establishing a federal APCD, and the Department of Labor should articulate that ERISA self-funded plans would not be exempt from submitting data. Furthermore, the public should have access to APCD data, with the secretaries of Health and Human Services and Labor given discretion to set reasonable fees to support the database's maintenance costs.

The federal government likely already has the authority to create a federal APCD, but researchers have suggested that congressional direction of and funding for such work would produce greater success.<sup>58</sup> The Brookings Institution has estimated that the annual operating costs for a nationwide APCD would be \$20 million, after initial start-up funding.<sup>59</sup>

The proposal for a federal APCD has a history of bipartisan support. In 2020, Senate HELP Committee Chairman Lamar Alexander (R-TN) and ranking member Patty Murray (D-WA) introduced the [Lower Health Care Costs Act \(S. 1895\)](#), which would have essentially created a national APCD. It mandated that state data, including from self-insured plans, be contained in a nonprofit entity.<sup>60</sup>

Short of establishing a federal APCD, Congress could require, or the administration could encourage via the Department of Labor, states to implement standardized state-level APCDs. In fact, via the bipartisan [Consolidated Appropriations Act of 2021](#) (CAA) ([P.L. 116-260](#)), Congress has authorized—though not yet appropriated—funding of up to \$125 million over three years, beginning in fiscal year 2022, for states to develop new or improved APCDs. As a condition of funding, the Labor Department could require states to adopt uniform data collection and reporting standards. As part of this recommendation, the department should implement the recommendations set forth by the State All Payer Claims Databases Advisory Committee (SAPCDAC). In 2021, Congress created SAPCDAC as part of the CAA to provide the secretary of Labor with the guidance necessary for states to collect claims data from plans—and, in particular, ERISA self-insured plans—in a standardized format. The goal was to enhance health care quality and affordability.<sup>61</sup> This guidance, in the form of a [report](#), provides valuable and useful information for the implementation of standardized state APCDs.

- **Congress should require the HHS secretary to establish a centralized data repository to host payer and provider pricing data and penalize entities that refuse to comply with transparency laws.**

Strong evidence shows that high, rising, and variable prices are the greatest contributors to health care cost growth in the United States.<sup>62</sup> Although APCDs can provide valuable information on the volume of health care services being utilized by consumers and on cost drivers in the fully insured market, additional cost and quality data, including data from the self-insured market, could provide a more complete picture of health care costs and their impact. Employers and policymakers are not well served by the black box that currently exists around the prices that commercial insurers negotiate with providers. Existing transparency efforts do not allow for more direct comparisons. Employers need adequate information about health care prices and quality to keep their plans affordable and fulfill their fiduciary responsibility.

Over the past decade, the Obama, Trump, and Biden administrations have attempted to improve [hospital](#) and [health plan](#) price transparency. In 2020, pursuant to authority under the ACA, the Trump administration expanded on Obama-era rules by requiring hospitals and health plans to publicly post data on their negotiated prices. The rules also required consumer-facing tools to help enrollees understand their out-of-pocket financial liability for health care services.

Just weeks after the Trump administration issued its rules in 2020, Congress passed several transparency provisions through the CAA ([P.L. 116-260](#)). The CAA also required a consumer-facing price comparison tool and banned gag clauses in contracts that group health plans enter with either providers, networks, TPAs or other service providers. This ban eliminated an avenue that insurers and third-party administrators have used to deny employers access

to claims and other data. The Biden administration has published guidance to providers, hospitals, and health plans to implement the new requirements.

The hospital price transparency rule, which went into effect on January 1, 2021, requires health systems to publish standard charges for 300 shoppable services on a public website, along with standard charges for all services in a digital file. However, as of February 2022, only 14% of hospitals and health systems had complied with the rule.<sup>63</sup> Furthermore, data from hospitals that did share pricing information was inconsistent and incomplete.<sup>64</sup> Although more specific recent data on compliance levels is unavailable, noncompliance remains high because making the data public is not in hospitals' financial interests and adds to administrative costs. In addition, penalties for noncompliance are limited.<sup>65,66</sup> The Centers for Medicare and Medicaid Services (CMS) has sent warning notices and the Biden administration increased penalties for noncompliance, but as of June 2022, the HHS secretary has only levied penalties on two Georgia-based hospitals.<sup>67</sup> The administration should continue to hold entities accountable by penalizing them for noncompliance.

The "Transparency in Coverage" final rule requires health plans to post on a publicly accessible website their negotiated in-network prices and allowed amounts<sup>ii</sup> for out-of-network services for all covered health care items and services, by plan and by provider. They must also make a price comparison tool available to consumers online beginning in January 2023. Additional requirements will take effect in 2023 and 2024 and require health plans to provide an explanation of benefits before an enrollee receives services; improve provider directories; report on prescription drug and spending information; and include in-network and out-of-network deductibles on ID cards.<sup>68</sup> The rule requiring health plans and insurance issuers to publicly post in-network negotiated rates, billed charges, and allowed amounts for out-of-network providers went into effect on July 1, 2022. Although compliance rates are already higher than with the hospital transparency rule, at the time of this writing, much of the data are not accessible or usable. One insurer can produce huge data files, requiring users to wade through millions of non-searchable data points.<sup>69</sup> Although many insurers are in compliance with the rule, CMS should revisit the guidance it gave to carriers on how to submit and display data so that the information is more usable.

The transparency rules implemented by the Trump and Biden administrations are a critical step forward in bringing actionable health care data into the light. However, inconsistent, inaccessible, and poorly formatted websites and data repositories do not allow for direct comparisons across providers and plans. Private companies and researchers are working to compile and analyze some of this data. Maintaining price transparency data in a centralized, publicly available data repository with a data dictionary ("collection of names,

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ii The maximum amount a plan will pay for a covered health care service.

definitions, and attributes about data elements that are being used or captured in a database”) would allow for apples-to-apples comparisons.<sup>70,71</sup>

Such a centralized database should also incorporate data showing how providers perform on key quality metrics and health outcomes, enabling employers, regulators, and policymakers to assess not only prices across health care markets but also the value employers are receiving for their health care dollars.<sup>72</sup> This effort would hinge on federal agencies’ ability to create a standard template for data submission and to issue detailed guidance on data presentation.

Moreover, hospitals should post prices both as a flat dollar amount and as a percent of Medicare rates. Research conducted by RAND has revealed that employers and private insurers paid, on average, 224% of what Medicare would have paid for hospital services.<sup>73</sup> Allowing an assessment of price variation relative to a Medicare benchmark can help identify when prices are more a function of a provider’s market power than its underlying costs for delivering services.

A data accumulation and standardization effort of this magnitude would be a huge undertaking for CMS, but without it, transparency efforts will not produce actionable data needed to enact transformative policy change.

Given existing compliance challenges, HHS may have to provide additional technical assistance and stronger oversight and enforcement to payers and providers for them to meet requirements. Vague language that leaves too much to interpretation burdens hospitals and health plans with uncertainty regarding compliance. Hospital leaders have indicated that confusing and complex regulations are their top barrier to complying with price transparency rules.<sup>74</sup> For any new requirements to be effective, a specific plan for improving rates of compliance is needed. Guidance and rulemaking, along with additional technical assistance and strong enforcement, would enable payers and providers to submit and publish actionable information.

Because policymakers, employers, and consumers will use transparency data very differently, HHS will need to facilitate data use based on the audience. For example, policymakers could use data on price variations to investigate bad actors and to craft informed policy. Employers can use transparency data to design networks and benefits for their employees. Transparency efforts aimed at consumers will need to display clear, digestible information so consumers can select a provider and compare prices and quality at the time they need to make a decision about a health care item or service. However, as noted previously, there is little evidence that price transparency efforts for consumers have a big impact on the cost of care.<sup>75</sup>

### ***To understand the impact of private equity on health care prices:***

- **Congress should consider creating a federal, publicly available database or clearinghouse to track health care ownership and require private equity firms to report health care provider purchases where concentration is high.**

In recent years—and particularly following enactment of the Affordable Care Act—private equity involvement in health care acquisitions and consolidation has grown.<sup>76,77</sup> As of 2021, private equity and venture capitalist investment in the health care sector was double what it was seven years ago.<sup>78</sup>

However, transparency is minimal regarding private equity involvement in health care acquisitions and its impact on quality and outcomes.<sup>79</sup> While the role of private equity in the health care sector continues to evolve and grow, transparency efforts focused on private equity could help to bring attention to the downstream effects on patients and reveal what positive effects private equity investment is having on health care delivery.

To better understand the nature and effects of private equity investment in health care prices and delivery—both positive and negative—Congress should consider the creation of a federal publicly available database or clearinghouse to track health care ownership where provider consolidation is high, or network participation is low. This data should be designed for use by federal antitrust enforcement agencies and researchers; it could also include data on cost to patients and quality outcomes.

Because the health care sector is often viewed as being relatively recession-proof, investors see the sector as both a way to shield themselves financially, and to diversify and balance out their portfolios.<sup>80</sup> On the payer and provider side, consolidation may be undertaken in an effort to insulate themselves in the face of new, disruptive players in the health care market, such as Amazon.<sup>81</sup> Furthermore, private equity investment can offer both payers and providers protection from risk and reduce administrative and regulatory burdens, as well as provide novel resources to improve their workflow, service delivery, and care coordination. Innovations in care delivery, technology, and other operational proficiencies can also result from such investments.<sup>82</sup> Indeed, private equity investment may be one way in which primary care physicians can be encouraged to pursue integrated, value-based care arrangements—thereby avoiding downstream excesses in hospital utilization and cost.

On the other hand, some researchers have found private equity investment in health care to be problematic, arguing that it creates pressure on entities to prioritize the interest of stakeholders over those of patients in decision making.<sup>83</sup> Others have suggested that private equity's involvement in provider consolidation has ultimately driven up prices.<sup>84</sup> Some evidence showed that private equity-backed entities have lower-quality care. For example, nursing homes acquired by private equity firms had higher emergency department

visit rates and hospitalizations.<sup>85</sup> Other researchers have found that specific health care providers—such as hospice care—might be especially vulnerable to exploitation by private equity.<sup>86</sup> In terms of hospice care, the Government Accountability Office (GAO) urged greater oversight.<sup>87</sup>

In her April 20, 2021, testimony before the U.S. House Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, professor Leemore S. Dafny of the Harvard Business School and Harvard Kennedy School, suggested creating a federal database that would allow researchers and antitrust enforcement agencies to review transactions more rapidly.<sup>88</sup> It would also allow researchers to determine where private equity investment in health care can be beneficially expanded.



## SECTION II: EMPOWER EMPLOYERS WITH PAYMENT AND PRICING TOOLS

Policymakers should ensure that employers have the tools they need to create a high value, employer-sponsored insurance system that prioritizes employee health outcomes while protecting families financially. Congressional and regulatory actions should allow employers to design better benefit structures and provider networks, with both prices and quality in mind. Additionally, policymakers should ensure that all stakeholders, not just employers, responsible for managing and deploying ESI plans are accountable for constraining health care cost growth.

*To provide clarity on fiduciary responsibility and promote stakeholder accountability for cost containment:*

- **The Department of Labor should leverage existing authorities to boost accountability for third-party administrators and other vendors, and issue guidance on what qualifies as a fiduciary function.**

Employers and service providers regulated by ERISA are accountable for maintaining and deploying health care benefits in the best interest of plan members. Under ERISA, the Department of Labor articulates that “the primary responsibility of fiduciaries is to run [health plans] solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses.” A key component of this fiduciary responsibility is to pay “no more than reasonable compensation” to service providers ([29 U.S.C. § 1108\(b\)\(2\)\(A\)](#)). The Labor Department’s Employee Benefits Security Administration (EBSA) also states that fiduciary status is based on the functions an entity performs for the plan rather than its title, and any entities that exercise discretion over health plan administration are fiduciaries.<sup>89</sup> Since

ERISA's passage, employers have shouldered the responsibility of carrying out fiduciary functions. However, there are several open questions regarding how fiduciary responsibilities apply in the context of health benefit plans. One specific area where more clarity is needed is the extent to which ERISA's fiduciary provisions require different entities involved in administering a health benefit plan to pay and be paid "no more than reasonable compensation" and what is "reasonable." Absent regulation, health insurers, TPAs, and other vendors with whom plan sponsors contract often do not have enough incentive to bring down provider prices and slow the rate of health care cost growth.

Moreover, evidence shows that insurance carriers (whether they are providing insurance policies to fully insured plans or whether they manage risk on behalf of employers as third-party administrators pursuant to Administrative Services Agreements) are more profitable as health care expenditures grow.<sup>90</sup> Clarifying fiduciary functions, and how they apply to employers and other vendors, could ensure that all stakeholders involved in managing and administering employer-sponsored health plans are held accountable for constraining health care cost growth and acting in the best interest of plan members.

Two main problems exist: The Department of Labor has not (1) clarified what constitutes fiduciary functions versus settlor functions—activities related to the formation rather than the management of plans; or (2) defined what qualifies as fulfilling fiduciary duties. TPAs often use section [29 CFR 2509.75-8 D2](#) of ERISA to argue that they are simply performing ministerial functions and therefore do not qualify as fiduciaries. However, the Labor Department's letters, notices, and legal cases suggest otherwise:

- In a 1998 [letter](#) to the Service Employees International Union the Department of Labor stated that hiring a health care provider qualifies as a fiduciary function.<sup>91</sup> These statements are somewhat murky. Although employers may qualify as fiduciaries while selecting networks offered by insurance carriers, TPAs could also qualify as fiduciaries when adding or subtracting providers after the plan signs the network access agreement.
- The Labor Department, when determining issues that arise under ERISA-covered health plans, is guided by the ERISA [statute](#). It states, "A person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan."
- In [Perez v. MagnaCare Administrative Services, LLC, et al.](#), in 2017, the department brought a case against a health plan TPA, MagnaCare, for charging undisclosed "network management fees" to ERISA plans, saying it



was a violation of ERISA's fiduciary duties. A settlement required MagnaCare to pay \$16 million to the department, including a civil penalty and compensation to health plan clients.<sup>92</sup> A representative for the EBSA stated, "This case serves as a reminder that a fiduciary must fully disclose fees to plan clients under federal law, as MagnaCare has agreed to do."<sup>93</sup>

- A Department of Labor lawsuit against United Healthcare under the Mental Health Parity and Addiction Equity Act of 2008 alleged that United breached its fiduciary duties while acting as a TPA. The department recognized that TPAs have significant discretionary authority and control over health plans in the mental health arena and should recognize that as well with respect to other functions.<sup>94</sup>

Despite the department's issuance of notices and letters and its commencement of court cases against TPAs for breaches of their fiduciary obligations, employers, TPAs, and other vendors are still left waiting for courts to determine fiduciary responsibility on a case-by-case basis—always after an entity has already caused harm to plan members. This is because, despite taking the positions noted above, the department has issued very little guidance on the fiduciary responsibilities associated with managing and implementing health plans.

The Labor Department should engage in rulemaking to address high and rising health care costs. It must first, however, assess how to leverage existing authorities to hold intermediaries and TPAs accountable. ERISA states that "[a] fiduciary is a person or entity with discretionary authority to control and manage the operation and administration of a benefit plan."<sup>95</sup> The department could therefore clarify, for example, that even if a plan sponsor nominally has final decision-making authority on claims, a TPA that exercises discretionary authority over plan management and/or exercises any authority or control respecting the management or disposition of plan assets is also a fiduciary and therefore required to fulfill a fiduciary obligation.

### ***To ensure that employers have access to health plan data:***

- **The Departments of Labor, Treasury, and Health and Human Services should issue guidance to clarify the so-called gag clause ban and that plan data are a plan asset.**

The CAA ([P.L. 116-260](#)) banned gag clauses in contracts that group health plans enter with providers, networks, TPAs or other service providers. However, TPAs and vendors are continuing to limit the ways employers can use plan data despite the CAA. Before enactment of this provision, gag clauses restricted insurers from making price and quality information available to other parties, including employers.

Despite congressional intent to ensure employers had unfettered access to claims data, TPAs and insurers are circumventing the law. BPC interviews with

experts found that TPAs are working around the ban by limiting the number of claims that employers can review and financially audit; by refusing to provide data fields required to perform an electronic audit; and by refusing to share claims data in regions where they are the only TPA. For example, one TPA limited financial audits to 225 claims from the previous year. TPAs have also tried to assert that national patient identifiers are proprietary data—preventing employers from running analytics.

Employers need access to their own claims data to ensure they are fulfilling fiduciary obligations—for example by monitoring whether TPAs are charging reasonable fees and paying claims properly in accordance with the plan document(s); recovering overpayments; and designing data-informed benefits for plan members. As such, the Department of Labor should issue further guidance articulating that plan data is a plan asset and that the data belongs to the plan, not the TPA. The department should clarify this means that plans should be able to electronically access claims data at all times and share with any business associates of their choosing, subject to relevant privacy provisions. It should also clarify that this means TPAs, networks, and other service providers have no right to use any of the data collected for any use outside of managing claims under the plan unless they have express permission from the plan and any affected participant.

TPAs and insurers might worry that giving employers unfettered access to claims will require them to share propriety information or put patient data at risk. However, employer groups assert that access to claims data is critical for reducing health care costs and meeting their fiduciary duty to administer the plan in the best interest of members. Furthermore, employers maintain that fears about putting patient data at risk are overblown. Industry experts widely agree that the main goal of TPAs in keeping this information confidential is to keep the negotiated discounts they have with providers confidential, and that is specifically no longer allowed under ERISA Section 724.<sup>iii</sup> Additionally, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws provide sufficient protection. Employer groups like the ERISA Industry Committee have pushed for the departments of Treasury, Labor, and HHS to issue “guidance and clarification on eliminating gag clauses in contracts between providers and health plans, as required by the CAA.”<sup>96</sup> Without additional clarification from the departments, TPAs could continue to thwart transparency efforts intended to ensure employers can improve health outcomes for employees while lowering health care costs.

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iii CAA states that “A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from-- (A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage.”

***To make it easier for employers to use tools that improve outcomes and contain costs:***

- **Congress should require HHS to nationally designate Centers of Excellence.**

Centers of Excellence are payer- or employer-designated providers that meet high quality, outcome, and cost-effectiveness standards for specific procedures or services (usually non-emergent care). Employers use this model to derive greater value from their health care dollar and generate savings by encouraging members to get care at high quality facilities that can produce positive patient outcomes. For example, Walmart deployed the Centers of Excellence model for spine surgery, which resulted in shorter hospital stays and reduced readmission rates—ultimately saving the company money due to avoided surgeries and better outcomes.<sup>97</sup>

Payers often waive out-of-pocket costs and cover travel costs if their employees or members seek services at the Center of Excellence. In exchange for the designation, providers may agree to accept lower negotiated rates or bundled payments for services to increase the volume of patients at their facilities.<sup>98</sup> These programs tend to be voluntary, and consumers have the option to choose other providers.

This model is frequently touted as an innovative and effective employer strategy to reduce costs, but not all programs are alike. The lack of a concise definition or trusted accreditation body has contributed to mixed evidence with respect to the desired outcomes.<sup>99</sup> While some assessments show that Centers of Excellence produced positive outcomes and cost savings, others yielded inconclusive results. For example, in a recent survey of state employee health plans, 23 plans reported establishing a Centers of Excellence program, but only two were able to associate the program with any quantifiable cost savings.<sup>100</sup>

Furthermore, many employers may face barriers, such as high administrative costs or inadequate resources needed to develop criteria, to implementing a Centers of Excellence program. This can limit programs to only the largest and most well-resourced employers and their TPAs.<sup>101</sup> A federal designation could enable more employers to use the program without having to devote resources to determining criteria and researching costs. Although a federal designation could help reduce significant administrative costs, it would not eliminate all of them. The employer would still have to negotiate an in-network rate for services delivered at the Center of Excellence.

A similar effort is underway at the state level. A state law in New York (and legislation advancing in California) will require insurance companies that administer Medicaid and marketplace plans to enter into payment negotiations with National Cancer Institute designated Comprehensive Cancer Centers. This effort aims to improve outcomes by bringing high quality cancer centers in-network for Medicaid recipients and exchange plan members.<sup>102</sup>

In federally designating Centers of Excellence, HHS will need to be explicit about criteria and ensure evaluations adjust for the populations that a particular hospital or health system serves to account for risk. Moreover, CMS should report on how it plans to designate these centers (for example by disease state) and what the qualification criteria is. These criteria will vary by clinical focus. The federal government should develop standards in conjunction with the National Quality Forum and incorporate proper risk adjustment. There is precedent for a federal Centers of Excellence program, but negative provider reactions to the criteria development and evaluation process halted previous progress. In 1990, Medicare chose four to six institutions as the standard of excellence for heart bypass centers. In a three-year demonstration project, CMS agreed to pay discounted rates if a beneficiary sought bypass surgery at these institutions. Participating doctors agreed to accept Medicare fees as full payment.<sup>103</sup> However, some hospital systems objected to the evaluation and selection process, and CMS did not continue the program after the three-year period. The federal government could build off this work in designating Centers of Excellence, while involving a variety of stakeholders to develop criteria.

This model has not always been popular with local providers, but Center of Excellence partnerships with these providers may help address challenges. Some local providers argue that the model can make it harder for smaller, independent physician practices to maintain business.<sup>104</sup> In response to some of these concerns, Cleveland Clinic's Center of Excellence program partners with local physicians to deliver follow-up care after patients return to their hometowns. CMS could encourage these types of partnerships when nationally designating Centers of Excellence.

### ***To further protect patients from surprise medical bills:***

- **Congress should urge the administration to fulfill implementation of the No Surprises Act by urging the Advisory Committee on Ground Ambulance and Patient Billing to finalize committee membership and hold its first meeting.**

Congress passed the No Surprises Act (NSA) as part of the [Consolidated Appropriations Act of 2021](#) (CAA) ([P.L. 116-260](#)). The law took effect on January 1, 2022. It protects insured patients from surprise medical bills when receiving most emergency services, as well as when receiving non-emergency services from out-of-network providers and services from out-of-network air ambulance providers.<sup>105</sup>

The NSA, however, does not apply to ground ambulance services. Rather, the NSA requires the secretaries of Labor, Health and Human Services, and Treasury “to establish and convene an advisory committee for the purpose of reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing.” It requires that the

committee submit a report with recommendations related to insurance coverage for charges and fees for ground ambulance services no later than 180 days following the date of its first meeting.<sup>106</sup>

The secretary of HHS signed the advisory committee's charter on November 16, 2021. A week later, CMS published a Federal Register Notice that announced the establishment of the committee and allowed interested individuals to submit their applications or nominations to be committee members by December 13, 2021. Since that time, the committee has taken no additional action, has not announced any committee members, and has not scheduled a first meeting.

As Americans continue to receive surprise medical bills from ground ambulance services, it is imperative that Congress urge the advisory committee to undertake its work—first and foremost, by finalizing membership and setting a date for a first meeting—in order to produce recommendations as soon as possible, and no later than 180 days following the date of its first meeting. Furthermore, the advisory committee should be encouraged to look for best practices at the state level by examining the ways in which states that currently provide some protections against ground ambulance out-of-network bills operate. As a part of this work, the advisory committee might also be urged to develop recommendations related to incentivizing more contracts between insurers and ground ambulance providers.

Before the NSA, about 25% of emergency room visits resulted in unexpected, or “surprise,” medical bills, as did between 9% and 16% of non-emergency, in-network hospitalizations.<sup>107</sup> Data available before enactment of the NSA revealed that the average surprise bill for a visit to an emergency room was above \$600, although more recent data from the HHS's Office of the Assistant Secretary for Planning and Evaluation found costs ranged more frequently between \$750 and \$2,6000, depending on the service.<sup>108,109</sup> In the first two months of 2022, after the NSA went into effect, a survey conducted by AHIP and the Blue Cross Blue Shield Association found that the law prevented more than 2 million potential surprise bills.<sup>110</sup> Promisingly, the Congressional Budget Office has [estimated](#) that the NSA “will reduce commercial insurance premiums by between 0.5% and 1%, saving taxpayers \$17 billion over 10 years and saving consumers about twice that much between reduced premiums and cost-sharing.”<sup>111</sup>

Ground ambulance services are usually operated by state and local governments, however, which can create greater complexity in billing.<sup>112</sup> According to the Peterson-Kaiser Family Foundation Health System tracker, in 2020, government organizations, such as local fire departments, provided nearly 2 in 3 ground ambulance rides.<sup>113</sup> Furthermore, regulations at the state and local level can make it harder for these government organizations to operate as in-network providers when they are dealing with insurance companies.<sup>114</sup> Unfortunately, researchers have found that significant shares of

ground ambulance services can result in surprise medical bills—nearly half of ground ambulance rides result in an out-of-network charge with an average patient cost of \$450 per ride.<sup>115</sup> Formally naming members to and convening the advisory committee on GAPB stand to both fulfill implementation of NSA and further protect patients from surprise medical bills.

***To motivate employers to offer and employees to choose high performance health coverage options:***

- **Congress could consider options for encouraging ESI use of high performance network (HPN) health plans.**

Previous attempts to rein in health care costs by discouraging high-cost health plans have faced resistance. For example, the ACA’s so-called “Cadillac tax” would have imposed a tax on high-premium plans with generous benefit packages. This cost-containment policy was unpopular among employers and employees, who worried that it would erode health benefits or burden employees. Eventually, in 2019, Congress repealed the Cadillac tax, much to the relief of employers, but without considering a replacement mechanism to contain costs.<sup>116</sup> The political feasibility of reviving any sort of tax on high premium plans appears to remain low.

To remedy this, Congress should consider funding an education campaign, led by HHS, to highlight the value of high performance provider networks. HHS should define the criteria for what qualifies as an HPN, and it should be sure to include measurements on delivery efficiency, quality improvement, and cost effectiveness. The American Academy of Actuaries has developed a comprehensive [issue paper](#) on high performance networks, which highlights the importance of ensuring that insurers, providers, employers, and health plan members are all engaged to meet the same objectives.<sup>117</sup> Such a campaign would ideally encourage employers to be more exacting in their health plan selection and network development, inspire employees to enroll in high performance health plans, and ultimately pass on savings to employees in the form of wage increases. Building greater interest in high performance networks might also encourage insurers to compete to develop and offer lower premium, high performance options.

If an appetite exists for more forceful action to promote high performance health care networks, Congress might also consider creating a tax credit or grant program that rewards the uptake of HPN health plans. A tax credit policy option might operate by redirecting a portion of the current employer tax subsidy to employers in exchange for decreasing their premium contributions.<sup>118</sup> Employers would receive a credit for each employee enrolled in coverage, and they would be required to standardize covered benefits. Such a tax credit policy would theoretically boost employees’ take-home pay in the form of wage increases, as firms would be required to apply these credits to the premiums workers owe for ESI enrollment.

Alternatively, a congressionally directed and funded grant program could incentivize employers to provide and promote high performance network health plans. Such a grant program might operate by providing additional funding to states, via HHS; the money could then be disbursed among interested employers for the purpose of developing and promoting the uptake of high performance network health plans. As a condition of grant funding, HHS should be given the leverage to determine requirements for participation, similar to, for example, requirements on employers participating in the ACA's reinsurance program, which were also subject to federal audits. Furthermore, HHS should develop a mechanism to measure improvements in health care quality and outcomes associated with HPNs.

Finally, in encouraging the use of HPNs, HHS could consider taking a closer look at the performance and value of health plans such as those provided by health maintenance organizations (HMOs). As opposed to preferred provider organization (PPO) plans, HMOs are a type of prepaid plan that offer beneficiaries access to a smaller network of providers, typically require referrals to see specialists, and do not cover any out-of-network providers. The attraction of HMOs is that they focus on primary and preventative care in order to keep beneficiaries in good health, thereby, ideally, preventing higher costs down the line. They accomplish this by charging on a per-patient basis, rather than by fee-for-service, within a narrower network of providers. For employees, HMOs tend to be more affordable, as they tend to have lower or no annual deductible: 43% of workers with single coverage via an HMO, and 42% of workers with family coverage, do not have a general annual deductible.<sup>119</sup>

HMOs gained prominence in the 1970s following passage of the Health Maintenance Organization Act of 1973. By the 1990s, however, HMOs began to fall out of favor as criticisms over the quality of care they provided grew. By 2001, nearly every state had passed legislation regulating HMOs, and some stakeholders would argue that these efforts provided the basis for pushes for a patients' "bill of right" within the ACA. Since 2015, however, the percentage of employees enrolled in HMO plans has increased slightly.<sup>120</sup> As such, and as a part of this option, Congress might also consider urging the GAO to complete a comprehensive review of the performance and cost effectiveness of HMOs following enactment of the ACA. As part of this review, GAO might also be encouraged to report on the performance and cost effectiveness of other types of managed care plans, such as Exclusive Provider Organizations.



## SECTION III: ADDRESS MARKET POWER DYNAMICS

Health care prices in the private market are shaped by negotiations between providers and payers. A variety of factors determine these prices, including geographic markets, demand for services, and payer and provider market power. Employers often do not wield enough market power to negotiate low prices due to provider consolidation. Indeed, provider consolidation continues to accelerate—nearly 67% of hospital markets are considered highly or very highly concentrated.<sup>121</sup> A large body of evidence shows that this consolidation can lead to increased health care prices.<sup>122</sup> BPC has proposed policy strategies intended to equalize market power dynamics to foster a more competitive employer-sponsored health insurance system.

*To give employers the ability to design provider networks that best serve their employees in concentrated provider markets:*

- **Congress should prohibit anti-competitive contract language (such as anti-tiering, anti-steering, and all-or-nothing clauses) in insurer contracts with providers.**

In an already consolidated hospital market, providers can include anti-competitive language in their contracts with health plan sponsors, and this can lead to higher prices. Employers and insurers are often forced to accept these terms due to their limited market power. For example, a dominant “must-have” provider in a health system might include an all-or-nothing clause in its contract that requires a health plan to contract with all of the system’s other providers. This practice prevents health plans from negotiating lower rates with another hospital or provider in the same health system.



Health systems can also use anti-steering and anti-tiering provisions in contracts, which prevents health plans from excluding them from the network or including incentives for their employees or members to choose a less costly alternative. These provisions hamper an insurer's ability to direct its members to higher value providers.<sup>123</sup>

Bipartisan support exists for banning anticompetitive terms in insurance contracts. Sens. Mike Braun (R-IN) and Tammy Baldwin (D-WI) have sponsored the [Healthy Competition for Better Care Act \(S. 3139\)](#), which would prohibit anti-tiering and anti-steering language in contracts. The ERISA Industry Committee, American Benefits Council, National Association of Insurance and Financial Advisors, and Council for Affordable Health Coverage are all supportive of the bill.<sup>124</sup>

BPC has included this recommendation in a previous [report](#), *Bipartisan Rx for America's Health Care*: Congress should prohibit hospitals from using noncompetitive contracting requirements, such as all-or-nothing requirements, which require plans to contract with an entire network in order to contract with a single hospital or provider group. Nothing in this provision would relieve plans of the responsibility of meeting network adequacy requirements.

#### ***To reduce administrative waste:***

- **The Department of Labor and the Center for Medicare & Medicaid Innovation (CMMI) should develop a standard model provider-payer contract to pilot at the state level, in Medicare Advantage plans, and in ACA qualified health plans.**

Often characterized as complexity-driven waste, billing and insurance-related administrative costs are higher in the United States than in any other country.<sup>125</sup> One of the reasons for the complexity is that providers have to administer dissimilar contracts for multiple insurers and meet plan-specific requirements. Few policymakers and advocates have proposed strategies to control billing and insurance-related administrative waste resulting from contractual complexity, although simplified solutions have been implemented in other industries. Standardized payer-provider contracts could be deployed in a multi-payer system. Researchers using a model to estimate fixed and variable costs found that standardizing contracts generated larger administrative spending savings and less variance than single-payer strategies.<sup>126</sup>

The Department of Labor, in conjunction with CMMI, could design a standard payer-provider contract template to use to cut down on administrative burdens. This template could standardize claims processes, payment protocols, risk sharing (if any), credentialing requirements, pre-authorization criteria, dispute resolution, payment codes, and quality and other reporting requirements. Additionally, the model contract could standardize how to designate in-network and out-of-network providers and network inclusion changes, so payers are still able to deploy high value benefit designs.

This policy is unlikely to lead to administrative savings without a critical mass of providers and payers in a particular market adopting standardized contracts. CMMI could work with the departments and state insurance commissioners to pilot standardized payer-provider contracts at the state level. The Balanced Budget Act of 1997 (BBA) and subsequent legislation could also offer the authority to introduce contract standards in Medicare Advantage plans. Another option is to use authority under the ACA to certify qualified health plans (QHP) on the health insurance marketplaces to include additional standardized elements in their contracts with providers. As defined by the ACA, a QHP is an “an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost sharing, and meets other requirements outlined within the application process”.<sup>127</sup> The federally facilitated and state-based marketplaces could establish additional requirements for QHPs that require them to use standard payer-provider contracts. Although these requirements would apply only to plans sold via the marketplaces or through Medicare Advantage and state plans, they could be used to measure the impact of a standard model contract and ultimately expand their use.

### ***To promote provider competition:***

- **Congress should strengthen federal enforcement agencies’ ability to identify and review potentially problematic transactions in the health care industry to avoid high concentration in markets and potentially reduce health care prices.**

The U.S. health care market is more consolidated than ever before.<sup>128</sup> Multiple studies have concluded that the consolidation—including both horizontal and vertical mergers—consistently leads to higher prices without improving the quality of care.<sup>129,130,131</sup> In regard to hospitals, a 2020 MedPAC report found that most of the literature—although not all of it—suggests consolidation results in higher prices.<sup>132</sup>

Many smaller but no less impactful transactions leading to consolidation do not meet the filing requirements under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, also known as the Hart-Scott-Rodino Act. This failure allows consolidation and increases in market concentration to persist. Before merging, companies surpassing certain thresholds are required under the act to submit notifications to the Department of Justice’s Antitrust Division and the Federal Trade Commission (FTC). The act also creates a waiting period before mergers can be finalized. The Hart-Scott-Rodino Act was designed to protect competition and prevent monopolies, and the FTC updates thresholds annually based on variations in gross national product.

To temper high prices that can be associated with high market concentration, Congress should consider strengthening FTC and DOJ antitrust enforcement by

providing additional appropriations for the review and prevention of potentially problematic transactions. Stronger review would help to prevent market consolidation and maintain industry competition.

The FTC leads investigations into acquisitions, mergers, and other consolidation transactions in the health care sector and, in the past, it has blocked some mergers by physicians and hospitals. The DOJ's Antitrust Division oversees mergers in the health insurance industry.

The FTC under the Biden administration has been both more aggressive and successful over the past year in combating provider consolidation.<sup>133</sup> In fact, the FTC recently sued to block a merger between two New Jersey health care systems, arguing that, by removing direct competition, prices would increase and the quality of care for patients would decrease.<sup>134</sup> In July 2021, the administration issued an executive order encouraging the federal government's antitrust agencies to focus their enforcement on particular markets, including health care markets.<sup>135</sup>

In addition to the administration's greater focus on combating anticompetitive transactions, recent increases in appropriations to the FTC over the past two years have also helped combat provider consolidation. The FTC has seen around a 6% increase annually, since 2020—far outpacing what was, on average, a decrease in funding since 2012.<sup>136</sup> In FY2022, the agency was funded at \$377 million.<sup>137</sup>

The same may be true of the DOJ. The DOJ's Antitrust Division suffered from nearly level funding—around \$160 million per year—between 2009 and 2020.<sup>138</sup> The division saw an unprecedented increase in funding—more than 10%, to \$184.5 million—from 2020 to 2021.<sup>139</sup> As part of the FY2023 budget request, the Biden administration called for substantial increases in funding for both the DOJ and the FTC.<sup>140</sup>

Antitrust investigations require time and sustained resources, and they could be strengthened by providing additional funding for merger and acquisition review and enforcement.

### ***To lower hospital prices in noncompetitive markets:***

- **Congress should permit hospitals in markets with a Herfindahl-Hirschman Index (HHI) score above 4,000 to enter negotiations with the Federal Trade Commission (FTC) to bring the HHI score under 4,000, unless market consolidation was the result of a regulatory exception to the Department of Justice (DOJ) guidelines related to hospital mergers. Hospitals that do not enter negotiations with FTC would be prohibited from charging private insurers more than an amount outlined below (or whichever is lower):**

**Option 1:** The maximum rate paid by a private insurer to a hospital for a service would be the average Medicare Advantage (MA) rate for that service in the market, with private rates phased down to MA rates over five years:

- Year 1 & 2 – HHS secretary and FTC define market concentration and notify providers
- Year 3 – 178% of Medicare Advantage Rates
- Year 4 – 150% of Medicare Advantage Rates
- Year 5 – 130% of Medicare Advantage Rates
- Year 6 – 110% of Medicare Advantage Rates
- Year 7 – 100% of Medicare Advantage Rates

**Option 2:** The maximum rate paid by a private insurer to a hospital would be a rate that reflects the average private insurance rate in a competitive market (defined as an HHI score of 2,500 or below) relative to the average Medicare Advantage rate in that market. For example, in a market with an HHI index below 2,500 with an average MA payment for a service of \$100 and an average commercial rate of \$200, the maximum commercial rate would be 200% of Medicare Advantage rates.

- Direct the FTC to publish a list of markets with an HHI score of 4,000 or greater. In determining HHI scores, the FTC must work with the secretary of HHS to define market concentration. This would allow for analysis that more accurately reflects today's markets and is not limited to inpatient admissions. Factors could include overall admissions and discharges, but would also allow specialties that may include outpatient-only services.
- Hospitals in consolidated markets should be prohibited from balance billing (charging patients the difference between the provider's charge and the insurer's allowed amount) patients. This prohibition on balance billing would have to apply to any hospital subject to the rate cap to prevent it from refusing to participate with commercial plan networks and then billing patients directly.

BPC included this recommendation in a previous report, [Bipartisan Rx for America's Health Care](#). Market consolidation is increasingly common, in part because of federal payment policy that encourages more integrated care and incentivizes provider risk. Not all mergers are anti-competitive; although they can lead to significant market concentration, some mergers may be done to preserve access to care, particularly in vulnerable communities—rural areas for example.<sup>141</sup> In some cases, consolidation has helped facilitate delivery system reform and preserved access to care. Hospitals argue that consolidation helps lower their costs through increased efficiency.

But in other cases, consolidation has resulted in increased market share and higher prices, according to multiple studies over more than a decade. In the 25

metropolitan areas with the highest rates of consolidation, prices increased in most areas by 11% to 54% in the years following a merger, a 2018 analysis conducted by the Petris Center on Health Care Markets and Consumer Welfare for The New York Times found.<sup>142,143</sup> The study also discussed trends in hospital acquisition of physician practices, concluding that this practice exacerbates market consolidation and leads to higher prices.<sup>144</sup>

In January 2018, hospitals or large health care systems employed nearly half of all physicians in the United States, compared with just 25% of physicians in 2012.<sup>145</sup> About half of all markets have a high market concentration (HHI of 2,500 or higher), about one-third of markets are moderately concentrated (1,500-2,500 HHI), and the remaining one-sixth are low concentration or unconcentrated (100-1,500 HHI).<sup>146</sup> In some of the more concentrated markets, the purchase of specialty practices has resulted in a disincentive for providers to negotiate rates because they know that plans must contract with them in order to meet health insurance network adequacy requirements. This lack of competition negatively affects health insurance premiums, particularly in non-group insurance markets. Several proposals seek to address the problem, including providing additional funding for the FTC to increase antitrust enforcement or providing incentives to states to eliminate or preempt state laws that hamper competition or address provider rates.

Options 1 and 2 would not apply to hospitals located in counties with a population below the U.S. median. At the same time, BPC recognizes that high market concentration has a significant impact in counties with populations below the national median, including rural areas. Some state attorneys general have taken steps at the state level to address high costs resulting from market consolidation, and we are supportive of those efforts.

When considering corporate mergers in other industries, the FTC uses the HHI to measure market concentration. According to the DOJ and the FTC, HHI is calculated by “squaring the market share of each firm competing in the market and then summing the resulting numbers” such that 10,000 is the maximum score (where the market is controlled by a single firm) and the score approaches zero when the market is comprised of many firms of varying size.<sup>147</sup> However, some stakeholders have asserted that HHI may not be an accurate measure of hospital concentration due to a lack of agreement on geographic area for calculating the index. Additionally, policy experts and researchers sometimes find that the link between market structure and prices is weak, making HHI a blunt instrument. For example, policy experts have stated, “Because of a range of institutional features, including insurance, which shields patients from the price of care, information problems, and product differentiation based on location or reputation, many hospitals in low-concentration markets may have market power and thus charge high prices.”<sup>148</sup> More specifically, an academic medical center that offers specialized care may wield a great deal of market power even in an unconcentrated market. In response to these concerns and ones recognizing that mergers or acquisitions may be done to preserve

access to care, BPC has stated that the FTC must work with the secretary of HHS to define market concentration and review HHI as a screening tool for hospital mergers.

As better measures of market concentration become available, the secretary could use them instead of HHI or develop additional tests to determine whether a health system or hospital would be subject to price ceilings. One such test could establish a threshold based on case mix<sup>iv</sup> numbers, so that health systems and hospitals that treat patients with complex needs would not be penalized. New methods to develop more-accurate predictors, including analyses of these tools on access to care, would ensure that policies do not reduce access to care for vulnerable populations.

***To encourage employers to use cost containment tools, limit price variation, and constrain provider prices:***

- **The Departments of Labor and HHS should issue guidance to encourage ESI plans to use reference-based pricing models and incorporate them into plan designs.**

Prices associated with health care services and products can vary greatly, even within a geographic market. For example, one study found that knee replacement surgery in Dallas ranged from \$16,772 to \$61,585 in 2017.<sup>149</sup> Armed with new transparency data, employers may be empowered to use cost containment strategies such as reference-based pricing to address high and variable prices. Using reference-based pricing, employers (often supported by a TPA) establish a “reference price” or cap for a health care service or product. Employees can select a provider at or below the reference price for their usual cost-sharing amount. However, if they choose a provider that charges more than the reference price, they would have to pay the difference. The goal is to bring down prices by forcing providers to charge prices closer to the reference price or lose business. Employers can implement reference-based pricing programs in a variety of ways. One such way is by using a reference price benchmarked to Medicare.

The California Public Employees’ Retirement System (CalPERS) used reference-based pricing to steer members to high value providers and lower prices. CalPERS paid a reference price of \$30,000 for initial hospital stays for total hip or knee replacements. Designated facilities accepted this payment rate, and PPO enrollees paid out-of-pocket if they used facilities that charged over that amount. The reference-based pricing design reduced average hip and knee replacement payments per case by 26.7% in the first year by forcing high-price providers to compete with lower-priced competitors.<sup>150</sup> As such, the CalPERS model can serve as a positive case study for employers hoping to use reference-based pricing.

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iv CMS developed the case mix index as a measure to indicate whether a hospital treats a greater number of complex, resource-intensive patients.

Reference-based pricing strategies are not a panacea and may not work for every employer, depending on provider markets, patient education, and existing coverage networks. The variability highlights the need for additional guidance. Home Depot, one of the United States' largest employers, implemented a reference-based pricing model to limit price variation and provide higher-value care for its employees. Its carrier, or TPA, created a "reference price" for colonoscopies and endoscopies (both significant cost drivers for the company) using price and quality information. If employees selected a provider charging more than the reference price, they paid the difference out of pocket. This program was rolled out in 30 markets and included big cities like Boston, New York, and Philadelphia—requiring the TPA to set a different reference price for each market. Home Depot also created a portal where plan members could find facilities that provide colonoscopies or endoscopies at or below the reference price; deployed a communications strategy; included program and contact information directly on medical cards; and posted a list of available providers on its website. One challenge was that the organization offered first-dollar preferred provider organization (PPO) coverage, so members were not used to shopping for coverage. Even with the employee education tools in place, plan members continued using referrals from their general practitioners to select specialists for colonoscopies and endoscopies. The team determined that engaging physicians is critical to guaranteeing program success.<sup>151</sup>

The departments could encourage employers to deploy networks that involve tiered cost-sharing to encourage plan members to select lower cost options and ultimately lower provider prices. Tiered cost-sharing programs have had success at the state level. The Minnesota State Employee Group Insurance Program operates a tiered cost-sharing system where enrollees incur different copays depending on which primary care provider they choose. The state assigns primary care clinics to tiers based on risk-adjusted total cost of care for the previous year, divided by the mean cost for all members. All primary care clinics fall within 1 of 4 tiers, with tier 1 being the lowest-cost clinics. Lower tier clinics (1 and 2) result in the lowest copays for plan enrollees. Members were most likely to select clinics in lower tiers, and the program increased the percentage of clinics falling in tier 1 and 2—from 49% in 2006 to 78% in 2017. This indicates that clinics elected to reduce their prices in response to enrollee behavior.<sup>152</sup>

Additional guidance from the departments would encourage employers to design and use reference-based pricing models. In 2014, the Departments of Labor, HHS, and Treasury addressed questions about appropriate use of reference pricing in their ongoing [guidance](#) about ACA implementation. The guidance stated that reference pricing can be used as a cost containment tool and that large group health plans can use reference-based pricing without violating the ACA. However, they said that "the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and

an adequate network of providers.”<sup>153</sup> Georgetown’s Center on Health Insurance Reform interviewed state employee health plan (SEHP) officials and found that developing a list of “shoppable” services and determining high value providers can be barriers to implementing reference-based pricing programs.<sup>154</sup> Additionally, employers and payers must develop tools that allow employees to compare services, and these tools can require significant investments.<sup>155</sup> Such challenges make it harder for smaller employers to use reference-based pricing. The Department of Labor could provide additional guidance on how employers and TPAs can develop a reference price for a particular market, which services are well suited for reference-based pricing, how to engage physicians, and strategies and tools available for employee education.

With 1.5 million members, CalPERS is unique in its market power.<sup>156</sup> Most employers do not have the volume of membership to negotiate a similar initiative with providers. Other strategies to boost employer market power may make it easier for employers to use reference-based pricing and similar strategies.

#### ***To give payers leverage in consolidated provider markets:***

- **CMMI should design a multi-payer coalition demonstration with employers and public-sector payers to develop high performance networks and provide grant funding to state employee plans or agencies to coordinate coalitions.**

The problem for employers is often scale—even the largest employers do not have the number of covered lives needed as leverage to address health care price challenges. To increase employer purchasing power, employers can band together with other payers to initiate strategies to bring down health care prices, especially in consolidated provider markets. These coalitions—sometimes called multi-payer coalitions or aggregated purchasing alliances—spread costs among payers, allowing them to pursue innovative approaches to improve outcomes and costs. However, private-sector employees would achieve the greatest benefit if they partnered with public-sector payers due to market power and scale.

Although CMMI has designed multi-payer models in the past, a recent CMMI report stated that “multi-payer models designed for Medicare providers have not consistently led to high levels of participation from Medicaid and commercial payers.”<sup>157</sup> This lack of participation may be because employers are not part of the model design process. If CMMI involved employers in the design process, they may be more likely to participate in multi-payer initiatives.

A state agency—for example, the Medicaid program, chambers of commerce, or state employee plan—could receive a grant from CMMI to carry out coordinating functions. States have experience as both regulators and purchasers and could function as an intermediary between CMS and the



coalition. Additionally, CMS could provide technical assistance to the state entity tasked with coordination. The National Academy for State Health Policy convened a focus group of 400 state leaders and found that states need additional support and guidance from the federal government on coordinating with private payers and employers to achieve multi-payer alignment.<sup>158</sup>

On the state level, existing purchasing alliances and multi-payer coalitions seek to improve health care quality and affordability for residents. The Colorado Purchasing Alliance, established in December 2020, brings together self-funded and fully insured employers to address unwarranted price variation and create a sustainable model of care—building off the Colorado State Innovation Model grant.<sup>159</sup> As of July 2022, the state’s employee health plan joined the purchasing alliance, giving employers even more leverage to negotiate health care prices.<sup>160</sup>

Although multi-payer coalitions can deploy a variety of strategies to address health care prices in their geographic market, CMMI could require the coalition to develop criteria for designing high performance networks, or networks that include higher quality, lower cost providers. While narrow networks emphasize low costs, high performance networks use both quality and cost information and rely on data sharing to enhance coordinated care.<sup>161</sup> CMS could further develop this definition of high performance networks. Using a multi-payer coalition to design criteria for high performance networks would lower the barriers to entry for employers, especially smaller ones. Only 18% of employers surveyed by Willis Towers Watson in 2020 offered high performance or narrow networks, likely due to the time and resources needed to develop criteria and select providers.<sup>162</sup> Moreover, employers may have reservations about making these investments, especially in the face of employee backlash to narrower networks. Joining forces with other payers to develop these networks would increase the potential for cost savings: Multiple payers working together are more likely to secure discounts from providers. In 2017, for example, Home Depot worked with Imagine Health to develop and offer a high value provider network to its employees. To be included in the network, providers agreed to make price concessions—leading to cost savings. The plan offers unlimited primary care visits and a lower out-of-pocket maximum and copayments. Nearly 75% of Home Depot employees in markets where high value network plans were offered selected those plans during open enrollment.<sup>163</sup> Although this strategy worked for Home Depot, many employers do not have the resources or covered lives to design and implement a high value provider network and secure cost savings. As such, a multi-payer coalition may enable even smaller employers to use them as an effective cost-saving strategy.

To the extent a multi-payer coalition pursues narrow or tiered networks or alternative payment arrangements with providers, the coalition can also pool resources to support associated administrative costs. For example, tiered networks can expose employees to high out-of-pocket costs unless they have actionable information about differential cost-sharing at the time they need

to use the services. A multi-payer coalition could design communication strategies and develop tools to allow employees to compare providers and shop for services.

***To promote pharmaceutical competition by encouraging biosimilar market uptake:***

- **Congress should prohibit settlements between biologic and biosimilar manufacturers that postpone the market entry of lower cost biosimilars.**
- **The U.S. Food and Drug Administration (FDA) should issue guidance to promote regulatory clarity in the biosimilar marketplace, including establishing clearer standards for interchangeability of biologic products.**

Scientific advances in the pharmaceutical sector have led to new treatments for a multitude of acute and chronic illnesses. While policymakers value the need to support continued innovation, they also seek ways to reduce pharmaceutical expenditures and increase the affordability and accessibility of drugs. Nearly half of pharmaceutical spending in the United States is on specialty drugs, primarily biologic medicines—pharmaceuticals derived from living systems. Similar to generics for small molecule pharmaceuticals, biosimilars are follow-on pharmaceutical products that are highly similar to the originator biologics and have the potential to decrease health care expenditures on drugs through competition. Biosimilar list prices tend to be 15% to 35% lower than the originator’s price and have the potential to decrease spending on pharmaceutical drugs by \$38.4 billion between 2021 and 2025.<sup>164</sup> One analysis found that self-insured employers would have saved \$1.4 billion in 2018 alone if they had utilized biosimilars for two biologic products (infliximab and filgrastim).<sup>165</sup> Although biologics have been on the market for decades, there was no pathway for biosimilar approval until the ACA’s Biologics Price Competition and Innovation Act was enacted. Despite the existence of this pathway, the biosimilar market in the United States has not taken off due to biologic manufacturers’ tactics and the lack of clarity around certain regulations.<sup>v</sup>

Biologic manufacturers sometimes engage in “pay-for-delay” tactics to postpone biosimilar entry into the market and avoid lower cost competition. The patent for Humira, the world’s most profitable drug, expired in 2016, but six biosimilars will not enter the market until 2023 due to settlement agreements between the originator’s manufacturer (AbbVie) and biosimilar manufacturers.<sup>166</sup> Bipartisan legislation, [the Preserve Access to Affordable Generics and Biosimilars Act \(S. 1428\)](#), aims to end these “pay-for-delay” deals.

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v According to the FDA, 36 biosimilars have been approved in the U.S.

Biosimilars are subject to stricter regulations than their small molecule counterparts, and the FDA could issue additional guidance on some of these regulations. For example, biosimilar manufacturers must separately seek FDA approval as an interchangeable product and demonstrate “interchangeability” before a biosimilar product can be treated as a substitute for the originator biologic. Even after a biosimilar product receives approval, it must be deemed “interchangeable” before it can be sold on the market. In 2019, the FDA released guidelines for interchangeability testing standards, allowing pharmacists to replace a biologic product with a biosimilar without consulting a physician. However, substitution laws vary by state. Clearer federal standards for these regulations and education, especially on interchangeability, may encourage biosimilar market uptake and allow for substitution.

The BPC team addressed other strategies to tackle prescription drug prices in greater detail in a report, [\*Examining Two Approaches to U.S. Drug Pricing: International Prices and Therapeutic Equivalency\*](#).<sup>167</sup> To date, many of the options to mitigate the high price of drugs have focused on increasing competition and transparency in the pharmaceutical sector, as well as on increasing value-based payments based on outcomes achieved. However, this report examines two additional tools: external reference pricing and internal reference pricing. External reference pricing uses international prices as a benchmark to set or negotiate the price of drugs. Internal reference pricing, which could be used in various scenarios to ensure that therapeutically equivalent drugs are priced similarly, encourages the use of the least costly alternative therapy.



## SECTION IV: PROVIDE OTHER OPTIONS FOR HEALTH INSURANCE AFFORDABILITY

While more than 70% of workers, on average, accept access to ESI when it is offered, this percentage is less—63%—among companies that employ a larger share of lower-wage employees.<sup>168</sup> Furthermore, and as compared to higher-income earners, lower-wage workers spend a higher percentage of their income on health care costs.<sup>169</sup> In general, then, ESI remains less affordable for lower-wage employees. To increase health care affordability for lower-income workers and expand health care coverage options, even outside of traditional group health coverage, the following options might also be considered.

### *To increase health care affordability and expand health care coverage options:*

- **Congress should adjust the ESI affordability firewall to align with the ACA marketplaces' percentage cap for contributions to health insurance premiums.**

Under the ACA, ESI is considered “affordable” so long as an employee’s premium contributions are less than 9.5% of household income. This threshold is also known as the affordability firewall. Adjusted for 2022, the ACA marketplace currently offers subsidies for individuals enrolled in ESI if they spend more than 9.61% of their household income on their company’s health plan premium. The inflation-adjusted amount for 2023 is 9.12%.

Congress should alter the threshold of ESI subsidy eligibility—or affordability firewall—to match the maximum percentage of income an individual or family must contribute toward premiums for an ACA marketplace benchmark plan. This would encourage employers to either make coverage more affordable

or allow employees to move to the ACA marketplace.<sup>170</sup> Most important, such a change would allow for greater policy consistency and reduce consumer confusion.

According to the Peterson-KFF Health System Tracker, lower-wage workers spend a greater percentage of their income to afford health care compared with higher-wage workers.<sup>171</sup> While an average individual with employer coverage will pay 4% of their income toward premium contributions and out-of-pocket payments, this percentage jumps to 10.4% for individuals making 199% or less of the federal poverty level.<sup>172</sup> The coverage offered is also often less robust.<sup>173</sup>

Furthermore, the Center on Budget and Policy Priorities has suggested that the affordability firewall at its current threshold results in lower-wage workers being worse off than if they had no coverage offer at all, because they would then be free to shift to the ACA marketplace for more affordable coverage.<sup>174</sup> This reality has led some stakeholders to suggest eliminating the affordability firewall in full, although such a step would likely be quite expensive for the federal government due to the expected influx of employees to the ACA Marketplace.<sup>175</sup> Adjusting the threshold to align with the maximum premium contribution threshold for ACA marketplace premiums, then, represents a middle ground between doing nothing and eliminating the affordability firewall.

The Build Back Better Act (BBBA), which passed in the House of Representatives in November 2021 but ultimately never cleared Congress in its original form, would have temporarily reduced the affordability threshold to 8.5%. Under the BBBA, the affordability firewall would have been reduced to 8.5% from 2022 to 2025, following which the threshold would return to 9.5%.

### ***To allow employers to utilize alternatives to traditional group health insurance:***

- **The Departments of Labor, HHS, and Treasury could provide guidance on and make improvements to alternatives to traditional group health insurance such as ICHRA and State Employee Health Plan buy-ins.**

A variety of alternatives to traditional group health offerings are at an employer's disposal. These alternatives, including Individual Coverage Health Reimbursement Arrangements (ICHRAs) and allowing private employers to buy into state employee health plans, could ease affordability problems. However, there are certain risks, opportunities, and barriers that employers and states must understand before utilizing these strategies. Likewise, ICHRAs, in their current structure, open the door to exacerbated health care discrimination and could undermine risk pools—pointing to the need for improvements.

ICHRAs allow employers to make defined contributions for employees to purchase health insurance on their own through the ACA marketplace. Although health reimbursement arrangements have existed for some time, a

2019 regulation allows employers to use an ICHRA to subsidize premiums on the individual market. While a small percentage of employers are currently utilizing ICHRA, a survey conducted by Kaiser Family Foundation found that 9% of smaller firms (50-99 workers) are “very likely” to offer ICHRAs to employees in the next couple of years.<sup>176</sup> Employers may feel that offering a traditional health plan is a critical recruitment and retention tool and have opted to forgo utilizing ICHRA, but it is also the case that many employers are unaware of this option.

The federal government does not allow employers to offer employees a choice between ICHRA and a traditional group health insurance plan. The Department of Labor, HHS, and Department of Treasury (Tri-Agencies) prohibited such a choice because “employers would also face strong countervailing incentives to maintain (or improve) the average health risk of participants in their traditional group health plans.”<sup>177</sup> Commenters responding to the ICHRA final rule voiced concerns that the arrangement would allow employers to dump older, sicker employees onto the individual market.<sup>178</sup> ICHRA currently contains nondiscrimination provisions intended to guard against discrimination favoring highly compensated individuals and benefits tests based on participant age.<sup>179</sup> However, experts disagree about whether these provisions would sufficiently protect older, sicker employees and limit adverse selection. In theory, if the departments allowed it, an employer could offer a choice between the group health insurance plan and individual marketplace coverage but design the group health insurance option so that it is unappealing to sicker workers. The Tri-Agencies could make meaningful adjustments to the program and alleviate these concerns with simple and equitable adjustments to the rule.

Despite the availability of CMS premium look-up tools, ICHRA uptake has been slow. HHS could conduct outreach and education to industries whose workers would most benefit from a shift to the marketplace (for example, small firms that cannot provide affordable, comprehensive coverage to employees). The CMS [ICHRA Employer Lowest Cost Silver Plan Premium Look-up Table](#) is intended to help employers decide whether ICHRA is the right option for their employees by giving them access to marketplace premium information by geographic location.<sup>180</sup> However, employers may need to consider several variables before choosing ICHRA. Additional assistance from HHS, the Labor Department, and Treasury could help employers make more informed decisions about ICHRA and to structure benefits in a way that does not create inequities. The Robert Wood Johnson Foundation is conducting an outreach campaign aimed at employers to correspond with open enrollment for plan year 2023. In Colorado, the Peak Health Alliance is working with small businesses to increase uptake of ICHRA.

Although ICHRA may be a good option for some employers, individual coverage in some markets is more expensive than the small-group market. Employees are currently ineligible for premium tax credits if an ICHRA is

deemed affordable. This affordability is based on the lowest cost silver plan, the employee’s primary residence, and the employee’s household income.<sup>181</sup> In many markets, ACA marketplace plans cost more than traditional group coverage through an employer. Additionally, stakeholders have raised concerns that marketplace plans offer less robust coverage than traditional employer group health insurance plans.<sup>182</sup> Despite affordability concerns, employees who receive an offer of an ICHRA that is “unaffordable” are able to get premium tax credits on the marketplace. However, giving employees a fixed dollar amount to shop for plans on the marketplace may expose them to higher costs.

Policy experts disagree about ICHRA’s impact on marketplace premiums. One theory posits that increasing employer use of ICHRA would encourage more plans to enter the ACA marketplace—thereby making it a more competitive arena where insurers compete to offer affordable, robust coverage. Advocates of this theory support requiring newly incorporated businesses to offer coverage through ICHRA to receive a tax break.<sup>183</sup> On the other hand, a Brookings [analysis](#) found that allowing employers to offer ICHRA alongside a traditional group health insurance plan could increase marketplace premiums by 16% to 93%, depending on how aggressive employers are about shifting employees to marketplace coverage.<sup>184</sup> To avoid unintended consequences, the departments could strengthen existing ICHRA safeguards and conduct education and outreach to employers that may benefit from allowing employees to purchase coverage on the individual market. Additionally, the announcement by the Center for Consumer Information and Insurance Oversight of a plan to track ICHRA use beginning in 2023 will allow analyses of the potential selectivity of ICHRA enrollees.

To further avoid unintended consequences and the likelihood that the system will lead to further health inequities, adverse effects on lower-wage workers, and a destabilization of the risk pool, the Tri-Agencies could consider the following improvements:

- *Ending the age discrimination requirement.* Under current ICHRA policy, older workers have to pay more than a younger worker for the same individual market coverage because of the ACA’s 3:1 age rating rules.<sup>vi</sup> Employers could be required—or at least permitted—to contribute enough to older workers’ ICHRAs to hold them harmless.
- *Reducing the potential for employers to shift risk.* Current ICHRA rules allow employers to offer ICHRAs only to certain classes of employees, such as hourly versus salaried workers. Eliminating this option would reduce the potential that some employers would offer ICHRAs only to classes of employees with a sicker profile.

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vi The ACA’s 3:1 age-rating rule prevents insurers from charging older adults (over 64) more than three times the premium paid by a 21-year-old with the same coverage.

- *Protecting workers from “junk” plans.* Current rules require workers to use the ICHRA for ACA-compliant coverage, but that is often difficult for the average consumer to discern, particularly with the proliferation and deceptive marketing of short-term and other less comprehensive insurance products. Employers should be required to substantiate that their workers are, in fact, purchasing ACA-compliant individual policies.
- *Collect information about ICHRA’s market impact.* Even with the changes described above to deter risk sorting, ICHRAs may harm the individual market risk pool (and increase federal costs) because they disproportionately appeal to employers with sicker workforces, who can use them to shift risk onto the community-rated individual market. Because carriers do not generally know which enrollees use ICHRA, there is currently no information about the risk characteristics of employees with ICHRAs. Federal agencies could require ICHRA plan sponsors to provide reporting that allows research about ICHRAs’ market impact.

Another option for private employers could involve collaborative purchasing agreements, such as partnerships with State Employee Health Plans (SEHPs). These plans are often the largest employer purchaser in their state and are uniquely positioned to deploy strategies to target high prices. SEHPs have used a variety of innovative models to address the rising cost of care in their states, for example reference-based pricing strategies in California or hospital payments caps using Medicare as a benchmark.<sup>185</sup> As a result of pressures from state employees, these plans also tend to be more affordable and more comprehensive than their commercial counterparts.

States have been reluctant to allow private employers to buy into the state plan because they would risk losing their status under ERISA as a “governmental” plan. States want to maintain this designation because it allows them to exempt themselves from certain Public Health Service Act (PHSA) requirements that apply to commercial plans. In an [advisory opinion](#) to the governor of Connecticut, the U.S. Department of Labor stated, “Section 3(32) of ERISA defines the term ‘governmental plan,’ in pertinent part, as ‘a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.’” Although the Labor Department does allow nonprofit organizations that contract with federal, state, and local governments to participate in a State Employee Health Plan without affecting its status as a governmental plan under Section 3(32), other private entities cannot participate due to the “governmental plan” definition. The Department of Labor could consider allowing states to request a waiver to establish a SEHP buy-in option and establish a threshold for how many private employers are allowed to opt into the plan. A threshold for the maximum number of employers or covered lives allowed to participate in a State Employee Health Plan, or limiting participation to small employers, could make the option more appealing to states. In BPC interviews, some stakeholders stated



that the Department of Labor does not have any authority to allow waivers to the statutory definition of a governmental plan or allow more than a de minimus number of non-governmental employees to be covered by a SEHP and any action to change these would require Congressional action.

States fear that allowing private employers to buy into their SEHP could raise plan premiums and adversely affect risk pools. A RAND analysis found that expanding eligibility for the SEHPs in Connecticut would improve affordability while having little to no impact on the state's budget. Costs associated with SEHPs were substantially lower than employer-sponsored coverage.<sup>186</sup> A Manatt model exploring a buy-in option to Nevada's Public Employee Benefits Program (PEBP) found that projected premiums would be 9% lower than similar plans on Nevada Health Link (the state's ACA marketplace). However, the buy-in would raise PEBP premiums by 2% to 3%.<sup>187</sup> Allowing states to develop a waiver option would enable them to design a buy-in option that suits their needs in a way that does not negatively affect SEHP premiums.

# Conclusion

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Although a majority of Americans rely on employer-sponsored insurance for their health benefits, ESI is on an unsustainable trajectory due to high and rising health care costs. Policymakers must act to address underlying cost drivers and empower employers with payment and pricing tools.

Administrators, policymakers, and regulators can restrain costs and improve the ESI system by increasing transparency in the health care system and ensuring existing transparency laws produce actionable data. Such changes would give employers the tools needed to design high value networks and address market power dynamics. This would also ensure that employers have other options for extending health insurance affordability.

Improving and strengthening our current system is the most politically viable approach to improving health outcomes and controlling health care cost growth.

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