

**MEMBERS OF THE
NATIONAL ALLIANCE
OF HEALTHCARE
PURCHASER
COALITIONS**

Alabama Employer Health Consortium
Business Health Care Group (WI)
California Health Care Coalition
Central Penn Business Group on Health
Connecticut Business Group on Health
DFW Business Group on Health
Employers' Advanced Cooperative on Healthcare (AR)
Employers' Forum of Indiana
Employers Health Coalition of Idaho
Florida Alliance for Healthcare Value
FrontPath Health Coalition (OH)
Greater Cincinnati Business Group on Health
Greater Philadelphia Business Coalition on Health
Health Services Coalition (NV)
Healthcare Purchaser Alliance of Maine
HealthCareTN (TN)
Houston Business Coalition on Health
Kansas Business Group on Health
Kentuckiana Health Collaborative
Lehigh Valley Business Coalition on Healthcare
Mid-America Coalition on Health Care (KS)
MidAtlantic Business Group on Health
Midwest Business Group on Health
Montana Association of Health Care Purchasers
Nevada Business Group on Health
New Hampshire Purchaser Group on Health
New Mexico Coalition for Healthcare Value
North Carolina Business Group on Health
Northeast Business Group on Health
Pittsburgh Business Group on Health
Public Employer Action Collaborative for Health
Purchaser Business Group on Health
Rhode Island Business Group on Health
San Diego Purchasers Cooperative
Savannah Business Group on Health
Silicon Valley Employers Forum
St. Louis Area Business Health Coalition
The Alliance (WI)
The Economic Alliance for Michigan
Washington Health Alliance
WellOK, the Oklahoma Business Coalition on Health
Valley Health Alliance (CO)

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Our members represent private and public sector, nonprofit and Taft-Hartley organizations, and more than 45 million Americans, spending over \$400 billion annually on healthcare.

We advocate on behalf of our members at the national level on a wide variety of policy issues with the purpose of increasing transparency and driving value in the healthcare employers purchase and provide on behalf of their employees and their families. Healthcare costs are growing at an unsustainable rate. Employers want to continue to provide critical health benefits to their employees and families but face major challenges in keeping cost growth manageable. Everything we advocate for is based on the need for increased transparency in the system with the ultimate goal of providing high quality care at an affordable price. The five policy topics we are most focused on currently are: 1) pharmacy benefit manager (PBM) reform, 2) high and rising hospital prices, 3) ERISA preemption 4) health savings accounts (HSA) flexibility, and 5) mental health integration into primary care.





Pharmacy Benefit Manager (PBM) Reform

Contrary to what some have suggested, employers are not satisfied with the current state of their relationships with PBMs. Spiraling drug costs are a large part of America's health care affordability problem, and rising drug costs have not happened in a vacuum. The three largest PBMs process more than 80 percent of prescription drug claims in the U.S., giving them immense market power, and making it impossible for employers to negotiate contract terms on behalf of their employees.

Needed reforms include commonsense changes to hold PBMs accountable to fair market practices when partnering with our nation's employers -- small, medium, and large -- who are the largest customers of PBMs. PBM transparency, as with transparency across all healthcare affordable, quality care. PBM transparency alone is NOT enough, but it is vital that Congress require complete and unrestricted transparency into the PBM "black box." Clear information on pricing, rebates, fees, and discounts is essential for employers and patients to make informed decisions and to build a functioning free market for prescription drugs. The complex rebate structure and total lack of transparency with respect to most PBMs makes it difficult for employers to manage prescription drug costs. Federal legislation requiring robust and frequent reporting from PBMs to employers-- with strong independent auditing rights--is critical for employer efforts to lower prescription drug costs.

Our Recommendation: *Congress should enact legislation to fundamentally reform PBM business practices and the drug supply chain, specifically the Pharmacy Benefits Manager Reform Act (S. 1339).*

Other bills that have been introduced, and that we support, include:

- H.R. 5377, the *Lower Costs, More Transparency Act* enhances PBM transparency for plan sponsors, but stops short of enacting meaningful reforms to PBM practices.
- S. 127, the *Pharmacy Benefit Manager Transparency Act* provides enhanced transparency and requires a 100% rebate passthrough to plan sponsors.
- S. 1542, the *Delinking Revenue from Unfair Gouging (DRUG) Act*, would "delink" PBM payment from the price of drugs, eliminating one of the perverse incentives in the PBM market.
- S. 2305, the *Biosimilar Red Tape Elimination Act* would amend the federal code to state that all biosimilars, upon approval and without requiring any additional data, shall be deemed interchangeable. An amendment to S. 2840 (*Bipartisan Primary Care and Health Workforce Act*) also does this.



ERISA Preemption

Since the U.S. Supreme Court decided *Rutledge v. PCMA* in late 2020, states have taken increasingly bold steps to regulate insurance markets in their states. While the National Alliance strongly supports reform of the pharmacy benefit management (PBM industry), state-by-state reform of self-insured health plans presents a significant threat to ERISA preemption for self-funded employer-sponsored plans. Our members are concerned with this trend and strongly oppose any measures that would directly or indirectly curtail, restrict, or otherwise diminish the original intent of ERISA's preemption provisions.

Our Recommendation: Congress must ensure that state laws attempting to delve into areas that are intended to be preempted by ERISA are banned.

In recent years, many employers have increasingly provided much greater flexibility with remote work arrangements. Today, employees of even relatively small employers are scattered across states. Requiring employers to manage multiple state laws related to benefit design exponentially increases the burden on those employers to unsustainable levels. This is of particular concern when it comes to benefit design. ERISA plans have successfully used network design to control healthcare costs in no small part because states have been forbidden from regulating in this area. This freedom has led to better and more cost-effective health benefits for employees and their families. Without ERISA's preemption provision, states—looking to protect local economic interests—will create a patchwork of variable network-design regulations that would make a uniform and administrable provider network virtually impossible for multistate employers.

We strongly believe that adopting or expressing any intention to allow otherwise preempted state policies to apply directly or indirectly to self-funded plans, or worse, to create an express carve out or "non-preemption," would be catastrophic for ERISA-governed self-insured health plans. ERISA and its preemption provisions have been instrumental in establishing a consistent and reliable statutory and regulatory framework that enables plan sponsors to design and uniformly administer health benefits for employees located in multiple states. Self-insured ERISA health plans should remain able to solely follow federal statutes and regulations as has been the case, successfully, under ERISA for nearly 50 years. These employer-sponsored self-insured health plans must continue to avoid the "patchwork" and quagmire of state-by-state laws or rules that directly or indirectly implicate plan design and administration to be able to continue to offer comprehensive, affordable, uniform health coverage to their employees equitably across their entire workforce.



Combatting High and Rising Hospital Prices

A growing body of evidence demonstrates that employer purchasers in the commercial market pay between 150 and 700% of Medicare for hospital services. These hugely inflated costs are borne by employers and passed on to employees and their families through higher insurance premiums, increased deductibles, and lower wages. Despite significant efforts by employers and purchasers to ensure negotiated commercial hospital prices are fair and reasonable, the cost of hospital care continues to increase year-over-year, with negotiated rates soaring, on average to 250% of Medicare rates. This year, employers are bracing for an average 7 percent increase in premiums in 2024. However, growing evidence suggests that hospitals can maintain reasonable profit margins, operate efficiently, and continue to provide important community benefits if they charge the private market 150-200% of Medicare.

Our Recommendation: Employers encourage federal policymakers to pass legislation to keep the focus on hospital price transparency and increase enforcement of anti-competitive practices in the hospital industry.

- We strongly support codifying existing price transparency requirements included in the *Bipartisan Primary Care and Health Workforce Act (S. 2840)*, including enforcement of hospital price transparency and transparency in coverage rules, and the levelling of meaningful civil monetary penalties for non-compliant hospitals and health insurance carriers. This bill also bans anti-competitive contracting terms in federally-regulated health plans, which we support as.
- We encourage CMS to continue to advance “site neutral” payment policies in Medicare, which reduce the financial incentive for continued consolidation among health systems. We support these provisions in the *Lower Costs, More Transparency Act (H.R. 5378)*.

We have been encouraged by the FTC’s efforts to aggressively block anti-competitive hospital and health system mergers across the country and encourage the FTC to continue this work. We also strongly recommend that CMS continue to vigorously enforce the ban on surprise billing, including provisions to stem higher payments to out-of-network providers, and strong transparency rules for hospitals and health plans.

The National Alliance has produced a Hospital Fair Price Guidebook to help employers as they attempt to gather meaningful data from vendors and then use that data to inform contract negotiations. Employers are often at a distinct disadvantage in these negotiations due to hospital consolidation and lack of viable competition in a market; price transparency is a critical component to ensuring employers are on as level a playing field as possible when attempting to get the best value hospital care for their enrollees and their families.

Improving Health Savings Account (HSA) Flexibility

Faced with high and rising health care costs, employers are pursuing innovative ways to provide high quality, low-cost health care to their employees and families. Health savings accounts (HSAs), paired with High Deductible Health Plans (HDHPs) have become increasingly common among employer-sponsored health coverage options.

Today, roughly two-thirds of large employers and purchasers (companies with more than 1000 employees) offer HSAs to their employees and their families.¹

Despite their prevalence, strict federal rules limit the set of services purchasers may cover pre-deductible in HDHPs. Employers must retain flexibility over the design of their plan offerings to encourage their covered populations to pay for high-value care that avoids costly complications in the future. This is especially true for the large and growing number of people managing chronic diseases.

Our Recommendation: Congress should pass legislation expanding the ways in which employees and their families can use HSA funds, especially regarding chronic care management and access to telehealth. A variety of bills have been introduced, all of which currently have bi-partisan support.

- The *Chronic Disease Management Act* (S. 655) would allow patients to use HSAs to pay for evidence-based care related to management of a chronic disease.
- The *Telehealth Expansion Act* (S. 1001) permanently exempts high deductible health plans from the requirement of a deductible for telehealth and other remote care services.²
- The *Primary Care Enhancement Act* (S. 628) allows a medical expense tax deduction for direct primary care service arrangements and provides that participation in such arrangements does not disqualify patients from making tax deductible contributions to health savings accounts.
- The *Bipartisan HSA Improvement Act* (H.R. 5688) contains multiple provisions which would expand flexibility for use of HSA funds, including for direct primary care arrangements and for on-site employee clinics.
- The *HSA Modernization Act of 2023* (H.R. 5687) also contains several provisions regarding HSA flexibility, including allowing individuals entitled to Part A of Medicare to receive and make contributions to HSAs, expanding the types of plans with which HSAs can be connected (i.e., “bronze” and catastrophic plans), and allowing both spouses to make contributions to a single HSA.

While each of these bills are at various stages of the legislative process, we fully support all legislation aimed at increasing flexibility and streamlining administration of HSAs for both employers and employees and their families.

¹ <https://www.kff.org/report-section/ehbs-2022-section-8-high-deductible-health-plans-with-savings-option/>

² The House companion bill, H.R. 1843 was reported out of Ways & Means on a bipartisan basis.



Integrating Mental Health into Primary Care

It is no secret that we are facing a mental health crisis in this country, and employer purchasers are at the forefront of trying to devise solutions to ensure employees and their families have access to critically important mental and behavioral healthcare. We are focused on two issues: 1) continued access to telehealth for mental and behavioral health services, and 2) investing in the integration of mental and behavioral health into primary care.

While mental health parity requirements have been in federal law for many years, parity laws alone are not enough if meaningful access to mental and behavioral health cannot be achieved by those who need it most. Parity laws alone are not enough to ensure access to these services. Integrating mental and behavioral health into primary care, especially through collaborative care models, has been shown to improve patient outcomes for behavioral health conditions. This patient-centered approach makes it easier for primary care doctors to include mental and behavioral health screening, specialty care, and treatment in their practices.

Our Recommendation: Congress must make access to telehealth for mental and behavioral health permanent, and pass the COMPLETE Care Act to provide incentives for integrating mental and behavioral health into primary care.

- Tele-behavioral health has grown dramatically since the onset of COVID-19 with barriers to implementation addressed overnight. These gains must be “locked in” while standards are established to support populations with disparate needs and access to technology. We urge Congress to ensure that any increased flexibilities for use of telehealth are not allowed to lapse or otherwise be taken away from providers and payers.
- While only applicable to Medicare, we support the COMPLETE Care Act (H.R. 5819) and its approach of increasing payment rates for certain Evaluation & Management (E&M) codes most often used in primary care settings when a primary care visit also includes mental or behavioral health screening or treatment.

Robust provider networks – including accurate directories – are a critical component to ensuring access to mental and behavioral healthcare services. Inadequate networks and inaccurate directories lead to a false sense of access for lower paid workers and result in a two-tiered system – broad access to care for those who can afford to pay out of pocket, and few choices for those that rely on in-network providers. There is significant opportunity at the federal level to ensure these critical providers are incentivized to join networks and that provider directories are maintained accurately; too many mental health providers are unwilling to work with payers because of administrative burden and below-market reimbursement rates.