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April 12, 2024

The Honorable Virginia Foxx
Chairwoman
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, DC 20515

Submitted electronically

Dear Chair Foxx,

I, Richard Hardin, appreciate the opportunity to respond to the committee's request. I am currently the President of Edison Health Solutions. Edison is a full-service TPA dedicated to patient-first health plans. Our core mission at Edison is to positively impact each of our member's lives through health insurance. I often tell my team to view each member as their own mother or father and to care for our members like they would their own family. We exist to serve our members with honesty, integrity, and compassion. I have been in the TPA space for seven years and have witnessed both the growth and the metamorphosis of our industry. TPAs are on the frontlines serving everyday Americans. We help patients navigate uncertain times in their lives when they face health challenges. Before working at a TPA, I worked in the insurance and financial services industry. I have been a board member of the Society of Professional Benefit Administrators (SPBA) for almost three years. During my tenure as a board member, I created and led a new program for emerging professionals in our industry. SPBA is a vital organization dedicated to educating independently-founded TPAs. SPBA member TPAs are different from self-funded divisions within an insurance company that could have access to the insurer network contracts. SPBA member TPAs are strongly focused on customer service and helping their clients comply with the complex government regulations for group health plans. I am honored to serve on the board of SPBA and to continue its impact on the self-funded industry.

I appreciate the Committee's willingness to hear how recent legislation has affected our industry, and I hope to share insightful information. My goal in participating is to share both accurate data and real-life experiences so the committee is fully informed when making decisions in the future. I am honored to participate in this discussion and appreciate all the legislation that has both challenged and grown our industry, pushing us to do better and be better for our patients, our colleagues, and our nation.

Data Sharing (Transparency)

SPBA member TPAs embrace the vision of the Transparency in Coverage rules. We can leverage the transparency data to validate our direct contract pricing, especially in new markets. Direct contracting eliminates the need for large networks to negotiate on behalf of patients thus lowering the price of care. Large networks often limit quality facilities, doctors, and care due to network constraints. Direct contracts eliminate this issue by going directly to the highest quality doctors or facilities and securing a set price, often much less than the network providers. Transparency has facilitated this change because TPAs, employers, and patients can shop not only for the best price, but also for the best outcomes.

TPAs work with a variety of networks, vendors, and PBMs on patient's behalf, and often times the contracting data is not shared with the TPA. This limits the TPA's ability to stay compliant and keep plans compliant with the transparency requirements. I encourage the Committee to focus their legislation on the entities that possess all the data surrounding the cost of care. TPAs are willing to report transparency data; however, they should not be held responsible if data is incomplete or inaccessible due to contracted entities restricting this information. I would also encourage the Committee to request the exact numbers on the cost of services and not accept averages. Entities and individuals can often hide behind these averages and continue to overcharge patients in the end.

The Transparency in Coverage rule would better serve plan participants if the requirements were at the procedure level, which is something the plan participants can understand. Plan participants typically do not know the medical names of the specific items and services associated with a procedure. The Transparency in

Coverage rules should include technical and definitional frameworks for searches made at the procedural level.

Gag Clause Attestation

The Gag Clause Attestation applies universally to self-funded plans and fully insured plans. While we fully agree with the Gag Clause Attestation, the reporting requirements are inequitable. Unlike fully insured plans from large networks, TPAs often do not have access to network contracts to check for Gag Clauses. TPAs rent networks for their clients, and the networks then hold the contracts. This presents a unique and challenging scenario for TPAs if held responsible for compliance to Gag Clause Attestation. We understand the challenge the Committee faces in assigning responsibility for maintaining compliance. Network contracts often contain proprietary information that these entities do not wish to share with potential competitors. Requiring the networks to share all contracts with TPAs so that TPAs could report on Gag Clauses would be unlikely and challenging at best. It is therefore, my suggestion that whichever entity builds the network and contracts should be held responsible for ensuring compliance to Gag Clause Attestation. TPAs are a third-party entity who do not have access to the necessary information to accurately report on Gag Clauses. We urge the committee to thoughtfully consider assigning reporting responsibilities to the correct entities in the future and revise current legislation in which TPAs are inappropriately held liable for Gag Clause Attestation.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act has revolutionized patient's access to mental health and wellness options in the self-funded industry. We are encouraged that the Committee values mental health and addiction recovery. While we agree with the *Mental Health Parity and Addiction Equity Act*, the requirements to ensure that a plan has mental health parity are both costly and cumbersome. The cost to employers to have their plan analyzed and reviewed for mental health parity is costly, especially for smaller groups with less than fifty employees. These small groups are expected to hire an ERISA attorney at upwards of ten to fifteen thousand dollars just to ensure that their health plan has mental parity. Employers are already spending thousands of dollars offering a health plan with creative solutions and

additional benefits to assist their employees. Requiring these employers to spend extra money on mental health parity limits the employer's ability to provide other benefits. It is a great financial burden to these small group employers, so they choose not to have the plan reviewed unless it is absolutely necessary. This then facilitates accidental non-compliance and future issues. I would suggest that the Committee encourage the Department of Labor to create an example or a template plan that achieves compliance with *the Act* for employers and TPAs to reference.

Specialty Drug Coverage

Specialty Drugs are remarkable and lifesaving. We are fortunate to have access to these drugs that save patients who are coping with complex health conditions. While these specialty drugs are vital to some patients, they are extremely costly to health plans. In the past the prescription drug spend for our clients was typically ten to fifteen percent of the plan's total spend; however, with the addition of specialty drugs we are seeing that the prescription drug spend is trending towards fifty percent of the total spend. This is challenging for both a TPA and an employer. Reformation of specialty drug costs is vital, but many of the current options to mitigate these costs not only produce minimal savings, but also harm patients.

I spoke with a patient at an infusion center who was distraught because of her plan's strategies to manage specialty drug costs. She was managing her disease quite well through her monthly infusion of a specialty drug, but her health insurance company introduced a step therapy program in which she had to participate. Therefore, she was forced to stop the medication that was working and try a much less expensive drug. The less expensive drug did not work for this patient and she ended up spending two weeks in the hospital. I want to note that a two-week hospital stay would also cost the plan significantly. Following her stay in the hospital, the patient was permitted to return to the specialty drug that worked in the beginning. Unfortunately, her body built up antibodies to the specialty drug and it no longer worked either. This patient was now forced to cycle through a variety of specialty infusion drugs to find something else that would work, all while her disease flared out of control. Again, this costs the plan and the patient dearly. Her story should remind us all that we cannot simply look at the numbers to make decisions regarding specialty drugs. We must understand that these policies affect every day Americans who have no choice but to follow the guidance of their health insurance. At the end

of the day, we exist to serve our members and help them maintain health and wellness. The solution to specialty drug costs should not cost patients their well-being to save the plan money. At the same time, this patient's story might have been completely different had the original specialty drug not been priced so high. The cost is astronomical, and it leaves plans searching for any way to alleviate the prices.

There are several options to mitigate specialty drug costs, but the root of the problem remains: the drugs are simply too expensive. I implore this Committee to work to reduce the price in the beginning, so patients and employers are not forced to make these difficult decisions. Some of the options we have seen are excluding specialty drugs thus allowing members to receive manufacturers assistance programs, participating in international sourcing programs, and direct contracting with drug manufacturers or infusion centers to lower costs.

Below are some suggestions to lower the cost of these specialty drugs:

- Employing a cap or maximum cost of any specialty drug.
- Manufacturer's Copay Assistance Programs.
- Manage PBM conflict of interest of specialty drugs.
- Professional Pharmacist review of specialty medications over a high-dollar threshold.
- Summary Plan Document language that allows for creative or alternative solutions surrounding specialty drugs such as sourcing alternatives, direct contracts with centers of excellence or infusion centers, and clinical review protocols.
- Risk pools for expensive gene therapies.
- Drug Money-Back Programs that allow the employer to receive money-back from the manufacturer if the drug fails to "cure" or manage a disease or condition.
- Stop direct to consumer advertisements on high-dollar specialty drugs.

Stop-loss carriers, TPAs, employers, PBMs, and others are all looking for ways to reduce specialty drug costs. Through collaboration we have found and will continue to find creative solutions to assist our clients with the high cost of specialty drugs.

Cobra and Portability

When COBRA was first implemented, it was utilized heavily because unemployed individuals did not have access to a health insurance marketplace, had pre-existing conditions or had long waiting periods. Since the adoption of the healthcare marketplace, COBRA participation is drastically reduced. Along with the diminishing COBRA usage, employers are often forced to pay high dollar claims for former employees on COBRA. I have witnessed hospitals and other providers pay COBRA premiums on behalf of a sick member receiving care to ensure that the facility or provider continues to get paid from insurance. The employer is then stuck paying the facility bills for former employees. Due to the decrease in COBRA enrollment and potential high-cost risk to employers, it is my suggestion that we reduce the timeframe of COBRA coverage from eighteen and thirty-six months to three and twelve months. COBRA premiums are quite expensive, and most individuals would find more affordable coverage from the marketplace anyway. Subsidies are also available to help members afford marketplace coverage. The long COBRA timeframe is no longer necessary due to the marketplace availability, and this adjustment will help businesses nationwide.

I appreciate your time in reading my thoughts and welcome any questions. I thoroughly enjoy discussing what TPAs do and the creative ways we impact and help our members. I look forward to discussing these and other issues in the future. I may be reached via email at rhardin@edisonehs.com, or phone at (918) 922-7284.

Best Regards,

Richard Hardin
President
Edison Health Solutions