National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Statement for the House Education & Workforce Subcommittee on Health, Employment, Labor, and Pensions

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Reducing Health Care Costs for Working Americans and Their Families

Submitted by
National Association of Benefits and Insurance Professionals

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Shaping the *future* of healthcare

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NAHU, a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NABIP help millions of individuals and employers of all sizes purchase, administer, and utilize health plans of all types.

The health insurance agents and brokers that NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through HealthCare.gov or a private direct enrollment partner's website. Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[3] Consequently, the NABIP membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

More than 175 million Americans, over half of the country's total population, are enrolled in health insurance coverage from their employer. Recent surveys indicate that most adults are satisfied with their current health coverage, with 63 percent those enrolled in employer-sponsored coverage "extremely satisfied" with their benefits.[4] Further, 76 percent of workers see health insurance as a primary or important factor for continuing to work at their current employer.[5]

While employer-sponsored coverage remains one of the most popular forms of health insurance in the United States, one in three employees saw their healthcare costs increase over the last two years. As a result of higher healthcare costs, surveys show that some employees have reduced their contributions to retirement savings plans and delayed going to the doctor, among other cost issues.[6] Thankfully, there are actions that Congress can take to control costs for employers and employees and, more broadly, preserve the popular employer-sponsored system.

One method of keeping healthcare costs low – especially for those covered by their employer – is to maintain the employer tax exclusion. The employer-based system is highly efficient at providing workers and their families with affordable coverage options through group purchasing and its associated economies of scale by spreading risk and avoiding adverse selection. The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where

[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013.
[4] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.
[5] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[6] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.

employer-paid contributions for an employee's health insurance are excluded from that employee's compensation for income and payroll tax purposes.

While eliminating or capping the exclusion would increase federal revenue, it would also eliminate most of the benefits of employer-sponsored insurance. Employers and individuals would lose many group purchasing efficiencies, and there would no longer be an effective means for spreading risk among healthy and unhealthy individuals. Healthier individuals would be likely to forego coverage if faced with a new tax burden, leading to adverse selection and a death spiral for those remaining in the insured pool. Small business owners would be especially hard-hit, finding themselves paying thousands of dollars in new taxes on their insurance premiums, making it even more difficult to offer comprehensive coverage for their employees. It is likely that, if a small business owner is compelled to drop coverage due to costs, over one-third of their workforce may quit within 12 months.[7] Workers would also be less likely to have their employer as an advocate in coverage disputes, and employers would be less likely to involve themselves in matters of quality assessment and innovation for their employees. At a time where employers are burdened by high inflation and high healthcare costs, eliminating this tax exclusion would be a grave mistake.

Regarding the viability of small businesses amid high inflation, tax credits are as crucial as ever. Certain small employers can qualify for the small business healthcare tax credit (SBTC); the SBTC was included as part of the Affordable Care Act to encourage small employers to provide health insurance to their employees, as roughly half of small employers offered health benefits to their workers at the time. Employers who purchase health insurance through the program may get a tax credit of up to 50 percent of their premium contributions. Unfortunately, many employers have been unable to claim the SBTC due to the current eligibility limitations. Presently, credits are only available to eligible small employers of up to 25 full-time equivalent employees that pay an average annual wage of less than an average of $50,000. Full credits are available to eligible small employers of up to 10 full-time employees with an average annual wage of $27,000 or less. As of 2014, small business owners can only claim the credit for two consecutive years in a row.

As a result of these limited qualification parameters, many employers who wanted to access the SBTC simply do not qualify, resulting in fewer employers claiming the credit. Most small employers who have not claimed the credit said it was due to the stringent wage eligibility standards, while others cited the overly complicated process for calculating the credit, which discouraged many from even applying. Sixty-three percent of small businesses feel that their business lacks the proper resources for handling tax credits.[8]

Another method of lowering healthcare costs for individuals and their families would be to establish reinsurance pools. Since the passage of the Affordable Care Act, we have seen adverse selection in the individual market – most likely because individuals are more likely to enroll in coverage if they are predisposed for a health condition or at a time when they become sick. To mitigate this, reinsurance

[7] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[8] Omega Accounting Solutions. Survey Finds Small Business Owners Lack Resources for Handling Tax Credits. December 2022.

pools or hybrid high-risk pools could be made available for the purpose of providing financial backing for carriers issuing coverage to higher-risk individuals.

Reinsurance programs work by spreading the costs of high-cost cases. Because employees with high expected healthcare costs can drive up the cost of coverage, reinsurance programs are designed to minimize the impact of high-cost cases on carriers and increase affordability of insurance for small businesses and individuals. The high-risk individual would not be aware that part of the risk of insuring them had been yielded to such a reinsurance pool, but doing so would lower costs for everyone purchasing coverage in the individual market. The covered individual would receive coverage through the carrier of their choice and could purchase the plan of their choice, and the carrier would have the option of ceding part of the financial risk of providing coverage to the reinsurance pool.

Every state that has implemented an innovation waiver-funded individual market reinsurance program has experienced lower unsubsidized premiums as a result.[9] Enacting a reinsurance program at this level would serve as a vital market stabilizer and would result in lower healthcare costs for Americans.

Widespread adoption of certain types of plan arrangements, such as association health plans (AHPs), have also been suggested as an effective way of lowering healthcare costs. An AHP is a type of group health insurance for employers that allows small employers, certain contractors, and self-employed individuals to access cost savings associated with the large group market. NABIP believes that, under certain circumstances, AHPs could provide ample cost savings and increased benefits that are very specific to the needs and desires of their membership. However, it is unlikely that widespread adoption of AHPs would result in significantly decreased healthcare costs for small employers or individuals broadly.

Each business member of the AHP will have unique service requirements, and both the human capital and actual costs of tending to many small businesses will be higher than those associated with a true single business entity. Even if an AHP attracts a considerable number of participants, its size and bargaining power is unlikely to overtake the scope of a smaller private health insurer's pool of participating small employers. Therefore, costs for many smaller companies' health insurance will be similar or even slightly more expensive than if coverage is purchased through a traditional small group plan. These entities may find the increased benefits AHPs could offer so attractive that any extra costs would be worthwhile but, based on the NABIP membership's longstanding observations of the health insurance purchasing behaviors of small employers, we do not believe there will be an overwhelming response by the small-business community to transition from the traditional small-group market to AHPs.

If Congress chooses to move forward with actions that expand the AHP marketplace, NABIP believes that there must be firm guidelines for the framework of new and existing AHPs. It is crucial that AHPs have a structure in place to support all members through their various health coverage needs. Their issues will include everything from ensuring sufficient provider network adequacy for associations with members in far-ranging states to maintaining appropriate service support for all members on a national

[9] Giovannelli, J, et al. The Benefits and Limitations of State-Run Individual Market Reinsurance. *Commonwealth Fund*. 11 November 2020.

level. There is a long history of consumer harm and fraud in the AHP market, which has cost small employers and their employees hundreds of millions of dollars in unpaid claims and excessive administrative costs[10]; NABIP urges Congress to address fraud prevention in any AHP legislation. We also believe that, for effective consumer protection, an AHP should be required to have a local presence in a specified state so that it is clear which state has regulatory jurisdiction over the plan. NABIP also cautions Congress to ensure that any AHP legislation does not make changes to Section 27 of the Public Health Service Act, which grants states the authority to regulate health insurance products sold within their boundaries.

Additionally, AHP beneficiaries will need a clear understanding of what association membership means and how it may differ from traditional coverage. To serve this need, we propose the development of an AHP-specific addendum to the Summary of Benefits and Coverage notice currently required to be distributed by all insurance carriers and group health plan sponsors. NABIP also requests that any AHP legislation be cognizant of the assistance and professional advice business owners require when it comes to their health coverage and allow for meaningful participation and fair compensation of health insurance agents and brokers.

Outside of plan arrangements, one factor in the United States' high healthcare costs is dishonest billing due to the lack of site neutrality among providers. Currently, providers that own multiple facilities can charge different amounts for the same care depending on where care was received. For example, the price of an X-ray or MRI in a free-standing facility can differ substantially from the price of the same test in a hospital-based outpatient department (HOPD), and a test received in a HOPD can differ substantially from a test received in a physician office – even when the same entity owns all providers in question.

The lack of site-neutral payment reform to ensure that prices remain the same regardless of where the service is received results in higher healthcare costs for patients and employers. Recent research indicates that employer-based insurance is typically paying three times more for clinical lab tests when billed by HOPDs compared to identical tests billed by physician offices and independent labs. In seven states, the markup for lab tests in HOPDs was over six times the median price for the same tests in physician offices. Overall spending on clinical lab tests in HOPDs has grown over 30 percent from 2016 to 2019, due almost solely to price growth.[11]

It is also common for hospitals to charge "facility fees" when patients receive care at a facility that the provider owns, even if the facility is a great distance from the hospital. Facility fees are believed to be the primary factor in the rapid growth in emergency healthcare costs that we have seen over the last two decades. On average, from 2004 to 2021, facility fees increased a staggering four times faster (531 percent) than professional fees (132 percent) for emergency department evaluation and management services.[12]

[10] Hospital Trust Fund to Employee Benefits Security Administration. Definition of Employer – Small Business Health Plans RIN 1210-AB85. 6 March 2018.
[11] Morning Consult. Coverage and Reforming the System. February 2023.
[12] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.

Additionally, an analysis released earlier this month found that private health insurance premiums and out-of-pocket payments would decrease by over $152 million over the next ten years if site-neutral reform were passed.[13] NABIP supports site-neutral rules to deter these facility fees and location-based gaming of coverage; enacting site-neutral payment reform will help decrease healthcare costs for workers and employers alike.

Regarding practices of dishonest billing, NABIP also implores Congress to ensure that the No Surprises Act is implemented as intended. The Consolidated Appropriations Act of 2021 included the No Surprises Act, which holds patients harmless from surprise medical bills, including from air-ambulance providers, by ensuring they are only responsible for their in-network cost-sharing amounts in both emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider. For other claims, this new surprise-billing agreement utilizes an arbitration process with some patient safeguards.

Following this law's passage, the Departments of HHS, Treasury, and Labor issued regulations on the arbitration process, including what entities could serve as arbitrators, and what data elements could be taken into consideration. Initially, agencies directed IDREs to focus their decisions on the qualifying payment amount (QPA), which is defined in statute as the payer-specific median contracted amount for an item or service in the geographic area. As a result, the local market payment was the most important factor in making payment determinations.

By using the QPA as a decisive point in the IDR process, the consumer would likely encounter lower costs at the end of the IDR process. In turn, driving down costs through IDR would yield lower premiums for all consumers as the costs of surprise bills become mitigated. Unfortunately, several lawsuits filed over the last three years have compelled agencies to release updated guidance that reduces the importance of the QPA and local payment rates substantially. NABIP supports the agencies' original interpretation of the No Surprises Act – which offered the greatest amount of cost savings to the consumer – and opposes any threats to the law's implementation.

When it comes to the impacts of inflation and high healthcare costs, rural communities have suffered the most. Since 2005, 190 rural providers have closed; of those 190 providers, 136 of them closed between 2010 and 2021.[14] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas,[15] so those who live on farms, ranches, and reservations often travel long distances to reach a provider. Greater distances between hospitals also result in longer wait times for rural emergency medical services. For specialists, the data is only starker; for example, as of 2022, fewer than 50 percent of rural counties have a healthcare facility with an obstetrical unit.[16] In addition to the lack of providers, compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in

[13] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[14] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[15] Hing, E, Hsiao, C. U.S. Department of Health and Human Services. State Variability in Supply of Office-based Primary Care Providers: United States 2012. NCHS Data Brief, No. 151, May 2014.
[16] Frankhauser, Margaret. Health Disparities in Rural America. *JSI.* 16 November 2022.

poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[17]

Another vital area of discussion is how to reduce healthcare costs for individuals covered by high-deductible health plans (HDHPs). While HDHPs are the best fit for some individuals, it can result in high out-of-pocket costs, with total yearly out-of-pocket expenses as high as $7,050 for an individual or $14,100 for a family.

Due to the pandemic, rules related to all aspects of telehealth were loosened, resulting in an immense increase in the use of telehealth services, enabling cross-state care which has been critical to underserved areas and rural communities. One of the most crucial telehealth flexibilities were for those covered by HDHPs. The Coronavirus Aid, Relief, and Economic Security Act created a safe harbor allowing a HDHP to cover telehealth and other remote care services without a deductible, or with a deductible below the minimum annual deductible otherwise required by law. Telehealth and other remote care services also are temporarily included as categories of coverage that are disregarded for the purpose of determining whether an individual who has other health plan coverage in addition to an HDHP is an eligible individual who may make tax-favored contributions to their health savings account.

While this safe harbor originally expired on December 31, 2021, it has since been extended on two occasions – most recently in the Consolidated Appropriations Act of 2023, where it was renewed for plan years 2023 and 2024. However, NABIP recommends making this safe harbor permanent. NABIP also recommends taking this logic one step further and allowing individuals covered by HSA-qualified HDHPs to receive primary care before application of the deductible. Enacting both reforms would result in decreased costs for rural patients, as well as any patients covered by HDHPs and the employers who offer them.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NABIP can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nabip.org.

Sincerely,

Janet Stokes Trautwein
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[17] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.