National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Statement for the House Ways & Means Subcommittee on Health

May 16, 2023

Health Care Price Transparency: A Patient's Right to Know

Submitted by
National Association of Benefits and Insurance Professionals

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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.

NABIP believes the principle of transparency is critical to lowering healthcare costs for Americans. The purchase of healthcare drives one-sixth of our economy, yet most consumers make related decisions with minimal regard to price and quality of care. In some cases, people make decisions without considering the actual necessity of the purchase. Since most individuals have health plan coverage with a predetermined network, their care selection process has become more about which providers and facilities are in their system rather than which people and institutions are proving high-quality services for the best price.

The Consolidated Appropriations Act of 2021 set the foundation for transparency in care. Now is the time to build on those actions to create an educational foundation so consumers can access the data needed to determine the quality of care and the cost associated with it.

One way that consumers mitigate costs is by combining a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), which allows patients to pay for certain medical expenses with money free from federal taxes. However, while HSAs were created nearly 20 years ago, regulations on how individuals can use their HSA dollars have not kept pace in today's changing benefits landscape. One vital change to consider would be to provide pre-deductible coverage for primary care.

Access to a primary care physician can drive down costs and increase patient utilization of preventive care. While we want as many consumers as possible to have access to a primary care physician, there are some barriers to care in the current system. When it comes to primary care, there are three options:

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[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.

direct primary care (DPC), traditional primary care and concierge medicine. Under current rules, consumers are able to utilize their HSA, HRA, or FSA healthcare accounts towards traditional primary care and concierge care. A traditional primary care provider's main source of revenue is third-party reimbursement billed through each patient's health insurance issuer. "Concierge providers" bill a patient's health insurance issuer for payment for services rendered as well; however, concierge doctors also charge patients an annual fee (typically in the $2,000 to $3,000 range) for expedited access to the provider. Finally, the DPC model involves a fully independent provider who does not accept any type of third-party reimbursement. Instead, DPC payments all come directly from individual patients or families.

Direct primary care is not currently defined as an insurance product under IRC §213(d) and therefore consumers are not able to use an HSA or HRA towards their monthly membership fee, which limits access to this avenue of care. Effective primary care, including direct primary care, is well-known to be one of the critical components of overall personal wellness. The DPC model has gained popularity over the past 10 years, with both individual patients and employers interested in helping employees gain access to higher quality care and a patient experience that exceeds what is typically available through traditional primary care practices. From 2017 to 2021, the number of active DPC clinicians per 100,000 people increased by nearly 160 percent – compared to a 6 percent increase overall in primary care providers per 100,000 people.[4] Since DPC providers maintain a much smaller patient load than the average primary care practice and have a much lower administrative burden due to the elimination of third-party reimbursement, they can spend more time on patient relationships and service. DPC providers focus on each person's comprehensive health so they can often eliminate the need for unnecessary tests and better target the need for specialty care and services. Patients in DPC practices typically have better overall healthcare utilization rates and less frequently use the emergency room or experience inpatient hospital admissions.[5]

Another outdated restriction on the use of HSAs is the ability for seniors over age 65 to contribute to an HSA. Seniors are now working longer than ever and deserve to be able to access the tax advantages of contributing to an HSA. Under current rules, Medicare beneficiaries may use funds from an HSA created prior to going on Medicare; however, beneficiaries may not open or continue to contribute to an existing HSA. This is a form of discrimination against working seniors and creates a barrier for them to be able to use pre-tax dollars to pay for out-of-pocket medical expenses or for dental and vision care which are not currently covered under Medicare. Since HSA funds remain in the account and are not "use it or lose it" type programs like flexible spending accounts, the use of HSAs encourages seniors to continue to save funds in an interest-bearing account for future healthcare expenses. NABIP has supported the chairman's Health Savings for Seniors Act in the past and would encourage continued bipartisan support for seniors to be able to contribute to an HSA.

Telehealth is another area that needs to be permanently addressed in the rules for HSAs. 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

[4] Hint Health. Trends in Direct Primary Care 2022. 27 April 2022.
[5] Eskew, Philip. In Defense of Direct Primary Care. *Family Practice Management.* October 2016.

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 HSA.

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.

When it comes to the impacts of inflation and high healthcare costs, rural communities have suffered the most and have the most to gain from increased health care access through telehealth. Since 2005, 190 rural providers have closed; of those 190 providers, 136 of them closed between 2010 and 2021.[6] 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,[7] 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.[8] 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 poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[9]

One method to address these rising costs and increase price transparency while ensuring a more competitive market is enacting site-neutral payment reform. 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

[6] The Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures.
[7] 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.
[8] Frankhauser, Margaret. Health Disparities in Rural America. *JSI.* 16 November 2022.
[9] The Cecil G. Sheps Center for Health Services Research. Rural Health Snapshot (2017). NC Rural Health Research Program. May 2017.

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.[10]

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.[11]

Additionally, an analysis released this year 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.[12] NABIP supports site-neutral rules to deter these facility fees and location-based gaming of coverage; enacting site-neutral payment reform will help increase competition and decrease healthcare costs for Americans.

I began my remarks by pointing out the work Congress has already done to address transparency under the Consolidated Appropriations Act of 2021. However, I want to reiterate that this is a foundation that needs to be built upon. In order to increase transparency in healthcare ensuring that providers comply with existing price transparency regulations. As of January 1, 2021, all hospital systems are required to keep on their websites clear, accessible pricing information about the items and services they provide. This pricing information is required to be stored in a machine-readable format as well as an easy-to-read, consumer-friendly format. The goal of these requirements is to enable patients to compare prices and promote competition in healthcare markets. However, as of February 6, 2023, only 24.5 percent of providers have complied fully with this rule.[13] Though the majority of hospitals have posted files, most hospitals' files are not considered compliant because they are incomplete, illegible, or the prices posted are not clearly associated with both payer and plan.

Last month, CMS released further guidance on hospital transparency rules in an attempt to enforce the rules on the over-75 percent of hospitals that are not in compliance. While this is a step in the right direction, more needs to be done to enforce the rules that are already on the books and to protect the ability of patients and consumers to choose quality healthcare at an affordable price.

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.

[10] Morning Consult. Coverage and Reforming the System. February 2023.
[11] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.
[12] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[13] Patient Rights Advocate. Fourth Semi-Annual Hospital Price Transparency Report. 6 February 2023.

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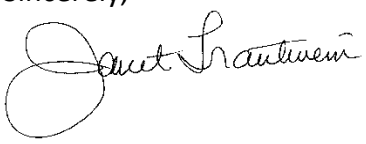
Sincerely,



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