Statement for the House Committee on Energy and Commerce, Subcommittee on Health

January 31, 2024

Health Care Spending in the United States: Unsustainable for Patients, Employers, and Taxpayers

Submitted by
National Association of Benefits and Insurance Professionals

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), 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. Due to the complexity of the plan-selection process, many beneficiaries rely on licensed and certified insurance agents to help them identify the coverage and benefits options that best meets their needs. 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. Consequently, the NABIP membership has a vested interest in ensuring that consumers have access to the most affordable health coverage that is the correct fit for their clients.

Since agents and brokers play such a personal role in helping consumers find the plan that fits their health and financial situation best, they are acutely aware of how high healthcare costs can be in the United States. As of 2022, the per capita healthcare spending in the U.S. reached $13,493.[3] In terms of GDP, healthcare spending peaked at 19.5 percent in 2020, largely influenced by the pandemic, and adjusted to 17.3 percent in 2022 as the economy recovered.[4] This level aligns with pre-pandemic proportions, suggesting a return to the long-term growth trajectory in healthcare spending relative to the nation's economic output. Private insurance expenditures, as of 2022, constituted 28.9 percent of total health spending, marking a notable shift in the financial burden of healthcare.[5] This change is coupled with a relative decrease in out-of-pocket costs as a share of total health expenditures, even though per capita out-of-pocket costs have been on an upward trend.

One effective action Congress could take to tackle these issues is to enact 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

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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] McCough, Matthew. How has U.S. spending on healthcare changed over time? Kaiser Family Foundation. 15 December 2023.
[4] Ibid.
[5] Gunja, Munira. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. *The Commonwealth Fund*. 31 January 2023.

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.[6]

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. Hospital purchases of physician practices have become common, allowing hospitals to add the facility fee for the same service previously provided by the physician practice without any improvement in outcomes. 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.[7] 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.[8]

One of the primary reasons that site-neutral payment reform is more necessary now than ever is due to the ever-increasing rate of provider consolidation. With more hospital systems merging, the potential for location-based gaming of coverage increases. Outside of site neutrality, however, a wide body of research has shown that provider consolidation leads to higher healthcare prices for those covered by private insurance.

When looking at the metropolitan areas with the highest rates of hospital consolidation from 2010 to 2013, the price of an average hospital stay increased in most areas between 11 and 54 percent.[9] Hospital systems that do not have any competitors within a 15-mile radius charge prices that are an average 12 percent higher than hospitals in markets with four or more competitors in the same radius. Additionally, analyses of all hospital mergers between 2014 and 2017 found that mergers of two hospitals within five miles of one another resulted in an average price increase of 6.2 percent, and that price increases continued for at least two years after a merger.[10] Studies have proven that these troubling patterns hold true even when looking at non-profit hospitals, who routinely exercise market power in the same way that for-profit providers do.[11]

Regarding physician practices, the amount of primary care physicians practicing in organizations owned by a hospital or health system increased from 28 percent in 2010 to 44 percent in 2016. Additionally, as

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[6] Morning Consult. Coverage and Reforming the System. February 2023.
[7] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? Kaiser Family Foundation. 27 March 2023.
[8] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[9] Abelson, Reed. "When Hospitals Merge to Save Money, Patients Often Pay More." *The New York Times,* 18 November 2018.
[10] Cooper, Zack. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *National Bureau of Economic Research.* December 2015.
[11] Vita, Michael. "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study." *The Journal of Industrial Economics*. 27 March 2003.

of 2018, approximately 35 percent of all practicing physicians of any specialty worked directly for a hospital or in a practice partly owned by a hospital.[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. Thankfully, the House passed the Lower Costs, More Transparency Act (H.R. 5378), which would enact a site-neutral payment policy to ensure that Medicare beneficiaries are paying the same rates for physician-administered drugs in off-campus hospital outpatient departments as they do in physician offices. While NABIP seeks additional site-neutral policy broader in scope to encompass more consumers and services, we are happy to support H.R. 5378 and look forward to the Senate's consideration of the bill.

Another action that Congress can take to control costs in the short-term would be to permanently expand telehealth flexibilities that have been active since the COVID-19 pandemic. The Coronavirus Aid, Relief and Economic Security (CARES) Act – passed in 2021 – provided temporary relief during the pandemic by allowing HSA-qualified HDHPs to cover telehealth services before reaching the deductible. It also allowed patients to choose and purchase telehealth services outside their HDHP without impacting their eligibility for an HSA.

The pandemic has radically altered the way in which consumers think about healthcare and receive healthcare services. With millions of healthcare consumers looking for a way to see their physician without needing to leave their home, telemedicine has become crucial. According to data from the CDC, approximately 37 percent of adults in the U.S. reported using telehealth services in 2021. [13] This usage was found to increase with age, from about 29 percent among 18-to 29-year-olds to 43 percent among seniors. Moreover, an analysis of telehealth trends from April 2021 through August 2022 showed that, while telehealth utilization had decreased from the peak of the pandemic, it remained significantly above pre-pandemic levels, fluctuating between 20 percent and 24 percent. Disparities in telehealth use, especially in video telehealth services, persisted among different populations and insurance types.[14]

These statistics underscore the critical role of telehealth in the U.S. healthcare system, especially in the context of the ongoing pandemic and the evolving healthcare needs of the population. The sustained high levels of telehealth engagement demonstrate its importance and potential as a healthcare delivery method. The flexibilities that enable continued telehealth access are slated to expire on December 31, 2024, unless action is taken. Many large employers are already making benefits decisions for the 2025 plan year, and need to know if these flexibilities will be in place. This is why NABIP supports the Telehealth Expansion Act of 2023 (H.R. 1843/S. 1001), which would make these flexibilities permanent.

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[12] Kane, Carol. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. American Medical Association. April 2019.
[13] Melchionna, Mark. "Telehealth Use Remained Popular Among US Adults in 2021." *mHealthIntelligence*. 14 October 2022.
[14] Lee, Euny C. "Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)." Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy. 19 April 2023.

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 jgreene@nabip.org or (202) 595-3677.

Sincerely,

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