National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Statement for the House Energy & Commerce Subcommittee on Health

April 26, 2023

Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care

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.

One method of increasing 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 states, the markup for lab tests in HOPDs was over six times the median price for the same tests in

[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.

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.[4]

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.[5]

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.[6] 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.

Another way to increase transparency in healthcare is to ensure 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.[7] 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.

In addition to enforcing hospital price transparency rules that are already on the books, NABIP believes that this price information must be coupled with quality data if consumers are truly to have the ability to compare services and make educated purchasing decisions. The price of a service with no additional context is not enough for individuals to make a truly informed decision. Consumers need further education and resources to assist them in determining the weight to give price, quality and other factors when making care choices.

Regarding transparency and competition in the pharmaceutical industry, NABIP supports proposals that would eliminate anti-competitive practices and ensure a freer, fairer market. One such proposal would be to eliminate "pay-for-delay" deals between pharmaceutical companies, in which one company pays a generic competitor to delay research, production, or sale of a competitive drug. The FTC estimates that ending these pay-for-delay agreements would save $3.5 billion each year for patients, insurers, and

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

government programs.[8] Research also shows that more widespread use of generic drugs could save Medicare $1.7 billion per year.[9] Putting an end to these "pay-for-delay" deals could level the playing field in the pharmaceutical market and allow for increased competition earlier in the lifespan of a drug.

Another way to stimulate a more competitive market would be to reform pharmacy benefit manager (PBM) practices. As of 2022, 80 percent of prescriptions in the U.S. are processed through just three PBMs: CVS Caremark (owned by CVS), Express Scripts (owned by Cigna), and OptumRX (owned by UnitedHealth Group). Many small pharmacies claim that they have little to no leverage when dealing with these conglomerates, and virtually no recourse if excluded from their networks. When such a small number of PBMs possess this much control over the prescription drug market, cost savings tend to move directly upward, rather than back down to the consumer.

PBM contract models are also complex and lack transparency. Payors often do not know the true costs of what they are paying because PBMs are not required to regularly report on costs, fees, and rebates. Further transparency in these agreements would increase competition amongst PBMs, lower costs for drug benefits offered by some plan sponsors, and allow payors to negotiate better contracts – resulting in considerable savings to the consumer.[10]

Another factor increasing prescription drug costs is spread pricing. Spread pricing is when a health plan contracts with a PBM to manage their drug benefits, then the PBM keeps some of the amount from the health plans for the drugs instead of including the total amount paid to the pharmacies. There is then a "spread" between the amount paid by the health plan to the PBM and the amount the PBM pays to the pharmacy. The PBM then profits from the spread. However, this increases the cost to the payor which, under current law, has not agreed to spread pricing. If PBMs were required to disclose the "spread" and allow the payor the option to agree to the difference, it is believed that many payors would either opt out of the spread or negotiate a better deal with the PBM which would lead to lower costs.[11]

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) 595-7589 or mbuckner@nabip.org.

Sincerely,

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[8] Federal Trade Commission. Pay for Delay. Accessed 25 April 2023.
[9] Kesselheim AS, et al. Paying for Prescription Drugs in the New Administration. *JAMA*. 2 March 2021
[10] CBO Cost Estimates. S.1895, as ordered reported by the Senate Committee on Health, Education, Labor and Pensions. 16 July 2019.
[11] Ibid.