National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Statement for the House Ways & Means Subcommittee on Health

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Why Health Care is Unaffordable: Anticompetitive and Consolidated Markets

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.

In order to ensure that healthcare services are affordable for Americans, the actors in our healthcare system must engage on a free and level playing field. Consolidation of care has become a prominent issue in the American healthcare market over the last two decades; overall, a total of 1,887 hospital mergers were announced between 1998 and 2021 – reducing the number of hospitals from about 8,000 to around 6,000.[4] As more hospital systems merge, consumers' care options decrease and the prices they pay increase. A transparent and competitive market is vital to keep prices reasonable for consumers, as well as for consumers to have the ability to choose their provider based on a variety of price and quality metrics.

One of the most effective actions Congress could take to ensure a more competitive market 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 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.
[4] Sloan, Allan. How Effective Is the Government's Campaign Against Hospital Mergers? *ProPublica*. 28 October 2022.

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.[5]

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.[6]

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.[7] 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.

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.[8] 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.[9] 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.[10] Overall, there were a total of 1,887 hospital mergers announced between 1998 and 2021 – reducing the number of hospitals from about 8,000 to around 6,000.[11]

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[5] Morning Consult. Coverage and Reforming the System. February 2023.
[6] Schwartz, Hope, et al. How do facility fees contribute to rising emergency department costs? *Kaiser Family Foundation*. 27 March 2023.
[7] Ellis, Phillip. Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare. February 2023.
[8] Abelson, Reed. "When Hospitals Merge to Save Money, Patients Often Pay More." *The New York Times,* 18 November 2018.
[9] Cooper, Zack. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *National Bureau of Economic Research.* December 2015.
[10] Vita, Michael. "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study." *The Journal of Industrial Economics*. 27 March 2003.
[11] Sloan, Allan. How Effective Is the Government's Campaign Against Hospital Mergers? *ProPublica*. 28 October 2022.

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 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]

While hospital mergers are the primary factor behind physician consolidation, private equity has also played a significant role in the market over the last decade. Private equity firms invest in businesses by purchasing a majority stake with the goal of increasing the value of the business and potentially selling it at a profit, and physician practices have proven profitable for many. One study found that private equity firms acquired 355 physician practices (including 1,426 sites of care and 5,714 physicians) from 2013 to 2016, and the speed of these acquisitions increased over the study period with 59 practices acquired in 2013 and 136 practices acquired in 2016.[13] In the wake of the Consolidated Appropriations Act of 2021 – which banned the practice of surprise billing by providers – private equity groups spent over $50 million in television and internet advertisements in an effort to weaken the reform.[14] If Congress is to ensure that healthcare services are affordable for the American people then lawmakers must take action to control the pace of provider consolidation and the pricing problems posed by the practice.

Another way to increase competition in the health economy 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.[15] 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.

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.

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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] Zhu, Jane. Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016. *JAMA*. 18 February 2020.
[14] Sanger-Katz, Margot. Mystery Solved: Private-Equity-Backed Firms Are Behind Ad Blitz on 'Surprise Billing.' *The New York Times.* 13 September 2021.
[15] Patient Rights Advocate. Fourth Semi-Annual Hospital Price Transparency Report. 6 February 2023.

Regarding 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 government programs.[16] Research also shows that more widespread use of generic drugs could save Medicare $1.7 billion per year.[17] 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 increase transparency in pharmacy benefit manager (PBM) practices. PBMs can help control prescription drug costs for consumers, as well as work on behalf of self-insured employers to temper drug spending and make sure that employees have access to certain medications. However, some opaque PBM practices have raised questions as to how much the entities are saving consumers and whether greater transparency requirements would increase those savings. Many large PBM contracts do not include details on rebates, prices, fees generated from manufacturers, or other charged amounts. Additionally, PBMs are not currently required to disclose clinical data used to decide which drugs they add or remove from a benefit plan – despite the fact that such information would be vital to an employer who is deciding which plans to offer to their employees, as well as to an employee who relies on the treatments in question.[18]

PBMs also engage in spread pricing, which is when a health plan contracts with a PBM to manage their drug benefits, then the PBM keeps some of the amount paid from the health plan 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.[19] NABIP supports fair and transparent PBM practices for the benefit of employers and consumers.

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,

[16] Federal Trade Commission. Pay for Delay.
[17] Kesselheim AS, et al. Paying for Prescription Drugs in the New Administration. *JAMA*. 2 March 2021
[18] Purchaser Business Group on Health. Pharmacy Benefit Tactics Drive Up Drug Prices, Limit Access, Contribute to Health Risks. December 2022.
[19] Kesselheim AS, et al. Paying for Prescription Drugs in the New Administration. *JAMA*. 2 March 2021

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