National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

Statement for the Senate Budget Committee

October 18, 2023

Improving Care, Lowering Costs: Achieving Health Care Efficiency

Submitted by
National Association of Benefits and Insurance Professionals

National Association of Benefits and Insurance Professionals

NABIP

Shaping the *future* of healthcare

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 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. 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.

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.[3] Further, 76 percent of workers see health insurance as a primary or important factor for continuing to work at their current employer.[4]

While employer-sponsored coverage remains one of the most popular forms of healthcare coverage 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.[5] Healthcare is highly individualized, so it is vital that Americans have a wide range of healthcare options, and today, there are a great variety of plan options available to employees across the country. To improve these options, there are actions that Congress can take to control costs for employers and employees and, more broadly, to strengthen and preserve the popular employer-sponsored system.

A key component to 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. There is more than a 4-to-1 return for the federal government because of the exclusion; for every dollar of tax expenditure, employers paid

[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] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.
[4] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[5] Employee Benefit Research Institute. Worker Satisfaction with Health Benefits is Higher, but Costs Remain a Concern. 6 January 2022.

$4.64 to finance health benefits.[6] The success of this system is possible because of the preferential tax treatment of employer-sponsored insurance coverage, where 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 could increase federal revenue, it would also eliminate the efficiency of employer-sponsored insurance. Employers provide a natural pool of people who are generally healthy for spreading risk. 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 would also remove the most important employee benefit, used to attract and retain talented 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.

Additionally, weakening or eliminating the exclusion could prompt millions of individuals and families to seek coverage in the individual exchange. As of 2022, an individual's premium contributions in group coverage (for all plans across all employer sizes) were, on average, nearly $350 less per month than the average premium for an ACA benchmark plan.[8] The average benchmark premium has also doubled over the last ten years.[9] Adverse selection has a significant impact on the individual marketplace – 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. If the foundation of the employer-sponsored system is shaken, the resulting massive influx of individuals and families seeking coverage will worsen the adverse selection issue and increase costs to untenable levels – a situation that could quickly lead to a one-size-fits-all single-payer system.

Another effective action Congress could take to lower costs 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

[6] American Benefits Institute. American Benefits Legacy, the Unique Value of Employer Sponsorship. October 2018.
[7] Accenture. Employer Beware: Workers Demand Health Coverage. June 2015.
[8] *Kaiser Family Foundation*. Marketplace Average Benchmark Premiums; *Kaiser Family Foundation*. 2022 Employer Health Benefits Survey.
[9] Ibid.

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]

Medicare pays an additional fee for services provided in hospital setting to account for the additional overhead. This has led hospitals to purchase physician practices and tack on the facility fee, thus adding revenue for the hospital but not improvement in health outcomes. 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] Meanwhile, consumers and Medicare beneficiaries are with higher out-of-pocket costs.

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.

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.[13] 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.[14] 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.[15]

---

[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] Abelson, Reed. "When Hospitals Merge to Save Money, Patients Often Pay More." *The New York Times,* 18 November 2018.
[14] Cooper, Zack. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." *National Bureau of Economic Research.* December 2015.
[15] Vita, Michael. "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study." *The Journal of Industrial Economics*. 27 March 2003.

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.[16]

Another way to lower costs and improve outcomes – in Medicare specifically – is through value-based insurance design (VBID) and other innovation techniques. As of August 2023, over 60 million individuals were enrolled in one or more parts of the Medicare program; over 30.8 million Medicare beneficiaries were covered by Medicare Advantage (MA) coverage.[17] MA plans focus on primary care, early intervention, care coordination, and wellness programs to slow disease progression and improve health status, particularly for beneficiaries with chronic conditions.

The broad availability of MA plan options means seniors have an array of plan choices for their health insurance coverage. MA plans also offer supplemental benefits that are often not covered by traditional fee-for-service Medicare. Most enrollees are in plans that provide access to eye exams or glasses, telehealth services, dental care, a fitness benefit and hearing aids. MA products provide other affordable, high-quality services as well, including care coordination, disease-management programs, access to community-based programs and out-of-pocket spending limits.

Medicare Advantage products also provide necessary coverage to some of the most underserved populations, particularly in densely populated urban areas. Compared to beneficiaries enrolled in traditional Medicare, beneficiaries enrolled in MA are more likely to report incomes below 100 percent of the Federal Poverty Level, with 52 percent of enrollees earning less than 200 percent of the FPL.[18] Nearly two-thirds of MA beneficiaries (60 percent) pay no premium for their plan other than the Medicare Part B premium.[19] MA beneficiaries are more likely to be 75 years of age or older and have educational attainment less than high school. Additionally, MA enrollees were more likely than fee-for-service Medicare enrollees to be dually enrolled and to have multiple health conditions.[20] Medicare Advantage beneficiaries also include a higher percent of Black and Latino beneficiaries than in fee-for-service Parts A and B; fifty-three percent of Latino Medicare beneficiaries and 49 percent of Black Medicare beneficiaries are enrolled in MA. While approval of MA coverage is high across all populations, non-white beneficiaries report an even higher level of satisfaction, with 99 percent reporting that they were satisfied with their coverage.[21] Although NABIP supports continued choice for Medicare

[16] Kane, Carol. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. American Medical Association. April 2019.
[17] Ochieng, Nancy. Medicare Advantage in 2023: Enrollment Update and Key Trends. *Kaiser Family Foundation*. 9 August 2023.
[18] Better Medicare Alliance. Medicare Advantage Outperforms Fee-for-Service Medicare on Cost Protections for Low-Income and Diverse Populations. April 2022.
[19] Freed, Meredith, et al. A Dozen Facts About Medicare Advantage in 2020. Kaiser Family Foundation. 13 January 2021.
[20] HHS Assistant Secretary for Planning and Evaluation Office of Health Policy. Medicare Beneficiary Enrollment Trends and Demographic Characteristics. 2 March 2022.
[21] Better Medicare Alliance. Medicare Advantage Satisfaction Hits New High Amid COVID-19 Crisis. 21 January 2021.

beneficiaries in the type of coverage they are able to select, MA plans have some advantages when it comes to overall management of healthcare.

MA plans provide all of the traditional fee-for-service (FFS) benefits that Medicare does. However, there is evidence that customized care tailored to individual health needs ensures beneficiaries are able to make use of care that improves outcomes, eliminates waste, and reduces costs. Because of this, some MA plans utilize the VBID model to meet the needs of enrollees by tailoring coordination and benefits to specific patient groups instead of the required uniform benefits. More than 1,500 MA plans will participate in the CMS Innovation Center's VBID model in 2024.

The VBID model is designed to demonstrate that reducing the co-payments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower healthcare expenditures. The VBID models operated within MA plans provide care coordination and help to reduce duplicative and unnecessary services, which, in turn, allows the plans to provide the same services at a lower cost.

As a result, analysis shows that each dollar spent by the federal government on MA provides beneficiaries with additional benefits and lower cost sharing than they would otherwise receive under traditional Medicare; for every dollar of costs for Medicare-covered services, the government's payment covers 89.5 cents of the costs for MA beneficiaries but only 85.2 cents of the costs for fee-for-service Medicare beneficiaries, with the MA and FFS beneficiary paying for the remaining 10.5 cents and 14.8 cents, respectively.[22] In recent years, MA plans have also turned their attention to addressing their beneficiaries' social determinants of health, the non-medical factors that influence health outcomes.[23] NABIP has long supported efforts to improve upon and expand the use of VBID and increase focus on social determinants of health throughout the healthcare system.

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,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals

[22] Gervenak, Chris, et al. Value to the federal government of Medicare Advantage. Milliman. October 2021.
[23] Better Medicare Alliance, Center for Innovation in Medicare Advantage. Innovative Approaches to Addressing Social Determinants of Health for Medicare Advantage Beneficiaries. August 2021.